Summary of five Year Plan 2014/15 to 2018/19
Lewisham & Greenwich NHS Trust

Introduction

This plan sets out how over the next five years Lewisham and Greenwich NHS Trust will provide people in Lewisham, Greenwich, and north Bexley who use our services with the best quality of health care we can, as we strive to become a clinically excellent and financially sustainable organisation with Foundation Trust status.

In getting there, we want to concentrate on providing local services for local people. We recognise that we face three major challenges:

1. **The quality of our services is not always good enough**: we do not yet consistently meet national and regional standards of care. As a result, we do not always provide the highest quality care to our patients. This hinders our ability to attract and retain staff. We are committed to both meeting the London Quality Standards and national performance standards, and to addressing the weaknesses we had already identified and which were confirmed in our recent Care Quality Commission inspection.

2. **The shape of health and social care in South London is changing**: together with our partners in the health economy, we rightly aspire to provide better care, sooner, at lower cost and closer to home for patients in South East London, so we must change how we work.

3. **We face major financial pressures**: like the rest of the NHS, we face a significant financial challenge over the next few years, which is only partly offset by the additional transitional funding we have for the next 2 years. We estimate we must reduce our costs by £125 million by 2019, which is an average of 5% reduction in costs each year.

We believe we have a coherent and credible plan for change

This plan describes how, as a recently created organisation that provides acute and community services, we plan to close our quality and financial gap. Developed by our Board and clinical divisions, and based on active engagement with commissioners and key partners, the plan shows how we expect to provide better care as one Trust – and at lower cost too.

It builds on the principal benefits we identified that we could realise from becoming integrated as a single Trust, including:

- having sufficient combined scale to meet increasingly prescriptive clinical quality and safety standards within a tightening financial position;
- using our strength as an integrated acute and community provider to support commissioners' plans to increasingly move care into new Locality Care Networks that include primary care and other services;
- ensuring local people will continue to have excellent access to a comprehensive range of safe, high quality services and providing improved local access to specialist networked services;
- delivering a better patient experience by embedding the learning from the Francis Inquiry and ensuring patients are at the heart of everything we do; and
- sharing best practice across sites in the short term, and redesigning clinical services in the longer term that will lead to improvements in the quality, safety and efficiency of care provided and will enable the delivery of more care closer to home.

We believe this is a credible plan that recognises that the vast majority of the opportunities for improvement are within our own control as an organisation. In practice, this means that we expect to close 95% of our £125 million challenge internally through improvements in our clinical divisions, with the support of our partners, and through corporate savings, including how we optimise the use of our estate.

The remaining 5% of our gap is expected to be closed from the net benefit of limited service development and activity growth over the next five years.

Our success depends on the backing of our partners and the public

We believe that this plan, although complex and challenging, is achievable in the five year timescale, given the right internal and external support. We are fully committed to delivering the plan and have already made a solid start. Our cost improvement plans for this year are set to deliver £26 million of the £125 million we need to save overall. We are now putting in place the workforce and organisational development plans to ensure we have the capabilities to sustain that progress over the long term.

Implementing this plan requires the support of our partners: the Clinical Commissioning Groups, Health and Wellbeing Boards, our neighbouring Trusts, our local councils and their leaders, the Trust Development Authority, and the Department of Health. In due course, we will submit a Development Support Plan outlining where we need the help of partners in building stakeholder backing for our plans, in securing capital investment to address quality pressures, and in building our capacity and capability to manage the significant change programme outlined in this plan.

With the diligence, commitment, and energy of our staff; the ideas and backing of our patients and local community; and the cooperation and resources of commissioners and our partners in the wider NHS, we are confident we can deliver high quality, safe, sustainable healthcare services for Lewisham, Greenwich and north Bexley.

□ □ □

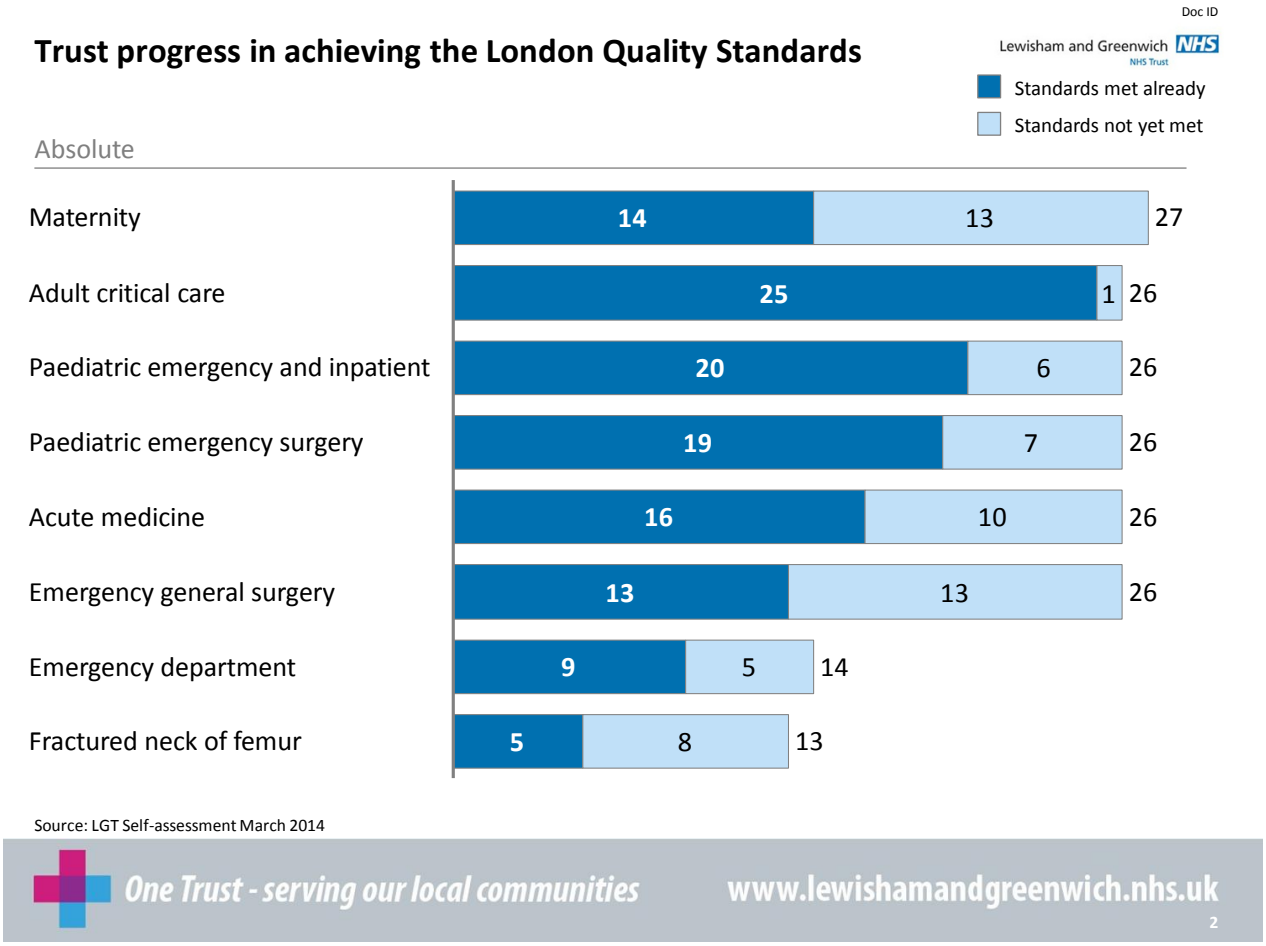
1. Strategic context and direction

Overview of the Trust and local health economy

1.1. Lewisham and Greenwich NHS Trust is a new organisation, established on 1 October 2013. Lewisham and Greenwich NHS Trust was formed from the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, formerly part of the South London Healthcare NHS Trust, which was dissolved following a decision of the Secretary of State for Health in January 2013.

1.2. The Trust has a recurrent turnover of around £460 million and employs around 6,000 staff. We provide a comprehensive portfolio of acute healthcare services to a critical mass of 660,000 people living across the London Boroughs of Lewisham and Greenwich, and the north Bexley area, together with a broad portfolio of community services, primarily, but not exclusively, for those living in Lewisham. Community services are provided across Lewisham and acute services are provided from two main hospital sites, University Hospital Lewisham and Queen Elizabeth Hospital. Some outpatient, maternity, elective surgery, and endoscopy services are also provided at Queen Mary's Hospital, Sidcup, and community services across Lewisham.

Figure 1: Map of local area showing our hospitals and community settings



1.3. Our Trust is based in the South East London health economy, which encompasses parts of the London Boroughs of Lambeth, Southwark, Lewisham, Bexley, Bromley, and the Royal Borough of Greenwich, and is home to a diverse and growing population of c.1.7 million people. While there are areas of relative affluence, it also includes some of the most deprived communities in England. The areas of highest deprivation are those closest to our main hospital sites. Over the next five years, we expect demographic change to drive a 2.3% growth per year in our activity, with the largest absolute

growth in younger age bands and the largest relative growth in adults over 85 years of age.

1.4. Around 80% of the Trust's income comes from local clinical commissioning groups, primarily Lewisham, Greenwich and Bexley Clinical Commissioning Groups.15% comes from non-service income such as education, or specialist services commissioned by NHS England. This primarily relates to a focussed portfolio of specialist services provided on the University Hospital Lewisham site to a wider catchment beyond Lewisham and Greenwich including: neonatal intensive care, cystic fibrosis, community children's nursing and community head and neck cancer rehabilitation. Figure 2 shows the Trust's market share in each South East London Clinical Commissioning Group based on all services - including specialties not provided by Lewisham and Greenwich NHS Trust.

Figure 2: Market share analysis (December 2013).

Clinical Commissioner Group	Lewisham and Greenwich NHS Trust acute market share
Bexley	38%
Bromley	8%
Greenwich	71%
Lambeth	0%
Lewisham	64%
Southwark	2%

1.5. The provider landscape in South East London includes:

- Two integrated acute and community Trusts: Lewisham and Greenwich NHS Trust and Guy's and St. Thomas' NHS Foundation Trust;
- One acute Trust: King's College Hospital NHS Foundation Trust;
- An integrated community and mental health Trust: Oxleas NHS Foundation Trust;
- A mental health Trust: South London and Maudsley NHS Foundation Trust;
- A community service provider, Bromley Healthcare, a social enterprise (a Community Interest Company);
- Private providers delivering NHS-funded services including three BMI Healthcare (private healthcare provider) hospitals: Blackheath Hospital, the Sloane Hospital and Chelsfield Park Hospital;
- Smaller independent clinic based providers including physiotherapy services at Crystal Palace;
- There are also significant patient flows to providers outside South East London, in particular to central London and Kent.

1.6. The South East London local health economy has faced significant financial challenges for some time. There have been several developments that have sought to address this including 'A Picture of Health' and the Unsustainable Provider Regime. Recommendations arising from the Unsustainable Provider Regime led to the development of the Trust in its present form.

Overview of commissioners intentions

1.7. As part of their aspiration to achieve much better health outcomes over the next five years the six Clinical Commissioning Groups in South East London are working together and with NHS England, to develop an integrated care system, delivered through seven clinically-led strategic interventions:

- Primary and community care (including social care);
- Long Term Conditions, physical and mental health;
- Planned care pathways;
- Urgent and emergency care pathways;
- Maternity pathways;
- Children & Young People's pathways;
- Cancer pathways.

The interventions are to be underpinned by the characteristics of an integrated system which are to:

- Build resilient communities;
- Promote health and wellbeing;
- Provide accessible and easy to navigate services;
- Join up services from different agencies and disciplines;
- Deliver early diagnosis and intervention;
- Raise the quality of all services to the same high standard;
- Support people to manage their own health and wellbeing.

1.8. South East London Clinical Commissioners also plan to improve primary care services across South East London by moving to 24 Locality Care Networks supporting a range of population sizes from 53,000 to 156,000, and providing at scale 'cradle to grave' services to the whole population. Within our local area this is likely to include nine Locality Care Networks, as set out in Figure 3 below:

Figure 3: Proposed primary care locality care networks.

Clinical Commissioning Group	Proposed locality care network	Population
Bexley	North Bexley	94,000
Greenwich	Eltham	56,000
	Excel	65,000
	Network	69,000
	Blackheath and Charlton	80,000
Lewisham	Neighbourhood 1 (Lewisham)	67,000
	Neighbourhood 2 (Lewisham)	109,000
	Neighbourhood 3 (Lewisham)	57,000
	Neighbourhood 4 (Lewisham)	66,000

Lewisham and Greenwich NHS Trust's five year strategic plan in the context of the merger, Integrated Business Plan and local health economy-wide plans

1.9. The Business Plan for the Merger of Lewisham Healthcare Trust and Queen Elizabeth Hospital, approved by the Trust Development Authority in September 2013, provides the detailed two year plan for our new organisation, which we are implementing already. The Integrated Business Plan:

- sets out the vision for the new organisation;
- provides our strategic objectives;
- identifies the benefits expected from the merger;
- provides a market assessment for our new Trust;
- sets out our service plans for the first two years of the organisation;
- outlines the enabling strategies to support delivery of those plans in key corporate services;
- provides the financial plan approved by the Department of Health and Trust Development Authority;
- outlines the new governance arrangements; and
- identifies the risks and challenges that will have to be managed.

1.10. This five year plan provides an update of the Integrated Business Plan and sets out our plans to ensure that the new Trust is clinically sustainable and financially viable in the longer term, that it meets the needs of local people and has the support of its local clinical commissioners.

1.11. Our plan aims to address the key internal and external challenges facing Lewisham and Greenwich NHS Trust and to enable us to identify the best balance of opportunities for ensuring clinical and financial viability. The plan and associated Long Term Financial Model (LTFM) are underpinned by the high-level five year clinical plans developed by our six clinical divisions and our corporate services.

1.12. A significant focus of our strategic plan is on transforming the quality of our services, including addressing legacy quality challenges such as difficulties with the emergency pathway and the poor

quality of estate at Queen Elizabeth Hospital, which affect patient experience and were criticised in our recent Care Quality Commission report. We have high aspirations for enhancing the quality of our services including addressing the issues raised by the Care Quality Commission and achieving the London Quality Standards for all services.

1.13. There are a number of key dependencies in this plan that are beyond our direct control. However, we are engaged as active partners in the development of the South East London Commissioning Strategy and are represented at various levels within the Commissioning Strategy Programme's governance structure. Additionally, our strength as an integrated acute and community provider enables us to respond well to commissioner plans to increasingly move care into the proposed new Locality Care Networks.

1.14. We recognise that successful and timely implementation of our own plans will require close and collaborative working with our local partners. In developing our clinical plans, we have been keen to ensure they align with the emerging South East London Commissioning Strategy and we have drawn on the knowledge we gained through our clinical representation on the Clinical Commissioning Group, Clinical Leadership Groups and our representation on the Clinical Executive Group and Partnership Board.

1.15. We are committed to supporting a balanced local health economy and will build on our Board's strong tradition of innovative and effective partnership working to continue to work closely with local General Practitioners, Clinical Commissioners, Local Authorities, the Trust Development Authority and others in developing and implementing the plans.

1.16. A key part of our plan is to build on existing clinical networks and pathways of care with other local providers. We will continue to work with local tertiary Trusts to strengthen the sustainability of our local clinical services and improve patient pathways. We also want to build on our experience as an integrated provider of acute and community services in Lewisham to improve the quality and responsiveness of community services across the local health economy and to explore opportunities for Lewisham and Greenwich NHS Trust to provide some community-based services to the Locality Care Networks being developed in Greenwich and Bexley where this is supported by commissioners.

1.17. More recently we have had discussions with Guy's and St. Thomas' NHS Foundation Trust to explore the concept of an alliance which would enable both organisations more quickly to achieve their own strategic objectives and support commissioners' plans for improving quality in south east London within available resources. Any formal agreement will require consideration and approval by our Boards but, at this stage, we see the principal focus of the alliance to be to improve pathways of care from the community setting through secondary care and tertiary service provision. Some of the ways we would do this are already reflected in our plan, for example our service developments in renal and urology services, and a reshaping of our paediatric service. In this spirit, we believe the alliance should enable us to play a greater part in achieving solutions to the challenges faced by the NHS in South East London.

1.18. We have also discussed other dimensions to the alliance. These include support for the development of our clinical leaders group; nursing development and rotational posts; and management collaborations. We will also review our back office functions, to see how closer working could add to the efficiency and cost effectiveness of these services, which we already plan to deliver.

1.19. We do not see that the creation of an alliance must be at the cost of existing relationships, which are important and in most cases work well. Guy's and St. Thomas' NHS Foundation Trust continue to work with other organisations in King's Health Partners, and Lewisham and Greenwich Trust works closely with a range of other NHS organisations and will continue to do so. However, the alliance gives us the opportunity to strengthen and deepen a relationship, which is already good, to mutual benefit and in the interests of our patients.

Risks and mitigations

1.20. The Trust's governance arrangements ensure that the risks to this plan that may affect the organisation are clearly identified, well understood, and effectively managed. Key themes emerging

from the known risks to the implementation of our five year strategy are around:

- the need to improve our emergency care pathway rapidly;
- our ability to recruit sufficient high quality staff with the right skill sets;
- living within our means;
- addressing site infrastructure inadequacies particularly at Queen Elizabeth Hospital;
- Cerner implementation of both iCareQEH and iCareUHL; and
- gaining wide clinical buy-in to our strategic plans.

1.21. A risk assessment for this strategy is included in Section 4.

□ □ □

2. Our approach to improving quality and safety

2.1. We are proud of our vision to be ***"One Trust – serving our local communities"*** and have set an overall mission which puts quality and safety at the core of our reason for being:

"*Our aim is to provide the best possible healthcare for our local communities, working collaboratively with all our partners*".

Underpinning this, the first of our strategic objectives set out in the merger Integrated Business Plan explains our overall approach:

> ***Provide consistently safe, high quality, patient-focused services.***
>
> *The Francis Inquiry into the failings at Mid-Staffordshire NHS Foundation Trust has given NHS organisations a stark reminder of the duty of care owed to patients, especially the vulnerable. Our mission… will mean not only addressing weaknesses identified in the most recent Care Quality Commission inspections at both University Hospital Lewisham and Queen Elizabeth Hospital, but also adopting the recommendations of the Francis Report; ensuring that the required mind-sets, approaches and working practices are central tenets of the culture of the new organisation. In practical terms this will mean:*

- *Embedding a high-performance culture through a comprehensive programme of organisational development;*
- *Providing the best possible patient experience, ensuring that patients have the information they need to be involved in decisions about their care;*
- *Providing timely access, high service quality and patient safety across the whole pathway. Not only is this the right thing to do for patients but these criteria are key to influencing General Practitioner referral patterns and patient choice, and therefore will help ensure the success of Lewisham and Greenwich NHS Trust going forward;*
- *Working closely with our General Practitioner colleagues to identify and target highly complex and high risk individuals and ensure a co-ordinated response to their care needs; and*
- *Developing innovative integrated care pathways that ensure we better meet the needs of our patients and local people.*

2.2. Our aim is to meet all national and local quality standards expected of us as soon as possible. This includes achieving both a minimum 'Good' overall rating from the Care Quality Commission and meeting all of the London Quality Standards.

2.3. Our new Trust is a genuinely clinically led organisation. Clinicians who have always been responsible for delivering quality day to day in each interaction with every patient, now also have the freedom and responsibility to lead their services overall, including how they deliver quality within available resources. The single integrated clinical leadership team who have been in place and meeting regularly since September 2013 have ensured that from day one, Lewisham and Greenwich NHS Trust is clinically led and its plans are clinically owned. Our plans for the next five years are first and foremost about enabling delivery of our quality and safety goals, and from this becoming a clinically and financially viable organisation. The planned service developments set out in Section 3 have been developed by clinical teams as the strategic means of embedding improved quality in our work.

2.4. In developing these plans, we recognise that the scale of the quality and safety challenges facing our new organisation is significant. We have identified the key clinical, operational, and financial issues that must be addressed and have developed plans to address these as set out in Sections 4 and 5.

