



Strategic Plan Document for 2013-14

Medway NHS Foundation Trust

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

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

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Date	31 May 2013

In signing below, the Trust is confirming that:

The Strategic Plan is 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 Strategic 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 Strategic 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;

All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name	Denise Harker, Chair
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Signature



Approved on behalf of the Board of Directors by:

Name	Mark Devlin, Chief Executive
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Signature



Approved on behalf of the Board of Directors by:

Name	David Meikle, Finance Director
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Signature



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EXECUTIVE SUMMARY

This annual plan outlines Medway NHS Foundation Trust's strategy for 2013/14 to 2015/16. The Trust is one of four acute NHS trusts in Kent, primarily providing acute secondary care to a population of over 400,000 in Medway and Swale, with a budget of £242m in 2013/14.

Strategic objectives for 2013/14 to 2015/16: The Trust has developed five strategic objectives for 2013/14 to 2015/16, having considered both local and national context:



NHS England strategies
Monitor guidance
Clinical Commissioning Group plans and local commissioning intentions
Competitor plans
Forecast population changes
Issues specific to Medway NHS Foundation Trust

These objectives are underpinned by 15 sub-objectives, with associated risks, mitigations, executive leads and committees responsible for overseeing delivery identified.

Approach to quality: Our first priority in everything we do is the delivery of safe, high quality care and the three key areas of quality (safety, effectiveness and experience) are incorporated into our central strategic objective. Although we have robust quality governance arrangements and good progress has been made against a number of key quality indicators, we acknowledge that we are an outlier for HSMR. As such, we are part of the NHS England review into quality and will action the recommendations alongside our own comprehensive Patient Safety Programme to ensure that we achieve an HSMR of 90 or below by 2014/15 (before rebasing).

Key developments: In 2013/14, our primary development will be of our emergency and urgent care pathway, including the implementation of the Urgent Care Plan (to ensure sustainable delivery of the 4 hour A&E access target), linked with the delivery of our Patient Safety Programme. Within 2013/14, we will be developing business cases to consider the potential development of several services, including cancer, vascular and fetal medicine. In the medium to long term, our proposed key development will be working in partnership with Dartford and Gravesham NHS Trust, which will provide additional opportunities to develop current and new specialist services.

Clinical sustainability: To ensure ongoing clinical sustainability, there will be investment and development in our clinical workforce: consultants in adult and emergency medicine, nursing via a nursing establishment review and junior doctors through the implementation of Deanery recommendations. In 2013, we will also carry out capacity and 7 day week modelling to ascertain how we can robustly match capacity and demand as we move forward.

Productivity and efficiency: We have a Transforming Performance Programme in place to deliver cost improvement plans, based on continuous improvement. Our top five schemes are: length of stay, bank and agency spend, procurement, theatre productivity optimisation and medicines management. We are also working with local Clinical Commissioning Groups to deliver a health system wide redesign of outpatient services.

Financial summary: We are planning for a break-even financial position by 2014/15 and a surplus by 2015/16, meeting a minimum Financial Risk Rating of 3 throughout 2013/14. Commissioning intentions have been considered and accounted for, where appropriate, as well as tariff reductions. In addition, specific provision has been made for quality development, capacity pressures and IT systems development.

Note: We have engaged with our governors in the development of this plan, in line with our statutory duty.

1. STRATEGIC CONTEXT AND DIRECTION

1.1. Overview of Medway NHS Foundation Trust

Medway NHS Foundation Trust is one of four hospital trusts in Kent and its main site is Medway Maritime Hospital, in Gillingham, Medway. **Table 1** summarises our key statistics.

Table 1: Key statistics

Key Facts and Figures (2012/13)	
Budget	£220m
Staff	3,676 wte
Births	5,111
Beds	594
A&E attendances	89,817
Outpatient attendances	311,099
Elective activity	31,300
Emergency activity	39,556



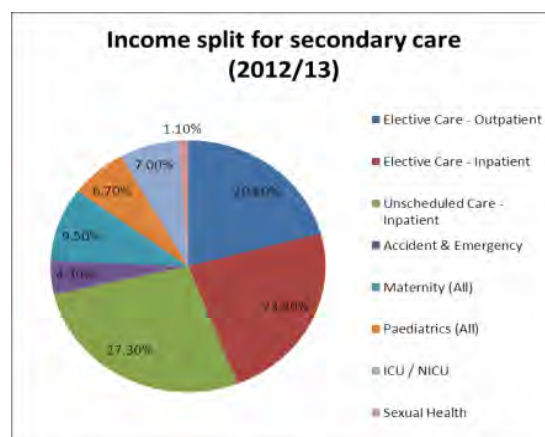
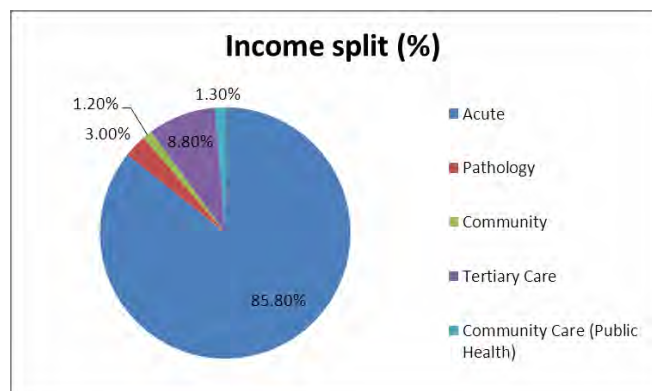
Our service lines encompass:



Working in partnership with local primary and community care services in the delivery of -



The diagrams below illustrate our % income split in terms of secondary, tertiary and community care, and the % income split for our core business of secondary acute care.



We also have a growing research and development programme, which incorporates an expanding portfolio of research trials.

1.2. Overview of our key competitors

There are three other acute trusts in Kent with one other London provider on the north-west border of Kent. These are illustrated below, and their key statistics summarised in **table 2**.



Table 2: Overview of the Trust's key competitors

Name	Staff	Turnover (approximate)	Population served
Medway NHS Foundation Trust	3,700 +	£240m	400,000 +
East Kent Hospitals University NHS Foundation Trust	7,000 +	£500m	759,000
Maidstone and Tunbridge Wells NHS Trust	4,750	£345m	500,000
Dartford and Gravesham NHS Trust	2,000	£169m	300,000
South London Healthcare NHS Trust	6,000 +	£439m	1,000,000 +

Historically, these trusts have all been key competitors, although the expected reconfiguration of services at South London Healthcare NHS Trust following the administration process, recently completed, is expected to have an impact. The precise impact is currently unknown, but will be factored into our plans as changes across South London develop over the next three years. In addition, there are also two private providers that are considered key competitors presently and an emerging competitor:

BMI Healthcare provides a range of elective services from two hospitals (Fawkham Manor Hospital and The Somerfield Hospital);

Similarly, Spire Healthcare provides services from the Spire Alexandra Hospital; and

The Kent Institute of Medicine and Surgery is currently under construction near Maidstone and is due to open to patients in April 2014. It will provide tertiary level specialist services to NHS and private patients, including: general and complex procedures in cardiology, cardiac surgery, neurology, neurosurgery, orthopaedics and surgical oncology, outpatient services, and imaging and diagnostic testing. It is part owned by clinicians and aims to be a centre of excellence and teaching hospital.

1.3. Assessment of strengths/weakness relative to our key competitors

We have assessed our strengths and weaknesses relative to our competitors, referenced to NHS Choices and the NHS inpatient survey, and this is summarised in **table 3** and **table 4**.

