King's College Hospital NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

King's College Hospital NHS Foundation Trust

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

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

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Date	**31 May 2013**

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Professor Sir George Alberti**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Tim Smart**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Financial Director)*	**Simon Taylor**

Signature 

Annual Plan Review 2013-14

1. Executive Summary

a) Background/Purpose

This annual plan for 2013 sets out how the King's College Hospital NHS Trust intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. It assesses the challenges the Trust faces within the organisation and across its local health economy and sets out our strategy and implementation plans for the next 3 years.

Until the acquisition of the Princess Royal University Hospital is formalised, this plan cover matters unconnected to this transaction. A unified plan to explain our merged strategy will be completed once agreement is finalised with the Trust Special Administrator's Office.

This plan nevertheless sets out the most important features of King's strategic approach and is a valuable reflection of our plans and the financial framework that underpins them, as such reflecting what we will be doing if the PRUH acquisition does not to proceed.

b) Vision, Values and Process

Everything King's does is focused on patient need and delivering the highest quality of care in our local services and our global specialties. With King's Health Partners (KHP), the South London Academic Health Sciences Network (AHSN), Southwark and Lambeth Integrated Care (SLIC) and other local healthcare providers, we will lead innovation that builds an integrated and well-managed healthcare system to meet the diverse needs of the many local communities we serve.

Kings Values express how we wish to be seen by patients, service users, staff, commissioners and other key stakeholders and these underpin our approach to our planning and implementation. They are:

- Understanding you
- Inspiring confidence in our care
- Working together
- Always aiming higher
- Making a difference in our community

In developing the 2013 Annual Plan, the Trust has had regard for the views of the Council of Governors and of members, local community and key stakeholders gathered at community events. The Board Strategy Committee and the Governor Strategy Committee, the Governors' Membership and Community Engagement Committee have been pivotal to developing the membership strategy, which is reflected in the membership return. The Board and the executives have conducted detailed reviews and discussions about the schedule of assurance, which has helped the Trust to understand the key factors relevant to delivering the proposed plans. The Finance and Performance Committee has also considered the budgetary information detailed in the plan.

c) Strategic Framework

The King's strategic framework underpins our approach to the evolving opportunities and challenges we face. It remains the basis of our plans – for this year and for the longer term. There are 3 strategic goals – with 10 supporting objectives each with a key focus for 2013:

i. *Goal 1: Quality improvement* – safe, kind and effective care

- Patient Safety – e.g. responding to The Francis Report and enhancing clinical and nursing standards particularly in times of pressure
- Clinical effectiveness - e.g. action on deteriorating patients

- Patient experience – e.g. expanding our volunteering programme

ii. *Goal 2: Financial sustainability and* efficiency – a more efficient and consistent hospital
- Cost improvement and income diversification – e.g. clinical service reviews, expansion of private patients and overseas commercial activity
- Service transformation and improved productivity - e.g. Out patient service redesign and medical productivity

iii. *Goal 3: Leading change across the system* – e.g. working with KHP and others to improve services to our community and beyond
- Developing integrated services – e.g. through acceleration of Southwark and Lambeth Integrated Care
- Developing regional and national specialist networks – e.g. through the paediatric neurosurgical and paediatric trauma centre
- Strengthening research and education at King's, KHP and the South London AHSN – e.g. Development of South London Collaboration for Leadership in Applied Health Research and Care (CLAHRC)
- Improving population health – e.g. focus on dementia and alcohol strategies
- Integrating with KHP – e.g. through the completion of the Full Business Case and the acceleration of existing priorities

d) **Strategic Context and Strategic Framework**

With significant structural changes in the NHS in England, local reorganisation of acute healthcare in SE London, changes to commissioning arrangements and continuing pressure on public finances – against a background of increasing unplanned admissions, King's has put together a robust strategy to deliver high quality care to its patients, now and in the future and address the following areas of especial challenge:

i. Responding to the Francis quality challenge

King's has developed five initiatives to help our efforts to improve the consistency of care across all services and departments at KCH.
- Enhancing Clinical and Nursing Standards
- Listening to Staff
- Listening to Patients and Families
- Performance and Quality Management
- Engaging with External Agencies and Stakeholders

ii. Challenge of the financial plan

The financial cost pressures driven by national efficiency targets, Commissioner QIPP targets, SIFT training and education central funding reductions and the demands on the emergency service delivery will continue to challenge the organisation. To manage this challenge we have set an annual Cost Improvement Plan target of £40m and a prudent recurring surplus target of £2m The financial delivery is also based on delivering a CQUIN plan of £13m; a £100m capital investment plan over 3 years, leasing modular wards (147 beds) and theatres (4) over 5 years; and a commitment to joint plans with the local CCGs to deliver integrated care in Lambeth and Southwark (£2.8m).

iii. Managing urgent care

Sustained and increasing pressure from unplanned admissions across the local health system throughout 2012 increased acuity and length of stay for patients over 75 years old. Plans to address this include:

- Working with primary care to co-ordinate and manage demand and flows of patients across South East London
- Developing a primary care led Urgent Care centre at KCH
- More pace, resource and focus working with Southwark and Lambeth Integrated Care to improve the care pathway for frail older people and those with Long Term Conditions

iv. Capacity planning

Lack of appropriate capacity is the major rate limiting step on King's being able to achieve its goals – impacting on finances and quality of care. To cope with this, capital plans cover:

- Infill Block 4 (August 2013) – 48 bed development and 2 theatres
- Infill Block 5 (November 2014) – 99 bed development , hybrid theatre and catheter lab (net bed gain 43)
- Critical care block (2015 / 2016) – 60 critical care beds (net gain 40)

v. Commercial services and private patients

To continue our strategy of income diversification and expansion to generate investment into healthcare, plans for this year include:

- New pricing structure for private patients and an expansion of theatre and beds (net gain 17) for 2014 / 5
- Further development of overseas contracts for training and service models
- Continued sales of Information systems
- Exploration of outsourced services e.g. procuring Sainsbury's to deliver pharmacy

vi. King's Health Partners

King's continues work with KHP to progress closer integration and drive the tripartite mission to achieve excellence in research, academia and clinical services. Plans this year focus on:

- Full Business Case for the closer integration of the four organisations including the potential merger of the 3 NHS Trusts and closer alignment with KCL
- Accelerating delivery of existing priorities
- Re-accreditation of the AHSC
- Supporting the Academic Health Sciences Network for South London

e) **Conclusion**

This plan represents a comprehensive strategic response to the changing context and challenges that KCH faces in the local and national NHS. It sets out the range of plans and the financial framework to support them. It will be used as a reference point for the monitoring of progress and delivery by the Trust Board and Strategy Committee.

2. Strategic Context and Direction

a) Our Role In The Local Health Economy

King's College Hospital NHS Foundation Trust is one of London's leading teaching hospitals, with a reputation for providing clinically excellent, efficient and innovative local healthcare in the boroughs of Lambeth and Southwark. We are the designated major trauma centre for SE London and Kent and one of the regional hyper-acute stroke centres. We are also recognised nationally and internationally for the excellence of our clinical services and research in a range of specialties including liver disease and transplantation, neurosciences, cardiac services, haemato-oncology and fetal medicine, where we care for patients from a much wider geographical area. King's plays a key role in the training and education of medical, nursing and dental students, as well as other health professionals.

