Epsom and St Helier University Hospitals NHS Trust

# EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

# 2019/20 OPERATING PLAN



March 2019

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## INTRODUCTION

This plan sets out Epsom and St Helier University Hospitals NHS Trust priorities for 2019-20. It builds on the two-year Operating Plan for 2017/19, and the 'refresh' published in April 2018. It takes account of the national NHS long-term plan published in January 2019 and the progress we are making locally within the South West London Health and Care Partnership and the Surrey Heartlands Integrated Care System.

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

Our two main acute sites are St Helier Hospital in the London Borough of Sutton, within the South West London Health and Care Partnership, and Epsom Hospital in Surrey, within the Surrey Heartlands Integrated Care System. We also provide out-reach services at a number of more locally-based care centres and are moving to increasingly integrated models of care working with local community, primary, and other service providers.

From 1st April 2019, the Trust becomes the host for the delivery of community health services across both of its local place-based communities of Surrey Downs and Sutton. Both community contracts will deliver through contractual joint ventures (Surrey Downs in partnership with the 3 local GP Federations and the community trust and Sutton in partnership with the local GP Federation, local authority and mental health trust). Discharging our host responsibilities to a high standard and working in partnership to transform pathways across hospital and community settings will be a key priority for the year ahead.



### Strategic Context

In 2015 the Trust set out its strategy for the next 5 years. This included our commitment to keep acute services, including A&E and maternity, at both our main sites whilst we develop an estates strategy for the period 2020-30. 2019/20 is the final year of our current five year strategy and our commitment remains to maintain acute services at both our main sites. A key priority during the year will be to develop our strategy for the next five year period 2020-25, which will be predicated on the outcome of the Improving Healthcare Together 2020-2030 programme, which our local CCGs are leading. This will be published in March/April 2020.

### Our Priorities for 2019/20

Our key objectives for 2019/20 continue to reflect our mission, aspiring to provide great care to every patient every day. In a change from 2018/19, we have adjusted our priorities to place the importance of our staff at the heart of delivery of our mission. As a result, we will prioritise the following areas:-

| Corporate Priority | Indicators |
|---|---|
| Build a culture in the organization that embeds the right behaviours to enable our staff to proactively raise concerns and work at their best by … | • Ensuring that Trust leaders role model high standards of behavior and reward and appreciate respectful behaviour and ensure all poor behaviour is addressed<br>• Setting clear and achievable strategic aims for the organization and give people adequate tools and resources to meet their objectives |

| | |
|---|---|
| | • Ensuring that decision making respects our patients and colleagues<br>• Enabling all our diverse teams to have regular meetings and 1:1s<br>• Making it safe for people to express concerns and to be heard fairly<br>• Creating an environment where everyone can flourish regardless of protected characteristics, profession, role or level<br>• Creating a safe environment for staff that is free of patient aggression |
| Deliver safe and effective care with respect and dignity by … | • Ensuring safe staffing levels in clinical areas<br>  ○ Deliver appropriate fill rates to all clinical areas<br>  ○ Build and deliver a Ward to Board assurance process around staffing levels<br>  ○ Deliver phase one of the nurse establishment review<br>  ○ Resource the right level of input into therapies<br>• Investigating complaints, incidents and deaths in a timely way to ensure learning is widely shared and embedded in the organization<br>• Ensuring that A&E (adult and paediatrics) becomes more sustainable<br>  ○ Enable A&E to be sufficiently and sustainably staffed<br>  ○ Implement and use a new A&E safety dashboard<br>• Developing and implementing a care strategy for both hospital and community services to ensure the needs of our elderly patients are met, to include:-<br>  ○ Dementia<br>  ○ Frailty<br>  ○ Optimising time spent in the most appropriate setting<br>• Embedding and auditing compliance against our managing the acutely ill patient (MAIP) policy |
| Create a positive experience that meets the expectations of our patients, their families and carers by … | • Investing £23.7m in our estate<br>• Involving patients as partners in the delivery of their care<br>  ○ Ensure that care is built around patient preferences<br>  ○ Work in collaboration with patients to ensure more involvement in setting care plans<br>  ○ Raise the profile of patient participation groups<br>• Improving the provision of patient transport services |
| Provide responsive care that delivers the right treatment, in the right place at the right time by … | • Transforming pathways and clinical standards across acute and community, to ensure we are giving the right care in the right place at the right time<br>• Delivering the constitutional standards/contractually agreed trajectories for<br>  ○ A&E<br>  ○ Cancer<br>  ○ RTT<br>• Delivering the projects relating out improving patient flow/length of stay and Outpatients<br>  ○ critical care<br>  ○ Stranded and superstranded |
| Being financially sustainable by … | • delivering the control total<br>• Delivering recommendations and outcomes from Getting it Right First |

| | |
|---|---|
| | Time (GIRFT) reviews<br>• Utilising the Model Hospital to achieve efficiency gains<br>• Delivering cost improvement programmes<br>  ○ Reducing length of stay<br>  ○ Elective throughput<br>  ○ Clinical support services<br>  ○ Maximising investments made in IT<br>  ○ Improving HR processes |
| Work in partnership in the places that we serve by … | • Adopting an active system leadership role around place based care through integrated care partnerships and at system level through Surrey Heartlands Integrated Care System and within the South West London Health and Care Partnership<br>• Discharging our host role for community contracts (Sutton Health & Care and Surrey Downs Health & Care) to a high standard and work in partnership to transform clinical pathways<br>• Supporting the CCGs in taking forward the Improving Healthcare Together programme of work<br>• Taking forward collaborative initiatives via the South West London Acute Provider Collaborative |

## ACTIVITY PLANNING

### Emergency Care



2018 /19 has been a year of transition for Emergency Care. The Trust has retained its position as one of the top 3 London Trusts for Emergency Access and remained in the top 20% of Trusts nationally. It has achieved this against a background of considerable change, having seen both of the Emergency Departments undergo extensive refurbishment to remodel their layouts and ensure that they better reflect the increasingly acute needs of our patients.

The year has seen staffing – particularly for middle grade doctors and registered nurses – emerge as a constraint, in part because of shifts in activity and acuity patterns. The Trust has opened a Surgical Assessment Unit in St Helier, expanded the use of the medical Ambulatory Care Unit, and adjusted the use of the Medical Assessment Unit to ensure more consistent clerking and reception of admitted patients. These adjustments to our Emergency pathway have supported a reduction in longer stay patients from a 3 month median of 182 to c.115 by December 2018.

Our aspiration for 2019 /20 is to sustain the changes we have made in length of stay and same day emergency care, right size the established and substantively recruited workforce of the Emergency Department, and use this to drive improvements in quality. Evidence indicates that a well-staffed and high quality ED will in turn drive good outcomes and performance. Our gains within each Emergency Department will, however, only drive good overall Emergency Access performance in partnership with the support of the wider Trust. To ensure that we maintain and improve our position as a high performing Trust we intend to:-

- Increase the use of Same Day Emergency Care through expanding the operating hours for Ambulatory Medicine, the Surgical Assessment Unit and our Frailty Service. In addition, we would expect to expand the range of conditions we can manage in each of these services and the number of patients being streamed directly into them from ED and from GPs and the wider system, rather than seeing ED as the ‘catch all’. In particular we expect to work with our partners to improve the process for GP advice, streaming, and the management of “GP expecteds”. The shift in reporting to capturing these patients

as “Type 5” through the Emergency Department Data Set will play a valuable part in highlighting and improving this process.

- Develop our Frailty Service, in particular, and redesign our Care of the Elderly service in general. We expect to develop the use of the current frailty zone in the acute medical unit into a frailty unit, working in parallel with our @Home services in both Sutton and Epsom, and leveraging our membership of the Acute Frailty Network to understand, import and embed the best practice for those most in need of our help.

Both of these improvements will be supported through a review of the use of prescribing, diagnostics, home care, therapies and the ambulance services to ensure that we provide the best care for every patient in the place they are best able to receive it.

We also plan to improve further the considerable gains made in delayed ambulance handovers. From Q3 17/18 to Q3 18 / 19 we have reduced the number of ambulance handover delays over 30 minutes on each site by 25%, and the new Rapid Assessment and Triage (RAT) and “fit to sit” areas created on both sites will support further improvements. Our principal challenge is now around clustering of ambulance arrivals, and we intend to work in partnership with our ambulance services to make further improvements.

Our final major Urgent Care work strand is around length of stay. In addition to improved process and medical planning and extensive use of same day emergency care this year, we have run a trial of discharge to assess in St Helier. This trial increased the weekly number of discharges, reduced stranded and super-stranded patient numbers, and yet saw no change to the readmission rate: we will roll this out at scale and our aspiration is to reduce the number of occupied beds by at least 30, creating additional surge capacity for use next winter.

### Planned Care

During the planning process for 2018 /19 a detailed demand and capacity analysis was conducted for outpatients, using the NHSI capacity model. This model formed the basis for investments in a small number of key specialties (see “challenged specialties” below) in order to stabilise the RTT waiting list and backlog in line with national direction. In addition, there has been significant work on internal assurance, planning process and the management of clinics and operating theatres. The impact in year has been to reduce the overall waiting list from 28781 to 27402, with the backlog dropping from 3997 to 3343 against the standstill plan and in-year trajectory.



The plan for 2019 /20 is to build upon these gains by completing the recruitment process for our most challenged specialties, whilst developing our end to end capacity plan to ensure that changes in demand patterns for diagnostics (particularly given the growth in cancer referrals). The key development areas for 2019-20 will be centred around:-

- Maintaining our current level of activity as a baseline to sustain further RTT improvements. This will require the Trust to maintain current recruitment levels and plans, but also to identify early in Q1 where peak demand in summer will require seasonal workforce enhancements and recruiting as early as possible.
- Working with our STP partners, along with the SW London Acute Provider Collaborative (APC) to ensure that there is a more formal understanding of substantive NHS capacity. This will allow us to begin to map out standard treatment pathways, and also to ensure that where patients are at risk of waiting more than 6 months, their alternate offer of treatment should be a local NHS provider.
- Reviewing our outpatient model. Our initial plans suggest that the optimal contracting arrangement is a PBR contract for new referrals, combined with a block contract for follow ups: this would support significant pathway review and ensure that capacity can be released by new methods of delivery at no cost to the CCGs. We plan to improve on the current 6% DNA rate through improved booking and reminder processes, whilst shifting to patient activated follow up will ensure that only those appointments adding value to a pathway will be needed. This will also create space to move to virtual and remote follow up to create a more convenient service for patients.

