King's College Hospital NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

King's College Hospital NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

Chief Executive's foreword

King's College Hospital has always been a high performing, very busy, acute hospital. The acquisition of an additional 68 percent capacity during 2013/14 was, in part, intended to enable King's to meet the needs of increased numbers of increasing elderly and acutely unwell patients with extended lengths of stay. The expansion has been very timely because there is no sign of demand management schemes working as yet, and the resulting operational and financial pressures faced by King's are intense.

This plan is designed to restore King's to its previous position as one of London's best performing academic hospitals, providing safe, high quality, compassionate care to a diverse population. It contains a number of programmes to increase capacity and efficiency, which will improve safety and effectiveness.

For the plan to deliver, the Trust Board is very well aware of the need for first class execution and delivery, and for improved and effective working with commissioners and partner hospitals and social care. The key determinants of our success will be not only our own capacity, but the success of our partners in helping to avoid unnecessary admissions, to more effectively repatriate tertiary patients to local hospitals and to support people to go home as soon as it is safe to do so.

1 EXECUTIVE SUMMARY

1.1 Context

King's College Hospital NHS FT provides a range of acute services from multiple sites. Our hospitals serve our local populations in Lambeth, Southwark and Bromley, with a full range of general and acute services as well as providing a major emergency centre and tertiary specialties to the South East London region, Kent and beyond.

At the core of our operational plan for 2014/15 – 15/16 is the successful integration of King's Denmark Hill campus with The Princess Royal Hospital, Orpington Hospital, and some services at Beckenham Beacon and Queen Mary's Sidcup acquired in October 2013. This transaction was the first of its kind under the Trust Special Administrator regime and the post-2012 Foundation Trust framework.

Changes and concerns in the local and national contexts will affect King's directly. These include:

- Demographic change and health needs: the SE London population and health needs for the socially excluded and frail elderly are growing. There is variation in care quality and excess early mortality in the region.
- The Francis Report: the ramifications of this report and its recommendations have profound implications for staff and organisational culture, as quality pressures continue to rise.
- Economy and finances: NHS and Social Care funding is squeezed. Local NHS providers, Local Authorities and CCGs must save at least seven percent per year for at least five more years.
- Activity rises: King's has seen increases in emergency admissions and acuity, particularly for elderly frail patients, significantly ahead of local forecasts and national averages. Elective tertiary referrals have also increased. A&E and RTT target performance is pressured and bed occupancy is frequently over 99%.
- Specialised commissioning changes: new care specifications from NHS England and fewer specialised providers are key strategic and operational issues for King's.
- Local commissioning intentions: QIPP plans and targets and new commissioning models (e.g. single tender pathways) are challenging.

1.2 Key themes for 2014-16

King's operational response for the next two-years has five key themes that are set out in this plan.

1.2.1 Consolidation and focus on the basics

King's first priority is our local patients who expect the basics to be right every time and to have a consistently good experience at any King's hospital site. Following a period of structural reorganisation and clinical pressures, the key aim for the next two years is to consolidate the recent changes, implement the integration plan and focus on delivering high quality, productive services to meet all operational and quality regulatory requirements and targets. We have agreed with Monitor the trajectories to deliver Government targets across the new Trust and we will focus on meeting the milestones and implementing recovery and improvement plans. We will provide staff with stability and enable them to improve care processes.

1.2.2 All Together Better

King's is now entering the first full year as an enlarged organisation, Our vision for the new hospital is ambitious and challenging:

- One high-performing hospital across multiple sites
- Consistently high-quality care at all times in all places
- Services re-organised across sites to improve quality and efficiency
- Excellent essential local health services
- A portfolio of specialised services and aligned academic developments of national and international prestige

Having acquired a set of buildings and transferred the staff, we now have a long journey to integrate our cultures and working practices so that we can be a single hospital with consistently high standards and shared pride in Team King's. We have developed and shared with commissioners and regulators our

detailed plans for the integration and transformation of the PRUH. We are already implementing these plans at pace.

1.2.3 Organising around quality

Despite major operational challenges, we continue to maintain our quality agenda to ensure fundamental care standards and to advance new frontiers in quality improvement.

In line with our focus on the basics, we are continuing the drive to ensure consistent, safe processes in surgery in every King's theatre. We are embarking on a programme of staff training and education, holistic patient assessment and better information and advice particularly for people with cancer, and we aim to see improvement in patient feedback as a result. We are also embedding our ethos of health improvement by expanding alcohol and smoking behaviour change strategies to improve outcomes in our local population.

Although we have identified specific priority programmes for quality improvement, King's aims to embed quality in the culture at every ward and patient interaction.

1.2.4 Integrating care across boundaries

King's aims to lead change in the local health and care economy to tackle major strategic challenges. We know the major health challenge for our locality is long term illness and frail old age. More effective integration of acute care with community, primary and social care to manage demand, particularly focusing on our local frail and elderly population is key to the sustainability of King's as emergency medicine is already saturating our operational capacity.

We are full participants in Southwark and Lambeth Integrated Care and this programme will accelerate during the next two years in collaboration with partners to transform care pathways out of hospital. Meanwhile we are pushing forward with integrated care as part of our emergency care plan, e.g. implementing 7 day diagnostic and discharge capability, ward based social workers and a homelessness team.

1.2.5 Rebalancing our service portfolio

We also need to review our service configuration in the new structure in order to achieve the benefits of the merger and to meet the very challenging demand and capacity requirements. We have begun to consolidate service provision across our sites in order to free up medical bed capacity and provide more protected beds for elective services. Our operational plan is to develop Orpington hospital as a cold elective facility working at high productivity rates

More detailed work on site strategy will be included in our five year strategic plan. Over the five year period, we will also further integrate clinical academic specialties across King's Health Partners.

1.3 Key deliverables

- Consistently high-quality care, incorporating safety, outcomes and experience across all sites.
- A sustainable financial base and release of cost savings as set out in the Business Case for acquisition of the PRUH.
- Re-distribution of services across sites in partnership with local commissioners to reduce bed-pressures with improved emergency pathways and creation of elective-only facilities.
- Partnership working across South London (e.g. King's Health Partners, South London Integrated Care (SLIC) and CCGs and service networks) to develop new models of joined-up care.
- The spread of innovation and change capability across wider South London as a leading partner in South London HIN and NIHR CLAHRC.

1.4 King's values

Following engagement with staff, patients and the community King's defined the five values that are at the core of the organisation's culture.

- **Understanding you**: Listening is the key to understanding what matters – whether it's one of our patients or another member of staff. Only by hearing what they say and trying to put yourself 'in their shoes' will you really appreciate their situation and understand their concerns.

- **Inspiring confidence in our care**: By providing the right information at the right time and attending to their needs in a calm and professional manner, patients will feel confident in their treatment and the people who care for them.
- **Working together**: We can't always make the right decisions as individuals - no one person can hold all the knowledge and skills required to answer every problem. By working together as a team - learning from each other and co-operating, we can get the job done.
- **Always aiming higher**: With such a rich pool of talent at King's, there are always opportunities to make things better for our patients and for each other. We look to find innovative solutions to overcome the problems that arise and to learn from our experiences.
- **Making a difference in our community**: King's is a hospital with a world class reputation, providing services both nationally and internationally but our roots lie in the heart of our local community. Many of our staff are local people, a large number of local businesses provide services and support for the hospital and we in turn look to support and sustain the local community.

1.5 Financial basis

The financial basis of our plans is as follows.

The projected cost improvement target for 14/15 is £71.9m and 15/16 is £70.9m. This is a challenging target on top of all the operational pressures in respect to the Emergency care patient pathway, RTT targets and high staff vacancy levels. The CIP target incorporates a number of immediate PRUH cost pressures and the CIP action plans reflect the medium term timescale to deliver the service synergies at DH, PRUH and other sites.

The CIP schemes and the transaction revenue subsidy is required to cover a number of the cost pressures on the PRUH site and cover the overall CIP gap. This leaves the Trust with a minimal contingency reserve of £10m and a necessity to reduce the cost base (agency nursing, medical locums and off-site working in the private sector).

The CIP gap needs to focus on cost savings rather than delivering margin on additional income. Any potential activity growth needs to focus on specialist tertiary work and non-local CCG services where additional capacity can be provided through efficiency developments.

The delivery of efficiency savings through the re-design of patient pathway's is crucial to maintaining Commissioner contracted activity and developing King's services (e.g. MSK contract with Bexley CCG).

The planned capital expenditure for 14/15 is £53.8m and for 15/16 is £72.5m. The main schemes are the Critical Care Unit and Infill Block 5 Development. Both these schemes require an investment in the Denmark Hill Infrastructure (£5.5m).

The annual plans covering the next 2 years are based on a break-even target for 14/15 and £4m surplus for 15/16 to maintain a Monitor Rating of 3 for each year.

The surplus in 15/16 is required to finance the Trust capital programme maintain the Liquidity Rating.

	Out-turn for Year ending 31-Mar-14 £'m	Plan for Year ending 31-Mar-15 £'m	Plan for Year ending 31-Mar-16 £'m
Operating			
Total Operating Revenue, IFRS	**867.410**	**1,017.373**	**1,004.312**
Employee Expenses	(488.858)	(588.599)	(586.521)
Drugs	(88.336)	(100.803)	(99.796)
Clinical supplies	(80.637)	(88.593)	(86.914)
Non-clinical supplies	(46.862)	(49.705)	(47.099)
Misc. other Operating expenses	(84.593)	(81.100)	(67.822)
PFI operating expenses	(40.048)	(50.467)	(51.274)
Depreciation and Amortisation	(17.296)	(22.140)	(23.603)
Impairment	(5.000)	(8.750)	(10.500)
Total Operating Expenses IFRS	**(851.630)**	**(990.157)**	**(973.529)**
Surplus (Deficit) from Operations	**15.780**	**27.216**	**30.783**
Non Operating			
Non-Operating income (incl. Gain on Transfer by Absorption)	**70.155**	**0.783**	**0.783**
Non-Operating expenses (incl. PDC Dividend)	**(40.453)**	**(55.996)**	**(57.201)**
Surplus (Deficit)	**58.562**	**(8.750)**	**(6.500)**
Surplus (Deficit) excluding Impairment and Gain on Transfer by Absorption	**(6.000)**	**(0.000)**	**4.000**
Capital Expenditure Totals	**(37.433)**	**(53.836)**	**(72.510)**

Capital Service Cover			
Revenue Available for Capital Service	38.393	58.939	65.289
Capital Service	(30.495)	(40.993)	(45.513)
Capital Service Cover metric	1.26x	1.44x	1.43x
Capital Service Cover rating	**2**	**2**	**2**
Liquidity			
Cash for CoS liquidity purposes	16.890	23.647	0.615
Operating Expenses within EBITDA, Total	(829.334)	(959.267)	(939.426)
Liquidity metric	7.3	8.9	0.2
Liquidity rating	**4**	**4**	**4**
Continuity of Service Risk Rating	**3**	**3**	**3**

This plan sets out our approach to our operational priorities for 2014/15 and will be used to monitor and track progress towards our goals over the next two years.

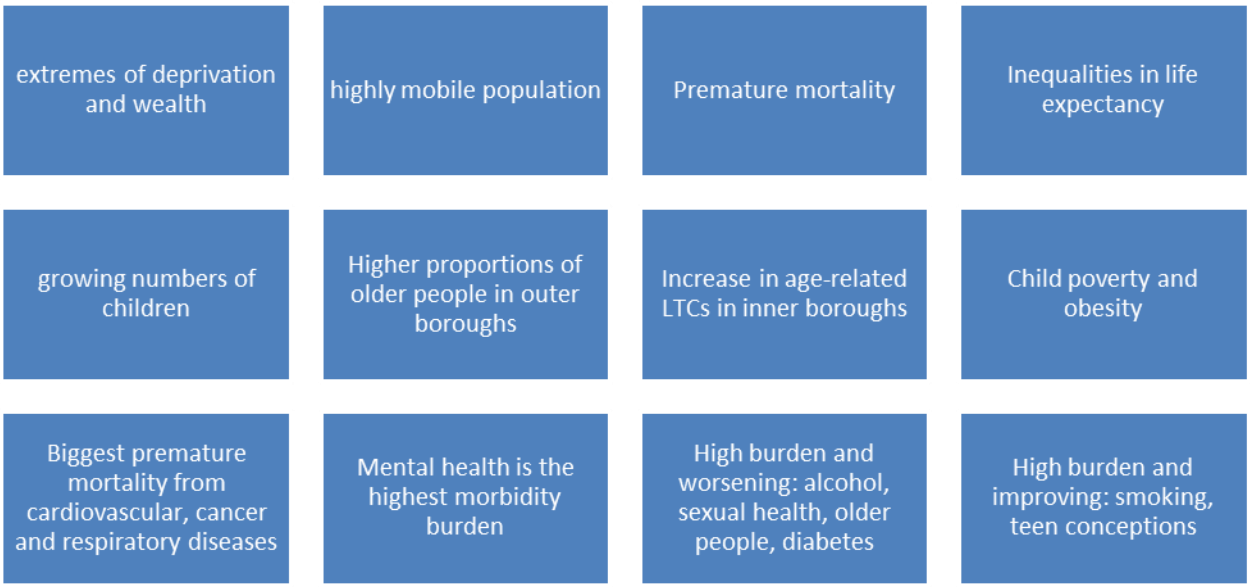
It lays the foundation for the wider and deeper transformation of models of care and organisation that will be set out in detail in our 5-year Strategic Plan (which we have started to develop concurrently with this two-year Operational Plan). The longer-term focus will be to radically redesign services across the system with local stakeholders, partner organisations and commissioners.

