EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

TWO-YEAR OPERATING PLAN 2017-2019 REFRESH 2018-19

INTRODUCTION

Epsom and St Helier University Hospitals NHS Trust produced its two-year Operating Plan for 2017 to 2019 in December 2016. This 'refresh' of the plan reflects progress against our objectives following the first of these two years and changes in the local and national strategic landscapes during this time. It gives greater focus to our objectives for delivery in 2018/19.

Epsom and St Helier University Hospitals NHS Trust provides a range of acute hospital and medical services to approximately 490,000 people living across south west London and north-central Surrey. In addition, we provide more specialist services, in particular renal and neonatal intensive care, to a wider area, covering Surrey and parts of Sussex and Hampshire, and we host the South West London Elective Orthopaedic Centre (SWLEOC) partnership. Our main commissioners are Sutton and Surrey Downs Clinical Commissioning Groups (CCGs) and we have a sizable specialist service contract with NHS England in relation to renal services.

Our two main acute sites are St Helier Hospital in the London Borough of Sutton and Epsom Hospital in Surrey; however, we also provide out-reach services at a number of more locally-based care centres and are moving to increasingly integrated models of care working with local community, primary, and other service providers.

STRATEGIC CONTEXT

In 2015 the Trust set out its strategy for the next 5 years. This included our commitment to keep acute services, including A&E and maternity, at both our main sites whilst we develop an estates strategy for the period 2020-30.

Progress against our trust key objectives in 2017/18 is set against a context of a challenging operational and financial environment, reflecting the position nationally, and is summarised in the table below:

PROGRESS AGAINST CORPORATE PRIORITIES 2017/18		
1. Deliver safe and effective care with respect and dignity		Achieving key 7-day standards, maintained broadly similar outcomes in infection control rates, launched our mortality review process
2. Create a positive experience that meets the expectations of our patients, their families and carers		Invested £27.9m in our estate (including commencement of £12m project to improve B and C blocks at St Helier and investment in Urgent Care Centre and new Paediatric outpatient facilities at Epsom) and secured our ITFF loan to invest further. Improved our complaints handling arrangements
3. Provide responsive care that delivers the right treatment, in the right place at the right time		Sustained delivery of the cancer standards, challenged operationally to achieve the A&E access standard (93.15 %), but consistently in the top 20 nationally. Performance has deteriorated against the 18 week elective pathway RTT standard (86.11%).
4. Being financially sustainable		Forecast to deliver our financial control total for 2017/18, while missing the STF A&E funding for Q2 and Q3.

5. Working in partnership		Delivered an expanded Epsom Health and Care, planning for Sutton Health and Care, and being awarded the Surrey Downs adult community services contract all in partnership. Supported the development of the South West London Health and Care partnership and Surrey Heartlands. Developed our Strategic Outline Case for our services in 2020-30 and supporting system partners to take these plans forward
6. Ensure that the organisation is well-led and recognises the importance of all the people within our organisation		Made sustained progress in recruiting and retaining key staff groups. Made less progress than planned in building a highly engaged workforce, including from BME groups. We have since recruited a dedicated BME lead officer and relaunched our BME network

OUR PRIORITIES FOR 2018/19

Our key objectives for 2018/19 remain unaltered and continue to reflect our mission to provide great care to every patient every day. We will focus our priorities on the following areas:

CORPORATE PRIORITIES FOR 2018-19		
1. Deliver safe and effective care with respect and dignity	by	improving the care we provide to our sickest patients
2. Create a positive experience that meets the expectations of our patients, their families and carers	by	investing c.£44m in our estate
3. Provide responsive care that delivers the right treatment, in the right place at the right time	by	delivering the A&E, RTT and cancer standards we have been set
4. Being financially sustainable	by	delivering the control total and improving our underlying deficit
5. Working in partnership	by	shaping the health economies we serve and delivering Sutton Health and Care, Epsom Health and Care, the Surrey Downs Adult community contract and progressing the Strategic Outline Case 2020-2030
6. Ensure that the organisation is well-led and recognises the importance of all the people within our organisation	by	delivering the CQC action plan and improving staff satisfaction and engagement in our core mission of delivering great care to every patient every day

The Trust recognises that in delivering these objectives we are working within the context of operational challenges, as experienced over the latter part of 2017/18, and ongoing issues with the estate.

OUR ESTATES CHALLENGE

We have a huge critical infrastructure backlog challenge and we have an estates strategy to address this over the next five years.

- Our estate has a significant backlog maintenance issue, totalling £125m in 2016/17, and is amongst the highest in NHS England.
- 50% of our backlog maintenance challenge (£62m) has been categorised as Critical Infrastructure, meaning significant or high risk and therefore is significantly impeding the Trust in delivering safe and effective healthcare facilities for our patients.
- The Trust is also aware that its estate is limiting its ability to ensure patients are treated in buildings that are fit for twenty-first century healthcare. In June 2015, the Trust Board was presented with a paper which outlined the current state of the estate and its link with current performance.
- During 2017/18, the Trust Board approved a strategic outline case to review the options to address the trust estate beyond 2020.
- In the meantime, the trust needs to ensure it continues to provide safe and effective care to all of its patients within the current environment and mitigates all the significant and high estate risks. Our 5-year estates strategy for 2016-2021, approved by the Trust Board in January 2017, sets out our plans to achieve this by:
    - Estate Rationalisation and Land Disposal
    - Addressing the Estate Condition to support 'business as usual'
    - Clinical services transformation schemes being delivered
    - Ensuring other estate related schemes are addressed.

Our plan provides a significant capital receipt for the NHS over 2017/18 & 2018/19. £14.1m was delivered in 2017/18 and the remainder is on track for 2018/19. The Trust plans to use its normal depreciation capital, NHS Loans and government environment loans to fund the investment planned to address our critical infrastructure challenge and estate rationalisation plan.

- The Trust is aware of its capital investment needs through a range of information sources, estate condition survey, IM & T strategy, equipment asset register, Trust risk register and clinical division's information as part of the 2017/18 and 2018/19 business planning process.
- The Trust's Capital Investment plans for 2017/18 and 2018/19 are designed to addresses some of our urgent challenges of backlog maintenance and infrastructure renewal, supports significant need to invest in our IT infrastructure, hardware and modern technology and address our priority replacement equipment. The plan also allows us to reduce the current estate.

Our Plan will mean that the size of the estate will fall from 17.71ha (December 2016) to 11.56 ha by end 2018/19. In 2017/18 we reduced the estate by 2.1ha, and a further 6.15ha is planned this year.

- The Trust has a challenging programme to undertake reconfiguration of inpatient wards at St Helier, to improve the patient environment and relocate some wards into the main hospital building. This work will enable the relocation of the Renal Unit within the main hospital and the closure of G Block and some modular buildings.
- At Epsom Hospital, there are a number of buildings which will be repurposed or closed (Langley Wing, Rowan and York House, Energy Centre) following the relocation of clinical admin services, staff accommodation and other clinical services.

As a result the cost of running our estate will fall by a range £5m to £7m per annum over the next 4-5 years

- This is achieved by reduce capital charges, energy reductions, reduced cleaning and less demand on maintenance services.

Delivering this will eliminate 40% of our critical infrastructure backlog and mean that both our main sites will be functional for the next 10 years.

- Through the closure of buildings and land disposal, we will reduce the investment ask to address the backlog maintenance challenge. Further investment required to maintain buildings to condition 'B' will also be reduced for future years.

We have done lots of the ground work for this strategy during 2016 and, during 2017, have progressed the following major improvement works;

- Structural works, external cladding and Roof/Window replacement to address critical infrastructure issues.
- Following a procurement process utilising a framework arrangement, our delivery partner, Breathe Energy, commenced works in July 2017 and are due to complete in December 2019.New Energy Centre at St Helier Hospital and lighting replacement.

  Detailed design is underway on a range of Energy Saving Schemes (CHP, Lighting, etc.) The Trust intends to utilise external funding streams, such as LEEF, and repayments will be funded from energy savings achieved.

- New ITU/HDU Function to improve the patient environment and CQC requirements.

  Work continues on decanting services to allow space for the new provision. Detailed design is underway with completion expected by March 2019.

- Re-provision of Dialysis Unit at St Helier to manage capacity issues and improve the environment to infection control standards. This will be funded through a managed service contract.

  Under the 2016/17 and 2017/18 capital programmes, we have undertaken extensive enabling works allowing this service to be re-provided within our main clinical building and our partner, Renal UK, is planning to complete the unit by Autumn 2018.

- Reconfiguration of Adult Inpatient Wards at St Helier to improve adjacencies and patient flows.
  In 2017/18 we have created a medical ambulatory care unit and a surgical inpatient unit in existing ward space and started enabling works for a surgical ambulatory care suite. Following completion of the ITU scheme we intend to commence relocation of renal inpatients into the main ward blocks.

- Provision of Primary care Streaming at both Hospitals
  During 2017/18 the Trust secured £1.75m of funding and undertook major work to provided increase capacity for primary care streaming and Urgent Care facilities.

  For Epsom Hospital, £1.9m was spent on relocating our paediatric out-patient and ante-natal services to Langley Wing, which then allowed for the creation of a new UCC facility which is led by GP's.

  St Helier Hospital also had £750k spent on providing new ambulatory care facilities, which allowed space to be freed up next to the Emergency Department allowing the expansion of our UCC for GP-led streaming.

- By 31st December 2016, we closed York House and the Doctors Flats at Epsom, to provide operational savings in 2016/17 and 2017/18. Over the next few years, subject to capital investment, we intend to close Rowan House and the Energy Centre at Epsom and redundant Renal Buildings, G Block and several modular buildings at St Helier. This provides significant reduction in estate operating costs, reduces our backlog maintenance position, and provides land for future disposal.

ACTIVITY PLANNING

DEMAND AND CAPACITY ANALYSIS

The Trust has invested in formal demand and capacity analysis to better match internal capability to demand and to support robust operational planning. This approach has now been used across all main specialties, with the surgical areas using a bespoke Microsoft Excel tool, which aggregates data from OPD referrals, activity and waiting lists along with planned/scheduled capacity in order to produce an output that can be used by Divisional Management teams to estimate required activity levels, the expected demand (new and follow up appointments in Outpatients) and the required capacity to meet demand for a 12 month period. The Medical specialties have used the NHSI Demand and Capacity tool, which has highlighted a general shortfall in routine capacity within outpatients to meet demand.

The output of these tools is now being used as the baseline to develop job plans, clinic templates and capacity, and inform workforce planning.

ACTIVITY PLANNING

The Trust began activity planning in August to inform the planning process for 2018-19 to the national timetable, conscious of the need to ensure that activity plans agreed with commissioners are representative of the levels of activity that clinical and operational managers expect to see in the following year. As 2018-19 is the second year of a two year Contract, we have only needed to refresh the contracts where there has been a material change to the activity levels, so some smaller commissioners have not been refreshed.

The Trust is conscious of the need to ensure that activity plans agreed with commissioners are representative of the levels of activity that clinical and operational managers expect to see in the following year. There is always tension between the levels of demand that the Trust plans for, based on historical modelling and the reductions in demand required by commissioners to deliver their control totals. Based on all indications to date we believe that 2018/19 and the following year are likely to be very challenging.

The Trust's planned income is predicated on baseline activity derived from 2017/18 forecast outturn, re-priced at the new national tariff and adjusted for growth and commissioner QIPP, combined with additional activity to ensure that the Trust maintains the overall size of the waiting list (as per Operating guidance). A consequence of this may also be a reduction in the RTT backlogs in some specialties. The additional activity to maintain the waiting list for non-admitted activity is £2.6m.

The key actions undertaken in building the activity plan for 2018/19 are:

- Ensuring clinical Divisions understand the 2017/18 outturn and planned 2018/19 activity in detail, and identifying any known changes.
- Ensuring detailed analysis of the impact of service developments that should be factored into our plans for 2018/19, including assumptions around activity growth to maintain the RTT position.
- Identifying any internal schemes which support demand management or patient flow, and which mitigate the impact of known increases, combined with a move away from face to face appointments to virtual where appropriate – particularly around follow ups.
- Consulting with the Divisions and Corporate teams on any changes intended for the 2018/19 contract that will affect payment of activity or have an operational impact.
- Identifying changes in coding and counting and managing these changes in-line with contractual requirements.
- Informatics, Business Services team and Divisions working closely to quantify and cost the proposed changes and profile the impact on the annual plan

The Trust is engaging with the two local STPs and individual commissioners to support delivery of commissioner QIPP. This will enable the Trust to reduce costs to deliver elements of the CIP programme and assist delivery of the system wide control total.

Commissioners continue to have significant levels of unidentified QIPP, but the Trust has received information for QIPP schemes which have been worked up and we will work to:

- Evaluate the likely impact of the scheme on activity levels, accounting for the phased effect
- Evaluate the capacity required to deliver contracted activity at a clinic, theatre and ward level.

- Understand the link between demand management schemes and the additional activity required to meet the RTT plan and discuss additional activity with commissioners where activity does not match any current trajectories.

EMERGENCY CARE

In the first 9 months of 2018/19, the Trust has seen non-elective demand through our emergency departments on both hospital sites increase by 3%. However, this winter the proportion of patients seen through the Majors stream has risen by 7.5%, and 9.8% for St Helier, posing considerable challenges to a site with significant infrastructure issues. Over the last 18 months the Trust has strengthened its patient flow transformation programme aimed at streamlining existing systems and processes to mitigate an increase in activity and effectively manage non-elective demand, and expects its acute reconfiguration to be completed by Oct 18.

