Kingston Hospital NHS
NHS Foundation Trust

Strategic Plan 2014/15-2018/19

For publication

June 2014

Contents

1. Executive summary

Kingston Hospital is a single site, medium sized District General Hospital (DGH), located within Kingston-Upon-Thames in South West London. We provide services to approximately 320,000 people locally on behalf of our main commissioners, including Kingston, Richmond, Wandsworth, Merton and Sutton Clinical Commissioning Groups (CCGs) in South West London and Surrey Downs CCG (East Elmbridge locality) in Surrey. In the last year we saw over 113,000 patients in A&E, undertook 355,000 outpatient appointments and cared for 65,000 admitted patients with consistently low mortality rates. We have a highly regarded maternity unit delivering nearly 6,000 babies per annum and rated 'Best in London' by mothers again this year in the Care Quality Commission (CQC) maternity survey. As well as delivering services from the main hospital base, we deliver ambulatory services at a range of community locations in partnership with GPs and community providers.

The local health economy faces two main significant challenges, improving the quality of services and ensuring financial sustainability. The draft South West London strategy focuses largely on the delivery of the London Quality Standards (LQS) by 2018/19. No provider fully meets these at present but Kingston Hospital meets more of the standards than other providers in South West London based on the recent self-assessment. Without any improvements in productivity, for South West London CCGs there is a forecast 'Do Nothing' savings challenge of £218m by 2018/19. CCGs are committed to achieving significant savings through transforming care out of hospital, assisted by the national mandate to create the Better Care Fund (BCF). The impact of this, plus cost inflation, deflation in tariffs and required improvements in quality means financial sustainability will be challenging for all acute providers. We will need to deliver a Cost Improvement Programme (CIP) of 4.3% of turnover, which is below the average for other trusts in South West London.

The strategies that we will pursue to support clinical and financial sustainability include:

- Increasing productivity through the development of strong and generative partnerships, the embedding of Service Line Management to strengthen local responsibility and the innovative use of information technology and;
- Strengthening our position as the hospital of choice for our local population and increasing our market share of services where we are strong.

Both of the above strategies will be supported by the achievement of the LQS. This will enable 24/7 consultant delivered care which will create opportunities to increase efficiency as decision making is taken at a more senior level. It will also help to differentiate us on quality and strengthen our competitive position.

Further detail of our vision and supporting service strategy are provided below.

Our Vision:

'To be the hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff'.

We aim to be at the leading edge of the changes that are necessary for DGHs to be successful in the future. We plan to deliver innovative models of care to provide high quality treatment 24/7 for acutely unwell patients, with core acute services increasingly delivered by consultants, ensuring mortality rates remain in the top 10% of the best performing comparable sized hospitals nationally. Through implementation of our dementia strategy we intend to become an exemplar site for dementia care over the next 5 years, responding to the age profile of our local population.

We will also deliver planned services, providing care for those patients whose illness requires more intervention than can be provided by a GP but who do not require specialist care. Services will be high throughput with low complexity and variability. Planned care will be provided in the most appropriate hospital setting, with more activity being undertaken on a day-case and outpatient

procedure basis. For elective inpatients we will continue our dialogue with South West London commissioners and providers on proposed arrangements for a multi-specialty elective centre.

Integrated community services will require us to support primary and community care to ensure that, where possible, our patients are treated closer to home. A key vehicle for this will be the Better Care Fund (BCF). We will also continue to develop hospital outreach services at a variety of sites, including new sites such as Raynes Park, Surbiton and Ebbisham Health Centres. This strategy will be underpinned by strong partnerships and we will work across organisational boundaries to deliver seamless integrated care to patients. We will maximise the use of technology to enhance the quality of service provision and communications across hospital departments and with GPs and patients.

Our vision is underpinned by four strategic objectives. Key plans to support the delivery of these objectives over the next five years are summarised below:

Strategic Objective 1: To ensure that all care is rated amongst the top 20% nationally for patient safety, clinical outcomes and patient experience

We will focus on achieving delivery of the London Quality Standards (LQS) where this is entirely within the control of the Trust. This will require an investment of £3.5m over the next five years and this has been reflected in our plans. We anticipate that all standards will be met by the end of year 4 with a trajectory for delivery that meets the requirements of commissioners.

We intend to be an exemplar site for dementia care, responding to the demographic needs of the local population.

We will improve the quality of care on the wards across all hours of the day and days of the week, reduce variation between wards, continue to develop a safety culture and, at the latest by year 4, ensure that we are in the top 20% of Trusts nationally for patient experience as reported through the Friends and Family Test (FFT) and national surveys.

We will improve the quality of care for patients through the implementation of our estates strategy. This will significantly enhance patient experience through refurbishment of outpatients, expansion of A&E, replacement of windows and refurbishment of the intensive care unit (ICU) and the theatres in Esher Wing, expansion of the Sir William Rous unit and the redesign of the main entrance of the hospital. The strategy will be delivered over the five year period with the majority of plans delivered in years 1 and 2.

We will also continue the development of an Electronic Patient Record (EPR) underpinned by further deployment of the Care Records Service (CRS) programme, involving the implementation of e-prescribing and clinical documentation. We will implement device integration and increase electronic links with GPs

Strategic Objective 2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients

One of our key plans in support of this objective is the embedding of Service Line Management, introduced in 2013, to strengthen the engagement of staff across the organisation by giving greater levels of autonomy to clinical managers.

We will also develop and deliver training to support administrative staff to provide excellence in customer care, to ensure improvements in FFT results and reduced complaints

We will ensure a strong focus on recruitment and retention and aim to reduce the need for agency staff by strengthening the bank and reducing turnover.

We will develop new roles and ways of working reflecting the need to work across organisational boundaries as more work is shifted into the community. This will include the development of integrated generalist roles to provide care for the frail elderly and close working with community providers to create opportunities for staff to work across the acute and community sectors.

Strategic Objective 3: To work creatively with our partners (NHS, commercial and community) to consolidate develop sustainable high quality care as part of a thriving health economy for the future

We will work closely with partners in the local health economy to develop and implement the five year plan for South West London including delivery of the LQS, development of the model for elective inpatient care and delivery of the BCF.

We will continue working with commissioners and other providers to develop further and deliver the BCF plan. This will include the implementation and development of plans in Kingston for multi-provider teams working across organisational boundaries to provide co-ordinated assessment and care to the frail elderly.

We will continue to focus on the pursuit of opportunities for growth to support future sustainability, including: improvements regarding access and administrative processes to improve the GP and patient experience; the further development of outreach services; responding to tender opportunities and; the refreshing of the private patient strategy with BMI Healthcare.

We will refresh the business case for the expansion of maternity services in year 1 to support a two phase expansion over the next five years. Pending further agreement and work up this has not yet been included in our base case at this stage.

Partnership working with other providers to deliver benefits to patients and support sustainability will continue, including: the implementation of new arrangements for the delivery of pathology services across Kingston, St George's and Croydon Hospitals.

We will also continue to develop and embed the full involvement of the community in the running of the hospital through members' events, engagement and through the delivery of the volunteering and fundraising strategies.

Strategic Objective 4: To deliver sustainable, well managed, value for money services

We will build on the consistent and strong financial performance of recent years and are planning to achieve a normalised surplus of at least 0.7% of turnover over each of the five years of the plan. The level of planned surplus in 2014/15 is broadly similar to the level in previous years. The level of surplus reduces in 2015/16 as a result of: the additional challenges posed by the BCF; the re-procurement of CRS, which requires revenue funding and; the start of the additional interest charges from the loan to support the estates strategy. Our plans for 2016/17 are to increase the surplus back up to 0.9%. We believe that these levels of surplus are reasonable, realistic and achievable given the current level of real-terms savings that the NHS is tasked with delivering as a whole.

To support the expenditure plan we will need to deliver a Cost Improvement Programme (CIP) of c£46m over the five years. We have a combination of cost improvement and revenue generation schemes each year. Delivery of the CIP programme across the five years will be challenging. However we have a good track record of delivering significant CIP programmes year on year demonstrating capability and have a number of mechanisms in place to assure the programme, including:

- Robust governance framework for the programme, including clinical leadership in development and delivery of schemes and central proactive monitoring of individual schemes on an ongoing basis
- Ability to achieve scope of programme validated by external benchmarking and national studies as well as local clinical and operational knowledge
- Detailed plans for early years with five broad themes identified for outer years

We are planning basic capital expenditure of £37.1m across the five year period in line with depreciation. In addition, we are planning a further £15.5m of capital investment to deliver the key initiatives outlined in the recently agreed estates strategy. We are working up the individual schemes underpinning the strategy and discussing the financing options with the Foundation Trust Financing Facility (FTFF).