As part of King's Health Partners Academic Health Sciences Centre (AHSC) we work in close collaboration with King's College London (KCL), The South London and Maudsley (SLaM) and Guy's and St Thomas' (GST) NHS Foundation Trusts. Together we are reshaping the model of acute care as part of the founding principles and leading the way in combining service provision, academic research and training.

During 2013/14 our work with KHP to achieve the AHSC's strategic objectives and support re-accreditation include: clinical, research and education strategies, work to integrate physical and mental health and development of the South London Academic Health Science Network (AHSN) in collaboration with St George's NHS Trust and other stakeholders. (AHSN priorities are to improve muscular-skeletal, cancer, diabetes, alcohol and dementia care, all of which feature in KCH clinical strategies).

KHP will also continue along a path of closer integration to achieve our tripartite mission to achieve excellence in research, academia and clinical services. The Strategic Outline Case (SOC) to create a single academic healthcare organisation was agreed in 2012. Work is now underway to develop a Full Business Case (FBC) for the closer integration of the four organisations, including the potential merger of the 3 NHS trusts and closer alignment with KCL. The FBC will also consider joint and innovative ventures to drive improved patient pathways. Service improvement is driven through our Clinical Academic Groups, focussing on cancer, cardiovascular, child health, dental, obesity/diabetes, transplantation and mental health and neurology.

b) The local competitive environment

There are number of important developments locally that are likely to have an impact on King's during the life of this plan.

a) The local health economy of South East England is being reorganised following the decision of the Secretary of State (SoS) to reconfigure services. South London Healthcare NHS Trust (SHLT) has been dissolved and A&E services at University Hospital Lewisham NHS Trust (UHL) are to be reduced. Services are being rearranged to resolve the financial and clinical instability at Queen Elizabeth Hospital Woolwich, Queen Mary's Hospital Sidcup, Orpington Hospital and the Princess Royal Hospital Farnborough. Key elements that concern King's are:

   i. The recommendation of the Secretary of State for Health that KCH acquires the Princess Royal University Hospital (PRUH), Farnborough. This offers the opportunity to create 'one hospital across two sites, improve healthcare services to the combined patient population, re-align several clinical services so that modern pathways and clinical service models can be created and address capacity constraints at both sites through a more cogent distribution of elective and unplanned admissions. Final agreement with the DoH on the acquisition will mean a radical change in KCH focus

and approach to the year. However, until then, this annual plan concentrates solely on the activities and plans at KCH that would occur without such a decision being taken and excludes consideration of matters relating to the PRUH.

ii. *The re-organisation of services at UHL*

- The down-grading of the ED at Lewisham. KCH expects there to be a diversion of some activity seen at Lewisham to our ED. Given pressures here already, we are engaged in discussions with Lewisham and others to understand plans and services there and to model potential leakage to KCH.
- The replacement of maternity services at Lewisham by a midwifery-led unit requires a planned response to expected increases in maternity flows from that area.
- The possible development of an elective surgery centre at Lewisham. At the moment this appears to be a long-term plan (2-3 years away) but KCH will seek to be involved and collaborate on strategic planning.

iii. The merger of Lewisham and Queen Elizabeth Hospital Woolwich may impact on the pattern of pathology provision. New capacity exists at Woolwich and the unified Trust may seek to expand activity across SE London. KCH will work with Guy's and St Thomas' (our pathology partner) to understand and position our services in response to the new configuration.

b) The Better Services, Better Value review (BSBV) is considering health services in South West London and Surrey/Epsom including hospitals at Croydon, Kingston, St George's, St Helier and Epsom. It has proposed only 3 A&E departments and 3 maternity units (led by obstetricians with midwifery led units alongside) across the 5 hospitals. Should final recommendations reduce A&E and maternity services at Croydon University Hospital, King's is likely to see increased patients flows.

c) Trusts across wider South London and Kent are experiencing bigger than expected financial problems and several are unlikely to achieve Foundation Trust status. Potential mergers and reorganisations are in flux (a proposed merger of Dartford NHS Trust and Medway NHS Trust has been mooted and then abandoned) with potential consequences to services and patient flows. This may be particularly important to tertiary flows of Neurology, Neurosurgery and trauma work from the South East London and Kent Trauma network.

d) The private sector has an established presence across South East London. Generally their market and activity pose little direct threat to our services. There is a history of positive collaboration between King's and independent hospitals for elective treatment of waiting list backlogs or capacity squeezes. We will continue to enter into agreements like these to the benefit of both sectors and our patients.

e) Providers of elective services are actively assessing opportunities in the area and across London, e.g. Optegra and Moorfields are active in Ophthalmology. As King's / KHP considers new models of Ophthalmic care, careful assessment of the approach of these players and discussions to explore opportunities for joint working are an important part of the strategy process.

3. Our Strengths and Weaknesses

a) Everything King's does is focused on patient need. Underpinning this ethos are King's Values which guide all that we do and reflect how we wish to be seen by patients, service users, staff, commissioners and other key stakeholders:

- Understanding you
- Inspiring confidence in our care

- Working together
- Always aiming higher
- Making a difference in our community

The importance of these values as a foundation for our culture of care and innovation has been highlighted again as we consider our role as a leader of our local health system in the light of the Francis Report and the subsequent recommendations.

b) Good relationships exist with commissioners and local GPs. This is helping us to co-develop transition plans to sustain and improve mutually agreed service models and portfolios while mitigating competitive threats and the impact of NHS changes

c) Other strengths include:
   - Internationally renowned specialties
   - Major Trauma and hyper acute stroke centre status
   - Good track record of performance on all mandatory targets
   - Strong internal clinical and corporate governance
   - Part of a large academic campus including KCL and the IoP
   - Foundation trust status and positive financial risk rating from Monitor
   - Highly motivated and committed and committed staff

d) Our role as a partner in the AHSC is also a strategic strength and the KHP partners are all relatively strong clinically, academically and financially.

e) Community services are integrated into KHP and this is helping patients move more seamlessly from acute into community care settings. As part of Southwark and Lambeth Integrated Care we are working with 6 other partner organisations and 95 GP practices to radically transform how healthcare professionals, citizens and communities work together to provide care.

f) Most of the challenges KCH faces over the coming years arise from potential service reconfigurations in the local health economy. King's considers itself to be in a relatively strong position to manage these challenges and leverage the benefit of the potential opportunities.

g) We recognise a number of areas in which we could do better:

   - Significant increases in emergency activity has overloaded capacity constraints limiting our ability to sustain tertiary and elective activity and impacting negatively on patient experience.
   - We have received good reports from the CQC but there remain a number of specific quality challenges e.g. infection control and our consideration of The Francis Report has reminded us that our quality of care is not consistent across the whole Trust 24/7.
   - Whilst we have managed to secure and FRR of 3 from Monitor for the last 3 years there is little headroom in our finances
   - We need to diversify our income and secure more from non-clinical sources

4. Forecast Health, Demographic, And Demand Changes

a) Our local population from Lambeth, Southwark and Lewisham (LSL), estimated 875,000-1,000,000 is expected to grow by 13% by 2020. We have a diverse, relatively young and mobile population with a high proportion of minority ethnic groups. People are living longer but locally we have high rates of long term illness (circulatory disease, cancer and respiratory conditions) and premature mortality. LSL deprivation scores are much higher than the national average.

