

UCLH NHS FOUNDATION TRUST

ANNUAL PLAN

2011/12

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1 BACKGROUND TO OUR HOSPITALS

University College London Hospitals NHS Foundation Trust (UCLH), situated in the heart of London, is one of the most complex NHS trusts. We serve a large and diverse population. In July 2004 we were one of the first NHS trusts to achieve foundation trust status.

We provide academically led acute and specialist services, both locally and to patients from throughout the United Kingdom and abroad. We balance the provision of highly rated, specialist services with providing acute services to the local populations of Camden, Islington, Barnet, Enfield, Haringey and Westminster.

Our mission is to deliver top quality patient care, excellent education and world-class research.

We have a turnover of £700 million and contracts with over 70 commissioning bodies. We see over 740,000 outpatients and admit over 115,000 patients each year.

The Trust is made up of the following six hospitals:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing) (UCH)
- Eastman Dental Hospital (EDH)
- Hospital for Tropical Diseases (HTD)
- National Hospital for Neurology and Neurosurgery (NHNN)
- The Heart Hospital (HH)
- The Royal London Hospital for Integrated Medicine (RLHIM).

In December 2006, in partnership with University College London (UCL) we became one of the country's five comprehensive biomedical research centres. We are a member of UCL Partners which brings together five of Britain's world renowned medical research centres and hospitals: UCL (University College London); Great Ormond Street Hospital for Children NHS Trust (GOSH); Moorfields Eye Hospital NHS Foundation Trust; the Royal Free Hampstead NHS Trust; and University College London Hospitals NHS Foundation Trust. UCL Partners was officially designated as one of the UK's first academic health science centres by the Department of Health in March 2009.

Alongside our close relationship with the Royal Free and University College Medical School, we have good links with London South Bank and City universities which offer high quality training and education.

2 DIRECTORS' REPORT: 2010/11 OVERVIEW / CEO REPORT

Performance overview

We had another good year in 2010/11:

- We performed strongly across a range of safety and outcome indicators in the Dr Foster Good Hospital guide, including one of the best mortality rates in the NHS, a high percentage of patients given “clot busting drugs” and a high percentage of patients with a fracture neck of femur primary diagnosis that have a related procedure within 2 days.
- The best results for a non-single specialty hospital in London for the annual inpatient survey
- Our A&E department delivered the best performance in London against the four hour waiting time target and we were ranked fourth nationally against major A&E (type 1) providers
- University College London, our academic partner, maintained its fourth place in the world university rankings
- We delivered on our key financial targets for 2010/11 and at year end achieved a Monitor financial risk rating of 4.

The introduction of “quality accounts” for all hospitals has been a real driver for improvements in patient safety, experience and outcomes. For 2010/11 we identified four priorities and have delivered successfully against them, including:

- a substantial reduction in harm from patient falls, exceeding our target reduction of 10%
- a reduction in reported hospital standardised mortality of 17%

More information can be found in section 5 below.

We remain very focussed on minimising the number of healthcare acquired infections at the hospital. As a result of improvement work in a number of areas there were 62 cases of Clostridium difficile, an improvement of 30% on the previous year and well within our threshold of 119 cases. We reduced cases of MRSA bacteraemia by 40% in 2010/11, although we were disappointed that we were not able to stay within our threshold of 8 cases while recording 13 cases. There will again be demanding targets for MRSA and Clostridium difficile in 2011/12, as well as targets for other types of infection such as MSSA and E.coli.

Our Service Commitment continues to underpin the determination of our staff to deliver excellent, compassionate care to patients. Their commitment is recognised by our results in the annual inpatient survey conducted independently by the Care Quality Commission: for the second year running we enjoyed the top results in London for a non-specialist trust. Our weekly surveys of patients keep us sensitive to issues that can emerge in the care provided to patients across all our hospitals, helping us stop small problems from becoming bigger ones and enabling us to share best practice across wards.

We have continued to deliver very strong performance against the A&E four hour waiting time target. In 2010/11 we delivered the best results for any acute trust in London and the fourth best type 1 performance nationally out of 153 trusts. Our annual performance against the national four hour standard was 98.5%, one of only three Trusts in London to keep its performance above the old national standard of 98%. We have also met all our referral to treatment waiting time targets, and have improved waiting times in some specialties that have previously struggled to meet the national standards.

We have delivered against most of the cancer waiting time targets, but have struggled to deliver against the 62 day target for treatment following referral from GPs and screening centres. Part of the challenge we face meeting this target is due to the type of cancers that we often treat. It is not always possible to fast-track some of the more complex and severe cases we see in the same way as more common cases. Our performance is also often significantly affected by other health providers' management and control of the early stages of the patient pathway. Where we can influence the speed of treatment we do. For example, we have improved the speed of access to diagnostic imaging and surgical facilities.

We will continue to look for improvements in areas within our control. This will remain a key priority in 2011/12.

As a result of the breaches of cancer waiting time targets and performance against the MRSA target we had an 'amber-red' governance rating under the Monitor compliance framework in quarters two, three and four.

We have delivered our key financial targets for 2010/11, and at year end achieved a Monitor financial risk rating of 4. This included our delivery of savings exceeding 4% of turnover. While this demonstrates our sound financial management, we are clear that along with all other NHS organisations, we face some very challenging financial years ahead. We are preparing for extremely demanding efficiency targets over the next five years, in the order of at least 6 to 7% in each year. Combined with changes in the commissioning environment, we are in a period of enormous challenge for the Trust.

Performance against our 2010/11 objectives

We set ourselves 10 objectives in 2010/11, and the table below summarises how we performed against them. The table also includes details of where to find more information about our performance against each objective.

Top ten objectives	Deliverable	Progress made
Deliver excellent clinical outcomes	<ul style="list-style-type: none"> Complete the Quality Strategy and prepare annual Quality Accounts 	✓✓
	<ul style="list-style-type: none"> Show year on year reduction in the Hospital Standardised Mortality Ratio (HSMR) 	✓✓
	<ul style="list-style-type: none"> Implement Patient Reported Outcome Measures (PROMS) 	✓✓
Improve patient safety	<ul style="list-style-type: none"> Deliver the 2010/11 infection prevention strategy, reducing levels of MRSA and Clostridium difficile in line with national objectives 	✓
	<ul style="list-style-type: none"> Achievement of NHSLA Level 3 in 2010/11 	X (did not apply for level 3)
	<ul style="list-style-type: none"> Reduce avoidable harm through evidence based care, including VTE risk assessment 	✓✓
Deliver high quality patient experience	<ul style="list-style-type: none"> Show year on year improvement in patient experience as measured by patient survey 	✓
	<ul style="list-style-type: none"> Develop programme for patient involvement to ensure compliance with the NHS Constitution 	✓✓
	<ul style="list-style-type: none"> Implement delivery plan to virtually eliminate mixed sex accommodation across all hospital sites 	✓✓
Work with partners to improve patient pathways	<ul style="list-style-type: none"> Subject to Board approval, implement plans for reconfiguration of: HASU & Stroke, Pancreatic Cancer Surgery, Neurosurgery, and ENT 	✓✓
	<ul style="list-style-type: none"> Work with colleagues in the NCL service and organisational review to develop proposals for service reconfiguration in local health economy, including proposals for integrating community services 	✓
	<ul style="list-style-type: none"> Build the cancer centre, redesigning pathways to deliver improved care and submit a case for the UK's first Proton Beam Therapy centre to be based at UCLH 	✓✓

Develop UCLP through world-class R&D and excellent education	<ul style="list-style-type: none"> Develop, approve and implement monitoring of research performance metrics to evidence return on investment 	✓✓
	<ul style="list-style-type: none"> Develop and approve an aligned clinical, research and education strategy for each of the major clinical specialities 	✓✓
	<ul style="list-style-type: none"> Successfully respond to tender from commissioners to become a provider of clinical education 	Through UCLP
Deliver cost savings through the Quality & Efficiency Programme	<ul style="list-style-type: none"> Implement clear governance arrangements for the delivery of the QEP savings 	✓✓
	<ul style="list-style-type: none"> Deliver QEP savings in 2010/11 as agreed by the Board, with plans for generating additional savings at a similar level in 2011/12 	✓
	<ul style="list-style-type: none"> Develop and approve a strategic approach to deliver productivity and efficiency savings over the next five years 	✓
Achieve sustainable financial health	<ul style="list-style-type: none"> Achieve income, expenditure, efficiency and cash targets as agreed by the Board 	✓✓
	<ul style="list-style-type: none"> Implement service line recharging and assign overhead/asset responsibilities leading to specific targets for return on assets 	✓
	<ul style="list-style-type: none"> Implementation of patient level costing 	✓
Develop and enable staff to maximise their potential	<ul style="list-style-type: none"> Develop and implement a plan for improving working lives, evidenced by year-on-year improvements in staff survey results and appraisal rate completion 	✓
	<ul style="list-style-type: none"> Develop and implement a management development programme 	✓
	<ul style="list-style-type: none"> Deliver the Electronic Staff Record implementation programme to enable effective and timely workforce planning 	✓
Deliver national wait times	<ul style="list-style-type: none"> Deliver 18 week referral to treatment time targets at speciality level 	✓✓
	<ul style="list-style-type: none"> Ensure maximum wait of four hours in A&E from arrival to admission, discharge or transfer for at least 98% of patients 	✓✓
	<ul style="list-style-type: none"> Meet the two week, 31 day and 62 day cancer waiting times targets within threshold 	✓
Develop Governance and Risk Management Strategy	<ul style="list-style-type: none"> Ensure that the Trust has appropriate governance arrangements in place to meet its terms of authorisation and objectives 	✓✓
	<ul style="list-style-type: none"> Implement phase two of the Information and Communications Technology (ICT) Strategy, including compliance with Information 	✓✓
	<ul style="list-style-type: none"> Set up and test plans to respond effectively to major incidents in line with national guidance on emergency preparedness 	✓✓

good progress made: ✓✓

some progress made, but not fully achieved: ✓

not achieved: X

The risks that we faced in 2010/11

As an organisation we are increasingly managing risk proactively to deliver better care for our patients. Clinical teams regularly update their risk registers. There is a clear line of governance all the way up to our Board of Directors within which we analyse and manage risks, identify recurring themes and put action plans in place to mitigate them. Our auditors consider our risk rating as "risk managed", just one step away from the least risky rating of "risk enabled".

During the year we worked hard to manage risk in a number of areas:

- **Financial risks**

The Board of directors adopted a balanced financial plan but there were inherent risks around delivery of planned activity levels (representing an income risk) and an ambitious cost efficiency target. During 2010/11 we successfully delivered against both of these targets.

- **Environment**

Much of our estate is modern as a result of capital initiatives, including the PFI initiative to build UCH phase 1 and 2. Parts of our estate do however require renewal. We have developed a three year programme, starting in 2010/11, which manages any risks associated with maintenance of our estate.

- **Patient safety**

We have continued to manage effectively those issues which are a current and ongoing challenge to all healthcare providers: medication errors, hospital acquired infections (although we did not stay within our threshold for MRSA, we did significantly improve our performance in 2010/11), venous thrombo-embolisms and pressure ulcers. Section 5 below on quality provides more detail on these important improvements.

- **Future uncertainties**

The NHS is facing a period of enormous change and uncertainty. During 2010/11 the north central London sector that we belong to faced major financial challenges that posed significant risks to our own financial position. We successfully managed this risk in collaboration with our commissioners. Financial challenges will only intensify during 2011/12. The move to GP commissioning, the "any willing provider" model for service competition and the requirement that all providers be foundation trusts by 2014 creates significant uncertainty in the coming few years, which may necessitate future changes in our strategic direction.

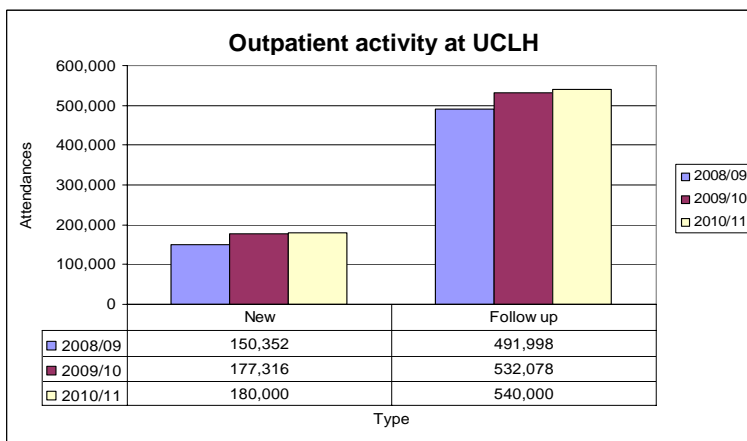
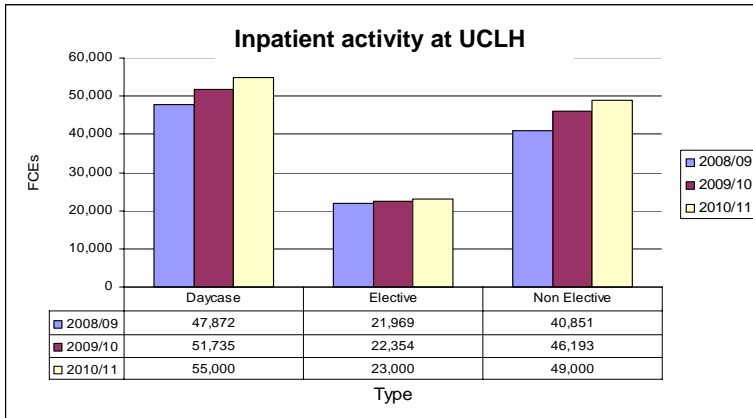
- **National targets**

We predicted in our annual plan submission to Monitor that we would face difficulties in delivering performance within threshold for MRSA and cancer 62 day waits, and we have invested significant energy and resources into managing the risks associated with these targets during 2010/11. By the end of the year we had unfortunately breached our MRSA threshold but had brought our cancer waiting times performance into a more robustly compliant position.

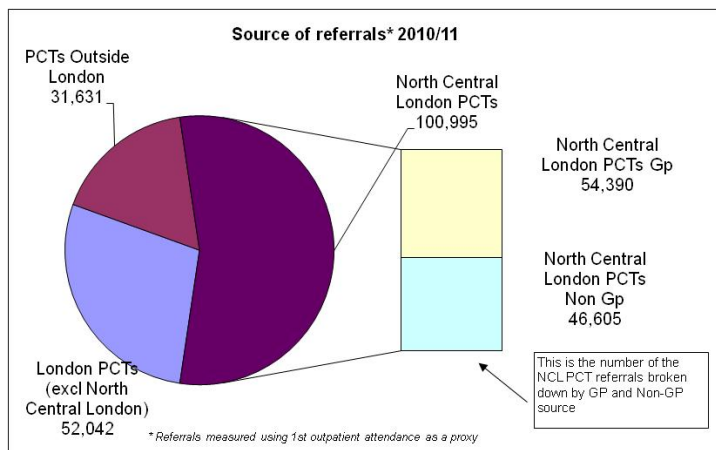
Activity at a glance 2010/11

In 2010/11 we provided over 48,000 non elective finished consultant episodes (FCEs), up 5.1% from 2009/10. The number of elective FCEs also increased in 2010/11. Elective growth was higher in daycases (11.3%) than elective inpatient FCEs (2.7%), reflecting an improvement in efficiency: our daycase rate improved from 69.8% in 2009/10 to 71.5% in 2010/11.