Cash remains broadly stable at between £8m and £11m over the five year period. This level of surplus combined with other metrics maintains a Continuity of Service Rating (COSR) of 3.

2. Market analysis and context

2.1 Local health economy challenges and plans

2.1.1 Overview of Challenges

The local health economy faces two main challenges, improving the quality of services and ensuring financial sustainability.

In London, clinicians have worked together to develop the London Quality Standards which build on Royal College guidance and detail the minimum safety standards patients should expect when they are treated in hospital. No Trust is meeting all of these standards currently and in South West London performance varies.

NHS funding is not increasing as quickly as the cost of providing health services. Spending is increasing faster than inflation due to: the increasing percentage of the population that are elderly; many with one or more long term conditions; public health trends such as increasing obesity; a trend of rising hospital activity; the costs of new drugs and technologies and; an aging estate that needs modernising.

Without any improvements in productivity, for South West London CCGs there is a forecast 'Do Nothing' savings challenge of £218m by 2018/19. This challenge, known as the QIPP (Quality, Innovation, Productivity and Prevention) challenge, is planned to be addressed in a variety of ways. CCGs are committed to achieving significant savings through transforming care out of hospital, assisted by the national mandate to create the BCF. Due to the planned delivery of more care in primary and community settings, the impact of CCG QIPP plans will be particularly significant for acute trusts. The impact of this, plus cost inflation, deflation in tariffs and required improvements in quality will mean financial sustainability will be challenging.

2.1.2 South West London 5-year strategy

The draft South West London strategy focuses largely on the delivery of the LQS by 2018/19, with a trajectory for delivery between now and then. It is proposed to use levers to ensure delivery of the standards, including decommissioning of services which are not compliant. Commissioners anticipate that delivery of these standards is likely to mean significant service change. Further work will be undertaken following the submission of the final strategy in June 2014 to agree how the strategy will be implemented, including the role of each trust in achieving it.

A summary of commissioning intentions by clinical work stream is provided below, focusing on those which have the most impact on this Trust.

Paediatrics – all hospitals are expected to meet the LQS by the end of year 3. Priorities for the first two years include evaluation of the Paediatric Assessment Unit (PAU) at St George's Hospital, with roll out of the PAU model to all providers in year 3. An enhanced children's community model will also be piloted in year 2 and fully rolled out in year 3. It is planned to review the viability of the existing inpatient units and in year 5 to finalise plans for the consolidation of inpatient provision.

Maternity - all units are expected to meet 168 hours of obstetric consultant presence per week by the end of year 5, with 98 hours achieved by the end of year 1, 110 hours achieved by the end of year 2 and 144 hours by the end of year 3. Units are also expected to achieve midwifery related LQS by the end of year 2. We are already compliant with 98 hours of consultant presence per week.

Commissioners have indicated that they intend to make decisions about business cases to expand services at Kingston Hospital and St George's Hospital over the next two years.

Integrated care - years 1 and 2 will focus on local BCF plans, the impact of which is discussed further below. Community services such as rapid response and discharge support will move to 7-days a week. In later years commissioners plan to implement innovative contracting arrangements, incentivising providers to drive improved outcomes and integrated working. Reduced A&E attendances and emergency admissions are anticipated as a result. In Merton, it is expected that medical outpatients will move out of hospital and closer to where people live through the Nelson and Mitcham Local Care Centre developments.

Urgent and emergency care - hospitals are expected to achieve the LQS by year 3. We are already fully compliant. Commissioners also plan wide-scale implementation of ambulatory pathways.

Planned care - the physical separation of elective (overnight+) and emergency surgery to a single multi-specialty elective centre (MSEC) is proposed, with urology identified locally as a suitable pilot specialty. This is expected to be achieved by the end of year 2, with progress towards shifting all suitable elective surgical procedures by the end of year 5. The site of a MSEC has not been determined and this could only be achieved as part of a wider agreement regarding future reconfiguration options. Discussions are ongoing with providers who have flagged operational concerns.

Cancer – this work stream will impact on the Trust though the intended increased uptake of bowel, breast and cervical cancer screening in years 1 and 2. In later years, commissioners plan to deliver chemotherapy either in satellite units, community settings or the patient's home wherever possible.

The implications of these commissioning intentions have been reflected in our plans.

2.1.3 QIPP and Better care Fund

In 2014/15 local commissioners plan to deliver savings through QIPP programmes, largely by preventing avoidable emergency admissions and shifting clinically appropriate outpatient activity to community settings. From 2015/16 the BCF starts to have a significant impact. Commissioners intend to enhance provision in community and social care to reduce avoidable admissions and length of stay for some conditions. It is therefore expected that funding will shift out of acute care. Income reductions supplied by commissioners in relation to QIPP and the BCF over the next five years equate to £13.3m. This creates a threat as we will still need to cover overheads despite a reduction in income. There are opportunities to mitigate this risk by being part of new models of care and we are working up plans in Kingston for multi-provider teams to work across organisational boundaries to provide co-ordinated assessment of care to the frail elderly with the highest care needs.

2.2 Developments in neighbouring health economies

2.2.1 North West London

North West London's 'Shaping a healthier future' programme was launched in January 2012 in response to similar challenges to those faced in South West London. In 2013, commissioners agreed with the recommendations put forward by the programme following public consultation, involving changes to hospital configurations, including the reduction of emergency care on some sites.

The plans are due to take 3-5 years to implement. The modelling undertaken by the programme indicates additional flows to Kingston Hospital as a result of changes at Charing Cross Hospital.

2.2.2 Surrey

Like South West London, residents of Surrey Downs CCG are healthier and longer living than the London and UK average, with the result that there are a disproportionately large number of elderly residents, many with one or more long term conditions. The CCG's long-term strategy, therefore, is strongly weighted towards out of hospital care, with emphasis on close integration of community and primary care services, more care closer to home, and investing in virtual wards. Surrey Downs are not planning to commission to the LQS at the present time.

2.3 SWOT

2.3.1 Overview

An overview of the SWOT analysis for the Trust is at table 1:

Table 1: Summary SWOT

Strengths	Weaknesses
• Strong performance on clinical quality • Good financial performance • Service Line Management implemented • Flexible estate • Effective partnership working • CRS/IT enabled productivity • Good access via public transport	• Administrative processes • Access to some services • Backlog maintenance requirements • Patient experience below our expectations in some areas • Recruitment and retention issues • Car parking facilities
Opportunities	**Threats**
• South West London strategy • North West London strategy • Competitive tendering • Further partnership working • New community outreach opportunities • Further strengthening of community engagement	• Lack of clear process to address configuration of acute providers locally • Local competition for services • BCF fails and activity continues but not paid for in full • Changes to specialist commissioning

In summary, the clinical quality of services at the Trust is good but the administrative processes detract from the GP experience and in some areas waiting times restrict access. These detractors will need to be addressed as a priority if we want to protect and grow GP referrals. Unlike many of our acute hospital neighbours we already deliver services at a range of community locations and this experience means we are well placed to take up new outreach opportunities in the future. However, we will need to strengthen our operational delivery, for example through improved IT connectivity, if we are to increase market share through this route.

We are operating in a competitive environment which has the potential to become more so in light of the challenging economic conditions. In response we will need to ensure that we continue to compete well on clinical quality including delivery of the LQS. We will also need to address the weaknesses that impact on referrals, particularly in relation to administration and waiting times. If we are able to do this there are a number of potential opportunities through competitive tendering and the expansion of our community outreach offering.

Further detail is provided below:

2.3.2 Strengths

Clinical quality

The clinical quality of services at the Trust is strong. The Dr Foster Hospital Guide 2013 highlighted that the Trust had lower than expected mortality rates. This was further endorsed by the Health and Social Care Information Centre in the same year which identified Kingston Hospital as one of 11 trusts in England having consistently lower than expected mortality rates over a two year period for both elective and emergency patients. We are fully compliant with CQC essential standards of quality and safety and we meet more of the LQS than other trusts in South West London and plan to achieve full compliance with all standards where this is entirely within our control. We have a good reputation locally, particularly in relation to maternity services which have been rated as 'Best in London' by mothers through CQC surveys. Our A&E department is one of the busiest in South West London, the department is fully compliant with LQS and we have a good track of delivering A&E wait targets. This provides a strong platform from which to grow market share.