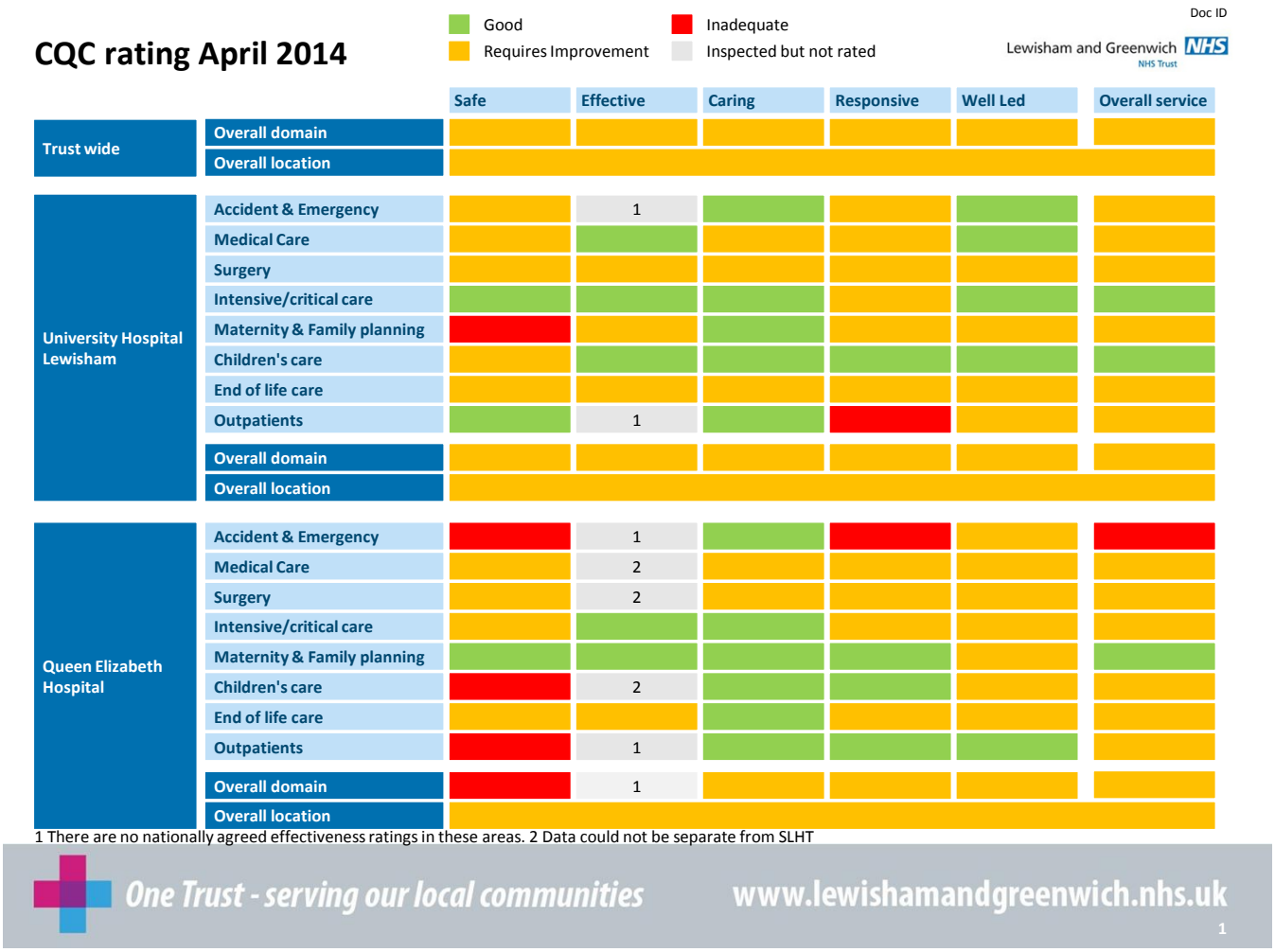
Care Quality Commission

2.5. The recent Care Quality Commission's Chief Inspector of Hospitals' Review of our acute services undertaken in February 2014 confirmed our assessment of our major strengths and challenges:

- On both sites, staff are committed to delivering good care, and a number of areas of good practice were identified including the process for managing and learning from complaints and incidents. The commitment to staff development and training, and the culture of staff engagement developed through the recent merger are also strengths upon which to build;
- Inspectors also registered a positive response to the merger by the staff at Queen Elizabeth Hospital;
- Overall, University Hospital Lewisham **Requires Improvement** but has **Good** rated services in intensive and critical care and in children's care;
- Queen Elizabeth Hospital also **Requires Improvement** overall, particularly in the emergency department which is **Inadequate,** as it is not fit for purpose and where there is a significant shortfall in bed capacity. Queen Elizabeth Hospital maternity and family planning services were rated **Good;**
- The two hospitals currently have different models of the acute medical pathway, and neither of these lead to efficient patient movement between different services;
- Although recruitment programmes are in place to try and fill vacancies, inspectors observed staff shortages in many areas;
- At the time of their visit, waste management procedures had weaknesses on both sites that needed to be addressed.

2.6. A summary of the ratings from the inspection for each site service is provided below.

Figure 4: Trust Care Quality Commission ratings April 2014.



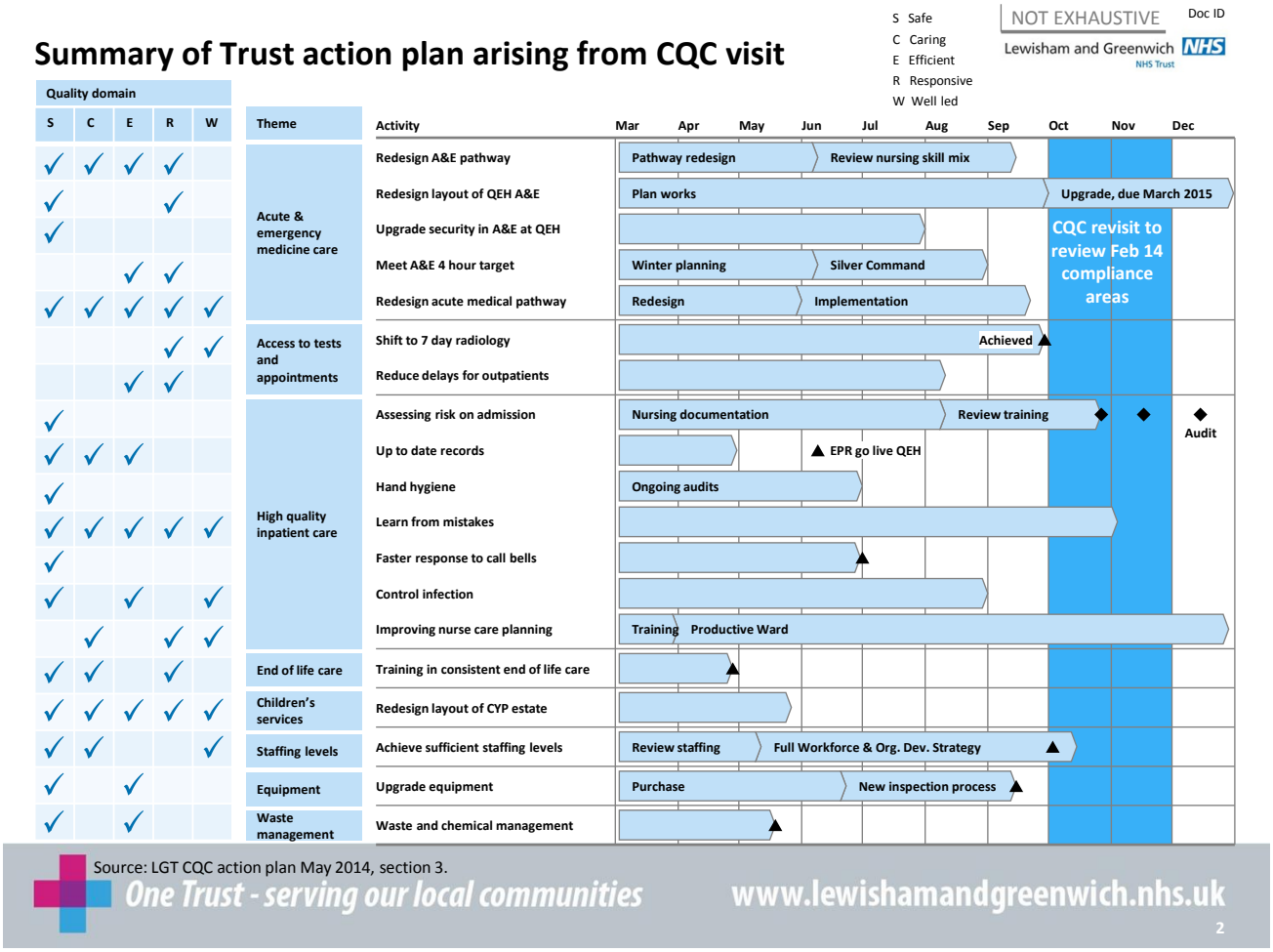
2.7. We have developed a comprehensive action and improvement plan following the inspection that addresses the changes taking place in the immediate term of 2014/15, and indicates how the Trust intends to embed change and move forward over the next five years. This action plan is a key part of our programme of work to quickly and sustainably achieve an overall 'Good' rating and become a high quality, clinically and financially sustainable Foundation Trust. The document sets out the actions we are taking to:

- Improve the Accident and Emergency Department at the Queen Elizabeth Hospital;
- Improve the emergency patient journey, from ambulatory care A & E, through admission to discharge, end of life care, or transfer to a more appropriate hospital or community service;
- Improve the numbers and core skills of all of our staff;
- Improve our management of clinical waste;
- Improve our hand hygiene compliance;
- Improve the knowledge we share with staff about our mistakes and how we handle them; and
- Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability.

2.8. A high-level summary of the action plan is shown below.

Figure 5: A summary of the Trust Action Plan May 2014 in response to Care Quality Commission

inspection.



Estates

2.9. In improving quality and safety across the organisation, we are also committed to addressing the significant, long-standing estates quality issues that were identified at Queen Elizabeth Hospital in legal due diligence prior to the merger. The Transaction Agreement relating to the merger identified an estimated investment requirement of £28 million, and provided a works schedule which included the following defects:

- Inadequate resilience of the main incoming electrical service;
- Insufficient emergency generator capacity;
- Poor quality water system leading to flooding as a consequence of equipment failure; and regular high counts of Legionella bacteria caused by poor systems;
- Poor and inadequate ventilation systems in a number of areas;
- Non-compliance of medical gas systems;
- Poor quality of steam due to non-compliant installation.

In addition there are issues inherited from work started by predecessor Trusts and poor contract conditions compounded with bad specifications, as well as an issue associated with the ownership of the hospital through-road, which requires significant investment prior to local authority adoption.

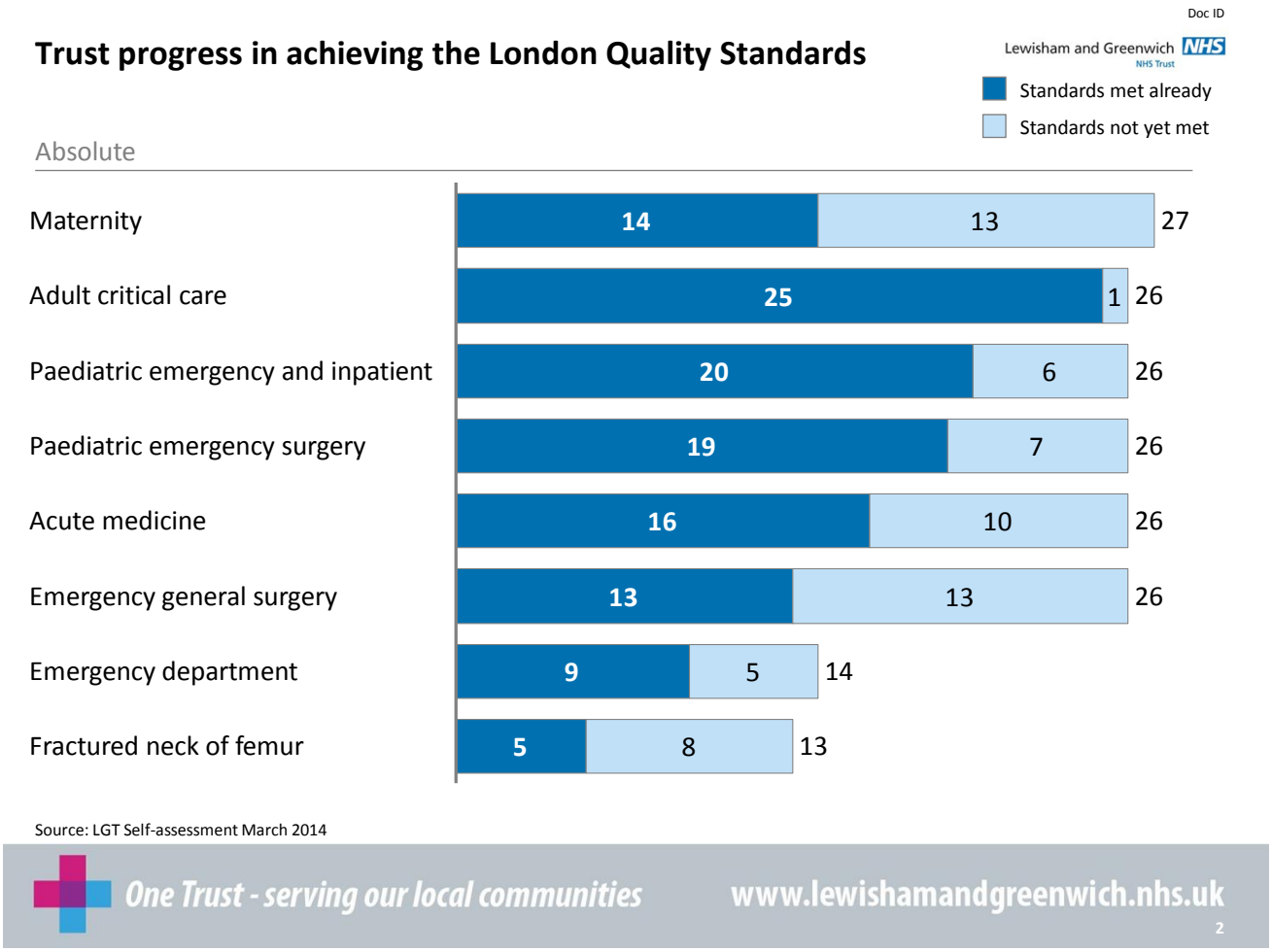
2.10. Given the seriousness of these challenges, we have established a Partnership Board, with membership including Meridian, the Queen Elizabeth Hospital Private Finance Initiative partner, and Trust Board representatives. The partnership board's remit is to use best endeavours, in keeping with

our Transaction Agreement, to resolve the legacy issues prior to any formal escalation through legal process. The merger Transaction Agreement provides for Trust Development Authority and Department of Health financial support in this process. To assist the resolution process, we have commissioned an independent technical audit of the hospital design, installations, and compliance with good industry standards, along with health and safety and resilience. This independent report will inform negotiations as we seek to develop robust plans, reach agreement, and find solutions to the many long-standing safety and operational issues.

London Quality Standards

2.11. Of the 184 individual London Quality Standards (LQS) developed across London, 63 are not currently fully achieved on at least one of our sites at some times of the week. The main areas where improvements are required are shown in the figure below;

Figure 6: London Quality Standards to be achieved and our position as of March 2014.



2.12. We believe that these London Quality Standards are important to deliver strong clinical outcomes and a good patient experience. In developing our five year clinical strategy, each of our clinical divisions have reviewed their progress against delivering the Standards, and produced plans to achieve them on a sustainable basis as quickly as possible. These plans enhance the existing London quality standards action plan, which has already been shared with NHS England (London).

2.13. In developing and implementing our plans for achieving the London Quality Standards, we will need the support of others. This includes help from other providers in providing inter-trust interventional radiology services from commissioners in helping us develop sustainable unscheduled care pathways so we can recruit staff and from education and training partners in developing our workforce.

2.14. Going forward, we expect progress in achieving the standards will continue to be monitored by our Board and by the Clinical Commissioning Groups through the Clinical Quality Review Group.

Safer staffing

2.15. In light of the Francis Report, the Trust has undertaken a detailed review of ward nursing staffing levels and is investing around £4 million in increasing establishment levels. This ensures that we meet the staffing levels as set out in the recent National Quality Board National Institute for Health and Care Excellence (NICE) guidance. Over the next two years, we expect further guidance on safe staffing levels to be published for other staff groups including non-ward based nurses, community nurses and allied health professionals. We will use this guidance to support a phased review of Trust safer staffing levels service by service. Work has already been undertaken within the development of our clinical divisional five year plans to identify and address what safe staffing levels are for medical staff.

Improved nursing and midwifery care – the 6 Cs

2.16. We are committed to improving the quality of our hospital and community nursing and midwifery services through the implementation of the national vision and strategy for nurses - '6C's' - which cover care, compassion, competence, communication, courage and commitment. Our senior corporate and divisional nursing teams are further developing our nursing strategy to align this work with the divisional five year clinical plans set out in Section 3.

Commissioning for Quality and Innovation (CQUIN)

2.17. We welcome the continued national and local focus on commissioning for quality and innovation (CQUIN) as a way of driving further improvements in quality. The CQUIN schemes we have agreed with our commissioners for 2014/15 reflect national and local priorities. These include seven local CQUINs agreed with Lewisham Clinical Commissioners, four local CQUINs agreed with Greenwich and Bexley Clinical Commissioners, and three Specialist CQUINs set by NHS England. Over the next five years, we expect that the level of ambition and financial impact of CQUIN schemes will remain broadly similar to the current challenging levels.

Quality Improvement Strategy and Quality Account

2.18. As a new Trust, we have already developed a Quality Improvement Strategy, which describes how we intend to provide the best possible healthcare in our hospitals and community settings. It primarily focuses on four key areas:

- Being Well Led;
- Ensuring Patient Safety;
- Delivering Effectiveness of Care (Clinical Effectiveness);
- Improving Patient Experience (Caring and Responsive).

This Quality Improvement Strategy provides the foundation on which we will build our priorities for improvement over all five years of this strategy.

2.19. Our latest Quality Accounts, to be published at the end of June 2014, focus on further developing and embedding the culture for quality improvement across the organisation, whilst we regularly review and update the Quality Improvement Strategy that sets out the vision and direction over the coming years. This plan is consistent with the forward-looking element of our Quality Account.

2.20. Through our Quality Improvement Strategy and from the work undertaken as part of our response to the Mid-Staffordshire Public Inquiry and recommendations, we will focus on embedding our existing quality priorities. Our Board will use The NHS Outcomes Framework 2014/15 and Care Quality Commission Inspection framework as the basis for setting, measuring and reporting on agreed priorities.

2.21. Our Board has set quality improvement priorities around each of the five quality Domains:

Figure 7: Quality Improvement Priorities 2014/15.

Domain	Our priorities
Safe	• Ensuring Patient Safety Incidents are reported; • Reducing the incidence of avoidable harm; • Delivery of the First Year of the Care Quality Commission Action Plan; • Improving the safety of maternity services; • Delivering safe care to children in acute settings.
Caring	• Promoting a culture of 'putting patients first' with care and compassion.
Effective	• Reducing mortality rates amenable to healthcare; • Reducing premature mortality - particularly through increased survival rates from breast, lung and colorectal cancer; • Improving outcomes and total health gain as assessed by patients for planned treatments; • Improving diagnosis, treatment & quality of life for people with Dementia.
Responsive	• Further implementation of the Department of Health Friends and Family Test; • Improving the experience of women in post-natal care; • Improving the way we manage and learn from complaints.
Well led	• Implement action plan derived from Board self-assessment; • Organisational development for all leaders including clinical leaders (Divisional Directors and Clinical Directors); • Promoting a workforce that has the right staff, with the right skills, in the right place; • Internal communications processes led by executives and clinical leads. Wide circulation of questions and feedback to ensure greater engagement of all staff groups; • We are developing a new appraisal process for 2014/15 to embed agreed values and behaviours, and to support succession planning; • Further strengthening the role of the Board sub-committees to ensure appropriate board to ward connectivity.

2.22. Our overarching priority for the next two years is to ensure the completion of a safe and sustainable transition, across all settings, during what will be a period of significant organisational change. Our

focus will be on maintaining a strong operational 'grip' ensuring that we meet service quality and performance standards and consistently deliver a good patient experience.

2.23. In years 3-5 will we will continue to implement the initiatives in our clinical strategy that deliver significant improvements, again first and foremost to quality and safety of our services. These longer-term initiatives, set out in Section 3, will involve significant redesign of how we provide many of our services, including emergency care, elective surgery, maternity services, elderly care, and services for children. The expected impact of these plans on quality is set out below:

Figure 8: Summary of the quality impact of divisional five year plans.

2.24. We use a set of key metrics to monitor our progress on improving quality and safety, which include friends and family test results, patient and staff satisfaction surveys, etc. Each division's performance is monitored against these measures, with the support of an integrated report, which records all the key performance metrics, such as the one below. The Integrated Governance Committee, a sub-committee of the Trust Board reviews the Quality Dashboard monthly. Further information on our approach to performance management of quality and other standards is provided in Section 5.

Figure 9: Example of Trust quality performance report produced each month.