2 THE SHORT TERM CHALLENGES

In the next two years King's aims to implement a major programme of organisational integration and service transformation in the context of the most significant health, quality and financial challenge the region has faced. Key internal and external issues are summarised here.

2.1 Demographic and health needs

The South East London Commissioning Strategy Programme has identified the following twelve key demographic and health challenges for the region:



The Commissioning Strategy estimates that 11,000 people died prematurely between 2009 and 2011. Despite improvements in health across the region, poor health remains a major challenge and requires step-change improvement and transformation of care models. This plan aims to change models of care for older people and long term conditions, addressing behavioural risk factors and through improved specialised care.

2.2 The quality challenge

The *SEL Case for Change* sets out the quality challenge for the region. For acute services, commissioners highlight the following concerns:

No Trust in SE London fully meets the London standards for safety and quality in emergency care and maternity services.

- All hospitals across SE London failed to meet the 5 London Adult Emergency Standards for medicine and surgery
- No SE London hospital met all of the key national standards for Critical Care, Emergency Department, Fractured Neck of Femur, Maternity and Paediatrics standards. There were two standards which all SEL hospitals failed.

Significant variation in the performance of acute Trusts

- All Trusts in SE London were in the bottom quartile for median time in Accident and Emergency from arrival to treatment
- Patients reported bottom quartile experience of care in 3 of 4 Trusts (South London Healthcare, King's College Hospital and Lewisham Healthcare Trust)
- Cancer patients experience above average over 31-day waits for their first treatment in most Trusts with Guy's and St Thomas' being in the bottom quartile

- Only King's College Hospital was above average for two week referrals to first outpatient appointment for breast
- Three out of four Trusts were in the first (top) quartile for the summary indicator on hospital mortality.

The integration and transformation of services described in this plan aims to raise and standardise clinical practice to the best standards across all our sites.

2.3 The financial challenge

King's has contracts in place with local commissioners as well as for NHS England specialised services. In the previous two years, approximately 52% of King's contract value came from NHSE specialised services, equating to £309.6m pa. Lambeth, Southwark and Bromley contracts came to a value of £178.5m pa (30% King's contract value) and Lewisham Bexley and Greenwich £43.9m pa (7%). £58.1m pa (10%) came from contracts with other commissioners. Since the acquisition of the PRUH, the balance of specialised services to local contracts has changed. In 14/15, £331m (42% total contract value) is agreed with NHSE, while the remaining is agreed with Lambeth, Southwark and Bromley (£315.3m, 40%), Lewisham, Bexley and Greenwich (£74.2m, 9%) and other CCGs (£76.8m, 10%).

King's financial and therefore clinical sustainability will thus be determined by the ability of the local health economy to meet the financial challenge. King's continues to lead local change to tackle strategic issues in the region as an active member of our Academic Health Science Centre and Integrated Care partnership. The creation of this plan and the five year strategy represents a joint enterprise between local health economy partners to sustain and transform health and care services for the future.

As the health needs of our local population are increasing with age, the resources available to meet these needs and deliver improved services are static, leaving a growing gap between costs and funding. This is reflected in our local commissioners' widening financial gap. Local health and care partners have shared their analysis of the financial challenge as set out in this section.

The scale of financial challenge for SE London CCGs increases from circa £60m in 2013/14 to almost double, at £108m, in 2014/15. This represents 6-7% of budgets in each CCG.

Local QIPP requirements and Provider efficiency requirements are combined and summarised below.

		Uplift for the year	Growth from uplift as above	Total net expenditure plans after QIPP	Total QIPP programme	QIPP programme as % of net spend	QIPP plus provider efficiency of 4% PA		
2014/15	NHS Lambeth	2.28%	£9.2m	£416m	-£19.7m	4.70%	8.70%		
	NHS Southwark	3.54%	£12.3m	£363m	-£15m	4.20%	8.20%		
	NHS Bromley	3.97%	£14.1m	£379m	-£12.0m	3.17%	7.17%		
2015/16	NHS Lambeth	1.70%	£7.1m	£430m	-£18.8m	4.40%	8.40%		
	NHS Southwark	2.78%	£10m	£381m	-£13m	3.40%	7.40%		
	NHS Bromley	3.66%	£13.6m	£397m	-£12.1m	3.05%	7.05%		

NHS England (London) spends £3.4 billion on specialised services, with a 6-8% growth in specialised services pa and a forecast population rise of 1 million in London in the next 7 years. The London region has set the QIPP requirement for specialised services at 9% over the next 2-years.

2.4 Local commissioner priorities

CCGs lead local systems and set the overall priorities. In 2014/15 we will collaborate with the Southwark and Lambeth change programme in the following areas:

Ensure local people can navigate and access appropriate care settings
- Consistent prevention strategies across health and social care so “every contact counts”
- Review and re-commissioning of Urgent Care Centres and Walk in Centres and 111
- Ensure urgent care services respond rapidly to patients in crisis and quick access to care packages (Mental Health, Alcohol, Homelessness)

Delivery of Effective and Efficient Care Pathways
- Enable communication between primary and secondary care clinicians
- Agreed pathways or guidelines for referrals
- Improve access to diagnostics in Primary Care
- Increase non-face to face contact with patients, reducing follow-up and onward referral
- Develop Community based care models and decommission acute outpatient pathways

Proactive and personalised care that supports independence
- Improve early detection, case finding, care coordination, medicine optimisation and risk stratification delivered through integrated services
- Increase independence through personalisation and personal budgets and self-management strategies
- Complete @Home redesign process including roll out of Homeward and further integration with social care services
- Ensure transfer through care system is safe, simple, timely, and coordinated, and available 7-days a week

Following King’s acquisition of PRUH, Bromley CCG is linking with Lambeth and Southwark CCGs and the SEL Commissioning Strategy Programme. We will work together on 5-year strategic plans to radically remodel systemic care models.

2.5 NHS England specialised services commissioning priorities

NHS England has produced 143 specialised service line specifications and assessed provider compliance. King’s specialised services were graded as follows:

- 59 specifications fully compliant
- Nine services Trust derogation
- Four services commissioner derogation
- Three services commissioner assessed non-compliant

King’s has agreed, or is negotiating, action plans in order to achieve compliance with Trust-derogated services. Incrementally, NHS England will raise the specifications in the standards and expect cost-neutral improvement.

NHS England’s commissioning intentions set out a programme of commissioning and service model changes which will be a key challenge for King’s:

- Reducing the number of specialised providers
- Encouraging Networks
- Prime contractor model and collaborative commissioning
- Market and strategic reviews including tendering

2.6 Changing models of care

Local and national commissioners envisage changing models of care to meet the strategic challenges facing the NHS. These transformational changes will be fully developed over the 5-year strategy period, but progress is expected in this 2-year period.

NHS England’s Call to Action sets out six transformational changes:

- Ensure citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care

- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

KCH's CIP, Integration and Transformation Plans and our work in SLIC and KHP (set out later in this plan), demonstrate how King's is embracing the need to modernise health systems. The current local over-dependence on emergency acute care, including high admission rates for ambulatory care sensitive conditions, is currently in crisis and unsustainable.

2.7 The Better Care Fund

The £3.8 billion Better Care Fund starts in 2014/15 to support the integration of health and social care. Commissioner plans include their vision for how health and social care work together to provide better support at home and earlier treatment in the community.

The three local Better Care Fund plans are summarised below, with a particular focus on the implications for acute care.

2.7.1 Southwark Better Care Fund Plan

2014/15 budget: £8.957m; 2015/16 budget: £21.967m

Aims:

- More people benefiting from community multi-disciplinary team approach.
- Reductions in avoidable emergency admissions, delayed transfers and lengths of stay especially for older people.
- Expanded community based admission avoidance and discharge support including support for 7 day working.
- More support to live independently at home.

Planned changes:

- Year 1: Funding for existing services rolled forward and reviewed for value added to BCF objectives. Funding also used for 'winter pressures' initiative e.g liaison psychiatry
- Year 2: BCF expanded to incorporate additional services including admission avoidance service and Home Ward, discharge support and 7 day primary, community and social care, self-management support and telecare.
- BCF will also be used to back-fill social services cuts and implementation of the Care Bill.

Acute implications:

- Planned savings from avoidable emergency admissions £150,000 in 2015/16.
- Planned savings from reduced admissions, readmissions and LOS are included in QIPP targets.
- Capacity will be rebalanced through increasing tertiary work and reducing acute medical and older people's beds, to be agreed and tracked through the SLIC programme.
- Non-delivery of acute demand is Red-rated as a risk, with contingency plans to fund excess acute demand.

2.7.2 Lambeth Better Care Fund Plan

2014/15 budget: minimum £6.961m; 2015/16 budget: £23.462m

Aims:

- Most commissioning will be integrated by default.
- Aim to use the BCF and other tools to shift support from 'doing to' to 'doing with'; promote self care; focus on prevention and early support; promote physical and mental wellbeing.
- Measures include reducing premature mortality; inpatient bed days; emergency hospital admissions including for ACS conditions; delayed transfers; and increasing experience measures and numbers undertaking diabetes education.

Planned changes:

- Develop and then test new commissioning and payment mechanisms for integrated care
- Integrate commissioning of admission avoidance/ discharge, community nursing and reablement to integrate the service offer and a single point of access.

- Commission 7 day working and neighbourhood based community and acute, primary and social care
- Increase access to self-management education programmes.
- Design and test integrated approaches to supporting people with multiple LTCs as the next phase of SLIC.

Acute implications:
- Preventing emergencies and reducing LOS; reduced reliance on urgent care services.
- Capacity and capability to bring savings is Red risk rated, with mitigations including performance managing integration programme, risk-sharing between commissioners and providers and focusing on highest impact components of programme. May also need to review acute capacity if specialised activity does not replace lost emergency income.

2.7.3 Bromley Better Care Fund Plan

2014/15 budget: minimum £5.456m; 2015/16 budget: minimum £20.837m

Aims:
- Promote independence and better management of health and care needs
- Early identification of needs and involvement in personalised care plans to help stay well longer
- Reduce urgent interventions, delayed transfers, emergency admissions, whole system beds and bed days and proportion of deaths in hospital.
- To improve patient experience and care planning for LTCs

Planned changes:
- To build a modern integrated service, move from a reactive bed based model to provision of proactive home and community based model.
- Building the Bromley 'House of Care' with non-recurrent investment in skills, capacity, behavioural and culture change, equipment and infrastructure.
- Effective care navigation and menu of self-management options.
- Enhance risk stratification and care planning tools to work effectively across health and care.

Acute implications:
- Adjustments to future activity will be supported by clear and credible plans and negotiated in the contracting process.
- Savings are incorporated into QIPP and will be managed using contractual terms, including CQUIN.
- Freeing up spending from acute care is rated as High risk with good communication and alternative commissioning models to mitigate this.

2.8 King's operating context

2.8.1 Integration of King's into one hospital on many sites

Integrating Princess Royal University Hospital, Orpington Hospital and services at Beckenham Beacon and Queen Mary's Sidcup will be at the core of our operational plan for the next 2-years.

This newly created multi-site hospital represents a step-change in organisational size and complexity and expands the size and diversity of the local population served:

	Before Acquisition	After acquisition	Percentage increase
Number of major service sites	1	5	400%
Number of beds	970 beds	1625 beds	68%
Number of staff	10,000	13,000	30%
Theatres	25 theatres	43 theatres	72%
Budget	£669m	£1bn	51%
Outpatient activity	775,000	1,312,000	69%
Day case activity	49,000	84,000	71%
Inpatient elective activity	13,000	19,000	46%
Inpatient non-elective activity	48,000	80,000	67%
Population	593,200 (Southwark 288,700, Lambeth	903,800 (+ Bromley 310,600)	52%

	304,500)		
Geographical spread	55.67 km^2 (Southwark 28.85 km^2, Lambeth 26.82 km^2)	205.82 km^2 (+ Bromley 150.15 km^2)	270%

The objectives and milestones set out in the Business Case for acquisition are being delivered through the Trust Transformation, Integration and CIP Programme whose key deliverables are:

- One high-performing hospital across multiple sites
- Consistently high-quality care at all times in all places
- Services re-organised across sites to improve quality and efficiency
- Excellent essential local health services
- A portfolio of specialised services and aligned academic developments of national and international prestige
- Cultural change to ensure consistently compassionate care

2.8.2 Demand and capacity challenge

King's has experienced growth in planned secondary and tertiary care and a significant surge in local acute medicine, in particular, in older people. Length of stay for older people has also increased due to higher acuity.

The impact of excessive demand and constrained capacity on operational performance is already evident, with concerns in the following areas:

- Emergency department performance
- Elective waiting times including very long waiters
- Cancer waiting times
- Finances
- Patient experience
- Patient safety especially infection prevention and control
- Staff overworking and stress levels
- Tertiary and academic activity

Space, capital and revenue constraints mean that capacity cannot expand in this period to accommodate greater demand. Alternative approaches including integrated care, cross site reconfiguration and strategic prioritisation are required.

2.8.3 Financial challenge

The Trust is seeing an impact on financial performance, particularly due to an over-reliance on bank and agency staffing to meet demand safely. The Trust is forecasting a £6m operating deficit in 2013/14.

The longer term financial challenge is set out below. Over the five year strategy period we are required to make savings equivalent to over a third of our turnover. In the two-year period this gap is 14.4% or £142.8m.