Good track record on financial performance

We have demonstrated consistent achievement of financial targets with normalised surpluses of at least £2.1m since 2009/10. This has involved strong performance on the Trust's CIP programme.

Service Line Management

During 2013/14 we introduced Service Line Management which is encouraging local ownership and responsibility and provides a strong foundation from which we can respond to the challenges ahead.

Flexible estate

The layout of our estate lends itself to a programme of refurbishment and development which can flex and adapt to change. The implementation of the estate strategy approved by the Board in 2013/14 will improve patient and staff experience and position the Trust well to respond to any future opportunities for growth.

Effective partnership working

We have many examples of working effectively with partners across primary and secondary care and with our contractors. Examples include: a contractual joint venture with St George's Hospital and Croydon Hospital for the delivery of pathology services; a partnership with the Royal Marsden Hospital for the provision of cancer services; a partnership with BMI for the provision of private patient services and; a partnership with the other South West London acute trusts for the delivery of orthopaedic services through the Elective Orthopaedic Centre. Through the Whole System Transformation Board we work with our primary and community care partners on initiatives to transform services across the local health economy.

Good access via public transport

The main hospital site is well situated, benefitting from excellent rail and bus links. This enables easy access for patients from a wide geographical area which supports plans to expand the catchment area. Through the Council of Governors Engagement Committee there is a mechanism to lobby to improve these links still further.

2.3.3 Weaknesses

Administrative processes

Although the clinical quality of our services is strong, some of our administrative processes need to be improved. This is a particular issue for outpatients and diminishes the experience of our GPs and

patients. Protecting and growing market share in the future will be dependent on getting this right. Consequently, addressing these administrative issues is a key priority for delivery in 2014/15.

Access to some services

Overall waiting times for first outpatient appointments at the Trust are on average 34 days[1], which is a similar waiting time as for neighboring trusts (range 32-37 days). However, there is significant variation across the Trust and to grow market share it will be necessary to reduce waiting times in some areas. This will improve Choose and Book slot availability which has fluctuated over the year and needs to be improved to make it possible for GPs to increase electronic referrals to the Trust.

Backlog maintenance requirements

A recent review of the estate identified a pressing requirement to invest in business critical backlog maintenance over the next five years, with an estimated cost of c£17m, to reduce the current level of risk associated with a failure of the business critical plant and equipment. In particular, this relates to steams mains, as well as the mechanical and electrical services in the older buildings on the estate such as Esher wing and outpatients. This is factored into our plans.

Patient experience below our expectations in some areas

The Friends and Family Test has been in use on adult inpatient wards at the Trust since February 2013 and benchmarking with other Trusts puts us in the bottom quartile of Trusts nationally. An analysis of improvement comments from the test has shown that patients have identified food, perceptions of staff numbers and communication with patients as the main areas requiring improvement on inpatient wards. Similarly, there is room for improving inpatient experience survey results and, whilst showing signs of improvement in some areas, have not been sufficient to shift the overall position when compared to the best performing Trusts. We will need to improve the patient experience on the inpatient wards and a range of developments are underway in response to patient feedback.

Recruitment and retention issues

Like all Trusts we face recruitment and retention difficulties, particularly in areas where there is a national shortage including sonographers, ward sisters, occupational therapists, cardiac physiologists and consultant and specialty doctors in areas such as A&E and paediatrics. Competition is also greater for London trusts due to the number of hsopitals.

We are aware of current and future recruitment and retention issues and take steps to monitor and address these. Examples include:

- The development of an internal training programme to support growing our own sonographers
- A review of different models of medical staffing for the paediatric service
- The creation of the Physician Associates role in A&E

Any future changes to the configuration of hospitals in South West London could ease recruitment issues in some areas and strengthen our ability to appoint new consultants to support the delivery of the LQS, particularly in maternity.

[1] Based on average time for a first outpatient appointment in 18 week specialties Q3 2013/14

Car parking facilities

Many patients have expressed their dissatisfaction with the pay and display arrangements for car parking and this is an area where we do not compare favourably with competitors. Plans have now been developed for pay on exit arrangements which will be introduced in Q1 2014/15.

2.3.4 Opportunities

South West London Strategy

We are the only Foundation Trust in South West London, perform well on quality and finance and can demonstrate plans to support clinical and financial sustainability over the next five years, including delivery of the LQS where these are fully within our control. We are therefore well positioned in relation to any potential future service reconfigurations across the sector.

North West London strategy

Implementation of the North West London strategy is likely to create additional flows to the Trust as activity is displaced from Charing Cross and Ealing hospitals.

Competitive tendering

The changing healthcare environment is likely to result in increased tendering for services, including the direct provision of and / or support for the delivery of services in community settings. This could be a risk for some existing income streams but could also create opportunities for us to secure additional income from new markets. Commissioning intentions have highlighted opportunities to gain new business in the next year through tendering and service re-design activities.

Further partnership working

There are a number of opportunities to develop further partnership working to support clinical and financial viability, for example:

- Closer working between acute providers in South West London to support the delivery of the South West London strategy
- Closer working with community, primary, voluntary and mental health providers to transform care to deliver the BCF. Discussions are progressing well with providers in Kingston regarding a potential contractual joint venture to delivering care differently for the frail elderly population
- Further development of the cancer partnership with the Royal Marsden
- Working with private providers to develop a commercial pharmacy opportunity

New community outreach opportunities

All CCGs are looking to develop a greater range of more integrated services at their community site and the trust will work with them to deliver this agenda.

Further strengthening of community engagement

As a Foundation trust there are a number of opportunities to further embed the community in the running of the hospital.

2.3.5 Threats

Lack of clear process to address configuration of acute providers locally

The case for change outlined in the Better Service, Better value review in 2013 identified that the current provider configuration across South West London is unaffordable but following the demise of the programme there is not a clear planned approach to addressing this. Delays in resolving this will

create pressures in the local health economy and will also make it more difficult to recruit to the new consultant posts necessary to deliver the London Quality Standards, particularly for obstetrics.

Local competition for services

The challenging economic environment is likely to result in local providers displaying more competitive behaviour as they seek to maximise income to maintain financial viability. There are a number of competitors for current tenders and potential mergers in Surrey and North West London could increase competition. Focusing on the delivery of the LQS and improving administrative processes will be key to ensuring that patients and GPs continue to choose us.

BCF fails and activity continues but not paid for in full

We are working closely with commissioners on their BCF plans to mitigate this risk. This threat has been reflected in our downside modelling.

Changes to specialist commissioning

NHS England is developing a five-year strategy for specialised services and it is expected that future contracts for this activity will be awarded to smaller numbers of specialist providers. The work we undertake is quasi specialist and it is anticipated that we will be able to continue to undertake this although there is a possibility that some work will be sub-contracted through a specialist provider.

3. Risks to sustainability and strategic options

3.1 Risks to sustainability

Based on the market assessment at chapter 3 the key risks to clinical and financial sustainability are summarised below:

Failure to deliver quality standards required by commissioners

Delivery of the LQS will be key to ensuring future clinical and financial viability. If these are not met services could ultimately be decommissioned. A cost pressure of £3.5m has been identified to enable full delivery of the standards and this has been built into our plans.

Impact of QIPP and Better Care Fund

Commissioners have supplied forecast reductions in income of £13.3m relating to QIPP and the BCF. This presents a risk to the Trust as we will not be able to reduce costs commensurately and the contribution to overheads will be reduced. These pressures have been built into our plans.

As outlined in the SWOT, there is a risk that the BCF fails and commissioners are unable to pay in full for the activity undertaken. This has been reflected in our downside modelling.

Scale of productivity requirements

The financial gap for the Trust over the next five years is £46m, when efficiency requirements, activity reductions and cost pressures are taken into account. This will require a productivity improvement of approximately 4.3% per.annum. This will impact on all Service Lines. Delivery will be very challenging and critical to the future viability of the Trust.

Although challenging, the Trust has a strong track record of CIP achievement, a robust governance process, and is confident that there is scope to meet the productivity requirements across the five year planning horizon. Local clinical knowledge and organisational horizon scanning have identified five broad areas in which further schemes can be developed.