Table 3: NHS Choices, Inpatient survey and governance assessment

NHS Choices			Other quality indicators				Inpatient Survey ¹			Governance
Trust	Users rating (1* to 5* scale) ²	Responding to patient safety alerts ³	Recommended by staff (out of 5) ⁴	Mortality rate (Dr Foster 2012) ⁵	MRSA (2012/13 incidences)	CQC registration ⁶	Above average	Average	Below average	FT status ⁷
Medway NHS Foundation Trust	Medway Maritime Hospital: 2.5*	Poor	3.44	SHMI: 114.5 HSMR: 112	1	Registered (fully compliant)	N/A	All except one	The hospital and ward	Yes (with enforcement undertakings)
East Kent Hospitals University NHS Foundation Trust	4* (William Harvey Hospital - 3.5*)	Poor	3.47	SHMI: 99.8 HSMR: 84.4	4	Registered (not fully compliant)	N/A	All areas	N/A	Yes
Maidstone and Tunbridge Wells NHS Trust	Maidstone: 4* Tunbridge Wells: 3.5*	Good	3.70	SHMI: 99.2 HSMR: 100.8	2	Registered (fully compliant)	N/A	All except one	Waiting lists and planned admissions	No
Dartford and Gravesham NHS Trust	4*	Good	3.73	SHMI: 102.9 HSMR: 93.3	3	Registered (fully compliant)	N/A	All except one	The hospital and ward	No
South London Healthcare NHS Trust	Princess Royal: 3.5* Queen Elizabeth: 2.5* Queen Mary's: 4.5*	Poor	3.21	SHMI: 98.5 HSMR: 96.3	2	Registered (not fully compliant)	N/A	All but four	The hospital and ward; Care and treatment; Operations and procedures; Leaving hospital	No

¹ NHS Adult Inpatient Survey (2012) (www.nhssurveys.org)

² NHS Choices (www.nhs.uk)

³ NHS Choices (www.nhs.uk)

⁴ NHS National Staff Survey (2012) (www.nhsstaffsurveys.com) – National average: 3.57; Best acute trust score: 4.08

⁵ Dr Foster Good Hospital Guide 2012

⁶ Care Quality Commission (www.cqc.org.uk)

⁷ Monitor (www.monitor-nhsft.gov.uk)

Table 4: Key strengths and weaknesses

Strengths	Weaknesses
Hospital of choice for our local communities – high degree of loyalty	High mortality rates (both HSMR and SHMI) and associated negative publicity
Significant improvements in last three years, with loyal workforce striving to continue our journey of improvement	Matching capacity to demand
Excellent proactive infection control and consistent delivery of access targets	Ability to recruit key clinical staff
Growing portfolio of secondary and specialist services	Enforcement undertakings are in place to ensure maintenance of Foundation Trust status
Growing Research and Development programme	Estate modernisation required

1.4.Threats and opportunities from changes in local commissioning intentions

1.4.1.National Context

'Everyone Counts: Planning for Patients 2013/14', NHS England (formerly the National Commissioning Board) outlined three key objectives and five offers for the NHS. Alongside this, the Chief Nursing Officer launched 'Compassion in Practice', a three year strategy and vision, aiming to embed six values (the '6Cs') throughout the NHS to improve care for patients. The national headlines are summarised in **table 5**, accompanied by the five domains of the NHS Outcomes Framework.

Table 5: National headlines

Three key objectives	Five offers	6Cs
1. Balancing change and continuity	Offer 1: NHS Services, 7 days a week	Care
2. Making assumed liberty a reality	Offer 2: More transparency, more choice	Compassion
3. Balancing annual requirements with the longer term	Offer 3: Listening to patients and increasing their participation	Courage
	Offer 4: Better data, informed commissioning, driving improved outcomes	Communication
	Offer 5: Higher standards, safer care	Competence
		Commitment



NHS Outcomes Framework 2013/14

- Our 2013/14 annual planning process has referenced the national headlines in the development of our 2013/14 strategic objectives and key deliverables.

1.4.2.Local Context: Forecast population, health and social trends

"The population of Medway is forecast to increase from 264,885 in 2011 to 290,337 in 2021; this represents an increase of 9.6% (+25,500). The rate of population growth in Medway at 9.6% is above the forecast growth for England (+8.6%) and the South East (9.3%). The largest growth in the Medway population is seen amongst those of retirement age, with over 64's increasing by 28% (+10,400), 0-15's increasing by 11% (+5,800) and those of working age up by 5% (+9,300). Natural growth – i.e. births exceeding deaths – is the major component of population growth in Medway accounting for around +17,000 increase, with inward migration contributing a further 9,000 residents up to 2021."

Population projections, Medway Council (November 2012)

“Population projections [for Swale] from the Office for National Statistics (ONS) show a rise in all age groups over the next five years with the largest percentage rises occurring in the 65+ age group. The rise in this group is predicted to increase by 19.5% in 2015. The overall population projected increase for Swale for 2015 is around 4.5% and would result in the size of the population being 139,000.”

Health and social care maps: Swale Local Authority, Kent & Medway Public Health Observatory (2013)

On the basis of this information, we expect an increase in demand for both elderly care services and maternity services over the coming years. The existing health profiles for Medway and Swale (Department of Health 2011) also highlight several other health and social trends, which we have factored into our planning:

An aging population.

Younger age groups with a significant prevalence of obesity, diabetes and other long term conditions.

Pockets of severe deprivation.

Increased prevalence of lung disease and other long term conditions due to similar historical activities such as men working at the dockyards and within the paper and cement industries.

Increased incidence of early deaths from cancer and an increased prevalence of coronary heart disease.

- With the population living longer, a greater incidence of long term conditions, and elements of the local community we serve needing specific specialist services, we will work closely with primary care and community care providers in the development of services across traditional boundaries, to ensure that such conditions can be effectively managed through a whole systems approach.

1.4.3. Local Context: Kent and Medway - Commissioning

Table 6 shows the income we receive for providing secondary care services, clearly demonstrating that our primary income is from unscheduled inpatient care.

Table 6: Historic income split across secondary care for Medway NHS Foundation Trust

	2010/11 £m	2010/11 %	2011/12 £m	2011/12 %	2012/13 £m	2012/13 %
Elective Care - Outpatient	33.40	20.1%	35.89	20.9%	37.07	20.8%
Elective Care - Inpatient	33.41	20.1%	35.91	20.9%	41.62	23.3%
Unscheduled Care - Inpatient	48.28	29.1%	50.60	29.4%	48.76	27.3%
Accident & Emergency	6.99	4.2%	7.35	4.3%	7.63	4.3%
Maternity (All)	17.28	10.4%	16.70	9.7%	16.98	9.5%
Paediatrics (All)	12.09	7.3%	10.99	6.4%	11.95	6.7%
ICU / NICU	13.08	7.9%	12.88	7.5%	12.59	7.0%
Sexual Health	1.59	1.0%	1.78	1.0%	1.98	1.1%
TOTAL	166.13		172.10		178.58	

Our primary commissioner is NHS Medway Clinical Commissioning Group (CCG), with Swale CCG and Dartford, Gravesham and Swanley CCG being the Trust's secondary commissioners.

- In line with NHS Medway CCG's Integrated Commissioning Plan for 2013 - 2015, we will be working together to deliver local commissioning intentions and the national drive to provide care closer to home.
- We are committed to developing strong ambulatory services to prevent admission, and work in partnership with primary care providers to manage long term conditions outside of the acute settings. The proposed shift of less complex activity from the acute sector and into the community setting, provides us the opportunity to develop our community services portfolio, in tandem with the opportunity to repatriate some of the more complex activity from tertiary centres in London, as they arise. An example of this,

already progressing well, is paediatric surgery. This will increase choice and be more economical for patients and commissioners, as well as aiding our clinical and financial sustainability.

- We acknowledge that CCGs are in the early stages of establishment. For this reason, we have not factored in any impact of commissioning intentions until after 2013/14.
- We are forecasting growth of 1.8% across non elective activity, 10% across chemotherapy, 3% within A&E attendances, and an increase in pathology and diagnostic testing.
- The total level of growth amounts to £1.6m. We also have specific service developments in relation to outpatients, inpatients and other cost per case, totalling £2.8m.
- Commissioners' Quality, Innovation, Productivity and Prevention (QIPP) plans cover inpatients, outpatients and A&E attendances and amount to £4.6m, and impact from these are assumed in our financial planning from 2014/15.