Indicator	Currency	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	Target	Actual
Overarching																
CQC Registration	y/n	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CQC alerts/warning notice	y/n										N	N	Y	N	N	N
Caring																
The % people likely to recommend our adult inpatient services	%	88.0%	91.0%	92.2%	89.7%	92.5%	91.3%	90.9%	89.2%	87.9%	93.5%	95.1%	92.3%	92.5%	tba	92.5%
Complaints - % resolved within 25 days - LGT	%							47%	46%	51%	49%	37%	27%		>=70%	27%
Complaints - % resolved within agreed timescales - LGT	%							48%	53%	57%	64%	64%	54%		>=95%	54%
Mixed sex accommodation breaches - LGT	No							0	0	0	0	0	0	0	0	0
Single sex survey - 'no' response to 'have you shared accomodation with the opposite sex?'	%			100%			98.4%			97.5%			99.6%		91.0%	99.6%
Dementia screening % of cases identified - CQUIN	%							97.6%	96.5%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%
Dementia referred for specialist diagnosis - CQUIN	%							97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%
Well-led																
Participation in national audits & confidential enquiries	%							98.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Clinical audit programme - registration of audits LGT	%							62.0%	63.0%	72.0%	79.0%	81.0%	100.0%		>67%	100.0%
Clinical audit programme - completion of audits LGT	%							16.0%	21.0%	23.0%	29.0%	39.0%	73.0%		>75%	73.0%
Effective																
Overall readmission rate (30 days) adjusted - LGT	%													10.3%	tba	10.3%
Out of ICU cardiac arrests (rate per month per 1000 bed days)	No	0.39	0.45	0.79	0.60	0.04	0.50	0.50	0.70	1.00	0.50	0.70	0.80	0.4	tba	0.4
Safe																
MRSA bacteraemia - LGT	No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Never event incidence - LGT	No							0	1	0	0	0	1	0	0	0
Medication errors causing serious harm - LGT	No					0.48	0.54	1	0	0	0	0	0	0	0	0
Number of incident reports associated with omitted medicines - medication not administered	No	8	12	25	22	15	14	15	10	12	9	18	14	11	tba	11
Safety thermometer - % of harm free care LGT	%							85.95%	85.65%	86.92%	86.21%	88.48%	87.19%	88.3%	tba	88.3%
VTE risk assessment - LGT	%							93.1%	94.2%	93.8%	95.4%	95.5%	95.8%		>=95%	95.8%
Serious incidents - number resolved within 45 days - LGT	No							86.4%	63.6%	64.3%	6	12	3	2	tba	2
Serious incidents - number submitted past deadline - LGT	No							2	3	3	8	10	3	2	0	2
Patient safety incidents involving severe harm or death	No	2	3	2	0	2	3	9	4	4	4	3	4	1	tba	1
Incidence of harm to children due to failure to monitor	No	0	0	0	0	0	0	0	0	0	0	0	0	0	tba	0
NICE - compliance with Technology Appraisals	No						95%			79.0%			88.0%		100%	88.0%
NICE - compliance with interventional procedures guidance	%						67%			31.0%			58.0%		100%	58.0%
Riddor reporting	No	2	0	1	2	0	1	3	4	5	1	0	4	3	tba	3
NHSLA compliance with level 2 or 3 risk management standards	%	71.5%	72.5%	94%	94%	94.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		>85%	
Responsive																
Certification of compliance with requirements regarding access to healthcare for people with a learning disability	y/n			A	A	A	A	A	A	A	A	A	A	A	G	A
Safeguarding mandatory training - LGT	%	81.30%	81.30%	82.14%	83.00%	82.50%	82.24%	64.00%	64.00%	64.93%	65.10%	66.43%	68.80%	71.3%	>=85%	71.3%
Safeguarding number of serious case reviews CYP - LGT	No	0	0	0	1	0	0	1	2	0	0	1		0	0	0
Safeguarding - CYP - referrals to childrens social care - LGT	No	11	6	8	21	26	18	38	92	47	27	35		10	tba	10
Safeguarding alerts raised adults - LGT	No			25	31	25	33	35	44	30	47	45	58	67	tba	67

(Note: the full range of indicators is not shown here.)

Improved response to and learning from complaints

2.25. The Trust Board expects 95% of all complaints to be dealt with within the timescale agreed with the complainant. This indicator reflects the importance the organisation places on resolving issues that patients have with the way the Trust provides its services. As this target has not been met since integration, a number of initiatives have been put in place:

- Each Division has developed a plan to improve response times, that is discussed at the cross Division Complaints Committee, chaired by the Chief Executive;
- An escalation process has been developed to ensure deadlines are not missed;
- The new Divisional Directors have resolving complaints as part of their job descriptions;
- A trial is underway allocating case ownership to specific Complaints Officers so that one person sees the complaint through from beginning to end. This improves relationships with the complainant and the staff involved;
- A trajectory is being planned with each Division to reach the 95% target.

Improvement plans for Serious Incidents and Never Events are shown in Sections 5.23-5.32.

Governance Arrangements

2.26. We have strong governance arrangements across the organisation to drive and track improvements in

quality and safety. These include:

- Risk and governance meetings are held in each Division;
- Trust-wide Clinical Effectiveness, Patient Safety, and Patient Experience Committees, which report into the Integrated Governance Committee;
- Monthly Trust Board reports which include delivery against the quality standards and access indicators (including the above dashboard);
- Monthly Divisional performance meetings, chaired by the Chief Executive, to monitor local progress;
- Regular reviews by both the Trust Board and by the external commissioner-led Clinical Quality Review Group into our progress in implementing the action plan we developed following the recent Care Quality Commission inspection;
- Our Board's commitment as an aspirant Foundation Trust to develop our quality and governance framework and to work with our membership and local population to bring a service user perspective to all we do, whether in designing new services or monitoring the quality of those we already provide.

□ □ □

3. Clinical strategy

3.1. In the short time since our organisation was formed, we have spent a significant amount of effort and energy as a clinical, managerial and Board leadership team, in developing our clinical strategy for how we will improve quality and become clinically and financially sustainable.

3.2. We can see substantial opportunities to improve our services as one Trust: an integrated acute and community trust operating across two sites. Currently some of our services, including our emergency care pathway, do not meet the high expectations that we and others have of us. An aim of this plan is to enable us to level up the quality of our services across our acute sites and then to improve them still further. Our expectation is that by the end of the five year planning period we will be providing better, safer, more efficient and effective care that fully meets the London Quality Standards, suits patients, and provides the best access and quality possible with the resources available to us.

3.3. In developing the plan for our acute clinical services, we have given careful attention to how we can best meet the quality standards in both of our hospitals. Our aim is that in future, where we provide a service on both sites, we will provide high quality services in both locations. If this is not possible on quality and safety grounds, we may look to combine our expertise on one site where this is clinically appropriate. In doing so we will ensure that, we can meet the needs of local people and are able to provide a better service there than is available at present at either location. Wherever appropriate we will also look to enhance the quality of local service provided to patients through improved community provision. This will include partnership working with Clinical Commissioning Groups as they move to Locality Care Networks and improved patient pathways working with tertiary centres, in particular through our alliance with Guy's and St. Thomas' NHS Foundation Trust.

3.4. There are five major elements to our clinical strategy, which is described in more detail in Section 3.7 onwards:

- We are improving the quality of our services, including the patients' experience, and will provide an increasing number of relevant services seven days per week. We are also investing in our staffing, buildings and equipment to support this;
- In response to the Clinical Commissioning Group strategy, and where clinically appropriate, we are moving unscheduled pathways of care to less acute settings with more ready access to appropriately trained clinicians so that patients get a better experience and we make best use of our staff and resources;
- We are further developing our elective surgery and endoscopy model. We are looking to separate elective and emergency pathways to make the patient experience far better, whilst enabling us to become more efficient;
- Where clinically safe and appropriate, we will look to provide much more care on a day-visit (ambulatory) basis so that fewer patients need to stay in hospital overnight. We also plan to transform our outpatient services to be designed around the needs of patients and to help move care closer to where they live.

3.5. Finally, these changes, together with enhanced training and a focus on organisational development, will make the Trust a more attractive place to work, enabling staff to provide the high quality of care that they joined the NHS to deliver. This will help us to recruit permanent members of staff more easily and reduce our reliance on expensive temporary staff. In implementing this plan, we will significantly improve quality and improve our financial sustainability as we reduce our net costs by £125 million over the next five years. We will do this by providing the right quality of care, at the right time, and in the right place. We will adopt the most efficient practices and make best use of the technology available to us.

3.6. We are proud of the progress we have made in developing this clinical strategy in recent months, but recognise that it is still at a high level and much further work is required with our external and internal stakeholders and consultation with patients and the public. In Section 8, we outline our engagement plan, and, in the remainder of this section, we provide more detail on each element of our clinical strategy.

Acute & Emergency Medicine

3.7. We want to improve our acute and emergency medicine services on both sites significantly over the next five years. They are the busiest set of services in our organisation, caring for some of the most poorly, frail and anxious patients we have the privilege to serve. We know that we do not consistently meet the high standards we and others expect of our services yet and want to move to a situation where we fully meet the accident and emergency waiting time targets, the London Quality Standards, the requirements of the Care Quality Commission and of our local commissioners.

3.8. Over the next five years, and starting very quickly, we will move to a new acute medicine clinical model across both of our hospitals, linked to the wider urgent care pathway across primary and secondary care that we are developing with commissioners. With a major focus on the care of frail elderly people, we will increasingly look to provide the majority of treatment on an ambulatory rather than inpatient basis. This will provide a better patient experience and move more care into the community, including through use of community nursing services provided by us and by other local NHS and providers. This will also help resolve the impatient capacity issues, especially at the Queen Elizabeth Hospital. Where patients do require inpatient care, we want to enhance our services so that people get access to consistently good care seven days a week, so that the care they receive is seamless, and so they can be discharged safely without unnecessary delay.

3.9. We recognise that our emergency department at Queen Elizabeth Hospital is no longer fit for purpose and requires substantial expansion and redesign. The Care Quality Commission also supported this view in its recent inspection. We are committed to radically redevelop the department, including supporting Greenwich Clinical Commissioning Group in their desire to use the site as a local hub for unscheduled and out of hours urgent care.

3.10. The key objectives of our plan for acute and emergency medicine services include:

Figure 10: Key objectives for acute and emergency medicine services.

Goal	Benefit	Method
Improved quality, with focus on Queen Elizabeth Hospital emergency department	Improved quality and patient experience.	• Re-design and refurbishment of the emergency department; • Reassessment and redesign of clinical model.
New frail elderly model	Lowers average length of stay. Improves patient experience. Enables a greater proportion of patients to be cared for in the community in the and long term. This is a crucial benefit because frail elderly patients, once admitted, deteriorate, sometimes permanently, meaning that often they cannot return home. Therefore, admission to hospital often triggers admission to a residential nursing home.	• Improved integration with primary / community care; • Faster and more coordinated input from geriatric and specialists; • Reduce delayed discharges and readmissions; • Limit number of moves for older people; • Ambulatory model

Urgent Care service at Queen Elizabeth Hospital	More coordinated and integrated with emergency department to provide flexible model of care.	• Participate and look to win tenders for these services.
Ensure a 24 hours a day service, seven days a week	In line with London quality standards and with growing needs of the population.	• More efficient use of our staff; • Innovative delivery model including non-medical staff.
Ambulatory model as default	Rapid access. Reduction of unnecessary admissions.	• Ensure admission only when necessary; • Extend Queen Elizabeth Hospital ambulatory care to seven days a week for weekend access and provide the same model at University Hospital Lewisham.
Single stroke service for post-acute care	Improved efficiency. Ease of access to rehab.	• Rehab in the community supported by hospital outreach where possible, and by inpatient rehabilitation only for those who still have acute needs.
Improved and enhanced community nursing services	Improved quality of care patient experience. Reduced length of stay in hospital. A wider range of patients can be cared for out of hospital.	• Rapid and systemic transformation of community nursing service. • Increased working through Locality Care Networks with primary care and other partners.

3.11. Starting now and improving each year, we aim to be providing far better, safer, more affordable services to our local population by 2019. Success in reaching these goals will depend on our ability to build on strong links with primary care and with those community services that we do not provide ourselves. Success is also dependent on our ability to build on the excellent progress we have made in developing our transformation programme for the acute medical model into a systematic approach. We are confident that we will meet both these key dependencies through the appropriate clinical and managerial leadership. We have begun this work and see it as a key focus of early implementation.

Long Term Conditions and Cancer

3.12. We want to use the next five years to alter our models of care for long-term conditions and cancer radically to bring them in line with commissioner aspirations to provide more responsive local services that better meet the needs of patients. Our vision is to provide a fast and efficient service, making the best use of our cross-site facilities, whilst freeing up time for our most highly qualified staff to focus on patients who need serious medical attention.

3.13. Across a range of clinical services such as individual medical specialties, cancer and radiology, we want to improve pathways of care with primary and community services as they move towards Locality Care Networks. We plan to increase access to imaging investigations, to increase access to advice to General Practitioners to enable more patients to be managed in the community, and to integrate our services better across the two sites to provide rapid access to specialist opinion and high quality, sustainable team-based clinical services.

3.14. We intend to improve our cancer services so that patients get consistently high quality care. This means access to diagnosis, treatment and care for the patient, and their carers, in a safe setting, within agreed timescales and as close as possible to where they live. In making these improvements we will work with tertiary partners to ensure we always meet the cancer standards. We will strengthen our management and coordination of cancer multi-disciplinary team meetings to ensure patient care is well coordinated and effective. We will look to move more treatment procedures into ambulatory care settings so that patients are less likely to require admission for treatment. Likewise, we will move to stratified risk follow-up where appropriate for patients in remission, so that they are able to continue life beyond cancer more independently.

3.15. In all of these services, we expect to realise significant quality and financial benefits by using technology. For example, as part of our plan to transform our outpatient services, we expect to use innovative technologies for self-booking of appointments, point of care diagnostic testing, sharing medical records across hospitals and community settings, and for holding clinic consultations through a range of communication technologies.

3.16. The key objectives of our plan for long term condition and cancer services include:

Figure 11: Key objectives for Long Term Conditions and Cancer services.

Goal	Benefit	Method
Improve imaging support to rest of the Trust	Safer, by avoiding diagnostics delay Faster discharge, lower average length of stay	• Transformation of imaging service with external support; • Seven days a week imaging service; • Optimisation of imaging modalities; • Invest in additional CT and MRI scanning capacity, first by extending hours, then by purchasing new equipment, if proven to be required; • Improved GP access to services to support Locality Care Networks.
Transform our outpatient services	Freeing up time for our most highly qualified staff to focus on patients who need serious medical attention; Lower costs.	• Better use of telemedicine and self-management; • Centralise the booking process and enhance self-service; • Adjust staffing mix to make greater use of consultant-led, nurse-delivered clinics; • Recruit or train more nurse specialists.

Ensure high quality local cancer services as part of the wider London Cancer Alliance	Improved patient experience, safety, and quality	• Increased access to CT scans, especially for brain cancer; • Increased access for General Practitioners to improve speed of diagnosis of cancer; • Better access to upper and lower endoscopy, and to flexi-sigmoidoscopy; • Improved turnaround times for histopathology; • Chemotherapy closer to home or seven days a week; • Develop complex haematology and breast service on site; • Integrated Trust-wide palliative care services; • Improve secondary:tertiary pathways in the cancer pathway; • Strengthen our training and development of clinical nurse specialists; • Fully support the development of risk stratified pathways to enable patients surviving cancer to have self-management and remote monitoring where appropriate.
Support our consultants to spend more of their time conducting more complex work	Better support for vulnerable patients; Better staff retention; Better recruitment; Increased clinical income.	• Deploy more specialist nurses and administration staff, to enable consultants to focus on more complex work, e.g. in cardiology, renal, neurology and gastroenterology
Improve support from specialist medicine to acute pathway	Faster access to specialist opinion; Lower average length of stay.	• Provide acute gastro rota and ensure responsive scoping service; • Ensure better responsiveness from all specialist teams to the acute pathway over extended hours as appropriate

Surgery

3.17. Our aspiration is to undertake a major transformation of our surgical services over the next five years. We will provide a clinically coherent model, concentrating our expertise into two main specialist centres of excellence: one for inpatient elective work at University Hospital Lewisham, which will also maintain access to emergency surgical services, and one at Queen Elizabeth Hospital, which will focus on elective outpatients, and day and emergency surgery. Focussed centres will not only allow us to provide a better patient experience with less likelihood of cancelled operations but will also provide improved quality, safety and productivity.

3.18. This model of surgical services will allow us to keep surgical support to the emergency departments at both sites whilst deepening the level of care we can offer at our specialist centres of excellence. It will also allow us to deploy more joint middle-grade rotas, saving money that we can use to provide better consultant cover. Making a better working environment will also enable us to attract and retain the right surgical staff, filling vacancies to reduce agency spend.

3.19. We are planning to develop a new higher quality scoping service across the Trust, with dedicated scoping centres at each site that bring together gastroenterology, surgery, gynaecology, and other relevant clinical services into shared high quality facilities. This will provide a better patient experience at lower cost. In developing our surgical plans we wish to strengthen our collaboration with local tertiary providers, in particular through our alliance with Guy's and St. Thomas' NHS Foundation Trust to ensure that people from Lewisham, Greenwich and north Bexley have access to the highest possible quality specialist care, as close to home as possible.

3.20. The key objectives of our plan for surgical services include:

Figure 12: Key objectives for surgical services.

Goal	Benefit	Method
Improve the quality of care and staffing cover	Better quality; Improved recruitment and retention, reducing agency spend; Increased utilisation of staff and equipment; Easier to share best practice.	• Develop a coherent surgical model that focuses elective inpatient care in a centre of excellence on one site; • Continue to provide surgical cover to the emergency department at both sites; • Rework staffing rota to remove duplication.
Developing high quality services	Faster access to better treatment.	• Development of dedicated shared scoping facilities at each site; • Develop in-Trust urology services in partnership with other tertiary providers.
See more patients as outpatients	Shorter average length of stay; A saving for Lewisham and Greenwich NHS Trust; Reduce travel time for patients.	• Overhaul, centralise and automate theatre booking procedure; • Use technology to see patients remotely, such as via video calls; • Dedicated elective centre of excellence.

Women's and Sexual Health

3.21. Our women's and sexual health services face a tough challenge in the next five years. We are seeking to redress the 10% reduction in births at Queen Elizabeth Hospital over the past four years since the opening of local midwife-led units elsewhere, and the recent 4% reduction at University Hospital Lewisham since the TSA process in 2012. We believe there are real opportunities to reverse this decline through offering a much more patient-friendly service including the introduction of a second midwife-led birthing unit at Queen Elizabeth Hospital and the development of maternity support workers. We are very keen to enable more mothers to choose a normalised birth (without medical intervention), including at home if desired, and appropriate. We will explore the potential to split our maternity services into a lower risk site and a higher risk site during the next five years as this will allow greater specialisation of care to support mothers.

3.22. Within gynaecology, we are looking to enable more women to have their care provided in one-stop outpatient and/or ambulatory care settings, including in settings provided by other partners such as the Locality Care Networks. Within our hospitals, we will also look to develop shared settings of care with surgery and other clinical divisions for scoping and outpatient services. In this way, we will enable patients to have a better experience of care by centralising booking and scheduling of services with more services available during evenings and at weekends.

3.23. Within our sexual health services, we recognise the need to respond to the increasing financial pressures our local authority commissioners in public health are facing. We plan to do this by accelerating the transformation of the service to ensure it is highly efficient and responsive, including increasingly delivering within primary and community care settings and via virtual technologies. We also recognise the need to work within the potential pan-London changes in HIV commissioning.

3.24. The key objectives of our plan for women's and sexual health services include:

Figure 13: Key objectives for women's and sexual health services.

Goal	Benefit	Method
Safer, better quality maternity service	Improved quality and delivery of London Quality Standards.	• Increase consultant hours at both sites to reach at least 98 hours per week of consultant cover; • Reach Clinical Negligence Scheme for Trusts (CNST) Level 3 by September 2018.
Normalise the birthing pathway, as per Department of Health aims on home births	Better patient experience; Shorter average length of stay; Better value for money.	• Increase use of midwife-led birthing unit, including at the newly developed Queen Elizabeth Hospital site; • Redesign discharge process.
Adjust staffing mix	Better value for money.	• Shift towards a 90:10 split of midwives to midwife support workers; • Train nurse colposcopists and midwife ultra-sonographers.
Transform outpatient services and redesign settings of care	Reduces average length of stay.	• Seven days a week working in gynaecology; • Introduce ambulatory gynaecology service; • Overhaul antenatal services.
Ensure our sexual health services meet commissioners' evolving needs	More convenient for the patient; Better value for money.	• Automate the booking and results process; • Improve HIV detection rates by testing all under-70 inpatients upon admission; • Deliver more services in primary care and community locations.

Children & Young People

3.25. We wish to develop our children's and young people's services Trust-wide through an integrated workforce team delivering effective clinical pathways across the two acute sites and in the community for the populations of our three boroughs. This will help us ensure services consistently achieve the best possible clinical outcomes. Over the next five years, we intend to continue to offer an acute paediatric service that works on both sites, with a comparable level of care, but different facilities in the two hospitals.

3.26. We are committed to achieving the London Quality Standards where we do not yet meet them. Having reviewed the challenges we face, we are exploring how to develop children's inpatient services further, working in a networked way to support the two emergency departments.

3.27. Where commissioners are supportive, we will be seeking to expand provision of children's community services in three boroughs. This will allow us to strengthen the out-of-hospital pathway, in both quality and working hours. In part, we will do this by strengthening our alliances with tertiary partners, which will enable us to provide more services locally and will have the benefit of releasing much needed capacity in the tertiary centres.

3.28. We are keen to develop a clinically sustainable model for neonatal services that builds on our existing strengths and that is aligned with the future direction of maternity and obstetric services. We look forward to doing further work on the development of this model with our staff and partners over the coming few months.

3.29. The key objectives of our plan for children's and young people's services include:

Figure 14: Key objectives for children's and young people's services.

