

Forward Plan Strategy Document for
East Kent Hospitals University NHS Foundation Trust

Section 1: Strategy

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

East Kent Hospitals University NHS Foundation Trust is a large hospital network managing healthcare across the peninsula geography of Eastern Kent, commencing its third year as a Foundation Trust. The majority of patient flows for the Trust services come from within the Eastern & Coastal Kent PCT area, although some specialist services are provided to a broader population. The Trust maintains full registration with the Care Quality Commission against the essential standards for quality and safety.

The Trust vision is now well established and shared amongst all our constituents, stakeholders, patients and the general public. The Trust's strategic planning follows an all-encompassing approach, recognising changes in national policy, the local health economy and initiatives and opportunities from within the organisation. The Trust's vision and mission remains as::

'To be known as one of the top ten hospital trusts in England and the Kent hospital of choice for patients and those close to them.'

'To provide safe, patient-focused and sustainable health services with and for the people of Kent. In achieving this, we acknowledge our special responsibility for the most vulnerable members of the population we serve.'

The Trust has commenced preparations to manage the transition to GP commissioning outlined in two documents linked to the White Paper: "Equity and Excellence –Liberating the NHS" & "Liberating the NHS: Legislative Framework and Next Steps. These changes to the economic and regulatory environment have not altered the Trust's vision to be known throughout the world as one of the Top 10 hospital trusts in England and as the Kent hospital of choice for patients and those close to them.

Current Position

In December 2010, the Trust was assessed against set criteria and was named as the overall Trust of the year by the Dr Foster Hospital Guide. The Trust also won a national award for Stroke Services.

In quarter three of 2010/11, the Board reassessed its strategic objectives in the light of the changing economic environment and revised its plans to meet the dual objectives of improving the quality of services to patients whilst reducing the costs of service delivery. This has been integrated into the Quality, Improvement, Productivity and Prevention (QIPP) plans which are vehicle that will help deliver the changes across the health economy.

The Trust has continually monitored its progress towards delivering its overall vision and strategy and the Board examines the metrics against each of the strategic and annual objectives for 2010/11 on a quarterly basis. In 2010/11 the Trust has made good progress with waiting times and is now compliant with the waiting times for cancer within the national target levels. Key achievements in 2010/11 include:

- Increased market share by repatriating specialised services back to East Kent. This encompasses establishing the William Harvey Hospital in Ashford as a Primary Percutaneous Cardiac Intervention (pPCI) centre for the whole of Kent & Medway area.
- Safety and effectiveness have been the key drivers in directing the Trusts investment in service change and this is reflected in the Trusts exceptionally low Hospital Standardised Mortality Rate (HSMR - 75) and good prevention rates. Progress has been made to reduce the annual rate of MRSA bacteraemia and Healthcare Acquired Infections when compared with national targets.
- The Trust has eliminated same sex accommodation across all sites and improved patients' satisfaction measured by real-time reporting against a series of questions. The ratio of compliments to complaints has also increased and the response times to formal complaints have seen a significant improvement.
- NHS-LA level 3 assessment (general standards) was achieved and NHS-LA level 2 for maternity standards was achieved in September 2010.
- A comprehensive programme and series of capital projects has been delivered. These include:
 - The centralisation of maxillofacial services to the William Harvey Hospital.
 - Repatriation of Age related Macular Degeneration (AMD) from the private sector.
 - Installation of a mobile theatre at William Harvey Hospital.
 - Introduction of electronic discharge notifications.

In 2010/11, the Trust maintained its Financial Risk Rating of 4, generating a surplus of £8.9m against a plan of £8.2m. Further details are outlined in Section 3.

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

In summary, the Trust strategy for 2011/12 through to 2014/15 is to remain the hospital of choice in the new NHS environment by continuing to repatriate specialist services back to Kent and therefore provide more local high quality and affordable services. An overarching aim will be to deliver high quality care effectively and efficiently to the local population enabling future investment in our services.

To achieve this, the Trust has set a range of domains (Safety, Effectiveness, Efficiency, Responsiveness and Innovation) which are linked to strategic and annual objectives. The Trust has established six strategic objectives:

1. To deliver safe care to patients.
2. To deliver effective care with excellent patient outcomes.
3. To provide an excellent patient experience.
4. To ensure staff are able, empowered and responsible for the delivery of effective care.
5. To deliver innovation through the services we provide
6. To deliver efficient services that generate funding to both enable and sustain future investment in local services.

Covering the next three years, the Board has identified a set of key priorities; these support the Strategic Objectives and are in turn supported by a set of Annual Objectives for 2011/12. The key priorities will ensure that the Trust continues to focus on providing high quality care to its patients by increasing the amount of care that is delivered locally, expanding its efficient and effective work programmes and reviewing and improving its input into community delivered care. In support of these priorities a full long term clinical strategy will be developed and delivered. The Trusts estate strategy is integrated with, and crucial to, the delivery of these priorities. With the change in the Trusts internal management structure to a Divisional basis construction of a new reporting and analytic framework is a priority. Delivery of the Trusts financial plan is also a key priority.

The Annual Objectives ensure that the Trust makes the required progress on its Strategic Objectives and key priorities each year, they also enable the Board and other key stakeholders to both see and monitor progress. The risks associated with the delivery of each Annual objective and priority have been outlined within the Trust Corporate Risk Register and any gaps in the control measures are monitored through the Board Assurance Framework in order to ensure that significant risks are identified and addressed.

These specific measures and controls are embedded within the Annual Objectives, which are summarised below:

AO1: To meet all the Governance requirements including, but not restricted to, the Monitor compliance framework, essential standards of quality and safety for CQC registration, Clinical Pathology Accreditation (CPA) and HSE legislation

AO2: Develop a robust Trust wide clinical strategy incorporating key service changes to drive improvements in use of physical resources, quality of care (by reducing length of stay) and financial efficiencies

AO3: Continue to upgrade and develop the Trust's infrastructure (Estates & IT) in support of the Strategic plan

AO4: Develop positive external relationships as part of a Trust wide Marketing strategy in order to position ourselves with key stakeholders/customers, within the new market

AO5: To guarantee Staff are able and responsible for the delivery of safe, effective care which provides a good patient experience and a planned financial surplus

AO6: Continue to develop and implement a comprehensive Quality Strategy to support improvements in patient safety, clinical effectiveness and patient experience/ outcomes.

AO7: Continue to support the development of R&D and innovation within EKHUFT

AO8: Develop a reporting and analytic framework to support the Trust in delivering operational objectives and corporate performance

AO9: Develop a robust 3 year financial plan with an explicit CIP and with a growth of EBITDA margin levels

From these Strategic and Annual objectives, the Trust has identified and agreed on several priorities that will be driven forward over the next three years to achieve the strategic vision.

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
To meet all the Governance requirements including, but not restricted to, the Monitor compliance framework, essential standards of quality and safety for CQC registration and HSE legislation	Ensures the Trust meets its regulatory obligations and required standards of patient care and staff safety (SO1, SO2, SO3 & SO4)	<ul style="list-style-type: none"> • Deliver revised 18 week access in line with the NHS Constitution and the standards outlined in the NHS operating framework and Monitor compliance framework. • Deliver revised A&E access standards on all 4 sites in line with the NHS operating framework and Monitor compliance framework by Quarter 2 • Continue to deliver cancer standards in line with NHS operating framework and Monitor compliance framework. • Deliver improvements in infection control meeting DH and commissioner's requirements for MRSA and C.difficile infection rates. Define and track baseline for MSSA and E.Coli sepsis • Maintain mandatory regulatory standards required for compliance with care quality commission (CQC) standards for essential quality and safety • Demonstrate good governance through the CQC quality and risk profile • Demonstrate good financial governance through the Monitor financial risk rating • Implement full recommendations from the HSE review 2011 	Milestones will be confirmed following publication of the 2012/13 compliance framework	Milestones will be confirmed following publication of the 2013/14 compliance framework
Develop a robust Trust wide clinical strategy incorporating key service changes to drive improvements in use of physical resources, quality of care (by reducing length of stay) and financial efficiencies	The clinical strategy will ensure the Trust maintains sufficient patient volumes to meet its service and financial objectives. And supports the Vision of becoming and remaining a Top 10 NHS organisation. (SO5, SO6)	<p>Publish a Trust wide 3 year clinical strategy</p> <p>Implement emergency care improvement programme (EC-IST)</p> <p>Commence use of robotic surgery in urology</p> <p>Deliver improvements in efficiency and productivity by:</p> <ul style="list-style-type: none"> • Reduction in the length of stay for specific elective and non-elective pathways • Roll-out of productive theatre programme across all day surgery theatres and specific specialties for in-patient surgery. • Improved efficiencies in outpatient booking and aim to move to full-booking of appointments. <p>Continue to use and develop LEAN principles across a number of clinical pathways. Review financial viability and clinical viability of continuing service.</p>	<p>Implement clinical strategy</p> <p>Fully implement robotic surgery in urology</p> <p>Start to reduce the number of sites from which the Trust operates</p> <p>To offer outpatient appointments within 4 weeks in all specialties</p> <p>Explore potential for an enhanced Trauma Unit (Level 2)</p> <p>Explore potential for a</p>	<p>Implement clinical strategy</p> <p>Complete reduction the number of sites from which the Trust operates</p> <p>To improve patient access to services. To offer outpatient appointments within 2 weeks in all specialties</p>

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
			specialist level 1 centre for Neuro-rehabilitation at KCH	
Continue to upgrade and develop the Trust's infrastructure (estates & IT) in support of the strategic plan	Improve patient experience through sustainable service improvements based on Estate optimisation (SO3, SO5, SO6)	<ul style="list-style-type: none"> • C section and laminar flow facility at WHH business case OPD: Commence on site • pPCI new & replacement cardiac lab at WHH: Start on site • Commence replacement of Generators at WHH • Commence Endoscopy at WHH • Oncology refurbishment at K&C completion <p>To continue to implement the Trust-wide IT programme to ensure resilient, robust infrastructure</p>	<p>Expansion of OPD at K&C and co-location of diagnostics to support one stop clinics</p> <p>Meet implementation target dates</p>	<p>Expansion of OPD at K&C and co-location of diagnostics to support one stop clinics</p> <p>Achieve target dates</p>
Develop and implement a plan to meet the timeline and address the changes detailed in the Health and Social Care Bill	The Health & Social Care Bill details significant changes to the commissioning process. This has the potential to affect the Trusts ability to achieve a number of its objectives (SO1, SO2, SO3, SO6)	<ul style="list-style-type: none"> • Develop and implement an overall health & social care bill project plan • Implement a systematic programme of engagement with the GPCC's • Develop a communication portal for GPCCs and local GP practices within East Kent to improve communication and responsiveness to primary care. • Review and update the Trusts marketing assessment and develop a new marketing and Communications to take forward the findings of the clinical strategy. • Engage with KSS in evolution of the new skills network 	Implement marketing and information strategy. Embed business systems for GPCC	Complete transition to GPCC
Implement the Trust workforce strategy, thereby ensuring that staff are able and responsible for the delivery of safe, effective care which provides a good patient experience and a planned financial surplus	The Trusts main asset is its Staff, maintaining the skill set is crucial to the Trusts ability to achieve its objectives (SO4)	Implement the Trust workforce strategy, to include implementation of the newly developed Trust organisational development (OD) strategy Prepare for consultant revalidation which it is anticipated will come into place October 2012	Implement the Trust's annual plans within OD and workforce strategies	Implement the Trust's annual plans within OD and workforce strategies
Continue to develop and implement a comprehensive	Supports service delivery and patient experience	<ul style="list-style-type: none"> • Prepare, consult and publish an over-arching quality strategy • Publish a patient and public 	Implement quality strategy NHS-LA Level	Implement quality strategy

