



STRATEGIC PLAN DOCUMENT FOR 2013-14

Chelsea and Westminster Hospital NHS Foundation Trust

Our Plan to deliver Excellent and Safe Care with Kindness and Respect

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Strategic Plan for year end 31 March 2014 (and 2015, 2016)

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

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

In signing below, the Trust is confirming that:

- The 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 (Chair)	Prof Sir Christopher Edwards, FRSE
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Tony Bell OBE
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Lorraine Bewes
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Signature



1 Strategic context and direction

1.1 The National context

Our planning process has taken into account the wider commissioning and operating priorities in the NHS, for example those set out in NHS England's planning guidance *'Everyone Counts'*. The Trust is planning services in the knowledge that meeting the entitlements of patients – as set out in the NHS Constitution – is vital, and that our services and systems should support the five domains set out in the guidance:

- delivering NHS services seven days a week;
- providing more transparency, more choice;
- listening to patients and increasing their participation;
- supporting better data, informed commissioning, driving improved outcomes; and
- achieving higher standards, safer care.

In addition, we are committed to improve service continuously to maximise health outcomes for patients; either working alone or in partnership across clinical pathways we are focused on delivering services that secure the five outcomes described in the 2013/14 *'Outcomes Framework'* so that we:

- prevent people from dying prematurely;
- enhance quality of life for people with long term conditions;
- help people to recover from episodes of ill health or following injury;
- ensure that people have a positive experience of care; and
- treat and care for people in a safe environment; and protect them from avoidable harm.

1.2 Description of our clinical activities

At Chelsea and Westminster Hospital NHS Foundation Trust we provide a broad range of services within our clinical portfolio. These include specialised activities commissioned by NHS England; planned and emergency local hospital services and community clinics, commissioned at both the CCG and local authority level. The Trust also provides a range of privately funded inpatient and outpatient care and we have ambitions to expand this activity within the planning period (detailed in Appendix 1).

Our main specialised services include paediatrics (including tertiary paediatric surgery), neonatal intensive care, burns, bariatrics, plastics and HIV. In terms of our local services we provide 24/7 adult and paediatric A&E services with co-located Urgent Care Centres (UCCs), a full maternity service and a range of medical and surgical specialties. In addition to our local hospital services we also provide community-based clinics in MSK, gynaecology and dermatology, and direct access sexual health services. The sub-sections below describe the high-level market analysis that we have undertaken as part of our business planning and set out the Trust's vision, objectives and delivery priorities for the planning period.

1.3 Demand-side analysis: changes in the commissioning environment

Demographics

The Trust is situated in the borough of Kensington and Chelsea (K&C) and our patient population is drawn primarily from this borough and the neighbouring boroughs of Hammersmith and Fulham (H&F), Westminster and Wandsworth. Our specialised services however have a broader population base covering most of North West London and further afield.

The population of the four boroughs of K&C, H&F, Westminster and Wandsworth is approximately 868,000, within which people of 0-15 years accounts for 16% of the population, 16-64 years accounts for 74%, and 10% are aged 65 years and over. Overall the population size has shown small growth (circa 0.4% p.a.) and the age composition has remained fairly stable, including for the very elderly population: people aged 85 years and over constitute approximately five per cent of the population.¹ However, the population of the boroughs in Outer London do show growth which needs to be taken into account for services that have a wider catchment area, and on this basis we have agreed with commissioners a general population growth assumption of 1.05%.

¹ Source: analysis of ONS mid-year population estimates (2006-2011)

The health of people in K&C, H&F and Westminster is mixed compared with the England average. Deprivation is higher than average and about more than 20,000 children live in poverty, but life expectancy for both men and women is higher than the England average², which presents additional health care challenges commensurate with a relatively more frail population. Somewhat differently for Wandsworth deprivation is lower than average, however about 12,500 children live in poverty, and life expectancy for both men and women is similar to the England average.

Underlying trends in demand

Using the activity delivered by the Trust as a broad signal of demand, over the past three years we have experienced:

- growth of approximately three per cent per year in A&E attendances;
- static activity in terms of the overall number of non-elective admissions (including maternity), but an increase of three-to-five per cent in non-elective emergency admissions (i.e. in line with the increase in A&E attendances);
- growth of approximately five per cent per year in elective admissions; and
- demand for private activity that was constrained only by the regulatory cap imposed by our terms of authorisation (where income could be no higher than 3.7% of income).

Future demand and commissioned activity

In terms of emergency procedures the trends in population size and composition do not suggest a significant increase in underlying demand from our local population. However, despite these trends, over the past five years we have experienced consistent increases in A&E attendances and emergency admissions. Without external changes we would expect future activity to follow a similar pattern of increasing A&E attendances and emergency admissions. In addition however, plans to significantly reconfigure the A&E provision might fall within this planning period – implementation is expected to begin in 2015/16 – which would see more of the underlying demand flow to Chelsea & Westminster as neighbouring A&E departments are downgraded to Local Hospitals with 24/7 UCCs.³ We await the outcome of the Secretary of State decision on implementation of the SAHF strategy for NW London.

In terms of elective procedures there is little in the population analysis to suggest changes in the underlying demand for services, but plans in specific service areas (e.g. Trauma and Orthopaedics) have incorporated assumptions about activity growth on the basis of a potential expansion in our market share where we have evidence of competitive advantage, particularly in terms of access times.

However, another factor we have incorporated into our planning is the local commissioners' work to reduce the local population's demand for both non-elective and elective services.

- Non-elective care demand management – we are working in partnership with commissioners and providers to reduce emergency admissions (or the conversion rate of A&E attendances into admissions), readmissions within 30-days of discharge following an episode of elective or non-elective care, and excess bed-days.
- Elective care demand management – commissioners have also asked for us to implement a range of measures that will reduce the number of Planned Procedures with a Threshold (PPwT), the number of non-GP referrals, and the ratio of new-to-follow-up outpatient appointments, in addition to the conversion of specified day-case activity into procedures in an outpatient setting.