KCH 5 year Indicative Planning Assumptions	2014/15	2015/16	2016/17	2017/18	2018/19	Total
	£m	£m	£m	£m	£m	£m
Tariff deflator	11.0	15.2	-	6.0	6.0	38.2
Inflation assumptions (Pay and Non-Pay)	19.7	23.5	35.7	27.6	26.8	133.4
Loss of CQUIN on drugs and devices	1.7	-	-	-	-	1.7
Loss of education funding (Dental tfr to GSTT)	1.2	-	-	-	-	1.2
Loss of education funding (SIFT)	1.4	1.4	1.4	-	-	4.2
Trust-led QIPP assumptions	13.1	15.0	15.0	15.0	15.0	73.1
SLIC (Integration investment)	1.2	-	-	-	-	1.2
2013/14 Operating deficit carried forward (tbc)	6.0	-	-	-	-	6.0
Cost pressures - AfC inc. drift / pension (staff increase and auto-enrolement)	5.0	-	-	-	-	5.0
Cost pressures - other (e.g PFI, nurse specialing, CNST premuim)	6.6	10.0	10.0	10.0	10.0	46.6
Cost of debt service (CCU, Orpington, IB5, helipad)	5.0	5.8	5.6	5.4	5.1	26.9
Total Savings Required	**71.9**	**70.9**	**67.7**	**64.0**	**62.9**	**337.5**
% of Turnover (circa £1,000m)	**7.3%**	**7.1%**	**6.7%**	**6.5%**	**6.4%**	**34.0%**

Notes:
- Annual efficiency tariffs as per Monitor guidance
- Monitor has notified Trusts that the 2015/16 efficiency target has been increased from 4% to 4.5%.
- NHSE 2014/15 contract proposal includes a 6% QIPP target of circa £19m.
- Figures exclude impact of Better Care funding in 15/16

2.8.4 King's Health Partners (see Annex)

King's College Hospital is a partner in King's Health Partners, re-accredited as an Academic Health Science in 2013. The other partners are Guy's and St Thomas' and South London and Maudsley (SLaM) NHS Foundation Trusts and King's College London. The AHSC serves over 3.6 million patients each year has 31,000 staff, 25,000 students and a combined annual turnover of £2.8 billion.

As part of King's Health Partners, King's offers a strong combination of clinical specialities, including mental health, which, through closer working and better alignment of research and development with services, delivers real benefits to patients and staff.

Whilst not proceeding now to merger, our two and five year plans reflect our wish to be an integrated organisation and our continuing work to consolidate and establish the best fit of services to enable this. A revised governance structure was implemented in Feb 2014 and an ambitious programme of work for the next 2-years includes:

- Treating the 'whole' person – ensure that patients' full mental and physical needs are met by addressing the physical health needs of patients with serious mental illness, and earlier identification and treatment of hospital inpatients with dementia.
- More integrated care – work with our partners through Southwark and Lambeth Integrated Care across local boroughs to integrate services. (See below)
- Better patient experience – create a step change in the quality and safety of care by sharing electronic patient records across King's Health Partners and use of anonymised data sets for research.
- Delivering value across patient pathways of care – A set of value based healthcare projects to increase value by improving outcomes that matter to patients per pound spent. Over time we will work with primary, community and social care to increase value across the health and social care economy.

2.8.5 Southwark and Lambeth Integrated Care (see also Annex)

SLIC involves local people, 95 local GPs, Lambeth and Southwark CCGs, KHP partners and social care in both local councils, to transform and integrate care systems so residents will be healthier, more independent and have a better coordinated experience of care. Reductions in hospital admissions, length of stay, hospital bed days used and admissions to residential care are expected. Staff are being empowered to work across traditional boundaries in new teams, take on new roles, communicate differently and lead change, with new IT solutions to help.

In 2012/13 the focus was co-designing care with older people and people with long term conditions. In 2014/15 work will develop medical, nurse, therapist and social worker training and new roles to support integrated care.

Key priorities for 2014 /16:

- Working with Primary care: introducing Holistic Health Assessments, Primary Care Case Managers and Community Multidisciplinary Teams to plan care for complex vulnerable people; 24/7 geriatrician hotline for specialist advice; pathway improvements for falls, infection, nutrition and dementia; mental health team to manage care home residents with dementia and challenging behaviour; improving the nutritional status of older people..
- Admission avoidance and early supported discharge: Bigger community enhanced rapid response and @ Home teams; better KCH use of Red Cross and MediHome; bring social workers into the MDTs on hospital ward rounds; investment over 3-years in out-of hospital care with social care investing in re-ablement.
- Long term Conditions: A programme of work on Long Term Conditions is currently in design for 2014; already investigating medicines non-adherence (70%) and interventions to improve.
- Working together to develop a framework for integrated commissioning: During 2014/16 a single budget will cover most forms of health, mental health and social care, for people in Lambeth and Southwark, allowing funding to move to where it is most effective; shadow form testing planned for 2014 / 15. SLIC will develop a single payment for the care of people who need care from a range of health and social care professionals. The payment would cover acute hospital care, community healthcare, health-funded social care and locally-commissioned general practice care.
- KHP partners have commissioned a feasibility study of the radical proposal to establish a single Academic Integrated Care Organisation (AICO) in the locality.

Bromley CCG and Bromley Healthcare have a similar focus on older people and people with long term conditions. King's has invested in additional discharge coordinators and will work in partnership with primary and community care to offer Bromley patients and carers the same schemes in place at Denmark Hill site.

2.8.6 Translating research into new models of care

Health Improvement Network (HIN), the South London Academic Health Science Network will facilitates collaboration to deliver service improvements and innovative change in areas of major public health concern: Diabetes, Dementia, Musculoskeletal, Alcohol, Cancer, Patient experience, Information, Wealth creation, Education and training, Research (see also Annex).

King's hosts the new South London NIHR CLAHRC, with a budget of £18m over 5-years. Researchers work with clinical staff to investigate new methods to prevent and treat chronic diseases. The major themes to tackle public health issues are: Alcohol, Diabetes, Palliative and End of Life Care, Infection, Psychosis, Public Health, Stroke, Women's Health, Patient and Public Involvement

The 9 clinical themes are agreeing workplans and these will be monitored. A new Centre for Implementation Science (CIS) will be set up in 2014 as a central resource to support research and test innovations. Close links with industry will be made in 2014, to look for ground breaking ways to improve patient care.

As part of KHP, King's Improvement Science (KIS), a dedicated team of improvement scientists, is supporting staff to take practical, effective decisions about service organisation and design systems using evidence-based methodologies for change. In 2014, KIS will be supporting the iMobile Critical Care project using mobile communications devices to better manage deteriorating patients at KCH.

3 QUALITY PLANS

3.1 King's approach to quality

Quality is at the heart of the King's College Hospital ethos. Everything King's does is focused on patient need and delivering the highest quality of care in our local services and our global specialties.

As an academic hospital, King's constantly aims higher for patients and seeks out new developments and innovations, be they surgical advances, innovative safety processes or new ways to improve comfort and dignity. King's is a leader in national recognised quality programmes – e.g. Electronic Patient Records; new dementia-friendly wards; a volunteering programme supporting patients in hospital and at home. Over 2014/16 we will continue to develop the next generation of quality improvement initiatives.

To understand the expectations of our local community and commissioners, King's regularly engages with patients, carers and the public on our quality priorities. This year we met with local stakeholders in both Camberwell and Bromley to explore the priorities that they wanted to be in the 2014/15 Quality Account.

Our Quality Plan is for 2014/15 and is reviewed annually. This allows us to re-engage with stakeholders and to adapt our plans to reflect changing national and local needs and priorities. The 2015/16 Quality Plans will be developed in Quarter 4 with stakeholders taking new audit findings, guidance and regulations into account.

3.2 King's quality priorities 2014/15

King's programme of quality improvement in 2014/15 focuses on embedding high quality practices and culture across all sites in the new organisation. The priority areas were agreed following the engagement with local stakeholders. These will be monitored through the year and reviewed by the Quality and Governance Committee. Performance for the year will be reported in the Quality Account 2015/16.

3.2.1 Patient safety

Patient safety is managed by the Patient Safety Management Committee reporting to the Quality and Board Governance Committee.

	Aims	Measures
Patient Safety Quality Account Priorities	Improve the identification and management of patients at risk of falling in hospitals	Reduction in falls with moderate and major impact to <3 per month, Reduction in falls by age band Appropriately assessed pre fall Implementation of a Safer Care Forum Engagement initiatives with staff pre change implementation/work around behaviors and decision making
	Improve Surgical safety (2nd year)	Zero never events Effective use of surgical checklist; completion & situation awareness

Further work on patient safety is set out in section 1.6 on key risks to the plan.

3.2.2 Patient experience

Patient experience is managed by the Trust Patient Experience Committee reporting to the Quality and Board Governance.

	Aims	Measures
Patient Experience Quality Account Priorities	Improve experience and coordination of discharge: Elderly, renal and surgery.	Significant improvement in "How Are We Doing?" (HRWD) patient survey that demonstrates a better experience for our patients Improvement on 2013-14 discharge audit results GP suggested measures – TBC Reduction in 'unsafe discharges' reported by our primary and social care colleagues.
	Improve the experience of cancer patients	Increase the number of clinicians who have undertaken the National Advanced Communication Course across the organisation Ensure patients receive an Holistic Needs Assessment (HNA) Patients are receiving appropriate information at the right time More patients having improved access to the trust e.g. Cancer Helpline Provide education for ward nurses to improve their understanding of cancer patients needs

A key focus for the coming year will be to use the national Friends and Family Test (FFT) to improve the experience of our patients. We will improve the response rates to inform service improvement. In the Emergency Departments, we will extend the use of SMS and introduce land line voice messaging. We will introduce the King's "How Are We Doing?" survey to PRUH and grow the inpatient and maternity survey response rates.

The FFT will start for outpatients and daycase patients in October 2014. At Denmark Hill we already gather outpatient feedback via HRWD and this will be extended to PRUH and other sites during 2014/16. There is a programme of staff engagement across all sites to promote the FFT to ensure its use for service improvement.

In 2014/15 we will review our patient feedback and reporting to ensure that we use it to maximum effect. As per the Francis Report, we shall seek to use qualitative data collected via Friends and Family comments, complaints, the Patient Advice and Liaison Service, patient stories and video stories imaginatively and compel active reflection and action. We will extend our video stories programme to the Princess Royal University hospital and other SE London sites and re-launch "Gold Fish Bowl "events at PRUH.

3.2.3 Patient outcomes

Patient outcomes, including clinical audit and effectiveness, are reported through the Patient Outcomes Committee reporting to the Quality and Governance Committee of the Board.

	Aims	Measures
Patient Outcomes Quality Account Priorities	Maximise King's contribution towards reducing ill health due to use of alcohol and smoking	Percentage of patients assessed Number of 'quitters' Number of patients referred to support services Staff trained
	Improve the experience and health outcomes of patients with hip fracture and knee replacement surgery	Reduce length of stay More patients discharged to their own home Reduction in time before surgery Increase in physio provision Reduced pain Increase in the % of patients who have a bone health and falls assessment

3.3 National quality priorities

As an academic hospital, King's is "Always Aiming Higher" for patient care. Our quality plan addresses the national quality priorities set by NHS England and other regulators. We seek comparative feedback on clinical quality, from inspections, audits and benchmarking programmes, and deliver improvement plans based on best practice and highest standards.

King's has plans to respond to the NHS England priorities set out in *Everyone Counts*.

3.3.1 Francis Inquiry response and creating a caring culture

King's has held discussions with staff and patients at our *"King's in Conversation"* listening events where we asked staff and patients:

- Are patients always our first priority?
- Would you recommend King's as a place to work and for treatment?
- If you had a concern, would you know how and feel able to raise it?

A staff survey examined cultural differences across the enlarged organisation and the 3-year "All Together Better" project (nested in the Transformation, Integration and CIP Programme) will tackle three priority themes:

- Doctors, Nurses and Managers working effectively together
- Promoting positive behaviours and performance
- Empowering staff to take confident decisions

3.3.2 Ensuring the right staff for safe care

King's measures and records patient acuity daily and monthly to compare actual staffing establishments with recommended levels by ward. This informs our nursing establishment planning and adjustments. Staff absence (sickness, study leave etc.) and nursing performance indicators (e.g. falls, pressure ulcers, HRWD) are also reviewed and acted on. Data collection is being automated to reduce clinical staff input time. Data is reviewed with divisional nursing teams and Executive Nursing Team at NMAS meetings.

A patient dependency app is used to identify 'Hot Spot' wards and real time staffing review used to ensure safe staffing levels at all times. An agreed format to display ward staff levels for public display will be implemented across the enlarged organisation.

To use existing establishments more effectively we are:

- Boosting recruitment of band 5 nurses across the enlarged organisation and introducing a slicker centralised recruitment process.
- Revising the e-roster policy and giving refresher training to all divisions to improve the efficiency of the rotas and staff in post through more effective annual leave planning, reduction in 'unused hours' and more pro-active staffing reviews.
- Updating the temporary staffing policy and improving usage data given to divisional teams to optimise staffing reviews and safe staffing levels.
- Considering a band 5.5 post and a Band 6 Leadership Development programme (May 2014) to improve retention

3.3.3 Compassion in practice

King's values "Understanding you" and "Inspiring confidence in our care" place compassion at the heart of our organisational culture. We have a programme of work to ensure that compassion is always our priority that includes:

- Enhanced Trust-wide training for staff: dignity training helps staff to incorporate meaningful activity into care for patients with dementia; induction training for all nursing and midwifery staff stresses dignity in care; a network of Dignity Champions coach and embed skills at ward level (to be extended to PRUH in 2014).
- Research into the value of dignified care with King's College London via the CHAT project (an NIHR funded multi-site study) whose interventions give enhanced training to HCAs caring for older people, and evaluate its effectiveness.
- Development of services to provide better quality, individualised care for patients with disturbed behaviour and high risk of harm who need one-to–one care. The specialling team in the Health and Ageing Unit will be extended across general medical wards in 2014.
- Improved patient and visitor information about dignified care at King's after a review of ward and department information for patients and visitors about what they can expect from us.
- Improved welcome/ dignity information boards for patients and visitors in all wards and departments and in 2014 will review and act on data on older people's experience of care at King's via the Older People's Committee.

