

Forward Plan Strategy Document for 2013-14

Liverpool Heart and Chest Hospital NHS Foundation Trust

Executive summary

This is the fourth annual plan submitted to Monitor by Liverpool Heart & Chest. This plan very much represents a consolidation of the strong financial and clinical platform established by the Trust since its authorisation as a foundation trust in December 2009. The key focus of this plan centres on the continuous delivery of our 7 key strategies;

- *Patient and Family Centred care*
- *Safe From Harm vision*
- *Clinical service integration*
- *Staff experience*
- *Financial sustainability*
- *Research and Development supporting clinical innovation*
- *Health economy" added value"*

LHCH aims to be the premier cardiothoracic integrated health care organisation. This ambition and our commitment to quality led, patient and family centred care was recognised in 2012 by the foundation trust being awarded "HSJ Provider of the Year". Our drive to build upon this in 2013/14 is through our key strategies and consolidating the success achieved via our 10 strategic change programmes;

- *Clinical Excellence:-Delivering the best clinical, quality and safety outcomes to our patients*
- *Patient and Family Centred Care:-Via the provision of an excellent, safe and compassionate experience to our patients and their families*
- *Service Portfolio:-To continue to deliver our clinical services portfolio*
- *Finance:-Delivery of a financial strategy that ensures long term financial sustainability underpinning our service offer to our patients and their families*
- *Research & Development:-To enhance our R&D portfolio, capacity and workforce to optimise the benefits of translational R&D*
- *Stakeholder Management:-Develop effective relationships in the new commissioning structures to ensure the continued delivery of exceptional care in an integrated framework*
- *Charitable Funds:-To continue to develop fundraising to invest in the future strategic ambitions of the Trust*
- *Education:-Facilitate lifelong learning and continuous improvement in our teams optimising the delivery of excellent, safe and compassionate care*
- *Staff:-The continued development of our staff to enable delivery of our patient and family vision alongside the recruitment of individuals who share our values*
- *Information Technology: To continue to use IT as a lever in the delivery of high quality staff and patient experience and outcomes.*

The Trust has set out its key strategies to ensure that patients and their families receive high quality and safe care. The Trust has built on its success following the launch of its three year Patient Experience Vision in 2010 by the inclusion of families and has launched its three year Patient and Family Experience Vision in April 2013. The Trust believes that involving families in care significantly enhances outcomes and provides safer care and we fully expect to see patient experience improve even further.

The Patient and Family Experience Vision and the Safe from Harm Vision have been prioritised by the Board of Directors as key drivers in ensuring safety and quality in all we do. Our leadership teams across the organisation have been fully involved in these key visions for the future. This is in line with our commitment to our staff which is outlined in our staff experience vision. In addition, the Trust has embraced the new nursing strategy - the six 6cs which are closely aligned to our Patient and Family Experience vision.

Underpinning our visions is strong governance from ward to Board. We assess all of our standards of care delivery in line with the CQC Essential Standards of Quality and Safety to ensure that our patients receive high quality and safe care. This information is reviewed at all levels across the organisation and is reported to the Board of Directors to provide assurance of the standard of care delivery for our patients and families.

The Trust has a strong track record of delivering its financial plans since its authorisation as a foundation trust. This provides a firm foundation for the future financial strategy contained in this annual plan. The financial strategy supports our unbending commitment to service quality and safety. Our track record of delivering year on year our financial plan aligned to our clinical service strategy provides the Trust with a robust platform to enable it to meet the increasing challenges being placed on providers of healthcare services.

The Trust is acutely aware of the economic environment it and the wider health and social care economy is working in. The plan incorporates a financial strategy underpinned by a range of robust and prudent planning assumptions that cater for the delivery of a financial risk rating (FRR) of 3 over the life of the plan and similarly under the Continuity of Services (CoS) risk rating a level 3 in the latter years of the plan. A summary of the key financial data is set out below:

	2012/13 Actual £'m	2013/14 Projected £'m	2014/15 Projected £'m	2015/16 Projected £'m
<i>Income</i>	111.3	111.3	110.5	108.6
<i>Expenditure</i>	104.3	104.3	103.3	101.3
<i>EBITDA</i>	7.0	7.0	7.2	7.3
<i>Normalised Net Surplus</i>	1.2	0.3	0.3	0.3
<i>EBITDA Margin%</i>	6.3%	6.3%	6.5%	6.7%
<i>Financial Risk Rating</i>	3.4	2.9	2.9	2.9
<i>FRR Rounded</i>	3	3	3	3
<i>Continuity of Services Rating*</i>	N/A	4	3	3

**Based on lowest quarterly rating*

Section 1: Strategic Context and Direction

A. The Trust's vision is summarised as:

To be the "premier cardiothoracic integrated healthcare organisation" is the headline of what the Board is setting out to achieve. The key strategies that underpin this are:

- 1. The Patient & Family Centred Care vision 2016 – patients and their families will be at the centre of everything we do. This introduces a new care model into the NHS where families (or carers) are part of the team that supports the rehabilitation of the patient.*
- 2. Safe From Harm (SFH) Vision 2016 – staff, and other key stakeholders, have been widely consulted on the launch of a Safe From Harm vision that sets out the aspiration of harm free care. The information, tools and techniques for achieving this have been developed and are in deployment.*
- 3. Integration – Our clinical services will work in partnership with DGHs, community services, social services and the voluntary sector to deliver personalised seamless care to patients and their families. The evidence of this will be demonstrable to key stakeholders.*
- 4. Staff experience 2014 - we have the expectation that the patient and family experience delivered by our staff will be world class; they can rightly expect that the staff experience should also be at world class standards. We have now moved into the top 10 of all NHS Trusts on the engagement score measure, and we intend to get stronger.*
- 5. Financial resources- we have determined a 10 year capital plan that will enable the Trust to continue to offer safe, excellent and compassionate services. We have a 3 year income and expenditure plan that delivers the required surplus and is prudent in its assumptions.*
- 6. Research, Technology and Innovation 2016 – the core USP of the Trust is tertiary leading edge services. We have set out ambitious goals that deliver real value to the health economy and cement our reputation.*
- 7. Commissioner value proposition – we will work tirelessly to deliver highly effective treatment/pathways/care that maximise value to commissioners and the tax payer. We recognise our responsibilities in current economic times and will work to improve the effectiveness of all related health services across the areas we serve to deliver on the QIPP challenge.*

B.The Trust's strategic position is summarised as:

The Trust is the hub for cardiovascular care in Cheshire, Merseyside, North Wales and the Isle of Man. The strategic model of operation is determined by safety, clinical quality and value for money i.e. it is in the interests of patients and tax payer. The Trust has a very high market share for cardiac work and most cardiology interventions. It is the regional centre for lung cancer surgery and Cystic Fibrosis and enjoys very high market share. Other services either have a strong tertiary element or a community element. The Trust has significant, but not dominant market shares in these services.

