

**Monitor Operational Plan for 2014/15
and 2015/16**

April 2014 Submission

**Chelsea and Westminster Hospital
Foundation Trust**

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i. Executive Summary

Our vision is to deliver the best possible experience and outcomes for our patients through focusing on high quality, integrated services that are delivered sustainably. This vision is underpinned by our values of safety, kindness, respect and excellence - and will be enabled by developing our people, processes, environment and technological infrastructure.

We face a short term challenge over the next two years to maintain our financial performance through continuing to deliver stretching efficiency targets (due to commissioner QIPP and tariff deflation), whilst also investing in our services to meet rising quality standards and demand for acute care.

Our Quality Plan describes how we will improve the safety, efficacy, patient experience and accessibility of our services – building on the good performance we have achieved over recent years. Over the next two years, there will be a particular focus on reducing harm, implementing the most effective clinical processes and delivering better care for Frail Elderly patients and those with Dementia.

Whilst our overall levels of activity are broadly in line with what we have delivered in 2013/14, there are some important contractual developments that mean we will need to deliver our planned care differently and also make more progress with our partners in how urgent and emergency services are delivered locally.

On both those fronts, we are committed to using resources jointly with our local commissioners and community care provider to deliver improved Emergency Care Pathways and Planned Care Pathways.

The main enabler for achieving our objectives is our workforce. So, we have developed a People Strategy and Plan that outlines how our leadership, capability and capacity will be enhanced – not only to deliver excellent care, but to deliver the change required to do so sustainably.

In order to maintain our financial risk rating, we have set a significant Cost Improvement Programme (CIP) target of £24.9 million for 2014/15, which represents 6.9% of turnover. To provide greater assurance for the delivery of this, we have taken a more rigorous approach to the identification, delivery and tracking of our CIP schemes, including the establishment of a PMO (Programme Management Office) to oversee delivery.

The significant CIP requirement, whilst reflecting the challenges in the local health economy, also reflects our investment programme, which over the next two years will see up to £3 million of revenue investment in staff and over £50 million capital investment in buildings, equipment and IT – largely focused on improving the quality and efficiency of our services.

So, whilst we face some significant challenges and have had to make some hard choices, we also feel confident that we have developed plans through which we can continue to deliver better services, more sustainably.

1. Introduction

Chelsea and Westminster Hospital Foundation Trust (CWFT) has set out a core vision, which is to:

Deliver the best possible experience and outcomes for our patients.

This vision is underpinned by our values of *safety, kindness, respect* and *excellence* – that must inform everything we do in delivering care to our patients.

To help realise this vision in a way that is aligned with wider NHS objectives (articulated in the *NHS Outcomes Framework*) and the needs of our local health economy, we have defined four supporting, interlinked Strategic Objectives:

- Excel in providing high quality clinical services;
- Improve population health outcomes and integrate care;
- Deliver financial sustainability; and
- Create an environment for learning, discovery and innovation.

Recognising that there are many aspects of how we work as an organisation that we will need to get right to achieve our vision, we have also defined four themes (referred to as “enablers”) through which organisational developments will be focused:

- *Our People* – building the leadership, capability and capacity to deliver high quality, sustainable and integrated care;
- *Our Processes* – ensuring that we adopt the most effective and efficient clinical, administrative and managerial processes to deliver care;
- *Our Technology* – adopting the IT systems and equipment to deliver services in a way that is commensurate with patients’ expectations and modern ways-of-working;
- *Our Environment* – investing in our facilities to ensure they are clean, modern and comfortable, whilst supporting staff to deliver care safely and respectfully.

The remaining sections of this document summarise the following aspects of our Operational Plan for the next two years:

- **The Short Term Challenge** – summary of the key challenges the organisation faces in delivering its strategic objectives;
- **Quality Plan** – an outline of the priorities for improving service quality;
- **Operational Requirements and Service & Workforce Developments** – description of significant changes to our activity and associated service developments, with an outline of our approach to developing our workforce;
- **Cost Improvement Programme** – summary of our objectives for (and approach to) identifying and delivering efficiency improvement;
- **Financial Plan Commentary** – commentary on our income, revenue expenditure, capital investments and financial risk ratings.

The Financial Plan Template, which is a separately submitted document, provides quantitative detail related to aspects of this plan, alongside other required data.

2. The Short Term Challenge

CWFT's activity and income profile reflects the three main sources of our activity and income:

- Locally-commissioned NHS Services;
- Nationally-commissioned NHS Services;
- Non-NHS Services.

The sections below describe the key challenges ahead pertaining to these different sources of activity and income.

The final section summarises how these translate into challenges for the organisation in delivering its Vision and Strategic Objectives.

2.1 Locally-commissioned NHS Services

2.1.1 Clinical Commissioning Groups

We deliver the vast majority of our services from the main hospital site on Fulham Road, with the patient population drawn primarily from Kensington and Chelsea and the neighbouring boroughs of Hammersmith and Fulham (H&F), Westminster and Wandsworth: the total population for these boroughs is approximately 868,000 – 10% of which are aged over 65 and amongst whom health is described as “mixed”, but whose [overall] life expectancy is higher than the national average.

Local services commissioned by North West London (NWL) Clinical Commissioning Groups (CCGs) include the following, which deliver 30% of overall trust income (approx £108 million in 2013/14):

- 24/7 adult and paediatric A&E (Emergency Department) services with co-located Urgent Care Centres (UCCs);
- Full Maternity service;
- Range of Medical and Surgical specialties;
- Community-based clinics in MSK, Gynaecology and Dermatology.

NWL Commissioners have agreed overall activity objectives and service development priorities for this group of services, primarily based on reducing emergency admissions and outpatient activity through a transformation programme during 2014/15.

NWL has recently had Secretary of State [for Health] approval to proceed with the planned reconfiguration of acute services within the local health economy, called Shaping a Healthier Future (SaHF). CWFT was successful in being awarded Major Hospital status through this [SaHF] programme, which also meant that a neighbouring hospital's Accident and Emergency Department (ED) has been downgraded.

CWFT is, therefore, expected to see a rise in ED attendance, non-elective admissions and some elective admissions from 2017/18 – which would lie beyond this document's planning horizon: however, the effect on non-elective admissions is expected to begin prior to 2016, with growing evidence that this is already happening

for some types of emergency activity. This places considerable risk to the ability to minimise increases in non-elective admissions, upon which the QIPP programme is predicated.

To meet these challenges, the Trust is working with local commissioners to transform services through the following programmes:

- Emergency Care Pathway transformation programme;
- Planned Care Pathway transformation programme.

Both of these programmes are described in more detail later.

SaHF does also provide the Trust with some activity growth opportunities, which are described in Sections 4 and 6: for example, the Trust is also being asked to prepare for an additional 1,000 births as a result of a local trust closing its maternity department, with the exact timing still to be determined.

2.1.2 Local Authorities

Our Sexual Health service is another key locally-commissioned service, though we deliver services to patients from all over London through facilities in Soho and Hammersmith in addition to our main site in Fulham. This is a direct access service, meaning that demand management is challenging to implement, leaving providers at risk if activity growth is not translated into commensurate income growth.

Income from our Sexual Health Services accounted for £20 million of income in 2013/14 (6% of overall income), having grown at a steady rate over the last 2 years, due to increasing activity and is forecast to do so over the period ahead.

The commissioning of these services is now led by Local Authorities, who are seeking to reduce their risk of expenditure growth in their budgets – which carries inherent challenges for the trust if activity (and associated service delivery costs) continue to rise. The 12 boroughs in NWL and North Central London have agreed to work together to negotiate as a single group, with agreed terms and conditions applying to the whole group.

