Monitor Independent Regulator of NHS Foundation Trusts

Forward Plan Strategy Document for

King's College Hospital NHS Foundation Trust

Plan for y/e 31 March 2012 (and 2013, 2014)

Section 1 - Strategy

The Trust's current position and vision are summarised as:

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

We are founder members of **King's Health Partners** (KHP) Academic Health Sciences Centre (AHSC), one of five accredited AHSCs in the UK, bringing together significant clinical and academic expertise spanning both physical and mental health. KHP seeks to drive the integration of research and education with clinical care, for the benefits of patients. Its mission also encompasses a focus on all aspects of patient care (physical and mental health and wellbeing), and on working with stakeholders to radically redesign patient pathways and improve public health, with more care delivered out of hospital.

King's Vision

Everything King's does is focused on patient need. Our patients will experience the highest quality of care in our local services and our global specialties. With King's Health Partners and other local healthcare providers, we will lead an integrated and well-managed healthcare system, which meets the diverse needs of the many local communities we serve.

Key achievements in 2010/11:

- Delivered strong operational and financial performance - met all access targets and achieved a challenging cost improvement programme
- Secured ARMS level 3 and Investors in People Gold Standard
- Fully established the Major Trauma Centre and Hyper Acute Stroke services
- Appointed leaders to all 21 KHP Clinical Academic Groups
- Secured agreement to consolidate BMT and vascular surgery across King's Health Partners
- Made significant progress on mixed sex accommodation and quality of food (patient survey)

Key challenges going forward:

- Finances: Significant financial pressures over the next 3 years will require further operational efficiencies, and potentially significant changes in models of service delivery
- Infection control: Despite better performance in 2010/11 against C-diff and VTE, KCH did not meet MRSA target. Proposed targets for 2011/12 are very challenging.
- Capacity: Continues to be challenging with the potential to create financial pressures (for example, by constraining elective care) and difficulties in ensuring consistent high quality care (with the potential to impact on A&E performance).
- Substantial demands on the Trust's capital programme with multiple schemes to address capacity constraints, support key service developments, and improve patient experience
- KHP development: maximising the benefits of the AHSC and delivering efficiencies through joint working

The Trust's strategy over the next three years is to:

With major structural changes in the NHS, and significant pressure on public finances, King's needs a robust strategy to deliver high quality care to its patients, now and in the future. We are focusing on three key objectives:

1. **Quality improvement** – safe, kind and effective care
2. **Financial sustainability and efficiency** – a more efficient and consistent hospital
3. **Leading change across the system** – working as King's Health Partners and with others to improve services for our local community and beyond

Quality improvement

Our first priority is to improve patient care, ensuring that patients are safe at all times. We are taking a zero tolerance approach to infection control, supporting front-line teams, but also holding them to account. Medication safety will be enhanced by the roll-out of e-prescribing. We will drive up clinical effectiveness in all services, focusing initially on Diabetes and End of Life care. Patient experience will be made more consistent, through helping ward staff to listen and respond appropriately to patients' needs and concerns. We will continue to drive improvements in cleanliness and the quality of food.

As part of King's Health Partners, we will ensure academic expertise translates into better patient care. The opening of a Clinical Research Facility at Denmark Hill will support clinical research, and as a teaching hospital we continue to train clinical professionals for KHP and the wider NHS.

Financial sustainability and efficiency

2011/12 will be even more challenging than 10/11. We will maintain existing cost controls (e.g. agency staffing), and continue to improve productivity in specific areas, i.e. theatres and outpatients, supported by better job planning arrangements (e-job planning and e-rostering). Transformation projects, such as the "safer, faster hospital", will be focused on productivity improvements, and we will make better use of hospital estate. To underpin quality and efficiency we are building on our electronic patient records to move towards a paperless hospital (e-prescribing, check-in kiosks in outpatients, emailing GPs, and texting patients).

We will increase income generated from non-NHS sources, and make savings by integrated working across King's Health Partners. Together with more efficiency measures this will enable investment in our capital priorities (Emergency Department, Maternity & Critical Care).

Leading change across the system

Together with Guy's and St. Thomas', South London and Maudsley, and King's College London, we are increasingly taking a leadership role in the wider health system. This means working better for the community, with primary, community and social care. The Integrated Care Pilot will lead to more joined up services across Lambeth and Southwark, transforming how we care for older people, and those with long term conditions.

Across KHP we are bringing together services and academic activities where this raises quality, e.g. elective vascular surgery and bone marrow transplant. We will better address patients' mental and physical care needs, e.g. piloting assessments for depression and anxiety in outpatient clinics. We will play a strong leadership role in clinical networks, developing the trauma and stroke networks, and shaping the new integrated cancer systems and tertiary paediatric networks.

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
1. Quality Improvement a) To improve <u>patient safety</u> in 3 key areas: Infection control, VTE, Medication safety	• Ensures patients are safe at all times at King's, supporting quality of care	• Delivery of action plans for meeting MRSA and C- Difficile infection reductions • Over 90% compliance with VTE risk assessment	• Electronic prescribing rolled out in all clinical areas	• To further reduce infection rates ensuring all national targets are met
b) To enhance <u>clinical effectiveness</u> in the priority areas of: End of life care & Diabetes	• Ensure appropriate outcomes in two areas of care that affect a high number of KCH patients:	• Increase the number of patients on Liverpool care pathway • Pilot & evaluate impact the 'Amber care bundle' across 3 wards, (set of key questions to support best practice in end of life care) across 4 wards • Working group established to improve insulin safety • Pilot specialist Diabetes Liaison	• Increase further the number of patients on the Liverpool care pathway • Further roll out of the 'Amber care' bundle or equivalent and increased use end of life care electronic register • Roll out the early identification of diabetic patients ensuring they receive appropriate	• Embed the use of the Liverpool care pathway, the Amber care bundle (or equivalent) and the end of life care electronic register • Demonstrable improvements in the care delivered to the approx. 20% of our patients who

		Nurse to identify high risk patients earlier to ensure effective care and treatment • Identify the proportion of diabetic patients currently receiving specialist diabetic care and set challenging targets for improvement	specialist care • Review progress against targets for the proportion of diabetic patients receiving specialist care	are diabetic
c) To ensure consistency of <u>patient experience</u> at KCH, and improve cleanliness	• Ensure all patients have a good experience of care at King's, and are treated in a clean environment	• Achievement of CQUINs for "responsiveness to patients' needs" • Be in top 20% of London acute hospitals in patient survey • Implementation of 'Ward 2020' across 5 wards to improve patient experience and safety, ward efficiency and staff satisfaction	• Be in top 10% of London acute hospitals in patient survey • Further roll out of Ward 2020	• Achieve 'How are we doing' patient survey benchmarks • Embed Ward 2020 practice and learning
d) To ensure the active contribution of our workforce to the delivery of high quality care	• Ensure all staff contribute to improving the quality of patient care	• Increase by 20% our compliance with statutory and mandatory training	• Increase by 40% our compliance with statutory and mandatory training	• Increase by 60% our compliance with statutory and mandatory training
e) To ensure research and education activities directly support improvements in quality of care	• Ensure patient care is informed by research findings, and delivered by knowledgeable staff	• Clinical Research Facility fully operational • Simulation centre established to improve training for doctors and hence enhance quality	• PSSQ research centre renewed	• Significantly improve the proportion of research which is translational
2. Financial sustainability and efficiency a) Divisional and Corporate	• Locally managed cost reduction schemes to ensure efficiency and value for money	• Achievement of CIP targets	• Achievement of CIP targets	• Achievement of CIP targets

