



Strategic Plan 2014-19

East Kent Hospitals University NHS Foundation Trust

Strategic Plan for y/e 31 March 2015 to 2019

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

Name	Melanie Hill
Job Title	Corporate Planning & Performance Lead
e-mail address	melaniehill1@nhs.net
Tel. no. for contact	01227 866305
Date	30 th June 2014

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five 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; and
- The 'declaration of sustainability' is true to the best of its knowledge.

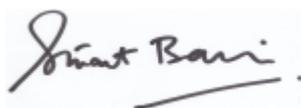
Approved on behalf of the Board of Directors by:

Name (Chair)	Nicholas Wells
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Signature 

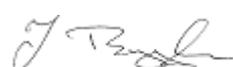
Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Stuart Bain
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Signature 

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Jeff Buggle
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Signature 

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STRATEGIC PLAN 2014/15 – 2018/19

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EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

STRATEGIC PLAN 2014/15 – 2018/19

SECTION A –DELIVERING SUSTAINABLE SERVICES

1. Trust Vision

East Kent Hospitals University NHS Foundation Trust (EKHUFT) is one of the largest acute Trusts in England. The Trust was awarded University NHS Hospital status by the University of London (King's College) in 2007 and Foundation Trust status on 1st March 2009. It serves a population of 750,000, employs over 7,500 staff and has 1,107 beds across three main acute hospital sites in Ashford, Canterbury and Margate. The Trust also provides local access to services with a range of outpatient and diagnostic services in its two community hospitals in Dover and Folkestone as well as a range of services throughout the local area in facilities owed by other organisations.

The three acute hospitals provide a hospital network predominantly serving the East Kent area with some specialist services provision at the Kent & Canterbury (K&C) site and Accident & Emergency services at both William Harvey Hospital (WHH) in Ashford and the Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate, giving accessibility to services and a critical mass for specialist services.

Our vision is to be known as one of the top ten hospital Trusts in England and the Kent hospital of choice for patients and those close to them.

Our mission is to provide safe, patient focussed and sustainable health services with and for the people of Kent. In achieving this we acknowledge our special responsibility for the most vulnerable members of the population we serve.

Our motto is 'putting patients first' and everything we do is guided by our vision and our values. We have a national and international reputation for delivering high quality specialist care particularly in cancer, kidney disease, stroke and vascular services. As a teaching Trust we play a vital role in the education and training of doctors, nurses and other health professional, working closely with local universities and King's College, University of London.

Our values are 'We care' so that people feel **cared** for as individuals; people feel **safe**, reassured and involved; and people feel that we are **making a difference**.

Against this backdrop, the Trust has undertaken several engagement events and has listened to staff and patients to identify both patient safety improvement priorities and the development of the Trust's values. Following these events and in line with the Local Health Economy's strategy, the Trusts own over-arching strategy is to:

- 1) Maintain core acute services across a network of local hospitals;
- 2) Become more efficient, effective and safer in the way the Trust provides services through transformational service redesign;
- 3) Continue to repatriate and expand specialist services where appropriate;
- 4) Grow market share in East Kent (for current and new service) and develop the market in West Kent where opportunities arise (as the available market there has been extended through patient choice); and
- 5) Provide services closer to patient homes.

The Trust has also engaged with a large number of clinicians to specifically establish how sustainable the current configuration of clinical services is over the next five to ten years. This strategic work, entitled "Delivering Our Future" and endorsed by the Trust Board, has demonstrated that from patient safety, workforce, quality and cost perspectives, it is no longer a



given that the current pattern of services can continue to be provided from three sites. A clear view has come from the clinical body that the Trust needs to develop plans towards a single emergency high risk hospital, not just for surgery but for other medical and specialist services, supported by local hospital bases. To deliver this and future sustainability, the strategic work determined that the Trust therefore needs to change by:

- a) **Reconfiguring Services:** Moving some services so that the Trust has a greater clinical critical mass to address clear workforce and training issues whilst maintaining high quality standards;
- b) **Innovative Models of Care:** Developing new innovative models of care that enhance quality and reduce cost;
- c) **Creating new business opportunities:** Exploring opportunities that support our strategic and clinical priorities, but that also enable access to new NHS and Non-NHS income streams; and by
- d) **Working in partnership with other LHE providers:** Working in partnership with the wider health community to transfer activity away from acute sites towards more appropriate settings closer to patients' homes.

Section D of this document details the range of strategic initiatives in each of the above categories, together with proposed timescales that will deliver this vision.

2. Risks to sustainability

The key risks to sustainability identified by the Trust through this strategic engagement and subsequent main drivers behind the strategic initiatives that will deliver the Trust's vision are:

2.1 Clinical

- Supply of clinical workforce across all staffing groups.
- Relationship between delivering high quality services within a restricted financial envelope across three acute sites, specifically the surgical services model and maintaining compliant rotas for non-elective care in general medicine and care for older people.
- Viability of sustaining two inpatient paediatric wards which, through clinical adjacencies, impacts on the delivery of higher risk planned maternity services and their location.
- Safely maintaining two full emergency departments and an emergency care centre over three sites and also delivering the requirements of a designated Trauma Unit.
- Utilisation of critical care beds across three acute sites.
- Delivering specialist services in East Kent such as Vascular, Spinal care and elements of Head & Neck surgery without the economies of scale required.

2.2 Operational

- Achieving and supporting the delivery of local and national Commissioning Intentions to reduce hospital admissions and establishing pathways of care that delivers a shorter patient length of stay (LOS) against a background of an achieved short average LOS across the Trust.
- Capacity constraints for delivering outpatient follow-up appointments due to the increasing pressure required for new outpatient appointments and inefficiency in booking systems.
- Managing the increasing referral profile in Orthopaedics that is building on the current capacity constraints in this specialty.
- The Trust is currently managing with the highest referral rate from GP's to access the two week wait cancer pathway, yet diagnoses a similar amount of patients through the new outpatient referral route. This puts major and potentially inappropriate strain on Trust capacity.



2.3 Financial

- Non-payment of services under local tariff or contract funding arrangement and poor liquidity or availability of cash from commissioners and other providers.
- Loss of financial control internally and funding significant unforeseen unavoidable cost pressures.
- Non achievement of CIPs or inability of Trust to meet CIP/efficiency requirements due to a requirement to invest in a quality or safety issue.
- Major costs associated with both planned and unplanned reconfiguration of services.
- Loss of a major service due to competition or alternative treatment being made available by a competitor.

3. Critical schemes to ensure sustainability of delivering high quality services

3.1 Reconfiguration of Services

- Emergency and High Risk Surgery centralisation
- Co-location of other specialities into an emergency & high risk hospital
- Reconfiguration of acute medicine
- Establishing a Kent & Medway hub for specialist services
- Re-location of Women's and children's services

3.2 Innovative Models of Care

- Ambulatory care – Delivery of commissioned pathways
- Kent Pathology Partnership
- Health & Social Care Village
- Support Services hub

3.3 Creating new business opportunities

- Orthopaedics Centre
- Older Peoples Strategy
- Private Patients Strategy

3.4 Working in partnership with other local health authority providers

- Internal Waits/ Delayed Transfers of Care (DTOCs)
- A&E attendance reductions
- Outpatient Follow-up reductions
- Management of Orthopaedics

4. Sustainability of delivering high quality services declaration

4.1 Trust Board Self-Assessment – Strategic Planning

As recommended by Monitor, the Trust Board has undertaken a self-assessment of its strategic planning process and capability, using the Monitor Self-Assessment Tool, to provide assurance on its declaration of clinical, operational and financial sustainability. Evidence was collated in order to demonstrate that the Trust has the necessary processes, skills and resources in place to support robust strategic planning and this was presented and endorsed by the Trust Board in June 2014.



4.2 Trust Board Declaration

<i>The Trust Board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.</i>	Confirmed
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The Trust Board recognises that in order to ensure future sustainability in all areas, the organisation has to change the structure of how it delivers care. Some specialist services will need to be managed across a wider geographical area across Kent to sustain rotas and deliver economies of scale and all patient pathways need to be more efficient, effective and collaborative with other LHE partners for both the benefit of patients and to allow the appropriate flow of funding. These, plus the major strategic initiatives the Trust plans to deliver over the next five years will potentially put significant strain on the organisation as it manages the strategic change required whilst continuing to deliver high quality care and remain in financial balance.



SECTION B – STRATEGIC CONTEXT AND MARKET ANALYSIS

5. Local Healthcare Needs Assessment

5.1 Demographic & healthcare trends in East Kent

EKHUFT is part of a local health economy servicing Kent and Medway which collectively has a total population of 1.75 million people. The Trust mainly services East Kent which is largely a rural area bordered by sea to the north, east and south and comprises a large number of hamlets, villages and medium sized towns. These geographical features result in limited population mobility for access to health care which is exacerbated by the fact that 22% of Kent households are without access to a car (albeit some through choice).

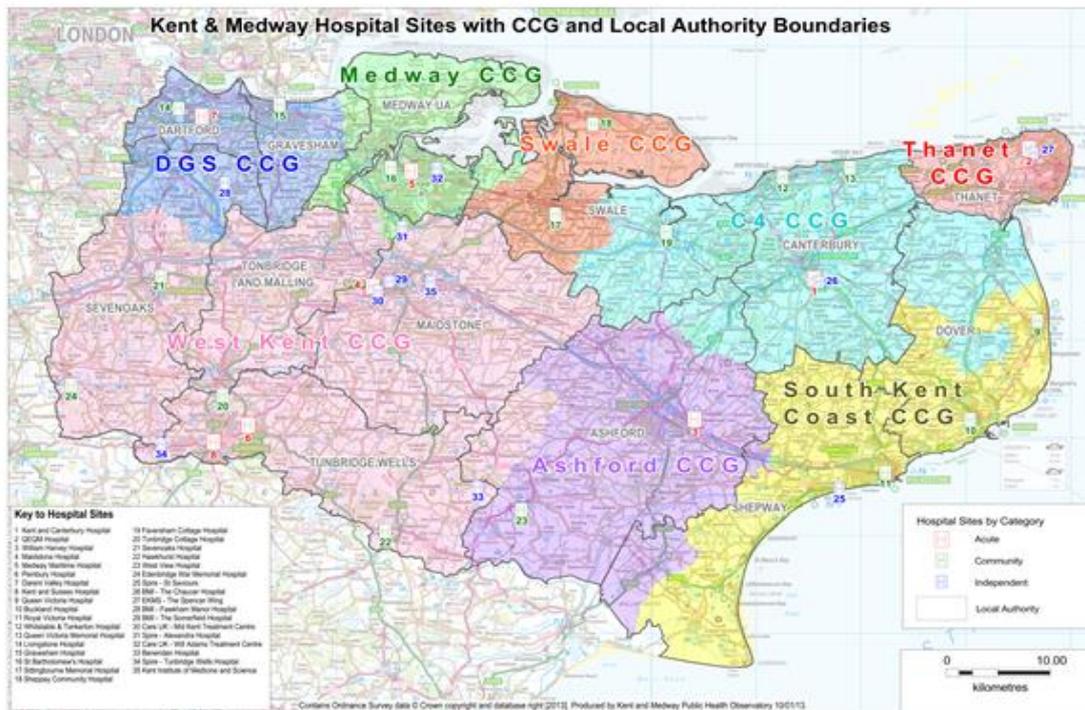


Table 1 – Map of East Kent Health Economy

The population in East Kent is also forecast to increase significantly over the next 10 years with a projected 10.6% increase in the total population and a 23.3% increase in the over 65 population.

The ethnic profile of the population is predominantly white (94.7%) with below average numbers of black and other ethnic minority groups. The socio-economic profile of the South East shows Kent's Gross Domestic Product (GDP) per head of population is below the regional average and the county's unemployment rate is higher than the region as a whole. However there are significant economic and demographic differences across the county, with a relatively high GDP in West Kent and a relatively low GDP in the North and East.

The county hosts several relatively affluent commuter populations in West Kent and in contrast areas of deprivation on coastal fringes in East Kent and Medway, owing to the decline of traditional industries in areas such as Thanet and Swale. Some 17% of East Kent's population live in wards that are ranked in the top 20% of England's most deprived areas. Poverty exists all over Kent and Medway. There are major concentrations of deprivation in the boroughs of Dartford and Gravesham and throughout the coastal east of the county, interspersed with some localised areas of high affluence.