We have implemented lean methodology across all inpatient ward areas and our clinical site management team on both hospital sites. A significant patient flow programme will build on this foundation for 2018/19, with clear direction to reduce the use of escalation areas and outlying patients. The work this year has led to a reduction in the number of patients with a longer length of stay on both hospital sites.

At Epsom we have developed the Epsom Health and Care Alliance @home service. This is a single, integrated service providing people over the age of 65 at serious risk of admission with an alternative to an in-patient stay. The service also provides supported discharge and 'discharge to assess' interventions for those people where admission is unavoidable, which in many cases will be an alternative to a longer hospital stay. The aim of this service is a reduction in non-elective admissions and shorter length of stay for people aged over 65 years. The Trust aims to implement a similar model for the St Helier site – "Sutton Health and Care" – and further streamline discharge processes across the boundaries with our community and social partners to ensure that patients are cared for in the most appropriate setting.

Additional elements of our non-elective transformation programme include the implementation of a rapid assessment hub on our acute medical units. These areas facilitate direct admission for GP referred patients and early transfer of medically referred patients from the emergency department. Patients benefit from an early consultant level review and early indications suggest an increase in zero length of length and increased admission avoidance. We have also established a GP/Nurse led medically fit for discharge ward on the St Helier Hospital site to support complex discharge planning for this cohort of patients and a reduction in the number of patients with a longer length of stay. We will develop Care of the Elderly services further over the next 12 months.

The Trust continues to perform well into the upper 20% for the emergency department 4 hour standard, particularly against the Type 1 standard.

In common with much of the NHS, we have seen large volumes of acutely unwell, older patients arriving through high acuity areas of our Emergency Departments over the winter of 2017/18. This has challenged our capacity to meet the needs of those patients in the timely manner we would wish, and the financial and operational planning reflects the work we are and will be doing to maintain our position as a high level performer against the emergency access standard. Our forecasts are therefore based on the following planning assumptions:

- That the estates work on each site to enlarge each Emergency Department is completed.
- That the reconfiguration of the first floor surgery estate in St Helier is complete by October.
- That the impact on Sutton Health and Care (launched in April 2018) has the same impact as Epsom Health and Care, improving flow on both sites.
- That the actions in the Emergency Access delivery deliver in the timescales highlighted.
- That the impact of our workforce recruitment programme continues to show improvements in the numbers available.
- That the performance required to achieve STF by quarter would be: 95%; 95%; 93.2%; 95% (March only)

PLANNED CARE

Delivering planned care has proved challenging in 2017-18 with our achievement of the 18 week referral to treatment target dropping to 86%. Based on rigorous demand and capacity modelling, detailed speciality plans, strengthened

governance and oversight and a review of clinical pathways, we anticipate that some graduated improvement is possible over 2018-19, noting the apparent gap between the national guidance and the potential costs for the CCGs. The Trust continues to routinely achieve the cancer 62 day standard, although further work will be required to manage the national guidelines around 38 day referral.

Over the preceding 18 months a number of issues contributed to a deterioration in the Trust's RTT position;

- As a relatively small organisation, many of our services are delivered by single handed consultants who in the majority are employed by another organisation and for which there is a cross charge arrangement in place. In addition, routine delivery of the service is often relied upon via a number of associate specialist staff, who have developed the appropriate skills for our case mix of patients over years of training at the Trust. It has become common place over time for consultants employed across two sites to gradually reduce their sessions at this Trust in favour of an increase in sub specialty sessions at their host Trust. Since RTT delivery has become an increasing challenge in one particular partner Trust we have seen a further considerable reduction in our consultant workforce.
- In conjunction with this workforce challenge, the associate specialist grade has now been withdrawn nationally. A large proportion of our non-consultant grade staff are at or near retirement age and identifying adequately trained replacements has been very difficult. For a number of specialities e.g. ENT, Paediatric dentistry, oral surgery this has required a complete review of the service workforce and these services will remain fragile for some time.
- The organisation had consistently relied upon additional ad hoc capacity both internally and externally to support delivery of this target, but without clearly defining whether the additional work allowed specialties simply to keep pace with the rate of referrals or materially reduce the backlog. It is clear from the demand / capacity modelling undertaken that there is a substantive shortfall in routine provision against likely demand – particularly for non-admitted work. Without substantial – and unaffordable – rates of activity across 2017-18 the backlog has risen at a steady and predictable rate, compounded by the cancellation of some activity over the winter of 2017-18 in line with national guidance.

CHALLENGED SPECIALTIES

ENT

Presently our ENT service consists of two separate teams; the Epsom facing team networked with The Royal Surrey Hospital which operates well within the RTT tolerance. The St Helier service is provided by St George's and over a period of 12 months has seen a retraction of consultant sessions to cope with their internal backlog and other pressures. In the interim we have employed agency staff to mitigate the capacity gap and run additional clinics and theatres lists in the evenings and weekends. In the long term we will need to explore options for a possible reconfiguration of this service.

UROLOGY

Our backlog of admitted patients within urology has continued to rise. Whilst the overall demand in raw numbers has remained broadly stable, the proportion of cancer or suspected cancer patients has steadily increased, thanks to the increasing strength of the clinical service. The diagnostics associated with these patients, particularly in relation to TRUS and template biopsy, requires multiple appointments and has had a disproportionate impact on our capacity available for routine patients. This coupled with an increasing number of subspecialty patients associated with our hub and spoke relationship has led to increased waiting times. A significant amount of work has been undertaken to reduce diagnostic waiting times, increase MRI capacity, provide additional template biopsy lists, review skill mix and recruit additional team members trained in specific sub speciality where the demand is high. We believe that urology will remain a challenged speciality and in the medium term we are working to reduce our backlog through additional theatre capacity in the working week, evening and at weekends.

ORAL SURGERY

The head and neck specialities within Epsom and St Helier are relatively small and in general rely heavily on their network arrangements with other large teaching hospitals and a tier of very experienced and increasingly rare associate specialists. As the associate specialist grade has now been removed nationally and the teaching hospitals

with which we have joint appointments have their own RTT challenges, the fragility of our services have become critical. We are working to develop joint appointments with a number of units to strengthen our service and provide more consultant input in the long term.

GENERAL SURGERY

Whilst we have taken steps to control our number of patients waiting over 18 weeks in this speciality, demand continues to rise significantly for the service. We will need to work closely with our commissioners over the next few months to understand which sub speciality areas have seen the biggest peaks in demand and devise a strategy for responding to this, whether through pathway redesign or investment in additional capacity.

MEDICINE

The demand for medical outpatient specialties has continued to outstrip supply, particularly for Cardiology, Dermatology and Gastroenterology. Each has faced bespoke staffing challenges but now has a capacity model with a clear plan for investment in 2018/19 in order to stabilise the overall list size and where possible reduce the backlog. The Trust expects to conduct a significant amount of outpatient work in the forthcoming year in order to improve waiting times, aiming to shift some follow up work to either virtual review or patient triggered follow up.

TRAUMA AND ORTHOPAEDICS

A shortfall in theatre session time and medical staff to meet the routine demand for orthopaedic services has led to an increase in waiting times. However, following an intensive recruitment campaign over the summer of 2017 the service is now fully staffed, and additional theatre capacity has now been made available through the reconfiguration of theatre services. We expect a gradual but long-term reduction in waiting times as a consequence.

CANCER SERVICES

The new 38 day cancer standard for inter-trust transfers is expected to be introduced from April 1st 2018 and we anticipate that this may present a challenge for some tumour types, and work is underway both internally and with our partners to ensure we are able to meet the 62 day standard both internally and when patients are managed as part of the South West London system. We are currently collaborating with the Cancer Strategic Leadership Forum as well as undertaking a full review of capacity within our cancer pathways to inform work needed to deliver the standard next year. Whilst some of this challenge may be overcome through pathway redesign, it is likely that a considerable investment in manpower and diagnostics will also be required.

ELECTIVE ORTHOPAEDIC CENTRE

The Trust hosts the South West London Elective Orthopaedic Centre (SWLEOC) on behalf of the three acute Trusts in South West London.

Plans are currently underway to build another theatre in the EOC in order to meet the current demand into the service, and to support delivery of the 18 week RTT target. As EOC receives referrals from partner Trusts, this proves particularly challenging as some referrals can arrive sufficiently late in the 18 week pathway that the target is impossible to deliver. We are continuing to work with partners to explore how we can receive referrals at the earliest opportunity to ensure the best possible care for our patients.

The EOC management team are currently working with partner Trusts to determine expected levels of demand for next year and any changes will be built into Contract plans following agreement with the Partnership Board.

CONTRACTING PRINCIPLES

The Trust entered into block contracting arrangements with our largest CCG commissioner and a marginal rate contract with our next largest commissioner for 2017/18 which allowed us to continue to focus on transformational change rather than transactional contractual disputes. We have sought to agree block arrangements for emergency care for 2018-19 and cost and volume arrangements for elective care, due to the complexities around RTT delivery. The block contracts have been agreed based on historical levels of growth. The activity growth which we have seen in the past year has been appropriately funded in the two contracts and the impact of commissioner QIPP schemes is in

line with Trust expectations. With smaller commissioners, the Trust was unable to agree the appropriate level of growth for non-elective activity and has therefore entered in to full cost and volume contracts.

Contract negotiations with the Trust's main commissioners have concluded and signed contracts are based on activity planning as follows:

- Month 1-8 of 2017-18 multiplied by 1.5
- Demographic growth based on the SWL STP levels (based on ONS population growth)
- Additional (Trust specific) non-elective growth and seasonality adjustment based on 2016/17-2017/18
- Specific adjustments for known changes (Service developments, counting and coding, pricing and RTT maintenance activity)
- Adjustments to thresholds (MRET and readmissions)
- QIPP at an agreed level

The Trust has agreed a £115.5m contract with Surrey Downs CCG based on a block contract for non-elective and cost and volume for elective activity, with a marginal rate for under or over-performance. The non-elective part of the contract includes growth in excess of 2.3% (based on the previous year's growth) and a number of pricing adjustments which increase the value of the block by bringing MRET and readmissions to a fair value.

The block has been risk assessed as fair value by both provider and commissioner and is linked to our joint work on the integrated Epsom Health and Care alliance model.

For elective activity, the upper value for the marginal rate is predicated on outturn plus growth and RTT activity and so ensures the Trust is paid fully for the expected 2018/19 outturn before QIPP. The lower value for the marginal rate to take effect includes QIPP of £3.4m. There is a risk to the Trust if a higher level of QIPP is delivered, but this will be mitigated by the marginal rate (70%).

For Sutton CCG, we have a contract of £106.6m which is block for non-elective activity and cost and volume for electives. As with Surrey Downs CCG, the block contract includes the observed level of growth for the last year and pricing adjustments which increase the value.

We are also jointly working on a new integrated care model 'Sutton Health and Care' which will start from April 2018, with all non-elective QIPP associated with this scheme. For elective activity, the contract includes £2.7m of QIPP but this is deemed to be low risk given that the activity will be paid for if QIPP does not deliver. Should there be a higher level of QIPP delivery, it is likely that this will allow the Trust capacity to improve our significant 18 week backlog. Across other SWL commissioners we have agreed full PbR contracts, to a value of £69.2m.

QUALITY PLANNING

SECTION ONE: OUR APPROACH TO QUALITY IMPROVEMENT

ORGANISATION WIDE IMPROVEMENT TO ACHIEVE A GOOD OR OUTSTANDING CQC RATING

In November 2015, the Care Quality Commission (CQC) undertook a full inspection of the trust. Subsequently, the trust was rated overall as 'Requires Improvement'.

A quality summit was held on the 1st June 2016 and, at this time, a high level action plan was agreed with the CQC and our partners/stakeholders. Subsequently the trust developed and has progressed a wide ranging action plan to address the corporate and divisional areas of concern raised within the CQC reports.

Scrutiny and delivery of the action plan has been underpinned by a robust governance process and all actions have been progressed to support closure or ongoing monitoring.

Progress on the action plan, including any identified challenges, has been presented to the Trust Executive Committee (TEC) and the Patient Safety and Quality Committee/Trust Board throughout the year. External scrutiny of our progress has been undertaken by the commissioner led Clinical Quality Review Group (CQRG). The action plan is now recommended for closure.

In January 2018 the CQC undertook a further announced, full inspection of the Trust. The outcome of this inspection is awaited and expected in the Spring 2018. Following review the Trust will commence a further period of action planning and implementation.

GOVERNANCE AND RISK

The CQC inspection report, received in May 2016, drew attention to a need to improve the management of risk, and also commented that governance structures required strengthening in many areas.

RISK

The Trust is committed to an open and transparent culture in relation to the management of risk and, throughout 2016, worked hard on improving its risk assurance documentation including a complete 'overhaul' and refresh of the corporate risk register and board assurance framework.

The new corporate risk register maps risks against four domains: staffing, variability in quality of care, the estate, and finances and enables the Trust to track changes in risks over time and to identify any trends. Each risk has a single executive 'owner' to ensure accountability for risk management/mitigation. From November 2016 onwards, the corporate risk register has formed part of the public Board pack. A new Board Committee, the Performance Assurance and Risk Committee (PARC), was established in April 2016 with direct responsibility, inter alia, for obtaining assurance on the risks to delivery of the trust's corporate objectives, with a particular focus on issues that are cross-cutting or trust-wide.