Goal	Benefit	Method
Higher quality paediatric inpatient care	Improved quality and patient experience.	• Inpatient activity delivered as a networked service across the Trust supporting our children's emergency service, co-located with the two emergency departments.
Consider developing a paediatric high dependency unit	Improved quality and access; Fewer transfers out of children with high dependency unit needs.	• Work with tertiary partner to develop a high quality service.
Develop new model of acute paediatric service	Equal access to paediatric expertise for the acutely ill child; Short stay facilities for children with appropriate conditions; Access within the Trust to extended inpatient care where required.	• Develop new service model of care by learning from best practice elsewhere.

Consolidate elective paediatric day surgery	Improved quality.	• Consolidate day surgery on one site.
Neonatal care aligned with maternity model	More equitable access to neonatal medical expertise across the Trust; Fewer neonatal transfers out of the Trust; Smoother and more effective care for neonates.	• Collaboration with women's and sexual health division; • Align with commissioners.
Work with tertiary partner around providing a step down inpatient ward at one of our sites	Ability to support paediatrics services on both sites.	• Strengthened partnership with tertiary children's services provider.
Transformation of pathways and outpatient services	Improved quality, reduction in admission.	• Working with General Practitioners, including access to real-time paediatrics advice; • Educational role in pathways and management of unwell children; • Responsive community services; • Common community service model across boroughs.

The Clinical Business Unit – Pathology

3.30. We aspire to provide a sustainable, clinically led, high quality pathology service that demonstrates value for money and meets all accreditation and statutory requirements.

3.31. In recent years, Queen Elizabeth Hospital operated as the 'hub' laboratory for South London Healthcare Trust, providing all pathology services to the Queen Mary's Hospital, Sidcup site, and the main laboratory services to the Princess Royal University Hospital site. Following the dissolution of South London Healthcare Trust, the Queen Elizabeth Hospital laboratory has continued to provide the hub laboratory service to the Princess Royal University Hospital site via a Service Level Agreement with King's College Hospital NHS Foundation Trust; and to provide pathology services to providers on the Queen Mary's Hospital, Sidcup site via Service Level Agreements with both Dartford and Gravesham Trust and Oxleas Foundation Trust. King's College Hospital NHS Foundation Trust have advised us of their intention to withdraw their pathology service requirement from July 2014, Dartford, and Gravesham NHS Trust will withdraw their service requirement from December 2014. Our financial plan reflects these intentions and provides the opportunity to rationalise pathology across our two acute sites.

3.32. Rationalising our pathology services will enable us to provide an improved service but will require the reconfiguration of the pathology services currently provided at both Queen Elizabeth Hospital and University Hospital Lewisham. In the period since the merger, we have invested significantly in designing the transformation of our services to enable this to happen. Working with front line laboratory teams we have redesigned systems, processes, and workforce roles to position the service well for the changes that are beginning to happen.

3.33. Over the first two years of this plan, we will reconfigure our pathology service to provide a rapid response laboratory on the University Hospital Lewisham site, supported by the existing hub laboratory on the Queen Elizabeth Hospital site, and ultimately point of care testing at local GP surgeries. The reconfiguration of pathology will require investment but it will reduce unnecessary duplication and improve the utilisation of current assets. It will make us more financially viable, but it will take time. As a result, the benefits are not likely to be realised until the end of 2015/16 at the earliest.

3.34. In the following 2-3 years, we will move to consolidate the service across the two sites. We will fully implement the IT and automation plans in order to integrate and improve the service to a highly competitive standard.

3.35. The key objectives of our plan for pathology services include:

Figure 15: Key objectives for pathology services.

Goal	Benefit	Method
Consolidation across two sites	Improved quality, effective use of resources.	• Establish a Rapid Response Lab at University Hospital Lewisham, and transfer cellular pathology to University Hospital Lewisham; • Redesign staff roles and structure; • Logistics to support service reconfiguration.
One workforce across 2 sites, 24/7	Improved quality and access.	• Team-wide working
IT and automation	Improved quality, effective use of resources.	• Implement Laboratory Information Management System and T-Quest order-comms; • Equipment replacement programme.
Rationalisation of services offered	Effective use of resources.	• Clinically-led determination of criteria and process; • Tests provided and tests sent out – best value procurement.
Make it easier for patients to access our services	Better patient experience; Frees up estates.	• Work with General Practitioners to create point of care testing in primary care and the Locality Care Networks.
Interaction with other agencies	Improve coordination; Positive impact on development and recruitment of workforce.	• Establish strong working relationships with service users – General Practitioners, commissioners etc.; • Links with tertiary partners for development and training; • Links with universities to improve staff training and recruitment.

The Clinical Business Unit – Pharmacy

3.36. Over the next five years, we wish to build on the strengths of our pharmacy service, which supports our own clinical services, and provides medicines management services and a specialist dispensing service to General Practitioners. We are currently concluding a review of pharmacy services with a view to moving to seven day working, improving the use of medicines in line with national guidance and exploring opportunities to expand our General Practitioner facing services in 2015/16.

3.37. We intend to deliver better care at better value by making better use of our skilled pharmacy workforce to ensure the right patient gets the right medicine at the right dose at the right time by the right route.

3.38. The key objectives of our plan for pharmacy services include:

Figure 16: Key objectives for pharmacy services.

Goal	Benefit	Method
Develop and deploy workforce more effectively	Improved quality and efficiency.	• Joint service across both sites.
Explore commercial partnerships	Improve patient experience and deliver financial benefits to healthcare system.	• Tender outpatient dispensing service; • Provide retail pharmacy facility.
Technological solutions	Reduced risk, improved efficiency.	• Introduce automated robot dispensing system at Queen Elizabeth Hospital.
Seven day working	Enhanced access.	• Providing increased access to specialist pharmacist knowledge.
Assist Clinical Commissioning Groups in delivering alternative Quality, Innovation, Productivity and Prevention (QIPPs)	Effective use of resources in the healthcare system.	• Vial sharing dispensing service; • Explore widening the implementation of the Lewisham “Dressings” and “Specials” QIPP schemes to Bexley and Greenwich Locality Care Networks.
Work more closely with patients and carers	Quality, effective use of resources.	• Extend the clinical pharmacist’s role; • Admission avoidance through development of community outpatient parenteral antimicrobial therapy services.

Ensuring the overall clinical sustainability of our services

3.39. The service specific plans, set out above, provide some of the richness of the detail developed by the clinical and managerial teams in each of our divisions. Our Board has reviewed these plans, and we believe they form a clinically coherent programme to ensure the sustainability of our services through:

- working with commissioners to deal with the very high levels of **emergency medicine** demand across our localities by jointly changing our model of care into one where ambulatory care is the default;

- supporting the move of Long Term Conditions management closer to the patient by working more closely with primary care and providing innovative new models of access to services;
- building internal Trust surgical centres of excellence for elective and emergency surgery on separate sites so we can provide dedicated capacity whilst maximising workforce efficiencies;
- strengthening our women's and sexual health services by regaining our market share in maternity services through improved patient experience and more responsive services;
- leveraging the benefits of network working with tertiary providers in Children & Young People, to ensure a critical mass of local services and workforce models that are attractive to staff;
- proactive identification and management of workforce risks; and
- underpinning each plan for clinical (quality, safety, and workforce) sustainability with sound action to ensure financial sustainability too.

Cross-cutting initiatives

3.40. As enablers to our clinical strategy, we have four cross-cutting initiatives in: procurement, seven day working, technology, and variable and agency pay. The quality and financial benefits from each cross cutting initiative are being captured within each clinical division's own five year strategy to avoid any potential for double counting. A high level description of each cross cutting initiative is given below:

3.41. On **procurement** we are aiming to make significant procurement savings of around £2-2.5 million per year via the implementation of a new procurement strategy led by our Director of Finance. We are supported in doing this through our continued involvement in the London Procurement Project. Our procurement strategy describes how we are:

- Improving our Operating Model, including re-structuring the procurement department;
- Introducing the new role of Category Managers within the procurement team to help our Divisional Business Partners to reach their procurement targets;
- Unifying the way we manage procurement across the Trust, improving standard operating procedures, providing targeted procurement training and identifying opportunities to improve our processes;
- Making better use of technology, including new e-procurement tools;
- Investing in analytics and increasing engagement with suppliers to identify cost reduction opportunities and improve supplier performance.

3.42. As part of our commitment to increasing our **seven day working,** we have established a cross-Trust initiative to support our clinical divisions to understand and implement the necessary changes. Under the leadership of our Director of Workforce and Medical Director we have modelled the pay implications of this shift at £6.5 million a year. That figure will change as we implement the other changes in this plan, but is made up of salaries for additional staff; weekend premia; and changes to rotas, on-call, and shift patterns. As part of this initiative, we are seeking to future-proof the contracts of future staff and beginning to plan the consultation on changes to existing contracts.

3.43. Within the Trust, we see **technology** as a critical enabler to our future success and to the implementation of the clinical strategy set out in this plan. Our strategy focuses on the following aims:

- Deploying single Cerner instances (iCare-electronic patient record) on each site, followed by iCareQEH exit from the British Telecom (BT) data centre and finally a merger programme; the latter activity ensuring a single patient administration system(PAS) and Trust-wide electronic patient record(EPR);

- Deployment of a virtual patient record (VPR) for the whole health economy to support integration with primary and social care through the Locality Care Networks;

- Provision of accurate clinical and management information; and

- Safeguarding infrastructure service quality and continuity.

We do face significant Information management and technology challenges and are working hard to address these to ensure that we meet both our immediate operational requirements and our longer-term strategic needs. Our most significant Information management and technology challenge is the deployment of the two separate Cerner systems in in July 2014 and early 2015 for which we are currently on track. Ensuring successful 'go-live' on both sites is critical for the safe delivery of services to patients on a day-to-day basis. A further challenge relates to the migration of iCareQEH from the British Telecom data centre prior to October 2015, which adds a new, costly, and currently unfunded, step to the original plan. Many of the benefits of Cerner will only come later as we integrate the two separate systems and deploy deep clinical functionality, such as ePrescribing. This will give staff a single view of activity across Lewisham and Greenwich NHS Trust.

3.44. On **agency and variable pay** we are working across our clinical divisions to minimise the £24 million we spend each year on agency staff and to get maximum benefit from the £52 million we spend on variable pay such as enhanced hours and pay protection. We are developing further details over the course of the summer 2014 for how we will reduce our pay bill through:

- Harmonising pay across the Trust where possible and appropriate;

- Reviewing pay protection and marked time;

- Job planning, e-job planning and improvements in clinical staff rostering, including further improving nurse e-rostering;

- Ensuring that the impact on levels of High Cost Area Supplement are actively considered when making changes to location of staff;

- Taking action to ensure best value from agency staff suppliers and to minimise spend;

- Recruitment (substantive and bank);

- Revising temporary staffing policy and controls.

Estates and Capital Planning

3.45. Strong estates, facilities planning, and management are essential to the delivery of this five year plan and the clinical strategy described above. Our enabling plan for our estates focuses on the following key aims:

- Ensuring that estates at both main sites and all community sites are safe, secure and sufficiently well maintained to ensure continued service provision to patients;

- Supporting the Trust to deliver its immediate service delivery plans through the provision of improved or additional capacity, such as the Queen Elizabeth Hospital emergency department and endoscopy at both Queen Elizabeth Hospital and University Hospital Lewisham;

- Developing a medium to long-term Estates strategy working closely with the clinical divisions to support the delivery of the new models of care set out in Section 3, while seeking to maximise the efficiency and productivity of the estate.

3.46. Following the creation of the Trust, we have developed a baseline stocktake of current and planned capital developments to support us in making medium to long term decisions on the use of our estate.

Given the heavy Private Finance Initiative footprint of our sites and the significant number of poor quality estates issues, which need to be rectified at Queen Elizabeth Hospital, we need the on-going support of our partners. In particular, we are working with the Trust Development Authority around four core schemes; theatres and endoscopy; road access to Queen Elizabeth Hospital; sterile services; and the emergency department at Queen Elizabeth Hospital. We are also continuing to invest in on-going schemes including a significant internal programme on IT and the development of a new midwife led birthing unit at Queen Elizabeth Hospital, detailed earlier in Section 3.

3.47. Our estate configuration provides us with a clear opportunity to reduce costs, in particular around the utilisation of the north end of the site at University Hospital Lewisham and the south end of the site at Queen Elizabeth Hospital. We believe there is a saving of around £15 million per year to be realised through altering our site footprint and have commissioned external support to evaluate the commercial opportunity, with a report due in early July 2014. We also believe there are opportunities to realise benefits through centralising our corporate services onto one site. This will allow us to maximise efficiencies, and develop or dispose of surplus property.

Clinical networks

3.48. We will continue to play our part in local clinical networks across South East London, particularly for specialist services such as cancer, cardiac, stroke, maternity, and neonatal services. These networks give local people access to tertiary centres of specialist care, whilst ensuring patients receive much of their care closer to home. The table below sets out the clinical networks in which we are involved:

Figure 17: Clinical Networks in which Lewisham and Greenwich NHS Trust is involved.

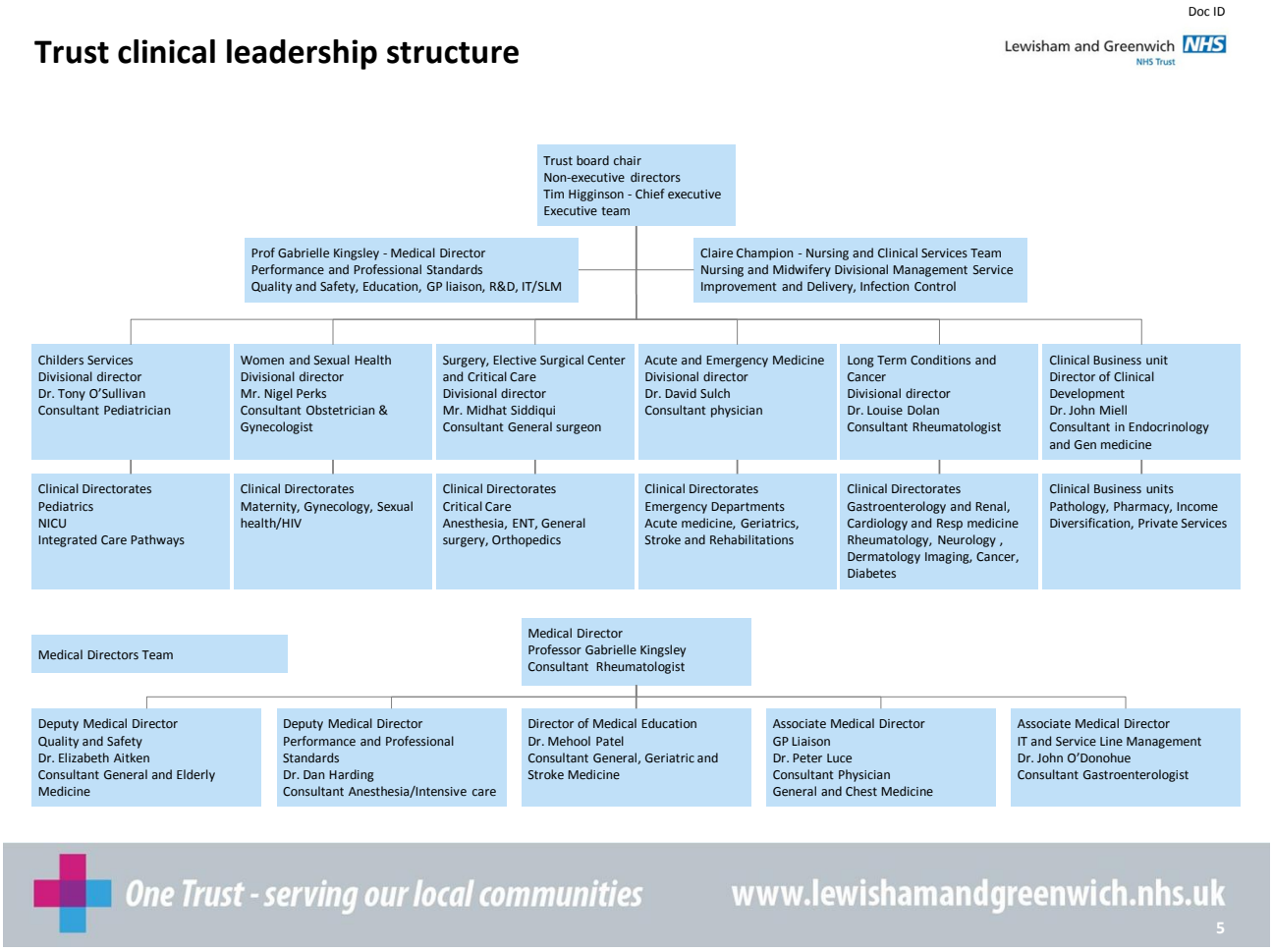
Network	Commentary
Clinical Networks	
London Cancer Alliance (Crescent Integrated Cancer System)	• Established 2011; • Serves catchment population of approximately 4.8 million; • Geographically covers three London Clusters: South East, South West and North West London; • Two Academic Health Science Centres; • Institute of Cancer Research; • Only Biomedical Research Centre for cancer in UK plus Biomedical Research Centres at KHP and Imperial; • Three Experimental cancer Medicine Centres; • Two Health Innovation and Education Clusters.
South London Cardiac and Stroke Network	• Two Boards – South East London, South West London; • Serves catchment population of approximately 3 million.
London South East Perinatal Network	• Serves catchment population of approx. 1.5 million; • Geographically covers six SE London boroughs: Lambeth, Southwark, Lewisham, Greenwich, north Bexley, Bromley.
Research and Education Networks:	
South London Academic Health Science Network (now known as South London Health Improvement Network)	• One of 15 South London Academic Health Science Networks across England designated in May 2013 to drive improvements in patient care by sharing innovations across the health system and capitalising on teaching and research strengths; • Geographically covers 12 South London boroughs.

South London Clinical Research Network	• One of fifteen local clinical research networks in England; • Hosted by Guy's and St Thomas's Trust, and covering the work previously undertaken by comprehensive and topic specific research networks, such as stroke, cancer and medicines for children; • Provides support for the delivery of clinical research.
South East Clinical Effectiveness Network	• Collaborative of professionals working in quality improvement including; clinical audit, effectiveness and governance.

Clinical leadership and Service Line Management

3.49. In designing and leading the new Trust, the Board have been eager to ensure we are a clinically led organisation. Clinicians are responsible both for delivering quality day to day in each interaction with every patient, but also overall for embedding quality into the leadership and running of all services. The single integrated clinical leadership team who have been in place and meeting regularly since September 2013 have developed the clinical strategy set out in this plan on behalf of the Board.

Figure 18: Trust clinical leadership structure.



3.50. Over the next five years we wish to significantly strengthen clinical leadership through:

- Supporting the divisional and clinical directors and other senior clinicians to develop their own leadership skills and to increasingly manage their divisions as semi-autonomous business units within an overall framework of accountability set by the Board;

- Embedding a culture of service line management down from divisions to front line clinical teams so that those who provide the service - and therefore know it best - are responsible for leading the

development and delivery of their services within available resources, to an appropriate quality standard;

- Reviewing those functions that we currently provide centrally and identifying those that clinical divisions could provide more effectively and efficiently. We expect that this will help shift more of the focus of our work in improving quality away from monitoring compliance and into embedding improvements locally.

3.51. Key executives within the organisation have been trained and supported in the implementation of service line management through a partnership with Monitor and external consultancy support. This learning is being applied in the Trust's clinical leadership structure, for example through devolved budgeting.

3.52. The patient level costing infrastructure that was in place at Lewisham Hospital will be further developed and re-launched having addressed the budget information complications that arose during the merger.

Further refinement of the plan, and dependencies

3.53. All of these plans need further refinement as the process of building this five year plan is not complete or closed. We believe that our plans align well with commissioner expectations, but further work is required to assure our respective plans further. Section 3.54 below sets out how we believe our plans are aligned, as a good starting point. In the course of the summer, we will also be working to improve the plan with public and staff feedback.

Alignment between our plans and health partners plans

3.54. In developing our divisional level clinical plans, we have built on the emerging plans from the South East London Clinical Commissioning Groups to ensure strong alignment. A number of our senior clinicians have been directly involved in the Clinical Commissioning Group led Clinical Leadership Groups that have designed the seven strategic interventions that are at the centre of the plans. We have mapped the key features of our respective plans in the table below:

Figure 19: Alignment between Trust and Clinical Commissioning Group plans.