There has been an improvement in life expectancy between 2000 and 2007 for the populations considered to have an intermediate level of deprivation. However, for the most deprived, a widening health gap has continued throughout this period. Analysis indicates that circulatory diseases contribute more towards life expectancy gaps across all district authorities compared to other long term conditions and diseases.

Mortality rates have improved for all socio-economic groups across Kent, however, the rates of improvement are differential and the greatest improvements are in the most prosperous and middle range quintiles of the Kent population. Whilst there have been notable improvements in rates for the poorest, these have not been as notable as for the majority of Kent's population. Over the last 10 years, the death rates from all causes and early death rates from cancer and from heart disease and stroke have fallen and are below the England average. The four major causes of death in Kent and related percentages of deaths at all ages are: Cancer (26%), Coronary heart disease (17%), Respiratory disease (15%) and Stroke (11%).

Additionally, the county has a relatively high morbidity in a number of areas compared to the national average including longer term conditions such as diabetes and mental illness. Also in addition, despite the levels of child poverty being higher than average, the number of children classified as obese remains relatively low compared to the rest of the country. Such groups will present an increasing challenge to the health economy.

5.2 Joint Strategic Needs Assessment (JSNA)

The Department of Health requires healthcare providers, Clinical Commissioning Groups (CCG's), local authorities and district authorities to produce a joint health care strategy based on local needs. The last Kent JSNA took place in 2012 and is being refreshed during 2014/15. Highlighted trends and issues in local healthcare include:

Chronic obstructive pulmonary disease (COPD)

Prevalence of COPD is 2% in Kent with a 1% estimated to be undiagnosed (12,000 people). Prevalence is higher in the East, 2.2% of adult population compared to 1.7% in the West. The areas of Thanet and Dover have the highest prevalence. Emergency admissions in Kent for COPD have increased from 2,535 in 2007 to 2,930 in 2010 an increase of 16%. COPD ranks one of the highest Ambulatory Care Sensitive Conditions in terms of readmissions and opportunity for admission avoidance. It is one of the key Long Term Conditions (LTCs) where an integrated health and social care team approach towards case management is most needed.

Coronary heart disease (CHD)

CHD modelled prevalence is expected to increase by at least 0.6% by the year 2020. East Kent has a prevalence rate which is consistently 1% higher than West Kent. Swale, Thanet, Shepway and Dover districts appear to have relatively higher mortality rates compared to the other districts in Kent. This will have profound effects on access and demand for cardiac services for surgical treatment, revascularisation and rehabilitation.

Stroke and Transient Ischemic Attack (TIA)

In Kent 26,411 people were recorded as having a Stroke or TIA in 2011. This is a prevalence of 1.7% across Kent similar to the national Quality Outcomes Framework (QOF) prevalence. The latest results of the National Sentinel Audit of Stroke Care (2011) across the six hospital sites in Kent indicate consistent performance in the upper quartile, although variation does exist between sites for some of the standards such as timely access to diagnostics and planning for rehabilitation.

Diabetes

The age adjusted prevalence of diabetes has increased slightly from 5.4% to 5.7% during the two year period from 2010 to 2012 in Kent. In terms of acuity, 86% of the diabetics are Type 2.

Cancer



Over the ten year period 2002 to 2012, the incidence rate for all cancers in Kent and Medway has remained steady for males, with a slight increase for females. There is a downward trend in mortality for all cancers in both males and females in Kent and Medway. Cancer of the breast, lung, colorectal and prostate together remain the four most common cancers in Kent and Medway and account for about 50% of all cancer diagnosed and causes of death from cancer. Lung cancer remains the main cause of death from cancer.

Dementia

The current prevalence (based on national estimates) is approximately 1.36% and 1.18% for eastern & coastal Kent and West Kent respectively equating to a combined prevalence of 1.28%, far higher than the General Practice recorded prevalence of 0.49%. This equates to approximately 17,400 people in 2006 rising to 30,100 in 2026. Dementia related emergency admissions have increased by almost 85% from 3,497 to 6,466 admissions over the last 5 years. Shepway, Sevenoaks, Tunbridge Wells, Tonbridge and Swale are district authorities with greater growth of dementia patients. One third of patients live in care homes as well as high risk groups such as learning disabilities and ethnic minorities. In 2009/10 KCC had a care homes admission rate of 75 per 10,000, 65 years and over population which is just above the England median rate of 71.

Falls and Fractures in the elderly

In Kent, there has been a 53% increase in falls related hospital admissions in West Kent and 30% in East Kent over the last 5 years. Almost 65% of these admissions resulted in no fracture and/or injury. The 2010 national falls and bone health audit showed considerable variation in access and availability of minimum standards of care across the community and acute Trusts in Kent. However, it should be noted that EKHUFT performs relatively better than other local Trusts on some of the indicators including the above mentioned.

The Trust has taken a view on the outcome of the JSNA and where relevant has built a forecast impact into the Trust projected activity plans.

6. Competitor Analysis

6.1 EKHUFT Competitive Position

EKHUFT believes it wins business based on the following attributes: presence (in a location close to peoples' homes), high quality services, reliability, flexibility (to new delivery models), good customer service, high speed of service delivery and provision of a good patient experience. EKHUFT has however identified the following key competitive forces affecting the Trust:

- Competition from local NHS and Foundation Trusts;
- Competition for provision of services closer to home (by providers other than EKHUFT); and
- Increased use of the independent sector, particularly in specialties such as orthopaedics which traditionally is pressured by increasing demand for services.

6.2 Competition - Local NHS Providers

Kent County Council (KCC) & Kent Community Health Trust (KCHT)

KCC has a gross budget of £611.3m (2011/12) in family and social care. KCC has a savings target of 30% of the total council budget and is working together with KCHT to expand integrated service models of care to achieve significant cost savings, by both reducing demand and providing a more economic model of care. KCHT currently receives its income on a block contract and there is no explicit linkage to activity. It is proposing to replace the block with cost and volume contracts allowing demographic changes (0.7% growth per year) to be funded. KCHT also predicts that the introduction of the 'Any Qualified Provider' policy will result in an adverse shift in market share, resulting in a loss of £11m over their 5 year planning period.



Income growth is expected to be achieved through activity growth within current contracts, accessing new markets outside Kent, demographic growth and the impact of service integration. KCHT is predicting that service developments will result in income increasing by £41.2m by 2016/17. Nearly all of this is in areas where they will be in direct competition with EKHUFT. KCHT's plans pose a competitive threat to EKHUFT market share. In turn, KCHT has identified EKHUFT as posing the highest level of competitive threat.

Acute Trusts

There are three acute trusts in Kent that have the potential to compete with EKHUFT for NHS patients:

- 1) Maidstone and Tunbridge Wells NHS Trust (MTW);
- 2) Medway Maritime NHS Foundation Trust (Medway FT);
- 3) Dartford and Gravesham NHS Trust (D&G).

Some cross border flow of patients exists between west and east Kent. Cross border referrals from the eastern region of West Kent typically flow to Ashford and Canterbury, particularly for renal and vascular services. Cross border referrals from the western region of East Kent flow to Maidstone Hospital, predominantly for specialist cancer treatment and Medway Hospital which is traditionally the major provider of acute services for the Swale population, EKHUFT has a minority market share of this area of under 10%. 'Dr Foster' shows that for 2012/13, EKHUFT's market share for Swale outpatient and elective inpatient activity is 8.6% and 8.9% respectively whilst Medway Maritime NHS Foundation Trusts market share for Swale is 60.4% and 56.9% in comparison.

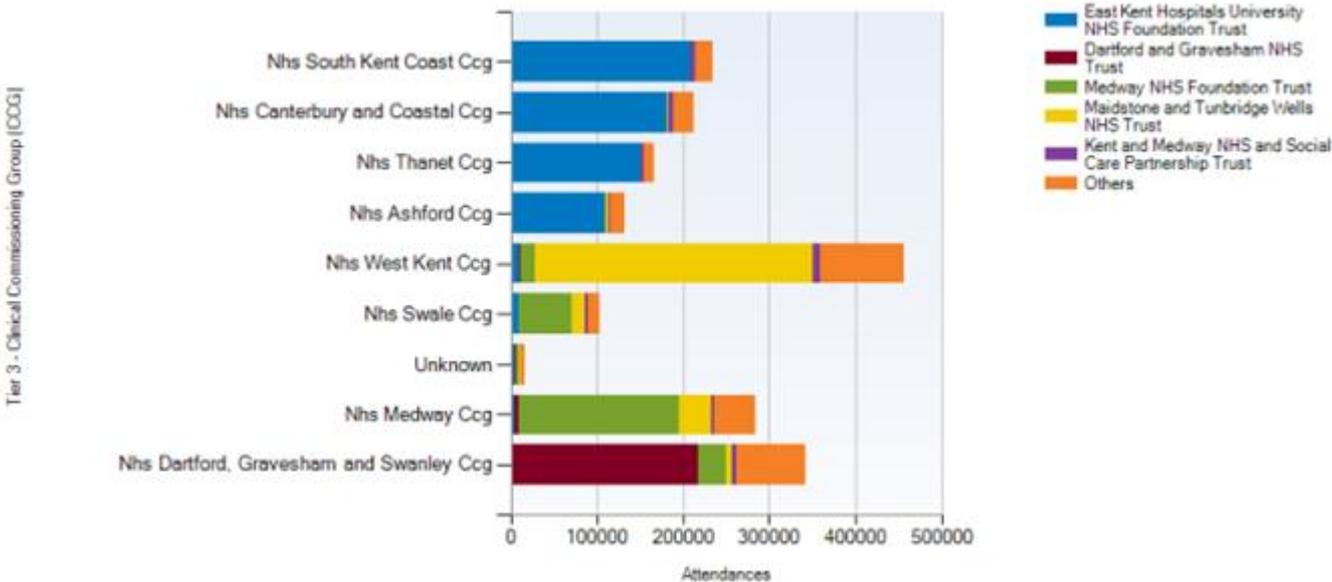


Table 2 – Outpatient Market Share for NHS Trusts in Kent by CCG

6.3 Competition - Private Providers

The Trust has undertaken an analysis of all its key competitors in the independent sector across Kent and where relevant, has built the potential impact into its financial plans. Key competitive providers include:

- Kent Institute of Medicine and Surgery (KIMS)
- BMI - Chaucer Hospital, Canterbury
- BMI - Somerfield Hospital, Maidstone
- Estuary View, Whitstable
- The Wells Suite, Maidstone & Tunbridge Wells NHS Trust (MTW)
- Spire Alexandra Hospital, Chatham



- Spire St. Saviours, Hythe
- Spire Tunbridge Wells Hospital
- Benenden Hospital Trust
- The Horder Centre, Crowborough

6.4 EKHUFT Market Share

Using data available from Dr Foster (based on the full year for 2011/12), the overall market share of EKHUFT across both its core and secondary NHS market can be seen in Table 3. The market share analysis is based on income share and includes elective and out-patient activity, since marketing activities tend to have minimal impact on the flows of non-elective activity.