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
quality strategy to support improvements in patient safety, clinical effectiveness/outcomes and patient experience	objectives (SO1, SO2, SO3)	engagement strategy <ul style="list-style-type: none"> Demonstrate improvement and compliance with commissioners' expectations of quality through achievement of CQUIN indicators, enhancing quality programme Prepare for NHS-LA level 3 for maternity risk management standards 	3 assessment June 2012	
Continue to support the development of R&D and innovation within EKHUFT	Crucial to the Trust being at the leading edge of clinical treatment developments and in attracting high calibre staff (SO4, SO5)	<ul style="list-style-type: none"> Further develop R&D and innovation within the Trust through implementation of the R&D strategy Increase links with partners in R&D including Kent Health Increased recruitment of patients to studies linked to CLRN and industry funded research 	Implementation of the R&D strategy Meet patient recruitment targets	Implementation of the R&D strategy Meet patient recruitment targets
Develop a robust 3 year financial plan with an explicit CIP and with a growth of EBITDA margin levels	Enables the Trust to meet all its financial commitments and produce a surplus that can be re-invested back into service and Estate upgrades (SO6)	<ul style="list-style-type: none"> Refresh financial strategy to ensure strong financial governance – endorsement at July 2011 Board Negotiate contracts with commissioners that deliver sufficient activity and finance to meet financial targets Enhance service line reporting patient level costing Delivery of CIP Actively participate in Kent wide QIPP with partner organisations to ensure financial stability across the Kent NHS network, deliver targets for which Trust is responsible 	Implementation of financial strategy Work with the divisions to develop cash releasing savings according to the target and ensure delivery	Implementation of financial strategy Work with the divisions to develop cash releasing savings according to the target and ensure delivery
Develop a reporting and analytic framework to support the Trust in delivering operational objectives and corporate performance	Improves the ability of the Trust to monitor performance and identify and investigate performance issues (SO2, SO6)	<ul style="list-style-type: none"> Update and agree the Trust's information strategy Develop and agree a reporting framework to effectively support monitoring and performance management Develop appropriate analytical approaches within the Trust's Information service to support evidence-based decision making within the Trust at all levels Support the education of key Trust staff in the appropriate use and interpretation of information to support decision-making Map the current data capture and coding pathway to identify system problems and bottlenecks and implement changes as necessary 	Deliver GP portal containing Trust activity data across Kent for renal service Complete development of phase 1 of demand and capacity modelling Develop capacity for activity reporting in new mediums	Deliver patient portal containing Trust activity data across Kent Extend GP Portal service for renal to include stroke services

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
Changes to NHS and local tariffs.	<p>Adverse impact on the overall level of funding for the Trust leading to reduced financial risk rating. Known changes for 2011/12 include:</p> <p>Tariff deflator (1.5%); MFF reduction (0.5%); NEL re-admissions penalty; Radiology/ Pathology Direct access price reductions; Local price reductions (NICU & Renal Haemodialysis).</p> <p>Some locally priced services are not fully funded under present contracts, diluting the financial performance.</p>	<p>Structure contracts in a way that limits the level of risk in the system.</p> <p>Undertake a thorough profitability review of services to ensure that appropriate business decisions around funding and cost efficiency are made.</p> <p>Establish a programme of full Service Line Reporting (SLR) from April 2011, to provide regular assessment of the profitability of the Trust's services and to form part of the performance framework.</p> <p>The Trust and PCT committed to rebase locally set tariffs during 2010. The agreed outcomes will be factored into 2011/12 plans to ensure that these services are as fully funded as possible and can be managed to benchmark cost levels.</p>	<p>Early assessment of tariff changes reflected in future plans.</p> <p>Pricing of local tariffs to fully fund service provided.</p> <p>Renegotiated Emergency Care block contract in 2011/12.</p>	<p>Programme on profitability assessment and subsequent actions to be overseen by F&I Committee.</p> <p>Service Line Reporting programme overseen by F&I Committee.</p>
Improving Quality as a result of external regulators (eg Care Quality Commission, Independent Safeguarding Authority and NHS Litigation Authority) and increased patient and public expectations.	<p>Financial penalty for non-achievement of CQUIN targets included within the main PCT contract and potential reductions in activity if patient perceptions are damaged.</p>	<p>Patient experience 'Ward to Board' measures developed to measure performance.</p> <p>The Patient Safety Board exists to ensure patient safety is being monitored and improved.</p> <p>Ensure enhanced information made available to patients, GPs and the public via the Trust website and the Directory of Services on Choose and Book.</p> <p>The monitoring process for CQUIN targets has been established as part of the development of a Balanced Scorecard. The Trust has risk adjusted total CQUIN 2011/12 income by £0.25m with £200k cost assumptions included within the plan to achieve the targets.</p>	<p>Quality to remain consistent at a minimum, and improve across most aspects of care, in line with local and national (eg Care Quality Commission and NHS Litigation Authority) indicators.</p> <p>For the Trust to become the Kent hospital of choice for patients.</p>	<p>Ward to Board metrics provide measures of progress.</p> <p>CQUINS, Quality measures, and a Dashboard of clinical metrics using the Synbiotix system.</p> <p>Quality KPI's will form part of the performance management system at Divisional level where appropriate as part of the Trust Balanced Score Card and will be overseen by the F&I Committee.</p>
Static or reduced funding for NHS Commissioners and other local public services.	<p>Potential reduction in the levels of social care provision could lead to an increase level of delayed discharges and</p>	<p>Engaging with local partners in health and social care to ensure joint planning decisions are made to manage the overall affordability and sustainability of services.</p>	<p>Overall cost reduction will be sufficient to deliver the required proportion of</p>	<p>Priority pathways have a nominated lead organisation and Clinical Chair; reporting to the East Kent Programme</p>

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	<p>increased cost.</p> <p>Excess activity above affordable levels leading to the need for community recovery plan and hence reduced income.</p>	<p>A Health System wide analysis of delayed discharges is being undertaken with the University of Kent which will propose pathway changes to improve discharge and achieve a reduced level of delayed discharges.</p> <p>Joint Integrated Planning Boards have been established with health partners developing priority programmes for healthcare reform with explicit activity impacts for each priority pathway.</p>	<p>the efficiency programme in 2011/12 and 2012/13 and the resulting Model of Care will be affordable to the local health system.</p>	<p>Board with executive representation from each healthcare organisation.</p> <p>Delayed discharges will be monitored as part of the Trust Key Performance Indicators, with a target reduction to below 2%.</p>
Significant changes to demand for acute services.	<p>Risk of excess demand leading to the delivering an increased level of capacity at short notice at high premium cost.</p> <p>Excess Non Elective growth (over 0.5%) may impact operational delivery - A&E waiting times and bed pressures potentially impacting the delivery of elective care and the referral to treatment target.</p> <p>Elective demand beyond planned levels may impact the Trust's ability to achieve both its elective access and financial targets. The PCT may be unable to fund the full level of demand and/ or the Trust may incur additional premium costs.</p> <p>Elective demand falling below planned levels as a result of successful demand management and health-economy change, resulting in reduced activity and income, leaving the Trust with excess</p>	<p>Regular monitoring with the PCT regarding activity referral and conversion rates alongside established groups with clinical leadership to review issues.</p> <p>The Trust forward plan assumes a decrease in cost of delivering additional capacity (including Independent sector provision) and demand being managed down. A corresponding cost reduction at marginal cost has been assumed in the Trust plan at 82% of full NHS tariff rates.</p> <p>Specifically, Musculoskeletal services, our most over-subscribed service, the Trust is working closely with the PCT to ensure best use of capacity across the health economy, including community and other secondary care providers</p> <p>Working with the wider health economy partners to undertake a LEAN project for emergency care services, with the objective to reduce the demand for emergency care and to address issues with the management of chronic conditions in the community, thus avoiding unnecessary emergency attendances and admissions.</p>	<p>Referral and activity assumptions are broadly in line with annual plan assumptions.</p> <p>Variations will be monitored at Specialty level and capacity will be flexed in-year to meet any changes.</p>	<p>Progress will be measured via review meetings and other performance measurement meetings.</p> <p>Revision of service specification around change of service provision in line with need.</p> <p>Elective demand will be monitored against PCT Demand Management plans.</p> <p>Accountability is to be shared between commissioners and service leads.</p> <p>Progress will be measured against the Data benchmarking system to profile referrals across the localities.</p>

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	fixed cost capacity.			
Vertical Integration of Patient Pathways with External Organisations.	Key risk to the plan concerns the Trusts ability to deliver proposed cost efficiencies through vertical integration proposals, when it is dependant on other external organisations.	Working with partner organisations to understand the potential gains of vertically integrating services. Pathways and priority areas have been selected for closer examination. The Trust is leading on the Musculoskeletal Pathway. In addition, the Trust is engaged in the Kent & Medway wide QIPP (quality, innovation, productivity and prevention) Provider Economics Study. The executive management regularly attend Kent & Medway STORM meetings. Both forums provide opportunities for the Trust to further understand the local healthcare economy and the potential for vertical integration of services and of organisations.	Smoother patient journey through seamless services. Patient experience should improve. Better joint working relationships with partners.	Current plans concern clinical pathway development. Integrated Care Boards (lead organisation to each of the selected pathways). Joint meetings, action plans and implementation schedules will indicate progress. Improved patient experience scores and better clinical outcomes, reduced length of stay and readmission rates would be additional measures of progress. Integration expected through 2011.
Market assessment - Competition from alternative providers.	Loss of market share through increased market activity resulting from a more competitive healthcare environment.	Continued collection and use of market intelligence to maintain flexibility in service delivery will ensure the Trust is aware of significant market changes as they are proposed. To monitor potential impacts, a weekly review of referrals received by specialties as part of the Trust's operational management process. Ongoing development of partnership working and alignment of strategies and a review of capacity in response to changes in demand in order to reduce costs will all continue.	All services will be monitored in order to ensure they are responsive to changes in markets and local priorities.	Progress will be measured via review meetings with commissioners and market intelligence gained through benchmarking.

