LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Operational and Financial Plan 2006/7

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EXECUTIVE SUMMARY

This Operational Plan for 2006/7 provides the building blocks of our second year as an NHS Foundation Trust. Although it has been a challenging first year and one that has seen a number of changes to the NHS, locally and nationally, Liverpool Women's NHS Foundation Trust continues to thrive. This plan sets the direction of the Trust over the next 12 months and will inform the longer term strategy for the Trust as set out in our Service Development Strategy.

2005/6 has been a year of success and change. We started the year with a change of Chairman as Rosie Cooper left her post in order to stand as Member of Parliament for West Lancashire at the General Election. Rosie was duly elected. Ken Morris took up his post as our new Chairman in August. We have also seen the arrival of Sue Lorimer as our Director of Finance who also provided Maternity Cover to Louise Shepherd between October 2005 and February 2006.

We also started the year with two very commendable successes; retaining our 3 star status and achieving Level 3 CNST in both maternity and general standards. These achievements allowed us, following a strong application to Monitor, to be authorised to proceed as an NHS Foundation Trust, one of only 35 in England.

We have continued to develop our clinical services through the extension of our antenatal model of care and the opening of the antenatal centre in Speke. We have also secured additional contracts for our Reproductive Medicine Service, most notably in North Wales and have fully supported the implementation of the Improving Outcomes Guidance for Gynae Cancer. The development of these service models will continue into 2006/7 and in particular we would look to replicate the antenatal model in Gynaecology.

The standard of our clinical services has also been endorsed through the achievement of CNST level 3 and our declaration to the Health Care Commission in October 2005.

The changing environment of patient choice and contestability has and will continue to challenge the way in which we provide our services and the standards to which we provide them. As the expectations of patients rises we need to be able to respond. As patients have access to more clinical and non clinical information we need to be sure that we are well positioned to compete with all other providers for women's services locally, regionally and nationally. Up until now, this Trust has remained relatively protected from the introduction of independent sector providers. We will however face some challenge from the new diagnostic providers entering the market in the next 12 months.

The development of the operational plan for 2006/7 has realised the alignment of operational service change and financial planning. This document brings together priorities for development, recognition of cost pressures, targets for cost improvement, outline capital programme and agreed equipment programme.

The operational plan for 2006 uses as its corner stone the 5 principles laid down in our 5 Year Service Development Strategy, as approved by DoH and Monitor as part of our successful application to become an NHS Foundation Trust. This draft operational plan for 2006/7 will continue to build on the very sound foundations of these core principles.

Our Core Principles

- We will continue to fulfil our key performance responsibilities
- We will strengthen our services for local women and their families in line with a social model of healthcare
- We will further develop our Specialist Services
- We will build our Research Strategy to further improve care for women and babies
- We will ensure we have robust supporting strategies to deliver our Trust plan

1. KEY ACHIEVEMENTS

In 2005/6 the Trust Board, in conjunction with Directorate Management Teams, agreed its corporate objectives and priorities. In our first year as an NHS Foundation Trust, we set ourselves a challenging agenda and one that strived for the development of our clinical services, for improvement in our clinical services and the experience of our patients and to provide a sound financial platform for the future.

As we reflect on 2005/6 it is clear to see that the Trust continues to improve the standards of all that we do and that we have a dedicated and skilled workforce that allows these standards to be achieved.

This section of the plan allows us the opportunity to reflect on our achievements and to be proud of work that we do for the women, babies and families we serve.

1. To operate and develop as a successful NHS Foundation Trust.

We will maximise the benefits of NHS Foundation Trust status to our patients, staff, membership and partner organisations.

- Achieved and maintained a risk rating of 4 against Monitor's 'metrics' throughout the year, signalling good all round performance.
- The Membership Council met formally four times and began to consider the Trust's service strategy. It also established a number of sub-groups to ensure that it is able to fulfil its constitutional roles and responsibilities.
- Achieved of a 100 percent coding completion from April 05 to January 06.
- Implemented and consistently delivered Schedule 5 (standard information agreement) of the Foundation Trust contract.
- Improved Theatre Utilisation at our Aintree site and Walton Day Surgery Unit
- Achieved contract sign offs and reconciliation with all our PCTs
- Achieved national recognition through the HFMA for Financial Corporate Reporting.

2. To ensure the Trust retains and enhances its position as provider of first choice for women and families who need and wish to access our services.

We will build upon our solid foundations of clinical excellence and strong performance in order to provide timely access and real choice to women and their families.

- Achieved the National Waiting time targets for Inpatients, Daycases and Outpatients
- Reduced the number of patients waiting for outpatient appointments
- Reduced the number of patients waiting for inpatient/day case surgery
- Achieved of 100% booking for inpatients and over 98% booking for outpatients
- Over 99% of patients have been seen and treated within 4 hours of attending the Emergency Room
- Over 99% of patients have been seen within 2 weeks of urgent referral by their GP for suspected cancer.

3. To further develop appropriate "women centred" and "managed pathway" models of care across organisational boundaries in conjunction with other healthcare partners.