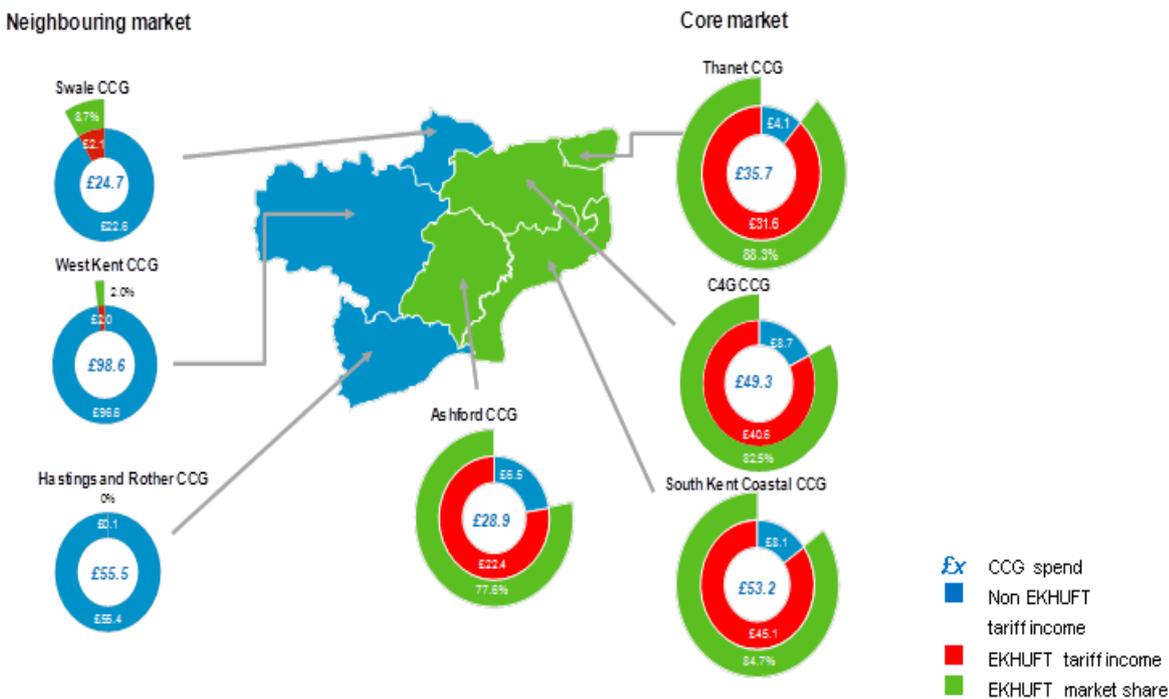


Table 3 – CCG Elective and Outpatient Market Share (based on 2011/12 Income distribution)

The market share analysis shows that EKHUFT delivers over 80% of the East Kent CCG spend on elective activity. The total elective & out-patient tariffs for the East Kent CCGs in 2011/12 were £167.1m, of which EKHUFT’s share of the Tariff was £139.7m. This means that £27.4m is spent elsewhere of which £11.3m is spent on activity going to London providers, £1.7m on other NHS local providers and £14.4m is spent on activity to Independent Sector providers.

On analysing the activity going to London, as expected this showed that the majority related to more complex procedures such as cardiac surgery; transplants; neurosurgery and complex paediatrics. It is likely that some of this activity would be appropriately referred onto London by EKHUFT clinicians as tertiary referrals. With the exception of Cardiology, it is assumed that where there are procedures (HRGs) treated in London, which the Trust also undertakes however they are referred to London because of overall complexity and co-morbidity factors.

In the neighbouring CCGs of Swale, West Kent, Hasting and Rother (East Sussex), EKHUFT is a minor player in these fringe markets, due to the close proximity of other providers. Across these three CCGs, EKHUFT delivers the highest proportion of spend for Swale CCG (8.7% income share). The elective spend for this area equates to £24.7 million, of which £22.6million is spent in providers other than EKHUFT. In Swale there are twenty one GP practices and as expected, 75% of the CCG spend that the Trust receives (£2.1million) is from GPs in mainland Swale which are located in the ME9 and ME10 postcode areas.



It is important to note that EKHUFTs market share of both our core and neighbouring CCG areas is largely unchanged and is within 1.0% of the previous year in most CCGs. Thanet CCG has shown the biggest shift and fell 1.3% in year, Ashford and West Kent both increased by 0.3%.

7. Future Challenges facing the Trust & Local Health Economy (LHE)

7.1 Assessment of Trust strengths, weaknesses, opportunities and threats (SWOT)

The Trust's assessment of its strengths, weaknesses, opportunities and threats (as outlined in Table 4) has been used to underpin many aspects of both the Trust Operational and Strategic plans and has supported determining the relative priority and order in which the strategic initiatives are being taken forward.

STRENGTHS
1 Largest Acute Trust in Kent – Critical mass of expertise, clinical services and equipment
2 Wide geographical spread across East Kent, giving an established presence within easy reach of the majority of the population in East Kent
3 Market Forces factor (MFF), EKHUFT has the lowest MFF of competing providers in Kent, between 5.1 and 17.4% cheaper than competitors): <ul style="list-style-type: none"> - EKHUFT = 1.04552 - KIMS = 1.109 - King's College Hospital NHS Foundation Trust = 1.228
4 Strong, established relationships with CCG commissioners and GPs
5 Strong financial performance <ul style="list-style-type: none"> - Making strategic investments (New Endoscopy Unit WHH & New Hospital Build in Dover) - Monitor risk rating (Financial COSR 4 & Governance rating Green)
6 Strong Clinical Performance <ul style="list-style-type: none"> - Patient safety (Low infection rates & low HSMR) - National recognition (Dr Foster large Trust of the Year 2010/ CHKS Top 40 Trust 2013)
WEAKNESSES
1 Mandatory service requirement means that loss making services have to be supported
2 May be financially vulnerable if patient volumes do not meet projections
3 Trust brand is not well recognised or exploited
4 Semi-rural location and poor public transport links
5 Limited capacity for increased activity whilst sustaining the 18wk RTT and cancer pathways. i.e. T&O capacity. Delivery involves use of independent sector capacity.
OPPORTUNITIES
1 Removal of the PPI cap creates an opportunity to increase income from private patients.
2 New commissioning relationships create opportunities to extend existing, and enter new markets
3 Effective use of tendering system to gain new business
4 Proximity to Europe may allow private patients to be targeted in Northern France
5 T&O and Ophthalmology - Examples of high demand profitable services. Increasing capacity could increase income
6 Maxillo-facial Unit – oral surgery - Alternative unit is in East Grinstead, with outreach in Medway/Dartford/Maidstone sites. For procedures, EKHUFT would be closer to patients
7 Radiology – oncology Linac in Margate and second CT Scanner in Ashford.
8 Out-patient Strategy – “embracing care in the community” Outpatient site reconfiguration to improve local access
9 Integrated Urgent Care Centre



THREATS
1 Increased competition for market share from NHS providers reacting to budget constraints
2 NHS organisations and private providers offering new/competing services
3 KCHT and the “Better Care Fund” (BCF) <ul style="list-style-type: none"> - The value of the BCF across Kent is £27m in 2014/15 and £101m in 2015/16. - It is recognised that the basis of the funding for the BCF is money that is already committed to health and social care services of many different types i.e. there is no new money. Detailed investment and benefit management plans will be designed throughout 2014/15 in line with CCG and Social Care commissioning plans. - Model of integrated care: By 2016 the need for hospital acute admissions will be reduced by 15% - through having one team, one estate working towards one budget with a focus on enablement, admission avoidance and crisis intervention. - If the BCF achieves its goals there will be a large reduction in income for EKHUFT and the transition to a lower cost base will need to be managed.
4 Financial issues caused by not meeting income targets
5 Potential new market entrants
6 Potential loss of income via AQP/ tender process
7 Pull from London and other competitors – search for referrals
8 Fast and improved road and rail network giving access to more providers

Table 4 – EKHUFT SWOT Analysis

7.2 Local Health Economy Affordability Challenge

Other acute Trusts across Kent are currently facing financial difficulties and constraints. The Trust’s main commissioner’s the East Kent Clinical Commissioning Group’s (CCG’s) and Specialist Commissioning (SCG) under NHS England, are also currently facing major financial challenges that are projected to continue. The delivery of agreed Commissioning Intentions (CI’s) have played a major part in the contracting process for 2014/15 and 2015/16, with a focus on appropriately transferring patient care into a non-acute setting, nearer to patients homes. With more treatment delivered in the primary care setting, the potential impact on the trust is managing a higher level of patient acuity whilst balancing reduced levels of revenue. The Trust is working close with both commissioners and the local health community to address these issues.

7.3 Competition (inc AQP)

Commissioners are testing the market and advertising opportunities for different organisations to deliver both clinical and non-clinical services. This includes the services currently provided by the Trust. In addition, as derived from the Competitor analysis in section 6, the Trust has a significant number of independent healthcare providers operating within the region. The Trust needs to exploit all appropriate new business opportunities and ensure that at every opportunity, a robust offering is made for the benefit of patients.

7.4 Bed Capacity

The Trust has undertaken a significant amount of work has already been undertaken to improve patient flow and support reduction of the adult bed base by 90 beds (2011 – 2013). Currently a review and benchmarking of Length of Stay (LOS) exercise is underway to make most efficient use of bed capacity across all specialties. The Trust recently undertook an Internal Waits Audit (October 2013), which indicated significant opportunity for transformation redesign and service improvement, both internally and across the whole Health and Social Care system, which would result in further efficiencies. The Top 30 waits Trust-wide have been separated into those which are:

Internal – waits which are solely attributable to the Trust

External – waits which are solely attributable to external providers

Integrated – waits which could be resolved through providers working together

Patient pathway redesign and empowerment of staff to challenge waits on a daily basis, through implementation of clear roles and responsibilities, would address the top 30 waits enabling further



bed reductions across the Trust. Enhanced awareness of the triggers which contribute towards a greater length of stay, such as avoidable ward moves, will improve patient flow, safety and experience.

Working collaboratively to support 'whole systems' efficiencies where appropriate, will increase the likelihood of change being sustained, as benefits will be shared between health and social care providers, although the main impact would ultimately remain within the Trust. Reportable Delayed Transfers of Care should reduce as a result of timely and co-ordinated patient flow between acute and community services.

Whole Systems bed modelling was also undertaken in July 2012 which demonstrated a capacity gap within community resources, contributing to bottlenecks within patient flow. In partnership with CCGs, Social Services and Kent Community Health Trust therefore, EKHUFT developed and piloted an innovative model of care to create additional capacity within the community named the Health & Social Care Village. The Trusts view is that provision of a fully Integrated Discharge Team, which replicates existing Health and Social Care Integration within the community would enable a more proactive approach to admission avoidance and facilitated discharge and it is working towards this. Several of the Trust strategic initiatives have forecasted planned bed reductions which will need to be balanced with ensuring the Trust has the appropriate amount of capacity to support the peaks and troughs of non-elective admissions.

7.5 Workforce

As the availability of middle grade doctors is expected to reduce, (as training numbers are reduced and traditional sources of supply from overseas become more limited) there has been and will continue to be an increased reliance on re-profiling roles, based on skills requirements. The Trust is currently working with Higher Education Institutes (HEIs) and Health Education Kent, Surrey & Sussex (HEKSS) in piloting a physician assistant programme to help mitigate this situation as well as employing fully trained practitioners where they exist. The Trust is also widely deploying Nurse Consultants and seeking to expand the use of alternative roles e.g. extended scope practitioners and clinical nurse specialists.

The Centre for Workforce Intelligence (CfWI) is predicting a pressure on the availability of nursing staff due to a reduction in the supply of registered nurses and the predicted increase in demand across the NHS nationally up to 2016. This is borne out in Whole Time Equivalent (Wte) movement trends within the Trust over the last year and the financial risk is included in projections for the coming years. The Trust increased its' funded establishment for nurses from April 2014 in response to the Francis Report and has also increased nursing bank and agency usage in year. This poses a risk as the Trust has used a number of overseas recruitment exercises which have been successful but there is a predicted worldwide shortage and these supply channels may be reducing as the internal European market becomes more competitive and other countries provide more incentives.

The use of assistant and associate practitioners will continue to increase over the five year planning period as the Trust looks to try and off-set the potential impact of reduced availability of registered nurses and other healthcare professionals. The support provided for non-clinical activities is planned to increase through extending admin and clerical roles to allow clinical roles to focus on care. All of this will be done within a clear framework that provides competence assessment and guidance and with full input and sign off from professional leads whilst also using the benefits of investments in technology to reduce pay costs.

Strategic change in workforce

The most significant strategic changes that affect workforce will be those surrounding reconfiguration to fewer sites, with an expected reduction in staff numbers, particularly of junior doctors. The further development of the Kent Pathology Partnership will lead to a reduction in scientific staff, whilst the delivery of the Older Peoples Strategy (including teaching Care Homes)



will increase the requirement for nursing staff. The impact of other strategic changes will be managed through redeployment and the Trusts internal change management processes.

Mitigating Risk of Managing Demand

Flexibility in capacity will be delivered by use of independent sector in limited circumstances, additional internal activity and recruitment where necessary. Reductions would be achieved by not replacing vacancies, reducing contractual hours and removal of physical resources. The Trust already has contingency and escalation plans for rapid fluctuations in demand which are used as and when necessary in the clinical Divisions.

Movement in Workforce numbers

Given that the Trust currently has an annual staff turnover rate of 11.2% and a vacancy rate of 5.8%, equating to approximately 400 posts there is scope in year to flex the Trust workforce in line with changes in activity as the need arises. Due to this level of turnover in staff, any required reductions in staff can be achieved without incurring the cost of redundancy. All these expected changes are reflected in the projected workforce figures through the strategic plan and also form a key driver behind some of the strategic initiatives the Trust is developing.