Schemes				
b) Trust-wide Schemes – procurement and pharmacy	• Cross-cutting initiatives to drive value for money	• Continuous review of all tenders • Active use of alternative and appropriate drugs • Identify KHP procurement opportunities	• Ongoing reviews of all tenders and consumables procurement	• Robust procurement processes delivering value for money
c) Productivity Improvements e.g. • Redesigning patient flows • Outpatients transformation •Medical productivity	• Ensure our clinical services and non-clinical activities are operating as efficiently as possible, within tariff to support critical investments	• Target top quartile ALOS across specialties • Increased theatre utilisation	• Further improvement in ALOS allowing activity increase in strategic areas • Increased medical productivity enabled by electronic job planning	• Ongoing review and analysis of efficiency across all hospital activities to identify further areas for productivity improvements.
d) Income Generation	• Increased income to allow investment in strategic priorities	• Clinical coding review to maximise accuracy and increase income • Initial increase in commercial income, strengthened team in place	• Further increase in commercial income & finalise plans for PP development	• Fully established commercial directorate • Increased PP income streams
e) Estate rationalisation	• Ensure we optimise the use of our estate	• Services moved from Dulwich hospital and Jennie Lee House	• Sale of JLH • FYE rental savings	• Review the utilisation of our estate to ensure optimal use
f) Workforce rationalisation	• Ensure we have the right number of staff, at the right grade, who are working as productively as possible	• Divisional workforce plans in place • Medical electronic job planning system implemented • Systems in place for effective deployment of staff and resources	• E-rostering rolled out to all staff groups • Data available from which to drive improved staff productivity	• Securing the full benefits the E-rostering roll out
3. Leading	• Ensures our	• Integrated Care	• Expansion of	• Integrated care

change across the system a) leading the development of integrated care <u>locally</u>	care is responsive to the changing needs of our local populations • Ensures healthcare provision (by KCH, and across clinical networks) is "fit for the future" • More efficient provision of care	Pilot progressed (supported by NHS London and GST Charity) including the implementation of new service model for frail elderly patients • "Virtual hospital" programme, with GST and community services • Jointly agree, with primary care, model for Urgent Care	Integrated Care Pilot to include new service models for patients with long term conditions e.g. COPD and serious mental illnesses • Roll out of mental health screening in other chronic disease clinical areas	pilot fully functioning and delivering anticipated benefits • Urgent care centre operating effectively
b) leading <u>regional and national</u> networks of care	• Provide clinical leadership in specialist services, across networks of healthcare providers – ensuring high quality patient care for our wider patient populations	• Implement centralisation of vascular surgery at St. Thomas' Hospital • Finalise the consolidation of BMT at KHP • Centralise all HASU beds at KCH	• Implement next wave of service reconfiguration, e.g. cancer surgery, cardiac services • Further development of Major Trauma Centre, including designation for paediatric trauma • Established Integrated Cancer System, with KHP's leadership role	• Robust network arrangements across South London for all KHP's major specialities
c) ensuring robust <u>governance</u> across our healthcare systems (KCH and KHP)	• Ensure that governance of all healthcare provision is robust, both through strong management skills, and through appropriate involvement of our governors, members and local community representatives	• Implementation of new Board governance framework • Achieve designation, as KHP and with Partners, as an integrated cancer system • As KHP, be lead provider for tertiary paediatrics in South London • Election of new KCH governors and their	• Consolidating reporting structures into the new governance framework • Build on our approach to community engagement in the development of the trusts quality accounts for 2012/13 and onwards	• KHP reaccreditation as an AHSC

		induction and development • The engagement of governors and members in key relevant projects • KHP partners agree governance arrangements for Clinical Academic Groups (CAGs)		

Section 2: External Environment.

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
1. Continued downwards pressure on NHS funding, due to national economic position and pressures on public finance	• Overall tariff reductions result in income reduction, whilst some costs continue to rise. • Trust income falls below levels predicted within the forecasts	• Mitigation – • Optimising clinical coding to ensure all income captured for clinical activity • Savings plans reviewed by E&Y and managed via Programme office • Transformation programme to drive efficiencies • Joint savings with KHP • Strengthened commercial team to increase non-clinical income • Residual risk – included in downside scenario planning	• Trust remains financially viable, but with reduced margin	• Monthly financial position, revised financial forecasts • Accountable lead: Chief Financial Officer / Director of Operations
2. Changes to national Operating Framework and tariff structure, including: • Further development of CQUINS (funding linked to quality and patient experience) • National Operating Framework targets (e.g. cancer waits, emergency re-admissions)	• Reduced income / financial penalties if quality targets not met • Emergency baseline at 08/09 level, with activity continuing to rise	• Working with PCTs to manage emergency pathways • Audit of re-admissions • CQUINS targets locally agreed (within KCH's control) and action plans set with PCTs • Quality has high profile reflected in performance management scorecards • Minimal risk remaining	• Maintain income levels	• Monitored via internal performance management systems and regular contract monitoring meetings with PCT • Accountable lead: Director of Operations / Director of Nursing

3. Commissioner-led reviews of specialist services including NHS London (cancer, cardiovascular) and national commissioning (specialist paediatrics)	• Risk of KCH / KHP not being designated, or not having certain specialist services commissioned any more	• Joint work with GSTT on integrated services provision greatly strengthens both parties (e.g. potential to create largest vascular & BMT centres in London) • Working with other key partners across the sector and South London to secure KCH and KHP's leadership role	• Working together, the full range of specialist services should be commissioned from KHP. • Site reconfiguration programme underway, with immediate priorities including cancer rationalisation and option appraisal for cardiovascular	• Business cases agreed and fully consulted upon • Accountable lead: Director of Strategy
4. Local commissioning arrangements via QIPP	• Reductions in activity levels commissioned & associated income (e.g. OP attends)	• Introduction of Referral Management System (Lambeth / Southwark / GST / KCH) • OP redesign project (transformation programme)	• Trust remains financially viable	• Contract monitoring • Accountable lead: Director of Operations / Director of Strategy
5. Ability to control clinical demand, with instability in other local healthcare providers	• Rising emergency activity impacts on elective activity plan & ability to admit specialist transfers • Repatriation problems • Impact on KCH A&E performance	• A&E re-development and work on redesign of emergency pathway • Emergency Care Board established • Referral Management System launched • KCH engaged in collaborative discussions with other SEL providers	• Continue to meet A&E target overall • Limited disruption to elective work	• Trust performance management systems • Accountable lead: Director of Operations
6. Impact of changes in competition in the NHS	• Any willing provider activity could mean loss of work for King's, or pressure to	• Strategic planning to determine areas where KCH is strong and should be	• KCH retains an appropriate balance of secondary and tertiary activity of sufficient	• Accountable lead: Director of Strategy

	reduce prices (reducing margin) • Acquisition of additional activity may be challenged	competing for activity and areas where work could be lost to other providers • Continued drive for efficiency to ensure KCH service competitive	levels to remain viable	
7. Changes in education and R&D funding	• Competition for funding for PSSQ research centre, and KHP BRCs • Potential reduction in other R&D funding streams (e.g. NIHR F&S) • Reduction in education funding received via NHS London	• Develop strong applications for R&D funding • Work with NHSL to ensure impact of education funding reduction fully understood	• Some reduction to funding streams anticipated	• Accountable lead: Medical Director

Section 3: Trust Plans.