Strategic intervention	Key feature of strategic intervention in Clinical Commissioning Group plan	How our plans align to these interventions
Primary and community care (including social care)	Primary care (defined in its broadest sense) will be provided at scale by 24 Locality Care Networks supporting populations of 53,000 to 156,000. This will be a universal service covering the whole population 'cradle to grave'. The changes to primary care will focus on four high impact areas, with at scale delivery in Access; Proactive care; Coordinated care; Continuity of care.	• We welcome the aspiration to deliver more care by primary care and more within community settings and have planned that 20% of current outpatient activity will not be necessary in five years as primary care services develop; • Further to this we expect we will deliver an additional 20% of our current outpatient appointments very differently, for example on-line or as group consultations; • We are developing the Virtual Patient Record to support joined up care across primary, secondary, and social care initially within Lewisham but we hope that other commissioners will also want to benefit from access to the system; • We are committed to provide increased access to imaging and point of care testing in the community; • We are planning a significant improvement in the

		quality of the adult community nursing services we provide to enable us to support more patients in the community; • Our clinical specialties are looking at how to develop their services further in order to support Locality Care Networks.
Long Term Conditions, physical and mental health	We will segment how we support those with long-term physical and / or mental health conditions into three levels of need. Locality Care Networks will play a lead role at all stages and there will be a consistent focus on reablement; not just the prevention of deterioration, but returning people to better health.	• We welcome the strong focus on segmenting services to meet patients' needs and pro-active management of patients through a consistent focus on reablement as this will support our expectations of reduced length of stay and readmissions and improve quality of care; • We are significantly improving our technology systems to support the better management of patients, through an electronic patient record but also including virtual patient records to enable cross-organisational coordinated care; • In acute and emergency medicine, we are developing a frail elderly pathway and adult ambulatory pathways that will be very focused on ambulatory treat and discharge models of care for patients with Long Term Conditions; • In Long Term Conditions, we are committed to integrating with other stakeholders. Our services will be increasingly primary care facing to reduce the reliance on in hospital care.
Planned care pathways	• Elective centre model; • Transformed diagnostics capability across South East London; • Shared standards; • Smart contracting	• We wish to improve local access to imaging and other diagnostic services including the development of scoping suites on each site; • We are planning to move our inpatient elective services onto a single site to provide a better, faster patient experience with fewer cancellations and improved standards of care; • We plan to integrate all of our booking services and make better use of technology to improve coordination of care and better efficiencies in our processes'
Urgent and emergency care pathways	Rapid access model: home ward and sub-acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health); urgent care centre co-located with emergency department and out of hours – minor illness, injuries and burns with diagnostics and	• We are committed to providing high quality integrated and co-located urgent and emergency care services on both hospital sites; • We will redevelop the emergency department at Queen Elizabeth Hospital to provide a significantly improved patient experience and ensure optimal capacity; • We will extend our current urgent care services to seven days a week and bid to provide these services on Queen Elizabeth Hospital site too. • We are developing a Trust-wide model of care for acute medical unit/medical admissions unit that will see ambulatory care as the default model for all but the sickest of patients;

	prescribing; Moving from an 'admit to hospital' default model to 'do and discharge'; Services meeting London Quality Standards.	• We will develop a frail elderly model to provide high quality care for this patient group and support their reablement without the need for hospital admission; • We will significantly improve the quality of our adult community nursing services and develop a virtual ward; • We will introduce new workforce models and extend our seven day working to ensure delivery of the London Quality Standards.
Maternity pathways	Single point of contact – to inform newly pregnant women of their options and choices; Promotion of normalised birth: including home birth for second and subsequent deliveries; birth centres for low risk first deliveries; Continuity of care through a 'midwifery led' model with improved/extended consultant cover; Assessing for women's toxic stress during pregnancy; Services meeting London Quality Standards and other maternity quality standards.	• We will build on our areas of high quality maternity care and achieve the London Quality Standards as quickly as possible; • We will open a second Midwife Led Birthing Unit (on the Queen Elizabeth Hospital site) and promote normalised births with an aspiration of having 25% of deliveries midwife led by 2018/19; • We will extend consultant cover on the labour suite in line with commissioner intentions; • We will improve patient experience and service efficiency by introducing Midwife Support Workers as 10% of our workforce; • We will train up some of our midwives to undertake sonography, providing better patient experience and helping us tackle workforce shortages for technical staff.
Children & Young People's pathways	Collective focus on the child including, 'every contact counts'; Improved Access – 'no wrong door'; Integrated step-down from hospital designed around child; Services meeting London Quality Standards.	• We will improve the quality of children's services and retain access to services on both acute sites; • We will move towards a paediatric services that meet the London Quality Standards and provide improved quality and patient experience • We will work with tertiary providers to provide improved network capacity; • Develop a new model of service for acute paediatric care on the non-inpatient site; • We will transform pathways of care by integrating our outpatient services with primary care, providing General Practitioners with access to real-time paediatrics advice, and by ensuring that community children's nurses, health visitors and school nurses provide more an extensive range of services in non-acute settings.

Cancer pathways	Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long-term condition and improved end of life care.	• We will increase our focus on providing high quality cancer services through strengthening our management capacity in this service and ensuring strong operational grip of cancer standards; • We will make best use of technology to support Trust-wide working including multi-disciplinary team meetings with access to Trust-wide imaging and pathology services; • We plan to integrate all of our booking services and make better use of technology to improve coordination of care and better efficiencies in our processes; • We will increasingly look to provide services closer to home. We will seek to bring tertiary patients into our secondary care where we deem it safe and appropriate to do so. We will aim to move patients in secondary acute settings into the community, or treat them on an ambulatory basis to provide improved patient experience and less need for inpatient care; • We will move to stratified follow up for outpatient services to provide faster access to care for those who need it and improved patient experience for all.

Alignment between our plans and local authority partner plans

3.55. There are strong and developing links between the Trust and our local authority partners. In Lewisham, we are working closely with the Borough through integrated health and social care models of working to maximise the benefits to patients and service users. Across all three Boroughs of Lewisham, Greenwich and Bexley we are working with the local authority representatives to ensure that the Better Care Fund and other joint programmes are successful. There are a number of important links and dependencies between our clinical strategy and this work including:

- Supporting the ambulatory and frail elderly models within our plans for acute and emergency medicine to avoid admission;
- Supporting the shift of care closer to home; and
- Supporting reablement, to accelerate discharge.

□ □ □

4. Service capacity and developments

4.1. In establishing the Trust, it was well recognised that we inherited a legacy deficit from the transfer of Queen Elizabeth Hospital. Our two year integration Business Plan set out how, with the support of transitional funding to 2016, we would begin the transformation of the Trust, and start the difficult process of becoming a clinically and financially sustainable organisation.

4.2. Our modelling of our five year financial challenge set out in the accompanying Long Term Financial Model (and described in more detail in Section 7) shows that we face a £125 million cumulative financial challenge over the next five years and describes how we plan to close this through two key levers:

- Implementation of the clinical strategy set out in Section 3 - which will radically improve quality and contribute £94 million to closing this gap over the five years;
- Reduced corporate and estate costs - which will contribute the remaining £31 million to closing the gap over the five years.

4.3. Of this £125 million financial challenge, the vast majority of the opportunity is to be realised by the Trust through quality, productivity and efficiency improvements in the way we work. We expect little, only around £11 million to be a net contribution gain to close the gap from increased activity. This is limited to repatriation of locally commissioned work that goes out of area today due to capacity constraints (such as cardiology services) and a small number of strategic service developments which we believe are likely to be supported by commissioners and existing providers (such as expansion to our urology service).

4.4. The five year divisional and corporate initiatives identified so far are expected to deliver £112 million of the £125 million financial challenge. We are continuing work both to develop additional plans to bridge the gap fully by 2018/19 and to create more detailed implementation plans to back these up.

Summary expected impact of five year plan

4.5. Over the next five years, we expect activity levels to be negatively affected by Clinical Commissioning Groups QIPP schemes and positively affected by the growth in local population and the small number of growth backed service developments. Overall activity is expected to reduce by 0.5% over the period, as shown in the accompanying long term financial model. It should be noted that the parallel activity trajectories submitted via Unify2 only collect information on a sub-set of the trust's commissioners and activity and therefore do not provide a comprehensive position and as such are not directly comparable to the analysis within the long term financial model.

4.6. Each division, and the corporate executive team, have carried out a preliminary assessment of the potential positive financial impact of the initiatives proposed in the current plan. The current estimates of the impact by year five are summarised below:

Figure 20: Expected financial impact of divisional and corporate schemes.

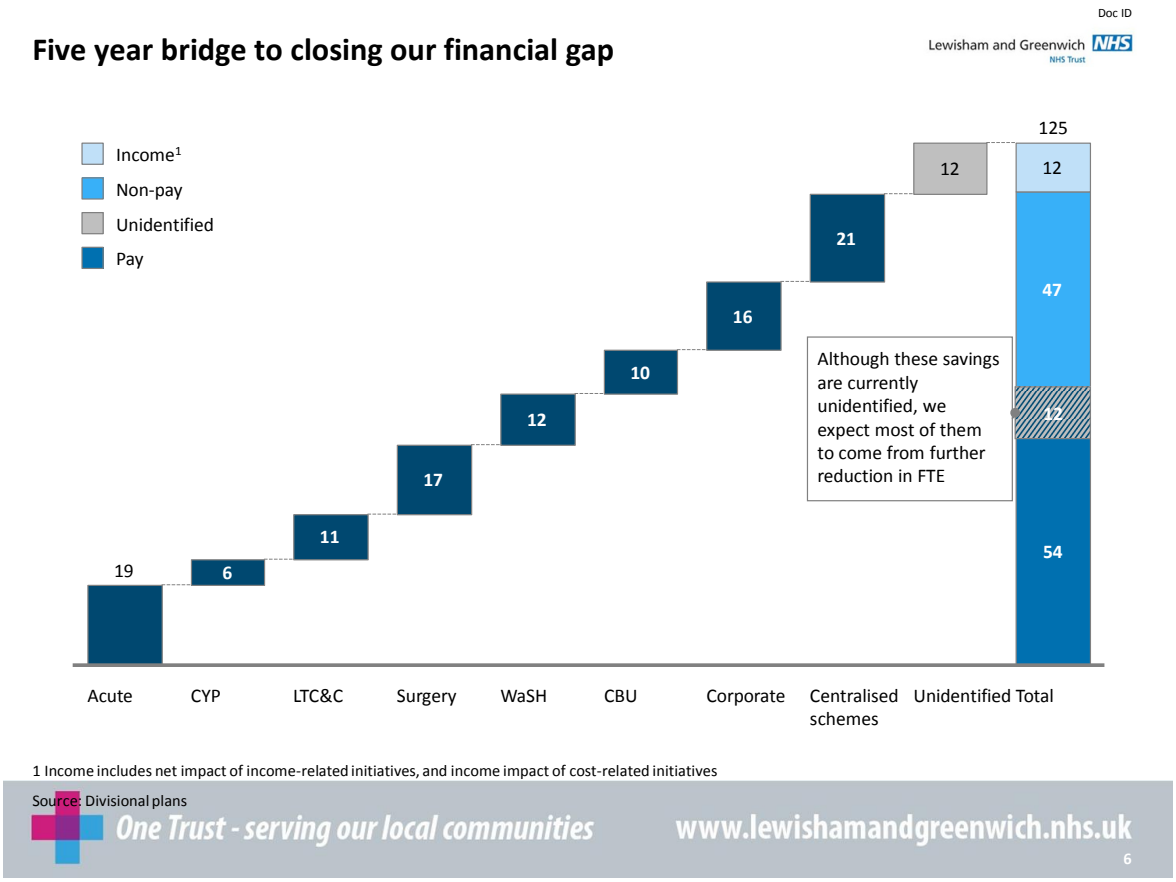
Division	2018/19 Impact, £000
Acute & Emergency Medicine	19,074
Children & Young People	6,249
Long Term Conditions and Cancer	10,813
Surgery	16,568
Women's and Sexual Health	12,142
Clinical Business Unit	10,465
Total clinical divisions	**75,312**
Corporate Divisions	16,158
Total All Divisions	**91,470**

4.7. We are also planning to carry out a number of centralised initiatives that will lead to a more efficient use of our resources. In particular, we are expecting a significant saving from the rationalisation of the estate, which is expensive and currently underutilised. Overall, the centralised schemes are expected to deliver the following financial savings to the Trust by the end of the period:

Figure 21: Breakdown of centralised schemes.

Centralised scheme	2018/19 Impact, £000
Medical equipment contract	1,500
CNST reduction	3,000
Estates Soft FM Services	1,500
Estates Rationalisation	15,000
Total centralised schemes	**21,000**

Figure 22: Bridge chart of financial impact of divisional and corporate schemes over the next five years.



Summary impact on workforce

4.8. The financial impact delivered by the plan is expected to be achieved by reductions in FTEs and by the move to a different skill mix in the workforce, as well as by reductions in non-pay expenses. Given our current level of use of agency staff, and our high attrition rate, we expect to be able to manage the transition over the next five years without the need for redundancies. Further details are set out in Section 6.

4.9. This is an ambitious plan. However, we believe it is a credible and clinically coherent plan. It is owned by the Board and already has significant clinical staff support. We have risk assessed our plan as outlined in Figure 23 below. This assessment is further supported by individual high level costed and risk assessed five year plans for each clinical division.

Our key strategic risks and plan for mitigation

4.10. The Figure below details our risk plan.

Figure 23: Key strategic risks to the five year plan and mitigating actions

Key risk	Description of key risk	Likeli-hood	Conse-quence	Risk level	Mitigation plan
Quality	Not able to deliver desired quality to meet our expectations, address Care Quality Commission concerns, and/or reach London Quality Standards.	3	5	15	• Strong Board primary focus on quality and safety; • Implement our clinical plan as set out in Section 3; • Close collaboration between clinical leadership and executive team to monitor risks and address swiftly; • Work closely with third parties and other stakeholders to address shared risks.
Workforce	Not able to quickly recruit and retain right staff, with the right skillset, in line with the needs of the proposed clinical models.	4	5	20	• Develop new flexible workforce roles to circumvent current skills gaps; • Focus on culture, transformation and organisation development as a way of changing organisational reputation; • Take advantage of current rates of attrition to introduce any necessary contract changes; • Explore workforce / service partnerships with Guy's and St. Thomas' NHS Foundation Trust.
Community services and district nursing	Quality and level of community service capacity insufficient to support the proposed changes in the acute model.	3	4	12	• A focussed project to rebuild community nursing workforce; • Work closely with Clinical Commissioning Groups and General Practitioners to develop model of care linked to primary care locality networks; • Collaborate closely with other providers where necessary; • Introduce and promote new way of working, including use of technology.

IT and other technology	Not able to identify and implement appropriate technologies, deploy planned technology quickly enough, and/or or with appropriate behaviour change to realise necessary benefits to deliver plan.	4	4	16	• Develop benefits realisation approach with each division linked to transformation programme; • Maintain Board level task and finish group to ensure Cerner deployment and migration from BT data centre by Oct 2015; • Close collaboration between divisions and IT executive team; • Accelerate IT training of workforce, including those in community services.
Internal clinical support for plan	Implementing plan will require the support of clinicians across the divisions, who may be resistant to change.	2	5	10	• Continue to support divisional leadership teams in developing plans in conjunction with their wider clinical team; • Develop internal communication strategy; • Use Trust Transformation capability building programme to equip divisional leaders with further enhanced skills in strategy development and peer and staff engagement; • Identify implementation barriers early on and develop risk mitigation plans.
Execution of plan and achievement of financial savings	Not being able to deliver the plan in smooth and timely manner, and to the required high standard within available resources	3	4	12	• Board to oversee implementation as core part of strategic oversight • Develop a robust implementation plan, including detailed overall timetable taking into account interdependencies • Monthly divisional performance reviews to check implementation progress, including against quality and financial metrics, and to escalate issues as required to Trust management executive and Board • Ensure good alignment between the strategy, finance, performance and transformation teams to monitor and support divisions in implementing plan • Continue strategy development process to October 2014 & link to 2015/16 operational planning

Changes in commiss-ioners' intentions	Unexpected changes in commissioners' plans, which could be inconsistent with our current plan	3	4	12	• Ensure Trust representatives are well connected to local and national discussions on commissioning. • Continue to improve quality (in all services but particularly in those that are weakest and therefore at increased risk) to minimise likelihood of Trust losing service contracts • Explore all opportunities to partner with commissioners on alternative QIPP schemes to reduce their need to change commissioning intentions
Competition from other providers	Competition among providers undermining collaboration	3	3	9	• Continue to engage in collaborative way with other providers • Continue to improve quality (in all services but particularly in those that are weakest and therefore at increased risk) to minimise likelihood of patients selecting to use other providers • Anticipate potential aggressive moves
Local community ownership of plan	Insufficient buy-in from local population.	3	3	9	• Early and well planned engagement and communication plan • Clinically-led and evidence-based engagement and planning
Stakeholder buy-in	Other key stakeholders resistant to proposed plan	3	3	9	• Early and well planned engagement and communication plan • Clinically-led and evidence-based engagement and planning

Lewisham and Greenwich NHS Trust Board mitigations

4.11. Should there be a significant change in the local or national context that affects the assumptions underpinning our plan, such as a significant unexpected additional reduction in funding, we would take all necessary and appropriate action internally to ensure that we can provide the high quality of services we wish to provide within the available resources. Our expectation is that we would continue to proceed with the clinical plan as set out in Section 3 as this is the best way we foresee of delivering our vision of "One Trust – Serving our local communities" and our mission to "…provide the best possible healthcare for our local communities, working collaboratively with all our partners".

4.12. We would not expect to rely on additional funding from commissioners. Instead, we would seek their help in other ways to help us to redouble our efforts. We would revise our implementation plans to achieve the same expected clinical quality through increased pace, tightened management grip; alternative approaches, such as a greater focus on reducing staffing establishment, rather than pay bill reductions; and from market testing of suitable additional non-clinical and clinical services that we could offer from Lewisham and Greenwich NHS Trust's estate.

□ □ □

5. Delivery of operational performance standards

5.1. In keeping with our commitment that quality and safety is our foremost priority, our plans for the next five years are built on a foundation of ensuring operational grip of performance standards, delivering and, where possible, exceeding performance expectations, and transforming our services to provide an ever better patient experience.

5.2. This Section highlights our key operational challenges in meeting our immediate priority of ensuring we consistently meet quality and safety standards across both sites, both now and in the future.

5.3. We recognise that our previous performance has not consistently been good enough. Weaknesses confirmed in our recent Care Quality Commission inspection are set out together with our improvement action plan in Section 2.5-2.8.

5.4. We have developed our clinical strategy in order to enable us to address those performance challenges on a sustainable basis.

5.5. Having reviewed current delivery of operational performance standards and considered the difficulties we are likely to face over the next five years, we believe that our main challenges in ensuring consistent delivery of the standards are:

- Improving patient experience – including as evidenced by national patient survey and friends and family test results;
- Ensuring as far as possible in year 1 that any remaining legacy performance reporting issues from the acquisition of Queen Elizabeth Hospital, which were not flagged in the due diligence materials or handover materials provided to us, are identified and rectified;
- Improving emergency access to treatment for emergency department against the 4-hour target, working closely with our partners in the urgent care network. Pressures here are due to increasing demand, capacity shortfalls and the need to modernise pathways of care into ambulatory / community based services;
- Ensuring continued high performance for elective access to treatment – particularly 18 week referral to treatment for smaller clinical services where we have limited flexibility to cope with variations in demand, and during the next 2 years as we change IT systems;
- Addressing cancer referral to treatment times – particularly where pathways cross organisational boundaries; and
- Continuing to deliver required performance standards during periods of service change and as commissioner Quality, Innovation, Productivity, and Prevention (QIPP) schemes take increasing effect.

Each of these challenges and our plans for addressing them are explained in more detail below.

Ensuring any legacy performance reporting issues at Queen Elizabeth Hospital are identified and rectified

5.6. Since the formation of the Trust there has been a major focus on identifying and resolving reporting issues at Queen Elizabeth Hospital which appear to have been a symptom of the complexity of the challenges that South London Healthcare Trust were facing. There have been multiple issues around data quality and the way reports are generated from the Queen Elizabeth Hospital IT system (the Hospital Information Support System), which we have explored with joint operational and information teams. Manual workarounds have been put in place pending either fixes to hospital information support system or the implementation of the Trust's new electronic patient record, iCareQEH in July 2014.

5.7. It is possible that over the coming 12 months some further legacy performance reporting issues will surface, although the scale of their impact will probably be lower than those identified in the last nine months. We have a programme in place to assure the quality of data reporting and will take robust action to fix identified problems as quickly as possible and in conjunction with our commissioners and the Trust Development Authority.

Improving emergency access to treatment in the emergency department

5.8. A key priority will be to deliver an emergency pathway that strengthens the emergency model of care and ensures robust and sustained delivery of our contracted emergency department performance on both sites, especially during the challenging winter period. This will play an important role in building public confidence in the new organisation.

5.9. The emergency pathway is crucial to ensuring patients are treated and managed by the right person, at the right time and within the right environment. Nationally the target is that 95% of patients attending the emergency department should be seen, treated, discharged, or admitted within four hours of their arrival at the emergency department.

5.10. This is a challenging target not just for Lewisham and Greenwich NHS Trust, but for the wider health economy and requires delivery of new ways of working to reduce hospital admissions, reduce length of stay and to create alternative access to urgent and emergency care. A process is in place to deliver these changes through the Urgent Care Network. We acknowledge that the significant changes needed will require whole-system support, and whole-system delivery, and that we have a significant role to play in this as a provider of acute and community services.

