

Kingston Hospital



NHS Foundation Trust

Strategic Plan 2013-14

June 2013



Living our values *everyday*



CARING



SAFE



RESPONSIBLE



VALUE EACH OTHER

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

Name	Rachel Benton
Job Title	Commercial Director
e-mail address	Rachel.benton@kingstonhospital.nhs.uk
Tel. no. for contact	0208 934 2880
Date	June 2013

The attached Forward Plan Strategy Document (the “Forward Plan”) and appendices are intended to reflect the Trust’s main business plan over the subsequent three years. Information included herein should accurately reflect the strategic and operational plans that have been agreed on by the Trust Board.

In signing below, the Trust is confirming that:

- The Forward Plan and appendices are an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Forward Plan and appendices have 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 Forward Plan and appendices are consistent with the Trust’s internal business plans;
- All plans discussed and any numbers quoted in the Forward Plan and appendices directly relate to the Trust’s financial template submission.

Approved on behalf of the Board of Directors by:

Name: Ian Reynolds (Chair)	Signature
-------------------------------	-----------

Approved on behalf of the Board of Directors by:

Name: Kate Grimes (Chief Executive)	Signature
--	-----------

Approved on behalf of the Board of Directors by:

Name: Simon Milligan (Finance Director)	Signature
--	-----------

Contents

	Page
1. Executive Summary	4
2. Strategic Context	6
2.1. Local healthcare economy	
2.2. Local commissioning intentions – threats and opportunities	
2.3. Collaboration and integration	
3. Strategy	10
3.1. Vision	
3.2. Strategic objectives and supporting plans	
3.3. Service line strategy	
3.4. Workforce strategy	
3.5. Membership	
4. Quality	15
4.1. Quality strategy	
4.2. Current performance and improvement plans	
4.3. Responding to the Francis report	
4.4. Board assurance	
4.5. Public and patient involvement	
5. Productivity & Efficiency	19
5.1. Overview of the Trust's productivity programme	
5.2. Governance	
5.3. Cost Improvement Programme profile	
5.4. Enablers	
5.5. Quality impact	
6. Financial & Investment Strategy	23
6.1. Current Position	
6.2. Priorities and Investment	
6.3. Risks and Mitigation	
7. Glossary of Terms	27

1. Executive Summary

Kingston Hospital is a large, single site DGH on the outskirts of London. We have a busy and popular maternity unit delivering 6,000 babies a year. We see over 113,000 patients in A&E, undertake 355,000 outpatient appointments every year and care for 65,000 admitted patients with consistently low mortality rates. We deliver care, not just from our base Hospital, but at many community locations in partnerships with GPs.

Our Mission:

'To improve the health and wellbeing of our community through the provision of high quality, patient focused healthcare'.

We aim to be at the leading edge of the changes that are necessary for DGHs to be successful in the future. We believe that our patients should have the most senior staff in the Hospital and on the wards seven days a week and into the evenings as well. We have achieved this in maternity and A&E and will continue this work in acute medicine in the coming year.

Access to information is vital to improving clinical quality and efficiency. We have to share and integrate the information we have about our patients - not just within the Hospital but across the entire health and social care system. To do this we have to move away from paper and we are leading the way in implementing an electronic health record. This summer we are adding clinical documentation and e-prescribing to our care records system, giving us the bases of a complete health record electronically. We are also working with six other Trusts in London to procure a portal that will enable us to share this information across the health system using cloud technology.

The first Francis report provided a very useful catalyst to enable the Board to truly transform its role in leading the delivery of quality care to our population. We have strengthened clinical leadership across the organisation and will continue this with the rollout of Service Line Management which will enable clinicians to have a far greater ownership and understanding of their services and how best to make improvements. Our staff and our patients are much more involved in decision making across the organisation and their experience has improved as a result. To provide even higher quality care to our patients we need to accelerate the move from an organisation that sees itself as delivering care to a grateful population to one that works in partnership with its patients and local stakeholders to maintain a healthy community and deliver care designed around each individual.

NHS London previously described our productivity programme as an exemplar and we have found that we have been able to continuously improve the quality of our services at the same time as reducing our costs.

To be able to realise our vision we need to continue to develop our culture. Our staff need to feel they have the freedom to innovate, to redesign services with their patients and partners in other trusts, to invest to save or to grow. Under these conditions, more of our staff will feel true ownership of their service that will encourage them to be flexible and agile in response to changing markets and patient needs.

Our Vision:

'To be the hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff'.

Key plans to support the delivery of this vision include:

- The **innovative use of IT**, in particular, the development of an Electronic Patient Record underpinned by deployment of the Care Records Service programme including the implementation of e-prescribing and clinical documentation in 2013/14. The Trust is also planning to increase electronic links with GPs.
- Embedding the effective use of **patient level costing** across the organisation as part of the introduction of Service Line Management, encouraging clinical ownership and accountability to improve quality and drive financial sustainability.
- Delivery of the Trust's **quality strategy**, including Quality Account priorities for 2013/14, developed with the Trust's key stakeholders, to reduce the number of clostridium difficile infections, reduce the number of patient falls, improve staff engagement and improve the patient experience by reducing waiting times in outpatients. The Trust is also implementing the Friends and Family Test and will be refreshing its patient and public involvement strategy in 2013/14
- Implementation of the **workforce strategy** with priorities for action including strengthening people management, leadership development, improving team working, supporting staff to look after their health and wellbeing and the introduction of Service Line Management as discussed above
- **Partnership working** to deliver benefits to patients, including leadership of the SW London pathology programme, improvements in partnership working at the Elective Orthopaedic Centre and delivery of the Strategic Alliance Partnership work streams with St George's Hospital, in particular the development of Queen Mary's Hospital to ensure it is financially viable. The Trust will also work closely with commissioners to develop integrated services, including progression of the frail elderly programme and other work streams to be established under the Whole System Transformation Board
- the provision of high quality **acute hospital services** for patients who need immediate care. To deliver this the Trust needs to provide accident & emergency, maternity and intensive treatment unit (ITU) services together with beds into which we can admit emergency patients. These acute services will be delivered by consultants, with effective community and outreach services.
- Provision of **planned care** for those patients whose illnesses need more intervention than can be available from their GP. The Trust will provide surgery and medical treatments locally so that local people have timely access to consultants, clinics and operations, and will only need to travel further afield for specialist care. The Trust's planned core services will be to care for a high volume of patients with less complex needs and conditions.
- Integrated **community services** in partnership with primary and community care so that patients can be seen out of the Hospital where clinically appropriate, supporting GPs in prevention, specialist advice and outreach services. Partnership working across primary, community and secondary care is much easier and more successful when the hospital is within the local health community.

The Trust's plans are influenced by significant change in the external environment. The provider landscape across London is expected to change over the next three to five years creating a number of opportunities for the Trust. In particular, the 'Better Services, Better Value' proposals to reduce the number of major acute sites in SW London are due to go to public consultation in Summer 2013 and if agreed will result in a significant increase in maternity and emergency flows to Kingston Hospital by 2017.

The Trust has developed plans to accommodate these potential increases and will continue to work closely with commissioners and other providers. Alongside this commissioners are seeking to shift more outpatient and urgent care activity into community settings and the Trust will be working collaboratively with them to deliver this change, including the delivery of Trust outreach services at the new Raynes Park and Surbiton Health Centres. The impact of these changes in the external environment will be reflected in the refreshed estates strategy for development in 2013/14.

