

## Operating Plan 2016/17 Lewisham & Greenwich NHS Trust

<b>1. Introduction</b>	
1.1	<p>LGT's focus is to provide local services for local people, with an ambition to be consistently high performing and financially sustainable. We recognise that we face significant challenges:</p> <ul style="list-style-type: none"> <li>• in meeting quality and national performance standards, where we have made significant progress but where we have more to do; and</li> <li>• in delivering the agreed control total for 2016/17.</li> </ul>
1.2	<p>Our Operating Plan for 2016/17 is consistent with the priorities set out in the SEL Sustainability and Transformation Plan and sets out LGT's priorities following a challenging and difficult contracting round with local Commissioners. Agreements have been reached on the contracts for 2016/17 but, following mediation and subsequent arbitration, we have agreed to conduct two independent reviews relating (1) to emergency care pathways and (2) to local pricing.</p> <p><i>(1) Emergency Care Pathways</i></p> <p>We have agreed a six month block contract with Commissioners for emergency care activity only at a value of £48.1m for Quarters 1 and 2, whilst we carry out a review of activity. Following the review the Trust's intention and planning assumption is that emergency activity will be paid for on a cost and volume basis at national tariff prices.</p> <p><i>(2) Local Pricing</i></p> <p>An independent review of services with a Local Price will be conducted in Quarters 1 and 2, with 25% of the outcome implemented during the last six month of 2016/17, a further 50% in 2017/18 and a further 25% in 2018/19.</p>
1.3	<p>In addition, we are currently working with commissioners to support the development of system wide QIPP plans aimed at reducing the demand and overall cost of the emergency pathway.</p>
1.4	<p>RTT plans have been agreed with Bexley and Lewisham Commissioners. The agreed plans are based on both delivery of the on-going business as usual demand as well as the activity required to clear the backlog for Trauma and Orthopaedics and ENT. However, Greenwich commissioners have not agreed to a plan that includes reducing the backlog for their population, although they are committed to paying for activity on a cost and volume basis at national prices.</p>
<p>Taking the above into account, and based on our activity assumptions, we believe our Operating Plan 2016/17 to be realistic and deliverable, with sufficient capacity identified to deliver the national performance standards.</p>	
<b>2. Approach to Activity Planning</b>	
2.1	<p><b>Activity Planning: Planning Assumptions 2016/17</b></p> <p>We have adopted a robust approach to 2016/17 activity planning to ensure realistic demand assumptions, which we have shared with commissioners in an open book process based on reasonable assumptions to reflect demand and the capacity required to deliver. Lessons learned from 2015/16 for performance delivery have been reflected in our plan.</p>
2.2	<p><b>Demand and Capacity</b></p>

Our methodology is detailed, but fundamentally is based on M6-11 2015/16 activities extrapolated for the full year to inform the 2016/17 baseline position. The baseline has then been adjusted for known issues, which occurred during the year, such as the impact of deployment of the ESR (iCare) on the UHL site in May 2015; data quality corrections and improvements and the impact of seasonality. Clinical engagement and operational ownership has been an important part of our contracting process with involvement of the Director of Service Delivery supported by the Medical Director and Director of Nursing and Quality, our clinical Divisional Directors and Divisional General Managers.

- **Maternity:** Improvements to the recording of complexity in maternity, largely the result of introducing the iCare system, have resulted in an increase in income for the Trust. We are satisfied that the recording changes were appropriate and now reflect more accurately the activity being undertaken. The impact will be phased from October 2016.
- **Emergency activity:** As an outcome of the mediation process an independent party will be commissioned by Lewisham CCG, as co-ordinating commissioner, on behalf of Greenwich and Bexley CCGs (collectively BGL) and the Trust to review the emergency care pathway and establish the basis on which emergency activity is counted, coded and billed for (see section 2.3).
- **Demographic Growth:** We have assumed demographic growth based on the GLA figures (see table 1). As a result of the agreement to block emergency activity for 6 months, the demographic figures below apply to all other activity (with the exception of Emergency activity which is applied in months 7 through 12 only).

**Table1. GLA Growth Assumptions**

CCG	Bexley	Greenwich	Lewisham
CCG Planning (%)	0.97	0.72	1.40
GLA (%)	0.41	2.05	1.24
ONS (%)	0.87	1.19	1.30
GP List Size (%)	1.31	1.92	1.78
NHSE (%)	1.09	0.72	1.53

- **Non Demographic Growth:** We have reviewed activity growth over a period of 18 months and identified a level of growth, over and above population growth, that should be factored into the plan to ensure that the forecast demand is realistic. This non-demographic growth is driven by the following factors:
  - Deprivation;
  - an ageing population;
  - technology advances; and
  - Patient expectation.

In 2015/16 national guidance suggested that population and non-population growth combined should be in the region of 3%. Our commissioners were unwilling to fund this as an increase in the contract related to non-demographic growth for emergency activity. They believe the growth was internally generated, which the Trust disputed. This non-demographic growth issue was part of the overall emergency care pathway issue taken to mediation, and as a result, we have a block arrangement for Quarters 1 and 2 to address this. From Quarter 3 onwards the Trust is clear that activity must be paid for on a cost and volume basis at national tariff and this will require commissioners to recognise non-demographic growth before they challenge the Trust on over-performance.

In addition to non-demographic growth, our forecast demand includes realistic increases in activity to enable delivery of access targets. Using a range of tools, including the IMAS system, we have attempted to identify the amount of activity over and above the outturn and growth assumptions that is required to ensure compliance with the national access targets. In addition, we planned for the repatriation of Urology services, which has transferred from the previous provider King’s College Hospital (Princess Royal Hospital) to LGT in May 2016.

**2.3 Capacity for winter resilience** - The 2016/17 resilience plan has been produced by the CCG hosted resilience team and includes a number of initiatives to support delivery of the emergency care pathway. Funding in the Trust's Plan assumes £3.1m to support in-hospital agreed schemes, excluding out of hospital schemes which we expect to be funded separately by our commissioners.

Significant challenges remain, with funding yet to be agreed:

- The funding for 2016/17 reflects a marked reduction in funding compared to previous years. In 2014/15 winter resilience funding was £10.64m which reduced to £7.3m in 2015/16, including the funding for additional bed capacity in the Foxbury Ward at Queen Mary's Hospital Sidcup and the Hospital at Home service;
- System capacity issues remain both in and out of hospital with a net reduction, in Quarter 1, of the baseline bed capacity of 85 beds; and
- The System Resilience Group (SRG) led schemes, for out of hospital care, have yet to identify any timescale for delivery for the following:
  - Home First (Greenwich); and
  - Home Ward (Lewisham).

**2.4 Managing unplanned changes in demand** - Actual activity against plan and impact on performance continues to be reviewed on an on-going daily basis and plans to increase capacity to cope with surges in demand in either attendance or admission are well established via our daily Silver/Platinum Command protocols. In conjunction with the surge protocols we have implemented a clinically led Diamond management process, which oversees the "Ready for Discharge" (RfD) and "Delayed Transfer of Care" (DToC) lists across all three boroughs, working in partnership on a twice weekly basis. A drop in demand would support the Trust's target occupancy reduction from 97% and over, which remains a key risk.

The industrial action by junior doctors in their contract dispute during the beginning of 2016 has impacted on service delivery. The Trust has to date mitigated difficulties as much as possible but elective procedures were cancelled on all days of action and this has impacted on the delivery of RTT.

**2.5 Emergency Care Pathways**

We are committed to developing a sustainable plan across the whole system, in line with expectations on the agreed trajectory,

Our plan for 2016/17 is based on our in-hospital schemes, which will deliver 90.1% overall emergency performance for the year. We believe this to be ambitious and challenging to achieve, as we are facing shortfalls in capacity in out of hospital services, with closure of community beds and a significant reduction in community teams such as the Falls Team and therapy provision in the community.

For UHL the focus will be on sustainably reducing the "Ready for Discharge" (RfD) list by 50%, currently averaging around 70 patients per day. Consideration by Commissioners on whether implementing "hospital at home" as a short term solution until the Home Ward is up and running will enable us to achieve this. Through the SRG we are currently working with our commissioners and other partners for Out of Hospital capacity, for example Eltham Community Hospital, to be used in a different way to provide more effective and efficient patient pathways.

An independent organisation has been commissioned by Lewisham CCG, as coordinating commissioner, on behalf of Greenwich and Bexley CCGs (collectively BGL) and the Trust to review the emergency pathway and establish the basis, on which emergency activity at the Trust should be counted, coded and billed for. This review will be completed by the end of August 2016 with the final report published by mid-September. The overarching principles under which the review is to be done are:

- Activity is recorded in line with national rules:
  - Data Dictionary
  - National Tariff Payment System
  
- The findings of the review will inform the counting, coding, billing of activity in Quarters 3 and 4

## 2.6 Delivering Operational Standards

2.6.1 **Emergency Pathway** - Over the course of Q4 of 2014 through to late Spring 2015 the Trust, with commissioners, community and social care partners, embarked on a detailed improvement programme for the delivery of the Emergency Care Pathway, entitled 'One Version of the Truth'. Supported by McKinsey, the programme aimed to reach a common understanding between health and social care partners of the key challenges in delivering the emergency care pathway and developing a set of jointly owned action plans that would address these.

As a result of the original outputs from 'One Version of the Truth' the Trust and commissioners agreed a joint approach to delivering the Emergency Access standard. The Programme identified that for 2015/16, given the constraints across the system, the Trust internally could deliver a performance of 93%, based on out of hospital bed capacity as at 2015, with the further 2%, needed to achieve the standard overall, needing to be delivered from further out of hospital capacity (i.e. community, social services, etc). From lessons learned throughout 2015/16, building on our record of improvement but recognising the on-going constraints in South East London and the reduction in out of hospital bed capacity, the delivery of the emergency performance standard over the course of 2016/17 is expected to be 90.1% for the year.

We recognise that this is an area that has provided significant challenge for the whole of the health economy and fulfilling this commitment depends on actions both within and outside the Trust. As well as concerns about the out of hospital capacity constraints, we have raised concerns with our commissioners regarding the model of care for the UCC at QEH. Discussions are on-going with the commissioners and their external contractor in order to address these and to close the gaps in the clinical model.

At the conclusion of the contracting round, £3.1m of resilience funding was agreed for the Trust to invest in initiatives that would support operational delivery throughout the year, in line with the schemes developed in line with One Version of the Truth recommendations, and a review of the successful initiatives implemented during winter 2015/16. In addition, commissioners confirmed during the contract negotiations that they had a further £2m available to support the system through the winter period in 2016/17.

