East Kent Hospitals University NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

East Kent Hospitals University NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

Name	Melanie Hill
Job Title	Corporate Planning & Performance Lead
e-mail address	melaniehill1@nhs.net
Tel. no. for contact	01227 766877 ext 76305
Date	4th April 2014

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;
- The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Nicholas Wells**

Signature 

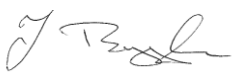
Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Stuart Bain**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Jeff Buggle**

Signature 

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

OPERATIONAL PLAN 2014/15 – 2015/16

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OPERATIONAL PLAN 2014/15 – 2015/16

SECTION A – PLAN OVERVIEW

1. Strategic Context

1.1 Background

East Kent Hospitals University NHS Foundation Trust (EKHUFT) is one of the largest acute Trusts in England. The Trust was awarded University NHS Hospital status by the University of London (King's College) in 2007 and Foundation Trust status on 1st March 2009. It serves a population of 750,000, employs over 7,500 staff and has 1,107 beds across three main acute hospital sites in Ashford, Canterbury and Margate. The Trust also provides local access to services with a range of outpatient and diagnostic services in its two community hospitals in Dover and Folkestone as well as a range of services throughout the local area in facilities owed by other organisations.

The three acute hospitals provide a hospital network predominantly serving the East Kent area with some Specialist services provision at the Kent & Canterbury (K&C) site and Accident & Emergency services at both William Harvey Hospital in Ashford (WHH) and the Queen Elizabeth Queen Mother hospital (QEQM) in Margate, giving accessibility to services and a critical mass for Specialist services.

1.2 Strategic Objectives and Core Values

In delivering against this background and in line with the Local Health Economy's strategy, the Trusts own strategy is to:

a) Maintain core acute mandatory services across a network of three district general hospitals;
b) Become more efficient, effective and safer in the way the Trust provides services through service redesign;
c) Continue to repatriate and expand Specialist service where appropriate;
d) Grow market share in East Kent (for current and new service) and develop the market in West Kent where opportunities arise (as the available market there has been extended through patient choice); and
e) Provide services closer to patient homes.

Our motto is 'putting patients first' and everything we do is guided by our vision and our values. We have a national and international reputation for delivering high quality specialist care particularly in cancer, kidney disease, stroke and vascular services. As a teaching Trust we play a vital role in the education and training of doctors, nurses and other health professional, working closely with local universities and King's College, University of London.

Our vision is to be known as one of the top ten hospital Trusts in England and the Kent hospital of choice for patients and those close to them.

Our mission is to provide safe, patient focussed and sustainable heath services with and for the people of Kent. In achieving this we acknowledge our special responsibility for the most vulnerable members of the population we serve.

Our values are 'We care so that:

- People feel **cared** for as individuals
- People feel **safe**, reassured and involved
- People feel that we are **making a difference**

The Trust has undertaken several engagement events and has listened to staff and patients to identify both patient safety improvement priorities and the development of the Trust values.

1.3 Trust Strategy

EKHUFT is currently in a strong financial position, delivering an operating surplus of £7m in 2012/13 and a consolidated forecast surplus of £3.9m in 2013/14. Compared against peer groups both locally and nationally, the Trust performs favourably against a number of key metrics connected to operational activity and clinical outcomes. However, over the longer term, the Trust faces a number of challenges to achieve continued and improved clinical and financial performance. It is within this context that the Trust proactively began to develop its strategic plan to address these challenges in order to protect the future sustainability of the organisation.

Against this backdrop, the Trust has commenced the development of an outline 5-10 year strategy 'Looking to Our Future', identifying key levers, drivers and their interrelationships, with a set of strategic options that illustrate the potential impact of those options on activity and the financial position of the organisation. This initial phase of work has facilitated initial discussions with stakeholders to support the planning for the longer term from a whole health economy perspective, however there is still a significant amount of work to be undertaken by the Trust in order the develop a clearly defined long term strategy that will enable the Trust to continue to operate with a financial surplus.

Alongside the development of the long-term strategy, the Trust has a number of existing clinical strategic plans in various stages of development across four areas of service provision; Emergency Care, Trauma, Outpatients and Planned Care. These plans will continue to be developed and implemented where appropriate with alignment to support the development and delivery of the longer term strategy, underpinned by an annually refreshed Financial Strategy and an embedded Quality Strategy.

1.4 Clinical Strategy

The Trust commenced work on a Clinical strategy three years ago and has subsequently successfully implemented the following service changes:

- Kent and Medway pPCI service development;
- 24/7 Stroke Thrombolysis services;
- Implementation of robotic surgery for prostatectomy;
- Maternity Strategy provision;
- Interim Trauma Unit – established April 2013.

Development and implementation is on-going and the following initiatives are in progress and development with a phased implementation over the next five years:

- Outpatient Services – public consultation complete with a decision due in June 2014 by the Board of Directors;
- Adult high risk general elective and emergency (abdominal) surgery – currently reviewing service model;
- Elective Breast Surgery centralisation – currently under review; and
- Emergency Services model – currently under review.

Several of these initiatives form the bedrock of the Trust operational plan for 2014/15 and 2015/16 and some are an aspiration and remain subject to Board of Director's scrutiny and approval. Table 1 below outlines a summary view of current and potential strategic initiatives.

Year 1 - 2014/15	Year 2 - 2015/16	Year 3 - 2016/17	Year 4 - 2017/18	Year 5 - 2018/19
Outpatients - Provision consolidated to six sites		Outpatient provision transfer to Community (Tiers of Care Review)		
Health & Social Care Village - Full implementation of 80 Step-down beds in Community	Internal Waits Reduction Programme fully implemented	Older People Strategy (inc community Geriatrician service)		
Ambulatory Care - Fully implement 12 Pathways	Ambulatory Care - Expansion of 6 further Pathways	Ambulatory Care - Expansion of further commissioned Pathways		
Implement interim solution for Adult High Risk General (abdominal) Emergency & Elective Surgery	Implement a 'hub & spoke' model for Adult High Risk General (abdominal) Emergency & Elective Surgery (pending Public Consultation)		Co-locate Specialist Services into an Acute Surgical Hub	
	Centralisation of Breast Surgery (Pending outcome of Public Consultation)		Establish a Kent & Medway Hub for Specialist Services (inc transfer from West Kent). Scope of services currently include: Vascular; Urology; Maxillo Facial; NICU; Interventional Radiology; Radio Pharmacy; Ophthalmology.	
		Establish single Cold Orthopaedic Centre		Women's Health/ Child Health and NICU Services co-located to a Single site (after feasibility testing - into Year 6)
Primary Care integrated into A&E departments - all sites		Co-locate Specialist Services into an Acute Medical Hub		
Establish Kent Pathology Partnership (KPP) model Centralise & integrate Pathology services for EKHUFT and Maidstone & Tunbridge Wells NHS Trust				
Establish Private Patient Strategy	Eatablish Private Patient Centre WHH			
	Establish a Support Services Hub (Remove from Clinical Sites)			

Table 1 – Trust Five Year Strategic Initiatives Summary

1.5 Quality Strategy

The Trust Quality Strategy was initiated in 2012 with the key aim of ensuring the Trust is 'Delivering excellence in the quality of care and experience of every person, every time they access our services'. Annually aligned to the Trust annual Objectives (see Section 3 for 2014/15 Annual Objectives) and entering year 3 of implementation, the strategy has evolved and now established a Quality Improvement Hub with the ethos 'connecting us to the best'. Whilst this initiative originated with the Trust's Quality Strategy, it has been refined through workshops with stakeholders with its aim - to support all staff to bring about improvements and developments in the way they work, practice and organise services both across the trust and the wider health economy so as to deliver on the four quality priorities and goals of the Trust's Shared Purpose Framework. These are:

1) **Person-centred care** – how we work with our patients, service users and each other to improve patient experience. This integrates the 'We Care Campaign' and the values into action
2) **Effective care** – how we use and develop evidence to underpin our interventions, approaches and the ways we organise care delivery to improve clinical effectiveness and reliability of care.
3) **Safe care** – how we practice safely and provide safe environments to improve patient safety and reduce harm.
4) **Developing effective workplace cultures and teams** - how we sustain the above outcomes through leadership, enabling continuous learning, improvement, inquiry and research, development and innovation.

1.6 Financial Strategy

The financial strategy reflects the Boards commitment to the overall strategy, vision, mission and values. It is refreshed annually but has remained relatively constant since the Trust became a Foundation Trust in 2009 with the main aims being:

- Maintain a financial Monitor COSR rating of 4.
- Generate enough cash funds and surplus through normal activities to sustainably invest in services, estate and equipment to support the Trust's overall strategy without having to enter into significant debt or reduce its financial risk rating.

Historically, the Trust's Financial Strategy covered a five year forward period to properly base the three year plan requirement for submission to Monitor. Following the extension of the Monitor submission planning period to five years from 2014/15, the Trust is well prepared to deliver a robust financial plan in support of the overall Trust strategy. The Trust also recognises that in order to properly develop a five year financial strategy, investments that might be made between years 5 and 10 also have to be considered at a high level, linked to the long term strategy.
The Financial Strategy also supports the Trust's view is that the overall financial environment will remain challenging for the NHS and specifically for acute providers like the Trust. The NHS has seen mean growth in funds of 4% but at best GDP growth is not expected to exceed 2.8% over the five years of the strategy. This means at best the Trust should only expect funding growth less than the long term trend but also conceivably receive no growth funding if the government decide to invest more in other public sector services.

	2014/15	2015/16	2016/17	2017/18	2018/19
Net Tariff Inflator/ (Deflator)	(1.9%)	(2.3%)	(1.9%)	(2.0%)	(2.0%)
Inflation built into PbR & Local Prices	2.1%	2.2%	2.1%	2.0%	2.0%
Tariff Efficiency built into PbR & Local Prices	(4.0%)	(4.5%)	(4.0%)	(4.0%)	(4.0%)

Table 2 – Financial Strategy Tariff Assumptions

As outlined in Table 2 above, the impact on the Trust is a baseline efficiency requirement of between 4% - 4.5% over the next five years, however the Trust will be required to deliver above this level in order to continue to invest in services and achieve the strong financial performance of the past few years.

1.7 Private Patient Strategy 2014/15 & 2015/16

The Trust is seeking a commercial partner to exploit Private Patient provision locally. A selection process is expected to be underway in early summer 2014 with a Board of Directors decision before the autumn. This proposal encompasses the Trust's current Private patient Unit and other private work.

2. The Short-term Challenge

2.1 Local Health Economy (LHE)

The financial stability of the local Health economy is less certain than it has been for a number of years. Historically the financial performance of East Kent Commissioners has been good and better than the financial performances of some of its commissioning neighbours. The strength of the Trust's main commissioners has been important to the Trust's own financial performance, however the new structure of commissioning and the transfer of commissioning budgets from local Clinical Commissioning Groups (CCGs) to the National Commissioning Board for Specialist Services have the potential to destabilise the finances of commissioners and therefore the Trust. In addition, due to the size of the former PCT covering the majority of the Trusts' commissioned services, financial issues could previously be more widely balanced across East Kent. In 2013/14, overspends in individual East Kent CCGs and Specialised Commissioning (SCG) has caused delays in payments to the Trust and an increase in contract challenges.

For 2014/15 onwards, the risk of a less coherent future strategy for commissioning across East Kent may increase. Lack of coherency could push up costs for the Trust as economies of scale are eroded through localised commissioning priorities. The Trust is activity engaged with Commissioners in developing effective activity-reducing service change models. This provides an opportunity to ensure, as far as possible, a consistent and coherent approach to service change across the LHE.

2.2 Commissioning/ Contracting Process 2014/15 – 2015/16

The Trust applies PbR rules and uses the National Tariff in its planning/ contracting processes and subsequent reporting where relevant. The Trust 2014/15 & 2015/16 activity plans are currently based on existing demand. It is considered that the current level of demand will be unaffordable for the Commissioners in 2014/15 onwards however the Trust is working with commissioners to identify schemes that will reduce activity, income and costs across the whole local health system. The scale of the current contracting gap with CCGs suggests that a recurrent improvement of circa £10m-£15m is required over the 2013/14 Trust financial outturn position with an additional contracting gap with NHS England (Specialised Commissioning – SCG) of between £6m-10m. The current financial level of commissioning intentions for 2014/15 amounts to £6.2m without adjusting for any part-year impact. A number of these schemes will not be ready to operate with effect from April 2014.

2.3 Current Performance

The finances of the Trust are broadly on plan for 2013/14. This performance builds on strong financial performances since the Trust became a Foundation Trust in 2009. Table 3 below outlines the forecast 2013/14 financial position in the context of the Trust consolidated financial performance over the past three years.

Year	Surplus/ Funds available for Reinvestment £m	Depreciation £m	Cash Generated from Operations (EBITDA) £m	Capital Expenditure £m
2010/11	8.9	(16.0)	32.2	(22.2)
2011/12	9.0	(16.9)	33.9	(15.0)
2012/13	4.0	(16.2)	35.7	(23.7)
2013/14 - Forecast	3.9	(16.6)	29.7	(30.5)

Table 3 – Trust Financial Position 2010/11 – 2013/14 FOT

To deliver this consistently strong financial performance, the Trust has had to make Cost Improvement Plan (CIPs) savings above the level of efficiency built into tariff. Demand for acute services in East Kent has systematically risen, which does increase income but also puts pressure on the system to deliver activity which drives up unit costs and dilutes returns. Operational pressures caused by delivering capacity and improved quality and safety has commanded management focus which now needs to be redirected to enable the Trust to deliver the longer term planned cost improvements. Despite this operational and financial pressure, as Table 4 outlines, since 2010/11 the Trust has demonstrated consistently good and improving performance across the Financial and Governance domains against which it is measured by external regulators Monitor and the Care Quality Commission (CQC).

Year		Q1	Q2	Q3	Q4
2009/10	Governance				
	Finance	4	4	4	
2010/11	Governance				
	Finance	3	4	4	4
2011/12	Governance				
	Finance	4	4	4	4
2012/13	Governance				
	Finance	4	4	4	4
2013/14	Governance				N/A
	Finance	4	4	4	N/A

Table 4 – Trust Performance 2009/10 – 2013/14
Note: FRR changed to COSR measurement in Q3 2013/14 – Trust remains a 4.

In planning for 2013/14, the Trust Contingency Reserve was uplifted to cover unexpected and generally non-recurrent cost pressures and was for the expected impact following publication of the Francis report. In response to the recommendations, the Trust has recurrently invested significantly in ward nursing staff levels and equipment which has utilised this contingency uplift and therefore in 2014/15, the Contingency Reserve has reverted back to its original level.

2.4 Cost Improvement Programme

The Trust has a proven track record in the successful planning and delivery of Efficiency programmes over recent years, with over £76m benefits gained in the previous 3 years. The main factors of success have been the combined approach of Corporate and Divisional schemes within an evolving understanding and ownership of the Financial Strategy across the organisation. In taking a strategic approach to efficiency gains, it has been recognised that cost savings deliverable from traditional sources and approaches as outlined above, are now considered unlikely to be achieved without major transformational service redesign from 2014/15 onwards. Indeed, performance through 2013/14 has proved more challenging than anticipated, with a forecast delivery of £26.1m savings. Primary factors in this position have been significant delays in progression of a number of high value supplies schemes requiring change management in addition to cost negotiations (inc managed service contract for prosthesis and CPAP/BiPAP equipment and consumables), and delays in progressing a major workforce programme including revisions to terms and conditions of service. Within the forecast position, recurrent savings total 73% and the recurrent shortfall will be addressed by Divisions as part of the 2014/15 budget setting process.

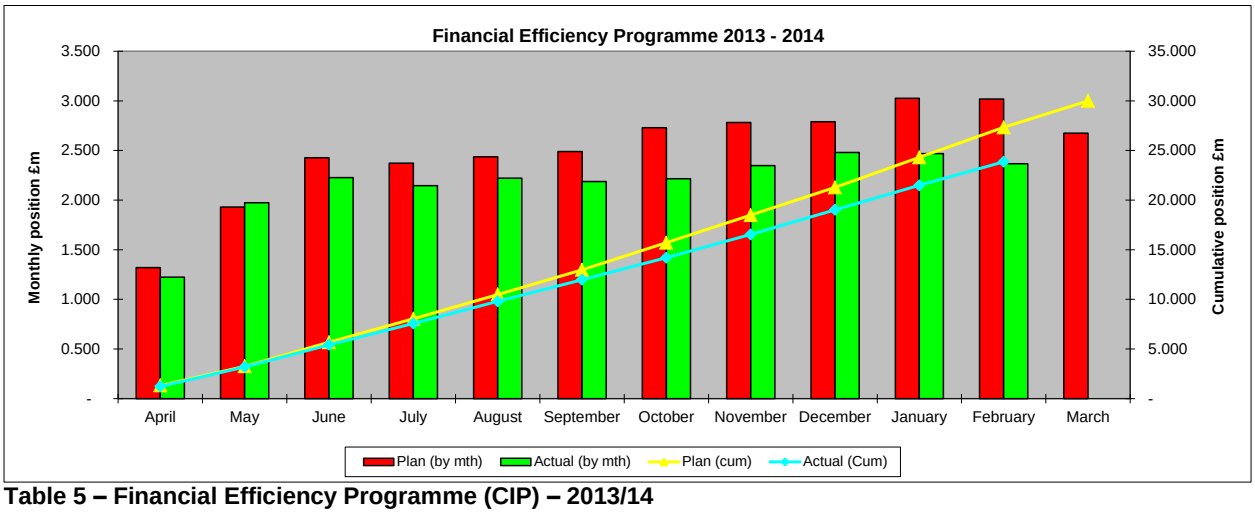

Table 5 – Financial Efficiency Programme (CIP) – 2013/14

The Trust has faced significant challenges in delivering the 2013/14 CIP plan reflecting the increasing financial pressures faced by a number of Divisions, with significant service demand pressures and associated expenditure exceeding income gains. As a result, the 2013/14 CIP shortfall is the first call on Divisional efficiency initiatives for 2014/15, placing an even greater challenge to the planning and achievement of the £26.8m 2014/15 target and 2015/16 onwards.

2.5 Quality Standards

A&E

A&E performance throughout 2013/14 has been variable with performance ranging between 91% at its lowest to 97% at its highest. The ability to meet the four hour standard in 2014/15 remains at risk due to high demand for emergency services and increased acuity of patients, demonstrated both locally and nationally. A further challenge for the Trust is the lack of community capacity in both bed capacity and care package availability and this is particularly difficult during holiday periods. The Trust is working collaboratively with external partners to improve discharge processes and provide a more streamlined approach to discharge planning. Action plans are in place to ensure that the Trust maintains it current compliant position and improves performance during 2014/15.