7.6 Estate Infrastructure (inc Buildings, Equipment & IT Systems)

The Trust occupies 188,000sqm estate valued at £228m (1st April 2013) with buildings ranging from late Victorian and Edwardian through to modern purpose built units. The complexities of managing and mapping this estate against the current and future needs of a highly complex health care provider, continue to pose a long term challenge for the Trust.

The Trust's Estate Condition Survey is a key management tool, providing a valuable understanding of the condition and safety of our current estate. Crucially, it also allows the estates teams to prioritise the annual revenue and capital backlog budgets of c£2m, set aside to maintain and improve the fabric of our buildings. The survey, which has addressed all of our main five sites, clinical and non-clinical space and the infrastructure required to power services such as water and heating, has identified a current backlog maintenance requirement of c£26m. For the long term management of EKHUFT's estate the survey indicates significant and high risks account for some 68% of the total backlog at £18m and although not unpredictable for an organisation which occupies such a diverse estate, will continue to not only limit the Trust's vision, but also pose long-term financial liabilities and maintenance costs.

It's important to note that should the Trust decide to increase its expenditure to reduce the liability over a shorter period, would bring the Trust within a more relatively comfortable parameter in terms of risk. It would not see the Trust significantly future proof its accommodation so as to aid the achievement of its key objectives, effectively this action would see an improvement in the current estate but not provide much flexibility for future needs.

Building on the 2009 Estates Strategy, that continues to form a substantial baseline from which to develop our strategic thinking, a number of additional work streams have been created to establish a new estates strategy that supports the Trust's vision to move towards a single specialist hospital supported by a network of local base hospitals. These work streams include:

- Continuing to modernise the estate from which care is provided;
- Ensuring the hospital's clinical sites maximise utilisation and prioritise the allocation of space to clinical services.
- The Trust is working with the private sector and property professionals to secure the necessary additional capital investment to support the delivery of the Trust's strategic ambitions. This could be in the form of a strategic estates partnership or a joint venture.

In addition, the Trust continues to invest heavily in the development and modernisation of its IT infrastructure to support innovation in clinical settings. Over the next three years, the Trust will



build on the successful implementation of new clinical systems such as VitalPAC, by investing in a new Patient Administration System, a new telephony system, an e-Prescribing system and Positive Patient Identification systems. Whilst also underpinning our cost improvement programme, the introduction of these new systems will improve patient experience and outcomes.



SECTION C – OVERCOMING RISK TO SUSTAINABILITY

8. Process to establish future sustainability

In the summer of 2013, the Trust Board commissioned a programme of work aimed at establishing the future sustainability of the organisation. Supported by KPMG, and recognising the organisation was in a strong clinical and financial position, the Board was cognisant of emerging risks that might challenge this position.

The scope of this work was to:

- Map the key levers, drivers and inter-relationships;
- Develop a five to ten year modelling tool that supported the development of a high-level clinical and financial future state;
- Develop a set of strategic options and illustrate the impact of these options;
- Present the organisation with a preferred direction of travel.

The programme of work took place between September and December 2013 and involved almost 40 senior clinical and operational leads, as well as members of the Trust Board and Senior Management Team. The “Delivering Our Future” programme identified that the Trust would not be sustainable in its current configuration. The modelling work that underpins the programme has identified that the Trust would face a substantial deficit of c£40m by 2017/18 which would grow to over £100m by 2022/23 if the Trust takes no action to address.

9. Strategic Options

The output of this work identified six potential options which built upon the work that was already in train as part of the Trust’s clinical strategy programme. The six options were:

- Business as usual (do nothing)
- Business as usual plus improvement initiatives
- Single centralised surgical operating model
- Single centralised surgical and medical operating model
- Single centralise surgical, medical and women’s and children’s operating model for east Kent
- Wider Kent focussed centralised surgical and medical model

Whilst these options appear to be focussed around reconfiguration of services, the model enabled the Trust to understand the implications of the continued implementation of new models of care as well as identifying clear areas for further partnership working that would see care transferred closer to people’s homes.

The modelling tool enabled the Trust to assess the impact of chosen options on all its service lines, as well as the potential quantum of activity that could be provided elsewhere in the local health economy either by the Trust or by another provider(s). The tool also enabled a clear assessment of the local health economy support that would be required in order to deliver change.

The Trust Board reviewed the outputs of this programme of work in March 2014 and supported the continued development and assessment of strategic plans that move the Trust towards a single specialist emergency and high risk hospital hub. This would be supported by a network of local base hospital sites that improve access to a wide range of core diagnostic and treatment services.

The initial view of the modelling work concludes that implementation of this option together with its related initiatives will enable the Trust to continue to remain sustainable over the next five years. This work has been further refined and forms the basis of the strategic plans that are outlined in the following section.



SECTION D – STRATEGIC PLANS

10. Trust Strategies

10.1 Overall position

EKHUFT is currently in a strong financial position, delivering operating surpluses since being licenced as a Foundation Trust in 2009. Compared against peer groups both locally and nationally, the Trust performs favourably against a number of key metrics connected to operational activity and clinical outcomes. However, over the longer term, the Trust faces a number of challenges to achieve continued and improved clinical and financial performance. It is within this context that the Trust proactively began to develop its strategic plan to address these challenges in order to protect the future sustainability of the organisation.

The Trust has, and continues to develop, a number of strategies to enable future clinical and financial sustainability. These strategies will continue to be developed and implemented where appropriate with alignment to support the development and delivery of the longer-term strategy, underpinned by an annually refreshed Financial Strategy and an embedded Quality Strategy.

10.2 Quality Strategy

The Trust's Quality Strategy was initiated in 2012 with the key aim of ensuring the Trust is 'Delivering excellence in the quality of care and experience of every person, every time they access our services'. Annually aligned to the Trust Annual Objectives and entering year 3 of implementation, the strategy has evolved and now established a Quality Improvement Hub with the ethos 'connecting us to the best'. Whilst this initiative originated with the Trust's Quality Strategy, it has been refined through workshops with stakeholders with its aim - to support all staff to bring about improvements and developments in the way they work, practice and organise services both across the trust and the wider health economy. This will enable the Trust to deliver on the four quality priorities and goals of the Trust's Shared Purpose Framework, namely:

- 1) **Person-centred care** – how we work with our patients, service users and each other to improve patient experience. This integrates the 'We Care Campaign' and the values into action
- 2) **Effective care** – how we use and develop evidence to underpin our interventions, approaches and the ways we organise care delivery to improve clinical effectiveness and reliability of care.
- 4) **Safe care** – how we practice safely and provide safe environments to improve patient safety and reduce harm.
- 5) **Developing effective workplace cultures and teams** - how we sustain the above outcomes through leadership, enabling continuous learning, improvement, inquiry and research, development and innovation.

As 2014/15 is the last year of this three year strategy, during the year the Trust will seek to refresh the strategy to ensure it is identifying and addressing the areas for improvement, collaboratively with commissioners. Public engagement will be sought to ensure the Trust is focussing on the right priorities for patients.

10.3 Financial Strategy

The financial strategy reflects the Board's commitment to the overall strategy, vision, mission and values. It is refreshed annually but has remained relatively constant since the Trust became a Foundation Trust in 2009 with the main aims being:

- Maintain a financial Monitor COSR rating of 3 or better.
- Generate enough cash funds and surplus through normal activities to sustainably invest in services, estate and equipment to support the Trust's overall strategy without reducing its financial risk rating.



Historically, the Trust's Financial Strategy covered a five year forward period to properly base the three year plan requirement for submission to Monitor. Following the extension of the Monitor submission planning period to five years from 2014/15, the Trust is well prepared to deliver a robust financial plan in support of the overall Trust strategy. The Trust also recognises that in order to properly develop a five year financial strategy, investments that might be made between years 5 and 10 also have to be considered at a high level, linked to the long-term strategy.

The Financial Strategy also supports the Trust's view that the overall financial environment will remain challenging for the NHS and specifically for acute providers like the Trust. The NHS has seen mean growth in funds of 4% but at best GDP growth is not expected to exceed 2.8% over the five years of the strategy. This means at best the Trust should only expect funding growth of less than the long-term trend but also conceivably receive no growth funding if the government decides to invest more in other public sector services.

The impact on the Trust is a baseline efficiency requirement of between 4% - 4.5% over the next five years, however the Trust will be required to deliver above this level in order to continue to invest in services and achieve the strong financial performance of the past few years.

It is probable that, in the context of the Trust having a financially prudent strategic plan, to deliver the strategic initiatives laid out in the plan, capital investment will potentially be required beyond the level of internally generated resources and cash reserves. The Trust Board has commenced exploring the options for external financing in preparation for this.

10.4 Marketing Strategy

The Trust Board received and agreed the organisation's Marketing Strategy in June 2013. The Strategy focussed on looking for opportunities to grow profitable income arising from repatriating activity from providers in its core market of east Kent and from capturing additional activity from neighbouring areas (Swale, West Kent and East Sussex). The Strategy clearly identified EKHUFT's current market share (as outlined in section 6.4) with particular focus on specialties and procedures providing a positive financial contribution and therefore identified the opportunities in these markets to grow. The size of the opportunity was scaled and strategies to capture the markets were also identified. Seven specialties were identified as a priority, these were:

- Trauma and orthopaedics
- Ophthalmology
- Cardiology
- Urology
- ENT
- Breast Surgery
- Oral Maxillo Facial Surgery

The work to address the opportunities around trauma and orthopaedics has been taken forward and is detailed as part of both the clinical strategy and private patient strategies. Work in two further areas (Ophthalmology and Cardiology) is also being progressed and will be fed into the overall clinical strategy as priorities become apparent.

10.5 Research, Development and Innovation (R,D&I) Strategy

Commensurate with the Trust's vision is an ambition to raise the Trust's profile in research, development and innovation to equal and support that accorded to clinical care. Developing and contributing to new knowledge through the systematic application of research methodologies and the rapid adoption and application of knowledge and innovation ultimately result in better healthcare. Put simply "we do research because that's how patients get better treatment" and, in essence, this means research is good for patient care and outcomes.



Various influences dictate the direction of travel for research within the NHS: government policy, patient and public expectations, reshaping of the NHS locally and nationally, the Trust's own strategic ambitions, and the scholarly and scientific curiosity of researchers themselves. Successful researchers tend not to work in isolation. Collaboration with internal and external partners, including Universities in Kent and beyond, will ensure that the Trust's endeavours lead to a sustainable and transformational improvement in research outputs through development of ideas and funding, ultimately delivering coherent programmes of research supported by substantial programme grants.

The National Institute for Health Research (NIHR) is the body that oversees, funds and supports clinical research within the NHS. For a number of years, EKHUFT has been the main source within Kent & Medway of participant accrual for NIHR 'Portfolio' studies – those studies that have been adopted onto the 'Portfolio' following open, peer-reviewed funding awards or those supported by industry. At the end-March 2014, approximately 1,560 participants were recruited into NIHR Portfolio studies. This represents a 25% increase on the previous year, which is a tremendous achievement for all those involved. The Trust plans to maintain this momentum and continue to offer patients and public the opportunity to participate in as wider choice of clinical trials with the capacity the Trust has to deliver. The aim is to achieve growth in patient recruitment of at least 15% per annum so that, by 2015/16 the Trust will be recruiting circa 2,500 patients per annum. In tandem with this, the aim is to grow a richer and more diverse research base around patient experience, knowledge mobilisation, health service delivery, leadership and quality improvement.

The year 2013/14 has seen other major gains for research, development and innovation in the Trust. Surveys tell us that patients and the public want their local NHS organisations to be active in research and innovation, and many people want the opportunity to participate in research studies. Notable achievements by include:

- A major innovation award to Dr Jeremy Bland (Consultant Neurophysiologist) for his Carpal Tunnel website;
- Publications in major medical journals, for example Dr Chris Pocock (Consultant Haematologist) in the Lancet;
- Award of a £2m grant from the NIHR Health Technology Assessment Programme to Dr Edmund Lamb (Consultant Clinical Biochemist) who is Chief Investigator for a pan-UK multi-centred prospective study in people with chronic kidney disease

The Trust R,D&I department has maintained a healthy balance between complex interventional (usually randomized controlled) and more straightforward observational and large-scale studies. Compared to 2012/13, there has been a 13% increase in new non-industry NIHR Portfolio studies being approved by the Trust and a 10% increase in publications in peer-reviewed journals. The Trust has received very significant increases in research-related income (£2.45m vs. £1.47m 2012/13). Although some of this increase is derived from greater support from Research Networks (principally Kent & Medway Comprehensive Local Research Network), much of it has derived from grant-related and industry-study related income.