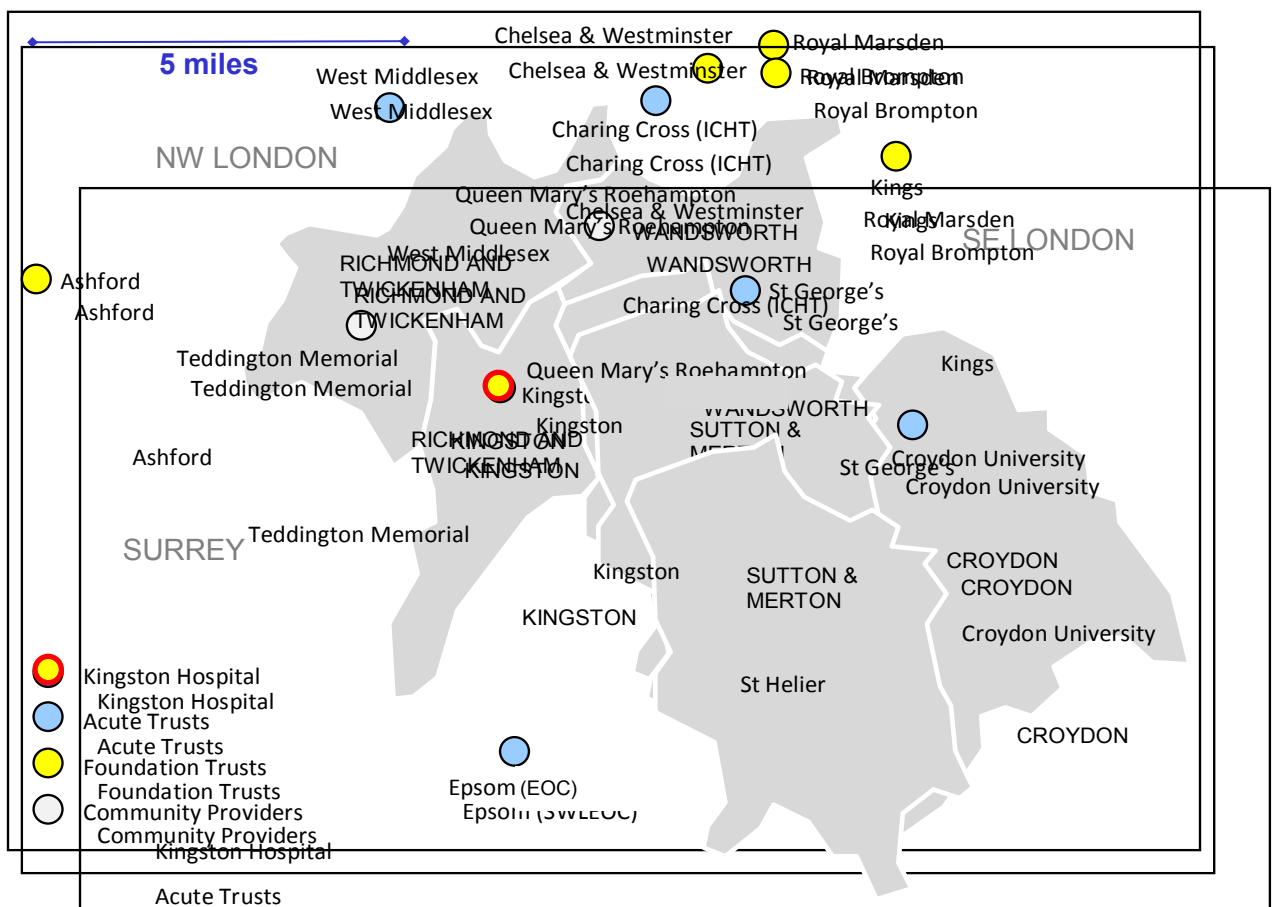
The Trust is looking to build on the consistent and strong performance of recent years and is planning to achieve a surplus of £2.3m (1.1%) for 2013/14. In the subsequent two years, the Trust plans to increase this surplus slightly to £2.4m and £2.6m. The income plan is under-pinned by a clear and meaningful contract that holds income at a similar level to 2012/13 outturn after which it reduces slightly. To support the expenditure plan the Trust has a well developed productivity plan for 2013/14 and 2014/15 and an embedded Programme Management Office structure. The Trust is maintaining its investment in its infrastructure at a similar level to its depreciation charge.

2. Strategic Context

2.1 Local healthcare economy

Kingston Hospital is a single site, medium sized DGH, located within Kingston-Upon-Thames in SW London. The Trust provides services to approximately 320,000 people locally on behalf of its main commissioners, including Kingston, Richmond, Wandsworth, Merton and Sutton Clinical Commissioning Groups (CCGs) in SW London and Surrey Downs CCG (East Elmbridge locality) in Surrey. Further information is shown at figure 1 below:

Figure 2.1: London Health Economy



The Trust generally compares favourably with neighbouring trusts, with a consistently strong relative performance across a range of indicators including waiting times, mortality, readmissions, control of MRSA, delivery of the financial plan and efficiency measures including length of stay, outpatient follow up rates and reference cost indices. The Trust also compares well on Care Quality Commission (CQC) surveys, performing better than competitors in the 2010 maternity survey (highest scores in London), the 2012 inpatient survey (one of the five best performing Trusts in London) and the 2012 staff survey (one of the sixth best in London for scores in the top 20% and overall engagement score above average). The Trust scored about the same as its competitors in the 2012 A&E patient survey and the 2011 outpatients survey.

Over the next ten years the population is predicted to grow by 6% in SW London and 5% in East Elmbridge, with the greatest growth in the 85+ band, which will increase demand in specialties such as orthopaedics, urology, ophthalmology, and cancer specialties. In line with this and discussions with commissioners, the Trusts plans assume growth of 2% p.a. across the next three years, with the exception of emergency admissions which are assumed to stabilise at 2013/14 levels.

The Trust's market share for key commissioners has been stable over recent years. At specialty-level, the Trust has seen recent increases in a number of areas, such as gynaecology, GI surgery, dermatology, neurology and nephrology. There have been small reductions in a few specialties including vascular surgery, where the establishment of specialist networks was expected to move activity on to fewer sites. The Trust has developed plans to protect and in some areas increase market share over the next few years, through a number of initiatives, including the development of outreach services, active management of capacity available on Choose and Book and continuing to strengthen the GP and patient experience. Prudent assumptions have been made in the Trust's financial plans including a modest increase in market share for Merton as a result of the provision of new outreach services.

2.2 Local commissioning intentions – threats and opportunities

The provider landscape around Kingston is expected to change over the next three to five years.

In SW London, during 2011 Epsom & St Helier NHS Trust declared that it does not have a future as a Foundation Trust in its current form. Alongside this, the SW London Cluster has undertaken the 'Better Services Better Value' (BSBV) review to look at how clinicians and hospitals can work more closely together to improve services for patients, be more efficient and achieve better value for money for local people. The review has proposed three major acute sites for SW London, with the fourth site becoming an elective centre and the fifth site a local hospital. An appraisal has been undertaken to identify the options for public consultation, all of which include Kingston Hospital as a major acute site. Subject to agreement by the NHS Trust Development Agency, SWL CCG Boards and the BSBV Programme Board in May 2013, public consultation is expected to commence in June 2013 for a period of 12-14 weeks. These changes, which are anticipated to come into effect in 2017/18, will result in a significant increase in maternity and emergency flows into the Trust.

In NW London, during February 2013, the Joint Committee of Primary Care Trusts agreed with all the recommendations put forward by the 'Shaping a Healthier Future' programme which included a reduction down to four major acute sites across NW London with effect from 2017/18. There are expected to be modest increases in activity at Kingston Hospital as a result of changes proposed at Charing Cross Hospital. However, the plans are currently with the Independent Reconfiguration Panel for consideration. Proposed changes at West Middlesex Hospital could also lead to some increased demand at the Trust.

The Trust will work collaboratively with commissioners to develop and implement proposals as required. The impact of increased flows to the Trust as a result of the proposed changes has been modelled and plans have been developed to accommodate these. Changes are expected to have a positive financial effect but have not been included in the base case at present.

Changes proposed in SE London, including Lewisham Hospital becoming an elective centre, could lead to increased pressure at Croydon and St George's Hospitals, with potential consequences for the Trust although these are anticipated to be small. SE London commissioners have set up a Programme Board to work through the patient flow impact and SW London will be factored into this work and consulted accordingly.