The Trust has also worked hard to improve its integrated performance report (IPR) to ensure good quality data on a wide range of performance indicators to ensure the Board has the necessary assurances that patients are receiving safe and effective care.

GOVERNANCE

The effectiveness of the Trust's corporate meeting structure was assessed in 2016, as a result of which a new Board Committee, the Performance Assurance and Risk Committee (PARC) was introduced. PARC scrutinises Trust performance against national and contractual standards (particularly in relation to the NHS access standards) and the risks to delivery of the Trust's corporate objectives.

In order to enhance Ward to Board identification of issues, the Trust has introduced a '15 Steps Challenge' walkabout session for all Board members prior to Board meetings. The results of the walkabout are fed back directly to the Board, and any areas of concern are logged on the Board action log for action and review. The Trust has also introduced Divisional presentations at Board which gives Board members the opportunity to hear directly from the Divisions about their successes and challenges.

The Trust has recently appointed an Equality, Diversity and Inclusion Manager who is developing a work programme that incorporates both patient and staff equalities.

In September/October 2017, the Board completed a self-assessment against the Well-Led domain, which will inform the scope of a broader externally facilitated Well-led Review, to be commenced in 2018/19.

In response to feedback from the Staff Survey which identified a disconnect between staff groups at the top and the rest of the organisation, in April 2017 the Trust held an engagement event for over 300 staff at Epsom Racecourse which marked the start of a programme of staff engagement intended to:-

- increase awareness of the vision for the future
- increase awareness of team interdependencies
- identify what leaders need to do to increase staff engagement and be 'outstanding managers', and to develop a strategy for wider engagement.

One immediate outcome from the event was the establishment of 'Daniel's Task Force' – a group of staff meeting regularly with the CEO to feed back on the 'mood' of the organisation and to make suggestions for improvement. A further outcome was development of an 'Outstanding Manager' training programme presented by Mike Chitty, Head of Applied Leadership at the NHS Leadership Academy, which commenced in October.

The Trust is also focussed on achievement of its 25 corporate priorities. The Board and Board sub-committees receive a quarterly, RAG rated, progress report with areas of concern referred to the relevant Board committee for review. Delivery of the corporate objectives is 'mirrored' at Divisional level, with the Trust Executive Committee receiving regular updates on progress, and the Divisions held to account for delivery via monthly performance meetings attended by Executives and the Divisions to look at all aspects of performance delivery.

Since the last CQC inspection, the Trust has also ensured resourcing to support improvements to clinical services via creation of a new Service Improvement Team which provides targeted support to the Divisions in delivering CIPs and CQUINs, and resolution of critical safety concerns.

BUILDING QUALITY IMPROVEMENT CAPACITY AND CAPABILITY TO IMPLEMENT AND SUSTAIN CHANGE

The Trust's named executive lead for quality improvement is Dr Ruth Charlton, Joint Medical Director and Deputy Chief Executive. In leading this work Dr Charlton is supported by her executive colleagues, five Associate Medical Directors, Clinical Quality leads within Divisions and an Associate Director of Quality who leads and manages the trusts corporate quality team.

The trust protects clinical staff time to attend Divisional 'Quality Half Days'. These days have built on previous audit time to create an opportunity for clinical staff to discuss more widely the quality issues within their areas. While audit remains a fundamental, the wider discussion links and triangulates the quality areas with learning from incident investigations, mortality review, patient feedback, audit and risk. Discussions are supported by Quality Reports produced by embedded Quality Mangers for Divisions

Education of clinical staff remains important in building improvement capacity and capability to sustain change and the Trust has integrated the education of our nurses, midwives, medical staff and allied health professionals. It is also progressing the development of new roles such as the nursing associates and apprenticeships in health care.

Change and redevelopment of services to reflect learning is led through our transformation programme. This programme aims to improve performance, quality and access enabling the trust to deliver health care with efficiency and effectiveness. Our aim is for an integrated, truly patient centric organisation with an agile and capable workforce, with data informing effective decision making. The trust has carefully selected and prioritised tactical, operational and strategic initiatives to successfully navigate a transformational path to becoming a transformed provider. Over the next four years these will embrace a number of areas with the aim of being one team; one trust:

- Process and practices improvement
- Corporate services transformation
- Estates and infrastructure for the future
- Governance structures and leadership
- Capability development
- Information and data analytics
- System leadership

Our transformation is about:

- Controlling the organisation
- Improving the current operating model
- Changing the current operating model
- Sustaining the new system leadership role

MEASURE BEING USED TO DEMONSTRATE THE IMPACT OF OUR INVESTMENT IN QUALITY IMPROVEMENT

The trust Integrated Performance Report is the central tool for supporting the trust demonstrating the impact of our investment in quality improvement specifically measuring progress against trust level priorities. This is underpinned by a number of dashboards that support measurement and analysis of progress across a wide number of areas. Examples include:

- Patient specific outcome data
- The transformation programme – milestone achievements
- Workforce measures
- The CQUINs programme
- Clinical audit

SECTION TWO: QUALITY IMPROVEMENT PLANS

The detail below summarises the trust quality improvement plans in a number of key areas

NATIONAL CLINICAL AUDITS

The clinical audit team will continue to support each clinical Division to participate and engage in both national and local audits relative to their field. There will be a particular focus on conducting audits which demonstrate compliance with regulatory requirements, for example audits with the aim of providing evidence of the implementation of NICE guidance and Quality Standards. The clinical audit team will also support audits which outline the trust commissioner's priorities, including national and regional CQUINS. The audit team will support Divisions in the development of robust action planning in order to drive forward and continually improve the quality of service provided to our patients. The results, actions and improvements of the trusts clinical audits will continue to be presented at the Quality half days which occur every 6 weeks in order to engage staff and to promote shared learning.

THE FOUR PRIORITY STANDARDS FOR SEVEN-DAY HOSPITAL SERVICES

Findings from the autumn 2017 audit of compliance with 7 day working standards showed that 90 % of patients admitted acutely to ESTH were reviewed by a consultant within 14 hours of admission. This is an improvement on the position in the autumn of 2016 when 62% compliance was reported. This has been achieved through alteration to consultant job plans and delivery of local action plans which were developed following on from the March 2017 survey.

Work still needs to be undertaken to improve the percentage of patients receiving information about their diagnosis, management plan and prognosis within 48 hours of admission and advice and action plans regarding how this can be achieved will be progressed through divisions.

NHS Improvement has indicated that the March 2018 survey will review Trust performance against daily consultant reviews. It is therefore important to continue to review, implement and adapt previous action plans and to ensure that steps are being taken to help improve the overall percentage of patients who receive daily consultant led ward rounds.

The trust undertakes annual reviews of staffing measuring acuity dependency of patients against ward staffing establishments. This is done using the Shelford Tool which is a nationally recognised audit tool for measuring safe staffing. In addition the trust is implementing the use of Safecare which is a daily acuity testing tool which will enable nurses to see the acuity of every ward electronically and enable decisions to be made about movement of staff for safety.

We collect the planned numbers of hours used and compare this with actual hours delivered, this is reported through the trust's integrated performance report and published on our website. The results of this are consistently over 85% staffing across the trust.

CARE HOURS PER PATIENT DAY

The Lord Carter Review highlighted the importance of ensuring that workforce and financial plans are consistent in order to optimise deliver of clinical quality and use of resources. The review recommended that Care Hours Per Patient Day (CHPPD) is collected monthly which started in 2016, the level has remained constant and within the range of our peers as measured through Model Hospital (NHSI).

MENTAL HEALTH STANDARDS (EARLY INTERVENTION IN PSYCHOSIS AND IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Our Trust has a specialist Liaison Psychiatry Service on both sites. The service is run in association with two different Mental Health Trusts – South West London and St George's Mental Health NHS Trust at St Helier Hospital, and Surrey and Borders Partnership at Epsom Hospital. Our Liaison Psychiatry services on each site are committed to building closer inter-service working relationships, particularly in terms of educating and training our Trust workforce - to optimise care for patients with mental health problems. Two key mental health standards, the teams are working to deliver are: a) early intervention in psychosis, and b) Improving Access to Psychological Therapies (IAPT). This includes a new quality improvement initiative, the Macmillan Cancer Psychological Support service (CaPS). The CaPS service offers in-patient and out-patient liaison psychiatry input for patients with cancer who are within 2 years of treatment for their cancer, and extends this to their carers.

ACTIONS FROM THE BETTER BIRTHS REVIEW

The Maternity Case for Change proposes a reconfiguration of the services at the Trust towards an integrated midwifery team approach. Increasing continuity of midwife care was identified as a priority for our maternity services and is in line with the recommendations from the strategic clinical network, recently published national maternity review and other maternity service publications.

We have set an ambitious strategy to progress a workforce review and explore options for an integrated model of midwifery care. Key objectives will drive the strategy:

- Women with uncomplicated pregnancies should have no more than two midwives providing their antenatal and postnatal care within a community setting.
- Wrapping services around women in order to increase women's experience and improve birth outcomes.
- Providing consistent reliable information to enable birth choices to be made, and this will be enhanced with continuity of care.
- Developing our continuity of care package.
- Developing our maternity workforce to be fully competent and skilled in all areas to deliver a seamless, safe service for women.

The integrated service is progressing well and during the next 6 months this will continue to become more embedded.

IMPROVING THE QUALITY OF MORTALITY REVIEW AND SERIOUS INCIDENT INVESTIGATION AND SUBSEQUENT LEARNING AND ACTION

The trust has established a Committee – RADAH (Reducing Avoidable Death and Harm) - to oversee and coordinate the work of the trust in this important area. Meeting monthly, the committee is chaired by the Joint Medical Director and membership comprises senior clinicians and managers of the organisation. The Committee receives reports and seeks assurance from a number of sub groups with the purpose of identifying and providing recommendations on specific initiatives to improve service transformation, improving recognition and treatment of the deteriorating patient, working towards the elimination of all avoidable in hospital mortality and ensuring transformational change meets clinical best practice.

This committee is also overseeing the Trust response to the National Quality Board guidance to reporting on, and learn from, deaths '*National Guidance on Learning from deaths: Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care*'.

In August 2017 the Trust ratified the '*Policy for mortality reporting and mortality peer review processes'*. This policy provides an organisational framework for the process and management of mortality reviews and reporting within the Trust and details the aims of the mortality review process including identifying and minimising potentially 'avoidable' deaths within the Trust and promoting organisational learning and improvement. The Trust is now working to implement the policy with oversight at the RADAH committee.

ANTI-MICROBIAL RESISTANCE

The Trust's plans to optimise antimicrobial stewardship are focused on the following:

- to complete the roll out of electronic prescribing and make full use of its surveillance facilities and prescribing data,
- to encourage consultants to take responsibility for their team's prescribing,
- to help access to the Trust's own antimicrobial guidance (e.g. promote our new App),
- for microbiologists and antimicrobial pharmacists to achieve a high profile on the wards ('antibiotic ward rounds'),
- to audit against the new National CQUIN 3 (2016) initiatives for antimicrobial review and reduction of antibiotic use,
- to continue formal and informal teaching of doctors and promote the two most important national guidance documents (DH toolkit for acute hospitals: Start smart, the focus, 2011, 2015; NICE Antimicrobial Stewardship quality standards, 2016),
- to recognise the potential conflict with current sepsis guidance which encourages antibiotic use (e.g. NICE Sepsis recognition, diagnosis and early management, 2016) and update Trust sepsis guidance with antimicrobial stewardship in mind.

INFECTION PREVENTION AND CONTROL

The infection prevention and control team developed an improvement plan to address the challenges that lie ahead for infection control.

Our key priorities were identified as follows:

1. Hand Hygiene. We have achieved an increase in compliance with and scoring of ward and departmental hand hygiene scores with consistent reporting month on month demonstrating improved hand hygiene practice in the trust.
2. We remain an outlier for MRSA blood stream infections however 4 of the 6 have been reported as unavoidable. We have instigated wide spread screening and decolonisation protocols to reduce the hospital acquired bacteraemia.

The newly formed vascular access working group with senior representation has been a positive step towards having a robust system to help mitigate the risks of invasive vascular access related infections. This has resulted in a reduction in bacteraemia due to vascular devices.

Our infection control training and education is more practical and more is delivered in wards than before. The link nurse system is in place and progressing well. The trust has procured two hydrogen peroxide vaporising machines to support decontamination post infection.

FALLS

The Trust has achieved a 30% reduction in falls in general adult inpatient areas per thousand bed days from 6.0 in the first 6 months to 4.4 in the second 6 months.

This is below the target set by the Royal College of Physicians.

SEPSIS

There have been a number of publications and initiatives relating to recognition and management of sepsis in the last two years. Of note is the national patient safety alert published in September 2014 which required Trusts to put into place a policy for sepsis recognition and management. Subsequent to this NCEPOD published a report in November

2015 into management of sepsis with recommendations about improving outcomes. Finally in July 2016, NICE have released guidelines on the recognition and management of sepsis which vary from those previously published.

In response to these guidelines and recommendations the Sepsis group published guidelines and algorithms. These are in the process of being updated to reflect the NICE guidelines. The Trust was successful in obtaining a Darzi fellow in clinical leadership and transformation and they commenced work in August and are leading on developing an educational package for staff and identifying areas of best practice to learn and disseminate. Sepsis champions have been identified in each clinical directorate whose remit is to promote good clinical practice at a local level. Communications have been approached regarding a campaign to raise awareness and it is hoped to coincide with the release of the updated policy. Further potential initiatives include mandatory annual training for clinical staff utilising an innovative and interactive training package (which the Darzi fellow is currently looking into), the use of sepsis alert stickers in patients notes and feedback to teams involved in cases of sepsis to promote learning and reflection.