2.2 Nationally-commissioned NHS Services

Our Specialised Services, commissioned by NHS England (NHSE) and comprising £108 million (30 % of our overall income) in 2013/14, include the following:

- *Women and Children* – Specialised Maternity, Neonatal Critical Care, Paediatric Medicine, Paediatric Surgery;
- *Internal Medicine* – Severe and Complex Obesity, Specialised Dermatology, Interventional Radiology, Specialised Imaging;
- *Cancer & Blood* – HIV, Chemotherapy (for Lung Cancer);
- *Trauma* – Burns Care, Specialised Pain, Adult Critical Care.

These are delivered from our main site on Fulham road, principally to the population of NWL (approx 2 million) – although our HIV Service, which has the largest patient cohort in Europe, has a broader national footprint in terms of patient provenance.

NHS England have QIPP and CQUIN programmes, though the financial impact of these on the trust over the next two years is not expected to be as great as those for locally commissioned services - as summarised in **Table 2a**, below:

Table 2a – NHS England QIPP, CQUINs and Metrics

Scheme	2014/15 Impact (£m)	2015/16 Impact (£m)
QIPP	-6.4	-6.4
CQUINs	1.5	1.5
Total	-4.9	-4.9

2014/15 is anticipated to be a year of consolidation, after the transfer of additional services to specialised commissioning in 2013/14 – so, significant changes to contracts or tariffs are not expected. However, NHSE is looking to continue assessment of services against national specifications and expecting trusts to address any gaps – and this carries significant risks of increasing our service costs.

CWFT will need to closely monitor and influence this process, as a number of our specialised services may expand or contract as well as change in financial viability, depending on changes in the wider specialised landscape.

Allied to these developments, NHS England has also signalled an intention to radically reduce the number of providers from which it commissions Specialised Services: whilst the detail has not been published yet, this has the potential to significantly destabilise the Trust’s service and income profile.

So, our emerging Clinical Services Strategy will assess the optimal portfolio of Specialised Services for this Trust, alongside looking for any early indications from NHSE about changes to their future commissioning plans for any services currently within our portfolio.

2.3 Non-NHS Services

2.3.1 Private Patient Services

The Trust also provides a range of privately funded inpatient and outpatient care: this generated £13 million income in 2013/14, a 9% increase on the previous year.

Along with other organisations, as NHS income growth has become more constrained, CWFT has identified increasing Private Patient Services income (where the profit-margins are significant) as a key means of delivering financial sustainability. However, there are challenges to achieving this growth at the levels we intend:

- *Market Size* – as insurers seek to control rising costs through taking action on prices and volumes;
- *Competition* – as other NHS providers seek to follow similar strategies and existing Independent sector providers try to protect their market share.

Both these factors suggest that the Private Patient market may become a more challenging environment in which to grow revenue profitably.

2.3.2 Education and Training

The Trust receives significant income from providing Multi-professional Education and Training; mainly undergraduate and postgraduate medical education, but also to other groups of healthcare professionals. This is also set to reduce over the next two years, as set out in **Table 2b**.

Table 2b – CWFT Multi-professional Education and Training Income profile

Scheme	2014/15 Impact (£m)	2015/16 Impact (£m)
Total	-2.2	-1.2

Reduction in the revenue contribution that these services provide will need to be mitigated, because removing the costs associated with delivery is likely to realise very limited – if any – financial savings.

2.4 Summary of Short-term Challenges

The combined impact of these factors means that we face the following key challenges over the next two years towards delivering our vision and strategic objectives.

High Quality Services

- Ensuring that our Cost Improvement Programme does not limit our ability to invest in improving safety, efficacy or patient experience;
- Ensuring that the agreement of block contracts for planned care does not limit our capacity to maintain access performance for non-elective and elective activity, if referral demand management is not entirely effective;
- Sustaining and delivering further reductions in non-elective admissions, especially if non-elective activity shifts to CWFT from other providers (due to SaHF) occur earlier than planned.

Integrating Care

- Working with partners in the local health economy to integrate primary care, community care and social care;
- Investing in the implementation of new transformative models of care in the prevailing financial environment.

Financial Sustainability

- Ensuring that we have the clinical capacity and service “offer” in place to deliver our income growth CIPs – particularly from Private Patient Services;
- Implementing a significant year-on-year Cost Improvement Programme with limited scope to deliver revenue growth through NHS income generation.

3. Quality Plan

3.1 Introduction

Realisation of our vision will mean achieving high quality care for all our patients. For us, high quality care comprises these three key features:

- **Safe and Effective**
 - *Safety* – eradicating harm and ensuring that care delivered is as safe as possible, regardless of when or where patients seek our services;
 - *Efficacy* – ensuring that we deliver the best clinical outcomes possible for our patients, deploying evidence-based care processes and procedures consistently throughout the organisation;
- **Excellent Patient Experience** – ensuring that we treat all our patients and their carers with kindness and respect in all their interactions with us, all of the time;
- **Accessible** – ensuring that emergency and planned care are delivered in a timely fashion, whilst also offering patients greater flexibility in how and when they access our services.

External analysis, inspections by regulators, patient survey results and nationally monitored performance data suggest that we are achieving good performance in key aspects of quality:

- The most recent Care Quality Commission (CQC) Intelligent Monitoring Report placed CWFT in the best risk banding possible (Band 6);
- Our last unannounced CQC inspection declared no concerns with care;
- Dr Foster reports on hospital mortality rates have placed us amongst the safest hospitals in the country year-on-year;
- We hold NHSLA level 3 for our general services, attained during 2013/14
- Assessment of compliance with the London Quality Standards for Urgent and Emergency Care showed us meeting more standards than any other Trust;
- Friends and Family Test results show positive and improving responses;
- Our access performance for non-elective and elective care continues to be strong, with waiting time performance in our Emergency Department amongst the best in England.

However, we recognise that there are a number of areas where we can improve, particularly the consistency of care we deliver, so that all our patients receive high quality care.

This section outlines our overall approach to sustaining and improving quality of care: what it means to us; the areas we have prioritised for improvement and how we plan to deliver and assure that improvement.

Our approach to quality may appear simple, but it will be challenging to deliver, especially considering the broader funding and delivery challenges outlined earlier.

But, we are also clear that pursuing quality and efficiency improvement cannot be perceived as mutually exclusive options. Therefore, we have also placed significant emphasis internally on articulating how improving quality can help deliver greater

efficiency – and also how efficiency improvements can improve quality; directly by helping to improve access and also indirectly, by allowing us the “headroom” to invest in improving our staff, technology and facilities. This year, we will be making up to £2 million worth of investments in quality. And this is a further reason why our Trust Improvement Programme is focused on joint goals of improving Quality and Productivity.

It should be noted here that our approach to improving quality links closely to strategies and plans that are described in other documents in greater detail, including our:

- Quality Account for 2014/15;
- Improvement Programme;
- Clinical Services Strategy;
- People Strategy and Plan (also summarised later in this document);
- IM&T Strategy;
- Estates and Facilities Plan.

More detailed delivery plans for each of our quality priorities are also provided elsewhere, so the intention here is merely to provide an overview of the key aspects.

NB - * **and in bold** denotes priorities that are included in our 2014/15 Quality Account.

3.2 Safe and Effective Care

What does this mean for us?

Safe care means ensuring that we do not harm patients under our care, either through the treatment we give (our actions) or neglecting their needs (our inactions).

Effective care means ensuring that we deploy the processes, products and devices with which to achieve the best clinical outcomes for our patients consistently across the organisation, so that our patients receive the best possible care regardless of when or where they are treated.

Over recent years, we have achieved sustained reductions in C Diff and MRSA Bacteraemias (two key healthcare-associated infections), but there is more we can do.

What are our priorities?

We have identified several priorities under this theme, reflecting its paramount importance to patients, commissioners and staff. We also recognise that these are likely to be the themes within “Sign up to Safety”; the SOS campaign to halve the harm caused in hospitals.

- Reducing Harm
 - Using the Safety Thermometer – covering Pressure Ulcers, Falls, Catheters and UTIs, **Venous Thromboembolism*** (VTE)
 - Infection Prevention

- Medication Safety
- Never Events
- Delivering Effective Care
 - Sepsis
 - Acutely Deteriorating Patient
 - **Dementia Care***
 - Caring for the Frail and Elderly

3.3 Patient Experience

What does this mean for us?