Referral to Treatment Waiting Times (RTT)

Referral-to-treatment waiting times have been met consistently throughout 2013/14 at Trust level. There remains a backlog of patients who have waited more than 18 weeks due to referrals consistently outperforming the contract plan, particularly in the Orthopaedic specialty. This is being managed jointly between the Trust and Commissioners, led by the Surgical Services Division, and the Trust is confident that it will maintain compliance in 2014/15.

Cancer Standards

Following non-compliance for the 62 day screening standard in quarter three 2013/14, a detailed pathway analysis of all breaches was carried out. The Cancer Services team have worked closely with the Surgical and Clinical Support Divisions to identify areas of failure and implement improvements to the pathways. An action plan has been developed and the standard is predicted to be compliant from quarter one 2014/15. There is no risk to achievement of any other Cancer standard in 2014/15.

Healthcare Acquired Infections (HCAI's)

The C-Difficile target for 2014/15 has been set and published by NHS England at 47 cases across the year. In comparison to the significantly challenging target in 2013/14 of 29 and based on the Trusts current year to date performance of 45 cases, the Trust considers it to be minimal risk in not achieving this target. The Trust has also had eight MRSA bacteraemias in 2013/14 (to end of February) with a target of zero in 2014/15. Financially however, the Trust has given consideration to the potential fines for non-compliance of HCAI targets within its forward plans.

External Compliance

The CQC targets/ indicators in the 2014/15 – 2015/16 APR do not relate to the new 'hospital inspection' framework that the Trust has recently been reviewed against in March 2014. The full CQC report is due to be shared with the Trust mid-April 2014. Following this, in mid-May, the Trust will present an Action Plan at a Quality Summit meeting that will include the CQC and commissioners. The quarterly publication of the CQC Intelligent Monitoring Report also provides a regular review of Trust performance against the five domains of quality.

Governance

The risks associated with the delivery of the Trust's quality objectives/ indicators are outlined within the Trust Corporate Risk Register and any emergent gaps in control measures are monitored through the Board Assurance Framework. Trust performance is reported within the Clinical Quality and Patient Safety Report to the Board of Directors.

2.6 Operational Pressures

The most significant risk in service delivery for the Trust relates to Surgical Services. In February 2014, the Trust's Board of Directors took the decision to centralise the management of all East Kent adult high risk and emergency (abdominal) general surgery on an interim basis. This decision arose because of an emergent serious clinical risk in high risk general surgery due to an insufficient number of Gastro - Intestinal surgeons being available to provide emergency cover, twenty four hours a day and seven days a week. The primary drivers are considered to be the increasing sub-specialisation of surgery, the lack of availability of surgeons with skills that are essential to managing high risk and emergency surgery and the difficulty recruiting both permanent and locum medical staff. The Trust has previously taken steps to address these issues, but there remains a problem in recruiting sufficient appropriate surgical staff to maintain the current structure of emergency rotas.

The decision by the Board is now being reviewed and considered by the Clinical Consultant body (alongside 13 focussed work-streams) to produce either a safe implementation plan or a workable and sustainable alternative, allowing the Trust to concentrate staff resources and ensure the provision of high quality care for patients, with positive outcomes as identified by national best practice.

The potential financial impact of the final service change solution has been built into the Trust Service Development investment assumptions for 2014/15 and five year capital plans.

3. Annual Objectives

3.1 2014/15 Objectives

In support of the Trust Strategy and to set in place a structured response to the challenges the Trust faces over the next two years, the Trust Annual Objectives for 2014/15 have been reviewed, updated and agreed by the Board of Directors. Measurement of achievement will continue to form a major part of the Trust Board Assurance Framework. The refreshed objectives for 2014/15 are outlined below:

1) AO 1 (QUALITY)
Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience/Person Centred Care.

2) AO 2 (QUALITY)
Develop and agree a Transformation Redesign Service Improvement Strategy that supports frontline staff to identify ways of working that cost less whilst maintaining high quality patient care.

3) AO 3 (ENGAGEMENT)
Improve the overall score in the annual Staff Survey and embed engagement into everyday practice in East Kent Hospitals University NHS Foundation Trust.

4) AO 4 (CLINICAL STRATEGY)
Agree with Commissioners and consult with the public to implement a sustainable clinical strategy which will in particular meet the standards for emergency surgery; ensure the availability of an appropriately skilled workforce and provide safe sustainable services with consideration of access for patients and their families and visitors.

5) AO 5 (MARKETING STRATEGY)
Identify and implement the commercial strategies which support the Trust maximise the opportunities to increase revenue, grow its business in profit making areas and retain its market share.

6) AO 6 (STRATEGIC DEVELOPMENT)
Drive increased efficiency and effectiveness of Trust corporate led services through the implementation of major infrastructure projects.

7) AO 7 (RESEARCH & INNOVATION)
Implementation of the Research & Innovation Strategy to increase "home-grown" research & innovation whilst continuing to support other's R&I endeavours by putting in place the right people, processes and facilities to support these goals and through effective engagement with R&I stakeholders.

8) AO 8 (INFORMATION TEAM)
Engage with the Divisions to develop and provide clinical information to support strategic decision making.

9) AO 9 (FINANCE)
Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and support a comprehensive internal cost improvement programme where all Divisions deliver cash releasing savings schemes to deliver Trust QIPP targets.

3.2 Delivery and Measurement

Each annual objective is both linked to a Trust strategic objective and has a detailed list of sub-objectives, each with an Executive Director lead and explicit milestones with measurable metrics. Progress against these metrics is currently reported to the Board of Directors every quarter.

3.3 Development of 2015/16 Annual Objectives

The Trust will be changing its process in developing the annual objectives for 2015/16 to ensure that its Divisions are involved in the process. The Strategic Group (part of the Chief Executives Group) will take the lead in developing and discussing the annual objectives to ensure that there is a “bottom up” as well as a “top down” approach. At the same time the Board Assurance Framework for 2015/16 will be designed at Trust and Divisional level.

4. Summary Financial Plans 2014/15 – 2015/16

4.1 Income & Expenditure Plan

The planned COSR (previously FRR) for 2014/15 and 2015/16 remains at 4 building on a strong 2013/14 forecast financial performance. A high level summary of the consolidated financial plans can be seen in Table 6. The overall aim in constructing the financial plans was to ensure that both savings and growth built into the plans can counteract the impact of the tariff deflator and emergent cost pressures as well as to deliver funds not only to ensure longer term sustainability, but also for capital investment into building and equipment and to deliver improvements in the quality and safety of service delivery.

	FOT 2013/14 £m	Plan 2014/15 £m	Yr on Yr Change £m	Plan 2015/16 £m	Yr on Yr Change £m
SLA Income	486.0	491.6	5.6	498.1	6.5
Other Income	39.1	45.6	6.5	45.3	(0.3)
Expenditure	495.4	506.9	11.5	511.8	4.9
EBITDA	**29.7**	**30.3**	**0.6**	**31.6**	**1.3**
Surplus	**3.9**	**(0.9)**	**(4.8)**	**1.7**	**2.6**
COSR	4.0	4.0		4.0	

Table 6 – Consolidated I&E Position 2014/15 – 2015/16

4.2 Year on Year Movement in Financial Plans

The cash generated from operational activity (EBITDA) increases by 2% amounting to £0.6m between 2013/14 forecast position and the 2014/15 plan, with a further increase of £1.3m in 2015/16. The largest movement below EBITDA between 2013/14 forecast and the 2014/15 plan is the impact of a new build impairment of £3.4m following the planned completion of the new Dover Hospital in March 2015. This movement is also comprised of an expected increase in depreciation and Public Dividend Capital (PDC) over the next two years due to both the investments in capital and indexation. The dominant drivers of changes in the income and expenditure position between years are outlined in Section C.

4.3 Liquidity

The consolidated planned cash holding at 31st March 2015 is £27.5m and on 31st March 2016 it is planned to be £24.1m. The forecast cash holding at 31st March 2014 is projected to be £44m. The main drivers behind the planned cash balances reduction is capital expenditure exceeding cash generated in year and a more prudent assumption on the collection of NHS debt.

4.4 High Level Capital Plans

The proposed Capital plans for 2014/15 to 2018/19 and the movement since the 2013/14 Monitor plan submission in May 2013 can be seen in Table 7. The updated capital plans show a reduction in planned capital expenditure for 2014/15 by £2.3m (£29.7m) and £3.9m (£25.5m) in 2015/16 when compared to the Monitor plan submission in 2013/14.

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Original Plan submitted to Monitor as part of 2013/14 Plan submission/ *Trust Internal Five Year Plan*	£32,043	£29,410	*£25,750*	*£25,500*	N/A
Proposed Plan 2014/15 - 2018/19	**£29,704**	**£25,460**	***£29,334***	***£28,000***	**£29,000**
Difference to Original Plan submitted to Monitor/ *Trust Internal Plan*	(£2,339)	(£3,950)	*£3,584*	*£2,500*	N/A
Difference - %	(7%)	(13%)	*14%*	*10%*	N/A

Table 7 – Updated five year capital plans compared to 2013/14 Monitor submission/ Trust Internal Plan

4.5 Service Developments/ Cost Pressures

The Trust is planning a net revenue investment in service developments in both 2014/15 and 2015/16 of £4m. This builds on a historic allocation of £2m with an additional £2m allocation as planned in 2013/14, to consolidate the Trust's response to the Francis report recommendations with regards to Ward level staffing. Summary plans are outlined in Table 8. Further detail on Service Developments can be found in Section C.

Year	Income £m	Gross Cost £m	Cost Reduction £m	Total Net Cost Impact £m
2014/15	23.2	(28.6)	1.4	(4.0)
2015/16	0.4	(4.3)	0.0	(4.0)
	23.6	(32.9)	1.4	(8.0)

Table 8 – 2014/15 & 2015/16 Service Development Investment Impact

4.2 Cost Improvement Plans

For 2014/15 and 2015/16, the financial strategy has set required respective CIP targets at £26.8m and £25.2m, with schemes above these target levels being sought. A programme of transformational service redesign projects is in development to deliver improvements in services and identify and deliver additional efficiency opportunities. This will include integration of quality improvement and SLR reviews. RAG rated schemes amounting to the full target have been identified but are not all ready for implementation. Additional schemes above this target have been identified and their potential impact is being worked through.

SECTION B – OPERATIONAL PLAN

1. 2014/15 – 2015/16 Planning Approach

1.1 Development and Approval of the Trust Operational Plan

The 2014/15-2015/16 planning process began in August 2013 and consisted of two key stakeholder meetings to discuss and formulate an approach to produce a robust plan. Following on from this, monthly meetings have taken place with the Divisions to ensure all aspects of the plan have been reviewed, communicated and actioned. Alongside this, the Divisions have had full involvement with the 2014/15 contracting discussions with commissioners. With full Divisional cooperation, the 2014/15 base plan was presented to the Finance and Investment Committee (FIC) in December 2013. Both the FIC and the Council of Governors (CoG) have been regularly updated on the progress of the plan with presentations at meetings held in February and March 2014. The full Plan was presented and agreed by the Trust Board of Directors in March 2014.

1.2 Governor Approval of Non-NHS Income Plans

The 2012 Health and Social Care Act awarded Governors decision-making rights and responsibilities concerning non-NHS income. These have been explained and developed in guidance produced by Monitor and also locally in the Trust guidance on the statutory duties of Governors. Key elements of the definition of non-NHS income have been drawn up by the Trust, including clarity around NHS income and a financially quantified list of the principal areas of non-NHS income and shared with the Council of Governors.

The 2012 Act specifically requires the CoG to satisfy itself that the Trust's generation of non-NHS income will not to any significant extent interfere with the Trust's fulfilment of its core (NHS) purpose. On the basis of the information the Trust provided within the Annual Plan, the CoG has confirmed no evidential reason to conclude that the non-NHS activity will interfere with the Trust's core functions and responsibilities. It has been agreed however, that further work needs to be completed by the Trust and the CoG collaboratively to better evidence the impact of non-NHS income delivery on core services to enable the CoG to fully test the effect. This work will be completed before the next Annual Planning cycle with the output consolidated into a single statement and formally agreed with the CoG.

2. Short-term challenges within the Clinical Divisions

2.1 Surgical Division Operational Challenges

The largest short-term challenge for most clinical specialities within the Surgical Division relates to higher demand than capacity for Elective services, specifically Orthopaedics and Ophthalmology. The environment is one of increasing demand combined with decreasing funds and the challenge presented with working with four CCGs to agree realistic plans for single specialty services. In addition, workforce challenges specifically related to the provision of high risk General (abdominal) emergency and elective surgery have instigated a possible change in the service model by site, subject to a future public consultation. A further challenge is the future of services such as Vascular Surgery which would ideally be a single Kent and Medway service however the Trust is one of two current providers.

2.2 Urgent Care & Long Term Conditions (UCLTC) Division Operational Challenges

There is a broad range of short-term challenges across this Division. Increasing demands on both Urgent Care and services supporting patients with long-term conditions (LTC) continues. Specific issues encompass:

- The Trust has been consistent in performance with regards to meeting the A&E standard in the face of high demand and an increasing acuity of patients which is expected to continue;
- Currently fragmented elderly care provision across the LHE resulting in unnecessary admissions and unclear arrangements for supporting patients at home resulting in increased length of stays (LOS);
- Insufficient capacity in Community and Primary Care Services resulting in increased numbers of Delayed Transfers of Care across the Trust;
- Fragmented LTC care across the LHE resulting in duplication, waste and unwieldy patient pathways resulting in poor patient experience and repeated crisis management resulting in unnecessary admissions;
- Workforce issues with regards to the recruitment in medical middle grade vacancies across the Specialties;
- Consistent delivery of effective Urgent Care services across 3 sites and Primary Care is becoming an increasing challenge;

2.3 Specialist Services Division Operational Challenges

There is a broad range of short-term challenges across this Division with the most dominant issues and risks linked to commissioner contracting of services. Specific issues encompass:

- Commissioner challenges that could have a significant impact on income:
  - Midwifery quality investment withdrawal.
  - Dermatology surgical activity – Financial risk if activity is classed as Outpatient (OP) procedures.
  - Paediatric Assessment Unit activity recording.
  - Withdrawal of all commissioner investment historically via Contract Variation.
- Lack of commissioning consistency and expertise in relation to Child Health and Maternity service has resulted in little progression in terms of agreeing an Emergency Care Pathway. Commissioning intentions for 2014/15 and 2015/16 have suggested the integration of Paediatrics, yet no detail has yet been shared of a timeframe for the work programme to be established and agreeing a collaborative way forward with Kent Community Healthcare Trust (KCHT).
- Dermatology service review – The Trust has the opportunity to gain provision or could potentially lose the service through Any Qualified Provider (AQP) commissioning. Both CCGs and local GP's are very supportive and impressed with the current service delivery however the AQP structure leads to additional steps in the patient pathway and potential confusion for both healthcare organisations and patients. CCGs have also served notice on the Dermascope service.
- The Trust is working with commissioners to avoid A&E attendances and develop 7 day service access for both the Early Pregnancy Assessment Unit (EPAU) and Emergency gynaecology services. There are concerns over lack of understanding by commissioners and also the threat to delivery due to the expected AQP of Ultrasound services on which both these services are heavily reliant.
- Specialist Commissioning (SCG) – Risks in terms of potential gaps in finances following services being transferred to NHS England from CCGs and also increasing activity in the services that fall under this commissioning umbrella i.e. Cancer services and ITU critical care.
- Increased activity demand relating to Adoption and Looked After Children (LAC) services provided to Social Services.
- Audiology – increased activity (reduced HV distraction tests, plus specific immigrant population)
- Therapies – New frameworks for Physical Disability, Challenging behaviours & Complex communication needs will have an impact on service structure and delivery.

- Capacity within Cancer Services as the Trust has seen and projects an increase in referrals across all tumour sites
    - Breast increases
    - Dermatology
    - Chemotherapy

2.4 Clinical Support Services Division Operational Challenges

There is a broad range of short-term challenges across this Division with the most dominant issue and risk linked to the implementation of the Kent Pathology Partnership (KPP). Other specific issues encompass:

- The creation of AQP framework for both Ultrasound and MRI services has generated operational challenges for the Radiology service. For the Ultrasound service, Sonographers (which are in short supply) have elected to leave the Trust and work for GP surgeries which has in turn increased costs as recruitment is difficult and the use of locums and support from third party and AQP suppliers has become the norm. In addition, the activity demand for direct access Ultrasound work has not proportionately declined.
- Increasing demand particularly for Radiology services and managing the move to 24/7 7 day per week service requirements for clinical support services.
- The need to introduce an in-house PET CT scanning service due to demand.
- Radiopharmacy requires infrastructure improvements for the service to expand.
- The deficiencies of the new Radiology Information system (RIS) provided by GE remains a significant challenge. The system will require further work through upgrades and along with the operational pressure this causes, this may add further delay to the identification of activity and the subsequent agreement of unbundled Radiology within the contract with commissioners.
- The need to review Outpatient booking and to create a centralised booking concept to support a required increase in the effectiveness of Trust outpatient capacity.
- Management of the transfer and integration of the Interventional Radiology service from the Surgical Services Division into Radiology could cause operational strain through the implementation phase.

3. Operational Requirements and Capacity

3.1 Surgical Division Operational Plan

The most significant issues are orthopaedics and ophthalmology where demand exceeds capacity. In orthopaedics, demand will be managed by working with primary care on streamlining MSK pathways and reducing multiple points of access. Internally, the service is moving to a team working approach to maximise capacity and reduce cancellations along with planning additional weekend operating, substantiating two new posts and continued use of the independent sector. Risks remain around managing levels of demand which has been historically challenging, recruitment to posts and implementation of team working. In the current business plan there remains a small gap in day case activity for which plans are being considered. In Ophthalmology demand is related to new treatment pathways approved by NICE this year and the ongoing monitoring, in secondary care, of long term conditions such as Glaucoma. To deliver these LTC pathways, the aim is for them to be managed in the community with clear and rapid access back into secondary care.