In 2013/14 commissioner Quality, Innovation, Productivity and Prevention (QIPP) plans focus on improved provision in the community, enabling a small reduction in inpatient admissions/length of stay, and tariff changes. These have been factored into the Trust's plans. Beyond that commissioners are seeking to deliver more clinically appropriate activity in primary and community care settings, rising to up to 30% by 2017/18. It is expected that Kingston Hospital clinicians will deliver a proportion of this care. The Trust has been supporting the delivery of outpatient activity at a number of outreach sites for many years, including Queen Mary's Hospital, Roehampton, Teddington Memorial Hospital and Emberbrook, Molesey and Cobham Hospitals in Surrey. Trust plans allow for an increased shift of activity to community settings in line with

commissioner intentions, including the development of outreach services at Raynes Park Health Centre in Merton and Surbiton Health Centre in Kingston in 2013/14.

Commissioners are also seeking to stabilise emergency admissions, with the four local CCGs intending to avoid between 15% and 17.5% of current emergency medical admissions by 2017/18. Joint working through such initiatives as the Whole Systems Transformation Board will help to deliver these targets.

The only Any Qualified Provider (AQP) contract that directly affects the Trust this year is for elective care pathways in Surrey. The Trust has approached this collaboratively by expanding its relationship with Epsom and Dorking Integrated Care (EDICs), the local Surrey GP led referral management organisation. The CCGs have indicated that there may be AQP tenders at a later point for diagnostics and therapy services. The Trust is well placed to respond to these.

2.3 Collaboration and integration

As well as competing in areas of strength, the Trust will need to collaborate with other providers where this will improve the quality of services and deliver better value for money. Key partnerships with other providers are summarised below:

- The Trust has a close partnership with St George's Healthcare NHS Trust, the tertiary centre in SW London. Both organisations have actively strengthened this relationship by developing a Strategic Alliance Partnership. A number of work streams have made progress, including understanding the economics of Queen Mary's Hospital, securing the future of the cardiac catheter laboratory at Kingston Hospital and the delivery of procurement savings. Future projects are to be confirmed but could include reviewing the delivery of clinical support services such as pharmacy, as well as opportunities to form closer partnerships in the delivery of some front line services such as urology. We will continue with the delivery of a wide range of outpatient services on the QMH site.
- The SW London Pathology Programme has progressed to the point that a business case for a new configuration of pathology services across the sector, demonstrating quality and financial benefits, has been to each Acute Trust Board for approval. Next steps over the next 12 months to deliver a single service will include IT procurement, harmonisation of working practices, standardisation of pathology testing and staff consultation.
- In 2008 the Sir William Rous Unit was opened at Kingston Hospital in collaboration with the Royal Marsden Hospital and Macmillan cancer support. This established partnership for the delivery of care to cancer patients has worked well both clinically and financially and the Trust is currently reviewing the potential to expand facilities, supported through charitable donation
- The Elective Orthopaedic Centre (EOC) is a joint initiative with the acute Trusts of SWL to centralise the provision of elective lower limb orthopaedic surgery in a purpose built unit. The centre is situated on the Epsom Hospital site and is staffed by consultants from all the participating Trusts. The partnership is hosted by Epsom and St Helier NHS Trust, with key decisions made by the Partnership Board which comprises of representatives from each partner Trust. The EOC enters into separate contracts with commissioners on behalf of the Partnership Group. The Partnership Board is currently reviewing governance arrangements with a view to strengthening these during 2013/14, including the appointment of an independent non-executive chair
- In 2009 the Trust established a partnership with BMI Healthcare for the provision of private patient services. This partnership allows the Trust to utilise the resources on site that are not required by commissioners for the provision of NHS services. The Trust benefits from this partnership through SLA income for service and facilities offered to the

private patient unit and from a profit share arrangement linked to overall revenue levels. As a Foundation Trust the Trust will be exploring other opportunities to diversify income streams

In addition to the above partnerships with other providers, the Trust has worked with its main commissioners to create a mechanism for joint working, the Whole System Transformation Board and supporting work streams. The main Board and its subgroups met a number of times during 2013/14 and good progress has been made in the delivery of joint priorities including the development of clinical pathways. A key work stream is the Frail Elderly subgroup which has been established with representatives from all CCGs, community and mental health providers together with Kingston Hospital. A modular programme has been developed by the Kings Fund to assist the group in cross boundary working and sustainable change management.

3. Strategy

3.1 Vision

The Trust's Vision for the next five years is to:

'To be the hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff'.

At the heart of this vision is the provision of high quality acute hospital services for patients who need immediate care. To deliver this the Trust will provide A&E, maternity and ITU services together with beds into which emergency patients can be admitted. These high acuity services will be consultant delivered with effective community in reach and outreach. Alongside this the Trust will provide planned care for those patients whose illnesses need more intervention than is available from their GP.

Where appropriate the Trust will provide surgery and medical treatments locally so that the patients only need to travel further afield for specialist care and will ensure timely access to consultants, clinics and operations. Planned care services will be high throughput, with low complexity and variability.

The Trust will also support the development of integrated community services and is working in partnership with primary and community care to move work from the hospital site where clinically appropriate, supporting GPs in prevention, specialist advice and outreach services as part of fully integrated care pathways.

3.2 Strategic Objectives and supporting plans

To realise the vision the Trust has identified five strategic objectives for delivery by 2017/18. Measures of success for these objectives have been set for each year of the plan. Supporting corporate objectives have been set for 2013/14. A summary of each strategic objective and the key plans to support these are summarised below:

Strategic Objective 1: To deliver quality, patient centred healthcare services with an excellent reputation
Key plans include:
<ul style="list-style-type: none"> Development of an Electronic Patient Record underpinned by deployment of two further phases of the Care Records Service (CRS) programme, involving the implementation of e-prescribing and clinical documentation in 2013/14 (phase 1). The Trust is also planning to increase electronic links with GPs
<ul style="list-style-type: none"> Embedding the effective use of patient level costing across the organisation as part of the introduction of Service Line Management (further detail at section 3.3)
<ul style="list-style-type: none"> Delivery of the outpatient improvement action plan
<ul style="list-style-type: none"> Refreshing and then implementing the revised Trust's estates strategy, particularly in the light of developments in the external environment including BSBV
<ul style="list-style-type: none"> Further strengthening the quality of nursing care on the wards through reconfiguration/skill mix changes and leadership enhancements
<ul style="list-style-type: none"> Delivery of the quality strategy (further detail at section 4), including the implementation of the Friends and Family Test and a refreshed patient and public involvement strategy in 2013/14

Strategic Objective 2: To deliver care by competent and caring staff working in effective and supportive teams who feel valued by the Trust
Key plans include:
<ul style="list-style-type: none"> Implementation of the Trust's workforce strategy (further detail at section 3.4)
<ul style="list-style-type: none"> Implementation of a system to measure people management skills across the organisation and enable improvement where required
<ul style="list-style-type: none"> Delivery of plans to strengthen the education and training environment

Strategic Objective 3: To work with partners to consolidate and strengthen the healthcare we deliver together for our local community
Key plans include:
<ul style="list-style-type: none"> Partnership working with other providers to deliver benefits to patients, including leadership of the SW London pathology programme, improvements in partnership working at the Elective Orthopaedic Centre and delivery of the Strategic Alliance Partnership work streams with St George's Hospital, in particular the development of Queen Mary's Hospital to ensure it is financially viable. The Trust will also continue to contribute to the development and implementation of BSBV plans for the strategic development of SW London (further detail at section 2)

Strategic Objective 4: To work with GPs and other providers to support the delivery of more care in primary and community settings
Key plans include:
<ul style="list-style-type: none"> Agreeing key work streams for the Whole Systems Transformation Board in conjunction with local healthcare partners including CCGs and progressing the frail elderly work stream (further detail at section 2)

Strategic Objective 5: To deliver well managed, quality services which are value for money for the tax payer
Key plans include:
<ul style="list-style-type: none"> Delivery of the Trust's financial plans, including delivery of the Trust's productivity programme that supports delivery of a long term financial plan for the Trust (further detail at sections 5 and 6)

3.3 Service Line Strategy

The Trust has been refining Service Line Reporting (SLR), supported by the Patient Level Information and Costing System for the last 18 months with reports produced quarterly. Outputs from SLR have been used in conjunction with other criteria, including service size, performance, reputation and potential to grow, to identify strategies to develop service lines. Through this exercise flagship services have been identified as maternity, A&E and trauma & orthopaedics. Services with potential to achieve this status with development include acute medicine, general surgery, paediatrics and ophthalmology.