The scope of these themes to deliver concrete savings has been validated by benchmarking data and internal analysis. External benchmarking, such as SaFE analysis, Better Care Better Value indicators and participation in national benchmarking clubs has demonstrated scope for reducing costs and increasing efficiency across the organisation. Internal benchmarking, including development of service line reporting data, has demonstrated that there is significant scope to turn existing loss-making services into profit-making services. Some national studies have informed local opportunities, such as the PwC analysis of potential Electronic Document Management (EDM) savings across the NHS which forms the basis for the Trust's EDM business case. Local clinical and operational knowledge has also informed opportunities to release efficiencies by working in clinical networks, or sharing back office or clinical support services.

Key to making these changes will be engaging with staff, key stakeholders, partner organisations and the public. We have a good track record of doing this, such as engaging clinical teams in the development of CIP schemes, or leading the South West London Pathology Programme across traditional organisational boundaries.

Lack of clear process to address configuration of acute providers locally

As outlined in the SWOT there is a risk that the lack of a clear planned approach to the future confifuration of acute providers locally will create significant pressures in the local health economy in the interim which could impact on the Trust and will make it more difficult to recruit to the new consultant posts necessary to deliver the LQS.

3.2 Strategic assessment

3.2.1 Overview

We provide large scale core acute services to the population of Kingston, Richmond, East Elmbridge and parts of Merton, Sutton and Wandsworth. Our maternity service is the largest in the sector and recognised as good quality with the highest level of patient satisfaction in London. Our A&E department is also very busy seeing 110,000 attendances p.a. and rising and has a good reputation with a strong track record of delivering operational targets. There is no capacity to deliver these core services at an alternative site locally. Furthermore, a detailed option appraisal undertaken as part of the Better Services, Better Value review of acute provision in South West London during 2012/13 determined that loss of major acute services from Kingston Hospital would not have a positive financial impact on the local health economy. The delivery of core acute services is therefore planned to continue at Kingston Hospital for the foreseeable future.

Options for merger with another organisation to support future clinical and financial sustainability are limited present but in the event that an opportunity arises in the future we would be keen to assess the benefits. With our track record of success we would also be keen to take on a leadership role to support improvement at other acute providers.

In light of the above, the strategic options that we will pursue at this time to support clinical and financial sustainability include:

1. Increasing productivity through the development of strong and generative partnerships, the embedding of Service Line Management to strengthen local responsibility and the innovative use of information technology and;
2. Strengthening our position as the local hospital of choice for our local population and increasing our market share of services where we are strong.

Both of the above strategies will be supported by the achievement of the LQS. The delivery of these will support 24/7 consultant delivered care which will create opportunities to increase efficiency as decision making is taken at a more senior level. It will also help to differentiate us on quality and encourage patients and GPs to choose us.

4. Strategic plans

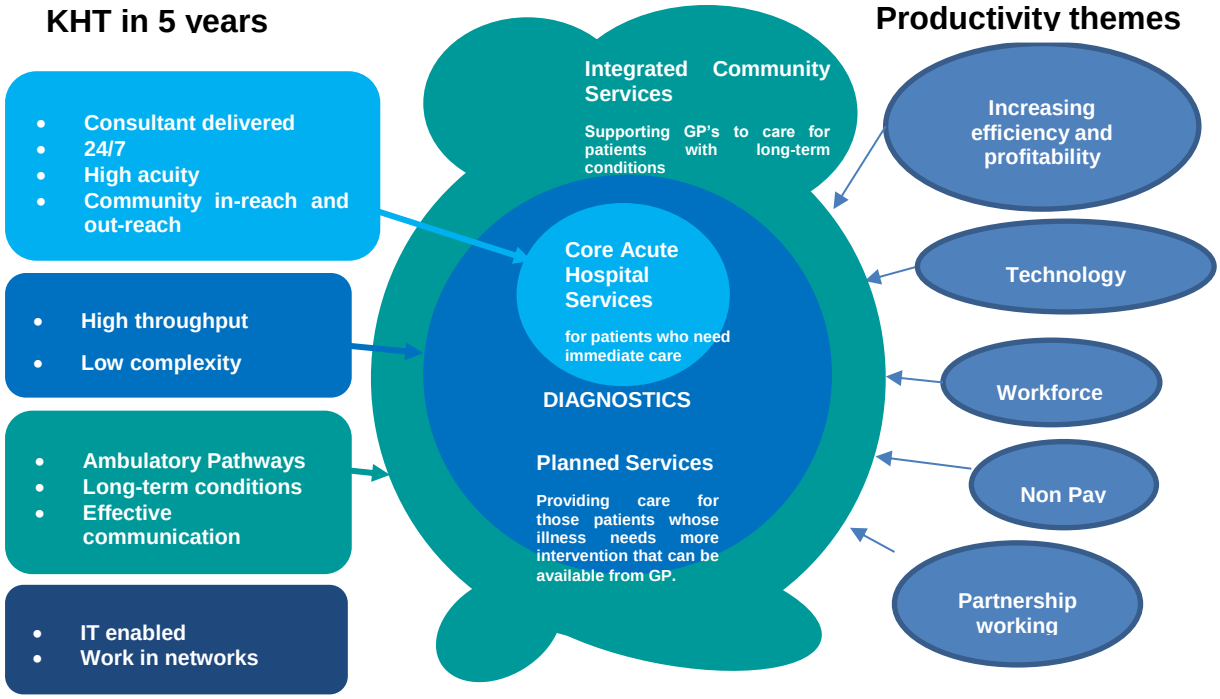
4.1 Trust vision and service strategy

Our vision for the next five years is to:

'To be the hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff'.

Underpinning this vision is delivery of our service strategy which is summarised below:

Figure 1: Summary of five year service strategy



At the heart of the strategy is the delivery of core acute services, including A&E, maternity and intensive care services, supported by acute medical and surgical services and diagnostics. We will work towards the delivery of 24/7 consultant delivered care, including the development of sustainable consultant rotas for acute medicine and surgery, gastrointestinal bleeding and interventional radiology.

Increased scale will be required to sustain viable consultant rotas to support 24/7 working and delivery of the LQS and we will seek to pursue growth strategies and accommodate flows from strategic reviews in North West London and South West London as required. Through implementation of our dementia strategy we will aim to become an exemplar site for dementia care over the next five years, responding to the age profile of the local population.

We will also provide planned services, providing care for those patients whose illness requires more intervention than can be provided by a GP but who do not require specialist care. Services will be high throughput with low complexity and variability. Planned care will be provided in the right hospital setting, with more undertaken on a day-case and outpatient procedure basis. For elective inpatients we will work with South West London commissioners and providers on proposed arrangements for a multi-specialty elective centre.

We will support primary and community care to ensure that patients are treated closer to home where possible. A key vehicle for this will be the BCF. We will also continue to develop hospital outreach services at a variety of sites, including new sites such as Raynes Park, Ebbisham and Surbiton Health Centres.

This strategy will be underpinned by strong partnerships, and we will work in networks to deliver seamless care to patients across organisational boundaries and will work closely with all partners on pathway redesign to transform care so that it is truly integrated. It will also be underpinned by the use of IT and we will maximise the use of technology to enhance the quality of service provision and communications across hospital departments and with GPs and patients.

4.2 Strategic objectives and overview of supporting plans

To realise the vision we have identified four strategic objectives for delivery by 2018/19. A summary of each strategic objective and the key plans to support these are summarised below:

