NORTH CENTRAL LONDON SHA
- THE WHITTINGTON HOSPITAL NHS TRUST

PROVIDER SUSTAINABILITY PLAN

2006/07 TO 2009/10

REPORT – 10TH MARCH 2006

VERSION IV

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1 EXECUTIVE SUMMARY

1.1 Summary of the Trust's strategy

Ratified in November 2004, the Trust's strategic vision is stated as follows:

"Our local community needs and deserves a high quality hospital service, provided in a caring, friendly and efficient way. The Whittington intends to be respected and selected as the hospital of choice, and regarded as a civic asset for the community within which we are rooted. We will be recognised as the Centre for Excellence in ambulatory care; the care of chronic disease; and the treatment of common cancers, by exploiting our strengths in these areas to reflect the needs of our population, and continuing to provide first class undergraduate and postgraduate education and training."

The Trust is currently in the process of implementing the strategy as part of the redevelopment and business planning process; it is intended that this sustainability plan will form a key plank of this work.

The Trust confirmed its strategic direction in November 2005 and approved the strapline *"the hospital of choice for local people"* to summarise its vision.

1.2 Impact Assessment

The strategy outlines a four-year forward plan, which reflects the Trust's stable recurrent financial position but in the current context of a £3m (approx) annual income and expenditure deficit arising from the application of the most recent information on PbR and the national tariff. This is based on analysis of past activity trends overlaid with opportunities for developing particular services where the Trust has invested in additional capacity in the redevelopment of the acute core of the hospital through the PFI. In order to mitigate the additional costs of the development, the Trust has implemented and is further developing its modernisation programme to streamline all services and maximise the throughput of in-patients through a lower number of beds.

The workforce plan combines a significant headcount reduction from 2005/06 relating to current levels of activity, with anticipated growth to deliver the additional workload at a higher level of productivity.

The current financial model does not yet incorporate the impact of the final PbR arrangements and tariff for 2006/07. The achievement of sustained balance will also be shaped by a challenging cost improvement and income generation programme with attendant risk to be managed. Cost improvements of the order of £6.5m are required for the current year, £3.4m in 2006/07, and approximately £5m pa thereafter.

1.3 Risk and Mitigating Actions

The Trust has identified seven key significant sources of risk which will impact on both income and expenditure and cash flow. These are set out in section 6, along with mitigating actions, and are incorporated in the sensitivity analysis in Annex 3.

The Trust will engage in constructive collaboration with PCT partners to optimise service delivery and share financial risk. It will foster excellent relationships with GPs through continuous improvement in quality and performance.

Income risk will be mitigated by the Trust's recent investment in marketing capacity through the appointment of a Head of Marketing working alongside the press and communications department and operational managers. A draft Patient and Public Involvement Strategy has also been drawn up as part of the preparation for working towards Foundation Trust status.

Expenditure risk will be managed through the rigorous monitoring of budget management and the delivery of the cost improvement programme.

1.4 Implementation and Monitoring

A detailed implementation plan will be agreed following approval of the I&E plan, with weekly monitoring of savings performance and monthly monitoring of the overall position at executive team level. Monitoring is being undertaken at non-executive level by the Finance & Performance Committee, which meets monthly and reports to the Trust Board.

1.5 Summary

The Trust is not yet able to demonstrate stable recurrent surplus by the financial year 2006/07 because of the current impact of PbR as set out in the guidance. With the continued need in 2006/07 to repay the historic deficit, together with the commissioning of the first phase of the PFI development, a balanced plan for 2006/07 could only be achieved with an unrealistic cost reduction. However financial sustainability will be pursued through a combination of the following:

- Continued strong financial management and cost improvements in the range 3%-5% per annum;
- Rationalisation/reconfiguration of services agreed with the PCTs and local providers;
- Expansion of efficient services such as day case surgery and endoscopy;
- Responding to new demands from the PCTs;
- Detailed review of the workforce and implementation of new ways of working;
- Appropriate capital investment to maximise revenue benefit
- Commercial partnerships with other public sector, not-for-profit and private organisations

The Board will develop and deliver its plans through the decision-making structure that was established in early 2005. The FT Project Board, (formerly the Business Strategy Committee) chaired by the Vice-Chairman of the Board will oversee the planning and development work. Monitoring of performance will continue to be undertaken by the Finance and Performance Committee, chaired by the chairman of the Trust Board to which it reports.

2 HISTORICAL CONTEXT

2.1 Overview

2.1.1 The Whittington Hospital NHS Trust

The Whittington Hospital Trust is an acute general teaching hospital, situated in the area between Archway and Waterlow Park in the London Borough of Islington. Amongst one of the oldest hospital sites in London, there has been a health facility on the Whittington site since 1473. It was formed as a shadow Trust in November 1992 and formally established in April 1993. The Trust serves two main population groupings within the sector: North Islington and West Haringey, with the total population for this catchment being approximately 300,000. In addition, the Trust is a large centre for the provision of undergraduate and postgraduate medical education, as well as its recognised role in the training and accreditation of a wide variety of health professionals. The Trust currently has 2,177 staff, and has a recurrent income for 2005/06 of approx. £132m.

Over the last five years, the Trust has embarked on an ambitious and wide ranging review and modernisation of its services, driven by its redevelopment programme, national targets and local priorities. A brief outline of these activities is given below.

2.1.2 Modernisation Plans

In order to deliver its vision for the future, the Trust undertook a comprehensive review of its service strategy during a series of workshops at the beginning of 2004, involving senior clinicians, managers, host commissioners and the SHA. Following approval by the Trust Board in November 2004, the objectives outlined in the document, '*Our Future Direction: A New Vision For Clinical Services*', (Appendix 1) are in the process of being embedded within our operational activities.

Elements of this work were informed by the Trust's participation in the first wave of the 'Improvement Partnership for Hospitals' (IPH) initiative. The application of new systems and process diagnosis tools delivered significant improvements across the organisation – but most notably in the Imaging Department, as well as in our executive monitoring procedures. It is intended that the benefits and lessons learned through this project will be implemented as part of the business planning process, to ensure the improvements continue to be sustained and extended to other services.

2.1.3 Site Redevelopment

The acute core site and service redesign project reached financial close under the Private Finance Initiative in October 2002, with the Full Business Case for the scheme also being approved at this time. This development - which will deliver amongst other services new and expanded ambulatory care facilities, state of the art diagnostics and an expanded critical care unit - is supported by a separate imaging equipment business case which was developed by the Trust and approved by commissioners in 2004. Delays to the new build during 2003/04 now mean that the first phase of the new facilities will not be fully operational until late summer 2006; however, this delay has in no way compromised the Trust's ability to deliver high quality care to patients whilst construction works take place.

The optimum operation of the new facilities in terms of the pathway for emergency patients also depends on the redesign of the Emergency Department located in K Block to enable a streamlined interface between ED and the relocated medical admissions unit in the new building. The business case for this investment is work in progress and will be submitted within the next three months.

A further business case will be submitted to the SHA in during 2006, supporting the development of Women's and Children's services at the Trust. It will propose the interim development of accommodation allowing the Trust to meet the needs for increased activity in upgraded and affordable premises. In the longer term these services are planned to be reprovided in new facilities as part of the full redevelopment of the remainder of the Whittington Hospital site.

2.2 Financial Performance

2.2.1 Financial Performance – Income & Expenditure

Since its establishment as a trust in 1993, the Whittington has been addressing an apparent underlying recurrent deficit through a combination of cash releasing savings and non-recurrent measures. A radical Financial Recovery Plan initiated in 1997 released an 8% reduction in net revenue spend over a three year period. However, this proved to be unsustainable in the face of emergency demand and performance targets which were not recognised in recurrent income growth. Financial balance was achieved in 2000/01 and 2001/02 with the benefit of additional income, and included successful one-off bids for funding. However, cost increases led to a year end deficit of just under £1m in 2002/03. The impact of the EWTD and other exogenous cost pressures resulted in a £3.4m deficit in 2003/04. The SLA settlement with the main PCT commissioners in 2004/05 included the requirement for a phased repayment of the deficits incurred in the previous two years, represented by an income reduction of £1,995k over this period. A package totalling £6.0m additional income from PCTs was negotiated during 2004/05, with SHA facilitation. This enabled the Trust to achieve a breakeven position against the original income plan, and a technical surplus of £1,995k, following a year-end income adjustment, allowing a reduction by this amount in the cumulative deficit to be demonstrated.

The position for 2005/06 as projected at Month 9 is a best case scenario of breakeven, with assessed risks of £0.5m expenditure variance against plan and an expected income loss of £0.5m. The latter represents a highly probable underperformance against the NICU consortium SLA of approx and a shortfall underperformance against SLAs with the two main commissioners arising from the policy to restrict non-urgent treatment that does not breach access targets.

The figure below shows the I&E position over the last four years.

Figure 1: I & E History (LTFM reference: worksheet 15)

	2002/03	2003/04	2004/05	2005/06 Forecast
	£m	**£m**	**£m**	**£m**
Clinical Income	83.1	86.8	97.1	105.5
Other Income	22.0	23.9	28.9	26.4
Total Income	**105.1**	**110.7**	**126.0**	**131.9**
Pay costs	(72.9)	(79.1)	(87.0)	(94.4)
Non Pay costs	(25.9)	(28.0)	(30.4)	(30.6)
Total Expenses	**(98.8)**	**(107.2)**	**(117.4)**	**(125.1)**
EBITDA	**6.3**	**3.5**	**8.5**	**6.8**
Depreciation, Dividends & Interest	7.3	(6.9)	(6.5)	6.8
Net Surplus / (Deficit)	**(1.0)**	**(3.4)**	**2.0**	**0**
Normalised Net Surplus / (Deficit)	**(0.3)**	**(3.5)**	**0.2**	**0**

2.2.2 Financial History – Cash and Working Capital

The Trust has experienced a tight cash management environment since the implementation of the policy to fix the target closing balance at 0.3% of turnover. Because of the deficit in recent years, an increasing level of brokerage was required from 2001/02. The Trust had brokerage at March 2002 of £2,000k. This was in addition to a year-end loan of £4,000k from Camden & Islington Health Authority. The brokerage requirement increased to £6,973k at March 2003 in order to repay the loan to Islington PCT in 2003/04. The increase to £10,500k at March 2004 was the cash consequence of the operating deficit of £3,400k being added to the brought-forward requirement.

Permanent re-basing of £6,000k was received in 2004, and £3,500k of brokerage was renewed in January 2005. There was therefore a net reduction in the brokerage requirement over the year of £1,000k, which can be attributed to improvement in both the I&E position and realisation of NHS debt through the new cash management regime. The increase in the level of invoiced debt at March 2005 results from the level of invoices raised in March relating to agreed SLA adjustments. The closing projected cash balance of £600k in March 2006 results from the net financial change implied by the EFL, including the repayment of permanent PDC of £4.6m and will be achieved through a combination of proactive debt recovery and management of creditor payments.

Figure 2: Cash and Working Capital History (LTFM reference: worksheets 6 + 15)

	2002/03	2003/04	2004/05	2005/06 Forecast
	£m	£m	£m	£m
Cash Flow from Operations	6.7	2.5	7.3	12.4
Cash Flow before Financing	3.1	(0.2)	3.6	8.0
Net cash inflow/(outflow)	0.0	0.0	0.0	0.2
Year End Balance Sheet Cash Position	0.3	0.3	0.4	0.6
End of year EFL undershoot / (overshoot)	0	11	20	0
Cash brokerage received/(paid)	6.9	10.5	3.5	(3.5)
End of year debtor balances	3.1	3.5	5.4	4.7
End of year creditor balances	6.5	5.5	4.5	9.7
End of year stock	1.2	1.1	1.2	1.3
Working Capital	(3.78)	(2.32)	(1.55)	(7.07)
Stock Days	84.78	75.02	76.58	84.09
Trade Debtor Days	10.74	11.59	15.62	13.07
Trade Creditor Days	24.12	18.58	14.05	28.65

2.3 HR performance

Over the last few years the Trust has seen a steady increase in staffing across the hospital, especially in the clinical services, to reflect the targets set by the NHS plan, introduction of the consultant contract and to meet legislative requirements such as the European Working Time Directive. In order to meet these service needs, it has been necessary to employ temporary staff external to the NHS, especially within the nursing and midwifery workforces.

However, following this additional investment in the workforce, the Trust is keen to increase the productivity from its resources and has a number of modernisation projects in progress which will enable staff to work smarter and thus enhance workforce productivity. These are detailed in section 3.3.

The vast majority of staff have now been assimilated on to Agenda for Change terms and conditions of service. Once the transactional part of Agenda for Change has been completed, then the emphasis will move to ensuring that the benefits of the new pay systems are realised, in terms of the way services are delivered both to meet patients needs/requirements and to secure value for the financial investment.

Figure 3: HR Information

	2002/03	2003/04	2004/05	2005/06 Forecast
WTE (average actual staff in post)				
NHS Staff				
Medical and Dental	241	249	268	286
Nursing and Midwifery	639	673	769	769
Healthcare Assistants & Other Support	252	271	323	347
Scientific, therapeutic & technical	141	168	196	208
Healthcare scientists	96	96	96	94
Administrative & Estates	402	424	492	473
All other NHS staff, ambulance staff and general payments	0	0	0	0
Total NHS Staff	1,771	1,881	2,144	2,177
Total Bank (inc. NHSP) element of the above groups			187	215
Total Agency (non-NHS staff)	231	191	135	98
Total Staff WTE	2,002	2,072	2,279	2,275
Total Pay Cost	£'000	£'000	£'000	£'000
NHS Staff				
Medical and Dental	17,081	19,996	23,737	23,708
Nursing and Midwifery	23,560	24,734	26,708	31,821
Healthcare Assistants & Other Support	3,703	5,395	5,945	6,631
Scientific, therapeutic & technical	5,340	5,918	7,120	8,618
Healthcare scientists	3,635	3,381	3,487	4,055
Administrative & Estates	11,037	12,321	13,915	14,415
All other NHS staff, ambulance staff and general payments	0	0	0	614
Total NHS Staff	64,356	71,743	80,912	89,773
Total Bank (inc. NHSP) element of the above groups				
Total Agency (non-NHS staff)	8,534	7,395	6,081	4,644
Total Staff Cost	72,890	79,140	86,993	94,417
Non-NHS usage (% of total costs)	11.7	9.3	7.0	5.1
Sickness Rate (%)	4.1	5.3	5.9	5.1
Turnover Rate (%)	19.5	19.0	17.3	16.5
Vacancy Rate (%)	13.9	13.6	12.7	12.6

2.4 Activity

2.4.1 In Patient and Day Case Activity

Details of our inpatient and day case activity are summarised in figure 4 below.

Figure 4: In Patient and Day Case Activity

	2001/02	2002/03	2003/04	2004/05	2005/06 Forecast
FCEs					
Elective	3,744	3,501	3,177	2,876	2,976
Day Cases	7,586	8,758	8,562	8,783	11,329
Emergency	19,989	22,304	23,681	25,645	26,820
Total	31,319	34,563	35,420	37,304	40,822
Spells					
Elective	3,720	3,443	3,104	2,852	2,976
Day Cases	7,589	8,670	8,446	8,718	11,329
Emergency	18,219	18,265	19,291	21,225	23,210
Total	29,528	30,378	30,841	32,795	36,874
Percentage Day Cases - Trust	67.1%	71.6%	73.1%	75.3%	78%
Percentage Day Cases - Surgery	57.5%	61.5%	63.2%	66.9%	70%

2.4.2 Other Planned Activity Types

Figure 5 describes other patient activity at the Trust.