PRESSURE ULCERS

The Trust set an ambitious target to achieve a 30% reduction in hospital acquired pressure ulcers in year 1 reducing hospital acquired category 2 pressure ulcers by 50% by June 2017 (first 6 months) and the remaining 50% by December 2017 (second 6 months). However during the year we have seen an increase in grade 1 and 2 pressure ulcers over the year but a reduction in the numbers of grade 3 and 4 pressure ulcers since October 2017. This correlates with an increasing acuity of patient we now admit.

END OF LIFE CARE

The Trust achieves the national recommendation of providing a face-to-face specialty visiting service for palliative care patients 9-5pm, seven days a week. This is in addition to our Palliative Medicine consultant on-call rota 24 hours a day, 365 days a year. New NICE Guidance is being developed for service delivery of End of Life Care for adults in the last year of life. This is expected to be published in January 2018, and we will participate in the national consultation process. 'Dying Matters' is a national initiative which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. Our Trust actively supports the Dying Matters week, by providing literature, information and an opportunity to talk.

We have an active and engaged End of Life Care (EOLC) Strategy Board, co-chaired by Deputy Chief Executive and Chief Nurse, with broad membership, including external community stakeholders. The Board scrutinises the quality of EOLC across the Trust and promotes strategies for ongoing improvement. We continue to develop our Trust wide Bereavement Survey and act on issues raised. Specific quality improvement plans in the coming two years include roll out of Trust wide documentation for the last days of life; developing the AMU in-reach service, which also involves a programme of education; the development and use of Personalised Anticipatory Care planning (PACE); and providing specialist palliative care to young adults Transitioning from children's to adult's palliative care services. Education and training underpin plans for all Trust wide initiatives in EOLC and there will be a rolling programme for a wide range of staff groups including foundation level communication skills training.

PATIENT EXPERIENCE

Our Patient Experience Strategy and action plan, updated annually, details our objectives in improving Patient Experience and how we work in partnership with external agencies such as Health Watch, the Patients Association, Commissioners and Patient and Public User Groups to identify and implement opportunities for improving patient experience. The Trust actively uses the information from the Friends and Family Test (FFT) to drive improvements at a local level and its Patient First programme has also been developed to enable delivery of the Patient Experience Strategy objectives. The focus of all this work is centred on driving shared learning from patient feedback.

NATIONAL CQUINS

The trust has a good track record of delivering CQUINs with attainment rates in excess of 90%. The Head of Service Improvement leads the delivery of CQUINS with the Joint Medical Director as the SRO of the CQUIN programme. There is good clinical engagement among senior clinicians in the development, implementation of project plans, monitoring and enactment of plans for delivery. A regular CQUIN steering board is chaired by the Joint Medical Director, and attended by Project Leads to track delivery and mitigate challenges. The trust maintains good communication with our commissioners to provide regular updates and clarification on the CQUIN programme.

CONFIRMATION THAT THE TRUST QUALITY PRIORITIES ARE CONSISTENT WITH STPS

The Trust is an integral partner within our two STPs and through strong clinical representation and dialogue is ensuring that the clinical priorities articulated within the STPs are prioritised within the Trust.

SECTION THREE: SUMMARY OF THE TRUST QUALITY IMPACT ASSESSMENT PROCESS

THE GOVERNANCE STRUCTURE

All cost improvement plans, and major service changes are assessed through the Clinical Assurance Panel (CAP). This is a clinically led panel of senior clinicians (doctors, nurses and midwives) across a range of clinical specialties, supported by a member of the Project Management Office. The CAP is chaired by the Joint Medical Director, and also attended by the Chief Nurse. Each scheme should be assessed prospectively before implementation. A detailed template is completed for every scheme including a description of the plan, quality impact assessment and assessment of risks to quality, patient and staff experience with associated mitigations. In addition, the SRO for each scheme is expected to outline how these risks are monitored within the division, and the route to escalation to the board.

Each scheme is expected to have a named responsible clinical lead. The Clinical Lead or SRO is invited to attend the CAP meetings to provide clarification for the panel if required. It is anticipated (as in previous years) that the CAP process will result in modification of some schemes and changes to the risk mitigation and monitoring.

At the end of the financial year, each division is expected to report back to CAP to outline the quality impact arising from the implementation of each scheme. Higher risk schemes are selected by the panel for more detailed assurance.

There is a tracker to monitor the assurance process for each scheme, and this is closely linked to the financial assurance process.

Our CCGs are invited to attend and detailed minutes are shared with our local CCGs and comments invited. The CAP is a standing agenda item on our monthly CQRG meetings with our commissioners.

OUR PLAN FOR IN-YEAR MONITORING OF QIA

Each scheme has a documented QIA and associated risk analysis (in the domains of patient experience and outcome, safety and reliability of care and team wellbeing). The mitigations for the risks are documented with associated adjusted risk score. For each scheme, the clinical lead must describe how the quality impacts will be monitored in each of the above domains. Furthermore, the clinical lead must describe the relevant forum within the directorate where these quality domains are monitored, and the route to the trust board (usually via the Trust Executive Committee, Clinical Quality Assurance Committee or the Patient Safety and Quality Committee).

The Clinical Assurance Panel will not sign off each scheme until it has received assurance that a thorough quality impact assessment, risk assessment and monitoring process is in place.

PROVIDER BOARDS VISIBILITY OF MONITORING ARRANGEMENTS

The detailed minutes of the Clinical Assurance Panel are presented and discussed at the Trust Board Patient Safety and Quality Committee (PSQ) by the Medical Director. The focus of this meeting relates to the quality of care. The PSQ triangulates this information with other components of quality of care. Where appropriate, the chair of the PSQ committee will cross-reference issues for discussion at other board sub-committees.

Enhanced productivity is achieved through successful implementation of these schemes. This is monitored and tracked through the CIP Programme Board, the Board Finance Subcommittee and the formal Trust Board meetings where transformation is a regular agenda item. The Medical Directors and Chief Nurse along with the Chief Operating Officer are present to discuss risks associated with these projects in relationship to quality and operational performance.

SECTION FOUR: SUMMARY OF TRIANGULATION OF QUALITY WITH WORKFORCE AND FINANCE

The trust recognises the importance of triangulation of key performance data to support understating and response to risk within the trust.

The Integrated Performance Report is central to the triangulation process and is considered monthly at various levels of the organisation prior to scrutiny by the trust Performance Assurance and Risk Committee (PARC) and presentation to the trust Board.

PARC is a subcommittee of the trust Board. PARC seeks assurance on trust performance against national and contractual standards and the risks to delivery of the trust corporate objectives, supporting specific issues that have been reviewed at the relevant Board subcommittee for Finance, People and OD, and Patient Safety and Quality.

Indicators cover the CQC five key questions and reflect the trust strategic objectives. The main trust Board agenda is structured around the trust Integrated Performance Report and the Board uses this information to assure of the trust's performance and risk and, where required, to request deep dives into areas of concern.

We are developing an action plan to build on the well-led self-assessment started in 2017 and will take in to account any comments made in the anticipated CQC inspection report.

WORKFORCE PLANNING

RECRUITMENT

In 2017/18 alongside the continued recruitment events in the United Kingdom the Trust undertook an international nurse recruitment campaign to the Philippines and India. Offers were made to over 200 qualified nurses who will be assisted by the Trust to obtain the required registration and ensure that we maintain a pipeline of qualified nurses to the Trust. The Trust has formed links with local universities to ensure that we are able to recruit student nurses and therapists to the Trust.

Our nursing workforce has been further strengthened by the introduction of the Band 4 Nursing Associate role. We have 49 in training with the first cohort due to qualify in January 2019.

We have successfully recruited a number of apprentice Health Care Assistants to further strengthen the nursing workforce and support the delivery of quality clinical services to our patients.

The Trust has had a well-established programme of open days to recruit registered nurses and in 2017/18 we have looked to expand this method of recruitment into radiology. In 2018/19 we will launch the programme of recruitment open days, which includes interview training for candidates, discussions with senior managers on career opportunities as well as site tours and one stop recruitment days including all clearances and first stage offer on the day of interview. During 2017/18 we have seen the nurses recruited from overseas start in the trust.

For 2018/19 the Trust has commissioned a medical workforce improvement programme, which has a focus on ensuring our rotas are adequately staffed. We will be further exploring the opportunities for taking on overseas doctors to solve our staffing issues, building on the relationships and networks we have in place and working in conjunction with the royal colleges to take on doctors via the Medical Training Initiative as a longer term solution. We also plan to introduce Physician Associate's / ANP's where possible to fill gaps in areas which have become hard to fill.

RETENTION

In 2017/18 the Trust ran a series of progression courses to develop our nurses who wishing to progress to band 6 and band 7 posts. This has been successful in retaining our experience nursing staff and helping them to progress to the next level of promotion in their career. Further programmes are planned to be run in 2018/19. Rotations posts have also been implemented to support staff to gain additional experience and a transfer option is also in place to support staff to move between specialties rather than moving to other organisation for experience. We have commenced a pilot in self-rostering across four medical wards and this has been facilitated by the STP funding a project manager post.

Facebook and WhatsApp have been effective methods of communication for with our nursing staff. We have also held keeping in touch afternoons, including afternoon tea and an opportunity to meet senior staff, has been effective in keeping in contact with student nurses that will be joining the Trust at the end of their training.

The Trust will be reviewing the medical staffing models in place and introducing rotational posts for doctors at junior and middle grade levels to make them more attractive and aid staff retention. We also aim to work with other trusts to create rotations that will be mutually beneficial.

STAFF PRODUCTIVITY

During 2017/18 the Trust implemented e-rostering for medical establishments, absence management and temporary staff management. This allows the Trust to manage all medical staffing, both substantive and temporary on one system, increasing transparency and supporting planning and utilisation. The medical rostering teams has been centralised and brought under the management of the e-rostering team. This has ensured consistency of approach to medical rosters and greater transparency of staff utilisation and planning. However the introduction of the 2016 contract has added considerable pressure to this team and different ways of working, which will continue to be addressed in 2018/19.

The Trust continues to work towards the implementation of theatre utilisation through the rostering system in 2018/19. This will ensure that there is clear planning for all theatre slots of the correct teams and any gaps or leave commitments can be easily identified and managed. It will also link theatre plans, consultant job plans and medical and nursing rosters on the one system.

The Trust has completed the implementation of Safecare for nursing staff in 2017/18. This allows the Trust to plan the nursing workforce according to the acuity of the patients in the hospital rather than a traditional model of nursing ratios. It is also being used as a part of the Trust site reports to inform site management teams and on-call manages of staffing levels and potential issues.

TEMPORARY STAFF

The Trust already has in place a comprehensive bank covering all staff groups that centrally manages all temporary staffing bookings. The Trusts CEO is the Executive lead and senior responsible officer for the South West London Collaborative Bank, which in phase one will allow nursing staff to work across all SWL Trusts through a single booking system and App. The Trusts have harmonised recruitment, rostering processes, pay rates compliance processes. Staff are only required to undertake one on-boarding process to be able to work anywhere in South West London via the App. Phase one will launch on April early 2018/19 increasing flexibility for staff and reduce the need for agency workers for the Trusts. Phase 2 will commence for medical staff and Allied Health Professional Staff in 2018/19.

WORKFORCE PLANNING

The broad workforce numbers are driven by the financial plan which, in turn, reflects the service level agreements with commissioners. This takes account of broad trends in the level of elective and non-elective activity. We have used the national demand and capacity modelling and will be using some local tools developed as part of our transformation programme to inform more granular levels of plans. The latter allows us to look at, for instance the demand for outpatient and theatre capacity from medical staff. The original focus on bank and agency expenditure is that the general workforce trend is flat – a result of activity growth being off-set by the demand for increasing efficiency. Reducing vacancies in order to grow the substantive staffing levels and reduce agency costs has therefore being our main workforce strategy at a Trust level.

At a service level we have been examining clinical service models and will continue to do this in 2018-2019. This includes expanding our joint venture with GPs, community services and social care in Epsom (Epsom Health and Care) to take on the Surrey Downs Community Contract. In addition, we will be working with partners in Sutton to create Sutton Health and Care. As part of this work and internal work on non-elective care we are re-designing working practices to improve patient flow. In planned care we are using the national and be-spoke demand and capacity tools to align our staffing to the capacity required to deliver the RTT recovery plan as well as maximise operational efficiency (e.g. e.g. revising job plans to achieve theatre efficiency and outpatients productivity) Also in planned care we are working with Commissioners and General Practice to introduce electronic referrals and electronic advice and guidance to achieve the national CQUIN requirement and the policy of paper switch-off by October 2018.

In non-medical staffing, we will be continuing to introduce the new Nurse Associate and Associate Practitioner roles. We are also planning for an expansion of Physician's Associates and Advanced Nurse Practitioners to reduce pressure in shortage medical posts. In terms of the National Apprenticeship Levy we have some good schemes underway but will be looking to expand these into the new financial year to make the most of the national funding available.

FINANCIAL PLANNING

1. Underlying deficit for 2017/18

1.1. The recovery plan aims to reduce the underlying deficit from £37.2m to **£32.9m** incorporating changes to the Trust's income, reflecting inflationary and local cost pressures and savings plan (CIPs). The table below shows the bridge from the 2017/18 outturn to the underlying deficit.