- Deepening our internal holding to account and tracking procedures to ensure that not only are diagnostics booked and acted upon, but also ensure that a rapid decision to treat can be made. The drop in those patients waiting over 40 weeks has been achieved in part through a revision of the oversight processes, and will in turn support the reduction of patients waiting over 52 weeks to zero. We intend to deliver the diagnostic standard in every month. However, the plan is an indication of potential risk. The key shortfall at present is in Urogynae urodynamics testing: we have now recruited to the two key posts needed and the equipment will be in place by the end of March. The April figure reflects that risk and the more general seasonal variation. Our staffing is a known risk, and much additional activity is currently required to support demand: when substantive staffing is absent this also denudes the pool of staff able to cover additional sessions. We are working on a revised demand capacity model to determine the right level of substantive staff and to determine if alternate models can be developed. We will also have to reflect the financial risk of insourcing and balance the cost of the activity against the performance.
- Reviewing service and individual job plans to confirm that they continue to meet the needs of our patients, and have been formally updated to reflect increased efficiency, the need to triage electronic referrals and changing patterns of demand – particularly the shift towards an increased number of cancer referrals.
- Increasing the capacity of our diagnostic pathways. The rise in cancer referrals has increased the complexity and number of our diagnostic pathways, whilst highlighting some niche areas of fragility in our diagnostic capacity. The shifts in acuity and demand in 18/19 led to a 35% increase in the most complex scans which required additional scanning capacity. We expect to produce detailed plans for the upgrade and replacement of CT scanners, anuplift in MRI capacity, and the replacement of our urodynamic equipment – supported by a review of the staffing and workforce structure in each area. These enhancements will ensure the Trust is able to consistently exceed the 99% diagnostic performance standard.
- Ensuring that the gains in theatre processes and efficiency are sustained and deepened. One of the key shortfalls identified during our theatre review was the relative lack of day case beds to support elective theatre capacity. We will bring sufficient day case beds online in Epsom early in Q1 to redress this balance, whilst a principal aim of the length of stay work in St Helier will be to create a formal theatre unit, again to enhance the capacity of our theatres and improve the quality of the patients' pathway.



### Cancer

Trust cancer performance has remained strong throughout 2018 – 19. We have delivered Q1-3 at 85% and expect to maintain this level. However, this is based on the old provider attribution rules: the timeline for this has been changed twice, and both the rules surrounding it and the national mechanisms are not yet clear. We are working towards the 28 day faster diagnostic standard, have several RMP grants pending for revised pathways, but the numbers reflect the 38 day risk. On the current rules we would expect to continue our current, high, level of performance.

The introduction of e-referral has been a success for cancer, but has also created its own challenges around locations and capacity of clinics, a definite shift towards more two week referrals, and the commensurate increase in tracking, MDT activity and clinic loading. In order to ensure that the Trust maintains its current strong level of performance we will:-

- Ensure that the overall demand and capacity models support sufficient cancer new appointment slots. Currently the Trust overachieves against the 14 day cancer standard, but 80% of our appointments happen after day 7. In order to embed consistent delivery we need to be able to consistently see 80% of our new referrals within 7 days, and to achieve this we will work with the clinical teams to ensure sufficient capacity from the 65th percentile week to the 85th.
- Focus in Q1 on introducing a Rapid Lung and Lower GI pathway, modelled on the success of the prostate work (and using similar seedcorn funding from Royal Marsden partners) to resource a frontloaded pathway to ensure that we are able to make decisions or referrals earlier based on straight to test pathways. We will also review the diagnostic pathway for Lung and Upper GI, and are seeking to introduce Endobronchial Ultrasound and Endoscopic Ultrasound testing within the trust to reduce the

time spent in handovers and external delays.

It is our assessment that consistently seeing patients earlier in the pathway, focusing on reducing the number of handoffs for diagnostic testing and redesigned pathways will deliver the 38 day cancer standard. In addition, we are already focused on the 28 day rapid diagnostic standard due to be introduced in 2020 – 21. Our plans outlined above will support this, but the increase in radiology capacity – particularly MRI – in 2019-20 will be key, as will be the review of the diagnostic workforce in the round.

### Challenged Specialties

The detailed capacity planning conducted to date has ensured that the Trust has a broadly stable waiting list, and is capable of achieving the 62 day cancer standard. However, the modelling has identified the correct shape of clinical workforce required for stability, and a small number remain out of balance at present, although each has a specific action plan.

Two years ago, we identified a number of specialties for which the demand and capacity gap was significantly challenged, namely; dermatology; gastroenterology; cardiology; neurology; respiratory and ENT. Subsequently, an operational plan was developed to recruit additional consultant and nursing staff to these posts, the plan consisted of an immediate remedial plan and a long term strategy to develop and recruit to substantive roles. Whilst we have had some success in identifying immediate remedial plans, it proved challenging to recruit staff in these areas in the first year. However we have now appointed substantively in dermatology and we have recently appointed a joint neurologist in conjunction with another tertiary provider. We have a longer term strategy for gastroenterology, in the meantime we have been able to attract staff to some additional sessions and by doing so we have significantly reduced the capacity gap. We are now reviewing the balance of acute medicine and endoscopy in the Gastro team to determine whether a more formal separation of acute and planned medicine would make the roles more attractive. In ENT - we have also recently recruited a third locum surgeon. Cardiology remains pressured and is currently supported by locum appointments whilst we undertake a full review of our cardiology service for both elective and non-elective pathways.



Radiology remains a challenged specialty, not simply due to the availability of equipment. Our sonography team is only 50% recruited, whilst the competing demands of a nearby tertiary teaching hospital make recruitment to the consultant radiologist workforce challenging, combined with a number in the team approaching retirement. We will review the recruitment and delivery models for each radiology sub-group as part of the capital programme in year.

Our demand and capacity analysis for 19/20 has highlighted some new gaps in orthopaedics, oral surgery, general surgery and urology. Some of this is driven by a significant increase in TWR referral. We have recently appointed a general surgery associate specialist, with further plans to develop a fifth colorectal consultant post. We are out to recruitment for a locum urologist. We have recently appointed two locum orthopaedic surgeons for upper and lower limb and we have appointed an oral surgery staff grade. We expect these plans to improve the resilience of our capacity plans for 19/20.

## QUALITY PLANNING

### 1. Approach to Quality Improvement, Leadership and Governance

In January 2018, the Care Quality Commission (CQC) undertook an announced inspection of the Trust. Subsequently, the Trust was rated overall as ‘Requires Improvement’. Within the inspection report the total number of domains across core services rated as ‘Good’ increased from 44 to 64. Four domains, previously rated as ‘Inadequate’, improved their ratings to ‘Requires Improvement’. Following receipt of the report, the Trust developed a wide ranging action plan to address the corporate and divisional areas of concern raised.

The Trust received an unannounced inspection by the CQC in October 2018. The inspection report was published in January 2019. Within the report, the total number of domains across core services rated as 'Good' increased from 64 to 70. The overall ratings for two core services increased from 'Requires improvement' to 'Good'. The overall rating for the 'Well-led' domain for Epsom General Hospital increased from 'Requires improvement' to 'Good'. In response to inspection reports, the Trust will develop and progress wide ranging action plans to address the corporate and divisional areas of concern raised within the reports.

Scrutiny and delivery of action plans is underpinned by a robust governance process and all leads are required to demonstrate appropriate progress prior to closure or ongoing monitoring.

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

The Trust's named executive lead for quality improvement is Dr Ruth Charlton, Joint Medical Director and Deputy Chief Executive. In leading this work Dr Charlton is supported by her executive colleagues, five Associate Medical Directors, Clinical Quality leads within Divisions and an Associate Director of Quality who leads and manages the Trust's corporate quality team. QI priorities are identified annually as part of the Trust corporate priorities. As such they are monitored formally via our Trust BAF and reported via Board committees to the Trust Board. Examples of the positive impact of QI include development of and recruitment to critical care outreach, enhanced time to administration of IV antibiotics in the ED, over 90% of acute admissions being seen within 14 hours by a consultant and the embedding or mortality reviews across the organisation

The Trust protects clinical staff time to attend Divisional 'Quality Half Days'. These days have built on previous audit time to create an opportunity for clinical staff to discuss more widely the quality issues within their areas. While audit remains a fundamental, the wider discussion links and triangulates the quality areas with learning from incident investigations, mortality reviews, patient feedback, audit and risk. Discussions are supported by Quality Reports produced by embedded Quality Managers for Divisions Education of clinical staff remains important in building improvement capacity and capability to sustain change and the Trust has integrated the education of our nurses, midwives, medical staff and allied health professionals.



The Trust recognises that having a structured approach to Quality Improvement yields significant benefits across all aspects of quality and performance and productivity, as demonstrated by those who have adopted formal approaches such as Virginia Mason. During 2019/20 the Trust will review and refresh its own arrangements to ensure that we are better able to apply these techniques in a more consistent and rigorous manner. As a first step, the Trust will commence the Board Quality Improvement Development Programme sponsored by NHSI.

## 2. Summary of the Quality Improvement Plan (including compliance with national quality priorities)

### Existing Quality Concerns and Plans to Address

Our corporate priorities on pages 2 and 3 identify the key quality challenges that we will tackle in 2019/20.

### The Top Risks to Quality and how the Trust is Mitigating

The top four risks to quality, as laid out in our corporate risk register together with mitigations, are:-

- Staffing
- Variability in quality of care
- Estates and infrastructure
- Finances

The December 2018 version of the Corporate Risk Register can be found at:-

https://www.epsom-sthelier.nhs.uk/download.cfm?doc=docm93jijm4n10100.pdf&ver=24981

### How learning from relevant national investigations has or will be implemented, including Gosport

In response to the Gosport inquiry, the Trust revised its processes regarding the use of opiates in end of life care (EOLC).