Table 2: Key plans 2014/15 – 2018/19

Strategic Objective 1: To ensure that all care is rated amongst the top 20% nationally for patient safety, clinical outcomes and patient experience
Key plans include:
• Delivery of the LQS in areas where this is entirely within the control of the Trust. This will require an investment of £3.5m over the next five years and this has been reflected in our plans.
• Improving the quality of care on the wards across all hours of the day and days of the week, reducing variation between wards, continuing to develop a safety culture and ensuring that we are in the top 20% of Trusts nationally for patient experience as reported through FFT and national surveys by year 4 at the latest. Initiatives to support this include: the use of feedback to inform the areas of key focus including food and the perception of staffing numbers in the first instance; the implementation of the leadership programme for ward sisters and aspiring ward sisters; the implementation of the team development programme for wards and; embedding a culture of improvement through the quality improvement programme.
• Developing and implementing proposals to improve patient engagement and experience, including: electronic mechanisms for engagement; improved patient experience with the discharge process; more virtual clinics; more services provided in community outreach settings and: increased information on staffing available to patients and the public
• Implementing the dementia strategy to support the Trust becoming an exemplar site for dementia care, including: ➢ Improving the environment of care starting with the care of the elderly wards in year 1 with rollout across all wards over the five year period. New developments as part of the estate strategy discussed below will incorporate dementia friendly plans ➢ Improving early recognition and diagnosis of dementia through training and education of staff and better signposting to community services ➢ Expanding the work with carers to improve their experience ➢ Improving the experience of people with dementia through the introduction of active days and calm nights, supported by a therapeutic activities programme and staff training
• Implementing the estates strategy, addressing key issues impacting on safety and patient

experience, through critical backlog maintenance, expansion of A&E and the Sir William Rous cancer unit, replacement of windows in Esher Wing, refurbishment of outpatients, theatres and ICU and dementia friendly improvements. Plans also include the refurbishment of the old nurses home to consolidate office accommodation, enabling the cessation of offsite leases and the sale of Regent Wing. The expansion of A&E and the creation of a future development site in the centre of the hospital campus, following the relocation of services from the command centre, will also provide flexibility for expansion as required. The strategy will be delivered over the five year period with the majority of plans delivered in years 1 and 2
• Developing an Electronic patient Record underpinned by further deployment of the CRS programme, involving the implementation of e-prescribing and clinical documentation. We will also implement device integration and increase electronic links with GPs

Strategic Objective 2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients
Key plans include:
• Embedding Service Line Management to strengthen the engagement of staff across the organisation. It is planned for 80% of service lines to be functioning autonomously by March 2015 and 100% by March 2016. This will be supported by our OD strategy and will incorporate a range of programmes including: the development of leaders within the service lines; business partnering to increase collaboration between the corporate and service line teams and; bespoke technical support for the service lines to support activities such as the further development of score cards and holding effective performance review meetings
• Developing and delivering training to support administrative staff to provide excellence in customer care, with improvements in FFT results and reduced complaints about staff attitude or behaviour
• Ensuring strong focus on recruitment and retention and reducing the need for agency staff by strengthening the bank and reducing turnover
• Developing new roles and ways of working reflecting the need to work across organisational boundaries as more work is shifted into the community. This will include the development of integrated generalist roles to provide care for the frail elderly and close working with local community providers to create opportunities for staff to work across the acute and community sectors

Strategic Objective 3: To work creatively with our partners (NHS, commercial and community) to consolidate and develop sustainable high quality care as part of a thriving health economy for the future
Key plans include:
• Working with partners in the local health economy to develop and implement the five year plan for South West London, including delivery of the LQS (as outlined at strategic objective 1), developing the preferred model for elective inpatient care and the delivery of BCF plans (as discussed below). Dialogue will continue with partners to explore any reconfiguration options which would support the delivery of the strategy.

• Working with commissioners and other providers to develop further and deliver the BCF plan. In year 1 this will include the development and piloting of plans for multi-provider teams working across organisational boundaries in Kingston to provide co-ordinated assessment and care to defined populations with the highest care needs. The results of the pilot will be evaluated in year 2 to inform the refinement of the plans
• Implementing the Trust's commercial strategy to support growth, including: ➢ Improvements to access and administrative processes to improve the GP and patient experience ➢ The further development of community outreach services ➢ Refreshing of the private patient strategy with BMI Healthcare ➢ Refreshing of the business case for the expansion of maternity services. Pending further work up and agreement this has not been included in our base case at this stage
• Partnership working with other others to deliver benefits to patients. This includes, for example, the implementation of the South West London Pathology Partnership in April 2014 with opportunities to increase pathology market share in years 3-5, and the development of a commercial pharmacy in year 1, with opportunities to increase profit share from retail sales in subsequent years.
• Developing and embedding the full involvement of the community in the running of the hospital through members events and engagement and through the delivery of the volunteering and fundraising strategies

Strategic Objective 4: To deliver sustainable, well managed, value for money services
Key plans include:
• Delivery of the Trust's financial plans, including delivery of the productivity programme that supports delivery of the long term financial plan. This involves developing individual plans at a Service Line level to increase efficiency and productivity. It will also include identifying and delivering corporate or cross-service line schemes. Key to delivery of the productivity programme will be robust and ongoing monitoring of individual schemes.
• Strengthening of information to support the effective and sustainable adoption of Service Line Management. This will include ongoing development and refinement of the balanced scorecards for each service line and fully developing recharging mechanisms for indirect costs and overheads.
• Ensuring corporate support of the highest quality to provide clinical areas and the Trust Board with adequate information to deliver and provide assurance on performance.

4.3 Delivering the productivity programme – key initiatives

4.3.1 Cost reduction initiatives

We have already begun the planning and implementation of a number of key initiatives designed to support the strategic objectives by reducing costs across the organisation. These projects are centrally managed, as they impact across a number of service lines and corporate areas. However local engagement and clinical ownership is key to ensuring the success and sustainability of these

key improvement projects, and clinical leads have been recruited for each to engage with colleagues and drive change from a grassroots level. The programme includes:

- **Increasing efficiency and profitability** – The introduction of service line reporting in year 1 is expected to provide a deeper understanding of which services across the Trust currently contribute a surplus to the Trust bottom line, and which make a loss. A formal programme of turnaround projects will then be implemented to maximise the efficiency of those services currently making a loss. Using the NHS Institute programme as a template, we are also seeking to maximise the productivity of our theatres. By improving scheduling and communications, and streamlining assessment, admission and discharge processes, less theatre time will be wasted in over-runs, under-runs and patients not attending.
- **Technology** – The increased use of electronic records continues to underpin our five year productivity programme. Although this is unlikely to generate cash releasing savings in years 1-2, it will release time for staff on the wards to care, thus improving the quality of services that are provided, as well as establishing a strong position to generate cash releasing savings in years 3-5 of the programme.
- **Workforce** – Skill mix reviews, incorporating benchmarking and establishment reviews, are ongoing in all service lines as local and national guidance and training changes and develops. Smoother administrative processes, quicker turnaround times and improved customer care skills will benefit patients who try to contact the hospital, as well as GPs who refer in. As outreach services grow, seamless administration between sites will also contribute to reduced costs. A major review of administrative services is led by the Deputy Chief Executive.
- **Non-pay** – There is an ongoing focus on procurement to generate efficiency savings. Participation in the London Procurement Partnership demand aggregation pilot programme will increase opportunity to release savings by generating economies of scale across multiple providers.
- **Partnership working** – We have a strong track record of working with partners to explore options for the provision of back office and clinical support services, which has directly led to the creation of South West London Pathology across three partner Trusts.

4.3.2 Growth

Some growth is expected to contribute to the 5 year CIP plans across the Trust. This will encompass both growth in patient care income as well as growth in other income received by the Trust. This will include:

- **Patient care income – tariff** – Some growth is assumed in planned income relating to tariff changes for groups of patients that we have been treating for some time for whom we have not been charging, or charging in full.
- **Patient care income –repatriation** – Significant work is underway to identify whether services that are currently sent out of the Trust could be provided in house more cheaply. Examples of this include services where the technology is elsewhere, services for where the expertise sits elsewhere or services that Kingston clinicians have historically provided elsewhere due to lack of space.
- **Patient care income – increasing market share** – Some growth is assumed in planned activity and income, both outpatient and admitted, due to market share increases. Commissioners have been engaged in the development of these schemes, such as the provision of ENT services with local provider Salentas in Surrey. Several of the schemes are

increasing capacity or adding specialties at established outreach sites, where we already have services that are very popular with local GPs.

- **Non patient care income – commercial partnerships** – Back office and clinical support functions are being reviewed to explore more efficient means of delivering the services without impacting the quality of clinical care delivered by the Trust. The South West London Pathology Partnership has formed a template for this work.
- **Non patient care income – private patients** – The Trust currently works in partnership with BMI to provide private patient services in the Coombe Wing. Plans are being developed in conjunction with the medical staff and BMI to grow this service over the next 5 years.

4.4 Demand forecasts

Table 3 below provides a breakdown of forecast activity in the base case for 2013/14 to 2018/19.