Our ambition is to deliver excellent Patient Experience: this means that patients and their carers should feel that they have been treated with kindness, respect and dignity in a clean, supportive environment.

Although we have achieved year-on-year improvements in our annual national patient surveys, the feedback we receive shows there is more we can do to deliver a consistently excellent experience.

What are our priorities?

Over the next two years, we are focusing efforts on improving the following:

- **End of Life Care***;
- Communication with Patients, Carers and GPs – particularly surrounding discharge from hospital;
- Customer Service in Outpatient Areas;
- **Staff Engagement***.

3.4 Access

What does this mean for us?

Access for us means ensuring not just that patients receive services in as timely a fashion possible – as set out in the NHS constitution, but also at a time and through modes that suit their needs and circumstances.

Our performance on the access targets for elective and non-elective care (set out in the NHS constitution) has been strong during 2013/14, with all key targets met or exceeded in a challenging operational environment. However, as described earlier, the challenges to meet these targets are becoming greater, so we will need improved ways-of-working to maintain our performance.

What are our priorities?

Whilst meeting existing performance targets remains a key priority, we are also looking to exceed these wherever possible and find new ways of facilitating patient access, as per the following priorities:

- *Timeliness* – ensuring that waiting times for services meet or exceed national targets – e.g. A&E waiting times, Referral to Treatment Times, Cancer Waiting Times etc;
- *Time of Access* – introducing greater flexibility to when planned outpatient or inpatient care is delivered, reflecting patient preferences – e.g. evenings and weekends;
- *Mode of Access* – using technology to deliver more services through virtual clinics, telephone consultations and postal testing services.

3.6 Enabling Quality Improvement

As outlined earlier, we have identified four organisational “enablers”, developments of which will help us to achieve our objectives – each of which is supported by strategy and plan articulating how developments will be aligned to support the achievement of the organisation’s vision and objectives. Below, we have drawn out the key components of those plans that will support quality improvement over the next two years.

3.6.1 Developing our People

Our People Strategy and Plan is organised into six themes (summarised in Section 4), particular elements of which are integral to the delivery of our quality objectives. Below, we have itemised the aspects of that plan that are most pertinent to delivering quality improvement over the next two years:

- *Culture, Values and Engagement*
 - Our values of Safe, Kind, Respectful and Excellent our directly related to the type of care and experience we want our patients and their carers to have.
 - Implementation of our values is supported by our recruitment, appraisal and reward processes – as well as by specific training and awareness activities that we are rolling out over the next two years.
- *Inspirational Leadership and Talent*
 - Leadership from clinical and managerial staff will be vital in communicating and reinforcing the vision and objectives amongst all our staff groups.
 - We are investing in leadership development programmes for all staff groups to make sure we have staff in all teams to lead change.
- *Workforce Strategy and Planning*
 - We will need to provide appropriate workforce capacity in frontline and support areas to ensure that time is available to guarantee the safety and experience of patient care.
 - A significant proportion of our investment programme for 2014/15 is allocated towards investing in frontline clinical capacity to ensure key service standards are met and we are also working closely with our commissioners to focus specific funding streams on these areas.
- *Skills and Capability*
 - We aim to ensure staff have the skills to implement and embed quality improvements in their roles and work across the NHS to ensure best practice and evidence-based reliable care.

- In addition to the investment in leadership training, we are also rolling out a trust-wide training programme for all staff groups in Quality Improvement methodologies – such as Lean.
- *Performance, Reward and Recognition*
 - Staff efforts to improve quality need to be recognised in the time allocated for these activities and the profile for achieving results.
 - We are funding time in doctors' Job Plans and other staffs' working schedules to focus on quality improvement activity, whilst also continuing our Star Awards scheme – which has a particular focus on recognising quality and productivity achievements.

3.6.2 Process Improvement

Our staff deliver care through a sometimes complex set of clinical processes or procedures, supported by administrative and management processes: all of these need to be fit-for-purpose in their own right and also interlink effectively to deliver high quality care. It is evident that this does not always occur and is one of the reasons why the experience of patients can vary significantly within the organisation.

We are embarking on an organisation-wide Improvement Programme aimed at optimising the organisation's clinical, administrative and managerial processes, so that they enable the delivery of consistently high quality care. In practice this means focusing on the following over the next two years:

- Implementing NICE Guidance and other Good Practice guidance – such as High Impact Interventions and Care Bundles;
- Achieving compliance with National Clinical Audit Requirements;
- Ensuring our processes are patient-focused and Lean, minimising time wasted by patients and staff;
- Adopting standardised processes for assessing and managing capacity across the organisation, particularly to help adjust to fluctuations in demand.

3.6.3 Technological Development

Our IM&T Strategy and Plan outlines several developments that will enable us to offer safer and more effective care, whilst also improving patient experience and access. Over the next two years, these include the rollout of a Patient Relationship Management (PRM) system to support a smoother planned care pathway and introduction of an Electronic Patient Record to facilitate the delivery of integrated care.

3.6.4 Facilities Development

To deliver high quality care, the physical environment needs to be clean, comfortable, support patient's privacy and dignity and be easily navigable. Although our main hospital site is a relatively new building, investments over recent years have maintained it as one of the best acute healthcare facilities in England.

Significant capital investment plans over the next two years are aimed at developing the Emergency Department, Outpatient area, Treatment Centre, Surgical Admissions Lounge and Medical Day Unit to support better emergency, ambulatory and planned care services.

3.7 Governance and Monitoring

The Board derives assurance on the quality of its services and safeguards patient safety in a variety of ways.

Our Performance Management Scorecard includes key elements of quality and is used throughout the organisation, including at Board where an exception reporting approach is adopted. We will add to this significantly this year ensuring that the Board takes full responsibility for the quality of care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

A yearly review of the quality governance framework is undertaken which assures the Board on the four areas of quality governance: strategy, culture and capabilities, structures and processes, and measurement. This assessment is RAG rated with proposed actions in areas requiring development.

The Assurance Committee is a subcommittee of the Board chaired by a NED and attended by two other NEDs and two governors, as well as the Executive Team. This committee oversees progress on quality objectives, indicators and other key areas of quality such as complaints and incidents, training and health and safety.

4. Operational Requirements and Service & Workforce Developments

In line with the commissioning intentions summarised earlier, the Trust is aiming to deliver broadly the same levels of overall activity over the next two years; however, there are some important shifts in particular types of activity, which we describe below.

We have also set out here what we are doing to innovate and transform how we deliver some of our key services to improve the quality and efficiency of care. These are also referred to in other sections within this document.

The second part of this section (4.2) summarises the key elements of our People Strategy and Plan, which describes how we are developing our most vital resource – our workforce – to help achieve our vision and strategic objectives.

Our Private Patient services developments are covered in the commentary in Section 6.3.2.

Section 6 also provides further detail on the financial implications of the changes in activity levels, as well as some of the related investments in capital and revenue expenditure.

4.1 Overview of NHS Activity Changes and Service Developments

4.1.2 Urgent and Emergency Care

Local commissioners, in line with national priorities, aim to reduce acute hospital attendances and admissions over the next two years. This is a key part of their QIPP programme, but is also a vital component of wider strategies to improve out-of-hospital care, so that only those who require acute care end up seeking it. We continue to support these initiatives, which are also important in enabling us to meet rising levels of acute demand from a reduced bed base.

To do this, as part of our overall Improvement Programme, we will be extending the Emergency Care Pathway Improvement Programme. This programme was set up in 2013/14, jointly funded by CCGs, the Trust and our local Community Trust (CLCH) with the specific objective of reducing the rate of emergency admissions, and the length of stay for those patients that did need to be admitted.

The programme has been successful in delivering a 6% reduction in emergency admissions in 2013/14 (compared to 2012/13) and is positive testament to what can be delivered when providers across the system work together in an appropriately resourced work programme.