1. The Trust provides EOLC teaching, as part of mandatory induction, to all new training doctors joining the Trust twice a year (in August and February). This teaching includes how to access advice and guidance about anticipatory prescribing in the last hours and days of life, and that specialist support (including advice about syringe pump medication and doses) is available through 7-day face-to-face service 9-5pm and consultant advice 24 hours a day including out of hours and bank holidays.
2. Audits of prescribing of EOLC anticipatory medication were completed in 2016 and 2017 and the results and action plans were presented at the Trust Quality half days. Another audit is planned for April 2019.
3. Syringe pump teaching is undertaken at Palliative Care Study Days, and also at ward level for individual patients.
4. There is a plan to develop national guidance for best practice anticipatory prescribing, and the Trust will be part of this and monitor progress.
5. We advise patients, relatives and ward staff that the ward nurse should assess the patient for reversible causes of pain/distress (such as full bladder, bowels, re-positioning in bed, mouth care) before considering administering 'as needed' medication.
6. To prevent inadvertent inappropriate use of the high doses of Morphine , the Trust never does anticipatory prescribing of morphine for a syringe pump or driver.
7. EOLC anticipatory medications for patients identified by a clinical team as in the last hours or days of life (ePMA) include 'as needed' low dose subcutaneous medications for the most common symptoms that may be experienced by a patient at the end of life; pain, nausea/vomiting, restlessness, excess airway secretions, agitation. This ensures that the patient can receive medication promptly to alleviate discomfort and distress at the end of their lives, should they occur.
8. The morphine dose (for opioid naive patients) is 2.5mg subcutaneously. In addition, all anticipatory medications are accompanied by the instructions that there needs to be a doctor review if >3 doses are required in a 24 hour period.
9. We do not use diamorphine at the Trust.
10. The Trust has a number of Nurse/HCA EOL Ward Champions, who have their own Study Days and CNS support to ensure that they have advanced awareness of the management of EOLC patients and medications used.
11. There is a project on-going to improve nursing documentation. Assessment of pain and the use of pain tools for patients with different needs is included in this review as is assessment and care planning with patients who need EOLC.
12. The nursing documentation work is also seeking to highlight the importance of good record keeping and as part of the project, a series of audits will be developed to audit practice when the documents have been launched.
13. The Chief Nursing team does regular planned and unplanned ward and department visits and uses these visits to encourage staff to highlight any concerns they may have regarding the delivery of care to patients.
14. Every ward/department has a poster with the telephone numbers for the Chief Nurse and Deputies, so that they can be contacted by staff or members of the public who may have any concerns regarding patient care or any other issues on the wards.



### 7 Day Hospital Services

Results from the seven day service audit which took place in March 2018 along with data collected for the February 2019 Board Assurance Framework, demonstrate that the Trust is fully compliant against clinical standard 2. Overall 91% of patients received a consultant review within 14 hours of admission to hospital

across the seven days. The weekday average for patients receiving a consultant review within 14 hours of admission was 91%, whilst the weekend average was 90%.

Overall the Trust is compliant with clinical standard 5, access to diagnostics, and clinical standard 6 access to interventions. The majority of diagnostic tests and interventions are available either on or off site via formal arrangement. The only exception to this is Echocardiology which is not currently available at the weekend either within the Trust or by a formal arrangement externally, however access can be sought for emergency cases on an ad hoc basis when required.

Results from the March 2018 audit indicated that the Trust is compliant against clinical standard 8 (twice daily reviews). 100% of audited patients who required a twice daily review on a weekday received both reviews. The audit sample size was small, however additional assurance has been given by the clinical leads that ward rounds take place at least twice daily for patients with high dependency needs and that there is a robust structure in place to ensure these take place. A recommendation was made as part of the March 2018 audit that in the next audit cycle, due to take place in spring 2019, an additional audit would take place to specifically assess if ward rounds are taking place in high dependency units twice daily. This will ensure a larger sample size to provide more robust evidence.

For standard 8, the March 2018 audit indicated that only 79% of patients on a Saturday and 76% of patients on a Sunday, who required a once daily consultant review, received one. This falls short of the required national standard of 90%. Data indicated that surgical areas were the poorest performers, however since the audit a number of improvements have been made across the Trust. The new surgical assessment unit has opened at St Helier meaning patients are more centrally located which should help to increase the efficiency of daily ward rounds across surgery as well as improve patient flow and outcomes. A new ward round proforma has also been introduced to ensure ward round information is being accurately captured. It is anticipated that the audit scheduled for spring 2019 will demonstrate compliance with this standard.

A seven day service steering group has been established which meets quarterly to inform and advise the Trust Board on whether the four priority standards for Seven Day Service standards are being met.



### How are we learning from deaths?

The Trust policy 'Policy for mortality reporting and mortality peer review process' details the requirements of a mortality review process supporting Divisions to adopt the principles of routine and systematic mortality review. The Trust aspires to all deaths being reviewed and progress is monitored through the Trust Reducing Avoidable Death and Harm (RADAH) Committee.

The Trust review process is at two defined levels:

- Level one: Clinical team review documentation to identify those patients that will go on to a higher, level two, review

- Level two review: A higher level of review that is performed by trained staff using a specific methodology (Structured Judgement Review). Cases for review include:

    - deaths where the bereaved or staff raise significant concerns about the care
    - deaths of those with learning disabilities or severe mental illness
    - deaths where the patient was not expected to die

The Trust has designed a report to support staff in identifying deaths that require a level one mortality review based on agreed case selection criteria. The report is available via the Trust Intranet and automatically updates each day with information from iPM and the level one mortality review data recorded on clinical documents.

The outcome of Structured Judgement Reviews, including associated learning, is fed back to teams through local governance processes. Any case where care concern and harm are identified will be raised as an incident through the Trust risk management system.

The Trust has a number of trainers who can support the training of staff in the process of Structured Judgement Review and work is ongoing to support training clinical staff to complete these reviews.

The Trust has appointed 5 clinicians to work part time as mortality reviewers. These staff will undertake daily reviews of all deaths within the organisation to determine if cases meet the threshold for structured judgement review or Root Cause Analysis in addition to initial mortality review. During the year 2019/2020 the Trusts plans to progress implementation of the Medical Examiner role.

### Plans to reduce gram-negative blood stream infection

We have the ambition to reduce gram negative blood stream infections by 50% by 2021.

As part of the government's plans to reduce E coli BSIs, a joint improvement plan with Sutton & Merton CCG IPC Lead Nurse has been developed and work on some of the recommendations has been implemented. Part of this plan is to raise awareness about E coli BSIs particularly in catheter care management and diagnosis and management of urinary tract infections (UTIs). There is a planned audit to get baseline data for UTI diagnosis and management across the Trust. The audit, which is a joint audit in collaboration with a Care of the Elderly Consultant and Urology nurse, should start in early February 2019. The Infection Control Lead Doctor is also supporting an ED doctor who is collecting data on UTI diagnosis/management in ED for her MSc. This data will help to inform any changes required.

Trust acquired E coli BSI surveillance and entering of risk factor data on the PHE data capture system was commenced in October 2018. Real time feedback and lessons learned is given to relevant staff at the time of the review. Data is analysed to determine trends and likely source of infection by the IPC Team and reported quarterly to all Divisions at the Infection Prevention & Control Committee.



In addition to E coli, the Trust continues to report on Klebsiella species and Pseudomonas aeruginosa BSIs to the PHE data capture system (DCS).

### Embedding of NEWS2 within the Trust

NEWS is currently well embedded across the Trust and plans are in place to roll out NEWS2 in early March 2019. The roll out is set for 6th March, 11am. A weekly steering group has been meeting since early January. The group is chaired by a Deputy chief Nurse, and the focus is on ensuring safe implemntation of NEWS2. Engagement has been good across all disciplines. Ward based champions have been identified and have received additional training to support the clinical areas on the day of roll out. The Royal College of Physicians Training tool has been used for all staff training and good assurance has been received around uptake of the training. Trust wide communications have further supported this work with a series of E-updates, bulletins, screensavers, posters and FAQs highlighting key changes, additional resources, training and contacts for further support.

This will be supported by use of the Royal College of Physicians' training tool for all staff groups and a system of local champions to support services on the ground. The communications strategy is a key element to the roll out plan with emphasis on simple core messages regarding differences between NEWS and NEWS2, timelines and available support mechanisms.

The Trust participates in the South London Collaborative for Management of the Deteriorating Patient, which has positively influenced the current roll out plan through a process of shared learning and feedback from early implementers.

The Chief Nurse is the executive sponsor for the project and the project lead provides regular assurance into core Trust quality meetings. There is good engagement from key groups of clinicians across the Trust, which is pivotal not only to roll out but to embedding the system in the longer term and its interface with

other key aspects of work such as Sepsis, development of the outreach team and roll out of the Care Flow system.

### Long Term Plan and relevant quality initiatives

Following publication of the Long Term Plan, the Trust is working with partners and stakeholders in Surrey and SW London to ensure a cohesive approach to delivery.

## 3. Summary of the Quality Impact Assessment Process and Oversight of Implementation

### The Governance Structure for CIPs

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

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

At the end of the financial year, each division is expected to report back to CAP to outline the quality impact arising from the implementation of each scheme. There is a tracker to monitor the assurance process for each scheme. Detailed minutes are shared with our local CCGs and comments invited. The CAP is a standing agenda item on our monthly CQRG meetings with our commissioners.



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

## WORKFORCE PLANNING

### Values and Behaviours: RESPECT

In response to a range of insights from our staff surveys and the CQC well-led review which demonstrated our staff engagement needed significant attention, in summer 2018 we launched a major staff engagement programme, 'Your voice, your values', to engage with staff about what it is like to work in our organisation and what our core values need to be. We received over 3,000 inputs from staff which has led to a proposed single value of RESPECT, for ourselves, our teams, our leaders and our patients. At the end of March we are launching our new ways of working through leadership masterclasses for everyone in a leadership or managerial position in the organisation, which will flow through in to how we recruit, manage, appraise and handle employee relations issues within the organisation. The core components are set out below:

- Ensuring that Trust leaders role model high standards of behavior and reward and appreciate respectful behaviour and ensure all poor behaviour is addressed
- Setting clear and achievable strategic aims for the organization and give people adequate tools and resources to meet their objectives
- Ensuring that decision making respects our patients and colleagues
- Enabling all our diverse teams to have regular meetings and 1:1s
- Making it safe for people to express concerns and to be heard fairly
- Creating an environment where everyone can flourish regardless of protected characteristics, profession, role or level

- Creating a safe environment for staff that is free of patient aggression

The component relating to equality, diversity and inclusion builds on the focus we have placed on this important area during 2018/19 as a response to staff survey findings and our WRES data and gender pay report. We have introduced diverse interview panels with a specific mandate that all recruitment panels for posts at band 6 and above as well as medical panels would have a BME representative as well as gender balance. For 2019/20, we will monitor the impact of this in terms of successful appointment of candidates from diverse groups through the Trust's Equality, Diversity and Inclusion Committee, established as a formal sub-committee of the Board in September 2018. We will initiate further actions to strengthen this area as required.