In addition to the demand management initiatives our contract with commissioners also includes a range of performance indicators with agreed quality incentives and penalties for either achievement or underperformance. We have assessed the impact of these changes on the activity and income that the Trust forecasts for the planning period, details of which are set out in Appendix 1.

² Source: London Health Observatory Health Profiles 2012

³ N.B. The impact of reconfiguration is not included within the Monitor Plan Financial Model, but the Trust has carried out extensive scenario modelling, including around reconfiguration, as part of our Long Term Financial Model

Demand for Private Healthcare Services

Funding for private care is driven by patients with private medical insurance (PMI) and patients who are self-funding. The PMI market was worth £3.64bn in 2010 with the top 2 providers securing two-thirds of the market; the main insurers in the UK market are BUPA, AXA PPP, Aviva and PruHealth. The proportion of the population covered by PMI has dropped from 12.5% in 2005 to 11.1% in 2010, with just under 7 million people currently covered. South East and London have the highest coverage in the UK with approx. 18% of the population covered, although this figure may be significantly higher in the catchment area the Trust serves.

The UK private acute healthcare market was worth an estimated £7,185 million in 2010, made up of: £5,154 million (72%) generated by independent hospitals; £1,587 million (22%) paid to specialists practising in independent hospitals; and (6%) £445 million in private patient fees collected by the NHS (including the Health Service in Northern Ireland).

Following revenue growth of approx. 4% in both 2008 and 2009, the UK private acute market stalled in 2010; growth was held back by reduced self-pay activity and reduced demand for private medical cover – which fell sharply in both 2009 and 2010.⁴

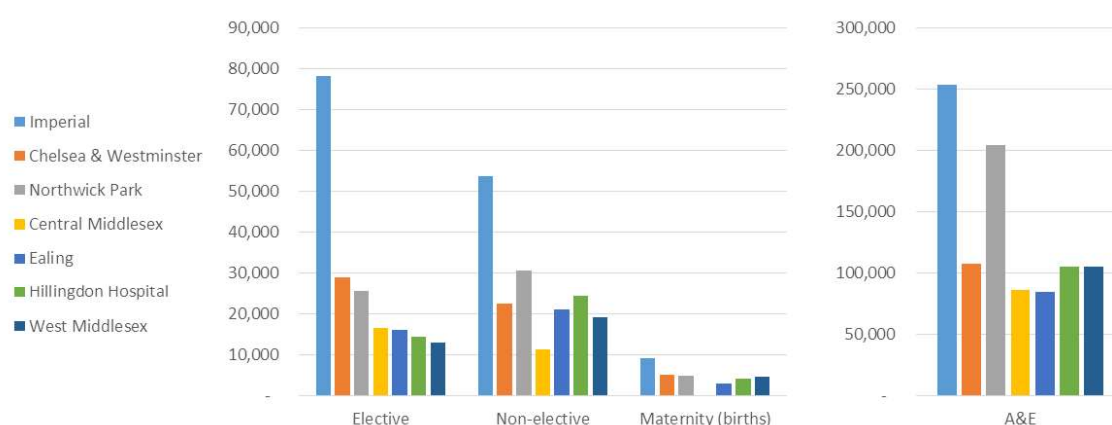
1.4 Supply-side analysis: the provider context within the health economy

Description of acute services in North West London⁵

Within NW London there are nine acute trusts and eleven hospital sites. This represents a relatively high number of sites for the size of population and geographical area and the majority of the acute hospital sites (excluding the specialist trusts) provide very similar ranges of services. Our A&E and non-elective volumes are similar to the majority of our neighbours, and we deliver comparably high elective case (N.B. Imperial College Healthcare accounts for three hospital sites, each with approximately similar levels of activity to Chelsea and Westminster).

Across the acute hospital sites (this excludes the specialist hospitals of Royal Brompton, Royal Marsden and Royal National Orthopaedic Hospital) in NW London there are approximately 4,060 acute beds of which 3,450 are adult and 610 paediatric or maternity.

Figure 1 - Chart of activity (number of spells/attendances) across North West London 2010/11, split by trust and POD (excluding Royal Brompton and Royal Marsden)



N.B. The Imperial Trust is composed of three sites: Hammersmith, Charing Cross, and St. Mary's

Analysis of 'five forces' acting within our health economy

The services within our Trust are, to a greater or lesser extent, exposed to a range of pressures in the local health economy derived from: competition within the acute sector; the threat of new providers entering the

⁴ Laing's Healthcare Market Review 2011-12

⁵ Data taken from *Shaping a Healthier Future Pre-Consultation Business Case – Volume One*

market; the threat of different services substituting for acute services; the relative strengths of suppliers; and the relative negotiating intentions of commissioners.