1.4.4. Local Context: Specialised services commissioning and Any Qualified Provider

We currently provide several specialised services, which are now commissioned by NHS England. With the introduction of a new specialised commissioning system, a number of national service specifications are being developed. NHS England will be reviewing specialised services against these specifications before 1st October 2013, to ensure compliance, or that plans are in place to ensure compliance or to stop the service if it is not feasible to become compliant.

We will respond on a service by service basis, with a particular focus on: neonatal intensive care/special care, vascular, cardiology, fetal medicine, cancer, HIV and specialised ear services. We will also review the development of CCG plans with regard to local tendering of services and respond in line with our clinical services strategy.

2. OUR APPROACH TO QUALITY

2.1. Our approach to quality

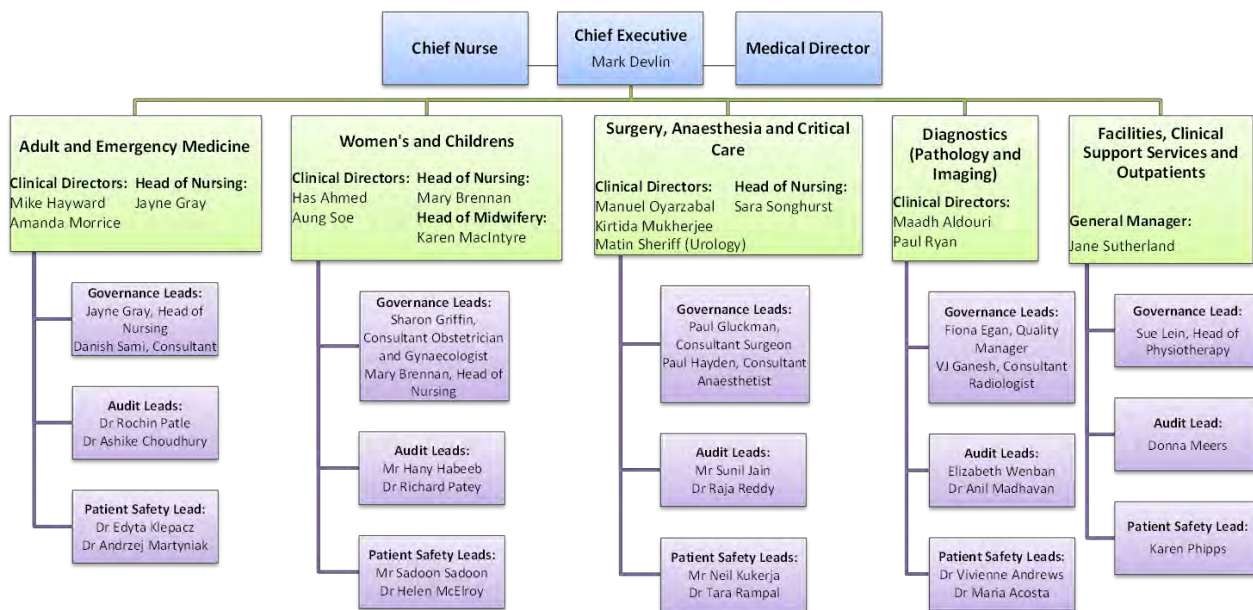


Our first priority in everything we do is the delivery of safe high quality care. There are three key deliverables in terms of safety, effectiveness, and experience. Over the last three years, we have made good progress in driving forward improvements in the quality of care provided to the local population. However, it is recognised that although good progress has been made against a number of key quality indicators, we must ensure that we deliver the necessary actions to achieve an HSMR of 90 by 2014/15.⁸

2.2. Quality governance arrangements – people

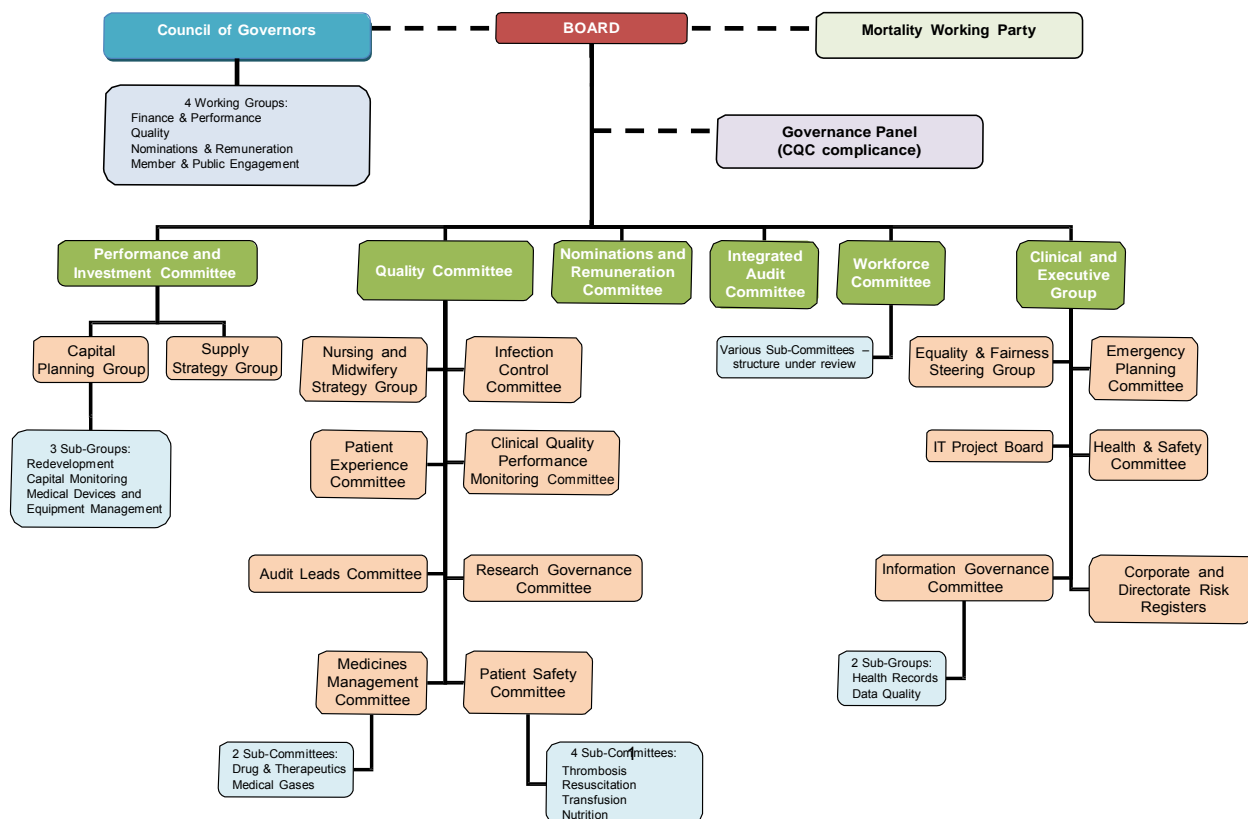
The Trust has dedicated corporate and directorate teams driving the quality agenda, supporting the directors. Each of our clinical directorates has patient safety, governance and audit leads, which are either a consultant or head of nursing and are highlighted over the page.

⁸ Before rebasing.



2.3. Quality governance arrangements – process

Our Committee structure is summarised below. We have a dedicated Quality Committee, which is a Sub Committee of the Trust Board.



2.4.Existing quality concerns and plans to address them

Each Directorate has its own audit, governance and safety leads, and holds regular directorate governance meetings. Trust-wide existing quality concerns, and plans in place to address, are detailed in our strategic objectives section, **section 3.1**.

2.5. Quality governance arrangements – assurance

Accountability to governors - The governors, to whom the Trust is accountable, have an established Governors' Quality Working Group, which meets quarterly. The non-executive chair of the Quality Committee and executive directors, as appropriate, attend each of the meetings.

Working in partnership - Our approach to improving quality is one of working in partnership. The Chief Nurse for the North Kent CCGs attends our Quality Committee, and we have established a Mortality Working Party, which is chaired by the local Director of Public Health, and whose membership is constituted of clinical leads, executive leads and non-executive leads of the Trust, neighbouring acute trust, CCGs and NHS England's Area Team.

Academic Health Science Network (AHSN) across Kent, Surrey and Sussex is being established and we already are an active leader in the Enhancing Quality and Recovery Programmes.