We will respond to the needs of women and babies locally, regional and nationally to develop the most appropriate models of health and social care to meet their specific needs.

- Opened the additional midwifery led antenatal community centre in Speke achieving a reduction in DNA rates.
- Improved smoking cessation services within pregnancy and introduced support services for domestic violence.
- Implemented the neonatal hearing screening programme across the trust with the majority of babies receiving a hearing screening prior to discharge.
- Established a pre-operative clinic to provide specialist antenatal care for women who are undergoing planned elective Caesarean section.

4. To further develop our Specialist Services in Conjunction with Specialist Commissioners and appropriate clinical networks.

We will work closely with established and developing clinical networks to provide integrated specialist services to our patients.

- Integrated the low risk and high risk pathway for patients with gynaecological cancer from Warrington, Southport & Ormskirk
- Received a very positive Peer Review for Gynaecological Cancer Service
- Developed a proposal for a network wide Neonatal Transport Service in conjunction with Specialist Commissioners,
- Improved productivity and reduced waiting times in all three Genetics Departments as a result of investment from the Department for Health
- Reduced the cancellation and transfer of patients requiring access to High Dependency Care as a result of fully establishing two beds in Gynaecology
- Secured the contract for Health Commission Wales for Assisted Conception Services (600 cycles over 3 years).

5. To further enhance the Quality and Safety of all Services for all patients.

We will continue to provide services that are of the highest quality that meet national standards and the needs and expectations of our patients and their families.

- Achieved CNST Level 3 (only 1 of 3 Trusts in the UK)
- Achieved the highest PEAT scores for our environment, cleanliness and food
- Improved the introduction and management and of Drugs through the establishment of a Medicines Management Committee
- Reduced the risk of missed pathology results through the deployment of the ICE laboratory results reporting system.
- Achieved 90% response rate within 20 days for all complaints against a national response rate of 74.7%
- Extended the availability of patient information in English and other languages – 21 leaflets approved through the Patient Information Group

6. To provide the best possible facilities and environment for patients and staff.

We will continue to develop our facilities to the highest standards to meet the needs of patients and staff.

- Refurbished the Quiet Room, Seminar Room and Waiting Area in Neonates.
- Developed a specialist obstetric antenatal day assessment unit and feto-maternal medicine unit at the Aintree Centre, as well as re-furbishment of the existing antenatal clinic.
- Undertaken an option appraisal and tender for accommodation for the clinical genetics team on the Alder Hey site.
- Identified new provider of bedside entertainment services following failure of previous supplier.
- Secured funding for additional parent accommodation in Neonates.

7. To ensure our staff are equipped with the right training and support to deliver this agenda.

We will invest in our staff to provide high quality training that is focused on the need of the individual and the services that are to be provided.

- Achieved the NHS Improving Working Lives Practice Plus standard.
- Reduced wastage through sickness absence and turnover ratios
- Made improvements in all areas of Staff Attitude on the previous year as demonstrated by the 2005 Staff Attitude Survey
- Implemented a Clinical Leadership Programme for Matrons and Ward Managers
- Launched the first Focusing on Excellence awards 2005 for the Trust
- Achieved Birthrate+ staffing levels in Obstetrics

8. To further enhance the Trust's reputation as a centre of excellence for Research

We will develop an integrated Research Strategy that will place the Trust at the forefront of its field.

- Developed a Trust Research Strategy that will integrate research and build on the Trust's reputation in this field.
- Continued to build on strong base for midwifery research in conjunction with UCLAN.

9. To further develop our IT systems to support service delivery

We will develop our IM&T strategy to provide secure and efficient systems to clinical and non clinical areas within the organisation and to enhance links with the communities we serve.

- Reduced the risk of systems failure for Trust IT systems through the replacement of IT infrastructure.
- Developed and launched an interim intranet and website to improve communication at all levels and to host all policy documents.
- Maintained electronic access for primary care referrals into the Trust through Choose & Book software.

- The first Trust to introduce the real time notification of NHS Number for Newborn Babies.

2. KEY DRIVERS FOR THE TRUST

As always, the NHS continues to face numerous external pressures and influences that impact on the way in which we are required to operate. In that respect, our Trust is no different to any other. However, the strong basis from which we started the financial year puts us in a enviable position to be able to respond.

The following are just some of the highlights of the national and local issues that we must be mindful of when developing in year plans and longer term strategies.

2.1 Payment by Results Regime

As has been the case over the last 2 years, Payment by Results continues to force challenge and uncertainty into the Trust. New tariffs and new guidance published for 2006/7 does not reduce that uncertainty in any way. The Trust has spent considerable effort challenging the setting of Obstetric tariff in 2005/6 and has succeeded in limiting the impact of the 2006/7 changes to tariff for this service.

However, as the tariff becomes more embedded into the funding structure for the NHS, we will be less able to challenge national decisions and will be required to respond to future changes as they arise. This will mean, in the first instance, that we have to be confident that we are as efficient as we possibly can be and secondly, that we may be in the position of providing services at a financial loss.