- **Competition within the NHS acute sector** is particularly important in terms of elective services and maternity where patients have a choice of provider. Our planning has incorporated a range of comparative analyses to ensure that we defend and grow sustainable services where we can offer comparably higher quality and faster access to diagnosis and treatment.
- **Competition within the private acute sector**⁶
 - In terms of private acute activity, revenues generated by NHS hospitals constitute approx. 6-8% of the UK private acute healthcare market with the remainder being provided by independent hospitals (72%) and specialists practicing out of independent hospitals (20-22%). The UK sector is dominated by five hospital operators: General Healthcare Group (BMI and Care Fertility), Spire Healthcare, HCA, Nuffield Health and Ramsay Health Care UK. Between them they formed an exclusive trade body in 2010, known as the Private Hospitals Alliance. These top five accounted for nearly 80% of the bed capacity and over 70% of independent acute hospitals' income in the UK in 2010.
 - Despite annual increases in private patient income taken by NHS hospitals, growth is slower than the market overall resulting in NHS hospitals actually taking a diminishing share of private patient income: over the past decade the share has fallen from 10-14% down to 6-8%.
 - Competition for private patient activity is also likely to increase as NHS trusts and foundation trusts seek to expand this income to mitigate expected revenue losses as a result of volume and price reductions in NHS activity. NHS private patient revenues are generated chiefly by around 70 units, wards or wings dedicated to private patients in NHS hospitals in the UK, and much of this provision is concentrated in London and the South East: the income from the top ten providers – eight of which are London-based – accounted for 70% of the income of all the PPUs (Chelsea & Westminster was ranked 11th).
- **New providers competing for NHS activity** is a factor that is most pronounced in services that are open to AQP contracting or tendering, for example MSK community services. We have undertaken internal business development to ensure that we can respond effectively to these new contracts to offset income lost through the movement of acute activity to these community settings.
- **NHS service substitution** that reduces activity in the acute sector has yet to create a noticeable change in the activity we see, but the Trust is mindful of detailed planning underway to implement Out of Hospital strategies that could move more activity towards primary and community care settings (e.g. diagnostics, step-up beds etc.). In some instances – e.g. for non-elective activity – the Trust is working in partnership to speed this transition so that patients with sub-acute needs are seen in appropriate care settings. This work is incorporated within our planning as a necessary step to respond to the reconfiguration of A&E and non-elective activity within North West London; full operational details and modelling of activity and income impacts is being undertaken throughout this year as part of an outline business case for implementation of the reconfiguration.
- **Supplier effects** have the potential to introduce significant cost pressures in areas such as drugs, consumables, equipment and maintenance, and estates. These cost pressures have been assessed in detail at the service level and mitigated through a range of Cost Improvement Schemes, the top five of which are set out in Appendix 2.
- **Commissioner intentions**, as described above, have the effect of reducing activity in some services as well as the effective price (e.g. through the application of marginal or non-payment above agreed thresholds). Our planning has taken these agreements into account and has sought to utilise any freed capacity to increase other clinical activity, including for private patients. In the private market insurers are deploying similar mechanisms to reduce or contain costs.

⁶ Laing's Healthcare Market Review 2011-12

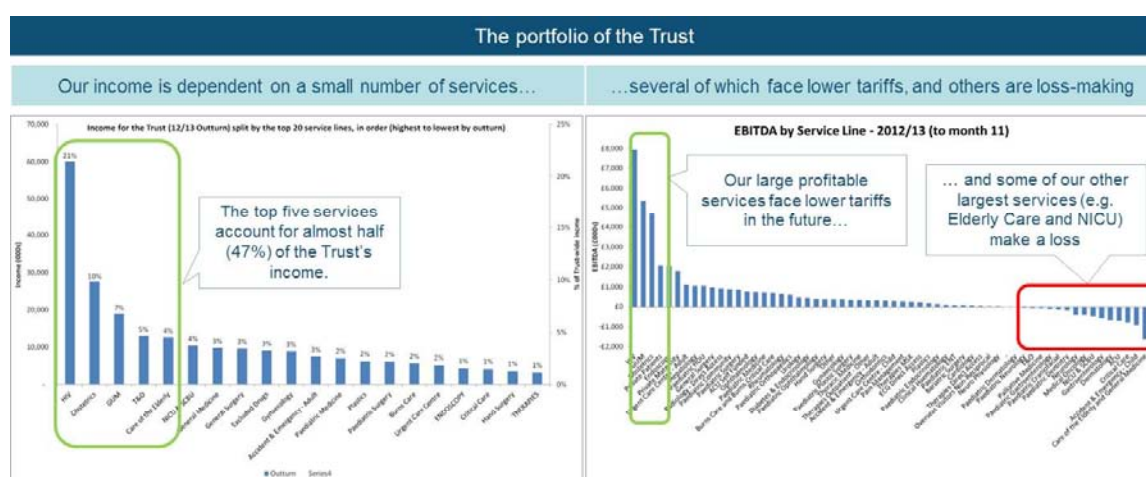
1.5 Summary: strengths, weaknesses, opportunities and threats

Strengths	Weaknesses
<ul style="list-style-type: none"> • Strong reputation and brand recognition • Continued high performance in terms of access to A&E and elective pathways (4 hour A&E, 6 week diagnostic access, 31 and 62 day cancer waits, 18 weeks RTT) • A track record of financial sustainability and good governance • A balanced portfolio of specialised, local and community services • Excellent clinical and managerial staff • A teaching hospital with active clinical and operational research • Operate from modern facilities • Excellent location to access and service private patient demand • Good relationships with local commissioners and providers, developed through partnership working – e.g. Integrated Care Pilot and Academic Health Science Partnership 	<ul style="list-style-type: none"> • Too often patients still experience fragmented care across pathways of care (particularly at interfaces between different providers) • Significant reliance of specialties on the continued operation of our A&E • Operate at high bed occupancy levels providing limited scope to manage significant fluctuations in demand – resulting in operational pressures and instances of ‘black alert’ status • Operate a single site with no access to step-up/down capacity • We have an ambitious programme of transformation that is reliant upon the effective implementation of new IT systems (e.g. EDM) but constrained capacity in this function • Our clinical services and administrative processes do not operate as efficiently as they could do: <ul style="list-style-type: none"> – Discharge processes could be better planned – Our booking systems and outpatient communication could be significantly improved – Insufficient guarantee of access to private theatre slots and beds leads to loss of private work
Opportunities	Threats
<ul style="list-style-type: none"> • Expansion of our non-elective activity, and safeguarding of our interdependent services, through designation as a ‘Major Hospital’ as part of the reconfiguration of services across North West London • Targeted expansion of sustainable elective services to grow market share and income • Expansion of maternity services through the implementation of a new co-located Midwife-Led Unit • Expansion of private patient income following the removal of the previous cap • Potential transfer of paediatric cardiac and respiratory services from the Royal Brompton & Harefield estate to the C&W Children’s Hospital, with the transfer of the associated PICU • Potential opportunity to acquire West Middlesex University Hospital NHS Trust following a process of due diligence • Opportunity to develop new more integrated pathways 	<ul style="list-style-type: none"> • Loss of acute activity to other acute providers • Loss of acute activity to new entrants in MSK and dermatology (under AQP and tendered contracts) • Loss of elective activity to primary care that is not replaced with other acute or tertiary activity • Commissioner intentions to reduce demand and apply financial penalties for activity above agreed thresholds • Failure of reconfiguration to proceed – following referral to the Independent Reconfigurations Panel – which reduces the opportunity for investment in Out of Hospital services and development of CX as elective centre in competition with C&W. • Loss of direct activity and income as sexual health services move from NHS commissioning to local authorities under a new tariff • Growth in private provision by NHS trusts and foundation trusts adds competition to the market; and competitive response by existing private providers could take market share – we need strong market analysis, service development, effective marketing and good delivery to mitigate this risk • Lack of written Board Succession Plan