3.3.4 Staff satisfaction

In 2013/14 King's garnered over 800 staff views through "King's in Conversation" focus groups and pop-up events exploring issues raised by the Francis report – an exercise now in progress at the newly acquired sites. We have also analysed the National Staff survey results and carried out a survey to assess and measure culture and attitudes at a deeper level and identify differences between the various sites.

The results have informed an "All Together Better" action plan focussed on three main themes - underpinned by a series of workforce and communications enablers.

The culture survey will be repeated in autumn 2014 to measure aspects of cultural maturity and change. We expect that cultural integration will take 3-5 years to achieve.

3.3.5 Seven day working

King's is committed to the vision of seven day services with consistent quality of care and optimal patient flow at all times of the day and week. We aim to ensure that access to high quality emergency care is consistent across 7-days and avoidable emergency admissions and delays to discharge are reduced through identifying and resolving gaps in primary care service provision. Patients admitted during the weekend will have equity of access to diagnostics, urgent and emergency care. Supporting business cases to establish 7/7 working will be produced during 2014/16.

7/7 initiatives piloted in ED at Denmark Hill this winter are being evaluated for impact on flow and discharges will inform priority actions and investments for 2014/16. We are also working with system partners to ensure that 7/7 is a whole system approach including social care and primary care.

3.3.6 Safeguarding

The Safeguarding Adults Team has been expanded following the acquisition of the PRUH with the addition of a Head of services supported by a Safeguarding Adults and Learning Disabilities Co-ordinator at each site.

A work plan for the next year will allows the team to focus on the more immediate issues that arise following the expansion of a service. This work will include;

- Developing a training strategy that better meets the needs of staff. This will take into account the role of staff and existing legislation using an agreed competency framework. Topics to be included are Safeguarding Adults, currently delivered in levels. Mental Capacity Act and DolS, currently delivered as a separate session. Learning Disabilities currently included as part of Safeguarding Adults level 2. Prevent which is part of the Governments anti-terrorism strategy. As of April 2013 this has been included as part of the NHS contract. No training currently being delivered.
- Review and revise the terms of reference for the Safeguarding Adults Committee to reflect the wider organisation
- Review the existing Policies that underpin Safeguarding Adults work to ensure these meet the needs of the wider organisation. Specifically these are the Safeguarding Adults Policy and the MCA Policy.

The Safeguarding Children's Team is led by the named Nurse in safeguarding and supported by a team of specialist nurses covering all sites within the newly enlarged organisation including the three Haven clinics.

Objectives for the forthcoming year include:

- Ensure compliance with the training plan by increasing the number of sessions available to achieve 80% compliance rate at level 2 & 3.
- Review of nursing establishment to meet additional demands with the introduction of new services
- Integration of Bromley Safeguarding team and establishment of steering groups to ensure staff engagement
- Ensure audit programme and projects within midwifery and maternity services are completed according to plan.

3.3.7 Care Quality Commission (CQC) inspections and action plans

King's has maintained Care Quality Commission's registration since 1 April 2010, adding the new sites acquired on 1 October 2013. The Denmark Hill site was inspected in August 2012 and was found to be compliant on all 5 outcomes assessed. The Trust will be inspected across all sites during 2014/15. CQC undertook an unannounced inspection of PRUH in December 2013. The CQC identified six compliance actions:

- Improving patient flow through the Emergency Department and the wider hospital
- Improving infection control practices, visibility of infection rates and infection control information for patients and visitors
- Training, appraisal and support for all staff
- Recruitment of new staff
- Embedding King's Quality and Governance Framework at the PRUH
- Increase availability of patient records and improvement of quality of record keeping

A detailed action plan was submitted to the CQC. Progress against actions will be monitored via the Quality Governance and Integration Frameworks, reporting to the Board regularly. King's expects an unannounced re-inspection of PRUH in 2014/15 to monitor improvements.

The CQC Intelligence Monitoring Report shows the enlarged organisation to be rated in the second lowest risk category (band 5) in October 2013 and March 2014. All 'risks' and 'elevated risks' identified are reviewed by responsible staff and actions are taken to address underlying issues and minimise these risks. These reported to, monitored and followed up by King's Executive.

In 2013/14 a Quality Monitoring system and assessment tool, mirroring CQC's new inspection methodology was implemented to assess compliance with the CQC's Fundamental Standards. The Quality Monitoring system will be rolled out across all services and Trust locations in 2014/15.

3.3.8 Monitor quality requirements

Monitor oversees the Trust's delivery of key targets in the NHS contract. We are working with Monitor and CCGs to agree trajectories in the next year for:

- Access targets (RTT and A&E)
- Infection control targets

We will provide recovery and improvement plans monthly to Monitor for any targets we are not meeting or are at risk.

3.3.9 National audits

King's participates in approximately 50 national clinical audits. Following review of results by Divisions and by the Clinical Effectiveness Committee there are many improvement actions in place, the most significant of which are:

Hip Fracture	Poor results against some national standards at both KCH Denmark Hill & PRUH led to issue being identified as a KCH Quality Priority for 2014-15
Myocardial ischaemia	The number of cardiology beds has recently increased and ongoing results will be monitored
Heart failure	Actions to improve results at the PRUH
Lung cancer	A joint action plan will be developed across all King's sites to improve care against national standards.
Diabetes	A detailed review is planned of diabetes care across Denmark Hill and PRUH sites to improve performance against the 8 care processes recommended by NICE
Emergency oxygen	A joint action plan across KCH sites is in development
Pain management in ED	A detailed action plan, based on feedback on patient outcomes, patient experience and patient safety is in place
Neonatal care	Improvements in the pathway for retinopathy screening for premature babies at the PRUH have already been made. Care quality will continue to be closely monitored.
Participation and data completeness	Improving participation and data completion at the PRUH

Additionally there are four national confidential enquiry programmes of relevance to King's.

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)
- Child Health Reviews UK (CHR-UK)
- National Review of Asthma Deaths (NRAD)

Gap analyses and action plans are produced following recommendations in published reports. Where possible, actions are incorporated into the action trackers of existing committees or workstreams. There are approximately 100 active actions, mostly relating to:

- Deteriorating patients
- Surgery in children
- Sub-arachnoid haemorrhage
- Alcohol-related liver disease.

3.3.10 NICE quality standards

NICE Quality Standards provide prioritised statements designed to drive measurable quality improvements based on approximately 900 guidelines that NICE has published. 54 Quality Standards have been published to date, 20 of which have been subject to detailed gap analysis and, where

required, action at King's Denmark Hill. The key NICE actions are therefore to ensure that these are completed across all King's sites for every Quality Standard.

A particular challenge for delivery in 2014/15 is the smoke free hospital NICE guideline.

3.3.11 National benchmarking

King's also monitors quality through benchmarking with other providers to identify areas for improvement:

- Healthcare Evaluation Database (HED) Purchased March 2014, HED is currently being set up to enable benchmarking internally and externally across a wide range of clinical effectiveness, patient experience and patient safety indicators.
- The Shelford Group hospitals are working with HED to agree a set of indicators to enable benchmarking across the Group.
- KHP Clinical Academic Groups (CAGs) are producing CAG Outcomes Booklets, to support benchmarking against patient outcomes, academic and research indicators across the KHP partners.
- Dr Foster Good Hospital Guide, published annually, provides information on performance against national average for a range of key indicators.
- CQC Intelligent Monitoring Report, published quarterly on the CQC website, this report provides information on performance against expected for a wide range of patient access, clinical effectiveness, patient experience, patient safety and staffing indicators.

3.4 Quality performance targets

Day to day operational performance management is driven by the contractual requirements set out in the contract. King's provides regular performance data to commissioners and Monitor against national and local quality requirements. These requirements are monitored by the Board through the Finance and Performance Committee.

3.4.1 Quality metrics

Quality metrics are measured routinely and reported to the Board through divisional scorecards and managed through monthly performance reviews. Non-delivery of targets results in financial penalties to the Trust and can lead to regulatory action. King's has operational plans to recover performance where metrics are at risk, notably RTT and ED (4 hour and 12 hour) waiting times.

National Operating Standards	RTT waiting times
	Diagnostic waiting times
	A&E waits
	Cancer waits - 2 weeks, 31 day and 62 days
	Mixed sex accommodation
	Cancelled operations
National Quality Requirements	MRSA and Clostridium difficile
	RTT waits over 52 weeks
	Ambulance handovers
	Trolley waits
	Cancelled urgent operations
	VTE risk assessment

	Publication of formulary
	Duty of candour
Local CCG quality metrics	Currently under negotiation
NHS England (London) quality metrics	Currently under negotiation

3.4.2 Commissioning for Quality and Innovation measures

CQUINs have been agreed with commissioners for key priorities where financial incentives are attached. These are monitored and reported quarterly to the Board and evidence is provided to the commissioners to demonstrate delivery.

National CQUINS	Friends and Family Test – where commissioners will be empowered to incentivise high performing providers.
	Improvement against the NHS Safety Thermometer, particularly pressure ulcers.
	Improving dementia and delirium care, including sustained improvement in
	Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR).
	Improving diagnosis in mental health – where providers will be rewarded for better assessing and treating the mental and physical needs of their service users.
Local CCG CQUINS	London Commissioning Standards
	Care Planning/ integrated care
	Medications review for elderly
	Public Health – screening etc (Making Every Contact Count)
NHS England (London) specialised services CQUINs	Currently under negotiation

3.4.3 Never Events

Never Event prevention systems are in place and are audited regularly and any incidences are reported and thoroughly investigated. In 2013-14 King's reported six never events. Each was investigated, a root cause analysis completed and reports made to the Board via the Quality and Governance Committee.

We are re-doubling our efforts to ensure the comprehensive and consistent use of the WHO surgical safety checklist to prevent any re-occurrences of wrong-site surgery and retained instruments.

3.5 Workforce implications of the quality plan - recruitment, training, education

The quality plans have significant expected impact on workforce, in particular the safe staffing actions discussed above. Additionally, the following approaches are being taken to ensure the workforce implications are met in order to deliver the quality plan.

- Close working relationship with Capita to reduce time to hire.
- UK wide and international recruitment campaigns to address the shortfall in nursing staff.
- New appraisal system being launched incorporating behaviours and values and linked to talent management.
- Range of leadership programmes across levels and occupational groups to develop skills.
- Coaching and mentoring programmes being extended.
- Increased training capacity to be developed on PRUH site.
- Emphasis on S&M training at PRUH to improve compliance levels.

3.6 Key identified risks to quality inherent in the quality plans and how these will be managed

The Trust Patient Safety & Risk Management Department maintains the Trust risk register and ranks and monitors risk and the completion of mitigation plans throughout the year. Key risks under close scrutiny this year include:

- Lack of physical capacity across the Trust (frequently operating at over 99% bed occupancy) limits the ability of the Trust to optimally manage acute ED admissions, elective surgical admissions and tertiary referrals with potentially adverse implications for patient safety (e.g. increased outliers, admission delays), patient experience, financial position (lack of elective surgical revenue) and reputation. The risk is being addressed through ongoing capacity planning workstreams which includes development of infill 5 and a 60 bedded ICU at Denmark Hill, the opening of a CDU at PRUH and the use of the Orpington site to manage over-flow.
- Failure to fully embed Safer Surgical Checklist culture in surgical environments leading to further surgical “Never Events”. As a safety quality priority for 2014-15 specific work plans will be developed to mitigate this risk – monitored through the Patient Safety Committee.
- Failure to meet Emergency Department 95% targets. The PRUH CQC action plan and the Transformation and Integration Programme are specifically targeting this problem.
- Lack of availability of medical records at PRUH could result in appointment/procedure cancellations or patient consultations with suboptimal clinical information. This risk is being addressed through the PRUH CQC action plan
- Failure to meet inpatient 18 weeks targets and failure to meet cancer waiting times targets. This is being addressed through action plans in each area.
- Lack of robustness in systems for ensuring timely acknowledgement and follow-up of patient test results. This risk is being addressed through the Screening and Diagnostics Committee led by an Associate Medical Director.
- Staff training rates (especially at the PRUH) adversely affected by lack of training facilities and/or failure to release ward staff due to local staffing pressures. This is being addressed through the development of additional training space at the PRUH.
- Risk of suboptimal staffing levels (especially at the PRUH) due to high vacancy rates, low establishment rate, and challenges with regard to filling short-term vacancies with agency staff. This risk is being addressed through workforce planning and improvement plans with our recruitment service.
- Suboptimal management of patients at risk of falls could lead to serious patient injuries. As a safety quality priority for 2014-15 specific work plans will be developed to mitigate this risk – monitored through the Patient Safety Committee

3.7 Contingency built into the plan, escalation and mitigations if risks exceed quantitative upper and lower limits.

The Patient Safety Committee monitors all Trust-wide patient safety risks and the Organisational Safety Committee monitors all other Trust-wide risks. Risks specific to Divisions/Specialties are monitored by Divisional/Specialty quality & governance meetings. All risks scoring 12 and above are reviewed on at

least a quarterly basis by the Quality & Governance Committee. This Committee scrutinises the risks, their scoring and the adequacy of the mitigation plans and makes recommendations where it feels further action is required. The most serious risks (those scoring 15 or more) are also reviewed by the Board of Directors on a quarterly basis.