Financial plans: income

The PCT contract income is based on 2010/11 outturn activity levels (using month 8 activity data) and adjusted for tariff changes, PCT QIPP targets and emergency re-admissions. The tariff reduction of 1.5% has been offset by favourable tariff improvements to the neurosciences tariff and an increased local tariff price for critical care activity.

The PCT QIPP reflects significant income reductions totalling approx. £5.8m of which reductions to new outpatient referrals and outpatient follow ups comprise a projected loss of income of £3.4m.

The £2.6m Trauma funding is included for 11/12 and this funding stream should be maintained through the implementation of trauma tariffs in future years.

The Project Diamond funding of £2.7m has been excluded from the income plan in 2011/12 although future work with NHSL and the Department of Health continues to ensure the tariffs reflect the resources used to deliver services.

The CQUIN 1.5% funding top up on contracts to meet patient quality targets and to improve patient experience has been included at 100%. Realistic and challenging targets have been agreed with the PCTs and plans are in place to achieve the key targets.

The transfer of BMT and elective vascular surgery services between KCH and GSTT have been built into the NHS income streams.

The training and education funding regime is under review and a prudent view of this income flow has been incorporated into the income plan for 2012/13 and 2013/14.

Additional Private Patient and Commercial income streams have been built into the financial plan. The Private Patient income should increase following the upgrade of facilities in 2011/12. This will enable the Trust to attract additional work and charge appropriate prices in line with competitors.

Key income risk	Amounts and timing 2011/12 2012/13 2013/14	Mitigating actions and delivery risk
Additional activity for bed and theatre efficiency workstreams	**£10m 2011/12**	**Phasing of workstreams to deliver additional capacity.** **Additional elective work and financial impact on local PCTs.** **Repatriation of patients to local Acute Hospitals and Social Services capacity in Local Authorities**

Trauma funding streams	**£2.6m pa in 2012/13 & 2013/14**	**Introduction of new tariffs – work with DoH PbR team to mitigate risk.**
PCT QIPP/ Decommissioning of Acute Care by PCTs to a community setting	**£5.8m in 2011/12.** **An additional £2m pa in 2012/13 & 2013/14**	**Achieving marginal cost savings or utilising the resource to generate additional income.**
Implementation of Urgent Care Centre by Southwark PCT	**£5-£10m in 2012/13 & 2013/14**	**The UCC model is currently being worked through with PCTs and KHPs. The income loss would be in respect to the patients being treated by GPs (40 to 60%). The income loss would be mitigated by the new HRGs for emergency work which will reflect the resources utilised to treat a more complex patient workload. There would also be an income stream for providing the UCC facility within KCH Emergency Dept.**
Private sector Competition under regulated market competition	**£500k in 2013/14**	**Dependent on new NHS regulations. Difficult to assess impact financially and timing. Ensure high quality care and tertiary work increase in the specialist areas such as BMT, Neurosciences, Liver, Renal and Trauma.**
Provider to Provider income streams	**£500k in 2012/13 & £ 750k in 2013/14**	**P2P work continues through Pathology JV income contract. Commercial viability and income risk to KCH.**
Commercial Income streams	**£1m in 2012/13 & £3m in 2013/14**	**Award of overseas contract work and implementation of commercial projects**
Commercial Research and Development	**£1.5m in 2012/13 & £1.5m in 2013/14**	**Additional income risk. KCH investment in R&D clinical staff and JCTO to provide capacity and support contract negotiations.**

Private Patient Income	**£1.5m in 2012/13 & £1.5m in 2013/14**	**Refurbishment of Guthrie Private Patient Wing**

Financial plans: Service developments

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Organic / innovation:				
Redevelopment of maternity facilities to address capacity issues, improve patient experience / provide choice of birth setting	Enables improved quality of care & patient choice	Pressure on capital plan, over-run of building programme	See capital plan	Completion of capital works 12/13 maternity
Expansion of critical care facilities	Supports tertiary services and major trauma centre	Pressure on capital plan, over-run of building programme	See capital plan	13/14 critical care words completed
Bone marrow transplantation for KHP consolidated at KCH	Supports high quality clinical service and academic development	Delays due to detailed planning & clinical model redesign	Waddington Ward redevelopment (£0.55m in 11/12)	BMT – planned transfer of GST work in September 2011
Acquisition, etc.:				
Transferred / discontinued activity:				
Reduction in Outpatient attendances (new and f/u) – via RMS and transformation programme	Responding to commissioner requirements, better patient experience through care closer to home	Outpatient redesign projects and RMS. Medical job planning	Change leader team support to projects	Achievement of 11/12 QIPP target for a 10% % reduction in follow up Outpatient attendances

Elective vascular surgery transferred to GSTT	Consolidation of specialist services supports improved outcomes / quality of care and mitigates risk of decommissioning	Resource-intensive planning process and capacity issues – managed through robust project management arrangements	Investment at GSTT to enable vascular surgery transfer	April 2012 – planned transfer of elective vascular surgery
Complex cancer surgery (lung, prostate) transferred to GSTT	Consolidation of specialist services supports improved outcomes / quality of care and mitigates risk of decommissioning	Business cases developed identifying key risks and mitigating actions	Potential investment at GSTT	Complex cancer surgery transfer

Financial plans: activity and costs

Cost Improvement Plans (CIPs)

Table A (Items included in the CIPs worksheet in the financial template:

Key operating efficiency programmes	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
1.Divisional and corporate schemes *Cost improvement programmes to be monitored monthly by the programme office*	£20.7m in 2011/12	Locally managed cost reduction schemes to ensure efficiency and value for money	Divisional managers responsible for managing local CIPs & service specific efficiency projects. (Monitoring across the trust via Programme Office) KHP clinical service integration plans progressed Risk – managing both tight controls and redesign projects challenging	Programme Office - Internally resourced from Change Leaders Team and Trust management teams Support from Ernst and Young	11/12 – deliver divisional CIPs and understand the level of requirement for next 5 years. 12/13 – increased CIPs in place by all divisions, with more of a focus on delivering KHP models 13/14 – further implement KHP models of care
2. Trustwide savings schemes Including procurement and pharmacy unit price reductions and control	£2.84m in 2011/12	Cross cutting initiatives to drive value for money	Procurement and pharmacy to identify detailed plans to ensure savings are realised. Risk – further inflationary rises in other contract areas to offset savings.	Programme Office - Internally resourced from Change Leaders Team and Trust management teams	11/12 – continuous examination of all tenders and contracts to ensure best price. Pharmacy to actively manage usage of alternative and appropriate drugs.

3. Productivity Schemes Efficiency schemes examining Beds, Theatres, Outpatients, Medical Productivity, and Diagnostic usage	£9.6m in 2011/12	Ensure our clinical and non-clinical activities are operating as efficiently as possible, within tariff to support clinical investments	Formal workstreams implemented with key actions and milestones, initially supported by EY and then subsequently Operations leads.	Programme Office - Internally resourced from Change Leaders Team and Trust management teams – Initially supported by Ernst & Young teams to drive dedicated workstreams	11/12 – Significant reduction in LOS across all specialties, aiming for top quartile performance, increased theatre utilisation 12/13 – further improvement in medical productivity following introduction of management tools such as electronic job planning. Further LOS reductions leading to increases in strategically important activity.
4. Income Generation Additional income through coding improvement and Commercial services	£3m in 2011/12	Increased income to allow investment in strategic priorities	Systematic review of clinical coding to highlight areas where coding is currently inadequate. Commercial income from King's Commercial services Risk – income risk where reducing overall funding	Programme Office - Internally resourced from Change Leaders Team and Trust management teams External coding resource to be employed	11/12 – Immediate coding review to yield benefits in 11/12. Commercial income to increase towards end of 11/12 12/13 – Further increase in commercial workstreams; finalisation of PP redevelopment and subsequent increased income. 13/14 – Fully established commercial and increased private work.
5. Estate Rationalisation Rationalisation of Jennie Lee House/Dulwich Hospital site	£0.7m in 2011/12	Ensure we optimise the use of our estate	Expediting plans to move from Dulwich hospital site; similarly to vacate Jennie Lee house to enable sale of unit.	Programme Office - Internally resourced from Change Leaders Team and Trust management teams	11/12 – Services removed from Dulwich and JLH 12/13 – Full year effect of changes.