### Our Approach

The workforce is at the heart of delivering high quality, effective services. Having sufficient numbers of trained and motivated clinical staff (doctors, nurses and allied health professionals) on every shift 24/7 and appropriate support services is challenging. It is recognised nationally that workforce shortages are currently the biggest challenge facing the health service, and whilst the NHS Long Term plan does make reference to some new workforce programmes, most of the necessary detail has been delayed until the publication of "the comprehensive national workforce implementation plan", due to be published later in 2019.

The Trust is part of South West London (SWL) Health and Care Partnership which has a well-established collaborative workforce programme across the STP footprint which currently includes the following for 2019/20:-

- Talent Mapping
- Apprenticeships
- Workforce Modelling
- Flexible Working
- Recruitment Hub
- International Recruitment
- Nurse Progression Course
- Induction and Benefits
- ESR Optimisation



### Retention

The Trust is participating in cohort 4 of the NHSI Retention programme and from this will be developing a retention plan. Our plan will include a refreshed approach to engagement with our nursing and midwifery workforce and updating, strengthening and developing nurse and midwifery leadership at all levels. We will increase participation in the Capital Nurse programme and take a generational approach to retention, offering workforce benefits in line with the needs of the different generations of nurses and midwives in our workforce.

In addition we will increase publicity around and develop the various career development offers at Epsom and St Helier and the benefits that we offer to staff. This will include strengthening our preceptorship and professional development opportunities and the support and career opportunities that we give to students who train with us so that we are competitive in the local employment market.

We will build on our development programme for Band 5/6 to enable us to retain our experienced nursing staff and help them to progress to the next level of promotion in their career. Rotation posts have also been implemented to support staff to gain additional experience and a transfer option is in place to support staff to move between specialties rather than moving to other organisation for experience. Self-rostering is in place across wards to support flexible working.

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

The Trust will be reviewing the medical staffing models in place and introducing rotational posts for doctors at junior and middle grade levels to make them more attractive and aid staff retention. A further programme of work will be undertaken in 2019/20 to focus on the retention of medical staff and this will include working with other trusts to create rotations that will be mutually beneficial.

### Recruitment

The Trust's focus in 2019/20 will be on recruitment and retention as staffing, particularly for middle grade doctors and registered nurses, has emerged as a constraint.

As at December 2018, the Trust's vacancy rate for nursing was 15.3% against the national nursing vacancy rate of 11.6%. We note from the NHS Long Term plan the national focus to reduce this to 5% by 2028, through various measures including an increase of clinical nurse placements and international recruitment. The Trust is currently working with other partners in South West London (SWL) as part of a system wide collaboration to develop a single international recruitment strategy for SWL.

Nursing establishment is a key focus for 2019/20 with a review currently underway. To complement the review, a nursing workforce strategy will be developed and this will take account of the new clinical areas in emergency care that we are opening, expanded planned care provision, and integration with community nursing services.

We know that the skill mix of a modern workforce needs to look different to meet current challenges. Our aim is to continue to increase the extended skills of our nurses through further implementing roles such as advanced clinical practitioner and emergency clinical practitioner roles. The nursing associates that we have recently trained have now joined the workforce and will shortly be registered with the Nursing and Midwifery Council. A new cohort has recently commenced their training with us. We see these and the apprenticeship roles that we are developing as key to sustainability and enabling pathways to nursing, particularly for local people.



There is a well-established programme of open days in place to recruit registered nurses and other clinical staff. The programme includes interview training for candidates, discussions with senior managers on career opportunities as well as site tours and one stop recruitment days including all clearances and first stage offer on the day of interview.

For 2018/19 the Trust commissioned a medical workforce improvement programme, which focused on resolving staffing issues, ensuring our rotas are adequately staffed. This included a programme of recruiting and developing overseas doctors that has been extremely successful. This involved working with the royal colleges to take on doctors via the Medical Training Initiative as a longer term solution. We also introduced Physician Associate/ANP posts where possible to fill gaps in areas which had become hard to fill. The number of Doctor vacancies has reduced from 91 to 47 with robust plans to bring this down further in 2019/20.

### Staff Productivity

The Trust implemented e-rostering for medical establishments, absence management and temporary staff management. This allowed the Trust to manage all medical staffing, both substantive and temporary, on one system, increasing transparency and supporting planning and utilisation. The Trust's approach to medical rostering has ensured consistency of approach to medical rosters and greater transparency of staff utilisation and planning.

In 2018/19 the Trust made considerable efforts to its medical staffing vacancies using innovative approaches to recruitment. Challenges remain with filling medical vacancies within ED and Peadiatrics specialties and this will be an area of focus for 2019/20.

The Trust continues to work towards the implementation of theatre utilisation through the rostering system in 2018/19. This will ensure that there is clear planning for all theatre slots of the correct teams and

any gaps or leave commitments can be easily identified and managed. It will also link theatre plans, consultant job plans and medical and nursing rosters on the one system.

### Temporary Staff

The Trust already has in place a comprehensive bank covering all staff groups that centrally manages all temporary staffing bookings. The Trust's CEO is the executive lead and senior responsible officer for the South West London Collaborative Bank, which in phase one will allow nursing staff to work across all SWL Trusts through a single booking system and App which encourages the booking of bank first over agency. The Trusts have harmonised recruitment, rostering processes, pay rates compliance processes. Staff are only required to undertake one on-boarding process to be able to work anywhere in South West London via the App. The focus in 19/20 will be to work collaboratively to harmonise bank rates for other groups such as specialist nurses and AHPs. The Trust will also be working with other Trusts within the sector to reach a capped rate card for medical locums to enable a consistent approach between Trusts within the SWL Collaborative health economy.

### Workforce Planning

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

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



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

Drawing all the strands of Workforce together in to a coherent People Strategy will be undertaken in 2019/20.

## FINANCIAL PLANNING - financial plan 2019/20

### 1. Control Total 2019/20

1.1. The Trust's Control Total for 2019/20 is a deficit of **£6.7m** after PSF, FRF and MRET. The 2019/20 plan shows how the Trust will achieve the Control Total**.** As a result of accepting the Control Total, the Trust will receive the following funding directly from DHSC:

- **£7.8m** Provider Sustainability Funding (PSF)
- **£14.8m** Financial Recovery Funding (FRF)
- **£3.4m** Marginal Rate Emergency Tariff (MRET) Funding

1.2. The Trust has concluded contract discussions with CCGs within South West London STP and Surrey Heartlands ICS. The Trust has an organisational Control Total however it has agreed a governance framework to deliver a system Control Total which includes delivering both the Trust and Commissioners' financial targets.

### 2. Financial forecast outturn 2018/19

2.1. The Trust is forecasting to improve on its 2018/19 pre-PSF control total of **£28.2m**, by £1.9m. Due to a number of non-recurrent adjustments and full year effects, the forecast recurrent outturn for 2018/19 is a deficit of **£36.5m,** an improvement of £0.7m on the prior year.

2.2. The 2018/19 forecast outturn was assessed using the Month 11 actuals. Within this position the Trust has certainty over its income, having secured year end deals with its two main commissioners- Sutton CCG, Surrey Downs CCG and NHS England. In terms of expenditure, the Trust's overall pay costs are relatively stable. However this represents a mixed position whereby steadily increasing nursing pay costs are being offset by an ongoing reduction in medical pay costs:

- Increasing nursing costs are driven by higher temporary nursing staff due to increased staff on wards: a quality improvement that is part of an NHSI assessed nursing review;
- The ongoing reduction of Medical Staff temporary costs is due to the recruitment strategy to recruit to hard-to-fill posts. This has reduced the Trust's use of temporary staff as staff are recruited on a permanent basis to posts, driving a year-on-year downward trend in medical staff locum and agency costs.



2.3. Non-pay costs have been relatively constant over the year but increase significantly in Quarter 4 following the 1st January 2019 start of one of the Trust's integration contracts with Surrey partners- Integrated Dorking, Epsom and East Elmbridge Alliance (IDEEA)- a partnership that brings together three GP federations covering all of the GP practices of Surrey Downs, with Central Surrey Health, and the Trust as host. The Trust will host the **£22m** annual contract on behalf of the provider alliance.

2.4. CIP schemes for 2018/19 are **£13.9m** (circa **3.0%**) out of a total target of **£17.0m**, including FYEs of **£2.2m**. The table below sets out a summary of the 2018/19 CIP delivery.

***Table 1 – 2018/19 forecast CIP delivery by theme***

| Savings Theme | Forecast 2018/19 £'k |
|---|---|
| Clinical Administration | 790 |
| Corporate Administration | 424 |
| Estates & Facilities | 198 |
| Income - Other | 401 |
| Management | 110 |
| Medicines Management | 311 |
| Non Pay - Clinical | 1,768 |
| Non Pay - Other | 850 |
| Pathology | 627 |
| Patient Pathway | 23 |
| Priority Based Budgeting- Surgery | 2,353 |
| Procurement/Carter | 932 |
| Efficiency from additional elective activity | 995 |
| Workforce - AHPs | 340 |
| Workforce - Medical Staffing | 304 |
| Workforce - Nursing | 1,268 |
| **Sub-Total** | **11,694** |
| Full year effect 2017/18 | 2,220 |
| **Total** | **13,914** |

***2.5.*** The 2018/19 forecast recurrent outturn is a deficit of **£36.5m**. The bridge from the forecast outturn of **£13.3m** to the forecast recurrent outturn of **£36.5m** is shown in Table 2 below and described in more detail in the section below.