Figure 15 – 2017/18 Outturn to 2017/18 Underlying Deficit

		Total Income £'k	Pay £'k	Non Pay £'k	Total NHS Performance £'k
1	**Forecast Outturn 2017/18**	**-398,538**	**267,649**	**144,250**	**13,361**
2	**Non-recurent Income**				
2.1	STF Income	13,756			**13,756**
2.2	Profit on Disposal of land			10,414	**10,414**
2.3	Block contracts income impact	-2,438			**-2,438**
2.4	Non recurrent MRET penalties	-3,255			**-3,255**
2.5	Cancer funding	575	-436	-139	**0**
2.6	Surrey Down UCC/Winter pressures	350	-350		**0**
2.7	Surrey Downs stroke consultant recharge	300	-300		**0**
2.8	Winter funding tranche 1 and 2	1,693	-1,693		**0**
		10,981	**-2,779**	**10,275**	**18,477**
3	**Non-recurrent Costs**				
3.1	Control total payment Kingston Hospital			-600	**-600**
3.2	Consultancy costs			-848	**-848**
3.3	Overseas nursing recruitment			-210	**-210**
		0	**0**	**-1,658**	**-1,658**
4	**Full Year Effects**				
4.1	Filling of pay vacancies and other FYEs		4,813	3,080	**7,893**
5	**CIPs**				
5.1	Non-recurrent CIPs	139	1,109	111	**1,359**
5.2	Full year effect CIPs	-389	-931	-900	**-2,220**
		-250	**178**	**-789**	**-861**
6	**Forecast Underlying outturn 2017/18**	**-387,807**	**269,861**	**155,158**	**37,212**

1.2. **The key areas in the bridge are as follows:**

1.2.1. **Non recurrent Income:** The Trust received non-recurrent income from a number of sources as detailed below:

- **STF Income-** The Trust received core STF of £7.7m for achieving the financial target and Quarter 1 of the A&E target. In addition the Trust also received incentive STF of £1.0m and bonus STF of £5.0m.
- **Profit on disposal of land-** Disposal of surplus land as part of the Trust's five year Estates Rationalisation Strategy. £10.4m shown in the table represents profit on disposal of the third

tranche of land disposals at the Sutton Hospital site. Sales proceeds are £14.1m with cost of sales £0.4m, Net Book Value of £3.3m, to give a net profit of £10.4m.

- **Block contracts income impact-** The Trust entered into a block contract with Surrey Downs. The £2.4m represents the Trust's assessment of the gross over-performance on the 2017/18 contract that will form part of the baseline for the 2018/19 contract.
- **Cancer funding-** The Trust, in partnership with the Royal Marsden, was successful in bidding for additional non-recurrent cancer funding to pilot multi-disciplinary clinics and increased scans for cancer pathways associated with Urology, Upper GI, Lower GI and Gynaecology. This income is matched with expenditure.
- **Surrey Downs UCC/Winter pressures-** The Trust made a successful bid for additional winter pressure funds to staff the new GP Streaming from Surrey Downs CCG. Costs were incurred against specific schemes and match the income received.
- **Surrey Downs stroke consultant recharge**- Funding from Surrey Downs CCG for additional costs related to the Trust's stoke service.
- **Winter funding tranche 1 and 2**- The Trust received £1.06m from tranche 1 and a further £0.6m from tranche 2 of winter pressures funding. Tranche 1 was received to improve the forecast. However the Trust had incurred unfunded escalation and winter costs therefore there was no scope for the forecast to improve. Tranche 2 covered specific schemes to improve A&E performance and matched the income received.

1.2.2. Non-recurrent Costs

- **Control total payment Kingston Hospital**- This represents a payment to Kingston Hospital in lieu of the control total adjustment for the impact of tariff on SWLEOC. If this was reflected in both organisations' control totals then this spend would not have been incurred.
- **Consultancy costs-** The Trust commissioned a number of consultancy services in 2017/18 for one-off programmes that will not be required in 2018/19.
- **Overseas nursing recruitment-** The Trust recruited nurses from India and Philippines and this is the cost of recruitment (agency fees, border agency costs, language tests, flights).

1.2.3. Full Year Effects

- **Filling of pay vacancies and pay FYEs**- This represents posts that are filled part way through the year e.g. medical staffing funded through cost pressures in 2017/18 recruited part way through the year and approximately 40 nurses recruited from overseas, commencing in quarters 3 and 4 in 2017/18.

1.2.4. CIPs

- **Non-recurrent CIPs-** £1.4m of non-recurrent CIPs mainly from the planned holding of vacancies. There are a small number of non-pay CIP schemes including one-off contractual rebates.
- **Full year effect CIPs-** this represents recurrent CIPs schemes that started part-way through 2017/18.

2. Plan to improve underlying deficit in 2018/19

2.1. The financial plan for 2018/19 incorporates changes to income contracts, inflationary pressures, Trust specific cost pressures and the impact of CIPs. This delivers a plan of **£13.7m** and achieves the 2018/19 control total.

2.2. The plan also reduces the underlying deficit from an opening deficit of **£37.2m** to **£32.9m**. The table below shows the bridge from the opening underlying deficit to the 2018/19 plan.

Figure 16– 2018/19 Financial plan

		Total Income £'k	Pay £'k	Non Pay £'k	Total NHS Performance £'k
1	**Forecast Underlying outturn 2017/18**	**-387,807**	**269,861**	**155,158**	**37,212**
2	**Recurrent planning changes 2018/19**				
	Income changes:				
2.1	Tariff impact (0.7%)	-2,639			**-2,639**
2.2	Growth	-7,545		805	**-6,740**
2.3	RTT	-2,556	1,601		**-955**
2.4	QIPP	11,287			**11,287**
2.5	Activity related changes	-6,373	449	2,200	**-3,724**
2.6	Pricing related changes	-3,176			**-3,176**
2.7	Other operating income	-500			**-500**
	Additional services				
2.8	Surrey Downs Adult Community Services	-11,359		11,359	**0**
2.9	Sutton Health & Care	-5,000		5,000	**0**
	Expenditure changes:				
2.10	National cost pressures		5,407	2,752	**8,159**
2.11	CNST			3,181	**3,181**
2.12	Local Cost Pressures	695	2,579	2,339	**5,613**
2.13	New CIP 2018/19	-792	-9,342	-4,646	**-14,780**
2.14	Changes in Facilities Management	0	-3,836	3,836	**0**
3	**Recurrent Plan 2018/19**	**-415,764**	**266,718**	**181,984**	**32,939**
4	**Non-recurrent planning changes 2018/19**				
4.1	Provider Sustainability Funding (PSF)	-14,529			**-14,529**
4.2	Other		3,840	-8,587	**-4,747**
5	**Financial Plan 2018/19 NHS Performance**	**-430,293**	**270,558**	**173,398**	**13,663**

2.3. **The key areas in the bridge are as follows:**

2.3.1. **Recurrent planning changes 2018/19- Income changes**- for 2017/18 the Trust entered into a block contract with Surrey Downs CCG and a risk share contract with South West London CCGs (the Trust's two largest commissioners). However for 2018/19 the Trust will have a PbR contract for elective activity and block contract for non-elective activity for these commissioners and remain on PbR for specialised commissioning. The changes from the 2017/18 recurrent outturn to the plan are detailed below.

- **Tariff impact (0.7%) £2.6m**- The second year of the tariff represents at 0.7% increase based on the Trust's casemix, this is similar to last year's uplift and is higher than the 0.1% national average tariff uplift.
- **Growth £7.5m-** The Trust and Commissioners have agreed growth for both elective and non-elective activity relevant to the local health system and in line with the operating guidance.
- **RTT £2.6m** – The Trust's demand and capacity modelling has calculated that the Trust will need to undertake activity to the value of £2.6m to ensure the number of patients on the incomplete pathway at March 2019 is the same as at March 2018.
- **QIPP £11.3m–** The Trust has agreed elective and non-elective QIPP based on evidence provided by the Commissioners.
- **Activity related changes £6.4m** - £3.5m of this relates to over-performance on elective activity and £2.2m relates to additional activity re-directed from providers in the alliance to SWLEOC. This over-performance and growth, when netted off against elective QIPP, results in the same level of activity as that undertaken during 2017/18.

- **Pricing related changes £3.2m**- This income increase relates to a number of adjustments that are not activity related, for example, re-pricing of the MRET baseline, changes in readmissions values, reduction in KPIs and changes to local tariffs.

2.3.2. **Recurrent planning changes 2018/19- additional services**- The Trust's strategic plan is to be an integrated care provider and for 2018/19 has built on the success of Epsom Health & Care by developing the following:

- **Surrey Downs Adult Community Services** – The Trust, in partnership with other providers, was awarded the tender to operate Surrey Downs Adult Community Services. The service will commence from 1st October 2018. The full year income is assessed to be £22.5m of which half has been reflected in the 2018/19 plan. The costs and income net to zero and any efficiency savings achieved in year will form part of the CIP programme.
- **Sutton Health & Care** – The Trust in partnership with providers in Sutton will implement an integrated care model, similar to Epsom Health & Care implemented in Surrey during 2016/17. This service is planned to start from 1st April 2018 which the Trust will host and contract with Sutton CCG for an additional £5.0m of income.

2.3.3. Recurrent planning changes 2018/19- Expenditure changes

- **National cost pressures £8.2m**- this represents inflationary uplifts for pay and prices in line with national guidance.
- **CNST £3.2m**- The Trust has been advised its CNST cost is increasing by £3.2m, reflecting a 27% increase in CNST costs compared to last year's cost. There has been minimal change in the underlying activity and medical staff volumes which are two of the main factors used in the calculation of the risk pool fee therefore the remaining factor, impact from recent claims, is driving the increased fee.
- **Local Cost Pressures £5.6m**- Trust specific cost pressures were identified through the business planning process and prioritised and approved by the Trust Executive Committee.
- **CIP** - The Trust has planned for £14.8m of new CIPs in addition to £2.2m of full year effects. Therefore CIPs totalling £17.0m are planned for 2017/18 (the details of these schemes are shown below).

2.3.4. **Non-recurrent planning changes 2018/19**

- **Provider Sustainability Funding (PSF) £14.5m-** The plan assumes full receipt of the notified £14.5m PSF for 2018/19
- **Other:**
  - **Land Sales-** The Trust is planning to dispose of surplus land at Epsom Hospital and the remaining surplus land at Sutton Hospital. The sales proceeds for the Epsom disposal are provisional as a commercial purchaser will be sought through competitive marketing. The Trust is developing an OBC and FBC to comply with delegated capital limits for this transaction.
  - **Contingency**- The Trust has included £1.0m contingency (0.2% of operating expenditure baseline) in the plan for unforeseen non-recurrent costs.
  - **Other cost pressures**- there are a number of Trust specific non-recurrent cost pressures (including development of Estates Pre-consultation Business Case and costs for additional overseas recruitment).

3. **Delivering the 2018/19 Savings Plan (Cost Improvement Programme)**

3.1. The Trust has planned for £17.0m (4.0%) savings plan (CIPs) for 2018/19. This compares to delivering £15.6m (3.7%) in 2017/18.

3.2. In developing the savings plan the Trust has used the following principles:

- Operate within the same governance framework for planning and implementation as the one used during 2017/18;
- Objectively assess the lessons learnt from 2017/18 and implement recommendations.
- Place greater emphasis on information and analysis from the Model Hospital, GIRFT, Dr Foster, NHS Purchase Price Index Benchmarking (PBIB) tool and the Trust's Service Line and Patient

Information and Costings systems to develop savings plan. This approach has been used to develop plans for savings from acute pathway, plans within Urology and Gynaecology and procurement. The Trust will also continue working closely with NHSI Director of Productivity.
The Model Hospital identified opportunities in a number of specialities (Geriatric Medicine, Obstetrics, Paediatrics and T&O). The Trust has developed detailed implementation plans for Geriatric Medicine, using data from the Model Hospital. We will adopt a similar methodology over the coming months and apply it to other service lines.

- Roll out Priority Based Budgeting across the Trust as this proved a successful methodology for identifying and implementing cost reductions during 2017/18.
- Obtain incremental benefits by working with other acute providers within South West London (South West London Acute Collaborative).
- Work with partners across the system (both commissioners and non-acute providers) to develop new models of care and deliver efficiencies and savings for the health economy.
- Examine innovative models for providing clinical support and facilities services by exploring the creation (in partnership with another acute Trust) of a new entity to transform the way facilities and services are provided and how their supply chains are managed.
- Increase resources and capabilities in key areas to support delivery of the savings programme. Re-defined the roles and responsibilities of the Service Improvement Team to focus on cost reduction schemes.