The number of new outpatient attendances we saw in 2010/11 also increased by 7,300 (4.1%) compared to 2009/10. Follow up outpatient attendances increased to 571,000 in 2010/11, up by 39,000 from 2009/10 (7.4%).



In 2010/11 around 55% of our referrals were from PCTs within North Central London (NCL), followed by 28% from other London PCTs and 17% from Non London PCTs. With 46% of referrals from beyond our immediate locality, this gives an indication of the importance of the tertiary and specialist services we provide.



3 THE STRATEGIC CONTEXT

Health economy

The coalition government has set out policies and funding plans that create opportunities and pose challenges for the NHS as a whole and in the North Central London (NCL) sector in particular. In response to concerns about the content and pace of the reforms, the government is currently pausing to engage more with stakeholders and there are likely to be changes to its proposals.

The NHS has, to a degree, been protected from the significant cuts to funding in other parts of the public sector. Nonetheless in January 2011 NCL was predicting a deficit in the sector of £730m by 2014/15 if no action was taken to change the delivery of services to the local health economy. NCL commissioners set out ambitious plans for the reconfiguration of certain services and for driving hospital efficiency within the sector. In response we have developed new ways of partnership working and new services that support their plans. We will work closely with commissioners to implement schemes which will genuinely save costs across the NHS. In particular we will work with commissioners to help move services out of hospitals and closer to the community in local primary care facilities.

As a result of these changes we predict having to find savings in excess of 6 to 7% per year for the next four years. Our challenge will be to continue to improve quality while delivering these demanding savings. We have established a quality, efficiency and productivity (QEP) programme that will help our clinical divisions and corporate teams to make fundamental changes in service delivery. We are clear that we must review quality and efficiency together, with a focus on improving the processes that deliver improved outcomes, safety and experience.

In a period of funding constraint, it is more likely that increased efficiency will be achieved through reductions in cost rather than increased output within the same resources. Our Quality Efficiency and Productivity programme reflects both kinds of efficiencies and is set out in more detail in section 7 below.

GP commissioning

The government wants GPs at the heart of commissioning. GPs are seen to be in the best position to translate patient needs into redesigned services that deliver what local people want. GP commissioning is seen as a key lever to deliver high quality services for patients in local and convenient settings and in a more efficiency way.

We have already seen clear benefits from working more closely with GPs as part of the commissioning process. The proposed forms have also prompted a careful consideration of where we can do more to support GPs in the services that we all provide for their patients. These initiatives are described in more detail in section 9 below.

Patient choice, and “any willing provider”

The concept of “any willing provider” provides the opportunity for all healthcare providers to supply specific services for which they are accredited. The model aims to facilitate the participation of a wider range of providers in the provision of health services, and to therefore create greater choice and competition. In part it aims to encourage more providers into the local marketplace by not requiring them to go through current tendering processes. This clearly represents a challenge to existing providers, although one that we feel in a strong position to meet as the quality of our clinical services is high. We are also encouraged by recent clarifications that competition between providers must not be based purely on cost.

Quality

During this period of transition and financial difficulty the NHS has been challenged to continue to improve the quality of the services that it provides. The first NHS Outcomes Framework was published in December 2010. From 2012/13, the framework will be used to hold the NHS Commissioning Board to account for improving quality and delivering better health outcomes for people using NHS services. New “levels of ambition” for improvement will be negotiated between the Secretary of State and the NHS Commissioning Board once it is in place. For the coming year, we will take heed of its direction of travel towards a focus on outcomes. We will collect data and establish baselines for all indicators wherever possible and, in doing so, identify how we can improve the quality of the services that we provide. The quality standards will providing authoritative definitions of what high quality care looks like for a particular pathway of care. The NHS Commissioning Board will use them to develop an outcomes framework for GP consortia and associated incentives, including high quality commissioning.

In 2010/11, Commissioning for Quality and Innovation (CQUIN) incentives provided UCLH with around £7.5m of additional income and they will continue to be a driver for quality services in 2011/12. CQUIN incentives have proved to be a positive force for improvement where hospitals and commissioners are able to design the indicators collaboratively and agree stretching but realistic targets.

The quality of services that hospitals provide – measured by clinical outcomes, patient surveys, infection rates and other safety measures - will continue to underpin the choices that patients and GPs make when choosing where to go for treatment.

Research and innovation

Academic health science centres will continue to be at the heart of NHS innovation, enabling research to benefit patients quickly. Our role in UCL Partners and our continuing designation as one of the five comprehensive biomedical research centres will help UCLH build on its position as a world-leader in research. We will strengthen our ties with partner hospital trusts – Royal Free, Great Ormond Street and Moorfields – and we use these to help develop more integrated pathways for patients at our hospitals.

4 TRUST OBJECTIVES FOR 2011/12

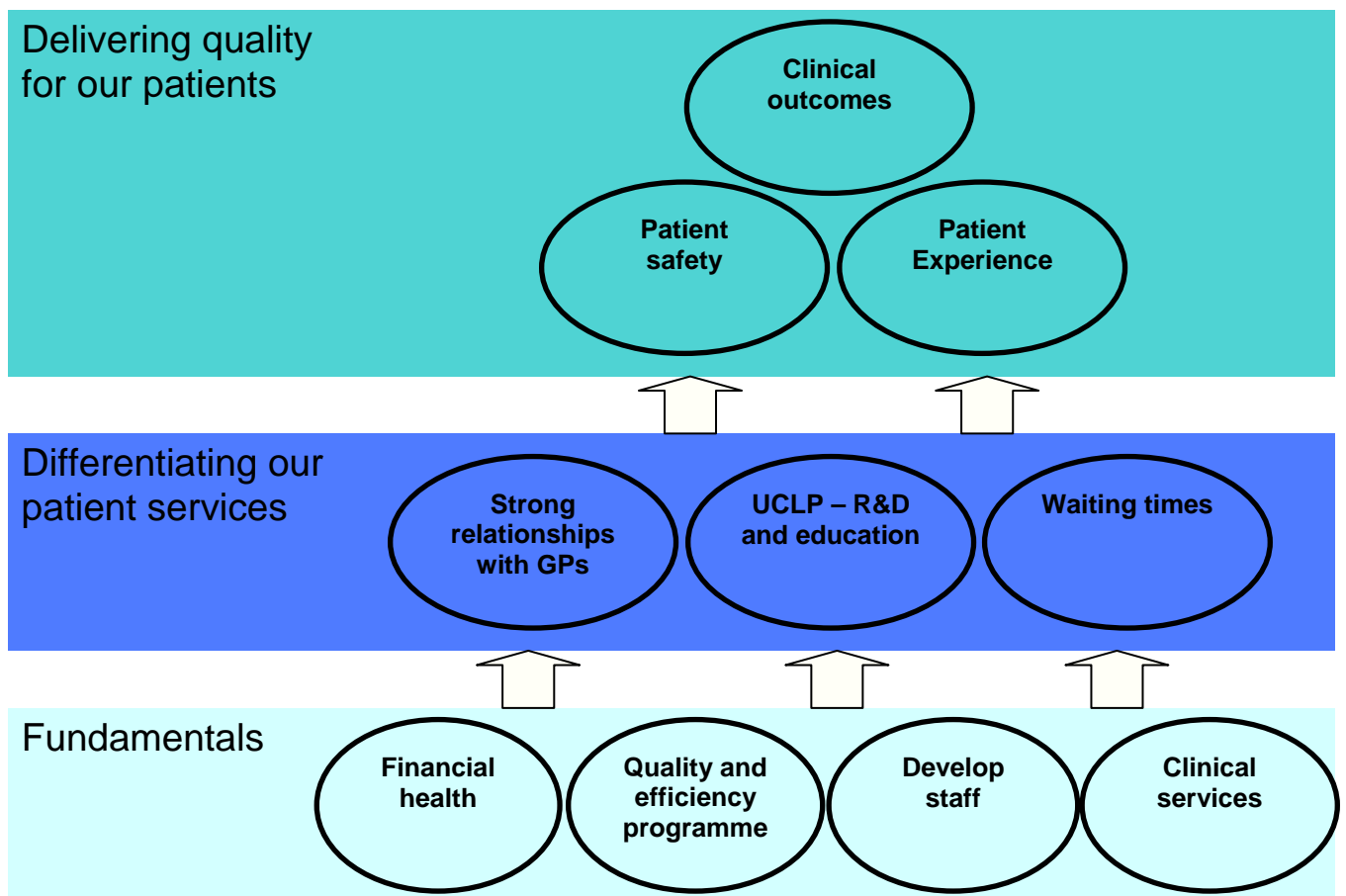
Based on our vision to deliver 'high quality patient care, excellent education and world-class research' within the strategic context set out above, and recognising the enormous challenges that the NHS faces during the next five years, the Board has agreed the following top ten objectives for 2011/12:

Objectives	Targets and thresholds
1. Deliver excellent clinical outcomes	
<ul style="list-style-type: none"> Improve performance on hospital mortality 	Improve our hospital standardised mortality rate
<ul style="list-style-type: none"> Reduce avoidable emergency readmissions 	Target for reduction in emergency readmissions to be agreed during Q1.
<ul style="list-style-type: none"> Achieve 100% participation in national and locally mandated clinical audits 	100% participation in national and locally mandated clinical audits during 2011/12
2. Improve patient safety	
<ul style="list-style-type: none"> Reduce infections, including MRSA, Clostridium difficile, MSSA, e-coli, surgical site and central venous line infections 	<p>Aim for zero MRSA, within the threshold 5 for 2011/12</p> <p>Keep within Clostridium difficile threshold of 59 during 2011/12</p> <p>Set targets for MSSA, e-coli, surgical site and central venous line infections during Q1</p>
<ul style="list-style-type: none"> Reduce numbers of blood clots 	Set target for reductions in blood clots during Q1
<ul style="list-style-type: none"> Eliminate hospital-acquired pressure ulcers and significantly reduce patient falls. 	<p>Zero grade 4 pressure ulcers outside of critical care areas during 2011/12, and zero in critical care by Q4.</p> <p>Reduce grade 2 and 3 pressure ulcers by 80% by Q4.</p> <p>Reduce falls with harm by 25% and total falls to 1.5 / 1000 bed days</p>
3. Deliver high quality patient experience	
<ul style="list-style-type: none"> Enable patients to manage their appointments easily and with confidence 	Targets to be constructed and set during Q1
<ul style="list-style-type: none"> Achieve patient experience results in the upper quartile in the national inpatient survey 	Results for annual inpatient survey stay in the top 25% nationally
<ul style="list-style-type: none"> Improve patient experience for cancer, maternity and outpatient services. 	Targets for improvement in patient experience for cancer, maternity and outpatient services to be set during Q1.
4. Build strong relationships with GPs	
<ul style="list-style-type: none"> Improve the patient pathways of five key conditions, as agreed with GPs. 	Five patient pathways redesigned and improved in collaboration with GPs, and agreed as part of the commissioning framework.
<ul style="list-style-type: none"> Improve the timeliness and quality of discharge letters to GPs 	<p>90% of outpatient letters sent within 5 working days</p> <p>90% of inpatient discharge letters sent within 24 hours</p> <p>90% of A&E discharge letters sent within 24 hours</p>
<ul style="list-style-type: none"> Make it easier for patients and GPs to contact hospital staff. 	Targets to be constructed and set during Q1

Objectives	Targets and thresholds
5. Achieve sustainable financial health	
<ul style="list-style-type: none"> Achieve agreed income, expenditure and cash targets 	Income, expenditure and cash targets as set in the Board-approved financial plan
<ul style="list-style-type: none"> Deliver service line management/reporting and patient level costing 	Patient level costing system being used by divisions and boards by Q3 2011/12
<ul style="list-style-type: none"> Replace the existing financial management system by mid-2012/13 	Delivery of milestones set in original project plan
6. Deliver cost savings through the Quality & Efficiency Productivity (QEP) Programme	
<ul style="list-style-type: none"> Deliver QEP savings in 2011/12 	Deliver QEP savings in Board-approved financial plan
<ul style="list-style-type: none"> Develop and implement a plan for long-term productivity and efficiency savings 	Plans for long-term productivity and efficiency savings in place, including by the end of 2011/12 risk-assessed plans for 100% of 2012/13 savings and outline plans for 2013/14 savings
<ul style="list-style-type: none"> Rationalise corporate and clinical support services across UCL Partners 	Specific targets to be confirmed during Q1
7. Develop R&D and education through UCLP	
<ul style="list-style-type: none"> Get the UCLH clinical research facility running at full capacity 	UCLH clinical research facility utilisation at 90% by Q4 2011/12
<ul style="list-style-type: none"> Achieve re-designation as a comprehensive biomedical research centre 	UCLH re-designated as a comprehensive biomedical research centre
<ul style="list-style-type: none"> Implement a leadership staff college. 	Leadership staff college operational.
8. Develop and enable staff to maximise their potential	
<ul style="list-style-type: none"> Reduce stress in the workplace and set a zero tolerance towards violence against staff 	Targets to be set during Q1 for reductions in levels of stress and reported violence, as measured by local staff experience surveys
<ul style="list-style-type: none"> Aim to appraise all staff and double mandatory training compliance by the end of the year. 	90% staff appraised by end 2011/12. 70% compliance with mandatory training by end 2011/12
<ul style="list-style-type: none"> Ensure that all staff roles are fit for purpose and affordable 	Nursing skill mix review implemented to agreed dates Administrative and Clerical review implemented to agreed dates Review of medical workforce job plans implemented to agreed dates
9. Deliver wait times in line with contract	
<ul style="list-style-type: none"> Deliver patient waiting times agreed with commissioners 	Median waits from referral to treatment, as agreed in our contracts with commissioners
<ul style="list-style-type: none"> Deliver standards for timeliness and quality of care in A&E 	Unplanned re-attendance rate < 5% 95 th percentile wait for total time in A&E < 4 hours Left without being seen < 5% 95 th percentile for time to assessment for ambulance cases < 15 minutes Median wait for time to treatment < 60 minutes

Objectives	Targets and thresholds
<ul style="list-style-type: none"> Meet the cancer waiting time targets 	Nationally mandated cancer waiting times targets, including 85% patients seen within 62 days of GP referral or screening referral.
10. Develop clinical services within available resources	
<ul style="list-style-type: none"> Succeed in our bid for proton beam therapy 	Win bid for proton beam therapy
<ul style="list-style-type: none"> Improve care for cancer patients by redesigning pathways and commissioning the Cancer Centre 	Improved results in patient experience for cancer patients to be set during Q1. Cancer centre commissioned to project timescales
<ul style="list-style-type: none"> Progress plans for phase 4 development 	Finalise next steps on the Royal National Throat, Nose and Ear Hospital Progress plans for the Eastman Dental Hospital

We summarise our objectives in the following way:



The following sections set out in more detail our key achievements during 2010/11 and our plans for 2011/12.