In 2013, and along with other NHS organisations, the Trust was the subject of an NIHR 'mystery shopper' exercise. The 'shoppers' told us that the visibility of our research to patients and public wasn't as good as it could be. Over the past year, the department has worked hard to deliver new patient-facing R&D webpages (see www.ekhft.nhs.uk/research). This will be followed by a major publicity campaign in late 2014 to raise awareness amongst patients, public and colleagues, the strapline for which is "Research: Good for you, good for the NHS". In addition, a patient and public representative has been brought onto the Trust's R&D Committee and Internal Grant awarding panel, and will soon be looking for volunteers to act as 'Patient Research Ambassadors' to help us promote the benefits of getting involved in research.



To support one of the Trust's core purposes 'provide person-centred, safe and effective care to patients, the Quality Improvement & Innovation Hub (QI&I Hub) is a Trust-wide 'one-stop-shop' resource that is currently being established will support colleagues in delivering this core purpose. Central to QI&I Hub is the integration of research and inquiry with development and improvement activities. The Hub will provide easy access to the resources, expertise, mentorship, programmes and templates required to build on organisational activities rather than reinvent them.

The Trust has continued and will continue to develop and strengthen our partnerships with local Universities (Universities of Kent & Greenwich and Canterbury Christ Church University) through various joint initiatives, co-hosted symposia, co-funded studentships and academic collaborations. Two of this year's KentHealth PhD studentships were awarded to clinical co-supervisors in the Trust. Building on these achievements in 2014/15, the intention is to develop more jointly funded positions between Universities and Trust to more firmly embed research, innovation & inquiry at the centre of what we do.

Overall therefore, there are many reasons to be optimistic about realizing the R,D&I vision and in particular, the Trust acknowledges the solid base of existing research in some areas that have achieved national and international recognition. The challenge now is to build on these foundations by delivering the seven specific goals of the strategy, growing an R,D&I culture, expand capacity and capability by recruiting more Kent people to studies, to win more funding, to develop more numerous and fruitful collaborations, to publish more research, to achieve greater recognition and, ultimately, to see our patients getting better care.

10.6 Clinical Strategy – 'Delivering Our Future'

The Trust commenced work on a Clinical Strategy three years ago and has subsequently successfully implemented the following service changes:

- Kent and Medway Cardiology pPCI service development;
- 24/7 Stroke Thrombolysis services;
- Implementation of robotic surgery for prostatectomy;
- Maternity reconfiguration;
- Implemented a patient observation and monitoring IT system;
- Established a Trauma Unit;
- Implementation of an Outpatients Strategy including a new hospital in Dover;
- Continued development of Endoscopy services; and
- Implementation of an interim solution for adult high-risk general elective and emergency (abdominal) surgery.

The Trust Board has identified a clear direction of travel for the organisation over the next five years. The drivers behind this are to ensure, as a priority, the clinical sustainability of quality services and to maintain financial sustainability over the forthcoming planning period.

Having undertaken a strategic review the Board has supported the continued development and assessment of strategic plans that move the Trust towards a single specialist emergency and high risk hospital. This specialist hospital would be supported by a network of local base hospital sites that will improve access to a wide range of core diagnostic and treatment services.

The strategic review identified a number of strategic initiatives that underpin the delivery of this vision. These initiatives fall into four main areas:

- e) **Reconfiguring Services:** Moving some clinical services so that the Trust has a greater clinical critical mass to address clear workforce and training issues whilst maintaining high quality standards;
- f) **Innovative Models of Care:** Developing new innovative models of care that enhance quality and reduce cost;



- g) **Creating new business opportunities:** Exploring opportunities that support our strategic and clinical priorities, but that also enable access to new NHS and Non-NHS income streams; and by
- h) **Working in partnership with other LHE providers:** Working in partnership with the wider health community to transfer activity away from acute sites towards more appropriate settings closer to patients' homes.

11. Reconfiguring Services

11.1 Centralisation of emergency and high-risk surgery: Over the past two years the Trust has been reviewing its surgical clinical strategy to ensure the continued safe provision of surgical services. In late 2012, the Trust invited the Royal College of Surgeons (RCS) to review its surgical services. As part of this it was recognised that a negative consequence of the current on call model is that, due to skill mix, there may be multiple and potentially significant delays for patients on an emergency general surgical pathway and emergency treatment may be being provided by inappropriately skilled surgeons.

The Trust subsequently delivered a programme of work to improve general surgical services and implement a model of care to support current service provision. However, as described in the Operational Plan that was submitted in April 2014, the Surgical Services Division informed the Trust's Executive Team and Trust Board of Directors at the end of 2013 of the need for urgent action due to an emerging serious clinical risk in general surgery. This increased risk was driven by workforce changes, specifically the balance between gastro intestinal and non-gastro intestinal surgeons, substantive consultants and locum filled posts and, linked to that, access for patients to substantive consultant decision making. All of these factors increased the risk of poor patient care, experience and outcomes, particularly at the WHH. As a result, on 14th February 2014, the Trust Board agreed to test the feasibility of an interim centralisation of adult high-risk general (abdominal) emergency and high risk elective surgery at the Kent and Canterbury (K&C) site from May 2014.

As described in the Operational Plan, the proposal to centralise surgery was reviewed alongside an additional proposal put forward by the clinical consultant body. This collaborative work has led to an agreed interim solution that will ensure a rota of eight gastro-intestinal surgeons will be available to manage emergency care at both the WHH and QEQUH. This would ensure the removal of non-GI surgeons (i.e. breast and endocrine surgeons) and recruitment to the current locum posts. Importantly this means that all eight consultants will support the emergency rota and thereby enable two consultants (rather than one), to manage the emergency activity for part of the day. This will increase significantly the access to consultant-led decision-making including evenings and weekends.

There is, however, agreement that this interim solution is not sustainable in the medium term for a number of reasons. Firstly, there is a continued drive towards further sub-specialisation within lower colorectal and upper gastrointestinal surgery. As has been seen with the current level of sub specialisation in surgery for urology, vascular, breast and endocrine surgeons, the emergency on call rota will continue to be populated by a smaller group of specialised surgeons. Secondly, the interim does not provide the depth of consultant cover considered necessary to support the emergency department, the wards and the operating theatre seven days a week. The Trust wants to ensure that these three complex service areas are covered for the majority of the time by two consultants that will ensure rapid access to consultant assessment. The interim model does not offer this for periods of the day. Thirdly, the interim solution does not fully provide consultant delivered care out of hours or at weekends. It is the Trust's stated aim to move to 24/7 consultant delivered care. Fourthly, there are additional workforce pressures around the availability of junior medical staff to support a two site model. In particular the numbers allocated as part of the foundation programme are reducing. Fifthly, the middle grade tier is also becoming increasingly difficult to source with doctors who have the right level of clinical skills and competence. Given all



these issues, it will be unsustainable to deliver this service from two sites because of workforce availability, an ability to maintain appropriate rotas at all levels on two sites, maintenance of appropriate clinical skills and the associated financial implications. Finally, the interim solution does not address unresolved surgical cover issues for medical patients attending K&C.

In the longer term, the creation of a single emergency and high risk hospital remains the strategic direction for the Trust.

11.2 Collocation of other specialties into an emergency and high risk hospital: The current configuration of surgical services is provided over three hospital sites. The creation of a specialist surgical hub will mean that, over time, other surgical services that are currently provided on different sites such as Breast surgery, Urology, Vascular, Gynae-oncology and Head & Neck surgery will need to be moved to the hub. The current model for this planning period deals directly with the move of Breast surgery. The priority and timing of the move of the other surgical services has yet to be determined.

11.3 Reconfiguration of acute medicine: The Trust currently provides unselected acute medical take on three of its sites. This is increasingly becoming a challenge due to workforce availability in particular junior doctors and the sub-specialisation of medical specialties. The clinical body through the strategic review has made it clear that in the medium to long term a single site solution would provide a sustainable solution to the current issues. This solution would need to be supported by collaborative working with our partners and the establishment of integrated urgent care centres and the associated infrastructure.

11.4 Establishing a Kent and Medway Hub for specialist services: The clinical and financial sustainability of some of the specialist services provided by the Trust has been challenged by the recent Specialist Commissioning Review and some derogation to some service specifications has been identified. Currently a number of these services are provided on selected sites throughout Kent and Medway and the only sustainable option for the future to meet the required service and clinical standards is to centralise the more specialist elements of these services onto a single site for Kent and Medway. The priorities for the Trust are Vascular Surgery, Interventional Radiology, Urology Surgery, Head and Neck Surgery, Ophthalmology and NICU.

11.5 Relocation of women's and children's services: A number of strategic options are currently being explored for these services. As part of the strategic review centralisation was identified by the Division as a priority however following executive challenge three options are currently being considered. These are a) centralisation onto the specialist surgical hub b) continue to provide services on two sites as at present, and c) to move to a stand-alone site.

12. Innovative Models of Care

12.1 Ambulatory care: The Trust has been working over a period of time to increase the number of patients that can receive their care without being admitted to hospital. Significant progress has been made in increasing the number of pathways that achieve this aim with increased Primary Care and Community Care support it is hoped that the objective of delivering all 49 pathways will be achieved within the five year period. This innovative model of care enables the Trust to see patients in an ambulatory setting shifting their care from inpatient wards and the emergency care pathway.

12.2 The Kent Pathology Partnership (KPP): The KPP initiative is a joint venture between EKHUFT and Maidstone & Tunbridge Wells (MTW) NHS Trust combining the Pathology services of both Trusts. This project has been approved by the Board of Directors of both organisations and will, over the next two years, see the creation of a Centralised Service Laboratory (CSL) for Blood Sciences located at the William Harvey Hospital. The CSL will be developed to undertake all analytical tests that have a turnaround time requirement of more than two hours i.e. all GP and



Outpatient work within both EKHUFT and MTW areas. A second CSL will also be created at MTW where Microbiology and Histology services will be centralised. Again, those tests above the two hour turnaround requirement for Microbiology and Histology will be undertaken at this CSL. Within the KPP area there are five District General Hospitals. All five will have Essential Service Laboratories (ESL). ESL's will undertake all analytical work from within the acute setting for tests that require a turnaround period of less than two hours i.e. A&E and inpatient activity.

The key challenges to developing KPP will be;

- 1) Adherence to a strict and tight timeframe;
- 2) The management of two different cultures and potential staff dissatisfaction and unrest;
- 3) Ensuring that the current high quality services delivered from all laboratories are maintained and further enhanced;
- 4) Managing any potential delays in the key enablers (IT, Estates, and Managed Service Contract);
- 5) Working with the CCGs to ensure Pathology activity is not lost;
- 6) Ensuring all the different departments across the partnership from both organisations are fit for purpose.

This initiative fits into both Divisional and Pathology objectives for 2014/15 – 2018/19:

- To standardise and rationalise Pathology services with a joint venture with MTW;
- To further consolidate services at QEQM and KCH;
- To review samples referred elsewhere with a view to repatriate the services if viable;
- To review and better manage demand placed on the Pathology service;
- To introduce and exploit the opportunities that KPP offer through marketing;
- To consolidate 7 day working across all disciplines.

The KPP initiatives have been approved by the commissioning body. The Key Commissioner for Diagnostics is fully supportive of the initiative. Within the next two years there will be an expectation from the Commissioners that there will be tariff harmonisation (potentially reduced income). The KPP initiative is designed to aim to meet these expectations.

12.3 Health & Social Care Village Model

The Health and Social Care Village Model (HSCV), provides dedicated bed capacity for non-weight bearing (NWB) patients and patients requiring rehabilitation or assessment. Following successful piloting of the model, the HSCV provides a safe and appropriate environment for patients who are medically stable but require a little longer recuperating, together with assessment and support to help them regain independence as able. The HSCV facilitates a focussed care pathway with a 21 day maximum length of stay (LOS) for patients requiring Assessment and Rehabilitation and a 56 day maximum length of stay for NWB patients.

Having revised the model of care, it is apparent that the model is sophisticated enough to be expanded (15 beds to 60 beds) and replicated across multiple care homes, without reducing quality or patient experience. Lengths of stay have also been shown to reduce over time, as the MDT develops a trusting and cohesive relationship.