Further work is planned over the next year to develop the Trust's Service Level Management (SLM) strategy. Two pilot areas, maternity and endoscopy, participated in an NHS London scheme to increase knowledge and awareness of SLM amongst clinical teams, and to develop service line tools and performance reports. One of the Trust's key priorities for 2013/14 is to roll these tools and reports out across all the services, encouraging clinical ownership and accountability to improve quality and drive financial sustainability.

3.4 Workforce Strategy

The Trust's workforce strategy was refreshed in November 2012. The aim is to enable the delivery of high quality care to patients by creating an environment where all the Trust's staff can thrive and flourish and are always able to give of their best. The elements of the workforce strategy are to have:

- the right staff (right number, right motivation, right deployment)
- doing the right things (trained, equipped and resourced, supported and held to account)
- in the right way (engaged, well managed, living the Trust's values and maintaining wellbeing)

so that staff are motivated and satisfied to support safe high quality care and good patient outcomes and experience.

In order to do this the Trust has identified five workforce priorities which are:

- Strengthening people management so that all staff feel they get good management. Good management practice will be defined and managers are being provided with feedback from their staff as part of the appraisal process to help them improve
- Leadership development to support the Trust's leaders in nurturing the Trust's values, providing positive leadership and inspiring and developing the Trust and its services
- Team working including clarifying the role of team working in delivering safe, effective high quality care, the membership of teams and the importance of providing mechanisms and times for teams to meet to reflect on performance and improvement
- Service line management to support local control, ownership and accountability
- Supporting staff to look after their health and wellbeing, helping them lead a fulfilled life with exercise, learning, connections and community

Workforce Plan

The Trusts workforce plan is intended to support the overall clinical strategy, delivering care through the most appropriate (usually most senior) clinical professional at the earliest stage in the patient's journey, based on best practice evidence and supported by increased senior clinical presence at key times of day e.g. extending consultant presence in the emergency department and labour ward.. This is to ensure that there is early diagnosis and treatment planning that supports rapid turnover of patients and avoids inappropriate investigation or waits. The senior clinicians undertaking this work need to be supported by appropriate junior and support roles who undertake more routine tasks that can be delegated. Through efficient and effective IT systems, supporting rapid access to information and stream lining administration processes, decision

support, communication of advice, results and care summaries will be provided to GPs and other healthcare providers more quickly and more easily. Access to clinicians will also take place in a wider variety of community settings, to offer greater choice to patients in locations closer to their homes. The Trust has invested in IT systems and the development of new roles to support this revised approach; for example use of midwifery support workers. as well as.

The Trust's cost improvement programme plans result in a 10% reduction in WTEs over the next two years. Plans have been developed within Divisions and individual clinical services are subject to challenge at budget and CIP review meetings (further detail at section 5). The workforce efficiencies envisaged were informed by detailed benchmarking including analysis undertaken by McKinsey and NHS London in January 2012. This confirmed that the Trust has the opportunity to make savings and ensure its sustainability by matching 'upper quartile' performance of an appropriate peer group of acute Trusts. The Trust will undertake further benchmarking work this year as part of productivity planning.

A summary of the changes by staff group is described below:

- Consultants – minimal change
- Junior doctors - reductions reflecting changes in education commissioning and a move to more senior doctor cover over extended hours
- Nursing - no change in nurse:bed ratios but WTE reductions based on bed number changes (due to earlier discharge and admission avoidance with more senior clinical input at the point of first contact) and some skill mix changes. E-rostering has been introduced to support monitoring of nursing staff deployment and safe ward staffing levels
- Midwifery - reductions in community midwives with some tasks allocated to midwifery support workers
- Health Care Assistants - reductions reflecting bed number changes as discussed for nursing above

Workforce challenges

The key workforce challenges over the period of the plan include an immediate issue of high turnover and vacancies for qualified nursing staff and in the longer term the ability of the organisation to create the capacity and leadership to sustain a large number of significant change programmes. These risks are reflected in the corporate risk register and board assurance framework.

The Trust is implementing an action plan to improve nurse recruitment supported by strengthened forecasting of recruitment demand. It is also taking action to reduce turnover through improved ward management including a ward sisters' development programme.

Leadership and management development work is planned as part of the Trust's organisational development in 2013-14. All managers and supervisors are receiving feedback this year on their people management skills from their staff as part of their appraisal. Planning is underway to ensure that the organisation can release staff for training for the deployment of phase 1 of the CRS programme in Autumn 2013 which is a substantial undertaking. A training ward environment has been created to support this roll-out. The Trust is also strengthening the use of e-learning ('learn on-line') to support easier access to knowledge development and mandatory training. Classroom training can then focus on issues that need teams to work together or are better delivered face to face.

Clinical Sustainability

The Trust has a clinically sustainable portfolio of core services, strengthened by participation in a range of clinical networks including stroke, cardiac care, trauma and cancer and shared appointments with tertiary and specialist providers, in particular, St George's Hospital and the Royal Marsden Hospital.

In common with most other acute providers the Trust does not meet all Royal College recommendations for staffing, including the recommendation to have 24 hours a day consultant presence on the maternity unit for 168 hours per week. The Trust has been moving towards this and is currently achieving 98 hours per week which is better than in many other units. Through plans to expand the service towards a capacity of 7,500 deliveries, in line with BSBV, the Trust expects to extend the hours covered by consultants in the future.

The Trust has undertaken a gap analysis against the London Emergency Standards for acute medicine and surgery and is progressing plans towards an extended consultant day and weekend delivery of care in both areas. It is unlikely that social care and therapy services will be delivered 7/7 as recommended without integration with community and social care services.

3.5 Membership Strategy and Council of Governors

The Council of Governors held the first of two shadow meetings in January 2013 and the second in March 2013. Since the Trust was authorised as a Foundation Trust on May 1st 2013, the Council has held two meetings on 2nd and 22nd May 2013. The Council has meetings planned for the remainder of the year and has considered the forward plan at each meeting. Following a skills audit of the Governors at induction, a training and development plan has been put in place and training and briefing sessions have been planned for the year. In June 2013 there will be a joint Board and Council of Governors development session at which discussion will take place on the Francis Report, significant transactions (with support from Capsticks) and strategic plans. Training will also take place to support governors participating in the recruitment process to select a new chairman and for the whole Council on choosing auditors (with support from Grant Thornton). At the meeting on 2nd May 2013 the Council approved the appointment of Frances Kitson as the Lead Governor.

The Council has established three sub-committees for Nominations and Remuneration, Membership and Engagement and Strategy. It is expected that a fourth sub-committee will be established to support the Trust in Quality Scrutiny. The Nominations and Remuneration Committee met for the first time on 20th May 2013 to consider the recruitment process for the position of Chairman and remuneration of the Chair and Non-Executive Directors, with recommendations due to be made to the Council of Governors at their meeting on May 22nd 2013. It is expected that the Membership Recruitment and Engagement Committee and the Strategy Committee will meet for the first time in the coming months.