3.8 Overview of board assurance on the quality of services and patient safety

The Trust's Board governance structure comprising Audit, Quality & Governance, Finance & Performance and Strategy Committees together with the quality governance reporting structure, provide the framework for reviewing the effectiveness of the system of control.

The Quality & Governance Committee monitors, on behalf of the Board, the three dimensions of quality: Patient and Organisational Safety, Patient Outcomes and Patient Experience through a series of management committees chaired by Executive Directors. This enables a strong Board focus on all aspects of quality, the Trust's quality priorities and Monitor's Quality Governance Framework.

Following the acquisition of PRUH, King's established a Transformation and Integration Programme to oversee and drive the ongoing work required to embed change across newly acquired sites. Executive oversight and assurance against all integration and transformation actions will take place through regular reporting to the Integration Steering Group that has accountability for the five year integration plan.

The Board receives regular reports on all aspects of quality through:

- Monthly performance reports and scorecards
- Quarterly reports on patient safety, patient outcomes and patient experience and organisational safety. The overall quality of services at the PRUH and other new locations will continue to be monitored within the Trust's Quality Governance and Performance Frameworks. Through this infrastructure the Trust will assess how sustainable changes and improvements in quality have been.
- Quarterly Quality and Governance Report including detailed analyses of all serious complaints and adverse incidents together with actions taken and related service developments/improvements.
- Regular review of Assurance Framework and the Trust Risk Register and related actions to mitigate risks.
- Monthly report of progress against transition and integration actions, goals and risks through the Board Integration Committee. This will include driving improvements and monitoring against CQC compliance actions.

All members of the Board regularly conduct unannounced visits to clinical areas (called "go-sees") to observe practice and to meet staff and patients to discuss quality issues and concerns.

4 OPERATIONAL REQUIREMENTS AND CAPACITY

4.1 Market Share

Over the last 5-years King's provided over 464,000 spells of care for SE London CCGs (240,000+ were elective and 224,000+ non-elective) - 18% of all the SEL spells, making King's the third largest provider. King's total market share in SEL increased by 25% over the last five years from 18.6% in 09/10 to 23.2% by end Q3 13/14. This increase in share is largely a result of the PRUH acquisition in October 2013. Previously, KCH market share had increased by 2% in 5-years.

King's is now the largest provider of non-elective spells in SEL. Before the acquisition, the King's market share had increased by 3.7% over 5 years. Post-acquisition the share at King's increased by 63%, to a total of 35.6%.

King's is now the second largest provider of elective care in SEL. Following the acquisition of PRUH King's market share increased by 66%, from 17.3% to 28.7% share.

Our market share strategy will be set out in our five year strategic plan. Due to capacity and funding constraints, and the need to change the model of care, King's cannot seek to increase market share across all our portfolio and we will need to prioritise our target growth and disinvestment plans.

4.2 Site strategy

The growth in emergency admissions, along with a rise in acuity of patients being admitted, and an increased number of repatriations and delayed transfers of care has resulted in bed occupancy levels at Denmark Hill rising to over 99% in quarter 4 of 13/14 for both ward and critical care capacity.

This high level of occupancy is significantly impacting on the Trust's ability to meet ED (4 and 12 hour), RTT and cancer access targets along with tertiary patients having to wait too long in referring hospitals to transfer.

In December 2013 the Centenary Wing, comprising an extra 47 beds opened. However, to deal with the increased demand for critical care capacity a ward has been converted into additional level 3 critical care capacity. This means a net increase of only 11 beds which have been used to help support emergency demand.

The PRUH site has also been running at high occupancy levels again impacting on the ability to meet key access targets on the site.

In order to deliver access targets in 14/15 the trust must decompress both the Denmark Hill and PRUH sites by reducing demand for beds from both ends of the pathway:

- Reducing the number of beds blocked by delayed discharges and repatriations
- Reducing the number of patients being admitted on both sites.

The trust has established a Site Strategy Steering Group to oversee both the programme of work to rebalance the trust in the short term and the development of the Trust's 5 year strategy. This group reports to the Board, is chaired by the COO with the membership comprising both senior management and clinicians and local commissioner representation.

The short term rebalancing includes two key pieces of work:

- Getting patients who no longer need to be in our beds out – the Trust is engaging with NHSE and the local commissioners to review out of hospital care and ensure arrangements are in place with other organisations to reduce delayed repatriations and transfers of care.
- Reconfiguring the distribution of services across our 4 sites where we provide inpatient and day case care- Denmark Hill, PRUH, Orpington and QMH.

The detailed plans are still being finalised but comprise:

- Increasing the level of ophthalmology and dental day case operating we provide at the QMH site by moving activity from Denmark Hill and PRUH to release capacity in the day surgery units on both sites. In addition, day case operating for orthopaedics will be introduced at the QMH site during 14/15 in line with the requirements of the Bexley MSK tender.
- Increasing the level of elective adult surgical activity undertaken at Orpington Hospital to reduce the elective inpatient activity undertaken at Denmark Hill and PRUH. This will enable RTT waits to reduce and improve patient experience by removing the risk of cancellation.
- Moving elements of both elective and emergency inpatient activity at PRUH and Denmark Hill to each sites' respective day surgery unit. For example, at the PRUH elements of emergency surgical activity will move to day case rapid access lists, various elective urological procedures will move to day case. At Denmark Hill certain emergency maxillo-facial patients will move to rapid access day case lists.
- Broadening the range of conditions where patients in tertiary specialties receive treatment on a 'treat and transfer' basis, this means patients would return to their referring hospital on the same day thus reducing the number of patients needing to be admitted and then repatriated at a later date.
- Looking to restrict access to some services. King's receive a number of referrals to secondary services from a very wide catchment area, these patients should be managed by more local services and do not need to be treated at Denmark Hill.

4.3 Waiting lists

Kings has seen 8-9 percent annual increases in waiting list demand on the Denmark Hill site. As a result, the total number of patients waiting on our lists has increased from 5,700 to 6,500 patients in 2013/14. The number of patients waiting over 18 weeks for treatment has also increased from 1,500 to 1,750 patients. Patients waiting 52 weeks or more increased from 57 to 75 patients by the end of January 2014.

The 90% admitted target was not achieved in 2013/14 due to the required clearance of historical backlogs of long waiters, consistent with our plans submitted to Monitor. The number of long wait patients has not reduced as far as planned due to a number of key factors: the sustained growth in elective demand and growth in emergency admissions which have increased by 9% year-on-year over the last 2 years, as well as critical care pressures and delays in additional ward and theatre capacity becoming operational. The Trust has continued to use off-site capacity to assist in maintaining the backlog position during 2013/14.

The Trust has achieved the other two main RTT Waiting time targets: 95% of all non-admitted patients treated within 18 weeks, and 92% of all incomplete pathways being less than 18 weeks.

Our approach to improving performance on RTT for the coming year is:

- Detailed demand and capacity theatre modelling using DH Intensive Support Team templates
- Make more effective use of the available bed and theatre capacity across the enlarged organisation's hospital sites
- Review of proposals to restrict demand from out of area catchments
- Move the final few waiting list bookings from paper systems to electronic ones
- Rolling programme of refresher training of staff in admissions offices, outpatient areas and central Data Quality teams in RTT waiting list management and validation
- Review of proposals to make more effective use of the available bed and theatre capacity across the enlarged organisation's hospital sites
- Continue to move all waiting list bookings from paper systems to electronic ones
- Conduct refresher training of staff in admissions offices and central Data Quality teams in RTT waiting list management and validation
- Reinforcement of internal referrals policy with all new non-clinically urgent referrals to be sent back to the GP rather than referring directly to other consultants in Kings
- Review and implementation of revised reporting systems for admitted and outpatient waiting lists to identify potential future pressure areas

Trolley waits are also an operational priority, with 88 breaches at the PRUH in the last six months. Plans to recover this performance include:

- urgent care now operating 24/7

- CDU opening end of April
- Additional staffing in ED
- Elective and emergency admission wards
- 3 elective theatres opened at Orpington
- New PIU models of care
- Redesign of systems and care pathways
- Planned 'Perfect week' (if we put this in I will need to understand how we are approaching this)

4.4 Education and training

As a major teaching hospital, King's has plans for developing and improving education and training across all professions.

With funding from London LETBs we are procuring and purchasing new equipment and innovative technology to enhance training, for example in Orthopaedics. We will be the first Trust in Europe to have VirtaMed Arthroscopic Simulation technology.

We have embedded Leadership development in all our programs and at all levels of the medical workforce, including Foundation level. These future clinical leaders are already leading quality improvement projects across a broad range of services.

As both Lead Provider and Local Education Provider, we continue to make significant progress to keep King's at the forefront of medical workforce training and development. Future plans include:

- Align education, training and development opportunities across the two sites for the whole workforce
- Work with KCL to develop accredited programmes in leadership and research skills
- Work with the wider community to develop robust community placements/experience for trainees
- Develop multi-professional simulation training programmes, focusing on patient safety and human factors training
- Develop robust governance arrangements with KCL to ensure the student experience, whilst on campus and on placement, is the best it can be.

King's hosts the largest and most comprehensive range of programmes for Dental Care Professionals in the UK. King's dental school provides specialist training programmes (HESL funded) in:

- Orthodontics
- Oral Surgery
- Oral & Maxillofacial Surgery
- Special Care Dentistry
- Restorative Dentistry
- Paediatric Dentistry
- Dental nursing
- Dental therapy
- Maxillofacial prosthetists

King's now also provides rotational training for the Kent, Sussex & Surrey Deanery in Paediatric Dentistry and Restorative Dentistry.

The Health Education South London (HESL) Board has granted King's £1m to develop several education, training and development projects over the next two years across the organisation to help us create a workforce capable of meeting the new challenges.

- Developing Action Learning Groups in Therapy disciplines for peer to peer learning and development.
- Providing enhanced medical education & training across all divisions and specialties.
- Overseas doctors development programme.
- Production of Structured Welcome Learning Pack for new nursing, midwifery, medical, and allied health professional students, to ensure consistent messages on culture, attitudes, expectations.
- New education programme for Health Care Assistants to provide continued skills development.

- New Health Care Sciences Career Path. 2 projects supporting apprentices in medical engineering and medical physics, to develop innovative ways to bring young local people through to foundation degree level to work as multi-skilled technicians across the Trust.
- New advanced communication skills training.

Further multi-professional training opportunities are planned for the next two years include:

- The use of simulation training via a 'body suit' is being extended to Health Care Assistants and Therapy Assistants in order to enhance their skills and care of elderly patients.
- The second and third cohorts of the Strategic and Operational Leadership programme will begin in 2014 for leaders across the expanded organisation.
- We continue to run the award winning Front Line Leadership programme in conjunction with GSTT.
- We will run an accredited Coaching programme in conjunction with SLaM, commencing 2014.
- Around 700 nursing and midwifery staff p.a. gain post registration qualifications. A key part of future plans is to ensure equity of access across all the sites in the expanded organisation.
- We continue to run an apprenticeship programme; 80% of the young people who started in 2012 gained employment post apprenticeship. 28 new apprentices started in March 2014 and a further 10 will be recruited specifically for the PRUH/Orpington summer 2014.

4.5 Research and development

King's aims to integrate clinical research into all patient care, with all staff being directly aware of the opportunities for patients to participate. Patients involved in transitional, clinical, or health services research, or treated by a team who are research aware get the best treatment, investigation, and outcomes.

From Oct 2012 – Sep 2013, 4,834 patients receiving health services provided or sub-contracted by King's were recruited to 197 NIHR portfolio research studies. There were also more than 600 non-commercial and 200 commercial clinical research studies. Nationally, King's has the second highest number of commercial trials (223), and the fourth largest number of complex trials (145). Grant awards exceeded £8.8m. Over 400 Principal Investigators across 26 specialities participated in research. There were 850 publications involving KCH staff or patients in 2013.

The next two years present a mix of opportunities and challenges. Collaborations with KIS and CLARHC are mentioned elsewhere. Plans are in development to expand research into the PRUH and recruit patients from the radically expanded population base. Our developing Research and Development Strategy includes plans to expand our portfolio of studies by fully utilising the Clinical Research Facility at KCH. As our NIHR performance against the 70-day target remains at 26%, we are restructuring our Research Support Team in concert with changes in the Clinical Research Networks and NIHR. Process improvements will deliver study approval and recruitment to NIHR defined targets. Planned staff restructuring reflects the move away from governance towards proactive feasibility testing and business development – and will arrest the 18% decline in recruitment of the last year.

5 PRODUCTIVITY, EFFICIENCY AND CIPS

5.1 Major Integration and Transformation Programme

Central to our operational task for the next 2-years is the effective transformation and integration of services across the enlarged organisation and the delivery of savings and benefits in line with the expectations of the Full Business Case for acquisition. We want to:

- Create one hospital across several sites and bring together services to maximise effectiveness and quality.
- Maintain an overriding focus on safety and quality - tackling variation and continuously learning.
- Secure financial sustainability as an enlarged organisation over 5-years (achieving all Monitor's required levels of financial and quality performance)

To do this, King's has set up an interconnected programme covering all aspects of the integration. The programme will set direction for the programme and support divisions and departments in delivering change. Activities include:

- Integration work streams.
- The major transformation projects relating to unlocking efficiency and productivity across the trust.
- CIPs monitoring and delivery support.