5 QUALITY

Our commitment to outstanding quality of care for our patients and placing patient safety and experience at the heart of all we do continues to be our central mission at University College London Hospitals NHS Foundation Trust. Translating this into meaningful and continuous improvements for patients depends on the individual acts of all our staff and on our commitment, at Board level, to provide the environment in which all our aspirations for improving the quality of our services can be delivered. This Quality Account reflects how we are going about this and the progress we are making.

During 2010/11 we have continued to build on our very strong foundations. Once again we achieved one of the lowest hospital standardised mortality ratios nationally, delivered one of the best A&E waiting times in London and continued our strong performance in the national inpatient survey. We worked with our Academic Health Science Centre partners (UCLP) to find new, more effective ways to provide support services as well as working with partner Trusts to develop clinical improvement projects in areas of common interest.

Despite the many successes during the year, there have been disappointments in some areas. Our performance in reducing MRSA was significant but despite a 40% reduction from 22 to 13 cases we failed to achieve our target. Our performance in the national cancer patient survey was also below what we had hoped for.

During 2010/11 we have, however, worked hard to find new and better ways to involve frontline clinical staff in improving services for patients. This Quality Account describes just some of these successes.

Our current view of the Trust's position and status on quality

During 2010/11 we continued to build on the quality improvements previously reported as well as starting new programmes. Some of these have been initiated at corporate level and others by local clinical teams, reflecting a Trust-wide culture that supports quality improvement.

We continued to refine our quality measurement framework. We want important information to reach clinical teams quicker and more often: on patient experience, on safety indicators such as infections and falls and on clinical outcomes such as stroke care, mortality rates and readmissions.

During the year we extended our leadership programme for clinicians and managers to include a Quality Improvement Network – helping to build the skills needed to lead and manage quality projects. We have also developed a new Staff College in collaboration with a military training academy and are in discussion with the Department of Health about a wider NHS rollout.

To help put quality improvement ideas into practice, we piloted and refined a UCLH Quality Improvement Framework. In 2011/12 this will be implemented on all wards throughout the Trust.

Last, but by no means least, we continued to use hand-held computers to collect “real time” feedback from patients in wards. We will be extending these surveys to other areas such as outpatients and A&E.

The following describes some of our quality highlights and challenges from the year:

Stroke care

The UCLH Hyper Acute Stroke Unit (HASU) opened at full capacity in July 2010. It serves the population of North Central London (NCL) and expects an annual caseload of 1800 patients. Its capacity may be exceeded by 10%. The service is based around 18 beds and requires efficient turnaround. Good communication is crucial to enable efficient transfer to local stroke units or discharge home. The unit provides consultant led services, seven days a week, and uses the expertise of all NCL stroke neurologists and physicians, fostering cooperation between them. The results so far are excellent. The rate of thrombolysis (also known as “clot busting”) has doubled across the sector

(currently to 18%). The in hospital mortality for patients treated through HASU has been exceptionally low at 6%, compared to the national average of 27%. The HASU has achieved excellence in all the performance standards intended of it in the London Stroke Strategy.

Enhanced recovery

We extended our enhanced recovery programme which helps patients to speed up their recovery after surgery. The programme helps patients to prepare mentally and physically for surgery and helps mobilise them afterwards, supporting early recovery and discharge. There is already national evidence that the programme improves outcomes and at UCLH we have seen positive results in bariatrics and colorectal patients.

We have extended the programme to trauma, orthopaedic and cardiac patients. In the coming year we plan to apply it to all surgical patients with particular emphasis on urology, gynaecology and some aspects of neurosurgery.

Quality Improvement Framework

We introduced the UCLH Quality Improvement Framework which provides a straightforward and consistent approach to quality improvement that can be used throughout the Trust. The framework draws on established international experience as well as our own experience of improving ward care. It also links well with national initiatives including the National Energising for Excellence programme and the High Impact Actions for Nursing and Midwifery.

The framework has five themes:

- transformational leadership
- safe and reliable care
- staff vitality and teamwork
- patient centred care
- value added care processes (for example, increasing nurses' time at the bedside).

The framework aims to:

- reduce harm from pressure ulcers, falls and urinary infections resulting from catheters
- simplify processes, for example, patient discharge
- improve patients' experience
- improve the use of resources.

In 2011/12 we will introduce five tried and tested interventions that will improve patient care and the effectiveness of ward teams:

- intentional rounding (regular checking of patient status on things such as pain and position at specific intervals through the day)
- patient status boards
- standard communication tool for patient handover (SBAR)
- lean process management techniques to improve the ward environment
- care bundles to help tackle key patient safety issues such as falls.

The UCLH Quality Improvement Framework will focus initially on wards but over time we expect all clinical areas and departments to follow.

Models of integrated care

The Trust recognises that we must constantly adapt to meet the changing needs of patients and the local community. More complex health care now undertaken within the community following improvements in technology and medicine has created new opportunities to help patients manage their conditions and maintain their quality of life. UCLH piloted the Post Acute Re-enablement Project in January 2010. The project identifies patients who can be discharged with a personalised home care package during the first seven to 14 days. The pilot started in medical patients and has the potential to extend to surgical patients over the coming year. We will work with local services to broaden, the range of home care projects that support patients in their homes.

We will respond to the growth of long-term conditions by working closely with local GPs on four or five pathways that impact most on the long-term health of patients. We have successfully redeveloped services for chronic obstructive pulmonary disease (COPD) and aim to significantly improve the overall health of local residents by working with local GPs to create integrated care pathways. This work will be led by one of our Medical Directors and the GP Partnership board.

Improving discharge

In 2010/11, we focused on improving discharge following concerns from patients about delayed discharge. We improved advice to patients on medication and the process of preparing patients on the day of discharge, We ensured regular communication with community teams about patients with complex needs from the moment they arrive at our hospital. We improved our turn around time for giving patients their medication. Our discharge lounge services now include the serving of hot food in the morning and helping patients to pack.

We discharge more patients earlier in the day – when more services in the community are available to enable people to adjust more easily to their return home.

Safer Patient Network (SPN) innovation project

We submitted a successful project application to the Safer Patients' Network (led by the Health Foundation and the Institute for Healthcare Improvement) which develops and tests innovations in patient care. The project assesses the effectiveness of a technique called "teach back" which tests each patient's understanding of the instructions they receive about what they need to do after leaving our care. Each patient explains their understanding of the instructions. The conversation continues until staff are confident the patient fully understands.

Use of "teach back" has been shown to deliver significant patient safety improvements, but the work around preventing readmissions is less well understood. We are very pleased to be leading this work in the UK. We will be trialling the scheme on our care of the elderly ward until August 2011.

Energise for Excellence

UCLH has been participating in the national Energise for Excellence (E4E) programme, which embraces a number of key programmes that nurses and midwives can use to drive quality improvement. The programme provides a clear link between delivery of care, patient experience, measurement of care, staff experience and getting the staffing right. Core to E4E

are the High Impact Actions (HIAs) for nurses and midwives which focuses on the improving the quality of the essentials of care.

In 2011 we intend to fully implement eight High Impact Actions for nurses & midwives as follows

- reduce hospital acquired pressure ulcers
- prevent falls
- improve nutrition and hydration
- promote normal birth
- provide choice of where patients die
- reduce urinary catheter related infections
- reduction in staff sickness.

Care of patients with learning disabilities

During 2010/11 we focused on improving the care of patients with learning disabilities. We developed an action plan with help from community service providers, users and carer representatives. We continue to exchange best practice with other hospitals and community services in North Central London.

We adopted the use of a butterfly symbol at the bedside of patients with Alzheimer's disease to help raise awareness among staff and visitors of the patient's difficulties remembering events, places and faces.

Over the coming year we will continue to improve services for patients with learning disabilities and their carers. We aim to train learning disability champions in each clinical area and increase the availability of patient information that's easy to read.

Healthcare associated infection

In 2010/11 we have continued to focus on minimising the number of healthcare acquired infections within the Trust. As a result of improvements in a number of areas there were 62 Trust Attributable cases of *Clostridium difficile*, an improvement of 30% on the previous year and well within our threshold of 119 cases. We reduced Trust Attributable cases of MRSA by 40% in 2010/11 as a result of our work on hand hygiene, care bundles and detailed analysis of the causes of MRSA cases. We were disappointed, however, that we did not stay within our threshold of 8 cases & recorded 13 cases for the year. We are redoubling our efforts in the coming year starting with the launch of a new zero tolerance campaign in April 2011

Waiting times

We have continued to deliver very strong performance against the A&E four hour waiting time target. In 2010/11 we delivered the best results for any acute trust in London. Our annual performance against the national four hour standard was 98.5%, one of only three Trusts in London to keep its performance above the old national standard of 98%. We have also met all our referral to treatment waiting time targets, and have improved waiting times in some specialties that have previously struggled to meet the national standards.

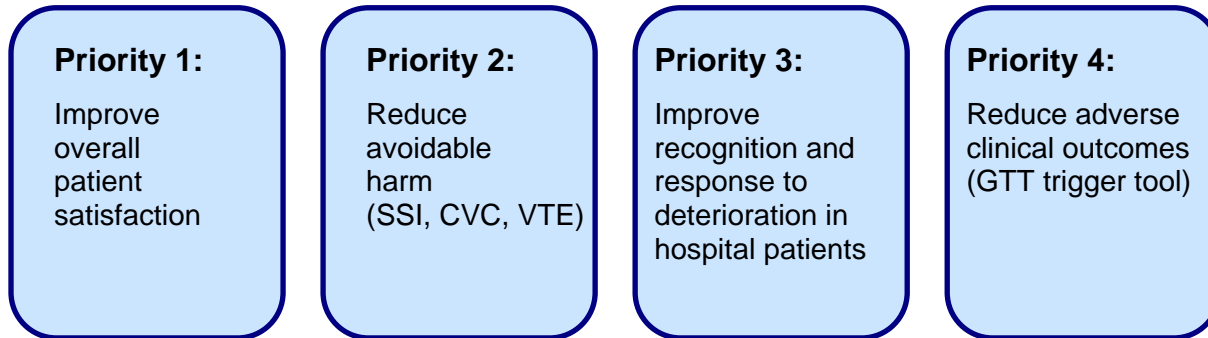
We delivered against most of the cancer waiting time targets, although we have struggled to deliver against the 62 day standards for treatment following referral from GPs and screening centres. Part of the challenge that we face on these two targets is due to the particular kinds of cancer that we treat that are not as appropriate to treat in the same fast-track way that other

cancers are rightly managed. Our performance is also significantly affected by the management of early stages of the pathways that are controlled by other healthcare providers. There are of course parts of these pathways that we could speed up, and as a result we have taken action in access to diagnostic imaging and surgical facilities during the course of the year. We will continue to identify areas for improvement that are within our control, and we will treat this as one of our key objectives for 2011/12.

Priorities and Statement of Assurance

Report on Priorities for 2010/11

Last year we identified four Quality Priorities and the following report describes our achievements against these priorities all of which continue to be relevant to our quality improvement strategy and are carried forward into this year. These were:



Priority 1: Improve overall patient satisfaction

2010/11 was the second year of this priority the success of which is measured by the national inpatient survey which is an independent survey conducted every year for all acute and specialist trusts. During the year we have continued to support ward teams with real time patient feedback from ongoing surveys. We have targeted poorer performing areas from the previous years' survey especially information given about anaesthetic and information given in A&E. Local teams have developed plans specific for their area and have used the ongoing survey to monitor the overall patient experience.

Our 2010 national survey results show that the specific areas we targeted have improved and our performance was strong compared to our peers in London. The survey showed that patients continue to rate their care highly and 97% of patients said they would recommend the hospital to family and friends.

Survey question	2009	2010
Did the anaesthetist explain how you would be put to sleep	88%	93%
How much information about your condition did you get in A&E	76%	87%
Overall rating of care	84%	83%

Improving overall patient satisfaction will continue as a priority for 2010/11

Priority 2: Reducing Avoidable Harm (SSI, CVC, VTE)

This priority targeted three areas of known avoidable harm by the implementation of safety interventions called care bundles, which are known to reduce harm from infections and thrombosis.

During 2010/11 year we set ourselves the task of establishing care bundles to prevent surgical site infection (SSI) and central line infections (CVC).

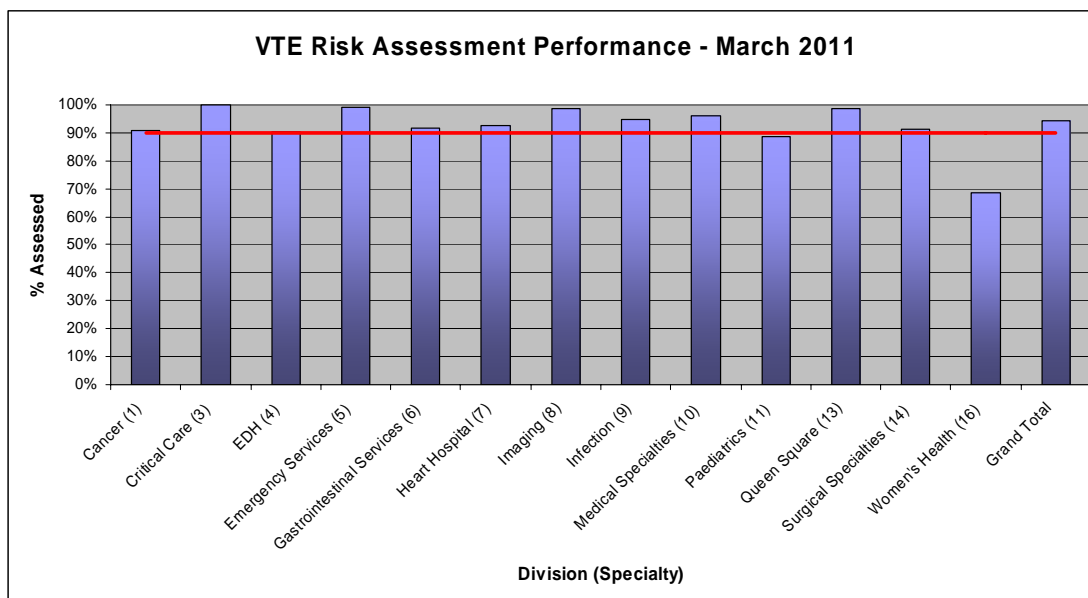
The planned initiatives were to establish:

- baseline data for SSI and CVC
- clinical leads and implementation methodology
- ongoing monitoring using a care bundle audit mechanism.
- a reporting mechanism leading to root cause analysis of all wound and line infections.