5.11. Additional resources will be required across both sites and additional capacity will be needed on the Queen Elizabeth Hospital site in the short-term to give assurance that the safety and quality standards will consistently be met. The key reason for poor performance at the Queen Elizabeth Hospital site has been the lack of inpatient bed availability causing flow issues within the emergency department itself. It will not be possible to create additional bed capacity at Queen Elizabeth Hospital in the near future, and the focus is thus on ensuring there is sufficient appropriate community bed capacity to meet patients' needs and the appropriate ambulatory pathways in place to mitigate a shortfall against demand and capacity projections. The focus on ambulatory care in our emergency care pathway will also mitigate some of these risks in the medium to longer term.

5.12. As with many emergency departments, Queen Elizabeth Hospital and University Hospital Lewisham have struggled to recruit sufficiently qualified members of staff on a substantive basis, causing an overreliance on bank and agency staff. The uncertainty over the future of both sites over the last 24 months and intense competition for staff from other local providers has exacerbated these issues.

5.13. All parties, including the Trust, Clinical Commissioning Groups, and Care Quality Commission agree that the current Queen Elizabeth Hospital emergency department is 'not fit for purpose'. Work has started to develop a business case to gain support and funding for its redevelopment in the medium term.

5.14. In parallel work is progressing to develop a sustainable solution to the emergency pathway, including the development of a frail elderly and single acute medical unit/medical admissions unit model across the Trust to improve patient experience and reduce length of stay. Section 3 outlines these transformation plans.

Ensuring continued high performance for elective access to treatment – particularly 18 week referral to treatment

5.15. Timely access to the elective pathway, and progression along it, is crucial to delivering a good patient experience and is an important factor influencing patient choice. Key quality indicators for the elective pathway include: 18 week Referral-to-Treatment target, the proportion of planned work undertaken on a day case basis and the number of operations cancelled on the day of surgery. Our key challenges

include a number of specialties that are challenged in delivering the standard and an increase in the total waiting list and backlog on both sites.

5.16. Section 5.6 outlines that there have been a number of difficulties with the inherited reporting system at Queen Elizabeth Hospital. The extensive analysis undertaken by Lewisham and Greenwich NHS Trust on the 18 week performance post-merger has identified that a number of the root causes were related to historic ways of working that did not comply with best practice. We have addressed these issues. However, the outcome has resulted in a short-term increase in the backlog. Moving forward we have developed a robust plan to clear this backlog with agreement from the commissioners and the Trust Development Authority, and will meet the target by mid-2014. Going forward, our aim will be to sustain delivery consistently.

5.17. We will be creating some additional bed capacity for elective inpatient surgery on the University Hospital Lewisham site, which will enable us to consolidate our inpatient services onto two rather than three sites, and this will enable us to achieve the London Quality Standards whilst improving efficiency.

Addressing cancer referral to treatment times

5.18. A cancer pathway that ensures prompt diagnosis and treatment is crucial to delivering the best possible outcomes and experience for patients with cancer. Historically both Queen Elizabeth Hospital and University Hospital Lewisham have struggled to meet the national cancer waiting time targets consistently, in particular two week waits and 62 day targets. In 2013, the Emergency Care Intensive Support Team undertook a review of both sites and produced a report, following which we developed an action plan to address the findings. As we move forward, we will strengthen our ability to meet the targets through participating in the South East London collaboration between providers to improve cancer performance.

5.19. We have strengthened management of cancer pathways by appointing dedicated clinical cancer leads and a dedicated senior cancer manager to provide a Trust-wide focus on cancer services and support the resolution of the issues. Our plan is to continue to build on this as we look to make additional clinical staff appointments in pressurised pathways for example gastroenterology / endoscopy, and dermatology. Figure 11 in Section 3 gives further details.

5.20. Using technology, we will ensure that there is support for Trust-wide working, including improving the access to pathology services as part of the pathology transformation project, and access to imaging that can be used remotely to support multi-disciplinary teams. Improved multi-disciplinary team coordination and tracking will help us meet the cancer waiting time standards. We will work to build a better method of capturing and analysing cancer data. This will allow us to improve the way we plan and target our cancer service delivery.

5.21. Our aim is to provide more ambulatory models of care, both electively and in the emergency care model, to improve the patient experience, and reduce the need for inpatient capacity.

Continuing to deliver required performance standards during periods of service change and as commissioner QIPP schemes take increasing effect

5.22. We have agreed high-level QIPP plans with our commissioners for 2014/15. Clinicians and operational management teams review and discuss the impact of the prime contractor agreements to ensure transparency and accuracy. Lewisham and Greenwich NHS Trust will continue to work in partnership with our commissioners to develop robust delivery plans for the identified QIPPs. Schemes agreed for 2014/15 affect the following areas:

- Reduction in excess bed days, follow up appointments, and consultant to consultant referrals;
- Convert inpatient to day case;
- Long Term Conditions – diabetes, chronic obstructive pulmonary disease, asthma;
- Community services in Lewisham;

- End of life care;
- Any Qualified Provider (dermatology, gynaecology, anticoagulation, phlebotomy);
- Planned care – including musculo-skeletal;
- Unscheduled care – including frail elderly;
- Children and women's services.

Other performance issues (For more detail, see the Quality Scorecard in Section 2.24 and complaints management discussion in Section 2.25.)

Never Events

5.23. Never Events and the response to them are an important indicator not just of the quality of care provided at a Trust but also a barometer for organisational culture around openness, learning and patient safety. Never Events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. In the period since merger on 1 October 2013, there have been three Never Events in the Trust – one at University Hospital Lewisham and two at Queen Elizabeth Hospital. We plan to drive down the incidence of Never Events.

5.24. Actions the Trust is going to take:

- We are planning a patient safety campaign to ensure all members of staff know that safety is their responsibility;
- Encourage greater reporting of incidents of all types through an extensive training and awareness programme;
- Ensuring that SI and Never Event reports address the root causes, and that the actions and recommendations are strong;
- Ensure learning from SI and Never Events is disseminated Trust-wide to all staff groups through patient safety leaflets and patient stories;
- Sign up to the Secretary of state's "Sign up for Safety" launching June 24th 2014 in which we will pledge to reduce avoidable harm and the costs of harm by one half, and in doing so contribute to saving 6,000 lives nationally over the next three years.

Mortality

5.25. Mortality rates are an important indicator of quality of care. The Summary Hospital-level Mortality Indicator is a mortality indicator, which was initiated by the Department of Health as a means of standardising how mortality rates are monitored and reported nationally. The Summary Hospital-level Mortality Indicator is the ratio between the actual number of patients who die following a treatment at the Trust and the number that would be expected to die, based on the average national figure for England. It includes deaths that have occurred outside of the hospital within 30 days of discharge as well as deaths within the hospital. The Summary Hospital-level Mortality Indicator is published quarterly on a rolling 12-month data period.

5.26. In the light of the findings of the Francis Public Inquiry we will build on and strengthen the systems that we have in place for reviewing mortality to reflect the new organisation and its structure and services. It has been difficult to disaggregate the data for Queen Elizabeth Hospital from that of South London Healthcare Trust but we will continue to aim for our Summary Hospital-level Mortality Indicator band to be sustained 'as expected' and will have the data for Queen Elizabeth Hospital resolved in 2014/15.

5.27. Risk Adjusted Mortality Index is similar to Summary Hospital-level Mortality Indicator but does not include deaths within 30 days of discharge from hospital. We regularly monitor mortality by using the Risk Adjusted Mortality Index, which allows monitoring of mortality rates for both sites, within individual directorates and specialities and to drill right down to specific cases that might need to be reviewed. These reviews take place at a specific mortality review group, chaired by the Deputy Medical Director (Safety & Quality). The Risk Adjusted Mortality Index score is reported alongside the Summary Hospital-level Mortality Indicator information on a monthly basis to the Trust Board.

Infection control

5.28. Infection control and reduction in healthcare associated infections continues to be a priority nationally and locally. The Department of Health sets levels of tolerance for incidents of meticillin-resistant staphylococcus aureus bacteraemia (zero) and C. Difficile with each hospital that reduce annually. Historically, Lewisham Healthcare Trust had a strong record in the prevention and management of healthcare acquired infection and met both its meticillin-resistant staphylococcus aureus and C. Difficile targets.

5.29. Queen Elizabeth Hospital's record was less consistent. Although Queen Elizabeth Hospital delivered a reduction in infection rates and met its meticillin-resistant staphylococcus aureus target in 2012/13, it breached its C. Difficile target in that year. We believe that we will be in a strong position to deliver the reduction of infection rates year on year by:

- adopting the strengths in our approach to managing infection control at University Hospital Lewisham;
- continuing to work with Public Health in both the Royal Borough of Greenwich and the London Borough of Bexley to address the wider issues of C. Difficile incidence and infection across the community and hospital settings; and
- transforming our emergency models of care..

Serious Incidents

5.30. A key marker of service quality relates to how the Trust deals with clinical incidents, in particular serious incidents (SI). Both University Hospital Lewisham and Queen Elizabeth Hospital have recorded high numbers of serious incidents in the previous years, in part because of the mandatory inclusion of grade 3 and 4 pressure ulcers, 60 minute ambulance handover breaches and 12 hour decision to admit breaches.

5.31. In order to strengthen our ability to reduce SI rates, we have strengthened the reporting mechanisms to support the directorates and divisions to monitor where incidents occur, themes and trends, which are included in the patient safety report reported to the Patient Safety Committee on a quarterly basis. Staff are actively encouraged and supported to report incidents. The number of reported patient safety incidents overall, and any incidents where severe harm or death has occurred as a result, is reported to the Patient Safety Committee each month. Any incident resulting in severe harm or death is investigated as a Serious Incident and reported externally to a national NHS database (strategic executive information system).

5.32. The Trust Board receives a list of any new Serious Incidents and the rate of patient safety incidents per 100 admissions resulting in severe harm and death monthly. Anonymised details of Serious Incidents are reported to the Board in part 2 of the Board meetings. In addition, we continue to hold a weekly SI Review Panel, jointly chaired by the Deputy Medical Director for Quality and Safety and the Director of Nursing and Clinical Services, which reviews every serious incident and ensures appropriate action is taken and that learning is shared.

Governance Arrangements

5.33. Operational quality performance data is examined in each Divisional Risk and Governance Committee and reported as relevant through the Trust's committee structure to the Patient Safety Committee, Clinical Effectiveness Committee, and Patient Experience Strategy Committee. These report to the Integrated Governance Committee. This is a sub-committee of the Trust Board, chaired by a Non-Executive Director. It reviews a Quality Scorecard that provides details of all the metrics relating to the quality of services provided by the Trust. A sub-set of these measures is included in every monthly Trust Board scorecard.

□ □ □

6. Workforce plans

Our workforce are key in delivering this plan

6.1. Our people are our greatest asset and we believe that the continued development of our workforce and workforce model is central to successfully becoming clinically and financially sustainable over the next five years. This will require us to recruit new staff, develop new skills, change our ways of working and make best use of the resources available to us.

6.2. In developing our clinical strategy, which is outlined in Section 3, we have identified the clinical and non-clinical changes that we intend to make. Each of these changes is dependent on our staff so it is essential that we develop the right workforce - of the right size, motivation, roles, and skills – to deliver this strategy. This Section sets out our current position, our five year vision for workforce, and the actions we are taking to realise this vision.

Where we start from today

6.3. Lewisham and Greenwich NHS Trust is a medium sized NHS Trust with a workforce establishment of 6,046, with 5,208 staff in post as of April 2014. This includes a small number of clinical staff employed by Lewisham and Greenwich NHS Trust who are temporarily seconded to Dartford and Gravesham NHS to support surgical services at Queen Mary's Hospital in Sidcup.

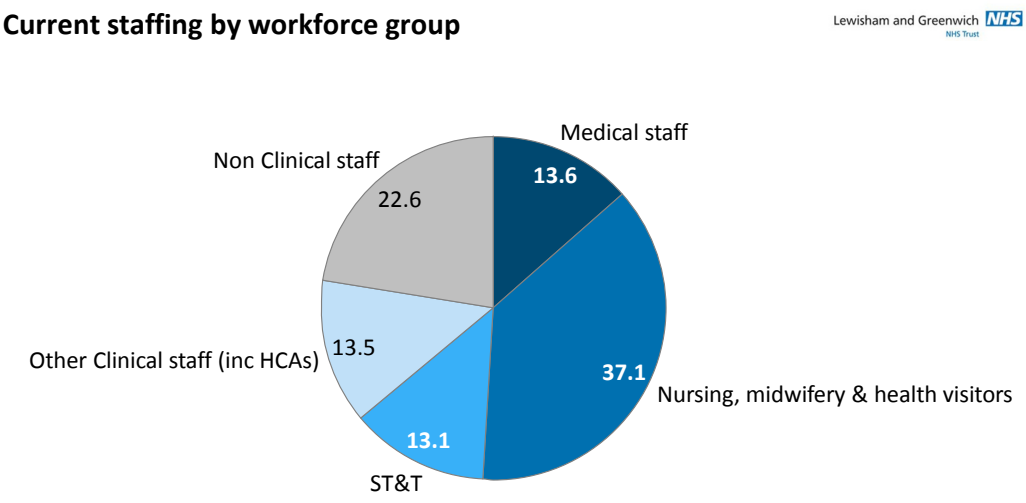
6.4. Our staff work across a number of settings of care as shown in figure 24.

Figure 24: Lewisham and Greenwich NHS Trust staffing profile by place of work.

Location	% of Trust workforce
University Hospital Lewisham	46.8%
Lewisham community	10.3%
Queen Elizabeth Hospital	42.9%

6.5. Our workforce split by staff group is shown in the figure below.

Figure 25: Lewisham and Greenwich NHS Trust staffing profile by staff group (position as at June 2014).



6.6. Pay is the biggest component of our costs and accounts for 60% of what we spend.

6.7. The table below sets out current key performance indicators against a basket of workforce measures compared to the target levels agreed by our Board. We are committed to becoming somewhere our staff say is a good place to work and to be treated. We recognise that like many other Trusts in London we have improvements to make. Over time, we expect to benchmark our aspiration and performance against other Trusts further to ensure that Lewisham and Greenwich NHS Trust continues to develop as an excellent employer.

Figure 26: Lewisham and Greenwich NHS Trust key workforce key performance indicators (KPIs) (position as at May 2014).

Workforce KPIs	Lewisham and Greenwich NHS Trust current	Lewisham and Greenwich NHS Trust Target
Sickness absence	3.4%	<4.3%
Turnover	13.1%	<12.7% (2014/15)
Vacancy	15.8%	<14% (2014/15)
Temporary staffing spend (% of total pay spend)	16.6%	-
Agency staffing pay (% of total pay spend)	8.4%	<5%
Performance development review (% non-medical staff employed with performance development review in last 12 months)	56%	>90%
Medical appraisal rate (% medical staff employed with performance development review in last 12 months)	91.6%	>90%
Mandatory Training (% staff up to date with mandatory training)	61%	>85%
Staff experience (Staff Survey 2013, Score 1-5)	3.75	>3.7
Retention (% new starters leaving the Trust in the first 12 months)	18.3%	<18%
Recruitment (time to hire: no of days from approval of vacancy to conditional offer)	42	<34

6.8. We are aware that our performance on indicators such as appraisal rates and mandatory training has been affected by issues of data collection following the merger. These are currently being addressed. Plans are in place to ensure compliance and these are monitored at a divisional level through Divisional Performance meetings, chaired by the Chief Executive, as well as corporately at the Workforce and Education Committee and the Trust Board.

We have invested in safer staffing

6.9. Nationally nursing and midwifery staffing levels have been under significant scrutiny since the publication of the Francis report (2013) which identified unacceptable delays in addressing the issues of shortage of skilled nursing staff. A consequence of the report has been a move towards recommended staffing ratios in the NHS.

6.10. Our Board have recently agreed changes to the Nurse Staffing establishment, following recommendations from the National Quality Board. The Director of Nursing and Clinical Services, in partnership with her executive colleagues, has developed the staffing model and this is reflected in the

workforce templates that accompany this plan, with the impact phased over three years. As described in Section 2, we have already committed around £4 million of investment to increase ward nurse staffing levels. It is a priority of the Trust to recruit qualified nursing staff to fill vacant posts to ensure continuity of care.

6.11. We expect further guidance from National Institute for Health and Care Excellence on safe staffing levels for other staff groups including non-ward based nurses, community nurses and allied health professionals, and will act accordingly. We have also invested in additional medical staff to enhance quality and safety, where appropriate.

We are getting better at attracting and retaining staff

6.12. In the recent past, it has been hard to attract and retain some staff groups. In common with other NHS Trusts, some of this relates a national shortage for a profession, such as Emergency Department staff, trained midwives, and sonographers.

6.13. However, the challenge to recruit and retain staff over the last three years has been exacerbated by factors particular to our Trust. The uncertainty over how acute services were to be delivered in South London has made recruitment more difficult and the upheavals of the past few years have also affected staff retention. The prospect of further change will continue to test our ability to retain staff, but significant effort is being put into addressing these risks and ensuring that staff are engaged in the planned changes. Significant progress has already been made since the merger, and we believe Lewisham and Greenwich NHS Trust will be increasingly seen as a great place to work because of the developments set out in this plan. During the recent CQC inspection, their inspectors noted that staff at Queen Elizabeth Hospital in particular had been very positive about the merger.

6.14. To address some of the recruitment challenges and support a reduction of temporary staffing usage, the Trust has recently undertaken an overseas recruitment campaign for nurses. The initial trip to Portugal has proved to be very successful with 38 nurses offered employment. We plan a second trip overseas, this time to Spain, in the coming months. In addition to these initiatives, and as part of the Trust's initiative to engage with the local community, the Trust is offering a Return to Practice Programme to encourage local residents, who may have a nursing qualification or lapsed nursing registration, to return to nursing. This is backed by a cross-Trust innovative recruitment advertising campaign.

Seven day working

6.15. As described in Section 3, as part of our commitment to seven day working we have established a cross-Trust initiative to support clinical divisions in understanding and implementing the necessary changes. Under the leadership of our Director of Workforce and our Medical Director we have modelled the pay implications of this shift at £6.5 million a year. That figure will change as we implement the other changes in this plan. That cost is made up of salaries for additional staff, weekend premia, and changes to rotas, on-call, and shift patterns. We have started talking to staff about these changes. As part of this initiative, we are seeking to future-proof the contracts of future staff.

Opportunities over the next five years

6.16. In developing our five year plan for the Trust and each clinical service, we have been very aware of the major workforce challenges we face going forward. A key focus has been, and will continue to be, on making sure our workforce has the right knowledge, skills, behaviours, and mind-sets to provide high quality services for patients. We anticipate that the impact of the planned clinical and non-clinical changes outlined in this plan are as follows:

- Most staff will need to adopt new ways of working as we seek to improve our patients' experience further. For example, the redesign of services to provide more care in outpatient and ambulatory environments and with greater use of technology will require staff to develop new ways of working that meet patients' increasing expectations of a personalised service;
- Many of our plans will require changes in the mix of staff that provide services, making greater use

of nurse specialists, allied health professionals and clinical support staff;

- As we improve quality and increasingly move more of our services to operate seven days a week, we are likely to see rota changes, including for senior medical staff. This will help ensure we provide consistently high quality care across the Trust.

6.17. In making an overall reduction in establishment, we will still be recruiting many over the next five years to:

- Fill current vacancies so we provide services with less reliance on temporary staff;
- Replace essential roles vacated by staff as they move on to new roles;
- Meet increased staffing numbers arising from the Francis Report;
- Expand seven day working to provide better patient experience and safety and make better use of our facilities;
- We also need to ensure staff are in the right place to deliver services and this will need to be managed carefully.

There are many opportunities for staff

6.18. In making these changes there will be many opportunities for staff:

- The significant investment we are making in improving quality through new ways of working and new technologies will provide many opportunities to learn new skills;
- By altering the staffing mix we are creating new opportunities for specialisation and promotion;
- Changes in the working pattern of the hospital to seven day working and greater use of technology will mean many staff can work more flexibly, including where it is appropriate from home or on a schedule that may suit them better;
- In developing new pathways of care we will be looking for innovative ways of working that best meet the needs of patients;
- In further developing our clinically led management structure and service line management approach there will be more opportunities for staff to lead and develop their own services;
- By achieving Foundation Trust status we will bring new opportunities for building a greater sense of ownership by staff in the work of the organisation.

The impact of our changes

6.19. This high-level five year plan has been developed by clinical and managerial leaders across the organisation to ensure the provision of high quality services and the longer term clinical and financial sustainability of the Trust. The changes will improve quality for patients and provide exciting new opportunities for many staff.

6.20. In building a clinically and financially sustainable organisation, we will reduce our current cost base by around 5% per year. As two-thirds of our expenditure is on pay it is necessary and appropriate that we will make significant savings in this area. Much of these savings will come through reducing our overall pay bill by reductions in agency staffing and by making best use of variable pay.

6.21. Overall, we expect that the net change in the size of our staffing establishment will be a 8% reduction by the end of the five year period covered by this strategy.

6.22. There will be an overall reduction in FTE posts across the five year period of 458 posts, taking our total establishment to 5,588 posts compared to 6,046 today. Where we do need to right size our workforce we expect

to do this through natural turnover, a reduction in temporary staffing levels and by changing roles of current staff by consent. The rate of turnover in staff across London hospitals means that there will have been a substantial turnover in our workforce by 2019. Almost half our staff in 2019 will have joined us since this five year plan was begun. This provides opportunities for enhancing the culture of the Trust in the selection, induction, and training of new staff.