Self-assessment and external review of our governance systems - We will refresh our Quality Governance Framework in 2013/14 as part of the development of our Quality Strategy.

3. STRATEGIC OBJECTIVES AND DELIVERY

3.1.Our strategic objectives

Shaped by the national and local agendas, engagement with our governors, members and staff, we have identified five strategic objectives illustrated below:



Each of these five strategic objectives has three sub-objectives beneath them. These fifteen sub-objectives will enable us to measure our progress against each of these areas, and our overarching strategic objectives. Our strategic objective headlines are summarised in **table 7**.

Table 7: 2013/14 strategic objectives

Strategic Objective 1: We will deliver safe, high quality care and an excellent patient experience			Executive Lead: Medical Director and Chief Nurse (supported by the Executive Team)	Committee overseeing delivery: Quality Committee
No	2013/14 Delivery	Ambition	Key risks	Mitigations
1.1	Ensure consistently safe services – get care right first time every time	Zero tolerance of never events Zero tolerance of infection Consistently low HSMR and SHMI Comparative year on year improvement in the NHS safety thermometer	Mortality data Learning from adverse events Tolerance of poor care and practice Engagement with staff at all levels Ratio of qualified to unqualified nurses Appropriate supervision of junior staff Seasonal variation in demand	Patient Safety Programme with dedicated resources in place, including local health economy-wide Mortality Working Party Nursing establishment review Working closely with NHS England review and committed to implementing recommendations to improve mortality Francis report recommendations action plan in place Comprehensive consultant appointment programme for 2013/14 Action plan to implement KSS Deanery recommendations for junior doctors Robust capacity planning Organisational Development and Communications strategy in development, to ensure appropriate stakeholder engagement
1.2	Ensure evidence based care for every patient, including both expanding and promoting research and development	Compliance with all national guidance All clinical audits result in service improvement To become the largest research and development centre in Kent	Data quality and information analysis unavailable to inform quality improvement Service improvement discipline Clinical audit does not result in improved outcomes Research and development is not seen as a priority	Active participation in KSS Academic Health Science Network, incorporating the Enhancing Quality Programme Directorate performance reviews to be established Appointment of an Executive Sponsor for service development Capacity review (including ECIST) Organisational Development and Communications strategy in development Research and development strategy to be developed Review establishment of a business intelligence unit
1.3	Ensure patient centred delivery: use patient experience insight to improve service delivery and patient satisfaction	To be truly patient centred and customer focused – treating patients respectfully To be within the top 20% of trusts in national patient surveys in the next 3 years To be rated as the best hospital in Kent in the next 3 years on NHS Choices and Patient Opinion	Translating feedback into changing operational delivery across our services Poor team working across all professions	All service improvement projects to include patient representation Patient experience action plans Monitoring of the Friends and Family test New food provision contract and review of meal choice process Estates planning focused on the key issues identified as offering sub-optimal patient experience

Strategic Objective 2: We will attract and develop a first class workforce			Executive Lead: Director of Organisational Development and Communications (supported by the Executive Team)	Committee overseeing delivery: Workforce Committee
No	2013/14 Delivery	Ambition	Key risks	Mitigations
2.1	Capacity Plan: Right professional, right grade, right place, maximising new roles and ways of working	A comprehensive workforce plan that supports our business plans, new ways of working and 7 day service delivery where appropriate Vacancy hot-spots addressed Excellent rate of retention	Vacancy rates and turnover Higher than planned activity Traditional staffing model Proximity to London hinders recruitment	Rapid recruitment plan 7 day services scheduled to be modelled in 2013 Nursing and midwifery establishment review, new roles and ways of working New employment brand and reputation
2.2	Capability plan: Competent and capable individuals and teams with the right values and behaviours	Develop a great reputation for training and research Comprehensive programme of professional development opportunities Values, team working and service improvement embedded throughout the organisation	Insufficient priority given to development High levels of DNA's "Our behaviours" not lived by everyone	Learning and development planned and reviewed at every level Review of delivery options (other than attending courses) in place "Our behaviours" embedded into job design, recruitment, induction, appraisal, staff awards and patient pathways
2.3	Culture and people experience plan: Best in class leadership, people and change management; health and wellbeing policies and practice	Change is driven by people feedback Pride in sharing best practice across the organisation and beyond Leading edge occupational health services Excellent opportunities for reward and appreciation at local and national level	Hierarchical culture Silo culture Insufficient priority given to health improvement Lack of opportunities for reward, recognition and appreciation at local and national level	LIA approach being embedded across the Trust Corporate calendar of events Calendar of health and wellbeing events and fast track physiotherapy service set up WOW! and staff awards and metrics for good news stories

Strategic Objective 3: We will run an efficient acute hospital			Executive Lead: Director of Operations (supported by the Executive Team)	Committee overseeing delivery: Performance and Investment Committee / Clinical and Executive Group (CEG)
No	2013/14 Delivery	Ambition	Key risks	Mitigations
3.1	Improve the way we work in Emergency and Urgent Care	Sustainable delivery of A&E targets throughout the year Reduced readmission rates Become an “ergonomic hospital”, beginning with Emergency and Urgent Care	Clinical and management capacity and capability to deliver Supporting administrative/information systems Medium to long term solutions will require significant capital investment <u>Demand management</u>	Working with ECIST to launch the “Medway Emergency Flow Programme”, building on the 2012 ECIST action plan, which forms the backbone of the Urgent Care Plan (ECIST Lead: Chief Nurse; Service Improvement Lead: Director of Governance and Strategy) Significant investment in the Adult and Emergency Medicine Directorate (including the appointment of additional clinicians) Appointment of a project manager for the Urgent Care Plan Closer working with commissioners on demand management <u>Directorate level workforce and capacity plans</u>
3.2	Deliver our QIPP plan (Transforming Performance Programme – “TPP”)	Balanced savings and investment profile Delivery of CIPs, with a focus on quarters 1, 2 and 3 to support quarter 4	Phasing Programme management of cross-directorate savings programmes Over performance on contract affects our ability to deliver safe, high quality services and meet targets	A PMO is being established, with a focus on continuous improvement and robust project management, linked in with the existing Listening into Action methodology A block contract for outpatient services has been agreed for 2013/14, to support the redesign of outpatient services (part of a local whole system QIPP project)
3.3	Deliver all mandated national targets, CQUINs and help CCGs achieve their quality premium	Delivery of all mandated national targets and CQUINs CCGs achieve their quality premium	Difficulty sustaining year-round hospital performance, including achieving 90% bed occupancy Capacity to meet seasonal demand Quality and administration of patients notes	Length of stay TPP project in place with the aim of achieving 90% bed occupancy Nursing establishment review to result in a stable but flexible workforce Patient safety programme includes review of the quality of patient notes <u>Capacity review</u>

Strategic Objective 4: We will manage our finances prudently			Executive Lead: Director of Finance and Director of Operations (supported by the Executive Team)	Committee overseeing delivery: Performance and Investment Committee
No	2013/14 Delivery	Ambition	Key risks	Mitigations
4.1	Achieve the 2013/14 plan, ensuring a Financial Risk Rating of 3 or better	Realisation of a surplus by 2015/16, and develop an effective investment plan	Significant investment identified to support continuous quality improvement Operational and quality pressures, such as over performance against contracts and underperformance against quality measures such as CQUIN Securing sufficient liquidity Temporary staffing spend	Robust planning and delivery mechanisms Embedding more robust spending controls Information systems are being replaced / updated Capacity review and subsequent capacity planning
4.2	Invest in our services with a particular focus on improvements in quality and new technology	Develop a 'just do it' mentality, with directorates having greater autonomy and accountability Having access to the most effective tools, such as e-procurement, a new patient administration system, e-rostering and business intelligence Elimination of duplication in paper based systems and move towards paperless referrals by March 2015 Real time patient and carer feedback by 2015	Staff training for new systems Staff engagement and involvement in both systems procurement and implementation, resulting in a lack of commitment to use new systems Clinical and management capacity and capability to deliver Replacement of the patient administration system in a relatively short timeframe	Plans for training and development for new systems in place Communication and engagement with specific staff groups to ensure understanding of benefits Project management resource allocated where required Learning from other organisations taken into account, such as from East Kent Hospitals University NHS Foundation Trust on e-rostering Development of control mechanisms to provide directorates with greater autonomy and accountability
4.3	Ensure the highest standards of financial governance and improve contract management	To be recognised for excellent standards of financial governance Annual delivery of contract on plan	Historic trend of over performance against contract	Whole health system service redesign to be established Effective information systems Improved contract management capability Robust contract management relationships with commissioners and services