***Table 2 – Bridge from 2018/19 Forecast outturn to 2018/19 forecast recurrent outturn***

| | | Income £'k | Pay £'k | Non Pay £'k | Total (NHS Performance) £'k |
|---|---|---|---|---|---|
| **1** | **Forecast Outturn 2018/19 NHS Performance incl PSF** | **-423,900** | **281,718** | **155,511** | **13,329** |
| 2 | Provider Sustainability Funding | 12,953 | 0 | 0 | **12,953** |
| **3** | **Subtotal Forecast Underlying outturn 2018/19 excluding PSF** | **-410,947** | **281,718** | **155,511** | **26,282** |
| **4** | **Non-recurrent** | | | | |
| 4.1 | Income block impact | -2,109 | 0 | 0 | **-2,109** |
| 4.2 | Profit on Disposal of Land | 0 | 0 | 12,827 | **12,827** |
| 4.3 | RAPID and Diagnostics | 641 | -185 | 0 | **456** |
| 4.4 | Other Non Recurrent Patient Care Income | 1,861 | 0 | 0 | **1,861** |
| 4.5 | Surrey Downs Stroke Service | 500 | -500 | 0 | **0** |
| 4.6 | Q4 IDEEA Contracting | -248 | 0 | 0 | **-248** |
| 4.7 | Other Non Recurrent | 1,306 | -6,102 | -5,908 | **-10,704** |
| | **Total Non-Recurrent Adjustments** | **1,951** | **-6,787** | **6,919** | **2,083** |
| 5 | **Full Year Effects** | | | | |
| 5.1 | IDEAA | -16,682 | 1,318 | 15,897 | **533** |
| 5.2 | SH&C | -2,022 | 0 | 2,469 | **447** |
| 5.3 | Drugs Adalimumab | 1,258 | 0 | -1,258 | **0** |
| 5.4 | RTT | 0 | 436 | 0 | **436** |
| 5.5 | Other Full Year effects | 461 | 6,033 | 262 | **6,756** |
| | **Total Full Year Effects** | **-16,985** | **7,788** | **17,370** | **8,172** |
| **6** | **Forecast Underlying outturn 2018/19** | **-425,981** | **282,719** | **179,800** | **36,538** |

## 3. Recurrent Forecast Outturn 2018/19

3.1. The Trust is forecasting a recurrent outturn of **£36.5m deficit,** an improvement on the prior year of £0.7m.

**3.2. Non recurrent income and expenditure:** The following paragraphs set out the non-recurrent income and expenditure within the 2018/19 bridge.

3.2.1. **Provide Sustainability Funding**- available PSF of **£14.5m** has not been fully achieved in 2018/19. The Trust did not achieve Quarters 1, 3 and 4 A&E target. This is a total of **£3.5m** PSF not achieved. The Trust has assumed the financial element of PSF will be received in full. The Trust has accounted for 1:1 incentive funding of £1.9m for exceeding the pre-PSF Control Total by this value.

3.2.2. **Income block impact**- The Trust had a block contract for non-elective activity with its two main commissioners in 2018/19. Overall the Trust delivered £2.1m more activity than agreed in the block and this activity is included in the opening contract baseline for 2019/20 contract negotiation. Therefore the impact of the block is removed as a non-recurrent item.

3.2.3. **Land sale**- The Trust has two land sales that completed in 2018/19 totalling **£12.8m** profit on disposal:

- **Sale of land at Sutton Hospital to London Borough of Sutton**. This sale has concluded and delivered proceeds of **£2.1m** and profit on disposal of **£0.7m**. Proceeds equivalent to the Net Book Value of the sales proceeds were used in full to partially repay an ITFF capital loan and the profit on disposal was as per the 2018/19 plan to contribute to achieving the Control Total.
- **Sale of land at Epsom General Hospital to a private sector purchaser following open market competition** – As described above the sale completed in Quarter 4. Sales proceeds were **£18.5m** and profit on disposal is be **£12.1m**. Sales proceeds equivalent to the Net Book value of **£5.2m** were utilised in full to partially repay the Trust's ITFF capital loan.



3.2.4. **Rapid and clinical services diagnostics** – The Trust received pump priming funding of **£0.6m** above tariff to invest in the pathway and this will not be repeated in 2019/20.

3.2.5. **Stroke Service Surrey Downs**- The CCG invested **£0.5m** in staffing costs to support the service in 2019/20 but the income will not be repeated.

3.2.6. **Q4 IDEEA**- **£0.3m** of non-recurrent commissioner deductions to contract values will not re-occur.

3.2.7. **Other Non-recurrent** - includes increased annual leave accrual due to one-off increase in the maximum number of days of annual leave that can be carried forwards to 10.

**3.3. Full Year Effects. The following paragraphs set out the full-year-effects within the 2018/19 bridge.**

3.3.1. **IDEAA**- Contract started on 1st January and full year effect on income and costs is **£16.7m**.

3.3.2. **Sutton Health & Care**- The service started in July 2018 and the full year effect on income is **£2.0m**.

3.3.3. **Drugs Adalimumab** – This drugs cost has a full year effect saving. This is a pass through drug that reduced significantly in price part way through 2018/19. The benefit to the system (flowing to the commissioner) is **£1.4m**.

3.3.4. **RTT** – The Trust undertook a number of initiatives to achieve Waiting List targets in 2018/19 and this is the full year effect of **£0.4m** permanent staffing changes put in place to support higher levels of activity, funded through tariff.

3.3.5. **Other Full Year effects** – total **£0.5m** income and **£6.3m** expenditure.

## 4. Efficiency Savings 2019/20

4.1. The Trust has set a target of **£15.4m** (**3.1%**) of 2019/20 CIPs. This comprises **0.5%** additional CIP to reduce the underlying deficit, **1.1%** tariff efficiency and **1.5%** further CIP to fund the inflationary cost pressures and local cost pressures. Full year effects of the 2018/19 programme are **£0.4m** of CIP.

4.2. The Trust has been developing a CIP programme that has identified **£9.2m (60%):** new schemes (£8.9m) and full year effects (£0.4m); against the **£15.4m** target. Total unidentified CIP target is **£6.1m**. All identified schemes are assessed through the Trust's CIP Gateway process and the table below shows the level of maturity of the identified schemes.

***Table 3 – Summary of Identified CIP by gateway***

| Maturity of schemes Gateway | description | CIP Plan £'k | % |
|---|---|---|---|
| **1** | Opportunity | 2,748 | 18% |
| **2** | Development | 5,291 | 34% |
| **3** | Implementation | 122 | 1% |
| 4 | Fully developed | 709 | 5% |
| 5 | Full year effects 2018/19 | 360 | 2% |
| | | **9,230** | **60%** |
| | Unidentified | **6,130** | **40%** |
| | | **15,360** | **100%** |

4.3. The CIP plan is expanded in the table below to show themes by Gateway.

***Table 4 – CIP Themes by gateway***

| Trust Efficiency Theme | Unidentified £'k | Opportunity £'k | Development £'k | Implementation £'k | Fully Developed £'k | Total £'k |
|---|---|---|---|---|---|---|
| Clinical Administration | | 63 | 312 | - | - | 375 |
| Corporate Administration | | 272 | - | - | - | 272 |
| Estates & Facilities | | 37 | 803 | - | - | 840 |
| Income - Other | | 1,006 | 24 | - | - | 1,030 |
| Medicines Management | | 166 | | 9 | - | 175 |
| Non Pay - Clinical | | 629 | 921 | 63 | - | 1,613 |
| Non Pay - Other | | 35 | 13 | - | - | 48 |
| Pathology | | 200 | 98 | - | - | 298 |
| Patient Pathway | | - | 620 | - | - | 620 |
| Private Patient Income | | 15 | 1 | 50 | - | 66 |
| Procurement/Carter | | - | 1,422 | - | 709 | 2,131 |
| Workforce - Medical Staffing | | 310 | 885 | - | - | 1,195 |
| Workforce - Nursing | | 15 | 192 | - | - | 207 |
| Unidentified | 6,130 | | | - | - | 6,130 |
| **Sub-Total** | **6,130** | **2,748** | **5,291** | **122** | **709** | **15,000** |
| Full year 2018/19 | - | - | - | - | 360 | 360 |
| **Total** | **6,130** | **2,748** | **5,291** | **122** | **1,069** | **15,360** |
| **Percentage of overall plan** | **40%** | **18%** | **34%** | **1%** | **7%** | **100%** |

4.4. Key steps in the development of the 2019/20 Efficiency Programme have included:

- Divisions have developed efficiency plans as part of their 2019/20 business planning process, identifying **£4.4m**;

- Procurement schemes identified are **£2.0m**;
- There have been two Trust Executive Committee workshops to develop Trust-wide schemes that have resulted in the following five work-streams as shown in the table below at **£2.9m**:

***Table 5 – Trust Wide CIP Scheme***

| | Trust Wide Schemes | CIP Plan £'k |
|---|---|---|
| **1** | Length of Stay Programme | 600 |
| **2** | Outpatient Improvement and Efficiency Programme | 1,242 |
| **3** | Clinical Support Services – Aligning to decision making | 400 |
| 4 | Corporate Services | 636 |
| | | **2,878** |

4.5. As part of the Trust's established governance process all schemes are assessed against Gateway criteria. The following has been put in place to assess the robustness/deliverability of all identified schemes:

- The Clinical Assurance Panel (CAP) is being held weekly until April 2019 so that all identified schemes even at an early stage in their development have been reviewed by the panel to provide an early indication of any concerns raised by the panel;
- All Clinical Divisions and Estates & Facilities will have presented their identified schemes to CAP prior to the submission of the draft plan;
- The schemes are reviewed with the Chief Financial Officer (CFO) at the regular CFO meetings to test their robustness;
- The CFO reports regularly to the CIP Programme Board on the status of the Efficiency Plan including risks to delivery;
- Leads attended the CIP Programme Board to report on progress and financial benefits
- To support the above the PMO are working with the divisions to populate scheme workbooks.



4.6. Key next steps include:

- Trust-wide Work-streams
- Agree governance arrangements
- Develop workbooks to monitor and report on delivery of the workstreams
- Regular updates to CIP Programme Board:
- Regularly review progress with the identification and development of new schemes
- Provide support to divisions
- Weekly progress meetings with CFO
- Regularly review progress with the development of schemes and test their robustness
- Clinical Assurance Panels to review new schemes in February/March
- Trust-wide work-stream leads to present their schemes
- Corporate Services to present their schemes.
- Clinical Divisions to return with their schemes
- Completion of workbooks
- The PMO to continue to work with the divisions to complete workbooks (planning) to allow the divisional management teams to sign off their schemes – key step to allow schemes to move to Gateway 3 Implementation.