Figure 5: Other Activity

	2001/02	2002/03	2003/04	2004/05	2005/06 Forecast
Out Patient – First Attendances	60,039	62,094	62,264	72,247	73,054
Out Patient – Follow Up Attendances	133,137	133,363	139,020	161,236	156,918
A & E Attendances (new)	65,310	66,347	71,203	78,000	83,210
Maternity Deliveries	3,237	3,148	3,402	3,240	3,372
Radiology Examinations Total GP direct access	109,094 18,626	109,751 16,467	108,688 16,831	107,427 17,227	113,064 19,640
Adult Critical Care Bed days	n/a	n/a	n/a	2,941	3,240
NICU bed days intensive high dependency special care TOTAL	1,232 854 4,921 7,007	2,094 1,390 4,518 7,954	2,086 1,683 4,957 8,676	1,031 1,322 5,174 7,527	1,284 1,008 5,424 7,716

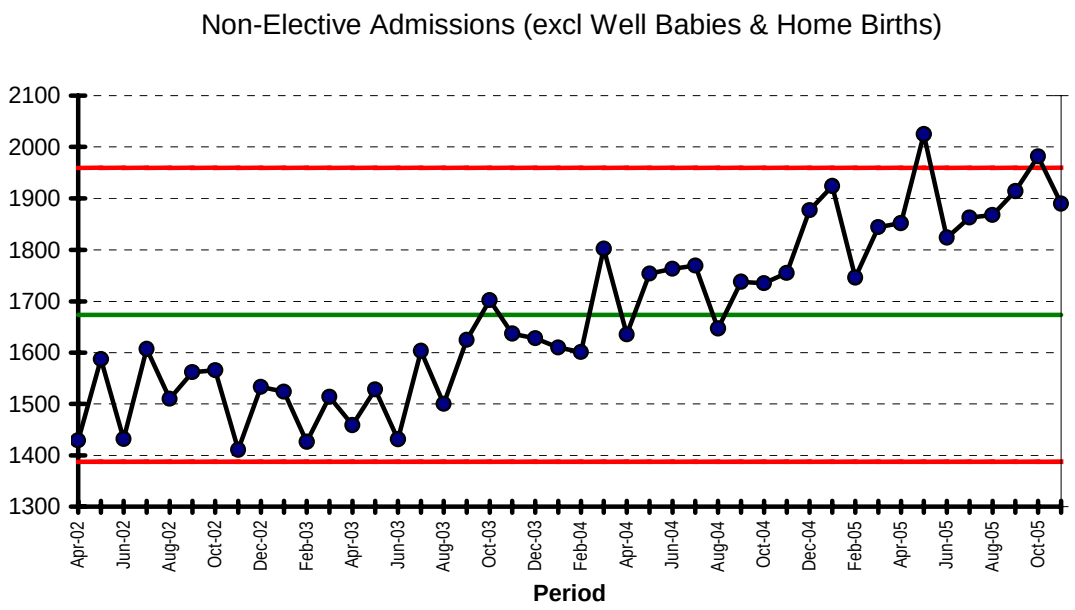
2.4.3 Analysis of Activity Trends

2.4.3 (i) In Patients and Day Cases

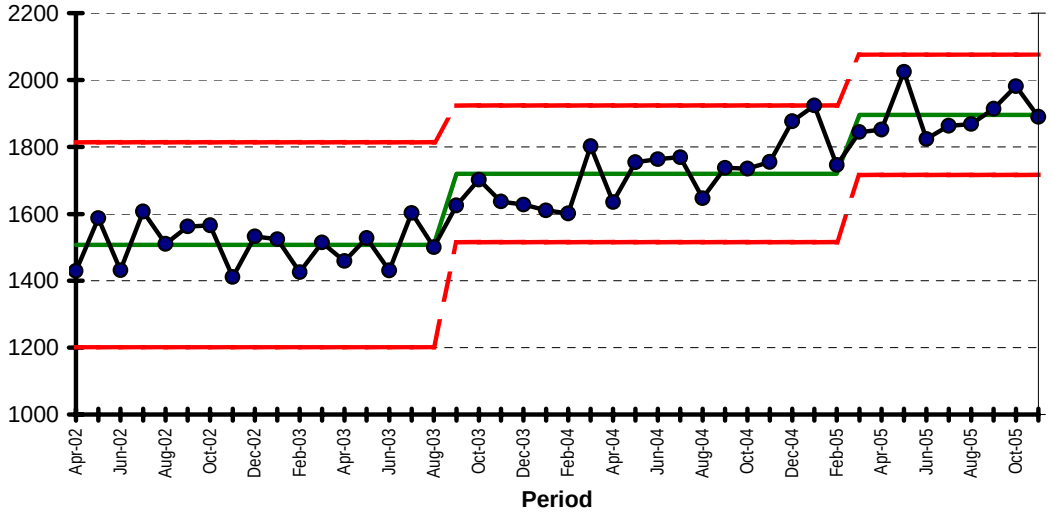
Emergency inpatient activity has been steadily rising for a number of years, in part due to the increased activity through the Trust's Emergency Department (see I-Charts 1 and 3 below).

Emergency inpatient activity is continuing to grow and has not yet stabilised at a new higher level. There was a significant change in the middle of 2003 when process changes in the Emergency Department to hit the 4-hour access standard were introduced. There was a further significant increase in admissions in March 2005 and emergency admissions are now an extra 400 admissions per month higher than 3 years ago; this is a 25% increase.

Run Chart 1. Non Elective/Emergency Admissions



Run Chart 1a: Non Elective Admissions (with significant changes in activity level)



Technical note: Graphs of the type shown in I-Chart 1 are a type of Statistical Process Control (SPC) charts. SPC is an improvement science technique used at the Whittington for understanding and managing the different types of variation within a system, and identifies significant shifts of performance in a system. The centre line is the average performance over the period and the upper and lower lines represent the upper and lower control or process limits. When some of the statistical tests have been met, some graphs also show a step change between the old and new systems; the centre line and process limits are recalculated to show the behaviour of the new system.

Elective activity has shown a switch between elective inpatient and day cases reflecting both the Trust's strategic direction and the national initiatives in the modernisation agenda. There has also been a shift of day case activity to outpatients in a small number of areas. The impact of GPs with a special interest has been very limited (simple dermatology procedures leaving a more complex casemix at the hospital).

There has also been a movement of some of the less common cancer surgery to the joint cancer centre. This shift of cases occurred in 2003/04 and in 2004/05 and no further shifts are expected.

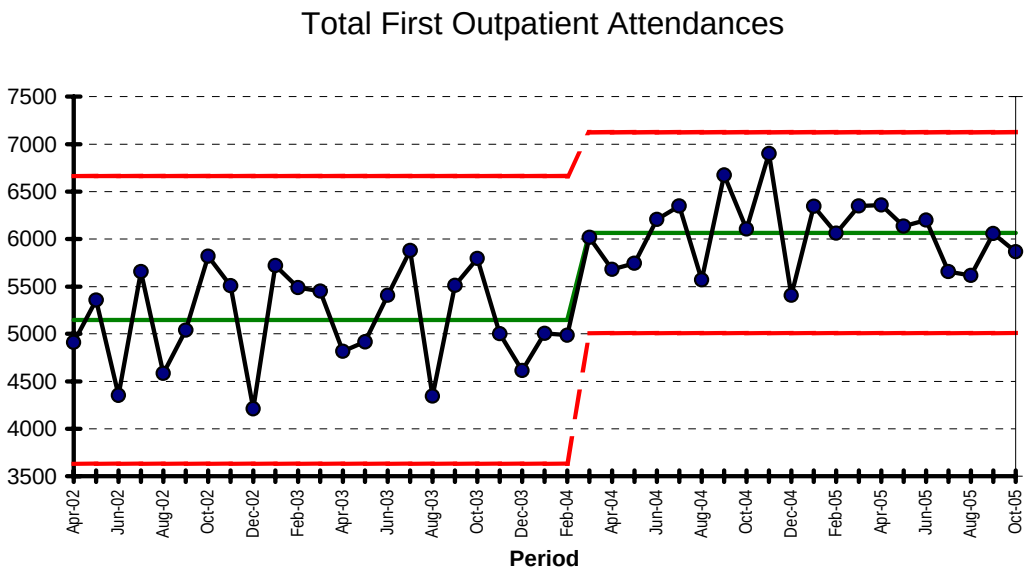
There was to be a corresponding shift of day cases to the Whittington and although this was agreed in principle some years ago it is now unlikely to happen in any great numbers. The Trust is currently working with local GPs, UCLH and Islington PCT to change the direction at the point of referral to the Whittington's direct access surgical service and thereby increase day case volumes, and with the Cancer Network to repatriate breast cancer patients identified through the screening programme to the Whittington.

The sharp increase in day case activity in 2005/06 reflects anomalies in data recording of cystoscopies and endoscopies in previous years. All these procedures are now consistently recorded as day case activity from 2005/06 onwards.

2.4.3 (ii) Out Patient Activity

There has been a significant increase in outpatient activity in 2004/05, much of this as a result of reducing waiting times in order to hit the outpatient access targets. Activity in 2005/06 appears to have stabilised around the new level of 6,000 attendances per month. GP referrals over the last three years have remained relatively stable at around 4,000 new referrals a month. Growth in demand has been in the other types of referral, in particular consultant to consultant, which includes referrals from ED. Part of the strategy to meet the 4-hour standard access time in ED was to identify alternative treatment pathways for some patients – including outpatients. Outpatient activity has also seen some fluctuation at the speciality level and some notable growth trends within specialties such as cardiology and paediatrics. Two services, oral surgery and orthodontics, were relocated within partner organisations during this period. I-Chart 2 shows the number of First Outpatient Attendances over the last three years.

Run Chart 2: First Outpatient Activity



2.4.3 (iii) Emergency Department Activity

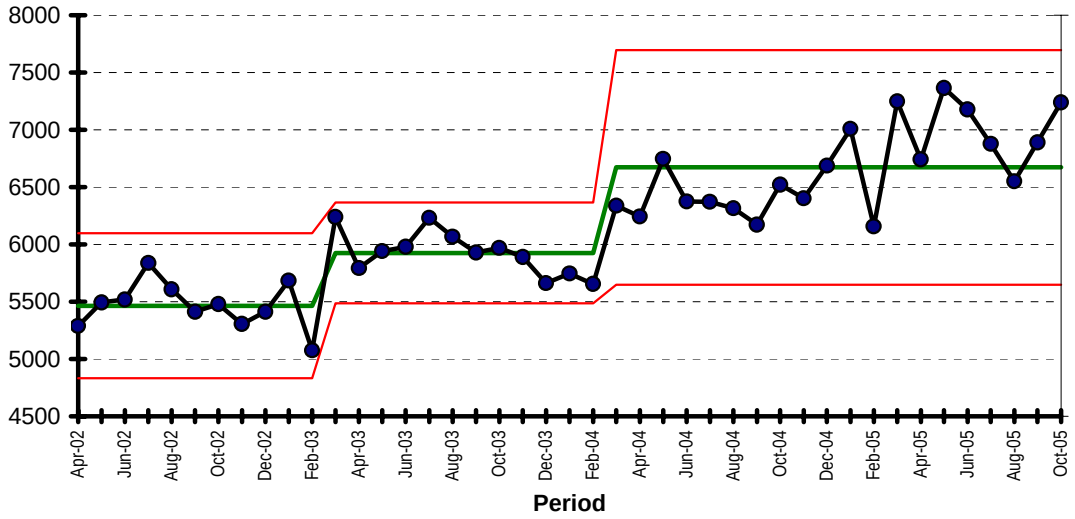
Emergency Department activity has increased considerably over the last two years, with significant growth of around 10% in numbers of attendances in 2004/05. 2005/06 is showing similar levels of growth (the forecast is 7%). Clearly ED and emergency admissions are linked activity types (a proportion of ED attendances will convert into emergency admissions) and neither is exhibiting stable behaviour, with ED activity growing in each of the last three years. I-Chart 3 shows the ED activity pattern since April 2002. The proportion of total ED attendances that convert into emergency admissions is running at 20%.

However, the majority of the ED activity increase is in the Group 1 or primary care type of patients that do not require admission. As noted above, there is growing evidence that patients are choosing to present at the Emergency Department, as they can be seen speedily, rather then having to wait for a GP appointment or use alternatives such as out of hours services, pharmacies etc. A number of patients presenting are also not registered with any GP Practice.

We are working with colleagues in primary care to develop effective ways of managing this demand, whilst at the same time increasing public awareness of alternative services and better matching staff numbers to attendances at all times.

Run Chart 3: Emergency Department Attendances – 2004/05

Figure 3: ED Attendances Since April 2002



2.4.3 (iv) Maternity & Neonatal Services

The number of deliveries at the Trust has remained stable at 3,200-3,300 per annum. There was an increase in deliveries at the Trust along with associated increase in neonatal activity in 2003/04 while the Royal Free maternity unit was refurbished. Once the unit has reopened, deliveries returned to their normal pattern.

Figure 5 contains the associated neonatal intensive care activity (NICU). NICU activity, in particular the intensive days, is distorted for the following reasons - changes in data collection systems, the introduction of recommended clinical pathways for babies, and a genuine increase in 2003/04 when the Royal Free unit was closed for refurbishment. Activity in 2004/05 fell back to below the previous baseline as the clinical guidelines led to a reduction in

the length of stay for babies. In 2005/06 there was a marked shift in activity towards intensive care from high dependency days.

2.4.3 (v) Radiology & Diagnostics Services

The Trust invested in new technology in the form of a Picture Archiving and Communications System (PACS) for the management and interpretation of diagnostic images over three years ago. One of the principal benefits of this system is the reduction in the number of repeat studies requested as a result of the original image not being located. The clinical benefits include the reduction in patient exposure to ionising radiation in line with Ionising Radiation (Medical Exposure) Regulations (2000), faster and more control over the reporting of images to clinicians and the introduction of electronic reporting over the secure NHS Net to general practitioners.

The impact of the introduction of PACS and associated service developments had been a reduction in the overall number of tests; recent increases in the number of direct access requests from general practitioners and the rise in Emergency Department activity has reversed this trend.

Figure 5 above describes the activity over the last 5 years.

2.5 Access Targets

2.5.1 Overview

The Trust has been successful in achieving inpatient, daycase and outpatient access targets in 2004/05 and is forecast to achieve those for required for 2005/06.

Figure 6a: Waiting Time Targets for 2004/05

Clinical Area	Target	Status
Inpatients	6 month maximum	✓ achieved
Outpatients	17 week maximum	✓ achieved
	Reduction in 13 wk+	✓ achieved
Booking	100% daycases	✓ achieved
	67% all patients	✓ achieved
Cancer	breast cancer treatment	✓ achieved

Waiting Time Targets for 2005/06

Clinical Area	Target	Forecast
Inpatients	6 month maximum	✓ achieve
Outpatients	13 week maximum	✓ achieve
Booking	100% daycases	✓ achieve
	67% all patients Dec. 2005	✓ achieve
	100% all patients March 2006	✓ achieve
Cancer	all cancers treatment	✓ achieve

Waits continue to reduce impressively. In particular it is notable that at 31 March 2005 the Trust had no patients waiting over 6 months for surgery. This is ahead of the national guarantee, which takes effect in December 2005 (see I-Chart 4).