Strategic Objective 5: In partnership, we will deliver great healthcare			Executive Lead: Director of Governance and Strategy (supported by the Executive Team)	Committee overseeing delivery: Clinical and Executive Group (CEG)
No	2013/14 Delivery	Ambition	Key risks	Mitigations
5.1	Maintain and improve our regulatory status	Monitor licence with no conditions Continued full registration with CQC Excellent reputation with Royal Colleges, KSS Deanery, Nursing and Midwifery Council, NHS England and other professional bodies and regulators	Governance risk rating (Monitor): A&E performance Flexible capacity is needed to meet the seasonal demand of the local population Overall outcomes of NHS England review into quality	Urgent Care Plan being developed (with ECIST) and significant investment being made in the Adult and Emergency Medicine directorate Actions in train in response to Royal College and Deanery recommendations, as and when they arise
5.2	Work with partners to ensure the sustainability of the Trust's services in the medium to long term	Ensure excellent healthcare for the populations we serve	Integration with Dartford and Gravesham NHS Trust is currently paused	Continued close working with Dartford and Gravesham NHS Trust Refresh our key strategies, including clinical and estates strategies, focusing on provision for those with long term conditions and care of the elderly Review of services and potential diversification in the medium to long term, to ensure the health needs of Medway and Kent are provided for Relationship building with local health and social care providers and commissioners
5.3	Working jointly with commissioners and other providers to develop whole system health services – developing partnership arrangements to deliver across the 5 domains and Francis report recommendations	Whole system pathways to ensure the right care in the right place at the right time, delivered by the right professionals	New relationships will take time to establish, following health economy changes in April 2013 Lack of whole systems planning	A leading member of the KSS Academic Health Science Network Building up existing relationships with commissioners Stakeholder engagement in capacity planning for 2014/15 Stakeholder strategy to be developed Member of the South East Coast Strategic Clinical Networks programme, reviewing key cross-cutting specialty pathways

3.2. Urgent Care Plan Summary

As part of the conditions on our provider licence with Monitor, we will take all appropriate actions to achieve sustainable compliance with the four hour maximum waiting time Accident and Emergency target.

3.2.1. Issues, findings, recommendations from the May 2012 Emergency Care Intensive Support Team (ECIST) 2012 Action Plan

3.2.1.1. Issues, findings and recommendations from May 2012 review

There were five key findings, which are summarised below:

The emergency patient flow required improvement, as the pathway at the time resulted in overcrowding in the emergency department, bed shortages, patients in the incorrect flow streams and multiple moves of individual patients. As part of this we identified that we needed to review our bed capacity.

We should focus on internal changes in clinical process, with a focus on improving downstream flow through inpatient wards. These changes should include the systematic use of Expected Dates of Discharge (EDD), clinical criteria for discharge and daily consultant-led board rounds or reviews.

The Emergency Department had made significant progress since ECIST's last visit in 2009, particularly in respect of "front-door" navigation and streaming, enhanced senior clinical presence, and new peer review arrangements.

The **Acute Medical Unit had made good progress** with several important changes since the 2009 ECIST visit. However, a second phase of development was recommended.

We needed to define internal professional standards along the emergency patient pathway. Covering all stages of treatment along the pathway, the aim should be to define what "good" service looks like, then regularly monitor and seek continuous improvement.

3.2.2. ECIST 2012 Action Plan

Three main projects were established to take forward the issues, findings and recommendations from the ECIST review. The ECIST action plan had three main components:

- Medical emergency pathway
- Surgery
- Diagnostics

The key workstreams of each project are summarised in **table 8**.

Table 8: ECIST phase one project workstreams

Medical emergency pathway	Diagnostics/Radiology	Surgery
Expected dates of discharge	Staffing	Emergency surgery
EDN	Vetting and protocolling and demand management	Surgical Assessment Unit
Pharmacy	Reporting and sub specialisation	On call cover and availability at peak times
AMU	Environment	Physical environment
Short stay stream	Supplies	
Home for lunch	Data and information support	
Imaging/diagnostics	Electronic requesting systems	
Bed Management	Portering	
Real time access to data	Hospital service users	
In patient care		
Emergency department		
Community partners		
Communication strategy		

All of these project workstreams were taken forward from May to November 2012. In November 2012, it was agreed that the majority of the actions had been taken forward and initiatives were then subsequently led at ward level.

3.2.3. Additional actions to achieve sustainable compliance with the A&E four hour target

On the 15th May 2013 ECIST revisited and toured the site. A constructive meeting was held encompassing all clinical and managerial areas across the Trust. At the meeting we reviewed which actions had not been fully implemented. These were:

Medical emergency pathway

- Senior treatment and review process in the emergency department
- Embedded practice of expected date of discharge
- To take home medications dispensing time still needed to be improved
- Acute Medical Unit streaming of patients and criteria led discharge
- Refocus on the short stay ward model
- Embedded practice of patients being discharged in the morning and 'home for lunch'
- Bed management – use of escalation wards, standardisation of paperwork
- Communications – Integrated Needs Portrayal process, nurse led discharge/criteria led discharge

Surgical pathway

- Review of the surgical on call rota
- Embedding improved performance metrics in the Surgical Assessment Unit

Diagnostics

- Electronic requesting system and portering.

On the 15th May 2013 it was agreed that we needed to refocus on the key headlines highlighted and this programme of work would be led by our Chief Nurse.

In addition, we agreed to take the following additional actions, which would be led by our Director of Strategy and Governance:

Establish a Medway Emergency Flow Programme, with robust programme governance and expert project management. Integral to this will be ensuring seamless working with our Patient Safety Programme which will be tasked with taking forward recommendations arising from the May 2013 NHS England quality of care review

Review the emergency and urgent care pathway and ensure sufficient capacity throughout the pathway from the front end to the back end of the hospital. As part of this review to assess the co-location of clinical departments

Ensure clinical buy in at all levels across the emergency care pathway. We will do this by holding a clinicians event, and as part of this agree our top five standards for the emergency pathway

Update and review progress across all frontline services of the original ECIST action plans through holding 'Big Conversations' and set new aspirations for moving forward

Develop plans for seven days a week working

With commissioners and partner agencies develop joined up sustainable plans for our local elderly population

3.2.4. Any additional actions necessary to ensure that we have sufficient capacity to ensure compliance with the target at all times including periods of peak demand such as winter 2013-2014

Four factors were identified as critical for successfully taking forward ECIST Phase 2. These were:

The need to ensure that for this phase internally there was robust cross directorate working, and externally that we genuinely worked in partnership with stakeholders, particularly community and mental health service providers, and commissioners

That frontline doctors, nurses and managers must have the appropriate time and support to take forward actions and ensure changes in practice were embedded, and able to sustain periods of peak demand;

That changes to individuals' clinical practice will be key in delivering improvements

That the agenda must be linked in with patient safety and improved outcomes, to ensure clinical support

3.2.5.Key performance indicators to monitor ongoing performance against the target

The three key performance indicators for ECIST phase 2 will be ensuring that we deliver at all times, including periods of peak demand:

The 95% four hour maximum waiting time target

No patient to wait more than twelve hours on a trolley in A&E

In tandem with a

90% bed occupancy.

Our Director of Operations is responsible for the operational management of urgent care, and ensuring the delivery of operational targets.

3.2.6.External assurance on our Urgent Care Plan

NHS England's Emergency Care Intensive Support Team will support the detailed development and implementation of our Urgent Care Plan. Our detailed action plan will be developed following stakeholder events in June 2013.