The focus during 2013/14 was on setting up ambulatory care infrastructure, improving discharge procedures and facilitating access to intermediate care bed capacity.

The second year of the programme will have similar support and collaborative working across organisations and aims to make further reductions in emergency admissions and length of stay, as well as focussing on care planning for specific cohorts of patients, linked to sector Whole Systems initiatives.

These objectives will be delivered through focusing on the following areas:

- *Ambulatory Care* – increasing our capacity for this service and the range of pathways for which care can be delivered to walk-in patients and those at home;
- *Discharge* – improving our procedures to enable discharge earlier in the day to free capacity that will improve flow of admissions;
- *Step-down / Intermediate Care* – increasing the bed capacity we have available to care for patients in a low-acuity environment – and also the efficiency with which this capacity is provided;
- *High-risk Patients in the Community* – putting better infrastructure in place to identify and manage (including improved *care plans*) those with long-term conditions who are at greatest risk of deterioration and acute admission.

The objectives of the programme will also support the medium-term objectives of the SaHF programme. SaHF efforts to move care closer to patients' homes are both reliant on commissioner Out of Hospital strategies succeeding in reducing non-elective hospital admissions and providers reducing Length of Stay for those patients who do need acute admission.

We believe that this programme, building on the gains made last year and with the continuing commitment of key partners in the local health economy, is well placed to deliver the transformation required to achieve a step-change in the provision of urgent and emergency care.

4.1.2 Planned Care

Similarly to emergency care, commissioners are seeking to reduce demand for planned care in the acute sector through – specifically reductions in some outpatient new and follow-up attendances, referrals generated within the acute sector (so-called internally-generated referrals) and moving certain procedures currently performed in a day case setting to outpatient settings: this is reflected in our activity plans.

From a provider perspective, we are supportive of efforts to use our planned care capacity more efficiently and improve access for those patients who need it.

To do this (building on the progress made on Emergency Care) we are working with commissioners to develop a Planned Care Improvement Programme, which will be aimed at delivering the following:

- Reductions in demand for and delivery of follow-up outpatient appointments;
- Increased productivity in use of theatre, outpatient and diagnostic capacity;
- Reduced length of stay for planned procedures.

These will be achieved through the following emerging work programme over the next two years:

- *Referral Management* - improved triage of referrals and use of direct access diagnostics;
- *Virtual Clinics* - increased use of virtual clinics for follow-up and protocols to reduce the number of patients that require follow-up;
- *“One-Stop Shops”* – redesign of more outpatient pathways to enable investigation and diagnosis of patients at one clinical consultation.

- *Daycase and Short-stay Surgery* – implementation of techniques and infrastructure to increase the proportion of procedures conducted as day-case and adoption of tried-and-tested whole pathway-approaches to reducing pre and post-operative length of stay for elective surgery.

It is also worth highlighting here some related developments to our Sexual Health services – broadly aimed at increasing the efficiency with which patients are diagnosed and treated:

- *Postal Testing Pilot* – developing a postal sexual health testing service, due to be launched in summer 2014 and would be the first of its kind;
- *Rapid Diagnostics* – building on our popular clinic at 56 Dean Street in Soho, we launched a rapid HIV testing service from 34 Dean Street (called Dean Street Express) which provides testing and all results within 6 hours.

Whilst our Sexual Health and HIV services are widely acclaimed for the innovative approaches exemplified above, we want the expertise and approaches we have built in those services to be deployed in other areas to improve the accessibility and efficiency of all our outpatient services.

4.1.3 Maternity Services

Our Maternity Services are expected to show slight growth over the next two years, having seen stable activity over the last two [years]. We anticipate more significant growth when the maternity department at Ealing hospital closes as part of the SaHF programme, which could potentially occur earlier than 2017.

Although most of the births that are due to be redirected from Ealing Hospital will flow to other hospitals in the more immediate vicinity, capacity constraints at other providers may lead to some activity being passed on to our Trust.

In response to this, we brought forward redevelopment of our Midwifery Led Unit, which has physical capacity for an extra 1000 deliveries per year. However, we are currently planning (and staffing accordingly) for 100 extra deliveries per year to respond to SaHF over the next two years.

4.2 Developing our Workforce

At CWFT, we aim to have high-performing, kind and respectful staff providing safe and excellent care, supported by visible and engaging leaders at all levels who enthuse and inspire colleagues.

To help us achieve this, we have developed a People Strategy and Plan – which outlines our ambitions and priorities for the next few years. The strategy has 6 main themes:

1. Culture, Values and Engagement;
2. Inspirational Leadership and Talent;
3. Workforce Strategy and Planning;
4. HR and Learning processes;
5. Skills and Capability;
6. Performance, Reward and Recognition.

4.2.1 Culture Values and Engagement

Our ambition: We aim to embed an open, positive and caring culture, where we challenge each other to drive continuous improvement and every individual (patient, relative or staff) wants to recommend the Trust as a best place to work and be cared for.

We already have good levels of staff engagement and a values-based culture. Since the overall staff engagement indicator was introduced in the staff survey in 2011, we have been in the best 20% of acute trusts. We are particularly proud to have been in the top 20% for the last 5 years on the key finding that “staff would recommend the trust as a place to work or to receive treatment”. However, we are not complacent and there is always more to be done. Our priorities for 2014/15 are to:

- Introduce the staff “Friends and Family Test”;
- Work to improve the less good areas of the staff survey – for example, staff perceptions of discrimination, bullying and harassment;
- Use social media more as a form of communication and engagement with staff.

4.2.2 Inspirational Leadership and Talent

Our ambition: We aim to have visible, approachable leaders who inspire, enthuse, motivate and provide a role model for others. They will coach and empower others, develop our talent, build links within and outside the organisation to deliver excellent outcomes for patients.

As our organisational strategy develops, it is clearer now what we need from our leaders, and how we will need to develop them to lead and support our staff in the future. Although we already have some good programmes in place to develop our leaders, much of these opportunities are taken up on an ad hoc basis; neither do we have a co-ordinated approach to talent management - and perhaps as a result of this, we have lost some key talented individuals to other trusts.

Therefore, our priorities over the next two years will be to:

- Pilot an approach to talent management with the Executive Team;
- Develop and rollout a Leadership Programme for the longer term;
- Introduce a “Coaching for Empowerment” programme for staff at all levels, using role-playing as a learning device.

4.2.3 Workforce strategy and planning

Our ambition: We aim to have a strategic workforce plan that enables us to deliver an integrated workforce fit for the future, which aligns with the trust’s vision and strategic objectives. The strategy will be supported by dynamic workforce planning for the short, medium and long term to ensure we attract and retain the best staff.

We have a strong reputation that enables us to attract good people, but as this is a high cost area to live in, we can lose people when they reach a particular point in their career or stage of life. We also have a significant CIP challenge and we need to

ensure we make the most cost effective use of our pay-bill which is consistent with providing safe and effective care.

More detailed analysis of our workforce data and turnover show that we have particular “hotspots” to tackle. In North West London, we also have some major workforce planning requirements, as we work together to ensure we can meet the needs identified under SaHF. Both these will drive our priorities for next two years, which will be to:

- Rollout a project focused on Health Care Support workers, to improve recruitment and retention;
- Develop more comprehensive workforce information which can be used for a variety of purposes, including the requirements of the National Quality Board;
- Work with NW London colleagues to develop frameworks and plans for ensuring workforce requirements for SaHF are met, particularly for consultant medical staff in the Emergency Department and Maternity services;
- Improve the retention of its staff and reduce the staff turnover rate in 2014/2015 through a variety of schemes;
- Work closely with area managers to reduce the Trust sickness rate, whilst also improving our reporting procedures.

4.2.4. HR and Learning processes

Our ambition: We aim to deliver simple, effective, efficient and customer-focused HR & Learning processes that reflect best practice and make optimal use of technology.