Run Chart 4: Patients waiting over 6 months for admission to the Whittington

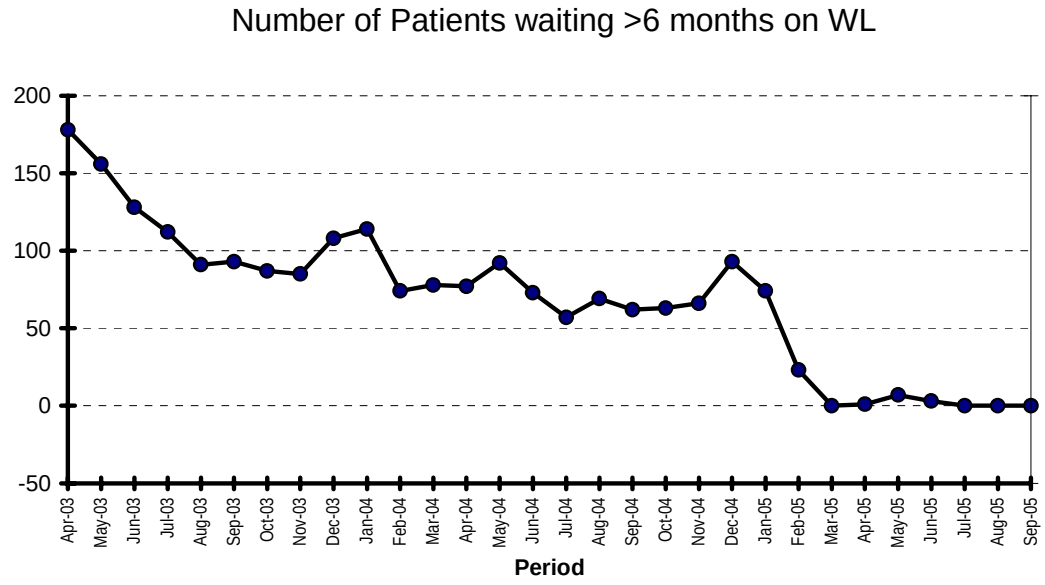


Figure 6b: % of Patients on the Waiting List as at 31st March 2005

Activity Type	% Under 3 months	% under 6 months
Day Case	84%	100%
Elective inpatient	81%	100%
Total	83%	100%

The total number of elective inpatients on the waiting list is also reducing (Figure 6c). The increase in daycases is as a result of correct data recording of these procedures.

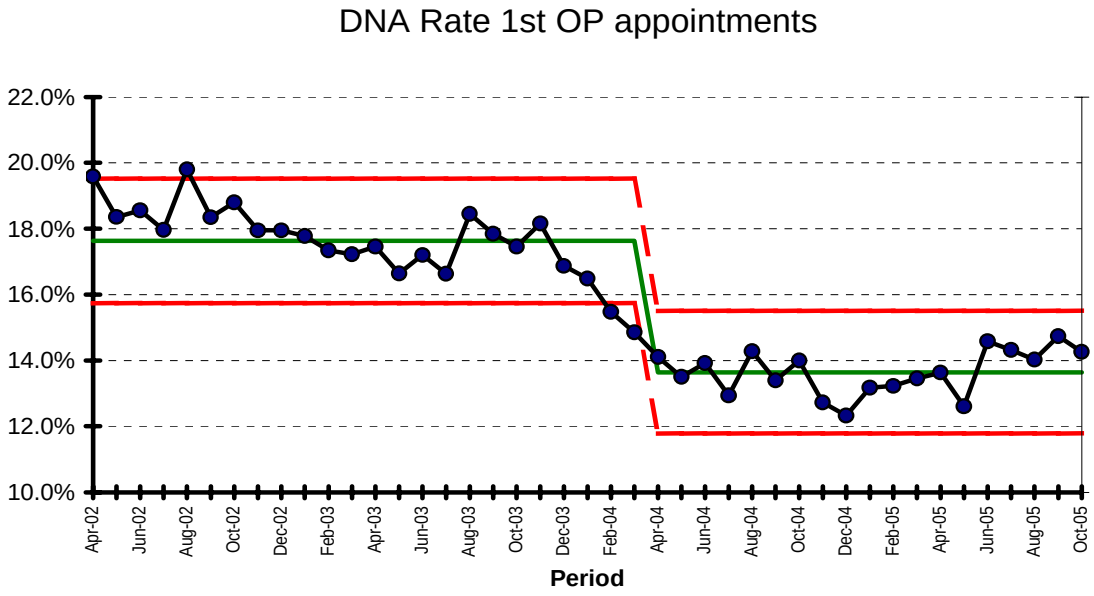
Figure 6c: Waiting Lists

	2001/02	2002/03	2003/04	2004/05	2005/06 Forecast
In Patient List at 31 March					
Total Number waiting	1279	893	674	629	600
Number waiting > 12 months	12	0	0	0	0
Number waiting > 9 months	73	36	0	0	0
Number waiting > 6 months	217	156	55	0	0
Day Case List					
Total Number waiting	884	648	928	962	1,190
Number waiting > 12 months	7	0	0	0	0
Number waiting > 9 months	18	7	0	0	0
Number waiting > 6 months	57	28	13	0	0
Out Patient List					
Total Number waiting	n/a	n/a	n/a	7,224	7,218
Number waiting > 26 weeks	0	0	0	0	0
Number waiting > 13 weeks	1523	623	239	296	0

2.5.2 Outpatient Waiting Times

82% of GP referrals to outpatients were seen within 13 weeks in March 2005 and by December 2005 this was 100%, in line with the national standard. Significant efficiency gains have been achieved by improving administrative processes and reducing the proportion of DNAs (did not attends) to outpatients (see I-Chart 5).

Run Chart 5: Outpatient Did Not Attend rates

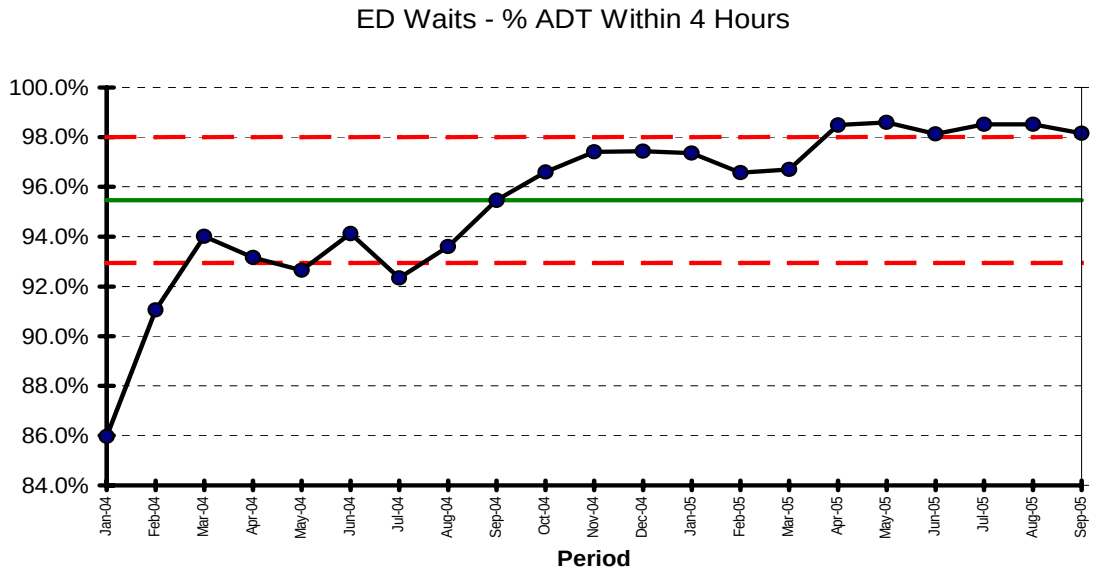


While the Trust's performance in terms of emergency waits was sustained despite the exceptional levels of attendance during March 2005, the target of 98% for the quarter was just missed by 0.78%.

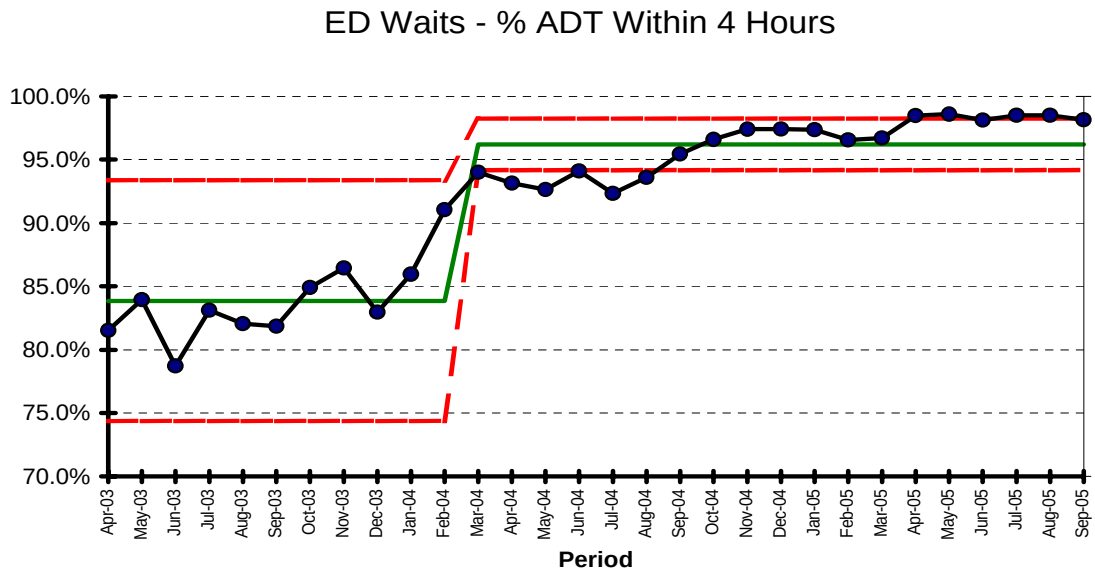
97.22% people attending the Trust's Emergency Department in the three months ending 31 March 2005 were seen, treated, admitted or discharged within four hours. Performance has been in excess of 98% from March 2005 to December 2005, even though activity levels have continued to rise. (See I-Charts 6 and 6a).

The Trust is working with PCT colleagues to develop effective ways of managing this demand. As maintaining the 98% target has required considerable investment in medical staffing in particular as much of the growth in demand is out of hours.

Run Chart 6: Emergency Department 4hr Target



Run Chart 6a: Emergency Department 4hr Target (with step changes)



2.6 Other Targets

2.6.1 Healthcare Commission

2.6.1(i) NHS Performance rating (2004/05)

The Trust was awarded two stars in the 2004/2005 NHS performance ratings system.

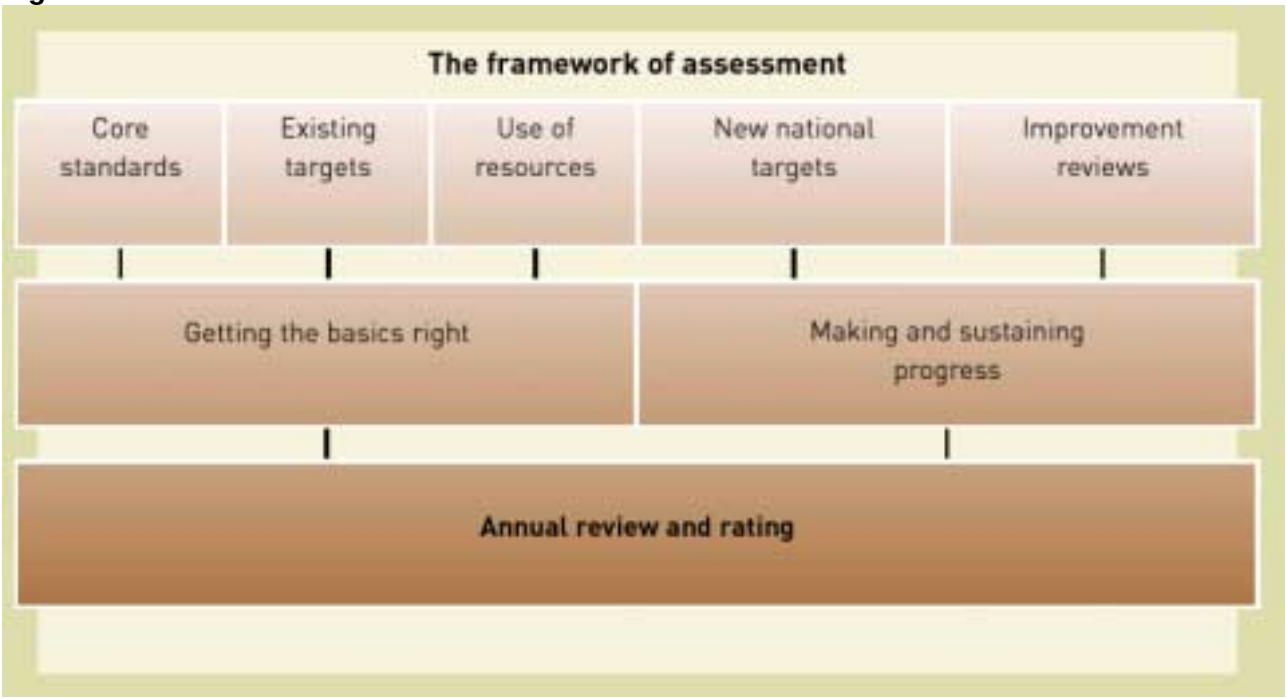
Key Targets: All achieved except 4-hour wait in ED (see above: target missed by 0.78%)

Patient Focus:	middle band of performance
Clinical Focus:	middle band of performance
Capability & Capacity:	top band of performance

2.6.1 (ii) Annual Health Check

The new Healthcare Commission Annual Health Check has a number of components in the assessment of health care organisations.

Figure 7: Annual Health Check Framework & Assessment



source: "Assessment for Improvement: Measuring what matters, Healthcare Commission, March 2005"

- **Core Standards**

The draft declaration that the Trust made in September 2005 identified one area of non-compliance:

Standard C14(a) Complaints processes. The Trust is unlikely to meet the overall standard of responding to complaints within 20 days, although significant improvements have been made since the assessment.

In addition, the Trust noted insufficient assurance with respect to two other standards:

C2 Child Protection

C23 Public Health

The Trust has action plans to improvement performance in each of these areas.

- **Existing national targets**

Figure 8: Matrix of Existing National Targets

Indicator	Standard	
All cancers: two week wait	Maintain two week maximum wait	✓
All cancers: one month diagnosis to treatment	Ensure maximum wait of one month from diagnosis to treatment by December 2005	✓
All cancers: two months urgent GP referral to treatment	Ensure maximum wait of two months from urgent referral to treatment by December 2005	✓
Cancelled operation not admitted with 28 days	From Apr 2002 all patients cancelled on the day for non-clinical reasons offered another date within 28 days or fund treatment elsewhere.	✓
Convenience & choice: provider information to support choice	Ability to select from at least healthcare providers for planned care from December 2005.	✓
Convenience & choice: elective and OP booking (split into 4 components)	Ability to select from at least healthcare providers for planned care from December 2005.	✓
Delayed transfers of care	Reduce to a "minimal level" by 2006	?
Number of inpatients waiting longer than the standard	Max wait of six months by December 2005	✓
Number of outpatients waiting longer than the standard	Max wait of thirteen weeks by December 2005	✓
Patients waiting longer than three months for revascularisation	Maximum wait of three months by Mar 2005.	
Thrombolysis: 60 minute call to needle time	10% increase per year in proportion suffering a heart attack who receive thrombolysis within 60 minutes of call.	
Total time in A&E: four hours or less	Maintain four hour maximum wait in A&E from arrival to admission, transfer or discharge.	✓?
Waiting times for Rapid Access Chest Pain	Maintain two week maximum wait for Rapid Access Chest Pain Clinics	✓

See the section below on Delay Transfers of Care and section 2.5 for ED performance issues. The revascularisation and thrombolysis targets do not apply to the Trust as it, respectively, does not perform the procedure or the volumes of cases are below the minimum threshold.