Delivery of the 2016/17 90.1% trajectory relies on the continuation of the Trust's current Emergency Care Pathway Improvement Programme (ECPiP) and the delivery of whole system change on admission avoidance and complex supported discharge that is now being developed through the SRG. The focus will be on the following 4 areas:

1. **LAS activity and handover times** - This has continued to prove a challenge for the Trust – in particular on the QEH site over the course of 2015/16. As with other providers across London, we have seen an overall increase in LAS attendances, including an increase in Category 'A' patients. This problem was particularly acute throughout 2015/16 Q3 and Q4. As such, the Trust held a summit with LAS in May 2016, to understand the drivers behind the LAS attendances to both sites and to link this with the local initiatives on ED demand and capacity. An action plan has been agreed with both LAS and local CCG partners which addresses the key challenges for both the Trust and LAS. These focus on:
  - Alternative care pathways;
  - Effective use of Urgent Care Provision; and
  - Timely off-loading through improved streaming and triage.
  
2. **Frailty Pathway** – We have made significant progress in delivering our improved frailty pathway.

We opened our 20 bedded frailty unit on Ward 2 at QEH, during June 2016. Two Consultant Geriatricians, plus their MDTs, ensure that frail patients requiring an acute admission have specialist input at the earliest possible stage, in order to reduce their length of stay. However the pathway is still reliant on external services to support discharge in a significant proportion of this patient group.

We have recruited to a Frailty Assessment Team (OPAL – Old Peoples Assessment and Liaison). Trials of this service have showed that it could avoid admission in up to 20% of the medical take. The team will see ambulant patients in a specially designed frailty friendly area of the expanded ambulatory care unit (described in section 4 below). We have a highly effective Frailty Working Group for the QEH site with good levels of commissioner, GP and community provider involvement, developing the initiatives as part of a CQUIN. We are joining the Acute Frailty Network's third cohort in October 2016, which we hope will support our further improvement in this key area.

3. **Medical Model Redesign** - We recognise that the current flow issues on both of our sites inhibit the delivery of our acute patient pathway. Difficulty in moving patients from AMU at both UHL and QEH to a specialty ward prevents them being used as designed for assessment and short stay. Patients under the Acute Physicians are spread over ED, CDU and AMU plus escalation areas reducing the effectiveness of the admitting team and increasing specialty response times in ED. We believe that the model for provision of Acute Medical Care is correct across both sites, with both the QEH and UHL sites now able to demonstrate a split take for acute and elderly patient and, along with the planned developments in ambulatory and frailty, the model will take us much closer to full compliance with London Quality Standards. This work stream within the redesign programme is continuing to work on delivering this model through appropriate use of AMU but this is currently hampered by lack of flow out of the hospital from downstream wards, particularly since the reduction in community bed capacity.

Key deliverables in the ECPIP are:

- Further embedding work on ward processes and simple discharge to achieve target of 40% discharges before 1pm;
- Agreeing plans with commissioners on Bed Occupancy thresholds for both UHL and QEH sites to support the sustainable delivery of the Emergency Access Standard. This will rely on the successful delivery of a number of initiatives across the sector (e.g. Ambulatory Care and discharge co-ordination), but should not exceed 95% bed occupancy (currently averaging 97-100%);
- Continued robust management with community and social care partners of patients with complex discharge requirements, with on-going reduction in time to complete paperwork;
- Improvements to Emergency Department resilience at UHL;
- Effective working with the UCC provider at QEH to close the gaps in the clinical model;
- Ensuring that site flow management can support the appropriate use of assessment areas within the emergency care pathway;
- Keeping the number of patients who are ready for discharge, (including those patients with continuing care and social needs), but occupying an acute bed below 5% of the total acute emergency bed stock (less than 30 patients on the combined Ready for Discharge list); and
- Ensuring that agreed timelines for discharge from hospital are met to enable patient flow:
  - Patients referred to Rapid Response teams are seen within 30 minutes;
  - Patients move to Intermediate Care Beds within 24 hours of referral; and
  - Packages of Care are delivered within 48 hours (restarts within 24 hours).

During 2015/16 we saw a reduction in Delayed Transfers of Care as a result of improving our processes around paperwork completion and increased partnership working with local authority, community providers and commissioners. For 2016/17 this work will continue through the Whole Systems programme which is focussing on:

- Simplifying and streamlining the assessment and referral process;

- Allowing easy and rapid access to intermediate care beds;
- Ensuring that community services are delivered within agreed timeframes.

4. **Ambulatory Care** - There is currently no Ambulatory Care service in place at UHL and a very limited service at QEH. Repeated rounds of joint clinical audits with commissioners have demonstrated a need for this model of care on both sites, to improve both the management of patient flow and patient experience; ensuring patients are seen and treated in the most appropriate clinical setting. Full Business Cases have been developed by the Trust, which includes the proposed Clinical and Operational delivery Model, establishing Ambulatory centres, which operate extended hours, 7 days per week. These have been endorsed by the Ambulatory and Emergency Care Network. Through its business planning process the Trust has committed a significant sum within its Capital Plan for 2016/17 to develop units on both sites. We aim to implement the service at UHL and improve the service at QEH at pace, noting that there are facilities developments required on both sites, which will take a minimum of six months to deliver. The service will be managed by our Acute Physicians and we have already implemented the Ambulatory Consultant of the Week model, ahead of the units on each site.

The Trust is clear that delivery of further improvements to the 90.1% trajectory for 2016/17, towards the NHSE expectations of c.93%, would require additional allocations from the £2m further funding commissioners have available to support the system through the winter period in 2016/17. Implementation timescales have yet to be identified for the SRG led improvement schemes for out of hospital care - Home First in Greenwich and Home Ward in Lewisham. However, following a review by the SRG, it has been agreed that commissioners will continue to fund the Hospital at Home scheme that supports the QEH site for 2016/17, scaling up from 18 bed equivalents in Q2 to a maximum of 30 in Q4

2.6.2 **RTT** - During 2015/16 we have maintained delivery at Trust aggregated level of the Incomplete Referral to Treatment standard (RTT), although some specialties have not achieved this standard due to the number of patients waiting over 18 weeks for treatment. This was partly due to a shortfall in capacity to meet demand, along with the introduction of the new Electronic Patient Record (EPR), iCare, at Lewisham Hospital in May 2015, which led to some data quality issues with the information included on the patient tracking lists (PTLs) and, more recently, the impact of cancellations during the junior doctor contract dispute.

The affected specialties include Trauma and Orthopaedics and ENT, due to their demand and capacity gaps, and Urology. Gastroenterology and Gynaecology also continue to have capacity challenges although these have improved throughout the year, with significant investment in the former.

We plan to maintain delivery of the incomplete standard in 2016/17. We have agreed plans with two of our commissioners for the clearance of the backlog in the challenged specialties (T&O and ENT, both including Paediatrics) and the delivery of the step change in capacity required, to close the demand and capacity gap. We will be starting 2016/17 with an RTT backlog of c.3,200 patients, which is 8% of the total number of patients waiting.

Demand and capacity modelling has been completed for every admitted specialty using the IMAS demand and capacity tool, which identifies the theatre capacity requirements needed to deliver the activity, and also takes into consideration the patient referral pathways. In order to identify ideal waiting list sizes we have worked to NHSE guidelines based on their calculations for the populations we serve.

Our theatre reconfiguration and expansion plan, which has been developed with clinical stakeholders, has been developed to align the capacity to the demand for each specialty. This capacity is reliant upon the delivery of improved productivity and an increase in funded activity to support the expansion of all available theatre sessions. The plan is being implemented in Quarter 1 of 2016/17 to ensure sustainable delivery of the RTT standard. The plans are

operationally deliverable and provide capacity and resources required to deliver the activity. The physical estate requirements are aligned to our five year capital plan. The constraints to delivery relate to investment in capacity required and recruiting substantive staff to deliver the services.

We have agreed separate plans with our commissioners, following the transfer of Urology services back to LGT (from KCH at the PRUH) to increase the capacity which will see improvements to the backlog within this specialty. We have instigated discussions with our commissioners to work together to reduce new to follow up rates within the early stages of the referral pathway. Plans are well established and an additional mobile theatre has been installed on the UHL site to provide the theatre capacity required.

Our plan aims to fully validate the Patient Tracker List (PTLs) for each specialty, reflects the ongoing work with commissioners, funded by NHSE, to ensure the data is accurate, increases in capacity required to clear the number of patients waiting over 18 weeks, and improve the clearance time of the overall backlog for all specialties.

**2.6.3 Cancer and Diagnostic waiting times** - During 2015/16 we found it difficult to deliver the Cancer Waiting time standards, in particular the 62 day standard. We failed to meet the 2 week wait standard from June 2015 but achieved this target in Q4.

Following an internal decision to implement a 'special measures' regime for Cancer services, Executive led meetings are being held twice a week, with all of the Divisional Managers and Trust Lead Cancer Nurse being held to account for the delivery of recovery plans. There are also twice weekly conference calls with other provider partners to support the management of patients being referred to a tertiary centre for their treatment and the delivery of the current Inter Trust Transfer target of 42 days.

A revised cancer recovery action plan, which demonstrates delivery of the 62 day cancer target from March 2016, has been developed with our CCGs and Clinicians and partner provider organisations across South East London and has been shared with NHSE. A revised trajectory by specialty, with an operational plan to deliver compliance, has been developed. Governance arrangements to ensure delivery are verified at the Cancer Special Measures meeting. In addition we will be sharing knowledge and understanding of cancer pathways with a monthly Clinician to Clinician forum where specialty pathways can be discussed.

We have agreed with local CCGs some additional resource to address the ongoing challenges with the cancer information system. We have also secured a joint cancer pathway navigator role with GSTT, for one year. The focus of this role will be to case manage all patients on a shared cancer pathway with GSTT, working with Trust colleagues to achieve the 42 day Inter-Trust Transfer 42 day trajectory.

As part of our sustainable plan for 2016/17, an enhanced programme of recruitment is underway to reduce reliance on temporary staff, following an episode of high attrition of administrative staff. We continue to utilise a core group of bank staff in the interim and plan to implement extended working shift patterns once all staff have been recruited. This will ensure that demand is managed more efficiently and patients contacted out of normal core hours. Agreed booking targets have been set to ensure that all referrals are being booked within 48 hours of receipt and patients offered appointments within 7 days. There is daily oversight of the management of 2 week wait activity.