6. Service rationalisation	£1.8m	KHP joint clinical and support services.	Procurement and Transport efficiency savings.	Joint service delivery.	11/12 – deliver savings. 12/13 and 13/14 to involve clinical services.
7. Workforce rationalisation Workforce and skill mix review	£5m in 2011/12	Ensure we have the right number of staff, at the right grade, who are working as productively as possible	Centrally-led review of staffing establishments / departmental profiles, using external benchmarking	Programme Office - Internally resourced from Change Leaders Team and Trust management teams. Dedicated HR project support to deliver necessary savings Risk – maintaining clinical and operational efficiency; lead in time due to consultation period.	11/12 – development of divisional workforce plan and monitoring to actively manage vacancy levels including retirements. 12/13 – fully integrate workforce planning tools including Consultant job planning and E-rostering in all areas.
8. Reduced Activity costs	£1.4m	PCT QIPP targets.	Reduced new outpatient referrals.	Implementation of PCT RMS and ability to reduce step cost reduction.	11/12 RMS planned implementation.

Table B (Other savings/efficiencies – not included in the CIPs worksheet in the financial template):

Other savings/ efficiencies	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Add rows as necessary					

Financial plans: Workforce

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Workforce: Fit for Purpose • Trust wide, 3 year workforce plan built 'bottom up' from local plans • Electronic Systems implemented • Staff health and wellbeing prioritised	• Key skills matched effectively to patient pathways • All staff deployed efficiently • Productivity maximised • Attendance targets met • Key organisational memory and skills are retained	• Senior Managers supported in completion of workforce plans • Exploration of role re-design potential in target areas • KHP e-job planning pilot completed • Medical e-rostering implemented • Partnership with NHS Professionals built with online link to e-rostering • Staff Health and Wellbeing Strategy approved • 'End of working life' strategy implemented	• Programme Office - Internally resourced from Change Leaders Team and Trust management teams. • Dedicated HR project support to deliver necessary savings • Ongoing funding for rostering and job planning systems	**Q2 2011** • E-job planning pilot completed **Q4 2012** • Non medical e-rostering rolled out • Attendance target met **Q4 2013** • Medical e-rostering rolled out
Workforce: Engagement • Organisational culture in line with Trust Values • Effective workforce communications implemented • Effortless inclusivity	• Knowledgeable workforce 'in tune' with annual plan • Team King's pulling together • Local peer group accountability • 'Aim higher' on GMC and national staff surveys and Investors in People	• 'Listening into Action' led by CEO • KCH Values actively assessed during recruitment and selection • Garnett Foundation actors/ facilitators to embed values	• Change Leaders and corporate communications facilitating	**2011** • Garnett Foundation: piloted; rolled out to 800 staff; evaluated • Improvement in staff survey results
Working in Partnership: King's Health Partners • Support CAGs & make progress	• KHP tripartite mission	• KHP partners working closely	• A combination of both internal and	• Dependent on CAG development

on KHP collaboration • Integrate staff transferred within KHP • Strengthen social partnerships • Explore potential for HR strategic business partner	progressed • Upward drift of pay bill contained • Patient experience enhanced by wider participation of volunteers • Employee relations enhanced • External investment into HR systems development is secured	together on joint initiatives, e.g. MDECS	additional KHP resource	progress
Workforce: <u>Education and Training</u> • Fully participate in KHP activity on 'Liberating the NHS: Developing the Healthcare Workforce' • Build on early success as MDECS Lead Provider • Simulation strategy developed	• Career pathways and skills development meet KHP/ KCH objectives • KHP Supported in developing an appropriately configured regional Skills Network • ARMS Level 3 maintained • KCH simulation activity aligns across KHP	• External non medical (SHA) funding at risk • Deliver Stage 1 MDECS Lead Provider responsibilities	• Resource requirements will be dependent on the national outcome of 'Liberating the NHS' and the success of MDECS bids both of which may include some external resource to support internal staff.	**Q1 2011** • Establish arrangements for Education Commissioning Skills Networks **Q3 2011** • Stage 2 MDECS bid submitted **Q4 2011** • Skills Network, becomes legal entity **2012** • Stage 3 MDECS bid submitted
Workforce: <u>Resourcing</u> • Co-ordinate resourcing activity across KHP • Streamline KCH recruitment systems & process	• The best candidates are attracted and retained non-competitively across KHP • Staff loyalty and commitment to KHP/ KCH is encouraged • Recruitment costs contained	• Recruitment Micro-site established, branded and marketed • Introduction of recruitment tracking and application system • Medical and non medical recruitment functions combined	• Website work in conjunction with Corporate Communications • NHS Jobs upgrade subject to DH procurement	**Q3 2011** • KCH recruitment micro-site established **Q4 2012** • NHS Jobs new functionality in place (or alternative)

Financial plans: Capital programmes (including estates strategy)

- **Development** – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities
- **Maintenance or replacement capex** – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities
- **Other capital expenditure** – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc.
- **Other estates strategy** – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.

Key capital expenditure priorities	Amounts and timing (including financing schedules)	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Development:			
Maternity Redevelopment (incl NICU)	11/12 - £1.0m 12/13 - £2.5m	Enables KCH to respond to the growing birth-rate, choice over birthplace, and improved environment	Await Preliminary Indicative Information (with pre-tender estimate costs) 21 May - Tender Return due 03 June. Reduction in scheme will necessitate redesign along with an assessment of patient pathways.
Emergency Department	11/12 - £5.0m 12/13 - £1.0m 13/14 - £0.1m	Expansion and improvements to support Major Trauma Centre and provision for patients with mental health needs	Reliant on reaching agreement with commissioners regarding the model for urgent care in the emergency department and the reconfiguration of Outpatients to release required space
Endoscopy Redevelopment	11/12 - £2.7m	Expansion of current facility. Improves patient experience, privacy and dignity compliance. Releases beds that are currently being used for recovery post-procedure to achieve single sex compliance	Review potential for joint working with GSTT
Clinical Research Facility	11/12 - £7.55m	Facilitates translational research to improve future patient care	Currently under construction. Risk associated with receipt of donated income