2.2 Patient Centred NHS

The reconfiguration of PCTs, SHAs and Ambulance Trusts to provide a more local and more patient centred approach to healthcare does provide this Trust with opportunities (and of course threats). The primary aim of the reconfiguration is to release cash back into the NHS for reinvestment in other areas. This is positive. However, once taken in conjunction with newly released ‘Our Health, Our Care, Our Say: White Paper’ it is easier to identify the risks associated with the implementation of the Patient Centred NHS.

Locally, the reconfiguration of PCTs does provide risks of lack of continuity and a potential change in patient flows. Discussions relating to Trust reconfigurations will also have potential impacts on this Trust and we remain involved in local discussions.

Efficiencies will also be sought from seeking economies of scale across corporate services such as procurement, IM&T, HR, pathology etc. Cheshire & Merseyside SHA have already published their first bulletin outlining some of these plans and the Trust is involved in them to varying degrees.

2.3 Out of Hospital White Paper ‘Our Health, Our Care, Our Say’

This is potentially the most influential paper, with regard to service redesign, to be published for a number of years. The paper strongly encourages, and indeed sets financial targets, for the shift of resources from hospitals to the community. There are specific sections in the paper that identify antenatal care and gynaecological services (infertility, menorraghia and menstrual problems) as being appropriate for transfer into community settings. The extent to which our PCTs and GPs will progress this agenda

is unclear but it should be the express intention of the Trust to be able to influence the decisions taken rather than respond to them when they have. Re-establishing links with individual GP practices will be important.

2.4 All NHS Trusts will become Foundation Trusts by 2008

As one of a still select group of NHS Foundation Trusts we have been able to successfully influence national policy and have been actively involved in consultation documents and guidance. As more NHS Trusts become Foundation Trusts, this level of influence will reduce. Equally, we have very successfully recruited staff, patient and public membership to support the Trust which is now in the region of 10,000. It is unclear what impact all other local Trusts becoming FTs will have on our ability to retain and engage our members.

Positively, the rigour with which the Trust has had to respond to the Foundation Trust financial and contracting regime should ensure that all NHS organisations are ultimately brought up to the same standard. Corporate Governance and Assurance should benefit in the same way.

2.5 18 week Consultation Document

In 2005, the Government produced the consultation document on achieving the maximum 18 week waiting time from referral to treatment by 2008. This is now a fixed target in the Local Delivery Plans of PCTs and the Trust will be negotiating activity levels with them for 2006/7 contracts. Explicit in the document is the inclusion of the infertility pathway. It expects that referrals for first level infertility will be subject to the 18 week target and that onward referral for assisted conception would also be subject to a subsequent 18 week target. It in not clear if or when definitive guidance will be issued.

2.6 Practice Based Commissioning

The devolvement of budgets from PCTs back down to GP Practices has a resonance with GP Fundholding. In fact, GP practices will hold their tariff related budgets and have a say in how those are spent and to deliver which services. This gives opportunities to GPs to implement the intent of the Out of Hospital White Paper, which is to shift services from hospitals to the community. While PCTs will continue to govern GPs and have some co-ordination role in the delivery of targets, there is a real risk that the transfer of some services will be implemented through practice based commissioning.

These are just some of the highlights of the key drivers in the coming year. The Trust continues to review national and local policy and will continue to respond appropriately to the challenges we face.

3. FINANCIAL POSITION AND FORWARD PLANS – Appendices 1 to 7

This section of the plan outlines the projected financial position for the current year as well as setting the ground rules for financial planning in 2006/7. The Trust will closely align operational planning, service development and financial planning to ensure the financial good health that is a primary objective for the Trust.

Clinical Directorates and corporate support departments will all be required to contribute to the sound financial management of our Trust. The following appendices set out in detail the financial plans for 2006/07:

- Forecast Income & Expenditure Account 2006/07 — Appendix 1
- Summary of Income Movements from 2005/06 to Budget 2006/07 — Appendix 2
- Schedule of Pressures & Schemes Highlighted in Operational Plans — Appendix 3
- Forecast Balance Sheet at 31st March 2007 & 2006/07 Cash Movement — Appendix 4
- Capital Programme 2006/07 — Appendix 5
- Medical Equipment Capital Bids and Approved Programme 2006/07 — Appendix 6
- Summary of Anticipated Risk Rating Arising from Financial Plan 2006/07 — Appendix 7

3.1 Financial Performance 2005/6

- **Against Budgets**

Clinical directorates have performed well in activity terms during the year and additional activity was expected to generate additional income of £1 million. However, the planned income for Obstetrics was reduced by £600,000 early in the year to reflect the continued reduction in births from 03/04 levels. The net result is additional income to the Trust of £400,000 and this has largely been taken up in covering cost pressures.

As income generated by activity is now our principal source of funding for service developments we aim to improve cost efficiency and budgetary control in 2006/07 so that we can provide a sound financial base from which to invest in improvements to enhance service quality.

We have been able to fund a capital programme of £2.8 million in the year and we expect to achieve capital expenditure of £2.2 million. The balance will be carried forward to 2006/07.