Section 3: Trust plans

Financial plans: income

Since the introduction of payment by results, patient choice and the drive to reduce patient wait times the Trust has dealt with significant demand growth. Despite more capacity being developed by primary care the Trust has seen referral growth of more than 10% since 2008/09.

The lead PCT (91.9% of Clinical Income) is in the process of delivering a QIPP agenda of £50m, which if successful, would generate significant reductions in acute work for the Trust, specifically emergency and non elective care as well as elective services such as Endoscopy, Ophthalmology, Diabetes and Dermatology. This represents a significant risk to the Trust and to mitigate this risk in the short term the Trust has devised a risk share agreement with commissioners that mitigates significant activity variations.

One area of known growth is seen in Cardiology where the new pPci service has been very successful in both increasing access Kent wide and repatriating activity from other specialist providers, further investment in this service is planned for 2011/12 and built into the income plan. No account yet has been made of a potential increase in demand from West Kent as Maidstone and Tunbridge Wells Trust reorganise its services.

The proposal with the main commissioner (92.4% of clinical turnover [see "Contracts" tab]) is expected to be set at activity levels broadly equivalent to the 2010/11 forecast outturn. The Trust's own activity projections for 2011/12 show a possible £7.5m worth of activity-driven income reductions across all commissioners. However, the significant risk to the Trust with risk share arrangement in place is that activity will continue to grow in 2011/12. However, the referral reviews undertaken through the later months of 2010/11 do reflect a change in referrals that might suggest a plateau or even a downward trend.

On top of the net 1.5% deflator in the tariff the Trust also faces some significant further income pricing changes in 2011/12. PbR income will be reduced by the 5% (£2.5m) downward change in Market Forces Factor and the income from non PbR sources will also be impacted by converting block income to cost per case and negotiated price reductions for Direct Access Pathology [For detailed impacts of net 1.5% tariff reduction and 5% reduction in MFF please see all PbR and other NHS revenue income tabs].

The change in block income is expected to increase the Trust's income by £5.0m and the change in direct access Pathology to reduce income by £4m. All these changes will happen independently of any change in activity and will therefore have no impact on cost. [Please see "Ac Other NHS revenue" tab for details].

During 2010/11 the Trust's non emergency admitted care and A&E contract was operated as a block. This meant that the Trust did not suffer challenges over coding and service change or the impact of the 30% marginal rate for the 2008/09 non elective threshold. As this arrangement ceases in 2011/12 the Trust will gain £6.0m as the non elective and A&E contract reverts to full PbR but will also lose £2.9m as the increased income is exposed to the 2008/09 threshold. [Please see "Ac A&E plan" and "Ac Non-Elective plan" tabs for details].

The contract with the Trust's main commissioner has been set at £416m.

The Trust is developing with commissioners alternative emergency care pathways and payment systems which are expected to reduce income to the Trust in both 2012/13 and 2013/14. The reductions of approximately £5.8m in each year are included in the "Ac A&E plan" and "Ac Non-Elective plan" tabs. Beyond the specific reduction in income from the emergency care pathway it is expected that only demographic growth will be seen in 2012/13 onwards and that this growth will be offset by reductions in price.

Key income risk	Amounts and timing	Mitigating actions and delivery risk
	2011/12 2012/13 2013/14	
Reductions in activity that generate income levels significantly below plan.	<p>During the last few months referrals from the GPs within the Trust's main commissioner have fallen by 4.5%. This is being investigated further. Initial findings suggest that changes in referral and treatment criteria are the main cause.</p> <p>2011/12 - £4m (full year affect) worse case potential risk</p> <p>2012/13 - £12m for lost income due to elective activity reductions. Figure assumes 4.5% reduction in elective activity and the loss of risk share benefit from 2011/12.</p> <p>2013/14 - £8m based upon continued reduction in elective activity.</p>	<p>Review the Model of Care.</p> <p>Through Contract negotiations, agree a contract that either limits or negates the impact of any change in payment for this activity.</p>

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:				
Trauma & Orthopaedic Services.	The Orthopaedic backlog has been managed in 2010/11 near to sustainable levels. The temporary staffing capacity is currently under review to ensure a sustainable service going forward and to manage the withdrawal from Independent sector usage and ensure there is a planned enhanced level of efficiency to be delivered from existing activities.	<p>Managing the transfer of care when the contract for the temporary theatre ceases and the new theatre is completed at WHH (June 2012).</p> <p>Further risks include:</p> <ul style="list-style-type: none"> • The impact of LPP • Demand & capacity planning • Assumptions and impact on the achievement of the Trust Median Wait RTT (with potential financial penalties). • Cost of Independent sector capacity (£7m in 2010/11) • Not purchasing regularly used equipment and continuing with the loan equipment will result in ongoing costs 	<p>£2.9m capital expenditure programme to create a permanent additional Orthopaedic laminar flow facility.</p> <p>Staffing capacity review</p>	<p>Achieving and sustaining the NHS constitution, monitor median waits and the PCT contact of referral to treatment (RTT) of 18 weeks.</p> <p>Achieving the work force plan</p> <p>Improved patient satisfaction & experience</p> <p>Reduction in length of stay (LOS) for emergency and elective patients.</p> <p>Withdrawal from Independent Sector usage by March 2012.</p>

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Gastroenterology and Endoscopy Services (inc Bowel Screening)	<p>The service has seen sustained growth over the past few years (>10% p/a). In 2011/12, an expansion of the Endoscopy suite at QEQM will be complete and the estate solution for WHH will be delivered over the next two years.</p> <p>Three main drivers underpin the case for change:</p> <ol style="list-style-type: none"> 1. Joint Advisory Group (JAG) accreditation for all Endoscopy providers; 2. Delivery of bowel cancer screening services in East Kent; 3. Meet current and future demand for Endoscopy and bowel screening services and provide a sustainable cost efficient service over the next five years across three acute sites.. 	<p>The risks include not being able to complete the building work within the JAG timescales (or achieving accreditation), being unable to recruit trained staff with the appropriate skills.</p> <p>There is also a risk that the take up of bowel screening is greater than planned levels for 2011/12.</p>	<p>Capital budget of £2.0m for 2011/12 with final costs in 2012/13 of £4.6m.</p> <p>Increased staffing levels in the short term to manage current demand growth.</p>	<p>Measurable benefits include an improved provision of bowel cancer screening, achievement of quality standards for GRS (Global Rating Scale) and JAG and the sustainable capacity to support Endoscopy growth.</p>
Investing in Community/ Ambulatory Care	<p>To provide local services in Dover, in modern fit for purpose premises that support the delivery of high quality healthcare services.</p>	<p>The key risks are:</p> <ul style="list-style-type: none"> • May be insufficient capital funds available to complete this project to the projected timescale. • Delay to decision may cause a delay in realising the benefits of the investment and impact the timing of external factors such as the timely progression of planning permission. 	<p>A provisional amount has been included within the Capital Programme for the three years 2011/12 to 2014/15, with the largest proportional expenditure planned for 2013/14. Final Capital valuations will be derived through the development of the Full Business Case for Dover Services.</p> <p>Current revenue resource will be</p>	<p>The intention is now to complete the Full Business Case for this project during the later part of 2011/12.</p> <p>Subject to the necessary approval of the Full Business Case by the Board, construction will commence in early 2012/13 and will be phased for completion in 2013/14.</p>

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
			transferred to any potential new facility..	
Outpatient Refurbishment Programme for KCH & WHH	<p>Focusing on the Outpatients department's model of care and the ambulatory care model at both the Kent and Canterbury (KCH) and William Harvey hospitals (WHH) with a view to developing:</p> <ul style="list-style-type: none"> The co-location of diagnostics within outpatients will ensure patient pathways will be as efficient as possible and a one-stop approach can be implemented. Maximisation of OPD estate into clinical space. Clinical space will be allocated to clinical suites to ensure optimised use of space with supporting services and nurse led clinics to ensure the use of one stop clinic Specialties will timetable clinics to maximise the ownership and utilisation of suites and to consider the potential use of Saturday and early evening clinics. 	<p>The delivery risks are;</p> <ul style="list-style-type: none"> Costs for the project may rise beyond what is budgeted. This will cause a shortfall and areas of improvement will have to be reduced. This will be mitigated through close linking in with estates and during procurement. Interdependencies may impact on the projects ability to delivery to cost. Additional resources are needed to run a 3 session day, 6 day working, such as manpower, support services, estate and facilities. This will be mitigated through linking closely with linked projects and communicating deadlines and plans along with the risk log Maintaining operational services during refurbishment,, mitigated by either / or adopting a multi phased approach / working nights and weekends and agreeing the programme with the service users. 	<p>Any amendments to resource requirements are being addressed via the Models of Care Board and the associated action plan. Capital costs of £4.6m have been included in the capital plan for 2012/13 – 2013/14.</p>	<p>Capital costs have been prepared by an independent Quantity Surveyor on the basis of a full refurbishment of the existing OPD's taking into account out of hours working. The measures of progress will be measured by the following;</p> <ul style="list-style-type: none"> The refurbishment project will come in on budget 85% of clinic space will be utilised. Due to one stop clinics the number of visits the ratio of NP to F/up will reduce – improving quality & patient experience
Management of Emergency Care	<p>Delivery of urgent care through an Integrated Urgent Care Board with representation from all key stakeholders with objectives to support improvements in the delivery and quality of care. Provide financial efficiency by reviewing</p>	<p>The following work streams have been established:</p> <ul style="list-style-type: none"> Primary care integrated response to urgent care Enhanced support to care homes and advanced care planning Review of primary care nursing and the community matron role 		<p>Performance targets forming part of the Trust Balance Scorecard performance framework:</p> <ol style="list-style-type: none"> Unplanned Re-attendance Rate Total Time is A&E