3.2 Surgical Services Review

In February 2014, the Trust's Board of Directors took the decision to explore the centralisation of the management of all East Kent adult high risk and emergency (abdominal) general surgery on an interim basis. This decision arose because of an emergent serious clinical risk in high risk

general surgery due to an insufficient number of Gastro - Intestinal surgeons being available to provide emergency cover, twenty four hours a day and seven days a week. The primary drivers are considered to be the increasing sub-specialisation of surgery, the lack of availability of surgeons with skills that are essential to managing high risk and emergency surgery and the difficulty recruiting both permanent and locum medical staff. The Trust has previously taken steps to address these issues, but there remains a problem in recruiting sufficient appropriate surgical staff to maintain the current structure of emergency rotas.
Proposals are now being reviewed and considered by the Clinical Consultant body (alongside 13 focussed work-streams) to produce either a safe implementation plan or a workable and sustainable alternative, allowing the Trust to concentrate staff resources and ensure the provision of high quality care for patients, with positive outcomes as identified by national best practice.
The potential financial impact of the final service change solution has been built into the Trust Service Development investment assumptions for 2014/15 and the five year capital plans.

3.3 UCLTC Division Operational Plan

The overall aim is that the implementation of Transformational Schemes, some supported through the Better Care Fund, will enable joint working across the LHE to deliver significant improvements across the whole system at pace and scale to ensure the best health and care is provided for people in the local community over the next five years. The aim is to ensure a level of high quality of care that maximises patients' ability to live independently and safely in their community and in their own homes wherever possible and also ensure service users and their carers can navigate the services they need and that their health and well-being needs are always met by the right service in the right location.
To support the delivery of this, several workstreams are underway as part of the Divisional Operational Plan for the next two years and beyond:

- Through working with external partners, plans are to develop an Integrated Urgent Care Centre (IUCC) model of integrated care including establishing a Hospital Integrated Discharge Team;
- Development of integrated admissions avoidance schemes across secondary care and the community to reduce admissions and readmissions;
- Exploring options for delivery of Urgent Care across the Trust as part of the development of the Trust Clinical Strategy;
- Exploring options for skill mixing to address medical middle grade vacancies;
- Working to improve engagement and formulate stronger links with primary care, the voluntary sector and patient groups to drive and facilitate service improvement across East Kent;
- Review of current Trust discharge policy to streamline current processes and ensure that patients and carer expectation is managed at the front door, and that the discharge planning process begins on admission.
- Implement 3rd room commissioned in Endoscopy WHH following completion of a new build Endoscopy Unit and implement 2nd wave Bowel Screening programme.
- Explore and identify potential benefits of investment in Respiratory Nurse led service capacity.
- Review opportunities to implement One-Stop Outpatient clinics as part of the Clinical Strategy workstream.
- Review the current service model for pPCI/ Pacemaker services following completion of the new 2nd Cardiac Catheter Lab at WHH.
- Neurosciences review to determine capacity of acute and rehabilitation beds required to meet an increasing demand.
- Review of number of EKHUFT Stroke hyperacute units to maintain quality of care, performance targets, BPTs and requirement for 7 day consultant working.

- Develop potential for 150% activity modelling within A&E which will enable absorption of surges in emergency care activity with minimal risk to performance

3.4 UCLTC Services - Specific areas for development over the next two years

Stroke, Falls, Healthcare of Older People, Neurosciences and Rheumatology Services

1) Delivering new models of care in response to commissioning intentions within existing resources (Community services, Telehealth/ Telecare, Year of Care Tariff's).
2) Delivering care closer to the patient whilst maximising efficiency in service delivery and clinical outcomes for patients.
3) Challenging culture, custom & practice to deliver greater efficiency in services and new models of care.
4) Reducing costs whilst improving quality of services.
5) Meeting increasing demand in response to new, long term treatment regimes for LTCs with a focus on developing clear and robust protocols for early supported discharge from secondary care to the community for patients with Diabetes, Heart Failure, Stroke and COPD.

Cardiology, Gastroenterology and Respiratory Medicine Services

1) Identify and implement Medical rota efficiencies in Gastroenterology and Cardiology as part of a demand and capacity review
2) Review and reduce medical agency spend and resourcing requirements in Gastroenterology.
3) Implement NICE guidelines for Cardiology Angiography.
4) Review the potential impact of a new private hospital in Maidstone (KIMS) on Cardiology services
5) Review of staff training and administration support particular Cardiology and Gastroenterology.
6) Review continuation of un-commissioned pathways in Gastroenterology.

3.5 Specialist Division Operational Plan

Specific developments over the 2014/15 – 2015/16 planning period include:

- Maximising OP or OP procedures capacity, maximise transfer of care to Day cases and 23 hour care to reduce Inpatients so less beds would be required. However it should be noted that these shift are potentially labour intensive and yet generates a lower PbR tariff so commissioner agreements need to be in place to ensure that there is a risk sharing in terms of income and also retaining staff with expertise.
- Explore opportunity for the Trust to become a Specialist commissioning Centre of Excellence.
- Develop workforce plan to address current multi-site working issues in Paediatric medical staff and Sonographers supporting the Gynaecology service.
- Review the Births to Midwives ratio risk if the commissioners withdraw current quality top-up funding.
- Develop and continue implementation of Cancer Action plans.
- Explore potential collaboration with Medway NHS Foundation Trust with regards to Neonatal Intensive Care (NICU) services.
- As part of the Trust Clinical Strategy, support the development of plans for seven day working and a single site model for Acute Care (hub) and spokes with maximised ambulatory care models and community support teams.
- Establish an emergency Paediatric Assessment Area at QEQM (utilising a Ward bay)
- Review in Gynae-Oncology of the benefits of conservative management versus laproscopic surgery expansion.

3.6 Clinical Support Services Division Operational Plan

Pathology

The proposed KPP changes will see a movement of activity i.e. the centralisation of Microbiology and Histology with a Centralised Services Laboratory (CSL) at Maidstone Hospital will see the activity undertaken at that site for these disciplines double. Similarly for the CSL for Blood Science at the William Harvey Hospital there will be a 62% increase in activity. The remaining three District & General Hospitals will see a reduction in their activity. The movement of activity will also see a corresponding movement of staff requirement. Any increase in activity (direct access/acute/other); will be addressed with the creation of the new ways of working. There is sufficient capacity currently and plans for the future to meet increased demand and that the new ways of working generated will require less staff.

Radiology

The demand on Radiological diagnostics over the last ten years has been relentless. Radiology in East Kent has five MRI scanners and four CT scanners, and are open 8am-8pm Monday to Friday and 8am-6pm Saturday & Sunday i.e. seven days per week. They undertake 200 plus CT's per day and 160 plus MRI's per day. The demand placed on the service increases each year. Investment into equipment and staff has been forthcoming in order to meet the demands placed upon it. Over the next two years there will be a need to introduce an additional CT scanner at the Ashford site as well as the replacement of the CT scanner at the Canterbury site. The Trust mobile MRI unit based at KCH will need replacement in the foreseeable future. Other equipment such as standard general X-ray rooms will require replacing over the next two years. There is a need to move towards a static PET CT scan facility and to upgrade both the Radiopharmacy and nuclear medicine department.

Outpatients

Outpatient appointments are dependent on the Divisions to produce robust capacity plans to avoid repeated escalations and additional capacity being provided at short notice. Turnover within outpatient appointments and health records is high due to the high number of band 2 staff that enter the trust via these departments. The staff receive training and then move onto to work in other areas of the trust. The Division will be leading on the Back Office Function Review, which will release overall efficiencies in OPD, Therapy and Radiology Administrative staff. This strategy will be expected to reduce pay/non pay by circa 5% over a period of 1 to 2 years.

There has been inconsistent cover of Speech and Language Therapy (SaLT) across the Trust, with QEQM and KCH service being provided by KCHT and at WHH provided by an in-house service. The KCHT staff will be TUPEd into EKHUFT and the service will be standardised across the Trust. Pressure on acute Therapy services to provide 7 day and extended hour cover, especially to the emergency floor however the service is working with UCLTC to provide training for non-therapy staff to increase discharges of mobile/non-complex patients. Currently evaluating winter pressure money funded service to provide evening and weekend cover to A&E/CDU. In addition, Commissioners have served notice on ICATs and Therapies are working with the Trust to look at developing pathways to continue to provide effective ICAT services. This may involve TUPE of ESPs currently working in ICATs. Pathway work for Therapy Outpatient services is taking place to improve capacity and the ability of services to flex to demands.

Pharmacy

Following a review of Aseptic services in 2013 an action plan has been produced with clear project timescales to improve current infrastructure and processes in 2014/15. The service also plans to develop a business case to expand the staffing complement of the specialist antimicrobial pharmacist team to strengthen delivery of key infection control targets and

adherence to antimicrobial prescribing guidelines. Estate and staffing resource issues relating to the medicine over labelling service, and repatriation of homecare service management will be resolved through the development of business cases. The team are also reviewing the opportunity to introduce with partners a Managed Service agreement for dispensing. This may deliver substantial savings.
Specific developments over the 2014/15 – 2015/16 planning period include:

- Strengthen internal demand management of Radiology services across the Trust.
- Manage the 24/7 7 day per week requirement partially through the extending the outsourcing of Radiology reporting.
- Introduce an in-house PET CT scanning service and potentially utilise the Divisional capital allocation to support the refurbishment of the Radiopharmacy.
- Modernisation of the Nuclear Medicine service to create an effective service and generate efficiencies.
- To combat the shortages of Ultrasonographer's, build on the creation of a training programme in collaboration with Christ Church University and continue an active recruitment programme for overseas Sonographers.
- Develop and support the development and implementation of a training programme for other staff groups from other Divisions to share the activity and risk of providing an ultrasound service.
- Manage the upgrades required to the RIS and negotiate the phased transfer to Unbundled Radiology reporting with commissioners.
- Implement a number of staff related initiatives to secure Radiographer reporting, creation of a daily duty Consultant Radiologist and the review of skill mix of various staff groups.
- Development of Consultant Practitioners (or equivalent) in key areas where recruitment of Consultant Radiologists has proven difficult.
- To implement the Outpatient clinical strategy and reduce outpatient services from 15 sites to 6 sites, with a more comprehensive range of services available over an extended working day.
- Repatriation of Deal Health records library and library staff and of medical secretaries supporting clinics at coastal sites and Deal.
- To work on the Patient Administration Review which is underway with the proposal to centralise all booking and reception staff within outpatient services to ensure standardisation of processes and patient experience- Need to ensure all Divisions engaged in the process. Currently outpatient appointment centre is situated within a clinical area at KCH and could be relocated off site.
- To identify the strategic direction for the health records service and to option appraise whether scanning would be more efficient than centralisation of off-site storage.
- CQUINS -Friends and family test to be implemented for outpatient services.
- Acute Speech and Language Therapy services at KCH and QEQM, currently provided by KCHT under an SLA, to be brought into EKHUFT. Staff will transfer under TUPE and acute services across the Trust will then be standardised.
- Therapies are working with UC&LTC Division to improve out of hours services. Looking at training for non-therapy staff who can then make a decision to discharge for non complex patients.
- Working with UC&LTC to implement the HC&SV project
- Working with the Division on developing a robust MSK pathway

3.7 Kent Pathology Partnership (KPP)

The Kent Pathology Partnership (KPP) initiative is a joint venture between EKHUFT and Maidstone & Tunbridge Wells (MTW) NHS Trust combining the Pathology services of both

Trusts. This project has been approved by the Board of Directors of both organisations and will, over the next two years, see the creation of a Centralised Service Laboratory (CSL) for Blood Sciences located at the William Harvey Hospital. The CSL will be developed to undertake all analytical tests that have a turnaround time requirement of more than two hours i.e. all GP and Outpatient work within both EKHUFT and MTW areas. A second CSL will also be created at MTW where Microbiology and Histology services will be centralised. Again, those tests above the two hour turnaround requirement for Microbiology and Histology will be undertaken at this CSL. Within the KPP area there are five District General Hospitals. All five will have Essential Service Laboratories (ESL). ESL's will undertake all analytical work from within the acute setting for tests that require a turnaround period of less than two hours i.e. A&E and inpatient activity.

The key challenges to developing KPP will be;

1) Adherence to a strict and tight timeframe;
2) The management of two different cultures and potential staff dissatisfaction and unrest;
3) Ensuring that the current high quality services delivered from all laboratories are maintained and further enhanced;
4) Managing any potential delays in the key enablers (IT, Estates, and Managed Service Contract);
5) Working with the CCGs to ensure Pathology activity is not lost.

This initiative fits into both Divisional and Pathology objectives for 2014/15:

- To standardise and rationalise Pathology services with a joint venture with MTW;
- To further consolidate services at QEQM and KCH;
- To review samples referred elsewhere with a view to repatriate the services if viable;
- To review and better manage demand placed on the Pathology service;
- To introduce and exploit the opportunities that KPP offer through marketing;
- To consolidate 7 day working across all disciplines.

The KPP initiatives have been approved by the commissioning body. The Key Commissioner for Diagnostics is fully supportive of the initiative. Within the next two years there will be an expectation from the Commissioners that there will be tariff harmonisation (potentially reduced income). The KPP initiative is designed to aim to meet these expectations. The financial impact of KPP has been built into the Trust financial plans for 2014/15 onwards and this is summarised in Table 9.

KPP movement from Trust 2013/14 Baseline	**2014/15**	**2015/16**
Activity Change	2,170,566	717,181
	£m	**£m**
Income	14.26	1.07
Expenditure		
Pay	(10.92)	(0.10)
Non-Pay	(2.01)	0.91
Misc	(2.23)	0.83
Net Surplus/ (Deficit)	**(0.9)**	**2.7**
Capital Expenditure	0.50	2.50

Table 9: Impact of KPP on Trust Consolidated plans

3.8 Radiology Information System (RIS)

The Central Government contract for PACS (the system that manages digital images such as x-rays, CT/MRI and ultrasound scans) expired on 1st July 2013. Locally the NHS Trusts in Kent and Medway collaboratively procured a new system and following evaluation of a number of companies' tenders, the contract was awarded. The planned 24th June 2013 system go live did not happen in any Trust within the Kent Consortium. This was due to data migration taking longer than expected from the old system to the new RIS and the need for the technical project team to test the system in accordance with the project plan.

During the testing of the system a high number of issues became apparent which resulted in a substantial delay in the system going live across Kent for all modalities. All Trusts agreed that testing should be fully completed before the system went live for use. This was finally achieved on Friday 12th July 2013. Following go-live, an assessment was undertaken by the Consortium across Kent with a judgement that the system was functioning at circa 40% of expected productivity. The Trust has escalated key service issues to the provider and has demanded the delivery of improvements. This includes the production of a Project Plan which enables the consortium to easily see set objectives, timescales for achievement, responsible officers and risk status. This plan is requested to be divided into immediate, medium and long term milestones with detail of how the supplier is going to recover the productivity performance within agreed timescales.

3.9 Clinical Pharmacy Services

The development and restructure of clinical pharmacy services to achieve key Patient Safety standards is a service and Trust priority to ensure effective monitoring and adherence to these standards. The development will also release savings due to more effective prescribing and medicines management processes and a reduction in drug errors. The benefits realised in the Near Patient Pharmacy pilot study will be rolled out Trust wide over 2014/15 following the recruitment of new staff funded through the Pharmacy Service Development Business Case. Key principles of the pharmacy staff consultation will be completed in 2014, embedding the seven day pharmacy service and the rationalisation of staffing structure. Alongside this, the Pharmacy service will lead on the development of the Trust's e-Prescribing Strategy in association with IT and Procurement and provide clinical expertise on the Kent and Medway project group for Oncology Service e-Prescribing, working in collaboration across Kent with other acute providers.

3.10 Acute Bed Capacity

Currently a review and benchmarking of LOS exercise is underway to make most efficient use of bed capacity across all specialties. A significant amount of work has already been undertaken to improve patient flow and support reduction of the adult bed base by 90 beds (2011 – 2013). The Trust recently undertook an Internal Waits Audit (October 2013), which indicated significant opportunity for transformation redesign and service improvement, both internally and across the whole Health and Social Care system, which would result in further efficiencies. The Top 30 waits Trust-wide have been separated into those which are:

- Internal – waits which are solely attributable to the Trust
- External – waits which are solely attributable to external providers
- Integrated – waits which could be resolved through providers working together

The planned bed numbers in 2014/15 and 2015/16 following the implementation of several bed utilisation initiatives are outlined in Table 10.

Bed Numbers	2013/14 FOT (Closing Position)	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2014/15 Plan (Closing Position)	2015/16 Plan
Number of ICU + HDU Beds	125	125	125	125	125	125	125
Number of Other Beds	982	965	981	978	962	962	962
No. of closed beds (i.e. not intended to be used)	-	17	1	4	20	20	-
Total Bed numbers (excluding closed beds)	**1,107**	**1,090**	**1,106**	**1,103**	**1,087**	**1,087**	**1,087**

Table 10: Trust 2014/15 & 2015/16 Bed plan

Patient pathway redesign and empowerment of staff to challenge waits on a daily basis, through implementation of clear roles and responsibilities, would address the top 30 waits enabling further bed reductions across the Trust. Enhanced awareness of the triggers which contribute towards a greater length of stay, such as avoidable ward moves, will improve patient flow, safety and experience.

Working collaboratively to support 'whole systems' efficiencies where appropriate, will increase the likelihood of change being sustained, as benefits will be shared between health and social care providers, although the main impact would ultimately remain within the Trust. Reportable Delayed Transfers of Care should reduce as a result of timely and co-ordinated patient flow between acute and community services.

Whole Systems bed modelling was undertaken in July 2012 which demonstrated a capacity gap within community resources, contributing to bottlenecks within patient flow. In partnership with CCGs, Social Services and Kent Community Health Trust therefore, EKHUFT developed and piloted an innovative model of care to create additional capacity within the community named the Health & Social Care Village. The Trusts view is that provision of a fully Integrated Discharge Team, which replicates existing Health and Social Care Integration within the community would enable a more proactive approach to admission avoidance and facilitated discharge and it is working towards this.

3.11 Health & Social Care Village Model

The Health and Social Care Village Model (HSCV), provides dedicated bed capacity for non-weight bearing (NWB) patients and patients requiring rehabilitation or assessment. Following successful piloting of the model, the HSCV provides a safe and appropriate environment for patients who are medically stable but require a little longer to recuperate, together with assessment and support to help them regain independence as able. The HSCV facilitates a focussed care pathway with a 21 day maximum length of stay (LOS) for patients requiring Assessment and Rehabilitation and a 56 day maximum length of stay for NWB patients.

Having revised the model of care, it is apparent that the model is sophisticated enough to be expanded (15 beds to 60 beds) and replicated across multiple care homes, without reducing quality or patient experience. Lengths of stay have also been shown to reduce over time, as the MDT develops a trusting and cohesive relationship.