- **Against Monitor's Financial Metrics**

Good financial performance is a key element of our success as a foundation trust. Our achievement of targets set out in the annual plan agreed with Monitor in May 2005 is measured on a scale of 1 to 5 with 5 being the best performance. It is this score that determines the Trust's risk rating, which in turn governs the level of intervention we will receive from Monitor and the amount we would be allowed to borrow for capital investment.

The risk rating is also used by the Healthcare Commission for the financial element of the Trust's overall assessment and a score of 3 is deemed to be the minimum acceptable level of financial performance. In this first year of foundation trust status we plan to achieve a risk rating of between 3 and 4. The maximum possible score for a Foundation Trust, in its first year, is 4.

3.2 Income Position for 2006/7

2006/7 will be no less challenging than any other year in the NHS. In fact the ongoing uncertainty of Payment by Results, national tariff and service reconfiguration will only increase those challenges.

Therefore it is important to see the income position for 2006/07 in the context of:

- **NHS inflation uplift**

The NHS inflation rate is 6.5% and as such is largely in line with the trust's own forecast of inflation on generic NHS issues such as pay inflation, Agenda for Change, consultants' contract etc. However, there is a requirement for Trusts to make a cost improvement of 2.5% resulting in a reduced uplift of only 4%. The cost improvement target is equivalent to £1.8 million on the Trust's income of £70 million.

- **Continuing development of "Payment by Results";**

The system of Payment by Results has been reviewed and tariffs have been adjusted and rebased to take account of activity levels. Nationally, this has led to a further average deflation of tariff by 2.5% in addition to the 2.5% cost improvement target, leaving a net inflation of tariff of only 1.5%. This has been reflected in the Trust's average uplift with a reduction in the Obstetrics tariff of 5% off setting small increases in other tariffs.

Guidance on outpatient procedures is clearer than in 2004/05 and there is now an explicit tariff for Hysteroscopy and Colposcopy procedures performed in an outpatient setting. There is no tariff for any other outpatient procedure in Obstetrics or Gynaecology and unless we can negotiate a local agreement and prove the procedure is high cost, income received will be in the currency of an outpatient attendance.

The changes in tariff result in a loss of income of £1million in addition to the cost improvement target.

We consider there is a case to be made in particular for a locally negotiated price for a number of outpatient procedures in Fetal Medicine. Critical Care has not come into the scope of tariff for 2006/07 but will run in shadow form with a view to its inclusion in tariff in 2007/08. It has been assumed that for services outside of the scope of tariff inflation will be applied at 4%.

As we are now an organisation that is losing income under tariff we will receive non-recurrent transition support in 2006/07 of £492,000. We have also agreed a contract adjustment with Liverpool PCT on outpatient procedures which means we receive an additional £1.1 million in 2006/07, again as a one-off benefit. We intend to use these sums as a contingency to help with organisational restructuring and risk management in-year. This will give the organisation time to formulate plans to reduce its cost base to be ready for 2007/08 and beyond.

- **An increasingly competitive environment**;

The Trust cannot be complacent in relying on increasing or even maintaining current income levels under tariff. Income estimates assume a level of activity consistent with 2005/6 outturn. Where the Trust may be in direct competition with other providers, including the independent sector and primary care, this level of activity could be reduced therefore reducing income. The Trust will need to remain competitive and the provider of first choice in order to continue to support its current infrastructure and staffing levels.

Provision has been made within the expenditure budget for generic NHS cost pressures such as pay awards, Agenda for Change, Consultant contract, CNST premium increase and general non-pay inflation.

3.3 Cost Pressures

Meetings with directorates and a review of budgetary performance in the current year has produced a list of cost pressures and financial commitments totalling some £1.1million. These are set out in the first 3 columns of the schedule at **Appendix 3** These pressures have been approved for funding in 2006/07 in order that directorates may start the year with an achievable budget. It is essential that having invested this level of funding, expenditure is managed within budget.

3.4 Service Developments

Service development bids were made totalling £3.3million. In the current financial environment it has been possible to fund only 2 developments.

- Consultant in Urogynaecology
- Consultant in Gynaecological Oncology and associated costs

These developments are planned to be self-funding through income streams from tariff. The Cancer Network has also supported one-off pump-priming of £154,000 for the Gynaecological Oncologist pending transfer of all planned oncology work to the Trust by 2007.

3.5 Cost Improvement Programme

The trust's cost improvement requirement is 2.5% of income, equal to the minimum required across the NHS and assumed in tariff. This is equivalent to £1.8 million. We have been working during 2005/06 to identify schemes in readiness for the current year and already have some advanced plans to achieve a large proportion of the cost improvement target.

Additionally, a number of cross-Trust initiatives have already commenced or are about to commence and areas to target will be identified through benchmarking during 2006/07. A schedule of the cost improvement initiatives identified to date is set out below. All directorates will be required, as part of their plans for 2006/07, to identify cost improvements amounting to £350,000.