1.6 Describing our strategic response

The clinical and financial context described above creates a range of pressures which shape the future planning of the Trust. Whilst we have a breadth of services, a large amount of activity and income comes from a relatively small number of services (nearly half of our income is derived from our top five services), which makes the trust vulnerable to activity or price reductions, or cost increases, in key specialties, for example: commissioning changes and tariff renegotiations are likely to affect our HIV and sexual health services. Furthermore for a number of our income generating services activity costs more to deliver than the income we receive to provide each episode of care. This is particularly true of non-elective (NEL) activity, and this income is under additional pressure as thresholds continue to be applied; our forecasts for NEL activity show that the EBITDA for these cases is likely to deteriorate significantly over the planning period which would have material effect on the Trust’s overall financial position.

Figure 2 – High level description of the income and profitability of our service portfolio



This creates a real very significant challenge in terms of sustainability which must be met in part by transformations in the way we deliver care so that we maximise the efficiency of the services we deliver, and in part by efforts to diversify our revenue base through service developments and market share growth in both NHS and private activity.

In addition, we are committed to improving the experience of care for our patients which will only be met through changes in the way we deliver pathways of care: for example we are working in partnership with community and social services to reduce internal and external delays and improve continuity of information so that inpatients feel that the transition at discharge is timely, seamless and supportive rather than delayed, fragmented and disorientating. In summary, operationally we recognise (and are acting to address) both a burning platform to secure financial sustainability and a burning ambition to improve care for patients.

As a response to these challenges the Board has agreed a range of outcomes, objectives and enablers that will form the foundation of our strategy over the next five to ten years. The Trust is therefore focusing on delivering:

- Safe and effective care
- Exceptional patient experience
- Financial sustainability

To achieve these outcomes we will:

- **Develop a patient-centred model to deliver 'always-events' and eradicate harm**
 - Work with patients and carers to understand their experiences of our services
 - Work with patients to co-design service improvements
 - Embed a culture of evidence-based service improvement to develop the most effective and efficient services
 - Encourage a culture of candour and improvement
- **Provide the right mix of unscheduled and scheduled services**
 - Establish ourselves as a Major Hospital whilst focusing on reducing avoidable attendances and admissions
 - Grow market share, or achieve designation, in elective services where we offer clinically excellent and operationally efficient services with exceptional patient experience
- **Integrate services inside and outside of hospital**
 - Develop and manage services that wrap around hospital inpatients so patients are treated in the most appropriate location and experience seamless transitions of care
- **Work with partners to take greater responsibility for the health management of a population**
 - Focus on prevention of avoidable illness as well as treatment

- Support care planning, self-management and expert advice for patients with chronic conditions
- **Ensure that our clinical and managerial staff are enabled to deliver these objectives by developing excellent**
 - **People** – recruiting and rewarding based on our values, developing and supporting staff to be excellent in their roles
 - **Processes** – supporting services with an effective toolkit (e.g. capacity and demand planning, an effective booking and appointments process), ensuring that information is captured accurately and used to improve performance, streamlining back office support, and enhancing commercial support for divisions
 - **Technology & Infrastructure** – ensuring clinical equipment, IT and estates support clinical excellence
 - **Research** – creating an environment where systematically we translate what we know into what we do
 - **Education** – providing an excellent clinical teaching environment, and ensuring development of all staff

2 Approach taken to quality

The CQC visited the Trust in July 2012 and identified no concerns; all standards assessed were judged to have been met. The majority of actions from the visit in February 2011 have been completed. The one outstanding action regarding an online risk system is planned for this year.

Our four quality priorities are described in our Quality Account. The main goals, the risks and how these will be managed are as follows:

- To have no hospital associated preventable venous thromboembolism (VTE) – risks to delivery include the reliance on one individual to co-ordinate data and the completion of root cause analyses. This requires constant vigilance, monitoring and education. The risks are mitigated through well-established systems and leadership within divisions by Divisional Medical Directors.
- Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients – risks to delivery include the scale of what we are trying to achieve and that some measures are still to be defined. It requires constant vigilance. The risks are mitigated through having a strong steer from a senior level Staff and Patient Experience Committee and a strong focus from the Board.
- To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do – risks to delivery include failure to meet the Trust target for appraisals. This will be mitigated through a further drive to complete appraisals and an increased focus on those not being completed.
- To improve choice and quality in End of Life care – risks to delivery include inadequate time and resources being allocated and the scope of the objective. This has been mitigated by realistic targets over two years and resources being identified from within the relevant teams

The Trust recognises one significant clinical risk: the potential to breach the *C. difficile* target of no more than 13 cases. Having had a target of 31 in 11/12 the Trust achieved 17 (but in the absence of an outbreak). Clearly meeting the target will be stretching even in the absence of an outbreak, but significantly more difficult if we do experience an outbreak. Providing excellent and safe services is at the very heart of our values as an organisation and therefore metrics within the compliance framework are reviewed at Executive and Senior Operations Boards and we have in place extensive infection control protocols, including root case analysis of each case of *C. diff*. Escalation procedures are also in place in the event of an outbreak, including: Immediate outbreak meeting chaired by Trust DIPC and Lead executive for infection control; direct reporting to chief executive; weekly executive reporting; and monthly reporting to the Trust Board.