The Board has undertaken analysis of competitive threats and opportunities. The strongest competitive threat comes from the drive to have more local services. This has resulted in the plan to develop a second cardiology interventional centre in Warrington. All other developments that have happened in hospitals or communities across our geographic foot print have been in full co-operation with this Trust as the Trust has believed them to be in the best interests of patient care.

The introduction of the single operating model and associated CRG specified services has made entry into the Trust's markets more difficult, but not impossible. The Trust has developed a long term plan that it is in the process of executing and with success. The plan can be summarised by the following;

- Where it is possible to form strong clinical and organisational relationships it will do so. There is clear evidence that partnerships enhance the role of the Trust, improve patient care and effectiveness at partner Trusts and reduce the motivation to offer competitive services. Examples of this are in Chester and Southport & Ormskirk.*
- Where it is not possible to form effective partnerships, then the Trust will compete directly with potential competitors. For example, in response to the potential Warrington cardiology development, the Trust now runs clinics in Warrington at a private facility with the aim of drawing referrals away from Warrington DGH.*

The Trust works co-operatively and fully with commissioners. We have a senior representative on every CRG (of the specialist commissioner board). We fully engage and support the cardiac network. We chair the cardiology QIPP programme for Merseyside. Our approach of openness and engagement has yielded effective influence with commissioners and knowledge of the priorities they face.

Commissioners are starting to use competitive procurement processes. The Trust has an established (and successful) bid process and identified capability to manage opportunities to bid for. We are currently bidding to be the single surgical site for Upper GI cancer and preparing for opportunities for bidding for community cardiology services in the region.

The Merseyside health economy is facing a significant funding threat. Its per capita funds are significantly higher than the English average. This gap is likely to close. As a result, there is considerable concern that the current level of hospital capacity is unsustainable. The Trust is playing its full part in shaping strategic reconfiguration discussions that are happening. It can evidence the quality of its clinical output, the world class patient experience it delivers and its financial viability. The Trusts services are, for the most part, not duplicated in other nearby hospitals and its economies of scale and operation (the largest single site cardiothoracic service in the UK) bring with it very large penalties to service efficiency and safety if breaking up or relocation are considered. The Board believes that it has developed an operating model that is fit for the future.

C .Clinical and Quality Strategy

Service Line Management Strategy

Given a planning scenario that as a minimum for the next three years centres around “flat cash”, this means that with the scale of this challenge and the consequent continuous requirement for efficiency levels of a minimum of 4% to be released year on year, the Trust has to ensure the whole of the organisation is committed to the delivery of high quality, patient and family focussed care within a reducing financial envelope. The Trust embarked on its Service Line Reporting (SLR) journey some 4 years ago. Through this approach the Trust has a mature, highly developed, devolved responsibility and accountability structure incorporating its service lines with strong levels of embedded clinical leadership. Through our SLR approach and governance structures the Trust is well placed for the challenges of delivering clinically led transformational change over the life of this plan whilst ensuring that quality is kept at the heart of everything we do alongside delivering year on year efficiencies. Within our service lines whilst our continued focus throughout the life of this plan will be on delivering year on year activity that at HRG level demonstrates continuous improvement in our costs per spell, additional specific pieces of work will be undertaken in respect of two major loss leading service lines namely Aortics and Cardiac surgery.

Our focus on removing clinical variation will continue in year one of the plan with service line clinical leads being challenged and engaging in a process of reducing product and practice variation. This will release benefits within our Cardiac service line. However, whilst some benefits will be released from within the Aortic service line this will not be at a quantum that tips this into a service line that delivers an acceptable level of margin to the Trust. The Trust will seek to continue to engage stakeholders at both a local and national level to:

- *Lobby and secure changes to PbR tariff*
- *Secure contractual agreements at a local level that will allow the continuation of this life saving service line to patients whilst Monitor colleagues review information to inform the 2014/15 tariff*

The Trust has developed its programme of efficiency and change for 2013/14. New governance structures which will be detailed later on in the plan will facilitate the delivery of CIP. The Trust will continue to utilise benchmarking information e.g. NCBC, Dr Foster data to firm up the work stream details for 2014/15 and 2015/16 programmes of efficiency. Through the detail available to the Trust a focus for delivering transformational change for the latter years of this plan will centre on:

- *Ward staffing*
- *Theatre utilisation*
- *Absence management*
- *Outpatients*
- *Perfusion services*

These core themes will be underpinned by the implementation of our Electronic Patient Record (EPR) and the continued use of IT as a lever for change.

Clinical Workforce Strategy

The Trust uses two nursing workforce models to provide assurance that safe staffing levels are in place across the organisation. The workforce models used are the AUKUH - an acuity based model and the Professional Judgement model. These methodologies are applied and completed for each in-patient ward on a 6 monthly basis and the findings are presented at our Workforce Assurance Committee. To ensure this process is robust, existing key performance indicators and measures are reviewed alongside the results – these include reviewing the ESQS dashboard, staff satisfaction, complaints, incidents, nurse sensitive indicators and workforce indicators. In addition, the Trust uses a governance framework named the ESQS which is used across all clinical areas in the Trust to assess the standards of care delivery against the CQC Essential Standards of Quality and Safety. The information from these assessments is triangulated with the workforce reviews to ensure the delivery of high quality and safe care to all patients and their families.