The Membership Recruitment and Engagement Committee will take on responsibility for delivering and reviewing the Trust's membership strategy, which is particularly focusing on increasing the diversity of the Trust's membership and, in particular, representation in hard to reach groups – both ethnic and socio-economic. The membership recruitment activity will continue to include working with local schools and community groups and recruiting within the hospital and will be enhanced by support from the Governors. The Trust currently has 5,900 public members and is working towards a target of 8,000 members by May 2015. A calendar of member health events is being planned for the Trust's current members and members will receive the Trust's new look magazine and e-bulletin during 2013/14.

4. Quality

4.1 Quality Strategy

The Trust's Quality Strategy, published in March 2012, describes how it will enhance the safety and effectiveness of care whilst continuing to improve performance against a background of financial constraints.

The Trust's approach to quality relies upon having the right culture throughout the organisation to enable staff to deliver high quality care. The Trust has engaged staff in developing the core values: caring, safe, responsible and valuing each other. The quality vision is to create the right environment for all staff to deliver the most appropriate care for patients.

The Trust has defined quality goals within the three domains of quality; safety, experience and effectiveness which reflect national and local priorities. These are to prevent harm (patient safety), improve clinical outcomes (effectiveness); and listen and respond to patients' concerns (patient experience). Each year the Trust develops specific measures of success for its quality goals with stakeholders including patients, public and clinical commissioners. 2013/14 Quality Account priorities, due for approval in June 2013, have been identified to:

- Reduce the number of Clostridium difficile infections
- Reduce the number of patient safety falls
- Improve staff engagement
- Improve the patient experience by reducing waiting times in outpatients

Each quality goal has a measure of success as a quality account priority with KPIs, and further organisational level measures of success. These will be tracked quarterly in the clinical quality report to the Trust Board. Local quality goals and measures of success are currently being identified at departmental level for each of the domains to reflect local priorities. These will be published and tracked locally.

Key elements of the Trust's Quality Strategy are set out below:

Capabilities and culture

- The culture puts quality first throughout the organisation from the wards to the Board and in all supporting and administrative areas
- The workforce will be fit for purpose and all staff will demonstrate behaviour which is consistent with the values all of the time to deliver compassionate care consistently

Processes and structures

- A robust systematic approach to governance and risk management, which permeates right through the organisation and creates and maintains reliable processes and continuous learning, eg quality being addressed first on the Board agenda and the Trust Board receiving a formal clinical quality report
- Communication systems must be effective and accurate and maximise the capacity of IT to share information efficiently within and outside of the organisation
- Patients and the public will be involved, heard from and are responded to
- Mechanisms will be developed to enable the Trust to place itself at the forefront of publishing accessible and useful information on the quality and outcomes of the services delivered for patients
- Services will be fit for purpose having captured patients ideas on improving efficiency and redesign of services
- Innovative solutions will be used to ensure that delivering efficient services enhances quality
- The impact of any service development or service change is assessed to ensure that the quality and equality of the service or care delivered is not compromised

Measurement

- Systematic flows of information are used from frontline staff to the organisational leaders and back, to achieve high reliability and enhance quality
- Quality standards are set, monitored and published to drive quality improvement

Continuous improvement

- The Trust seeks to continuously improve by setting challenging goals, building on successes, evaluating achievements and taking lessons and implementing best practice from world-wide exemplars.

4.2 Current performance and improvement plans

The Care Quality Commission (CQC) visited the Trust in October 2012 to carry out a full compliance visit as part of their routine schedule of planned reviews. Whilst on site, they reviewed the Trust's compliance with 8 of the 16 essential standards of quality and safety. The Trust was found to be fully compliant with the eight outcomes reviewed.

As discussed at section 2 the Trust has generally performed well in CQC surveys, in particular the 2012 inpatient survey, the 2012 staff survey and the 2010 maternity survey. Whilst the results for the 2011 outpatient survey and the 2012 A&E survey were broadly in line with other local Trusts, they demonstrated that more work needs to be done, particularly in relation to communications and waiting times.

The Dr Foster Hospital Guide 2012 highlighted that the Trust has lower than expected mortality rates which means less people die in its care. This has been further endorsed by the Health and Social Care Information Centre, which in January 2013 identified Kingston Hospital as one of 11 Trusts in England having consistently lower than expected mortality rates over a two year period (June 2010 – June 2012) for both elective and emergency patients. Kingston Hospital has also recently been named in the CHKS Top 40 Hospital's list for the twelfth year running.

The Trust Board has undertaken a number of self-assessments against Monitor's Quality Governance Framework since October 2011, and commissioned an external review in March 2012. The Trust has confirmed a Quality Governance self-assessment score of 2.5, with no area being entirely red rated. The Trust has an action plan to continuously improve the score and will review the self-assessment at least annually.

Whilst the Trust demonstrated a generally strong performance against quality targets in 2012/13, there are some areas where further action is required and plans are described below:

Falls

Following an increase in falls in October and November 2012 the Trust is committed to reducing the number of patient falls below the 4.8 per 1000 bed days National Patient Safety Agency (NPSA) threshold. This objective is reflected in the 2013/14 Quality Account. Actions to improve performance will concentrate on:

- Providing patients with adequate information on falls prevention
- Embedding the falls care bundle across all clinical areas
- Focusing on two hourly nurse rounding
- Improving targeted reduction activities based on incident reporting

Clostridium difficile

In 2012/13 the Trust had 23 cases of hospital acquired clostridium difficile against an annual threshold which had been set at 15 cases. In response to increased cases in Q3 the Trust requested an external review of its practices in November 2012. This indicated no major areas of concern but provided some areas for further strengthening. The following actions have been implemented and will continue in 2013/14 for which the annual threshold remains at 15:

- Strengthened performance monitoring of antibiotic prescribing and adherence to antibiotic clinical guidelines
- Timely collection of stool specimens on arrival to the Trust for those patients with diarrhoea
- Timely isolation of symptomatic patients
- Continued dissemination of learning from post infection reviews

Pressure ulcers

For the second year running, in 2012/13 the Trust reduced the rate of patients experiencing hospital acquired stage two pressure ulcers by more than 40% and eliminated grade 4 pressure ulcers. However, grade 3 pressure ulcers did not reduce as planned and actions to address this in 2013/14 include:

- Focussed training in A&E and the Acute Assessment Unit ensuring patients are always assessed promptly
- Continuation of focussed training for staff
- Introduction of a communication sheet to share information with community colleagues at the time of discharge
- Implementation of the pressure area management patient information leaflet.
- Review of Trust performance at monthly Skin High Impact Action Group multi-disciplinary team meetings
- Weekly ward rounds to review any specialist mattresses in use
- Implementation of a modified pressure area risk assessment for use in maternity
- Extension of the Skin High Impact Action Group to include community partners
- Audit of the pressure area management bundle

Patient experience in outpatients

The 2011 national outpatient survey results and the Trust's Net Promoter Score for 2012/13 highlighted a need to improve the patient experience for outpatient services. Actions to support this include:

- An outpatients redesign team with patient representatives convened to prepare new reception design and signage
- Patient experience action plan driven through the Patient Experience Improvement Group (Ambulatory Care)
- Movement from Net Promoter Score to Friends and Family Test re-launched and publicised to support increased returns and feedback
- The issue of waiting within outpatients has been added as a 2013/14 Quality Account objective

Hand washing facilities

The 2012 staff survey identified that staff had concerns regarding the availability of hand washing facilities. Actions taking place to address this issue include:

- Reviewing and addressing deficiencies in hand washing facilities in non-clinical buildings
- Introducing a new hand sanitiser complete with enhanced awareness raising materials across the Trust

4.3 Responding to the Francis Report

Since the publication of the Francis Enquiry into the failures at Mid Staffordshire NHS Foundation Trust, listening events have been held with staff and patients across the organisation. A detailed review of the government's subsequent response has been undertaken identifying areas for the Trust to undertake a gap analysis.