Identified Schemes	2006/7 £000s	2007/8 £000s
Reduction in the overheads with Aintree Hospitals	450	450
Increase in transitional funding from Breast Service Level Agreement with Royal Liverpool	230	460
Visitors Car Parking income	80	80
Contribution from North Wales Services	130	130
Additional income from Specialist Tariff	40	40
Interest Receivable	20	20
Total Identified Schemes	**950**	**1,180**

Potential Schemes	2006/7 £000s	2007/8 £000s
Standardisation of NHS IVF contract price	200	400
CNST premium reduction due to lower birthrate	250	250
Procurement Savings	50	100
Total of Potential Schemes	**1,450**	**1,930**

Balance of CIP from Directorates	**350**	**350**

It is becoming clear that the level of cost savings required in 2007/08 will not be achievable from non-pay expenditure alone. The balance will therefore have to be found from finding more efficient ways of working to enable the total pay bill for the organisation to be reduced and productivity improved. By planning early we should be able to avoid decisions being made on a purely reactive basis.

Clearly, it is essential that rationalisation plans are in line with the business and service objectives of the Trust, whilst achieving the required productivity gains. It is proposed that we establish a special Efficiency and Productivity Group to address this issue comprising members of the Executive Team, Directorate Managers, Staff Side representatives and the Deputy Director of Finance, to be chaired by the Director of Finance. This group will report into the Finance and Contracts Committee.

3.6 Capital Programme for 2006/7

The contribution that the capital programme makes to maintaining and developing the Trust's infrastructure and environment becomes more important in the context of patient choice and new capital builds in primary care and by independent sector providers. At the end of 2005, the Trust commissioned a review of space across the Crown Street and Aintree Centre sites. The review assessed utilisation of space and fitness for purpose. The outcomes of the review will provide a focus for capital spend in the coming year.

The following tables outline the draft plan for the Capital Programme, including equipment for 2006/7. A full list of approved equipment expenditure is provided in **Appendix 5**.

- **Funding Available**

Funding Available	£ 000s
Depreciation estimate	2732
Slippage c/f 2004/05	620
Decontamination - New Instruments - SHA	743
Parents Accommodation - Neonatal Network	300
Total Funding	**4,395**

- **Proposed schemes for 2006/7**

Building:	£ 000s
Aintree Admin and Foyer	150
Clinical Genetics Modular Building	450
Estates - Infrastructure	200
Estates - Environmental	100
Estates - Strategy	400
RMU Redevelopment	500
Parents Accommodation - Neonatal Network	300
Total Building	**2,100**

Equipment:	£ 000s
Medical	800
Decontamination - New Instruments - SHA	743
IM&T	300
Slippage from 2005/06 - Medical Equipment	80
- Genetics Equipment	180
- Slippage on CCTV	100
- Slippage on On-Call System	60
Total Equipment	**2,263**

Contingency	**32**

Total Capital Programme	**4,395**

3.7 Summary Financial Position Appendices 1 to 7

We have been able to produce a financial plan which will achieve a risk rating of 3 based on Monitor's financial metrics. This is the minimum rating deemed acceptable by the Healthcare Commission in assessing the overall standing of the organisation. However, this plan is reliant on non-recurrent income, achievement of planned activity levels and tight budgetary control and it is essential that the organisation responds to this tightening of the financial environment in the coming year.

4. ACTIVITY PLAN for 2006/7

The Trust activity plan for 2006/7 has been drafted and is included at **Appendix 8**. The plan reflects agreements that have been reached with PCTs by 14th April 2006, or where agreements have yet to be finalised it reflects national commissioning guidance for PbR and non PbR activity.

There are a number of assumptions that have driven the formulation of the activity plan and these are described below.

- For activity which attracts a national tariff the plan reflects the actual forecast outturn for 2005/6 as identified in December 2005.
- For Gynaecology elective activity and non elective activity there is additional activity associated with the two new Consultant Appointments in Gynae Oncology and Urogynaecology. Additional outpatient activity is also included.
- For out patient procedures the only nationally recognised procedures in 2006/7 are Hysteroscopy, Colposcopy and some subcutaneous injections. Any other activity recorded as an outpatient procedure in 2005/6 is now recorded against a new or follow up outpatient attendance as appropriate.
- National Payment by results Guidance for 2006/7 has recognised previously excluded outpatient activity such as Pre Operative Assessment and MacMillan nurse contacts.
- For activity which has no recognised national tariff, local prices apply and the 2006/7 plan is equivalent to the 2005/6 plan.

Directorates are reminded that budgets set for 2006/7 assume the delivery of this level of activity as a minimum.

Tariff based activity plans are now more realistically and appropriately aligned with historic delivery.

Non tariff based activity is based on historic plans which are, on the whole, lower than the activity levels that the Trust has delivered in 2005/6. If this pattern continues in 2006/7 additional income will be received over plan.

More detailed breakdowns of activity is possible and this will be shared with Directorates on an individual basis.