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
	care pathways to : <ul style="list-style-type: none"> • Reduce unnecessary admissions/ re-admissions • Reduce hospital length of stay • Prevent unplanned exacerbations of illness • Avoid unnecessary acute (A&E) attendances 	<ul style="list-style-type: none"> • Intermediate care review • Minor injury unit and walk-in centre review • Integrated ambulance pathways and transportation services • Urgent and emergency model of care • Emergency ambulatory care • Integrated discharge and transfers of care 		3. % of patients leaving A&E without being seen by a doctor 4. Time to initial assessment in A&E 5. Time to Treatment in A&E 6. Ambulatory Care ambulatory pathways (DVT and cellulites)
Expansion of Cardiac Services (pPCI)	The Trust is expanding the new service launched in April 2010 that offers a pioneering new treatment for patients who have suffered a particular type of myocardial infarction. Clinical evidence demonstrates that for suitable cardiac patients, a more effective intervention is pPCI (primary Percutaneous Coronary Intervention) replacing the current practice of Cardiac Thrombolysis.	<p>The key risk factor relating to the pPCI service is the risk associated with the transportation of both patients and staff, as the target performance measurement is 150 minutes from 'Call to Balloon'. This is particularly around the modelling assumptions as this service serves a large population and covers a large geographical area.</p> <p>This is being mitigated by a robust Network Review every three months.</p> <p>The Trust plans to further develop Cardiac services at the WHH by creating a second Cardiac Catheter Laboratory and to refurbish the current Laboratory. This will enable WHH to provide a 24/7 pPCI service 365 days of the year.</p>	<p>A 24x7 rota has been developed using Trust staff and Consultant representation from the four Kent & Medway Acute Trusts (10 consultants in total).</p> <p>Capital budget is £2.0m (2011/12) and £0.7m (2012/13). for the refurbishment of the current Cardiac Catheter Lab and the building of a second Lab at WHH.</p>	<p>Retaining and expanding a Kent Centre for pPCI in line with commissioning intentions, national policy and best practice. pPCI has now been shown to lead to:</p> <ul style="list-style-type: none"> • Better survival rates post MI • Reduced rates of readmission to hospital • Significant reduction in the average length of stay within the hospital • Faster recovery times • Better quality of life outcomes <p>Metrics based on the measures outlined above have been developed following the assessment of year one (2010/11) baseline activity and outcome data.</p>

Financial plans: activity and costs

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
Workforce efficiency programme	2011/12 £10.0m 2012/13 £21.8m 2013/14 £23.1m	The Trust has a pay dominated cost base. It is therefore a key area for focus on productivity and payment rates. The workforce strategy promotes the reshaping of the workforce and reduction of agency staff and premium payments, both from a cost perspective but also for improved service quality and safety through reduced risks in use of non contracted staff.	Controls on agency and locum spend Revising working practices with the consequent staffing requirements. Other initiatives include: Ts and Cs (including on-call) Reduction in Junior Doctor Bandings. Clinical nurse specialist review. Bandings and AfC hours. Salary Sacrifice. Harmonising Spencer Wing payments. Savings from Professional Registration. Use of technology: EDN & VR at POC. General use of Voice Recognition. Audio Visual Communications. Central Room Booking. E-Rostering. Observation & Decision IT. ESR Benefits.	Directorate management, HR, Service users and finance. New e-Rostering IT system.	Some commenced during 2010/11 and benefits arising in 2012/13. Enhanced payment policy implemented April 2011. Recruitment to vacant posts to Directorate timetables.
Clinical coding programme	2012/13 £2.0m	Corporate Programme (Clinical Coding and Income Board) to identify and revise operational practices that improve Trusts income position within existing cost base. Workplan includes clinical coding, outpatient procedure activity records, uncoded episodes and full review and identification of PbR exclusions Consideration is also being given to implementing commercial opportunities across the Trust as	A range of schemes have been identified, including; Coding of patient events and activities, visitors, patients and staff car parking fees. The key risks are where PCT funds may be restricted (PbR exclusions) and where consultation is required to progress to intended outcome. Many of the benefits identified may not be recognised by the PCT.	Senior clinical leadership (CCIB). Engagement of Divisional management and clinicians. Finance and Information teams (inc clinical coders and contracts team). Estates team. HR. Outpatient service managers	2012/13: Clinical coding benefits realised from Qtr 1

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
		part of response to changing economic environment.			
Outpatients programme	2011/12 £0.1m	To improve the performance of outpatient services, through increased productivity, better use of facilities and improved patient booking arrangements	Rationalisation of offsite clinics Revised booking systems and practices Improved communication systems with patients to book or revise appointments Key risks include delays in defining action plans for practice changes and supporting systems (pilot projects for specific areas an option)	Executive leadership Full involvement of Divisional managers, Outpatient services management and Finance support Input from public and patient representatives to support communications development	To be agreed following the finalisation of the Clinical Strategy.
Patient pathways (inc LoS programmes).	2011/12 £1.7m 2012/13 £0.40m 2013/14 £0.40m Current bed base 1,150 inpatient beds. Indicative bed reductions for next 3 years 2011/12 60 beds 2011/12 40 extra beds 2012/13 17 beds 2013/14 40 beds	Planned reductions in lengths of stay, particularly longer stays, to release bed capacity for additional activity (linked to reduced use of independent sector) and reduce costs of excess and established beds. This programme is aligned to the care pathway redesign programme (ECIST and Emergency Care Board workstreams.)	Review and agree benchmark LoS data. 'Left shift' patient management (admission avoidance and discharge planning measures) Key risks of not attaining full cost reductions will be due to PCT not implementing demand management measures and revisions to community capacity and internal delays in operational and clinical process changes	Executive and Clinical leadership Engagement of all Divisional clinical and management teams Collaboration with PCT and service commissioners	2011/12: Avg 50 extra beds closed by end of April 2011 60 bed reduction by Qtr 4 (phased approach) 2012/13: 40 bed reduction by Qtr 4 (phased approach) 2013/14: 40 bed reduction by Qtr 4 (phased approach)
Theatre productivity programme.	2011/12 £2.7m 2012/13 £2.0m 2013/14 £2.0m 2012/13 and 2013/14 - data to be reviewed	Planned 20% improvement in theatre productivity (linked to ambulatory and capacity programmes).	Improvement action plans include: On time starts, list booking and reduce cancellations Defining Theatre income and costs (at per session and per case level) From performance and financial information decisions to be taken on future theatre programmes and	Executive and Clinical leadership Engagement of all Divisional clinical and management teams Theatre Productivity Board Routine information reporting,	2011/12: All Divisional action plans implemented by April 2011 Realisation of planned efficiencies (inc additional cases booked, under utilised lists withdrawn) from Qtr 1.

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
			workload based on financial viability of caseload by theatre teams Key risks include sustaining improvements across all actions, maintaining strong clinical leadership to challenge existing boundaries (inc list allocations and practices) and provision of appropriate IT and information systems to support decisions	covering Theatre activity, costs and income	Full roll out of pre assessment service and revised list booking arrangements in Qtr 2
Overhead reduction (incl. Facilities, Estates & Back Office functions).	2011/12 £1.60m 2012/13 £0.50m 2013/14 £0.50m	A Corporate programme to deliver a minimum 15% expenditure reduction over 3 years within Estates, Facilities and Back Office functions. Key areas for review include; Payroll and expenses processing, Healthcare transport, Estates premises and management.	Estates – disposal of surplus accommodation and reduction in utilities, maximisation of rental of Trust property Facilities – Soft and Hard FM re-tendering, transport and grey fleet Reduction in management consultancy service expenditure A number of schemes have been developed to achieve further efficiencies, including; a cross county healthcare transport review (and possible tender process) a payroll consortium review and tender broadband charges within accommodation fees clinical and non clinical waste reductions and IT maintenance contracts, The principal risk to these schemes is the possibility of timescale slippage with the need to develop complex tenders with partner organisations. Demand for patient transport increases mitigated by adherence to eligibility criteria.	Executive leadership to Overhead Reduction Group HCT team and finance to support back office cost reductions. Use of SEC Collaborative Procurement Hub to support some Tenders. Resource to achieve next level CNST standards (maternity services).	2011/12 Soft FM contract extension from July 2011

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
Procurement programme	2011/12: £1.2m	The Trust has a well established procurement function that also plays a leading role in working alongside the SEC NHS Commercial Solutions (Previously CPH).	Procurement team to link with NHSCS and progress agreed work plan Risk – savings not realised at levels expected, timing of savings slips due to agreement on Tender specification. Delays at NHSCS.	Executive leadership Full engagement of Divisional clinical and management staff in partnership with procurement teams to progress product changes and support practice changes that arise.	Plans to be finalised June 2011
Medicines management programme.	2011/12 £0.8m	The Trust has a well established Pharmacy procurement and medicines management programme.	Pharmacy team to link with Drug & Therapeutic Advisory Committee and consultant body to implement drug changes. Key staff from each specialist area and CURG to meet with procurement regularly to ensure workplan is implemented.	Engagement by clinicians & nursing to implement changes in drug usage.	Plans agreed February 2011, action by various groups throughout the year.
Other schemes.	2011/12: £4.5m	In addition to the main corporate (cross cutting theme) programmes the Trust has a number of service specific efficiency plans	AMD business case – to repatriate service from independent sector Reduction in internal pathology activity NHS (level 2 to 3 in maternity standards) in 2012/13	Divisional management teams	Specific to individual projects

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
Marginal Rate cost reduction following a reduction in activity	- Trauma & Orthopaedics - £1.2m reduction in 2011/12 - £0.6m reduction for Physiotherapy services transferring to alternative providers - £1.3m for the transfer of Dermatology outpatient activity to primary care.	Removal of costs driven by a reduction in activity will help the Trust maintain a financial risk rating of 4.	Final agreement of contract changes. Conclusion of potential impact of TUPE. Setting and monitoring of appropriate expenditure budget.	Contracting resources. HR resources. Legal review. Strategic review.	2011/12 – Will be test of PCT ability to divert activity and implement published commissioning intentions that significantly impact the Trust's income. 2012/13 to 2013/14 – No significant service change proposals identified although activity is expected to at least plateau and potentially be influenced by the QIPP agenda.

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
Safe and effective workforce - By implementing the key recommendations of the Boorman Review that relate to NHS providers.	To improve the productivity, health and well-being of all our staff and reduce sickness absence.	Implement an early intervention musculo-skeletal service by January 2012. Employee health & safety programme (partnered by the Health & Safety team) focusing on Work-related stress. Healthy Lifestyle programme over 3 years. Delivery Risk: Staff understanding of the importance of these issues in an increasingly challenging environment. Mitigated by communication and engagement plans.	Clinical Service Manager and Clinical Director from Occupational Health plus Healthy Working Steering group. Business case support.	Year on year reduction in sickness rate from 2010/11 benchmark rate of 3.8%. Maintain EWTD compliant rotas. Improvements in self reported stress levels in staff survey and other self assessment tools.
Safe & effective Workforce - Continue to ensure that staff are well trained and developed to meet the standards expected internally and externally and deliver against the trust strategic objectives.	Increase in quality of care to patients	Robust training plans in place. Focus on performance management & appraisal. Meet policy changes and developments including ISA and revalidation. Use of in-contract CPD monies to support changes in patient pathways.	Staff availability to undertake development activities. Resources and skills to support staff training and development.	Improved mandatory training compliance each year as measured by staff survey results. Increase staff with an appropriate qualification every year as measured by external regulatory bodies. Annual report of the quality of training and development opportunities through level 3 evaluation. Successful revalidation of all consultants.
People - the right people in the right place at the right time.	Improving workforce planning to support the clinical strategy	Improve the links between the LTFM and the budgetary planning of the future workforce. Develop Divisional workforce plans and Staff group specific workforce strategies and plans. Re-profile the workforce to support the clinical strategy, efficiency and patient pathways. Development of career pathways with generic sets of	HR Business Partners, Financial planning and management, divisional directors, and professional leads.	Year on year reduction in vacancies from 2010/11 benchmark. Year on year reduction in agency spend as a percentage of total paybill from 2010/11 benchmark.