An MDT co-ordinator workforce plan has been developed to manage the workload across all tumour sites across both Trust sites. A training plan has commenced for this group of staff with support from the Transforming Cancer Services Team for London and an administrative forum has been developed for the SEL sector. In addition to this, a review of CNS capacity including differences in roles, responsibilities and line management arrangement has been undertaken and a business case is being developed for the additional workforce that is required to address the gaps.

The Survivorship Agenda has been a key priority in 2015/16, as we undertake a programme of work focused on Recovery Packages and Stratified Follow up Pathways. This will strengthen the

service, which is offered to patients beyond Cancer, and will foster stronger relationships with Primary Care colleagues. The Outpatient Transformation programme of work, and in particular potential additional capacity which will be released, will also directly correlate with the delivery of Cancer Waiting time standards.

There are discussions currently ongoing about replacing the function previously served by the London Cancer Alliance, (LCA) in the context of the development planning for the vanguard initiatives and the possibility of metamorphosing the LCA's functions into a pan-London office, which is also of interest to NHSE (London). Discussions are being held within the provider groups about suitable models for SEL and attempts are being made to secure investment from the HIN, GSTT charity and local CCGs.

The aim is that the development of a SEL-wide infrastructure will help to improve early diagnosis; facilitate care closer to home, supported by improved quality assurance, integrated governance models and better resilience of our services.

### 3. Approach to Quality Planning

#### 3.1 Approach to Quality Improvement

**3.1.1 Governance** - We have a clear statement of our vision and values, driven by quality and safety and defined within both our strategic and annual corporate objectives. Through the Board Assurance Framework and Corporate Risk Register the Board is aware of the potential risks to the quality and safety of its services and has an organisational governance framework to continually monitor and review its progress in improvement of the quality and safety of its services and in minimising risk.

The Trust Board and the organisation's clinical leaders prioritise safe, high quality, compassionate care and promote an open, transparent and quality focussed culture. The Trust will continue to promote its duty of candour, honesty and transparency through our leadership actively promoting staff empowerment to drive improvement and in valuing the benefits of raising concerns.

We have a well-established governance framework and committee structure which has quality, safety and patient experience at the core. Led by the Integrated Governance Committee, and supported by the Board Executive for Quality and Safety, the Director of Nursing and Clinical Quality, the Trust, together with the three local CCGs, sets annual quality and safety priorities which are published through its Quality Account but also include priorities which have resulted from all external reviews (CQC, Peer Reviews) and internal learning.

The governance and assurance framework established within the Trust is one which is overseen through joint partnerships with our three local CCGs, the NHSI and NHSE, through the Clinical Quality Review Group.

The Trust governance framework is structured from Board to Ward and is supported through the establishment of Trust Board, Integrated Governance, Quality and Safety, Patient Experience, Transformation, Divisional Governance and Directorate level Governance Committees/Groups/Panels.

These structures provide the quality improvement framework together with the systems and processes for measuring, monitoring, reviewing and reporting the maintenance of quality and safety of services and quality improvement requirements.

**3.1.2 Quality Improvement Plan 2016/17** - The Trust's approach to quality improvement is underpinned by principles, recognising preferred methodology and theoretical approach to quality improvement, laid out in the Trust's revision of its Quality Improvement Strategy. These principles harness the national and local policy drivers which have had a direct impact on ensuring healthcare organisations have quality embedded into everything they do. Together

with the annual setting of Trust objectives, the Trust has an annual review of its quality improvement initiatives through its setting of quality improvement priorities within its Quality Account.

Following our CQC inspection in February 2014, we have been working through our quality improvement plan and the majority of actions have been completed. The remaining actions centre on the longer term strategy for the redesign of services across our sites, development of agreed primary and secondary care pathways, linking up with Our Healthier South East London Strategy. The Report identified the Emergency Department at QEH as 'inadequate' and this is described in section 5.6 in our proposed capital developments.

Our governance process for reviewing and assessing compliance with the CQC standards and domains is well developed and involves all our partners in reviewing and inspecting all geographical areas and assessing readiness for inspection. The Trust has a well-established CQC review group with key stakeholders playing a part in supporting the Trust with its quality improvement initiatives. This group reports through the Trust governance committees up to Trust Board and the Trust Clinical Quality Review Group.

Through the work of the Trust's Quality Improvement plan, the Trust has identified a range of quality and safety priorities which form part of some key initiatives and developments already established across the organisation.

**3.1.3 Quality Priorities for 2016/17** - Together with the "Sign Up to Safety" programme initiatives, the following areas have been identified as areas for key focus during 2016/17:

- Improving the pathways and management of the Frail and Elderly including Dementia;
- End of Life Care pathways; and
- Improving Patient Experience, including improving management of complaints and using the outcomes to affect change.

The Trust committed to the national "Sign Up to Safety Plan" in 2015/16 with a full programme of 12 separate initiatives (details of which are available) and will continue its work with this programme focussing on additional work in three key areas:

- Early detection and treatment of the deteriorating patient, including patients who present with sepsis;
- Reduction in number and level of harm from patient falls; and
- Reduction in the number of pressure ulcers attributable to the Trust.

In addition, as part of our commitment to reducing antimicrobial resistance rates we have an approved Medicines Optimisation Strategy, delivery of which is monitored through the Trust Medicines Management Committee (MMC). The Antimicrobial Steering Group (ASG) reports into the MMC and has developed an Antimicrobial Resistance strategy which includes an action plan against the 5 key elements of the strategy that are applicable to acute hospital Trusts.

**3.1.4 Top 3 Risks and Mitigation** - Although the Trust has a challenging and ambitious plan for 2016/17 the review of risks associated with maintaining and improving quality has been assessed and the following risks have been identified as the top three risks:

- Resources – staffing, recruitment and retention of a skilled work force. The on-going junior doctors contract dispute adds to this, both through the impact on services and performance during days of action and in the unknown long term risk of increased vacancies;
- Inability to maintain Quality and Safety across the Emergency Pathway due to the rate of change of community provision; and
- Cultural shift required in improved ways of working and ability to deliver standards consistently across all staff groups.

**3.2 7 day Services**

We continue to implement improvements to 7 day services with an incremental approach to extend provision. Work continues with commissioners to deliver this in an affordable way. Key plans for 2016/17 include the implementation of an ambulatory care unit and consolidation of changes to diagnostic services. The Trust has embedded the Royal College guidance on the responsible consultant into day to day operational processes.

As part of the medical redesign programme we are increasing our middle grade medical cover at the weekends and by extending the Ambulatory care on both sites we will ensure that this pathway can continue at the weekend.

Risks to delivery include recruitment and funding to deliver extended cover. For example in diagnostic services, working patterns are changing to shift patterns across seven days, rather than previous arrangements for on-call and additional payments for weekend working. The risk of failing to recruit sufficient staff for the new patterns will be mitigated through bank working.

### 3.3 **Quality Impact Assessment Process**

We have an effective Quality Impact Assessment (QIA) process in place for our Cost Improvement Programme (CIPs). The QIA process ensures that every saving scheme has been approved clinically before being implemented. We seek to ensure that no saving scheme will have an adverse clinical quality impact on the service provided by the Trust to its patients.

Each saving scheme goes through a gateway process as follows:

1. Idea generation.
2. Feasibility assessment - This includes the preparation of 3 documents:
  - i) Project Initiation Document (PID)
  - ii) Financial Impact Assessment
  - iii) Quality Impact assessment (QIA)
3. Project Implementation.
4. Project Performance Assessment

The QIA is prepared using a proforma that assesses risks to patient safety, clinical outcomes, patient experience and staff experience and authorised by the Divisional General Manager (or Project Owner if delegated) and the clinical lead of the Division (or clinical lead of that particular scheme if delegated) using a scoring matrix; and is then submitted to the QIA Board for final approval. The QIA Board is chaired by the Deputy Medical Director and includes the Director of Nursing and Clinical Quality.

The Trust rates all CIPs in terms of risk to quality. These are reviewed by the Director of Nursing and Clinical Quality and the Medical Director or her Deputy, who has a specific remit around quality and safety. CIPs are agreed with a rigorous quality impact assessment by the Medical Director and Director of Nursing and Clinical Quality and through the Trust's CIP Programme Board, which is chaired by the CEO and has the Trust Chair amongst its membership.

The signing off of the QIA by the QIA Board is the formal authorisation required for a scheme to become "active"; which means the Trust will implement all the actions required by a saving project and realise the financial benefits.

The Programme Management Office is then responsible for monitoring and in year reporting of QIAs' completion to the CIP Programme Board. QIA's are tracked and reviewed monthly by the QIA Board, to assure the Board that there is no adverse impact to implementation.

### 3.4 **Triangulation Indicators**

The Trust currently uses a balanced score card to monitor quality, operational and financial performance. Performance reports are reviewed by the Board each month and these reports will be reviewed and modified to allow workforce, quality, finance and activity to be triangulated on a regular basis, probably quarterly.

## 4. Approach to Workforce Planning

### 4.1 Approach

We have a robust approach to workforce planning with strong clinical engagement, through our clinical leadership model, which does encourage robust clinical engagement. Workforce plans and key issues are discussed at divisional performance meetings which are held monthly and are chaired by the Chief Executive. Further engagement is provided through the Trust's Clinical Leaders Group, where there is representation from all clinical divisions and corporate services and which is also attended by Trust Non-Executive Directors.

Workforce plans are developed locally within divisions alongside the development of clinical operational plans. They are reviewed through divisional board meetings chaired, by the Divisional Director with clinical directors, with nursing and service leads in attendance. Through monthly performance review meetings, chaired by the CEO, the following are reviewed:

- Divisional workforce metrics, including vacancy rates, turnover, absence, mandatory training and appraisal, temporary staffing spend, annual leave management and job-planning;
- Workforce changes in particular in the consultant workforce requirements;
- Quality and Equality Impact assessments; and
- Risks.

Our workforce activity is monitored on a monthly basis through the Trust Joint Partnership Committee as well as the recently established Workforce and Education Operational Group. This Group feeds into the Trust's Workforce and Education Committee which is a sub-committee of the Board and chaired by a Non-Executive Director. The Trust Board receives monthly reports on recruitment activity and quarterly reports on workforce and education performance.