We know from talking to internal customers that some our HR processes are more cumbersome and time-consuming than they need to be. We are, therefore, working closely with HR colleagues across London on the "Streamlining" Programme to ensure that we get the best possible benefits from that initiative, as well as working on developing more efficient processes internally.

As such, our priorities for the next two years are to:

- Develop an HR and learning intranet portal to enable customers to find information quickly and easily;
- Deliver the first phase of ESR self service for managers and staff;
- Work with HR for London colleagues on streamlining recruitment and the "skills passport" to support the transferability of mandatory and other training requirements between organisations.

4.2.5 Skills and Capability

Our ambition: We aim to have competent, capable, professional and flexible people who are supported to provide the best care and experience for our patients in a great learning and teaching environment.

We already have a good reputation for our delivering education and now need to integrate this better with our future planning. We will take a multi-disciplinary approach to learning, development and education as we believe this is the best way to approach learning in a realistic, patient-facing environment.

Alongside redesign of our care pathways, there will be continued staffing and skill-mix reviews to ensure that the staff are recruited and trained appropriately to deliver care throughout the patient pathway and in preparation for delivering more integrated services.

Our priorities for the next two years are to:

- Develop the new roles and capabilities our staff will need to support SaHF and our aim to deliver more integrated care;
- Improve the experience of those who join our organisation by developing a new, simpler, and more engaging induction programme;
- Improve the E-learning offer for our staff, especially junior doctors.

4.2.6 Performance, Reward and Recognition

Our ambition: We aim to have high performing people and teams to deliver our services, who are rewarded and recognised for delivering or supporting the delivery of safe, excellent, kind and respectful care – and who are in-turn supported by robust performance and reward systems.

We will use our new locally-agreed incremental reward and progression procedures to ensure we reward and recognise our excellent staff, as well as help all our staff to work at their full potential.

Our priorities for the next two years are to:

- Promote existing staff non-pay benefits packages more widely;
- Introduce new salary sacrifice schemes, e.g. for lease cars;
- Continue development of our Health and Wellbeing Strategy;
- Better align our recognition schemes with the trust's new strategic objectives and our values;
- Improve staff appraisal rates from 85% to 90% over the coming year.

5. Cost Improvement Programme

5.1 Cost Improvement Programme (CIP) Target

Given the levels of expected income and planned revenue and capital expenditure over the next two years, in order to maintain a CoSRR of at least 3, the Trust has set overall Cost Improvement Programme (CIP) targets as shown in Table 5a.

Table 5a – Trust CIP Targets over the next two years

	2014/15	2015/16
CIP Target	£24.9 million	£13.4 million
CIP Target as % of Turnover	6.9%	4%

The 2014/15 figure represents a significant one-year challenge, mainly due to under-delivery of CIPs in 2013/14. The challenge is even greater, considering that (unlike in previous years) there is very limited scope to generate income from over-delivery of NHS activity, due to our local contractual agreements for both planned and emergency NHS activity.

Therefore, apart from particular opportunities to deliver increased income from Private Patient services (over and above our budgeted income – which already represents nearly 50% growth from 2013/14), this year's CIPs will need to be delivered through economy or productivity improvements which will allow us to reduce our overall unit costs.

5.2 Our Approach to CIPs

Our approach to CIP identification and delivery has been integrated into our overall Annual Business Planning process to ensure that we have learned key lessons from last year's programme (both where we did and didn't deliver objectives), namely:

- Greater scrutiny of investments to grow income and more conservative phasing of the income arising from such proposals;
- Continued formal assessment of impact of CIP proposals on service quality, building on the efficacy of last year's process;
- More rigorous delivery planning, so that each CIP scheme (of greater than a certain value) has robust project management protocols and governance;
- Pan-organisational and whole system approach, working with primary care and community care partners, to planning and delivery of key transformational components of the programme;
- Building on successful collaboration on emergency care with delivery partners in the local health economy, extend this approach to planned care;
- Dedicated resources, through our PMO, to help drive quality and productivity improvements that can be translated into efficiency gains;
- Taking a multi-year approach wherever possible, so that programmes can set realistic milestones for delivery, whilst ensuring that early preparation is made for delivery in future years.

This year's CIP Programme has built proposals along the five interlinked themes:

- **Quality and Productivity Improvement Programme** – for **Emergency Care** (building on last year’s programme) and **Planned Care** aimed at transforming use of the following resource areas:
 - *Beds* – through reducing length of stay and reducing the need for use of inpatient beds;
 - *Theatres* – through increasing throughput in our planned theatre use and thus reducing the theatre capacity required to deliver expected levels of activity (NB – capacity released to be redeployed to deliver Private Patient Services);
 - *Outpatients* – through increasing the throughput of new patient consultations, either reduce the capacity provided or redeploy the capacity to deliver other activity;
 - *Diagnostics* – through increasing throughput of our scanners (CT, MRI, USS) to increase the capacity available (and activity delivered) for Private Patient Services and Direct Access NHS diagnostic services.
- **Workforce Headcount and Expenditure** – aimed at reducing expenditure on workforce through:
 - Reducing the usage and, therefore, the amount paid for agency staff;
 - Translating productivity improvements into reductions in staff capacity through reducing establishment headcount or temporary staff spend;
 - Reviewing skill-mix to identify opportunities to implement more cost-effective staffing structures.
- **Procurement** – aimed at improving the economy and level of expenditure on resource inputs such consumables, drugs and equipment through:
 - Negotiating lower prices with suppliers;
 - Improving stock and inventory management.
- **Corporate Services** – aimed at optimising the efficiency of expenditure on corporate and support services through:
 - Outsourcing or shared-services models – e.g. in Finance, Procurement, IT;
 - Lean approaches so that there is a focus on value-adding activity and trimming back on non-essential bureaucratic tasks.
- **Income Contribution** – aimed at increasing profitable income through:
 - Private Patient Services growth;
 - Other non-NHS income growth (e.g. commercial ventures);
 - NHS income growth – though it is recognised that this is limited.

5.3 Planning and Delivery of CIPs

Table 5b shows the distribution of our CIP schemes across the key themes outlined: the remaining value of CIP is to be delivered through income generation and is not included below.

Table 5b – CIP Scheme Groupings

Theme	2014/15 CIP Value £M	2015/16 CIP Value £M
Theatres Cost Reductions and Efficiencies	1.1	Nil
Outpatients Cost Reductions and Efficiencies	0.4	0.1
Diagnostics Cost Reductions and Efficiencies	0.4	Nil
Workforce Efficiency	10.1	11.7
Procurement	4.0	2.3
Corporate Cost Reductions	3.6	0.1
Total	19.6	14.2

For 2014/15, these CIPs have been phased to over the financial year to deliver the following proportions of the overall CIP during each quarter: **Q1** – 15%; **Q2** – 25%; **Q3** – 30%; and **Q4** – 30%.

Phasing for 2015/16 will be confirmed later this financial year, once there is greater definition of the proposed schemes.

5.3.1 Improvement Programme

Over the next two years, as described in the previous section, we are looking to build on our Improvement Programme in two main areas:

1. Extending the **Emergency Care Improvement Programme** to deliver even greater reductions in admissions through extending the scope of Ambulatory Care provided and the development of further Step-down bed capacity;
2. Establishing a **Planned Care Improvement Programme**, jointly funded by the Trust and commissioners, to provide the support and infrastructure that can deliver reductions in demand for planned activity and productivity improvements that will be translated into efficiency gains.

5.3.2 Workforce

A detailed analysis of our paybill has been carried out and the Director of Finance and the Director of HR and OD are working together closely to ensure that the workforce aspects of the CIP are delivered. Any plans which affect clinical areas will be quality assured by the Medical Director and the Director of Nursing and Quality.

5.3.3 Procurement

The government is targeting £2bn nationally from procurement savings. The FT recognises that a step-change must be achieved in the way that procurement savings are delivered to achieve the overall efficiency requirement.