The 60 beds currently commissioned are required all year round, and ongoing funding is being considered, during joint discussions with CCG's with regards the Better Care Fund (Reablement). Alternate funding could be provided through additional income generated by excess bed days (H&SCV working as a virtual ward – Thanet pilot). A further 20 beds are required (total of 80 beds) across East Kent, and the Trust are working in partnership with private providers to identify remaining capacity requirements.

Whilst H&SCV beds are predominantly utilised as 'step down' capacity, access for 'step up' has been successfully trialled. The Trusts aim is that commencing in 2014/15, the H&SCV model will be re-energised to include robust step up and step down access, to support increased admission



avoidance and facilitated discharge, aligned with the Integrated Discharge Teams and East Kent Integrated Urgent Care Service.

12.4 Support service hub: The Trust has undertaken a space utilisation survey and in collaboration with the Back Office Review Group assessed that a significant number of non-clinical staff are housed within clinical space and/or on acute site settings. The Trust is developing a business case to understand the opportunities of decanting non-clinical administrative posts from clinic space with the ensuing rationalisation of space. A shared service support hub will be developed to house the majority of corporate and non-clinical administrative functions, housing these services in more appropriate, cost effective and fit for purpose off site office accommodation, thus enabling the Trust to operate from leaner clinical footprints.

13. Creating new business opportunities

13.1 Orthopaedic Centre: The Trust has been exploring with the Consultant Orthopaedic Surgeons the opportunity of creating a stand-alone, single, elective orthopaedic centre. A detailed demand and capacity analysis has been undertaken which identifies the current capacity and demand for the service, alongside population growth projections for the next fifteen years. The demand and capacity review has been cognisant of the published Commissioning Intentions to reduce demand in this area. In addition, an assessment of potential patient activity flows from West Kent has been factored into the model. Finally, the work has been informed by best practice benchmarking to ensure high levels of utilisation in theatres and beds. This work will continue to be informed by the Trust's private patient strategy work and any partnership arrangements that arise from this. A full business case is planned for review through the Trust's investment approval process in October 2014.

13.2 Older people's strategy: Demographic trends in east Kent point to a significant increase in the elderly population over the next 20 years (as seen in the joint needs assessment in section 5.2). It is anticipated that this will place severe pressure on the Trust's services. One approach to this is to exploit the commercial opportunities presented by a growing population of elderly patients, in parallel the Trust can use this opportunity secure the ongoing viability of the Health and Social Care Village model by bringing it in-house onto Trust sites and reducing the reliance on commissioning external providers to provide the service. The vision is to provide at least three teaching nursing homes co-located on the Trust's hospital sites that offer a mix of NHS, Local Authority and privately funded placements.

13.3 Private patients' strategy: The Trust has advertised via the Supply to Health portal for an Independent Sector / Private Patient Partner to work jointly with the Trust to establish a comprehensive Private Patient Strategy. As part of this opportunity the Trust has asked potential partners to explore opportunities to support the Trust's continued delivery of waiting time targets. The Trust is keen to ensure that as part of the collaborative working arrangements best practice can be extended across not only private patient work but also across NHS delivered care.

14. Working in partnership with other LHE providers

14.1 Internal waits and Delayed Transfers of Care (DTOCs)

This initiative is directly linked to the Health and social Care village model that is described in section 12.3.

14.2 A&E attendance reductions: There is a proposed reduction in A&E attendances planned in the final three years of the plan. This is in recognition of the centralisation of acute services alongside the collaborative work, led by the Trust, across primary, acute, community, ambulance, mental health and social care to introduce local urgent care centres. The ultimate aim of this work is that all urgent care will be accessed through integrated urgent care centres and an immediate assessment and navigation and will ensure a maximum two hour response to any referral received.



The IUCC will, through a decision support tool, identify the correct multi-disciplinary service / most appropriate intervention to ensure the patient is placed on the correct treatment pathway. The IUCC will have direct access to book patients into urgent care clinics, planned care clinics, GP appointments, as well as access to community and social care neighbourhood teams and mental health community teams.

14.3 Follow-up outpatient reductions: As part of the strategic review the Trust has worked with KPMG to establish best practice in terms of transfer follow-up outpatient appointments to primary and community care settings. KPMG sourced benchmarking data which demonstrated high-performing health economies both nationally and internationally could outsource up to 85% of these appointments from the acute setting. Work is ongoing to test these assumptions at specialty level across the Trust with a view to engaging local health economy providers in how best to provide this care. A major element of the “Delivering Our Future” programme was establishing a model to identify tiers of care ranging from tier zero (self-care / preventative activity), tier 1 (primary care), tier 2 (non-acute care), tier 3 (secondary / non-complex acute care), tier 4 (tertiary / complex acute care). This work is being used to inform discussions with other providers in this area. In addition, the trust aims to promote collaboration with consultants and GP’s to agree the number of outpatient follow-up appointments that patients, on average, require by specialty (service line) to better match demand and capacity in the shorter term.

15. Strategic Initiatives Summary

The Trust recognises that this represents an enormous programme of strategic change for the organisation and the local health economy over a relatively short strategic planning period. The majority of the changes outlined above will require staff, stakeholder and public engagement and in some instances formal public consultation processes, balanced with the Political will to make the changes required. In addition, each initiative will be subject to completion of a formal business case to allow full Trust Board scrutiny of the quality, commercial, and strategic benefits. Table 5 provides a summary of the timelines for developing further these plans, signing them off ready for delivery and stakeholder engagement and consultation.

	2014/2015			2015/2016				2016/17	
	Q2	Q3	Q1	Q1	Q2	Q3	Q4	Q1	Q2
Clinical pathways & adjacencies agreed									
Workforce planning									
Business case preparation									
Staff engagement									
Stakeholder engagement									
Public engagement									
Estates design and planning									
Preparation of Public consultation material									
General election									
Public consultation									
Independent analysis of consultation									
Trust Board decision									
Commence Implementation									

Table 5 - Timetable for developing the plans

The Trust has quantified the financial benefit of each initiative, however in recognition of the size of the agenda a down-side risk assessment of their impact has been played into the overall financial



plans. A timetable of when the net financial benefit impact is included in the strategic plan is outlined in Table 6.

Strategic Initiatives	Year 1 2014/15	Year 2 2015/16	Year 3 2016/17	Year 4 2017/18	Year 5 2018/19
Reconfiguring Services					
High risk & emergency surgery centralisation					
Co-locate specialties into emergency & high risk hospital					
Creation of a Breast surgery Unit					
Reconfiguration of Acute Medicine					
Establish Kent & Medway hub for specialist services					
Relocation of Women's & Children's services					
Innovative Models of Care					
Ambulatory Care - Delivery of Commissioned Pathways					
Support Services Hub					
Kent Pathology Partnership (KPP)					
Creating new business opportunities					
Older People Strategy					
Orthopaedic Centre					
Private Patient Strategy					
Working in partnership with LHE providers					
Internal Waits/ Delayed Transfers of Care (DTC's)					
A&E attendance reductions					
Outpatients follow-ups reductions					

Table 6 – Trust strategic initiatives



SECTION E – FINANCIAL PLANS

16. Financial Plan 2014/15 – 2018/19

16.1 Income and Expenditure Plans for 2014/15 to 2018/19

The financial plan delivers a Continuity of Services Risk Rating (COSRR) of four (best rating) across the five years 2014/15 to 2018/19 of the strategic plan. Table 7 summarises the finances for each of the five years.

	2014/15	2015/16	2016/17	2017/18	2018/19
	£m	£m	£m	£m	£m
Income					
SLA	490.0	496.5	505.0	517.8	516.5
Other	47.2	46.9	47.3	53.6	52.6
Total Income	537.2	543.4	552.3	571.4	569.1
Expenditure					
Pay	(308.2)	(305.6)	(308.1)	(316.6)	(313.4)
Drugs, medical equip ¹ and consumables	(120.9)	(123.4)	(130.4)	(140.2)	(142.1)
Other miscellaneous costs	(77.8)	(82.8)	(82.1)	(82.3)	(81.2)
Total operational costs	(506.9)	(511.8)	(520.5)	(539.1)	(536.6)
EBITDA	30.3	31.6	31.8	32.3	32.5
Below EBITDA costs	(31.3)	(29.8)	(30.8)	(31.4)	(31.5)
Surplus/ (deficit)	(0.9)	1.7	1.0	1.0	1.0

Table 7: Trust 2014/15 & 2015/16 Income & Expenditure Plan

16.2 Financial Risk

The Trust has taken a prudent view on financial risk. The Trust considers the most dangerous risk to be associated with

- unavoidable cost increases,
- Trusts ability to reduce costs in line with national efficiency requirements
- Income price reductions due to changes in the National Tariff or the ability of commissioners to support local service prices.
- Trust not being able to modernise its services which may result in funds not being available to improve quality and service.

To mitigate these risks the Trust hold provisions against the risk of commissioner's ability to pay, provisions against the failure to deliver required future service changes and a general contingency of approximately 1.5% of turnover against any other potential financial shortfall.

16.3 Activity Projections

The numbers of patients sent to the East Kent Trust by GPs has grown consistently over the last couple of years (5.5% growth in 2013/14). Due to reductions in other patients the net referral growth in 2013/14 remained at about 0.4%.

Growth in GP referrals has had a direct impact on the volumes of planned care the Trust has had to deliver more capacity especially for outpatients and non-emergency patient treatments. Emergency work especially through A&E did reduce slightly overall but peaks in demand for emergency services have generated service pressures on certain days and certain times of the day.



The Trust's main Commissioners have adopted the Trust's 2014/15 activity plan as the basis for the 2014/15 contract. This is a reflection of the joint approach that has been adopted to concentrate on delivering on the key challenges that face the whole health economy. The Trusts clinical Divisions are also working collaboratively with primary care colleagues in order to deliver a more sustainable level of activity for both commissioners and the Trust without losing the focus on quality and accessibility for patients. Schemes have been worked up jointly with assigned leads from each organisation to ensure change is driven forward and benefits are jointly realised. This model of managing service change will be an important element of maintaining service and financial sustainability whilst delivering change. Commissioners and the Trust have set a target to reduce costs by £4m and focus on quality through this joint approach.

In the short term (up to 2 years) the Trust will be working closely with commissioners and GPs to try and manage demands upon the Trust. A collaborative approach is the only approach that has historically delivered so the Trust believes variations from planned activity and income to be less likely in the near future. The Trust has planned for growth levels of circa 1.5% year on year beyond 2014/15 using an analysis of local population need projections adjusting for deprivation using the information produced from the JSNA. Longer term projections are inherently more risky as they are more susceptible to changes for issues that the Trust could now be ignorant of. However in general terms, the aging population will require more intensive treatment and care.

16.4 Tariff Assumptions

The National Tariff and published tariff deflator has been used to price the 2014/15 plan and a net deflator of 2.3% used for 2015/16. The 2015/16 negative tariff adjustment of 2.3% is based on Monitors published efficiency of 4.5% with an inflation uplift of 2.2%. The 2014/15 to 2018/19 expected tariff % impact is shown in Table 8 below.

	2014/15	2015/16	2016/17	2017/18	2018/19
Net Tariff Inflatior/ (Deflator)	(1.9%)	(2.3%)	(1.9%)	(2.0%)	(2.0%)
Inflation built into PbR & Local Prices	2.1%	2.2%	2.1%	2.0%	2.0%
Tariff Efficiency built into PbR & Local Prices	(4.0%)	(4.5%)	(4.0%)	(4.0%)	(4.0%)

Table 8: % Tariff assumptions

16.5 Bridging movements from 2014/15 to 2018/19

The dominant drivers of changes in the income and expenditure position between years are outlined in Table 9 below.