- **New national targets**

Figure 9: Matrix of New National Targets

Indicator	Standard	
Access to GUM clinics	Proportion of patients attending within 48 hours of contacting the service	
Data quality on ethnic group	Completeness of coding for ethnicity in patient datasets	✓
Drug misusers: information, screening and referral	Increase participation of problem drug users in treatment: information & referral systems in place in ED departments	✓
Emergency bed days	Reduce emergency bed days by 5% by 2008 against baseline of 2003/04).	✓
Experience of patients	Sustained improvements in NHS patient experience by 2008.	?
Infant health: data completeness	Data completeness: Breastfeeding and smoking in pregnancy used as proxy indicators for infant health.	✓
MRSA bacteraemia	Achieve year on year reductions in MRSA bacteraemias and a 60% reduction by 2007/08 of the 2003/04 rate (trusts with number of infections >12).	?
Obesity: identification and treatment in secondary care	Acute trusts should be able to identify, provide seroves or refer overweight or obese people within their adult patient populations.	✓
Participation in audits	Acute providers should participate fully in comparative clinical audit	✓
Processes in place to ensure compliance with NICE guidelines for treatment of self harm in ED departments	This indicator will assess trusts on their compliance with NICE guideline 16 on the treatment and management of cases of self harm (published in July 2004).	✓
Smoke free NHS: recording of smoking status and reduced smoking	Trusts will be assessed on their progress towards becoming smoke free by the end of 2006, in line with the process described in 'Guidance for smokefree hospital trusts'.	✓
Waiting times for MRI and CT scans	Maximum wait of 26 weeks for MRI and CT scans	✓

The target relating to Access to GUM clinics does not apply to the Trust.

2.6.2 MRSA

Latest DH figures (Apr-Sept 05) show 17 MRSA bacteraemias over the period (0.24 per 1000 bed days), an increase on the two previous periods. Whittington is ranked 143 out of 172 acute trusts in England.

2.6.3 Delayed Discharges

The percentage of beds occupied by patients whose discharge has been delayed has reduced over the last four years from 9.9% down to 3% in November 2005. The introduction of reimbursement following the Community Care Delayed Discharges Act (April 2003) has led to a marked reduction in the number of Delayed Transfer of Care (DtoCs) at the Whittington. This improvement has been delivered through effective partnership working with local Primary Care Trusts and Social Services Departments, and increased investment in beds and services considered most likely to deliver the greatest impact upon reducing the barriers to discharge.

In order to meet the challenging targets facing the Trust, such as the emergency department 4 hour waits, reduction in emergency bed-days and the performance indicator for DToCs, the Trust needs to maintain the reduction in delayed discharges that has been achieved to date, and is working with local PCTs to reduce the number of DToCs further to below 2% of current bed stock. In order to achieve this reduction, there will need to be a continued joint health and social service commitment to the following actions:

- Continued investment in those services that are able to demonstrate that they reduce discharge delays, including EMI placements.
- Increased investment in non-acute rehabilitation services, nursing and residential home (including EMI) placements.
- To agree joint responsibility for 'patient choice' delays, which are delays caused by 'self funding;' patients choosing the home of their choice to ensure ongoing commitment by social services to invest time and resources to resolving these delays.
- To ensure that all staff are committed to the principles and practice of effective and efficient discharge planning, and that patients are transferred out for the hospital as soon as they are ready for discharge.

Figure 10: Delayed Discharges

	2001/02	2002/03	2003/04	2004/05	2005/06 Forecast
Total Number	1,833	1,803	1,182	843	504
Occupied Acute Beds	18,458	19,686	18,697	18,895	19,368
Total Occupied Bed Days	129,206	137,802	130,879	132,265	132,088
Rate Total Occupied Beds	9.9%	9.2%	6.3%	4.5%	2.6%
Rate Total Occupied Bed Days	1.4%	1.3%	0.9%	0.6%	0.4%

Notes:
1. Source of data: SITREP
2. Healthcare Commission methodology used

2.6.4 Improvement Reviews

Information about the Healthcare Commission Improvement Reviews including the Audit Commission's Acute Hospital Portfolio is not yet available from those organisations.

2.7 Other Supporting Information

The Trust has identified a number of additional key factors which are relevant to creating a picture of its performance and sustainability.

2.7.1 Reference Costs

The Trust has made serious efforts over the last few years to maximise its efficiency and productivity in order to move towards recurrent balance. Although there are few robust measures of efficiency within the NHS, the gradual refinement of the reference cost index makes it an increasingly useful indicator. The fact that the PbR tariff is based on submitted reference costs lends further credence to this measure. The Trust's position on the index was 97 (excluding excess bed days) on the basis of 2005 submissions, representing continuous improvement from 98 in 2004 and 101 in 2003. The Trust believes that this reflects an ethos of financial awareness and commitment to productivity growth.

2.7.2 SLA experience and PbR

The Trust has developed constructive relations with our two main commissioners in an economic climate in which all organisations face difficult challenges. Haringey TPCT in particular has been financially stretched for some years. As a result, differential local prices have evolved as Islington PCT has historically tended to be less reliant on additional activity being rolled over from year to year at marginal cost. Income support from Islington, as host purchaser, has also been significantly higher. However Islington is now also facing severe financial pressure and has been unable to provide additional income at previous levels.

The initial baseline PbR exercise in early 2005 indicated that the Trust would be entitled to additional income of £11m at tariff applied to 2004/05 levels of contracted activity. Under the revised arrangements for tariff on elective activity only, the Trust would have benefited by c.£1.7m in 2005/06. However, with the 2% cap on change, the Trust's benefit reduced to c.£221k. This sum is included in the 2005/06 I&E position. There have been two further baseline exercises since the initial cut and successive iterations have changed the position for the Trust. The most recent assessment indicates that for 2006/07 the transitional position is a net loss of approx £0.5m including £0.5m transitional relief. This is an adverse change of approx £2m from the previous assumption. The final PbR and tariff position for 2006/07 is awaited.

In moving towards the principle of PbR the Trust has for the first time negotiated cost and volume contracts for Emergency Department activity and GP direct access, both of which are growth areas. The PCTs are developing plans for demand management, particularly in the management of chronic disease and minor illnesses. These are not expected to impact on the Trust's activity in the short term and dialogue is taking place with PCTs to assess the potential longer term impact.

3 STRATEGIC DIRECTION

3.1 Analysis of the environment

3.1.1 Patient Population

The Whittington Hospital is located close to the boundary of 4 PCTs (Islington, Haringey, Barnet and Camden), although geography and transport links mean that 80-85% of our patients come from Islington and Haringey (there are variations by service). Approximately 50% come from Islington, 30-35% from Haringey, 5% from Barnet, 4% from City & Hackney, 3% from Camden with the residual 3-8% from all other London PCTs plus small flows from Essex, Hertfordshire and others.

3.1.2 Population Demographics

Islington is classed as inner London and Haringey as outer London. The Office of National Statistics publishes population projections for each London borough/PCT.

The relevant population estimates for Islington and Haringey are shown below.

Figure 11: Population Demographics for Islington & Haringey

Borough	Patient Type	Population 2005	Population 2015	Change	% Change
Islington	Female	92.7	97.4	4.7	5.1%
	Male	91.4	100.0	8.6	9.4%
	Total	184.1	197.4	14.3	8%
Haringey	Female	111.7	112.2	0.5	0.4%
	Male	111.8	113.6	1.8	1.6%
	Total	223.5	225.8	2.3	1%

Source: ONS (in thousands)

For planning purposes a value of 5% over the next 10 years has been used for non-elective/emergency admissions only.

Elective/Day Case and Outpatient activity projections **have not** been adjusted for a population growth factor OR for the effect of demand management by primary care. Much more (long-term) modelling is necessary to understand the dynamics of these factors with information not yet available. For the purposes of this document, the following assumptions have been made:

- Population growth will directly impact on emergency admissions – increasing numbers of men living longer in particular needs further consideration on service provision.
- The effect of population growth and demand management will together be broadly neutral. This assumption is subject to further analysis when primary care developments are known and the impact on referral patterns is clearer.

3.1.3 Connecting for Health (CfH)

The Trust is well placed to implement the CfH programme in order to support the transformation of business and clinical services: -

- As part of Haringey Local Health Community, the Trust is the national flagship for Choose and Book, with 80% of services available to be booked electronically

- A Trust wide Picture Archiving and Communication System (PACS) has been live for four years accruing significant operational and educational benefits from being filmless in all modalities, except MRI which is not PACS compatible, but will be when the new MRI is installed in the PFI build in summer 2006

- The Trust was shortlisted for the HSJ "Improving Care using e-technology" category in 2005, in recognition of the successful implementation of e-clinical networks e.g. e-Radiology and Pathology results to GPs, e-Images to the National Neurology Hospital for head trauma patients

- A modern and robust IT infrastructure with high levels of access for all staff, plus a history of successful IT system deployments enabled the Trust to secure an implementation slot as early adopter for the Care Record Service (CRS)

- Because the deployment of CRS has been delayed by the LSP, the Trust has successfully secured implementation slots for a new Theatres and a new Pathology system during 2006 to support their service improvement projects

- Subject to CRS becoming available in mid 2007, the Trust would re-apply to be an early adopter to secure the clinical and business benefits provided by the new CfH services

- The replacement of other hospital systems as part of the ICRS programme will not impact upon activity projections. The financial model for "Connecting for Health" is under development.

3.1.4 Position in the health economy

The Trust is providing secondary acute services within an area in which two high profile teaching hospitals with significant research and teaching capacity are providing both local acute and specialised tertiary services. Although there is scope for establishing complementary services, there is currently a significant degree of duplication creating unnecessary cost pressures.

The Trust's services are firmly rooted in the community with strong links into primary care and community-based services provided by the PCTs. Significant levels of activity, such as therapy led outpatient attendances, although recorded, are not recognised in terms of SLA currencies and this needs to be addressed in the context of the move towards more comprehensive PbR, and in recognition of increasing alternatives to the standard hospital referral pathway.

The impact of "*Commissioning a Patient-Led NHS*" is difficult to assess at this stage but is included as an element of the income risk factor in the sensitivity analysis.

3.1.5 Impact of teaching and research

The Trust is a major contributor to undergraduate medical education provided by the RF&UCMS with an increasing proportion of student WTEs over the last few years. However, there has not been a corresponding increase in posts funded by the medical school. Although the clinical placement funding has kept pace with the increase this represents only 20% of the total. The facilities element has remained stationary up to 2004/05, which means that there is now a significant discrepancy between the overall level of SIFT funding per student at the Whittington compared with the other two major teaching centres. A rebasing exercise carried out during 2004 would have allocated an additional £1.3m to the Trust. However, it was

considered to be too destabilising for other institutions and was not implemented. The Trust will continue to argue the case for additional recurrent SIFT. For 2005/06, approximately £300k formerly non-recurrent development funding was brought into the Facilities recurrent baseline and the SHA has anticipated that similar annual growth will be provided over the next few years. However, the development funding of £220k in 2005/06 has recently been withdrawn because of the shortfall on inflation funding for MPET overall. This will add to the Trust's cost pressures in 2005/06 unless alternative sources can be found, as over £100k of development funding was committed in 2005/6.

The Trust's research activity does not attract significant NHS R&D funding support, being more service than science based. However, there is potential for generating additional resources and the R&D Strategy will be developed in partnership with the medical school to maximise the opportunities provided by our local patient base.

3.1.6 PFI scheme

The redevelopment of facilities is underway and has involved the demolition of old Victorian ward blocks to create space for a new building integrated with two more recent existing buildings (dating from 1977 and 1992) to create the acute core of the hospital. The displacement of services in the Victorian buildings required the construction of temporary accommodation (20 year life) and the redesign of other accommodation. This complex decanting programme resulted in a significant increase in capital charges contributing to the I&E deficit in recent years.

The impact of the unitary charge from the PFI investment and the associated imaging Managed Equipment Service (total FYE approx.£ 6m) will have to be absorbed from 2006/07. The original business case demonstrated affordability on the assumption of an opening position of recurrent balance. This will have to be revisited in the context of the Trust's current financial position and the revised financial regime under PbR. The new facilities include an integrated diagnostic and day treatment centre (DTC) offering capacity for increased day surgery, endoscopy and interventional radiology. The Trust aims to become a centre of excellence for day surgery, not only as the hospital of choice for local people but attracting patient flows from a wider catchment. There is already, for example, evidence of increased flows from Barnet and City &Hackney.

Although the increase in independent sector capacity is recognised in planning assumptions, it is anticipated that this will not impact strongly in the short term. The Trust is actively exploring opportunities for collaboration with other providers for the relocation and consolidation of particular services. Currently these include ophthalmology and colposcopy. Preliminary discussions have also taken place private sector providers around the leasing of facilities. A comprehensive option appraisal is underway and detailed cost/benefit evaluation will be developed over the next few months.

3.1.7 Estates strategy

In 2003, the Trust's Estates Strategy and Development Control Plan both confirmed that the space on the Whittington site is either fully used or over crowded, and concluded that the functional suitability of many departments and the relationships between them were below an acceptable standard, resulting in sub-optimal functional adjacencies. While some of these issues will be addressed through the acute core development, much of the trust's clinical services will continue to be delivered from outdated Victorian buildings. There thus remains a pressing need to tackle the remainder of site improvements, enabling the provision of high quality care from modern and appropriate facilities.

Work carried out by the Trust in conjunction with Finnamore Management Consultants has confirmed the need to prepare a full Strategic Outline Case that supports the identified need for change. This pre-SOC work was completed during 2005, and involved consultation with the SHA, Capital Investment Unit, Primary Care Trusts, academic partners and the Patient

and Public Involvement Forum. The Capital Review Group at the SHA has decided that the commencement of this work should be postponed until the Trust has developed a sustainable balanced financial plan and will further review the position.

3.2 Service Change

Building on the work undertaken during a Strategic Away Day in September 2003, the Trust held a series of workshops at the beginning of 2004 aimed at firming up the strategic vision of the hospital. With the involvement of its largest commissioners and the SHA, senior clinical and management staff a framework for the future was developed which is reflective of the Trust's clinical and educational strengths, national policies and local health economy plans. Service change under this model is essentially about providing healthcare in a different way to meet the needs of a modern NHS:

- expanding the Trust's ambulatory care facilities through the new unit;
- taking a case managed approach to complex chronic conditions
- provision of comprehensive emergency services through the existing ED and the new Walk in Centre;
- acting as a key provider of women's and children's health
- establishing the Trust as the first choice for planned care, diagnostics and therapy services.

Changes to services or policies will be assessed for their potential impact upon the local community in line with the Trust's Race Equality Scheme.

3.3 The Modernisation Agency "10 High Impact Changes"

Launched alongside the Trust's strategic direction in November 2004, the "10 High Impact Changes" developed by the modernisation agency have been used to shape and drive the Trust's 2005/6 service development objectives.

In addition to maintaining current and meeting new key access targets in 2005/6, there is a commitment to review the Trust's systems, to ensure that the Trust offers more choice, and personalises the care that is delivered, providing faster, more convenient access to services through increases in capacity and changed ways of working. The Trust strives to be the hospital of choice for its local population, and aims to be operationally excellent, delivering high quality of care to patients at all times. These core principles have guided the Trust's service objectives, as has the requirement to continuously plan ahead in respect to future access targets, and develop services to support delivery of these.

Distinct Service Development Objectives will be delivered through 10 sizeable but distinctive projects, six of which are focussed on achieving the High Impact changes. Further detail on these projects and their linkages are provided in Figure 12.