The benefits associated with the H&SC Village model are:

Length of Stay

- Reduced LOS in acute beds (155 patients transferred to H&SC Village beds 2/9/2013 - 7/2/2014)
  NB: TOTAL patients transferred since introduction of pilot site (Ashford) – is 295 patients
- Impact of the H&SCV pilot site was clearly demonstrated via the internal waits audit, which evidenced fewer 'External Waits' within the William Harvey Hospital.

- KPI's achieved regarding referral / response and transfer to H&SC Village beds from acute sites
- Reduced LOS for Assessment & Reablement beds from 20.5 to 19 days (Dec 2012 – Jan 2014)
- Significant reduction in NWB pathway patients from 56 to 44 days (Dec 2012 – Jan 2014)
- Dedicated NWB beds has enabled a reduction in Community Hospital LOS
- Reduction in 'bed days lost' associated with Reportable Delayed Transfers of Care

Quality KPI's

- Increased number of patients returning to their own homes with little or no support (71% in 12/13 compared to 74% in 2013/14)
- Reduced number of patients requiring permanent placement provision (13% of total patients transferred)
- Reduced number of patients readmitted to acute hospitals (from Care Homes 6.5% to 3%)
- High level of patient satisfaction and positive patient feedback
- Supports achievement of Francis Report recommendations for older people and 'Responsibility for, and effectiveness of, healthcare standards'

The 60 beds currently commissioned are required all year round, and ongoing funding is being considered, during joint discussions with CCG's with regards the Better Care Fund (Reablement). Alternate funding could be provided through additional income generated by excess bed days (H&SCV working as a virtual ward – Thanet pilot). A further 20 beds are required (total of 80 beds) across East Kent, and the Trust are working in partnership with private providers to identify remaining capacity requirements.

Whilst H&SCV beds are predominantly utilised as 'step down' capacity, access for 'step up' has been successfully trialled. The Trusts aim is that in 2014/15 the H&SCV model will be re-energised to include robust step up and step down access, to support increased admission avoidance and facilitated discharge, aligned with the Integrated Discharge Teams and East Kent Integrated Urgent Care Service.

4. Workforce

4.1 Workforce Changes

As the availability of middle grade doctors is expected to reduce, (as training numbers are reduced and traditional sources of supply from overseas become more limited) there has been and will continue to be an increased reliance on re-profiling roles, based on skills requirements. The Trust is currently working with Higher Education Institutes (HEIs) and Health Education Kent, Surrey & Sussex (HE_KSS) piloting a physician assistant programme to help mitigate this situation as well as employing fully trained practitioners where they exist. The Trust is also widely deploying Nurse consultants and seeking to expand the use of alternative roles e.g. extended scope practitioners and clinical nurse specialists.

The Centre for Workforce Intelligence (CfWI) is predicting a pressure on the availability of nursing staff due to a reduction in the supply of registered nurses and the predicted increase in demand across the NHS nationally up to 2016. This is borne out in Wte movement trends within the Trust over the last year and the financial risk is included in projections for the coming years. The Trust increased its' funded establishment for nurses from April 2014 in response to the Francis Report and has also increased nursing bank and agency usage in year. This poses a risk as the Trust has used a number of overseas recruitment exercises which have been successful but there is a

predicted worldwide shortage and these supply channels may be reducing as the internal European market becomes more competitive and other countries provide more incentives.

The use of assistant and associate practitioners will be increased in year as the Trust looks to try and off set the potential impact of reduced availability of registered nurses. The support provided for non clinical activities is planned to increase through extending admin and clerical roles to allow clinical roles to focus on care. All of this will be done within a clear framework that provides competence assessment and guidance and with full input and sign off from professional leads whilst also using the benefits of investments in technology to reduce pay costs.

All these expected changes are reflected in the projected workforce for 2014/15 through to 2015/16 and has also driven some of the work in the clinical strategy. Table 11 outlines the expected workforce movement over the next two years in Whole time equivalents (Wte's):

	Wte
2013/14 FOT (Consolidated)	**6,953.8**
KPP Service Development (PYE)	204.0
Ward Staffing Review Service Development	50.6
Increase in Midwives	15.0
Reduction in Temporary Staff/ CIPs	(66.3)
2014/15 Plan	**7,157.1**
KPP Service Development (FYE)	68.0
Reduction in staff (CIPs)	(23.8)
2015/16 Plan	**7,201.3**

Table 11: Trust 2014/15 & 2015/16 Workforce movement

The Trust predicts that the underlying trend for WTE will slightly increase whilst the reduction in the overall pay bill will be achieved through the use of skill mix reviews identified above and the management of premium payments for agency work. As the use of schemes such as apprenticeships and associate practitioners increases the WTE may increase further but the pay bill will remain constant or reduce. Given the Trust currently has a turnover rate of 11.2% and a vacancy rate of 5.8%, equating to approx. 400 posts there is scope in year to flex the Trust workforce in line with changes in activity as the need arises.

Succession Planning

All Divisions are asked to identify their key posts and a short and medium term successors for these posts. Following analysis of data that is available and considering previous recruitment exercises Divisional Director posts have been identified as needing particular interventions. With the agreement of the Remuneration Committee and working alongside Canterbury Christ Church University the Trust has developed an Aspiring Divisional Director programme which will be rolled out this coming year with a view to providing potential candidates for these posts in 3-5 years.

Mitigating Risk of Managing Demand

Flexibility in capacity will be delivered by use of independent sector in limited circumstances, additional internal activity and recruitment where necessary. Reductions would be achieved by not replacing vacancies, reducing contractual hours and removal of physical resources. The Trust already has contingency and escalation plans for rapid fluctuations in demand which are used as and when necessary in the clinical Divisions.

4.2 Specialist Services Division Workforce Plan

The Division is at the stage where continued incremental removal of workforce funding from budgets is no longer a viable proposition. In order to deliver meaningful workforce efficiencies, there is a recognised need to engage in transformation changes to services, particularly in the areas of child and women's health. Over the next 12 months, discussions will need to ensue about reviewing the provision by site. Potential options may increase economies of scale in terms of recruitment to difficult to fill posts, provision of on call arrangements (reducing from two rotas to one), provide high quality placements for doctors in training and will reduce the tensions within services about trying to find short term jobs when doctors in training places are not filled centrally.

Child Health

In Acute Paediatrics, work will be on-going to establish emergency paediatric services to improve the pathway for children, with the establishment of paediatric assessment centres.

A fourth neonatal consultant (as part of transitional care funding) will start work in the trust in May 2014 and the Neonatal Outreach service business case will be progressed in order to return NICU babies to their home sooner.

In Paediatric Dermatology There will be a review of pathways with the intention of repatriating children currently referred to London for eczema

In Community Paediatrics, as part of the government's intention to expedite the adoption process and increase the numbers of children being adopted, demand on the service has increased (over 150%) which has increased the workload for Medical Advisors and the associated secretarial support. It is therefore the intention to increase capacity of Adoption Medical Advisors. The commissioners have recognised this increased activity and the need for additional workforce to support it and they have produced a business case (to be approved) to support this additional work.

In Paediatric Audiology – A review of the East Kent Children's Hearing Service has identified lack of resource in Audiologist and Admin time to meet the demands of the service. This is causing extremely long waiting times for patients. A business scoping document has been presented to the Divisional Management team and further work has been approved to work up into a full business case. This will require investment for expansion of workforce

Dermatology

Over the past few years a number of commissioning plans relating to Dermatological service have been implemented across east Kent. Some pathways are now based outside of the acute sector; whilst many remain to be provided by secondary care. Whilst changes to pathways have introduced new providers to the market GPs have reported a lack of clarity over which services they should be referring to, and see dermatological services as being fragmented. At present the collective spend of the four east Kent Clinical Commissioning Groups equates to £6.7m. The health economy supports NHS England's call for open and honest debate about the future shape of services aiming to identify and remove inefficiencies within current services, and improve patient outcomes. There will therefore be a review all of the existing services with a view to developing an integrated service model, whereby care, where it is clinically appropriate, is delivered in a community setting with clear and responsive referral routes into secondary care services. It is crucial links with the Cancer pathways are explicit and in line with national guidelines. A task and finish group which includes representation from service users, commissioners, GPs, GPwSI (Including Surgery in Primary Care) community and secondary providers has been established to review current service provision and support the development of the integrated model. This group will be integral to the business case to ensure patients and clinical knowledge is at the heart of the commissioning process.

Renal Service

There is continued marked growth in the Transplant programme linked with the repatriation of patients on discharge from Guys Hospital. The growth is currently 50 patients a year, activity 520 patients at present. As a result the projection of growth is currently being mapping over the next five years to look at new ways of nurse led working in transplant to predict the requirement of additional nursing posts over this period. This will be transposed into a business case for investment to be presented to April 2014.

Midwifery

As part of their initial commissioning intentions the CCGs have stated their intention to remove the investment in maternity workforce in East Kent. This funding was allocated to the trust in the last 24 months following a public consultation about the provision of maternity services and to enable us to meet the midwife/birth ratio as laid out in 'birth rate plus'. This investment has allowed the trust to open the Midwifery Led Unit at QEQMH. The Trust is strongly resisting the proposal to remove funding, which would result in closure of the MLU and would be against the outcomes of the public consultation.

Births

There was also a significant contracting challenge in 2013/14 due to the unexpected fall in births. The maternity service responded this and to the change in funding arrangements in 2013 by managing the midwifery vacancy to maintain a woman to midwife ratio of 1:28. Birth rates are now showing a steady increase in line with previous trends.

Early Pregnancy Unit (EPU)

The Division will continue to develop its plans for and EPU. Developing sonography skills amongst the Women's Health nursing team is essential if the aim to provide a seamless emergency gynaecology and early pregnancy service is to be realised. These nurse sonographers will work Trust wide and help provide a more effective, responsive and woman centred service.

Gynaecology

The development of Gynaecology Admissions Unit at the WHH continues to be delayed because of bed pressures and funding issues. However the Divisional view is that this plan should be implemented.

4.3 Surgical Services Division Workforce Plan

The Division is in the process of reviewing, developing and implementing a new Divisional meeting structure, to support a more robust Governance structure, in line with the Quality Strategy. To support this, the Division will ensure effective recruitment to Clinical Lead roles within the Division, including the appointment of 2 x Deputy Medical Directors (for Anaesthetics and Governance) to support the Division achieve a robust governance and quality structure, cultural and behavioural change and effective job planning to support patient and business needs.

A review of out of hours and on call rotas for Medical staff, including a review of job banding for Head & Neck doctors in training is underway, with regards also to identifying and implementing new roles to support the medical workforce and remove the risk of being unable to recruit, such as Clinical Fellows, Physician Assistants and Consultant Nurses.

To ensure a quality workforce, the Division is updating and reviewing the Divisional Succession Plan for business critical and leadership roles, such as developing leadership and business skills for Clinical Leads, Ward Managers and Ops Managers.

It is highly important that the Division continues implementing and embedding the We Care values and behavioural framework across the Division to improve communication, staff morale, reduce sickness absence and turnover, and improve the quality of service to patients.

The Division is currently recruiting to the Nursing Establishment business case across the Division, increasing the amount of direct clinical care on Wards by removing many of the administrative duties for Ward Managers by implementing the Ward Manager Assistant role, and increasing the Band 6 nursing establishment.

The risk of the new Kent Institute of Medicine & Surgery (KIMs) service will be mitigated through effective recruitment of nursing and theatre staff. In recent months, several initiatives have been put into place. These include a rolling monthly recruitment drives by site rather than by ward; identification of HCA staff who can fast track to nurses through overseas adaptations; implementing the Ward Establishment business case; implementing the Bradford Factor sickness management tool to support Ward managers in reducing sickness; and working with Clinical Support Services to design and implement a clinical apprentice route into the Trust/Division.

The Trust is in the process of transferring the Interventional Radiology team (4.00 Wte Consultants, 1.60 Wte A&C staff) into the Clinical Support Services Division from the Surgical Division.

A project group is underway to realise the benefits of the Theatre Utilisation project and implement any outcomes and recommendations. Project groups are also running to complete and make recommendations for improvement, following a review of Ophthalmology, Trauma & Orthopaedic and Urology services.

The Division will continue to work with teams to support effective team working and leadership through the Clinical Leadership programme, Team Based Working programme and the shared purpose framework.

4.4 Clinical Support Services Division Workforce Plan

To support the Quality agenda the Division has carried out a number of restructuring exercises to ensure the workforce is aligned to service needs. Most notably, a 7 day service being delivered by Pharmacy has resulted in investment in additional 20 wte staff with significant benefits to patients. Implementation of the Outpatients Clinical Strategy will also result in quality one stop clinics being delivered with the associated benefits to patients. Re-introduction of the CT scanner at WHH site whilst having staffing implications will support quality service being delivered to patients in this locality. The current review patient administration service is expected to streamline practices and inevitably improve communication with patients; it is envisaged that this will result in a 5% reduction in A&C staff. The recently approved KPP will see increased benefits to the quality agenda given benefits from economies of scale and streamlined services across the geographical area.

On-going challenges recruiting Sonographers exacerbated by AQP arrangements locally continue to pose a risk to the delivery of the Trust Ultrasound service. In mitigation a fast track 1 year training programme has been put in place that will increase this workforce in addition to the use of a third party provider. Plans by the local CCGs to re- provide the ICATS service could have an impact on the workforce given the forecast increase in activity for ESP staff. It is envisaged that TUPE could be put in place in the event that a final decision is taken by CCGs.

Continual issues with the recruitment of Consultant Radiologists are being mitigated by the development of Radiographer Practitioners who have the competency to report MRI and CT.
The Division has given notice on the Speech and Language Therapy service currently provided by the KHCT. Staff will TUPE to the Trust from 1st April 2014.

The Trust has agreed that the 4 wte Interventional Radiologists currently in the Surgical Division will transfer to CSSD from 1st April 2014. The Division will be supporting the team and will recruit 2 wte to achieve a 1:6 rota which is a must do due to the derogation notice that has been submitted to the Trust by the Royal College.

5. Quality Plans

5.1 Quality Priorities

East Kent Hospitals University NHS Foundation Trust recognises that quality is at the centre of all that we do. The Trust quality plans are detailed in the Trust's Quality Strategy. This year sees the delivery of year 3 of this strategy. The key priorities are:

1. **Person-centred care and improving patient experience**
   This priority is focused on delivery of a high quality responsive experience which meets the expectations of those who use our service;

2. **Safe care by improving safety and reducing harm**
   This priority is focused on delivering safe care and removing avoidable harm and preventable death;

3. **Effective care by improving clinical effectiveness and reliability of care**
   This priority is focused on increasing the percentage of patients receiving optimum care with good clinical outcomes;

4. **An effective workplace culture that can enable and sustain quality improvement**

5. **Deliver improvements incentivised through Commissioning for Quality & Innovation (CQUIN)**
   These are the priorities set by the local Clinical Commissioning Groups (CCGs) and National Specialised Commissioning clinical reference group (NHS England).

Person-centred Care and Improving Patient Experience

The key priorities are to embed the Trust values: Caring, Safe and Making a Difference, into everyday care. Delivery of the objectives will:

1. Improve the complaints process by responding effectively to patient and visitor feedback and ensuring the feedback is acted upon and learning embedded;
2. Deliver on the Friends and Family Test achieving the required response rates and improving the net promoter score;
3. Implement the Friends & Family Test for Outpatients and Day cases;
4. Improve essential aspects of nursing care with a specific focus on pain management, nutrition and hydration.

Safe Care by Improving Safety and Reducing Harm

Patient safety is of paramount importance to the Trust and a key priority. Delivery of the objectives aim to:

1. Reduce deaths by 10% in crude mortality & achieve HSMR less than 75 by 31st March 2015;

2. Reduce the recorded harm event rate as measured using UK Trigger Tool Case Note Review (UKTT);
3. Improve the completion rate of the Patient Safety Checklist;
4. Reduce the number of falls resulting in harm;
5. Reduce the number of category 2, 3 & 4 pressure ulcers;
6. Increase the percentage of harm free care to 95% by March 2015;
7. Reduce 'Never' Events to zero;
8. Increase our achievement of openness and transparency, 'duty of candour'.

Effective care by improving clinical effectiveness and reliability of care

Objectives to improve clinical effectiveness include:

1. Implement the Ward Staffing Business Case to ensure safe staffing;
2. Increase the number of patients receiving care within a Best Practice Tariff pathway, e.g. stroke, neurology, ambulatory care and fractured neck of femur;
3. Deliver improved infection prevention and control;
4. Implement 7-day working e.g. therapy services;
5. Expand the use of technologies to enhance care delivery;
6. Reduce avoidable unplanned readmissions;
7. Increase the monitoring of PROMS responses in order to improve patient satisfaction with outcomes from surgery;
8. Respond to the findings of the recent CQC assessment.

An effective workplace culture that can enable and sustain quality improvement

Delivering this purpose and objective includes:

1. Implement the Quality Innovation and Improvement Hub;
2. Deliver the We Care programme;
3. Integrate Service Improvement Team and Programme Management Office to align quality improvement, productivity and financial efficiency from 1 May 2014;
4. Redesign elective and emergency pathways to enhance patient care and quality whilst maximising efficiency.

Deliver improvements incentivised through Commissioning for Quality & Innovation (CQUIN)

The Trust plans annually to always achieve set CQUIN commitments in order to continuously improve quality of care. The Trust's aim is to agree CQUINs that add value to the patient pathway and patient experience. This also includes our Enhancing Quality Programmes.

5.2 Quality Concerns

Key quality risks to the Trust in delivering the Quality Strategy are around the results and findings of the CQC assessment and Trust healthcare associated infection rates, in particular MRSA bactaermias, C-difficile and E-coli rates. The delivery of the CQUIN standards is an ongoing risk to quality and also a financial risk that is managed and mitigated throughout the year.

5.3 Providing Board Assurance

The Board of Directors receive assurance around the quality of services in the Trust via a number of ways. There are robust reporting structures in the Trust that feed into the Board of Directors on a monthly basis. Quality is reported via sub-groups to the Board and also via the Clinical Quality and Patient Safety Report. This describes the trends in each of the standards and metrics and also the actions in place for improvement. Behind the reporting are a number of committee and groups whose remit is drive up quality and work towards delivering the Quality

Strategy. These groups and committees are cross Divisional with clear terms of reference and formal reporting strands of their own.