This infra structure is now in place and we will begin reporting SSI and CVC infections on our monthly Quality and Safety scorecard with effect from April 2011 enabling us to set targets for reduction and report progress in our Quality Account next year.

The care bundle for Venous Thrombolysis (VTE) is aimed at preventing thrombosis (blood clots) and begins with the implementation of VTE risk assessments for all admitted patients.

The 2010/11 target was to achieve 90% risk assessments for all admitted patients by March 2011. During the year we have developed and introduced the means for on line recording of VTE risk assessments, providing a monitoring mechanism and a prompt for clinicians. A robust system of reports is now in place which clinical teams can access on a daily basis to see any patient's risk assessment status. As a result of these initiatives we are pleased to report we have achieved the 90% target.

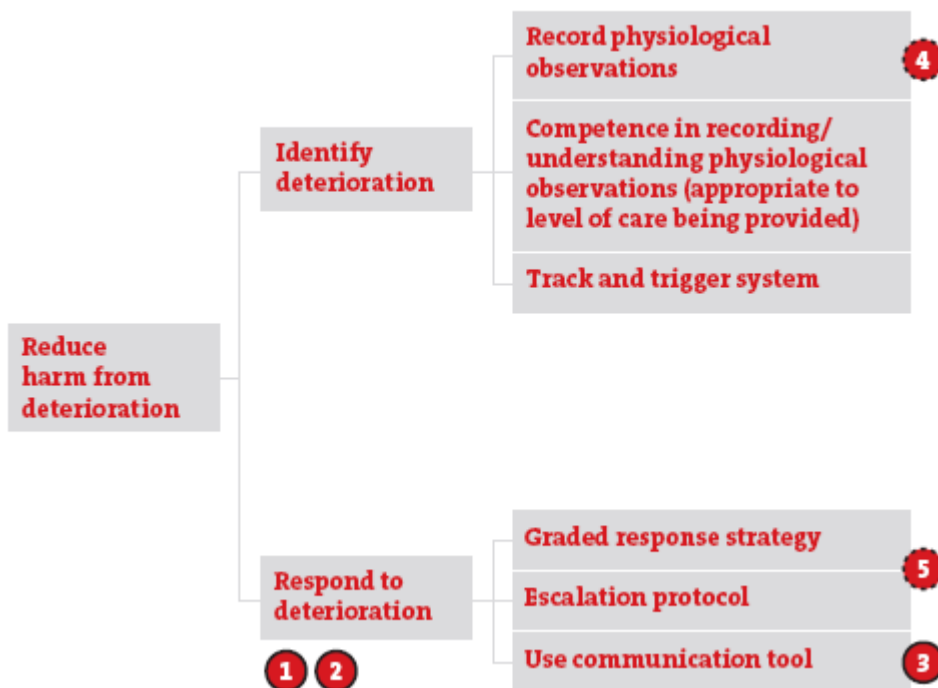


Prevention of VTE will continue to be a quality priority for 2010/11 as we shift our focus to other aspects of the care bundle, particularly to “appropriate prophylaxis”. This means that, once risk assessed, those patients who have a risk of VTE will be given appropriate treatment to prevent it occurring.

Priority 3: Improve recognition and response to deterioration in hospital patients

This priority focuses on the implementation of a care bundle that recognises when patients are deteriorating and enables swift action to take place to prevent complication and ultimately cardiac arrest from occurring. The care bundle includes regular recording of vital signs (pulse, blood pressure, temperature etc.); using triggers to alert staff to potential deterioration and

using a validated communication tool (SBAR – see Box 1) so that staff can escalate their concerns effectively.



During the year we focused on improving the consistency and competence of our performance in recording and responding to vital signs as the first level alert system for preventing deterioration. We are pleased to report that monthly audits have demonstrated a significant improvement in performance

	APRIL	MAY	JUNE	JULY
All UCH (& Maternity Care Unit)	46%	37%	62%	76%

When vital signs are outside of normal parameters, the SBAR communication tool is a crucial next step. It ensures that information is transferred quickly and accurately to medical staff and the Trust Patient Emergency Response Team. We have begun using SBAR in all areas of the Trust

We will carry out monthly audits of compliance with vital signs recording throughout the coming year and we will monitor the proportion of referrals to the Patient Emergency Response Team (PERT) that use SBAR.

Box 1: SBAR communication tool explained

SBAR:

Situation – Where you are and why you are calling, what you are concerned about
Background – relevant patient history, why they are in hospital what has happened to them so far
Assessment – what their condition is now; vital signs, urine output, mental state etc.
Recommendation – what you want to happen; e.g. “I would like you to come and see the patient straight away”

Improving recognition and response will continue to be a quality priority in 2011/12 – helping to further reduce our Hospital Standardised Mortality Ratio. In the coming year we expect to introduce a new early warning system that has been developed by the Royal College of Physicians.

Priority 4: Implementation of Global Trigger Tool to detect and reduce adverse clinical outcomes

The Global Trigger Tool, used extensively across the world, was devised for the purpose of identifying the types and scale of adverse events. It is much more sophisticated than the routine system of clinical incident reporting and identifies potential as well as actual harm. Organisations that are using the global trigger tool can be very focussed in their action to reduce harm and are seen to be at the forefront of the drive to improve patient safety.

It involves patient case note review using the Global Trigger Tool (GTT) which identifies adverse events which may lead on to complications of care and adverse outcomes. Working via a manual review of patient records this method uses a checklist of over 50 trigger events. Specially trained doctors and nurses examine patient records to see if any of these triggers are present and if so, did they lead on to an adverse clinical outcome. Unplanned clinical outcomes such as return to theatre, nausea for a prolonged period and pressure ulcer are just some of the triggers that may indicate a complication of treatment.

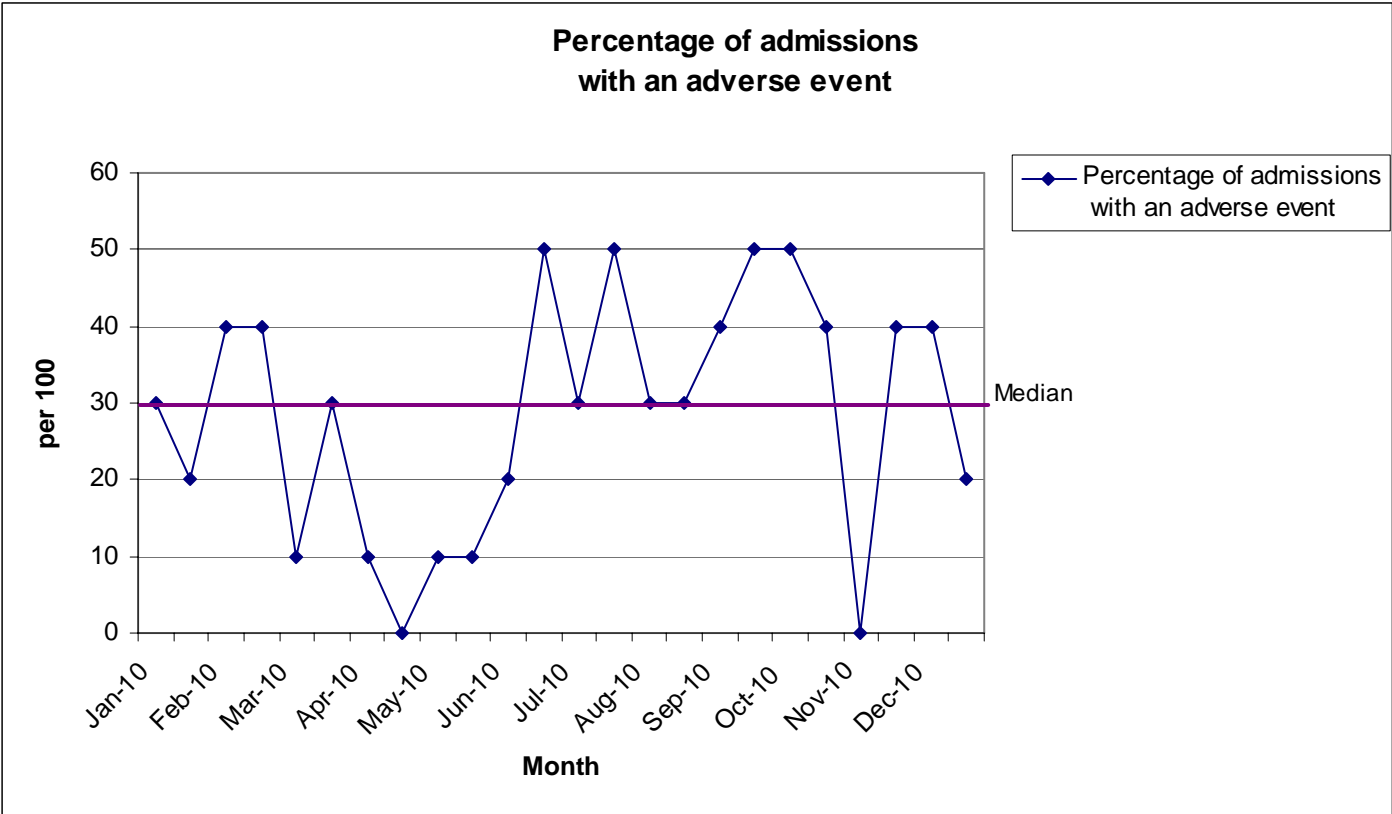


The target was to implement fortnightly case note review and build a baseline of data from which recurring themes could be identified. We have now fully implemented the Global Trigger Tool both for fortnightly review and also carry out twice yearly mortality reviews.

The next step is to examine the types of adverse events to determine whether they could be anticipated or prevented and to put actions in place accordingly.

Our aim was to reduce the percentage of admissions with an adverse event by 5% from the baseline of 37% (2009/10) to 32% and our latest analysis shows we have reduced this to 31%. Whilst this may seem high, evidence shows that the routine clinical incident reporting system shows a 10% harm rate as being only the tip of the iceberg. A high identification of adverse events with a corresponding reduction in serious incidents is known to be a good thing – this is the case in UCLH.

The accepted way of displaying this information is by use of run charts and the chart below shows run chart data for the percentage of admissions with an adverse event throughout 2010.



NB: International average for percentage of admissions with an adverse event is 30 – 35%

Implementing GTT effectively will continue to be a priority in 2011/12 as part of our ongoing commitment to reduce our Hospital Standardised Mortality Ratio.

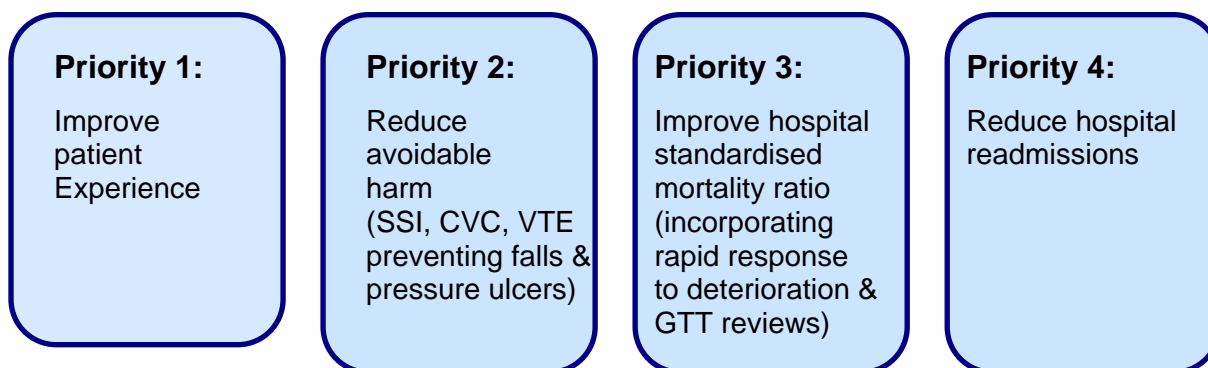
Priorities for 2011/12

How we prioritised our quality improvement areas for the coming year

Our starting point for choosing the quality priorities for the coming year was to review last year's priorities and ask which if any of them should be carried forward. In the course of the review we used a range of information, including performance against our quality and safety measures, information from national survey reports and clinical audits, risk reports and issues raised by staff during Executive Safety Walk rounds. We consulted with Trust staff and governors through face to face discussions, surveys and presentations. We consulted with local PCTs and commissioners through our Clinical Quality Review Group. We also involved our local LINK before making a final choice.

The conclusion of these discussions is that our priorities for 2010/11 should continue as our overarching aims in 2011/12. We have set new or more ambitious objectives within each area. We will combine two of the priorities from last year into a single priority of improving our Hospital Standardised Mortality Ratio. We expect to achieve this through early recognition and response to deterioration and by applying lessons from the findings of global trigger tool reviews. There will be a new fourth priority to reduce readmissions.

Our priorities for 2011/12 which have been agreed by the Board will therefore be:



Priority 1

Improve patient satisfaction as measured by national patient surveys

Rationale

Treating the clinical condition of patients is the fundamental purpose of any hospital; however excellent healthcare is about more than that. The experience of our patients during their hospital journey is of equal importance to their health outcomes and is central to our mission of providing outstanding quality of care.

Improving patient satisfaction as measured by the national in patient survey has been a quality priority for the past two years. In 2011/12 we will add a new dimension to this priority by including out patient experience and improving the experience of our cancer patients. This priority continues to have the full and specific support of our staff, governors and commissioners.

Current status

Inpatient Survey

The 2010 national in patient survey result showed that our good performance in 2009 was maintained in 2010.

We were particularly pleased that our 2010 performance was in the top 20% for all hospitals nationally for providing patients with information and feedback on their operation or procedure. We also retained our top 20% performance in the 'overall views and experiences' section of the survey. Both these sections are green rated by the Care Quality Commission. In the individual questions the Trust was in the top performing 20% nationally for a total of 27 out of 64 questions.

The full results of the UCLH 2010 inpatient survey are available on the CQC website.

Based on patients' responses to the survey, this trust scored:	How this score compares with other trusts
8.2/10 For questions about → the emergency / A&E department, answered by emergency patients only	
6.7/10 For questions about → waiting lists and planned admissions, answered by those referred to hospital	
8.1/10 For questions about → waiting to get to a bed on a ward	
8.2/10 For questions about → the hospital and ward	
8.9/10 For questions about → doctors	
8.4/10 For questions about → nurses	
7.7/10 For questions about → care and treatment	
8.7/10 For questions about → operations and procedures, answered by patients who had an operation or procedure	
7.3/10 For questions about → leaving hospital	
7/10 For questions about → overall views and experiences	

In the coming year we will focus on some specific areas which include those identified in the national CQUIN for patient experience. These are shown in the table below together with other areas where the 2010 survey shows there is most room for improvement.