Table 3: Activity Forecasts 2013/14 – 2018/19

	2013/14	2014/15	+ / -	2015/16	+ / -	2016/17	+ / -	2017/18	+ / -	2018/19	+ / -
Daycase/ RDA	26,578	28,371	*7%*	29,716	*5%*	30,650	*3%*	31,351	*2%*	31,719	*1%*
Elective IP	4,682	5,010	*7%*	5,261	*5%*	5,495	*4%*	5,809	*6%*	6,022	*4%*
Elective total	31,260	33,381	*7%*	34,977	*5%*	36,145	*3%*	37,160	*3%*	37,741	*2%*
Emergency	44,589	44,808	*0%*	43,008	*-4%*	43,417	*1%*	42,943	*-1%*	42,797	*0%*
Inpatient total	75,849	78,189	*3%*	77,985	*0%*	79,562	*2%*	80,103	*1%*	80,538	*1%*
New OP	128,105	137,728	*8%*	144,503	*5%*	143,422	*-1%*	146,673	*2%*	147,297	*0%*
Follow-up OP	220,977	230,728	*4%*	240,361	*4%*	240,966	*0%*	245,201	*2%*	245,279	*0%*
Outpatient total	349,083	368,456	*6%*	384,864	*4%*	384,388	*0%*	391,874	*2%*	392,576	*0%*
A&E	112,083	114,512	*2%*	117,629	*3%*	113,565	*-3%*	109,491	*-4%*	108,990	*0%*

The above forecasts are driven by the following:

Growth

Over the next ten years the population is predicted to grow by 7% in South West London and 5% in East Elmbridge, with the greatest growth in the oldest age bands (70+). Benchmarking has shown that due to the long life expectancy and low rate of early deaths locally, the Trust has 50% more 80+ year old admissions than London or England averages, and twice as many 90+ year old admissions. As a consequence, there are around twice as many emergency admissions with dementia at the Trust when compared with the average for London or England hospitals. The growing population will lead to an increased demand for services overall, with the growth in older groups applying particular pressure on areas such as orthopaedics, urology, ophthalmology, and cancer specialties.

Growth rates of 2-3% p.a. have been provided by South West London commissioners and incorporated into our modelling, reflecting both demographic and non-demographic growth[2].

Commissioning assumptions

South West commissioners have provided demand management assumptions resulting from their commissioning intentions discussed at chapter 2 and these have been reflected in our modelling, with similar assumptions applied for Surrey Downs. These include:

- Reductions in emergency admissions due to BCF schemes (-£9.2m over five years)
- Reductions in A&E attendances due to alternatives in the community (-£1.0m over five years
- Reductions in elective admissions due to efficiencies (-£0.9m over 5 years)
- Reductions in outpatient activity due to shifts to primary and community settings (-£2.2m over 5 years)

It is assumed that in the event that a multi-specialist elective centre is created all participating trusts would retain ownership of their activity.

A moderate level of increased activity has been assumed as a consequence of acute provider reconfiguration in North West London, in line with forecasts provided by commissioners.

[2] Covering for example patient expectations, lifestyle changes, improved diagnosis and technological developments

5. Financial Plans

The five year financial model has been updated, incorporating the continued 4% efficiency target and the impact of the BCF planning, local activity changes, meeting the London Quality Standards and delivering the estate Strategy. It is assumed that in the event that a multi-specialist elective centre is created all participating trusts would retain ownership of their activity and that the impact on the bottom line would be at least cost neutral due to perceived efficiencies associated with this approach.

Further detail of the financial plan for the next five years is set out below.

5.1 Income and expenditure projections

5.1.1 Overview

The projected overall performance is to deliver an annual recurring normalised surplus of at least 0.7% of turnover in each of the five years. The level of planned surplus in 2014/15 is broadly similar to the level in previous years. The level of surplus reduces in 2015/16 as a result of i) the additional challenges posed by the BCF, ii) the re-procurement of CRS, which requires revenue funding and iii) the start of the additional interest charges from the loan to support the estates strategy. The Trust's plans for 2016/17 are to increase the surplus back up to 0.9%.

We believe that these levels of surplus are reasonable, realistic and achievable given the current level of real-terms savings that the NHS is tasked with delivering as a whole. Table 4 below summarises the forecast income and expenditure of the Trust over the five years to March 2016 in the base case planning assumptions.

Table 4: Income and Expenditure 2014/15 – 2018/19

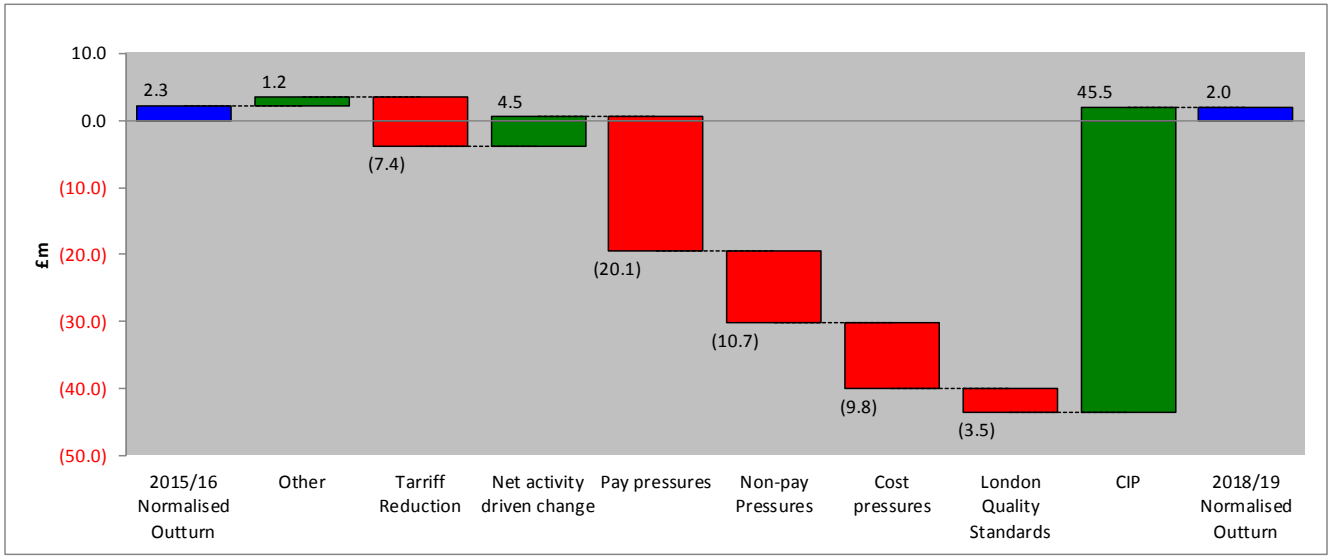
Income and Expenditure £m	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
NHS clinical income	188.7	188.3	193.1	196.2	198.6
Other operating income	26.1	27.0	28.0	29.1	30.1
Non-recurrent income	1.0	0.9	0.7	0.4	0.0
Total Income	215.8	216.1	221.9	225.6	228.7
Pay	(135.4)	(136.3)	(141.3)	(144.2)	(147.0)
Non-pay	(63.9)	(63.2)	(63.2)	(63.9)	(64.3)
Non-recurrent costs					
Total Operating Expenses	(199.3)	(199.4)	(204.4)	(208.1)	(211.3)
EBITDA	16.5	16.7	17.4	17.5	17.5
EBITDA margin (%)	*7.6%*	*7.7%*	*7.9%*	*7.8%*	*7.6%*
Depreciation and amortisation	(7.4)	(8.0)	(8.4)	(8.6)	(8.8)
PDC dividend / interest	(5.9)	(6.2)	(6.5)	(6.6)	(6.7)
Non-Operating expenses, Total	(13.3)	(14.3)	(14.8)	(15.2)	(15.5)
Surplus	3.2	2.4	2.6	2.4	2.0
Surplus margin (%)	*1.5%*	*1.1%*	*1.2%*	*1.1%*	*0.9%*
Normalised EBITDA	15.5	15.8	16.7	17.1	17.5
Normalised EBITDA margin (%)	7.2%	7.3%	7.5%	7.6%	7.6%
Normalised surplus	2.2	1.5	1.9	2.0	2.0
Normalised surplus margin (%)	1.0%	0.7%	0.9%	0.9%	0.9%

The underlying position after excluding non-recurrent income and expenditure is one of profitable performance as shown by the normalised surplus position. The normalising adjustment relates to the planned £3m charitable income to support capital spend as part of the estates strategy as outlined in section 5.2.

5.1.2 Income & Expenditure Bridges

A bridge chart is shown for the first two years of the plan and the subsequent three years at figure 2 below.