A specialist centre has both risks and benefits in relation to medical staffing. In some areas, the reputation of the Trust as a national Centre of excellence means we are able to attract the very best candidates from around the world. In other specialties, the skills required to perform such specialised work are rare, and when these individuals are available they are always in great demand. We face both these scenarios at Liverpool Heart and Chest Hospital. Within cardiology there are currently no recruitment issues with strong applicants as posts arise, the same applies for Respiratory Medicine. Historically, Radiology has been a difficult to recruit to speciality and the Trust has recently seen a consultant retire and return on a part time basis. The Trust is exploring a number of models to assist in this area including the excellent relationship with colleagues at the Royal Liverpool and Broadgreen University Teaching Hospitals. A key challenge remains for the Trust within cardiac surgery and middle grade surgical cover with the number of College approved trainees reducing over the last three years. Locum cover is available but has been variable in quality and the Trust has introduced a number of fellowships which have enabled the Trust to recruit high calibre individuals and currently there are no vacancies at middle grade. The single biggest challenge in respect of medical workforce sits within Anaesthesia which is the largest single speciality seeing rising demands over the past two years. Currently and historically, consultant anaesthetists with specialty accreditation have been in great demand. There are a number of such unfilled vacancies nationally. The Department formed a working group to address these issues. A consultant from Canada has been recruited and is currently being assessed in a locum position at the Trust. A local trainee and previous Fellow at the Trust will be available to appoint from August onwards. Traditionally our in-house Fellowship programme has been a good recruitment source for our consultants. The Fellowships became less attractive when the Deanery decided that a Fellowship year could not be included in the training programme and now has to be completed outside of this. However, efforts to recruit Fellows have been invigorated with good result and recruitment of further consultant staff over the next 2 years is likely to flow.

Clinical and Quality Strategy

The Trust's Clinical and Quality strategy over the next three years is:

Trust approach to quality & safety

Patient & Family Experience

The Trust launched its three year Patient Experience Vision (PEV) in April 2010 detailing the six steps of the patient journey. The vision described a compelling vision for Patient Experience and the transformational work that would be undertaken towards 2013.

The Patient Vision has been instrumental in introducing a standard by which all our activities, clinical and non-clinical, are measured. The vision has energised staff and given them permission to challenge care that does not meet our ambitious standards and focused investment of resources. Staff performance is measured by their contribution to the vision, investment in our estate is determined by the vision, our Electronic Patient Record programme has the vision at its heart and the Board uses an innovative set of metrics to monitor progress.

Paramount to the Trust is to keep the vision alive continuing the journey of improvement and set the vision for April 2013 and beyond. We believe this will be delivered by the development of our Patient and Family Experience Vision building upon the great work delivered over the past three years. We believe this will bring richness in the quality and safety of care and experience that our ambitions demand. The core of the new vision will be the development of patient and family centred care – a first for acute hospitals in the country. The evidence is that family centred care significantly enhances outcomes, provides safer care and gets best value out of NHS resources. We fully expect to see patient experience improve even further, harms such as falls to reduce, re-admissions to decline and staff satisfaction to increase.

Patient Safety

2012/13 saw a major shift in the Trust's approach to quality and safety which resulted in the plan being realised albeit differently than originally envisaged.

As the focus of both the Care Quality Commission(CQC) and the Francis enquiry is on patient safety, the Board of Directors have prioritised, in addition to patient and family centred care, the minimisation of harm as a major guiding principal for its clinical quality and safety strategy for the next three years. Naturally, in aspiring to this aim, work in the other dimensions of clinical quality (effectiveness and patient experience) will take place but these will be aligned to what we are calling "Safe from Harm" (SFH) where it makes sense to do so.

This vision was developed following the decision to focus on safety by:

Holding a Management Congress to which all senior leaders in the organisation were invited. The concept and anticipated benefits of SFH were described, and there was unanimous support for the focus this work would provide.

The Executive team then led road shows in every ward and department, using the opportunity to describe types of harm, levels of current harm and values and behaviours expected.

Each Head of Department then engaged with their staff over how they would like to see the vision take shape. The outcomes of these discussions were fed back to the Executive team.

The Executive team then developed a draft narrative for SFH, articulating what had been fed back to them as a vision of what the Trust would look like in three years' time as a consequence of embracing SFH. This vision statement went to final consultation in late March and was launched in April 2013.

Key changes required to progress from current position:

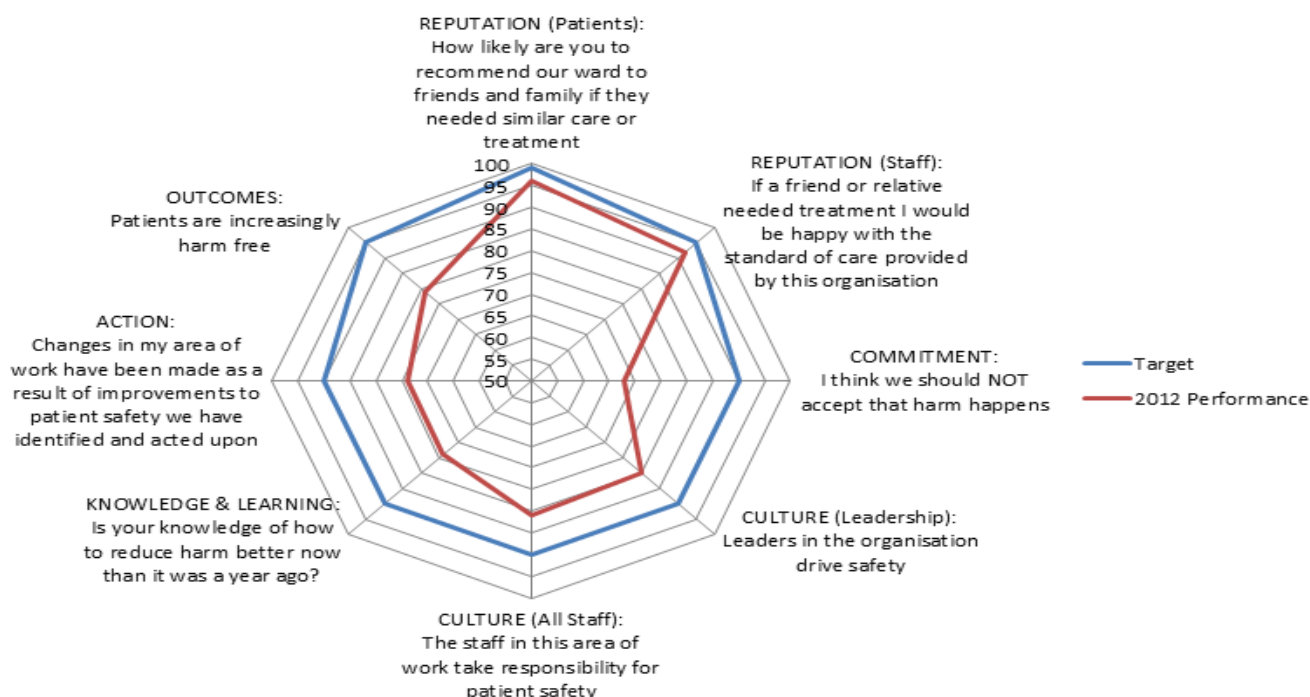
Launch of Safe from Harm

Sub strategies that need to be in place:

The following is a first draft of the implementation plan for SFH. This plan is actively being worked upon and will be refined as the Trust progresses with implementation.