## 5. Financial Plan 2019/20

***5.1.*** As stated above the Board has accepted the Control Total to deliver a **£6.7m** deficit.

***Table 6 –Financial Plan 2019/20***

| | | Income £'k | Pay £'k | Non Pay £'k | Total (NHS Performance) £'k |
|---|---|---|---|---|---|
| **1** | **Forecast Underlying outturn 2018/19** | **-425,981** | **282,719** | **179,800** | **36,538** |
| **2** | **Tariff changes 2019/20** | | | | |
| 2.1 | CQUIN moved into tariff | -4,084 | 0 | 0 | **-4,084** |
| 2.2 | CQUIN previously earned | 3,516 | 0 | 0 | **3,516** |
| 2.3 | PSF moved into tariff | -6,713 | 0 | 0 | **-6,713** |
| 2.4 | MFF Year 1 reduction | 159 | 0 | 0 | **159** |
| 2.5 | Other Tariff impacts | 789 | 0 | 0 | **789** |
| 2.6 | MRET from DHSC* | -3,353 | 0 | 0 | **-3,353** |
| 2.7 | National cost pressures | -9,837 | 10,313 | 2,477 | **2,953** |
| 2.8 | AFC Pay Awards move from DHSC to Tariff | -3,497 | 0 | 0 | **-3,497** |
| 2.9 | AFC Pay Awards paid directly in 2018/19 | 3,613 | 0 | 0 | **3,613** |
| 2.10 | CNST/ PES/ LTPS | 2,339 | 0 | 366 | **2,705** |
| 2.11 | CIP to fund tariff efficiency 1.1% | 3,594 | -3,110 | -2,225 | **-1,741** |
| 2.12 | Procurement top slice from contracts | 1,176 | 0 | 0 | **1,176** |
| | Net Tariff Impact 2019/20 | **-12,298** | **7,203** | **617** | **-4,478** |
| | **Plan subtotal after tariff and other uplifts** | **-438,279** | **289,922** | **180,417** | **32,060** |
| **3** | **Other Planning changes 2019/20** | | | | |
| 3.1 | Removal of resilience funding | 872 | 0 | 0 | **872** |
| 3.2 | Demographic Growth | -2,976 | 0 | 1,628 | **-1,348** |
| 3.3 | Repatriation | -1,203 | 0 | 417 | **-786** |
| 3.4 | Drugs Growth | -1,086 | 0 | 1,324 | **238** |
| 3.5 | QIPP | 3,784 | 0 | 0 | **3,784** |
| 3.6 | Increase in SWLEOC Plan | -821 | 0 | 653 | **-168** |
| 3.7 | Sexual Health new Service | -1,396 | 1,314 | 82 | **0** |
| 3.8 | RTT Maintenance | -3,686 | 1,956 | 0 | **-1,730** |
| 3.9 | Sutton Community Service | -18,241 | 13,563 | 4,678 | **0** |
| 3.10 | Acute Therapies | 0 | 2,364 | -2,364 | **-0** |
| 3.11 | Pricing changes | -1,159 | 0 | -1,100 | **-2,259** |
| 3.12 | Service Developments | -233 | 233 | 0 | **0** |
| 3.13 | Frimley Renal Service | 561 | 0 | 0 | **561** |
| 3.14 | Financing Costs/ Capital Charges | 0 | 0 | 1,172 | **1,172** |
| 3.15 | Local Cost Pressures | 0 | 6,531 | 2,355 | **8,886** |
| 3.16 | CIP required to receive FRF (0.5%) | -92 | -1,443 | -768 | **-2,302** |
| 3.17 | CIP to fund pressures | -293 | -4,608 | -2,454 | **-7,355** |
| 3.18 | Other Planning Changes | -3,496 | 0 | 0 | **-3,496** |
| | **Recurrent Plan 2019/20** | **-467,744** | **309,832** | **186,041** | **28,129** |
| **4** | **Non-recurrent planning changes 2019/20** | | | | |
| 4.1 | POLCE penalties | 454 | 0 | 0 | **454** |
| 4.2 | CNST Maternity Incentive Scheme | 0 | 0 | 728 | **728** |
| 4.3 | PSF | -7,768 | - | - | **-7,768** |
| 4.4 | FRF | -14,807 | - | - | **-14,807** |
| **5** | **Financial Plan 2019/20 NHS Performance** | **-489,865** | **309,832** | **186,769** | **6,736** |
| **6** | **Control total** | | | | **6,736** |
| **7** | **Gap to Control Total** | | | | **0** |

* MRET: in 2019/20 MRET is non-recurrent however it will be incorporated in the tariff in 2020/21 and therefore will form part of the underlying position

5.2. The Trust has assessed recurrent planning changes as shown above, from an opening recurrent deficit of **£36.5m** to a recurrent plan of **£28.1m** deficit, covering the following items.

- **CQUIN moved into tariff £4.1m** – Assumes CQUIN moves into tariff at 100%.
- **CQUIN Reduction £3.5m** –1.25% CQUIN reduction.
- **PSF moved into tariff £6.7m**- A&E and Non Elective tariff assumed to reflect full PSF movement per the Control Total letter.
- **MFF Year 1 gain £0.2m** – there is an MFF rate reduction for the Trust but overall MFF values increase by £0.2m due to the new MFF rate applied to higher tariff income in Year 1 of the transition compared to the 2018/19 outturn.
- **MRET funded centrally by DHSC £3.4m** – The Control Total has been adjusted to account for the Trust receiving MRET funding equivalent to the value of penalties being reflected in the 2019/20 contracts.
- **Demographic Growth £3.0m of income** – differential growth percentages across PODs and commissioners has been applied to proposed contract values, delivering a contribution of £1.3m (45%).
- **Drugs Growth £1.1m income**- this relates to high costs drugs that are all pass through costs to the commissioners.
- **QIPP £3.8m –** No cost release assumed. Under negotiation with commissioners but the level assumed is significantly less than the QIPP proposed by both of the Trust's main commissioners.
- **Sexual Health Service £1.4m**- this is a new service transferring into the Trust, commissioned by the London Borough of Sutton.
- **RTT Maintenance- £3.7m** increased income under negotiation with commissioners for delivering ongoing higher levels of activity to retain RTT performance at March 2019 levels.
- **Sutton Community- Award of £18.2m** community contract by Sutton CCG. The contract is agreed and the service is transferring to the Trust from The Royal Marsden Hospital on 1st April 2019.
- **Pricing changes - £1.2m** net reduction in income across a range of services, of which Epsom Health & Care (£0.7m) is covered by associated cost reductions.
- **Developments - £0.2m** to cover development in diabetes service.
- **Frimley Renal £0.6m** – reimbursement of dialysis, inpatient and outpatient income to Frimley Health as per agreed contract.



5.3. The remaining recurrent changes to the plan mainly account for expenditure impacts as follows:

- National cost pressures (based on rates provided within the Tariff);
- Local cost pressures (identified and approved through Trust's internal business and financial planning); and
- CIP schemes.

**5.4. Non-recurrent planning changes 2019/20.**

5.4.1. The Trust has not included any profit on disposal of land in the plan however there are two small plots that the Trust will formally assess whether they are surplus to requirements. The Trust would seek to retain the sales proceeds (circa £1m) to reinvest in capital.

## 6. Agency Rules

6.1. The Trust's agency target has increased to £15.1m to include the two community contracts awarded to the Trust– IDEEA and Sutton Community- and both these services have high levels of

vacancies and agency usage. They will be subject to the Trust's agency approval and governance process, as detailed below:

- The Trust is a partner in the SWL Nursing Bank comprising the four Acute providers in the STP. The Bank has set common rates of pay and implemented an App enabling nurses from all Trusts to access available shifts across the STP. During 2019/20 the Bank is aiming to extend to medical staffing.
- The Trust issues weekly temporary staff usage information to budget holders and this is used as a monitoring tool to enable budget holders to take remedial action;
- The Trust is continuing to recruit nurses from overseas to supplement local recruitment.
- During 2018/19, overseas recruitment for medical staff commenced and this will continue during 2019/20.
- The Trust has put in place processes to comply with NHSI's break glass rules.

## 7. Risks

### 7.1. Continuing workforce challenges

- The Trust has experienced significant workforce challenges across clinical staffing during 2018/19. It has been particularly acute in medical staffing. This has created operational pressures and resulted in increased locum and agency costs to maintain safety and performance standards. Although there is increased focus for 2019/20, there is still a risk that in some specialities high vacancy rates will result in greater than planned locum/agency costs.

- The Trust has also experienced challenges in its nursing and midwifery workforce during 2018/19, particularly following the nursing establishment review. The Trust plans to continue to focus on recruitment and retention during 2019/20 to minimise reliance on temporary staffing. However, as with medical staffing, there is still risk that high than assumed levels of vacancies will cause an increase in agency costs. This risk has been increased as agency spend over the last quarter has been increasing.



### 7.2. Operational pressures

The Trust, in common with other acute providers, has seen unprecedented levels of activity and acuity levels during 2018/19 which has peaked during winter. The broad financial impact of this has been:

- Additional unplanned costs as the Trust has utilised escalation capacity,
- Operational managers focusing on managing these pressures resulting in less focus on delivering CIPs (management "bandwidth").

The risk for 2019/20 is that unplanned surges in emergency activity will have a similar impact on delivering the financial plan.

### 7.3. Cost Improvement Plans

- The Trust has planned for a CIP programme of £15m, and at the start of the financial year the full CIP programme has not been fully identified. There is also an implementation risk. As has happened in past years, some schemes do not deliver as planned as a result of in-year operational pressures.

### 7.4. Risk share of Commissioner QIPP

- As part of the Trust working together with the commissioners as one system, sharing financial risk, the Trust has agreed a risk share to absorb 50% of any undelivered Commissioner QIPP.

### 7.5. Cost pressures

- The Trust does not hold a contingency budget for in year, unforeseen cost pressures. In 2018/19 the Trust had a contingency budget of £1.0m which was fully utilised during the year. There is risk that any unforeseen cost pressures will have to be absorbed from existing budget.

### 7.6. Unplanned Capital Requirements

- The Trust recognises a risk from significant unforeseen capital requirements arising in year due to the age and condition of the Trust's estate that cannot be accommodated within the capital contingency. There is a risk the Trust will have to deprioritise elements of the current capital programme which may result in operational pressures that have financial consequences.

### 7.7. Increase in activity

- The Trust has entered into a block contract for all activity (except SWLEOC which is on a full PbR contract) and any activity undertaken and costs incurred will not be recovered through over-performance.

### 7.8. Community Services

- There is a risk that costs of delivering Sutton Adult Community Services and Surrey Downs Community Services will be higher than the costs assessed during financial due diligence at the tendering stage.