This programme is governed by the Board Integration Committee (a sub-committee of the Trust Board with delegated authority) and executed by the Integration Steering Group (chaired by the SRO, attended by all members of the Executive and the core programme team).

The Transformation and Integration Programme Office (TIPMO) led by the Transformation and Integration Director has been established to:

- Design and plan major projects.
- Monitor progress of major projects and CIPs.
- Provide delivery support, project management and monitoring of integration workstreams.

The integration work streams cover a range of priority activities relating to 1) Clinical operations; 2) Corporate services; 3) Governance and workforce. We also have an underpinning programme of engagement and communications, to support culture change.

Driven through the work streams and major projects, the current priority of the integration is to ensure change is embedded and we focus on securing a strong sustainable operational baseline. Activities include increasing the levels of front line staffing, establishing unified governance, optimising the entire clinical estate and establishing the best configuration of services to increase access and quality for all.

5.2 Transformation projects

Six major transformation projects have been set up with work plans for the next 2-years aimed at driving increasing productivity and efficiency and summarised as follows:

5.2.1 Outpatients

Objectives: an assessment of core OP productivity metrics (e.g. DNA, N/FU activity) to identify CIPs. The improvement plan includes:

- roll-out the successful pilot for auto-check-in and patient streaming using a call-forward system, development of outpatient services at Orpington
- centralised booking for all appointments and full roll-out of noteless clinic operation
- a demand & capacity model, and the implementation of room management systems.
- DNA 10% target £3.1m (based on income), Patient Cancellations- Rebooking of short term cancellations £900k, New to follow ups £0.5-1.8m.

5.2.2 Length of Stay

Objectives: reduced Length of Stay (upper quartile) to reduce occupancy and bed-pressure at Denmark Hill to create capacity for tertiary services. This will improve patient experience, reduce outliers and ensure elective capacity is used for elective patients, increasing income. The workplan includes:

- Benchmark LoS data showing performance against agreed peer units
- Specialty level action plans to reduce LoS and release capacity / cash benefit
- Stretch LoS targets for elective-only sites (Orthopaedics at Orpington and Denmark Hill, Gynaecology at PRUH)
- Financial target: 2014/15 is £3.4m

5.2.3 Nursing Productivity

Objectives: ensure a substantive nursing workforce across the whole organisation that is fit for purpose; correct establishment, appropriate skill mix and efficient ways of working with reduced reliance on temporary staff. The workplan includes:

- Processes to minimise temporary staff usage by improving vacancy fill rates, active monitoring of spend, and effective rota planning
- Developing a system to reduce reliance on agency specials and optimise use across departments
- Improved E-rostering, reporting, planning and monitoring
- Specials: £1.7m reduction in temp spend (£250k CIP)
- Temp staffing*:* £3m (based on 10% reduction) £4.5m (based on 15% reduction)

5.2.4 Admin and Clerical Staffing productivity

Objectives; ensure an administration staff that organised to carry-out support tasks with consistent and defined quality with maximum efficiency. The workplan includes:

- role assessments and proposals for reduction/redeployment;
- alignment of job descriptions and bandings;
- standardised best-practice medical secretarial service to consultants using IT solutions;
- review of temporary A&C staff request process and reduced use;
- vacancy review and removal of posts;
    - Medical Secretaries: £500k
    - Temp staffing: £600k

5.2.5 Medical productivity

Objectives; ensure a medical workforce that consistently and optimally productive across all sites and specialities. The workplan includes:

Objectives:

- Complete consultant job planning cycle (including Specialty Doctors) across all sites by April 2014
- Develop medical productivity outcome metrics that result in productive, DCC-heavy consultant practice. Establish internationally driven stretch productivity targets. Develop CIPs for WLIs, Agency Spend, SLAs etc.
- Use demand/capacity models to plan matched consultant and medical resources
- Service Review Methodology – Develop and pilot in orthopaedics
- Innovative Service Models - Develop operational models that maximise use of plant and medical workforce using international and private sector exemplars
- CIPs to reduce PAs >12, clinical lead roles: £410K
- Reduction in additional sessions/temp staffing £710K (cost avoidance)

5.2.6 Theatres Productivity

Objectives; ensure the operation of theatre capacity has (1) robust scheduling (2) ‘pull’ processes for cases through theatre. The workplan includes:

- Optimal planning of in-patent lists to match case lengths and increase single speciality allocation of theatre capacity
- Reconfiguration of ‘cold elective’ specialties theatre capacity to decompress Denmark Hill
- A demand & capacity model and ‘use it or lose it’ operating principle
- Operate an ‘all elective surgery to default to day case’ system

- Stretch targets for elective-only capacity
- DSU 14/15: £1.7m
- IP 14/15: £0.38m

5.2.7 Information Management and Technology

IT is critical to the successful integration of the organisation and the adoption of modern paper-light patient-focused processes that are consistent and standardised across all sites. This work will continue in parallel to the Transformation, Integration and CIP Plan. The priority in 2014 / 15 is to bring the ex-SLHT sites into line with the Denmark Hill systems. The major pieces of work are:

- Migrate to i.PM at the ex-SLHT sites
- Combine and rationalise the diagnostic systems and services
- Implement an Electronic Document Management System
- Upgrade i.CM to suitable hardware and software levels
- Upgrade the infrastructure at the ex-SLHT sites – install a wireless network (working with PFI)
- Implement EPR at the ex-SLHT sites (end of 2015)

Other developmental work to improve existing systems and support heath system working includes:

- Clinical information sharing across KHP, SLIC and Primary Care.
- Development of electronic clinical forms via KSSF

5.2.8 Culture and Workforce

A key priority of integration in 2014 /16 is to develop and enhance the organisational culture and perceptions of the workforce to the impact of the transaction. Bringing together 2 large organisations with a total of 11,000 staff is challenging. The transformation programme has developed ‘All Together Better’, a programme of culture change designed to respond to the feedback provided to us by our staff on the issues that matter to them. We will undertake a range of engagement, communications and other activities seeking to bring together the culture of the enlarged organisation into one high-performing “Team King’s”.

6 FINANCIAL PLANS

6.1 Cost Improvement Programme

6.1.1 Historic Performance

The CIP process is on course to yield a 70-75% achievement rate over the past year, although some cost reduction elements have been underachieved and in some cases replaced. The CIP achievement rate has historically been higher than this (82%), despite targets of £45m and £40m over the past two years.

6.1.2 Overview of PMO

The Chief Financial Officer and Chief Operating Officer are accountable for the delivery of the CIP programme. This is managed by an internal PMO group, with support from the Transformation & Integration PMO to develop the more complex schemes.

There is robust project management of the process and detailed documentation which highlights the risks to implementation by employing a RAG rating system to all plans, and requires detailed project planning of all schemes above £100k in value.

On a monthly basis, CIP achievement is logged onto delivery trackers and reported to the PMO and to the finance committee. Divisions and responsible leads then meet monthly to discuss progress and risks identified. If the PMO lead is not satisfied with the management of any element of the programme, then the named lead for the CIP will report either to the PMO in full, or the executive at the monthly performance meetings.

Risks are identified through the trackers, and reports produced highlighting those areas of red risk, including an assessment of the impact of these risks. This is identified both at the planning stage, and throughout the implementation of the schemes, including continual assessment of those schemes yet to begin. Mitigations are the Trust holding a central reserve against non-achievement, and also through a change control process whereby original plans may be substituted if suitable replacements can be found.

6.1.3 CIP Profile

The Trust has set a Cost Improvement Programme target of approximately £40m year on year which combines cash releasing savings and additional income generation schemes. However, with the acquisition of the PRUH the CIP target for 14/15 has increased to circa £70m.

The Cost Improvement Programme has various productivity and efficiency gains built into plans, including the following which are made up of various schemes:

- Length of stay: £2.8m
- Theatre productivity: £2.1m
- Outpatient Productivity: £4.5m
- Workforce Productivity (incl. Nursing, Medical & Admin & Clerical): £5.8m
- Additional bank and agency spend reduction: £5m
- Procurement: £5.1m

6.1.4 Key CIP Schemes

The Cost Improvement Programme (CIP) covers a wide range of areas to achieve the targets, including:

- Outpatient productivity schemes focussing on QIPP, DNA rates and Follow ups – mostly risk rated red
- Workforce productivity reviews focusing on medical, nursing and administration staff with the aim to reduce staff sickness, recruit to vacancies and therefore reduce temporary staffing use – mostly risk rated amber
- Trust wide financial controls including procurement, pharmacy and energy initiatives – various rag ratings
- Divisional and Corporate specific tactical cost saving measures – mostly rated amber and green
- Income growth and diversification - mostly rated amber

These CIP themes are supported by an internal Programme Management Office (PMO) combining with the Trust's Transformation & Integration Programme and currently external support from Ernst & Young to develop the more complex schemes.

A key factor of the productivity gains will be managing the reconfiguration of Cold elective specialties theatre capacity in order to support decompression of Denmark Hill site, as well as embedding the Denmark Hill culture at the PRUH.

The Trust will maintain a focus on financial expenditure controls such as reducing expensive agency and locum spend by permanently recruiting to new posts and reducing absence leave through effective rota planning. This will improve the quality of care and meet the rising acuity demands of the hospital case-mix, as well as facilitating improved Length of Stay schemes, and cessation of offsite outsourcing of certain procedures.

The development of cost improvement and income diversification schemes includes:

- The maintenance of existing cost controls (e.g. reducing agency staffing)
- The design and delivery of focused Cost Improvement Programmes (CIP)
- The identification of new income streams including increased private patient work, taking advantage of the relaxation of the Private Patient Income cap.
- The implementation of hospital based transformational and productivity projects to deliver 'step change' efficiencies
- An on-going programme to transform outpatient care and improve productivity
- A continuation of the programme of Nursing, Medical and Admin & Clerical productivity
- Embedding King's values across all sites, including the PRUH, Orpington and Sidcup

6.2 KCH Financial Position 2013/2014

Turnover is expected to be £867m by 31 March 2014. Income from patient activities is £721m (83%) and other operating income is £146m (17%).

Operating expenses are expected to be £852m for 2013/14 of which employee expenses are £489m (57%).

The Trust is expecting to achieve an operating loss of £6m in 2013/14 (excluding any property impairments charged to operating expenses) against a surplus plan of £2m. The reason for the £8m variance is due to the requirement to use off-site working in private hospitals at a cost of £6m and the substantial increase in nursing agency and medical locum expenditure. This related to high acuity patients (elderly and frail) requiring 1:1 nursing care, medical investment in acute medicine services and vacancies in specialist nursing wards.

Under Monitor's Compliance Framework, the Trust maintained a financial risk rating of 3 over the last couple of years throughout each quarter. From 1 October 2013, the Compliance Framework was replaced by the Risk Assessment Framework and the 5 financial risk rating were reduced to two financial sustainability (continuity of services) ratios: Capital Service Cover and Liquidity. At quarter 3 2013/14, the Trust obtained a Continuity of Service Risk Rating of 3 and is forecasting to maintain this rating at quarter 4 2013/2014 and over the next 2 years.

The increasing revenue cost base and capital plan commitments are impacting adversely on these ratios as the surplus margin has not increased in line with turnover and the liquidity days is deteriorating. The central 4% efficiency targets, PCT QIPP requirements, inflationary cost pressures (e.g. PFI and utilities) and off-site facility cost pressures have all restricted the surplus margin to the bare minimum.

Income from activities has increased by £132m in 2013/14, approx. £82m of this increase relates to activity at the PRUH and QMS. The increase at the Denmark Hill site was across all patient services: elective, non-elective, outpatient, A&E and all national specialist services provided across London and nationally. The planned income generation for Denmark Hill was £22.6m and the unplanned income related to additional non-elective emergency work and activity growth not funded by Commissioner's in the baseline contract. The Private patient income remained static and below plan due to capacity related issues and loss of work to the Private Sector.

There was a significant amount of non-recurring, unplanned funding from the local CCGs in respect to winter pressures (£5.9m). The Acute medicine admissions for high acuity patients (frail and elderly) impacted on the Trust's elective bed capacity and off-site private facilities had to be utilised for elective RTT work. There was also a necessity to employ additional medical and nursing staff (1:1 patient care) in Acute Medicine and the investment in the development of Infill Block 4 (providing additional bed and theatre capacity), additional CDU capacity and Interim Critical Care capacity (Christine Brown ward) ahead of new Critical Care development. This investment was crucial to maintain patient quality.

The income relating to drugs (excluded from the tariff) increased from £29.9m to £53.2m, £1.3m of the increase relates to the PRUH and QMS. This year there was a change in the way CCGs funded some drugs. Previously drugs companies billed the CCG's directly but this year the companies were required to bill the trust and the trust then had to recover the income from the CCGs. Some of the increase relates to activity growth.

The CIP achievement for financial year 2013/2014 is expected to be £32.2m of which £18.3m relates to income generation schemes. The income generation schemes included CCG demand management activity reductions (activity reductions without robust plans), income coding improvements and income productivity gains.

The activity increases will be recurring and built into the 14/15 contract baselines.

The Trust is due to bill £60m in respect to Commissioner Contract over-performance for 13/14. The cash balance is expected to improve from £40m to £72m in year due to cash being held for payments against the capital program. The net current asset position is expected to be maintained in 2013/14, but will begin to deteriorate from 2014/15 due to the large capital program which will reduce cash reserves.