As such, on top of the business as usual procurement through negotiating lower prices with suppliers and improving stock and inventory management, the focus of the procurement CIP work plan will involve the FT participating in new special purpose vehicles being developed London-wide to bring more committed volumes to

market and thereby leverage the London NHS collective buying power more effectively.

In addition to this, the FT will explore opportunity to scale up its procurement shared service with the Royal Marsden out to other organisations in NW London and to implement an outsourced integrated procurement and finance system which will allow greater transparency of price benchmarks, supplier management and contract compliance.

Finally, the FT has developed processes for achieving more meaningful clinical engagement on the procurement of clinical supplies which will allow savings to be delivered through consolidation of suppliers and more product standardisation.

5.3.4 Governance and Reporting

This year, we have aimed to strengthen Governance and Reporting of our CIP Programme, through the following mechanisms:

- Each CIP Theme has an **SRO from the Executive Team**, with the Executive Team collectively accountable for delivery of the overall CIP;
- Our Programme Management Office (**PMO**) has now been set up with a particular focus on delivering quality and productivity improvement and helping to ensure that these benefits are translated into tangible efficiency gains for the CIPs identified.
- Each CIP of a significant value must produce a **Project Initiation Document** describing how it will be delivered, which must be signed-off by the SRO and the FD before it is considered an “Identified CIP” – as opposed to a “Proposed CIP”;
- **Weekly reporting** (to Executive Management Team) of progress with CIP proposal and identification until we have identified 100% of this year’s CIPs, thereafter **monthly updates** of progress delivering 2014/15 CIPs and identification of 2015/16 and 2016/17 CIPs.

We are confident that the approach and plans we have developed this year will provide greater assurance about the delivery of our CIP targets, whilst mitigating risks to delivery of the quality, activity and income objectives we have set.

6. Financial Plan Commentary

6.1 Financial Summary

In 2013/14, the Trust is forecasting a £5.4m surplus against a plan of £9.0m. The shortfall was driven by a number of in-year pressures and non-delivery of CIPs. CIPs under-delivery is forecast to be £6.7m against a full year target of £18.9m. Significant areas of under-performance were on income generation (from increasing market share and improving clinical coding) and procurement schemes. There was also increased agency expenditure in all staffing groups in the first half of the financial year, however the Trust responded by implementing greater controls which resulted in a reduction in usage in the last quarter. It is expected that there will be further reductions as this framework is embedded in 2014/15. The Trust also received £4.9m non-recurrent income and undertook non-recurrent cost reduction initiatives during 2013/14. Following a detailed analysis, the Trust forecasts that the underlying 2013/14 financial position is a deficit of £0.5m.

The Trust's financial strategy is to maintain a sustainable COSR of 3 over a five to ten year period to enable the delivery of the Trust's clinical strategy and the local health economy reconfiguration. Therefore, over the next two years, the Trust plans to deliver significantly higher CIPs than required through the tariff efficiency in order to generate surpluses and cash balances to achieve a COSR of 3 while having sufficient headroom to continue clinical innovation and service reconfiguration.

Table 6a - Key financial data 2013/14, 2014/15 and 2015/16

	2013/14			
	Forecast	Outturn	2014/15 Plan	2015/16 Plan
	£m	£m	£m	£m
Operating Revenue	362.9	367.5	367.5	368.0
Employee Expenses	(185.2)	(186.2)	(186.2)	(181.2)
Other Operating Expenses	(160.7)	(162.2)	(162.2)	(168.0)
Non-Operating Income	0.1	0.1	0.1	0.0
Non-Operating Expenses	(11.7)	(12.1)	(12.1)	(12.6)
Surplus/(Deficit)	5.4	7.1	7.1	6.2
Net Surplus %	1.5%	1.9%	1.9%	1.7%
Total Operating Revenue for EBITDA	359.4	367.5	367.5	368.0
Total Operating Expenses for EBITDA	(332.7)	(334.4)	(334.4)	(335.4)
EBITDA	26.7	33.1	33.1	32.6
EBITDA Margin %	7.4%	9.0%	9.0%	8.9%
Period-end cash	22.3	21.0	21.0	25.8
CIP	12.5	24.9	24.9	14.6
Liquidity Ratio Rating	4	3	3	3
Capital Servicing Capacity Rating	2	3	3	2
Continuity of Service Risk Rating	3	3	3	3

The Trust is currently evaluating its options for strategic growth which include the acquisition of West Middlesex University Hospital and a strategic outline case for a joint venture on children's services with the Royal Brompton and Harefield NHS FT. The financial implications of either transaction have not yet been factored into the plan pending completion of the due diligence and Board approval of the cases. We

therefore anticipate some changes may be made to the 2 year plan as part of the submission of the 5 year strategic plan at the end of June 2014.

6.2 Income & Activity

6.2.1 NHS Clinical Income & Activity

The Trust's NHS Clinical activity and income for 2014/15 and 2015/16 is based on the 2013/14 forecast outturn, with adjustments for the tariff deflator, demand growth, service changes and Commissioner QIPP (demand management schemes) and Commissioner productivity metrics. Further details of these are outlined in the sections below.

6.2.2 Contracting Update

The contract principles have been agreed with NWL for the local CCG contract, including a block financial value for outpatients and emergency care, with all other elements on a cost and volume basis. This is to allow the Trust to work with commissioners to transform the way these services are provided during 2014/15, continuing the work to reduce emergency admissions and length of stay and targeting a reduction in outpatient activity by delivering care in a different way. The contract will incorporate transformational funding to support delivery of these changes through two joint transformation boards for planned care and emergency care with attendance from CCGs, local community health provider, and the Trust. The funds for pump-priming this transformational work will be drawn from reduced stretch on metrics and reinvestment of fines.

The Trust has agreed financial contract values with NHS England for both specialised services and directly commissioned services for 2014/15. Contract values have not yet been agreed with Local Authorities for Sexual Health services, but good progress has been made and the Trust is working to agree financial values by the end of April. The Trust does not foresee any material changes to the contract values as all significant matters have been agreed.

The quality and information schedules and CQUIN themes have been agreed in principle with both local CCG and NHS England commissioners, which are focused on supporting their out of hospital strategy, improving access to patients and improving the emergency care and planned care pathways.

6.2.3 Commissioners QIPP and Metrics

The Trust's local Clinical Commissioning Groups and NHS England are planning for a significant reduction in activity through QIPP/ demand management schemes to reduce acute spend over the next five years. The value of the planned reduction in activity through these schemes in 2014/15 and 2015/16 is £8.3m and £8.2m respectively. In addition to QIPP schemes, the Trust is planning for income reductions of £2.4m in 2014/15 and a further £2.5m in 2015/16 in relation to contract productivity metrics, primarily aimed at improving the emergency and outpatient pathways.

In 2014/15 the metrics and QIPP schemes for local CCGs have been grouped into two programmes – emergency care pathway transformation and planned care pathway transformation, with associated CQUIN schemes and KPIs to ensure that all penalties and incentives in the system are aligned and joined up with community,

GPs and social care providers. Of these schemes, £3.5m relate to management of non-elective admissions and £3.5m relates to avoidance of outpatient attendances or change in pathway by tendering for community services. The main QIPP schemes for NHS England relate to the reduction in cost of tariff excluded drugs, particularly for HIV anti-retroviral drugs, which would be offset by a reduction in cost for the Trust.

The Trust has assessed the likely impacts of changes to the income and activity expected to move to an out of hospital setting for 2014/15 and 2015/16 and plans to offset this reduction in income by tendering to run current services in the community. The assumption is that this would be at 65% of the acute setting tariff and this equates to £2.7m offsetting additional income for both 2014/15 and 2015/16.

6.2.4 Demand Growth, Activity Changes and Service Developments

The Trust is planning for demand growth in a number of key areas in line with the Trust's plan to strengthen the main areas of local and specialist activity. £5.6m of growth is planned for 2014/15 and £4.0m in 2015/16 plus an additional £3.8m in 2014/15 and £3.0m in 2015/16 for the Dean Street Express service development.