## 8. Capital Plan

### 8.1. Overall Programme

8.1.1. The Trust is in Year 4 (2019/20) of its five year Estates Strategy. The strategy contains a number of essential infrastructure works, development schemes and enablers for land sales, funded from a number of internal and external sources. The remaining two years of the strategy's implementation are summarised in Table 6 below and detailed in the remainder of this section.

***8.1.2.*** The overall capital plan for 2019/20 is **£35.2m** funded from depreciation, brought forward cash, ITFF loan, Mayor of London's Energy Efficiency Fund (MEEF) loans, London Energy Efficiency Fund (LEEF) loan and Wave 4 capital PDC award.



***Table 7 – Summary of Capital expenditure and Capital Funding***

| | | | 2019/20 | 2020/21 | Total |
|---|---|---|---|---|---|
| | | | £'m | £'m | £'m |
| **1** | | **Capital Funding** | | | |
| | | **Internal Funding** | | | |
| 1.1 | | Depreciation | 14.1 | 14.5 | 28.6 |
| 1.2 | | Brought forward cash | 3.0 | 0.0 | 3.0 |
| 1.3 | | Less, loan repayments | -0.8 | -3.1 | -3.9 |
| | | **External Funding** | | | |
| 1.4 | | Wave 4 capital bid (PDC) | 2.0 | 5.4 | 7.4 |
| 1.5 | | ITFF Loan (DHSC) | 4.2 | 0.0 | 4.2 |
| 1.6 | | St H Energy Loan (MEEF and LEEF) | 6.8 | 0.0 | 6.8 |
| 1.7 | | Epsom Energy Loan (MEEF) | 4.9 | 2.4 | 7.3 |
| 1.8 | | Charitable Funds - EpStH | 0.5 | 0.0 | 0.5 |
| 1.9 | | Charitable Funds - LoF | 0.5 | 0.0 | 0.5 |
| | | **Total Capital Funding** | **35.2** | **19.2** | **54.4** |
| **2** | | **Capital Expenditure** | | | |
| 2.1 | | Total internally funded capital | 16.3 | 11.4 | 27.7 |
| 2.2 | | Total externally funded capital | 18.9 | 7.8 | 26.7 |
| | | **Total Capital Expenditure** | **35.2** | **19.2** | **54.4** |

### 8.2. Capex Funding

8.2.1. The Trust's main source of internal funds over the next two years is depreciation. The available funding has been reduced to ringfence funds for loan and finance lease repayments. The Trust has also planned to utilise brought forward cash of £3.0m from excess land sales proceeds delivered above plan in 2018/19. This is set out in the table below.

***Table 8 - Routine Capital Investment Funding Sources 2019/20 and 2020/21***

| | | 2019/20 £'m | 2020/21 £'m | Total £'m |
|---|---|---|---|---|
| 1 | Depreciation | 14.1 | 14.5 | 28.6 |
| 2 | Brought forward cash | 3.0 | 0.0 | 3.0 |
| 3 | Less, loan repayments | -0.8 | -3.1 | -3.9 |
| | **Total** | **16.3** | **11.4** | **27.7** |

8.2.2. All of the Trust's external loan funding sources are contractually agreed. The PDC has been approved and award is subject to approval of the OBC and FBC. Development of the OBC is underway. The Trust has also planned two schemes partially funded by donations: The first donation for £500k is a legacy which the Trust will use as planned for a refurbishment of the local renal dialysis unit; the second donation is for £460k from the League of Friends to refurbish the Epsom Atrium. Funding sources are set out in the table below.

***Table 9 -External Capital Financing Sources 2018/19 and 2019/20***

| | | 2019/20 £'m | 2020/21 £'m | Total £'m |
|---|---|---|---|---|
| 1 | ITFF Loan (DHSC) | 4.2 | 0.0 | 4.2 |
| 2 | Wave 4 capital bid (PDC) | 2.0 | 5.4 | 7.4 |
| 3 | St H Energy Loan (LEEF/MEEF) | 6.8 | 0.0 | 6.8 |
| 4 | Epsom Energy Loan (MEEF) | 4.9 | 2.4 | 7.3 |
| 5 | Charitable Funds - Epsom and St Helier Charity | 0.5 | 0.0 | 0.5 |
| 6 | Charitable Funds - League of Friends | 0.5 | 0.0 | 0.5 |
| | **Total** | **18.9** | **7.8** | **26.7** |

## 8.3. Capital Expenditure

8.3.1. As noted above the capital programmes for the next two years was part of the Board approved estates strategy and any updated priorities are incorporated so that the most critical infrastructure projects are prioritised. In addition the Trust is hosting integrated community contracts for Sutton and Surrey Downs and sexual health services for London Borough of Sutton and the capital expenditure requirements of these new services have also been included in the programme for the next two years.

8.3.2. The table below sets out the capital expenditure for internally funded schemes **(£16.3m** in 2019/20 and **£11.4m** in 2020/21).

***Table 10 - Routine Capital Investment funded from Internal Sources 2019/20 and 2020/21***

| | | | 2019/20 £'m | 2020/21 £'m | Total £'m |
|---|---|---|---|---|---|
| 1 | Building | Mandatory and Statutory compliance | 1.0 | 0.5 | 1.5 |
| 2 | Building | Lift renewal programme | 0.8 | 0.8 | 1.6 |
| 3 | Building | Backlog maintenance | 0.6 | 0.6 | 1.2 |
| 4 | Building | Plant replacement | 0.3 | 0.3 | 0.6 |
| 5 | Building | Comfort cooling AHU replacement | 0.7 | 0.7 | 1.4 |
| 6 | Building | Additional MRI | 0.5 | 0.0 | 0.5 |
| 7 | Building | ITU/HDU phases 2 and 3 | 0.3 | 3.5 | 3.8 |
| 8 | Building | Day nursery phase 2 | 1.0 | 0.0 | 1.0 |
| 9 | Building | Woodcote third floor | 1.5 | 0.0 | 1.5 |
| 10 | Building | SACU completion | 0.5 | 0.0 | 0.5 |
| 11 | Building | Deck car park | 0.0 | 1.0 | 1.0 |
| 12 | Building | Changing place toilet facilities | 0.1 | 0.0 | 0.1 |
| 13 | Building | St Helier Energy Scheme | 1.2 | 0.0 | 1.2 |
| | | | **8.5** | **7.4** | **15.9** |
| | | **Medical Equipment** | | | |
| 14 | Equipment | Equipment Replacement | 2.0 | 1.0 | 3.0 |
| 15 | Equipment | Radiology Managed Equipment Service | 1.3 | 1.3 | 2.6 |
| | | | **3.3** | **2.3** | **5.6** |
| | | **Information Technology** | | | |
| 16 | Information Technology | Information Technology | **2.0** | **0.6** | **2.6** |
| 17 | Information Technology | IDEEA | **1.4** | **0.0** | **1.4** |
| 18 | Building | Contingency Fund | **1.1** | **1.1** | **2.2** |
| | | Total | 16.3 | 11.4 | 27.7 |

8.3.3. The table below sets out the externally funded schemes **(£18.9m** in 2019/20 and **£7.8m** in 2020/21).



***Table 11 -Externally Financed Capital Investment in capital plan 2019/20 and 2020/21***

| | | | 2019/20 £'m | 2020/21 £'m | Total £'m |
|---|---|---|---|---|---|
| 1 | | **ITFF Funded** | | | |
| 1.1 | Building | ITU/HDU phases 2 and 3 | 3.5 | 0.0 | 3.5 |
| 1.2 | Building | Deck car park (Epsom) | 0.7 | 0.0 | 0.7 |
| | | | **4.2** | **0.0** | **4.2** |
| 2 | | **Charitable Funds** | | | |
| 2.1 | Building | Renal dialysis Croydon fit out | **0.5** | **0.0** | **0.5** |
| 2.2 | Building | Epsom Woodcote Atrium | **0.5** | **0.0** | **0.5** |
| 3 | Building | **Wave 4 capital bid- transfer of NEECH to EGH** | | | |
| 3.1 | Building | Transfer of NEECH to EGH | **2.0** | **5.4** | **7.4** |
| 4 | | **Epsom Energy loan** | | | |
| 4.1 | Building | Epsom Energy | **4.9** | **2.4** | **7.3** |
| 5 | | **St Helier Energy Loan** | | | |
| 5.1 | Building | St Helier Energy Scheme | **6.8** | **0.0** | **6.8** |
| | | Total | 18.9 | 7.8 | 26.7 |

## 9. Cash Plan

9.1. **Forecast Cash Outturn 2018/19 -** The Trust has forecast a cash balance of **£30.2m** at 31st March 2019. The table below shows the breakdown of the forecast year end cash balance.

***Table 12 -Forecast cash balance breakdown at 31st March 2019***

| | | Forecast Cash Balance at 31/3/19 £'m |
|---|---|---|
| 1 | Brought forward cash | 3.0 |
| 2 | 2018/19 Block contract under performance | 2.3 |
| 3 | 2018/19 Exceeding Control Total | 1.9 |
| 4 | Capital creditors | 15.3 |
| 5 | STF Q3 to be repaid | 4.5 |
| 6 | LEEF St Helier Energy loan cash carried forwards | 1.3 |
| 7 | Minimum Cash balance required at 31st March 2019 | 1.9 |
| | **Total** | **30.2** |

9.2. **Capital repayments 2018/19 –** The Trust has made **£6.5m** of capital loan repayments in March 2019 to DHSC, in line with the 2017 ITFF application and Estates Strategy. This repayment was possible due to the successful completion of Epsom land sale in March 2019 and the Sutton Land sale in December 2018. The repayment is from the sales proceeds equivalent to the Net Book value of the assets sold, as follows:

- Sutton land sale proceeds **£2.1m**, Net Book Value **£1.3m**;
- Epsom land sale proceeds **£18.5m**, Net Book Value **£5.2m**

9.3. **Revenue loans 2018/19** – The Trust has planned for total revenue loans of **£105.1m** carried forward into 2019/20, as detailed in the table below

***Table 13 – Total revenue loans forecast as at 31st March 2019***

| | | Forecast at 31/3/19 £'m |
|---|---|---|
| 1 | Prior year Revenue Support Loans | 72.1 |
| 2 | Deficit Control total | 13.7 |
| 3 | 2018/19 PSF Unachieved | 3.5 |
| 4 | Exceptional working capital relating to Epsom land sale (to be repaid in 2019/20) | 9.2 |
| 5 | 2018/19 PSF earned but not received in cash (to be repaid in 2019/20) | 6.6 |
| | **Total** | **105.1** |



9.3.1. **£9.2m** of exceptional working capital support to cover the working capital pressure created by having proceeds of the 2019/20 Epsom land sale paid in two tranches, with **£9.3m** of the total proceeds to be paid 12 months after sale. The loan was received in March 2019 and will be repaid in March 2020.