Due to the over-performance billing arrangements with NHSE and CCGs, an in-year cash-flow problem is created for the Trust. A working capital facility needs to be maintained to cover this risk. The working capital facility is currently £40m, but will be reduced to £10m from March 2014, as this facility is not factored into the calculation of the Liquidity ratio, and reducing the facility will reduce the costs of arrangement and non-utilisation fees.

In summary, the Trust has not been able to maintain financial balance due to capacity constraints in face of the emergency activity demands. The investment plans to expand the bed and theatre capacity are key to meeting patient demand and providing quality patient services, within the financial constraints.

6.3 The Trust's Financial Strategy and Goals over the Next Two Years:

6.3.1 Summary

The Trust's fundamental objective is to maintain financial stability in a difficult economic climate over the next two years, while delivering positive outcomes to patients in particular achieving RTT access targets and improving ED/acute medicine patient pathways. The financial targets will be a breakeven position for 14/15 and £4m for 15/16 (excluding asset impairments) and to achieve a Continuity of Service Risk Rating of 3. The CIP will be divided between cost savings and income generation and with the acquisition of PRU the target has now increased to £70m.

6.3.2 Capital and Capacity Plans

The key capacity investments are:

- Critical Care Unit (2015 - 2017): 60 Critical Care beds in two equal phases
- Infill Block 5 (July 2017): 120 new beds and a Hybrid theatre/Catheter Lab and Cyberknife (enabling works will reduce the bed pool permanently by 56 beds).

This is in conjunction with current operational plans to reduce demand management, increase off-site care provision (MediHome contract), improve in-hospital productivity and drive further quality improvements.

Over the course of this plan the Trust needs to address two key capacity constraints:

- The expansion of Critical Care facilities is vital to the Trust in order to meet the demand for Critical Care Services and consolidate its position as one of the leading Trauma and Stroke centres in

London. The planned expansion of these facilities is a core component of the Trust's capital plan, requiring an investment of £60m over the next 2 to 3 years.
- The establishment of new, temporary ward and theatre facilities to create sufficient capacity to meet the increase in emergency activity, reduce waiting times (both elective and urgent tertiary transfers), deliver all access targets and accommodate strategic changes in activity. The Trust has installed a modular built ward and theatre block (Infill Block 4), replacing a current temporary building; and the plan is to build an additional ward and theatre block (Infill Block 5) to create further capacity. These two developments provide a net increase of 112 beds, an additional theatre, catheter lab and hybrid theatre. This development will also increase the Private Patient capacity to ensure these investments are financially viable. These medium term investments will enable the Trust to develop and maximise any opportunities regarding the break-up of SLHT.

The capital plan requires investment of £53.8m in 2014/15 and £72.5m in 2015/16. £72m of which is to be funded through external loans from the FTFF as well as Capital funding from the Trust Development Authority (TDA) of £20m for Infill Block 5 for which the Trust is currently working on the business case.

Key capital developments over the two years include:

- Critical Care Unit - Critical Care Service expansion is to support the Hyper Acute Stroke Centre and Major Trauma Unit. This project is estimated to cost circa £60m and to be completed in 2016/17. Circa £42m will be spent within the next two financial years.
- Infill Block 5 – This development is to increase the Trust's capacity. A business case for this project is being developed and more information on this will be available shortly. This project is estimated to cost circa £80m and will be completed in 2017/18.
- Site wide infrastructure - Due to the Trust expansion which includes the Critical Care Unit and Infill Block 5, the Trust need to upgrade the infrastructure to support the expansion and future developments. This is expected to cost £4m over the next three years. Also, £1.5m is to be spent on the installation of Second Ring & Generators as the current systems are stretched to capacity.
- The Helipad - The Trust needs to build an Helipad on top of Ruskin wing building to reduce the current time taken to transfer patient from the park currently been used by the Trust. This project will cost £5m. In addition, £1.9m will be spent in 2015/16 on replacing and upgrading windows on the upper floors of the Ruskin Wing to reduce noise and the admittance of aviation fuel fumes.
- Energy Infrastructure project is geared towards driving efficiency savings as well as creating an environment to support further development. The project commenced in 2013/14 and will be completed in 2014/15 at a total cost of £8m.
- Orpington Hospital - Circa £2.4m will be spent on Orpington hospital to increase capacity as part of the Trust's reconfiguration strategy. This will include modular theatre facility, relocation of Medical Records Library and reconfiguration of reception, security and dining areas.
- Princess Royal University Hospital – Spend on the PRUH site will include an on-site Medical Records facility, Paediatric Outpatients move from Beckenham Beacon site, changes to the Antenatal Clinic and the redevelopment and expansion of the Chemo service.
- The ultrasound reconfiguration and vascular project (£2m), Emergency Department reconfiguration (£0.2m), Mortuary expansion (£0.3m) and Renal Dialysis capacity (£1.5m) are all focusing on activity growth and improving the quality of care.

Other major projects and minor works will ensure the Trust provides a clean and safe environment for patients, staff and visitors as well as meeting obligations regarding mixed sex accommodation, patient dignity and infection control. An investment in the energy and utilities infrastructure; together with IT systems investment will drive cost efficiency targets.

6.3.3 Quality and Productivity

The financial strategy focuses on the patient quality and productivity challenges in light of the General Medicine emergency activity pressures. The financial plan incorporates a balance of investment in key services and productivity measures across the organisation as a whole to achieve the patient and efficiency targets. This involves investment in infrastructure and nursing staff to meet national Access targets, and CQUIN/NICE quality targets. The CQUIN value in the 2014/15 Commissioners' contracts should reach £15m impressing the requirement to meet the quality targets from a financial perspective. Managing the increasing Emergency and Critical Care activity demand is crucial to the Trust's financial and operational strategy. These services have to be managed without detrimental effect on the rest of the hospital, in the delivery of services within the allocated theatre, bed and diagnostic resource.

6.3.4 Operating Revenue

The Trust's income plan is built upon last year's activity outturn less the projected PbR tariff deflator and Trust-led QIPP savings (£10m in respect to Lambeth, Southwark and Bromley CCGs and potentially £3m in respect to the NHSE contract). The tariff deflator is based on 4% efficiency savings less Treasury pay and prices estimates; resulting in reductions of 1.5% in 2014/15 and 1.6% in 2015/16.

The impact of CCG led demand management targets are built into the financial plan however, no robust evidence has been provided for these plans. Therefore the capacity and planning modelling has to be flexible to meet the likely demand beyond contract values and the anticipated RTT targets. The Lambeth, Southwark and Bromley CCG led QIPP is circa £9m based on reducing emergency admissions and outpatient first attendances.

The turnover is projected to increase due to the new developments and the income generation schemes from £872m to circa £1,000m next year. This income figure includes £26m from Private Patients and Commercial sources and impact of PRUH. The increase includes PFI support £11m, Revenue Integrations £11m (14/15) and £5.5m (15/16) and bridging support £19m (14/15) and £8.4m (15/16).

The local CCGs have invested in the additional capacity for AAU and CDU on a recurring basis, together with the Emergency Admission investment regarding the PbR marginal rate to cover the winter pressure investments on a recurring basis.

Income growth is based on demand and capacity planning to meet RTT targets, and specific service developments to meet tertiary activity and private patient demand. Based on the current waiting time performance, the following specialties require additional investment and greater productivity: general surgery, orthopaedics, neurosurgery, urology, ophthalmology and gynaecology. Not achieving these targets could be a material financial risk based on the NHS National Contract penalties.

Income diversification is a key strategic opportunity, and we are developing our Private Patient and Commercial services both at home and abroad to generate further investment into NHS care. A number of joint venture projects are underway; involving an Abu Dhabi Consortium, Bhurjeel Hospital Fetal Medicine, Saudi Homecare and a Kuwait Clinic.

A further financial strategic pressure on the organisation is the reduction in Training and Education funding for 2013/14 was £4.4m and an additional £2.6m in 14/15 on a recurrent basis. There is very limited cost savings associated with this income reduction and this funding gap creates additional pressure on the cost improvement programme.

The Trust has received Project Diamond funding (£2.6m) and the R&D MFF income (£0.7m). This is transitional funding and will eventually be wrapped up in PbR prices for 15/16, but could still be a potential income risk for 14/15.

6.3.5 Operating expenses

In order to achieve last year's activity outturn, recurring investments in additional staff, drugs and clinical supplies have been established and aligned to the planned activity levels. The need to recruit additional staff, rather than recruit expensive agency staff is a key objective for the Trust to maintain patient quality standards and financial stability. A further £3.2m has been invested in Nursing establishments recurrently to ensure patient quality care is provided in a safe and caring environment. This is subject to each Division developing medium term recruitment plans and reducing sickness levels.

The inflation assumptions are risk adverse; pay (1% to 1.7%) and non-pay (1.5% to 1.2%). Current inflation is 2.5% and therefore a contingency reserve has been established within the downside inflation assumptions.

6.3.6 Short term focus

The Trust has set a Cost Improvement Programme target of approximately £40m year on year which combines cash releasing savings and additional income generation schemes. However, with the acquisition of the PRU hospital the CIP target for 14/15 has increased to circa £70m.

The Cost Improvement Programme (CIP) covers a wide range of areas to achieve the targets, including:

- Outpatient productivity schemes focussing on QIPP, DNA rates and Follow ups – mostly risk rated amber

- Workforce productivity reviews focusing on medical, nursing and administration staff with the aim to reduce staff sickness, recruit to vacancies and therefore reduce temporary staffing use – mostly risk rated amber
- Trust wide financial controls including procurement, pharmacy and energy initiatives – mostly rated amber and green
- Divisional and Corporate specific tactical cost saving measures – mostly rated amber
- Income growth and diversification - mostly rated amber

These CIP themes are supported by an internal Programme Management Office (PMO) combining with the Trust's Transformation & Integration Programme and currently external support from Ernst & Young to develop the more complex schemes.

A key factor of the productivity gains will be managing the reconfiguration of Cold elective specialties theatre capacity in order to support decompression of Denmark Hill site, as well as embedding the Denmark Hill culture at the PRU.

The Trust will maintain a focus on financial expenditure controls such as reducing expensive agency and locum spend by permanently recruiting to new posts and reducing absence leave through effective rota planning. This will improve the quality of care and meet the rising acuity demands of the hospital case-mix, as well as facilitating improved Length of Stay schemes, and cessation of offsite outsourcing of certain procedures.

6.3.7 Medium term focus

The main NHS additional income stream will be the Critical Care service expansion in 2015/16 and 2016/2017.

Income diversification is the other key strand to this element of financial strategy, along with the reconfiguration of services with KHP and at the Princess Royal Hospital.

6.3.8 Commercial Activities

The current commercial strategy is framed around a number of discrete sectors where there is considered to be a commercial opportunity:

- Information systems
- Private patients
- Outsource services
- Overseas opportunities
- Other IP development and commercial trials
-

It is intended that over the period of this plan KCH Commercial Services will seek to maximise opportunities within these sectors. The surplus generated from additional commercial activity will be re-invested in NHS services.

6.3.9 Reconfiguration of Services

The Trust will continue to work with Commissioners and others to improve GP and Community services, to ensure patient services are provided in the most appropriate setting to secure the best clinical outcome. The Trust will mitigate any financial impact of activity moving from the hospital to the community by using released capacity to develop and extend specialist hospital services.

6.4 Key risks to achieving financial strategy and mitigations

6.4.1 Funding cuts

Funding cuts as a result of tariff changes (national efficiency deflator across tariff and non-tariff prices), education and training tariff reductions and no additional investment in emergency in-patient services.

Potential Impact: Breach of terms of authorisation (financial rating), inability to meet cash commitments; material reduction in income; inability to invest in CAPEX; difficulties in recruitment (agency high cost).

Mitigating Actions: Implementation of Medium Term Financial Strategy:

- Increased cost controls to improve margins, with a focus on agency staff and procurement approval limits to include medical locums, nursing and admin and clerical staff

- Improve productivity through capacity developments and reduce Acute Medicine outliers
- PMO performance meetings with Division's to deliver CIP targets (weekly and monthly)
- Cost improvements are linked to transformation programme to ensure benefits realisation. Savings plans reviewed by E&Y both King's and PRUH
- Ongoing programme of internal audits across Estates, Financial Management and Financial Reporting
- Executive led weekly review of cost improvement programme (CIP)
- Income diversification through commercial services arm with strengthened team to increase non-clinical income
- KHP joint working to minimise direct costs and overhead costs

6.4.2 Lack of capital

Failure to develop King's estate as a result of lack of capital expenditure and financial constraints.

Potential Impact: Detrimental impact on patient experience as a result of the inability to provide the range of services needed; Adverse impact on income; Failure to deliver access targets; Loss of tertiary referral base due to increased waits and loss of Private patient work to the private sector.

Mitigating Actions: Capital programme produced to provide major developments in: Critical Care and Infill Block 5, as well as expansion of services at PRU and Orpington Hospitals. Progress of schemes will be dependent on the delivery of the financial strategy.

6.4.3 Loss of income

Loss of clinical activity and therefore income as a result of strategic commissioning decisions, the instability of local healthcare economy (Trust and CCG led QIPP targets circa £20m) and the aspiration of other local providers.

Potential Impact: Loss of specialist service(s) adversely impacting on supporting dependencies and trust reputation resulting in loss of income; Risk of reduction of secondary services potentially leading to viability problems.

Mitigating Actions: Regular engagement and joint working with new Commissioners at local and national level.