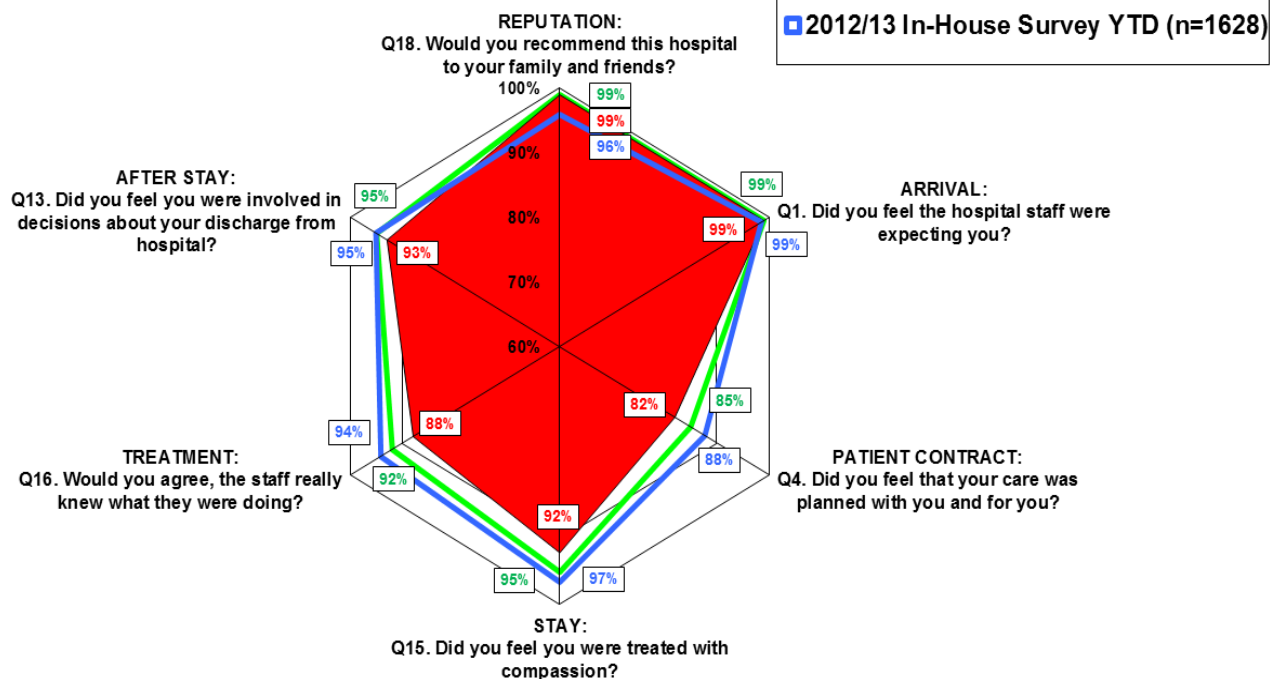
Need	Development Required
Launch vision and demonstrate clarity of goals and integration across all visions	Launch event - April 2013 team brief
Demonstrate the benefits with objective evidence	Annual culture survey and six monthly temperature check survey. Integrated harm measure demonstrates outcome. Spider diagram and Directorate based harm measures; Deep dive benefits realisation work.
Articulate the benefits at every opportunity - patient (safer care) and non- patient (e.g. reduced costs)	Internal communications plan including direct executive engagement sessions, team brief (how low can we go), adapt induction and mandatory training. External communications plan re: outcomes on web (transparency post Francis), social media, eCommunity (ID improvement opportunities and track progress), SLR integration with outcomes.
Trust Executive and clinical leads actively involved in Safe from Harm	Executive sponsorship for improvement projects; introduce presentations at team brief; safety improvement slot on audit days and management board
Staff identify own safety priorities	Safety diagnostic tool, integrated harm data and MRG reports by Directorate. Directorate safety champion takes priorities to Patient Safety Group (PSG).
Set the expectation that all staff will contribute to Safe from Harm	Adapt PDR - demand evidence of how staff have contributed
Test believability of the benefits and reinforce	Safety walk rounds
Adopt distributed leadership for leading and delivering on safety improvements	Recreate Patient Safety Group with safety champions - reports into Directorates. Shared membership. Improvements built into contracts. Hot topics and six monthly detailed reports on progress with Safe from Harm to Clinical Quality Committee.
Institute and sustain safety improvement training	AQuA safety champions; IHI Open School licence; Facilitated by Service Improvement Team
Adapt support infrastructure	Prioritise safety for support in risk management, clinical quality and service improvement annual work plans
Staff celebrate their achievements in safety	Annual safety showcase

The draft framework for monitoring progress will be based upon a spider diagram which is in use for feeding back performance on other strategies actively running in the Trust. An example is shown overleaf, targets and questions remain to be agreed and are therefore indicative only.



The above spider diagram demonstrates baseline information against the draft metrics that will be used to measure progress against Safe from Harm. This approach complements the approach used in implementing the Patient Experience Vision (below).

Patient Experience Vision



Our main quality goals are driven by CQUINS, Quality Account Priorities and the commitment to our visions (Safe from Harm (SFH), Patient & Family Experience Vision (PFEV)).

Quality Dimension	Priority	Key actions to deliver	Milestones	Risks to delivery
Safety (Quality Account & CQUIN)	Reduce pressure ulcers to 1.6% as recorded by NHS Safety Thermometer	In partnership with commissioners, establish a health economy wide pressure ulcer group Feedback Trust acquired and upon admission ulcer prevalence rates Share best practice	Establish group (June) Quarterly meetings (Sept, Dec, Jan)	Failure to engage rest of health economy
Safety (CQUIN)	Maintain VTE risk assessments at > 95%	Business as usual	Monthly snapshots, Six monthly audits (March & Sept)	Record keeping of poor quality, Migration to EPR delayed
Safety Safe From Harm (SFH)	Implement actions to achieve year one of the Safe from Harm	Launch Vision Use of safety diagnostic tool by Directorates	Safety champion training March/April Launch April Safety projects identified and in Directorate contracts by April	Safety champions may not complete training Cannot identify Patient Safety facilitator
Safety (CQUIN & SFH)	Implement relevant recommendations of the Francis report	The Trust has carried out a series of briefings following publication of the report with staff Trust wide. The Trust awaits formal request to provide a detailed response to the report. Internally the Trust has reviewed the recommendations and will work with commissioners in providing a response as requested to do so.	Bi Monthly review of any actions identified from the recommendations as per the report that will be requested. This work will be tied into "Safe from Harm"	Implementation of strategy overload for staff and subsequent engagement given other pressures
Safety (CQUIN)	Timely admission of ill cystic fibrosis patients from the out-patient clinic	Bed review. Demand & capacity review. Protocol development for admission within standardised timeframes depending on clinical risk	Bed review by June. Baseline assessment by September. Implementation of plans from October.	Insufficient beds to make the change.