			streams.
Private Patients Refurbishment	11/12 - £1.0m	Improves quality of the environment	CEF and design team undertaking value engineering exercise to reduce costs.
Unit 6 Development	11/12 - £1.6m	Allows non-clinical departments to be re-located so core hospital maximised for clinical use	Capacity to relocate all staff from Jennie Lee House
Critical Care Expansion	11/12 - £0.5m 12/13 - £6.5m 13/14 - £12.5m	Expansion of Critical Care facilities to support MTC and tertiary specialities, ensuring specialist patients (e.g. neurosciences) can be admitted rapidly to KCH	Feasibility of options, planning permission and tendering to enable construction to start April 2012. The project may require a contracted-out design team.
Paediatric Expansion	12/13 - £2.6m	Improves patient & family experience. Expansion of inpatient facilities to meet the changes in paediatric service reconfiguration	Requires other services to move to free the space from development
Waddington Ward	11/12 - £0.55m	Allows strategic expansion of Bone Marrow Transplantation activity	Completion of activity contracts
Other Major - Windsor Walk development (Women's)	13/14 - £0.1m	Improves patient experience through creation of a dedicated Women's unit, adjacent to main site	Requires commercial joint venture funding
Other Major - Admin & Discharge	12/13 - £0.3m	Improves patient flows / patient experience and reduces length of stay	Reliant on the release of space from other capital developments
Other Major - Single Sex Compliance	11/12 - £0.5m	Improves patient experience, privacy and dignity compliance	Operational disruption
Other Major – Refurbishment of Day Surgery (23hr Recovery)	12/13 - £0.5m	Improves patient experience, privacy and dignity compliance	Requires a solution that enables Day Surgery to continue to run to full capacity whilst the redevelopment takes place
Other Major Works Schemes	11/12 - £2.54m 12/13 - £1.03m	Improves quality of care / patient experience	Loss of operational space while projects are in progress.
Maintenance:			

Minor Works Schemes	11/12 - £1.0m 12/13 - £1.0m 13/14 - £1.0m	Improves quality of care / patient experience	Loss of operational space while projects are in progress.
Other capital expenditure:			
IT Schemes (incl Intangibles)	11/12 - £2.0m 12/13 - £2.0m 12/14 - £2.0m	Supports efficient service delivery, and specific initiatives such as "Paperless Hospital"	Risk of unplanned essential IT works being unfunded
Medical Equipment Replacement and Purchases inc PACU	11/12 - £1.02m 12/13 - £0.9m 13/14 - £0.9m	Supports efficient & safe service delivery	Risk of unplanned essential medical equipment replacement being unfunded
Other estates strategy			

Clinical plans

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2010/11	3 year targets / measures for 2011/12 2012/13 2013/14
Patient Safety: 1. Reduce hospital acquired infection	Supports King's objective to deliver high quality, patient centred and efficient care.	**Actions** • Strengthen accountability and ownership, e.g. through medical "champions" and junior doctor auditors • Improve performance management & new scorecard piloted • Improve IV line care, including roll-out of bio patch for line insertion. • Further improve of antibiotic stewardship **Risks** • Risk associated with KCH's particular complex case mix, e.g. liver, neurosciences	KCH has further reduced MRSA numbers by 16% and C. diff by 21% in 2010/11 compared with 2009/10. The number of MRSA cases in 10/11 was 16 against target of 9. The number of C. Difficile cases in 10/11 was 106 against target of 162.	2011/12 MRSA target – 6 C. Difficile target - (national) -75 2012/13 and 2013/14 To further reduce infection rates and ensure national targets are met.
Patient Safety: 2. Improve VTE Prophylaxis and Education	Support King's objective to deliver high quality, patient centred and safe care.	**Actions**: • establish a regular audit system in selected areas • use of the VTE link practitioner network, working closely with the Thrombosis Team • roll-out training to ensure robust clinical knowledge of "appropriate thromboprophylaxis" • Establish electronic recording of audit data	Currently 'appropriate thromboprophylaxis' rates are monitored on an ad hoc basis VTE risk assessment compliance rate for all adult inpatients currently at 93.5% (March 2011)	Risk assessment compliance rate > 90%
Patient Safety: 3. Improve Medication Safety	Support King's objective to deliver high quality, patient centred and efficient care.	**Actions**: • Roll out e-Prescribing across all wards / departments • Introduce E-learning programme • KHP collaborations on medication safety (including PSSQ)	Currently e-Prescribing has been rolled out in 28 of 44 selected areas.	2011/12 2012/13 2013/14

Clinical effectiveness 4. Improve End of Life Care	Support King's objective to deliver high quality, patient centred and efficient care.	**Actions**: • Engage frontline teams in awareness campaign to increase % of patients discharged from hospital with a palliative care summary within 2 working days • Further training and performance monitoring to increase no. of patients entered onto an electronic register - improving coordination of care across health care teams & organisations • the 'Amber care bundle', (set of key questions to support best practice) across 4 wards	Palliative care staff trained in the use of the web based end of life care electronic register Implementation plan for the of 'Amber care bundle' pilot in selected clinical areas Roll out of 'PEACE' (proactive planning for patients being discharges to care homes about their future care wishes) programme in dementia care	2011/12 Composite measure for CQUINs, including: aim to increase the number of patients who are on the Liverpool Care Pathway when they die, roll out of 'Amber care' and improved communication with primary care
Clinical effectiveness: 5. Improve Diabetes Care	Support King's objective to deliver high quality, patient centred and efficient care.	**Actions**: • Review National Diabetes Inpatient Audit, and develop robust improvement plan • New educational models piloted & best practice rolled out; including a 'diabetes link nurse' approach • A new electronic system to identify patients with the highest need for specialist diabetes care • A new screen for diabetes care to be developed as part of the e-prescribing system. • To pilot specialist Diabetes Liaison Nurse role, working across a number of clinical areas to identify high-risk patients earlier and ensure the effective care and treatment • An Insulin Safety Group will ensure compliance with National Patient Safety Authority recommendations regarding insulin management • research programme on improving patient safety in diabetes to be initiated	2010 National Diabetes Inpatient Audit demonstrated that King's performed well in providing diabetes care compared to the national average. A key area for improvement is in insulin management errors	2011/12 Improve insulin safety – by reducing prescription and management error for current patients Develop key frameworks for KCH to meet NICE Quality Standards for Diabetes (standards 11,13) – delivering better outcomes for our patients

		with the King's PSSQ		
<u>Patient Experience:</u> 6. Improve consistency of positive patient experience	Support King's objective to deliver high quality, patient centred and efficient care.	**Actions** • Ensure achievement of CQUIN "responsiveness to patient need") by working with lowest performing wards in team action planning • Energise the culture of care through events such as "In Your Shoes" to embed King's Values • Roll out drama based training to promote excellent patient-centred service • Continue work to improve nutritional care and patient food services • Expand & enhance the volunteering programme (e.g. tailored training) • Improve patient discharge– e.g. communication with GPs **Risks**: • Ensuring staff engagement in PPI and patient experience activity • Achieving low response rates for How are we doing Surveys	We have successfully achieved our CQUIN targets for three specific wards for 2010/11. We are committed to continuing to roll out this focused improvement to another three wards in 2011/12.	2011/12 Achieve target satisfaction scores for CQUIN pt experience metrics To reach the top 20% of acute hospitals in London for the national patient surveys 2012/13 - To be in the top 10% of acute trusts in London for national patient surveys
<u>Patient experience:</u> 7. Improve cleanliness of the hospital environment	Support King's objective to deliver high quality, patient centred and efficient care.	**Actions**: • Develop new more effective ways of measuring and managing of the performance of our cleaning contractors • Engage teams to ensure ownership of local improvement action plans, to improve consistency and raise standards across the Trust	In both HRWD measures of cleanliness of rooms/wards, and bathrooms/showers we have witnessed a downward trend line from March 2010 to February 2011, though some improvement thereafter.	Achieve HRWD benchmarks for cleaning in rooms/wards and bathrooms/showers Improved contractual performance of cleaning partner

The Board's clinical plans and core quality priorities have been developed in consultation with a wide range of internal and external stakeholders including senior clinical teams, Commissioners, Overview and Scrutiny Committees, LINks and Governors and members. The Board receives regular reports on all aspects of quality through monthly performance reports and scorecards, a monthly integrated patient experience report including feedback from patient surveys, PALS and complaints. The Board also receives a separate quarterly Quality and Governance Report which includes detailed analyses of all serious complaints and adverse incidents together with actions taken and related service developments/improvements.