Figure 2: Bridge 2013/14 – 2018/19



Further detail of the factors driving the movement in the normalised surplus is provided at table 5

Table 5: Factors driving movement in normalised surplus 2013/14 – 2018/19

Category	Narrative
Tariff Effects	This is based on the Monitor tariff assumptions and equates to a c1.4% tariff deflator in year one, 1.6% in year two (and yr3 +0.4%, yr3 -0.6%, y4-0.7%)
Activity Driven Changes (net of costs)	The Trust has aligned activity assumptions with the SWL Commissioning Collaborative. Plans are for a net £2.3m growth in 2014/15 and no net growth in 2015/16 (due to the effects of the BCF). Thereafter an average QIPP of c1.8m and growth of c£3.9m has been assumed in each year.
Pay Pressures	It is assumed that pay inflation is only for those who do not receive increments. Plans reflect the impact of incremental drift at c0.75%. Pay increases are set at 2% with an additional pressure in 2016/17 arising from reforms to the pension.
London Quality Standards	The Trust is providing for investment in services to meet the London Quality Standards with all paediatric and maternity standards except 168hrs and paediatric A&E met by the end of 2015/16.
Non-Pay Pressures	Inflation increases of c2.2% are assumed except for drugs (where 4.5% is assumed to account for price increases and new drugs approved), 2.5% for PFI and 3% for Clinical Negligence Scheme for Trusts (CNST). For the outer three years inflation increases of c5% have been assumed except for drugs (where 5% is assumed to account for price increases and any new drugs approved), 2.4% for PFI inflation and 2.8% for CNST costs.
Cost Pressures	Additional cost pressures have been allowed due to the Keogh and FFT costs. There is also an assumption of pressures included for the start-up costs of CIP schemes
Cost Improvement Plans	CIP has been set at c5% of Operating costs

5.1.3 Efficiency Requirements

Five year plans have been set to meet the efficiency requirements put forward by Monitor. In 2014/15 the inflationary pressure on pay was decreased following release of the pay awards for NHS staff. All other years' efficiency is set at 4.0 - 4.5% as per the guidance.

5.1.4 Cost Improvement and Revenue Generation Schemes

We have a combination of cost improvement and revenue generation schemes each year. For the first three years schemes are set at 5% of plan due to additional pressures in these years for the BCF and LQS. The level of CIPs then decreases to approximately 4% linking with the efficiency guidance. Further detail is provided below:

Table 6: Cost improvement and revenue generation schemes

Category (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Patient Care Income Generation	3.2	1.7	1.7	0.7	0.6
Non Patient Care Income Generation	1.5	0.9	0.8	0.8	0.8
Cost Reduction - Pay	2.0	3.6	3.4	3.2	3.0
Cost Reduction - Non pay	2.9	4.0	4.1	3.2	3.3
Total	**9.7**	**10.2**	**10.0**	**7.9**	**7.8**

5.1.5 Income

Table 7 shows the income impacts anticipated for the period 2013/14 to 2018/19 expressed as incremental changes against the previous year's outturn.

Table 7: Incremental changes in income against previous year's outturn

Income Category (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
SLA Income (see table below)	4.1	(0.4)	4.8	3.1	2.4
Non SLA Income Generation Schemes	1.5	0.9	0.8	0.8	0.8
Other Income	(0.3)	0.2	0.3	0.2	0.2
Non-recurring income	(0.1)	(0.1)	(0.2)	(0.3)	(0.4)
Education funding	(0.1)	(0.2)	0.0	0.0	0.0
Changes to Total Income	5.2	0.3	5.7	3.8	3.1

SLA Income

Table 8 below breaks the SLA income changes noted above into the major constituent parts (expressed as incremental changes against the previous year's outturn).

Table 8: SLA income changes

Category (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
QIPP - demand management	(2.3)	(4.8)	(1.7)	(1.6)	(2.1)
Activity growth	4.6	4.8	3.3	3.6	4.7
Transfers from NWL				0.9	0.6
Activity SDPs	0.9	0.5			
Other income generation	3.2	1.7	1.7	0.7	0.0

Other	0.2	0.4	0.8	0.6	0.6
Total activity driven changes	6.7	2.6	4.1	4.2	3.8
Tariff effects	(2.6)	(3.0)	0.8	(1.2)	(1.4)
Changes to SLA Income	**4.1**	**(0.4)**	**4.8**	**3.1**	**2.4**

The activity changes above reflect the scale of the current South West London Commissioning Collaborative plans for the sector. The net QIPP effect is higher in 2015/16 due to the impact of BCF plans which are emergent at this stage. In addition, an assumption has been made that we could successfully bid to re-provide a proportion of the services that the CCGs are looking to shift into the community. This is in line with discussions with commissioners. From 2016/17 commissioner QIPP remains at broadly 1% with growth increasing from 1.7% to 2.4% of income. We are planning for additional income transfers from North West London in 2017/18 and 2018/19 following the reorganisation of services in that sector. This is in line with commissioning assumptions.

Broadly speaking, across the five year period, the effect of the activity decommissioning and tariff reduction is offset by the Trust re-providing an element of this activity and also by the impact of activity growth.

Other Income

This is the increase in contribution from the contract with BMI for private patient activity. There are also revenue generating schemes as discussed earlier. We expect to incur capital spend funded by charitable funds, as part of the estate strategy. The income for this is shown as non-recurrent income over the first four years.

Education Funding

For 2014/15 and 2015/16 a 2.5% loss of education income is forecast in line with the anticipated reduction in the national MPET allocation. From 2016/17 no reduction or increase in income is assumed.

5.1.6 Costs

Overview

The impact on costs is driven by both the changes to activity and also the specific cost pressures set out in the planning assumptions. Costs increase by a net £16m over the five years. The cost of additional activity and the cost of service developments are £6.7m over the two years, reflecting the Trust's strategy of aligning QIPP reductions with community outreach and other re-provision schemes. The Trust plans to meet the London Quality Standards by the end of 2017/18 with the majority of standards met by the end of 2016/17 and £3.5m of investment is planned over the five years to meet these targets. Costs also increase due to anticipated cost pressures and anticipated inflation movements and these are partially offset by CIPs.

Table 9 below shows the impact on costs anticipated for the period 2014/15 to 2018/19 (expressed as changes against the previous year's outturn levels).

Table 9: Impact on costs 2014/15 – 2018/19

Category (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Consequence of activity changes (see table below)	(1.4)	(0.5)	(1.0)	(1.6)	(1.5)
Service Developments	(0.7)	0.0	0.0	0.0	0.0
Cost Improvement Plans	4.9	7.6	7.5	6.4	6.3

Pay Inflation	(0.7)	(2.0)	(4.5)	(2.8)	(2.9)
Pay impact of increments	(1.0)	(1.5)	(1.2)	(1.2)	(1.3)
Discretionary points	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Non-pay inflation	(0.6)	(0.8)	(1.5)	(1.3)	(1.1)
Drug inflation	(0.6)	(0.6)	(0.7)	(0.7)	(0.7)
PFI cost inflation	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)
CNST inflation	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)
Quality Standards	(0.4)	(0.4)	(1.6)	(0.7)	(0.5)
Other costs	(3.1)	(1.0)	(0.9)	(0.5)	(0.5)
CRS		(0.9)	(1.1)	0.0	0.0
Movement in contingency		0.7	0.5	(0.5)	(0.5)
Total	**(4.0)**	**(0.1)**	**(5.0)**	**(3.7)**	**(3.2)**

Consequence of Activity Changes

Table 10 below shows the impact on costs of the anticipated income changes shown at table 10 below:

Table 10: Impact of activity changes on costs 2014/15 – 2018/19

Category (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Activity QIPP	0.9	1.9	0.7	0.6	0.8
Growth	(2.3)	(2.4)	(1.7)	(1.8)	(2.4)
Activity other	0.0	0.0	0.0	(0.5)	0.0
Total	**(1.4)**	**(0.5)**	**(1.0)**	**(1.6)**	**(1.5)**

Overall we expect to incur increased costs. We are planning for 50% cost increase from growth with a 40% decrease for QIPP after re-provision. Additional activity refers to transfers from North West London due to their reconfiguration. The effect on Whole Time Equivalents (WTEs) of these changes is brought together with the productivity savings described at chapter 4.

Cost Improvement Plans

CIPs of £45.5m are required across the five years. Details of plans were provided at chapter 4, which split to £32.7m for cost reduction schemes and £12.8m for income generating schemes, of which £7.9m are patient care income.