   Poverty and social exclusion are two of the wider determinants of health which are particularly challenging in LSL. King's Health Partners has representation on the Lambeth and Southwark Health and Wellbeing Boards to develop and implement their strategies which prioritise:

- Alcohol abuse
- Mental health and wellbeing
- Early intervention
- Exercise
- Childhood obesity

b) Non-elective activity has been a constant concern during 2012/3 and winter pressures were acute with increased ED activity. However, admitted emergencies remained constant but the LOS for those admitted patients increased – especially for the over 75's. In 2013/4 KCH will analyse this trend in-depth with partners across the local health system (including London Ambulance, Social Care and Commissioners) at a series of summits in order to understand and influence emerging changes in the local health system.

Based on current projections we would expect year-on-year demand growth of approximately 3-4% overall contract value. Activity assumptions, based on historic trends for the past three years are:

- Elective Inpatients will grow by 3.1%
- Emergency Inpatients will grow by 3.6%
- Non-Elective transfers will decrease by 1.0% (due to displacement caused by Emergencies)
- Critical Care will increase by 7% (as a one off compared to 12/13 due to increased capacity from M6 12/13 onwards, but unlikely to be recurrent)
- Outpatients will grow by 0.9%
- A&E activity no growth expected

These expectations have not been adjusted for the change in commissioners. Growth at these levels is not sustainable within King's current capacity. Current plans to expand King's capacity are necessary to meet current demand, and are not anticipated to create any additional supply led growth. All growth assumptions are gross of any QIPP reduction schemes.

5. Impact assessment of market share trends over the life of the plan

Until the structural change currently underway in the NHS subsides, we expect our current patient flows to remain relatively unchanged with no significant market share changes. However, as the new implemented, potential changes in market share could include:

- Increased emergency activity (UHL and Croydon Hospital ED downgrades)
- Increased maternity activity (reductions in obstetrician led units in SE & SW London)
- Potential increases in elective activity (catchment area extension from PRUH acquisition)
- Potential increases in tertiary activity (catchment area extension from PRUH acquisition)

King's is already capacity constrained, and whilst we have plans to address much of this, these potential increases would create additional demands on our capacity that will have to be planned for and mitigated. We will monitor the system changes closely in year.

6. King's Vision And Strategy

The King's strategic framework underpins our approach to the evolving opportunities and challenges we face. It remains the basis of our plans – for this year and for the longer term. The board monitors the deployment closely, believing it to be a robust approach to ensure delivery of high quality care to our patients in the face of the challenges outlined above.

The Trust's clinical, quality and financial vision is articulated through 3 key strategic goals and 10 supporting objectives – each with key areas of focus for this year.

a) Quality Improvement – Safe, Kind And Effective Care Focusing On (Greater Detail In The published Quality Account)

After careful consideration of the Francis report an overarching theme of our approach to quality in 2013/14 will be to improve the consistency of the care we deliver across KCH. Ensuring the right conditions for care exists in all places at KCH at all times, is an additional dimension of effort that requires explicit and concentrated effort. Our response to this challenge falls under five headings:

- *Enhancing Clinical and Nursing Standards* – reviewing standards, developing enhanced training and support for the clinical workforce and ensuring consistent application
- *Listening to Staff* – a rolling programme of discussions with staff to gather and act on deeper feedback about working experiences and issues, improving the KCH staff survey
- *Listening to Patients and Families* – using videoed patient stories to allow staff to reflect on care given and possible improvements, enhance the role of patients and families in assessing and shaping services
- *Performance and Quality Management* – develop detailed qualitative assessment and action from board to ward
- *Engaging with External Agencies and Stakeholders* **–** ever closer working with Governors and the Membership Council and reinforcing the cultural commitment to openness and transparency

Our focus in the objective areas include:

i. Patient safety

- Improvements in the identification and escalation of acutely ill patient shows some improvement but more focus and effort is required to understand root causes and find better ways to respond early to patient deterioration.
- King's will prioritise robust implementation of the WHO Surgical Safety Checklist - there were 3 incidents of retained swabs reported last year.

ii. Clinical effectiveness

- We plan to improve the detection of dementia for elderly people, implement the NICE guidance for carers and develop an annual training plan.
- We will improve care of patients admitted with COPD exacerbation and improve patients' commissioning arrangements become established and proposed services reconfiguration plans are understanding of the disease to reduce reliance on secondary care and hospital admissions.

iii. Patient experience

- Through national surveys, PALS and complaints data we know that outpatient services need to improve. In 2013/14 we will undertake a further national survey to see if changes put in place have improved the patient experience. Further redesign in the out-patient setting is planned.
- We also plan to improve the quality of information and communication about discharge from hospital.
- The volunteer service has now recruited over 750 volunteers. Recent inpatient survey scores in volunteer areas have improved - 85% to 92% of patients find their contact with a volunteer helpful. Over the next 18 months, we will expand our in-house programme to 2,000 volunteers, for volunteer coverage across all areas of the Trust, Monday to Sunday, 8am to 8pm. In conjunction with the National Endowment for Science, Technology and the Arts (NESTA), we will pilot a scheme for volunteers to support patients leaving hospital and promote health and wellness in our local community. We will conduct an evaluation study of volunteering at King's and describe our volunteering model so it can be adopted at other hospitals.

b) Financial sustainability and efficiency - a more efficient and consistent hospital delivered through:

i. Cost Improvement Plans (CIPs) and income diversification

We have a Cost Improvement Plan target of £40m, a more challenging CQUINs plan of £13m, a £100M capital investment plan over 3 years all of which will be monitored throughout the year by the Programme Management Office. (See later detail)

ii. Transformation and improved productivity

An on-going programme to transform services will be maintained and strengthened in 2013. One area of work is out-patient care - trialling technology that supports the development of outpatients e.g. automated check-in and electronic document management, continuous improvement of medical and nursing productivity and a strategy to progress towards a paperless hospital (including the development of electronic patient records, e-prescribing, e-consent).

c) **Leading change across the system – working as King's Health Partners (KHP) and with others to improve services for our local community and beyond by**

i. Developing local integrated services

Our work in Lambeth and Southwark Integrated Care aims to transform care for older people and those with long term conditions, enhancing the responsiveness of community and primary care services.

ii. Developing regional and national specialist networks

Tertiary paediatrics is a key focus area for this year

iii. Strengthening research and education across King's, KHP and the South London AHSN

There is planned investment in academic chairs for Neuro-trauma, Stroke and Metabolic Surgery. There are plans to develop translational research capacity at the Rayne Institute – where existing tissue banks will be better exploited in work to find routes to new treatment paradigms.

iv. Improving population health through integration of physical and mental health

Implementing the alcohol strategy and work on the homelessness project

v. Supporting the integration of KHP

In 2013 AHSC re-accreditation will be sought, the full business case for closer working will be completed and the acceleration of existing priorities be closely monitored by the Partner's Board.