CQUIN focus	2010	Issues arising from 2010 survey	2010
Involvement in care decisions	75%	Storage for personal belongings	67%
Privacy when discussing treatments	82%	Dr's and nurses working well together	79%
Discharge medication side effects	53%	Trust and confidence in nurses	84%
Knowing who to contact after discharge	73%	Availability of alcohol hand rub	95%
Finding someone to discuss worries and fears	60%		

Cancer survey:

In 2010 the Department of Health commissioned the National Cancer Patient Experience Survey. All acute hospitals providing cancer services took part. It was the first national survey of its kind and included results for all tumour groups as well as the overall trust performance.

The overall results for the Trust were very disappointing and although the experience of our patients did vary between tumour groups we hope to make a significant and sustained improvement in the experience of all cancer patients.

In particular in 2011 we are targeting improvements in the following areas:

- providing clear and understandable explanations and information
- providing choice of treatments and involvement in decisions
- providing support from a clinical nurse specialist



Survey Question	2010 Results	2011 Target
Patient felt they were told sensitively that they had cancer	77%	83%
Patient completely understood explanation of what was wrong	64%	73%
Patient definitely involved in decisions about which treatment	66%	69%
Last time seen, time spent with CNS about right	90%	94%

Patient had trust & confidence in all doctors treating them	80%	82%
Patient had trust and confidence in all ward nurses	55%	63%

Outpatient survey

For many patients the majority of their experience within the Trust takes place in an outpatient setting and we are keen to make improvements to that experience. In 2011 there will be a national outpatient survey - last conducted in 2009 – in which we aim to improve our overall performance as measured by responses to the following questions:

Survey Question	2009	2011 Target
Overall were you treated with respect and dignity	90%	93%
Overall how would you rate the care you received	81%	83%

How will we do it?

We reported last year that we had introduced a system of real-time patient feedback on wards. In 2011/12 we will extend the real-time survey programme to include outpatient areas and we will include specific surveys for cancer patients to cover all settings where cancer diagnosis and treatment takes place. We will explore new ways of gathering patient feedback throughout the year.

We will also use the following:

- We will analyse the national surveys and prioritise areas for improvement
- We will provide weekly/monthly real time survey results to wards & clinical teams so that they can monitor their performance
- We will provide analysed information showing trends over time in order to measure progress
- We will develop action plans at Trust and specialty level
- We will monitor & report progress at the Trust Quality & Safety Committee

Measuring progress:

- Monthly review of real time surveys within wards & divisions
- Monthly reporting via Trust performance scorecard at Quality & Safety Committee & Executive Board
- Annual national surveys

Priority 2: Reduce avoidable harm in identified areas

Rationale

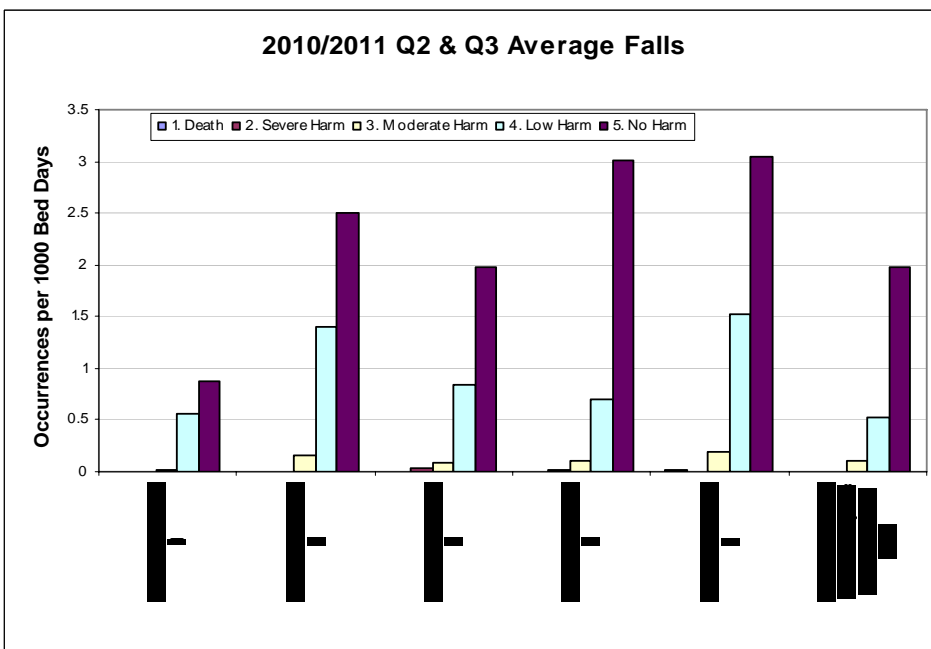
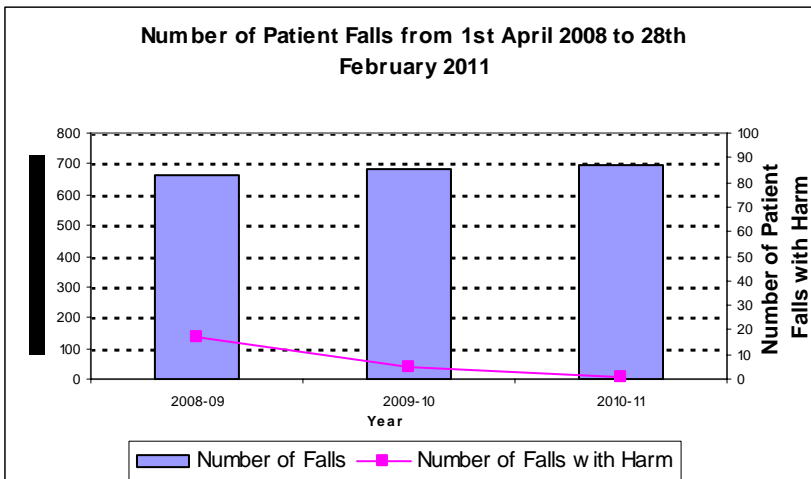
Keeping patients safe is a fundamental & long standing expectation of both healthcare providers and patients. The concept of avoidable harm however is a more contemporary notion. Over recent years more attention has been focused on the complications which sometimes occur on a patient journey which result in harm which could be avoided if certain steps are taken. Healthcare associated infection and thrombosis are two such areas which were identified in last years Quality Account. This year we add falls in hospital and hospital acquired pressure ulcers both of which have the specific support of governors, the Board and commissioners.

Current status

Falls

Reducing patient falls will be a key focus in 2011/12. As the graphs below show, we have succeeded in reducing the number of falls which result in harm over the last three years. UCLH's falls rate (2.5/1000 days) is less than half the national average and lower than most of its London peers. However, despite introducing a number of new interventions in the last year, the overall fall rate remains higher than we would like and we want to reduce it considerably. Even when there is no injury associated with a fall, we recognise that a fall is an unpleasant experience for patients and we need to do all we can to prevent them taking place whilst preserving patients' independence. In order to achieve this we will be introducing a falls care bundle in addition to the measures we are already taking.

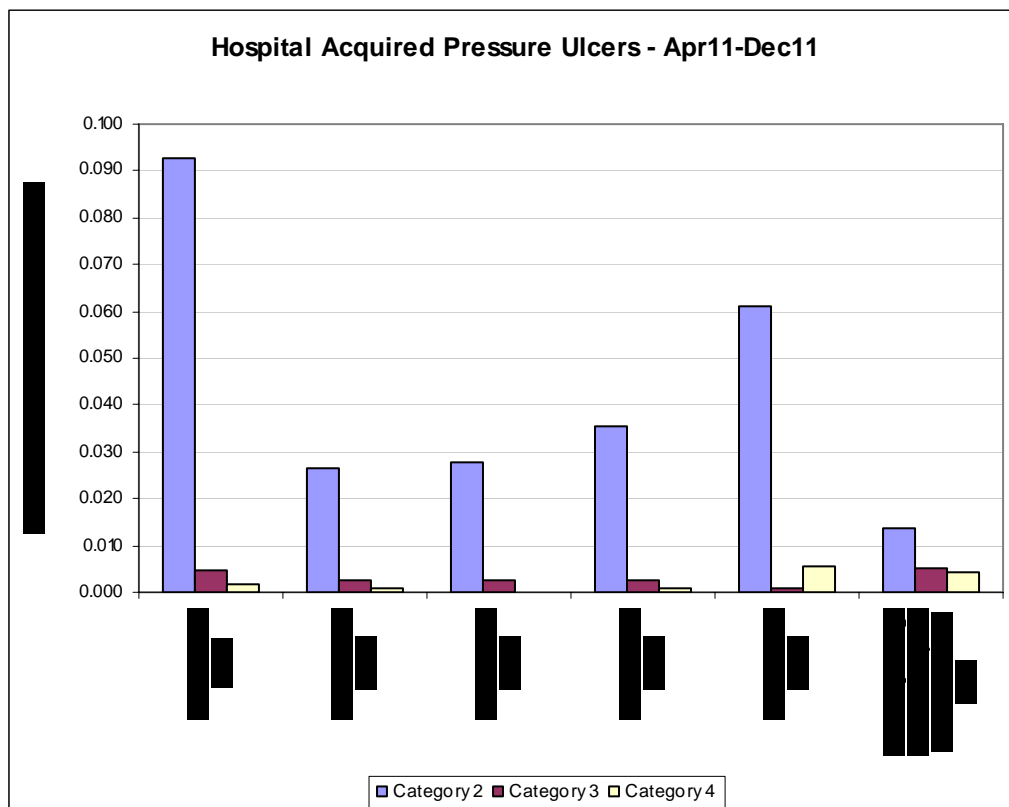
This year a national CQUIN has been introduced which requires trusts to introduce measures that help reduce falls. UCLH has already introduced the majority of these but will consolidate them in 2011/12 as well as introducing additional measures of our own.



Hospital acquired pressure ulcers

Reducing and preventing hospital acquired pressure ulcers (HAPU) is another key national imperative and UCLH is committed to driving down both their number and severity. Whilst raising awareness has led to better reporting of HAPU, we are concerned that we still have too many. Compared to other London trusts, we have a lower overall rate of HAPU but the proportion of category 3 and 4 HAPU – the more serious cases – seems to be higher. This requires further exploration and action and, as with falls, we are introducing a HAPU care bundle.

UCLH vs London Peers



How will we do it?

We will continue our implementation and monitoring of care bundles, described in last years report, for the prevention of surgical site infection, line infection and venous thrombosis. In addition this year we will add care bundles for the prevention of falls and pressure ulcers. Care bundles bring together a number of proven interventions and then apply them in rigorous and consistent manner across the whole organisation. Some of the key actions to prevent falls and pressure ulcers are shown below in Box 2 and 3.

Box 2: Preventing falls

Falls care bundle: the SAFE bundle

Safe environment – keep the ward free of hazards, have the right equipment and use it correctly
Assessment of risk and care planning – all patients to have accurate falls risk assessment and individualised care plans if deemed to be at risk

Footwear – eliminate falls from slips by use of appropriate footwear

Education and reassurance – ensure patients and relatives know about the risk of falling and how they can reduce it. Ensure that patients call for help when they need it and that their needs are proactively met through the use of intentional rounding.

Target: **Further reduce number of falls with harm by 25%**
 Reduce overall falls rate to 1.5/1000 bed days or less

Box 3: Preventing pressure sores

HAPU care bundle: the SKIN Bundle

Surface – ensure the patient is on the right mattress, keeping wrinkles out of sheets, daily HAPU risk assessment

Keep moving – regular change of position and skin inspection, early mobilisation

Incontinence – help with toileting, keeping skin clean and dry

Nutrition – regular nutritional risk assessment, maintaining optimal diet, keeping hydrated

Target: **Reduce category 2 and 3 HAPU by 80%**
 Eliminate category 4 HAPU

Measuring progress

In 2011/12 we will measure our progress using monthly audits to monitor falls and HAPU including:

- monthly audits of care bundles
- monthly measurement of incidence of falls and pressure ulcers
- monthly performance monitoring within divisional, nursing and Quality and Safety Committee

Priority 3:

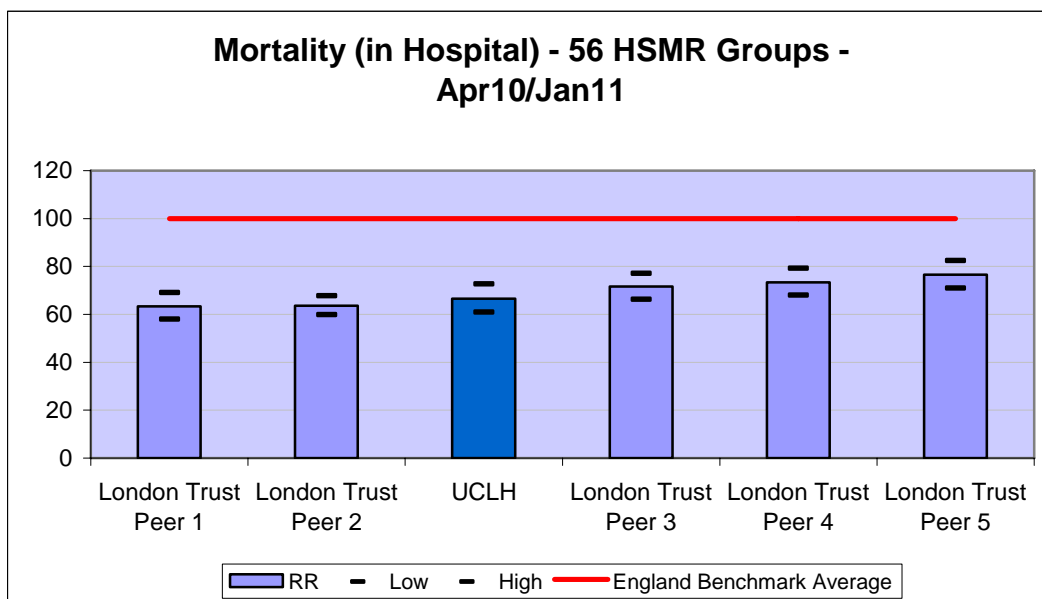
Reducing Hospital Standardised Mortality Ratio (HSMR) to best performing hospital in the country

Rationale:

Hospital Standardised Mortality Ratio (HSMR) compares a trust's actual number of deaths with their expected number of deaths. The prediction calculation takes into account factors such as age, sex, diagnosis, whether the admission was planned or emergency and length of stay. An HSMR of 100 indicates the expected number of deaths. Lower than 100 means fewer than expected.

Current status

Our current HSMR is 67 which means there are significantly fewer deaths than average for the country – one of the lowest rates nationally – but we wish to reduce that still further and regain our position as lowest HSMR nationally.



How will we do it?

A number of our quality improvement programmes contribute to achieving our low HSMR and will help us to drive it lower still.

In particular, our work on early detection of deterioration in hospital patients means that by recognising and responding to signs of deterioration at an early stage we are able to quickly deploy our Patient Emergency Response Team to treat and manage acutely ill patients and thereby avoid further deterioration.

Similarly we will continue our programme of mortality reviews to examine and understand when and where untoward deaths take place with a view to identifying if we can do anything differently and thereby avert the outcome.