During 2015/16 there has been a dedicated focus on recruiting to vacant posts and streamlining recruitment processes, which has resulted in significant improvements. The focus for 2016/17 will include retention, including further expansion of 100 day reviews for new starters, the development of additional routes for staff to raise concerns, expansion of the existing staff benefits programmes, and building on improved appraisal rates for all staff groups. There are plans to roll out values based recruitment methods to ensure that we recruit staff with the right skills, attitude and behaviour that are aligned to our values. As part of the development plans, a number of workforce priorities have been identified for inclusion in the Trust's workforce plans for 2016/17 and these include:

- transformational job planning;
- workforce skill mix review; and
- job re-profiling and redesign.

Approximately 65-70% of CIP savings for 2016/17 are expected to be achieved through pay, largely through reductions in agency spend in order to meet the ceiling of £19.1m set for the Trust. In addition, the vacancy level going into the year provides an opportunity for CIP schemes and service changes to be achieved without any significant impact of substantive staff. Specific schemes emerging include medical productivity through job planning and use of e-roster; further implementation of schemes to support agency savings; and a full review of roles and bandings to support service change.

Workforce CIP schemes are monitored at a corporate level through the Trust's CIP Programme Board meeting chaired by the Chief Executive. Also in attendance is the Trust's Chairman, Director of Finance and Information, PMO lead and CIP programme lead. CIP meetings are held with divisional representatives on a monthly basis in order to review and monitor progress. The Trust's PMO office provides dedicated support to divisions around their CIP Workforce Optimisation workstreams. Full Project Identification Documents (PIDs) are completed, together with cost benefits analysis, risk assessments and project timescales. These are reviewed at the

CIP meeting.

We have agreed a set of objectives designed to meet the Equality Delivery System requirements. An Equalities Committee, chaired by the Chief Executive, meets quarterly and monitors progress on the action to meet the objectives. For workforce, these objectives aim to achieve the goals of a representative and supported workforce and inclusive leadership, and to address issues arising from the Trust's Workforce Race Equality Scheme assessment.

The Equalities Committee is also reviewing the implications of the recent Kings Fund publication "Making the Difference. Diversity and Inclusion in the NHS," and will update the EDS objectives in line with these findings.

#### 4.2 **Key drivers in workforce planning**

We take account of a range of strategic drivers in developing our workforce plans and for 2016/17 these include:

- Workforce priorities outlined in national guidance;
- Our Healthier South East London workstreams;
- Emerging workforce strategy from the Lewisham Adult Integrated Care Board;
- Carter review recommendations around optimising productivity and efficiency; and
- Local workforce transformation programmes and productivity schemes.

Examples of the impact on workforce include:

- Changes to working patterns in radiography - in order to expand diagnostic service across seven days, and similar changes in pharmacy;
- development of new roles such as advanced clinical practitioners (ACP's) to work in emergency departments (supported by HESL); and
- implementation of the new junior doctor working arrangements and changes to agency arrangements in response to agency cap requirements is on-going.

#### 4.3 **Agency Usage**

We have implemented the agency ceilings and caps rules since introduction and will continue to do so. The ceiling for agency nurse use, of 10% of total spend on qualified nursing and midwifery, was met in Q3 2015/16. This has become increasingly challenging for medical roles since the April 2016 cap changes although at the point of submission of this Plan, and across all other staff groups, the Trust has had very few breaches.

The Trust has in place a Temporary Staffing Group chaired by the Director of Workforce and Education, with divisional representation covering all staff groups. This group meets on a monthly basis and has oversight of temporary staffing usage and the Trust's implementation of the agency caps. Regular updates on the Trust's progress against the caps are communicated by the Trust's temporary staffing team to group members on a weekly basis. The Trust has a process in place where all agency booking are managed centrally by the team and any requirement to break the agency cap ceiling and framework overrides are escalated to the divisional director for approval and once approval is received, the request is reviewed and signed off at executive level and reported to the Board. All divisions have been briefed about the controls, and regular updates are being provided to ensure that staffing needs are balance alongside the requirements of the rules in order to manage demand and decrease costs.

Weekly NHS Improvement returns on agency caps and framework are authorised by the Director of Workforce and Education and performance against caps, ceilings for nurse agency spend and non-approved frameworks are all now included on the Trust Performance Scorecard, and discussed at the Board every month. Since January 2016 we have reported an average of approximately 70 qualified nursing shifts a week, which are provided through a non-framework agency and which therefore breach rules on framework use. The agency used provides reliable and good quality nursing staff and rates are within the national cap rates. These nurses are only

booked when other routes mean shifts cannot be filled and they are then booked to avoid closing capacity and to avoid quality or safety concerns.

An e-rostering system, linked to a bank requesting module, is in place for the majority of nursing across acute and community areas, and there are plans in place to extend this across a number of AHP areas, notably radiography. The Trust is considering the benefits of further expansion across all staff groups during 2016/17 and beyond.

The Trust's temporary staffing processes were fully reviewed in 2015 as the part pilot programme for the DH National Temporary Staffing Toolkit, which has since been recommended for implementation across the NHS. The toolkit provided guidance supporting improvements to internal controls and a better balance of safe staffing/ patient care with the desire to reduce agency spend. The Trust's Temporary Staffing Group, chaired by the Director of Workforce and Education, led the pilot with three work streams covering governance, workforce planning and procurement. Key actions were:

- embed temporary workforce best practice policies/procedures, regular weekly and monthly reporting together with recommended key performance indicators and approaches to risk management within day-to-day workforce related working practices;
- assessment of models for provision of temporary staff including revised Master Vendor Agreements; and
- reduction to the Trust's reliance on non-permanent staff supplied by agencies.

We have achieved significant reductions of around £3m in agency spend during 2015/16, compared with 2014/15 and are working to reduce this further, through recruitment to permanent and bank roles and continued scrutiny. The plan is to continue to embed good practice to encourage a shift in behaviour and practice around the use of bank and agency workers.

Since February 2016, the Trust has seen a positive shift in medical agency workers requesting to join the Trust bank. Innovative advertising initiatives are being developed to support both bank and permanent recruitment. Recruitment to vacancies, in particular hard to fill areas, is of utmost importance to the Trust. A number of bulk recruitment campaigns are planned for 2016/17, including local divisional open day events, recruitment of student nurses to Band 5 nursing posts and recruitment of Healthcare Assistants from the local population.

#### 4.4 **Education and development plans**

We are currently represented on the HESL board by the Director of Nursing and Quality and works with HESL on commissioning plans and strategies to address local needs. The development of the ACP programme, referred to in section 4.2, above, is an example of this in practice.

However, gaps in the supply of qualified roles remain, regardless of strong relationships with HESL and training providers across all staff groups. These issues are particular evident in terms of numbers of available nurses and the ongoing need to recruit overseas; in AHP roles in particular in imaging services, where a high level of agency will continue to be needed; and in some junior doctor roles and consultant specialities. The Trust will continue to review recruitment campaigns along with retention information, in order to understand if there are any additional initiatives that can be employed to reduce these gaps.

Looking further ahead, the apprenticeship levy scheme which is due to be implemented in April 2017 and is currently under consultation, will lead to a 0.5% levy from the Trust's pay-bill. The Trust will work closely with HESL to consider how best to manage this and to ensure maximum opportunity is gained.

#### 4.5 **Quality and Safety indicators**

Workforce indicators form part of the “well led” section on the Trust’s overall performance scorecard, and are also reviewed in a similar way at divisional and directorate level. This allows the review of workforce and quality and safety metrics concurrently. Examples include:

- using a comprehensive range of workforce metrics to inform action planning and decision making;
- reviewing staff and patient friends and family data together at the Trust’s Integrated Governance Committee;
- ensuring that temporary staffing data and fill rates/FTEs used is reviewed alongside analysis of the permanent workforce; and
- Board level scrutiny of safer staffing data and performance on a monthly basis.

As at April 2016, the Trust has a workforce headcount of 6,664 with a substantive FTE of 5,524. This includes a small proportion of staff seconded. The table below provides a breakdown of workforce establishment by Directorate. The Trust’s corporate workforce includes support and back office functions such as Workforce and Education, Finance, Business and Strategy, Corporate Nursing and Governance, Research and Development, IT and Estates and Facilities.

**Table 2. Workforce Establishment**

Directorates	Establishment	Staff in Post FTE	Staff in Post Headcount
Acute and Emergency Medicine	1,949.52	1,554.70	1,667
Surgery	1,123.19	981.80	1,000
Women and Sexual Health	661.64	572.12	664
Children’s	700.08	602.13	684
Long Term Conditions and Cancer	827.13	660.09	767
Clinical Business Unit	555.05	455.21	492
Corporate	765.42	629.07	670
Estates	82.76	69.37	73
<b>Total</b>	<b>6,664.79</b>	<b>5,524.47</b>	<b>6,017</b>

Table 3. Workforce Indicators, below sets out current key performance indicators scores against Trust target.

**Table3. Workforce indicators**

Workforce KPI’s	Actual (March 2016)	Target
Vacancy rates	17%	12%
Sickness absence	3.9%	4.3%
Turnover	14%	12%
Appraisal	72.5%	90%
Mandatory Training	81%	85%

**4.6 Quality Impact Assessments**

All workforce related CIPs are assessed under the Trust’s quality assurance processes using the same methodology as for other CIP schemes as outlined in section 3.3 of this Plan. This is undertaken by the Director of Nursing and Clinical Quality and the Deputy Medical Director. The QIA process is outlined in section 3.3 above.

**4.7 New Workforce initiatives**

Plans for new workforce initiatives in part depend on the outcome of contract discussions. To date, examples of changes include:

- **Pharmacy** - The department’s vision is ‘to make even better use our skilled pharmacy

workforce to ensure that the right patients get the right choice of medicine, at the right time'. Initiatives to achieve this vision have included the introduction and development of the non-medical prescribing pharmacist role, enabling effective use of medicines in specialist areas and reduction in bed days e.g. anticoagulation and cystic fibrosis. The aim is to continue to introduce this role and train two non-medical prescribers (NMPs) (1 on each site) in 2016/17.

- **Surgery** - We have a theatre transformation programme which will impact on staff in terms of potential changes to working patterns and the need to review job plans to link to revised capacity plans.

The repatriation of the Urology service to LGT will bring care closer to home for many of our patients. A number of staff will transfer their employment to the Trust but a robust and innovative recruitment campaign will also be needed to fill workforce gaps and accommodate additional capacity.