3.3. Supporting strategies

Supporting our main strategies (quality, finance, workforce) detailed in **section 3.1**, are our service development, estates and IM&T strategies. The associated headlines are summarised below.

3.3.1.Development of our clinical services portfolio

3.3.2.Clinical service portfolio

Our clinical service portfolio is summarised in **table 9**.

Table 9: Clinical Services Portfolio

Emergency Services and Medicine	Surgery, Trauma & Orthopaedics and Critical Care
A&E / Emergency Medicine	General Surgery, including Lower GI, Breast and Vascular surgery
General Medicine	Urology
Gastroenterology	Trauma and Orthopaedics
Diabetes and Endocrine Medicine	ENT
Cardiology/ Coronary Care Unit	Head & Neck Cancer
Thoracic Medicine	Intensive Care, including ICU and outreach services / Surgical High Dependency Unit
Oncology	Theatres & Daycare Unit
Clinical Haematology	Anaesthesia & Chronic Pain
Renal Medicine	
Neurology	

Rheumatology	23 hour surgery
Elderly Acute, Rehabilitation and Stroke	Pre operative care Unit and assessment,
Sexual Health and HIV Service	Endoscopy
Endoscopy	
Dermatology	
Women & Children	Clinical Support Services
Hospital Maternity Service, Community Midwifery Service, Midwifery Led Unit	Imaging Services
Special Care Baby Unit, Paediatric HDU beds & Neonatal Unit level 3	Laboratory Medicine
Gynaecology	Therapies
Fetal Medicine	Inpatient physiotherapy, Speech & Language
Acute Paediatric Services, Community paediatrics, Children's Learning Disability, School Nursing, Children's home care team	Pharmacy
Paediatric General Surgery	Outpatients management & Medical records

3.3.3.Key developments for 2013/14

Key developments for 2013/14 are the development of our emergency and urgent care services and rehabilitation service. In addition, a number of business cases have been approved for implementation in 2013/14:

- Pain management – expansion of the current service
- Spinal services – appointment of a second spinal surgeon
- Specialist paediatrics
- Audiology service – recruitment of additional audiologists to increase service capacity
- Non-invasive ventilation service – provision of a local service

We will also be developing business cases to assess the options for the development of the following services:

- Cancer
- Vascular
- Fetal medicine
- Endoscopy
- Development of a cold elective surgery centre
- Integrated maxillofacial, ear, nose and throat and head and neck surgery service

Over the past year, Listening into Action, of which we are one of ten national pioneers, has also seen staff at all levels and from all departments, get together at Big Conversations to identify how we can work together better and identify improvements.

As part of this process we will also be developing business cases to assess the options for the development of our cardiology and respiratory services, a new blood ordering and tracking system and the implementation of the Medway Rehabilitation Service. Many of our QIPP projects are also closely linked with service improvements, such as theatres productivity optimisation, normalising births, length of stay and five day gynaecology ward projects.

We are also working in partnership with our local CCGs on the development and implementation of our local health economy QIPP plans.

We will also continue to develop our R&D portfolio, after significant recent expansion of our clinical trials programme and securing external funding towards the purchase of an additional MRI scanner, which will enable participation in more clinical trials and studies.

3.3.4.Key medium term developments

Our major service line developments are detailed in our agreed Integrated Business Plan (IBP) for integration with Dartford and Gravesham NHS Trust, with the 2012 IBP headlines summarised in **table 10**. The IBP is published on the internet at <http://www.medway.nhs.uk/about-the-trust/integration-with-darent-valley-hospital/our-plans/>. Plans for integration were approved by the Cooperation and Competition Panel.

Integration with our neighbouring trust is currently subject to an agreed pause. The integration provides the opportunity to sustain a comprehensive portfolio of secondary care and develop the tertiary portfolio through repatriation of clinical activity which is currently referred to London.

Table 10: IBP key service development headlines

Pre Day 1	Year 1	Year 2	Year 3-5
Fetal Medicine	Paediatric Endoscopy Service	Repatriation Across Specialties	Repatriation Across Specialties
Paediatric Surgery	Repatriation Across Specialties	Paediatric Neurology Service	Paediatric Cardiac Reconfiguration
Paediatric Neurodevelopmental Clinics	Centralise Neurology	Develop Ophthalmology Service	Fibroid Embolisation Service
Combined Rheumatology Service	Single Booking System to Share Radiology Capacity	Centralise Endocrine / Parathyroid	Infertility Service
Collaboration of Diabetes Services	Pelvic Floor Service		Nephrology Service
Trauma Unit	GI Bleed Rota		
Joint Urology Service & Links with Renal			
Consolidation of Spinal Surgery			
Potentially Elective Day Case Centre at Queen Mary's Sidcup in line with Trust Special Administrator Recommendations			
Pathology – Hot & Cold Laboratories			

Even with the integration on pause we continue to work together on the development of clinical services portfolios with the establishment of joint pathology and urology services. The IBP also outlines the development of a feasibility study for the development of private patient services in year one of the integration. In 2013/14 we will be developing a marketing and stakeholder development strategy.

3.3.5.Clinical sustainability

We have identified adult medicine and accident and emergency services as areas with potential clinical sustainability issues. It is within the non-elective activity of these areas that we are an outlier for mortality (SHMI and HSMR), specifically general medicine and geriatric medicine.⁹ In 2013/14 our Emergency Services and Medicine Directorate will be taking forward plans to develop these services. In addition we are focusing on:

Consultants - Significant investment is being made in particular areas to ensure sustainability, including elderly care and the provision of an orthogeriatric service, gastroenterology, chest medicine and respiratory services.

Junior doctors – The Kent, Surrey and Sussex Deanery (KSS Deanery) have made a number of recommendations for improving the training we provide for junior doctors. We will be implementing the relevant actions in 2013/14.

⁹ Health Education Data (HED) – Dec 2011-Nov 2012

Nursing and midwifery - We are undertaking a nursing establishment review, with recommendations being reported to the Trust Board at the end of Q1.

Seven day a week working - In context of the national move towards seven day a week working for hospitals, during 2013/14 the Trust will carry out a modelling exercise to identify the changes that would be required to operate on this basis. This modelling exercise will take into account capacity, workforce, quality and financial impact. The outcomes of this exercise will guide the Trust in moving towards seven day a week working in the coming years.

Integrating service and estates planning – we will be updating our Estate Strategy in 2013/14 to ensure that our clinical services and estates planning dovetail.

3.3.6. Innovations in care delivery

2012/13 has seen a number of innovations in care delivery at the Trust. These include:

The development of an ‘app’ to support the wellbeing and recovery of patients receiving intensive care, which was highly commended at the Nursing Times Awards 2013.

The launch of the Butterfly scheme to help dementia patients, which will be followed up with the introduction of a buddy scheme in 2013.

Service improvements in obstetric theatres identified and carried out by a management trainee and a clinical trainee working together as part of a pilot project launched by KSS Deanery and the NHS Management Scheme.

The application of the ‘Enhancing Quality’ programme to further areas including acute kidney failure and dementia, following success in the development of pathways in the initial five areas (pneumonia, heart attack, heart failure, hips and knees).

A partnership with Breakthrough Breast Cancer to launch a service pledge and information booklet for those diagnosed with breast cancer.

The development of a ‘one-stop-shop’ for multiple sclerosis sufferers, which includes ensuring that they can have all investigations completed on a single day.

3.3.7. Estates

In 2013/14 we are planning to review our Estates Strategy. There are several areas of development anticipated for 2013/14 to 2015/16, and we will be working in close partnership with a number of external stakeholders who currently provide services on site, on future reconfiguration and addressing our backlog maintenance.

3.3.8. Information Management and Technology

In 2013/14, we will procure and implement a new Patient Administration System (PAS), establish e-rostering, and go wireless in the main areas of the hospital. We are working to ensure universal adoption of the NHS number as the primary identifier and plan to publish the required individual consultant data on its website within the expected timescales (“Everyone Counts: Planning for Patients”, NHS England).

These developments are the first step towards greater electronic working, such as real-time feedback, paperless referral systems, and electronic record keeping.