Quality Dimension	Priority	Key actions to deliver	Milestones	Risks to delivery
Effectiveness (CQUIN)	Deliver plans for implementation of high impact innovations	Implement telecare with 42 new units Improve use of IOFM in upper GI and aortic surgery cases Implement EPR	Agree plan with Commissioners March Introduce new IOFM protocols April Transfer documentation to EPR June	Plans may not be acceptable EPR programme may slip
Effectiveness (CQUIN)	90% of > 75yr old patients admitted emergently receive risk assessment for dementia	Business as usual	Monthly audits	Small numbers mean missing a single patient has a large impact on performance
Effectiveness (CQUIN)	>95% compliance with heart attack, bypass grafting and heart failure care bundles	Business as usual	Monthly audits	Small numbers in heart failure mean missing a single patient has a large impact on performance
Effectiveness (CQUIN & Quality Account)	>95% of discharge summaries and out-patient letters to be delivered electronically to GP's	Completion of pilot Roll out to all wards and all 95 GP practices in Liverpool Develop and implement plan for out-patient letters	Pilot results March Roll out summary solution from April Plan (Sept), pilot (Dec), Implement (Jan)	Recurrent IT problems that cause delay Failure to implement EPR on time
Effectiveness (CQUIN)	Implement new Cancer Network arrangements for timely referral of suspected cancer patients	Network wide agreement on changes Implementation of new arrangements	All CEO's in Network agree Automatic breach reallocation from April	Inability to get consensus
Effectiveness (CQUIN & Quality Account)	Develop and implement a health economy wide discharge checklist	Establish best practice Engage with health economy Develop & implement	Establish group (June) Implement (Dec)	Failure to engage rest of health economy
Effectiveness (CQUIN)	>80% of DGH referrals for cardiac surgery transferred within 7 days	Capacity & demand review Dynamic flexing of urgent and elective capacity	5% gain in transfer times per quarter Monthly review of performance	Compromise of 18 week target
Patient Experience (CQUIN & PFEV)	Deliver the 6 C's of the national nursing strategy	Bi monthly review of all Patient and Family satisfaction survey information and qualitative feedback from Patient and Family engagement events trust wide and within the directorates	Implement Friends and Family Test(FFT) (Apr) Monthly patient and family experience surveys Engagement events (June, Sept, Nov and Jan 14)	Capacity within the directorates for staff to be released to attend sessions relating to the Patient and Family Centred Care vision
Patient Experience (Quality Account & PFEV)	Deliver the national plan for the Friends & Family test	Adhere to national rollout plan	Completion of pilot March Live April	Patients may not engage with hand held devices
Patient Experience (PFEV)	Refresh and re-launch the Patient Experience Vision as the Patient & Family Experience Vision	Launch of the updated Patient and Family Experience Vision in April 2013	Launch (April) Six monthly directorate governance reports	Capacity within the directorates to release staff to engage in activities that will develop PFCC due to competing priorities

Quality risk identification & review:

The Board of Directors takes a multipronged approach to the review and monitoring of quality.

As part of the annual planning cycle, the Executive team lead a process whereby every CIP scheme is reviewed for its impact on quality & safety. Traditionally, the medical and nursing directors sign these plans off after a confirm and challenge process has occurred directly with the Directorates. However, a new approach is being adopted for 2013/14 which will see every Director sign off these plans. Finalised plans are then reviewed by the Board.

The Board Assurance Framework is proactively used to identify and mitigate against major strategic risks.

A top down process is in place whereby new operational initiatives (annual plan and throughout the year) are risk assessed and mitigation introduced. These are monitored via the Executive Risk Register.

There is also a bottom up process whereby each ward and

department maintains their own risk register. Risk registers are reviewed routinely in Directorate meetings and major risks are escalated directly to the Executive. Such risks are discussed and if not moderated, are added to the Executive risk register. Major risks are then managed by one of the Trusts five assurance committees. Failure to resolve the issue within three months of it being escalated results in the risk being escalated to the Board of Directors.

Quality metrics reported and reviewed are those that comprise the governance risk rating, CQC minimum standards, our CQUIN contract and our quality account commitments. Particular service developments will also have metrics identified and reviewed throughout the implementation of the development and into business as usual.

Mitigating risks to quality:

All performance indicators for the Trust have been allocated to a relevant assurance committee. Every assurance committee agenda has a section dedicated to risks and performance where our integrated performance report is reviewed and actions taken as necessary.

Ensuring effective arrangements going forward:

The Board of Directors:

Undertakes an annual review of assurance committee structure and its fitness for purpose.

Leads dashboard development in accord with any new quality and safety priorities. These are planned to become much more live and interactive for wards and departments in 2013/14.

Continues to develop its quality governance framework. Our approach in 2011/12 was awarded significant assurance and is due for re-audit of recommendations in 2013/14.

Will implement our electronic patient record in June 2013. This will make information about clinical care much more accessible, transparent and rich.

Uses a tool developed locally to measure the implementation of the CQC essential standards of quality and safety in all clinical areas. Use of the tool is dictated by performance, with areas that perform less well being scrutinised more often.

D Productivity and Efficiency

CIP Governance/ CIP Enablers

Identification and Development

Identification and development of CIPs is led by the Trust Senior Management Team (TSMT). This builds upon the identification of potential work streams and opportunities generated through the Trust's devolved directorate management structure where each directorate is led by a lead clinician.

The Trust adopts a 3 tier approach to the identification and development of Cost Improvement schemes:

- Budget setting process/Directorate Contracts;
- Procurement Board – Procurement Action Group
- Corporate Projects - Project Management Office (PMO)

Financial Management

The Trust has a strong track record of robust financial management aligned to the delivery of its overall strategic vision with a coherent strategy for the delivery of productivity and efficiency.

The Trust sets budgets using forecast outturn as a baseline for the forthcoming year's budget requirement. A CIP target of 4.0% was identified for 2013/14.