	2014/15	2015/16	2016/17	2017/18	2018/19
	£m	£m	£m	£m	£m
Opening Surplus/ (Deficit)	3.9	(0.9)	1.7	1.0	1.0
Non recurrent and other technical adjustments	(3.5)	3.2	4.5	4.8	5.2
Contingencies and risk provisions	(6.5)	(6.5)	(10.1)	(12.2)	(6.7)
Cost pressures and cost inflation	(18.3)	(22.7)	(20.7)	(20.9)	(21.4)
Impact of changing patient numbers	0.7	7.5	5.3	5.0	5.1
Service developments and strategic initiatives	(4.0)	(4.0)	7.8	10.8	5.4
Cost improvement programme (CIP)	26.8	25.2	12.5	12.5	12.5
Closing Surplus/ (Deficit)	(0.9)	1.7	1.0	1.0	1.0

Table 9 – Bridge from 2013/14 to 2018/19 Plan

Non recurrent and technical adjustments are driven by a technical adjustment associated with the opening of the new Dover hospital in 2014/15 and the ongoing impact of prior year adjustments such as the full year impact of CIPs. Contingencies and risk provisions increase in 2016/17 as the risks associated with the delivery of the strategic initiatives are taken into account. Service developments and strategic initiatives are expected to make net financial returns by 2016/17 as



investments in supporting service changes for elderly patients and patients with muscular or skeletal problems commence. The cost improvement programme (CIP) or savings target reduces in 2016/17 to £12.5m generic targets as the benefits of strategic initiatives start to contribute to the Trust's financial sustainability. Cost pressures and inflation is a result of cost inflation such as expected pay rises for staff and reductions in tariff for services provided to patients as set for the NHS by Monitor as well as the impact of cost pressures such as pension cost increases. The cost improvement programme (CIP) or savings reduces in 2016/17 as the benefits of strategic initiatives start to contribute to the Trust's financial sustainability.

16.6 Cash Plan & Continuity of Service Rating

Cash as shown in Table 10 below reduces from £44.0m in March 2014 to £14.1m in March 2018/19. This is a result in reduced surpluses as a result of both more difficult economic circumstances and increased levels of risk provision being made as well as an increase in cash spent on the equipment and buildings associated with delivering patient care. A significant proportion of the capital spend will be in order to deliver the strategic initiatives.

Summarised cash flow	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Opening balance	44.0	27.5	24.1	20.6	17.6
Surplus/(deficit) after tax	(0.9)	1.7	1.0	0.9	0.8
Non-cash flows in operating surplus/(deficit)	31.2	29.8	30.7	31.3	31.4
Increase/(Decrease) in working capital	(3.8)	1.2	0.1	0.5	0.0
Net cash inflow/(outflow) from investing activities	(33.2)	(26.0)	(25.0)	(25.0)	(25.0)
Net cash inflow/(outflow) from financing activities	(9.8)	(10.1)	(10.3)	(10.6)	(10.7)
Closing Balance	27.5	24.1	20.6	17.6	14.1

Table 10: Summarised Cash Flow 2014/15 to 2018/19

The Trust may have to look at other sources of capital to ensure it has enough funds to carry out the required investments. The final decision on other sources of capital will be made once a full evaluation of the potential returns in investments, the availability of funds and the cost of new sources of capital has been undertaken.

COSRR

The Trust plans to maintain its current and highest possible Monitor COSRR rating of 4 throughout the five year planning period.

Continuity of Service Risk Rating (COSRR)	2014/15	2015/16	2016/17	2017/18	2018/19
Capital Service Cover Rating	4	4	4	4	4
Liquidity Rating	4	4	3	3	3
	4	4	4	4	4

Table 11: Breakdown of COSRR by year

16.7 Statement of Financial Position

Table 12 represents a summary of the Trust Statement of Financial position from 2013/14 to 2018/19. The Trust has constructed this projection on the assumption of income and expenditure as stated above and no significant changes in policy over working capital.



	2013/14 FOT £m	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Assets						
Assets, Non-Current, Total	302.5	311.3	317.5	322.1	326.4	330.7
Assets, Current, Total	84.7	67.2	62.7	59.2	56.3	53.0
Assets Total	387.2	378.5	380.2	381.3	382.7	383.7
Liabilities						
Liabilities, Current, Total	(62.1)	(54.3)	(54.3)	(54.4)	(54.8)	(54.8)
TOTAL ASSETS LESS CURRENT LIABILITIES	325.1	324.2	325.9	326.9	327.9	328.9
Liabilities, Non-Current, Total	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)
TOTAL ASSETS EMPLOYED	322.8	321.9	323.6	324.6	325.6	326.6
Taxpayers' and Others' Equity						
Public dividend capital	189.5	189.5	189.5	189.5	189.5	189.5
Retained Earnings/ (Accumulated Losses)	49.5	48.5	50.3	51.3	52.2	53.2
Other Reserves, Total	83.8	83.8	83.8	83.8	83.8	83.8
TOTAL ASSETS EMPLOYED	322.8	321.9	323.6	324.6	325.6	326.6

Table 12 – Summarised Financial position 2013/14 – 2018/19

16.8. Costs Assumptions

The plans for 2014/15 and 2015/16 are built upon forecast actual performance in the base year of 2013/14, adjusted for activity projections, financial assumptions (including CIP delivery and identified cost pressures, and net of contingencies and provisions. Cost inflation assumptions have been made consistent with the assumptions around inflation funding through tariff, range from 2% to 2.2% per annum. Pay inflation for 2014/15 and 2015/16 has been set at 1% per annum to reflect expected pay rises. Other pay inflation, covering issues such as incremental drift, has been estimated at an additional cost of £2.1m in both 2014/15 and 2015/16. Drugs cost inflation for 2014/15 and 2015/16 has been set at 4%. In addition, these costs have been volume adjusted for rechargeable High Cost Drugs and assumed within commissioning contracts. The non-pay plan also includes cost pressure estimates e.g. for the impact of changes to the Trust CNST premium and on-going Legionella estates works. To support financial control within these assumptions, a marginal cost impact of 30% has been applied to all direct and indirect budgets to reflect the overall impact on expenditure for movements in activity driven income between years.

17. Productivity, Efficiency & Cost Improvement Programmes (CIPs)

17.1 Sustainability of CIP Schemes

The Trusts approach to CIP target setting in years 2016/17 onwards is to set a CIP target for pure efficiency improvements. Further improvements associated with service transformation and strategic choices will be dealt with separately. The Trust has calculated that a CIP target of 2.5% beyond 2015/16 would be required and that even though the Trust does have a recent history of delivering CIPS in order of 5% it is recognised that level of pure CIP would be difficult to sustain.

17.2 CIP Programme 2014-16

During the past 3 years the Trust has achieved over £76m cost savings at the same time as improving service quality and safety, reducing waiting times, expanding services and improving patient experience. For the 2014/15 and 2015/16 years, the Trust's Financial Strategy requires savings programmes of £26.8m and £25.2m respectively (at 4.9% and 5.1%). To develop a programme of this scale, the Trust senior management, in conjunction with the Clinical Divisional teams, have agreed a framework approach comprising a combination of:

- Divisions developing their service specific savings plans (traditional CIPs) - including workforce cost reductions, non pay spend changes and service revisions with income gains (best practice tariffs and repatriated services).



- Identification of Trustwide opportunities - Including workforce efficiencies, supplies and procurement, medicines management, market expansion and patient pathways, scoped for detailed schemes and values. These are shared with the Divisions for validation and if agreed, for inclusion within the Divisional plans. These schemes encompass both traditional CIPs and Transformational redesign.
- Transformational redesign service improvement - 18 projects (see Table 15) have been identified, focussing on improved efficiency of patient flow through clinical pathways, a reduction of internal waits and length of stay reductions. Improvements to emergency care pathways place particular emphasis on integration with primary and community care, to support increased admission avoidance, enhanced facilitated discharge and reduced avoidable readmissions.

The Trust has adopted a 'bottom up' approach to the development of the 2014/15 and future years CIP plans to ensure full ownership and responsibility for delivery of the component schemes, at the Divisional level. The overall plan therefore comprises 3 distinct elements; Divisional specific efficiency initiatives, Divisional agreement and acceptance of Trust wide efficiency opportunities and the specific Divisional components of the Service Improvement (Transformational Redesign) programme.

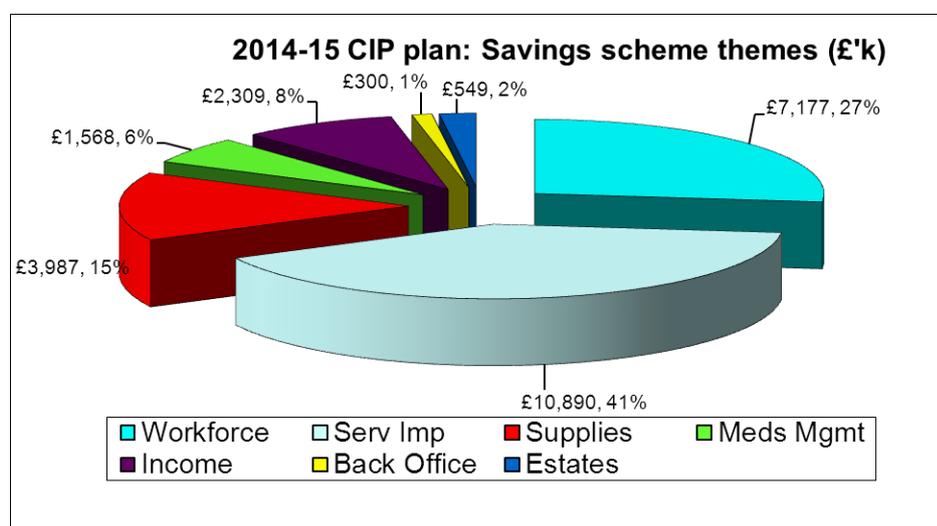


Table 13 – 2014/15 CIP Schemes Breakdown

Note: some service improvement and Estates schemes include revenue (income) benefits

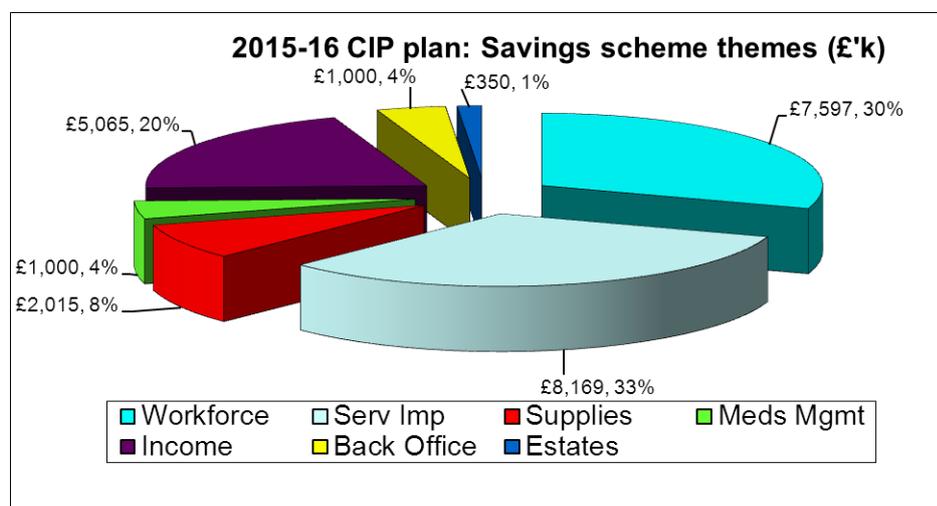


Table 14: 2015/16 Indicative CIP Schemes



17.3 Transformation CIP Programme 2014-16

As part of delivering the Trusts' Annual objectives, the Trust has introduced a Transformation Redesign Service Improvement Programme which will enable radical service review and efficiency identification utilising knowledge and skills from clinical, operational, planning and financial staff.

A two year Programme of transformation redesign within East Kent will focus on the development of both Elective and Emergency Schemes which ensure alignment with national and local strategies for integration and partnership working. Table 15 provides an overview of the operational transformation schemes (1-2 years) identified, and how they align to local commissioning intentions. These schemes also reflect the Trust's Clinical Strategy as well as supporting a step change, where appropriate, with strategic transformation (3-5 years).

The contract with East Kent Commissioners in 2014/15 also provides an opportunity to directly benefit from a health economy wide approach to service improvement. Table 15 below shows the current alignment of Trust transformational CIP schemes and Commissioners commissioning intentions.