3.3. The table below shows the Trust's risk assessed savings plan by themes (see Figure 17 below).

Figure 17 – 2018/19 Savings forecast by theme

Savings Theme	Unidentified	High Risk	Medium Risk	Low Risk	Total (£'k)
		£'k	£'k	£'k	£'k
Clinical Administration		-	180	400	580
Corporate Administration		-	-	402	402
Estates & Facilities		-	-	170	170
Income - Other		-	82	226	308
Managed services		-	500	500	1,000
Management		-	25	86	111
Medicines Management		-	-	200	200
Non Pay - Clinical		-	100	995	1,095
Non Pay - Other		75	50	403	528
Pathology		-	92	38	130
Patient Pathway		750	144	37	931
Priority Based Budgeting- Surgery		250	50	1,200	1,500
Private Patient Income		-	-	-	-
Procurement/Carter		-	1,053	355	1,408
Efficiency from additional elective activity				495	495
Efficiency from Sutton Health & Care				500	500
Efficiency from Surrey Adult Community			250	150	400
GIRFT (ENT, Gynaecology, Urology)		300			300
Acute collaborative			300		300
Workforce - AHPs		-	81	94	175
Workforce - Medical Staffing		1,000	-	540	1,540
Workforce - Nursing		-	394	627	1,021
Unidentified	1,686		-	-	1,686
Sub-Total	**1,686**	**2,375**	**3,301**	**7,418**	**14,780**
Full year 2017/18	-	-	-	2,220	2,220
Total	**1,686**	**2,375**	**3,301**	**9,638**	**17,000**
Percentage of overall plan	**10%**	**14%**	**19%**	**57%**	**100%**

3.4. The Trust has assessed the savings plan for financial risk based on the following criteria:

- **Red rated**– plans have not been identified or scheme does not have an adequate number of detailed milestones. In addition, the scheme has not been approved by the Clinical Assurance Panel.
- **Amber rated**- the scheme has been delayed from the initial planned start date and as a consequence these schemes may deliver below plan at the year-end. They have been approved by the Clinical Assurance Panel (or have a planned date to present to the Clinical Assurance Panel) and have an adequate number of detailed tracking milestones. However, the Divisions are working on mitigation plans to bring the scheme back to plan.
- **Green rated**- the scheme has been approved by the Clinical Assurance Panel (or has a planned date to present to Clinical Assurance Panel), has an adequate number of detailed tracking milestones and is forecast to deliver to or above plan by the year-end.

3.5. Based on this, the Trust's assessment is that 76% of schemes are green or amber risk-rated and are forecast to deliver the planned savings. The Trust has used risk stratification for the purposes of this plan, however, our Governance and Delivery framework utilises gateways to assess and monitor progress during both the planning and implementation phase.

3.6. The schemes within the savings programme are summarised into the following themes:

3.6.1. **Clinical Administration-** There are a number of schemes across the Trust to further rationalise and streamline clinical administration functions. This builds on centralising the outpatient booking function implemented during 2017/18.

3.6.2. **Corporate Functions-** Corporate areas have been set 6% savings target. All corporate areas have developed plans to meet this target. Schemes range from restructuring parts of a corporate function, redesign of roles and critically assessing the value-add of reports and support provided to clinical divisions. This will be supported by the Priority Based Budgeting programme.

3.6.3. **Estates and Facilities**- There are a number of estate rationalisation schemes as part of the 5 year Estates Plan that will be implemented in 2018/19 and deliver savings. The department will also implement plans to restructure the department and release savings.

3.6.4. **Management**- There are a number of management posts that will be rationalised and deliver savings.

3.6.5. **Efficiencies from Sutton Health & Care and Surrey Adult Community Services –** These are new services which will start during the year. The Trust plans for synergies by running these services and thereby making savings in areas such as Corporate back-office and pathway redesign.

3.6.6. **Non-Pay (Clinical)** – These schemes will reduce clinical non-pay, primarily by reducing the value of contracts for bought in clinical services (therapies, dialysis costs). The divisions will redesign elements of service delivery to accommodate these changes. These non-pay savings are in addition to procurement saving outlined below.

3.6.7. **Non-pay (Other)** – There is a programme to review all non-clinical contracts and develop plans to amend, replace or cancel these contracts. There are also savings arising from reviewing all areas of non-clinical non-pay to identify cost reductions. These savings are in addition to the procurement savings outlined below.

3.6.8. **Pathology** – The Pathology department has developed a number of schemes building on the Priority Based programme implemented in 2017/18.

3.6.9. **Patient Pathway –** The Trust has utilised data from the Model Hospital, Dr Foster and other benchmark tools to identify opportunities in the way the Trust delivers elements of the acute pathway. The Trust will also work with Sutton CCG and providers in South West London (community provider, mental health trust, social services and GPs) to develop Sutton Health and Care similar to the integrated care model developed as part of Epsom Health and Care. This model will release capacity and reduce the need for escalation costs particularly during winter.

3.6.10. **GIRFT (ENT, Gynaecology, Urology)** - The Trust is developing improvements across GIRFT assessed specialties to deliver services more efficiently.

3.6.11. **Procurement** – The Trust has developed a number of schemes to deliver this plan. The Trust has used the NHSI Purchase Price Index Benchmarking (PBIB) tool to identify some schemes within this programme. We are also an active participant in the South West London Provider Collaborative (as detailed in section 9) and undertaken large scale joint procurement exercises (Non-emergency patient transport, orthopaedics prosthesis and we are currently working with Kingston Hospital on a joint procurement for sterile services). The department has also been restructured to increase resources and capability to improve data analytics and working with clinical divisions.

3.6.12. **Workforce AHP** – The Trust will build on the work started in 2017/18 to change the therapies model. This programme also includes a new pharmacy model and builds on the Trust's Pharmacy Transformation Programme in response to the Carter report.

3.6.13. **Workforce Medical** – This programme has three key elements:

- Designing of new roles
- Focusing on recruitment

- Reducing temporary staffing costs based on better information, stronger governance and approvals process.
- The 2018/19 programme builds on the work started during 2017/18. The Trust has increased resources (dedicated medical staffing specialists aligned to divisions and new head of medical staffing role) to deliver this CIP.

3.6.14. **Workforce Nursing** – Significant savings have been realised from nurse staffing during 2016/17 and 2017/18. This year's programme focuses on the roles of Clinical Nurse Specialists and reducing "Specialling" costs.

3.6.15. **Full year Effect of 2017/18 schemes** – The Trust has a number of schemes that started part way through 2017/18.

3.7. **CIP Pipeline -** The following schemes are in the pipeline for further development to close the £1.7m unidentified gap:

- Rolling out PBB across other clinical divisions and corporate areas (estimated benefits of circa £0.9m Corporate and £0.4m clinical divisions);
- Reducing agency expenditure to meet the new cap (circa £0.3m to £0.4m);

3.8. The chart and table below shows the profile for the savings plan.

Figure 18 – Chart of Monthly 2018/19 CIP plan

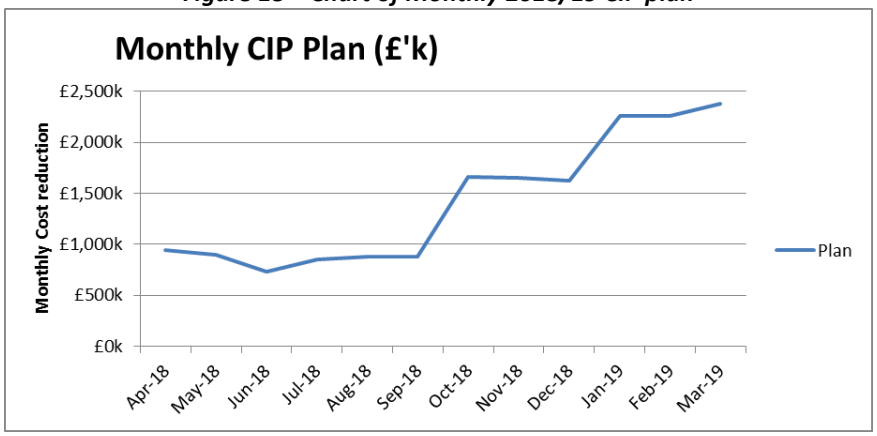


Figure 19 – Table of monthly 2018/19 CIP plan

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Savings Plan Profile 2018/19	£946k	£894k	£730k	£853k	£875k	£874k	£1,664k	£1,648k	£1,625k	£2,258k	£2,259k	£2,374k

4. Risks

4.1. Continuing workforce challenges

- The Trust has experienced significant workforce challenges across clinical staffing during 2017/18. It has been particularly acute in medical staffing creating operational pressures and resulting in increased locum and agency costs to maintain safety and performance standards. Although there is increased focus for 2018/19 (as outlined above), there is still a risk that in some specialities high vacancy rates will result in greater than planned locum/agency costs.

- The Trust has also experienced challenges in its nursing and midwifery workforce during 2017/18. The Trust plans to continue to focus on recruitment and retention during 2018/19 to minimise reliance on temporary staffing, however, as with medical staffing, there is still risk that high than assumed levels of vacancies will cause an increase in agency costs.

4.2. Operational pressures

The Trust, in common with other acute providers, has seen unprecedented levels of activity during 2017/18 which has peaked during winter. The broad financial impact of this has been:

– Additional unplanned costs as the Trust has utilised escalation capacity,
– Loss of elective activity and income to accommodate emergency activity
– Operational managers focusing on managing these pressures resulting in less focus on delivering CIPs (management "bandwidth").

- The risk for 2018/19 is that unplanned surges in emergency activity will have a similar impact on delivering the financial plan.

4.3. Cost Improvement Plans

- This recovery plan has outlined the process for developing the CIP plan and details the constituent elements of the programme. However, the full CIP programme has not been fully developed. There is also an implementation risk, has happened in past years, that some schemes do not deliver as planned as a result of in-year operational pressures.
- This risk is partly mitigated with the appointment of a Director of Turnaround and Transformation to support the divisions and executive team.

4.4. Cost pressures

- The Trust has budgeted £1.0m (0.2%) contingency for unforeseen in-year cost pressures. The 2017/18 plan had a contingency for £2.0m which was fully utilised during the year. There is significant risk that the 2018/19 contingency will not be sufficient. This risk arises from potential increased costs in the development of the PCBC (circa £1m) and other operational costs that could be a further £1m to £2m.

4.5. Income

- The Trust has signed contracts with our main commissioners. The Trust has contracted for an additional £2.6m of elective activity to maintain the waiting list (as per the operating plan guidance). The risk is that the Trust will not be able to deliver this additional activity and therefore underperform again the contract, or deliver it at premium rates.

4.6. Delivery of A&E Access Standard

- £4.4m (30%) of Provider Sustainability Funding is dependent on delivering the A&E Access Standard in each quarter of 2018/19. The Trust did not achieve the A&E standard in the last three quarters of 2017/18. Although the Trust has made a number of improvements and is planning to expand the A&E departments on both sites, there is still risk that pressures during the winter period may jeopardise achievement of the target.

4.7. Land sale

- The Trust is planning to sell a large section of surplus land at Epsom Hospital. The Trust will have to prepare an OBC and FBC which requires approval from NHSI. The transaction value potentially exceeds the Trust's delegated capital limit and the approval process may result in the transaction falling into the next financial year.

- The Trust would have to undertake commercial marketing to secure the appropriate purchaser and sales proceeds, potentially adding further risk and delay into the process. The Trust has not undertaken this type of transaction in the past and has based the sale proceeds on indicative surveyor values and potential use for this land.

- The Trust will have to undertake a number of decanting moves (including moving clinical and office areas) to facilitate the sale. There may be a number of operational challenges resulting from the complexity of these moves.

5. Financial Outlook 2019/20

5.1. In the past two years the Trust has achieved its control total through land sales totalling **£28.1m** – delivering profit on disposal of **£11.1m** in 2016/17 and **£10.4m** in 2017/18. In 2018/19 land sales are again planned. However there are no further land sales beyond 2018/19 delivering any profit and therefore the Control Total will need to be changed to reflect this position.

CAPITAL PLANNING

1.1. The Trust has a significant need for capital investment over the next few years if it is to maintain the ability to provide safe care. Historically the Trust has underinvested in its infrastructure whether it be plant, building, medical equipment or IT.

1.2. We must ensure that we respond to the CQC regulatory breach notice which we received in April 2016. This focussed on two issues both the overall fitness for purpose of the main fabric of St Helier and in particular the physical environment of the critical care facility.

1.3. It is recognised that capital availability over the next few years is very limited and the Trust has therefore set a capital programme that explores alternative funding sources for all schemes, where possible.

1.4. We have constructed a multi-year capital plan that will resolve some of the most major critical infrastructure issues at the St Helier site.

1.5. The Trust has secured external funding via a Department of Health loan (£25.1m) to fund the capital ask over and above our normal depreciation capital. In addition the Trust is sourcing funding for investment in energy schemes.

1.6. We intend to sell all the remaining land that the Trust owns that is or could be surplus to requirements over the period to both meet our control total and with NHSI support be converted into PDC / loans for the capital.

1.7. The Trust is aware of its capital investment needs through a range of information sources, estate condition survey, IM & T strategy, equipment asset register, trust risk register and clinical divisions' information as part of the 2017/18 and 2018/19 business planning process.

1.8. The Trust's Capital Investment plans for 2017/18 and 2018/19 were designed to address some of our urgent challenges of backlog maintenance and infrastructure renewal, supports significant need to invest in our IT infrastructure, hardware and modern technology and address our priority replacement equipment. The Trust is also planning to invest significant capital over the next two years to rationalise its estate, thus reducing its operating costs, reducing the back log challenge and providing options for further land disposals.