Figure 12: Service Development Projects

Project Objective	High Impact Change/ *Strategic Objective*	Measurements of Success (Examples)
Project 1 - Theatres **1a To become the centre of excellence for day surgery**	**High Impact Change 1** Treat day surgery as the norm for elective surgery.	• 10% increase in surgical day case rate by March 06. • Uptake of direct access and Emergency Day Surgery. • Increase effective theatre utilisation by 10% March 06
1b Theatre Review	**High Impact Change 4** Manage variation in patient admission.	⇨Closure of one operating theatre ⇨Conversion of IP to DC reduces number of elective bed days required: contributes to Project 4 (Beds)
Project 2 – The Changing Outpatients Project	**High Impact Change 8** Improve patient access by reducing the number of queues. **High Impact Change 7** Apply a systematic approach to care for people with long-term conditions. **High Impact Change 5** Avoid unnecessary follow ups **High Impact Change 9** Optimise patient flow by using process templates.	• 100% templates reviewed March 06 • Single pre-assessment service. • Reduction in % follow-ups. • Reduced DNA rates • Clinical administration roles will be reviewed and new roles developed ⇨ Efficiency gain in better utilisation of OP capacity to meet access targets ⇨ Capacity to treat more patients ⇨ Efficient use of staff
Project 3 – The Rapid Diagnostics Project	**High Impact Change 2** Improve access to key diagnostics tests.	• 26 week MRI CT target • Improve GP report turnaround to 95% received within 3 days of image taken. ⇨ Efficiency gain in better utilisation of diagnostic capacity to meet access targets

Project Objective	High Impact Change/ Strategic Objective	Measurements of Success (Examples)
Project 4 – Making Best Use of Hospital Beds	**High Impact Change 3** Manage variation in patient discharge. **High Impact Change 6** Increase the reliability of performing therapeutic interventions through a 'Care Bundle' approach.	• Reduced length of stay. • 100% nurse led discharge1 • 10% reduction in variation of discharge day. • Reduce variation in service for critical care patients. ⇨ Reduced number of occupied bed days ⇨ Temporary & permanent closure of beds
Project 5 – Modernising Secretarial Systems	**High Impact Change 8** Improve patient access by reducing the number of queues. **High Impact Change 10** Redesign and extend roles ***Being Operationally excellent***	• Improving quality & responsiveness of service to users. • Clinical administration roles will be reviewed and new roles developed ⇨ Efficient use of staff ⇨ Effective use of technology
Project 6 – Our Changing Workforce	**High Impact Change 10** Redesign and extend roles	• Introduce new roles examples are within radiography, medical secretarial and clinical administration roles. • Workforce strategy, which complements and supports the service strategy.
Project 7 – Hit All Targets for 2005/6	***Meet or exceed all performance targets for 2005/6***	• All targets achieved or exceeded and plans are underway for future targets.
Project 8 – The Physical Environment for Care	***Developing the Hospital Site***	• PFI stage 1 complete and operational. • All services provided from buildings 'fit for purpose'.
Project 9 – Finance	***Being financially robust***	• Breakeven position at end of year.
Project 10 – Become the Hospital of Choice	**Become the Hospital of Choice for our local population.**	• Maintenance and growth of activity • Development of marketing plans.

3.4 Finance

As indicated in section 2, the Trust's financial strategy is set against a background of financial pressure within the local health economy. The deficits incurred in the previous two financial years are are subject to a phased repayment programme over 2004/05, 2005/06 and 2006/07. Financial performance has also been influenced by sector resource levels, the need to meet NHS Plan Targets, and statutory compliance issues such as the Junior Doctors New Deal, EWTD, and more recently the new consultants contract and implementation of Agenda for Change.

The strategy for achieving financial targets has been developed in close consultation with PCTs and NCL SHA, and contains a number of elements:

- Maximising patient service income in the context of PbR and patient choice;
- Utilising additional capacity for ambulatory care and critical care in the PFI facility;
- Reviewing with other providers opportunities for rationalising services;
- Identifying services which can be modified or eliminated without reducing net income
- Creation of facilities for private patient activity;
- Reducing the cost of meeting emergency demand through collaborative demand management and appropriate use of facilities (e.g. the Walk in Centre);
- Pursuing non-patient service and commercial income generation opportunities;
- Implementing a demanding cost improvement and containment programme including savings from the 10 high impact changes;
- Optimising capacity and the use of the estate;
- Evaluating the potential net benefit of achieving Foundation Trust status.

The assumptions made in relation to these elements are set out in Section 5.

3.5 Activity

The activity projections have drawn on previous capacity planning exercises conducted within North Central London as part of the LDP and long term planning process. The Trust will seek to maximise the day case rate and to meet emergency demand, while working with the PCTs to improve models of care in the interest of patients. A comprehensive review of out-patient services is currently under way which may affect levels of activity.

There are a number of strategic "drivers" of activity change over the next three years.

3.5.1 Meeting national waiting time standards

The mandatory requirement to reduce the elective or planned patient journey time to maximum of 18 weeks (from Outpatient referral to treatment) has activity implications. The modernisation projects described in section 3.3 above form part of the solution in the redesign of the patient journey, but there will be a requirement not only to match capacity and demand but also over time to reduce the queues already in place within the system by bringing forward some types of activity.

The activity & planning exercise referred to above was a model of the activity implications in meeting these mandatory standards.

3.5.2 New Clinical Building (PFI scheme)

The Whittington's PFI scheme will deliver current and additional clinical capacity within the current three-year planning cycle.

The additional capacity available within the scheme, together with an indicative timetable is:

- **Critical care beds**

The new unit can accommodate 15 critical care beds from 2006/07 onwards. The Trust has 9 beds currently (7 on the ITU unit and a further 2 HDU beds in another location). Plans are underway to open a further 2 HDU beds in advance of the new unit opening. The new unit will then open with 11 staffed beds and increase to 15 beds over the next two years. Currently a high proportion of out of sector transfers are for non-clinical reasons. This is a cause for concern clinically, as well as expensive for commissioners who have to fund out of area transfers. There is local PCT support of this development as it is anticipated transfers out will be significantly reduced.

- **Day Case Surgery**

The Trust currently has two day case theatres. The new building will have 4 theatres plus a fifth imaging theatre for cases requiring high levels of imaging control. This facility is in a dedicated unit separate from main theatres and can only be used for elective surgery. Alongside theatre capacity the associated recovery areas have been designed for the full five theatres plus the endoscopy workload (see below).

The exact casemix of the additional day case surgery has not been fixed and is dependant upon a range of factors – capacity issues elsewhere in the sector/London, patient choice, and clinician choice.

In the quantification of the additional capacity, a conservative estimate has been made. Higher numbers could be available if higher utilisation factors were used in the model.

The new unit is the second phase of the building and is expected to be available for use by April 2007. For planning purposes the additional activity has been scheduled from 2007/08.

- **Endoscopy**

The same day surgery unit described will also contain an endoscopy suite of four rooms – again a doubling of the current capacity of the unit. Endoscopies are a key diagnostic test in both the elective and non-elective patient journey and essential to meeting the 18 week total journey time standards (see section 3.6.1).

3.5.3 Healthy Starts, Healthy Futures

The strategic review of maternity, neonatal and paediatric services across North Central London is currently expected to result in one of the sector's four in-patient paediatric centres being located at the Whittington. This would mean that the Trust would expand its children's unit - including medical and surgical day and inpatient facilities for children - a level 2 Neonatal Unit and a designated children's A&E. However, proposals have not yet gone out to consultation and therefore the implied additional paediatric activity has not been factored into the model. However, additional level 2 NICU activity has been assumed following agreement with the Royal Free hospital on how the neonatal service will be managed across the tow sites.

3.5.4 Other Service Specific Developments

Whilst a number of these developments have already taken place; such as, shifts in complex cancer related surgery to cancer centres, a number of others are planned or at an early stage of development, one being the day case transfers from University College Hospital in return for the inpatient cancer patients.

The main activity development is the shift from elective inpatient to day case surgery. The Trust is aiming to achieve 80% of surgery elective work as a day case in line with the Trust's Strategic Direction, High Impact Change No.1/Service Development Project 1 with the attendant Payment by Results benefit.

3.5.5 Patient Choice

Activity projections assume that Patient Choice is neutral. Whilst this is an assumption that can cut both ways, at this stage it is not possible to be more definitive in the activity projections.

A number of positive factors can be stated here:

- The overall strategic objective of the Trust, as shown in the Strategic Directions document, is to be the hospital of choice for the local community. This primary objective is a focus for the Board
- The opening of the new clinical building in 2006 is an opportunity to promote the Trust and its services
- Building on its strong reputation for women's and children's services, the Trust has been recommended as one of the hub sites for maternity and paediatric services in the extensive Healthy Starts, Healthy Futures evaluation process (not yet at consultation stage)
- Within the Trust's objectives in section 3.3 above is Project No. 10 – developing our choice strategies for services, commencing with maternity care
- The Trust has also commenced a strand of work focusing on marketing its services more effectively. The first stage of this focuses on ensuring that the GP and primary care community are aware of the services we provide. This includes the production of a clinical services prospectus within our annual report for 2004/5 and events that bring clinicians together across primary and secondary care. Additionally we are discussing the new day surgery capacity that will open in 2006 with GPs and PCT colleagues to make use of this facility for local people.
- The service development objectives are effectively a three year plan to progressively improve the services we provide to patients. The impact of such projects upon patient choice is built into each project – user and patient involvement in changes to services is a central feature.
- Due to its strong track record in electronic booking, the Whittington is a national flagship hospital for the Choose & Book project (within the NHS Connecting for Health programme).

3.6 Clinical Strategy

As outlined in section 3.3, the Trust has developed an integrated operational strategy aimed at capitalising on the key strengths, whilst delivering the core principles of the NHS Improvement Plan. The Trust will provide a range of clinical services covering:

- Emergency Care
- Ambulatory Care
- Planned Care
- Services for Women and Children
- Services for those with Chronic Disease
- Diagnostic and Therapy services
- Academic services for under- and post-graduate students

Part of this strategy will be supported and delivered on completion of our PFI building. The clinical working groups established to design the individual departments, were also tasked with focussing on the changes in service delivery required for the future. Implementation of the above has been planned and costed as part of the approved business case for the scheme. Although the business case was predicated on a stable level of overall activity but with a shift in the balance towards ambulatory care, the new facilities do provide the opportunity for significant growth in day case activity and in high dependency/intensive care.

More recently, the Trust has been engaged in the sector wide consultation on Women's and Children's health, which saw the Whittington recommended as one of the four major centres for the provision of inpatient care for mothers, babies and young children in north central London. The Trust is developing a series of schemes specifically aimed at delivering this service change to an early timetable and within affordable expenditure limits.

3.7 Marketing Strategy

The newly-established marketing function has drawn up a draft action plan covering the period up to 2007 when the second stage of the redevelopment, including the new day care facilities, will be fully operational.

This action plan is based on the 5 objectives of the PPI strategy whose aim is to prepare the Trust for the dual challenges of preparation for FT statutory governance consultations and the implementation of the choice agenda. The objectives are:

- Develop Trust wide knowledge of PPI and ensure all staff understand and are trained for their role in the relationship.
- Develop mechanisms to facilitate a true two way communication process with both patients and the wider public, including different race and minority groups, to ensure equality and improve accountability.
- Increase public and lay participation in hospital business to develop services, management and recruitment.
- To increasingly involve patients and public, including all minorities, so that their views effect decisions taken about the design, improvement and modernisation of services.
- Develop a comprehensive communications plan, using the full range of methods available, to take the Trust's message to all areas of the community; paying particular attention to the poorly represented and more vulnerable areas of society.

The first stage of the plan will concentrate on three areas; an audit of current activity, market research to identify our current position and implementation of some quick wins to energise the process. The second stage will identify activities to achieve the improvement targets associated with each objective and will be closely linked to the FT consultation process. This

stage will also utilise the opening of the new hospital as a key communications tool to launch a number of initiatives. The third and final stage will review progress through the year with further market research; this information will then be used to develop the subsequent year's action plan

3.8 Human Resources

The Trust recognises that its human resources are one of its most important assets, and are crucial to the delivery of care to patients. It also recognises that its services need to continually improve and change to meet its local community's needs. The initial quest to improve services in order to meet the needs of its local population impacts upon Trust staff, their skills and ways of delivering services. The Trust requires a flexible workforce, able to adapt and change to pioneers services in the best way. The Trust's workforce strategy is based on

- Contributing to the delivery of the NHS modernisation agenda including workforce productivity
- Ensuring we have a workforce of the right numbers and skills to deliver quality services to our patients

The Trust is committed to improving the quality of our staff's working lives as well as their work and life balance. The Trust will continue to prioritise this approach as this is seen to be key to its recruitment and retention strategy. The Improving Working Lives steering group has identified staff health as the area for particular emphasis over the next year. This also fits and supports the Trust's requirement to reduce sickness absence, key to the achievement of compliance with a number of the Healthcare Commissions core standards. It will also be keen to meet the further level of accreditation to demonstrate to its staff and the local community that the Whittington deserves to be their employer of choice.

3.8.1 Workstreams

There are a number of workstreams, which will contribute to the delivery of this human resources strategy. These include:

3.8.1 (i) Efficient and effective use of staff.

It is essential that the Trust is utilising its workforce in an effective way but also that its services are providing value for money. There are a number of significant projects currently underway to ensure this is achieved:

- Review of nursing and midwifery rostering/establishment. This review is now completed for all general nursing and as a result has improved continuity of patient care whilst significantly reducing reliance on agency nurses i.e. by 85%.

- increasing use of bank staff to meet the Trust's requirements and minimising its use of agency staff. The increased availability of bank nursing staff has also contributed to the significant reduction in agency usage.

- Efficient use of medical staff including minimising use of agency staff. Measures have been put in place in some specialities already to reduce the reliance on agency staff by reviewing rosters or employing NHS locums. This work is continuing across all relevant specialities

- Managing sickness absence more effectively. The introduction of a specific project, with a dedicated project manager, has made significant improvements in the sickness rate to date - reducing from 6% early in 2005 5.1% late in 2005/06. This has been supported by a communications strategy and policy review.

These projects are underpinned by the aim of improving quality, whilst getting better value from resources. Enhancing the Trust's current workforce data is key to this too.

3.8.1. (ii) Modernisation of services

The deployment of the workforce is continually being reviewed by the Trust to enable its utilisation to match the changes in the shape of clinical services. The changes which have the most significant impact upon staff deployment and utilisation are:

- Cost improvement programmes
- Service development projects – which incorporate the10 high impact changes
- Development of services for women and children
- Payment by results
- The move into the new building.
- Ensuring the Whittington is the patients' hospital of choice

The shape of the workforce is inextricably linked to the services the Trust needs to deliver. Increased workforce productivity will be delivered through such measures as aiming to reduce sickness absence to the target of 2.7%, reducing turnover rate by 1% each year and ensuring that junior doctors comply with 2009 EU legislation, whilst gaining value for money from addressing their rotas.

3.8.1 (iii) Implementation of Agenda for Change pay system

This will place all staff (except doctors and directors) on national terms and conditions of service and will also facilitate the modernisation of the way services are delivered. Initially modernisation of careers will concentrate upon radiography and administrative support to medical staff. Other major service modernisation, such as the way outpatient services are delivered will utilise the benefits of the flexibility of careers offered by Agenda for Change. The aim will be to ensure that the Whittington is the patients' and staff's hospital of choice.

3.8.1 (iv) Improving Working Lives practice plus

The Trust was one of the first trusts in London to achieve validation. Improving Working Lives is a cornerstone of the Trust's recruitment and retention of staff strategy: and underpins our human policies strategy. The core elements of this validation are:

- Human resources strategy and management
- Equality and diversity
- Staff involvement and communications
- Flexible working
- Healthy working
- Training and development
- Flexible retirement, childcare and support for carers

Clearly it is vital for the Trust to be able to attract and retain the skilled workforce it requires, when needed. The achievement of Improving Working Lives Practice Plus demonstrates to staff that the Trust takes seriously its pledge to be the employer of choice.