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
		roles and competencies Deliver the Talent Management Policy.		
People - the right people in the right place at the right time	Improving skills	Year one focus will be on performance management Develop a more appropriate approach to coaching within the organisation. Implement new leadership competency model. Enhancing team working through team based training	As above, in addition resources will be required as detailed in the business case supporting the Organisational Development Strategy and plan described in next section.	Improvement in organisational operational and strategic performance year on year
People in the right place at the right time - Effective management of core staff establishment.	Support workforce efficiency programme.	Reduction of premium costs of both agency staff and employees will result in a reduction in the mean cost per WTE. Work with Divisions to reduce the establishment and workforce through natural wastage. Review of specialist nursing roles and development of Band 4 associate practitioner roles. Improve back office efficiency through use of new technologies and other initiatives. Move to a three sessions and six day week for some staff.	Working Group consisting of Finance, HR, and General Managers to carry out the controlling actions. Staff Committee, HR Business Partners and Business Managers.	Year on year 5% efficiencies on staff costs Zero redundancy costs Workforce efficiency programme delivers required drop of 297 budgeted Wte in 2011/12 (based on expected activity drop and consequent cost reduction deriving a Wte based on Trust average salary). A further 300 Wte drop planned for 2012/13 and 2013/14.
People in the right place at the right time - To ensure effective utilisation of technology to improve efficiency and productivity.	Increase in quality, patient flow and patient outcomes.	Voice recognition, Audio visual comms reducing travel costs, e-rostering project, observation and decision support IT and Electronic Discharge Notices.	HR Business Partners, General Managers and IT Team.	As above. Reduced LOS. Improvement in Patient Safety and Quality outcomes.
Supporting Organisational Change.	Organisational Development Strategy in place.	OD strategy and plan approved by Board in Apr 2011 Business Case to support the strategy and plan approved by the executive team by April 2011.	Executive Team, HR and Divisional Directors, business case.	Strategy and Plan approved. Business Case funding approved and additional resources secured. Plan implemented

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
		Deliver key milestones and activities in the Organisational Development (OD) plan.		in key phases over next 5 years and success measured in accordance with the strategy and plan as well as overall organisational performance.
Supporting Organisational Change	Moving the Board to high performance	Identifying external partner to work with the Senior Team on development and leadership Board to re-consider Trust's Mission, Vision and Values.	Senior Team	As above
Supporting Organisational change - Support the implementation of the new Divisional Structure.	Improving services through improved leadership and management.	Implement of structure from 1 st April 2011. Testing and finalisation of the Operational Framework for the organisation (by Finance, Strategic Development and the Divisions)	Head of Human Resources, Executive Team, Finance and Strategic Development. .	Compulsory redundancies avoided. Year on year Staff Survey improvements in perception of leaders and understanding of message.
Developing the Human Resources and Occupational Health Services	Ensuring excellence and value for money, contributing to back office review	Benchmarking of services across public and private sectors. Working with partners to develop a shared service approach for each back office function Developing internal SLA arrangements with new Divisions.	HR senior team, Divisional Directors and external customers	Year on year increase in contribution to EBITDA from these services.

Financial plans: Capital programmes (including estates strategy)

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:			
Expansion of Cardiac Services pPCI	Planned capital expenditure is £2 Million in 2011/12. With the remaining £700k in 2012/13. The scheme is due to commence Summer 2011 and the programme for completion during 2012/13	The Kent Cardiac Network identified the William Harvey Hospital as the first Centre in Kent & Medway for primary angioplasty, enabling further repatriation of work from London and the provision of the service to the whole of Kent and Medway	<p>The scheme will be monitored by the Estates Team and the Trusts Procurement Team to ensure it is on programme and to budget.</p> <p>The key risk factor relating to the pPCI service is the risk associated with the transportation of both patients and staff, as the target performance measurement is 150 minutes from 'Call to Balloon'. This is particularly around the modelling assumptions as this service serves a large population and covers a large geographical area.</p> <p>This is being mitigated by a robust Network Review every three months.</p> <p>With this scheme, the Trust is planning to further develop Cardiac services at the WHH by creating a second Cardiac Catheter Laboratory and to refurbish the current Laboratory. This will enable WHH to provide a 24/7 pPCI service 365 days of the year.</p>
Endoscopy Expansion (including Bowel Screening) – Trustwide	<p>In addition to the work undertaken during the last three financial years, the capital expenditure plan for the next two years for Endoscopy services is:</p> <p>2011/12 - £2.0m</p> <p>2012/13 - £4.6m</p> <p>Refurbishment and expansion of the QEQM scheme will complete in July 2011.</p> <p>The WHH scheme has been delayed to carry out a further Strategic Review. Work is due to commence at the WHH in Q3 2011/12, with completion in 2012/13</p>	<p>There are three main drivers that underpin the case for change:</p> <ol style="list-style-type: none"> 1. The national requirement for all Endoscopy providers to be accredited by the Endoscopy Joint Advisory Group (JAG); 2. The need for the Trust to continue and expand the provision of bowel cancer screening services in East Kent; 3. The need for the Trust to meet current and future demand for Endoscopy and bowel screening services within an 18 Week RTT pathway. 	<p>Delivery risks include:</p> <ol style="list-style-type: none"> 1. Under estimation of costs associated with implementation. Project Management and progress will be managed by the Trust's Strategic Estates Team. 2. Inability to complete building work within JAG timescales will be mitigated through careful resource planning, effective project management, Strategic Investment Group and Executive Team buy-in to the risk secured and continuous liaison with JAG to ensure they are content the Trust has a plan in place to deliver required improvements.

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)
New Main Theatre and C Section Theatre WHH (Trauma & Orthopaedic Services)	Planned capital expenditure is £2m in 2011/12. With the remaining £860k in 2012/13. The scheme is due to commence Summer 2011 and the programme for completion during 2012/13	The new main theatre (replacing the temporary theatre on site) will provide the site with a much needed Laminar Flow facility for supporting specialties such as T&O. The development will also provide a fully compliant C Section Theatre on the WHH site.	Underestimation of costs associated with implementation. Project Management and progress will be managed by the Trust's Strategic Estates Team.
New Generators WHH	Planned capital expenditure is £2.1m in 2011/12. With the remaining £0.6m in 2012/13. The scheme is due to commence Summer 2011 and the programme for completion during 2012/13	The provision of new generators for WHH will take account of all the current power requirements and provide for future needs under the Estates Strategy	The most significant risk relates to the provision back up power for core services. A hired standby generator is currently in place in an emergency Underestimation of costs associated with implementation. Project Management and progress will be managed by the Trust's Strategic Estates Team.
Maintenance:			
Medical Devices – Medical Devices Group	The capital allocation for replacement equipment for 2011/12 is currently set at £2m per annum and will continue to be managed by the Medical Devices Group until deemed otherwise by the Strategic Investment Group.	This is an on-going Investment Programme for medical equipment replacement and decisions are currently made by the Medical Devices Group based on business cases submitted on an ad hoc basis.	This capital allocation is managed by the Medical Devices Group, which reports to the Strategic Investment Group (SIG) with an Executive Director chair. Progress and expenditure updates are formally reported monthly, with actions to address any variances to plan. In response to a request from the SIG a 10 year costed and prioritised rolling equipment replacement strategy and programme against which all aspects of the management and procurement of medical equipment (capital and revenue) items will be assessed with effect from the 1 April 2011 .
Digital Mammography equipment in support of the symptomatic service	The Trust is planning to invest £1.3m in Digital Symptomatic mammography equipment with the majority of funding expected to be provided through public appeal through the East Kent Hospitals Charity. Official launch of the charitable appeal was launched in June 2010 and is ongoing through 2011.	The key aim of the investment is to provide digital Mammography equipment in support of the symptomatic service, in place of the current analogue equipment. This will result in equitable service provision to those accessing the digital breast screening service.	Clear risks revolve around the raising of funds in sufficient time to deliver the planned benefits. Fundraising milestones will be overseen by the Charitable Funds Committee. A re-prioritisation of the Capital Programme may be required should the appeal fail. However, the structure of the Appeal has been based on successfully delivered models by other NHS organisations.

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)
Major Medical Equipment Inc XRay	This allocation has been increased to £3m to provide one replacement and one new MRI scanners at WHH.		Under estimation of costs associated with implementation. Project Management and progress will be managed by the Trust's Strategic Estates Team and the Trusts Procurement Team

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 MRSA bacteraemia and Clostridium difficile (C. diff) infections - reduction in the number of reported cases annually in line with national and local stretch targets	This is a key component of the overarching programme to improve patient safety and patient outcomes. The measure is part of the routine Board Quality Report, the Trust Quarterly Compliance submission and the published Annual Quality Account, directly linked to the Trust strategic objectives.	Detailed annual program of infection prevention and control is in place with robust monitoring systems. RCA investigation completed for all MRSA bacteraemias within five working days. External assurance is provided through monitoring and reporting to the PCT and SHA against agreed metrics. Risk surrounds the achievement of reduced targets both for MRSA and C difficile infections for 2011/12, which has a low tolerance level to enable improvement	MRSA – 6 cases Clostridium difficile – 96 cases	<u>MRSA:</u> 2011/12 – 5 cases. 2012/13 & 2013/14 – target will be based on the National HCAI DH Objectives, to be agreed with the PCT (including local stretch targets). <u>Clostridium difficile:</u> 2011/12 – 75 cases. 2012/13 & 2013/14 – target will be based on the National HCAI DH Objectives, to be agreed with the PCT (including local stretch targets).
Patient safety Reduction in standardised mortality rates a) Hospital Standardised Mortality Rate (HSMR) b) Summary Hospital Mortality Indicator (SHMI)	To aim for top 10 performance by further reducing mortality and 'harm events' to patients, linked to the Trust strategic objectives.	<ul style="list-style-type: none"> • Monitored through the development of the clinical quality and patient safety dashboard and supported by the Patient Safety programme reporting monthly to CMB and Board. • Clinician-led mortality reviews commenced in 2010/11. Due to the number of deaths occurring, it is not possible to review all mortality occurring in the Trust. • Measurement against the two indicators is required to ensure consistency around this metric. • Monitoring of the use of Z515 and Z513 coding (end of life care) influences standardised mortality. Reducing the level of coding in these areas may affect standardised mortality performance adversely. 	a) 2010/11 – 75 (Figure to be confirmed after final data lockdown and re-baseline of the normalised figure). b) 2010/11 – not available as this is a new indicator.	a) HSMR 2011/12 – 75 2012/13 – 72 2013/14 – 70 b) SHMI (Awaiting National data to become available) The targets may require revision as the new national algorithm may result in performance against peer.
Patient safety Reduce patient harm events (using the UK Trigger Tool).	This is a key component of the overarching programme to improve patient safety and patient outcomes. The measure is used as part of the published annual	An on-going programme of assessing a series of healthcare records to assess the rate of patient harm events occurring during an in-patient episode. This process is undertaken at each site, with an aggregated score for the Trust. Performance targets will be monitored via the Patient Safety	Two-year assessment shows a harm event rate = 3.9/1,000 occupied beds.	Monitoring performance will continue and focus on the four key drivers in the patient safety programme. Where possible external national and international