Pay Inflation

Pay inflation allows for reduced NHS pay increases for the 2 years to 31st March 2016. Pay increases in respect of incremental drift have been allowed for. Pressures due to changes in the pension schemes for staff are also included.

Non-Pay Inflation

Non-Pay Inflation is assumed at c2% for the first two years and c4% the later three, apart from drugs where inflation is assumed as c5% for all years. Inflation on the Private Finance Initiative (PFI) schemes (which are linked to retail price index RPI) is taken as c2.5%.

Other costs

In 2014/15 £4.1m of cost pressures are assumed in the position. This is due to additional costs to be incurred due to actions from the Keogh report and the FFT costs. Other costs also include a recurring provision of £0.5m covering other pressures in all years.

Quality Standards
We plan to meet the LQS by the end of 2017/18 with the majority of standards met by the end of 2016/17. £3.5m of investment is planned over the five years to meet these targets.

CRS costs
We have implemented CRS as part of a national initiative promoted by the Department of Health to 28tilize28ize care records. The rollout nationally is nearing completion and individual Trusts will be required to contribute towards the on-going costs. Costs are assumed to be incurred as a part year effect in 2015/16 (£0.9m) and a full year effect thereafter of £2.0m per annum.

Non EBITDA costs
Capital costs are assumed to increase by 2%. Costs also increase due to the additional interest from the £10m loan anticipated to support the estates strategy and the associated depreciation costs on the assets.

5.2 Capital plans

There are two elements to the Trust's capital plan. The first is basic capital expenditure and we are planning to maintain our basic capital programme at a level broadly equivalent to retained depreciation. The second is the estates strategy recently approved by the Trust Board that will cost £15.5m over a 5 year period. The strategy is mostly refurbishment with a limited amount of new-build. It is the intention to fund this partially through a loan from the FTFF of £10m, Trust own funds of £2.5m and charitable sources of £3m. These plans will be supported by the sale of Regent Wing. We have had initial discussions with the FTFF and submitted the final business case in May 2014. Further details of the capital expenditure plan are shown below:

Table 11: Capital expenditure 2014/15 – 2018/19

Capital Investment Programme (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Basic Capital Programme					
Medical equipment	1.0	1.1	1.2	1.2	1.2
IT assets	3.2	3.7	2.6	3.5	3.5
Estates maintenance	3.0	2.7	3.7	2.8	2.8
Total Basic Expenditure	7.2	7.5	7.4	7.5	7.5
Estates Strategy	**5.6**	**8.2**	**1.1**	**0.8**	**0.0**
Total Capital Expenditure	**12.8**	**15.6**	**8.5**	**8.3**	**7.5**

5.3 Balance sheet projections

The projected balance sheets shown below reflect the outcomes of the assumptions, productivity plans and overall asset management of the Trust over the period to 31 March 2019.

Table 12: Balance sheet 2014/15 – 2018/19

Balance Sheet (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Fixed Assets	132.2	142.6	145.6	148.2	149.9
Inventories	1.1	1.1	1.1	1.1	1.1
Receivables and prepayments	10.1	10.1	10.1	10.1	10.1
Cash and cash equivalents	9.1	8.0	8.9	10.1	11.8
Total current assets	**20.3**	**19.3**	**20.2**	**21.3**	**23.1**
Total Assets	152.6	161.9	165.8	169.6	173.0
Payables and accruals, current	(19.8)	(19.8)	(19.8)	(19.8)	(19.8)

Total current liabilities	(21.3)	(21.3)	(21.3)	(21.4)	(21.4)
Net current assets / (liabilities)	(1.0)	(2.0)	(1.1)	(0.0)	1.7
Non-current liabilities	(31.4)	(35.5)	(33.9)	(32.4)	(30.8)
Total Assets Employed	**99.9**	**105.1**	**110.5**	**115.8**	**120.7**
Public dividend capital	58.1	58.1	58.1	58.1	58.1
Retained earnings (accumulated losses)	22.6	25.0	27.6	30.0	32.0
Revaluation and other reserves	19.2	22.0	24.8	27.8	30.7
Total Taxpayers' Equity	**99.9**	**105.1**	**110.5**	**115.8**	**120.7**

The fixed asset net book value is forecast to increase over the planned period principally as a result of the proposed impact of the estates strategy along with a slight impact of asset inflation. We plan to 29tilize surpluses to support i) the re-payment of principle on the PFIs, ii) direct support to the estates strategy, iii) the re-payment of principle on the loan to support the estate strategy and iv) to improve the working capital position. Thus, net current assets are stable in 2014/15 and fall back slightly in 2015/16. The fall in 2015/16 is principally as a result of the lower level of surplus in that year. As surpluses increase in the later three years the net current assets moves to positive in year 5.

Non-current liabilities reflect indebtedness in relation to long-term PFI schemes and other loans. All debts are fully serviced and the balances above include the repayment of principle. The £10m loan to support the estate strategy will be drawn down over 18 months with the Trust receiving cash of £3.5m in 2014/15 and £6.5m in 2015/16. The loan is due to be repaid over 20 years from the date of first draw down with the first payment in 2015/16 for £0.6m. The surpluses generated over the five years are reflected in the planned £9.4m rise in retained earnings, whilst the (mainly) asset price inflation pushes up revaluation reserves by £11.5m.

5.4 Liquidity

From the trading, operational performance management and investing activities set out in this plan, the Trust will generate broadly neutral cash flows in the first two years. We will be investing less in maintenance capital than depreciation and surpluses above debt service cover in the later 3 years which is reflected in the growing cash balance. Further detail is shown in table 13 below.

Table 13: Cash flows 2014/15 – 2018/19

Cash Flow (£m)	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
EBITDA	16.5	16.7	17.4	17.5	17.5
Less Charitable funding	(1.0)	(0.9)	(0.7)	(0.4)	0.0
Movement in working capital – net increase (decrease)	0.8	(0.9)	0.0	0.0	0.0
Capital expenditure	(11.8)	(14.7)	(7.8)	(7.9)	(7.5)
Loan funding	3.5	6.6	0.0	0.0	0.0
Cash flow from financing activities (Ex. PDC & PFI capital)	(3.3)	(3.7)	(3.7)	(3.7)	(3.7)
PDC dividend payment	(2.6)	(2.5)	(2.8)	(2.9)	(3.0)
Capital element of PFI / Finance leases	(1.0)	(1.6)	(1.6)	(1.5)	(1.5)
Net cash inflow/(outflow)	**1.1**	**(1.1)**	**0.9**	**1.2**	**1.8**

5.5 Risk ratings

Under the plans set out above the Trust achieves a Continuity of Services Rating (COSR) of at least 3 in each year of the plan.

Table 14: Risk ratings 2014/15 – 2018/19

Metric	Plan 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Debt service cover	*3*	*3*	*3*	*3*	*3*
liquidity	*3*	*3*	*3*	*3*	*4*
COSR Weighted Average	**3.0**	**3.0**	**3.0**	**3.0**	**3.5**
Overall Rating	**3**	**3**	**3**	**3**	**4**

6. Glossary of Terms

A&E – Accident and Emergency
BCF – Better Care Fund
BMI – Private Healthcare subsidiary of the General Health Group
BSBV – Better Services, Better Value
CAGR – Compared Annual Growth Rate
CCG – Clinical Commissioning Group
CHKS – Caspe Healthcare Knowledge
CIP – Cost Improvement Programme
CNST – Clinical Negligence Scheme for Trust's
CQC – Care Quality Commission
COSR – Continuity of Services Rating
CRS – Care Records System
DGH – District General Hospital
DNAs – Did Not Attends
EBITDA – Earnings before interest, tax depreciation and amortization
EDICS – Epsom and Dorking Independent Care Services
FFT- Friends & Family Test
FTFF – Foundation Trust Financing Facility
ICU – Intensive Care Unit
KPIs – Key Performance Indicators
LoS – Length of Stay
LQS – London Quality Standards
MSEC – Multi-Specialty Elective Centre
PAU – Paediatric Assessment Unit
PFI – Private Finance Initiative
PMO – Project Management Office
QEIA – Quality and Equality Impact Assessments
QIPP – Quality, Innovation, Productivity & Prevention
RPI – Retail Price Index
SLA – Service Level Agreement

SWLP – South West London Pathology
SLM – Service Line Management
TPOT – The Productive Operating Theatre
UCC – Urgent Care Centre
WTE – Whole Time Equivalent