3.9 Capital Investment

The Trust estate strategy is under review. The potential need for a Strategic Outline Case was identified during 2005 and although its development has been postponed there remain a number of fixed points in addition to the current PFI development. These include the

refurbishment of the Emergency Department, as part of the acute core scheme, and the creation of the primary care element of the Walk-in-Centre which has been funded by the Department of Health. The ED scheme will require additional public sector funding over and above the sum currently reserved in the SHA capital programme, and a business case for this is currently being prepared.

Negotiations with C&I Mental Health & Social Care Trust have now been concluded and will result in the sale of Highgate Wing with the Trust as tenants. This will enable the sector to gain an improved capital receipt, whilst reducing the rent paid by the Trust from the high level of capital charges required by the previous valuation of the property.

The Waterlow Building, which was vacated by the Mental Health Trust in September 2004, is not currently in use. However it provides an important asset for dealing with medium term accommodation problems associated with operating from a congested site. Non-core activities could be relocated to the Waterlow Building from prime clinical space, allowing for improved clinical services from the Outpatients Building. This is consistent with activities supporting delivery of the 10 High Impact Changes. In addition, or alternatively, we will continue to explore collaborative partnerships with other health providers, from both within and outside the sector in order to fully utilise the potential for synergy and income generation from cross organisation partnerships. Initial market testing suggests considerable interest in the site.

The Trust has no other surplus property for disposal in the short term, but it is anticipated that the northern part of the site (including the Waterlow Building) will eventually be available for alternative use.

In anticipation of the new building becoming available, the Trust reviewed space utilisation with a view to implementing a range of medium to long term measures that support delivery of our strategic direction, whilst we continue to work towards modernising the remainder of site buildings. In consultation with clinicians, the Trust has developed a package of solutions for new and refurbished facilities for the following services:

- Emergency Department refurbishment which will separate adult and paediatric flows; provide direct links to the primary care Walk in Centre; include an extended clinical decision unit; and be integrated with the Medical Assessment Unit (MAU) located within the acute core;
- NICU: accommodation suitable for the level 2 service to be provided within a centralised maternity ‘block’;
- Midwife-Led Unit: provision of a new facility for mothers as part of the modernisation of maternity services;
- Relocation of a number of inpatient wards and other services to achieve improvements to patient flows and functional adjacencies, enabling the Trust to mothball suitable areas making further savings on estate costs and capital charges.

It is anticipated that the above improvements can be achieved through a combination of central funding and the Trust’s own capital allocation. The Trust has also recently developed its fund-raising capacity and will seek to contribute charitable funds to specific capital investment. Business cases for the schemes are in the process of being developed, with submission planned for summer 2006.

3.10 Potential barriers to progress

One of the most important potential constraints on the delivery of the Trust’s plans is the availability of capital for investment in the replacement of facilities to ensure they are fit for

purpose for the delivery of services in the 21st century. Delays to the overall redevelopment programme will hamper the Trust's ability to confirm its position as "the hospital of choice for local people", with corresponding impact on income. It will also have a negative impact on the recruitment and retention of high quality staff and will make it more difficult for modernisation plans to be realised.

More specifically, continued delay of the current PFI construction scheme poses an immediate and potentially serious risk to the Trust's market position and income. The first phase of the scheme is subject to a delay of almost two years and while there has been no impact on the volume of existing services, it has delayed the implementation of planned service improvements. These include more efficient and effective imaging services using digital technology, and better use of beds through the planned new assessment unit for emergency admissions. It has also delayed the availability of additional critical care beds for which there is currently excess demand. Not only does this affect the quality of care for patients who have to be transferred to other units, but restricts a material source of income to the Trust and imposes additional costs on PCTs where alternative facilities are more expensive.

The consequential delay on the second phase is potentially even more damaging. The refurbishment of the floor of the Great Northern Building will significantly increase the capacity for day case procedures including surgery, endoscopy and interventional radiology. The longer the delay, the harder it will be for the Trust to secure the additional day case workload which is a cornerstone of its financial strategy.

Contingency planning is being developed with investigation of options for alternative use of the space, including entering into arrangements with other NHS providers and the independent sector. The first stage of this work was completed at the end of February 2006 and detailed evaluation is now underway. Provisional estimates of potential mitigation are incorporated in the risk assessment in section 6.

3.11 Summary

As can be seen, the Trust has embarked on a wide-ranging modernisation and redevelopment programme which culminated in the production of its strategic direction in 2004. This model envisaged the Whittington as a centre for excellence in ambulatory care, the care of chronic disease and the treatment of common cancers, whilst maintaining its position as a foremost provider of undergraduate and postgraduate education.

These changes are set against a challenging financial background, with the Trust required to address a cumulative deficit. A detailed recovery plan is being continuously developed with some support from external consultants (Green & Kassab) from which the Trust aims to achieve both recurrent and non-recurrent savings. It is intended that this work will be set in the context of both cost reduction income maximisation, adopting a phased approach to arriving at financial balance.

The analysis of activity and productivity trends demonstrates that the proposed clinical strategy can only be sustainable within the context of PbR, patient choice and a plural health economy if further income and/or cost reduction totalling £3m-£4m can be secured. Delivery will be supported by the completion of our PFI building, implementation of the service improvement objectives, and progressing with the work described in our capital investment proposals. There nevertheless remains a considerable challenge in securing sustainable balance.

4 IMPACT OF THE PROPOSED STRATEGY

4.1 Income and Expenditure

The income and expenditure analysis summarised below and set out in detail in Appendix 2 and the Long Term Financial Model (LTFM) indicates a potential year-end breakeven in 2005/06 with normalised EBITDA of £6.8m. This is shown to improve further in 2006/07 and grow steadily thereafter. This is achieved on the assumption that the onset of the unitary charge for the PFI development and the impact of inflation and generic cost increases will be offset by savings and additional income arising from the increase in clinical capacity.

Figure 13: I & E Forecast
(LTFM reference: worksheet 15)

	2006/07 Forecast £m	2007/08 Forecast £m	2008/09 Forecast £m	2009/10 Forecast £m
Clinical Income	114.1	125.6	129.0	132.0
Other Income	26.2	24.2	24.4	24.5
Total Income	**140.3**	**149.8**	**153.4**	**156.5**
Pay costs	(100.2)	(104.3)	(106.0)	(107.0)
Non Pay costs	(34.9)	(41.6)	(43.2)	(44.9)
Subtotal Expenses	**(135.1)**	**(145.9)**	**(149.2)**	**(151.9)**
EBITDA	**5.2**	**3.9**	**4.2**	**4.6**
Depreciation, Dividends & Interest	(7.8)	(6.7)	(7.1)	(7.1)
Net Surplus / (Deficit)	**(2.6)**	**(2.9)**	**(2.9)**	**(2.5)**
Normalised Net Surplus / (Deficit)	**(3.0)**	**(3.3)**	**(3.1)**	**(2.7)**

Further discussions will be held with our principal commissioners to ensure consistency in assumptions that are being made about activity and capacity. While opportunities for further cost reductions will be sought, it is considered that these are now limited following the in-depth review by external consultants and in the light of the Trust's reference cost position and PbR baseline assessment. The Trust Board has already agreed a radical workforce review and this is being implemented whilst taking account of the risks to the achievement of performance targets and income loss.

As outlined in section 3, the Trust is also assessing the potential for increasing day case surgery beyond the current plans for switching from in-patient to day casework. This will require us to attract referrals from a wider area, including other sectors, bearing in mind the Trust's accessibility from both East and South London. There is also scope for increasing endoscopic investigations in the new facilities.

A feasibility exercise for investment in private patient facilities is now being piloted on a surgical ward. This will enable the Trust to consolidate and streamline its services to ensure the more efficient identification and recovery of income. The ward was released as a result of operational efficiencies.

With the new arrangements for payment for critical care, the Trust is revisiting the costs and benefits of the phased opening of additional capacity provided in the new building.

4.2 Income and Expenditure Bridge Analysis

The bridge analysis has been further developed, and the table below shows the latest assessment.

In addition, year on year changes can be tracked in the analysis in Appendix 2 which shows incremental changes to the recurrent and non-recurrent position. The assumptions underlying specific changes are set out in section 5.

Figure 14: Bridge Analysis (LTFM reference: worksheet 10)

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
Normalised bottom line from previous year	(2.2)	(3.0)	(3.3)	(3.1)
Baseline/Inflation	(7.7)	(8.5)	(4.7)	(4.8)
Growth	2.8	3.0	0.3	0.2
Payment by Results	(0.7)	(0.3)	(0.3)	0
CIPs	3.4	4.5	5.0	5.0
Developments	0	0	0	0
Other	0	0	0	0
Total net marginal changes	0.3	(1.3)	0.3	0.4
New normalised bottom line (carried forward to next year)	(3.0)	(3.3)	(3.1)	(2.7)

4.3 Balance Sheet

The balance sheet projections are based on the existing financial regime reconciled to the notified CRL and EFL for 2005/06. They now include a repayment of PDC in March 2006 of £4.6m as notified, representing the withdrawal of cash to repay brokerage brought forward from previous years.

Changes in the balance sheet in future years include the creation of a deferred asset and build up of residual interest in respect of the PFI development; the estimated impact of revaluation of fixed assets and associated reserve entries; a reduction in outstanding debtors as a result of NHS cash management rules and other management efforts to improve debt liquidation; an initial increase in non-NHS creditors (2005/06) with the level remaining constant thereafter at approximately 30 days.

Stock levels reduce slightly annually, with stock days reducing from 84 in 2005/06 to 67 in 2009/10.

Total assets employed increase from £95.8 in 2005/06 to an estimated £105.8m in 2009/10.

Figure 15: Balance Sheet Forecast

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
	£m	**£m**	**£m**	**£m**
Fixed Assets	100.87	101.08	101.31	101.57
Current Assets	9.19	11.31	12.28	13.59
Long Term Debtors	2.05	2.05	2.05	2.05
Creditors (less than 1 year)	16.31	18.10	18.55	19.24
Creditors (more than 1 year)	2.20	2.20	2.20	2.20
Total Assets Employed	**93.59**	**94.13**	**94.89**	**95.77**
Equity	0.53	1.24	2.17	3.22
PDC	45.29	45.29	45.29	45.29
Revaluation Reserve	46.64	46.64	46.64	46.64
Donated Asset Reserve	1.13	0.97	0.80	0.63
Total Taxpayers' Equity	**93.59**	**94.13**	**94.89**	**95.77**

4.4 Cash and Working Capital

The planned position implies a working capital facility or brokerage of £1.3m in 2006/07 rising to £9.2m in 2009/10.

Figure 16: Cash and Working Capital (LTFM reference: worksheets 6 + 15)

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
	£m	£m	£m	£m
Cash Flow from Operations	8.4	9.3	8.8	9.2
Cash Flow before Financing	4.2	5.1	4.6	5.0
Net cash inflow/(outflow)	0.8	1.5	1.0	1.3
Year End Balance Sheet Cash Position	**1.4**	**2.9**	**3.8**	**5.1**
End of year EFL undershoot / (overshoot)	0	0	0	0
Cash brokerage received/(paid)	1.3	3.1	6.1	9.2
End of year debtor balances	6.5	7.0	7.0	6.9
End of year creditor balances	16.3	18.1	18.6	19.2
End of year stock	1.3	1.5	1.5	1.5
	Days	Days	Days	Days
Working Capital	(7.12)	(6.79)	(6.27)	(5.65)
Stock Days	77.36	72.72	69.81	67.02
Trade Debtor Days	11.76	10.74	9.76	8.96
Trade Creditor Days	28.47	28.85	28.48	28.57

Further analysis will be contained in the following when it is updated in the final version:

- Annex 1.: 2006/07 cash flow analysis
- Annex 2.: working capital headroom requirement
- Annex 3.: calculation of liquidity ratio

4.5 Capital Programme

The draft capital programme for 2006/07 as approved at the February Finance & Performance Committee is summarised below. The programme was prepared based on estate, equipment and IT service requirements and has been discussed in detail at the Trust's Capital Monitoring Committee.

Figure 17: Capital Programme 2006/07

Project	Funding Source	Total Project Cost	Planned Start Date	Planned 2006/07 spend £m
H&S, Backlog and DDA	Op cap	1.1	April 06	1.1
IM&T	Op cap	1.1	April 06	1.1
PFI	Op cap	0.1	April 06	0.1
Medical Equipment	Op cap	0.6	April 06	0.6
WIC phase II	Op cap	1.2	Sept 06	1.2
Total		**4.1**		**4.1**

4.6 Income, Activity and Payment by Results

4.6.1 Income

SLA proposals for 2005/06 were drawn up in line with sector guidance.

Table 15 includes the estimated total income from SLAs with PCTs. In particular, it is noted that both Islington and Haringey PCT have indicated that their current strategy includes demand management with plans to reduce hospital activity and expenditure. This reduction is not currently reflected in the Trust's plan, however, assumptions are being discussed with both PCTs and plans will be refined to reflect agreed changes.

The figures below incorporate planning assumptions issued by the SHA but do not include the impact of Department of Health guidance notified in the week commencing 30 January 2006. This will be included in the next iteration.

Figure 18: Income Plans

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
	£m	£m	£m	£m
Income from PCTs				
Islington	64.3	70.9	72.9	74.6
Haringey	32.8	36.1	37.2	38.0
Other	17.5	19.4	20.0	20.7
Total	114.6	126.4	130.1	133.3
Other Income	25.7	23.4	23.3	23.2
Total Income	140.3	149.8	153.4	156.5

The following table shows the breakdown of income generated by PbR in 2006/07 as distinct from other sources.

Figure 19: Income Reconciliation – 2006/07

Project	Contracted	Expected additions at full cost	Expected additions at marginal cost	Other additions	Total
	£m	£m	£m	£m	£m
Activity covered by PbR	93.8	2.1	0.9		96.8
Other activity related income	16.6	1.2			17.8
Other income	25.7				25.7
Total Income	**136.1**	**3.3**	**0.9**		**140.3**

4.6.2 Activity

The income projections are based on the following assumptions about levels of activity from 2006/07.

Figure 20: Planned In Patient and Day Case Activity

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
Spells				
Elective	2,930	2,271	2,017	2,025
Day Cases	11,738	21,623	21,868	21,898
Emergency	24,000	25,354	25,750	26,162
Total	38,668	48,401	48,789	49,253
Trust DC%	80%	90%	91%	91%
Surgical DC %	75%	80%	82%	82%

Figure 21: Planned Other Activity

	2006/07 Forecast	2007/08 Forecast	2008/09 Forecast	2009/10 Forecast
Out Patient – First Attendances	70,372	71,091	71,091	71,091
Out Patient – Follow Up Attendances	158,512	161,058	161,058	161,058
A & E Attendances (new)	89,867	98,853	102,808	106,920
Adult Critical Care	3,815	4,508	5,201	5,201
Maternity deliveries	3,472	3,472	3,472	3,472
NICU bed days	8,543	8,543	8,543	8,543

Figure 22: Additional Activity/Service Developments

This table contains a breakdown of the additional elective activity contained in the totals in figure 17 above

	2005/06	2006/07	2007/08	2008/09	2009/10
Endoscopy					
▪ switch OP to DC	2,181	2,290	2,404	2,404	2,404
▪ extra PFI capacity	0	0	2,500	2,500	2,500
Day Cases - PFI	0	0	5,200	5,200	5,200
Number of additional ICU beds	0	2	2	0	0
ICU Bed days (at 90% bed occupancy - cumulative)	0	985	1,970	1,970	1,970
NICU – bed days (2 extra cots @ 90% occupancy)	0	650	650	650	650
Other Healthy Starts, Healthy Futures Activity **– NOT in activity projections (Table 17 & Appendix 2)**					
Maternity					
Deliveries	0	150	150	150	150
Antenatal admissions (HRG N12)	0	450	450	450	450
Antenatal outpatients	0	450	450	450	450
Post natal outpatients	0	300	300	300	300
Paediatrics DC	0	408	408	408	408
Paediatric Surgery					
Elective IP	0	400	400	400	400
Emergency IP	0	440	440	440	440
Paediatric Medicine					
Emergency	0	730	730	730	730
Paediatric OP					
New	0	147	150	150	150
Follow up	0	251	256	256	256
Private Patients (the Highgate Hill Treatment Centre)					
OP	79	309	309	309	309
Day Cases	194	969	969	969	969
Elective IP	0	0	0	0	0
Amenity Bed days	0	500	500	500	500

4.7 Analysis of Activity Trends

4.7.1 In Patients

Elective inpatient activity is relatively stable now with minor increases required to meet waiting time standards (for example by March 2006 it is predicted that less than 100 patients will be waiting over 3 months.