Measuring progress

- monthly audit and review of cardiac arrest calls
- monthly audit and review of vital signs recording
- monthly Global Trigger Tool review
- twice yearly mortality review
- measurement and analysis of trends over time to enable action plans to be formulated
- reporting to Quality & Safety Committee

Priority 4:

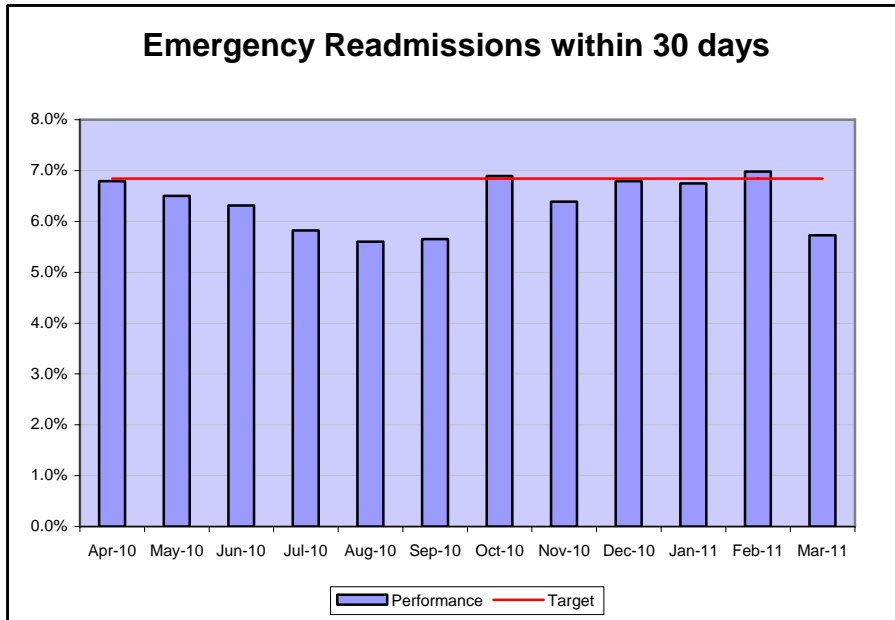
Reducing readmissions to hospital within 30 days by 30%

Rationale

Across the country there are many patients who are discharged from hospital only to be readmitted very shortly after discharge. In some instances the readmission is unrelated to the previous admission but there are a number of instances where the readmission is for the same condition. The reasons behind readmissions is highly complex and what is clear is there is no single cause but a combination of factors including availability of community services, changes in clinical practice and coordination between services. Avoidable readmissions are not in the interests of patients or the hospital and

therefore the Trusts will make this a priority this year and has the full and specific support of the Trust executive and our commissioners. Nationally 8.3% of all admissions are readmissions within 30 days. At UCLH that rate is below the national average and using our own internal measurements we set a target of 6.8% for 2010/11. This year we aim to significantly reduce this and in conjunction with partners in primary and community care we are examining the causes and conditions which result in patients needing to be readmitted and aim to reduce the incidence of readmission by 30%

Current status



The readmissions graph for 2010/11 (above) shows that whilst there was some monthly variation there was no sustained reduction. In 2011/12 we will introduce new pathways and preventative measures and we will track the impact of these on readmissions.

How will we do it?

We will use the following methods to help reduce readmissions:

- establish a Readmissions Strategy Group (RSG) with overarching responsibility for setting priorities and overseeing work streams
- review the main types and causes of readmission by specialty
- Identify the most common conditions which result in readmission and audit what leads to it
- redesign pathways for chronic conditions to provide more effective community support
- outreach support from the hospital to support care at home
- more effective patient discharge information and teaching
- set targets for reduction in readmissions for specific workstreams.

Measuring progress

- monthly reports of readmission rates and categories to clinical teams, Boards and RSG
- monthly validation of readmission data & audit of causes by divisional clinical lead
- monthly reporting and monitoring of readmission rates by Readmissions Strategy Group and Quality & Safety Committee
- measure progress against targets by RSG and report to Quality & Safety Committee

6 WAITING TIMES

We have continued to deliver very strong performance against the A&E four hour waiting time target. In 2010/11 we again delivered the best results for any acute trust in London, the second year running, and the fourth best type 1 performance nationally out of 153 trusts. Our annual performance against the national four hour standard was 98.5%, one of only three Trusts in London to keep its performance above the old national standard of 98%. It was particularly notable given the continuing increase in A&E attendances, which grew by 6.0% during the year. The efficiency with which we manage the flow of patients through the hospital has also been reflected in the cancellation of fewer operations (down by 0.31 percentage points) and a reduction in length of stay for a number of key conditions.

A&E waiting times performance for Q2 – Q4 2010/11: patients seen within 4 hours *	
England average	95.6%
London average	95.7%
UCLH	98.5%
<i>* Due to the change of operational standard from 98% to 95% in late June 2010, the 'Year to date' figure in national reporting has been reset starting w/e 4th July 2010.</i>	

The Department of Health has set down new challenges for A&E departments in 2011/12. In place of the four hour waiting time target there is a new range of indicators designed to measure the quality of care provided in A&E departments. The new indicators are useful ones, in some cases encouraging us to work more closely with primary care to prevent re-attendance of patients at A&E. The targets set for a number of the indicators will require us to fine-tune some of our processes, in particular reducing the number of people who leave without being seen by a doctor and reducing the average time that patients have to wait. Given our success in improving our processes in A&E in recent years we are confident that we will rise to the new challenges during 2011/12.

In 2010/11 we provided our patients with access to services within national referral to treatment waiting times across the full range of national targets. We were compliant every month, with the 18 week referral to treatment targets for admitted and non-admitted pathways. We also made good progress in delivering compliance with the standards for each of our specialties, bringing neurosurgery, neurology, gastroenterology and orthopaedics to a position where they are now more consistently compliant with 18 week targets.

During the year the Department of Health signalled a move to median waits as the preferred method for measuring waiting times. We perform reasonably well against median waits for inpatient and outpatient care, although during 2011/12 we need to improve the quality of the data that we use to manage our waiting list: currently, problems with data management mean that we are shown as not performing well for waiting times for patients who are currently waiting for treatment. This is a priority for us to fix.

We have delivered against most of the cancer waiting time targets, including the 14 day standard for a first appointment following a GP referral and all four of the 31 day standards for treatment following diagnosis. We have however struggled to deliver against the 62 day standard for treatment following referral from GPs and screening centres. A significant number of the cases we treat under the 62 day GP standard are for prostate cancer. The Department of Health agrees that it is not as appropriate to fast-track some cases of prostate cancer since decisions about treatment carry significant implications for patients and the decisions don't need to be rushed. Our performance also suffers as a result of onward referral of complex cases from other providers at a point in the patient's pathway where it is impossible for us to honour the 62 day standard. We continue to work with our cancer network colleagues to improve the overall pathway that patients travel along from the time that they are referred by their GP.

We have also failed to meet consistently the 62 day screening standard. Again, our workload is dominated by referrals for possible cases of bowel cancer or by referrals from the screening service – where it is not as appropriate to fast-track treatment since the patient's condition is usually less clinically urgent, patients have yet to develop symptoms, and it is appropriate to allow patients to

choose appointments in their own time. Our performance against the 90% threshold for this standard is also extremely challenging on account of the low numbers of cases involved, with a single breach of the standard in any quarter meaning that we are not compliant.

There are of course elements of both the GP and screening pathways that we could improve upon, and as a result we have taken action in access to diagnostic imaging and surgical facilities during the course of the year. We will continue to identify areas for improvement that are within our control. Improvement of our reported performance against both of these standards will continue to be a top priority for us during 2011/12.

7 FINANCES

We are pleased to report that our underlying financial results (prior to exceptional items) for the year ending 31st March 2011 were better than plan and similar to the previous year. Unsurprisingly given the public spending climate, our income growth was at a lower level than that of recent years, and this trend is expected to continue.

Overall our turnover increased by 6% on the previous year to £738m (09/10 £700m), NHS clinical income increased 8% to £533m (09/10 £493m), and earnings before interest, tax, depreciation and amortisation (EBITDA) increased 6% to £67m (09/10 £63m). Our surplus (before exceptional items) of £11.4m was more than £2m ahead of plan and very similar to last year (09/10 £11.5m). This resulted in an overall financial risk rating of 4, indicating strong financial performance on the scale from 1 to 5 against which we are measured by the Foundation Trust regulator, Monitor.

Throughout 2010/11 we have focussed on our Quality, Efficiency and Productivity (QEP) programme, which aims to improve the efficiency with which we deliver healthcare to our patients, reducing waste and making financial savings whilst maintaining or improving our high standards of quality and safety. We successfully achieved 98% of our QEP saving requirement in 2010/11.

Aside from operational factors, the modest improvement in London property values resulted in an upward revaluation of our estate, requiring us to reverse £5m of the impairments suffered in recent years (09/10 -£22m), distorting our reported surplus/deficit (post exceptional items) from an £11m deficit in 09/10 to a £17m surplus in 10/11. Removing the impact of these revaluations shows that the underlying surplus was broadly the same in both years.

The summary year-end position is shown in the table below:

£ million	2010/11 Plan	2010/11 Actual	2009/10 Actual
Operating income	716.9	737.8	700.1
Operating expenditure	(652.0)	(670.6)	(636.8)
EBITDA	64.9	67.2	63.3
Depreciation costs	(20.7)	(20.1)	(18.8)
PDC dividend	(9.0)	(8.5)	(8.2)
Interest income and costs	(26.2)	(27.1)	(24.9)
PRE-EXCEPTIONAL SURPLUS	8.9	11.4	11.5
Impairment	0	5.1	(22.5)
Retained surplus/(deficit)	0	16.6	(11.0)

Note – all figures rounded to nearest £0.1m

Specialist Hospitals and Medicine Clinical Boards delivered strong financial results, while Surgery and Cancer board struggled to deliver against a challenging plan. Our overall EBITDA margin, an important measure of productivity, was 9.1%. This was exactly on plan and consistent with last year (9%).

Our balance sheet remains strong, with a cash balance at the end of the year of £107m, although this includes the draw down of £20m of a loan to partially offset the costs incurred on the construction of the new UCH Macmillan Cancer Centre, due to open in April 2012. The cash balance also includes the sale of estate, which will be partially used to provide funding to enable the re-provision of pathology facilities during 11/12.

Forward Look

Moving forwards into 2011/12, pressures on our financial sustainability will increase significantly and it is in this context that the Trust is planning a break-even financial position for the next three years, with much lower activity growth than has been the case in recent years and with a consequent knock-on effect upon the trust's cash plan and the ability to re-invest financially in service developments and develop the innovative, research-led care that we strive to provide.

We will be impacted adversely in 2011/12 not only by a significant reduction in the tariff price chargeable for treating our patients and the introduction of strict restrictions upon payments for patients "re-admitted" within 30 days of being discharged from hospital, but also by a material reduction in the

Market Forces Factor (MFF) funding that compensates for the additional costs of providing services in a high cost area such as London.

We currently estimate that the level of cost saving that we will need to deliver in 2011/12 will be at least £45m (or 6.3% of turnover). In common with most healthcare providers, our target significantly exceeds the value of savings delivered in recent years. Unlike many areas of the public sector, the opportunities within a major hospital to save money through cutting or reducing services are limited, as our income is based upon the amount of activity that we do. The emphasis, therefore, has to be upon providing the same service at the same quality but at a significantly lower cost, a tough challenge to our staff at all levels.

We continue to co-operate with commissioners in their programme of demand management, aiming to treat patients in primary care where this is the most clinically appropriate setting, rather than acute hospitals such as ours. As a PFI-funded modern hospital there is also a strong argument that greater efficiency for the taxpayer would be achieved with increased rather than decreased patient flow through our main UCH facility, and we will continue to work with those planning sector, regional and national service provision to ensure the maximum utility of all our facilities.

2011/12 will also see the full roll-out of a patient level costing system (PLICS) to enable us to better understand the costs of delivering care to our patients – this system is now producing its first detailed results which will need to go through an extensive validation process. The system will support a much clearer understanding of what drives costs across the Trust at a detailed level and help us identify opportunities for efficiencies in the care we provide patients. The Trust also made significant progress in its development of Service Line Management, further empowering clinicians in financial leadership and enabling them to make informed financial decisions in line with the trust's devolved and clinically-led management structure.

We are also working jointly with the Royal Free Hospital to implement a new financial system, working to common processes and standards across the two organisations to help create further efficiencies and improvements in quality through working closely together on the provision of the finance service. A project to explore synergies like these between all members of UCLP (University College London Partners) has now been running for a year and represents a significant part of our drive for future savings alongside quality improvement.

Our efficiency programme

Given the national challenge in improving quality and reducing cost that will face all organisations over the next five years, in January 2010 we put in place a quality, efficiency and productivity (QEP) programme to help the organisation achieve the challenging financial targets while continuing to delivery high quality care.

The year one programme had a target of £32m, and we achieved 98% of this demanding target. Our Board of Directors monitors very closely the interplay between how we save money and the quality of the services that we provide. At present quality metrics are performing strongly, including improvements in patient satisfaction rates and HMSR rates recently at an all time low. With a savings target for 2011/12 at £45m we still aim to make improvements in quality. Additional savings requirements in 2011/12 and future years will also be closely assessed for their potential impact on the quality of the services we provide to our patients.

The success of the programme has been due to commitment across the organisation and the delivery of many schemes at local level, driven by clinicians and local management.

The work was taken forward through five major strands plus considerable local activity. We are using the same structure for year two of the QEP programme in 2011/12, including:

- workforce: minimising the use of agency staff, which has been halved during the year
- productive clinical services: making our clinical teams as efficient and productive as they can be, with a focus on reducing length of stay, cutting out unnecessary steps on the patient pathway and improving the efficiency within outpatient clinics

- procurement: getting the best value for money out of the contracts we have with all our suppliers, and ensuring that we get the best value with new purchases
- asset utilisation: getting the best use out of the buildings that we own and lease, including estate rationalisation
- back office services: making Trust processes more efficient including the use of business process management software, and looking to see if any of our administrative or clinical support services can be shared across UCL Partners or taken on by alternative arrangements to deliver a better value service.

The programme's approach is based on five guiding principles:

- make life simple
- keep patients safe
- get everyone involved
- use the evidence
- spend money wisely

Each strand and clinical and corporate team has agreed savings targets in support of the QEP programme and these are reported on through the QEP Project Management Office to Executive Board and the Board. In year two we are using the same approach and structure to achieve £45m in savings at the time of writing. We are close to identifying schemes for all of this target, although this of course represents a significant challenge in terms of delivery.

We have agreed our five year strategic approach to QEP in a strategy document called "Thriving Through the Downturn". The strategy was approved by the Executive Board in December 2010 and communicated to all staff during a major QEP week of events in March 2011. These celebrated the hard work and results achieved in the first year and focussed on the task ahead in year two and beyond.