In year, we have strengthened the Trust's Board Assurance Framework and linked this explicitly to the Board Self Certification of the Annual Plan. In 2010/11, the Board introduced a new Quality Governance Framework with the implementation of a new Board governance structure. At the heart of this is a new Quality & Governance Committee which, on behalf of the Board, monitors the three dimensions of quality, Patient Safety, Patient Outcomes and Patient Experience through a series of management committees chaired by Executive Directors. This enables a strong Board focus on all aspects of quality and is the vehicle through which the Trust's quality priorities and Monitor's Quality Governance Framework are monitored. The Trust is undertaking a self assessment of the framework informed by an internal audit of current arrangements for quality governance.

In 2010/11 the Trust made good progress against most of its quality priorities with the exception of MRSA where the target was not achieved. The Trust has a detailed action plan to secure improvement on an ongoing basis. Reducing hospital acquired infection is one of the Trust's core quality priorities for 2011/12 and beyond. The King's 'Quality Philosophy' outlined in the Quality Account makes it clear that the safety of patients is the Trust's number one priority and that there is zero tolerance of anything that puts patients in harm's way.

Section 4: Regulatory requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
1. Service Performance and Clinical Quality & Governance	• Failure to achieve all core national targets leading to breach of terms of authorisation, e.g. (Referral to Treatment targets, Cancer targets, etc)	• Systematic monitoring of all targets monthly by Finance & Performance Committee to the Board of Directors. • Strong clinical leadership and performance management framework, with monthly scorecards for each clinical division. • Action plans against all core national targets implemented • Implementation of Board governance framework to strengthen monitoring of patient safety, patient experience, outcomes and safety. • KPMG review of Trust's process of self certification against annual plan targets 2010/11 following of MRSA breach in Q2 • Board of Directors and Governors 'Go and See' inspections to all clinical areas. • Hygiene Code action plan reported monthly to the Board • New IV line management team in place • Infection control scorecard implemented • Implementation of EMSA action plan • Trust Operational Strategy addressing operational priorities and core targets	• Monitor Governance risk rating year on year • Annual declaration of compliance with EMSA requirements – April 2011 and annually • Implementation of action plan addressing KPMG recommendations by May 2011

	• Failure to maintain unconditional registration (achieved March 2010) of regulated activities under the CQC.	• Board governance framework strengthened to ensure effective monitoring of safety, patient experience, and outcomes linked CQC outcomes • Monthly review of the CCQ Quality Risk Profile (QRP) by the Executive Directors and quarterly by the Board Quality & Governance Committee. • Implementation of a software solution during 2011/12 to enable systematic, continuous monitoring of the QRP and other data sources to assess ongoing compliance with the CQC Essential Standards. • Establishment of compliance group to monitor ongoing compliance against all regulatory requirements.	• On-going compliance with CQC registration
2. Governance processes and procedure	• Failure of Board level assurances leading to potential breach of terms of authorisation or CQC registration	• BAF and BAF Policy reviewed regularly by the Board Exec. Risk owners identified and accountable. BAF risks linked to risk register, which is reviewed by the Quality & Governance Committee and Board on a quarterly basis. • Internal and external Audits of Systems and processes: • Review of Board governance structures to include a stronger focus on quality • Cross membership of Board committees chaired by Non-executive Directors • Board Assurance framework reviewed substantively in April	• New Board structure implemented October 2010, and supporting structure April 2011 onwards • Quality Report and Accounts published annually • Annual plan and self certification process reviewed • Quarterly returns to Monitor • Continued registration under CQC • Maintain NHSLA Level 3 accreditation in 2013

		2011 and quarterly by the Board thereafter • Review of effectiveness of Board self certification of annual plan • Annual audit by independent auditors of compliance with terms of authorisation • Quality Accounts developed and monitored by Board committee • Substantive review of risk register framework in April 2011. • Centralised risk management systems.	
3. Financial stability, profitability and liquidity	3.1 Lower Commissioned activity levels and loss of income. 3.2 Failure to deliver operational efficiencies and hence reduced profitability 3.3 Reduced Liquidity due to capital commitments and surplus generation	• To collaborate and share the financial risks with lead commissioners in order to ensure a planned transitional activity reduction in agreed service areas and to develop new patient pathways • To identify potential savings associated with the activity reduction and income loss. • To diversify income sources increasing that from commercial activities. • To ensure commissioner investment in key strategic developments. • To ensure robust CIP plans are approved by the Board with Divisional Managers/Directors accountable for the targets. • Implement Transformation	• PCT contracts reflect realistic activity levels and incorporate strategic developments. • Commercial and PP income to increase • Quarterly Service Line Reporting to Divisional Managers. • Action plans produced to achieve CQUIN targets. • Maintain a Monitor risk rating liquidity ratio of 3.

		programmes to deliver local efficiencies and joint savings work with KHP partners. • To provide financial service line reporting information to ensure patient activity services are financially viable.	
4. Risk to the provision of mandatory services	• PCTs / GPs decommissioning services • Reconfiguration of services within KHP may result in the cessation of a service on a site • Impact of unplanned activity shifts e.g. major incident or seasonal flu	• Implementation of RMS in consultation with commissioners • Integration of community services within KHP provides opportunities for the implementation of care pathways and the more effective delivery of services • Development of the full business models to ensure the continued effective delivery of services to all KHP patients • Robust, managed business continuity plans	• Monitor delivery to plan • Trust business continuity plans maintained and up to date.
5. Co-operation and/or competition rules	• Introduction of increased private sector competition in regulated market	• Initiatives to improve quality of services • Development of tertiary services • Collaborative relationships with local commissioners	• Maintain current levels of contract income
6. Information Governance	• Failure to comply with the CfH Information Governance Toolkit	• Suite of IG policies in place • Implement a staff awareness training programme • Implement an encryption programme for data transition • IG breaches are reported as Adverse Incidents and investigated / reported via the Trust's Risk	• **IG Toolkit 2010/11** – Trust has achieved level 2 for all key items

		reporting framework. • Data Protection & IT Security Manager and Caldecott Guardian in post • IG Strategy Group monitors compliance with toolkit requirements and reviews progress with action plans on a monthly basis • Internal Audit of compliance with IG Toolkit requirements • The Trust's Senior Information Risk Owner (Chief Financial Officer) and Caldecott Guardian provide annual reports to the Board of Directors with 6 monthly reports to the Quality & Governance Committee.	• Internal Audit March 2011 – Action plan agreed to address recommendations and identified gaps • Key areas to be addressed are the pseudo-anonymisation of all data being transferred and implementation of a comprehensive records management system for all Trust records.
NHS Constitution	• Compliance with the NHS Constitution requires the Trust to establish the principles and values of the NHS; set out patient, public and staff rights and responsibilities	Compliance achieved via: **Section 1** • Active engagement of FT members • The engagement of FT members and other stakeholders in the hospitals governance processes • Ongoing work with local commissioner's and local authority oversight committees. • Through continued oversight from Monitor and the CQC **Section 2a** • Compliance with all elements of the operating framework and continued authorisation **Section3a** • Availability of a suite of employment policies/ procedures • Regular involvement of staff representatives in consultation/ engagement meetings • Monitored via national	

		staff survey **Section 3b** • Recruitment/ selection and 'onboarding' website for new hires • Comprehensive induction, development and training • Monitored via NHSLA ARM Standards **NHS Values** • In conjunction with key stakeholders King's Values were developed and launched in 2009, also reflecting the NHS values	