The service developments for elective inpatients in figure 19 are as a result of the move of paediatric inpatients under Healthy Starts, Healthy Futures.

Emergency inpatient activity is still predicted to grow driven by increases in attendances to the Trust's Emergency Department. Historically the Trust has seen growth of 10% per annum in recent years and this is predicted to increase even further, with the opening of a Walk-In Centre. In the short term it is anticipated that this will drive up admissions – however a reduction in growth in subsequent years is predicted along with a reduced ED to admission conversion rate reflecting the increased minor illness/primary care nature of the WIC workload. Nevertheless in overall terms emergency admissions will continue to rise.

The management of long-term conditions in primary care is still at an early stage and the impact this service change will have on ED and Emergency Admissions is still not clear. Work is underway to fully model potential scenarios – as part of the making best use of beds project (section 3.3). It is expected that this work will inform the longer germ planning – which will, in turn, lead to bed reductions and cost efficiencies.

4.7.2 Day Cases

One of the strategic objections of the trust is to undertake higher proportions of elective activity as day cases. The distinct themes for day case growth are as follows:

- Increases to meet waiting time standards
- Consistency in data collection (previous undercounting of day case activity)
- High Impact Change No.1 (treat as day case)
- Increased capacity in the new clinical facilities under construction (covers surgical, endoscopy and other diagnostic procedures)
- Opening of the new private Highgate Hill Treatment Centre that will undertake mainly day case activity.
- Increased paediatric day case under HSHF

The effects of the first two are contained within the LTFM.

4.7.3 Out Patients

GP referrals to outpatients are broadly stable, with some specialty variations. There has been a required growth in outpatient activity for the following reasons:

- To achieve and maintain waiting time standards;
- Increases in ED attendances (which has led to an outpatient attendance being offered as an alternative to an emergency admission).

No additional growth has been factored into the model to cover patient choice, marketing initiatives or for national flagship status for Choose & Book.

4.8 Cost Improvement Programme

The strategy for achieving financial targets has been developed in conjunction with PCTs and NCLSHA, and incorporates a demanding cost improvement and containment programme to be implemented by the hospital.

The current year plan is to achieve savings of £6.5m. Proposals for 2006/07 remain under development with final details and values to be confirmed, however in overall terms schemes have been identified to meet the target. The most significant component is the further in-year effect of the headcount reduction planned in October 2005 for implementation in the last quarter of 2005/06 (corporate services) and during 2006/07 (operations directorate and facilities), with the balance to the overall target for 2006/07 to be met via the Green & Kassab review (individual schemes agreed).

Figure 23: Cost Improvement Programme

Details	2006/07 PYE Saving (including FYE of 05/06 schemes)		2007/08 FYE Saving		Responsible Director	Implement. date	Monitoring arrangements
	Recurrent	Non-Recurring	Recurrent	Non-Recurring			
	£'000	£'000	£'000	£'000			
Establishment review	2,094		2,267		All	April 2006	Weekly ET Monthly HMB
Green & Kassab Review	580		711		All	April 2006	Weekly ET Monthly HMB
Income	750				All	April 2006	Weekly ET Monthly HMB
To be identified			1,488				
Total	**3,424**		**4,466**				

4.9 Human Resources

Following a steady growth in staff numbers over the past four years it is anticipated over the next 3 years that overall the workforce requirements will be reshaped. There is currently a cost improvement plan in place which will see a reduction in posts of approximately 97 wte in the next year. This will be on top of 30 wte posts being reduced during the current financial year. There are plans to review a number of administrative processes notably merging appointments with admissions and reducing the level of Imaging administration following the move to the new build. These changes will result in a reduction in the number of clerical positions. A number of medical and nursing posts are also under review

However there are a number of service changes planned over the next three years which will require additional staffing resources. Increased capacity within intensive care will require over the next two years a year on year increase of 2 beds per year. The increases in staff are predominantly nursing but also medical staff and allied health professionals. From 07/08 onwards it is planned to increase the number of day cases by circa 7,500 per annum which will require additional nursing, medical and allied health professional staff. Additionally the

new service model planned for the Emergency Department and Walk in Centre following the opening of the new build will require additional staff from 06/07. These will be a mix of nursing, medical, clerical and other support posts.

Supply of staffing is improving due to national education and training programme, yielding fruit, as well as changes in the local/national labour market due to significant changes in the healthcare market. It is anticipated that this will continue for the next 3-5 years. In tandem with this, the Trust is also working to increasingly recruit from its local community, as well as enabling staff to gain greater skills, for example with pathways for health care assistants to becoming qualified nurses through structured progression. Increases in the supply of staff will in turn reduce the reliance on temporary staff either through the Trust's own Temporary Staffing Office or more importantly via external agencies. Significant evidence of this is already being seen as described in section 3 The implementation of Agenda for Change will also see a more efficient utilisation of workforce resources over the next three years. Services will be reviewed on a rolling basis to ensure that benefits of the implementation of Agenda for Change are realised. The Trust's sickness absence management programme as described in section 3 is also proving effective.

Figure 24: Planned Manpower

	2006/07	2007/08	2008/09	2009/10
WTE (average actual staff in post)				
NHS Staff				
Medical and Dental	284	313	314	314
Nursing and Midwifery	753	794	796	795
Healthcare Assistants & Other Support	353.5	351	349	347
Scientific, therapeutic & technical	206	207.5	207.5	207.5
Healthcare scientists	88	90	90	90
Administrative & Estates	437	433	431	428
All other NHS staff, ambulance staff and general payments	0	0	0	0
Total NHS Staff	2121.5	2188.5	2187	2181.5
Total Bank (inc. NHSP) element of the above groups	190	170	160	150
Total Agency (non-NHS staff)	80	70	65	60
Total Staff WTE	2397.5	2444	2428.5	2407.5
Total Pay Cost				
NHS Staff				
Medical and Dental	24,662	24,865	24,550	26,058
Nursing and Midwifery	35,432	37,477	38,498	38,755
Healthcare Assistants & Other Support	6,649	6,902	7,082	7,269
Scientific, therapeutic & technical	10,460	11,351	11,663	11,755
Healthcare scientists	4,922	5,343	5,489	5,532
Administrative & Estates	12,604	12,964	13,338	13,471
All other NHS staff, ambulance staff and general payments	440	391	420	307
Total NHS Staff	95,169	99,293	101,040	103,147

Total Bank (inc. NHSP) element of the above groups				
Total Agency (non-NHS staff)	3,106	3,184	2,324	2,104
Total Staff Cost	98,275	102,477	103364	105,251
Non-NHS usage (% of total costs)	4.1	4.2	4.2	4.2
Sickness Rate (%)	4.0	3.5	3.0	2.7
Turnover Rate (%)	15	14	13	12
Vacancy Rate (%)	12	11	10	9

4.10 Key Performance Indicators

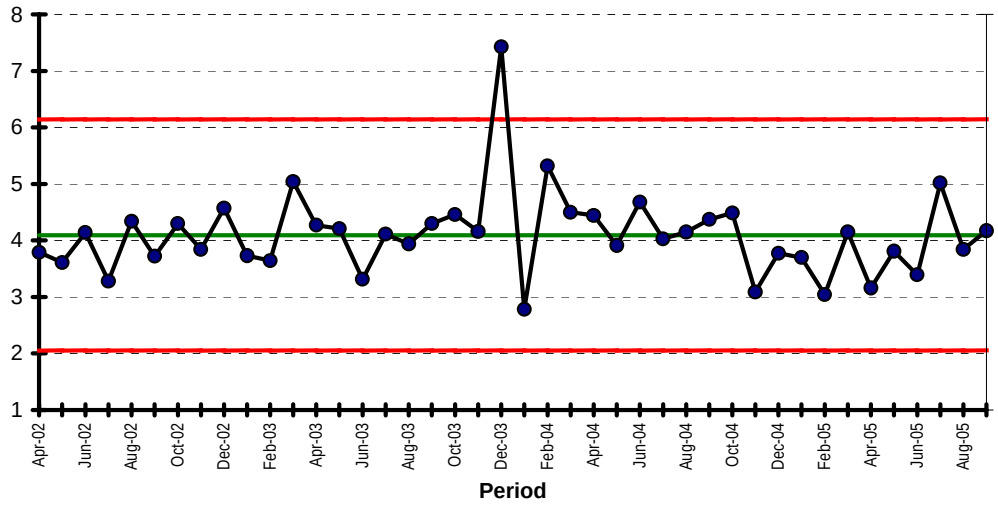
4.10.1 Average Length of Stay

The average length of stay for non-elective medicine, non-elective and elective surgery is presented below (the volume of elective medical activity is very low). Specialties have been grouped together into medicine or surgery. Maternity and paediatrics are excluded as the average length of stay for these two types of patient is only 2 days and is fairly stable.

The acute medical and surgical services represent 83% of the total bed days used in the Trust. The split between elective and non-elective is more marked. Adding all non-elective services together (i.e., including paediatrics and maternity), they represent 93% of the bed days used at the Trust.

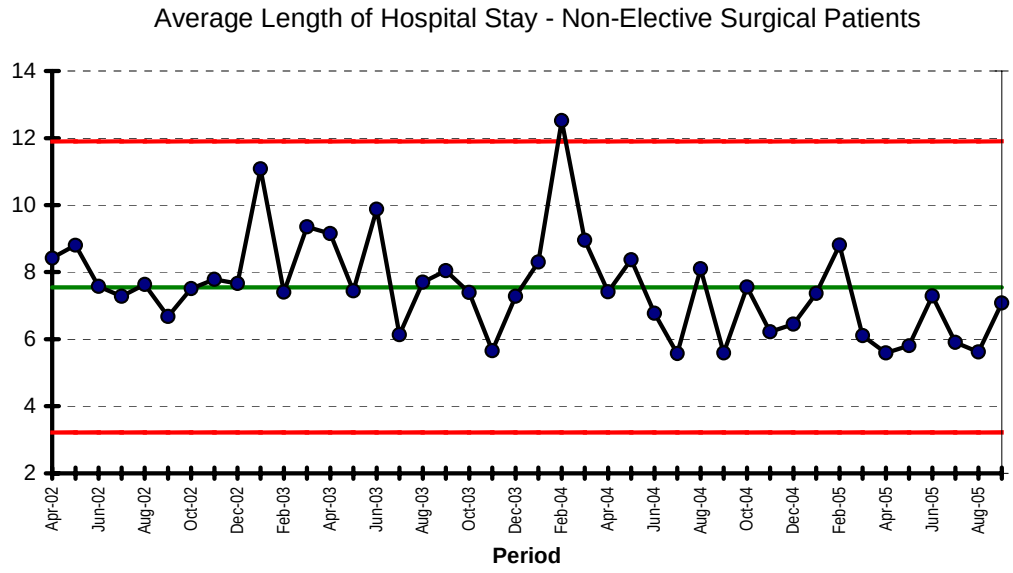
Section 3.3 describes service developments/modernisation project plans for length of stay. The expected outcome for reduced length of stay is reduced beds and the consequent cost improvement programme (see section 4.8)

Run Chart 7 Average Length of Hospital Stay - Elective Surgical Patients



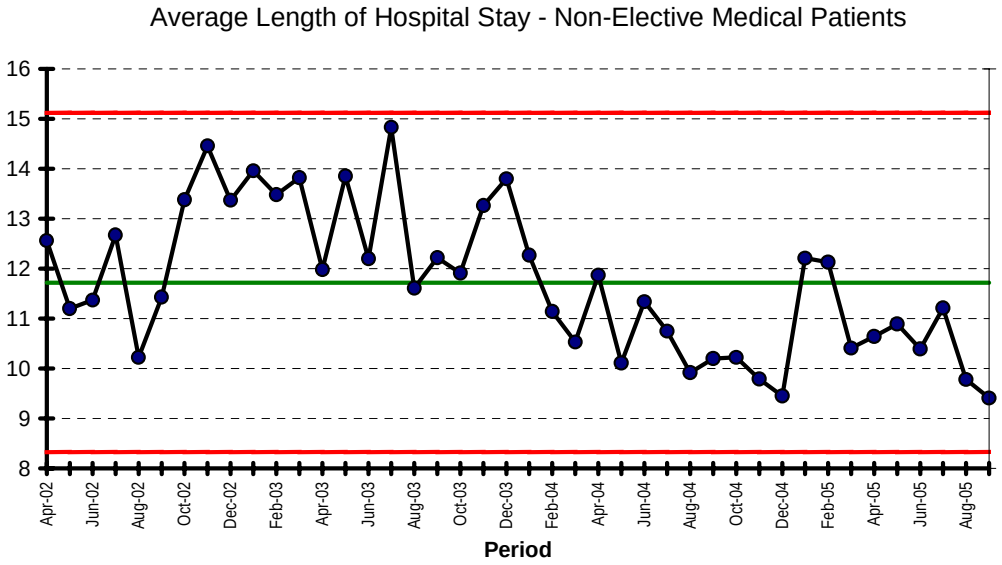
Commentary: Relatively stable. The very high value for December 2003 is statistically abnormal (could be the discharge of a small number of very long stay patients in that month or even a data error!). From November 2004 and through the first part of 2005/06 there was a sustained reduction in AvLOS that has now stopped but did permit the closure of beds (see section 4.8).

Run Chart 8



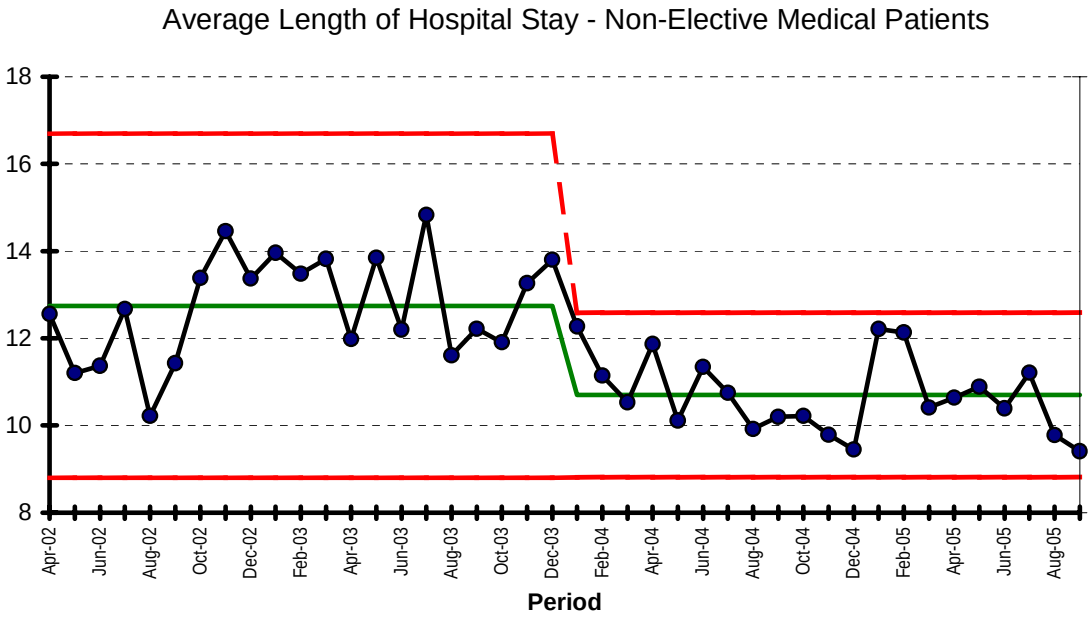
2004/05 and 2005/06 have been relatively stable for AvLOS for non-elective surgery patients and the modernisation/service development project on length of stay will address future LOS reductions.