As part of the annual budget setting process there is a detailed review of costs with the Service Line Management Teams (SLM's) to discuss and identify specific areas to target CIP efficiencies. Whilst the nature of schemes identified will deliver incremental savings, building on successes previously achieved (looking at providing the same service in a more efficient way), additionally for 2013/14 further identification of transformational opportunities to eliminate clinical practice variation utilising SLM and outcomes data will be implemented. This approach enables the Trust to have clear sight of the potential level of savings in conjunction with an impact assessment on agreed quality metrics.

The Trust continues to build upon previous work carried out to identify how the use of benchmarking data can support the identification of areas where saving can be realised. Two examples of this approach are firstly how we have used the National Cardiac Benchmarking Collaborative (NCBC) benchmarking data to discuss and identify efficiency savings for those outlying areas highlighted in the NCBC report and ERIC estates data supported by additional due diligence through the commissioning of an external "i-clean" audit to identify an additional savings within our housekeeping service. In addition given the prudent assumptions utilised in the Trusts' medium term financial strategy meetings were held with service line consultant teams and the executive team to discuss and identify other opportunities for CIP schemes moving forward into 2014/15 and beyond.

The key enabling schemes arising from this approach over the planning period include:

- Clinical Standardisation, with identified reductions in variation (£1.1m).
- Procurement Savings with enhanced bulk purchasing to deliver price reductions, reviewing Contracts to ensure Value for Money measures are built in as standard (£1.4m);
- Workforce Review – reviewing spans of control, skill mix changes building upon NCBC data, reduced Premium payment level (£0.8m);
- EPR – Benefit realisation following the introduction of the new IT system (£0.3m)

Procurement Board

Our procurement governance arrangements have been enhanced with the establishment of a Procurement Board, chaired by the Deputy Director of Finance which is supported by a Procurement Action Group (PAG) with multi-disciplinary membership tasked with delivering both the annual procurement savings target and horizon scanning for future procurement efficiencies.

Project Management Office (PMO)

A Project Management Office has been established, with the primary function of facilitating the delivery of change programmes to release productivity and efficiency savings whilst co-ordinating and ensuring the continual alignment of the IT/EPR strategy, Estates Strategy, Service Improvement Board, wider Trusts benefits realisation and Cost Improvement Programme.

The key themes identified that will drive efficiency savings include:

- IT Strategy - Benefits realisation from the EPR business case*
- Corporate based schemes which span different areas of the Trust such as MRSA screening, Pathology contract etc*
- Estates Strategy*
- Additional Benefits from the introduction of EPR including the redesign of workflow and care pathways.*

CIP Process for 2013/14

The development of annual CIP plans started at the planning (budget setting) process in November. This also incorporates a review/refresh of the medium term plan/strategy. Plans are developed at departmental level and are then aggregated into Directorate Plans, which are discussed and either approved/rejected at Quarterly Directorate Business & Governance Meetings. These meetings are represented by Clinical Leads, General Managers, Service Line Managers and Ward Managers.

Each directorate has a list of potential schemes that are uploaded onto the Trusts CIP Tracker so that there can be further discussions on the viability of the scheme. All schemes that are agreed to progress are then discussed at TSMT and if on further scrutiny of financial and clinical viability are approved are then included in the CIP plan. Schemes will then be uploaded onto CIP tracking documentation for all agreed work streams. The documentation captures safety and quality information, risk to delivery, key milestones/deliverables action plans, financial information and RAG rating information.

Building upon the Trust's historical approach for 2013/14 all schemes supported by TMST will then be scrutinised by a new CIP Assurance Committee. The aim of this committee is to ensure that all CIPs that are approved have been assessed for both their impact on patient safety and quality and also for their financial viability and risk and to provide a further level of challenge and scrutiny. Once schemes have gone through the review process they will then be submitted to the Executive Team for final approval.

As part of the Trust's enhanced governance arrangements a monthly CIP progress meeting will take place with the General Managers, senior clinical and nursing colleagues from each of the directorates. This meeting will discuss progress using the information held within our CIP project tracker documentation on an exception basis i.e. focusing on schemes which are behind schedule or are deemed to be unachievable. This process is aimed at providing both support and rigour to give the Trust the maximum opportunity of a successful outcome from agreed work schemes.

CIP Process for 2014/15-2015/16

The development of CIP plans for the three year planning period is led by the Trust Senior Management Team (TSMT). The Trust will continue to build upon the work streams identified in the first year of the plan with a range of opportunities identified and incorporated into the CIP programme for 2014/15. However, the Trust is cognisant of the continuing challenge to deliver efficiency levels of the order of circa £10.m in the latter years of the plan, whilst maintaining safety and quality. The Trust does not underestimate this challenge and will regularly review its governance structures and processes to ensure the delivery of CIP is continually aligned to our vision of providing high quality, patient and family centred care within increasingly limited resources.

CIP schemes for 2014/15 will be reviewed on quarterly basis throughout the 2013/14 financial year to ensure steady progress is being made and that schemes with a long lead in time for delivery continue to be progressed in line with agreed key milestones and key deliverables.

Project Management Office

The implementation of a Project Management Office will support the co-ordination of all of the major change programmes including the Estates Strategy, IT/EPR Strategy, and Service Improvement Board and ensuring and maximising the delivery of benefits realisation from projects.

Contingency Reserve

As part of the planning process, the Trust has built in a contingency reserve of £500k, split across Pay and Non Pay. This not only provides headroom against the risk of under-delivery of CIPs, but also provides an opportunity for new investments that will drive additional efficiencies.

Mitigation Plan

As part of the Annual Business Planning process, the Trust evaluates potential financial risks over the 3 year planning period, demonstrating the impact on the base case net surplus and cash flow. A mitigation plan has been developed, which would be implemented in the event of the risks being realised.

Historic CIP Performance

The table below demonstrates the Trust's strong performance historically in delivering cost savings.

	2010/11 £'000	2011/12 £'000	2012/13 £'000
<i>Pay</i>	1,780	2,259	1,290
<i>Non Pay</i>	2,188	3,115	2,395
<i>Income</i>	0	488	596
Total	3,968	5,862	4,281
<i>% of Operating Expenditure</i>	4.06%	5.85%	4.11%

E Financial and Investment Strategy

The Trust's financial strategy and goals over the next three years:

The Trust's financial strategy was approved by the Board of Directors in March 2013. The strategy has been formulated using tariff guidance, draft financial assumptions agreed with lead commissioners (subject to final contract sign off) and detailed internal planning culminating in the production of internal divisional financial, service and performance contracts.