8 DEVELOP AND ENABLE STAFF TO MAXIMISE THEIR POTENTIAL

Our workforce continues to be our most valuable asset and underpins our future success. We recognise and acknowledge the correlation between high quality HR practices and improved patient outcomes and safety.

The health agenda over the coming years will require the us to work even harder to communicate and engage with our workforce and other strategic partners including trade unions during a time of significant change. We will have to support and challenge our staff, to be more productive and innovative to improve further the already high quality of care expected by our patients and commissioners with less resource.

Improved two way communication, regular staff feedback and supporting the development of all staff and their leaders will be important to delivering success in the coming years.

Key achievements during 2010/11 include:

- A reduction in agency spend of £11.5m pa, from £24m pa in 2009/10
- The highest bank fill rate on record: 91% in March 2011, an improvement of 21% from the same period in 2010
- More than 1000 additional bank workers have been recruited since the 1st of April 2010
- Maximising the use of technology (ESR, NHS Jobs), to reduce the length of time to hire. This has resulted in an average from receipt of request to advertise to conditional offer taking 9.6 weeks
- e-CRB implemented in January 2011 and delivering turnaround times of 4 working days on average
- Reducing the average cost of management of employment relations cases from £7,500 to £1,700 per month
- Recruitment activity in 2010/11 has been considerable: 47,537 applicants applied for 1750 posts.
- Key recruitment focus has been on providing positive support to enable the opening of the Hyper Acute Stroke Unit and the Brain Tumour Unit and to re-configure services through the tower re-stack.
- Assessment centres for appointing to large scale advertisements, for example health care assistants. During September through one such event 22 full-time equivalent posts were appointed.

In 2011/12 we will continue to make improvements to our core workforce and to the quality of support we provide to our clinical boards and corporate teams. We will use comprehensive performance measures to track effectiveness and ensure they offer value for money. We will focus on 5 key areas of development in 2011/12 to help improve patient care, meet customer needs and value for money.

The five key areas of development will be:

Stream 1:

Reduce workforce costs

Remove waste, improve productivity and reduce workforce costs whilst improving patient outcomes, safety and experience.

Reduce our pay bill: Pay continues to be the single most significant element of the Trust's budget and over 45% of our income is spent directly on staff. The pay bill in 2010/11 was £360m. Financial pressures and efficiency gains will mean that our pay bill will have to reduce.

In March 2010 we employed 6789 whole time equivalent staff. In March 2011 this figure rose to 7170, an increase of 5.6% in 12 months. Over the past 3 years our income has grown by 37.1%, our paybill 31.6% and headcount by 17.9%. 5.6% of this headcount growth is accounted for by bank and agency staff. Our Medical and Dental workforce has grown by 15.3%, our consultant workforce by 18% and

healthcare support worker roles have grown by 20%. This sustained period of growth will end in the coming year.

Quality Efficiency Program (QEP) programmes that deliver planned increases in productivity and efficiency and reduce waste will continue to impact on our staff, in terms of skills mix, working arrangements and ultimately in numbers. We are aiming to reduce our pay expenditure over the next four years, to match the inevitable reductions in our income. This means our workforce will necessarily be smaller. To support the delivery of this reduction in expenditure, the focus of workforce delivering efficient workforce solutions and working collaboratively to improve productivity in clinical and non clinical areas. The levels of workforce change will be delivered against a number of our principles:

- Use natural wastage and planned workforce changes to deliver the required workforce reductions. Our staff turnover is around 13%. We have worked hard to minimise any redundancies and we will work hard to maintain this during the 2011/12. However, other workforce approaches including mutually agreed resignations schemes will be considered and made available as required.
- Focus whenever possible on protecting clinical, front-line staff from staff reductions, in the first instance targeting management and administrative costs for reduction, ensuring they are as efficient and as effective as they possibly can be.
- Increase efficiency and productivity of front-line staff so that the same number of staff can deliver care for more patients, in redesigned services, whilst continuing to reduce temporary staffing use.
- Ensure that we achieve value for money in relation to our workforce costs, ensuring we pay the right rates for our staff and incur only necessary costs
- Ensure that our workforce practices are efficient and effective, this applies in both our workforce policies and in their operation.
- Support and challenge our staff to be innovative in their approaches to the way they work and skilled in increasing productivity and reducing waste.
- Work with all our colleagues to engage the workforce and their representatives in the challenges ahead. This will require that they are effectively communicated with to understand the need for change, are fully involved in them and that they remain enthusiastic about the services they deliver, enhancing our reputation.

Bank and agency usage: We will continue to derive better value from our bank and agency contracts and drive up quality through regular and robust audit. Work continues to improve absence management and timely recruitment to support dependence on agency staffing. Targeted recruitment campaigns will continue to increase the number of workers registered with our agency bank.

Our challenging targets for 2011/12 mean we aim to achieve a further 20% reduction in nursing and midwifery temporary staffing requests and zero agency use from July 2011. An increasing number of areas are achieving zero or near zero agency spend for nursing and midwifery staff, including:

- Patient Emergency Response Team
- Bed Management
- Infection
- Medical Specialities
- All paediatric wards with the exception of T12S;
- 6 wards within Queens Square Division
- All wards in the Heart Hospital (excluding Theatres and ITU);
- All midwifery areas (excl. NNU)
- Haematology and Oncology OPD
- T14
- Ophthalmology
- T2 Day Surgery and Surgical Reception.

Focussed work in the past year has significantly reduced agency expenditure, however, the Trust still spent over £28.21 on temporary staff in 2010/11, down from £36.2m in 2010. Included within this 2010/11 figure is over £13.8m spent on agency staffing across all staff groups including medical and dental, nursing and midwifery, clinical and non-clinical support services. Since April 2010, however, the proportion of total temporary staffing expenditure spent on agency staff, for all staff groups, has reduced from 65% to 44%. Bank expenditure for all staff groups has increased from 35% to 56%.

Stream 2: Engage staff

Fully involve staff in the significant changes ahead, enabling them to understand and contribute to the changes, support the Trust's goals and aspirations and to feel supported and valued by the organisation.

During 2010/11 Trust staff continued to be involved in a range of working groups and projects aimed at supporting Trust objectives. A new approach to Team Briefing seeks to ensure that staff remain informed and engaged in Trust activities and have the opportunity to influence and support them.

The Trust remains committed to engaging with staff and unions to deliver improvements to services, improvements to working conditions and to work with them to manage change. We are committed to promoting health and wellbeing, providing staff benefits, delivering training and protecting the health and safety of our workforce and those who access our services. The contribution by staff this year has been significant and is highly valued by the Trust.

Staff feedback: Ensure frequent, structured staff feedback including monthly surveys focussing on key issues. This will be especially important during a time of major change and uncertainty.

Employee relations: Foster positive employee relations and further reduce the incidence of grievances and disciplinary procedures that we have to deal with. We will streamline processes, and train and develop staff to be more accountable and autonomous. We will continue to invest in training our managers in how to avoid and manage the most common causes of complaints against us.

Health and wellbeing: Develop a comprehensive health and wellbeing strategy which will support and enable staff to improve their performance and the quality of care for patients. This strategy will be developed with staff and managers so that all levels of staff and all areas of the Trust are involved and are able to support its development. It will have measurable outcomes so that progress can be clearly monitored.

Stream 3: Enhance leadership

Develop leaders at all levels across the organisation so they are confident and competent in their roles.

Framework for staff development: Following consultation and discussion with a range of internal stakeholders, we have adopted a new framework for the development of staff and managers. It will be implemented further in 2011/12. The framework identifies five levels of development linked to different stages of career development in the Trust. It is designed to complement professional training and development already in place for clinical staff. Each level links to specific development opportunities, providing staff with the knowledge, skills and approach they need at each level of the organisation. Once implemented, the framework will help the Trust to meet its obligations, including compliance with external regulatory frameworks.

Management and leadership development: The UCLP Staff College has been launched to help develop our leadership skills during a period of rapid change. We have also developed a training programme for managers, "Leading for Improvement" which will be launched during the coming year.

Staff development and appraisal: Our ability to develop staff depends upon effective appraisal. We need to ensure all staff take part in appraisals of their work. To help achieve this

in the coming year we will introduce new policies and procedures. These will help our Human resources and Organisational Development teams to see where we need to make change.

Stream 4: Improve compliance and performance; Develop workforce metrics to include reporting and levels of sickness absence, mandatory training, appraisals and induction.

Non clinical support service programme (back office): Collaborate with UCL Partners to find new ways of managing back office functions that save money and reduce overheads and waste. We will use our greater collective purchasing power to obtain economies of scale. This programme will deliver agreed year on year financial savings over the life of the programme.

Recruitment: Introduce new systems and processes to support workforce compliance and help our clinical and corporate teams to recruit high quality staff.

Mandatory training compliance: Ensure that staff have the right skills and experience to do their jobs well and reduce risk to patients. Develop a new mandatory training programme for all our staff. We will use e-learning to improve our compliance with training requirements.

Stream 5: Simplify and standardise workforce processes; make it easier for managers to manage and leaders to lead.

Employee management: ESR is enabling us to streamline how we manage all aspects of staff management, including new starters, employee detail changes and absence management. Benefits of this approach have included more accessible and robust reporting on workforce. In partnership with ICT we will introduce ESR self-service, where managers enter certain information about staff directly themselves. There will be further work on job planning across professions in clinical teams to ensure that there is a standardised ratio of clinical time across all health care professions. This relates to allied healthcare professionals as well as medical and nursing staff.

Procurement and implementation of a whole staff rostering system: subject to a successful business case, we will use a rostering system to generate savings by making sure that all staff are deployed as effectively as possible.

Probationary periods: we will continue to ensure all new starters receive proper training, induction and performance management during their probationary periods.

9 WORKING IN PARTNERSHIP / BUILDING STRONG RELATIONSHIPS WITH GPs

We aim to improve the quality of care we provide for patients and reduce costs by working with colleagues in primary care across the North Central London (NCL) sector to develop new, integrated care pathways.

One of the biggest challenges for us both will be to help patients receive more healthcare closer to home. A critical factor will be ensuring there is enough capacity in the community for patients previously seen in hospital and ensuring safety and high quality.

The development of integrated care pathways with primary care colleagues in the NCL sector offers excellent opportunities for focussing the healthcare resources where there are the biggest improvements for patients. This shift in how the NHS delivers care depends upon changes in how we manage patients at UCLH. It also depends upon changes in the primary care infrastructure, most notably ensuring that there is enough capacity in place to receive patients previously seen in hospital, and ensuring that standards of patient safety and quality will be met.

The aim of our integrated care work will be to design reduce duplication in patient pathways, support self care and ensure that patients have rapid access to hospital services when they need it. We also implemented a post acute care re-enablement scheme in January 2011 that supported patients receiving the personalised care in their own home by our hospital staff following discharge. Post Acute Care Enablement has been trialled nationally over the past year and has received very positive feedback from patients who are delighted with their continuity of care following discharge. We aim to expand out the project this year to cover a much wider group of patients.

Our elderly care team have developed their model of care to provide greater input at the start of a patient's admission to the Trust. This model of working has meant that elderly patients who often have very complex care requirements following discharge are been assessed much earlier, communication with community teams is starting much earlier to develop plans for ongoing care and reduce any delays that may occur later in the patients pathway. We have also developed our model for COPD by enhancing the expert respiratory care for patients and linking with community teams.

We have been doing a lot of work to improve the quality and timeliness of the information that we make available to GPs about the patients that they send to us. We have continued to develop our "GP portal", which is a web-based solution that enables GPs to access information about patients they have referred to UCLH using a secure connection to our systems. The information includes appointments, admissions, clinical documents, results, discharge summaries, A&E attendances and other key clinical information. The system is on a secure NHS IT network and access is through an individual log-on, with GPs only able to look at their patients. The GP portal will provide more transparency to GPs on exactly where patients are on their sometimes complex pathways through our services. We aim to roll out the GP Portal to all GPs in Camden, Islington and Westminster by the end of June 2011, followed by our other key referring GPs by the end of September 2011. During 2011/12 we will also be putting in place an e-messaging solution that will allow us to send electronic clinical documentation directly into GP systems, fitting into how GPs manage their work and reducing the amount of paper they receive.

The GP portal and e-messaging solutions will be key to improving the time we take to get discharge letters to GPs so that they and their patients receive information on our services much faster. This has been a key concern of GPs and we are determined to resolve the issue during 2011/12. We will also continue to improve the quality of the information that we provide in discharge letters, and have agreed with commissioners to use incentive payments under the "Commissioning for Quality and Improvement" (CQUINs) scheme to drive delivery of higher quality letters.

We try hard to keep our GPs as up-to-date as possible with developments at the hospital. Our UCLH GP Liaison Committee (GPLC) is a long-established high level forum providing clinical leadership to oversee the co-ordination and management of clinical interface issues between primary and secondary care. The Committee is made up of GPs and PCT representatives from Camden, Islington and Westminster, as well as a mix of senior clinicians and managers from UCLH. The group meets quarterly and discusses a range of issues. As a result of GPLC

feedback, significant changes have been made to the way the Trust works. Some of the notable successes of 2010/11 have included:

- Review of terms of reference, and confirmation of continued role for GP Liaison Committee addressing clinical management issues at interface of primary care and acute local hospital part of Trust in particular.
- Supporting the roll-out of access to the UCLH GP Portal, a web-based solution which will allow GPs to access information about patients they have referred
- Supporting a series of improvements at the interface between Trust and GPs including: new processes for notifying GPs of a patient's admission and discharge from the Acute Medical Unit, and of a patient's death; gastroscopy access forms; patient information leaflets and communication of biopsy results; interim solution to problems of discharge letters to GPs about patients attending the Emergency Department.
- GPs were kept updated on projects including: a COPD initiative to reduce admissions and length of stay; UCL Partners' engagement with primary care; transforming the diagnostic pathway in prostate cancer and the new UCLH website.
- Aligning GP seminars to meet GPs' requirements.

For 2011/12 the committee will be:

- Providing feedback on the results of the 2011 GP survey
- Supporting improved communication with GPs about a new pathway for vascular surgery patients
- Improving the process for GP referral to specialist teams for emergency assessment
- Sustaining improvement in discharge letters from the Emergency Department
- Reviewing the process for booking outpatient ultrasound scans.

Local primary care practitioners are also kept informed of developments at our hospitals through the distribution of a bi-monthly newsletter, GP Links. We hold evening educational seminars for primary care and subjects covered in 2010/11 included early onset dementia, women's health and colorectal cancer.

10 RESEARCH

Our designation as one of the UK's five comprehensive biomedical research centres continues to create excellent opportunities in research and development.