The Board derives assurance on the quality of its services and safeguards patient safety in a variety of ways. A yearly review of the quality governance framework is undertaken which assures the Board on the four areas of quality governance: strategy, culture and capabilities, structures and processes, and measurement. This assessment is RAG rated with proposed actions in areas requiring development. The Assurance Committee is a subcommittee of the Board chaired by a NED and attended by two other NEDs and two governors as well as

the Executive Team. This committee oversees progress on quality objectives, indicators and other key areas of quality such as complaints and incidents, training and health and safety.

In addition, quality has been at the heart of our planning process: clinical services have been asked to undertake assessments as the basis for identification of improvement actions and the prioritisation of investment cases; and all CIP schemes are now routinely assessed in terms of the likelihood of adverse consequences and the magnitude of that impact on quality.

3 Clinical Strategy

3.1 *Description of our approach to planning*

We operate a Service Line Management approach to planning, allowing for analysis of quality, activity and financial performance at the service line level. Plans are then coordinated at the divisional level which allows for the divisional operational and medical managers to assess local plans before a wider discussion with the Executive Team through a series of 'Joint Review Meetings'.

Our planning approach has sought to build plans 'bottom up' and to ensure clinical engagement and ownership through a range of clinical workshops, joint review meetings and formal sign-off processes. Central aspects of the development of service line plans include:

- **Demand forecasting** – using analysis of population level data, internal activity data and HES data to see local trends in demand and referrals, and undertaking comparative analysis of waiting times to identify potential opportunities for growth in market share
- **Capacity forecasting** – looking at available clinician time and the physical capacity of outpatient, inpatient, theatre and diagnostic areas (taking into account throughput) to determine the available capacity to service demand
- **Financial investment and cost improvement** – using a mixed approach including service line reviews, comparative cost and performance benchmarking, and market testing through our procurement function to inform assessments of cost pressures
- **Development of formal business cases** where investment above delegated thresholds is sought which allows for comparison of the benefits and costs of schemes

3.2 *A summary of our service line priorities*

Chelsea & Westminster Hospital intends to remain a major acute hospital for NWL with supporting specialised services, whilst also growing secondary and community elective services where we have a competitive advantage and the development is financially sustainable. This is underpinned by some overarching strategic priorities:

- following the reconfiguration processes, prepare for designation as a Major Hospital with 24/7 A&E and the associated growth in activity in emergency care following the downgrading of neighbouring Charing Cross;
- achieve designation as a regional centre for burns, and improving specialist coding to ensure that complex work is properly recorded and receives the appropriate tariff;
- successfully implement service developments – set out in our 2012/13 plan – to provide a new Diagnostics Centre, set-up our community-based MSK service, and provide new co-located Obstetrics-Led and Midwife-Led Units;
- secure opportunistic growth in a small number of elective specialties, such as T&O (where we have already agreed to provide additional activity as part of a waiting list initiative); and
- undertake transformation programmes to improve our emergency care pathway, our theatre and surgical productivity, and our outpatients and appointments processes.

Other priority developments for our services include:

- ***In Medicine*** – expansion of ED and Acute model to meet AES standards and expanded activity (post reconfiguration), and growth in Gastroenterology work
- ***In Surgery*** – growth in General Surgery (Colorectal), Ophthalmology, Urology, Pain Management, T&O, Burns, and Bariatrics
- ***In HIV/Sexual Health and Dermatology*** – growth in screening via new Dean St Express, and expansion of our phototherapy service
- ***In Paediatrics*** – growth of elective paediatric dental work, maximisation of capacity to deliver activity under the tertiary surgical network, and the potential transfer of paediatric cardiac and respiratory services in partnership with RBH
- ***In Women's Services*** – development of an ambulatory unit in Gynaecology, implementation of a Midwife-led Unit and an Obstetrician-led Unit in Maternity, and focus on recruiting nurses into NICU to reduce bank and agency spend
- ***In Clinical Support*** – expansion of Endoscopy work, changes in staffing and rotas in Diagnostics to enable emergency cover in line with AES standards, and the potential expansion of our MSK community outpatients service
- ***In Private Patient services*** – development of joint ventures with local private providers, expansion of use of ambulatory facilities for private outpatients and development of the Fulham Road private patient facilities with RMH and RBH.

This clinical strategy will continue to be informed by regular 'Clinical Summits' aimed at developing long term clinical strategy, alongside formal clinical engagement in our annual 'High Quality Planning' sessions.

3.3 A summary of our clinical workforce strategy

The clinical workforce priorities will be modelled based on the Trust clinical and strategic priorities over the coming years which involve:

1. **Ensuring the workforce is fit for the future** – this will include workforce planning and remodelling to assure we have the right staff to deliver major acute hospital services with supporting specialised services, whilst also growing out of hospital services. This will encompass NWL Shaping a Healthier Future plans; collaborative working with hospitals on the Fulham Road and also plans for more integrated care models to serve our population(s). Where transfers of services occur this will involve transfer of staff (e.g. TUPE) and in some cases may involve expansion of our clinical staff resource to provide more acute or specialist care. Specifically, areas such as Emergency, Obstetrics and Gynaecology will see further medical consultant recruitment and remodelling to provide 24/7 cover for our patients. Specialities where we want to increase our market share will also see planned workforce growth such as Trauma and Orthopaedics, Gastroenterology and Sexual Health.
2. **Recruiting and ensuring our staff live our Trust values** – we will continue work to embed our Trust values of safety, kindness, respect and excellence in everything we do. Particular work will continue on ensuring we assess and select the right staff who will not only have the right qualifications and clinical skills to care for our patients but equally demonstrate the right values and behaviours to ensure our patients and their relatives/carers have an excellent experience consistently at any point in their care pathway or contact with the Trust.
3. **Staff Innovation and use of Technology** – this will involve investment in IT and training of staff to ensure we are equipped to communicate, provide information and schedule bookings via a variety of media to meet our present and future populations' expectations of our modern services. We will also focus on workforce innovation and skills to translate the latest research into clinical staff skills to provide the best clinical care for our patients so they stay in hospital for less time.
4. **Staff who can provide patient services in and out of hospital settings and within the community where appropriate** – this will require remodelling of pathways, roles and contracts away from solely acute settings so staff are skilled and able to deliver care throughout the patient journey.