The Trust's financial strategy is to maintain a level 3 financial risk rating (FRR) under the current risk rating regime and a level 3 Continuity of Services(CoS) risk rating. This financial and investment strategy is underpinned by our historical performance over the last three years and supports our objective of the continued delivery of our 10 strategic change programmes.

The Trust's financial strategy is informed by the economic environment we are working in. Health as a whole has been relatively protected compared to the rest of the public sector, with funding being maintained at just above GDP deflator. However, it is expected that demands for increased quality and costs associated with shifts in demographic change will lead to increased cost pressures of circa 4-5%. The financial constraints in the NHS and the wider public sector are well known and are appropriately reflected in our three year financial strategy with efficiency levels of circa £14.0m being required to be delivered over the life of the plan.

In the wider environment, other parts of the public sector are being placed under even greater constraints, with some of our key partners in care (local authorities, third sector) being particularly hit hard. Liverpool Heart and Chest recognises that the importance of working with all of our partners will become increasingly important to ensure we minimise waste and duplication, and ensure with renewed vigour and focus creating integrated care pathways across our services to deliver our mutual financial challenges as we have done in our Knowsley model of care.

The Trust continues to recognise the challenges it is facing but sees opportunities to strengthen its position supporting its vision of becoming the premier integrated cardiothoracic healthcare organisation. The detail provided in the annual plan supports the view that the Trust will continue to be successful and that commissioner focus on service quality and patient choice play to the strengths of this Trust.

At the end of 2012/13 the Trust reported a normalised net surplus position of some £1.2m against a plan of £1.1m. Key issues faced by the Trust impacting upon the delivery of the planned surplus are noted as;

- Impact of use of premium rate agency staff eroding EBITDA margin and net surplus*
- The impact of above plan activity performance and associated costs in delivering this activity*

With regards to clinical income the financial strategy prudently accommodates 2012/13 forecast outturn and broadly flat lined activity going forward. As the Trust continues to pursue its strategy of integrated care, unplanned for growth will generate upsides to EBITDA and net surplus position. The consequences of flattened activity levels, minimal growth and little service development (other than full year effect of those previously catered for) means that income is reducing over the life of the plan reflective of the impact of continued down ward pressure on tariff.

Similarly, over the lifetime of the financial strategy, expenditure will remain broadly flat due to the Trust's programme of delivering increased efficiency targeted at circa £14.0m (circa 4.3% per annum). At this level of efficiency cost pressures are mitigated against. The financial strategy caters for inflationary figures over the lifetime of the plan at 5% for drugs and other non-pay inflation at 2.5%. Pay inflation has been calculated on the basis of a 1% pay award and the annual cost of increments at circa £0.9m. The summary income and expenditure position is detailed below:

	2012/13 Actual £'m	2013/14 Projected £'m	2014/15 Projected £'m	2015/16 Projected £'m
<i>Income</i>	111.3	111.3	110.5	108.6
<i>Expenditure</i>	104.3	104.3	103.3	101.3
<i>EBITDA</i>	7.0	7.0	7.2	7.3
<i>Normalised Net Surplus</i>	1.2	0.3	0.3	0.3
<i>EBITDA Margin%</i>	6.3%	6.3%	6.5%	6.7%
<i>Financial Risk Rating</i>	3.4	2.9	2.9	2.9
<i>FRR Rounded</i>	3	3	3	3
<i>Continuity of Services Rating*</i>	N/A	4	3	3

**Based on lowest quarterly rating*

The financial strategy over the life of the plan incorporates a moderated assessment of the Trust's ability to deliver net surplus levels at the rate delivered historically. The prudent levels of net surplus planned for reflect the overall challenge the Trust faces in delivering efficiencies of circa £14.0m over the next three years broadly in line with historical levels of CIP delivered.

The Trust remains focused on the following areas to ensure delivery of its financial plan:

- Continued emphasis on controlling costs and delivery of the first year of our change and transformation programme*
- The implementation of a more granular approach to the project management of the delivery of efficiencies, including a new framework for the reporting of CIPs and guidance on the overall governance structures on process and review*
- The maintenance of our clinical income base in conjunction with seeking opportunities for growth aligned with our overall vision to be the premier integrated cardiothoracic organisation in the country*
- The continued use of our Service Line Reporting information to drive increased efficiency and reduce costs e.g. by our work stream to remove clinical variation*
- A tight control of its liquidity position*

Key risks

The key risks to the delivery of our financial strategy are:

- Financial controls not being fully developed to deliver our three year financial strategy. A key component being the delivery of our 2013/14 programme of efficiency to provide a firm base for additional change and transformation in the latter years of the plan.*
- More aggressive than catered for repatriation of activity to other providers*
- Pressure on clinical income levels from commissioners demand initiatives, service disinvestment and /or application of contract penalties(e.g. readmissions , KPIs, CQUIN)*

These risks are all being actively managed. The financial plan for 2013/14 caters for £0.5m in respect of risk mitigation.

In order to achieve the financial strategy the Trust will continue to ensure that it has a firm control of the financial consequences of all its decisions ensuring that robust control of costs is maintained.

Historically the Trust has successfully met its financial plans through a combination of strong clinical performance, attracting market share and increased clinical income levels in conjunction with a tight control on the marginal costs of unplanned activity and the identification and delivery of efficiencies in line with plans. This approach will continue and will support the delivery of our plan albeit on a much more moderated level with regards to income growth.

As noted above failure to deliver the required levels of efficiency identified represents a significant threat to the Trust's Income and Expenditure plan. In addition failure to deliver the required levels would potentially reduce the level of resource available to fund our capital investment aspirations. As previously noted the Trust has instigated new governance arrangements with regards to its CIP programme.

Service Developments

The financial plan caters for the full year effect of prior year service developments. Given the inability of commissioners to support developments going forward (albeit where opportunities arise these will be the subject of discussion) the financial plan caters for minimal service development of the life of the plan. The Trusts aims to consolidate the provision of clinical services at its site whilst proactively discussing with DGH partners the ability to work together collaboratively to secure improved clinical outcomes whilst at the same time delivering improved productivity and efficiency.