5.4 The Impact of Quality on the Trust's Workforce

The Quality Strategy and on going quality improvement requires a culture of transformation. This in turn has implications on the workforce. Examples of this include:

- The cultural work surrounding the implementation of the Quality Innovation and Improvement Hub;
- New ways of working / Extended Practitioner Roles for Radiographers and Allied Health Professionals;
- Greater focus on integration, provides an opportunity to integrate staff (? shared staffing pools between EKHUFT & KCHT) and combine generalist and specialist knowledge;
- Opportunity for acute staff to work within a community environment (Community Geriatricians, Health & Social Care Village);
- Greater understanding, knowledge & appreciation of what each other provides – culture shift towards caring for people within their own homes;
- Nurse-led discharge.

5.5 Trust Response to Berwick, Francis and Keogh

Alongside a substantial investment in ward staffing, the Trust has nominated the Trust Secretary to be responsible for drawing together all action planning and reporting in these areas. The Board Assurance Framework describes the risks where work is required to meet these recommendations. The Annual Objectives reflect the improvements in place to meet the reports' standards. There are Trust wide action plans in place that are reported to Board that demonstrate progression towards delivering these recommendations. These are threaded through local action plans and link with four purposes through a number of workstreams. An example of this is that every month the Board of Directors invites members of staff to attend to discuss a theme from the Francis Report. Actions from these listening events are then taken forward.

5.6 Management of Quality in Divisions

Urgent Care & Long Term Conditions (UCLTC)

In UCLTC, the Governance structure within the Division has been reviewed with a newly established Quality and Assurance Board which is being attended by all Clinical Leads, Senior Matrons and General Managers. The Board will focus on addressing issues relating to patient safety, effectiveness and experience including falls, pressure ulcers, infection control, patient feedback, clinical audit and clinical outcomes. The new structure includes a monthly Divisional Embedded Learning meeting to ensure that learning from complaints and incidents across the Division is captured and disseminated to individual health care professional level; qualified and unqualified. The Quality and Assurance Board will also support development and monitoring of the Divisional quality improvement plan in response to the Francis report.

Pathology Service

Pathology services require the accreditation of Clinical Pathology Accreditation (CPA), as well as adherence to MHRA and HTA requirements. Currently Pathology has full accreditation and meets the requirements of these bodies. This is also the same for the new partners MTW.

Nationally there is a drive to move from CPA to UKAS with the utilisation of ISO15189.
The quality management systems in both trusts with the KPP are robust and are preparing for the implementation of KPP as well as the introduction of ISO15189. A robust governance

infrastructure is in place within Pathology. The following are deemed quality risks, along with mitigating actions;

- Operational disruption during the transition process in creation of CSL's and ESL's.
  Mitigation – Robust project implementation plan and project management arrangements.
- Difficulty in recruiting and maintaining staff during the transition process and the creation of KPP.
  Mitigation – Effective staff engagement and support as part of the HR transition process.
- A potential reduction of the quality of the services provided.
  Mitigation – To develop and implement a KPP Quality Improvement Plan.
- Transportation delays or failures.
  Mitigation – Procure and manage effective transport arrangements.
- Reduction in efficiency during the transition period.
  Mitigation – The preparation of a business plan, business development plan, and recruitment of commercial expertise.
- Potential rules by the Office of Fair Trading and the anti-competitiveness of Pathology mergers.
  Mitigation – Monitoring the announcement expected by the OFT and to adhere to advice from the solicitors.

Radiology Service

Radiology is regulated by Ionisation of Medical Ionisation Exposure Regulations IRM(E)R. There is also a requirement to adhere to the standards set by the Environment Agency (EA), in terms of radioactive waste management. As a priority the service intends to establish an accredited radiation waste adviser (RWA). In addition, there traditionally has never been a Quality Manager within Radiology departments within England. EKHUFT Radiology are introducing a Quality Manager (similar to that of Pathology), in order that the relevant ISO can be obtained.

A robust governance structure is in place within Radiology however current areas of concern regarding quality relate to;

- The need to adhere to the EA requirements.
- The CQC requirements by IRM(E)R.
- The GE RIS implementation has generated a number of issues that are being worked through by appropriate teams.

Outpatients

Health Records are launching a 'Your Responsibility Campaign' to raise awareness of all staffs responsibility in caring for Health Records and ensuring case note tracking is adhered to. In addition, the misfiling in Health Records is now raised on Datix and is included on the Francis Report action plan and is an agenda item at IGSG and DQ steering group meetings. Partial booking of follow up appointments is being implemented as part of the clinical strategy. The aim is to give patient more choice regarding their outpatient follow up appointment and to reduce the number of appointments that are rescheduled by the hospital and the patient.

The self check in proof of concept is due to be launched at Kent and Canterbury Hospital in April and will provide patients with a secure and private option for registering for their appointment. The system will also provide patients with accurate up to date information regarding the running of the clinic that they are attending. Outpatient clinics have supported extra clinical activity for 3 years without substantive funding using existing resources working additional hours which has potentially resulted in higher than normal sickness absence. Access policy training needs to be embedded within department training to ensure consistency.

Pharmacy

The rollout of the Near Patient Project will ensure optimal deployment of staff to achieve national patient safety standards such as Medicines Reconciliation on admission and discharge, and targeted feedback to medical and nursing staff to achieve effective learning from medication incidents.

To develop and implement an electronic prescribing system across Trust, in association with the Associate Medical Director(medicine management) and the IT department, over the next eighteen months to two years.

An initiative to work collaboratively with Community Pharmacists in developing a more streamlined handover of pharmaceutical care on admission and discharge will be pursued in 2014, involving hospital, community and CCG pharmacists.

In response to the Francis Report, a Leadership development programme commenced in 2013 at senior management team level, and will be cascaded in 2014/15. This follows on from the staffing restructure, which has improved role clarity, and an action plan developed on the Trust Clinical Leadership programme to improve communication and feedback across the department.
To provide professional advice and leadership to commissioners and GPs to ensure NICE compliance in medicines management is adhered. To horizon scan medicines that can be prescribed effectively with financial benefits for the Trust.

When considering future savings for Pharmacy to review with partners the opportunity to procure a Managed Service which improves KPI compliance and generates recurrent savings.

To optimise the Aseptic Service which will not only respond to clinical care within the Trust but also offer the opportunity to income generate via responding to tenders over the next 2 years.

SECTION C – FINANCIAL PLANS

1. Financial Plan 2014/15 – 2015/16

1.1 Income and Expenditure Plans for 2014/15 and 2015/16

The financial plan delivers a COSR risk rating of 4 for all years and quarters until March 2016. Table 12 summarises the finances for each of the two operational years.

	FOT 2013/14 £m	Plan 2014/15 £m	Yr on Yr Change £m	Plan 2015/16 £m	Yr on Yr Change £m
SLA Income	486.0	491.6	5.6	498.1	6.5
Other Income	39.1	45.6	6.5	45.3	(0.3)
Expenditure	495.4	506.9	11.5	511.8	4.9
EBITDA	**29.7**	**30.3**	**0.6**	**31.6**	**1.3**
Surplus	**3.9**	**(0.9)**	**(4.8)**	**1.7**	**2.6**
COSR	4.0	4.0		4.0	

Table 12: Trust 2014/15 & 2015/16 Income & Expenditure Plan

1.2 Financial Risk

Those risks that are non-activity based would be potentially the most damaging as there would be no mitigation through reducing costs through reduced activity. The Trust has a planned general contingency in 2014/15 and plans to retain the same level of contingency into 2015/16. The Trust has also made some prudent provisions based on pricing changes that the Trust is expecting and also the price impacts that the commissioners are pursuing. The Trust does not plan to fall short on its CQUIN achievement or miss any finable quality targets, but does hold provisions against such eventualities in-part. Similarly, a prudent view over expenditure provisions and the valuation of service Developments in the plan has been taken. In addition, the Trust is aiming to identify and deliver further CIP schemes beyond the 2014/15 and 2015/16 targets it has set and will slow or delay expenditure on service developments or the capital programme if required.

2. Activity Projections

2.1 2013/14 Context

During 2013/14 referrals have remained broadly in line with the levels seen in 2012/13, with a 0.4% increase overall. Breaking this down into Primary and Non-Primary Care however shows that through improved triage processes the levels of Non-Primary Care referrals has decreased by ~4.5% with referrals in from Primary Care increasing by 5.5%. As a result of the increases in Primary Care referrals and also in response to a required reduction in outpatient waiting times outpatient activity has increased over the previous year. Similarly elective points of delivery demonstrate increased activity in comparison to the previous year, +1.4% in Elective Inpatients, and similarly in Day Case activity. A&E attendances reduced by 1.1% in 2013/14 with emergency admissions also showing a small reduction when compared to the previous year.

2.2 2013/14 Commissioning Contracts

In developing the contract plan for 2014/15 the Trust has worked closely with commissioners to agree a forecast outturn on which to base the subsequent year's activity levels. From this agreed base intentions have been layered in such a way that they can be easily adjusted following the outcomes of contract negotiations. These layers include areas such as Trust Service Developments, Commissioning Intentions (CI's), and delivery of access standards. The profile of the plan has been constructed to take into account phasing of individual schemes as well as working days and productivity of specific days of the week.

2.3 Commissioning Intentions

The Trusts clinical Divisions have worked collaboratively with primary care colleagues in order to assess and agree an achievable level of activity reduction relating to CCG commissioning intentions. Schemes have been worked up jointly with assigned leads from each organisation to ensure change is driven forward and benefits are jointly realised. Key areas of focus are; urgent & emergency care provision (inc A&E), expansion of ambulatory care pathways and appropriate reductions in planned care follow up attendances/progression towards a 'one stop' approach. The Trust has not currently recognised any activity reductions associated with CCG commissioning intentions.

2.4 Growth beyond 2014/15

The Trust has planned for growth levels of circa 0.8% year on year beyond 2014/15 using an analysis of local population need projections over a ten year period based on age profile and areas of deprivation. In addition to this specific areas of known growth/reduction or service development have been factored into the plan for 2015/16, for example continued growth at ~10% in cancer referrals, activity adjustments relating to expansion of ambulatory care pathways, provision of one-stop services and transition from day case surgery to outpatient procedures.

2.5 Risk in Activity Plan

The Trust sees the delivery of all the CCG CI's and subsequent activity reductions as being very challenging without significant effort from both the Commissioners and the Trust. As a result, if those CI's due to deliver early in 2014/15 fail to be fully implemented, the Trust may see an initial over performance to plan which should be addressed by CI impacts later in the year. The Trust has built into the plan a provision for the potential impact on income reduction as a result of CI's. This is a prudent position for the Trust to take when considering the historic impact of CI's on Trust activity demand.

3. Income & Contracting

3.1 Demand Drivers impact on Income Plans

Section 2 above explains the dynamics of demographic impacts and improved triage and pathway management and the demand trends that are expected to continue into 2014/15 and 2015/16. these dynamics have been built into the Trust income plan where they can be reasonably quantified and signed off by Operational staff.

3.2 Tariff Assumptions

The National Tariff and published tariff deflator has been used to price the 2014/15 plan and a net deflator of 2.3% used for 2015/16. The 2015/16 negative tariff adjustment of 2.3% is based on Monitors published efficiency of 4.5% with a inflation uplift of 2.2%.

3.3 2014/15 – 2015/16 Contracts

At the time of plan submission, no major commissioning contracts for 2014/15 or 2015/16 have been agreed. Detailed and lengthy discussions have taken place between the Trust and Kent & Medway CCGs and include the pursuit of mutual benefits from Commissioning Intentions. The income figures in the submitted plan are consistent with the contract negotiations as they currently stand.

3.4 Phasing

The phasing of the plan is based upon observed seasonal trends in activity and observed trends in expenditure. This basic phasing is then amended to reflect known commissioning intentions, major CIPs and service developments.

3.5 Major Movements in the model between 2013/14 and 2015/16

The dominant drivers of changes in the income and expenditure position between years are outlined in Tables 13 and 14.

	Income £m	Expenditure £m	EBITDA £m	Below EBITDA £m	Surplus/ (Deficit) £m
2013/14 outturn	**525.1**	**495.4**	**29.7**	**25.8**	**3.9**
Contract Changes	(4.7)	(1.0)	(3.7)	0.0	(3.7)
Impact Non Recurrent and FYEs	(5.5)	(13.2)	7.7	0.0	7.7
Reinstatement of General Contingency	0.0	6.5	(6.5)	0.0	(6.5)
Recognised cost pressures	0.0	2.0	(2.0)	5.4	(7.4)
Service developments	23.2	27.2	(4.0)	0.0	(4.0)
Impact of 2014/15 tariff	(9.1)	0.0	(9.1)	0.0	(9.1)
Impact of cost inflation	0.0	7.2	(7.2)	0.0	(7.2)
Incremental drift	0.0	2.1	(2.1)	0.0	(2.1)
Cost improvements	6.1	(20.7)	26.8	0.0	26.8
Change in activity	2.2	1.5	0.7	0.0	0.7
2014/15 Plan	**537.3**	**507.0**	**30.3**	**31.2**	**(0.9)**

Table 13 – Bridge from 2013/14 FOT to 2014/15 Plan

Income Movements

The impact of contract changes, non-recurrent income and the full-year effect of 2013/14 income changes have predominantly been caused by the cessation of funding for Winter Pressures and Re-ablement and the potential impacts of notified pricing changes beyond the national tariff reductions in 2014/15. The service developments include significant changes for the transfer of Pathology Services from Maidstone & Tunbridge Wells NHS Trust under the Kent Pathology Project (KPP) and other service changes including the Health & Social Care Village. The tariff reduction has not been applied to 'pass-through' payments such as High-Cost drugs and Devices. Cost Improvements income includes the planned benefit of joint commissioning intentions and market expansion projects.

Expenditure Movements

The Trust general contingency has been reinstated at £6.5m. As with the income movement, the most significant movement relates to service developments including KPP and the Health & Social Care Village and an expansion in the nursing workforce following the Ward Staffing Review in response to the Francis report recommendations. The other major drivers in the movement of the expenditure position is the Trust CIP programme which is detailed in Section 6, the full-year impact of 2013/14 CIP schemes, the disinvestment of Winter Pressures and Re-ablement from commissioners and the cessation of the Transport service.

	Income £m	Expenditure £m	EBITDA £m	Below EBITDA £m	Surplus/ (Deficit) £m
2014/15 Plan	**537.3**	**507.0**	**30.3**	**31.2**	**(0.9)**
Impact Non Recurrent and FYEs	0.0	(3.7)	3.7	0.0	3.7
Reinstatement of General Contingency	0.0	6.5	(6.5)	0.0	(6.5)
Recognised cost pressures	0.0	1.6	(1.6)	(1.4)	(0.3)
Service developments	0.3	4.3	(4.0)	0.0	(4.0)
Impact of 2014/15 tariff	(12.4)	0.0	(12.4)	0.0	(12.4)
Impact of cost inflation	0.0	8.5	(8.5)	0.0	(8.5)
Incremental drift	0.0	2.1	(2.1)	0.0	(2.1)
Cost improvements	7.5	(17.7)	25.2	0.0	25.2
Change in activity	10.7	3.2	7.5	0.0	7.5
2015/16 Plan	**543.4**	**511.8**	**31.6**	**29.9**	**1.7**

Table 14 – Bridge from 2014/15 Plan to 2015/16 Plan

Broadly, the main movements between the 2014/15 and 2015/16 financial plans relate the expected tariff decreases, cost inflation, service developments and the impact of the Trust CIP programme. Further detail on these assumptions can be found in the relevant sections within Section C.

4. Liquidity & COSR

4.1 Cash Plan & COSR

Table 15a shows the cash plans for the two years until March 2016. The reduction in cash from the closing in March 2014 to the closing in March 2016 is as a result of increased capital expenditure plans, tighter economic circumstances, expected delays in collecting NHS debt due to the changed commissioning structure (as it has seen in 2013/14) and reduced levels of planned surplus in future years. The consolidated planned cash holding at 31st March 2015 is £27.5m and on 31st March 2016 it is planned to be £24.1m. The forecast cash holding at 31st March 2014 is projected to be £44m.

	2013/14 FOT £m	2014/15 Plan £m	2015/16 Plan £m
Opening Cash	**64.1**	**44.0**	**27.5**
Surplus/ (deficit) after tax	3.9	(0.9)	1.7
Non-cash flows in operating surplus/ (deficit)	24.9	31.2	29.8
Increase/ (decrease) in working capital	(12.9)	(3.8)	1.2
Net cash inflow/ (outflow) from investing activities	(30.2)	(33.2)	(26.0)
Net cash inflow/ (outflow) from financing activities	(5.7)	(9.8)	(10.1)
Closing Cash	**44.0**	**27.5**	**24.1**

Table 15a – Summarised Cash Flow 2013/14 FOT to 2015/16 Close

The Trust is working to improve cash flow through the planning period and also has a flexible approach in managing capital and investments expenditure to address any emergent issues if required. The Trust maintains its current COSR rating of 4 throughout the 2014/15 – 2015/16 planning period.

4.2 Statement of Financial Position

	2013/14 FOT £m	2014/15 Plan £m	2015/16 Plan £m
Assets			
Assets, Non-Current, Total	302.5	311.3	317.5
Assets, Current, Total	84.7	67.2	62.7
Assets Total	**387.2**	**378.5**	**380.3**
Liabilities			
Liabilities, Current, Total	(62.1)	(54.3)	(54.3)
NET CURRENT ASSETS (LIABILITIES)	**325.1**	**324.2**	**325.9**
Liabilities, Non-Current, Total	(2.3)	(2.3)	(2.3)
TOTAL ASSETS EMPLOYED	**322.8**	**321.9**	**323.7**
Taxpayers' and Others' Equity			
Public dividend capital	189.5	189.5	189.5
Retained Earnings/ (Accumulated Losses)	49.5	48.5	50.3
Other Reserves, Total	83.8	83.8	83.8
TOTAL ASSETS EMPLOYED	**322.8**	**321.9**	**323.6**

Table 15b – Summarised Cash Flow 2013/14 FOT to 2015/16 Close

Table 15b represent a summary of the Trust Statement of Financial position including forecast for 2013/14. Significant changes in 2014/15 include an impact of the financial settlement of the 2013/14 contract with Specialised Commissioning (SCG) and a reduction in capital creditors driven by the expected payment of outstanding 2013/14 capital debt.

5. Costs Assumptions

5.1 Overall Cost Plan assumptions

The Trust recognises it must reduce its costs to ensure financial sustainability. Specific pressure points currently are the use of agency staff and incurring additional expenditure to manage workforce and substantive capacity gaps. The Trust also faces a continuing issue with junior doctor workforce gaps both in both trainees and substantive posts which currently requires expensive resource solutions to ensure quality is maintained.