5. **Review of corporate/business support functions to optimise productivity** – we will work on modelling possibilities for providing the most efficient administrative and support functions. This will include review of services that can be improved through better use of technology such as EDM and electronic patient scheduling and bookings. It will also include review of services where greater economy of scale, the most productive use of time and added value to the business may be achieved in partnership with West Middlesex, via our Fulham Road Collaborative shared working or via outsourcing options. For example we have already merged our procurement and soft services provision, plus contracted out our Occupational services. Other opportunities will be explored in areas such as IT, Finance, Payroll, Estate and Facilities, Governance and HR.
6. **Review of pay and reward strategies** – in April 2013-14 we will commence work to review our pay and reward strategies so we are able to recruit, retain and develop talent and leaders to meet our patient needs and expectations. Both the recommendations from the Francis Report and revised Agenda for change terms and conditions provide the building blocks from which to assure we assess, reward, support and manage staff well based on delivery of excellent patient outcomes and objectives alongside the right skills, competencies and values. We will work on improving our objective and performance management systems and further improving our appraisal rates.
7. **Staff wellbeing** - Staff wellbeing and benefits strategies will continue to grow and play a big part in the wellbeing, morale and retention of our staff and their experience which will in turn have positive effect on patient experience. This will be measured via our staff survey results, internal HR metrics and delivered via internal initiatives such as the fast-track direct referral to physiotherapy service launched in 2012 and our mini health MOTs for staff.
8. **Recruitment, Retention and QIPP initiatives** – We recognise that having our own permanent trained and able staff who live by our Trust values is the best way of achieving the best experience for our patients. In addition, we will always need and value a small proportion of flexible resource to support our services, however we need to keep this proportionate and focus on initiatives to reduce high cost agency temporary cover and sickness absence cover by developing speciality specific recruitment, retention and agency reduction plans. This will include areas, such as NICU nursing where it has been difficult to recruit and retain nurses on NHS pay rates due national shortages compounded by the competitive London labour market. This will include skill mix and role review, local staff feedback via ‘pulse’ surveys and also a review of incentive options.

In other clinical ward areas , we will develop roles to care for our ageing population and with that people with long term conditions, and/or dementia and will educate staff Trust-wide on changing health needs so they are empowered and able to provide care in the right way for each individual.

In addition, in non-clinical areas we will focus on a reduction of short term contractors/agency staff and we will to develop an in house Project Management Office to support the clinical divisions to work on Trust wide initiatives to improve patient experience and flow.

9. **Education and Training** – We aligned all education and training functions and provision in 2012/13 and formed a new education and training board. Going forward, key workforce priorities will be to deliver excellent leadership and clinical leadership programmes so we have excellent role models to our staff. Mandatory training will also be reviewed to assure it is appropriate and fit for purpose plus easy to access via a variety of mediums and compliance will form a key condition of staff incremental progression.
10. **Research** – We will continue to support our clinical staff to be research active by maintaining Principal Investigators across our main specialties and supporting other staff to become involved in research programmes. Importantly we will support generating research funding through the main research funding bodies and continue to collaborate closely work closely with Imperial College. We will continue to work with our local charity partners to fund PhDs and Research Fellowship placements; providing in-house multi-professional training and awareness programmes; supporting a Research Champion Programme to create links between clinical and research teams; retaining a core team of research associates; and supporting staff to participate in improvement science projects run in partnership with the NIHR CLAHRC for Northwest London.

4 Productivity and efficiency

4.1 Productivity and efficiency gains built into the forward plan

A number of CIP programmes have been put in place, largely led by the HR department, to provide Bank and Agency efficiencies. These include a number of schemes looking at reducing the reliance and use of Agency staff, moving them to Bank and Contracted where possible; directorate trajectories are being set to measure in-year performance; there are also targeted schemes of reducing sickness and improving recruitment turnaround times, aided through the appointment of a new and dedicated member of staff reviewing these processed in detail. In addition, there will be a continued recruitment drive, targeting specific hard to recruit to areas.

In relation to theatre productivity there is potential to improve active times in theatres. The key enablers to achieve this are review and development of the scheduling process; development of the patient pathway; and a programme of clinical engagement to promote ownership of the issues and acceptance of change.

With emergency readmissions rates, bed occupancy and length of stay, transformation boards have been set up to review both the emergency and elective care pathways. Key aspects of this are the development of the current ambulatory care service, maximising its potential; and secondly of more potential is the improved discharge programme of acute physicians leading patient discharge process, with a dedicated clinical team who will review patients on wards daily to assess appropriateness of discharge and continue to manage their post discharge care. The total financial value of the planned efficiency gains for all Transformation work is £4.5m in 13/14, £5.4m in 14/15 and £4.2m in 15/16.

4.2 CIP Process and governance

CIP development, approval and resourcing:

The CIP requirement is identified through the Trust's financial planning process which reflects our strategy for services and capital investment. Once the level of capital investment to achieve the Trust strategy is identified we are able to calculate the level of internally generated cash we need in order to fund either the capital investment or service any loans we may utilise.