7. Threats and opportunities from changes in local commissioning intentions

There are two key transition risks this year resulting from national NHS commissioning changes:

i. CCGs take up their new responsibilities as from April 1st. As new organisations, they will be finding their way both in terms of process and strategy. King's has actively worked over the last year to enter into constructive dialogue to provide consistency and continuity and to

support a smooth transition. However, the situation will be volatile and our contracts team are focussing on building relationships and understanding with the key players in the new system.

ii. The expanded role for specialist commissioning through NHS England means that 50% (previously 17%) of activity will be commissioned nationally, rather than through CCGs. This changes respective negotiating powers, and provides some risks and opportunities with forging new working relationships with NHS England. Activity plans for both sets of commissioners have been built up on 12/13 M6 x 2 with an adjustment for expected full year outturn, and the expectation that over-performance is paid in full.

8. QIPP

We are still negotiating QIPP schemes with commissioners but expect Trust targets to remain in line with 12/13 delivery (in the region of £7-10m with a 50:50 risk share). We intend to work more closely with commissioners in 13/14 to jointly deliver required changes. A project manager is being appointed to lead activity related to QIPP across the Trust. Initiatives to reduce out-patient follow-up activity include:

- reducing consultant to consultant referrals
- reducing emergency department referrals to outpatients
- reducing follow-up appointments post day case surgery
- reducing the number of multiple appointments per patient
- substitute face to face consultations where appropriate e.g. telephone or webex consultation
- shift outpatient activity to community settings (diabetes and CVD).

9. Waiting Lists

Patient waiting times improved a King's during 2013. Total patients on the waiting list reduced by 661 (10%). Long waiters (over 18 weeks) saw a reduction of 828 patients (35%). Patients waiting 52 weeks or more reduced by 170 (77%).

The 90% admitted target was not consistently achieved in 2012/13 due to this significant clearance of historical backlogs of long waiters. This reduction in waiting times has partly been achieved by King's Clinicians using capacity at 11 other providers in 2012/13.

The Trust has achieved the other two main 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 maintaining or improving performance on RTT for the coming year is:

- Detailed demand and capacity modelling, with concomitant changes to theatre lists in 2013/14 to better match the two, hence improving RTT performance
- Changes to admissions processes including moving all booking from paper systems to electronic ones
- Tightening rules around waiting list management, including new DNA and Cancellation policies
- New reporting systems to look at better early warning of pressure areas

10. Decommissioning

We expect 13/14 to be a year of “steady state” whilst transitioning to new commissioning arrangements, with no formal decommissioning. Planned co-redesign work on reducing hospital based activity continues across Lambeth and Southwark.

11. Any Qualified Provider (AQP)

The impact of “Any Qualified Provider” tenders are expected to be minimal, and our local commissioners are supportive of minimising that impact.

12. Shifting Care delivery outside of hospitals

King's works with Lambeth and Southwark Clinical Commissioning Groups and the Clinical Support Units to shift appropriate hospital activity to community and primary care settings. King's is represented on the Lambeth and Southwark Planned and Unplanned Care boards run by the CCG's. Clinicians and managers attend pathway specific redesign groups with representatives from GSTT and the CCG. We have jointly produced referral guidelines and referral checklists. King's clinicians are involved in training and education for primary care clinicians to enable better management of patients in GP surgeries e.g. Virtual clinics in diabetes and respiratory medicine where hospital specialists spend regular dedicated time in GP practices advising and supporting GPs on clinical management.

King's is planning 14 dental chairs in the Lambeth Norwood Hall neighbourhood resource centre, due to open in 2014

The Southwark CCG is currently undergoing public consultation on the Southwark Dulwich Community Hospital and King's are working with the CCG to plan for services on this site e.g. a larger 20 station renal dialysis unit as part of the future community facility.

13. Urgent Care

A local primary care partner will develop an urgent/primary care service in the King's Emergency Department. The service will run as a pilot for 12 months after which a detailed analysis of patient attendance patterns & outcomes and patient feedback will inform the development of a longer term partnership agreement and service structure.

14. Benchmarking

In compiling our strategy and contracting plans KCH uses benchmark data from independent sources. To date, CHKS have provided trust-wide data on length of stay, mortality, quality metrics, readmissions and new-to-follow-up rates. To improve the sensitivity of our analysis, and to allow specific operational improvement work we are switching to the Birmingham HED Evaluation Tool in 2013. This provides analysis at sub-specialty level.

15. Capacity Plans

Although we expect a reduction in demand for out-patient services in the future due to decommissioning, shift or AQP we are not yet seeing any material impact. Emergency pressures are expected to continue with high levels of admission and increased acuity resulting in longer length of stay. The Trust continues to better manage demand for emergency beds through admission avoidance pathways, the use of out of hospital care and monitoring internal processes.

To deal with the emergency pressures and increase on site and off site capacity to enable more elective inpatient activity to be undertaken to reduce current waiting list backlogs and respond to tertiary demand the Trust needs to address two key capacity constraints:

- Expansion of Critical Care facilities in order to meet the demand for Critical Care Services and consolidate KCH 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 investment of approx. £60m over 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 plan is to install two modular built ward and theatre blocks in two areas of the hospital, replacing current temporary buildings. Providing a net increase of 91 general NHS beds, an additional theatre,

catheter lab and hybrid theatre. Current plans are to have the additional theatre capacity operational by August 2013 and additional bed capacity phased in 2015-16

16. Capital Plan

The capital plan requires investment of £52.6m in 2013/14, £35.6m in 2014/15 and £10.2m 2015/16. £56m is funded through an external loan approved by the FTFF for the Critical Care Project.

The key capital development is the Critical Care Service expansion to support the Hyper Acute Stroke Centre, Major Trauma Unit and tertiary specialties to address increased acuity of patients. In 2013, we plan to expand the 'majors' area within the emergency department as a priority to address increased demand for this type of patient presentation.

The Maternity capital development will be completed in Sept 2013 providing 20% additional delivery capacity which will improve the quality of services and address rising birth rates.

The Clinical Research Facility is now operational to generate additional academic and patient related Research and Development.

Other major projects 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.

17. Commercial Strategy

The Trust has an overarching commercial strategy which focuses on opportunities in line with its core strengths; namely expertise in frontline patient care and information services. KCH Commercial Services Ltd and its subsidiary Agnentis Limited are actively pursuing opportunities in the following sectors

- Overseas opportunities (including healthcare management and training)
- Outsourced services in partnership with the private sector
- Information Services
- Small income generation schemes

In addition, and as part of King's commercial services the trust treats private patients from across the UK and over 50 countries worldwide, via King's International Private Patient Services (IPP). This private facility generated revenue of c. £16m for the fiscal year. With a net contribution to the Trust of c. £4.1m. KCHFT believes that there is substantial untapped revenue available to IPP from consultants domiciled at KCH who, due to capacity constraints, currently refer their private patients to other private patient facilities in London. The Trust is planning to relocate the existing 21 bedded private ward to a new 38 bedded private wing during the Summer 2014/2015, thus providing additional accommodation for all specialties.

The reconfiguration of Trust theatres during 2013/2014 will also enable additional theatre space being made available to private patients and this, combined with the new private wing, will enable KCHFT to actively market tertiary specialties to an international market.

Following the removal of the PP Cap and in preparation of the increased theatre access and improved facilities, IPP is actively sourcing additional business.

In addition, a review of the IPP pricing structure has secured increases for specialty beds in particular, well in excess of market inflation.