5. SERVICE DEVELOPMENTS

The development of clinical services in line with patient needs is a priority for the Trust. The introduction of the payment by results regime offers opportunities, as well as threats, to service development. Opportunities arise where we can prove an established or emergent need for a service, a revenue stream through tariff and are confident that we will cover our costs. The disadvantages arise where we are unable to identify an income stream or find that the cost of providing the service is not covered by tariff.

These challenges have resulted in the categorisation of developments highlighted by Departments and Directorates into:-

- Service Development for which Income Business Case Required
- Other Service Development for which no funding source identified

Two developments have already been approved in 2006/07 and they are related to Gynaecological Cancer Services and Urogynaecology. In addition, it is proposed that Directorates commence working on those developments identified as requiring a Business Case. Approval of Business Cases is unlikely to take place before the end of Quarter 1 (June) 2006 when more informed decisions can be made regarding tariff income and the Trust's financial performance. These Service Developments are listed in Section 4.1 and will be supported by the Corporate Departments as required.

At this point, those Service Developments with no source of funding have not been agreed and do not require Business Cases to be developed. These will be reviewed in year on the basis of any changes in PCT commissioning intentions or assessment of risk.

In addition to the two categories described above, there are distinct pieces of work, which have been highlighted as requiring support from the Trust's service improvement team. These are schemes which do not necessarily required additional investment but would benefit from elements of redesign to deliver improved efficiency or patient/staff experience. Support could come in the form of planned and formal involvement or as ad hoc requests to support individual management teams. Section 4.2 below outlines those schemes proposed to form the work programme for the Service Improvement Team during 2006/7. The traffic lights indicate the level of involvement anticipated from the Team.

5.1 Business Cases to be Developed

Lead Directorate	Business Cases to be Developed
Neonates	**Development of Neonatal Transport** – to support the efficiency of the Neonatal Network across Cheshire & Merseyside. LWH would be the host of the service and financial support would be provided by the Network
Service Improvement	**Picture Archiving and Communications System** – project led by service improvement with the involvement of IM&T, Radiology and other Directorates. Part of the National Programme and part funded by DoH.
Radiology	**The development of Hycosy –** as an alternative for laproscopic investigation or Hysterosalpingogram for the majority of patients with reduced fertility. Reduces the risk and level of intervention for patients. Relies on ultrasonographer input rather than radiographer input. Potentially cost neutral.

Lead Directorate	Business Cases to be Developed
Theatres	**The Development of High Dependency Services** – Outline business case taken to the Board in January 2006 which highlighted 3 phases of development; consolidating gynae beds and outreach, developing case of need for additional gynae beds and exploring the potential for an integrated service across obstetrics & gynaecology.
Gynaecology	**Pre Operative Assessment** – to work closely with Anaesthesia and Obstetrics to develop appropriate standards of pre operative assessment for all patients requiring surgery,
HSSU	**Business Case to move to Super Site** – to continue to actively participate in the regional business case to transfer services from local units to a super site. Project will include redesigning the residual on site services and the model for interaction with the super site.
Theatres	**Support for emergency Theatre Provision** - in conjunction with the Directorates of Gynaecology and Obstetrics to identify proposals for the staffing of emergency theatre sessions from within current establishment and redesigning ways of working.
Genetics & RMU	**Pre Implantation Genetic Diagnosis/Screening** – soft monies are currently funding a pilot project. Explore the potential to develop locally removing the need for patients to be referred to London for testing and subsequent assisted conception.
RMU	**Sperm Bank** – to develop a regional service for sperm donors and storage
Gynae Critical Care	**Breast Services** - to develop a response to the PCT commissioning process for an integrated breast service for Liverpool and South Sefton PCTs

5.2 Schemes Requiring Service Improvement Support

This is the first year that the Trust has produced a work programme in relation to service improvement. This will be facilitated by the appointment of a Head of Service Improvement in April 2005 and the establishment of a group of Trust wide projects under the umbrella of the Service Improvement and Development Forum.

Those schemes described in the table below have been identified by Directorates, through their plans, as potentially benefiting from service improvement support to assist redesign and produce efficiencies rather than requiring additional investment. The level of support anticipated is indicated through the traffic light system.

Recent experience from projects undertaken by the Hewitt Centre and Aintree admin, support the concept of “redesign” teams focusing on a time limited rapid redesign process offering a “short, sharp, shock” approach and moving quickly to implementation. On this basis eight schemes have been highlighted as priorities for “Rapid Redesign”.

Originating Directorate	Description of work	Support needed	Time scale
Corporate	**Modernising Medical Careers** Supporting the shift of work from junior medical staff to other health professionals.		On-going
Corporate	**Out of Hospital White Paper** Working with Primary Care to maximise opportunities through the White Paper – including devolving obstetric, gynaecology and clinical genetics services out into the community.		By Mar 2007
Corporate	**Choose & Book** To support the migration from the Indirect to the Direct Booking Service (DBS) of Choose and Book.		Sept 2006
RMU	**Hewitt Centre** To support the intensive redesign project for RMU for both NHS and Private patient flows.		April 2006
Gynae	**Gynae Capacity Planning** Supporting the mapping of capacity to demand across all gynaecology outpatients, inpatient and day case areas and theatres.		June 2006
Critical Care	**Modernising Radiology Services** To undertake a demand & capacity review of radiology services and supporting increased capacity to meet the 18 week pathway.		Mar 2007
IM&T	**Patient Services** Assist in the redesign of processes to support the introduction of electronic booking and introduce a patient access centre.		July 2006
Corporate	**Improvement Partnership for Hospitals** To deliver planned and measurable outcomes for all four Improvement Partnerships for Hospital workstreams; emergency, 18 weeks, scheduling and guidelines		March 2007

The remaining schemes also offer opportunities to realise efficiencies and will become the focus of smaller task and finish groups guided by the “Efficiency and Productivity Group.