With a target EBITDA agreed the Trust assesses all internal and external financial factors such as inflation and shifts in activity and demand, and the impact these have on profitability. At the end of this assessment the Trust will have a gap between the target EBITDA and the level of EBITDA which would be achieved without CIP – this gap is in essence the CIP target for the Trust. This assessment and resulting CIP target is then approved by the Trust Board which delegates the agreed budgets to the Management Executive for the financial year, which are in turn devolved to the clinical and corporate divisions in line with our Service Line Management structure.

Central support

The Trust is planning to implement a designated Project Management Office (PMO) with responsibilities for managing and reporting the identification and delivery of CIP for the Trust; this will provide additional capacity and capability to support clinical divisions, freeing managers and clinicians from their day jobs to innovate and adopt best practice. Specific funding has been reserved recurrently from 2013/14 for transformation initiatives (£1.6m) and the Trust's Dragons Den initiative (£200k) which is available to services that identify innovative new solutions to the challenges of health care delivery. The divisional schemes are supplemented with central CIP initiatives such as procurement, prescribing, workforce redesign, and Facilities & Back Office re-engineering which will deliver CIP.

Monitoring and assurance

In recent years the Trust has developed an extensive system of monitoring and assurance for CIP identification and delivery including weekly monitoring reports to the Trust Management Executive and monthly updates for the Trust Board including Non-Executive Directors. This monitoring includes local risk assessment of individual schemes in terms of likelihood of delivery in line with planned implementation dates and anticipated value of the CIP.

Other key indicators monitored are the split of CIP identified and achieved by Income, Pay and Non-Pay with a minimum requirement of all services to achieve cost reducing savings of at least the national Gershon efficiency target in year and recurrently (4% during 2011/12 and 2012/13).

The existing controls and assurance scheme has worked well as is demonstrated in the CIP achieved in previous years. However we have identified improvements to this system to ensure it is more proactive in its nature and ensure that any CIP scheme is fully assessed to determine what impact it is likely to have on the clinical quality of services and to mitigate that impact, for example:

- We have implemented bi-weekly CIP review meetings chaired by the Chief Operating Officer and Director of Finance which will track the identification of CIP and progress on delivery plans to ensure that all service areas are on track to achieve their targets. Where areas are identified as being at risk of not achieving their CIP targets they are expected to identify schemes to mitigate this which would include non-recurrent under-spends against existing budgets.
- We have stipulated that all CIP schemes with a value greater than £100k per annum should be run with a project management methodology and specifically reviewed by the service lead clinician to ensure that any impacts to clinical quality have been evaluated and where necessary mitigated. Trust-wide templates for this project based approach have been developed and are submitted to the bi-weekly CIP review meetings for assurance that schemes are on track to achieve their CIP target, this template also requires the lead clinical to sign that a clinical impact assessment has been undertaken.

Services are required to assess each identified CIP scheme for the risk of slippage in implementation and must ensure that appropriate mitigation or substitution is identified and implemented.

Clinician involvement and quality assessment:

The Trust requires that all CIPs are approved by clinicians who have responsibility for clinical quality to ensure that any CIP does not have an adverse impact on the clinical quality of a service and if any impact is identified that actions and changes have been identified and implemented in order to mitigate this impact. The Trust has also now required that all CIP schemes be formally approved by Divisional Medical Directors and that this be officially documented to ensure this process is being followed and that all CIP have been subject to clinical appraisal. Any CIP initiatives which have trust-wide implications are reviewed and agreed by the Medical Director and Director of Nursing to ensure that clinical quality is not adversely affected by such schemes.

Historic performance

The Trust has successfully delivered challenging cost improvements in previous years. This experience has been used to establish a clear and accountable approach to ensure the delivery of identified savings through CIPs. The table below sets out the historic CIP delivery for the Trust and planned level of CIP for the 3 years to 2015/16.

Table 1 – Historical CIP performance and future targets

	2011/12		2012/13		2013/14	2014/15	2015/16
	Plan	Actual	Plan	Actual	Plan	Plan	Plan
	£m	£m	£m	£m	£m	£m	£m
Pay Cost Savings CIP	8.300	5.733	7.932	5.393	4.858	5.693	4.557
Drugs Cost Savings CIP	0.490	0.696	0.600	0.745	0.280	0.500	0.500
Clinical Supplies CIP	3.815	3.921	2.728	1.895	1.978	3.599	3.255
Non-Clinical Supplies CIP	2.050	3.776	4.940	3.822	2.114	2.011	1.962
Misc. Other Operating Expenses CIP					3.471		
Revenue Generation CIP	5.000	6.803		5.227	4.247	3.697	3.175
Total	19.655	20.929	16.200	17.083	16.949	15.500	13.450
% Achieved		106%		105%			

This table shows that the Trust has a strong record for achieving the necessary levels of CIP to support achieving our financial strategy. During 2012/13 the Trust successfully delivered £17.1m of CIP through a combination of cost reductions and revenue generation schemes.

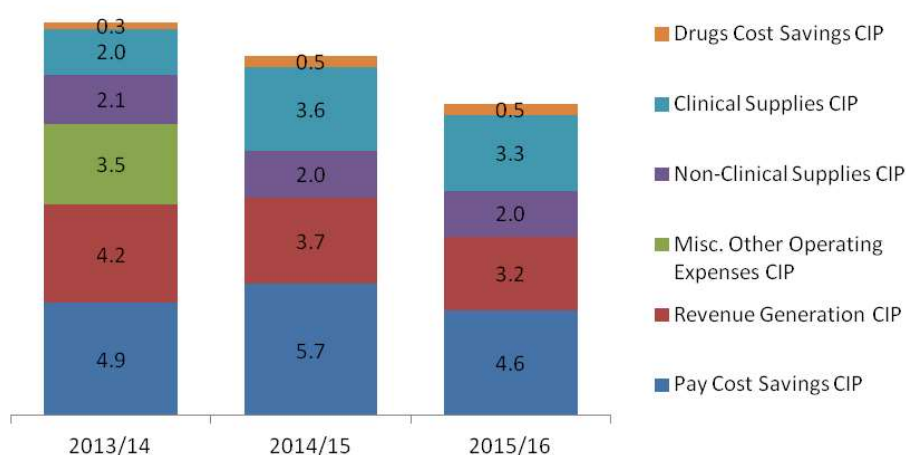
The main drivers of successful delivery of CIPs include: strong design with ‘bottom-up’ and realistic analysis of the opportunity; regular executive-level discussion of progress; early development of implementation plans with identification of the required factors to enable delivery; and regular monitoring of the delivery through divisional and executive structures, including quarterly planning and performance reviews between the Executive Team and divisions.