Capital Investment

Given the scale of historical investment made by the Trust in its estate and infrastructure the plan caters for a more moderated level of capital investment for the next three years consistent with our vision set out in our 10 strategic change programmes. Approximately £16.9m will be invested across the following key areas;

- EPR/IT £5.0m: The Trust will go live in June 2013 on its Electronic Patient Record and will continue to invest in IT to enable it to "transform information for health and care. Our aim through this investment programme is to achieve higher quality care and improve outcomes for patients and service users.*
- Estate Redevelopment £4.1m: The Trust will continue its modernisation programme of its wards and other patient facilities to ensure its facilities remain state of the art and offer the highest quality experience to our patients and families.*
- Medical Equipment £4.8m: Our replacement/ investment programme in equipment will enable the Trust to continue to deliver efficient and clinically safe services.*
- Backlog Maintenance £0.95m: Ensuring our estate is maintained.*

F Leadership and Organisational Development

During 2013/14 the Board will have 5 directors that were not there at the start of 2012/13. The 5 vacancies, 3 Non- Executive and 2 Executive, were taken as an opportunity for the Board to refresh and recruit people with the values and competences we believe to be vital in forthcoming years.

The Board has a development plan. In 2013/14 this entails the Board developing an IBP and undertaking an external assessment process to identify development areas for ensuring that it is fit for purpose over the next three years. Interestingly, this was thought of before the proposal in the RAF, so it is good to have confirmation of its potential value.

The Board continues to invest in leadership. Every leader has a development plan. A coaching style is deployed across the Trust. Clear accountability frameworks and performance management processes are in place. This provides further feedback for development. The Trust continues to be a paid up member of the NW Leadership Academy and utilises additional expertise, including the Kings Fund, Cass, Yale and Oxford University Business School to develop its top leaders.

Four years ago, the Trust started its journey on service line management and strengthening clinical leadership. This has yielded significant success. The challenges of the future make clinical leadership even more important. As a result, the Trust has developed its decision making processes. It has enhanced clinical membership of the "Management Board" – the key decision making/recommending to Board body of the Trust. All business cases and developments are evaluated at this Board. The directorate management teams have been enhanced by clearer accountabilities and additional responsibilities being given to clinical leads. The clinical leads are all on development programmes. We have a succession plan that is refreshed every six months and given the size of the Trust, identifies potential recruits who are employed by other Trusts.

The Trust's risk management process is reviewed annually. They have been commended for the strength and adopted elsewhere. We continue to assess their effectiveness and will see further development in 2013/14. This will include strengthening the controls that deliver CIPs in 2014/15 and 2015/16.

G Regard to the views of Trust Governors

The Trust has had regard to the views of Trust Governors by:

In preparing the Annual Plan, LHCH has taken some time to ensure that the views of our Governors and Members can be expressed and referenced in our plans. Our approach to engaging these important views has been through:-

- *The Board of Directors and Council of Governors participate in an annual joint development day in November each year. Part of the agenda for the development day is consideration of the Trust's strategic objectives.*
- *In relation to the 2013/14 annual plan, the governors have been informed and invited to comment on the estates strategy, capital plans and investment in IT; as well as engagement in the review of strategic objectives and change programmes via a workshop dedicated to the proposed Annual Plan.*
- *At the start of each quarterly meeting, the Council of Governors receives a presentation from a clinician or service manager on a topical clinical service development issue.*
- *Governor attendance and participation in a working group that has considered the quality account indicators for 2013/14 and the outcome of this work has been reported to the Council of Governors.*
- *Governors participate each year in the selection of indicators for inclusion in the Trusts Quality Account and monitor delivery of them together with CQUIN schemes throughout the year.*

The Trust building on the programme involving governors in patient and family engagement events will continue this again in 2013/14.

In March of each year, governors are briefed on the assurance processes that the Board of Directors have put in place to ensure the operational capacity and capability to deliver the annual plan for the forthcoming year.

Membership size and movement:

Public Constituency:

Our target for public membership was to maintain 10,100 by 31st March 2013 – this has been achieved. Public constituency membership representation increased by 85 over the course of the year to achieve a total of 10,150 public members by the 31st March 2013. Compared to the position in 31st March 2012, the number of members within the Cheshire class increased by 2%; in North Wales by 10%; Rest of England and Wales increasing by 9% and the Merseyside constituency remaining the same. As a result the geographical representation of public members has improved and better reflects the populations served by the Trust. Our aim is to continue to retain a cohort in the region of 10,100 members going forward and our membership strategy will focus upon improved engagement and representation within this optimal membership size.

Staff Constituency:

Our target for staff membership is that all staff employed on permanent contracts become and remain as members whilst they are employed by the Trust. We employ approximately 1300 staff and membership increased by approximately 5% compared to the number of staff members at 31.3.13, reflecting the increase in headcount of our workforce. There has been no staff 'opt outs' to date.

Analysis of current membership of the public constituency

Whilst our membership is broadly representative of that of the population, the Trust is less well represented in the lower age groupings (0-16 and 17-21) when compared to the general population but recognises that its patient population largely comprises the 22+ age group. In addition to this it is important to note our members' minimum age is 16 years old due to joining criteria, which explains low representation in the 0-16 category.

Election Report

Election results are contained in the completed template. The Board of Directors can confirm that elections for public and staff governors held in 2012/13 were conducted in accordance with the election rules as stated in the constitution and approved by Monitor.

Membership Plan

During 2012/13 we have focused on maintaining our membership target of 10,100 public members and improving representation and engagement within our membership communities. Our governors' Membership and Communications Committee, chaired by a Public Governor has been active in this work. The group has set and monitored a plan of activities that has included targeted mailings to recently discharged patients. We have also undertaken a range of recruitment activities, including presence at University Freshers' Fairs and a local health fair organised by a voluntary organisation. We have continued with our successful 'Medicine for Members' programme. In particular, two of these events have focused on attracting younger members with a subject on Sudden Cardiac Death in Sport. In order to engage and retain our members the Trust also held its first annual health day, whilst a cohort of our members continue to become active hospital volunteers and provide support to our patients and families in many ways. Our Council of Governors has also reviewed and updated the Membership Strategy.

We continue to communicate with our members in a variety of ways including through our membership newsletter – of which we have increased the frequency from two to three per year to better meet the needs of our members. In addition to this we introduced a text service which helps notify our members of events which may be of interest to them specifically. We believe good communication and engagement is essential in the retention of our members.

In 2013/14, we will continue this work and have planned a programme of activities for the year that will focus on continuing to improve representation and engagement rather than growing the membership in size. In our aim to recruit more younger members, our engagement plan includes exploring stronger links with various universities within our catchment area and continued presence at freshers fairs. In order to improve representation with our patient population we will be focusing on recruiting members in the Merseyside constituency through a series of mailshots to recently discharged patients.