The Trust Board held a joint development session with senior leaders from across the organisation in April 2013 and discussed the context of the enquiry, the key themes of the recommendations and commenced detailed population of the gap analysis against the identified areas for focus. It is clear from this initial analysis that the Trust is in a good position against the areas highlighted by the review, for example it has supervisory ward sisters already.

A joint Trust Board and Council of Governors session is planned to take place in June 2013, which will include a focus on the Francis Enquiry and the comprehensive gap analysis will be presented to the Trust Board in July 2013. The completion of the gap analysis may inform additions to the quality plan. At this stage early indications suggest there are no major areas for concern but the Trust wishes to continue to work towards still higher standards of care in a continued cycle of quality improvement.

4.4 Board Assurance

The Trust Board has established robust mechanisms to ensure that it is aware of risks to quality. The Risk Management Strategy sets out the Trust's approach and mechanisms for comprehensive risk identification, assessment and control and for gaining assurance on the effectiveness of controls. These include:

- A high level structure for reviewing risks (Trust Board and Trust Board sub-committees) which are all chaired by non-executive Directors
- Risk Management Committee and sub committees which are all chaired by executive directors. A non-executive director attends the Risk Management Committee on a rotating basis
- The board assurance framework is monitored operationally by the Risk Management Committee, scrutinised by the Audit Committee and the Quality Assurance Committee and received at each Board meeting. It identifies risks to corporate objectives, mitigating actions and controls already in place
- The risk identification, assessment and risk register procedure describes the responsibilities, mechanisms and processes used to identify, escalate and manage risk. The corporate risk register is influenced by internal and external risks and built up of divisional and departmental risk registers. It is reviewed by the Board quarterly and links to the board assurance framework. Departmental/speciality risk registers are escalated to Divisional Risk Boards. Divisional risk registers are reviewed at Divisional Risk Boards (with mitigating actions) and presented to the Risk Management Committee and Quarterly Performance Review meetings.

The Trust has mechanisms to capture staff concerns which include:

- A whistleblowing policy. Evidence of its use is reported annually to the Trust Board
- Non-executive and executive director walkabouts focusing on safety.
- Team Briefing, with some divisions also holding open forums
- The ward based quality focused assessment, Frontline Focus Friday, led by the Director of Nursing and including frontline nursing and midwifery staff each week.

The Board has established mechanisms to ensure that quality is not impacted by CIPs and this is discussed further at section 5. The Trust Board is assured that it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving quality of care

4.5 Public and Patient Involvement

The Trust is committed to involving patients and the public in the development and improvement of the Trust's services. As part of the Trust's plans to improve the patient experience we are developing a Patient and Public Involvement Strategy. This is due to be approved by the Trust Board in July 2013. The strategy is being developed in partnership with patients, Healthwatch, staff, governors, local stakeholders and the Patient Assembly. We also have a [Patient Assembly](#) that meets quarterly. The Assembly is a group of people who volunteer their time to partner the Trust in improving patient experience. There are currently twelve members who represent the voice and views of patients and members of the public. Members of the Assembly also attend other forums and committees at the Trust and participate in a number of service improvement projects and events.

As part of the Trust's wider plans to improve the patient journey and collect information about [Patient Experience](#), The Net Promoter Score was replaced by the new Friends and Family Test in April 2013. The results will be published on wards and in departments, and the results for the Trust will be published on NHS Choices website and the Trust website which means performance will be benchmarked against other NHS trusts.

The Trust has now developed a library of [Patient Video Stories](#) which have documented the experience of patients using a range of services. The patients in the films describe positive experiences as well as those where improvements are needed and these are then used to help promote best practice within the Trust and to make improvements to areas identified. These videos are used at Board meetings, at Team Briefs, and at staff training and development sessions.



5. Productivity & Efficiency

5.1 Overview of the Trust's Productivity Programme

Planning for the productivity programme was launched by Chief Executive in October 2010. It involved a bottom-up process involving many staff, ensuring local clinical and management ownership and leadership of the emerging programme. Clinical divisions were set a target of 5% pa reductions with 6% pa reductions set for corporate directorates and planned additional schemes to deliver a further stretch target in addition to that required for the Long Term Financial Model. Service Line Reporting was used to determine specialty contributions as a proxy for relative efficiency. Benchmarking information was shared with divisions to identify productivity opportunities.

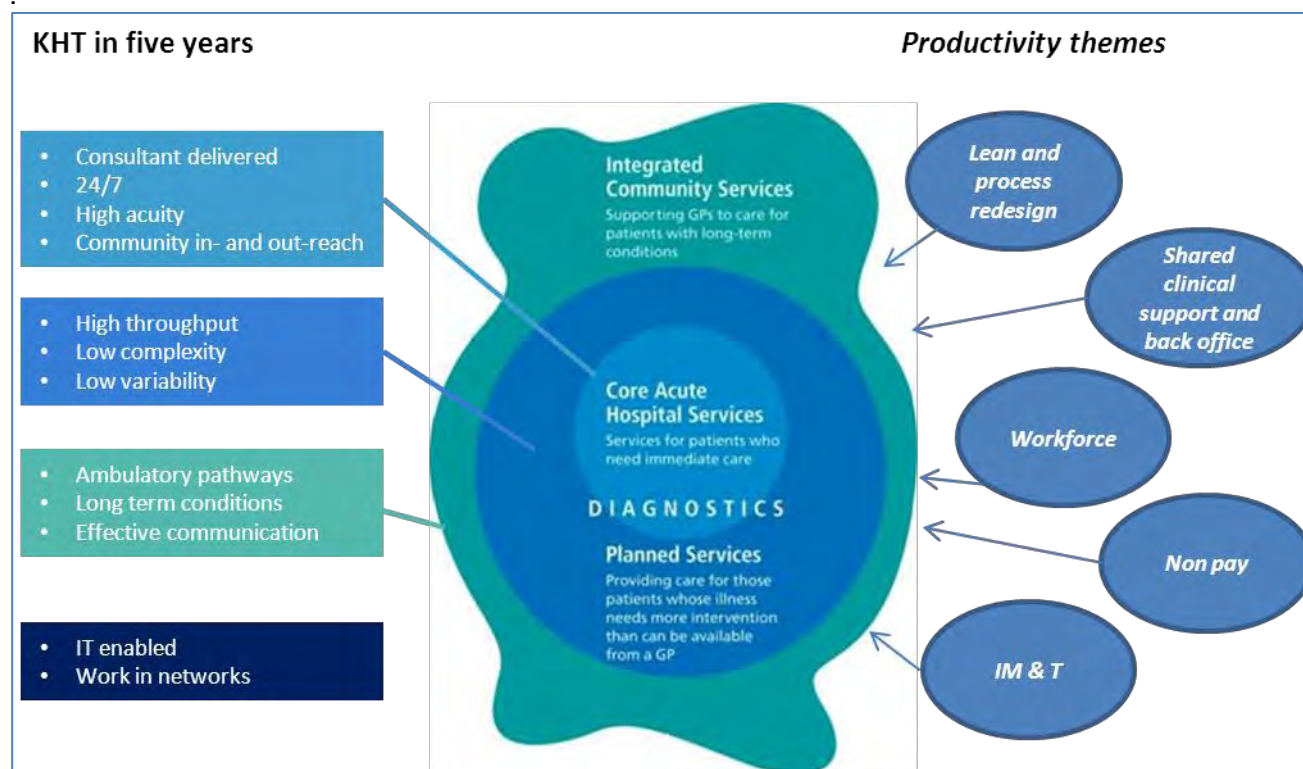
A five year plan (2010/11-2015/16) was identified in January 2011. All schemes had outline project plans and were assessed for quality & equality impact. A detailed challenge session was held between the Trust Board and divisions during February 2011, with the full programme agreed at the April 2011 Trust Board. Additional schemes to the value of £1.5m were subsequently incorporated in July 2011, following conclusion of challenging SLA negotiations with significant additional demand management required by commissioners.