- **Acute and Emergency Medicine** - The division has altered its workforce skill mix to support increased specialism required due to increased acuity of service users in acute and community services. Autonomous Clinical Practitioner roles have been developed and introduced in the last year and there are plans in place to develop the role further in 2016/17 focusing on therapy. Nurse Specialist roles will also be introduced to support the establishment of a Multi-Disciplinary Frailty Assessment service.

#### 4.8 Workforce Risks

As outlined in section 4.5 a comprehensive range of workforce metrics are used to track performance and identify concerns and risks. Workforce risks are included on the risk register and reported to the Board and appropriate sub committees. These are reviewed every quarter as a minimum.

The highest workforce risks on the risk register currently are vacancy rates and ability to fill given workforce supply issues; agency costs and agency cap rules; and the impact on the workforce of potential changes to immigration rules and the tier 2 arrangements.

In addition, there is a significant risk to workforce costs if demand for services exceeds commissioner planning and expectations expressed in the 2016/17 contract. If activity exceeds planned demand additional staffing would be likely to need to be secured at premium rates.

### 5. Approach to Financial Planning

#### 5.1 Financial Summary

- 5.1.1 In accordance with the NHS Improvement letter - 2016/17 Financial framework and planning - dated 15 January 2016, the Trust is planning a deficit of £20.2m in 2016/17. Details of the planning assumptions are described in more detail below.

During the course of 2015/16 the Trust embarked on a detailed analysis to understand the reasons for the current financial deficit. The review identified five key themes that are contributing to the Trust's position:

1. National Pressures
2. Transaction Related
3. Subsidising Commissioners
4. Internal Efficiencies
5. Estates Related

National pressures and Transaction related costs have been a significant driver of the deterioration in the Trust's underlying position; however, there is little the Trust can do about this

in 2016/17. The Transaction related funding refers to the support funding received at the point of the merger of QEH with LHT, which has been reducing in each of the three years since merger. There was significant investment made by the Trust in staff, estates and technology to meet necessary operational and quality standards especially at the Queen Elizabeth Hospital site. Given the limited ability to influence themes one and two the Trust focus in 2016/17 will be on themes three and four, ensuing we are recompensed fully for the activity undertaken and ensuring that we improve internal efficiency.

With respect to theme three, the Trust has undertaken a detailed review of activity and prices in conjunction with PwC. The work has identified that the Trust is currently subsidising commissioners directly by c£13m and also incurring costs of at least another £4m through lack of our partners' community and social care capacity. This work has been shared with commissioners and our plans for 2016/17 are predicated on the CCG's substantially funding the identified areas in the report. The commissioners' initial response to the review had been to refuse to fund any increase in local prices in 2016/17 and instead look to phase in the increase over four or five years starting 2017/18. The Trust was unwilling to accept this position and as a result the matter was taken to arbitration. The arbitration panel's final verdict was that 25% of the total value of the change was to be paid in year (2016/17), 75% of the value in year two and 100% of the value in year three. The terms of reference for this review have now been agreed and an independent party will be appointed to carry out the review.

The Trust welcomes the Lord Carter report into potential NHS efficiencies and is working to ensure that the results of the report form a core part of our CIP programme. The Trust was set a ceiling for agency nurse use, of 10% of total spend on qualified and nursing and midwifery staff and is currently compliant with this. Similarly the Trust is working to ensure full compliance with the new agency rates in 2016/17. In 2015/16 the Trust has brought down agency spend from c£8m in Q1 to c£6m in Q3 and detailed plans to reduce this further to form a core component of each clinical division's plans for the forthcoming year.

Building on the success of 2015/16, the Trust has planned for a CIP programme delivery of £23m in 2016/17. We will maintain the multi-faceted approach we have taken this year with clinical divisions being tasked with their own targets supported by a number of cross cutting/matrix themes. The delivery of the CIP programme has been supported by the PMO and Transformation teams.

The plan assumes that all non-recurrent CIPs from 2015/16 are delivered in year or are offset by the FYE of 2015/16 schemes. The plan assumes receipt of £10.5m run-rate support from NHSI/NHSE as set out in the Transaction Agreement for merger in 2013.

In 2015/16 we agreed a cap and collar contract with the main three CCGs (Lewisham, Bexley and Greenwich). This contract covered all Acute and Community Services provided by the Trust - other than services that were outside of the cap and collar contract (maternity care, GUM outpatient activity and AQP activity for Bexley CCG, along with block funding agreed for System Resilience support).

The cap and collar approach agreed upon was predicated on the understanding that risk would be shared in the system and that the CCGs would manage demand. However, as the 2015/16 year progressed it has become apparent that the levels of overall activity have not reduced and the impact of the cap is likely to be a loss of at least c£4.4m to the Trust.

As a result of the arbitration outcome the Trust has agreed to block emergency activity only for Q1 and Q2 2016-17 at £48.1m (see section 5.2.2). The Trust assumption is that following the review emergency activity will be billed on a cost and volume basis at national tariff from Q3 onwards.

**5.1.2 Impact of the 2016/17 National Tariff** - Monitor has confirmed that HRG4+ will not be implemented for at least another year and the tariffs in 2016/17 will continue to be based on the 2015/16 ETO tariffs with some specific changes.

We have quantified the benefits of tariff changes at £7.4m per the table below which would

represent a tariff increase of 1.8%. The increase of 1.8% is in line with NHS Improvement (NHSI) expectations and consistent with a general 1.1% tariff inflator and specific 0.7% increase to fund the increase of £2.9m in CNST premiums. (Excludes CQUIN).

**Table 4. Tariff Changes**

POD	Baseline at 2015-16 Prices	Baseline at 2016-17 Prices	Price Change (£000s)	Price Change (%)
Elective IP	£15,992	£16,450	£458	2.9%
Day Case	£32,537	£32,930	£394	1.2%
Non Elec & Emergency	£132,735	£135,655	£2,919	2.2%
Outpatients	£83,961	£85,449	£1,488	1.8%
A&E	£27,994	£28,721	£727	2.6%
Adult - Critical Care	£16,888	£17,074	£186	1.1%
Paediatric - Critical Care	£6,685	£6,759	£74	1.1%
Direct Access	£20,428	£20,647	£219	1.1%
Other	£43,940	£44,423	£483	1.1%
Community Services	£40,691	£41,138	£447	1.1%
<b>Trust Total</b>	<b>£421,852</b>	<b>£429,247</b>	<b>£7,395</b>	<b>1.8%</b>

5.1.3 **Standard Contract** - The Trust has used the standard national contract as the basis of any agreement with local commissioners for the year 2016/17. Work on alternative contracting arrangements has been progressing through the course of the year. The intention is to monitor alternative contractual arrangements in shadow format in 2016/17 with a view to implementation in 2017/18.

We will work with commissioners to ensure trajectories are in place from the start of the year that work towards achieving the national standards by the end of the financial year. However we will not accept any form of local financial consequence (fines) or KPIs that reduce the income to the Trust. Only nationally mandated consequences will be applied and where those are waived as part of the Sustainability and Transformation Fund the Trust will expect CCG's not to withhold funds.

5.1.4 **CQUIN** - Following a difficult and protracted CQUIN negotiation the Trust and Commissioners have now jointly agreed the CQUINs for 2016-17. The Trust has maintained throughout the negotiation that in a year where financial grip is imperative, the Trust would not accept the entire risk of committing significant amounts of funding to non-recurrent schemes. The Trust at present will be required to commit c£1m of expenditure in order to achieve the agreed CQUINs, and this will be reviewed regularly.

5.1.5 **QIPP** - We requested that details of all QIPP schemes be provided by 30 November 2015 but received these from commissioners at the end of January 2016. We were explicit that we not agree a contract that included assumptions on QIPP that were not supported by detailed information or clinical evidence and were not been developed with Trust engagement. Our position was that QIPP schemes could not be a balancing item to achieve a CCG affordability envelope. We challenged commissioners to demonstrate how the schemes reduced activity and allowed the Trust to remove costs from its baseline. This issue was taken to arbitration and as a result, a number of CCG QIPP schemes were removed from the contract, while we continue to work with commissioners to identify opportunities to remove cost from the system and work proactively on admission avoidance schemes these must be fully worked up with detailed delivery plans and robust assumptions signed off by both parties. At the present time, based on the lack of information provided by our commissioners, we have been unable to make any assumptions on cost reductions linked to the commissioner QIPP schemes as there is no granular level of detail on the areas to be targeted, no timescales or milestones.

5.1.6 **Other key movements** – Our plan for winter resilience funding 2016/17, as outlined in section

2.3, assumes £3.1m funding as agreed with commissioners for the Trust to invest in initiatives that would support operational delivery throughout the year. The schemes being taken forward have been developed in line with One Version of the Truth recommendations and a review of the successful initiatives implemented during winter 2015/16.

**5.1.7 Sustainability and Transformation Fund** - Following notification of the 'offer of payment' from NHS Improvement, we have planned at this time to achieve a deficit of £20.2m subject to receipt of £16.6m of funding from the general element of the S&T Fund, and based on the assumptions described below which are also included in our formal response to the offer. Access to the funding is predicated on compliance with the conditions set and the Trust is currently reviewing its position against these with the intention to ensure compliance against the conditions with agreed trajectories by the end of the 2016/17 period, further details can be found in the Trusts formal response.

In addition we are assuming receipt of the £10.5m run-rate support from NHSI/NHSE as set out in the Transaction Agreement for merger in 2013.

## 5.2 Forecast Plan 2016/17

**5.2.1 Planned Deficit** - In accordance with the NHS Improvement letter of 15 January 2016 the Trust has been set a proposed deficit control total of £20.2m after accounting for the receipt of £16.6m of income from the general element of the Sustainability and Transformation Fund. The Trust Board has discussed the offer and in principle accepts the proposed control total. However this control total is accepted only on acknowledgement of the following planning assumptions. If any of these assumptions do not materialise the Trust will not be in a position to accept the deficit control total of £20.2m:

- SLA Income – Increase from £421m to £447m
- NHSI Funding – £16.6m from the S&T Fund General Element
- HNSI funding - £10.5m run-rate support as set out in the Transaction Agreement for merger in 2013
- The financial impact of fines related to national/regional/local KPIs and contract measures is not enforced in 2016/17
- The CCG's/NHSE do not withhold CQUIN payments
- There are no financial consequences from Local contractual standards or KPIs
- That the Trust cannot be held solely responsible for the delivery of access targets laid out in the conditions of the S&T Fund. Specifically delivery of the emergency care performance standard relies on delivery of actions both within the Trust and across the whole health economy. Our commitments are outlined in section 2.4.1 of this Plan.