4.3 CIP Profile

The Trust has a target CIP over the next 3 years of £45.9m, broken down as follows: 2013/14 £16.9m, 2014/15 £15.5m and 2015/16 £13.5m. As is shown in Figure 3, pay cost savings and combinations of non-pay cost reductions are the largest categories of scheme.

There are 5 key CIP themes across the Trust (set out in Appendix 2) that have been identified and developed by divisions and directorates, where each area is expected to deliver against a centrally determined CIP target. In addition there are locally identified and driven schemes, specific to each individual service area. Whilst the responsibility for the delivery of CIPs is devolved, the identification of CIP opportunities is not completely locally driven. The Trust utilises benchmarking when identifying opportunities for CIP with a variety of sources including local (e.g. internal benchmarking and North West London reconfiguration), national (e.g. Dr Foster) and international (e.g. Advisory Board and G.E.) benchmarking tools and consultants in line with the Trust aspiration of achieving upper decile performance in all the services we provide in terms of clinical quality and financial performance.

Figure 3 – Profile of CIP schemes (2013/14-2015/16), split by theme (£m)



The Trust takes a combined approach of seeking to achieve major transformational changes on a division or trust-wide basis alongside locally identified and delivered incremental changes.

4.4 CIP enablers

As outlined above the Trust devolves management responsibility to divisions and directorates for CIP identification. The clinical leadership of each area is a key sponsor of each individual CIP scheme, with sign-off a key requirement by clinical leadership (both nursing and medical). Where a CIP scheme requires an invest-to save approach, including those that require capital expenditure, the CIP schemes are net of revenue costs and where appropriate capital expenditure required is set aside in the Trust’s capital programme. As part of the Trust’s business planning process CIP templates help facilitate the clinical engagement and the requirement to identify the relevant enablers.

5 Financial Investment Strategy

The Trust achieved a year-end Financial Risk Rating of 5 for Q4 of 2012/13 compared to a planned rating of 4. The Trust made an EBITDA of £33.6m (9.8%) against a plan of £33.6m, with a surplus of £13.0m against a plan of £12.6m. The Trust had a CIP plan of £16.2m in 12/13 and delivered £17.1m through a combination of revenue generation and expenditure CIP schemes.

Table 2 - An assessment of the Trust's current financial performance

	Plan YTD	Act YTD	Var YTD
	£m	£m	£m
Operating revenue	342.9	345.9	3.0
Employee expenses	-171.8	-176.9	-5.1
Other operating expenses	-147.9	-145.1	2.8
Non-operating income	0.2	0.0	-0.2
Non-operating expenses	-10.7	-10.9	-0.1
Surplus/(Deficit)	12.6	13.0	0.4
Net surplus %	3.7%	3.8%	0.1%
Net surplus rating	5	5	0
Total operating revenue for EBITDA	341.2	344.0	2.7
Total operating expenses for EBITDA	307.6	-310.3	-2.7
EBITDA	33.6	33.6	0.0
EBITDA margin (%)	9.8%	9.8%	-0.1%
EBITDA margin rating	4	4	0
Capex (Cash spend)	-41.7	-18.6	-23.1
Net cash inflow/(outflow)	-10.5	0.6	11.1
Period end cash	30.5	41.6	11.1
CIP	16.2	17.1	0.9
Financial risk rating	4	5	1

Key financial priorities and investments and how these link to the Trust's overall strategy

The Trust's key financial priority is to deliver financial sustainability through transformation of service provision to improve patient experience and secure efficiencies. In terms of financing the delivery of clinical and strategic priorities the Trust has a strong track record of achieving planned financial surplus and CIP targets to enable significant investment in specialist infrastructure. Key investments within the forward plan will facilitate the following strategic priorities:

- Chelsea & Westminster's designation as a 'major hospital' within the reconfiguration of services across NWL – investment to expand A&E and clinical expansion, enabled via the purchase of Doughty House to provide additional capacity;
- Exploration of a collaboration with Royal Brompton Hospital to provide paediatric respiratory and cardiac services at Chelsea & Westminster Hospital – Development of a PICU and dedicated clinical accommodation within Chelsea Children's Hospital;
- Expansion of sexual health services delivered under a new model of care adopting innovative technology, greater patient involvement and reduced staffing costs – redevelopment and equipping of 35 Dean Street to provide the Dean Street Express clinic;

- Expansion of maternity deliveries to provide choice to women by offering a midwife-led birth – construction of a midwife-led unit, co-located on the same floor of Chelsea & Westminster as the birthing unit and private maternity unit; and
- Private patient growth to expand within current facilities out of hours, development of joint ventures with local private providers and developing the Fulham Road private patients brand with the Royal Marsden Hospital and the Royal Brompton Hospital.

Key Risks to achieving the financial strategy and mitigations.

There are a number of financial risks that need to be considered and mitigated in the Trust's forward plan, the main items being:

- non delivery of CIP programmes;
- transfer of Sexual health commissioning to local authorities;
- demand risks of QIPP schemes beyond planning assumptions;
- delivery of commissioner productivity metrics;
- slippage of delivery of capital schemes resulting in delays in service developments; and
- competition for private services from other NHS and independent providers.