Comprehensive Biomedical Research Centre

The UCLH/UCL National Institute for Health Research (NIHR) Comprehensive Biomedical Research Centre (CBRC) aims to translate pioneering scientific research into tangible treatments that will directly benefit patients. Work is divided into 15 research themes which build on the Trust's recognised expertise in areas such as cancer, cardiovascular disease, neurosciences, women's health, gastroenterology and technologies such as cellular and gene therapy. Key strands of work include:

- **Investing in new research projects.** Over £5m has been allocated towards high-quality research projects. It is also estimated that the CBRC's combined funding pot has attracted in excess of £60m from external sources for new projects.
- **Building research capacity.** The Centre for Neuromuscular Diseases is supported by the CBRC and is supporting clinical trials that link to specialist clinical services. Other developments include: a new UCL Partners' obesity programme, investment in a UCL-led biobank for disease risk assessment, screening and prediction, genetic profiling of the UCLH head and neck tissue bank and infrastructure development for a new Comprehensive Infection Research Centre for Investigation, Translation and Training (CIRCITT).
- **Supporting world class research teams.** The CBRC has established several courses and studentships to produce future research leaders. Twenty-three CBRC staff have been awarded Senior Investigator status by the NIHR.

UCL Partners

The CBRC continues to be the driving force for research behind the population health gain objectives of UCL Partners (UCLP). The current list of UCLP programmes and their objectives are shown in table 5.

UCLP programme and core objectives for population health gain

Programme	Core objectives for population health gain
Cancer	<ul style="list-style-type: none"> • Develop a provider network to deliver integrated, patient focussed, care pathways - brain cancer treatment to provide the first model • Reduce mortality and morbidity by promoting early diagnosis • Increase availability of clinical trials of innovative cancer treatments
Neurosciences	<ul style="list-style-type: none"> • Reduce mortality and morbidity from stroke • Improve outcomes for neurosurgical and neuro-oncology patients. • Improve outcomes for dementia and other central neural system degenerative conditions
Cardiovascular	<ul style="list-style-type: none"> • Prevention of premature cardiovascular disease • Congenital heart disease: prevention, integrated paediatric to adulthood care, suitably powered studies to inform and improve outcomes • Improve outcomes for major cardiac events - acute coronary syndromes, heart failure, atrial fibrillation and cardiovascular surgery

Immunology and transplantation	<ul style="list-style-type: none"> • Develop and implement new genetic tests for auto-immune diseases and immunodeficiency • Develop and implement new treatments for immunodeficiency and opportunistic infections • Improve outcomes for patients requiring transplantation
Infection	<ul style="list-style-type: none"> • Reduce mortality and morbidity caused by imported infection • Integrated model of care for HIV and large scale studies of new agents
Eyes and vision	<ul style="list-style-type: none"> • Improved management and outcomes of chronic glaucoma in the community using innovative new technology and education
Child health	<ul style="list-style-type: none"> • Tackling obesity in 0-19 year olds • Improve care for juvenile diabetes
Women's health	<ul style="list-style-type: none"> • Improve maternity care (outcomes for mother and baby, satisfaction and efficiency), • Focus research and development on major determinants of prematurity and pre-eclampsia • Improved STI screening and care of sexual health closer to home; reduce teenage pregnancy by switching to more effective methods, especially intrauterine devices

Other research issues

In 2009/10 we developed funding mechanisms to improve the transparency of research income to the Trust and to increase accountability for research activity through formal acknowledgment in consultant job plans. We have used this to be more rigorous in the control of research costs, more assertive in pursuit of new income and more explicit about the benefits that our research brings to patients.

Planning continues for the UK Centre for Medical Research and Innovation at St Pancras which will establish the country's largest concentration of biomedical scientists and will provide major collaborative opportunities for research at UCLH.

We continue to support a large portfolio of clinical trials and studies. The portfolio is one of the largest in the country (1,500 projects). We are one of the largest recruiters of patients to NIHR studies.

We completed refurbishment of our clinical research facility and it is now fully operational. The new centre can conduct clinical trials and other studies in a purpose built environment, enabling research to be conducted rapidly, effectively and safely.

11 OUR STRATEGY TO IMPROVE SERVICES

Our overall corporate strategy is framed by our commitment to clinical and research excellence. We provide excellent general and specialist services to our local population and to patients from across the country. Driven by our strong research capability we are always striving to improve the quality and range of our services.

The landscape of the NHS is shifting fast. GP commissioning will galvanise plans to move services from acute hospitals into primary and community care settings. As part of our plans to work closer with primary and community care we describe our close involvement with GPs in redesigning pathways in section 9 above. For 2011/12 we will be changing our service delivery models in 5 key areas so that funding and organisational arrangements make it much easier for patients to be treated in community settings.

Equally, the increasing emphasis on outcomes will encourage renewed efforts to centralise specialist services where increased numbers will drive improvements in quality. We invest in specialist services where they are underpinned by a sound business case and where there is:

- a well functioning and effective multi-disciplinary team making good use of existing resources and demonstrating clear collaborative leadership
- a secure patient referral base and evidence that centralisation at UCLH improves outcomes
- a major associated research and development programme (or UCL commitment to develop such a programme)
- compliance with wider strategic initiatives.

In February 2008 we described our seven areas of strategic focus as:

- neurosciences
- cancer
- cardiac
- women's health
- dental
- paediatrics
- acute surgery and medicine

We believe these seven service areas remain the right core specialties for the Trust. However, if the Royal National Throat, Nose and Ear Hospital (RNTNEH) joins the Trust during 2011/12 we will broaden the existing strategic focus on dental services to one which focuses on creating a national centre of excellence for mouth, ear, nose and throat.

In recent years we have made good progress on our strategic priorities. We have opened our women's health facilities in the Elizabeth Garrett Anderson Wing – part of the second phase of our redevelopment programme. Work is well underway for our new cancer centre, the Macmillan/UCLH Cancer Centre, which is one of the first of its kind in the UK. We have developed ambitious plans to become a centre for innovative proton beam therapy.

Our strategic priorities this year include:

Commissioning the UCH Macmillan Cancer Centre

In 2009/10 the Board approved the business case to build the innovative UCLH cancer centre in Huntley Street, directly opposite the UCL Cancer Institute, on the site of the old Elizabeth Garrett Anderson and Obstetric Hospital. The cancer centre will be phase three of our strategic development plan and will open in 2012. The building itself will be completed in January 2011 and will open to patients by April 2012. To support services in the new environment we have invested in the first PET-MR scanner in the UK which will be installed in autumn 2011.

The cancer centre will provide a world-class patient environment for outpatient and day case cancer services at UCLH and the innovative design will provide a welcoming and supportive environment and range of services for patients living with cancer. Working with our partners Macmillan, we will improve patient experience through

- bringing different specialists treating cancer together to provide a better service

- reviewing patient pathways so that we diagnose and treat patients faster
- new appointments systems so that patients receive one pathway, not separate appointments with different Departments
- communication with patients and GPs via the telephone, the website and using patient information and new IT systems

Macmillan are also supporting us to establish a new Patient Experience Board to give patients a real voice in how we design and deliver services, and to make sure that we deliver our commitments to patients.

Securing Proton beam therapy

We are working to become the first centre in the UK to provide Proton Beam Therapy (PBT). PBT is an advanced form of radiotherapy which can target tumours far more precisely than conventional methods. This new technology is only available in a handful of centres worldwide and is beneficial for child, brain and eye cancer cases. We have formed a partnership with other hospitals in our national bid to be one of two national centres which are planned to be established in the UK by 2014. UCL Partners is supporting the development.

It requires a site the size of a football pitch due to the scale of the equipment, and single centres can cost up to £150m. UCLH already owns a suitable site – the “Odeon site” – close to University College Hospital.

There are currently no high-energy PBT facilities in England. Patients who require the treatment are sent abroad. PBT will reinforce our aspiration to be one of the top three cancer centres in Europe.

The Department of Health wrote to us in September 2010 confirming that it was proceeding with the evaluation of two options for provision of PBT facilities:

- A two site solution comprising UCLH and the Christie
- A three site solution comprising UCLH, the Christie and University Hospitals Birmingham

A decision on next steps is expected early in 2011/12. The PBT facility will be part of phase four of our development programme.

Developing a Mouth, Ear, Nose and Throat national centre of excellence

As described above the transfer of the RNTNEH to UCLH will provide the platform to develop a national centre of excellence for mouth, ear, nose and throat services. ENT services are already one of the priority research themes for UCL partners. This development will bring together ENT with the head & neck services at the Trust, dental services at the Eastman Dental Hospital and ENT cancer services. A state of the art new facility for mouth, ear, nose and throat services is part of our plans for phase four of the Trust's development.

Developments in other priority areas

Our hyper-acute stroke unit (HASU) opened in summer 2010. It is based at the UCH site and is led by neurologists from Queen Square. A highly skilled multi-disciplinary team provides rapid assessment, treatment and continuous monitoring to patients within the first 72 hours following a stroke. This maximises acute management and rehabilitation of stroke patients in the most appropriate setting. We are delivering the service in close partnership with stroke units at the Royal Free, Barnet and Chase Farm and North Middlesex hospitals, with patients sent to these partners once they have had all necessary specialist input at UCLH.

During 2011/12 we will continue to work with partners in North Central London and beyond to develop our **cardiac services** and cardiac facility strategy in light of the recent London review of cardiovascular services.

Our **clinical support services** are fundamental to the successful operation of the Trust but also provide world-class services in their own right. In order to maximise the opportunity to not only reduce costs but provide the benefit of our expertise to the wider London market and beyond each of our clinical support services is developing plans this year to build critical mass through partnership with other trusts from UCL Partners or through joint venture initiatives with the private sector.

12 OUR MEMBERSHIP

Increasing our membership and improving engagement and involvement are the key strands of a membership strategy agreed by both the governing body and board in 2009.

In April 2010 we set a target to increase the public and patient membership by 10% and 5% respectively by the end of the year and this has been met. At 31 March 2011 we have 7983 patient and 1663 public members; we now have a total of 16,469 members from across the country including staff. Our objective in 2011/12 is to steadily build a strong membership who are informed, engaged and involved in the work of the Trust.

We have three membership constituencies and all members are eligible to vote for or stand as governors. Information about membership constituencies can be found on our website at www.uclh.nhs.uk

Membership numbers and analysis

	Last year 2010/2011	Next Year 2011/2012
Public Constituency		
At year start - April 1	1494	1663
New Members	246	-
Members Leaving	77	-
At year end - March 31	1663	1829
Patient Constituency		
At year start - April 1	7599	7983
New Members	840	-
Members Leaving	456	-
At year end -March 31	7983	8222
Staff Constituency		
At year start - April 1	c.6233	6752
At year end - March 31	6752	c.6752

In March 2011 the trust analysed its membership using demographic information provided by its members. Analysis of the public constituency indicates that the membership is broadly representative. In some areas i.e. in areas of ethnicity members from both the Asian community and the other ethnic minority group, are of a greater proportion than that of the eligible membership. During 2011 the number of members from an Asian background increased by 20%; this equates to 12% of the public members which is greater than the proportion of eligible members (8%) This demonstrates that the Trust's membership strategy has been successful - it focussed on engagement with local community groups predominately Black and Asian groups which in previous years were under represented.

The number of members in the 0 – 16 age group has increased from 5 – 11 members; although this is more than a 100% increase the number of members is too small to be significant. More important is the increase in members who are between 17 and 21 years of age which is now 5% of the public membership compared to 7% of the population. Links were made in 2010/11 with the Somers Town Youth Centre; we will continue to engage with the younger community next year. During the year more men were recruited narrowing the gap between the number of men and women members. Whilst the proportion of women at 54% is still higher than the eligible membership (51%) men now represent 46% of the membership compared to 44% in 2009/10.

Internally we reviewed our patient membership to assess how representative it was of the patients we serve. This analysis indicated it was broadly representative. Patient members are more often female with 57% in our membership compared to 51% of all Trust patients.

Members' ethnic groups are very representative and, as with the public membership, there are a higher proportion of Asian members than patients. There has been an increase in Black members with 6% of the membership coming from a Black ethnic background compared to 3% of our patients.

Overall the analysis of the combined public and patient membership confirms that there has been no significant change to our demographic profile and that a "typical" UCLH member is still a white female from the "older" age group.

In the 2010 elections the voting turnout for staff was the highest to date with 22.3% and 23.9% of staff voting for the administrative and clerical and the doctor and dentist governors respectively. We have set up a staff intranet forum to improve the interface between staff governors and their members so that staff understand what their governors do and why it matters. One of its aims is to increase the number of staff standing for election in 2012.

There will be six public and patient seats available for election to the governing body in 2011. Elections will be held in accordance with the election rules set out in the Trust's Constitution. Verification of membership constituency, class and numbers will be carried out prior to the 2011 election.

Membership activities

The governing body is made up of three public, fourteen patient, and six staff governors elected from the three membership constituencies together with ten appointed representatives from partner organisations.

During the year governors have worked on a number of initiatives to improve the patient experience and the service we provide to our patients. This has included following up action from experience mapping projects carried out in previous years to see if and how recommendations are being put into practice. Governors have also contributed to work to improve the quality of patient information in a number of areas including the patient questionnaire.

Governors have also engaged in activities which focus on the patient experience providing valuable feedback as participants in, for example, Patient Environment Action Team inspections and the nursing essence of care benchmarking programme. They are now joined by members in these activities.

In 2010/11 the High Quality Patient Care Group (HQPCG), chaired by the lead governor, has continued to champion quality issues within the Trust. HQPCG members produced information to illustrate the problems patients' can experience with the trust's appointment systems; this was to help the trust improve its administrative processes. A sub group of the HQPCG also carried out an interview based experience mapping project with cancer patients. This investigated how patients experience their care at UCH; it will work closely with the cancer team to look at how the patient experience could be improved.

For 2011/12 the HQPCG plans to:

- Continue to focus on projects that improve patient experience e.g. out-patient services
- Consider how governors might set up a quality watch programme
- Continue working with the Trust on patient information
- Continue to monitor disabled parking and drop off arrangements
- Contribute to the development of the Trust's Public and Patient Involvement Strategy

We have continued to improve engagement with members and have worked closely with groups in Camden including a successful event at Full of life in Camden, and a diabetes seminar at the Bengali Workers Association. Governors support the sessions, they talk about their role and answer questions about how they meet their responsibilities. This work resulted in an increase in members from the local Asian community.

Engagement with members increased and through a members' survey more than 50 members indicated they are interested in standing for governor. We have introduced new technology to support the strategy and now use the UCLH twitter page to advertise our MembersMeet health seminars. Members are getting involved in service improvement projects including outpatient focus groups and are invited to give their views on the Trust's forward plan.

Recruitment has taken place at local GP surgeries and plans are underway to visit more surgeries. A letter sent by the chairman to patients has proved an extremely successful recruitment tool and members are also helping the trust meet its membership strategy. Led by a governor, designated trust membership champion, a group of trained members are carrying out recruitment sessions across the trust's hospital sites.

For 2011/12 we plan to:

- Link our membership strategy with our public and patient involvement work and include engagement sessions with disability groups, the local Bangladeshi community and Camden youth groups.
- Seek to involve and engage with more members and undertake an evaluation of the delivery of its membership strategy.
- Carry out a resident's mail shot campaign
- Further promote the role and work of governors including considering the impact on their responsibilities of the new health bill.