Based on the key assumptions above the Trust is planning to deliver a deficit plan of £20.2m (post-IFRS adjustment). The table below summarises the current 2016/17 Plan and compares it to the initial 2015/16 Plan Outturn position.

**Table 5. Summary Financial Plan 2016/17**

Summary Financial Plan (£000's)	Draft 2016/17 Plan (Feb Submission)	Updated 2016/17 Plan
Patient Related Income	464,717	467,059
Other Income	59,241	61,093
<b>TOTAL INCOME</b>	<b>523,958</b>	<b>528,152</b>
Pay Expenditure	(346,679)	(348,224)
Non-Pay Expenditure	(180,662)	(180,473)
Pay CIP 16/17	14,747	16,286
Non-Pay CIP 16/17	5,253	6,714
Pay CIP - To Be Achieved 15/16 (NR and Unachieved)	5,910	0
<b>TOTAL OPERATING EXPENDITURE</b>	<b>(501,431)</b>	<b>(505,697)</b>
<b>EBITDA</b>	<b>22,527</b>	<b>22,455</b>
Depreciation and Finance Charges	(52,511)	(52,146)
<b>(DEFICIT) Before Technical Adjustments</b>	<b>(29,984)</b>	<b>(29,691)</b>
<b>IFRS Technical Adjustment</b>	9,783	9,491
<b>(DEFICIT) After Technical Adjustment</b>	<b>(20,201)</b>	<b>(20,200)</b>

- Cash Management – Deficit Revenue Cash Support** - The Trust required revenue cash support from DH in 2015/16 in order to manage the cash flow implications of the planned deficit. This support initially came through a Revenue Working Capital Facility (RWCF) arrangement which was then formalised into a £45.2m Revenue Support Loan (RSL) agreement.

The 2016/17 financial plan assumes continuing and additional revenue cash support from DH as a consequence of the planned deficit. It has been assumed that a similar two stage, RWCF and RSL, process as in 2015/16 will apply in 2016/17 for anticipated cash support totalling £26.8m.

The table below details the composition of the cash support across 2015/16 and 2016/17, after factoring in capital to revenue transfers, actual revenue cash support totalling £40.2m was received in 2015/16. No capital to revenue transfers have been included in the £26.8m assumed cash support for 2016/17.

**Table 6: DH Revenue Cash Support Summary**

	2015-16 £'000	2016-17 £'000
I&E Deficit	33,500	20,200
DH Loan Repayments	788	787
PFI IFRIC 12	5,912	5,778
Working Capital Requirement	5,000	-
<b>Total Loans</b>	<b>45,200</b>	<b>26,765</b>
Capital to Revenue Transfer - Trust	(6,696)	-
Capital to Revenue Transfer - DH	(8,828)	-
<b>Total Support - Utilisations</b>	<b>29,676</b>	<b>26,765</b>
Capital to Revenue Transfer - DH Income	8,828	-
<b>Total Support - Received</b>	<b>38,504</b>	<b>26,765</b>

Total interest charges of £1.1m are included in the financial plan in relation to the RWCF and RSL; at rates of interest of 3.5% and 1.5% respectively.

Total revenue cash support related loans are expected to reach £67m by the end of 2016/17.

## 5.2.2 Income

- **Key Income Assumptions:**

- Run Rate Support will continue but reduce from £11.6m to £10.5m from 2015/16 to 2016/17;
- PFI Support will increase by £0.4m from 2015/16 to 2016/17;
- Application of Monitor 2016-17 tariff assumptions as published in December 2015; and
- Demographic Growth assumed has been based on the GLA figures as per last year.

- **Contract Income:**

- **Baseline** – As outlined in section 2.2, our methodology is detailed but fundamentally is based on M6-11 2015/16 activities extrapolated for the full year to inform the 2016/17 baseline position. The baseline has then been adjusted for known issues, which occurred during the year, such as the impact of deployment of the EPR (iCare) on the UHL site in May 2015; data quality corrections/improvements and the impact of seasonality.

- **Demographic Growth** – We have assumed demographic growth based on the GLA figures (see table below) As a result of the agreement to block emergency activity for the first six months, the demographic figures below apply to all activity (with the exception of emergency activity applied months 7 through 12 only).

**Table 7. GLA Demographic Growth 2016/17**

CCG	Bexley	Greenwich	Lewisham
CCG Planning (%)	0.97	0.72	1.40
GLA (%)	0.41	2.05	1.24
ONS (%)	0.87	1.19	1.30
GP List Size (%)	1.31	1.92	1.78
NHSE (%)	1.09	0.72	1.53

- **Non Demographic Growth** – We have reviewed activity growth over a period of 18 months and identified a level of growth, over and above population growth, that needs to be factored into the plan to ensure that the forecast demand is realistic. This non-demographic growth is driven by factors such as deprivation, ageing, technology advances and patient expectation. In 2015/16 national guidance suggested that population and non-population growth combined should be in the region of 3%. Commissioners were unwilling to fund an increase in the contract related to non-demographic growth for emergency activity as they believe the growth was internally generated which the Trust disputed. This non-demographic issue was part of the overall emergency issue taken to mediation and, as a result we have a block arrangement for Q1 and Q2 to address this. From Q3 onwards the Trust is clear that activity must be paid for on a cost and volume basis at national tariff and this will require commissioners to recognise non-demographic growth before they challenge the Trust on over-performance.

In addition to the non-demographic growth referred to above, our forecast demand includes realistic increases in activity to enable delivery of access targets and for the repatriation of Urology services, which will transfer from the current provider King's College Hospital (Princess Royal Hospital) to LGT in 2016/17.

- **Access Targets** - Using a range of tools, including the IMAS system, we have attempted to identify the amount of activity over and above the outturn and growth assumptions that is required to ensure compliance with the national access targets. This work is on-going but in the first draft proposal made to commissioners, we identified £1.8m of additional activity required to achieve RTT standards. In addition £1.4m of additional income has been planned for as a result of the repatriation of the Urology service from Kings (PRUH) which will support delivery of the

cancer targets.

Further details of the activity planning assumptions can be found in section 2 of this document.

- **Other Operating Revenue includes reduction in:**

- Run Rate Support from £11.6m to £10.5m
- Transitional Funding from £5.2m to Nil
- Increase of PFI Support from £15.6m to £16.0

5.2.3 **Expenditure** - The Financial Plan assumes an overall increase in its expenditure baseline in 2016/17 due primarily to inflation and cost pressures related to the increased activity the Trust has seen.

The 2015/16 budgeted expenditure, excluding the IFRS adjustment, was £544.2m. The outturn expenditure for 2015/16, excluding the IFRS adjustment, is expected to be £549.2m.

- **Pay Inflation** - Trust has reduced Pay assumption from 4.3% to 2.8%, as set out in the table below. Assumed that Pay inflation in Public Sector will be capped at similar levels as previous years.

**Table 8. Inflation assumptions 2016/17**

Expenditure	2016/17
Pay	2.8%
Drugs	4.5%
Clinical Supplies and Services	1.2%
Other Expenses	1.2%
Unitary Charge Indexation	2.2%
Capex Inflation	3.1%

- The Trust has assumed pay inflation to be approx. 2.7% for 2016/17 - 1.7% is for the uplift in Pensions and 1.0% for pay. These assumptions are based on the continuing emphasis of pay restraint in the Public Sector in line with previous years pay inflation.
- The Trusts expectation is that Public Sector in line with previous year's pay inflation.
- Trust also has a vacancy factor of approximately 15% so therefore impact of incremental drift will be expected to be reduced
- **Non-Pay Inflation** - will result in an increase in costs of £2.4m (incl. PFI, Drugs, Clinical Supplies and Services and Other Expenditure)
- **Cost Pressures** - The Trust has planned to fund £18m of identified cost pressures the majority of these related to funding the costs associated with the increase in activity that has been seen in 2015/16. In 2015/16 the Trust received c£2m of central funding for the upgrade and implementation of the Cerner iCare PAS system this funding is not being made available in 2016/17 and is therefore the single largest cost pressure faced by the Trust in 2016/17.
  - CNST - The Trust has received the CNST Contribution letter from NHS Litigation Authority and will have an increase of £2.9m on its 2016/17 contributions
- **Depreciation and Finance Charges** - Based on the increase in PFI inflation, indexation and the planned capital programme for 2016/17 the Trust is planning for an increase in charges of £3m compared to 2015/16. This figure is still currently under review and may increase in the final submission. A significant increase will potentially impact the ability to hit our control total in 2016/17.

5.3 **Efficiency savings for 2016/17**

5.3.1 **CIPs** - The CIP allocation for 2016/17 is £23m. Continuing on from the success of 2015/16, the programme is configured on a matrix basis that ensures local, divisional targets and ownership

of efficiencies, while providing the oversight and leadership of Executive-led cross-cutting themes. The recent introduction of a new programme management software system has enabled full real-time visibility and transparency of the Cost Improvement Programme. This enhances ownership and accountability, and provides auditable, paperless records of planning, governance and decision-making.

- 5.3.2 **Lord Carter's provider productivity work programme** - We are actively engaged with the recommendations set out by Lord Carter for efficiencies across workforce, estates, purchasing and medicine management. Based on early work the Trust has identified and are currently reviewing approximately £2m of new Procurement savings that could be made in 2016-17, in addition to the full year effect of £1.2m schemes from the preceding year. These £2m of schemes have been built-in to the delivery of the £23m CIP plan for 2016-17. Further work continues on maximising the potential savings identified in the Lord Carter review and additional information will be provided in the final version of the plan.

#### 5.4 Agency rules

The Trust has implemented the agency ceilings and caps rules since introduction and will continue to do so. The ceiling for agency use on qualified nursing and midwifery is 10% of total spend on qualified nursing and midwifery. During 2015/16, the Trust has taken steps to limit its expenditure on agency staffing, and has reduced expenditure from £8.7m in Q1 of 2015/16 to £6.1m in Q3, whilst permanent and bank staff expenditure has remained broadly consistent. Actions taken have included:

- Further promoting the use of the staff bank to cover vacant shifts;
- Introducing processes requiring Executive Director approval for the use of agency cover in administration and clerical roles;
- Weekly reviews of expenditure on temporary staffing in all areas;
- Recruitment of nurses from overseas. Following the recruitment of 135 nurses from the Philippines between November 2014 and August 2015, the Trust undertook a further recruitment exercise to recruit nurses from Spain and a further 60 nurses from the Philippines in December 2015; and
- In response to the mandatory use of frameworks for nursing agency staff and an hourly cap on rates for nursing, medical and other staff groups, the Trust has reviewed all rates currently paid to agency staff and is seeking to deliver reductions in line with the stepped rates proposed. In 2015/16 we were already compliant with the agency rate up until February 2016. With the required limit of 55% for all staff groups from April 2016, the Trust anticipates further savings of £2.4m during 2016/17.