18. Research and Development

R&D continues to grow within the Trust and to be a cornerstone of maintaining good clinical practice; facilitating optimal management and care pathways and securing research grant income.

The Trust previously invested (£1.6 million over 4 years; 2009-13) in research, through a competitive application process. The return has been seen in both publications (with utilization through the REF), esteem for the Trust, incorporation and development of national and international guidelines, and leverage of grant income.

Close working continues across Kings Health Partners and researchers and patients benefit from the BRCs at SLAM and GSTT.

The aspiration for all staff and patients to be aware of research and offered the opportunity to partake in it remains the goal.

19. Intellectual Property

King's aims to launch 'Kings Ideas' during the course of the coming year. The aim is to:

- Value and encourage innovation & best practice
- Enable the sharing of new ideas, innovations, best practice and research evidence where this is available (open forums, cross discipline meetings etc)
- Provide assistance in the discovery, development and diffusion of innovation and best practice
- Clearly signpost how staff can access this assistance
- Incentivise and reward innovation
- Seek to be an early adopter of innovations and best practice originating elsewhere
- Create a pipeline for ideas that have a potential commercial value

King's is now a founding member of the Innovation Investment Fund, an NHS Confederation backed organisation to secure private sector investment in commercially viable innovations and inventions.

20. Collaboration, Integration and Patient Choice

a) Plans to integrate services and provide better care and / or increase efficiency

We will continue to develop local integrated services in partnership with KHP, primary care and social care providers. A major initiative is the Lambeth and Southwark Integrated Care (SLIC) project or programme in which KCH is a leading partner.

In looking at the care and outcomes for significant sections of our local population, we recognise that collectively care to individuals is too often fragmented and there is unacceptable variation in the user experience. Our aim, via SLIC is to build healthier, happier and longer lives through a radical transformation of how healthcare professionals, citizens and communities work together. This requires systemic change in health and social care in Lambeth and Southwark. It requires paradigm shifts in behaviours from service users and service providers too.

To achieve this we intend to:

- Build community with assets, capabilities and skills to support patients to self-care.
- Ensure that people reliably receive the right care in the right place at the right time.
- Ensure that we are treating the whole person with care centred around the empowered individual.

- Ensure professionals are best able to deliver this new approach and thinking creatively about who best provides support – professionals, peer support workers or volunteers.
- Ensure better working lives for the staff we are working with

The benefits across the local health economy will include:

- Ensuring that money is better spent so that in a time of reduced resources we are best placed to meet rising demand
- Better well being
- Better health outcomes
- Contribute to closing the gap in inequalities, for example, through targeting the smoking cessation work

This year the programme of work will extend from the Older People's project to action on Long Term Conditions. Work will be done to build community assets, a suitable workforce, commissioning arrangements that incentivize change and suitable information systems. Improvements to these system enablers will be focused on driving lifestyle changes that counter the onset and deterioration of LTCs.

21. Development of partnerships and collaborations with other providers

a) Developing regional and national specialist networks is critical for the coherent development of our tertiary services and we will:

- Continue to actively engage and inform the London Cancer Alliance
- Proactively respond, with KHP and other key NHS providers, to all relevant external services reviews
- Work with commissioners and other providers to explore options for improving the quality and efficiency of services across South East London
- Consolidate and improve our services provided in our roles as a major trauma centre serving the trauma network for South London and Kent and as a Hyper-acute Stroke Unit
- Develop the community dental service for South West London for which KHP/KCH is now the identified provider.
- Work to secure designation as a paediatric neurosurgical centre and a paediatric trauma centre. We will also continue to build a paediatric respiratory services. A joint paediatric neurosurgical rota has been established with St George's Hospital.

b) Working with KHP partners to deliver all elements of the tripartite mission of our Academic Health Sciences Centre and continue to strengthen research is a core strategic goal. We will:

- Improve educational facilities and research infrastructure in our services and Clinical Academic Groups
- Continue active engagement in the establishment of the South London Local Education & Training Board
- Support the bid for accreditation as an Academic Health Sciences Network for South London currently being developed by King's Health Partners in partnership with St George's NHS Healthcare Trust, local authorities, general practice and academic institutions in South London. The aim of the initiative is to speed up the time it takes the NHS to access new and better quality treatments and approaches to improving health because of the unique partnerships between researchers and NHS staff working at the front line delivering patient care.

The four main objectives of the South London AHSN will be to:

- Bring academic and scientific rigour to service improvement;
- Focus on key public health issues in south London;
- Deliver lasting improvements on a wide scale across the whole of South London;
- Generate wealth for the local economy and improvements to patient care at the same cost or reduced investment.

c) Our mission to intensify inter-working of research, training and service is also being developed through our participation in:

i. *King's Improvement Science (KIS)* - a KHP collaboration supported by grants from the Guy's and St Thomas' Charity and The Health Foundation. It is founded on closer working relationships between i) Trust practitioners (managerial and clinical) ii) patients and their advocates iii) research scientists. Their combined effort aims to accelerate scientific discoveries into health and social care practice for better patient outcomes by:

- Improving local research capability and identifying value-adding innovations
- Applying these innovations systematically at pace
- Improving the value of delivered care and the wellbeing of our population
- Creating an international centre of health improvement theory

ii. *The South London National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC)*. This alliance of academic and healthcare organisations will work to develop and promote more efficient, accelerated and sustainable uptake of clinically innovative and cost-effective research interventions into patient care across the South London Academic Health Sciences Network (AHSN). It will;

- draw membership from South London Trusts, CCGs and other primary care organisations, Public Health Departments, Heath and Well Being Boards, patients and carers, for profit, and not for profit organisations and the AHSN Membership Council
- focus upon a specific area of long term conditions/public health (e.g. diabetes, alcohol, psychosis, infection and palliative medicine) and set specific deliverables and milestones that will be monitored

iii. KHP integration to secure the full potential of the partnership

- A full business case for merger of the three acute health providers in the partnership is being prepared. It is expected to be considered by the boards of all partners in the autumn of this year.
- Closer service integration between the four KHP partners continues under the direction of the Clinical Academic Groups. The co-ordination and progress management of this work is being strengthened to help accelerate the delivery of the KHP mission.
- The Academic Health Sciences Centre is due for re-accreditation in the autumn of this year and KCH is integral to the preparation required for a successful outcome.

iv. Collaboration to improve the health of our local population and address the inequalities will include:

- Support the implementation of a KHP Alcohol Strategy, working with the Addictions Clinical Academic Group, an Obesity strategy and Dementia Strategy
- Build on current initiatives to further the integration of mental and physical health – especially the development with KHP / KCL of the Integrating Mental Physical Healthcare Research Training Services (IMPARTS) programme

v. KHP integration to secure the full potential of the partnership

- A full business case for merger of the three acute health providers in the partnership is being prepared. It is expected to be considered by the boards of all partners in the autumn of this year
- Closer service integration between the four KHP partners continues under the direction of the Clinical Academic Groups. The co-ordination and progress management of this work is being strengthened to help accelerate the delivery of the KHP mission.
- The Academic Health Sciences Centre is due for re-accreditation in the autumn of this year and KCH is integral to the preparation required for a successful outcome.

22. Consideration Of Impact Of Proposals In Relation To Competition Rules And Patient Choice

All our development work involves engagement with commissioners, partners and key stakeholders. We do not believe our current strategic plans will restrict patient choice but will involve the CCP should this be appropriate.