The plan for 2014/15 and 2015/16 is built upon forecast actual performance in the base year of 2013/14, adjusted for the projections and assumptions set out in the rest of Section 5, and net of contingencies and provisions.

5.2 Cost Inflation assumptions

Pay inflation for 2014/15 and 2015/16 has been set at 1% per annum to reflect expected pay rises. Other pay inflation, covering issues such as incremental drift, has been estimated at an additional cost of £2.1m in both 2014/15 and 2015/16. Drugs cost inflation for 2014/15 and 2015/16 has been set at 4%. In addition, these costs have been volume adjusted for rechargeable High Cost Drugs and assumed within commissioning contracts. Inflation and unknown cost pressures in years 2014/15 and 2015/16 are assumed to be funded through tariff inflation funding. Excluding drugs, all other non-pay inflation headings have been set at 2013/14 outturn, adjusted for marginal cost movements in 2014/15 and 2015/16. The non-pay plan also includes cost pressure estimates e.g. for the impact of changes to the Trust CNST premium and on-going Legionella estates works.

5.3 Marginal Cost assumptions

A marginal cost impact of 30% has been applied to all direct and indirect budgets to reflect the overall impact on expenditure for movements in activity between the forecast 2013/14 forecast outturn position and the 2014/15 activity plan (and subsequently in 2015/16).

6. Productivity, Efficiency & Cost Improvement Programmes (CIPs)

6.1 Sustainability of CIP Schemes

The Trust recognises that the sustainability of CIP schemes will only be achieved through whole systems integration and pathway mapping, which meets the affordability challenge of matching costs with budgets and overall service demand. Patient pathway redesign will reflect the Trusts' Quality Strategy and Shared Purpose Framework which requires development of a culture that continually enhances the provision of patient centred, safe, efficient and effective care. The fundamental principle of ensuring patients access the right pathway at the right time, which results in the right care in the right bed, with the right outcome, is considered the key success factor. For 2014/15 the ratio of traditional CIPs and Transformational changes is approx 60:40 with an expectation that this will become more weighted to transformational chnage over coming years.

6.2 CIP Programme 2014-16

During the past 3 years the Trust has achieved over £76m cost savings at the same time as improving service quality and safety, reducing waiting times, expanding services and improving patient experience. For the 2014/15 and 2015/16 years, the Trust's Financial Strategy requires savings programmes of £26.8m and £25.2m respectively (at 4.9% and 5.1%). To develop a programme of this scale, the Trust senior management, in conjunction with the Clinical Divisional teams, have agreed a framework approach comprising a combination of:

- Divisions developing their service specific savings plans (traditional CIPs) - including workforce cost reductions, non pay spend changes and service revisions with income gains (best practice tariffs and repatriated services).

- Identification of Trustwide opportunities - Including workforce efficiencies, supplies and procurement, medicines management, market expansion and patient pathways, scoped for detailed schemes and values. These are shared with the Divisions for validation and if agreed, for inclusion within the Divisional plans. These schemes encompass both traditional CIPs and Transformational redesign.

- Transformational redesign service improvement - 18 projects (see Table 16) have been identified, focussing on improved efficiency of patient flow through clinical pathways, a reduction of internal waits and length of stay reductions. Improvements to emergency care pathways place particular emphasis on integration with primary and community care, to support increased admission avoidance, enhanced facilitated discharge and reduced avoidable readmissions

6.3 Transformation Programme 2014-16

As part of delivering the Trusts' Annual objectives, the Trust has introduced a Transformation Redesign Service Improvement Programme which will enable radical service review and efficiency identification through a triangulation of knowledge and skills within the Service Improvement team (SIT), the Programme Management Office (PMO) and Service Line Reporting (SLR) team. The Trust recognises that radical redesign needs to occur if efficiency and

productivity are to be optimised, therefore service redesign is driven by the principle 'good quality costs less'.

The two year Programme will be supported through a structured Programme Management Framework, with clearly defined roles, responsibilities, monitoring and governance arrangements. Transformation redesign within East Kent will focus on the development of both Elective and Emergency Schemes which ensure alignment with national and local strategies for integration and partnership working. Table 16 provides an overview of the operational transformation schemes (1-2 years) identified, and how they align to local commissioning intentions. These schemes also reflect the Trust's Clinical Strategy as well as supporting a step change, where appropriate, with strategic transformation (3-5 years). In addition, tools such as SLR and Reference Costs (RCI indicators), as well as internal audits, have been utilised to understand inefficiencies and identify services for review.

Trust Transformation Scheme	Commissioning Intentions
Internal Waits	Ambulatory Care / Better Integrated Working / Integrated Urgent Care: Medical / Integrated Urgent Care: Surgical
Integrated pathway redesign	
External Waits	
Reablement at home	Better Integrated Working / Integrated Urgent Care: Medical / Integrated Urgent Care: Surgical
Stroke	NONE
Acute Neurology and Rehab	NONE
#NOF	NONE
Implement 6 + 3 new ambulatory pathways	Ambulatory Care Pathways
Optimise 5 of the 6 ambulatory pathway	Ambulatory Care Pathways
LTC pathway	Links to CQUINS
Acute Oncology Nurse role	NONE
Pressure Ulcer reduction	Links to CQUINS
Elective Pathway: Optimise Day Surgery (BADS) / 23hr Surgery Ambulatory Care	Ambulatory Care pathways / CQUINS / Planned Care, MSK Pathway
Elective Pathway: Reducing Cancellations on the day	Ambulatory Care pathways / CQUINS / Planned Care, MSK Pathway
Elective Pathway: Theatres	Transformation of Outpatient Services / Planned Care - MSK / Link to reduction in Outpatient Follow-up's
ICATs and Musculo-Skeletal Tender	Transformation of Outpatient Services / Planned Care - MSK / Link to reduction in Outpatient Follow-up's
Reduce Follow up appointments	Reduction in Outpatient Follow-up's / Transformation of Outpatient Services
Nurse Led Therapy Discharge	NONE

Table 16 – 2014/15 – 2015/16 Service Improvement Schemes aligned to CI's

6.4 Current Transformational Schemes

Some transformation schemes are already underway including the integrated use of Reablement funding from Commissioners, to support early implementation of a Health and Social Care Village model which facilitates a reduction in delayed transfers of care and dedicated provision for patients on a non-weight bearing pathway. This model of care clearly demonstrates improved patient outcomes and reduced long term placements, thereby providing the Trust with Strategic transformation opportunities regarding provision of innovative, but sustainable older peoples' services.

A number of Ambulatory Care pathways are already established or have been agreed and subsequently commissioned by surrounding CCG's. Supporting projects undertaken to inform transformation redesign service improvement for 2014-16, includes a review of diagnostic use within existing emergency pathways, a 'deep dive' into theatre utilisation with particular emphasis

on cancellations and patient 'did not attends' (DNA's), and a review of End of Life Care in partnership with Pilgrims' Hospice.

6.5 Future Transformational Schemes

Various schemes have been identified which support transformational redesign of both Elective and Emergency care pathways. Through combining service improvement and SLR data, two key areas have been highlighted which focus on the reduction of 'internal, external and integrated waits' and elective pathway redesign to enhance provision of day surgery, 23hr surgery and enhanced recovery / supported discharge via reablement at home. The Better Care Fund also provides an opportunity to work with Local Health Economy partners to develop integrated ways of working which provide a high quality continuum of care and better utilisation of resources. Robust admission avoidance schemes and facilitated discharge processes will support the reduction of acute inpatient beds, through the development of an integrated admissions and discharge team, provision of additional community capacity to support proactive patient flow and fully integrated rapid response teams to manage urgent care within the patients' own home. Clear opportunities exist to develop schemes which enable shared risks and benefits across the health economy. Redesigning the #NOF Pathway for instance, will enhance links with the falls reduction service within the Community, review medicines reconciliation and poly-pharmacy, and support a reduction in falls in hospital, acute length of stay, mortality rates, complaints and claims.

Schemes have been agreed with Divisions and are being formally developed through the use of project initiation documents. Operational, financial and information leads have been identified to ensure schemes are accurately scoped to meet the 'affordability challenge'. Where appropriate, clear demarcations have been established between Operational and Strategic CIP Schemes to avoid duplication however, all stakeholders will remain apprised of CIP schemes underway &/or identified to ensure all efficiency opportunities are optimised. An example of this is in relation to the reduction of external waits within acute beds through the provision of additional short term capacity and 7 day working across the whole system.

6.6 CIP Programme Schemes

The Trust has adopted a 'bottom up' approach to the development of the 2014/15 and future years CIP plans to ensure full ownership and responsibility for delivery of the component schemes, at the Divisional level. The overall plan therefore comprises 3 distinct elements; Divisional specific efficiency initiatives, Divisional agreement and acceptance of Trust wide efficiency opportunities and the specific Divisional components of the Service Improvement (Transformational Redesign) programme. Table 17 outlines the current progress in identification of CIP schemes.

	Urgent care & Long Term Conditions £m	Surgical Services £m	Specialist Services £m	Clinical Support Services £m	Strategic Development £m	Corporate £m	Trustwide £m	Totals CIPs £m
Workforce	1.95	0.64	0.10	0.89	0.00	0.32	3.27	7.18
Service Improvement	1.24	1.02	0.00	0.00	0.00	0.00	8.63	10.89
Supplies & Procurement	0.28	0.18	0.15	0.90	0.75	0.46	1.28	3.99
Medicines Management	0.06	0.12	0.04	0.02	0.00	0.00	1.33	1.57
Income	1.11	0.25	0.06	0.34	0.05	0.00	0.50	2.31
Back Office review	0.00	0.00	0.00	0.00	0.30	0.00	0.00	0.30
Estates	0.00	0.00	0.00	0.00	0.55	0.00	0.00	0.55
Totals	**4.65**	**2.21**	**0.36**	**2.14**	**1.65**	**0.78**	**15.00**	**26.78**

Table 17 – 2014/15 CIP Schemes Financial Impact Summary
Note: some service improvement and Estates schemes include revenue (income) benefits

All CIP schemes are risk rated (RAG ratings), have a designated project lead, a defined start date and are profiled by month for monitoring and reporting. Supporting these planning considerations, the Divisional management teams (Divisional Director, Clinical Director and Lead Nurse) formally sign off their respective CIP plans, including an assurance that the plan can be delivered without an adverse impact on service quality and safety. This formalisation of the plan is then subject to review and challenge within the Divisional Executive Performance review meetings to provide independent scrutiny before final sign off of the overall CIP plan at Executive level.
Whilst the CIP planning has focused on Divisional level plans, the overall CIP plan can also be described by key themes as outlined in Table 18.

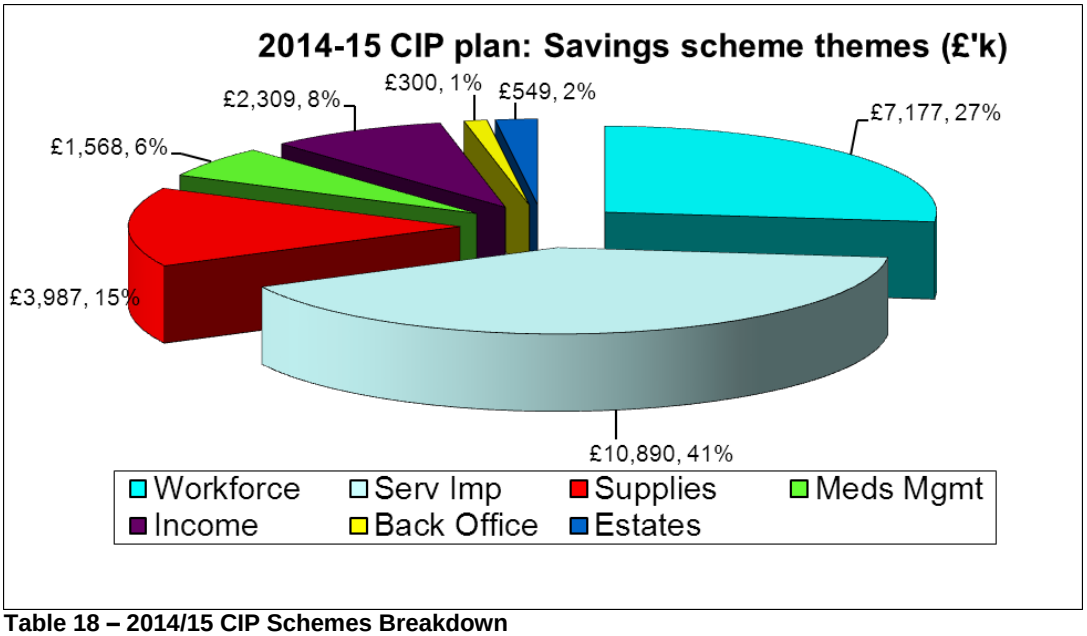

Table 18 – 2014/15 CIP Schemes Breakdown
Note: some service improvement and Estates schemes include revenue (income) benefits

Workforce Schemes

Pay related efficiency schemes have been developed from a combination of Trustwide workforce opportunities (reducing unit cost of labour) and Divisional led initiatives (pay cost reductions). The scheme encompasses;

- Agency expenditure reductions (Medical and Nursing)
- Junior doctor rota review and revised bandings
- Sickness absence management
- Review of Consultant job plan and PA reductions
- Review of Clinical Excellence Awards
- E-Rostering benefits (reduced overtime payments)
- National pay award benefits
- Admin & Clerical staffing review
- Extension of salary sacrifice schemes
- Buying/selling annual leave
- Review of ward staffing levels (realignment of staffing ratios between sites)
- Skill mix changes – including nurse led services, Assistant practitioner roles
- Enhanced recruitment process

A Trustwide workforce programme group, led by the HR Director, meets regularly to develop and review proposed schemes and to share efficiency opportunities across the Divisions. Further

workforce schemes are under consideration, including other medical staff pay cost revisions and options to revise terms and conditions through discussion/agreement with Staff Side representatives; these will take time to develop and reach agreement and are therefore more likely to be included in the latter part of 14/15 or be 15/16 plans.

Service Improvement Schemes

As described earlier, a number of high value efficiencies have been developed from the Trust's evolving Transformation Redesign Service Improvement Programme. With the primary focus on improving clinical services and patient experience, significant levels of financial benefits have provided from these projects, including;

Emergency pathways:

- Internal waits – revision of patient pathways to improve flows (from admission to discharge) through revision of a range of inefficient processes and practices, leading to reduced bed capacity requirements and shorter lengths of patient stays.
- Integrated pathway redesign, again improving patient flows through revised working relationships with external partners.
- Implementation of new of ambulatory care pathways and optimisation of existing pathways
- Design and implement optimal pathways for top 4 long term conditions

Elective pathways:

- Administration review of full elective pathway (from referral to treatment)
- Review of elective pathways (outpatient/ambulatory treatments v daycase v inpatient)
- Review and revision of 18 week RTT process and practices
- Review and reduction of internal Diagnostic service demands
- Review of specific service efficiency opportunities using SLR (high cost variances against national averages)

CCG Demand management Schemes

The Trust has been working in partnership with CCG commissioners to support their objective of managing service demand across the following activities;

OPD pathway redesign (follow up demand management)
Admission avoidance
Discharge management

Within the contract negotiations with CCGs the Trust is seeking to share the income benefits gained from this proactive approach to demand management; although not concluded there is a common goal to reduce activity levels and at this stage the potential shared income benefits have been risk adjusted accordingly within the CIP plan.

Supplies & Procurement (inc non pay cost reductions) Schemes

Over recent years the Trust has developed a comprehensive Supplies & Procurement savings programme, derived from the operational workplan of the S&P department. This ensures a cross referencing to other service projects with procurement input and reduces the risk of double counting within the resulting efficiency plans. The (cash releasing) Supplies savings plan is built up from a combination of supplies produced initiatives, opportunities provided by supporting agencies (NHS Commercial Solutions and NHS Supply Chain, review of all contract renewals, and local developed (Divisional) schemes. These are then formally reviewed and agreed by the Divisions with the Supplies team providing technical procurement support and also business partner and change management support for scheme development and implementation at Divisional level. Specific high value (>£100k) schemes include;

- Drapes & Gowns
- Orthopaedic Prosthesis (Managed service contract)

- PACS/RIS project
- Agency contract (NHS Professionals)

A reorganisation of the S&P department has recently been approved, supporting a more proactive integration with service areas (through relevant category and change management) and providing an increased level of supplies and procurement efficiencies. Divisional teams and the S&P department are currently developing a programme of product standardisation to promote the additional savings. In addition to the overall S&P savings plan, Divisions have also adopted a number of local savings initiatives for non-pay budget lines, including reduced travel costs, reduction or cessation of SLA contracts with outside parties (rationalisation of outpatient sites), printing and postage cost reductions.

Medicines Management Scheme

The Trust has run a Medicines management programme for a number of years, to provide efficiency opportunities in association with the clinical process and prescribing practice decisions developed through the Drugs & Therapeutic Committee. The annual efficiency plan is comprised of the benefits gained through specific prescribing practice changes, drug cost reductions provided through supporting agencies (NHS Commercial Solutions) and internal service changes and initiatives, including significant reductions in antibiotic prescribing through introduction of Procalcitronin testing. The plan has also been supplemented through the savings benefits to be gained from a major change in pharmacy services with a move to ward based pharmacists to support improvements in patient pathway management and more effective prescribing practices through the patients stay and at discharge.

Revenue (Income) benefits Schemes

Whilst income benefits have been a significant contribution to the Trusts CIP plan over previous years, this is no longer the case as local CCGs and the SCG face financial pressures and are restricting payments for service growth. The planned income CIP benefits will be derived from a combination of service activity (SLA) and other sources, including;

- Service repatriation (EBUS service)
- Service development (bowel cancer screening and EPS growth)
- Best practice tariff increases
- Direct access (Radiology) service developments
- ITU beds additional income (agreed with Commissioners)
- Improved theatre utilisation and reduction in use of independent sector
- Increased Diagnostic service contract with local Private hospital
- Market expansion of Trust private patient services/income.
- CCG demand management – shared benefits (see Service Improvement above).

Back Office Programme Scheme

The Trust has developed a Back Office programme, with an initial focus on efficiencies to be gained from a reorganisation of both the Hard FM and the Supplies & Procurement services. Both were the subject of a detailed outsourcing review, in partnership with the Trust's Soft FM service provider (Serco) but in-house options were ultimately considered the most appropriate and efficient way forward. Further projects are in development covering other back office functions, including Finance, HR and Medical Records services.