Section 5: Leadership and governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
Succession planning Succession plans at Board level (Directors); and succession plans at other levels of the organisation (clinical, operational and corporate teams)	• Perceived preference for external candidates filling senior posts [N.B. the succession 'pool' for senior appointments includes the wider NHS in KHP, London and elsewhere]	• Training in assessing Board level and senior management potential • Development of transparent assessment process to include post holder self assessment • Coaching to be made available to develop those identified as having potential	**Q3 2011** • Assessor training complete **Q3/4 2011** • Front-line leadership programme in conjunction with KHP acute partner
Board effectiveness Continue to develop effective Board leadership of the organisation Board of Directors	• Insufficient focus/time on Board development and appraisal. • Changes to Board membership including appointment of new Chair from December 2011 • BAF does not drive the Board agenda	• Continued Implementation of the tailored induction programme for all new Board members • Plan dedicated time for Board development • Deliver an externally facilitated programme of Board evaluation • Implement programme of NED training and development • Fully review the BAF	• Board induction programme is ongoing • Board development sessions/ seminars are scheduled into Board programme • Annual programme of Board evaluation Quarterly review of the BAF by the Board New Chair appointed – December 2011

Board of Governors	• Board of Governors' elections leading to significant membership changes – December 2011	and cross reference to Board agenda • Ensure all Directors receive an annual appraisal • Develop a process for induction of new Chair – Autumn 2011 • Continue to develop and deliver the Board 'Go and See' Programme • Develop a process for induction of new Governors – Autumn 2011	New Board of Governors elected – December 2011
Board assurance Develop trust governance arrangements to ensure continued effective Board governance and assurance	• Short term operational imperatives do not allow sufficient Board and Executive focus on longer term strategic issues • Risk to maintaining ongoing compliance with core governance targets are not fully articulated	• Review of Board governance structures to include a stronger focus on quality and strategy • Cross membership of Board committees chaired by Non-executive Directors • Board Assurance framework reviewed substantively in April 2011 and quarterly by the Board • Review effectiveness of the Board's self certification process for annual plan • Annual audit by independent auditors of compliance with terms of authorisation • Quality Accounts developed and monitored by Board committee • Substantive review of risk register framework by April 2011.	• New Board structure implemented October 2010, and supporting structure April 2011 onwards • Quality Report and Accounts published annually • Annual plan and self certification process reviewed • Quarterly returns to Monitor • Continued registration under CQC • Maintain NHSLA Level 3 accreditation in 2013

In preparing the trust's "forward plan", the board of directors must have regard to the views of the board of governors. In that respect, please set out below how the board of governors have been engaged (including any material feedback received) in relation to the production and finalisation of this plan.

Annex A

The Board of Governors has a quarterly Strategy Committee which reviews the Trust's forward plans and provides ongoing comment throughout the year. The Trust also holds annual engagement events for Foundation Trust members, where members and governors are invited to participate in roundtable discussions on key strategic issues, and offer views on the Trust's strategic priorities, in order to inform the Annual Plan. Both the Governors' Strategy Committee and Board of Governors were engaged in debate during January- February 2011 on the Annual Plan priorities and subsequently, during April and May, were invited to discuss and comment on the draft Annual Plan.

As representatives of the local community and patients, the Governors' provided helpful feedback regarding certain areas of emphasis in the document. In particular, they suggested a stronger focus on the following areas:

- Planned estates improvements
- Work force issues including the roll out of the Values Project
- Education and training
- The community contribution and links through expansion of the volunteering programme, links with community voluntary organisations and as an employer and procurer of services in the local area.
- Working with patients and their carers
- Dementia Services

As result of these discussions, the Trust has reflected Governor comments in the final Annual Plan.

Detailed Financial Summary £m		2010-11 Actuals	2011-12 Plan	2012-13 Plan	2013-14 Plan
Total operating income		583.2	583.3	578.6	578.3
Employee Expenses		(339.6)	(327.3)	(321.2)	(319.8)
Drugs expense		(55.0)	(55.3)	(56.7)	(58.3)
Supplies (clinical & non-clinical)		(93.8)	(82.7)	(82.4)	(82.5)
PFI expenses		(20.7)	(22.9)	(23.2)	(25.0)
Other Costs		(42.2)	(57.1)	(54.0)	(50.9)
Total operating expenses		**(551.2)**	**(545.3)**	**(537.5)**	**(536.3)**
EBITDA		**31.9**	**38.0**	**41.0**	**42.0**
Net Surplus / (Deficit)		**0.7**	**1.8**	**(0.5)**	**1.7**
EBITDA % Income	%	5.5%	6.5%	7.1%	7.3%
CIP% of Op.Exp. less PFI Exp.	%	3.5%	6.3%	6.0%	5.5%
Capital expenditure		(19.0)	(26.4)	(18.1)	(17.0)
Net cash inflow/outflow		**12.1**	**(9.7)**	**2.5**	**2.4**
Cash and cash equivalents		**22.7**	**13.0**	**15.5**	**17.9**
Liquidity days		**19.1**	**16.3**	**16.9**	**19.1**
Net current assets/(liabilities)		**5.4**	**0.7**	**1.1**	**4.3**
Planned borrowings		**92.1**	**90.2**	**88.4**	**86.5**

Service Developments Totals Totals	Plan for Year ending 31-Mar-2012 Value £m	Plan for Year ending 31-Mar-2013 Value £m	Plan for Year ending 31-Mar-2014 Value £m
Revenue from Service Development	**0.000**	**0.000**	**0.000**
Expense of Service Development	**(8.108)**	**(7.237)**	**(7.237)**
1 **Short Name or Description** Acute assessment unit/ ED Staffing			
Total effect of this service development	**(1.936)**	**(1.936)**	**(1.936)**
2 **Short Name or Description** Hospital at night			
Total effect of this service development	**(1.200)**	**(1.200)**	**(1.200)**
3 **Short Name or Description** Midwifery led unit			
Total effect of this service development	**(0.800)**	**(0.800)**	**(0.800)**
4 **Short Name or Description** Admisssion & Discharge Lounge			
Total effect of this service development	**(0.848)**	**(0.848)**	**(0.848)**
5 **Short Name or Description** Other e.g. Surgical Wards & Annie Zunz nursing establishment,			
Total effect of this service development	**(3.324)**	**(2.453)**	**(2.453)**