23. Approach taken to quality

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

At the heart of the Quality Governance Framework is the Quality & Governance Committee which, on behalf of the Board, monitors the three dimensions of quality, Patient Safety, Patient Outcomes, this group addresses clinical audit and effectiveness, Patient Experience and Organisational Safety through a series of management committees chaired by Executive Directors. This enables a strong Board focus on all aspects of quality and is the vehicle through which the Trust's quality priorities and Monitor's Quality Governance Framework are monitored. The Trust's centralised patient safety, clinical effectiveness, patient experience and assurance teams work closely together, to ensure that the processes for the identification, analysis, monitoring and reporting of quality issues are robust, systematic and responsive to the changes in the regulatory environment.

The Board's clinical plans and core quality priorities have been developed in consultation with a wide range of internal and external stakeholders The Board receives regular reports on all aspects of quality through monthly performance reports and scorecards, and quarterly reports on patient safety, patient outcomes and patient experience and organisational safety. The Board also receives a separate quarterly Quality and Governance Report which includes detailed analyses of all serious complaints and adverse incidents together with actions taken and related service developments/improvements. The Board considers the Assurance Framework and the Trust Risk Register on a quarterly basis and agrees actions as necessary to mitigate risks.

The Care Quality Commission visited the Trust as part of their programme of scheduled but unannounced reviews in August 2012. The Trust was found to be compliant with each of the five outcomes against which it was assessed and no service improvements were required.

In January 2013, the Trust successfully registered renal dialysis satellite units in Dulwich, Bromley, Woolwich, Dartford and Sydenham and the Frank Cooksey neuro-rehabilitation unit located in Lewisham Hospital. During the registration process the CQC assessed the declarations and evidence supplied to them by the Trust and found that all required standards had been met.

On-going compliance with the registration requirements is monitored through the Trust's Quality Governance Framework. The underpinning management committees: Patient Outcome, Patient Safety, Patient Experience and Organisational Safety Committees have specific responsibility within their terms of reference for reviewing and monitoring compliance against the Care Quality

Commission's Essential Standards, the NHS Outcomes Framework and the NHS Litigation Authorities Acute Risk Management Standards. To support this and to maintain a strong focus, the Trust appointed Assurance and Regulatory Performance teams and in addition, a quality governance Information technology support system, *HealthAssure*, has been implemented and is being rolled out. The Assurance team work closely with Divisions in supporting the registration of services or new locations.

Our Quality Account sets out the priority areas and new initiatives for the coming year and is endorsed by governors, members and our partners in community and social care sectors. We have a good track-record of delivering improvements in this way.

Our safety, clinical effectiveness and patient experience objectives and priorities are summarised below as set out in the published Quality Account:

	Priority	Key Objectives (Outline)
Clinical Effectiveness	1. Dementia	To improve the care of patients with Dementia by focusing on the detection of undiagnosed patients admitted to acute care, support for carers of patients with dementia and level of staff with specialised dementia training.
	2. Chronic obstructive pulmonary disease (COPD)	To improve the self-management of symptoms for patients with the long term condition COPD and improve community support in a way that reduces acute COPD related readmissions.
Patient Experience	3. Improve outpatient experience	To make focused speciality specific improvements, based on, and measured by, direct patient feedback on the Outpatient *How Are We Doing* survey.
	4. Improve patient experience of discharge	To implement key elements of the Discharge Policy and deliver improvements to patient satisfaction in relation to discharge information.
Patient Safety	5. Management of the acutely unwell patient	To build on the work in 2012/13 to establish a consistent performance framework for the identification and escalation of acutely ill patients.
	6. Surgical Safety Checklist	To develop and implement a strategy to ensure the Surgical Safety Checklist (SSC) is integrated into the working practices of all theatre/interventional teams.

24. Workforce

In order to continue to deliver first rate clinical services, it is essential that King's optimises the strength of its workforce, ensuring that clinical and non-clinical functions are structured and staffed to maximum efficiency. Safety and quality depend on planned, appropriate skill mix and adequate available resource.

Continuous improvement, performance management and individual development will be facilitated by an enabling organisational development strategy. Our plans to enhance workforce productivity include:

a) *Talent management and appraisal*
   - NHS usage of appraisal and talent management systems will be evaluated for implementation at King's

b) *Improving Attendance at Work*
   - We will further develop our holistic, multidisciplinary approach to employee health and wellbeing through our specialist in-house occupational health service and appropriate external intervention to support absent staff back to work speedily
   - We aim to secure '*Safe, Effective, Quality Occupational Health Service'* (SEQOHS) accreditation complemented by an occupational health and wellbeing strategy
   - We will proactively manage absence to improve attendance and thus secure progress towards a 3% target

c) *e-rostering*
   - Having completed e-rostering roll out across the Trust, we plan systematic roster review to identify where and how staff can be deployed more efficiently to reduce bank/ agency spend

d) *Resourcing*
   - King's plans to further develop its approach to workforce resourcing and retention and to reward high performing staff
   - Hard market testing of our HR transactional services will be concluded in May 2013, the outcome will identify where efficient processing can shorten 'time to hire', reduce bank/ agency spend, deliver quality recruitment services to the front line and minimise payroll errors

e) *Workforce engagement*
   - There will be a focus in the coming year on engaging with staff, listening and responding in the wake of the Francis enquiry

f) *Education and Training*
   - As a founding partner of the KHP, King's is committed to excellence in education, training and development
   - We embrace, multidisciplinary undergraduate and postgraduate clinical placements alongside professional development and delivery of skills, leadership, management, statutory, mandatory and other training, together with vocational qualifications and apprenticeships
   - We will work closely with the KHP Education and build on our own active participation in the development of the newly formed Health Education South London to influence its activity; we will take special interest in: how expenditure is prioritised, its integrated clinical and non-clinical leadership development and the extending of the apprentice programme
   - In conjunction with KHP, we will bid for and deliver on the Medical and Dental Education commissioning contracts

The success of the above priorities will be evaluated in early 2014 through the triennial re-accreditation of the Investors in People well recognised kite mark which measures people management skills and attainment.

25. Medical workforce

Much work has gone into defining the optimum establishment of both senior and junior medical staff within Kings in recent years. A rigorous Trust wide consultant job planning round was undertaken between 2011 and 2012 with rollout of metrics of individual consultant productivity. This work has led the way nationally in the field of medical productivity, and dovetails with the Trust Medical Workforce Committee in ensuring that the consultant establishment is correct across the specialties. This view has been supported by the various Royal Colleges. The productivity work, as well as consultant numbers per specialty, has been benchmarked by the Shelford National Medical Directors Forum. We feel that Kings has a high direct clinical care component in its set of job plans.

The roles of allied health professionals have been expanded to maximise consultant interventional sessions, with knock-on benefits in job satisfaction and income (for example in Cardiothoracic Surgery). A work stream has been set up ensuring that women in medicine achieve their maximal career potential, as well as satisfactory work-life balance.

An expectation has been set that all consultants will deliver undergraduate teaching and clinical research; to maintain our status as a leading Academic Health Science Centre. This has been set out in a job planning guidance agreed with GSTT.