#### 5.5 Procurement

We have reviewed and restructured the Trust's Procurement function to ensure good governance, while delivering robust financial savings via a systematic programme of review of all purchasing and supplies.

The Trust established a strong relationship with GSTT in operating the procurement function in 2015/16, with senior staff seconded in to operate the function and integrate some procurement with GSTT. This work will be expanded in 2016/17 and could be expanded to develop further efficiencies across South East London providers. In addition we have taken advantage of strategic partnership opportunities to drive-down the unit cost of supplies, while simplifying and rationalising suppliers in order to maximise opportunities of scale. We simultaneously continue to renegotiate contracts to ensure best value is achieved, while maintaining safety and quality.

A Product Selection Board, comprising clinical leaders and decision-makers from each service, maintains oversight of clinical product switches to ensure that quality is guaranteed, and that clinical buy-in is maintained throughout any change in supplier or product.

The Cost Improvement element of the procurement programme is overseen by the Director of

Nursing and Clinical Quality and Deputy Chief Executive as the Senior Responsible Owner, and has identified £2m of savings to be delivered in 2016/17.

## 5.6 Capital planning

5.6.1 We have developed a five year Capital Plan, which is consistent with our emerging clinical and estates strategies and the SEL STP. The capital plan identifies the capital investment required to deliver safe and productive services within estate that is optimised but that is also fit for purpose.

Our five year Capital Plan includes some larger investment schemes (over £5m) as well as a number of smaller schemes where investment will be allocated to the priorities identified from the Trust's capital allocation. Details of all schemes are available and, for some schemes, business cases are developed and already within the approvals process.

### 5.6.2 Priority Externally Funded Developments

- **QEH infrastructure**

A Full Business Case (FBC) has been developed and shared with the NHSI, which describes the state of building infrastructure on the QEH site and reviews options for the rectification of critical building defects, infrastructure issues and failings against compliance standards. The need for these works is heightened by the known existence of legionella on the site and the associated risk to patient safety as well as the risk to electrical supply which, in October 2015, resulted in a prolonged power outage.

The Transaction Agreement for the merger of Lewisham Healthcare NHS Trust and the Queen Elizabeth Hospital acknowledged that significant funding would need to be made available to the Trust for site-wide infrastructure and compliance works, both in terms of capital (should a capital funding route be agreed with the Department of Health) and revenue to support the operational cost consequences of the investment.

The strategic drivers of this request for investment to address all of the QEH legacy estate issues are detailed below:

- To implement the enhanced programme of remedial works initially described in the Transaction Agreement for LGT upon dissolution of the predecessor organisation SLHT.
- To undertake further works to address all outstanding critical estate works, including those identified subsequent to the Transaction Agreement, in order that full compliance can be achieved with mandatory and statutory estate-related obligations effective at 2014.
- To ensure that the Trust can comprehensively and consistently discharge its statutory obligations and in particular ensure the highest levels of safety and quality arising from use of the estate by its staff, patients, visitors and contractors.
- To enable the Trust to meet the requirements of its regulators, particularly CQC.
- To ensure that, by settling all legacy matters with the estate, the Trust can effectively operate the PFI contract and secure optimal value for money through robust commercial management of the contract.
- To create a resilient and flexible core estate and engineering services infrastructure as a platform to support future re-developments and site reconfigurations.

- **Improved access to diagnostics – Endoscopy Capacity**

This scheme is a high priority to address the shortfall in capacity on both of our acute sites, UHL and QEH, to meet the growing demand for diagnostics and timeliness of Cancer service delivery. The scheme will ensure compliance with JAG accreditation standards and address issues on the QEH site around the same-sex accommodation standards.

LGT is designated as the centre for Bowel Cancer screening services for South East London, under the national programme, and increased capacity is critical to meet both demographic

growth and the additional demand created by the expanded National Bowel Cancer Scoping and Screening service.

The Strategic Outline Case (SOC) for endoscopy was approved by the NHSI in April 2015. The Outline Business Case (OBC) has been approved by the Trust Board and was submitted to the NHSI in May 2016.

- **Emergency Department at QEH**

Following their inspection in 2014, the Care Quality Commission Report identified the Emergency Department at QEH as 'inadequate'. Since that time considerable effort has been expended to re-design and improve the emergency pathways and included, in late 2014/15, the creation of a new ED clinical decision unit and discharge lounge. These works and the re-designed pathways have resulted in improvements both to the tracking and monitoring of the patient's progress through the ED and their experience of the emergency care service.

The re-design and development of a new ED at QEH will be complex and challenging, given the constraints of the site and the service pressures. The draft five year plan includes a notional sum, that will need to be confirmed, to improve both the capacity of, and flows within, the Emergency Department to bring them closer to current standards.

- **IT Cerner Merger**

An Outline Business Case (OBC) has been developed and shared with the NHSI, which describes the creation of a single digital clinical record solution across the Trust. Following iCare deployments planned before the merger and establishment of LGT, we currently have two separate instances of Cerner Millennium at UHL and QEH and, therefore, two separate digital clinical records. The creation of a single record is an absolute necessity to enable the trust to deliver its vision of 'One Trust – serving our local communities'. A key ambition of that vision is to integrate LHT and QEH in a way that truly unites our services and staff across our sites. The creation of a single record will support the following:

- Integrated patient journeys that span the two hospitals;
- Reducing clinical risk through having access to the same patient record at both hospitals;
- Standardising treatment across both hospitals via common decision support tools;
- Ensuring a shared and accessible patient record from all Trust hospital locations; and
- Strengthen operational resilience and business continuity.

Furthermore, the single solution will include clinical decision support for embedding standardised best practice and patient safety across the hospitals.

The Business Case for the merger of LHT and QEH identified the unique challenge faced by the new organisation in the deployment of two separate Cerner systems, which it was clear would need to be merged to form a single digital record.

### 5.6.3 **Priority Internally Funded Developments**

The Capital Plan over the next five years includes a range of schemes that have been prioritised to address clinical priorities and include:

- our joint ambition with commissioners to see more care provided in ambulatory settings with the creation of an **ambulatory care units** on each of our hospital sites, as described in section 2.3;
- our need to provide additional **theatre capacity** to meet the demand for surgery and achieve RTT performance targets;
- the second phase of the **pathology transformation** programme across our sites and the considerable efficiency benefits that strategy achieves; and
- continued **investment in IT** to support our organisation's delivery of the information revolution outlined in the Forward View. Our plans include our continued support of the roll out of the local interoperable patient record 'Connect Care'; update of clinical information

technology; enabling ever increasing mobile working and extending wireless access across our sites.

In line with our estates strategy, the draft Capital Plan also includes necessary expenditure on backlog maintenance and medical equipment as well as essential upgrade of ward and outpatient accommodation to ensure that facilities, which sit outside our PFI buildings, are fit for purpose. Our prioritisation process ensures that resources are targeted on projects that deliver better quality outcomes for our patients together with improved productivity.

In addition, we are considering options for future equipment procurement opportunities through managed services, in particular with respect to Trust wide management of medical devices. The existing management equipment contract at QEH, started in 2001, comes to an end in 2017 and we are reviewing whole-trust opportunities to replace that contract on its expiry.

## 5.7 Estate

### 5.7.1 *Trust Estate*

Optimisation of the Trust's estate will be critically important to the organisation's future viability. We are clear that our strategic plans will need to ensure that we have the right estate, of the right quality and in the right place to deliver our clinical strategy but also that we should aim to reduce the estate footprint to match our needs and reduce our running costs. We believe we have exciting opportunities to deliver, which include the rationalisation of estate and the potential for disposal of unwanted obsolete estate as plans unfold. The estate strategy will ensure that:

- Clinical service, education and estates needs are aligned;
- Investment is focused on business priorities and unlocks financial benefits for the trust;
- Space allocation is proportionate to need, productivity and income opportunities;
- Plans are consistent with those of our partners within the health and social care economy in South East London, including commissioners;
- Resources are targeted on projects that deliver better quality outcomes for our patients together with improved productivity; and
- We maximise the opportunities for joint working with other providers including primary care.

Positive discussions are taking place with our PFI partners on both the Lewisham and Queen Elizabeth Hospital sites regarding the release of land that currently sits within the PFI curtilage, land that could be redeveloped in its own right (subject to planning approval) to provide clinical space in support of new models of patient care, low cost back office space and essential housing stock.

Options are also being considered for improving value and efficiencies with a variety of back office and support functions. We are undertaking a strategic review of the delivery of back office functions considering how they might be delivered differently and more efficiently. Our aim is to reduce demand on the estate, moving away from the silo office and embracing a more collaborative approach with staff groups. Opportunities under consideration include:

- flexible working;
- home working;
- working from hubs or locality care networks;
- open plan or hot desk facilities; and
- working generally in a more mobile way.

In addition, we are making good progress with regularising leases and SLA's with our various tenants in the buildings we now own and are progressing the formalisation of our own tenure within buildings we deliver services from and that are owned by either NHSPS or CHP. Both of these initiatives will give all parties clarity on cost, space occupied and security of tenure.

The estate infrastructure at Queen Elizabeth is fragile, the quality and scope of the installation

having been compromised from construction. Our five year Capital Plan includes a 'QEH Infrastructure' scheme. We have submitted a business case to the NHSI for a significant amount of capital and revenue funding to be made available that will enable the Trust, through negotiation with the PFI Company, to agree a level of investment in the infrastructure and so bring the services and systems to current standards.

### 5.7.2 **Community Estate**

In early 2015 the Trust led a pilot in a Lewisham neighbourhood to explore the efficiencies possible for consolidating Trust, LA, CCG (Primary Care) and mental health property, in order to create a neighbourhood hub and in so doing release unwanted publicly owned estate; the outcome of the pilot demonstrated there are opportunities if all parties sign up to the concept. More recently further collaborative opportunities are being developed with local partners through the Lewisham devolution agenda (see section 6.2).