The growth in 2014/15 is centred in 5 key areas:

- Additional planned care to address waiting list pressures (£1.4m);
- Expected increase in maternity by 100 deliveries and 100 emergency Trauma and Orthopaedic emergency spells due to early implementation of Shaping a Healthier Future for maternity services and de-designation of Charing Cross Hospital as a major trauma centre in 2014/15 (£0.7m);
- Increase in the musculoskeletal service following being awarded the contract in 2013/14 for an extension to the Queens Park Practices section of West London CCG (£0.5m);
- Planned demand growth primarily for adult medical, paediatric and sexual health specialties (£2.4m);
- Service Development for Dean Street Express sexual health clinic (£3.8m), further detail in the Strategic Developments section below.

6.2.5 Revenue generation CIPs

The Trust has planned for revenue generating Cost Improvement Plans of £5.3m (gross income of £6.6m; £3.7m for NHS and £2.9m for private patients; with associated costs of £1.3m) in 2014/15 and a further £0.6m in 2015/16 relating to both NHS and non-NHS income. The main schemes for 2014/15 relate to commissioner agreed counting and coding changes, improved productivity in theatre and outpatients, improvements in delivery of contractual metrics, growth in NHS income at marginal costs and private patients growth, primarily in private paediatric, maternity and assisted conception. Revenue generation schemes for 2015/16 follow the same themes.

6.2.6 Non-NHS Income

The Trust's Private Patients strategy, which is still subject to Board approval, is to significantly expand the service and income from private patients over the next two years. The Trust has appointed a new Commercial Director to lead the expansion of private patients (£3.9m in 2014/15 and £1.8m in 2015/16), which is outlined in more

detail under the Strategic Developments section below and is focussed on increasing private adult surgical throughput. The clinical divisions have also identified a number of local areas to expand private work as part of the revenue generating CIPs (£2.9m in 2014/15) which focus on increases in private paediatric, maternity and assisted conception activity.

Education and Training income is decreasing over the planning period, due to reductions in the Learning Development Agreement income over the next 3+ years of £1.2m per year. This is as a result of the move to an Education and Training tariff and reduction in volume of placements.

6.3 Strategic Developments

The Trust is planning two major service developments in the next two years in line with strategic objectives; to develop additional clinical space for the integrated sexual health service and expansion of the private patient service.

6.3.1 Dean Street Express

The Dean Street Express sexual health clinic was a key service development in 2013/14, and the Trust opened the new clinic in February 2014. The original 56 Dean Street clinic opened in 2009 offering integrated sexual health care and has been extremely successful. The development of the additional clinical space for 'Dean Street Express' provides physical space for asymptomatic screening, whilst freeing capacity at the main clinic for expansion of the acute treatment and chronic management services for GUM and HIV patients. This is a modern state of the art service using innovative technology to empower greater patient involvement in screening and as a consequence the model will experience lower staffing costs whilst offering much more accessible and convenient services. The income associated with this development is £6.8m, with associated costs of £5.4m, over 2014/15 and 2015/16.

6.3.2 Expansion of Private Patient Income

The Trust plans to significantly increase private patient income over the next two years (as noted above, subject to Board approval); with a £6.8m increase on the 2013/14 outturn incorporated in the 2014/15 plans and a further £2.3m increase in 2015/16, with associated costs of £3.1m in 2014/15 and £0.4m in 2015/16. It should be noted that the total planned expansion in private patients income include revenue generating CIPs described above.

The development of Private patient services has six elements:

- The development of the tariff to reflect recent improvements in the offering (£0.3m in both planning years);
- A focus on the service mix offered, targeting the development of services which offer the highest returns on investment improving the overall EBITDA (£0.3m in 2014/15 and £0.1m in 2015/16);
- Improved utilisation of the current private patient bed base, moving from 60% to 85% occupancy rates. The bed quantum in the current footprint will be increased by two via a £0.8m capital investment, (£3.0m in 2014/15);

- The development of a joint venture with another private patient provider in 2015/16 with an expected increase in the bed compliment of 12 to 15 and an anticipated profit share of £0.7m per annum;
- The Trust is targeting growth in private maternity and additional cycles per month in the private Assisted Conception Unit, (£1.8mm in 2014/15 and £0.8m in 2015/16);
- Introduction of a new service in sexual health of offering a postal testing service and an increase in Dermatology private patients (£0.8m for both services in 2014/15).

6.4 Expenditure

The financial plan reflects:

- National pay and non-pay inflationary pressures;
- Investments in workforce and capital to increase market share;
- Investments in workforce to ensure compliance with quality standards and performance targets;
- Cost reductions in response to commissioner QIPP/ metrics.

6.4.1 National inflationary pressures

Pay awards of 1% in 2014/15 (£1.8m) and 2015/16 (£1.9m) and cost of incremental increases (£1.0m in 2014/15 and a further £1.0m in 2015/16) have been included in the plan. In addition, non-pay inflationary costs for drugs, utilities, CNST and general non-pay inflation totalling £7.4m in 2014/15 and £8.0m in 2015/16 have also been factored into the plan. The Trust assumption is that any cost pressure relating to changes in employers' pension contributions in 2015/16 will be funded through tariff.

6.4.2 Investments to increase demand growth

The Trust plans to increase market share in a number of service lines including sexual health, maternity, paediatrics and private patients. The financial plan includes additional staffing requirements to enable this. The Trust has applied rigorous financial criteria before approving these investments and £9.8m in 2014/15 and £6.3m in 2015/16 has been included in plan. Non private patient income growth plans are consistent with commissioners' intentions.

The Trust is also exploring a number of strategic partnerships with other trusts; the plan therefore includes project management costs of undertaking this work (£0.4m).

6.4.3 Investments in meeting quality standards

The Trust has continued its commitment to invest in clinical staff to meet quality and performance standards. The plan includes investment of £2.0m and £1.0m in 2014/15 and 2015/16 respectively. The Trust has planned a number of investments to increase senior medical cover to provide additional support to junior medical staff in services such as Burns and Hands surgery. In addition, the Trust has invested in specialist nurses in Palliative Care and Endocrinology as well as embarking on ward establishment and skill-mix review. The Trust is also in discussion with NHS commissioners to fund further investments in A&E and maternity as part of the North

West London sector re-configuration of services. The plan will incorporate the associated income and costs once they have been agreed.

6.4.4 Cost reductions in response to commissioner QIPP/ metrics

The Trust has assumed cost reduction relating to the activity reduction following commissioner QIPP, primarily in outpatients and emergency admissions. The plan has assumed a prudent level of costs reduction at 31% (£3.2m cost reduction on a total QIPP of £10.7m in both years).

£1.0m contingency has been planned for in 2014/15 and 2015/16.

6.4.5 Workforce Summary

Staff numbers and paybill will remain steady over the next 12 months with investments in clinical staff being offset by savings in other areas, for example corporate services.

We have done a lot of work in recent months to reduce our agency spend which means that our pay on contracted staff, and therefore our Whole Time Equivalent staff numbers have increased to the highest level since we became a Foundation Trust.

Further investments will be made over the next 12 months, for example, to develop our sexual health services at Dean Street Express, our innovative sexual health service in Soho, and to develop our Private Patients Service strategy. We have assumed a pay award of 1% which also accounts for part of the paybill increase.

Given the size of our CIP challenge, some reductions in staffing will be made to offset the planned investments. These will mainly be in corporate areas such as Finance and IT, enabling front line service staffing levels to remain broadly similar to now.

Further changes will take place during 2015/16 prior to the implementation of the SaHF reconfiguration. We expect to increase our staffing in maternity and in the Emergency Department to support the increased level of activity. However, these figures, which remain uncertain at this point in time, are not yet included in the plan.