A review was undertaken in the last quarter of 2011/12 to learn from experiences and provide assurance that the on-going programme would meet Trust requirements. The programme was restructured under five key productivity themes agreed by divisional directors and senior managers at the Executive Management Committee. Focus shifted towards larger cross cutting and transformational schemes, each with executive sponsors responsible for ensuring that schemes are well-specified and any risks or blockages to delivery are identified and addressed. Through this development programme, the Trust has been able to articulate how its productivity plans will support the achievement of its vision and strategy, incorporating schemes that give priority to:

- Providing a consultant-delivered core of 24/7 high acuity hospital services with rapid turnover supported by community in- and out-reach;
- Undertaking a range of high throughput and low complexity planned care services;
- Being an effective partner, supporting and working with GPs and other colleagues to care for more patients outside of hospital through agreeing care pathways for ambulatory care and for longer term conditions;
- Working in networks across the health and social care system, enabled by effective use of modern information technology.

The Executive Management Committee identified five key productivity themes to support these strategic objectives, as illustrated in figure 5.1 below. These informed the structure of the programme from 2012/13 onwards, although learning from experience, it has become clear that many schemes in reality incorporated elements of both workforce transformation and process redesign. From 2013/14 onwards, the Trust Board therefore agreed that these two categories should be merged into one overall category of operational efficiency and process redesign.

Figure 5.1: Productivity themes mapped to the Trust's strategy



5.2 Governance

The Trust's track record of Cost Improvement Plan (CIP) delivery has enabled it to achieve its planned levels of surplus over the past three years, and a robust programme is now in place under the leadership of a Director of Productivity and an established Programme Management Office (PMO). The programme is subject to on-going challenge and refresh, learning from experience, and over time has seen an increased emphasis on larger more transformational schemes, as well as building in of robust accountability through the budget setting and PMO processes.

Between 2010/11 and 2011/12, the Trust delivered CIPs of £21.7m, with a further £10.2m delivered in 2012/13 (102% of the year's target). The Trust has learned and embedded into its programme design important lessons to support programme delivery, including:

- The need for robust and achievable plans, with granular information at an early stage subject to a detailed challenge process
- The importance of building plans into signed-off budgets from the outset, with staff held accountable for schemes which are understood, owned and achievable
- The need for clinicians to be closely involved in the planning to generate both realistic and deliverable schemes
- The need for an understanding of demand and capacity to provide clarity on how many staff are required to deliver the services expected within the Trust's plans
- The value of building in contingency through the setting of an additional stretch target for which granular plans are developed and which divisions are expected to deliver – thus providing a buffer in case of slippage
- The importance of having detailed plans available for future years, some of which can be pulled forward as mitigating actions if there is slippage experienced in-year
- The role to be played by the PMO in tracking key milestones and providing assurance about future delivery and emerging risks – early enough for successful mitigating action to be agreed and taken.

The PMO has developed comprehensive documentation to underpin the productivity programme, designed to ensure clarity about its constituent schemes, the responsibility and timescales for their delivery, associated risks and impacts, and mitigation plans required to manage these. The documentation is completed by the scheme owners in order to embed their ownership, with support from the productivity team as required.

Documentation includes a one pager for each scheme, which notes the scheme owner, rationale, anticipated ease of implementation, financial detail and key milestones with responsible owner. The one pagers also note the key actions required by whom and by when, and the impact of the CIP at budget/account code level to enable robust monitoring of implementation.

Other documentation includes Quality and Equality Impact Assessments (QEIAs), discussed further below and project implementation documents. Schemes are allocated a level between 1-3 depending on their size, quality impact and complexity, with greater detail on milestones and implementation required for level 3 schemes.

Schemes for 2012/13 and 2013/14 were subject to challenge meetings (including external challenge from KPMG) before incorporation into the refreshed programme. Clinical leads were involved to ensure local clinical ownership of the programme. All schemes were identified and signed off in budgets at cost centre and account code level, with clarity about who is responsible for delivery.

At a local level, delivery of the schemes is monitored via weekly divisional manager meetings, monthly divisional performance meetings and quarterly divisional governance meetings. The Trust has clear central structures and processes both to manage in-year delivery of CIPs as well as to ensure delivery of milestones to support the larger cross-cutting schemes. These include:

- An established PMO which provides a dedicated resource to assist clinical divisions and corporate directorates in the design and delivery of their savings schemes.
- A Productivity Programme Board, chaired by the Chief Executive and reporting to the Executive Management Committee, which monitors progress on delivery of the productivity programme. The Productivity Programme Board acts as a forum to scope opportunities and develop new savings plans, identify and remove barriers which may arise that would hinder delivery of the overall programme, and ensure schemes are appropriately resourced to enable delivery. It also identifies and removes barriers which may arise that would hinder delivery of the overall programme.
- Reports to the Finance and Investment Committee and to the Trust Board to allow progress on the delivery of existing schemes to be monitored. The Trust Board report has a particular focus on the cross-cutting programme and achievement of milestones required for continued future programme delivery.
- Project documentation where necessary, agreed through the PMO, which tracks the delivery of key milestones to ensure plans will be achieved in full.
- A named project manager, executive sponsor and, wherever appropriate, an accountable clinical lead for each scheme.
- Risks and Key Performance Indicators (KPIs) for level 2 and 3 schemes which are identified and monitored on an on-going basis within Divisions and/or by the PMO, with regular reports to the Productivity Programme Board.
- Quality indicators which are produced monthly. These are monitored at the Productivity Programme Board and bi-monthly at the Quality Assurance Committee chaired by a Non-Executive Director.
- Annual review of the following years' schemes through budget challenge sessions.

5.3 Cost Improvement Programme profile

Schemes in the programme for 2013/14 fall into the following themes:

- Improving flow through the hospital, including reducing length of stay, increasing bed occupancy and increasing theatre productivity (£1m)
- Encouraging service profitability, such as improving access for paediatric patients referred by their GP (£2.9m)
- IT enabled schemes, such as digital dictation (£0.4m)
- Skill mix schemes, ensuring the most appropriate use of staff throughout the Trust (£2.7m)
- Procurement schemes (£1.8m)
- Partnership working, including working with other acute Trusts in the region (£0.6m)
- Other schemes, such as Estates-related savings (£1.7m)

5.4 Enablers

The Trust had identified local ownership as a key risk during the early development stages of the programme, and has therefore ensured a high level of clinical involvement in the CIP programme and delivery. Clinical leadership and engagement in the programme can be demonstrated by the following:

- All schemes allocated a named clinical lead.
- Divisional Directors are participants at Productivity Programme Board meetings.
- Information on clinical engagement required as part of the QEIA form.
- Post implementation reviews on larger schemes are produced and presented to the Productivity Programme Board by the clinical lead for the project.
- CIP progress is reviewed at quarterly performance meetings, which includes clinical representation.
- Regular reporting on key quality indicators to the Quality Assurance Committee, on which clinicians (including the Medical Director) sit.

Investment in infrastructure to support delivery of CIP schemes is built into the Trust's 2013-14 plans. Capital expenditure, including IM&T, is reviewed in the knowledge of the CIP priorities for the year.

5.5 Quality Impact

Every scheme, or group of schemes, follows the QEIA process. A written QEIA is undertaken, identifying potential benefits and risks to patient care/safety, outcomes and experience. The QEIA also identifies monitoring measures (KPIs) that will be tracked through the duration of the scheme. The risk to quality is then RAG rated and if scored at eight or above then progression to a full risk assessment is required.

The QEIAs are assessed and approved by the Medical Director, Director of Nursing and Director of Productivity. Schemes are then either approved, or rejected and sent back for further work or replacement if the risk to quality is too great.

KPIs identified in the QEIAs are monitored through the Quality Assurance Committee, and noted in the productivity report to the Trust Board. At the end of the year, key schemes will complete a post implementation review which will contain details of the KPIs and the overall impact on quality of the schemes as they are completed.