Trust Transformation Scheme	Commissioning Intentions
Internal Waits	Ambulatory Care / Better Integrated Working / Integrated Urgent Care: Medical / Integrated Urgent Care: Surgical
Integrated pathway redesign	
External Waits	
Reablement at home	Better Integrated Working / Integrated Urgent Care: Medical / Integrated Urgent Care: Surgical
Stroke	NONE
Acute Neurology and Rehab	NONE
#NOF	NONE
Implement 6 + 3 new ambulatory pathways	Ambulatory Care Pathways
Optimise 5 of the 6 ambulatory pathway	Ambulatory Care Pathways
LTC pathway	Links to CQUINS
Acute Oncology Nurse role	NONE
Pressure Ulcer reduction	Links to CQUINS
Elective Pathway: Optimise Day Surgery (BADS) / 23hr Surgery Ambulatory Care	Ambulatory Care pathways / CQUINS / Planned Care, MSK Pathway
Elective Pathway: Reducing Cancellations on the day	Ambulatory Care pathways / CQUINS / Planned Care, MSK Pathway
Elective Pathway: Theatres	Transformation of Outpatient Services / Planned Care - MSK / Link to reduction in Outpatient Follow-up's
ICATs and Musculo-Skeletal Tender	Transformation of Outpatient Services / Planned Care - MSK / Link to reduction in Outpatient Follow-up's
Reduce Follow up appointments	Reduction in Outpatient Follow-up's / Transformation of Outpatient Services
Nurse Led Therapy Discharge	NONE

Table 15 – 2014/15 – 2015/16 Service Improvement Schemes aligned to CI's

17.4 Transformational Schemes

Some transformation schemes are already underway including the integrated use of Reablement funding from Commissioners, to support early implementation of a Health and Social Care Village model which facilitates a reduction in delayed transfers of care and dedicated provision for patients on a non-weight bearing pathway. This model of care clearly demonstrates improved patient outcomes and reduced long term placements, thereby providing the Trust with Strategic transformation opportunities regarding provision of innovative, but sustainable older peoples' services.

A number of Ambulatory Care pathways are already established or have been agreed and subsequently commissioned by surrounding CCG's. Supporting projects undertaken to inform transformation redesign service improvement for 2014-16, includes a review of diagnostic use within existing emergency pathways, a 'deep dive' into theatre utilisation with particular emphasis on cancellations and patient 'did not attends' (DNA's), and a review of End of Life Care in partnership with Pilgrims' Hospice.



Various schemes have been identified which support transformational redesign of both Elective and Emergency care pathways. Through combining service improvement and improved activity, operational and financial data, two key areas have been highlighted which focus on the reduction of 'internal, external and integrated waits' and elective pathway redesign to enhance provision of day surgery, 23hr surgery and enhanced recovery / supported discharge via Reablement at home. The Better Care Fund also provides an opportunity to work with Local Health Economy partners to develop integrated ways of working which provide a high quality continuum of care and better utilisation of resources. Robust admission avoidance schemes and facilitated discharge processes will support the reduction of acute inpatient beds, through the development of an integrated admissions and discharge team, provision of additional community capacity to support proactive patient flow and fully integrated rapid response teams to manage urgent care within the patients' own home. Clear opportunities exist to develop schemes which enable shared risks and benefits across the health economy. Redesigning the #NOF Pathway for instance, will enhance links with the falls reduction service within the Community, review medicines reconciliation and poly-pharmacy, and support a reduction in falls in hospital, acute length of stay, mortality rates, complaints and claims.

Schemes have been agreed with Clinical and Managerial (Divisional) staff and are being formally developed through the use of project initiation documents. Operational, financial and information leads have been identified to ensure schemes are accurately scoped to meet the 'affordability challenge'.

18. Service Developments

18.1 Investment Prioritisation

As part of the Trust's planning process, in October 2013, the Trust compiled a list of proposed business cases and outline service developments that totalled circa £14.5m in recurring revenue costs. Against a planned revenue investment allocation of £4m per annum, (£2m Strategic Investment Group allocation plus £2m to support organisational change following publication of the Francis report), there was a circa £10m gap between requests for investment and available funding resource.

To address this, the investment proposals were put into the context of the benefits that they drive (clinical, quality and financial) both in 2014/15 and in future years, in order to be fairly and appropriately compared. Using a Trust developed Benefits Scoring Model under the banner of the Trust's Strategic Appraisal Framework, the Executive Team held and led several discussions on the list of approved and potential schemes in order to identify both the most beneficial ones to support going forward and those that could be deferred. This prioritisation process also supported the phasing of improvement projects over the next 12 months in 2014/15 and helped provide clarity for the other requested projects for the coming years to all key stakeholders.

18.2 2014/15 Investment Summary

A summary of all the prioritised service developments that are included in the 2014/15 financial plans can be seen in Table 16.



APR Scheme Ref	Service Development	Income 2014/15 £m	Gross Cost 2014/15 £m	Cost Reduction 2014/15 £m	Total Net Cost Impact 2014/15 £m
1	KPP Project	14.3	(15.2)		(0.9)
2	Dover Hospital Rebuild			0.1	0.1
2	Clinical Strategy - Outpatients/ High Risk Surgery		(1.6)		(1.6)
2	ITU Expansion at WHH	0.8	(0.6)	0.1	0.3
3	SACP	3.1	(3.1)		0.0
4	Pharmacy Service Development		(0.8)		(0.8)
5	Ward Staffing	1.1	(2.9)	1.1	(0.7)
5	MDG Recurrent Revenue Equipment Funding		(0.4)		(0.4)
6	Healthcare & Social Care Village	3.9	(3.9)		0.0
7	Electronic Workflow		(0.0)	0.2	0.2
7	Telephony		(0.2)		(0.2)
		23.2	(28.6)	1.4	(4.0)

Table 16 – 2014/15 Service Developments

18.3 2014/15 Service Development Schemes

1) **Kent Pathology Project (KPP)**

2) **Clinical Strategy Schemes**

These schemes encompass the rebuild of Dover Hospital (due for completion in March 2015), Outpatients department infrastructure changes to support delivery of one-stop clinics; infrastructure and workforce changes to support the interim emergency and high risk surgery provision; POD Theatre & ITU WHH.

3) **Southern Acute Cluster Project (SaCP)**

Replacement of Trust Patient Administration System (PAS) and Maternity System

4) **Pharmacy Service Development**

Investment to establish a Near Patient Service that delivers savings through re-use of Patients Own Drugs, reduction in turnaround of discharge medication, and reduction in drug errors through increased Medicines Reconciliation rate.

5) **Ward staffing Review Investment**

Paediatrics; Adult; Maternity cover; Medical equipment

6) **Health & Social Care Village**

7) **New Systems**

Includes implementing a new Electronic Workflow system and installing and upgrade to the Trust Telephony system to support CIP schemes.

18.4 2015/16 onwards Service Development Schemes

£4m investment has been built into the 2015/16 financial plans for service developments encompassing the potential impact of Clinical Strategy schemes. An executive team led prioritisation process will commence in October 2014 to inform the investment plan for 2015/16.

APR Scheme Ref	Service Development	Income 2015/16 £m	Gross Cost 2015/16 £m	Cost Reduction 2015/16 £m	Total Net Cost Impact 2015/16 £m
2	Surgical Assessment Unit		(0.1)		(0.1)
2	Hospital at Home		(0.4)		(0.4)
2	Second Cardiac Cath Lab - Staffing		(0.7)		(0.7)
2	Clinical Strategy - Breast Surgery		(0.5)		(0.5)
2	Clinical Strategy - Emergency Care	0.3	(1.8)		(1.5)
5	MDG Recurrent Revenue Equipment Funding		(0.4)		(0.4)
7	"Better Training, Better Care"		(0.2)		(0.2)
7	ePrescribing		(0.2)		(0.2)
		0.3	(4.3)	0.0	(4.0)

Table 17: 2015/16 Potential Service Developments



For 2016/17 onwards, the service development funding is allocated to the cost of delivery of the strategic initiatives.

19. Capital Plans

19.1 Five Year Capital Plan

The Trust has a clear capital expenditure plan for the next five years to 2018/19.

It is probable that, in the context of the Trust having a financially prudent strategic plan, to deliver the strategic initiatives laid out in the plan, capital investment will potentially be required beyond the level of internally generated resources and cash reserves. The Trust Board has commenced exploring the options for external financing in preparation for this.

APR Scheme Ref	Scheme	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
-	Donated Assets	500	500	500	500	500
1	2013/14 Schemes Continuation	1,672	525			
2	Dover - Reprovision of services	13,832	627	0	0	0
3	Clinical Strategy - Approved Schemes	1,200	5,412	584	0	0
4	Recurrent Allocations	8,000	7,200	9,200	9,200	9,200
5	Clinical Strategy - Schemes not yet Approved	2,000	7,096	8,750	14,222	15,300
6	Laundry Equipment	1,000	0	0	0	0
7	Computer Aided Facilities Management (CAFM)	500	0	0	0	0
9	Energy Project - Phase II	0	0	3,000	1,078	0
10	Telephony	1,000	600	0	0	0
11	Kent Pathology Network (KPP)	500	2,500	0	0	0
12	Nursing Home Strategy	0	1,500	3,000	0	0
	Total	30,204	25,960	25,034	25,000	25,000

Table 18: 2014/15 – 2018/19 Capital Plan

Scheme level detail can be seen in Table 18. This table includes £0.5m of donated assets that the Trust broadly expects to receive in each financial year primarily supporting the purchase of medical equipment to enhance patient experience. This expenditure is fully supported by income streams from charitable organisations.

19.2 Capital Schemes

Three projects that commenced in 2013/14 are due to continue into 2014/15. These are the Endoscopy upgrade (completion April 2014), the Energy project Phase I (completion in Autumn 2014) and the PACs RIS replacement scheme that will continue into 2015.

Dover Hospital Rebuild

The largest allocation in 2014/15 will be the new hospital at Dover. The scheme is well underway and the main build due for completion at the end of February 2015. The new building will therefore be operational from March 2015. There will be some minor additional capital work undertaken to the car park in 2015/16.

Recurrent Allocations

Annually the Trust has held some expenditure under Recurrent Allocations to address issues such as backlog maintenance and equipment replacement. A key element of challenge from Monitor as part of the FT assessment was the likely timescales for the eradication of a major backlog maintenance programme. It is also a requirement of the Trust Terms of Authorisation to have a



detailed annual maintenance and equipment replacement programme and this is reflected in the on-going allocations.

- Purchase of new/ replacement major items of medical equipment;
- Replacement of current medical devices and equipment;
- Backlog maintenance;
- Replacement and purchase of new IT equipment; and
- Divisional capital requirements.

Clinical Strategy Schemes

The Clinical Strategy Approved Schemes are the CT scanner WHH and the Outpatients refurbishment KCH (including polyclinic). The CT scanner at WHH will be located in the current Fracture Clinic which is due to move into the Celia Blakey area once Endoscopy unit is complete and the area is refurbished.

Clinical Strategy Schemes at the 'not yet approved' stage are the Fracture Clinic WHH and the Surgical Services centralisation.

Laundry Service

The existing Laundry equipment needs to be replaced and a business case will be going to SIG in early 2014/15. This scheme is essential in supporting a Kent-wide amalgamation of Laundry services phased over the next few years and has a current planned cost savings of £0.4m in Year 1 and a further £1m in 2018/19.

Computer Aided Facilities Management System

Computer Aided Facilities Management (CAFM) is an asset database which manages planned and reactive maintenance, and supports an ambitious savings plan.

Energy Project Phase II

Funds have been set aside in 2015/16 for the Energy Project Phase II, to carry out the next phase of the Energy Project. This will ensure the Trust meets its Carbon Reduction Commitment (CRC) going forward. The scheme will be subject to approval of a business case and will again release substantial savings to the Trust as well as drive up quality in the service.

Telephony System Replacement

The Telephony system project covers both the replacement of the Trust's current telecommunications infrastructure and also introduces the use of video on a wider scale.

Kent Pathology Project

There is an allocation for the Kent Pathology Project (KPP). This is a joint business case with MTW and has been approved at the Board of Directors. The funds in the 2014/15 programme are mainly for an integrated IT system and some professional fees for the design and specification of the refurbishments which are due to take place in 2015/16. Again, this project offers substantial cost savings to both Trusts.

Nursing Home Strategy

Funds have been set aside in 2015/16 and 2016/17 for the Nursing Home Strategy. The Trust faces large demographic increases in the over 65 population in East Kent over the next 10-15 years. The over 65 population has a disproportionate effect on demand for Trust services and increased pressure on these services is expected to result. To address this issue the Trust is considering if it should invest in this sector to both ease operational pressures in terms of bed utilisation, but also to look for profit from the commercial side of the business.



END – EKHUFT STRATEGIC PLAN 2014/15 – 2018/19 MONITOR SUBMISSION