6.5 Capital

The Trust has delivered significant milestones in its Estates and IT strategies in 2013/14 and will continue implementation of the plans over the next two years. The Trust is forecasting a capital expenditure outturn of £43.0m against a plan of £49.9m, delivery of 86% of plan. The Estates Strategy is influenced by some significant external developments and key deliverables, for example completion of Chelsea Children's Hospital within the footprint of the main hospital, which formally opened in March 2014, and purchase of a new building adjacent to the main hospital to enable clinical expansion. Year two of a five year IT Strategy was delivered in 2014/15 and has successfully moved forward a number of schemes to develop patient centric clinical information systems and innovative technical infrastructure support, for example roll out of Electronic Document Management across clinical departments started in 2013 and creation of an NHS shared service IT joint venture started in early 2014.

Table –Key Capital data 2013/14, 2014/15 and 2015/16

	Forecast Outturn 2013/14 (£m)	2014/15 (£m)	2015/16 (£m)	Total
Buildings Expanded footprint	20.0	1.7	7.6	29.2
Buildings Development and Maintenance	15.0	13.3	9.4	37.6
Equipment	4.1	3.3	4.1	11.4
IT Strategy	4.0	10.5	5.7	20.2
Total (£m)	43.0	28.6	26.7	98.4

6.5.1 Estates Strategy

The Estates Strategy over the next two years is designed to support clinical service redevelopment and expansion necessary to implement *Shaping a Healthier Future* (SaHF) and a potential paediatric joint venture with the Royal Brompton Hospital NHS Foundation Trust (RBH). In March 2014 the Trust purchased Doughty House for £20m, a neighbouring property of circa 6,000 square metres currently used for key worker accommodation. The additional footprint is a key enabler to provide the additional space required to deliver clinical capacity for SaHF and the RBH paediatric development. Over the next three years the Trust will progress through steps to achieve planning consent, design and procurement of contractors and thereafter begin redevelopment of the site. There are therefore minimal capital expenditure activities and costs over the two year planning period however the Trust has engaged a housing association to manage the property to maximise rental income until redevelopment can begin. Estates capital expenditure priorities over the next two years are summarised as below.

- Shaping a Healthier Future** – The capital expenditure programme to deliver the clinical capacity required for SaHF covers a five year period from 2014/15 to 2018/19 and comprises redevelopment of existing hospital space and development of the Doughty House footprint. This programme of work is partially dependent on the achievement of planning consent for Doughty House however it also includes relocation of university space located within the hospital, redevelopment of ward and outpatient space and expansion of ITU onto existing roof space, for which the Trust has planning consent. Some elements of this work can be undertaken in advance of the Doughty House redevelopment and this is forecast at **£8.4m** over the next two years. SaHF capital plans are being taken forward as part of the LHE overall service reconfiguration and subject to application and agreement of loan or PDC funding. The costs largely lie beyond the two year planning period but are assumed to be fully loan funded in their entirety.
- Emergency Department (ED) Expansion** – At the request of the Local Health Economy the Trust agreed to accelerate the emergency department expansion plans within the SaHF reconfiguration to provide an early enabler for SaHF implementation. The Trust is due to accommodate an additional 18,000 adult (majors and standard) attendances per annum from the closure of Charing Cross Hospital ED and the department was already operating at capacity levels. The ED will expand from 1352 square metres to approximately 3005 square metres. The Trust secured an ITFF loan to

undertake the development and is at an advanced stage of contractor procurement. The programme of works is expected to start on site in summer 2014 and conclude before end December 2015. Overall capital expenditure is forecast at **£10.8m** of which **£10m** is loan funded.

- **Private Patients** – The Trust’s strategy includes the expansion of the private patients’ service within existing footprint of the hospital over the next two years; and beyond that within additional capacity located within Doughty House. Capital costs will be incurred on design of the Doughty House private patients’ solution within the two year planning period.

6.5.2 Information Management and Technology Strategy (IM&T)

The Trust is two years into implementation of a five year IMT Strategy, which builds on the current advanced IT Infrastructure and aligns with the business needs of the Trust and to improve the patient experience. The Trust is working in close partnership with CCG commissioners and community services to support innovative models of service delivery and to seamlessly interlink the patient pathway with external organisations. Overall IT capital investment over the next two years totals £14.4m to deliver the following work streams of the IT strategy.

- **Patient Relationship Management (PRM) - £1.2m** - Transformation of patient administration to a patient focussed design to improve the patient’s experience for example in appointments and scheduling.
- **NHS IT Shared Services - £1.6m** - The Trust has established a joint venture with Royal Marsden NHS Foundation Trust to manage and deliver IT Infrastructure from an NHS Shared Service. The company was formed in February 2014 and staff members have started to transfer to the new company in readiness for an 18 month programme of implementation, beginning with a service desk and then rolling out network, servers and telephony.
- **Technology support for ACO pilot – £0.5m** - Development of a common technological platform to underpin the model of care proposed in two ACO proposals the Trust is taking forward with partners. The technological solutions being explored will support improved patient experience and outcomes.
- **Picture Archive Communication system (PACS) - £3.3m** – The Trust’s national contract with BT ends in July 2015 and therefore procurement of a replacement application licence will be undertaken and implemented in early 2015/16. The new PACS installation is expected to deliver recurrent revenue savings.
- **IT Clinical and Administrative Portals - £1.3m** – development over two years of (i) clinical portals for use by clinical staff to seamlessly access patient and clinical information development and (ii) development of administrative portals incorporating the Trust’s intranet and corporate data, for example HR data.
- **Electronic Patient record (EPR) - £3.9m** - development over two years of the Trust’s electronic patient record and related applications for example Order Communications (linked to the PACS replacement), Radiology Information Systems, and potential replacement of parts of the core EPR to support seamless interlinking of patient pathway data across organisational boundaries.

- **Electronic Document Management (EDM) – £0.6m** in 2014/15 next phase of the roll out EDM across clinical areas.

6.5.3 Equipment replacement programme

The Trust has in place an ongoing programme of investment in replacement medical, non-medical and IT equipment over the two year planning period (£12.4m), including the following significant items:

- Microsoft licence replacement £0.6m;
- Leased radiology equipment replacement £0.5m;
- Automated medicine cabinets £0.4m;
- CT Scanner replacement £0.6m;
- Diagnostic equipment replacement £0.7m.

6.6 Risk Ratings and Liquidity

Within the strategic planning assumptions for 2014/15 and 2015/16 the Trust has set the goal of achieving an overall COSR rating of 3 as a minimum. The minimum requirements to achieve a 3 rating for each element of the COSR rating are that liquidity days must be -7 or above and the ratio of revenue available for debt service must be at least 1.75x.

The current plan is for the COSR for 2014/15 and 2015/16 to be an overall 3. In order to build sufficient financial headroom to achieve the 3 rating throughout the two years of the plan, the Trust has set challenging CIP targets of 6.9% in 2014/15 and 4.0% in 2015/16.

6.7 Risks/ Mitigation

Although the Trust was unable to deliver its financial plan in full for 2013/14, it identified and put in place a more robust monitoring and control framework in the latter part of the financial year, with a recurrent improvement of £700k in the last quarter. The intention is to maintain this level of scrutiny and control to ensure that there is early sight of plans deviating and that there are robust mitigations in place.

The Trust has identified two key risks:

- Under-delivery of CIPs;
- Level of increase in private patients and demand growth income less than planned.

6.7.1 Under-delivery of CIPs

30% under-delivery of CIPs (£7.5m) has been modelled as a down-side sensitivity in our financial projections. Specific mitigations for this risk include:

- Delaying and stopping investments;
- Use of contingency funds;
- Identification of non-recurrent CIPs;
- Further cost controls, including implementing a turnaround process.

6.7.2 Reduced level of income growth

The Trust has identified a further risk of 30% under-delivery of the planned income growth across NHS and private patients (£3.0m). The mitigations against the reduced level of growth are as follows:

- Delay of investments associated with income growth;
- Discussions with commissioners regarding potential redirection from providers with capacity issues;
- Increased marketing of private patients;
- Review of private patients operating model including potential offsite accommodation.