What will we need to do to manage the changes

6.23. Significant additional work is required to develop the plan further in conjunction with staff and other stakeholders such as commissioners and the local public. As we look to co-develop the plan with these groups we will focus on:

- Supporting staff to understand the need for change and engaging them in developing a shared future vision for services. – including a range of communication and engagement mechanisms (again described in Section 8);
- Training staff to adapt to the use of new technology and different ways of working;
- Enabling staff to innovate in how they deliver high quality personalised care to patients;
- Training and supporting our leaders to implement and manage the changes outlined in the strategy successfully. This is included as part of our Organisational Development Strategy and the capability building strand to our Transformation Programme (both described in Section 8).

We will need new skills to deliver the plan

6.24. We recognise that we will need to recruit and/or develop staff with the skills required by our clinical strategy. The list below includes some of the specific staff roles we expect to expand over the next five years:

- Community nursing staff including district nurses and health visitors;
- Ultra-sonographers and midwife-sonographers;
- Advanced Nurse Practitioners and Extended Scope Practitioners;
- Maternity Support Workers;
- Allied Health Professionals; and
- Senior medical staff in services affected by the London Quality Standards.

Medical education

6.25. Over the coming years the way in which medical trainee programmes operate are set to change significantly. Funding for medical trainee posts is likely to decrease year on year and this will mean that only the highest performing Trusts are likely to fill their training posts.

6.26. Health Education England is also looking to prioritise training for psychiatric and community doctors, which will have a direct impact on the number of trainee hospital doctor posts. In response, we will need to increase our non-training based doctor posts and introduce physician associate posts. We will introduce a multi-professional, cross-site education framework, with substantial exposure to community health to provide flexibility in our workforce.

High quality human resources and workforce support

6.27. In taking forward this plan, we have set high aspirations for our organisation. We want to become:

- Highly regarded as a place to work;
- Exemplar of flexible working for staff, with demonstrable productivity and engagement gains as a result;

- High performing against workforce targets;
- Known for strong track record on investment in training and development of staff;
- A zero-based approach to complaints about staff attitude;
- Skilled in using technology to support our workforce in all aspects of their working lives.

6.28. Throughout these changes, we expect our Workforce & Education directorate to be a standard-bearer and role model for the Trust we want to be, responsible for generating and sustaining the energy to succeed in delivering the plan year in and year out for the full five years.

Metrics

6.29. From a staff perspective we will measure our success in implementing this plan using the following indicators:

- Staff ”Friends and Family” and national staff surveys;
- General Medical Council surveys;
- Workforce KPIs - pay bill, turnover, absence;
- Increased numbers of suitable applicants for vacancies especially consultant roles , specialist roles and managerial posts.

Governance arrangements

6.30. The Trust Board receives regular workforce reports and key workforce indicators are included in the monthly performance scorecards. The Workforce and Education Committee which is chaired by a non-Executive Director and is a sub- committee of the Trust Board, is responsible for overseeing the workforce plan and strategy and for monitoring the workforce indicators. Monthly divisional performance meetings, chaired by the Chief Executive, are in place to monitor local progress and the workforce plans are a key agenda item at these meetings.

□ □ □

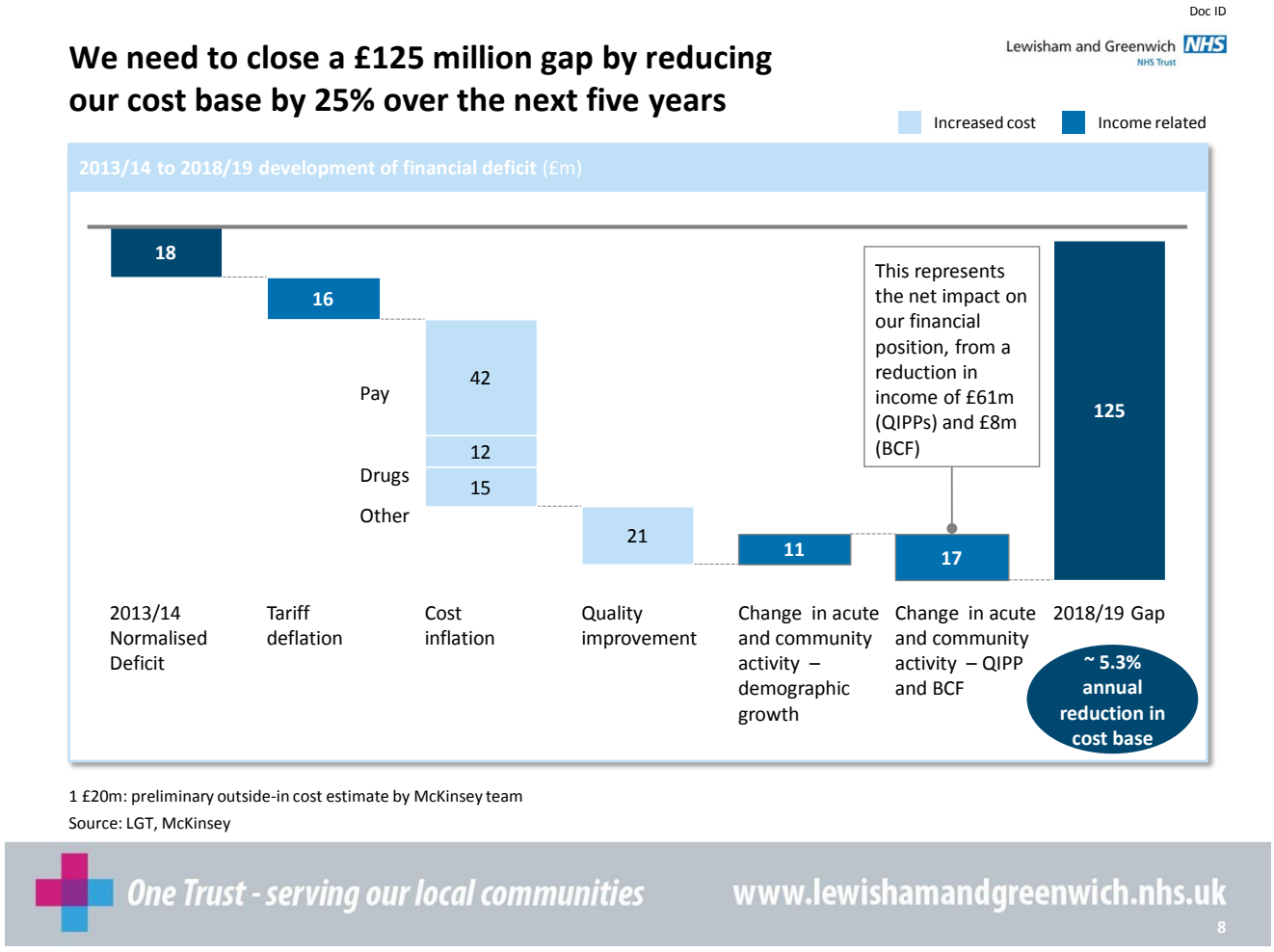
7. Financial and investment strategy

Introduction

7.1. This section sets out our intention and plan for becoming a financially sustainable organisation over the next five years. It shows how we intend to address our starting deficit and the significant additional financial pressures we expect to face in the next few years.

7.2. Taken together we estimate that our Trust will face a £125 million deficit in 2018/19 should we not take the scale and pace of action set out in this plan. The plan overall significantly improves our efficiency and use of all our resources, including staff, consumables, equipment and estate. In making this scale of improvement we will only be successful by continuing to work closely with our key partners and stakeholders, mutually supporting delivery of each other's plans.

Figure 27: five year waterfall chart of financial challenge



1 £20m: preliminary outside-in cost estimate by McKinsey team

Source: LGT, McKinsey

7.3. This means that, in addition to the required national efficiency challenge of 4%, we need to achieve a further 1% reduction in costs in each of the next five years. The majority of the savings in the plan will be delivered through internal efficiency improvements rather than relying on external sources of funding. Only a small proportion of the financial improvement driven by the plan is based on income-related initiatives (gains in market share or provision of new services).

7.4. The five year divisional and corporate initiatives identified so far are expected to deliver £112 million of the £125 million financial challenge through two key levers:

- Implementation of the clinical strategy set out in Section 3 - which will radically improve quality and contribute £94 million to closing this gap over the five years;

- Reduced corporate and estate costs - which will contribute the remaining £31 million to closing the gap over the five years.

7.5. We are continuing work both to develop additional plans to bridge the gap fully by 2018/19 and to create more detailed business cases and implementation plans to back up the expected gains of £112 million.

Figure 28: Summary of Financial Plan: Income and Expenses.

Income & Expenses	2014/15	2015/16	2016/17	2017/18	2018/19
Total clinical revenue	398.1	402.3	402.2	394.6	386.5
Other operating revenue	97.9	76.9	70.6	65.4	60.1
Operating revenue and income, total	**496.0**	**479.2**	**472.9**	**459.9**	**446.6**
Operating expenses					
Employee benefit expenses	(289.3)	(285.9)	(289.7)	(287.9)	(287.8)
Drug expenses	(36.0)	(37.9)	(37.5)	(38.0)	(38.5)
Clinical supplies and services expenses	(31.8)	(30.2)	(30.5)	(30.8)	(31.0)
Other expenses[1]	(82.9)	(66.4)	(46.4)	(33.4)	(19.1)
PFI operating expenses	(17.2)	(19.0)	(16.9)	(16.7)	(17.6)
Operating expenses, total	**(457.2)**	**(439.3)**	**(421.0)**	**(406.8)**	**(394.0)**
Surplus / (deficit) from operations	**38.7**	**39.9**	**51.9**	**53.1**	**52.6**
EBITDA	**38.7**	**39.9**	**51.9**	**53.1**	**52.6**
Non-Operating expenses					
Total depreciation & amortisation	(18.7)	(20.2)	(23.5)	(23.0)	(22.5)
Total interest payable on loans and leases	(18.5)	(18.1)	(18.7)	(18.7)	(18.7)
PDC dividend	(9.7)	(10.2)	(9.7)	(11.4)	(11.4)
Non-operating expenses, total	**(47.0)**	**(48.5)**	**(51.9)**	**(53.1)**	**(52.6)**
Surplus / (deficit) before tax	**(8.3)**	**(8.6)**	**0.0**	**(0.0)**	**(0.0)**
Tax expense / (income)	0.0	0.0	0.0	0.0	0.0
Net surplus / (deficit)	**(8.3)**	**(8.6)**	**0.0**	**(0.0)**	**(0.0)**

[1] "Other expenses" includes general supplies, establishment, premises and fixed plant, and other expenses. It also includes non-recurrent items, including transitional expenses.

Background

7.6. Due in part to the recent merger, we recorded a deficit in 2013/14 as planned (before run rate support), and this is expected to repeat in the current financial year.

7.7. We have agreed transitional funding of £37.6 million in 2014/15, £16.8 million in 2015/16, £10.5 million in 2016/17, and £10.5 million in 2017/18 with the Trust Development Authority through the Transaction Agreement. The funding will support underlying run rate deficits in the short term and provide us with the opportunity to invest in our transformation programme so that we will be financially sustainable in the longer term.

Quality, Innovation, Productivity and Prevention

7.8. South East London commissioners face a substantial challenge over the next five years in terms of improving outcomes, quality, reduced variability, and sustainability. Their plans for meeting this challenge are set out for the first two years in the Operating Plans of the six Clinical Commissioning Groups, and for all five years through the South East London Commissioning Strategy 2014-19.

7.9. Over the next five years, the South East London Clinical Commissioning Groups' revenue allocation is forecast to increase by 10% cumulatively, with expenditure set to increase at approximately the same rate, after delivery of QIPP. In order to meet the rising demand and cost of living increases their strategy forecasts a requirement to deliver a total of £307 million net QIPP efficiencies on a recurrent basis for the South East London system as a whole by 2018/19. Around 75-78% of these reductions in forecast spend on care in the Commissioning Strategy are expected to come out of acute spending.

7.10. Using the information provided in the South East London Commissioning Strategy 2014-19 we have modelled the forecast impact of commissioner QIPP on the Trust. Based on our market share in each of the Clinical Commissioning Groups, this amounts to £61 million over the five years.

Figure 29: South East London CCG QIPP impact on Lewisham and Greenwich NHS Trust.

Clinical Commissioning Group	Total QIPP programme over five years, £m	Lewisham & Greenwich NHS Trust acute market share	Lewisham & Greenwich NHS Trust total QIPP share[1], %	Lewisham & Greenwich NHS Trust share, £m
Bexley	38.8	38%	29.2%	11.4
Bromley	42.9	8%	6.2%	2.6
Greenwich	32.2	71%	54.7%	17.6
Lambeth	81.1	0%	0.0%	0.0
Lewisham	53.6	64%	53.0%	28.4
Southwark	57.9	2%	1.5%	0.9
Total	**306.4**			**60.9**

[1] Clinical Commissioner Group QIPP schemes apply to a wider range of services than what the Trust offers. The Trust's QIPP share has been calculated based on weighted market share, therefore considering that the Trust only provides acute and community services.

7.11. In 2014/15, some of the forecast QIPP savings to the Clinical Commissioning Groups will come back as income to the Trust under different contract arrangements such as prime contracting. Similar arrangements may follow in future years but these have not been assumed in our plans.

Patient care income

7.12. We have clear and credible high level income plans aligned with our commissioners' intentions. These plans are consistent with the planning efficiency requirements set out by the Trust Development Authority, and assume minimal growth.

7.13. The population served by the Trust is growing slightly more than the national average. Any net increase in income from local Clinical Commissioning Groups is likely to be marginal given the QIPP challenge that commissioners face.

7.14. Previously, demographic growth has been recognised by commissioners but the funding within the baseline contracts is not consistent. Any activity the Trust does over the baseline that is attributed to demographic growth is funded as over performance. The plan is, wherever possible, to ensure the growth is correctly reflected in baselines.

7.15. The 2014/15 contracts have been signed with all Trust commissioners, except NHS England where a signed heads of agreement has been reached. The nature of these contracts is enabling our activity contracting to be more closely aligned to Payments by Results than has been the case previously.

7.16. We have clear processes and timetables in place to ensure that the financial position of the contracts are signed off with commissioners on a monthly basis.

7.17. We are assuming tariff pressures of 1% per year.

7.18. A shift in activity towards community from secondary and from secondary to tertiary may squeeze our sources of income. However, this is mitigated by continuing to be a community provider in Lewisham, focusing on improving the quality of that service and thus positioning us, with support from commissioners, for growth into other community services.

7.19. Looking ahead, we consider that there is some risk that some of our specialist commissioned activity will go elsewhere, due to national specialist commissioning developments by NHS England. Therefore, our modelling does not rely on growth in specialist activity. This is consistent with our focus as a secondary provider of good local services for local people.

7.20. We are seeking to maintain our income base by:

- improving the quality of our services. Our current quality is service is not in line with our ambitions. This also means we are expensive. The expected improvement in quality will will have a positive impact on our accounts as it will minimise fines and penalties.
- using technology in a way that supports General Practitioners to provide more of the care pathway
- providing more of the current Divisions' clinical work in the community;
- repatriating existing commissioned activity from tertiary centres for those services we already provide;
- working with commissioners to consider other service developments they may wish to see us support; and
- working with other local providers to explore other income oppportunities.

Other income

7.21. We receive other patient care income for Road Traffic Accidents and Overseas Visitors.

7.22. We also receive additional income for services that are provided to other NHS organisations and some non-NHS bodies. Work is underway to ensure there are formal, appropriately costed, service level agreements in place to minimise financial risk.

7.23. Other income received includes Training and Education, Research and Development.

7.24. The total amount of other income expected in 2014/15 is £51 million.

Support from Wider Health System

7.25. The Trust Development Authority have agreed financial support as part of the merger Transaction which been included in our five year plan. Income for Private Finance Initiative is assumed to be recurrent at 2017/18 levels although this does not fully cover the Trust's Private Finance costs. The non-Private Finance Initiative funding will be invested in schemes that ensure long term financial sustainability, and which represent an important opportunity for us to transform the way we work, becoming more productive and efficient, and also benefitting from the introduction of IT solutions.

Figure 30: Support income profile (£ million).

	2014/15	2015/16	2016/17	2017/18	2018/19
PFI support	12.7	15.6	16.0	16.5	16.5
Transformation	14.6	5.2	-	-	-
Run rate support	23.0	11.6	10.5	10.5	-
Total support	**50.3**	**32.4**	**26.5**	**27.0**	**16.5**

7.26. The run rate support shown in Figure 30 is the agreed position, however to avoid the challenges of avoiding a major drop in funding in 2018/19 we have assumed that the run rate support funding in 2017/18 will be at 50% of the agreed level.

Expenditure

7.27. The current expenditure in the Trust is as follows:

Figure 31: Expenditure profile.

Category of expense	£ million	% of total expenses
Pay	234.5	60.1%
Non-pay	137.6	35.3%
Total operating expenditure	**372.1**	**95.4%**
Other costs	17.8	4.6%
Total	**389.9**	**100%**

7.28. Fixed costs within the Trust are relatively high. The proportion of the cost base that we can influence easily is therefore limited. Having recognised our high fixed costs as an opportunity, our plan includes initiatives to optimise the use of our estate.

7.29. The plan assumes roll forward of expenditure budgets, taking into account the partial year impact of budget increases and reductions, the removal of non-recurrent funding, the full year effect of Queen Elizabeth Hospital baseline, and known cost pressures.

7.30. We are committed to improving the quality of the services we offer. This includes the need to respond to Care Quality Commission concerns, to meet the requirements of the London Quality Standards, and to deliver the safer staffing initiative. Based on the current configuration of services, we have estimated implementation costs for these quality improvements at £21 million.

Inflation

7.31. Plans are based on credible cost inflation rates specific to each cost category, such as pay, drugs, and non-clinical supplies. Other things being equal, over the five year period we expect pay to increase by over £40 million, drug spending by over £10 million, and a further £15 million increase across other expenditure categories.

Capital expenditure

7.32. The Trust Board has approved capital programme for 2014/15 and is developing a longer-term capital plan to underpin this five year strategy.

7.33. Following the creation of the Trust, we have developed a baseline stocktake of current and planned capital developments to support us in making medium to long term decisions on the use of our estate. Given the heavy Private Finance Initiative footprint of our sites and the significant number of poor quality estates issues that need to be rectified at Queen Elizabeth Hospital, we need the on-going support of our partners. In particular, we are working with the Trust Development Authority around four core schemes: theatres and endoscopy; road access to Queen Elizabeth Hospital; sterile services; and the emergency department at Queen Elizabeth Hospital. We are also continuing to invest in on-going schemes including a significant internal programme on IT and the development of a new midwife-led birthing unit at Queen Elizabeth Hospital, detailed earlier in Section 3.

7.34. We have not fully identified the capital requirements required to deliver the plan but are committed to doing this over the coming months in conjunction with the clinical divisions.

7.35. Funding sources are less defined for future years and therefore for planning purposes it has been assumed the Trust will invest the amount of depreciation projected into capital acquisitions. Funding will be requested via the submission of business cases to the Trust Development Authority for additional public dividend capital to fund the larger strategic projects. Alternative sources of funding will be investigated if public dividend capital is not available.

7.36. Renegotiation of our Private Finance Initiative contracts is expected to give us opportunities to improve the quality and cost of estate and equipment being used by the Trust.

Figure 32: Capital plan, £000.

Capital plan	2014/15	2015/16	2016/17	2017/18	2018/19
Funding					
Internally funded	10,641	14,217	16,427	16,766	16,241
Carried forward	1,749				
Proceeds from sale	-	3,216			
DH funded	1,398				
TDA funded	11,048				
PDC funded	-	27,275	8,340		
Funding, total	24,836	44,708	24,767	16,766	16,241
Proposed / approved projects					
Information technology	11,356	14,237	2,500	2,500	2,500
Medical equipment	1,345	1,300	2,000	3,000	3,000
Backlog maintenance	1,318	1,418	1,418	1,418	1,418
Contingency	1,441	2,965	10,509	5,548	2,023
Building / refurbishment / upgrades	9,376	24,788	8,340	4,300	7,300
Proposed / approved projects, total	24,836	44,708	24,767	16,766	16,241

Balance sheet

7.37. The non-current assets have increased in the first three years to reflect the additional capital investment required to support the plan. Additional PDC for capital is assumed in years 2014/15 for £12.5 million, 2015/16 £26.7 million and 2016/17 £8.3 million.

7.38. The working capital increased significantly in 2013/14 following the transfer of the balances from SLHT. A planned programme of work is being undertaken on the working capital, which includes the wind down of the SLHT balances during 2014/15. This will ensure all outstanding creditors are paid and that debt is collected or written off. The working capital position is affected in years 1 and 2 by the planned deficit but stabilises once the Trust achieves in year break even. This delivers an improvement in both debtor and creditor days to just over 30 days.

7.39. The cash position of the Trust decreases in year 2 due to the in-year deficit but is held steady over the remaining years of the plan.