9.3.2. **£6.6m** relates to PSF earned but not received in cash, which the Trust will repay when the PSF is received in 2019/20;

9.3.3. **The remaining loans (£78.7m prior year loans, £13.7m 2018/19 deficit control total and £3.5m unachieved PSF)** are normal revenue support loans which mature three years after being granted. **£37.6m** (comprising five loan agreements) will mature in 2019/20 and **£38.5m** in 2020/21: the Trust is planning for these loans to be re-financed by DHSC in 2019/20 and 2020/21 respectively.

9.4. **2019/20 Cash planning -** There are two main assumptions underpinning the Trust's cash plan for 2019/20:

- DHSC will provide cash in the form of a revenue loan to fund the I&E deficit;
- DHSC will re-finance the five revenue loans totalling **£37.6m** that mature in 2019/20 financial year

9.5. There are no planned land sales in 2019/20 and therefore the Trust will not be able to make any additional ITFF loan repayments in 2019/20.

9.6. The Trust is not anticipating any new sources of external financing for revenue or capital purposes in 2019/20 beyond the MEEF, LEEF and ITFF capital loans signed in prior financial years.

**9.7. Forecast revenue loans as at 31st March 2020** – The Trust is forecasting opening revenue loans balance of **£105.1m**, repayment of loans of **£15.8m**, refinancing of **£37.6m** and new loans of **£6.7m**. See table below.

**Table 14 - Summary of 2019/20 revenue loan movements and forecast balance at 31st March 2020**

| | | £'m |
|---|---|---|
| **1** | **Revenue loans brought forward** | **105.1** |
| | | |
| 2 | **Repayments 2019/20** | |
| 2.1 | Repayment of PSF earned in 18/19 but not received in cash until 2019/20 | -6.6 |
| 2.2 | Repayment of exceptional working capital relating to Epsom land sales | -9.2 |
| | **Total repayments 2019/20** | **-15.8** |
| | | |
| 3 | **Refinancing of existing loans** | |
| 3.1 | Repayment of revenue loans in 2019/20 | -37.6 |
| 3.2 | Refinancing of revenue loans in 2019/20 | 37.6 |
| | **Total** | **0.0** |
| | | |
| 4 | **New loans 2019/20** | |
| 4.1 | Control total 19/20 | 6.7 |
| | **Total new loans in 2019/20** | **6.7** |
| | | |
| | **Total loans forecast at 31 March 2020** | **96.0** |



9.8. **Capital Loans and repayments 2019/20**- The Trust has planned for capital loan repayments and finance lease repayments totalling **£0.9m** in 2019/20 and it should be noted that this increases to **£3.1m** in 2020/21 following completion of the energy schemes- see table below. These repayments are funded via internal sources from a reduction capital expenditure.

***Table 15- Repayment of loans 2019/20 and 2020/21***

| | | | 2019/20 £'m | 2020/21 £'m | Total £'m |
|---|---|---|---|---|---|
| 1 | Building | ITFF repayments | -0.4 | -0.8 | -1.2 |
| 2 | Building | Energy loans repayments | 0.0 | -1.8 | -1.8 |
| 3 | Equipment | Radiology loan repayments | -0.5 | -0.5 | -1.0 |
| | | **Total** | **-0.9** | **-3.1** | **-4.0** |

**9.9.** Capital loans are forecast to be **£44.5m** at 31st March 2020 as shown in the table below.

***Table 16 – Forecast capital loans balance as at 31st March 2020***

| | | Radiology Finance lease £'m | Energy Effciency (LEEF and MEEF) £'m | ITFF £'m | Total £'m |
|---|---|---|---|---|---|
| 1 | Forecast at 31/3/19 | 2.4 | 8.1 | 17.6 | **28.2** |
| 2 | New Capital Investment loans | 1.3 | 11.7 | 4.2 | **17.2** |
| 3 | Capital Investment loans repayments | -0.5 | 0.0 | -0.4 | **-0.9** |
| | **Forecast at 31/3/20** | **3.2** | **19.8** | **21.4** | **44.5** |

9.10. Closing cash is forecast to be **£4.5m** at 31st March 2020, comprising minimum cash balance of **£1.9m** and closing capital creditors of **£2.6m**.

**9.11. PDC**

The Trust has been awarded **£7.5m** of PDC for Wave 4 capital bid and this is subject to approval of the business in 2019/20.

## LINKS TO THE LOCAL SUSTAINABILITY AND TRANSFORMATION PLAN

### Community Contracts

From 1st April 2019, the Trust becomes the host for the delivery of community health services across both of its local place-based communities of Surrey Downs and Sutton. Both community contracts will deliver through contractual joint ventures (Surrey Downs in partnership with the 3 local GP Federations and the community trust and Sutton in partnership with the local GP Federation, local authority and mental health trust).



The Care Model across both places is centred upon what local people have told us is important to them and builds upon the work we have done together and with local people over the last few years. Central to the Care Model across all ages and all health needs is the commitment to prevention and self-care through empowerment and maximising assets within our local communities. To support this and to provide the local organising framework for the way people access services are Primary Care Networks (PCNs). Clinically led and managed, the default will be to provide fully integrated care through PCNs. PCN teams will integrate primary and community, health and social care into a single team approach with care wrapped around the individual and the family, not the employing organisation. PCNs will offer both proactive and coordinated care through care planning and using an MDT approach incorporating extensivists and specialists.

Shared expertise will come into the PCN to reduce appointments outside of the network. Enhanced responsive urgent community response will be developed to reduce the need for emergency hospital services. We have re-thought our approach to acute care. We want patients to spend as little time as necessary in specialist care. To achieve this, we will develop single pathways between specialist centres, the local District Hospital with post-acute beds, the community hospital and home. We see all of these settings as our 'bed-base'.

In 2019/20 are priorities are to:

- Establish clinically led and managed Primary Care Networks as the organising framework prioritising the mobilisation of the adult services contract to deliver the step-change in integration between primary and community care

- Ensure that patients receive the urgent and reablement care they need, when they need it in the setting appropriate to their needs reducing LOS in acute settings and super-stranded patients and increasing on the day emergency care
- Re-design our planned care pathways valuing people's time and introducing new approaches to outpatient follow ups and re-designing key pathways such as MSK to improve quality and outcomes
- Align our key enablers of shared approach to care planning, clinical IT, estates and workforce to deliver the shared model of care focusing on use of GP clinical systems across community and partners; re-location of community bedded unit to Epsom District Hospital site and introduce our new workforce models in line with our agreed workforce plan.

### System Ambitions

Whilst the Trust is situated within the South West London STP area, as a two-site trust it is increasingly playing an active system leadership role as part of the two systems of South West London and Surrey Heartlands Health and Care (ICS) Partnership.

### Surrey Heartlands

As well as being a wave 1 ICS, Surrey Heartlands is in a unique position through being one of only two ICSs to obtain devolution status. In June 2017 a devolution agreement was signed between NHS England, NHS Improvement and Surrey Heartlands. That agreement has helped to accelerate work taking place to:

- bring the NHS and local government together locally to take shared control and ownership of the health and wellbeing of our population
- devolve or delegate regional and national health budgets and responsibilities - working towards a population based budget for all health and care services with local decision making
- secure freedoms and flexibilities to get the maximum benefit from our collective resources and efforts for the benefit of our residents

Partners across Surrey Heartlands have identified their strategic priorities, reflecting the 10 year Strategic Plan for Surrey and the NHS Long Term Plan:-



- Our 2019/20 System Ambitions have been developed collaboratively and articulate our intent for the year ahead.
- We will work much more collaboratively, both as a system and across our local Integrated Care Partnerships. We will give greater emphasis to prevention, early intervention, and tackling the wider determinants of health.
- It is expected that the local system will start to look different by April 2019, although work will continue past this date as the system evolves and matures and this strategy will be updated periodically to reflect this.
- We will be moving decision-making from a national to a local level (our devolution agreement), and working in collaboration with local people, to achieve much greater benefits for our community and improve the financial sustainability of our system.
- We have established an ICS Development Programme and as part of this we will be working towards:-
    - Identifying which services should be planning across larger areas (the Surrey Heartlands geography, across the county or beyond), and those that are better delivered at a more local level
    - looking at how we might be able to collaborate across a number of key support functions, exploring where there might be potential benefits in working together either across Surrey Heartlands, or at a more local level
    - designing our 'system architecture' to support robust governance and decision-making
    - considering what quality means in our system and agreeing quality standards that can be applied across Surrey Heartlands.

## USE OF DIGITAL TECHNOLOGY

The Trust recognises the importance of digital technology in supporting the delivery of patient care and the necessary enabling processes. The Trust's current approach is set out in its "Towards a Digital Strategy" document which acknowledges the need for considerable investment in IT to deliver a modern technology environment and our continued search for a route to deliver a modern Patient Administration System/Electronic Patient Record. While this remains unresolved, the trust in the meantime is investing in:-

- Fixing the basics by improving the core networks and infrastructure, PC/user devices and applications
- Making the most of what we have, for example implementing electronic Prescribing as part of our current PAS/EPR solutions, and making it easier for clinicians and other staff to access the information they need more effectively and efficiently
- Innovating where we can, for example deploying electronic whiteboards to support patient flow through the hospitals, building on top of existing systems, and becoming a high adopter of the national Electronic Referrals System in 2018/19

In 2019/20 our priorities are to continue to invest in our digital infrastructure, user devices and applications to continue to make improvements in the IT service provided to the Trust to make it easier for patients to access our services, including information electronically, and for our staff to be more productive by having access to clinical and other information more readily and consistently with appropriate levels of cybersecurity. We will also continue to explore how to make a step change in standardising clinical pathways across South West London through options around a future PAS/EPR.

We will also be working with our partners to ensure effective clinical IT solutions for the new services we are providing in partnership in Sutton Health and Care and in IDEEA in Surrey Downs.