For the past year we have been working collaboratively with the wider South East London network, through the OHSEL programme and subsequent STP development, to explore opportunities for improving the utilisation of the public sector estate across the six south east London boroughs. This work has included the CCG's and Primary Care, the Local Authorities, South London and Maudsley Foundation Trust and Oxleas Foundation Trust.

In addition, we are working with our local CCG partners to create local Strategic Estate Plans. This work will help identify what the estate and infrastructure requirements are to enable delivery of new models of patient care, supporting delivery of the Five Year Forward View at a local level. It has become clear, through considering the potential opportunities with local partners, that there is discrepancy in the methodology applied to charging for space occupied. Guidance is awaited as to how to structure charges reflecting market rates and thereby true costs of occupation. Guidance is also expected on funding and reimbursement arrangements. NHS Property Services (NHSPS) are in the process of further restructure but a number of interesting initiatives are being developed including a void space policy, intended generally to assist CCG's to manage the costs and risks associated with void space in their patch and pass that liability over to NHSPS; improvements in the management of billing and improved processes for the delivery of projects, providing increased value for money.

## 5.8 **Information and Technology**

### 5.8.1 **Information and Technology Strategy**

The IT strategy (2014-2018) drives the Trust towards NHS paperless objectives and encompasses the Interoperability themes outlined by the National Information Board (NIB) in their paper 'Using Data and Technology to Transform Outcomes for Patients and Citizens'. Furthermore the IT strategy (2014-2018) dictates a rationalisation and standardisation of IT platforms and a broadening of the digital roadmap.

The EPR programme delivered two EPR systems at QEH (July 2014) and UHL (May 2015) to a quality which is unparalleled by other Trusts undertaking similar scale IT transformation projects. The implementation of the two EPRs has resulted in significant improvements in operational capability to track and record activity.

The next key strategic initiative on the EPR roadmap builds on the two successful deliveries, to merge the two EPR systems. The EPR merger programme will rationalise the number of EPR systems whilst at the same time deploying added functionality for UHL ED and rollout Trust wide e-Prescribing and clinical support. The rationalisation of platforms and replacement of paper processes are in accord with the IT strategic themes.

The timelines for the EPR merger programme are extremely challenging and are dependent on the NHSI approval of the business case.

Various other rationalisation programmes will commence in 2016 such as a single Radiology system (work beginning in Q3 2016) and a single integrated Pathology system (delivery mid

2016).

The virtual patient record system is at the heart of the Trust's Interoperability strategy. This system is a patient-centric health and social care record, hosted by LGT, which has been rolled out across Lewisham and Greenwich. Connect Care displays key details from the main patient information systems in use at Lewisham and Greenwich NHS Trust; the GP practice systems across Lewisham and Greenwich; the local authority social care systems in both Lewisham and Greenwich and Oxleas Foundation Trust.

The first (live) phase of Connect Care has already rolled out across the Trust and to GP practices. The second phase will then include our local Boroughs of Lewisham, Royal Borough of Greenwich, Bexley (new addition) and Oxleas Foundation Trust. Furthermore, the second and third phases will include increasingly rich data sets from partner organisations.

This platform allows patient information to be securely viewed quickly and safely by primary, acute, community and social care clinical staff. This will bring improvements to the quality, cost effectiveness and timeliness of the services provided to patients in our care.

The Trust's RiO Community system is already delivering some paperless benefits to the organisation but now includes the mobile store and forward functionality (available spring 2016). Further mobile initiatives for 2016/17 include introduction of a remote virtual desktop environment which aims to release time back to the Trust workforce, whilst attempting to minimise paper processes.

Building upon this the Trust will pursue opportunities and partnerships to facilitate the creation of patient –centric mobile applications.

Two infrastructure projects' initial phases will complete in 2016 delivering Trust wide wireless connectivity, including patient access and state-of-the-art telephony services. These deliveries will replace and rationalise the incumbent 'burning' platforms and provide a springboard for future mobile initiatives.

## 6. The 'Sustainability and Transformation Plan' (STP) and Lewisham Devolution

### 6.1 Sustainability and Transformation Plan (STP)

The Trust is clear that the STP process will require health and care systems to work together to develop and deliver a sustainable plan that both meets quality and performance standards and ensures financial sustainability. The SEL STP was submitted to NHS England on 30 June 2016 in accordance with the national timeline.

Organisations in South East London determined that the transformation footprint for our STP should be the south east London footprint, including the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. CCGs in SE London were previously developing a transformation strategy and the STP process has broadened this, bringing organisations together to establish a place based leadership structure focused on the population of SE London rather than the individual organisations. The aim is to collectively identify our priorities and to help ensure that health and care services are built around the needs of residents.

The STP governance structure for the STP development (provided in Figure 2 below) has used, as its starting point, the OHSEL governance, which is being amended to reflect the requirements of the STP and will be developed further going forward. A Strategic Planning Group has been introduced, which brings together Providers and Commissioners for strategic planning. Decision-making and accountability will continue to sit with statutory bodies in South East London.

The governance principles aim to ensure that there is:

- joint ownership
- strong clinical leadership
- patient participation

The STP focuses on five priority areas that are expected to have the greatest impact on the SEL challenges and pressures to collectively address the three gaps of health, quality and finance while increasing value.

The SEL key challenges are summarised as follows:

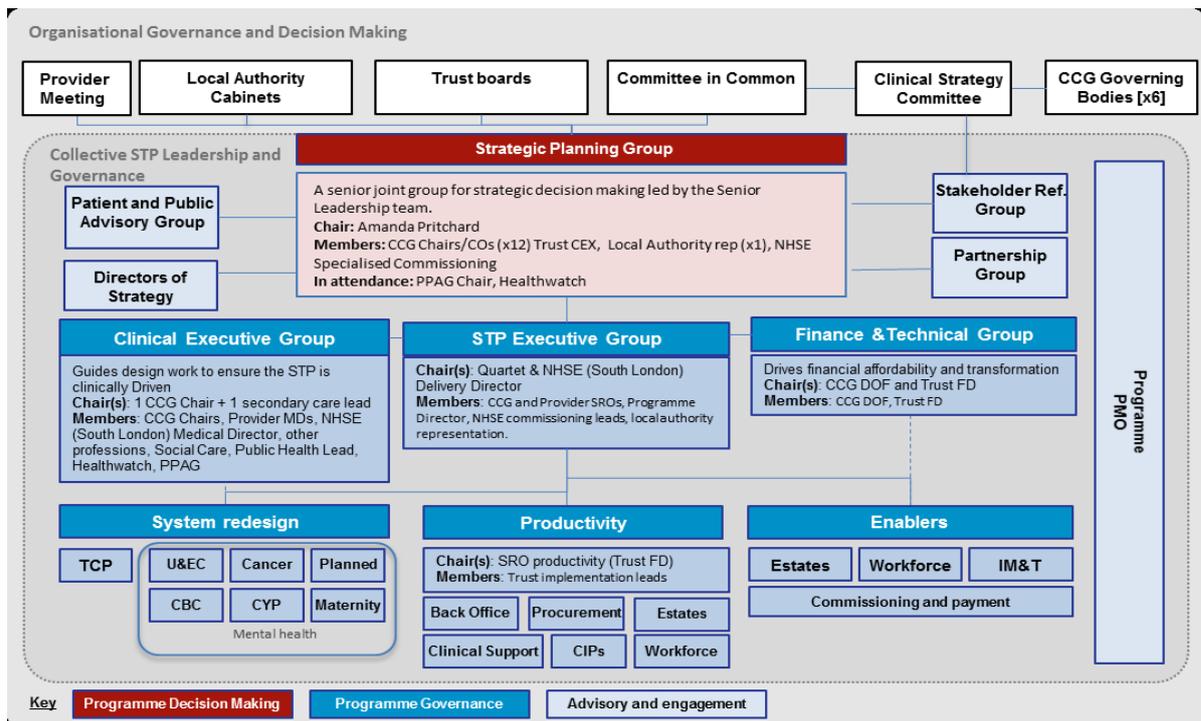
- demand for health and care services is increasing;
- there is unacceptable variation in care, quality and outcomes across SEL;
- our system is fragmented resulting in duplication and confusion; and
- the cost of delivering health and care services is increasing

In the face of these challenges the STP has identified the following five priorities:

1. developing consistent and high quality community based care and prevention;
2. improving quality and reducing variation across both physical and mental health;
3. reducing cost through provider collaboration;
4. developing sustainable specialised services; and
5. changing how we work together to deliver the transformation required

The STP governance structure is provided in Figure 2 below:

**Figure 1. Proposed STP Governance Structure**



## 6.2 Lewisham Devolution Pilot

Lewisham is a health and care economy, which has a long history of collaborative work, built on strong local relationships between health and care leaders. The Lewisham Health and Care Partners (LHCP) have been working together to develop and deliver integrated services for the adult population of Lewisham since the integration of acute and community health services in

2010. The work has been overseen and co-developed with the Lewisham Clinical Commissioning Group and Lewisham Council. In recent years, this work has been overseen by the Health and Wellbeing Board, Children and Young People’s Strategic Partnership (CYPSP) Board and the Adult Integrated Care Programme (AICP) Board and funded through section 75 pooled budget arrangements and the Better Care Fund.

In the spirit of the wider London devolution model, Lewisham has been successful as a local integration pilot to explore how the core principle of subsidiarity will be operationalised to realise the benefits of better health and wellbeing outcomes and reduced inequalities, whilst containing costs, thereby delivering better value for money for the people of Lewisham. We see the pilot as the means to enable us to build on our Better Care Fund, by exploring the options for pooled funding, developing integrated commissioning and devolution of powers currently held at national level.

LHCP share a collective Vision for Lewisham in 2020, which is consistent with the SE London STP. During the pilot the STP footprint will consider the lessons learnt and how they can be applied elsewhere in south east London. Currently the aim of the pilot is to explore:

- *Workforce:* develop new workforce models and enhanced roles to support new models of care, including joint health and care roles working with Health Education England, Skills for Care and professional bodies amongst others;
- *Estates:* working with NHS Property Services, Community Health Partnerships, London partners and sub-regional strategic estates boards to facilitate the release of primary care and hospital estates to support the development of new models of care and release relevant resources for transformation;
- *Aligned incentives and reimbursement, and funding structures:* flexibilities around tariffs and new payment models to support new models of care, beyond current flexibilities, multi-year cycle and accelerated roll out of Connect Care, our virtual patient record system, across all parts of Lewisham Health and Care system to support the planning and delivery of care.

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