4. PRODUCTIVITY AND EFFICIENCY

4.1. Transforming Performance Programme (Cost Improvement Programmes and Service Improvement)

We have established a dedicated Project Management Office (PMO) for our Transforming Performance Programme (TPP), which is the name for our programme which oversees our cost improvement programme (CIP). TPP will focus on the delivery of recurrent savings and embedding a culture of change and continuous improvement.

4.2. Productivity and efficiency gains built into our plans

Our headline planned productivity and efficiency gains are summarised in **table 11**.

Table 11: Productivity and efficiency gains and targets for 2013/2014

Key workstreams	2012/13	2013/14
Length of stay (days)	Elective: 2.6 Non-elective: 4.3	Elective: 2.0 Non-elective: 4.1
Bank and agency spend	£10m spend (medical and nursing only)	£6.6m spend (medical and nursing only)
Theatre productivity	65.5%	85%
Procurement	2% savings	5% savings
Medicine management	2% savings	13% savings

4.3. Joint QIPP programme with our local CCG delivering system redesign

A whole systems outpatient improvement programme has been set up across Medway and is led by Medway CCG. We are working with local CCGs and patients to deliver a range of improvements to pathways and outpatient services during 2013/14. The programme is underpinned by seven principles:

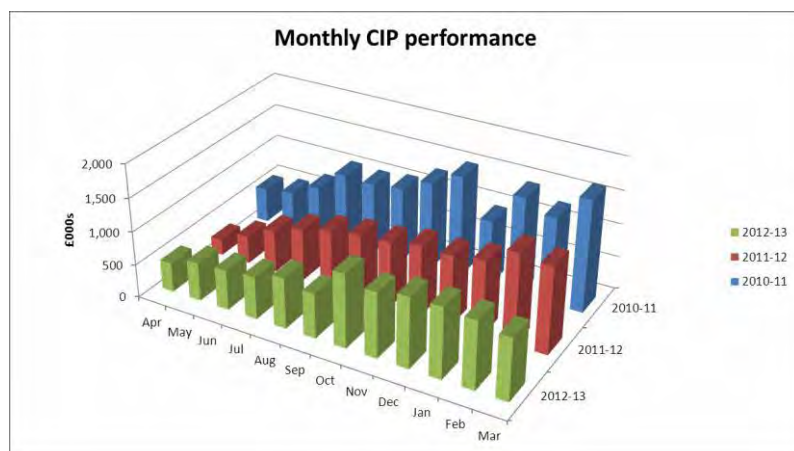
1. To improve the patients experience from referral to treatment and post discharge
2. To provide patients access to appropriate, high quality healthcare services at the right time and in the right place and with the right clinician or health care provider
3. To ensure knowledge and experience from all providers and users of healthcare are listened to and their ideas for improvement are embedded into the redesign of services
4. To ensure that disadvantaged patients are given equal and equitable access to services across Medway and Swale
5. To ensure that clinical pathways, referral criteria, and information regarding the patients care are communicated effectively across Medway and Swale to improve clinical communication
6. To provide a streamlined and efficient booking service for all patients
7. To ensure that patients are treated within national waiting times and are offered choice at all points of the pathway

Together we will:

- Improve the patient experience and overall satisfaction with the outpatient services provided
- Identify and develop cost efficiency schemes in outpatient services
- Reduce the volume of additional outpatient sessions for planned and commissioned activity levels
- Implement ongoing capacity planning and management in outpatients
- Reduce the volume of 'did not attends' (DNAs), cancellations and rescheduled clinics

4.4.CIP governance: Historic performance

The following graph shows our historic cost improvement programme (CIP) performance.



There are two main lessons we have learnt from our historic performance:

Phasing – we need to improve CIP delivery in quarters 1, 2, and 3, so that we are not over reliant on quarter four when services are at their busiest; and
Management of cross directorate schemes.

4.5.CIP governance

The ‘Transforming Performance Programme’ (CIPs) PMO is responsible for ensuring that our CIP programme is appropriately phased, with all the appropriate actions taken to ensure both directorate and corporate level delivery.

People – Our central resource, the PMO, is led by an experienced programme director, reporting to the Director of Operations. The Programme Director is supported by three integration managers and an analyst.

Process - A monthly Transforming Performance Programme Board chaired by the Chief Executive with senior membership across the Trust, is responsible for overseeing the delivery of our CIPs. For assurance purposes, this Board also reports to the Performance & Investment Committee, a subcommittee of the Trust Board. In turn a summary report is presented monthly to the Trust Board. Informally, the Transforming Performance Programme Director reports progress jointly to the Chief Executive, Director of Operations and Director of Finance on a weekly basis.

4.6.CIP Profile

Table 12 summarises our key CIP schemes for 2013/14:

Table 12: Key 2013/14 CIP Schemes

Scheme	Description
Length of Stay	There are a number of schemes developed by individual directorates that will contribute to reduced lengths of stay and improved bed occupancy rates across the Trust.
Bank and Agency Spend	Focus on exchanging agency for substantive staff and increased efficiency in recruitment.
Procurement	Review of existing clinical consumable supply contracts and overall review of NHS Supply Chain costs. We have engaged procurement expertise from Guy’s and St Thomas’ NHS Foundation Trust.
Theatre Productivity	Improve theatre productivity by increasing the throughput of cases and increase utilisation.
Medicines Management	Five areas have been identified following a medicines management review: aseptic (process savings), homecare (all appropriate products to be moved to homecare), recycling and

reducing
waste,
clinical
choices
and
outpatie
nt
prescribi
ng.

4.7.CIPs enablers

The TPP has established links with our organisational development team to build on the existing Listening into Action work, so as to ensure a joined up approach. This approach will involve all front line staff, empowering them to suggest their ideas to improve efficiencies within their areas, as well as suggestions to improve patient pathways and care. This approach will generate savings and will be embedded across the Trust over the coming months, to ensure that our front line staff continue with this way of working.

The financial cost of implementing the Transforming Performance Programme is nominal, however we need to ensure that from the ward to the board there is the appropriate time to develop and learn new ways of working, which has an associated 'time cost'.

4.8.Quality Impact of CIPs

A Quality Impact Assessment Tool is used to evaluate the quality impact of each proposed cost improvement. An initial assessment (stage 1) quantifies projects in terms of potential impacts positive or negative on quality. Where potential negative impacts are identified they are risk assessed using a risk scoring matrix to reach a total risk score. Where there is deemed to be a significant risk of negative impact on quality, a more in depth quality impact assessment is carried out in conjunction with clinical governance leads.

All proposed worked up schemes have to be approved by the Medical Director and Chief Nurse.

We are working in partnership with local CCGs to ensure that they also carry out quality impact assessments on our CIP, in line with NHS England guidance.¹⁰

5. FINANCE AND INVESTMENT

5.1.Financial overview

Our financial strategy is focused upon delivering financially sustainable and clinically effective health care services over the three year planning period and beyond, in collaboration with our partners across the local health economy. The main assumptions underpinning our planning are detailed below:

We have adopted commissioner estimations around non-elective activity, Accident and Emergency attendances and chemotherapy.

The impact of commissioning intentions on our income is summarised in **table 13**.

Table 13: Impact of commissioning intentions on income

Financial year	Income reduction
2013/14	£0.3m
2014/15	£3.6m
2015/16	£4.6m

For 2013/14, we have assumed that only commissioning intentions where notice of cessation of service has been given will impact in the financial year. For 2014/15 and 2015/16 the net contribution impact of commissioning intentions have been included at the stated levels.

The tariff reductions applied in our financial modelling are summarised in **table 14**.

¹⁰ "Everyone counts: Planning for patients 2013/14", NHS England

Table 14: Tariff reductions

Financial year	Tariff reduction
2013/14	-1.3%
2014/15	-2.0%
2015/16	-1.5%

Contracts for 2013/14 will be between Clinical Commissioning Groups (CCGs), Specialised Commissioning (SCG) and the NHS England (NHS Commissioning Board) through Local Area Teams (LAT). We have signed agreements with all CCGs within Kent and Medway, and all CCGs outside of Kent that are subject to a contract.