Originating Directorate	Description of work	Support needed	Time scale
Corporate	**PACS** To produce a benefits realisation plan for the PACS development - seeking improved patient experience and cost savings.		Oct 2006
Corporate	**Marketing Strategy** To develop a Trust Marketing Strategy incorporating, market data, opportunities for promotion and service development		May 2006
HR	**Agenda for Change** Supporting the benefits realisation or “change” element of Agenda for Change. National examples are already emerging.		On-going

	Originating Directorate	Description of work	Support needed	Time scale
8	Corporate	**Registration Authority** Continue to support the infrastructure of the RA Project. Next steps to register and issue Smart Cards for Direct Booking Services users		Aug 2006
10	RMU	**Donor Sperm Bank** To support the design of a new service offering a donor sperm bank on a regional level.		June 2006
12	Gynae	**Pre-Op assessment** Support directorates in the design of pre operative assessment for all patients requiring surgery,		Aug 2006
13	Gynae	**Rapid Access Cancer clinic** Redesigning the provision of first stage diagnostics for patients with suspected cancer.		June 2006
14	Theatres	**High Dependency Services** Supporting the phase 3 of the business case – exploring the potential to integrate services across obstetrics and gynaecology		Mar 2007
15	Obstetrics	**Obstetric Triage** Assist in the mapping and redesign of patient pathways and the design of the triage area		Sept 2006
17	Theatre	**Emergency Theatres** with the Directorates of Gynaecology and Obstetrics to redesigning ways of working.		Oct 2006
18	Radiology	**Hycose** Map the potential to switch from HSG to Hycose (infertility test)		July 2006
19	Pharmacy	**Pharmacy redesign** Following recommendations from the department review, assist in the mapping of workflow & department layout		Oct 2006
20	Neonatal	**Neonatal Ophthalmology** Process map the Ophthalmology service to understand patient flows and data collection		April 2006
21	Neonatal	**Neonatal Transport** Assist in the design of pathways to support the transfer and repatriation of babies across Cheshire & Merseyside.		Aug 2006
22	Genetics	**PGD/PGS Business Case** map the potential patient pathways and costs associated with developing the service		Oct 2006
24	HR	**Implement the Electronic Staff Record** Provide the project lead and support to the implementation of the System and the ongoing work relating to benefits realisation		Sept 2006

6. TRUST WIDE PROJECTS for Commencement in 2006/7

Through the Operational Planning meetings between Directorates and the Executive Management Team, a number of valid cross-trust pieces of work have been identified. These are projects which do not fall under the remit of any one particular directorate but would have benefits that would be realised across the Trust. They have been identified as requiring a corporate focus to take them forward.

The table below outlines the schemes and identifies a responsible manager to provide the lead and focus and the Group or meeting that will provide the mechanism for reviewing progress. Directorates and departments will be required to feed into the pieces of work as appropriate.

The benefits associated with these schemes have not been taken into consideration against cost improvement targets in 2006/07. Progress towards realising benefits will set us in good stead to achieve our further cost improvement target in 2007/08. Achievement in 2006/07 will obviously contribute toward the current year's plan.

Description	Responsible Manager	Responsible Group
Maintenance Contracts To review all maintenance contracts within the Trust to understand content, value for money and alternative options i.e. tendering, bringing in house	Steve Begley	Procurement Advisory Group
Finance for Non Financial Manager Training To roll out the training across all Directorates and Departments and including the section on 'Delivering CIP'.	Dave Renouf	Performance Meeting
SLA for Bought in Diagnostic Tests Highlighted specifically by Radiology, Neonates and Obstetrics because of the high cost to the Trust. Need to understand clinical protocols for referral, price benchmarking with a view to tendering.	Jeff Johnson	Clinical Governance & Procurement Advisory Group
SLA for Pathology Tests to undertake a review of the requirement for and costs of pathology tests across all providers with a view to reducing current overspend and ensure consistent standards of service.	Angela Douglas	Performance Meeting
Aligning Post No with Budgets Every Directorate/Department has struggled with the management of operational budgets due to the missing link of post numbers aligned with budgets. Project to introduce matched post numbers across the Trust.	Dave Renouf Kim Doherty	Performance Meeting
Development of Trading Accounts Commencing with the RMU trading account (income and expenditure) and then rolling out across directorates.	Dave Renouf	Performance Meeting