- Regular fora with other local acute providers to review strategy and discuss possible areas of joint working.
- King's is closely involved in the development of the integrated cancer system and South London tertiary Paediatric network and is a leading stakeholder in the local Integrated Care Pilot.
- Consolidated response to commissioners' reviews as King's Health Partners.

6.4.4 Insufficient capacity

Insufficient capacity to meet increases in demand from emergency and 'winter pressure' activity

Potential Impact: Inability to meet activity and income targets; RTT financial penalties.

Mitigating Actions: Capacity investments – Infill Block 5; Critical Care Unit.

6.4.5 Liquidity Ratio

Liquidity ratio (days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown): issues due to non-payment by new commissioners (CCG and NHSE) for activity over-performance, a committed capital programme and monthly leasing payments for modular units.

Potential impact: the Trust's expansion in capacity and turnover could lead to delayed patients from commissioner's resulting in cash-flow problems and breach of terms of authorisation (liquidity rating).

Mitigating actions: Maintain a working capital facility of £10m reduced from £40m to obtain savings in regards to non-utilisation fees and arrangement fees.

6.4.6 Capital Servicing Capacity Ratio

Capital Servicing Capacity Ratio (the degree to which the organisation's generated income covers its financing obligations): additional financing costs, such as interest on external financing borrowed to fund large capital projects, reduces the ratio of income generated to financing obligations and the resulting Trust risk rating.

Potential impact: the Trust's expansion in capacity through externally funded capital projects and PFI schemes could lead to a reduction in the Trust's ability to service these debts and a breach of terms of authorisation (Capital Servicing Capacity).

Mitigating actions: Maintain a working capital facility of £10m reduced from £40m to reduce interest payments. Increasing revenues generated by the new developments will offset the increased financing costs.

7 Annex: King's Health Partners, Southwark and Lambeth Integrated Care and Health Innovation Network – joint statements for partners' Operating Plans (FOR PUBLICATION)

7.1 King's Health Partners

King's Health Partners is one of six Academic Health Sciences Centres (AHSCs) in England. King's Health Partners was first accredited by the Department of Health in 2009 and was recently awarded a further five years from 2014 following a competitive application process. The partners are Guy's and St Thomas and South London and Maudsley (SLaM), Kings College Hospital NHS Foundation Trusts and King's College London. The AHSC serves over 3.6 million patients each year and includes 31,000 staff, 25,000 students and has a combined annual turnover of £2.8 billion.

The combination of the University and three leading Foundation Trusts in our AHSC enables a strong focus on the integration of our tripartite mission: to equally promote clinical, education and research excellence. Enabling the improved pace of translational research from bench to bedside will support our patients, commissioners, staff and students in their ambitions to be part of highly effective health services that deliver high quality and financially sustainable healthcare.

King's Health Partners has been considering a number of options about how the partners might work more closely together in future and achieve more for patients by reducing constraints in the current model. An Outline Business Case was produced in October 2013 which considered options including a full merger of the three Foundation Trusts and even closer working with King's College London.

In November 2013 the King's Health Partners Board announced that it was not the right time to progress merger considerations, due to uncertainties in the regulatory path. The need for organisational change on such a scale and complexity requires a measured pace, informed by clear evidence of the benefits for patients and communities. It was agreed that a full business case for merger would be launched as soon as the environment allowed feasible.

Whilst recognising that we will not proceed immediately to merger, it is important that the 2 and 5 year organisational vision and goals are considered within the spirit of our wishes to be an integrated organisation and as such we will pursue the consolidation and best fit of services to enable this.

In the meantime, King's Health Partners is committed to an ambitious programme of work, and a revised governance structure which will be announced soon. Programmes leading to better health for our patients are set out below.

Treating the 'whole' person – with SLaM at its heart, King's Health Partners is working to ensure that patients' full mental and physical needs are met along clinical pathways of care. These include addressing the physical health needs of patients with serious mental illness; earlier identification and treatment of large numbers of hospital inpatients with dementia and long term conditions and those who enter our emergency trauma and acute medicine services. We will achieve this by:

- Ensuring all patients with chronic physical disease are screened for mental health co-morbidities through extending the IMPARTS programme that supports our objective to deliver integrated care for the 'whole person'. Data collected will drive research and promote continuous improvement in clinical practice
- Training our students and staff to deliver more integrated care (including physical and mental health). We will integrate care around the patient by bringing together our academics and clinicians to overcome traditional distinctions between mind and body
- Extending opportunities for students to undertake more joint or intercalated degrees with other academic disciplines. We will support new professional roles, such as integrated care practitioners, who work across physical and mental health and social care.

Delivering improved patient experience and value across patient pathways of care- KHP has a strong commitment to, and capability in value based healthcare. Across the partnership we will increase value by improving outcomes that matter to patients per pound spent. The changes we make to our services will be based on the value proposition. Over time we will work with primary, community and social care

to increase value across the health and social care economy that will influence new and innovative integrated care pathways. We will achieve this:

- Prioritising patient experience and outcomes are the most appropriate measures of the success of our mission to integrate research, health education and patient care. We will measure and share key outcomes across our CAGs, recording metrics including academic outcomes as well as quality of care and clinical measures
- Publish CAG outcome books and develop internal scorecards to improve variation of quality, safety and patient experience outcomes
- Developing our informatics so that patient electronic records can be shared across the partners to improve safety, quality and timely care.

We will build on our position as Europe's lead provider of health education, and continue to strive for international academic and research excellence to improve care delivery, we will deliver this by:

- Strengthening our Education Academy to ensure consistent standards of excellence. Roll out more innovative courses, including MScs, and further develop our online Learning Hub so that within five years it is a national and international resource for healthcare staff, students and trainees
- Pooling clinical and academic expertise within our CAGs, using our research infrastructure to accelerate the translation of research into new drugs and treatments
- Using improvement science to inform practice and develop improved evidence-based care models. Researchers in KIS will work closely with clinicians to take practical, effective decisions about safe and efficient service organisation and design, to benefit the health and well-being of patients. Our inter-disciplinary team of over 300 engineers and physical scientists in imaging science are developing novel diagnostic and image guided interventional tools that will have a major impact on the management of children and adults with cardiovascular disease, cancer and neurological problems. In cancer, we are trialling imaging technology for use during surgical resections to ensure complete tumour removal. In cardiovascular, we expect that our current work on biomarkers to translate into novel diagnostic markers for patients with heart failure. In dental, our research commercialisation will enable teams to visualise the extent of dental decay without x-rays
- Increasing staff, students' and trainees' access to research opportunities across all our organisations and the AHSN, improving research infrastructure and support for a greater range and number of health professionals enabling them to be involved in research
- Expanding our use of anonymised patient data for research through integrated IT systems across KHP and with external healthcare organisations and industry. Leveraging the scale of electronic clinical data sets , we will establish a larger number of patient trials addressing the health issues that matter to our local population, in partnership with our AHSN and CLAHRC
- Widening our local access to healthcare careers, provide innovative learning opportunities and extend our reach into our communities as a local employer. We will work together to transform our workforce, giving staff the skills and expertise necessary to excel in the demanding tripartite environment of the modern AHSC.

7.2 Southwark and Lambeth Integrated Care

King's Health Partners is committed to working with our partners across local boroughs to integrate services at local level to improve patient care. To this end we will use much of the 2014/2015 to test the provider offer and new models of care to enable a more integrated academic health system.

Whilst our Foundation Trust offers national, regional and sub-regional services, a large part of our local catchment encompasses the residents of Southwark and Lambeth, a population of 600,000 people. Despite the institutional and professional excellence available, this local population is characterised by relatively high levels of deprivation and relatively poor health outcomes.

King's is a founder member of Southwark and Lambeth Integrated Care (SLIC), a movement for change that aims to genuinely shift how care services are delivered so that they are coordinated around the needs of people, treating mental health, physical health and social care needs holistically. This programme is vital to address the crisis of value within our health economy: quality must improve significantly so that people receive effective care and experience it positively; and a future local system-wide funding gap of £350-400m must be addressed by changing how and where care is provided so that it is more preventative, and less cost intensive per person.

SLIC is governed by a federation of the leading commissioning and provider organisations across Southwark and Lambeth. This includes the two local authorities, the two local CCGs, representation from local LMCs, three foundation trusts (encompassing acute and community services and physical and mental health), as well as the King's Health Partners (the AHSC) and Guy's and St Thomas's Charity. In practice SLIC has fulfilled two main functions: it provides a neutral space where partners come together to work through the difficult practical challenges associated with leading system transformation; and it supports the rapid testing and implementation of specific interventions aimed at improving the value of care received by the frail and elderly.

A lot has already been achieved. Work to date has built an ever deepening shared understanding of the issues, a commitment to action, and an understanding of the options to reduce avoidable emergency admissions, speed up delays in discharge, improve mental and physical health liaison, and reduce admissions to residential care. New services have been delivered – for example, 3200 people have had a Holistic Health Assessment within General Practice to generate a care plan, and 322 people have had their care co-ordinated by an Integrated Care Manager. Experience from patients and staff suggests that care is changing for the better.

A lot still needs to be done. Building on the first two years of the programme there is a clear recognition of the need to do more, both in terms of the scope of new services, and in terms of more fundamental changes to the care system. We believe that work over the next two years will significantly improve the effectiveness and efficiency of care leading to material reductions in avoidable emergency admissions, delayed discharges, and admissions to residential care.

To make the fundamental changes needed in the care system we will, through SLIC, work closely with commissioners to transform how care is commissioned, paid for and provided. This work will:

- Identify if and how health and social care budgets are brought together to fund services for specified segments of the population (e.g. people over 75 with multiple long term conditions), rather than funding based on settings of care
- Recommend different financial mechanisms (e.g. capitated contracts) and incentives to help providers focus on preventing avoidable activity and providing care in the right place at the right time
- Establish ways in which the various providers can come together across the full value-chain, either in formal or virtual organisations and networks, to manage contracts and sub-contracts for the provision of coordinated care.

This type of transformation is well aligned with the Call to Action, endorsed by NHS England, Monitor and the CQC. However, as is widely recognised, such a transformation will require a fundamental change in the way that resources (including people, buildings and infrastructure) are utilised within the whole health economy. When viewing similar types of transformation in other geographies or other industries these changes necessarily, and intentionally, cause a disruption to the existing business models. In order to be successful in meeting the imperatives of improving quality and experience and reducing average cost we will work collaboratively, at all levels of the system, to navigate the uncertainty and disruption of a transition to better value care.

7.3 Health Innovation Network

The Health Innovation Network is the Academic Health Science Network for South London, established in 2013 along with 14 other AHSNs. Each of the AHSNs works to a common purpose, and has 4 strategic objectives set by NHS England:

- to meet the needs of patients and local populations
- to spread innovation and good practice
- to promote partnership and collaboration
- to create wealth through private partnerships

South London has a population of around 3.4 million, which is very diverse both ethnically and socio-economically. There are significant variations in service provision and health outcomes across the 12 boroughs, and real expertise to draw upon, including an AHSC. The Health Innovation Network has a number of key characteristics, reflecting the central nature of patients and population health in our work:

- Choice of clinical themes was based on Joint Strategic Needs Assessments (Diabetes, Dementia, Musculoskeletal, Alcohol and Cancer) and deliberately inclusive – being of relevance to all member organisations
- Our approach to patient involvement has patients at all levels of governance arrangements (e.g. patients present within leadership teams and at performance meetings)
- Strong collaborative relationships with local partner organisations (e.g. KHP, HESL, CLAHRC) focusing on common population health needs (e.g. Alcohol, Dementia)
- Wealth creation is at the heart of our work programme, with industry engaged in scoping and implementing projects, with all projects aiming to enhance value whilst meeting needs of local patients.
- We believe in transparency of information for patients, through provider benchmarking clubs, and through London Connect programmes which explore patients' perspectives on use of health information
- Our philosophy is to promote self management and personal responsibility for health and wellbeing (approach common to all themes, and cross-cutting work such as the obesity strategy)
- We encourage "whole person" approaches; integrating physical and mental health and social care needs
- We are the only national AHSN to have patient experience as a work programme

The Health Innovation Network will deliver through a focused number of Clinical Themes. We have selected a small number of clinical priorities (see above), which will enable both (i) "Proof of concept", in terms of a collaborative working approach, implementation at scale, and embedding innovation in commissioning, as well as (ii) Supporting wider cultural change – including adoption of good ideas (vs "not invented here" syndrome) embracing private partnerships, continual improvement approaches, and valuing academically robust service change.

The HIN will deliver through our role as systems integrator and co-ordinator. Our ability to perform this role effectively builds our non-elitist approaches and inclusive governance arrangements, as well as through our strong collaborative relationships and mutual trust that our senior leadership team have built up with partner organisations.

The HIN will also deliver by supporting and spreading local innovation & best practice initiatives. Through facilitating the adoption of best practice, sharing methodologies and celebrating successes, we aim to support local innovation initiatives to allow them to develop regional momentum.

2013/14 was a year of "set-up" with a primary focus on establishing governance structures, recruiting key posts, determining priorities and specific projects, systematically engaging our membership and forging new relationships within the local health and care system. We have successfully created a strong new organisation, with a good reputation nationally, and effective local partnerships. The coming year needs to build on this and deliver real progress. Our over-arching aims for 2014-15 include maintaining a focus on a small number of priority areas where we can make a demonstrable difference, developing meaningful commercial partnerships, and aligning priorities and initiatives with members and partner organisations to achieve maximum impact across the health economy.

The Health Innovation Network aims to work collaboratively to improve health outcomes and enhance wealth, by spreading innovation and good practice in South London