6. Financial & Investment Strategy

6.1 Current financial position 2012/13

Following strong performance in previous years, the Trust met all its key financial targets for 2012/13 as summarised below:

Table 6.1: Financial Performance 2012/13

Target	Performance
I/E performance	The Trust has achieved a surplus of £2.6m against a planned surplus of £2.1m. The increase in surplus is mainly due to additional donated income.
Capital Resource Limit performance	Target of £7.8m achieved (undershoot of £0.3m within allowable tolerance)
External Financing Limit performance	Target of -£0.9m achieved (undershoot of £0.9m within allowable tolerance)
Net return after financing	Achieved the target of 3.5%

Income over performed by £1.1m for the year, mainly driven by an over performance in education income, private patient income, provider to provider contracts and donated income. This was only partially offset by patient care income being slightly lower than plan.

Pay costs were £0.8m overspent for the year, driven by overspends in medical & dental and nursing. A programme to manage pay costs was brought in during the year and as a result the last few months show overall positive pay cost variances. Non pay costs were higher than plan mainly on activity related areas.

The Trust achieved CIPs of £10.2m. This was an underperformance against the internal stretch target of £10.9m but an over performance of the original target. There were areas of underperformance in Surgery, Ambulatory Care and Operations with key failing schemes being productive theatres, PFI benchmarking and microbiology pay review.

The cash position at the end of 2012/13 was £6.3m which was slightly higher than the previous year. In addition the working capital position (measured as net current liabilities) improved from -£4.0m to -£3.3m.

The Trust achieved a Financial Risk Rating (FRR) score (assuming access to the working capital facility that is now in place) of 3.4.

2013/14

The Trust signed a Head of Agreement with CCGs at the end of March 2013 and is very close to having a signed contract. The baseline, growth and QIPP assumptions in the contract are consistent with the Trust's original planning.

The Trust has provided for inflationary pressures and cost pressures and has planned a CIP of £10.8m (which includes a stretch element of £0.8m); these are all consistent with the Trust's original plan. The Trust has planned a bottom line surplus of £2.2m (1%) and a Financial Risk Rating of 3.4.

The capital programme has been set at £7.3m, split between Estates (£3.1m), IT (£3.2m) and equipment (£1.0m).

6.2 Key financial priorities and investments 2013/14 – 2015/16

The Trust intends to build on its long term record of financial success and to continue to generate a surplus of slightly larger than 1% for each of the years 2013/14 to 2015/16. As the capital programme is being kept at a level similar to retained depreciation, this will allow overall liquidity to improve.

Table 6.2: Income and Expenditure and inter-year movements for the period to March 2015

	End 12/13	△	Start 13/14	△	Start 14/15	△	Start 15/15
	£m	£m	£m	£m	£m	£m	£m
SLA Income	180.3	0.0	180.3	(2.2)	178.1	(0.5)	177.6
Other Income	26.6	0.4	27.0	0.0	27.0	0.1	27.1
Operating Costs	(191.9)	0.2	(191.7)	2.7	(189.0)	1.1	(187.9)
Dpn, Int, PDC	(12.9)	(0.4)	(13.3)	(0.4)	(13.7)	(0.5)	(14.2)
I / E	2.1	0.2	2.3	0.1	2.4	0.2	2.6

The key financial priorities for each year are therefore:

- 1) To achieve the I/E target:
 - Income
 - Work with the commissioners on a balanced outcome against the contract
 - Ensure that income is properly recorded and coded in relation to the new patient pathways
 - Ensure that the Trust horizon scans and takes advantage of opportunities
 - Deliver the outreach strategy worked up with commissioners
 - Expenditure
 - Achieve the CIP programme (and ensure that quality standards are not impacted)
 - Ensure cost control is maintained
 - Achieve the capital programme within the bounds set
- 2) To support the implementation of the next release of CRS
- 3) To reduce the level of business critical backlog maintenance in accordance with the Trust's estates strategy
- 4) To maintain the functional capability of the Trust's equipment base
 - Work with the sector on the reconfiguration strategy. Develop the Trust plans for how to support this
 - Support the work with St George's Hospital to take advantage of joint opportunities for cost control

These priorities support the delivery of the Trust's overall strategy and will be underpinned by:

- Creating a programme to move to service line management with the aim being to increase local autonomy, increase clinical engagement and sharpen management focus
- Further embedding the use of IT through:
 - Deployment of the next release of the CRS programme
 - Optimising the use of the new general ledger and e-procurement system
 - Optimising the use of e-rostering

6.3 Key risks to achieving the financial strategy and mitigations

Key Risks

The Trust has a comprehensive risk register and risk management methodology. The key financial risks are as follows:

Table 6.3 Financial Risks

Description of risk	Rating (*)	Key mitigating actions / contingency plans in place
Achieving the productivity schemes	12	<p>Divisional detailed actions plans to ensure delivery with each scheme having a nominated lead</p> <ul style="list-style-type: none"> • CIP challenge sessions prior to sign-off • Performance against each scheme tracked on a monthly basis • Rigour of programme management plus support from PMO (eg actions needed in programme to generate savings tracked prospectively) • 2014/15 programme developed & can be used to source alternative schemes
Trust fails to i) influence thinking on service reconfigurations and ii) fails take advantage of opportunities	12	<p>Trust working closely with BSBV process</p> <p>Trust horizon scanning and has a well developed commercial function</p> <p>Maintain flexibility to respond to any emerging changes in demand / opportunities as required.</p>
Failure of QIPP action plan to achieve the reduction in volumes expected by CCGs resulting in financial tensions in the local health economy	9	<p>Trust and CCG plans aligned through the BSBV process.</p> <p>Liaising closely with CCGs to understand how progressed / effective the CCG plans are, linked to clear contracting process.</p> <p>Co-ordinating all interactions on demand management with the Trust through the contracts team and disseminating from there.</p> <p>Developing action plans to implement robust monitoring mechanisms.</p>
Failure to release sufficient costs as activity shifts to the community, resulting in an overall cost to the local health economy	9	<p>Productivity programme to include contingency.</p> <p>5 year savings plan to cover full value of QIPP</p> <p>Close working with the CCGs and close connection with Better Service Better Value to understand and anticipate the likely pathway and service changes</p>

(* The risk rating is based on score of 1-5 for likelihood multiplied by a score of 1-5 for severity; the higher the number, the higher the risk)

Downside modelling

The Trust has spent extensive time considering downside scenarios and has constructed a five year model that has had external input from NHS London and commissioners. A refresh took place in February 2013 in a horizon scanning session with the Trust Board. There were three broad areas of risk that were considered by the Board:

- Activity risk (includes activity growth not paid for, activity reductions and loss of market share)
- Sector reconfiguration risk (i.e. changes in the external environment)
- Cost and price risk (includes CIP slippage and additional redundancy costs and further tariff deflation and cost inflation)

The Trust has developed a detailed set of mitigations against the specific risks and further central mitigations that can also be deployed. These mitigations would allow the Trust to maintain a surplus and a FRR of 3.

7. Glossary of Terms

A&E – Accident and Emergency
AQP – Any Qualified Provider
BMI – Private Healthcare subsidiary of the General Health Group
BSBV – Better Services, Better Value
CCG – Clinical Commissioning Group
CIP – Cost Improvement Programme
CQC – Care Quality Commission
CRS – Care Records System
EDICs – Epsom and Dorking Integrated Care
EOC – Elective Orthopaedic Centre
FRR – Financial Risk Rating
ITU – Intensive Treatment Unit
MRSA - Methicillin-resistant Staphylococcus aureus
NHS – National Health Service
POD – Point of Delivery
PMO – Project Management Office
QEIA – Quality and Equality Impact Assessments
QIPP – Quality, Innovation, Productivity & Prevention
SLM – Service Line Management
WTE – Whole Time Equivalent