Description	Responsible Manager	Responsible Group
Procurement To review the efficiency of current procurement processes and maximize cost benefits. Potential to join the Manchester Procurement Hub.	Dave Renouf Sue Brown	Procurement Advisory Group
Interpreters One of the biggest areas of overspend on non pay budgets for Gynae and Obstetrics. Review has started but need to consider alternative methods and/or providers of the service. Also to look to alternative sources of funding.	Liz Campbell	Performance Meeting
Admin & Clerical Bank Given the high cost of agency administrative staff, the Trust to consider the establishment of an A&C bank (note: article in HSJ 09.02.06 regarding the modernisation of admin roles through A4C)	Kim Doherty	HR Committee
Confidential Waste High expenditure on processing costs for confidential waste - clarity on what is confidential and what isn't and option to use volunteers to do pick ups across the Trust and centralise shredding.	Jane Appleton	Recycling Group
Home Drug Delivery Home delivery of drugs attracts VAT exemption - review in light of RMU drugs (30% of budget) and any other suitable areas.	Sue Lorimer	Medicines Management Committee & RMU Project Board
Patient Services Review the configuration of patient services across both sites and review the role of filing clerks (Band 1 in Genetics)	Cathy Fox	IM&T Steering Group
Review of Meditech and Meditech Financials Contract As a joint project, review the PFI contract clauses and undertake a review of financial systems during 06/07. Use HealthCheck days with Meditech in 1st instance.	Zafar Chaudhry & Gareth Worsley	IM&T Steering Group
Document Printing Review the status of end of life kit and look to collective use of printers in some areas. Also review the purchasing of ink cartridges i.e. named v re-inked	Zafar Chaudhry	IM&T Steering Group Procurement Advisory Group
Stationery Review the cost of stationery - quality of paper, printing of full colour headed paper and choice of supplier	Erica Saunders Steve Begley	Procurement Advisory Group
Digital Storing of Health Records 2 potentials for reviewing storage of data (i) to avoid the high costs of off site storage with Iron Mountain (ii) to maximise the potential of digital image storage via PACS (consideration for Genetics)	Zafar Chaudhry	IM&T Steering Group PACS Project Board

Description	Responsible Manager	Responsible Group
Introduction of Medisec Explore the cost and operational benefit of introducing meditech - reduction of administrative time required and improved quality of correspondence with primary care	Caroline Salden	IM&T Steering Group
Blood Transfusion Service In need of review in terms of increasing cost and clinical risk	Sue Brown	Clinical Governance
Benchmarking To develop clinical and non clinical benchmarking of services to ensure efficient, value for money and clinical excellence.	Sue Lorimer Caroline Salden	Performance Meeting

This is should not be seen as an exhaustive list of areas of work and it is anticipated that additional suggestions will come forward from directorates and departments during the course of the year, in fact this would be strongly encouraged.

Through the meetings that have been identified as co-ordinating the individual pieces of work, key outcomes will be quantified. These will include improvements in efficiency and quality.

7. RISK

7.1 Process

As in 2005/06, the main tool that will be employed by the Trust in the coming year to measure and monitor its corporate risks will be the Board Assurance Framework. Having begun to develop a framework for assessing the principal risks to the achievement of corporate objectives late in 2003/04, the Trust was in a strong position to be able to refine and develop this process so that during 2005/06. The methodology has become more deeply embedded within the organisation, enabling the same approach to be adopted by Directorates in relation to identification of key operational risks.

During 2005/06 the overall Board Assurance Framework, containing the full picture of risks identified against every one of the 73 individual goals within the Operational Plan, was considered by the Corporate Assurance and Standards Committee (CASC), in quarter 1 and quarter 3.

At the beginning of the year the CASC highlighted those risks which it felt posed the greatest threat to the delivery of the corporate objectives. These have been reviewed at each meeting throughout the year.

It is proposed that this methodology be adopted for 2006/07 in relation to the key risks outlined within this year's plan.

7.2 Principal Risks

In advance of the development of the full Board Assurance Framework for 2006/7, a number of risks can be highlighted as a result of the planning process undertaken to date:

- **Finance**
  Maintaining a healthy Financial Position throughout the year, in light of changes to tariff and contract variations and pressures on the Private Patient Cap

- **Capacity**
  Ensuring the Trust has the capacity to deliver key services within national targets (18 weeks) and therefore maximises the capacity we do have available across all sites.

- **Patient Choice**
  Ensuring we remain the provider of first choice and do not loose activity to other NHS providers (i.e. Loss of births to Ormskirk and Whiston), to primary care (i.e. outpatient based services) or to independent sector (i.e. gyane ultrasound and dexa scanning)

- **Staffing**
  Maintaining a skilled workforce to deliver core and support services. Areas of particular risk include Anaesthetists, HDU Trained nurses and ultrasonographers

- **Connecting for Health Projects**
  Need to implement on time with full compliance and avoid heavy financial penalties, although as yet unspecified.

- **Services**
  Following the publication of the Out of Hospital White Paper the risk to some of our core services becomes more apparent and includes outpatient Gynaecology and Direct Access Services.