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
	Quality Account.	Board, with a quarterly report to the relevant sub-Board Committees.		benchmarking will be used to assess performance and progress.
Patient safety Reduction in the number of injurious and non-injurious patient falls.	Falls prevention is a fundamental component of the provision of safe care to patients. It is aligned to the overall national strategy to reduce 'harm events' following a fall while in care and is reported monthly as part of the Board Patient safety and Quality Report.	<ul style="list-style-type: none"> • Clinical quality and patient safety dashboard reporting monthly performance to the clinical management (CMB) and Board. • Priority associated with a number of initiatives including falls risk assessment; mapping of falls incidents to understand contributory factors such as the environment and the use of sensor alarms to alert staff for those patients who are most at risk. • Externally, a monthly joint Clinical Excellence Group run in conjunction with the lead commissioning PCT, reviews performance and provides assurance. The falls reduction programme will be incorporated into local initiatives around the High Impact Actions and QIPP programmes. 	2010/11 = 2,335 falls 2010/11 Injurious falls rate per 1,000 admissions = 2010/11 non-injurious falls rate per 1,000 admissions = 2010/11 falls rate per 1,000 admissions = Falls resulting in fractures 2010/11 = 23	Year on year 2% reduction in all patient falls. 2011/12 = 2,288 2012/13 = 2,242 2013/14 = 2,197 Rate to be confirmed as year end figures not yet available 2011/12 = 22 2012/13 = 21 2013/14 = 20 Year on year reductions may be revised based on the number of falls/ fractures occurring in the previous year.
Patient outcome Reduction in the number of hospital acquired Grade 3 and 4 pressure sores (including the level of deterioration in a pressure sore during a hospital admission to Grade 3 or 4).	Reducing patient harm from pressure sores is a fundamental component of the 'provision of safe care to patients' key priority.	<ul style="list-style-type: none"> • Clinical quality and patient safety dashboard reporting monthly to the CMB and Board. • Priority associated with a strategy to ensure that pressure sores are identified early and appropriate action is taken to prevent further deterioration. The number of pressure sores continues to vary monthly; however the severity level has shown an improvement overall. This suggests the screening and treatment across the Trust is improving overall and the aim is to continue this positive trend. • Avoidable hospital acquired pressure sores at grade 3 and 4 are included as a CQUIN measure for 2011/12. • Externally, a monthly joint Clinical Excellence Group run in conjunction with the lead commissioning PCT, reviews 	Hospital acquired pressure sores 2010/11 Grade 3 = 15 Grade 4 = 13	Number of hospital acquired grade 3 and 4 pressure sores. 2011/12 - Grade 3 = 12 2011/12 – Grade 4 = 10 2012/13 = to be agreed as part of local targets 2013/14 = to be agreed as part of local targets

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
		performance and provides assurance. The falls reduction programme will be incorporated into local initiatives around the High Impact Actions and QIPP programmes.		
Patient outcome Improvement in the agreed patient outcome measures and quality indicators for Stroke patients, fractured neck of femur patients and achieving primary percutaneous coronary intervention (pPCI) rates.	Improving patient outcome measures for agreed clinical conditions is aligned with the Quality Improvement Programme agreed with the commissioning PCT.	Development of the clinical quality and patient safety dashboard which is reported monthly to the CMB and Board of Directors. Quality initiatives, approved with the lead commissioning PCT will be reported quarterly against the agreed targets for each indicator. This programme of quality indicators is also subject to external assurance via the monthly Clinical Excellence Group. There is a risk that the performance against the pPCI indicator is not met in 2011/12 due to increasing demand. although first year activity suggests this risk is being managed.	Stroke patients receiving a brain scan within 24 hours = 96.7%; Percentage of patients with a fractured neck of femur (assessed as fit for surgery), operated on within 24 hours = 53.6%; Primary Percutaneous Cardiac Intervention (pPCI) service commenced on 12th April 2010 = 75.2%	Stroke patients; 2011/12 = 70% 2012/13 = 95% 2013/14 = 98% <u>Fractured neck of femur:</u> 2011/12 = 50% 2012/13 = >70% 2013/14 = 100% <u>pPCI "call to balloon" target:</u> 2011/12 = Target contingent upon national performance target but 75% minimum target. 2012/13 = 75% 2013/14 = 75%.
Patient experience Reduce the number of formal (written) complaints received.	The Patient Experience Programme aims to improve quality from a patient perspective by responding and resolving to concerns and complaints in an effective and timely way.	As well as other quality metrics being established for 2011/12, progress will be monitored through the clinical quality and patient safety dashboard. Additionally, the development of the Patient Experience Team has continued to progress with greater involvement of service users and patients in the complaints management process and this will continue into 2011/12 and beyond. Response rate and resolution targets agreed with the individual complainant in line with national best practice and local targets.	Formal complaints = 721 (to date) Percentage of complaints resolved within the target time = 85%	Crude number of formal complaints 2011/12 = (2.5% reduction) 2012/13 = (2.5% reduction) 2013/14 = (2.5% reduction) Percentage of complaints resolved within the target time 2011/12 = 90% 2012/13 = 95% 2013/14 = 100%
Patient experience Increase the number of compliments received as a proportion of the number of concerns raised.	The Patient Experience Programme aims to improve quality from a patient perspective by responding to and resolving concerns and complaints in an effective and	Monitoring through the clinical quality and patient safety dashboard and the further development of the Patient Experience Team. This is the first attempt made to capture data on compliments and there is a risk that there is not a well embedded system in place to record this information consistently across the Trust.	Compliment vs complaint ratio = 15:1	2011/12 – 12:1; 2012/13 – 14:1; 2013/14 – 16:1.

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
	timely way.	Further assurance around this data set is required and will be developed in 2011/12.		
Patient experience Improve patient experience about the overall quality of care received.	The patient experience programme aims to improve quality from a patient perspective and is a composite score included as part of the national CQUIN.	This indicator is based on a composite of 5 questions relating to 'Responsiveness to personal needs'. Risk of not receiving the full CQUIN income value if the target is not met. All CQUIN indicators are scrutinised internally using the governance structure outlined above; externally, a monthly joint Clinical Excellence Group run in conjunction with the lead commissioning PCT, reviews performance and provides assurance.	66.1% - Weighted average score from the 5 questions based on the annual inpatient survey 2010/11.	2011/12 - contingent upon the CQUIN target and as yet to be agreed. 2012/13 - upon patient survey results 2013/14 - contingent upon patient survey results A revision to the target may be required for 2012/13 and 2013/14 contingent upon performance in previous years.
Patient experience Improve patient experience by eliminating same sex accommodation (EMSA).	The Patient Experience Programme aims to improve quality from a patient perspective; this is part of the overall programme. Clinical scenarios for mixing on patient safety and choice reasons have been agreed with local commissioners based on DH and CNO issued guidance. .	<ul style="list-style-type: none"> • Patient experience feedback using a hand-held computer to gather the views of patients regarding same sex accommodation. • Systems and process to improve patient flows. • Staff culture – this aspect is reflected in the clear culture of the trust where mixed sex accommodation is not tolerated unless it is as a result of patient choice or is a risk to patient safety • Feedback on performance is given to the Board and relevant clinical sub board committees. • Subject to external assurance via the monthly Clinical Excellence Group. • Data will form part of the Unify2 monthly data extract. Changes to the NHS contract will result in the levy of a financial penalty in 2011/12 for cases of mixing outside patient choice or safety reason. 	Rate of mixing 12.73 per 1000 occupied bed days, equivalent to 99.25% compliance (all for justified clinical reasons or patient choice).	2011/12 - 100% 2012/13 - 100% 2013/14 - 100% (excludes periods of mixing for safety or patient choice as agreed with commissioners)

The primary responsibility for maintaining and improving quality rests with foundation trusts boards, consequently a risk assessment against Monitor's Quality Governance Framework was requested by the Board of Directors. The board will consider the framework as part of the preparation of the Annual Report for this and for future years. The assessment of current position was presented to the Integrated Audit and Governance Committee in April 2011 with an improvement programme to cover the period of the plan to be developed. The model, once devised, will be promulgated to each divisional management team for further risk assessment at this level. This process will support embedding the principles of the Quality Governance Framework across the Trust for the period of the plan.

The Board receives an update of all open serious incidents (SIs) and complaints monthly. This includes all complaints referred to the Parliamentary Health Service Ombudsman (PHSO), an outline of the clinical issues raised in all complaints received in the reporting month and progress against key milestones for all root cause analysis investigations as part of SI investigation. This, in turn, forms part of the routine reporting schedule to the lead commissioning PCT monthly. Progress against the action plans developed, for all the areas outlined, will form part of divisional performance dashboards. Dashboards will be received monthly by the Board, which should ensure awareness of all the actions recommended. Trends in complaints are difficult to analyse as the pattern shows normal variation over time. The Trust took immediate action following a cluster of incidents in a maternity department, commissioning an extensive internal and external review. Some training requirements were identified and a review of midwifery staffing is in progress.

EKHUFT is investing, through 2011/12, in an updated Corporate Balanced Scorecard which will be used to report across the new four clinical divisions and, importantly, for a fifth, corporate division. This Balanced Scorecard will contain a range of metrics designed to be generic across the divisions and also a series which will be pertinent just in that area. These are then aggregated into seven domains (example metric listed in brackets); Patient Safety (MRSA incidence), Effectiveness (Readmission rate), Workforce (Sickness), Innovation (Culture for Innovation score), Productivity (DNA Rate) and Finance (Recurrent savings YTD). The first two of these domains will record and monitor, on a monthly/weekly/daily basis as appropriate a range of clinical quality improvements, some which are targets required externally but many which are standards which have been set internally. It is planned that the Balanced Scorecard be published through a secure browser-based technology such as Qlikview in order that progress against these clinical quality improvements can be monitored internally at the Trust but also by NEDs externally to the Trust. The Trust aims to increase its transparency by publishing this data in time to GPs and in the future to patients.