In response to the National Students' survey 2012, we have put greater emphasis on consultant-delivered undergraduate teaching. This will continue to be closely monitored for quality through regular student surveys. Effort will be put into developing and maintaining additional educational facilities.

We will build on the new doctors' shadowing programme we developed 2 years ago; to further enhance quality of patient care as well as training experience of junior doctors.

As one the main Lead Providers for postgraduate medical training in London, we will build on our success in delivering high quality training programmes across all main specialties in South London; with significant emphasis on clinical leadership development, Research and Teaching skills- producing high calibre doctors for the future.

In response to Revalidation legislation and the Francis report, all doctors- senior and junior will be expected to actively participate in, and drive quality improvement culture within the organisation.

26. Nursing workforce

Plan to:

- Ensure that the workforce is right sized in relation to the throughput, acuity and dependency of patients, by routinely using a validated nationally available acuity/workforce assessment tool (The Safer Nursing Care Tool). This is expected to lead to an initial increase in current staffing levels.
- Improve ward level leadership
- Measure quality and safety to assure the staffing efficacy
- Improve recruitment and increase retention

27. Workforce Pressures and Plans To Address Them

a) Pressures

Increasing patient volume and patient acuity, associated difficulties in recruiting sufficient volumes of nursing staff. Particular pressures are recruitment to:

- Traditionally hard to recruit areas (neurosciences, theatres)

- Middle grade ward level staff, particularly in specialised areas (Intensive care, haematology, the emergency department)
- Risk of difficulty in recruiting newly qualified staff due to reduction in student nurse commissions

b) Plans

Recruitment strategies include:

- Overseas recruitment
- Continuing to build relationships with UK education providers in areas of the country where jobs are scarce (Ireland and Scotland)
- Rotational and development programmes to develop and retain cadre of experienced middle grade ward level staff
- Liaison with the local LETB's to ensure that numbers of student commissions are regularly reviewed to match demand.
- In addition, all of the elements identified in the Trust workforce strategy

c) Costs

Ensuring that the workforce is right-sized by regular assessments of staffing levels will reduce dependency on agency staff which will reduce costs. In the longer term, if acuity continues to increase, and in the wake of the Francis report, costs may also increase.

28. Benchmarking

The Trust is a member of the Shelford group of Academic Health Science Centres and the Association of UK University Hospitals. We have taken part in a number of benchmarking exercises of staffing levels in different services. Many of these are flawed due to different models of service making comparisons less relevant but in general the Trust is found to be neither over or understaffed in comparison with peers.

29. Clinical sustainability

The need for succession planning is recognised, particularly the retention of international profile in specialties such as Fetal Medicine and Liver Surgery. In line with achievement of HfL Trauma Centre status, consultant establishment, comprehensive 24/7 cover and infrastructure in the shape of bed and theatre capacity have been expanded over 2012/13. The need to further develop areas such as Paediatric Surgery at junior and senior level is recognised, and is a priority in coming months.

On-call rotas have been reviewed at senior and junior level to ensure seamless 24/7 quality care. For example, Acute Medicine consultant numbers have expanded to deal with the ongoing growth in volumes of medical take, as well as providing better continuity of care. These care pathways will continue to be refined going forward. Bariatric Surgery has been expanded across Kings Health Partners and will be further augmented by an Academic appointment.

A program delivering daily consultant ward rounds has been successfully implemented ('Safer Faster Hospital'), leading to improved safety, quality as well as maximising bed capacity. Numbers of temporary medical staff have been tracked and transferred to permanent establishment, reducing cost and improving consistency.

30. Productivity & Efficiency

The Cost Improvement Programme has various productivity and efficiency gains built into plans, including:

- Length of stay: £1.7m
- Bank and agency spend: £2.5m
- Theatre productivity: £1m
- Outpatient Productivity: £5.4m

which are made up of various schemes.

31. Historic Performance

The CIP process has yielded an 82% achievement rate over the past year, although cost reduction elements were underachieved and in many cases replaced. The CIP achievement rate has historically been no lower than this, despite targets of £45m and £40m over the past two years.

32. 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 current support from Ernst and Young 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.

33. 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.

34. 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 amber
- Workforce productivity reviews focusing on medical, nursing and administration staff and reducing staff sickness – various risk ratings

- 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 and green
- Income growth and diversification - mostly rated amber and green

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

A key factor of the productivity gains will be managing Emergency admissions in order to ring-fence elective theatre and bed capacity. Additional capacity for wards and theatres are planned for August (Infill Block 4) to support this strategy. Protecting the tertiary activity flows is a key element of the demand and capacity model and financial income plan. The additional capacity will provide the scope to improve the Trust's overall financial margin and meet the excess demand by operating the plant more efficiently. The Acute Medicine integrated service review will also be important in reducing the number of medical patient outliers.

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. 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.

Develop cost improvement and income diversification schemes

- 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.

Implement 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 Medical and Admin & Clerical productivity
- Plan patient flow and capacity to significantly improve the use of existing hospital estate and undertake modest expansion where appropriate e.g. to meet anticipated emergency demand (Infill Block 4 and 5)

35. Clinician Engagement

Clinicians are engaged at a divisional level for divisional CIPs, and also lead the medical productivity work-stream which is a sub-set of the workforce work-stream.

36. KCH Financial Position

Turnover as at 31.3.2013 is £679m. Income from patient activities is £589m (87%) and other operating income is £90m (13%).

Operating expenses for 2012/13 were £668m and employee expenses were £374m (56%).

The Trust has achieved an operating surplus in last two years excluding any property impairments charged to operating expenses. These were £3.21m (2012/13) and £3.66m (2011/12) respectively against a plan of £4m.

The financial risk rating has constantly remained at a 3 over the last couple of years throughout each quarter. The liquidity ratio and the I&E surplus margin have been the weaker elements of the financial performance criteria.

The increasing revenue cost base and capital plan commitments have impacted adversely on these ratios as the surplus margin has not increased in line with turnover. 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. The PbR emergency marginal rate has also been detrimental to the Trust's financial position.

Income from activities has increased by £43m in 2012/13 and this 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 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 PCT's in respect to winter pressures (£6.5m). 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 additional in General Medicine beds, an Acute Assessment Unit (AAU) and additional Clinical Decision Unit (CDU) beds. This investment was crucial to maintain patient quality.

The income relating to drugs and devices (excluded from the tariff) increased from £24.9m to £29.9m, reflected the specialist tertiary growth. The Trust has increased productivity to meet the patient demands across emergency, secondary and tertiary care and maintain financial balance.

The CIP achievement was £32.1m of which £22.6m related to income generation schemes. The income generation schemes included PCT 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 13/14 contract baselines.

The Trust billed £36.7m in respect to Commissioner contract over-performance for 12/13 and £2m remained outstanding at 31.3.13. The cash balance improved from £27m to £40m in year but the net current assets reduced due to additional provisions regarding pension liabilities and redundancy liabilities from new transactions regarding Dental services in Greenwich and Bexley.

The slow progress regarding contract agreement and billing arrangements with NHSE is creating a cash-flow problem for the Trust and the working capital facility will need to be increased to cover this risk. The working capital facility is currently £35m. This will need to increase to £40m and probably £45m in the following year based on the projected increase in turnover.