Estates Scheme

In addition to the efficiencies gained from the Hard FM service review, other Estate savings include;

- Managed service contract for estate maintenance
- Rental income benefits for Trust properties

- Utility cost savings
- Hospital manager site plans

6.7 2015/16 CIP Programme

Planning of the 2015/16 CIP schemes is at an early stage and is expected to be heavily reliant upon progress and contributions from the evolving Transformational Redesign Service Improvement programme and the development of the Trust 5-10 year long-term strategy. The Trust recognises that radical redesign needs to occur if the future levels of efficiency and productivity are to be optimised and sustained. Other major contributions to the 2015/16 plan will include the benefits associated with the Kent Pathology Partnership, a joint pathology service venture between the Trust and Maidstone & Tunbridge Wells NHS Trust and a reconfigured Laundry service across the Kent & Medway Trusts. The indicative CIP plan for 2015/16, by key theme and contribution is shown in Table 19.

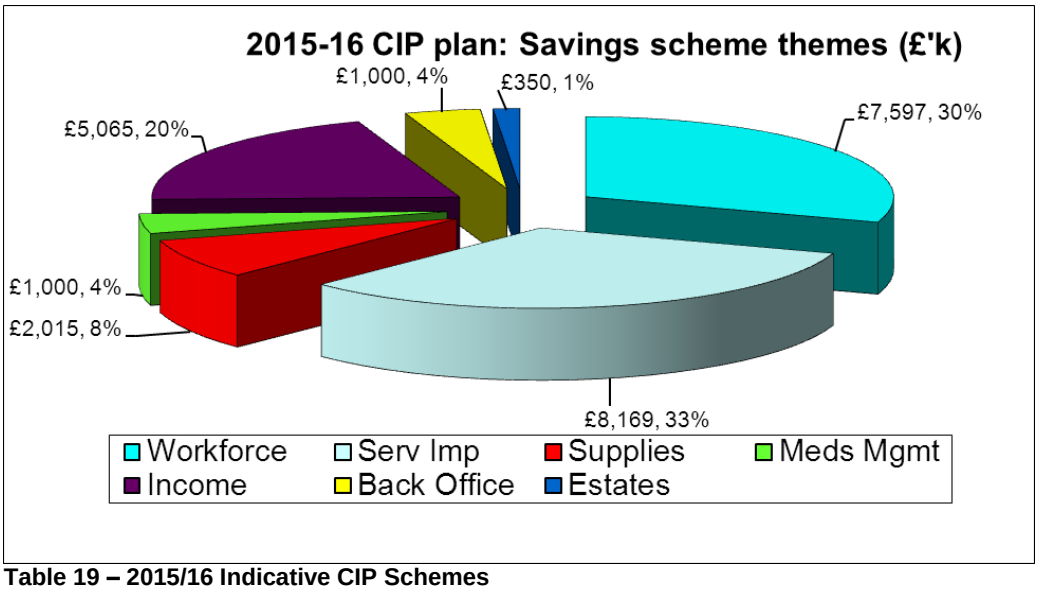

Table 19 – 2015/16 Indicative CIP Schemes

6.8 Service Level Initiatives

Supporting the CIP programme through to 2015/16, there are other initiatives underway across both clinical and non-clinical services to ensure productivity and efficiency is tested across all aspects of all services. Initiatives include:

- Ensuring consultant job plans support increasing service demands.
- Optimisation of clinic utilisation across all specialties (UCLTC).
- Increasing demand on Neurology, Rheumatology and Falls OP services require new models of care and benchmarking OP utilisation and new:Follow-Up ratios to make most efficient use of available capacity & resource.
- Use of Theatreman system to monitor efficiency/productivity of Cardiac Catheter Suite at WHH.
- Modelling the impact of move to daycase Angiography service to release beds cardiology.
- Cardiophysiologist led services to release consultant time.
- Kent Pathology Project (KPP) – Service Development Scheme.
- Review of booking process in Radiology and the introduction of centralised booking.
- Cost avoidance by reducing reliance on Sonographer locums and external service providers.
- Cost avoidance by exploring the potential to replace locum Radiologists with Extended Role Practitioners.

- Review repatriation opportunities for Interventional Radiology service.
- Outpatient Obesity Clinics – potential plans to provide an obesity management programme funded through income generation.
- Archiving Service provision to other NHS organisations - Currently producing an options paper to identify whether archiving or scanning would be more efficient.
- Back Office Review of the management structure of Therapies to look at improving efficiency and value for money.
- Developing central booking for Therapies services to improve efficiency and economies of scale.
- Pathway work for Therapy Out Patient services is taking place to improve capacity and the ability of service to flex to demands changes for Specialty clinics
- Outsourcing of Pharmacy outpatient dispensing will be implemented, involving private sector or in house suppliers operating dispensing services within three main sites and the new Dover hospital.
- Repatriation of over labelled medicines from external suppliers to in house production.
- Aim for a reduction in waste through less expired medicines.
- Development of regular medicine usage reports from specialist pharmacists to Divisions and specialities, identifying schemes to improve cost effective prescribing.

6.9 CIP Programme Governance

Whilst transformational CIP's will be monitored through the Transformation redesign service improvement steering group and governance framework, the Trust's overarching CIP programme will be closely monitored by the Programme Management Office. CIP scheme development and achievement progress is a standard agenda item at monthly Divisional Executive Performance review meetings in addition to the monthly Finance & Investment Committee who scrutinise planning and performance for Trust Board assurance. The programme governance also includes an impact assessment on key schemes, to provide assurance that no efficiency scheme has an adverse impact on patient safety or quality. All schemes are quality assured by Divisional Medical directors and Lead Nurses and signed off by the Trust Medical Director and the Trust Chief Nurse & Director of Quality & Operations.

7. Service Developments

7.1 Investment Prioritisation

As part of the Trust's planning process, in October 2013, the Trust compiled a list of proposed business cases and outline service developments that totalled circa £14.5m in recurring revenue costs. Against a planned revenue investment allocation of £4m per annum, (£2m Strategic Investment Group allocation plus £2m to support organisational change following publication of the Francis report), there was a circa £10m gap between requests for investment and available funding resource.

To address this, the investment proposals were put into the context of the benefits that they drive (clinical, quality and financial) both in 2014/15 and in future years, in order to be fairly and appropriately compared. Using a Trust developed Benefits Scoring Model under the banner of the Trust's Strategic Appraisal Framework, the Executive Team held and led several discussions on the list of approved and potential schemes in order to identify both the most beneficial ones to support going forward and those that could be deferred. This prioritisation process also supported the phasing of improvement projects over the next 12 months in 2014/15 and helped provide clarity for the other requested projects for the coming years to all key stakeholders.

7.2 2014/15 Investment Summary

A summary of all the prioritised service developments that are included in the 2014/15 financial plans can be seen in Table 20.

APR Scheme Ref	Service Development	Income 2014/15 £m	Gross Cost 2014/15 £m	Cost Reduction 2014/15 £m	Total Net Cost Impact 2014/15 £m
1	KPP Project	14.3	(15.2)		(0.9)
2	Dover Hospital Rebuild			0.1	0.1
2	Clinical Strategy - Outpatients/ High Risk Surgery		(1.6)		(1.6)
2	ITU Expansion at WHH	0.8	(0.6)	0.1	0.3
3	SAcP	3.1	(3.1)		0.0
4	Pharmacy Service Development		(0.8)		(0.8)
5	Ward Staffing	1.1	(2.9)	1.1	(0.7)
5	MDG Recurrent Revenue Equipment Funding		(0.4)		(0.4)
6	Healthcare & Social Care Village	3.9	(3.9)		0.0
7	Electronic Workflow		(0.0)	0.2	0.2
7	Telephony		(0.2)		(0.2)
		23.2	(28.6)	1.4	(4.0)

Table 20 – 2014/15 Service Developments

7.3 2014/15 Service Development Schemes

1) **Kent Pathology Project (KPP)**
   Further detail in Section B 3.7
2) **Clinical Strategy Schemes**
   These schemes encompass the rebuild of Dover Hospital (due for completion in March 2015, Outpatients department infrastructure changes to support delivery of one-stop clinics; infrastructure and workforce changes to support Medium/ High Risk Surgery provision (dependant on selected service model); POD Theatre & ITU WHH.
3) **Southern Acute Cluster Project (SaCP)**
   Replacement of Trust Patient Administration System (PAS) and Maternity System
4) **Pharmacy Service Development**
   Investment to establish a Near Patient Service that delivers savings through re-use of Patients Own Drugs, reduction in turnaround of discharge medication, and reduction in drug errors through increased Medicines Reconciliation rate.
5) **Ward staffing Review Investment**
   Paediatrics; Adult; Maternity cover; Medical equipment
6) **Health & Social Care Village**
   Further detail in Section B 3.11
7) **New Systems**
   Includes implementing a new Electronic Workflow system and installing and upgrade to the Trust Telephony system to support CIP schemes.

7.4 2015/16 Service Development Schemes

£4m investment has been built into the 2015/16 financial plans for service developments encompassing the potential impact of Clinical Strategy schemes. An executive team led prioritisation process will take place in mid 2014/15 to inform the investment plan for 2015/16.

APR Scheme Ref	Service Development	Income 2015/16 £m	Gross Cost 2015/16 £m	Cost Reduction 2015/16 £m	Total Net Cost Impact 2015/16 £m
2	Surgical Assessment Unit		(0.1)		(0.1)
2	Hospital at Home		(0.4)		(0.4)
2	Second Cardiac Cath Lab - Staffing		(0.7)		(0.7)
2	Clinical Strategy - Breast Surgery		(0.5)		(0.5)
2	Clinical Strategy - Emergency Care	0.3	(1.8)		(1.5)
5	MDG Recurrent Revenue Equipment Funding		(0.4)		(0.4)
7	"Better Training, Better Care"		(0.2)		(0.2)
7	ePrescribing		(0.2)		(0.2)
		0.3	(4.3)	0.0	(4.0)

Table 21 – 2015/16 Potential Service Developments

8. Capital Plans

8.1 Five Year Capital Plan

The Trust has a clear capital expenditure plan for the next five years to 2018/19. As in previous years, the programme will be managed flexibly with an internal 'stretch' programme that includes outline schemes that can be brought forward to replace schemes within the approved capital plan if required and have identified schmes that could be deferred. The capital plan has been developed with cash not currently being a limiting factor, however with the outlined flexible approach to management, the programme has the ability respond in a planned way to unexpected changes in the Trust financial position. Nevertheless, it is recognised that the decisions around the prioritisation of revenue schemes and the phasing of those schemes, will impact on the phasing of Trust's capital expenditure plans over the next few years.

APR Scheme Ref	Scheme	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
1	2013/14 Schemes Continuation	1,672	525	0	0	0
2	Dover - Reprovision of services	13,832	607	0	0	0
3	Clinical Strategy - Approved Schemes	1,200	6,400	584	0	0
4	Recurrent Allocations	8,000	7,000	9,000	9,000	9,000
5	Clinical Strategy - Schemes not yet Approved	2,000	3,000	15,000	15,000	20,000
6	Laundry Equipment	1,000	0	0	0	0
7	Computer Aided Facilities Management (CAFM)	500	0	0	0	0
8	Linac	0	0	1,000	4,000	0
9	Energy Project - Phase II	0	3,328	750	0	0
10	Telephony	1,000	600	0	0	0
11	Kent Pathology Project (KPP)	500	2,500	0	0	0
12	Nursing Home Strategy	0	1,500	3,000	0	0
	Total	**29,704**	**25,460**	**29,334**	**28,000**	**29,000**

Table 22 – 2014/15 – 2018/19 Capital Plan

Scheme level detail can be seen in Table 22. This table does not include £0.5m of donated assets that the Trust broadly expects to receive in each financial year primarily supporting the purchase of medical equipment to enhance patient experience. This expenditure is fully supported by income streams from charitable organisations.

8.2 2014/15 – 2015/16 Schemes

Three projects that commenced in 2013/14 continue into 2014/15. These are the Endoscopy upgrade (completion April 2014), the Energy project phase I (completion in July 2014) and the PACs RIS replacement scheme that will continue into 2015.

Dover Hospital Rebuild

The largest allocation in 2014/15 will be the new hospital at Dover. The scheme is well underway and the main build due for completion at the end of February 2015. The new building will therefore be operational from March 2015. There will be some minor additional capital work undertaken to the car park in 2015/16.

Clinical Strategy Schemes (Approved)

The Clinical Strategy Approved Schemes are the CT Scanner WHH and the Outpatients refurbishment KCH. The CT Scanner at WHH will be located in the current Fracture Clinic which is due to move into the Celia Blakey area once Endoscopy unit is complete and the area is refurbished. The Outpatients refurbishment at KCH that will provide a polyclinic has commenced and will be completed in August 2014. Further work is planned on the other sites in 2015/16.

Recurrent Allocations

Annually the Trust has held some expenditure under Recurrent Allocations to address issues such as backlog maintenance and equipment replacement. A key element of challenge from Monitor as part of the FT assessment was the likely timescales for the eradication of a major backlog maintenance programme. It is also a requirement of the Trust Terms of Authorisation to have a detailed annual maintenance and equipment replacement programme and this is reflected in the on-going allocations.

- Purchase of new/ replacement major items of medical equipment;
- Replacement of current medical devices and equipment;
- Backlog maintenance;
- Replacement and purchase of new IT equipment; and
- Divisional capital requirements.

Clinical Strategy Schemes (Not yet Approved)

Clinical Strategy Schemes at the 'not yet approved stage are the Fracture Clinic WHH and the Surgical Services centralisation. The Fracture Clinic WHH is at business case development stage and a case is expected to the Trust Strategic Investment Group (SIG) in early 2014/15. A refurbishment is planned of the soon to be vacated area of the Celia Blakey current occupied by Endoscopy. This will be moving in May 2014 and expenditure for this scheme has been planned to commence in Q3. The Surgical Services centralisation Board of Directors decision is being reviewed (as per Section B 4.3) and until the outcome of this, only initial planning on this scheme will go ahead.

Laundry Service

The existing Laundry equipment needs to be replaced and a business case will be going to SIG in early 2014/15. This scheme is essential in supporting a Kent-wide amalgamation of Laundry services phased over the next few years and has a current planned cost savings of £0.4m in Year 1 and a further £1m in 2018/19.

Computer Aided Facilities Management System

Computer Aided Facilities Management (CAFM) is an asset database which manages planned and reactive maintenance, and supports an ambitious savings plan in Hard FM recently approved by the Finance & Investment Committee (FIC).

Energy Project Phase II

Funds have been set aside in 2015/16 for the Energy Project Phase II, to carry out the next phase of the Energy Project. This will ensure the Trust meets its Carbon Reduction Commitment (CRC) going forward. The scheme will be subject to approval of a business case and will again release substantial savings to the Trust as well as drive up quality in the service.

Telephony System Replacement

The Telephony system project covers both the replacement of the Trust's current telecommunications infrastructure and also introduces the use of video on a wider scale. A tender process has been completed and the initial orders are expect to be placed in the next two months. This project will also enable VOIP across the Trust but will also facilitate a project looking to house corporate functions off-site enabling the Trust to consolidate it's estate and focus on providing clinical space in its hospitals.

Kent Pathology Project

There is an allocation for the Kent Pathology Project (KPP). This is a joint business case with MTW and has been approved at the Board of Directors (as per Section B 4.11). The funds in the 2014/15 programme are mainly for an integrated IT system and some professional fees for the design and specification of the refurbishments which are due to take place in 2015/16. Again, this project offers substantial cost savings to both Trusts.

Nursing Home Strategy

Funds have been set aside in 2015/16 and 2016/17 for the Nursing Home Strategy. The Trust faces large demographic increases in the over 65 population in East Kent over the next 10-15 years. The over 65 population has a disproportionate effect on demand for Trust services and increased pressure on these services is expected to result. To address this issue the Trust is considering if it should invest in this sector to both ease operational pressures in terms of bed utilisation, but also to look for profit from the commercial side of the business.

8.3 Movement in Capital Plan from 2013/14 Submission

The movement in capital plans since the 2013/14 Capital Plan submission to Monitor in May 2013 is outlined in Table 23. In summary, the capital spend has reduced by £2.3m in 2014/15 (£29.7m) and £3.9m in 2015/16 (£25.5m).

	ORIGINAL MONITOR PLAN		REVISED MONITOR PLAN - 14/02/14		TOTAL MOVEMENT	
	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16
	£'000	£'000	£'000	£'000	£'000	£'000
2013/14 Schemes	250	0	500	0	250	0
Dover - Reprovision of services	12,085	0	13,832	607	1,747	607
Clinical Strategy Approved Schemes	4,890	7,427	1,200	6,400	(3,690)	(1,027)
Recurrent Allocations	9,000	9,000	8,000	7,000	(1,000)	(2,000)
Clinical Strategy Schemes not yet Approved	4,646	9,130	2,000	3,000	(2,646)	(6,130)
Laundry Equipment	0	0	1,000	0	1,000	0
Computer Aided Facilities Management (CAFM)	0	0	500	0	500	0
Telephony	0	0	1,000	600	1,000	600
KPP	0	0	500	2,500	500	2,500
Nursing Home Strategy	0	0	0	1,500	0	1,500
Revised Draft Plan (Monitor Submission)	**32,043**	**29,410**	**29,704**	**25,460**	**(2,339)**	**(3,950)**

Table 23 – 2014/15 – 2015/16 Capital Plan Movement

The main reason for this movement is primarily due to the ongoing development of the Trust Clinical Strategy. The Trust has just concluded consultation on its outpatient service strategy. A final decision will be taken in June 2014 around consolidation onto six sites. The panned refurbishment on existing sites has been slowed to enable additional expenditure on Dover, as well as to support the strategic decision to establish KPP and the need to replace the Trust's telephony system. There has also been some movement around the recurrent allocations where the allocation for major medical equipment replacement has been removed in 2014/15 and 2015/16 to support the expenditure on the CT Scanner at WHH. Also the allocation for the Patient Environment Investment Committee has been increased by £1m in 2014/15 to support the upgrade of the building infrastructure to the Arundel Unit at WHH.

8.4 Capital Governance & Reporting

A Capital Report is presented monthly to the Strategic Investment Group (SIG) & quarterly to the Finance & Investment Committee (FIC). The report includes tables showing the Programme position in terms of timescales, financial position and forecast position for both the financial year and for the completion and the scheme.