Section 4: Regulatory requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
CQC registration compliance.	The Trust has no conditions to registration. There are areas within the Quality Risk Profile (QRP) which will be used as a lever for improvement against peer. Overall, the QRP shows the Trust is performing well in general against the 16 essential standards for quality and safety overall. The Trust will be subject to on-site inspection by the CQC over the next two years' where external intelligence suggests Trust performance could be a concern.	Two areas of partial non-compliance declared in 2010. Consent to treatment training mandatory for clinical staff supported by e-learning programme. Programme of clinical audit was undertaken; this shows an improving position for Mental Capacity Act (2005) compliance. Standards Monitoring Group set up, with governor and NED membership to review compliance, overseen by the Risk Management and Governance Group (RMGG) quarterly. System of assurance built into the annual work programme of the RMGG. Monthly monitoring of QRP by RMGG and overseen by the IAGC and Board. Programme in place to identify gaps.	2011/12 – All sections of the QRP categorised in green or yellow. 2012/13 - All sections of the QRP categorised in green or yellow. 2013/14 - All sections of the QRP categorised in green or yellow.
Compliance with key national performance targets.	Failure to meet key targets in some areas; specifically new A&E targets and the updated MRSA and C.difficile stretch targets, with resultant reduction in risk rating and financial penalties levied. Due to a small target it will not be possible to control the risk if MRSA or C.diff performance is outside tolerance levels at the start of the year.	Three work streams identified for A&E all overseen by BoD 1.Improved workflow model in A&E 2.Increase number of ambulatory care pathways and reduce short stay non-elective emergency care 3.Review discharge process and reduce length of stay. MRSA target set at 5 for 2011/12. Monthly reporting of performance with RCA of all cases.	2011/12 - A&E \geq 95% - MRSA \leq 5 -C. diff \leq 75 2012/13 - monthly performance dashboard figures contingent upon the scoring thresholds. 2013/14 - monthly performance dashboard figures contingent upon the scoring thresholds.
Financial stability, profitability and liquidity.	Trust fails to deliver its savings programme, is exposed to significant fines levied by the PCT under the terms of the National Contract and is adversely impacted by variations in activity.	Contract signed that limits potential exposure to fines and shares the risks and benefits of activity changes with the PCT. Work underway with the PCT and other public sector partners to review and potentially change the service provision especially to non elective patients. The CIP target has been raised to 7.5% for 2012/13 and 2013/14. Progress in developing plans for 2012/13 onwards under the scrutiny of the Executive Team and Finance Committee.	2011/12 - Development of Patient Level Costing to identify potential efficiencies and savings. Risk share contract agreed with PCT. 2012/13 and 2013/14 – CIP target uplifted to 7.5% with early scrutiny of scheme development. Developing more efficient emergency patient pathways with commissioners.

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Monitor governance rating.	The Monitor governance risk rating applied to the Trust suggests concern with specific or a range of issues identified and evaluated and the risk of breach of its Authorisation. The Trust receives an adverse third party report which impacts upon the governance risk rating.	Depending on nature of risk, some additional work/supplementary information may be required to scope the issue on an exception basis. This programme, contingent upon the areas of concern identified, will be initiated by the Board of Directors and monitored through the most appropriate sub-Board committee. Specific areas of concern will be recorded onto the corporate risk register, with clear actions for mitigation outlined. The CRR will be reviewed monthly by the RMGG, Audit Committee and the board. Quarterly reports to Monitor unless more frequent reports are required.	The Trust maintains, as a minimum, an amber-green rating throughout 2011/12
Quality improvements within the enhanced NHS contract for acute services	National CQUIN goals on VTE, patient-reported outcome measures and patients' experience and local CQUINS relating to the Enhancing Quality Programme may not be met in full. NICE quality standards on stroke care, VTE, dementia and neonatal care may not be met in full. Breaches the requirements to eliminate mixed sex accommodation. The consequences of each breach affect the overall financial position and the trust's ability to deliver against the new performance targets. Definitions for readmission rates at 30 days following an elective admission not yet agreed.	Monthly and quarterly targets set by commissioning PCT against all CQUIN targets and other clinical quality indicators. Quarterly review of compliance against NICE targets and specifically for those outlined in the NHS operating framework at quarterly Clinical Effectiveness Committee. Compliance against Eliminating the Mixed Sex Accommodation (EMSA) requirements reported on Unify2. Readmission rate definitions to be agreed locally with scenarios agreed	2011/12 - Set baseline for all CQUIN measures and secure an additional £0.25m CQUIN income. EMSA compliance: 2011/12 = 100%, 2012/13 = 100% 2013/14 = 100% This excludes periods of mixing for safety or patient choice as agreed with commissioners. Readmissions at 30 days 2011/12 = 0%, 2012/13 = 0% 2013/14 = 0% This excludes locally agreed readmission criteria
Enhancements to the NHS contract for acute services; schedule 3 part 4C: nationally specified events as part of the national quality priorities.	The trust breaches in the new areas designed to assess compliance with the national quality agenda for "never events", as defined by the Department of Health (DH).	Included the monitoring of reported "never events" via the Trust's incident monitoring system and feed back through the Clinical Income and Coding Group for monitoring. Monthly feedback of all cases to the RMGG in the aggregated quarterly report.	2011/12 - "never events" = 0; 2012/13 = 0, 2013/14 = 0.
Organisational structural change completed by April 2011	Organisational change and the implementation of refreshed governance and accountability may impact on business continuity during the transitional period. There is a risk that	Robust and thorough recruitment process to identify Divisional Directors, Heads of Nursing and Medical Directors. Clarity with the organisational operating framework and governance arrangements. Robust business continuity plans.	Monitoring of business continuity plans and key areas of performance. Staff satisfaction survey.

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
	this may impact on performance.		
Health and Safety at Work etc Act 1974 compliance	Five improvement notices served following recent HSE inspection	Develop and action all improvement plans to address all the improvement notices served. Plan to be overseen by overarching H&S committee with reports going to RMGG	Monitoring of plans at RMGG with relevant minutes throughout 2011/12. – 2013/14
Compliance with Information Governance toolkit	Quality of supporting evidence for annual information governance assurance statement is inconsistent. The evidence reported as being in place is not available. Evidence can become outdated or not sufficiently robust to continue to meet requirements.	Develop and put into action IG Improvement Plan for completion end December 2011, 2012 and 2013. Responsibility will be delegated to the Information Governance Steering Group and ratified by Risk Management and Governance Group.	Information Governance Toolkit compliance level 2011/12 = 70% 2012/13 = 75% 2013/14 = 78%
Revalidation for medical staff in 2012	All doctors wishing to practice in the UK will require a license to practice, which will be issued by the General Medical Council (GMC) and will need to be renewed every five years.	Processes to be developed to ensure the systems required to record appraisal and revalidation information is accurate and maintained	Meeting the revalidation requirement for 100% of medical staff in line with GMC published time scales
CPA compliance	Conditional approval for cellular pathology and clinical biochemistry and haematology and blood transfusion in current Clinical Pathology Accreditation assessments.	Develop and put into action plan for completion in all areas of pathology. All gaps in compliance to be identified by the time of the next scheduled inspection. The responsibility for monitoring will rest with the Clinical Support Division.	Full accreditation with CPA by June 2011 for clinical biochemistry Cellular pathology compliance review in October 2011 All areas to hold full CPA compliance by December 2011.

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
Embed the new organisational structure and internal operating framework.	Vacant posts. Individuals do not understand the new way of operating.	Vacant senior post to be filled using an assessment centre approach Organisational Development plan with external input ensures robust performance culture established. Trust Secretary covered by Director of HR & Corporate Services until post holder returns. Director of Strategic Development maternity covered by Deputy	Initial phase of the Organisational Development plan started by April 2011 and continues to 2014 Workforce Plan with robust talent management plans in place by May 2011 Substantive Trust Secretary in post by June 2011 Substantive Director of Strategic Development in post by July 2011 Recruitment to all Divisional Posts complete by August 2011
Workforce, Efficiency and Estates project roll out.	Lack of drive to implement efficiencies Future reductions in surpluses restrict the estates strategy.	Executive Director leads for corporate efficiency projects with internal consultancy support Prioritisation of estate strategy to concentrate on delivering efficiencies. Estate strategy designed in packages so projects can be halted to reflect capital.	Executive Director led project specific groups in place by: April 2011, April 2012, April 2013. with targets and plans agreed for efficiencies. Trust Board to re-evaluate estate strategy priorities April 2011, April 2012 and April 2013.
Financial and Operational Challenges.	Inability to increase organisational capacity in sub-specialty areas as part of normal activity without increasing long term fixed costs. Thus producing future financial and access target risks, especially around the in-patient 18 week RTT target	Improve theatre efficiency With PCTs commission activity linked to capacity and use Referral and Treatment Criteria Clinicians ensure that all referrals are appropriate. Vary the temporary workforce to meet changing sub-specialty needs	Using benchmarking data improve theatre efficiency each year By May 2011 PCT contracts based on realistic capacity agreed by Trust Board. By March 2012 use of private sector reduced whilst activity rises. Extension of annualised hour's job plans by April 2012.
Continuity of Non-Executive Director and Governor Positions.	The Chairman's term of office ends on Sep 12. All NEDS initial terms of office conclude 11 to 14 One third of the elected Governor positions to be re-elected in 11/12 and all subsequent years Requirements of "Liberating the NHS" not evident in Governor actions	Process to re-appoint Chairman and NEDs or appoint new Chairman and NEDS completed. Continue the delivery of a comprehensive list of members standing for election each year. Review CoG and update Constitution to ensure Governors fulfil their roles	CoG review roles and Constitution to meet needs of "Liberating the NHS" by October 2011 Process to renew/extend 2 x NEDs by October 2011. Process initiated to secure Chairman in April 2012 and completed by September 2012. Process to renew/extend 2 x NEDs by November 2012 Process to renew/extend 3 x NEDs by February and December 2013 All Governors in place by January of each year.

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
The re-tendering of the Soft FM contract.	Effective leadership and governance is not in place to ensure benefits are realised.	Executive Director lead established. Multi-disciplinary steering group with NED and consultancy support. Market testing of services Extension of existing contract by 1 year	All Tender documents issued to successful PQQ bidders July 2011 Board approved supplier chosen by December 2011. Contract commences July 2012.
Board Effectiveness.	Board is not working as effectively as it could.	Individual appraisal and PDP for all Board . Evaluation of Board effectiveness undertaken Use of external consultancy to support the execution of a detailed Board development process	Individuals appraised, objectives set and PDPs established by May each year. Formal evaluation of Board effectiveness completed by Mar each year. Board development process commences August 2011

Governors have participated in developing the criteria now used to assess investment proposals. They have also been involved in the formulation of Savings/efficiency programmes. Governors have participated in planning workshops held in 2011 and have been kept up to date as the Annual Plan has developed, through regular presentations at Council of Governor public meetings and Away Days from senior finance and strategic development managers.

The draft Annual Plan was shared with the Council of Governors in April. Comments/observations were collated by the Vice Chairman of the Council of Governors and brought to the April Board of Directors meeting.

The final Annual Plan was shared with the Council of Governors in May for any final feedback prior to sign off by the Board of Directors.