1.9. We have set out this section in a series of steps:

- Capital to be funded from depreciation in 2018/19
- Critical infrastructure replacement programme 2018/19 -– 2019/20
- Site rationalisation plan that leads to land disposals 2018/19 - 2019/20 and capital required to make the land surplus
- Financing of the capital

Routine capital Investment funded from depreciation capital 18/19

1.10. This section sets out how we intend to use our depreciation capital for 2018/19 (Table 4 below).

Table 4 – Routine Capital Investment internally funded 2018/19

			2018/19 £'m
1	Building	St. Helier- Critical Infrastructure Risk, B & C Blocks	6.6
2	Building	Backlog and Plant Replacement/ Statutory and Mandatory Compliance Trust- wide	0.9
3	Building	Epsom/St Helier ED reconfiguration design/enabling	1.3
4	Building	Old PGMC/Chapel Space	0.6
5	Building	Sutton Completion of car parking and roadway	0.1
6	Building	Site rationalisation	0.2
7	Building	Ebbisham and Casey Ward Alterations	0.4
8	Building	17/18 schemes brought forward	0.4
9	Building	Feasibility Studies and 2019/20 planning work	0.3
			10.7
		Medical Equipment	
10	Equipment	Beds managed service contract	0.5
11	Equipment	Radiology Equipment	1.5
12	Equipment	Other Medical Equipment - planned	1.0
13	Equipment	Other Medical Equipment - contingency	0.2
			3.2
		Information Technology	
14	Information Technology	Information Technology	**3.0**
15	Building	Contingency Fund	1.2
		Total	**18.1**
		Funded by:	
		Depreciation	13.4
		B & C Block	4.7
		Total	**18.1**

1.11. Information and Computer Technology

1.11.1. The Trust has an ICT Strategy which is currently being reviewed and refreshed. The Strategy details the challenges the trust face in achieving a 'fit for purpose' systems and network to allow the continuation of our services delivered safely and to allow expansion, capacity and increased access, as an enabler for transformation of services to meet the Trust's financial challenges and the actions set out in the Carter review.

1.11.2. The ICT requirements for the next 4 years have been categorised into seven key domains, PC Replacement, Core Network and Security, Electronic Prescribing & Medicines Administration, Server Environment, Data Backup Environment and Transformation Investment.

1.11.3. It is vital that the Trust continues to invest into ICT, not only to allow its systems to stand still and continue to operate, but to ensure ICT is developed and expanded as technology continues to grow. Furthermore, ICT will need investment to support the large amount of work the trust has begun on transformation and reconfiguration of its services. ICT will be a key enabler of this work.

1.12. Medical Equipment Replacement

1.12.1. The Trust has a high demand in replacing portable medical devices, re-useable medical devices, diagnostic equipment and Therapeutic Equipment. As part of the 2017/18 capital planning process, a range of data and information has been gathered to allow the amount of capital investment to be quantified. A similar process will be followed for 2018/19.

1.12.2. The Trust has also entered into a managed equipment service to replace the radiology equipment over the next 5 years which requires the Trust to commit to £1m p/a of capital investment. The business case for this demonstrated that this was the most cost effective way to replace our aging equipment

1.12.3. In 2017/18 we have replaced our endoscopy washers on both sites to allow our decontamination process to change to a chemical based solution. This is following the previous salt process losing its UK licence in May 2017.

1.13. The Estate

1.13.1. The estate has a significant backlog maintenance issue, totalling £125m in 2016/17, and is amongst the highest in NHS England. 50% of the backlog maintenance challenge (£62m) has been categorised as Critical Infrastructure, meaning significant or high risk and therefore is significantly impeding the Trust in delivering safe and effective healthcare facilities for our patients. These figures are based on a six-facet survey undertaken in Autumn 2016. The report highlights that the Trust backlog maintenance position is significantly worse than the previously reported figure.

1.13.2. The plan funded from depreciation includes the following investments all of which are deemed essential – either directly or indirectly - to maintain safe services

- Mandatory and statutory compliance;
- Routine plant and engineering infrastructure replacement;
- Investment in Epsom Outpatients (fit out of Woodcote 1st floor and relocation of clinics from Langley and Headley Wing);
- The fit out of external offices and move of staff from Epsom to allow site rationalisation.

Critical infrastructure replacement plan 2017/18 - 2018/19

1.13.3. The Trust is aware that its estate is limiting its ability to ensure patients are treated in buildings that are fit for twenty-first century healthcare. In June 2015, the Trust Board was presented with a paper which outlined the current state of the estate and its link with current performance.

1.13.4. The CQC issued a regulatory breach notice against the Trust in its report published in April 2015 following our routine whole hospital inspection. The action plan that we completed and agreed with NHSI committed us to securing additional capital to significantly reduce the critical infrastructure backlog in particular at St Helier. Work underway includes the external refurbishment of our main St Helier ward block, with design of replacement boilers at both sites advancing.

1.13.5. NHSI requested that we complete a revised 6 facet survey to determine the scale of the investment required. This was completed in November 2016 and shows that the Trust backlog maintenance position is significantly worse than the previously reported figure above and totalling £125m

The SW London STP also recognises the poor state of St Helier. The financial appendix to the document includes the following section.

"*Epsom and St Helier (E&SH) is facing major problems with its estate particularly at St Helier. The trust's most recent CQC report commented that "The NHS estates and facilities dashboard placed the trust in the lowest (worst) quartile for the amount of functional and suitable space available for the delivery of clinical care."*
Addressing the issues at St Helier will be in two stages:
Safety critical capital investment in 2016-17 - 2018-19: The main building at St Helier hospital has major problems, including, most significantly, water ingress which has caused the closure of A&E twice over the last year. The Trust is undertaking a new six faceted survey of the St Helier site to get a full understanding of all the immediate priority issues. The trust expects to fund work to address these immediate safety issues in the first years of the STP through land sales and other internally generated funding.

Making the buildings fit for purpose from 2018-19 onwards: South west London anticipates that a decision will be made on reconfiguration during 2017 or 2018. The funding required to improve St Helier will depend heavily on what decision is made around reconfiguration:

1.13.6. There are four main elements that we wish to address during 2017/18 and 2018/19 at St Helier

- The structural integrity of blocks B and C
- Re-providing the critical care facility
- Replacing the power and heating plant
- Re-providing the renal wards

1.13.7. **Structural repairs to Blocks B and C** – these are two of the main ward blocks at St Helier which contain 12 of our inpatient wards. The walls are no longer waterproof and the rendering has degraded to such an extent that the structural steel is now corroding. We have let a contract to repair the exterior of these blocks which commenced in July 2017. The contract value is approx. £12m and is expected to be completed in December 2018.

1.13.8. **Critical care facility** – this facility is currently located in two separate parts of the building and is not adjacent to the other infrastructure relating to sick patients. The environment is very poor as picked up by the CQC. In 2016/17 and 2017/18 we have designed a new location and by March 2018 will have cleared the space to create a new critical care facility on the 1st floor of the ward block. This will allow us to have on one floor our emergency assessment units, coronary care and critical care. This new department will take 1 year to complete and will cost £6m

1.13.9. **Combined heat and power plant** – the current steam boilers at St Helier are over 50 years old. They are long past their replacement date and along with the steam pipework distribution network, provides a significant risk of failure, resulting in operational challenges. We wish to replace them with a combined heat and power plant. We have spent 2016/17 and 2017/18 designing the new facility with our delivery partner, Breathe Energy. In addition, we have over 50% of our lighting which is over 15 years and not energy efficient. We wish to replace these with modern LED lighting. We intend to finance this work through a LEEF loan or other energy funding. The work will take 2 years and cost approx. £12m spread over the two years.

1.13.10. **Re-providing our renal facility.** These wards which have some of our sickest patients are located at the back of the St Helier site. Each of the 3 wards is entirely inappropriate to look after patients in. We also have our dialysis facility in the same location where the environment is poor. We are re-providing the dialysis unit in the main building under a managed service contract. Once the critical care re-location has taken place we can create a floor in the main hospital ward block to move all the 3 renal wards into. This will improve patient safety and enable us to vacate the existing renal facility and G block. This will save £500k p/a in estates costs, c£500k in nursing costs and enable a land sale to be realised (see next section). The costs of moving renal into the main ward block are ~£6m, which includes the works on the existing medical and surgical wards to improve their environment and infection control compliance.

Financing - apart from the combined heat and power plant which is financed through a LEEF or other energy loan we will finance all of these developments through DH Loans. To finance this we have secured £15.7m in 2018/19 and £4.2m in 2019/20 (Table 5 below).

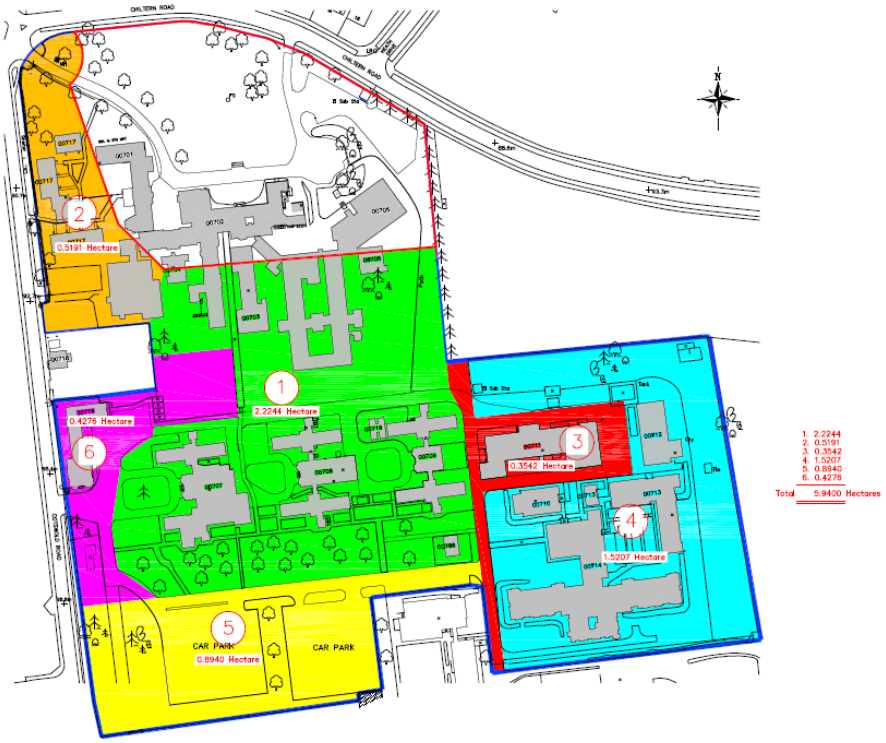
Table 5 – External Financing in capital plan 2018/19

			2018/19 £'m
1	Building	**ITFF Funded**	
2	Building	St. Helier- ITU/HDU/CCU new provision	2.8
3	Building	St. Helier- Provision of New Day Nursery	2.2
4	Building	St Helier - Surgical Ambulatory Care Unit	3.5
5	Building	Ward Reconfiguration (Frank Dees)	0.1
6	Building	St Helier ward re-stack	0.0
7	Building	Epsom rationalisation- off site accommodation	1.5
8	Building	Oxygen VIE and Cycle Shower/changing/Waste Compund	0.7
9	Building	Re-provision of services to Headley and Oak Suite	0.4
10	Building	Epsom Rationalisation (other)	0.4
11	Building	Epsom rationalisation - External buildings	0.0
12	Building	Epsom rationalisation- Langley Wing	1.1
13	Building	Epsom rationalisation- Woodcote Wing	3.2
14	Building	St. Helier- Reprovision of Services from Sutton Site	
15	Building	St Helier option agreement	0.0
		Total ITFF Loan	**15.7**
		Epsom Energy loan	
16	Building	Epsom rationalisation- energy centre	**4.7**
		St Helier Energy Loan	
17	Building	St Helier- Energy Savings Schemes (CHP & Lighting)- Energy Loan funded	**7.0**
		St H Energy Loan - 19/20 allocation used in advance	
18	Building	St Helier PBB scheme completion	0.8
19	Building	Window ReplacementBradbury Building - includes Simon stewart Ward	0.4
20	Building	St Helier Ward Reconfiguration	0.0
21	Building	Croft & Britten Ward alterations	0.2
22	Building	Renal – Dialysis Unit	3.3
		Total	**32.0**
		Funded by:	
		ITFF Loan	15.7
		St H Energy Loan - 18/19 allocation	11.6
		Epsom Energy Loan	4.7
		Total	**32.0**

1.13.11. This programme will deal with some of the most critical essential backlog maintenance issues either for repairing the existing buildings or remove services from them so we don't have to maintain them.

1.13.12. To create the cash to service the loans that we intend to continue the surplus land sales that we have commenced in 2016/17 and have completed a disposal of land at Sutton in January 2018, while planning further disposals in 2018/19. The total value of the land we are selling is significantly less than the value of the loans.

1.13.13. **Sutton site** – we have divided the land that we own at Sutton into 6 plots.