In summary, the Trust has maintained financial balance through high levels of productivity and efficiency but the capacity constraints in face of the emergency activity demands do threaten to undermine the financial stability of the Trust. The investment plans to expand the bed and theatre capacity are key to achieving patient demand and quality patient services, within the financial constraints.

37. The Trust's Financial Strategy And Goals Over The Next Three Years:

a) Summary

The Trust's fundamental objective is to maintain financial stability in a difficult economic climate over the next three years, while delivering positive outcomes to patients. The financial targets will be restricted to a £2m surplus for each year (excluding asset impairments) and to achieve a financial rating of 3. The CIP will be divided between cost savings and income generation and a stretch target of £40m set each year. A contingency of £10m will be held in reserve based on an achievement of £30m per year. This is in line with recurrent efficiency projections ranging from 4% to 4.5% per annum over the next three years. The Trust has a demanding capital investment programme (new build) and short term capacity plans (modular build) to implement; all of which have positive revenue consequences and are incorporated into the financial plan. The Trust's operating revenue will increase within the three year plan due to the capacity developments.

The Trust needs to expand capacity to create additional beds and theatres in order:

- to meet the increased demand in emergency activity,
- to reduce waiting times and deliver all access targets,
- to accommodate strategic changes in specialist tertiary activity,
- to increase private patient capacity and re-invest in NHS care

The modular builds are a short term revenue operating lease cost and has a shorter lead time, ensuring facilities are commissioned in time to meet the critical capacity demands of the Trust. Converting non-clinical space is not viable due to decanting constraints and other clinical reconfigurations such as the Golden Jubilee Wing offer insufficient space. The Trust needs flexible capacity pending the implications of SLHT.

The key capacity investments can be summarised as:

- **Infill Block 4 (August 2013)** : 48 new beds and 1 theatre
- **Infill Block 5 (November 2014)** : 99 new beds and a Hybrid theatre/Catheter Lab and Cyberknife (enabling works will reduce the bed pool permanently by 56 beds).
- **Critical Care Block (2015/ 2016) :** 60 Critical Care beds in two equal phases.

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.

b) Capacity Plans

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

- 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 £56m over the next 2 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 plan is to install two modular built ward and theatre blocks in two areas in the hospital, replacing current temporary buildings. These two developments provide a net increase of 91 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.

c) 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 2013/14 Commissioners' contracts should reach £13m 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.

d) Operating Revenue

The Trust's income plan is built upon last year's activity outturn less the projected PbR tariff deflator and Commissioner proposed QIPP savings (£10m – 2013/14 and recurring). The tariff deflator is based on 4% efficiency savings less Treasury pay and prices estimates; resulting in reductions of 1.3% in 2013/14, 2014/15 and 0.2% 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. The Trust contract over-performance last year reached £36m, including RTT activity targets and winter pressure funding. Therefore the capacity and planning modelling has to be flexible to meet the likely demand beyond contract values and the anticipated RTT targets. The only areas of activity growth excluding RTT activity; built into the contracting round are for HIV and Renal services (£1.8m – 2013/14), both contracted by NHSE.

The turnover is projected to increase due to the new developments and the income generation schemes from £679m to £764m in 3 years. This income figure includes £26m from Private Patients and Commercial sources.

The Trust has also committed an investment of £2.8m into local CCG joint plans (Integrated Care Pathway – ICP) to primarily reduce emergency re-admissions within 30 days, but also to support reducing emergency admission and attendances. This investment will be monitored through hospital activity audits involving local GPs.

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 onwards. The Medical/Dental SIFT and NMET funding streams could reduce by £6m in 2013/14 alone. There are very limited cost savings associated with this income reduction and this funding gap creates additional pressure on the cost improvement programme.

The Project Diamond Funding (£2.8m) has been treated as recurring income from 2013/14 and is yet to be confirmed by NHSE, to help maintain the financial viability of Tertiary services.

e) 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 £2.7m is to be invested in Nursing establishments 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 (2.9% to 3.2%) and non-pay (3.7% to 4%). Current inflation is 2.4% and therefore a contingency reserve has been established within the downside inflation assumptions.

Other contingency reserves have been built into the plan to mitigate the CIP risk, across pay and non-pay budgets.

f) Capital

The gross capital plan requires investment of £52.6m in 2013/14, £35.6m in 2014/15 and £10.2m 2015/16. £56m is funded through an external loan approved by the FTFF for the Critical Care Project.

The key capital development is the Critical Care Service expansion to support the Hyper Acute Stroke Centre and Major Trauma Unit. The trundle ward upgrade will deliver additional Critical Care Capacity in a purpose built area as opposed to a mobilised CC service on the wards.

The Maternity and Emergency Department capital developments will be completed in 2013/14 to improve the quality of services.

The Energy Infrastructure project is geared to driving efficiency savings as well as creating an environment to support further development. The decked car park is necessary to support the development of Infill Block 5.

The enabling works for a scanner, ultrasound capacity project, diabetic foot clinic and Renal Dialysis project 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.

g) Short term focus

- *Cost Improvement Programme*

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.

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

- Improving clinical coding to ensure all tariff income is recovered
- Workforce productivity reviews focusing on administrative staff and technology to improve efficiency
- Trust wide financial controls including procurement; and reducing agency spend by implementing robust recruitment plans and reducing staff absence
- Divisional and Corporate specific operational cost saving measures
- Income growth and diversification through service business cases and productivity measures
- Pharmacy outpatient prescribing, reduction in FP10 prescriptions and the use of cheaper alternative drugs
- Commercial income from overseas joint-ventures

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

A key factor of the productivity gains will be managing Emergency admissions in order to ring-fence elective theatre and bed capacity. Additional temporary modular wards and theatres are planned for August (2013) and November (2014) to support this strategy in the winter months. Protecting the tertiary activity flows is a key element of the demand and capacity model and financial income plan. The additional capacity will provide the scope to improve the Trust's overall financial margin and meet the excess demand by operating the plant more efficiently. The Acute Medicine integrated service review will also be important in reducing the number of medical patient outliers.

The Trust will maintain a focus on financial expenditure controls such as reducing expensive agency and locum spend by permanently recruiting to new posts. This will improve the quality of care and meet the rising acuity demands of the hospital case-mix. The workforce productivity CIP will determine the appropriate establishment levels and opportunities to maximise patient facing time.

The Project Diamond Group will also be continuing its work with NHSE to ensure tertiary tariffs are reviewed and the MFF on Research & Development funding streams is made recurrent.

h) Medium term focus

The main NHS additional income stream will be the Critical Care service expansion in 2014/15 and 2015/16.

Income diversification is the other key strand to this element of financial strategy, along with the reconfiguration of services with KHP and South London Healthcare Trust

i. 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.

ii. 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.

Key risks to achieving financial strategy and mitigations include:

a) **Fiscal squeeze** 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
- 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

b) **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, Modular theatres and wards, Maternity and Emergency Department. Scheme progress will be dependent on the delivery of the financial strategy

c) **Loss of clinical activity and therefore income as a result of strategic commissioning decisions, the instability of local healthcare economy (QIPP targets £10m) 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 AHC.

d) 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 4 and 5; Critical Care Unit

e) ***Liquidity 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.

Mitigating actions: to increase the working capital facility from £35m to £40m in 2013/14; and to £45m in 2014/15