The Council of Governors established a Strategic Committee in April 2011. Going forward, one of the roles of this Committee would be to co-ordinate Council of Governor responses to the Trust's strategic and annual plans.

The Council of Governors have made suggestions regarding opportunities to develop cost improvements as part of their involvement in the development of the plan. A programme of feedback sessions have been arranged to update the Governors on the development and delivery progress of those ideas. Financial forecasts, CIP targets and schemes as well as investments for 2011/12 and 2013/14 will be shared with the Governors throughout 2011/12. This will provide opportunity for their involvement in the development of the Trust's plan for 2012/13 onwards.

Detailed Financial Summary		2010-11	2011-12	2012-13	2013-14
£m		Actuals	Plan	Plan	Plan
Total operating income		487.3	483.0	472.6	464.5
Employee Expenses		(284.5)	(286.2)	(278.4)	(274.6)
Drugs expense		(36.7)	(39.3)	(39.9)	(40.1)
Supplies (clinical & non-clinical)		(103.7)	(105.2)	(104.5)	(103.5)
PFI expenses		0.0	0.0	0.0	0.0
Other Costs		(30.1)	(19.3)	(15.5)	(12.9)
Total operating expenses		(455.0)	(450.0)	(438.3)	(431.0)
EBITDA		32.3	33.0	34.3	33.5
Net Surplus / (Deficit)		8.9	8.0	10.5	8.8
EBITDA % Income	%	6.6%	6.8%	7.3%	7.2%
CIP% of Op.Exp. less PFI Exp.	%	4.2%	5.1%	7.2%	7.5%
Capital expenditure		(22.2)	(20.0)	(25.6)	(25.7)
Net cash inflow/outflow		18.4	4.1	1.3	0.1
Cash and cash equivalents		42.8	46.9	48.3	48.4
Liquidity days		34.1	43.8	46.1	46.9
Net current assets/(liabilities)		19.2	26.2	27.5	27.6
Planned borrowings		0.0	0.0	0.0	0.0

Service Developments Totals		Plan for Year ending 31-Mar-2012	Plan for Year ending 31-Mar-2013	Plan for Year ending 31-Mar-2014
Totals		Value £m	Value £m	Value £m
Revenue from Service Development		1.016	0.217	0.000
Expense of Service Development		(2.327)	(0.284)	0.388
1 Short Name or Description				
	Gastroenterology and Endoscopy Services (inc Bowel Screening)			
	Total effect of this service development	(0.090)	(0.122)	(0.124)
2 Short Name or Description				
	Expansion of Cardiac Services (pPCI)			
	Total effect of this service development	(0.229)	(0.459)	(0.003)
3 Short Name or Description				
	Development of Band 4 Associate Practitioner roles (continuation)			
	Total effect of this service development	(0.155)	0.041	0.510
4 Short Name or Description				
	Health Records Service & Estates Statutory Compliance			
	Total effect of this service development	(0.738)	0.450	0.005
5 Short Name or Description				
	Da Vinci Robot			
	Total effect of this service development	(0.099)	0.023	0.000

Cost Improvement Plans (CIPs) Totals		Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012	Plan for Year ending 31-Mar-2013	Plan for Year ending 31-Mar-2014
Totals			Value £m	Value £m	Value £m
Analysis of Revenue Generation and Expense CIPS					
Recurring CIPs + revenue generation schemes		18.400	18.242	30.789	29.612
Non-recurring CIPs + revenue generation schemes		1.603	5.761	5.433	5.226
Total (agrees to above)		20.003	24.003	36.222	34.838
1 Short Name or Description					
Other Schemes					
Total revenue generation scheme effect			5.384	31.302	31.938
2 Short Name or Description					
Clinical coding					
Total revenue generation scheme effect			0.000	2.020	0.000
3 Short Name or Description					
Outpatients programme			0.086	0.000	0.000
4 Short Name or Description					
Procurement programme			1.234	0.000	0.000
5 Short Name or Description					
Medicines management programme			0.816	0.000	0.000
6 Short Name or Description					
Workforce efficiency programme			10.000	0.000	0.000
7 Short Name or Description					
Overhead reduction. Estates			0.352	0.000	0.000
8 Short Name or Description					
Overhead reduction (incl. estates/back office). Facilities			1.048	0.500	0.500
9 Short Name or Description					
Overhead reduction . Back Office Reduction			0.652	0.000	0.000
10 Short Name or Description					
Patient pathways (inc LoS programmes)			1.737	0.400	0.400
11 Short Name or Description					
Theatre productivity programme			2.694	2.000	2.000

List of Directors, Governors and elections for East Kent Hospitals University NHS FT

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

Role	Job Title	Name of Director	Tenure	Date appointed
Chief Executive	Chief Executive	Stuart Bain	Permanent	13th August 2007
Finance Director	Director of Finance and Performance Management	Jeff Buggle	Permanent	1st February 2011
Nursing Director	Chief Nurse and Director of Quality and Operations	Julie Pearce	Permanent	Joined Trust 9 July 2007 - Current post from 1 January 2011
Other Board Director	Director of HR and Corporate Services	Peter Murphy	Permanent	Joined Trust 5/6/2000 - Current post from 18/12/2002
Medical Director	Medical Director	Neil Martin	Permanent	Joined Trust 1/1/77 - Medical Director from 01/08/2007
Other Board Director	Director of Strategic Development and Capital Planning	Liz Shuttle	Permanent	21/01/2004
Chair	Chairman	Nicholas Wells	Permanent	01/09/2008
NED	Non Executive Director	Jonathan Spencer	Permanent	01/11/2007
NED	Non Executive Director	Martyn Scrivens	Permanent	09/11/2010
NED	Non Executive Director	Richard Earland	Permanent	01/01/2011
NED	Non Executive Director	Richard Samuel	Permanent	01/11/2007
NED	Non Executive Director	Valerie Owen	Permanent	01/12/2008
NED	Non Executive Director	Valerie Owen	Permanent	01/12/2008
NED	Non Executive Director	Richard Suthers	Permanent	25/02/2010
NED	Non Executive Director	Christopher Corrigan	Permanent	06/01/2009

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

Constituency Type	Full Name of Constituency	Name of Governor	Origin	Date appointed/elected
Public	Ashford Borough Council	Jocelyn Craig	Elected (Contested)	01/03/2009
Public	Ashford Borough Council	Terence Golding	Elected (Contested)	01/03/2009
Public	Ashford Borough Council	David Smith	Elected (Contested)	01/03/2011
Public	Canterbury City Council	Stuart Field	Elected (Contested)	01/03/2009
Public	Canterbury City Council	David Shortt	Elected (Contested)	01/03/2009
Public	Canterbury City Council	Philip Wells	Elected (Contested)	01/03/2011
Public	Dover District Council	Liz Rath	Elected (Contested)	01/03/2009
Public	Dover District Council	Stephen Collyer	Elected (Contested)	01/09/2009
Public	Dover District Council	Laurence Shaw	Elected (Contested)	01/09/2009
Public	Shepway District Council	Molly Hunter	Elected (Contested)	01/03/2009
Public	Shepway District Council	Ray Morgan	Elected (Contested)	01/03/2009
Public	Shepway District Council	John Sewell	Elected (Contested)	01/03/2011
Public	Swale Borough Council	Ken Rogers	Elected (Contested)	01/03/2009
Public	Swale Borough Council	Paul Durkin	Elected (Contested)	01/03/2009
Public	Thanet District Council	Jeanne Lawrence	Elected (Contested)	01/03/2009
Public	Thanet District Council	Reynagh Jarrett	Elected (Contested)	01/03/2009
Public	Thanet District Council	Tricia Swift	Elected (Contested)	01/03/2011
Public	Rest of England and Wales	Jamie Bennie-Coulson	Elected (Contested)	01/03/2009
Staff	Staff	Karen Bissett	Elected (Contested)	01/03/2009
Staff	Staff	Lesley Long	Elected (Contested)	01/03/2009
Staff	Staff	Mandy Cartell	Elected (Contested)	01/03/2011
Staff	Staff	David Bogard	Elected (Contested)	01/03/2011
Stakeholder	Kent and Medway NHS and Social Care Partnership Trust	Marie Dodd	Appointed	01/03/2009
Stakeholder	Canterbury Christchurch University	Hazel Colyer	Appointed	01/03/2009
Stakeholder	NHS Eastern and Coastal Kent	Karen Benbow	Appointed	01/03/2010
Stakeholder	Kent County Council Social Services	Janice Duff	Appointed	01/02/2011
Stakeholder	Local Authorities	Cllr Patrick Heath	Appointed	01/01/2011
Stakeholder	South East Coast Ambulance Services NHS Trust	Geraint Davies	Appointed	01/07/2009
Stakeholder	University of Kent	Peter Jeffries	Appointed	01/06/2010
Stakeholder	Volunteers working with the Trust	Michael Lyons	Appointed	01/03/2009
Stakeholder	Eastern and Coastal Kent Community Services	Philip Greenhill	Appointed	01/01/2010
Stakeholder	Voluntary Sector	Barry Coppock	Appointed	01/07/2010

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
Public	Ashford Borough Council	2	173	17.6%	934	Feb. 2011
Public	Canterbury City Council	3	499	16.9%	2,853	Feb. 2011
Public	Dover District Council	5	280	24.2%	1,116	Feb. 2011
Public	Shepway District Council	4	231	28.3%	803	Feb. 2011
Public	Thanet District Council	4	376	20.1%	1,775	Feb. 2011
Public	Staff	6	1,208	17.3%	6,763	Feb. 2011

Membership return for East Kent Hospitals University NHS FT

Membership size and movements

Public constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	8,718	9,430
	New members	+ve	1,288	1,443
	Members leaving	+ve	576	500
	At year end (31 March)		9,430	10,373
Staff constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve	6,304	6,804
	New members	+ve	658	200
	Members leaving	+ve	158	500
	At year end (31 March)		6,804	6,504
Patient constituency			2010/11	2011/12 (estimated)
	At year start (April 1)	+ve		0
	New members	+ve		
	Members leaving	+ve		
	At year end (31 March)		0	0

Analysis of membership at 31 March 2011

Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
Age (years):			
	0-16	10	9,154
	17-21	1055	41,788
	22+	4911	498,660
	Unknown	3,454	0
			549,602
Ethnicity			
	White	7,850	671,750
	Mixed	116	5418
	Asian or Asian British	385	5,295
	Black or Black British	200	2250
	Other	79	3374
	Unknown	800	-138,485
Socio-economic groupings*:			
	ABC1	6,292	269,318
	C2	233	85,627
	D	779	90,219
	E	781	88,144
	Unknown	1,345	16,294
Gender:			
	Male	3,175	260,092
	Female	6,144	289,510
	Unknown	111	0
Patient Constituency		31 Mar 2011 members	Eligible membership
	Age (years):		
	0-16		
	17-21		
	22+	0	
Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	6,804	7077