Cost Improvement Plans (CIPs) Totals Totals	Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012 Value £m	Plan for Year ending 31-Mar-2013 Value £m	Plan for Year ending 31-Mar-2014 Value £m
Analysis of Revenue Generation and Expense CIPS				
Recurring CIPs + revenue generation schemes	17.745	41.804	40.000	37.000
Non-recurring CIPs + revenue generation schemes	1.300	3.218	3.000	3.000
Total (agrees to above)	**19.045**	**45.022**	**43.000**	**40.000**
1 **Short Name or Description** 11/12 Divisional & Corpoarte Depts CIP specific plans				
Total revenue generation scheme effect		**20.707**	**31.000**	**31.000**
2 **Short Name or Description** Productivity schemes/Income generation schemes				
Total revenue generation scheme effect		**12.612**	**5.500**	**5.500**
3 **Short Name or Description** Trustwide Schemes focusing on Procurement controls and contracts		**2.842**	**0.000**	**0.000**
4 **Short Name or Description** Estate Rationalisation (off site buildings)		**0.700**	**1.000**	**1.000**
5 **Short Name or Description** Workforce rationalisation (Establishment reduction)		**5.000**	**5.000**	**2.000**
6 **Short Name or Description** Variable cost reduction from reduced activity in respect to PCT QIPP/Decommissioning		**1.378**	**0.000**	**0.000**
7 **Short Name or Description** Other schemes such as Service rationalisation (KHP - Clinical Academic Groups and Corporate Depts)		**1.783**	**0.500**	**0.500**

Directors *(at 31 May 2011 or date of submission, whichever is earlier)*

	Role	Job Title	Name of Director	Tenure	Date appointed
mple	*Finance Director*	*Director of Finance and Information*	*Ms Jane Doe*	*Acting*	*01/05/2010*
	Chair	Chairman	Mr Michael Parker	Permanent	01/02/2002
	Chief Executive	Chief Executive	Mr Timothy Smart	Permanent	01/11/2008
	Finance Director	Chief Financial Officer	Mr Simon Taylor	Permanent	01/09/2002
	Medical Director	Medical Director	Mr Michael Marrinan	Permanent	03/02/2010
	Nursing Director	Director of Nursing and Midwifery	Dr Geraldine Walters	Permanent	07/09/2009
	Other Board Director	Director of Operations	Mr Roland Sinker	Permanent	06/07/2009
	Other Board Director	Director of Workforce Development	Mrs Angela Huxham	Permanent	04/05/2009
	Other Board Director	Director of Strategy	Mr Jacob West	Permanent	01/02/2010
	Other Board Director	Director of Corporate Affairs	Mrs Jane Walters	Permanent	01/01/2004
	NED	Non-Executive Director	Prof Sir George Alberti	Permanent	01/10/2010
	NED	Non-Executive Director	Mr Robert Foster	Permanent	18/03/2004
	NED	Non-Executive Director	Ms Maxine James	Permanent	01/05/2004
	NED	Non-Executive Director	Prof Alan McGregor	Permanent	01/10/2003
	NED	Non-Executive Director	Mr Marc Meryon	Permanent	02/08/2010
	NED	Non-Executive Director	Mr Martin West	Permanent	22/07/2007

Governors *(at 31 May 2011 or date of submission, whichever is earlier)*

	Constituency Type	Full Name of Constituency	Name of Governor	Origin	Date appointed/elect
mple	*Public*	*North west ourtown*	*Mr John Jones*	*Elected*	*01/05/2010*
	Public	Lambeth Central	Ms Cherry Forster	Elected (Uncontested)	01/12/2008
	Public	Lambeth Central	Mr Rashmi Agrawal	Elected (Uncontested)	01/12/2008
	Public	Lambeth North	Mrs Ann Mullins	Elected (Uncontested)	01/12/2008
	Public	Lambeth North	Mrs Christiana Okoli	Elected (Uncontested)	01/12/2008
	Public	Lambeth South	Mr Timothy Mason	Elected (Contested)	01/12/2008
	Public	Lambeth South	Mrs Saleha Jaffer	Elected (Contested)	01/12/2008
	Public	Southwark Central	Mr Andy Alatise	Elected (Contested)	01/12/2008
	Public	Southwark Central	Ms Hedi Argent	Elected (Contested)	01/12/2008
	Public	Southwark North	Mr Tom Hoffman	Elected (Contested)	01/12/2008
	Public	Southwark North	vacant		01/12/2008
	Public	Southwark South	Mrs Michelle Pearce	Elected (Contested)	01/12/2008
	Public	Southwark South	Mr Michael Mitchell	Elected (Contested)	01/12/2008
	Patient		Mr Paul Corben	Elected (Contested)	01/12/2008
	Patient		Mrs Jan Thomas	Elected (Contested)	01/12/2008
	Patient		Ms Pida Ripley	Elected (Contested)	01/12/2008
	Patient		Mr Tom Duffy	Elected (Contested)	01/12/2008
	Patient		MsLisa Hayles	Elected (Contested)	12/06/2010
	Patient		Mr Andy Glyn	Elected (Contested)	01/12/2008
	Staff	Nursing & Midwifery	Mr Anthony Agosu	Elected (Uncontested)	01/12/2008
	Staff	Nursing & Midwifery	Ms Nicky Hayes	Elected (Uncontested)	20/05/2010
	Staff	Allied Health Professionals	Prof Mark Monaghan	Elected (Uncontested)	01/12/2008
	Staff	Managerial, Administration & Clerical	Mr Brady Pohle	Elected (Contested)	01/12/2008
	Staff	Support Staff	Mrs Rowenna Hughes	Elected (Contested)	01/12/2008
	Staff	Medical and Dental	vacancy		
	Stakeholder	Lambeth Council	Cllr Jane Edbrooke	Appointed	26/05/2010
	Stakeholder	Southwark Council	Cllr Dora Dixon-Fyle	Appointed	15/07/2010
	Stakeholder	Lambeth PCT	Mrs Caroline Hewitt	Appointed	01/01/2010
	Stakeholder	Southwark PCT	Mr Richard Gibbs	Appointed	09/05/2011
	Stakeholder	Joint Staff Committee	Mr Frank Wood	Appointed	01/12/2006
	Stakeholder	King's College London	Mr Chris Mottershead	Appointed	01/07/2009
	Stakeholder	London South Bank University	Ms Anne Garvey	Appointed	22/06/2009
	Stakeholder	South London & Maudsley NHS FT	Mr Stuart Bell	Appointed	01/12/2006
	Stakeholder	Guy's & St Thomas' NHS FT	Ms Diane Summers	Appointed	06/10/2010

Elections Held *(between 1 April 2010 and 31 March 2011)*

	Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
mple	*Public*	*North west ourtown*	*4*	*1,345*	*16.3%*	*8,230*	*01/05/2010*
		not applicable					

Membership size and movements

Public constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	4,023	4,022
	New members	+ve	362	500
	Members leaving	+ve	363	400
	At year end (31 March)		4,022	4,122

Staff constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	6,431	6,629
	New members	+ve	1,181	1,100
	Members leaving	+ve	983	900
	At year end (31 March)		6,629	6,829

Patient constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	4,028	4,246
	New members	+ve	583	700
	Members leaving	+ve	365	400
	At year end (31 March)		4,246	4,546

Analysis of membership at 31 March 2011

Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
	Age (years):		
	0-16	5	5,526
	17-21	52	31,175
	22+	3648	474,406
	Unknown	317	
			511,107
	Ethnicity		
	White	1,877	320,327
	Mixed	163	21866
	Asian or Asian British	267	22,149
	Black or Black British	1404	131953
	Other	140	14571
	Unknown	171	241
	Socio-economic groupings*:		
	ABC1	3,049	233,055
	C2	28	36,645
	D	76	64,671
	E	815	68,024
	Unknown	54	108,712
	Gender:		
	Male	1,725	251,173
	Female	2,256	260,189
	Unknown	41	-255

Patient Constituency		31 Mar 2011 members	Eligible membership
	Age (years):		
	0-16	2	
	17-21	34	
	22+	4,210	

Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	6,629	