These CCG contracts account for £174.9m of our clinical income. Heads of Terms have been signed with Specialist Commissioning Group and Public Health. We are discussing the baseline amounts to be removed from CCG allocation with NHS England LAT but do not expect this to have a material effect on our financial position.

The signed or expected values of contracts with commissioners is summarised in **table 15**.

Table 15: Contract value

Commissioner	Contract value (incl. CQUIN) £000
Medway CCG	118,603
Swale CCG	39,818
DGS CCG	8,795
West Kent CCG	5,637
Other Kent and Medway CCGs	1,086
Non-Kent and Medway CCGs	3,448
Specialised Commissioning	18,584
NHS England LAT	2,060
Public Health	3,434

We will receive a further £24.2m, comprising of education and training, income from other NHS bodies and what is termed “other income”. This category is necessarily diverse and will include income flows as wide ranging as those received for performing post mortems on behalf of Kent County Council, the depreciation of donated capital assets, and the secondment of staff to other organisations.

Within this category, an allowance has been made for unspecified non-recurring income (and also later expenditure) that the Trust invariably receives in-year on an adhoc cost pass through basis of £1m.

This financial plan includes provision for:

- Capacity pressures - £0.2m
- Balance sheet issues - £0.3m
- Quality development – £1.9m
- IT systems development - £0.5m
- Other reserves - £0.2m

5.2.Key actions to deliver the financial strategy

Clinical Directors and General Managers have agreed 2013/14 budgets, which will be managed in accordance with our Standing Financial Instructions. Budgets will be adhered to and can only be varied with the authorisation of the Director of Operations.

There will be monthly performance meetings with the directorates and the Executive Team where financial, operational, service and quality performance will be reviewed to ensure delivery is in line with projections.

Financial performance will be reported monthly to the Performance & Investment Committee and the Trust Board. Our key financial risks are summarised in **table 16**.

Table 16: Risks to delivery and mitigation

Description	Potential Impact	Mitigating Actions/Contingency Plans	Residual Concerns	How Trust Board will monitor residual concerns
CQUIN Gateways affect income levels.	The risk is that CQUIN Gateways impact upon income levels, particularly in quarter 1 for orthopaedics.	We will monitor performance levels and work with its commissioners to minimise impacts.	Impact upon financial plans.	CQUINs will be regularly monitored and discussed with commissioners and by Trust Executives, P&I Committee and the Trust Board.
We perform significantly above contract requiring additional capacity	Additional non-elective activity is paid at 50% marginal rate. Additional activity likely to incur premium costs to deliver	We will mitigate this risk through regular holistic performance meetings with directorates and the Executive team. We will further mitigate this risk by improvements in efficiency and effectiveness of our patient pathways in conjunction with the local health economy	Impact upon profitability and ability to deliver financial plan	Regular contract and performance monitoring. Trust Executive, P&I Committee and Trust Board monitoring.
Phasing of CIP programme	Over reliance on quarter 4 could result in non-delivery of our CIP target.	PMO is overseeing the development of a robust programme management approach	Long term CIP programme to be developed	Monthly Transforming Performance Programme Steering Group meetings and monthly monitoring by Trust Executive, P&I Committee and Trust Board.

5.3.Financial Risk Ratings

Financial risk is measured on a scale of 1-5 with 5 being the most secure, and 1 the least. The proposed budget produces a risk rating of 3 for the 2013/14 financial year.

The risk ratings identified accrue evenly over the year, with the following cumulative quarterly profiles being recorded:

- Quarter 1 = 2.8 (rounded to a 3)
- Quarter 2 = 2.8 (rounded to a 3);
- Quarter 3 = 2.8 (rounded to a 3); and
- Quarter 4 = 2.6 (rounded to a 3).

6. CORPORATE GOVERNANCE STATEMENT 2013/14

The Trust Board has reviewed the following seventeen statements listed below:

Quality

1. The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against Monitor's *Quality Governance Framework* (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of health care provided to its patients.
2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

Finance

4. The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.
5. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

Governance

6. The board will ensure that the trust remains at all times compliant with its licence and has regard to the NHS Constitution.
7. All current key risks to compliance with the trust's licence have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.
8. The board has considered all likely future risks to compliance with its licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

Risks and mitigating actions

9. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.
10. An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).
11. The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.
12. The board is satisfied that its NHS foundation trust can operate in an efficient, economic and effective manner.
13. The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.
14. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience, training and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.
15. The board is satisfied that: the management team has the capacity, capability, training and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.

16. For an NHS foundation trust engaging in a major Joint Venture, or Academic Health Science Centre (AHSC), the board is satisfied that the trust has fulfilled, or continues to fulfil, the criteria in Appendix C4 of the Compliance Framework.
17. The board is satisfied that plans are in place to ensure that the trust will at all times comply with its statutory requirements.

The Trust Board has confirmed anticipated compliance with fifteen of the seventeen statements. For statements 11 and 12, we have summarised the risks and our mitigating actions in **table 17**.

Table 17: Corporate governance statement main risks and mitigating actions

Corporate governance statement	Risks and mitigating actions
The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.	Q1 A&E performance –operational performance management, and development of urgent care action plan
The board is satisfied that its NHS foundation trust can operate in an efficient, economic and effective manner	We have three conditions on our Monitor Provider Licence - our Annual Plan and associated plans detail the actions we are taking to address these conditions

7. MEMBERSHIP REPORT

We have over 11,000 public members and 3,800 staff members, regularly holding members events and circulating both a quarterly magazine and a regular e-bulletin, to share Trust news, events and opportunities for involvement.

Table 18, highlights that we are projecting a slight reduction in membership recruitment for the public constituency across 2013/14. We will also be undertaking a data cleanse of our membership database this year, which will have the effect of a resulting overall reduction in the number of members by the end of 2013/14.

Table 18: Membership size and movements

Public constituency	2012/13	2013/14 (estimated)
At year start (April 1)	10,943	11,397
New members	1,294	1,000
Members leaving	840	1,300
At year end (March 31)	11,397	11,097
Staff constituency	2012/13	2013/14 (estimated)
At year start (April 1)	3,887	3,880
New members	657	371
Members leaving	664	298
At year end (March 31)	3,880	3,953
Patient constituency	2012/13	2013/14 (estimated)
Not applicable – the Trust does not have this type of constituency		
Analysis of current membership		
Public constituency	Number of members	Eligible membership
Age (years):		
0-16	14	5,164 ¹¹
17-21	781	21,784
22 +	7,818	344,597
Ethnicity:		
White	7,399	343,975
Mixed	103	3,470
Asian or Asian British	455	7,920
Black or Black British	331	2,140
Other	27	1,939
Socio-economic groupings:		
ABC1	7,298	133,709
C2	2,345	51,500
D	79	50,552
E	506	38,640
Gender analysis		
Male	3,777	177,060
Female	7,165	182,260

¹¹ Please note that only persons aged 16 years and over are eligible to become members, as per the Trust's constitution.

In 2013/14 our focus will be on membership engagement, although targeted recruitment drives will also continue.

Key characteristics of the Trust's public membership are:

Age: over 22 years

Ethnicity: White

Socio-economic grouping: ABC1

Gender: Female

As the majority of our members are within the 22+ age category, we plan to increasingly focus on recruitment of younger members during 2013/14. The minimum age for membership is 16 and we have successfully developed a relationship with Mid Kent College in 2012/13 in order to target a younger age group with recruitment projects continuing on an annual basis.

We will be exploring the possibility of working with other colleges to target a wider base of younger age groups, to ensure a more representative membership. During 2012/13, we have also worked in partnership with Kent and Medway NHS and Social Care Partnership Trust (our local mental health services provider) to attend and hold recruitment events, to ensure that our membership is representative. This has been an effective partnership which both organisations plan to continue.

With regards to the staff constituency, we are proud that all members of staff are members.

Two governor elections were held during 2012/13, one for a public constituency position and the other for a staff constituency position. The voting turnout for these elections was 15.2% and 22.8% respectively. All elections to the Council of Governors have been held in accordance with the election rules