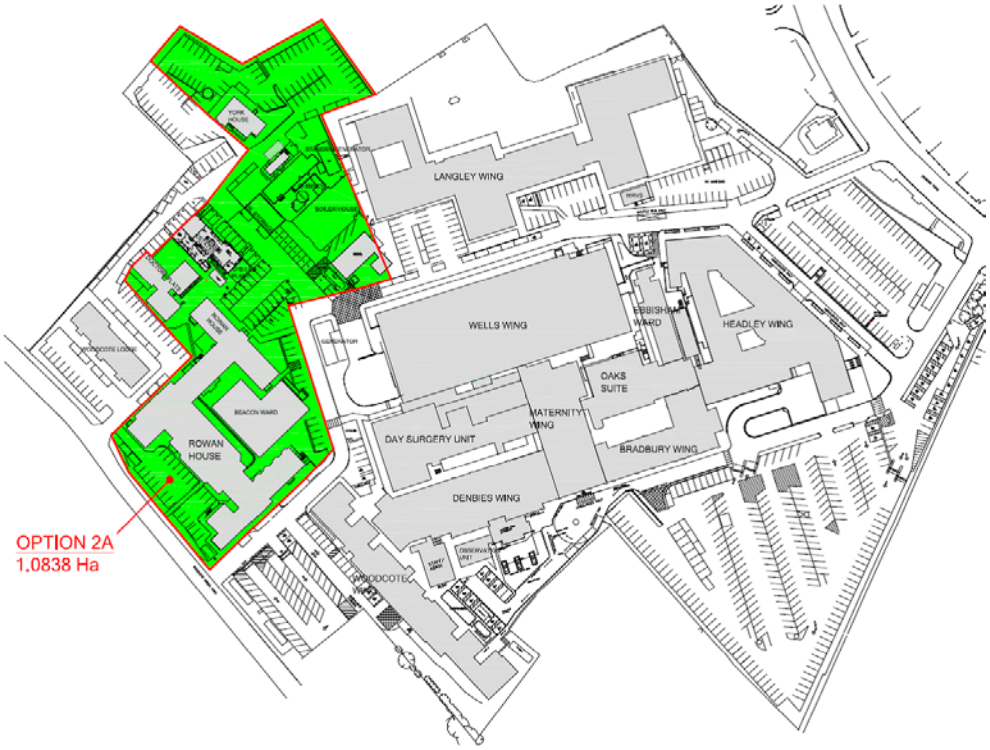
1.13.14. We sold plot 1 in 2016/17 to Sutton Council which generated £12.3m. As a result of this sale, NHS Improvement gave us permission to start the repairs to B and C block in 2017/18 with this funding.

1.13.15. We sold 3 of the remaining plots to Sutton Council in 2017/18 (3, 4 and 6) which generated £14.1m gross proceeds. We do have some services that are being re-provided to enable this land sale to be completed. These are a nursery used by our staff, key worker accommodation, the chronic fatigue and pain services and phlebotomy. There will also be legacy asbestos issues to deal with in these buildings. The cost of re-providing these services and dealing with this legacy issue will be £5m. The capital funding to be able to do this was included in the ITFF loan in 2017/18.

1.13.16. We are planning to sell plot 2 in 2018/19. This contains staff residential accommodation. We are currently negotiating a rental of staff accommodation units in Epsom which will allow some re-provision.

1.13.17. During 2017/18, the Trust Board approved a strategic outline case to review the options to address the trust estate beyond 2020. One of the scenarios considered is a co-located hospital with the Royal Marsden at Sutton. For this not to be ruled out, we need to maintain ownership of the last remaining plot of land on the site and so we are not declaring this surplus to requirement.

1.13.18. **Epsom site** - This is the most valuable site the Trust owns. We have identified that we can release 1.08 hectares of the site. This is shown in the illustration below. To enable this land to be released we need to re-provide nursing accommodation, office space, and build a new power facility. We intend to do this in 2018/19 and so as with the Sutton land sale needs capital funding to do the re-location works before the sale can be delivered



1.13.19. **St Helier site** - when the renal facility has been re-provided we would like to demolish these buildings. This will enable us to sell surplus land for high density housing. This land sale could be scheduled for 2019/20.

1.14. Overall summary of capital plan

1.14.1. Table 6 below sets out a summary of the overall capital programme and funding source over the next year.

Table 6 – Capital Programme Summary 2018/19

		2018/19 £'m
1	**Capital Expenditure**	
1.1	Total internally funded capital (Table 4)	18.1
1.2	Total externally funded capital (Table 5)	32.0
	Total Capital Expenditure	**50.1**
2	**Capital Funding**	
2.1	Depreciation	13.4
2.2	B & C Block Funding	4.7
2.3	ITFF Loan	15.7
2.4	St H Energy Loan - 18/19 allocation	11.6
2.5	Epsom Energy Loan	4.7
	Total Capital Funding	**50.1**

2. Cash 2018/19

2.1. The closing cash balance for March 2018 was £12.8m, which included £4.7m carried forwards for the B&C blocks infrastructure project. At March 2019 the Trust is planning to hold a cash balance of circa £2.0m as required by DH. The cash forecast is based on a total capital spend of £50.1m during 2018/19, funded from the following:

- Internally funded £18.1m
- DH loan £15.7m
- St Helier energy loan £11.6m

- Epsom energy loan £4.7m

2.2. The cash requirement for 2018/19 is based on the following assumptions reflected in the plan:

- **£14.2m revenue loan in 2018/19**: The Trust is planning for an NHS performance deficit of £13.7m which is an I&E deficit of £14.2m after receipt of PSF of £14.5m. Due to in year cash flow phasing in 2018/19 the gross revenue loan requirement is circa **£24.1m**, which will be fully drawn by February 2019. Profit from the sale of land at Sutton Hospital and Epsom Hospital will be utilised to part-repay the revenue loan in March 2019.
- **£15.7m DH Capital Loan in 2018/19:** This represents the second year of the ITFF loan to fund critical capex works and re-provision of services to enable land sales. The Trust is planning to repay a proportion of this loan in March 2019 from land sale proceeds equivalent to the net book value of the disposal.
- **Loans for Epsom and St Helier energy centres:** The Trust is planning to secure loans from non DH sources for the Epsom and St Helier energy centres. The Trust started the process to secure a loan for the St Helier energy centre during 2017/18 (£12m), where the Trust has previously approved initial design works.

LINKS TO THE LOCAL SUSTAINABILITY AND TRANSFORMATION PLAN

The Trust has been engaged in two Health and Care Partnership footprints, reflecting our service geography which spans the south west London/Surrey border. These are the South West London Health and Care Partnership (our host or designated Partnership– the one within whose footprint we officially sit) and the Surrey Heartlands Health and Care Partnership which incorporates Surrey Downs CCG, which is one of our two largest commissioners, responsible for the population around our Epsom site. The Trust's current acute site configuration and potential options for the future, impact upon and have informed, both Partnerships.

On 30th November 2017 The south west London Health and Care Partnership published its draft refreshed strategy document: The South West London Health and Care Partnership: One year on for discussion with local organisations and stakeholders. This discussion document reflects the feedback received over the last year, strengthenening the focus on partnership, prevention and keeping people well – the greatest influences on our health and well-being are factors such as education, employment, housing, healthy habits in our communities and social connections. This is not a final document and they will continue to work together in partnership with the local NHS, local authorities, the voluntary sector and Healthwatch to develop "local health and care plans" in each area. These plans will provide clear and detailed actions to address the local challenges set out in the discussion document. The local plans will be published in autumn 2018. The draft document is available from:

https://www.swlondon.nhs.uk/wp-content/uploads/2017/11/STP-discussion-document-final.pdf

Surrey Heartlands Health and Care Partnership has put in place a robust process to develop a System Operating Plan Narrative with dedicated resource to support; and key milestones in this process are as follows:

• System Efficiency Workshop on 1 February to identify opportunities which will inform the priorities for 2018/19

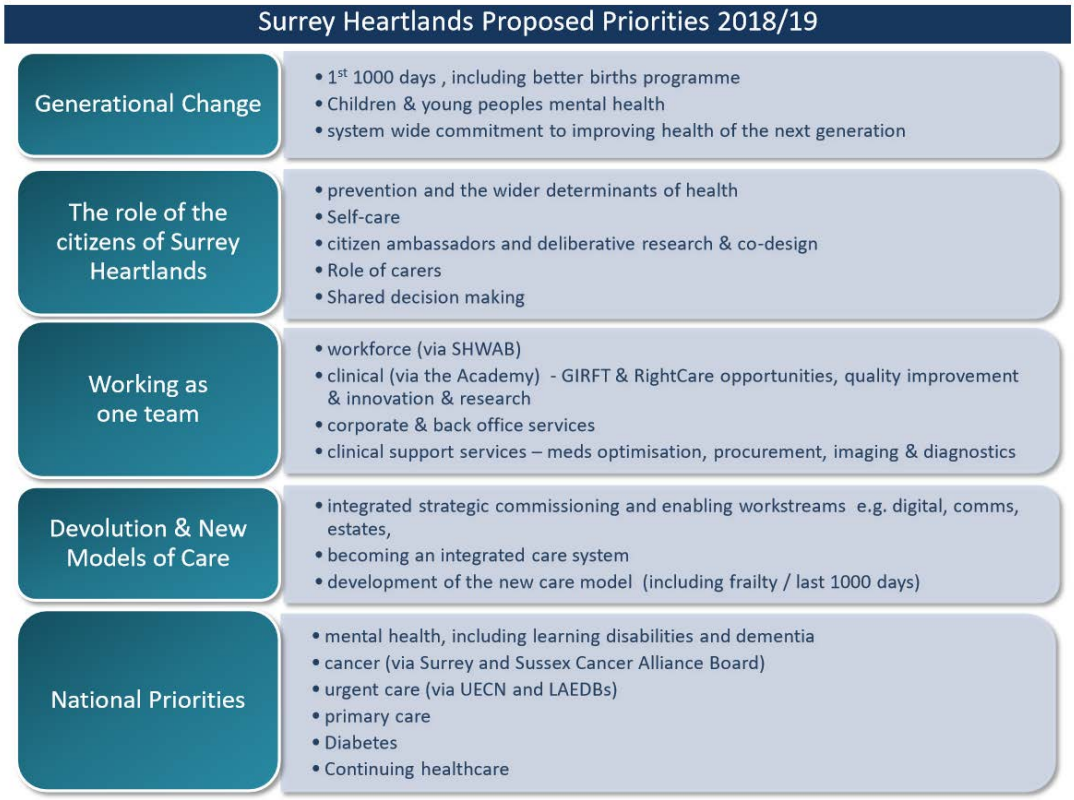
• System Planning workshop with Chief Executives and Finance Directors on 7 February to understand the implications of the Planning Guidance for Surrey Heartlands and agree next steps

• System Planning workshop with Chief Executives and Finance Directors on 6 March to test alignment misalignment between individual organisational plans, informed by outputs from the aggregation tool released by NHSE and NHSI on 28 February

• Leadership Programme (including Workstream Strategy Leads, Chief Executives and Finance Directors) taking place w/c 12 March to allow collaborative development of the narrative.

• System Operating Plan narrative signed off at the Transformation Board meeting on 4 April 2018.

Surrey Heartlands has agreed the following priorities for 2018/19:



Further details of Surrey Heartlands's plans are available from:

http://surreyheartlands.uk/wp-content/uploads/2017/04/Our-refreshed-operating-plan-April-2018.pdf

Both Partnerships focus on the development and transformation of out-of-hospital services, improved preventative and health maintenance measures and a more integrated approach across the whole system, including social care, as a means to improve the health of the whole population and reduce reliance on acute services to intervene at points of crisis. On any given day, there is a cohort of patients who no longer need to be in an acute setting and could be cared for at home or in an alternative setting closer to home if adequate out-of-hospital services were available. Additionally, there is a further cohort for whom acute admission might be avoided altogether, given access to alternatives. Development of out-of-hospital services to support these identified cohorts would reduce pressure on hospital services and could offset increased demand expected due to a growing and ageing population demographic. Acute services would support, and be integrated with, new out-of-hospital care pathways and continue to provide a 'safety net' for all patients who do experience a crisis or acute exacerbation that cannot be managed in a non-hospital setting.

Overall, the Trust endorses and is committed to the principles contained in the plans - focussing on keeping people healthy, investing in services in the community to do this, ensuring that acute hospitals are integral to delivering this, and resolving the longstanding issues with the configuration of the acute hospital sector in South West London. The Trust is already engaged in the delivery of a new, integrated model of care in the Epsom area, built around these principles, through the Epsom Health and Care vehicle. This is a joint enterprise between the Trust, the community service provider (CSH Surrey), Surrey County social services and the local GP federation. We have made progress in Sutton to roll out similar arrangements commencing responsibility for service delivery in 2018. Significantly in February 2018 we, in partnership with the 3 GP federations and CSH Surrey, have been awarded the contract to run adult community services in Surrey Downs from October 2018. This inclusive partnership – the Integrated Dorking East Elmbridge and Epsom Alliance (IDEEA) is committed to transforming services to deliver boundary-less care to patients in the most appropriate setting.

On specialist services, we are leading work across south London to review renal services. The Trust is also discussing other opportunities for clinical collaboration with St George's where these have potential to raise quality and improved patient experience, help to deliver the London quality standards and seven-day working, whilst reducing operational costs and ensuring clinical sustainability.

In December 2017 our Board endorsed our Strategic Outline Case for future services for 2020-30. We are now working with our regulators and local system partners to make progress towards decision-making and potential public consultation in 2018. In the meantime further significant capital is required to bring the St Helier estate up to an acceptable standard. The hospital has suffered from systematic planning blight and underinvestment over the past 20+ years. The recent CQC report on our Trust was very clear that we must have an agreed plan to do this. It is clear to us that if we fail to address these issues, our ability to provide a safe environment to treat patients at St Helier by the end of the STP planning period will be severely compromised. Partners have recognised the scale of the Trust's critical infrastructure backlog and have acknowledged our proposal to fund work to address this through land sales and other internally generated funding.

We do not underestimate the challenges we and our Health and Care partners face in achieving the plan. The projected shift away from hospital based services is very ambitious. We believe there are significant risks in achieving this within the timescale of the STP, especially given the associated capital and workforce requirements. However, the Trust has embraced this challenge and we will play our full part in transforming care across the sector to a more integrated and less hospital-dependent model. We believe that the provision of sub-acute beds at both our main sites in our Strategic Outline Case modelling provides the flexibility to enable us to adapt to the success of delivering the community based strategy.