Figure 33: Balance Sheet, £000.

Balance Sheet	2014/15	2015/16	2016/17	2017/18	2018/19
Non-current assets	422	446	447	442	436
Current assets:					
Trade and other receivables	52	56	36	29	24
Cash and cash equivalents	14	5	5	5	7
Other	22	23	22	21	20
Current liabilities:					
Trade and other payables	(32)	(36)	(19)	(13)	(9)
Provisions	(3)	(4)	(4)	(4)	(4
Borrowings	(1)	(1)	(1)	(1)	(1)
PFI leases	(3)	(3)	(5)	(4)	(4)
Other liabilities	(46)	(46)	(40)	(39)	(37)
Non-current liabilities:					
Provisions	(5)	(5)	(5)	(4)	(4)
Borrowings	(9)	(9)	(8)	(8)	(7)
PFI leases	(113)	(110)	(104)	(100)	(97)
Other financial liabilities	(2)	(1)	(1)	(1)	(1)
Total Assets Employed:	296	315	323	323	323
Public Dividend Capital	198	226	234	234	234
Retained earnings	(49)	(58)	(58)	(58)	(58)
Revaluation reserve	147	147	147	147	147
Other reserves	-	-	-	-	-
Total Taxpayers' Equity:	296.0	315.0	323.0	323.0	323.0

The cash position of the Trust is expected to improve over the five years of the plan reflecting an improvement in the debtor's position.

Cost Improvement Programme

7.40. In 2013/14 Lewisham and Greenwich NHS Trust delivered our recurrent Cost Improvement Programme target of £23.6 million.

7.41. Our Cost Improvement Programme challenge for 2014/15 is £26.5 million, which is in line with the

negotiated amount agreed with the Trust Development Authority in the summer of 2013. The majority of savings are expected to be delivered through thorough prudent divisional reviews of spending, recovering temporary over investments required post-merger, and through some early gains realised by the launch of the Trust's transformation programme.

7.42. Our longer term financial modelling has shown that Lewisham and Greenwich NHS Trust needs to reduce our costs by £125 million by 2019 to deliver a recurrent break-even position. This reduction means that in addition to the required national efficiency target of 4% we need to achieve a further 1% reduction in costs in each of the next five years.

7.43. We have developed an ambitious five year plan that will lead us to reach break-even, although we have yet to identify a small proportion of the necessary savings. The five year divisional and corporate initiatives identified so far are expected to deliver £112 million of the £125 million financial challenge. We are continuing work both to develop additional plans to bridge the gap fully by 2018/19, taking into account the risk that not all the plans will be delivered in a timely manner, or in full, and to create more detailed implementation plans to back up the expected gains of £112 million.

7.44. Other than 2014/15, the phasing of targets has not been fully worked through and it is therefore assumed the same target is met each year over the planning period.

Figure 34: Cost Improvement Programme savings planned by year, £ million.

	2014/15	2015/16	2016/17	2017/18	2018/19
CIP savings	26.5	23.6	16.8	22.7	22.9

7.45. In developing our Cost Improvement Programme, we have benchmarked our productivity and efficiency relative to peer trusts and identified areas where our services appear inefficient. Historically some of the inefficiency is driven by the configuration of services (e.g. emergency department at Queen Elizabeth Hospital). As detailed in the Clinical Strategy set out in Section 3 above, there are opportunities to reconfigure the services offered across the two sites so they can be delivered more efficiently and with improved quality.

7.46. The key themes the Trust is focussing on are:

- Average Length of Stay to be reduced which in turn will take out capacity;
- Shift roles to different staff groups;
- Consolidate some services across sites;
- Bring in a small volume of activity under repatriation to use current spare capacity;
- Non-Pay procurement, an initiative currently supported by external consultants.

7.47. The plan comprises a number of significant initiatives both within the divisions, and at corporate level. We also have a number of centralised, cross-cutting schemes that will have an impact across the Trust. The savings have been identified as follows:

Figure 35: Savings by division, corporate, central schemes.

Division	2018/19 Impact, £000
Acute and Emergency Medicine	19,074
Children and Young People	6,249
Long Term Conditions and Cancer	10,813
Surgery	16,568
Women's and Sexual Health	12,142
Clinical Business Unit	10,465
Total clinical divisions	**75,312**
Corporate Divisions	16,158
Total All Divisions	**91,470**
Central Schemes	21,000
Total All Schemes	**112,470**

7.48. As part of the Business Planning Process within the Divisions, the Trust is working up a full programme to deliver the saving requirements. This will involve reaping rewards from investment of the transformation income secured via the Trust Development Authority.

7.49. The five year clinical plans set out in Section 3 have been built into our Long Term Financial Model. The table below sets out the main assumptions that have been used in forecasting the financial impact of planned developments.

Figure 36: Summary of Assumptions and Impact on Commissioners of Schemes.

Area	Division	Impact
Demographic growth	Trust-wide	• We have modelled our baseline activity levels assuming a 2.3% effect, driven by demographic growth across the population we serve; • We are assuming that commissioners will recognise activity increase due to population growth.
Outpatient transformation	Multiple divisions (Long Term Conditions and Cancer, Surgery, Women's and sexual health)	• We expect that the re-design of our Outpatient services will lead to a significant reduction in cost to ~20% of activity; • This will result in a significant saving for the commissioners. We expect to be able to retain part of that saving, in part by providing support for care of such patients in Locality Care Networks.
Strategic	Multiple divisions (Acute and	• Some divisional plans assume the provision of services not currently provided that are coming up

market gains	Emergency Medicine, Long Term Conditions and Cancer, Surgery, Women's and Sexual Health, Children & Young People)	for tender; • Such changes are included in our financial model as Service Development; • There will be no impact for the commissioners, other than the change of provider for that service.
Repatriation	Multiple divisions (Long Term Conditions and Cancer, Women's and sexual health)	• Some divisional plans assume the repatriation of activity relating to population in our catchment area and currently provided by other providers; • Such changes are included in our financial model as Service Development; • There will be no impact for the commissioners, other than the change of provider for that service.
Readmissions	Acute and emergency medicine	• We expect to be able to significantly improve our readmissions performance; • As a consequence, we expect a reduction in the income that is currently withheld by the commissioner based on the annual audit of readmissions.

7.50. Delivery of the Cost Improvement Programme is led by the Divisions and overseen by the Trust Cost Improvement Programme Board chaired by the Chief Executive. Our approach to Cost Improvement Programme delivery has been strengthened by:

- Establishing a Cost Improvement Programme Programme Management Office since the creation of the Trust. This Programme Management Office was been initially staffed by external consultants; however a substantive Director of Programme Management Office has recently been appointed by the Trust to enhance our internal capabilities and reduce reliance on contractors;
- Recruiting an in-house Programme Management Office support team, providing five whole-time equivalent staff members to support the divisions.

7.51. The in-house Transformation Team and Programme Management Office will support divisions to deliver their schemes. Many initiatives are already underway (e.g., Pathology, Maternity, Acute Medicine, Elective Surgery) which will deliver savings in 2014/15. We will continue to strengthen our own management team in order to reduce our reliance on external consultants.

7.52. Further work is required by the Programme Management Office and our Divisions to produce a careful staff engagement plan to ensure the Cost Improvement Programme plans set out in Section 3 are further developed and delivered. Patients and commissioners will also need to be involved and consulted.

7.53. Developments in financial reporting, in particular the roll out of service line reporting, will help increase transparency and ownership by the Divisions of the numbers and benchmarking. This is essential to allow full ownership and accountability when delivering the plan, which was developed by the divisions. The implementation plan will be completed during 2014/15.

Key financial risks

7.54. Section 4.10 sets out the overall strategic risks to this plan. Within the overall financial risk of delivering our £125 million Cost Improvement Programme target there are a number of more granular financial risks which include:

- Capacity and capability within the divisions and central teams to deliver the savings targets;
- Non-delivery or delays to the implementation of service line reporting / management;
- Lack of stakeholder involvement, particularly by commissioners, in supporting efficiency and productivity plans;
- Financial pressures on Clinical Commissioning Groups may result in non-payment for overperformance and/or additional pressures;
- Impact of penalties and the loss of re-investment monies;
- Weaknesses in information systems resulting in the Trust losing income for work undertaken. This risk is increased during the implementation of iCare at our sites.

Improving our financial management capability

7.55. We have continually made significant progress since merger in terms of financial management and reporting. Work will continue to ensure that we are in a position to continue aligning divisional activity with our service level agreements.

7.56. We are making developments in financial reporting. In particular, the roll out of service line reporting will help increase transparency and ownership of the numbers and benchmarking. Implementation will be completed during 2014/15.

7.57. Further work is required within the corporate and divisional teams to strengthen our financial management capability.

Governance arrangements

7.58. The Trust Board receives regular financial reports, which are designed to reflect Monitor's Risk Assessment Framework and incorporate a high-level dashboard that includes the Financial Risk Rating scores, which Lewisham and Greenwich NHS Trust would generate as a Foundation Trust.

7.59. The Finance and Investment Committee, a sub-committee of the Board that is chaired by a Non-Executive Director, is responsible for overseeing financial performance. The Audit Committee, which is also chaired by a Non-Executive Director, has the responsibility for overseeing the financial reporting process.

7.60. Our independent auditor, KPMG, will report on our management's assessment of the effectiveness of internal control over financial reporting. The Cost Improvement Programme Board, which is chaired by the Chief Executive and includes Non-Executive Board members too. It is responsible for ensuring the divisions deliver their plans.

□ □ □

8. Organisational relationships and capability

8.1. This document sets out our ambitious and credible plan for the next five years. It will require the support of patients and the public and other stakeholders across the local health economy, and the drive, energy and determination of our staff. We have solid processes to engage with all these groups and plan to strengthen our approach further as we build a stronger organisation as part of our aspiration to become a Foundation Trust.

Engaging with patients and the public

8.2. We take public engagement seriously and have a dedicated Patient Engagement Strategy that details the range of approaches we take. These include: how we build a relationship with the local HealthWatches; how we actively collect feedback on our services and plans, and how we support and benefit from the Patients' Welfare Forum at Lewisham and Patients' User Group at Queen Elizabeth Hospital. Our approach of undertaking ward visits and collecting patient stories via the Trust Complaints Committee helps ensure that our Board are very focussed on the needs of the public and our patients in particular.

8.3. We are fortunate to have a large, motivated group of local people interested in the provision of healthcare in Lewisham, Greenwich, and North Bexley. We recognise that because of previous changes to healthcare provision in South East London, many of these people share a significant concern about any further changes in local provision. Rather than seeing this as a threat, we see it as an opportunity to build stronger local engagement in our services and governance. As an early expression of our commitment to this way of working, we will be consulting the public on our five year plan more extensively than is formally required. We plan to harness public interest in a number of ways:

- We want patients to be and feel more involved in their care as we make services better tailored to their needs. We will encourage and support our staff to be better at listening to the voice of patients and to identify 'shared care models' where patients can better manage their own conditions and access services as and when convenient to them;
- We recognise the proven health benefits to patients of being involved in research trials and wish to build on our success as an early site for the "It's OK to Ask" campaign to promote participation for more patients in research trials. This may also generate additional income for the Trust so that we can improve local services for local people;
- We will use the opportunity of moving towards Foundation Trust status to more extensively involve the public in having a say on the future direction of the Trust. We already have 5,000 local people registered as members from a previous exercise from the previous Lewisham Healthcare Trust Foundation Trust application, and will build on this. Given the South East London Clinical Commissioning Groups' moves to 24 Locality Care Networks we will give careful consideration to structuring our future Foundation Trust Governor Constituencies around primary care localities;
- We will involve the local HealthWatches in designing our public engagement strategy;
- We will make better use of technology to collect feedback more easily from patients, visitors and the public –and in real time so that we can act on feedback more quickly than at present.

Engaging with stakeholders

8.4. We wish to build on our strong record of working with key stakeholders including local Clinical Commissioning Groups, local authorities, neighbouring NHS Trusts and Foundation Trusts and other health service organisations. We have engaged with South East London Commissioners in the development of their strategic pans and we believe that our clinical strategy plans are mutually aligned. We will work together over the coming months to ensure that our detailed operational implementation plans continue to be so.

8.5. In Section 1.16 we have referred to discussions we have held with Guy's and St. Thomas' NHS Foundation Trust to explore the concept of an alliance which will enable both organisations to achieve their own strategic objectives, and to support commissioners to improve quality in South East London within available resources. In that context, we are already working with Guy's and St. Thomas' NHS Foundation Trust on service developments in renal, urology and paediatric services.

8.6. We will work closely with the London Boroughs of Lewisham and Bexley, and the Royal Borough of Greenwich in three main ways:

- In ensuring we meet public expectations through their leadership of their respective Overview and Scrutiny Committees and Health and Wellbeing Boards;
- In ensuring seamless pathways of care across NHS and social care services which we each provide;
- In providing public health services which they commission from us, such as sexual health and smoking cessation services.

8.7. Furthermore, we are planning a set of briefings and discussions with public representatives including MPs and councillors to explain our plans and gather feedback. We will continue to engage with a range of wider stakeholders including other providers (Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Dartford and Gravesham NHS Trust and King's College NHS Foundation Trust) and HealthWatch.

8.8. We already actively participate in local Clinical Networks, the Clinical Senate and the South London Academic Health Science Network, and will look to build on this engagement further. In addition, we will continue to support staff to help improve the wider NHS, including through taking part in Chief Inspector of Hospital inspections, peer review visits, education and training activities, and Royal College programmes. We engage well with the Local Clinical Research Network including hosting the Clinical Research Network cluster Research and Development office for district general hospitals in this region. We also engage with the South London Academic Health Science Network and will engage with the newly established South London Collaboration for Leadership in Applied Health Research and Care. In primary care, we will reach beyond the Clinical Commissioning Groups to work together with localities where this is appropriate, for example in providing outreach clinics from hospital.

Building our own capabilities

8.9. We recognise that the next five years are going to be very challenging and that we will need to continue and accelerate our development as an organisation in order to ensure the successful delivery of high quality, clinically and financially sustainable services. We are making good progress in building capabilities across a number of areas.

Board governance and leadership

8.10. Effective governance, risk, and performance management arrangements are critical to managing our services effectively across multiple acute and community sites and to becoming an NHS Foundation Trust.

8.11. In establishing the new Trust and successfully managing the initial merger with Queen Elizabeth Hospital, we feel we have built a Board that has the experience, capacity, capability, and the wide cross-section of skills required to govern our organisation effectively. This is not to say we are complacent and we recognise that we must further develop in order to address the scale and pace of challenges ahead.

8.12. As well as underpinning the delivery of our mission, the assurance and performance culture and governance arrangements we have been developing since before the establishment of the new Trust will continue to be refined. This will enable us to harness greater public, user, and stakeholder involvement in developing our strategy; to improve our services; to ensure we provide the best value

for money; and to ensure that we continue to work together with other local partners for the benefit of local people.

8.13. We will develop our Board governance and leadership capabilities by:

- Having a significant focus on continued Board effectiveness in readiness for a Foundation Trust application;
- Holding regular Board strategy away days to ensure an appropriate split of Board time for strategic, tactical and operational issues;
- Continuing to keep our post-merger additional assurance and risk management mechanisms for key developments such as implementation of iCareQEH and iCareUHL in place until such time as these risks have been suitably addressed – which will likely be in late 2015/16;
- Making careful appointments to key Board level roles as vacancies arise over the next five years.

Developing a Single Culture to support our vision of "one Trust – serving our local communities"

8.14. The development of Lewisham and Greenwich NHS Trust as a new organisation provides a valuable opportunity to provide the best possible healthcare for our local communities, working collaboratively with our partners. To support this we have invested in a bespoke Organisational Development Strategy and delivery programme. The strategy is designed to ensure that all systems, processes and developmental interventions – for the organisation, our staff, patients and the partners with whom we work – are aligned and consistent, helping to build momentum to achieve our aims to establish a safe, unified and patient-focused organisation. The three areas of focus for the Organisational Development Strategy are:

- Creating one organisation;
- Establishing a performance culture that is aligned with our Trust values; and
- Investing in leadership development.

8.15. We believe that one of the key enablers of this plan will be the increasing development of a single culture across the new organisation so that we operate as a single service across each of our sites. The Organisational Development Strategy we have in place will support this development, specifically to:

- Build the capacity and capability of our organisation and people to achieve our vision and strategic objectives – becoming an integrated organisation, providing the best care for the communities we serve; and to meet the challenges and expectations of our commissioners, regulators and other stakeholders;
- Ensure that the organisation's values are 'hardwired' into the way that we operate. These are that Trust staff, systems and processes should work to demonstrate: Respect and Dignity; Commitment to Quality of Care; Compassion; Improving Lives; Working together for patients; Everyone Counts.

8.16. The Organisational Development Strategy was agreed in September 2013 and current priorities are being reviewed in line with this five year plan, but will continue to include:

- Sustainable organisation design with enhanced levels of clinical leadership;
- A common high performance culture focused on the delivery of great patient care and experience;
- Development of people who are involved in the organisation so they feel supported by us to deliver great care for patients;

- Strengthened capacity to address problems and manage change;
- Aligned set of systems and processes for developing and managing people that reinforce our values and objectives; and
- Effective partnerships with stakeholders and communities which are maintained and developed.

Clinical leadership and service line management

8.17. In designing and leading the new Trust, the Board have been keen to ensure that the Trust is a clinically led organisation, with clinicians responsible both for delivering quality day-to-day in each interaction with every patient, and also for embedding quality into the leadership and running of all services overall. The single integrated clinical leadership team who have been in place and meeting regularly since September 2013, has ensured that from day one, Lewisham and Greenwich NHS Trust is clinically led and its plans are clinically owned.

8.18. Over the next five years we plan to strengthen clinical leadership significantly through:

- Supporting the divisional (clinical) directors and other senior clinicians to develop their own leadership skills and to increasingly manage their divisions as semi-autonomous business units within an overall framework of accountability set by the Board;
- Embedding a culture of service line management all the way down to front line clinical teams so that those who provide the service - and therefore know it best - are responsible for shaping the development of their services;
- Reviewing which functions that are currently provided centrally could be more effectively and efficiently provided within clinical divisions. We expect that this will help shift the focus of our work in improving quality away from monitoring compliance and towards embedding improvements locally.

8.19. We recognise that the implementation of this plan is going to require even greater leadership by our senior clinicians going forward. In strengthening clinical leadership across the Trust, the senior medical leaders in our divisions and directorates will be taking part in the new capability-building programme that is being delivered as part of our transformation programme.

Transformation

8.20. We have significant direct experience of managing change but have also recognised the need to build an in-house transformation programme to tackle some of the things we need to do that involve radical change. For Lewisham and Greenwich NHS Trust transformation is about creating a radical step-change in performance and organisational health; this is usually whole scale, radical and rapid. This sort of change requires a lot of extra work, special skills, and particular attention to making sure that all staff understand, are engaged, and able to contribute to the effort. In short, the transformation programme is larger and more complex than it is possible to do as part of 'business as usual'. We believe that transformation will amplify and reinforce the new organisation's ability to deliver wholesale improvement in the quality of services it delivers and maximise the potential to deliver unprecedented improvement across the whole system and drive changes in strategic direction across new boundaries and sectors.

8.21. Using the transition funds that we have been provided for 2014-2016 we have established a Transformation Team who are acquiring capability from external partners and then embedding it within the organisation on a sustainable basis to support continuous improvement of services within our allocated budget. We have been working for some months now with colleagues around the Trust to identify and take forward significant transformation projects which include:

- Radiology - to support development and improvement at the Queen Elizabeth Hospital;
- Pathology - to implement the hub and spoke model and modernise service provision;
- Surgery - consolidating the future model of surgical services across our sites;

- Maternity - to unify service model and further raise quality;
- Cerner - to support iCare implementation and the realisation of transformational benefits from the electronic patient record;
- Acute medical model – to support the transformation of our unscheduled care pathways, particularly for frail elderly patients; and
- Community nursing – to improve significantly the quality of service and support the move of care closer to home.

8.22. As part of the transformation programme, we are also running a significant capability-building programme for senior and aspiring clinical and managerial leaders across the organisation. Building on a framework of improving organisational performance and organisational health, the programme is designed to equip participants with enhanced skills in driving real change within their services.

Programme management and Cost Improvement Programme Delivery

8.23. We recognise that a plan of this scale and pace requires dedicated programme management: to support clinical and corporate divisions; to provide the necessary assurance to the Board that appropriate governance arrangements are in place; and to ensure that risks have been identified and steps taken to mitigate those risks. We have, therefore, established a dedicated Programme Management Office initially with external contractor expertise to monitor implementation. We are now well advanced in bringing this service in-house, building appropriate internal capacity and capability to provide a high quality Programme Management Office function.

□ □ □

Conclusion

8.24. This plan sets out how over the next five years we will strive to provide people in Lewisham, Greenwich and north Bexley who use our services, with the best quality of health care as we strive to become a clinically excellent and financially sustainable Foundation Trust.

8.25. We believe it is an appropriately challenging and credible high-level plan for our new organisation – but one that we can only successfully implement by continuing to work closely with our key partners and stakeholders, mutually supporting delivery of each other's plans.

□ □ □