SECTION D – COMMERCIAL IN CONFIDENCE

1. Radiology Information System Issue - Negotiations with GE

The Trust Chief Executive and senior team has met with GE's senior management team in January and February 2014 to reiterate required actions, based on the identification of the gap of system deliverables following implementation. Agreed actions are:

1) The consortium will only pay GE for the functionality which has been delivered which equates to circa 40%. However this is predicated on GE paying the consortium £1.8m, which constitutes remuneration for the delay in go live, productivity losses due to lack of system functionality and £200,000 for the potential loss of income due to the inability of the system to produce monthly activity reports. When the £1.8m has been received the consortium will pay GE for 40% of the managed service payment for the period 1st September to 31st December 2013.
2) The consortium will remunerate GE from 1st January 2014 for the functionality at a level of 20% of the managed service payment. This reduction is due to the on-going costs the consortium continues to fund for the additional workforce required to run services at the level of productivity which was achieved before the GE PACS/RIS implementation.
3) The consortium will not pay for any part of the gap analysis until this has been fully delivered by GE.

It is therefore expected that subject to outcome of negotiations with GE, the consortium will receive remuneration for the costs associated with the non-delivery of the managed service. If the required functionality is not achieved the consortium will only pay GE for the % of functionality achieved. The consortium does not believe there is any advantage to apply a breach of contract due to the impact this will have operationally on patient care.

2. Financial Risk Mitigation & Contingencies

2.1 Financial risks within the Operational Plan

The tariff in the Trust planning model assumes a 4% efficiency requirement in 2014/15 and 4.5% in 2015/16 per the published tariff for 2014/15 and published planning guidance by Monitor. Against this income assumption, issues that may cause a significant variance to the Trust financial plans are:

- Non-payment of services under local tariff or contract funding arrangement;
- Significant failure in delivering fineable quality targets such as CDiff, Readmission levels, A&E wait times and 52 week access targets;
- Poor liquidity or availability of cash from providers;
- Loss of financial control internally;
- Non achievement of CIPs or inability of Trust to meet CIP/efficiency requirements due to a requirement to invest in a quality or safety issue;
- Significant unforeseen unavoidable cost pressure;
- Major costs associated with unplanned reconfiguration of services;
- Loss of a major service due to competition or alternative treatment being made available by a competitor;

Those risks that are non-activity based would be the most damaging as there would be no mitigation through reducing costs through reduced activity.

2.2 Mitigations against financial risk

The Trust has a planned general contingency of £6.5m in 2014/15 and will if possible ensure the same level of contingency continues into 2015/16. The Trust has also made some prudent provisions based on pricing changes that the Trust is expecting and also the price impacts that the commissioners are pursuing. The Trust does not plan to fall short on its CQUIN achievement or miss any finable quality targets, but does hold provisions against such eventualities in-part. Similarly, a prudent view over expenditure provisions and the representation of service Developments in the plan has been taken. In addition, the Trust is aiming to identify and deliver further CIP schemes beyond the 2014/15 and 2015/16 targets it has set.

Further mitigations include:

- An appropriate contracting process developing closer relationships with commissioners;
- A prudent approach to cash planning and a recognition of slowing/ reducing capital expenditure plans if required;
- Development of early warning dashboards (live A&E reports and balanced scorecard review);
- Routine and regular financial reviews of internal processes at Divisional and Departmental levels and at Executive Performance Reviews;
- Regular review of CIP performance and a routine and continuous process to develop CIP schemes and identify inefficient processes and care pathways for review;
- On-going strategic review of services;
- Continued investment in quality and research;
- Continued reporting to the Finance & Investment Committee of competitive tenders and horizon scanning with competitor analysis assessments.

2.3 Service Level Risks

- The cost of delivering non substantive additional capacity that is not financially or clinically efficient;
- Trust is unable to meet current access standards for Orthopaedics however is compliant at a Trust level;
- The development of an Integrated Urgent Care Centre (IUCC) will focus on reduction of admissions and reduction in LOS which will potentially reduce income;
- Commissioner view that the Better Care Fund should be funded from a reduction in Acute income of circa 30%;
- AQP/ Commissioner tendering of Pathology direct Access services. If the Trust lost the direct access Pathology activity then this would represent a £9.5 million loss of income (for MTW this represents £6m of lost income);
- Repatriation of Homecare – business case approval required for staffing resources;
- Repatriation of ‘Specials’ – may need to bring back in house if GPs do not continue to prescribe.

2.4 Service Level Mitigations

- Correct coding of treatment to ensure appropriate tariff;
- Reduction in waste and duplication within services;
- Strict adherence to commissioning contract i.e only delivering services that are commissioned;
- Establishing KPP. It is in the interest of both Trusts to support and mitigate this potential large loss by the full support that has been given to the creation of KPP. KPP has a drive to further improve quality as well as reduce costs significantly so that unit costs are reduced, and therefore allow potential markets to be exploited, KPP’s vision is to create an efficient

and innovative diagnostic service of the highest quality which delivers the best patient outcomes and is the first choice for clinical users, patients, and staff against a background of an organisation which is competitive, commercially aware, and market focused.

- Mitigation through 'gain share' arrangement with commissioners.

2.5 Income & Expenditure Contingencies

As per the Trust Financial strategy, in 2014/15 a 1.5% General Contingency has been reserved to handle issues over which the Trust has minimal control. Alongside this, with broad estimates of the potential impact of Re-admissions and Infection related fines, delivery of CQUIN targets and provision against the Trust CIP target, a high level summary of the Trust income and expenditure contingencies is outlined below:

£6.5m General Contingency (Expenditure)
£3.8m Re-admission/ Infection Penalties (Income)
£0.9m Delivery of CQUIN's (Income)
£4.9m Contract Rules/ Tariff risk (Income)
£16.1m Total Contingencies

2.6 Mitigation of Longer term risk impacts

Mitigation of any longer term financial risk assumes full utilisation of contingencies and relevant provisions. Any balance will be dealt with by the delay of investments in 2014/15 and any further balance taken into 2015/16 would again be mitigated by reducing investment and if required increasing CIPs.

The key actions the Trust would take therefore encompass:

- Increase CIPs in later periods
- Reduce investments into service developments
- Accelerated service review and change.

The Trust is also yet to build in any potential financial benefit from both its' Nursing Home Strategy or its' Private Patient Strategy which could individually and collectively have a materially positive financial impact on the overall Trust financial position in 2015/16.

3. Sensitivity Risk/ Downside Modelling

2.1 Loss of Internal financial control

At an operational level, the most significant risks to the Trusts short term plan is loss of financial control due to poor budgetary or service level management or a failure of the Trust to meet its quality targets. Loss of financial control should be considered as temporary as it assumes service action will be taken (a 2013/14 example would be the extra support provided to the Surgical Division) and should not be significantly material as long as poor performance trends are identified at a reasonably early stage through the Performance Management process.

The Trust has recently had an internal audit completed on its internal Performance Management Process in which significant assurance was given so the risk is in part mitigated as the Trust is assured that any deteriorating trends should be picked up early.

2.2 CIP Delivery

Further to this, the Trust has made significant CIPs in recent years and its continued ability to deliver high levels of CIP without significant service change in future years must be considered in year 2 (2015/16) onwards of the plan. Work programmes are currently being developed with commissioners that will aim to deliver system wide cost reductions and these work programmes

will make up a significant element of the Trust's CIP programme for 2014/15. More strategic service changes will form a significant part of CIP programmes for the years that follow as an inherent part of the Trust 5-10 year strategy.

2.3 Fines following non delivery of Quality targets/KPI's

The development of a downside has focused on the impacts of a system wide failure in delivering finable quality targets. Despite being non recurrent in nature the scenario does allow the Trust to describe the level of contingencies and provisions it carries in its plan. Potential fining has been used as an example in the operational plan as it is one of the more relevant scenarios and could be a more material in the early years of the plan. Therefore a worst case scenario has been identified to play into the downside.

Area of potential fine	Worst Case Impact (2014/15 & 2015/16)
CDiff and other infections	£3.7m
Readmissions	£6.0m
52/18 Weeks	£1.6m
62 Day Cancer	£0.1m
A&E waiting times	£0.9m
Loss of CQUIN	£3.0m
Investment to correct	£1.4m
Fines for worse case in Downside Plan	**£16.7m**

Table 24: Worst Case Commissioner Fines

The impact of the worst case would be mitigated immediately as follows:

	2014/15 £m
Worst Case Fines Chargable	16.7
Readmissions/ Infection Rates Provisions	(3.8)
Delivery of CQUINs Provision	(0.9)
Contract Rules/ Tariff Risk Provision	(4.9)
General Contingency	(6.5)
Delay Service Development Investment	(0.6)
Fines for worse case in Downside Plan	(0.0)

Table 25: Worst Case Mitigations

APPENDICES

1. Divisional Activity Bridges – 2013/14 FOT to 2014/15 & 2015/16 Plans

	Ref Primary Care	Ref Non-Primary Care	OP New	OP Follow Up	Elective Daycase	Elective Inpatient	Non-Elective Inpatient	A&E
2013/14 RE-Modelled FOT	**36,916**	**58,989**	**36,751**	**71,619**	**27,125**	**2,302**	**46,948**	**198,709**
Observed growth and demographic	499	617	384	509				
Growth in overall attendances (SECAMB)								1,260
Growth in follow up from Ambulatory Care			145	144				
Increase in Gastroenterology re Bowel Screening				420				
Increase in Ambulatory Care							266	
GP Direct Admission							385	
Increase in Bowel Cancer screening and consistent overall grown from Business Case					814			
Actual Activity Adjustments (largely DA Cardiology moving from PBR to Non PBR)	(-9,823)	(-41,285)	(-2,624)	(-3,249)	32	35	144	
Adjustment due to flat line of SECAMB attendances								991
Movement of on-going impact of winter schemes							80	
2014/15 Final Business Plan (Pre-Contracting)	**27,592**	**18,321**	**34,656**	**69,713**	**27,971**	**2,337**	**47,823**	**198,978**
%	(-25.6%)	(-69.0%)	(-6.8%)	(-2.7%)	3.0%	1.5%	1.7%	(-2.9%)
Additional HCOOP and Neurology Growth (against IPM challenge)	238	323	153	86				
Additional decline due to OP efficiency			(-84)					
Ambulatory Care Growth								
Growth in Stroke and Endoscopy (additional to demographics)					274			
Small growth due to A&E attendances and conversion rate							182	
2015/16 Demographic Growth	1,151	1,164	1,061	1,843	645	63	1,368	4,390
2015/16 Final Business Plan (Pre-Contracting)	**28,981**	**19,808**	**35,786**	**71,642**	**28,890**	**2,400**	**49,373**	**203,368**
%	5.0%	8.1%	3.3%	2.8%	3.3%	2.7%	3.2%	2.2%

Table 26 – UCLTC Division Activity Bridge

	Ref Primary Care	Ref Non-Primary Care	OP New	OP Follow Up	Elective Daycase	Elective Inpatient	Non-Elective Inpatient	Cost Per Case - Other	Block Contract Activity	Non Income Activity
2013/14 Forecast Outturn	**30,249**	**33,074**	**49,597**	**160,639**	**15,271**	**2,692**	**14,915**	**137,723**	**27,102**	**184,266**
Removal of Non Recurrent Activity	(-132)	(-875)	37	(-401)	0	0	(-1)	(-41)	0	(-608)
Remodelled FOT	**30,117**	**32,199**	**49,634**	**160,238**	**15,271**	**2,692**	**14,914**	**137,682**	**27,102**	**183,658**
Dermatology Rapid Access Increase + PUVA Increase	348		348	463	129					
Paediatric Recording Shift - Pt2 - Cons Led WA to UCA			(-1,710)	(-1,782)			3,840	(-420)		
Chemotherapy Growth				1,235				880	768	1,080
Renal Growth (Increase in Referrals + Renal Transplantation)	61	35	79	472						
Maternity Forecast (7400 Births)							590	668		
Hysteroscopy BPT				807	(-807)					
Service Development (Neonatal Outreach + Bailey Testing)				567				(-517)		
Actual Activity Adjustments	(-162)	(-76)	567	(-4,289)	(-229)	(-16)	114	3,347	157	(-13,189)
Anti-Coagulant Drug Impact (EKHUFT View)				(-1,465)						
Paediatric Recording Shift - Pt3 - CAU Activity project			1,706	2,188	497		(-1,142)	(-3,476)		967
Gynaecology Unscheduled Care Tariff			(-1,177)				1,177			
Removal of Neonatal Outreach Service Development from FOT				(-517)				517		
NICU SCBU (4 Year Average)								306		
Commissioning Intentions	0		183	1,087	(-1,270)			(-108)		
Final 2014/15 Business Plan (Pre-Contracting)	**30,364**	**32,159**	**49,630**	**159,004**	**13,591**	**2,676**	**19,493**	**138,880**	**28,026**	**172,516**
%	0.4%	(-2.8%)	0.1%	(-1.0%)	(-11.0%)	(-0.6%)	30.7%	0.8%	3.4%	(-6.4%)
Chemotherapy Growth								951	784	904
Hysteroscopy BPT				430	(-430)					
Gynaecology GAU - Extended Hours and Additional Site							1,585			
Long Term Public Health 1.6% Birth Rate Projection					0	0	127	401		2,408
NICU SCBU (4 Year Average)								1,458		
Neonatal Outreach				517				(-517)		
2015/16 Demographic Growth	661	865	1,075	4,786	174	35	289	2,981	429	1,167
Final 2015/16 Business Plan (Pre-Contracting)	**31,025**	**33,024**	**50,705**	**164,737**	**13,335**	**2,711**	**21,494**	**144,154**	**29,239**	**176,995**
%	2.2%	2.7%	2.2%	3.6%	(-1.9%)	1.3%	10.3%	3.8%	4.3%	2.6%

Table 27 – Specialist Division Activity Bridge

	Ref Primary Care	Ref Non-Primary Care	OP New	OP Follow Up	Elective Daycase	Elective Inpatient	Non-Elective Inpatient	Cost Per Case - Other
2013/14 Forecast Outurn	**77,556**	**55,149**	**108,138**	**187,598**	**36,873**	**11,635**	**15,436**	**57,130**
Removal of Non Recurrent Activity	**0**	**0**	**-960**	**-960**	**0**	**0**	**0**	**0**
RE-Moddelled FOT	**77,556**	**55,149**	**107,178**	**186,638**	**36,873**	**11,635**	**15,436**	**57,130**
1.5% Population growth	611	125	1,025	2,129	253	119	282	624
Pain/T&O I injection policy					(-356)			
Breast Surgery Year on year escalation	520		523	510	36	42		
Waiting List Control measures (101,110 and 191)					744	144		
growth at 2.5% for ENT	298		347	372	69	30		
Urology Bladder Cancer FUP clinics				1,401				
Pain management improved data recording	120	120	240	(-240)				
Max Fax FUP service change			(-1,114)	(-666)	(-380)			
AMD increases				1,170	1,542			
Addition of 2 ITU beds								464
Reduction in ENT clinics/lists to maintain WL			(-700)	(-770)	(-238)	(-161)		
2014/15 Plan	**79,105**	**55,394**	**107,499**	**190,544**	**38,543**	**11,809**	**15,718**	**58,218**
%	2.00%	0.44%	0.30%	2.09%	4.53%	1.50%	1.83%	1.90%
Urology 1 Stop clinic				(-1,200)				
Continued Growth in Breast	600		600	600	72	72		
2015/16 Demographic Growth	1,929	1,359	2,798	4,672	1,077	308	402	1,430
2015/16 (Pre-Contracting)	**81,634**	**56,753**	**110,897**	**194,616**	**39,692**	**12,189**	**16,120**	**59,648**
%	3.2%	2.5%	3.2%	2.1%	3.0%	3.2%	2.6%	2.5%

Table 28 – Surgical Division Activity Bridge

	Ref Primary Care	Ref Non-Primary Care	OP New	OP Follow Up	Elective Daycase	Elective Inpatient	Non Elective Inpatient	Cost Per Case Other	Block Contract	Non Income Activity	Total
2013/14 Forecast Outturn	**12,099**	**19,595**	**33,808**	**79,224**	**4**	**42**	**0**	**4,740,727**	**0**	**5,837,949**	**10,723,447**
Non Recurrent Activity	5	80	40	60	0	0	0	3,000	0	0	3,185
Re-modelled FOT	**12,103**	**19,675**	**33,848**	**79,284**	**4**	**42**	**0**	**4,743,727**	**0**	**5,837,949**	**10,726,631**
AQP Non Obstetric Ultrasound	0	0	0	0	0	0	0	(-3,000)	0	0	(-3,000)
Improved ESP Patient coding	0	240	60	90	0	0	0	0	0	0	390
Increase in Birth Rate affecting Radiology Scans	0	0	0	0	0	0	0	0	0	1,080	1,080
Additional Hand Therapy Activity	0	0	350	1,485	0	0	0	0	0	0	1,835
Dartford Community GUM	0	0	0	0	0	0	0	7,500	0	0	7,500
Chemotherapy Pathology Increase	0	0	0	0	0	0	0	0	0	10,800	10,800
MTW Pathology Data Transfer Kent Pathology Partnership	0	0	0	0	0	0	0	2,170,566	0	2,594,294	4,764,860
Other	0	0	0	65	0	0	0	0	0	0	65
2014/15 Plan (exc switch from Surgery for Inverventional Radiology)	12,103	19,915	34,258	80,923	4	42	0	6,918,793	0	8,444,122	**15,510,160**
% Movement from 2013/14 FOT	**0.04%**	**1.63%**	**1.33%**	**2.14%**	**0.00%**	**0.00%**	**0.00%**	**45.94%**	**0.00%**	**44.64%**	**44.64%**
Interventional Radiology Switch from Surgery	3	603	318	118	297	139	3	0	0	262	1,743
2014/15 Plan (inc switch from Surgery for Inverventional Radiology)	12,106	20,518	34,576	81,041	301	181	3	6,918,793	0	8,444,384	**15,511,903**
MTW Pathology Data Transfer Kent Pathology Partnership	0	0	0	0	0	0	0	717,181	0	859,018	1,576,198
Demographic Growth	230	400	641	1,484	7	4	0	166,051	0	202,665	371,483
2015/16 Plan	12,336	20,918	35,217	82,525	308	185	3	7,802,024	0	9,506,067	17,459,584
% Movement from 2014/15 FOT	**1.90%**	**1.95%**	**1.85%**	**1.83%**	**2.40%**	**2.40%**	**0.00%**	**12.77%**	**0.00%**	**12.57%**	**12.56%**

Table 29 – Clinical Support Services Division Activity Bridge