Run Chart 9



There has been a consistent reduction in the length of stay since 2002. This type of patient is the primary focus of the service development project on length of stay as medical patients use over two thirds of the acute medical and surgical total. I-Chart 10 below restates the above graph with a step change and shows the new baseline that further LOS improvements will be measured against.

Run Chart 10



4.10.2 Bed Occupancy and Bed Numbers

Figure 25: Bed Numbers

	2003/04	2004/05	2005/06		
	annual	annual	Q1	Q2	Q3 (part)
Bed Occupancy	95%	92%	92%	88%	93%
Bed Numbers# Min – max range	390-400	390-400	376-400	332-396	367-376

excludes maternity & NICU (73 beds)

Bed Numbers fluctuate according to demand therefore ranges of beds have been specified.

In 2005/06, as a result of length of stay reductions, beds that could be closed were grouped together. One surgical ward has now permanently closed and been converted into the private Highgate Hill Treatment Centre. A medical ward was also temporarily closed in Q1/Q2 and reopened in Q3.

The ward closure programme forms part of the service development project plans and the benefit of this programme is a contributor to the cost improvement plan.

5 UNDERPINNING ASSUMPTIONS

5.1 Finance

5.1.1 SLA Proposals for 2005/06 and 2006/07

As a result of the restriction of the implementation of PbR to elective activity only, the Trust's SLA proposals for 2005/06 were priced using a combination of national tariff (for electives) and local effective prices for other activity. Effective pricing applies a price to activity within the contract, based on overall contract values being rolled forward for a number of years, uplifted for inflation, and does not accurately reflect the cost of individual services. This pricing methodology was in line with sector ground rules for 2005/06 SLA negotiations. Pricing services in this way contributes to the Trust's underlying recurrent deficit as costs are not fully recovered for services provided.

The PbR stage 2 baseline assessment indicated an income increase in excess of £11m for the Whittington. Of this, the impact of re-pricing elective activity at National Tariff is £1.741m, although the actual increase in income in 2005/06 is capped (per DH guidelines) at 2% of the overall PbR benefit, or £221k, which is recognised in the plan.

The latest PbR baseline exercise (PbR3) indicated an income loss of just over £1m for the Trust. Transitional support of £0.5m is anticipated in 2006/07, reducing to £0.25m in 2007/08 and to nil by 2008/09. This is recognised in the latest iteration of the financial plan (March 2006) as advised by the SHA.

Following the withdrawal of the 2006/07 tariff, income for services included in PbR for 2006/07 onwards is estimated using the interim tariff. An adjustment has been made to reflect the likely funding of non-elective growth at a marginal tariff of 50%, as indicated in recent guidance. Further information is awaited and the plan will be updated to reflect this once the tariff is re-issued.

SLA proposals for 2006/07 are being discussed with PCTs, with Islington PCT taking a lead commissioner role. As a result of the tariff withdrawal, negotiations are currently focussed around activity levels.

A tariff uplift of 1.5% had been used to inflate income in the financial model. This is in line with sector guidance.

5.1.2 Private Patient Income

The plan currently assumes additional private out-patient activity can be attracted. This has been estimated at 30 patients per week from mid 2005/06 (anticipated income of £80k and marginal cost of £40k). Savings plans for 2006/07 include an increase in income targets, which will partly be met via any full year increase in private patient income.
It is acknowledged and reflected in plans from 2007/08 that private patient income is capped (at 2002/03 out-turn as a proportion of total income) for Foundation Trusts.

5.1.3 Capacity Increases

The plan assumes additional day case capacity, increased endoscopy activity and additional critical care beds once the new building is operational, as detailed in section 5.4.1 below. In terms of income and expenditure the additional activity is phased from 2006/07 onwards.
Increases in out-patient activity in order to meet waiting targets are included. This is reflected in Income and Expenditure from 2006/07 onwards with a marginal cost of 40% applied.

In addition an estimate for increased emergency in-patient activity has been included in the model, this is based on the level of continued growth experienced in ED attendances. This is expected to generate additional income in 2006/07 and 2007/08 (recurrently) for which a marginal cost of 40% is assumed. Based on recent guidance this income is included at 50% of tariff.

5.1.4 Inflation

Inflation is applied to both income and expenditure based on SHA guidance. For clinical income, this is 1.5% on all items included in tariff / PbR and 4% (reducing to 2.5% from 2007/08) on non-tariff items.

Income received via the Workforce Development Directorate (WDD) has been inflated at 1.5% as advised by the SHA. This includes major income sources such as SIFT, Madel & R&D Levies plus salary replacement income and other ad-hoc educational items.

Individual income targets, devolved to operational areas, have been assessed and the maximum inflationary increase applied (in most cases 5%).

Inflation on expenditure has been assumed at 5.3% for 2005/06 onwards. This was based on guidance received early in the planning round in relation to likely uplifts to the national tariff before deductions for efficiency and is anticipated to include the impact of :

- Pay awards
- Pensions Indexation
- Non Pay inflation, incl secondary care drugs
- Clinical Negligence Costs
- Consultants Contracts
- Agenda for Change
- NICE
- Capital Charges

The plan currently assumes that generic and inflationary cost increases in will not exceed this overall level of increase.

5.1.5 SIFT Income

Other than inflation (1.5% annually), plus an increase of £100k (SIFT Development) in 2006/07 no additional recurrent SIFT income is currently anticipated in the plan.

5.1.6 PFI & RoC Support

Income support for PFI fees has been included on a non-recurrent basis at £811k in 2005/06, reducing by £200k p.a. as advised by the SHA.

Additional income support to compensate for the loss of savings resulting from the change in return on capital from 6% to 3.5% has been included at £600k in 2005/06 reducing annually to £124k in 2009/10 and then to zero, as confirmed by the NHS Bank, via the SHA.

5.1.7 Cost Pressures

5.1.7 (i) Agenda for Change

The financial plan reflects fully all income received for the implementation of Agenda for Change. The majority of posts in the Trust have now been assimilated with a small number of remaining posts either relating to starters or leavers or in query. Arrears are now being processed. The plan includes the estimated costs of agenda for change in 2005/06 including

the impact of arrears for 2004/05 and assumes that any incremental impact in future years is incorporated in the inflationary uplift applied to pay budgets. Details continue to be further refined and a detailed exercise training the impact on a post by post basis has commenced.

5.1.7 (ii) PFI Projects

The plan assumes the unitary charge for Imaging Managed Equipment Service will commence in June 2006 and for the new building in August 2006.

5.1.7 (iii) Local Pressures

As part of the annual planning process the Trust undertakes an exercise to identify cost pressures that are in addition to generic cost increases. Although substantial costs are identified on an annual basis, the Trust plans to manage these down as far as possible within available resources and to offset unavoidable new items with additional savings.
An estimate of £500k has been included annually for unavoidable pressures that cannot be offset by additional improvements.

5.1.7 (iv) NPfIT (Connecting for Health)

The plan currently assumes this is cost neutral. The position will be updated as plans are finalised.

5.1.8 Savings

As detailed in section 4.8, the total savings requirement for 2005/06 was £6.5m, representing 6.74% of SLA income. The savings targets included in the plan are £3.4m for 2006/07, £4.5m for 2007/08 and £5m for 2008/09 and 2009/10. These savings, in excess of the national requirement contribute towards bridging the gap between funding uplifts and cost increases plus anticipated unavoidable cost pressures.

5.1.9 Deficit Repayment

The plan assumes that repayment of the remainder of the Trust's cumulative deficit as at 31st March 2005 (i.e. £1.2m p.a. in 2005/06 and 2006/07) is offset by non-recurrent income support in both years. This is agreed with the SHA.

No further repayment of deficits is included in the current iteration of the plan, as the overall I&E position will be re-calculated once the revised tariff for 2006/07 becomes available.

5.1.10 Debtors

The base case assumes that in order to improve cash availability, the Trust will manage to reduce the level of outstanding debtors as a result of the revised requirements of 'Cash Management in the NHS' and changes to internal management processes.

5.1.11 Independent Sector

The plan currently assumes a loss of income, estimated at £860k, as a result of activity transferring to the independent sector. This value is based on Strategic Health Authority guidance and implementation has been phased from 2006/07 (£215k income reduction) to 2008/09 (£860k reduction) as advised.

5.1.12 Capital

The financial plan reflects the re-cycling of £1.2m, from capital in 2005/06 as agreed with the Strategic Health Authority.

The capital allocation for 2006/07 is £4.189m, (per guidance received during February), has been included in the plan.

5.2 Activity

The significant increase in day case activity is a combination of the planned shift between elective inpatient to treating as day case, with clear linkages with the Trust's strategic direction, and the utilisation of the additional daycase capacity provided by the PFI scheme

Additional elective activity will need to be scheduled over the next two years in order to achieve the NHS Improvement Plan target of 18 weeks between referral and treatment. Discussions with PCTs are underway to agree the activity modelling parameters, and the impact upon waiting times and activity levels.

Over the last few years the Trust has seen a 10% growth in Emergency Department attendances in 2004/5 and 7% in 2005/6 Although there are plans to provide alternative services outside the Trust, these are not yet in place or not being used by patients. Therefore the Trust considers that in the short term certainly, that this growth will continue, particularly once the 2nd phase of the WIC opens, and that the hospital needs to consider how the additional work will be managed through the development of alternative services within the Whittington and through modernisation efficiencies.

The Trust has also seen a year on year growth (5%) in non-elective admissions, which increases the demand on diagnostic services as a result of extra unplanned activity. Demand on diagnostics is also driven by new screening initiatives, the need to eliminate waits for diagnostic tests, changes in best practice guidelines, clinician behaviour, new technology, and patient expectations. It is anticipated that the new imaging facility provided within the PFI block will be adequate to meet expected demand, through employing digital technology.

Service configuration changes. The principal service change in the sector is "Healthy Starts, Healthy Futures". As highlighted earlier in this plan The Whittington has been selected as one of the sites for maternity and neonatal services and if the proposals are agreed an increased number of deliveries will take place at the Trust. The financial plan currently assumes additional income in 2006/07 (£251k) and marginal costs of 67% for NICU Services. This is a conservative estimate, until the outcome of HSHF is finalised.

5.3 Human Resources

The key underpinning assumptions which will shape the workforce are:

- Increased supply of qualified staff
- Reduction in usage of temporary staffing especially agency
- Decreased levels of sick absence
- Vacancy rates improving steadily
- A degree of staff churn resulting from Agenda for change bandings
- Increased productivity in terms of process re-engineering of services
- An overall reduction in headcount linked to modernisation initiatives and productivity gains
- Increased reliance upon a flexible workforce to support the delivery of additional activity in the new build.

5.4 Other

5.4.1 Clinical Services

Whilst there are no plans to change the portfolio of services currently delivered from the Whittington, the Trust will be seeking to optimise activity in ambulatory and diagnostic services, and is assuming continued growth in emergency attendances, an increase in day case capacity, endoscopies and critical care beds.

The following additional capacity has been identified for 2007/08 onwards:

- 4,600 Day Cases
  An estimated value is included in the plan based on income at the average day case tariffs and marginal costs of 40%. 5,500 additional endoscopies
  An estimated value is included with a marginal cost of 40%
- Between 620 and 1,862 additional critical care beddays
  (Based on opening between 2 and 4 new beds and a mix of HDU and ICU days. The plan assumes a marginal cost of 67% for this activity.

  These items would yield a recurrent improvement in the region of £0.8m in 2006/07 rising to £4m in 2007/08.

5.4.2 Non-Clinical Services

5.4.2 (i) Shared Services

The Trust currently provides a payroll service for four other organisations within the local health economy. Opportunities for expanding the delivery of this service to include other organisations will be explored. The Trust has also agreed an SLA with HPC, a sector-wide procurement consortium which is planned to yield savings in 2005/06 of £400k. Further savings are anticipated in future years and will contribute towards achievement of the targets included in the plan.

The potential for contracting out non-clinical services will continue to be explored. However, at this stage no assumptions have been made as to the potential impact of these initiatives.

6 RISKS AND MITIGATING ACTIONS

6.1 Approach

The Executive Team has undertaken the risk analysis around the longer term financial plan by reference to the Trust's Assurance Framework. Relevant directors were asked to review those items with risk scores above the threshold of 12 on the 5 by 5 rating system (impact x probability) used by the Trust. In comparing the Trust's rating system with that described in the Corporate Risk Assessment template, it was found that the trust categories 4 and 5 equated to the FT Diagnostic category 4. The threshold for more detailed analysis of financial impact was therefore retained at 12. In the case of governance risk assessment, in addition to the existing Risk Assurance, account was taken of the report on lessons learned from the recent review of governance arrangements in Foundation Trusts. Risks above the threshold are itemised and quantified below followed by the planned mitigating action and potential financial effect in 2006/07. These comprise six financial risks and one clinical risk. It should be noted that where risk and mitigations are quantified, this is over and above what is included in the base financial plan. The net effect of risks and mitigations will be built into the sensitivity analysis in Annex 3 once the 2006/07 tariff has been finalised.

6.2 Risks

Figure 26: Risk Analysis

Risk	Impact on I & E	
	2006/07 £'000	**2007/08 £'000**
1. Base costs increasing (eg from Agenda for Change, consultant contract, new technology, unfunded inflation) combined with volatility of tariff leading to costs exceeding income under PbR.	(1,400)	(1,500)
2. Significant delay in opening new surgery facilities. Exemplified delay – 3 months in 2007/08		(630)
3. Significant delay in opening new acute core facilities. Exemplified delay 2 months in 2006/07	(65)	
4. Failure to attract additional elective PbR activity in the expanded day treatment facilities		(3,760)
5. Adverse changes in strategic decisions of commissioners of services or changes in flows due to patient choice (impact 2007/08)		(1,520)
6. Insufficient investment in the physical environment (impact 2007/08)		(280**)**
7. Failure to reduce rates of healthcare acquire infection	(1,440)	(1,475)
Total	**(2,905)**	**(9,165)**

6.3 Mitigations

The Trust has a number of plans to mitigate these risks. In particular a major option appraisal is under way to consider alternative uses for the new day treatment facilities in addition to a natural expansion of Trust day case activity. Although this is very much part of its strategic service direction, the volume of increase is likely to be influenced by elements of the system reform agenda – particularly competition, PbR, patient choice and independent sector treatment centres.

The mitigating factors associated with the risks identified above are set out below, with benefits quantified where appropriate. Each action is linked to one or more risks (R) in the risk table.

Figure 27: Mitigating Actions

Mitigating Action	Impact on I & E	
	2006/07 £'000	**2007/08 £'000**
1. Optimise activity to maximise income through accurate costing and coding. (R1)		*
2. Review and implement plan to optimise productivity benefits realisation from Agenda for Change and consultant contract (R1)		1,000
3. Continue to implement plans to reduce staffing levels within the Trust. (R1)		Ref action 2
4. Continue controls over implementation of new drugs, NICE guidelines, new equipment through existing mechanisms. (R1)		
5. Develop ISIP plan to maximised benefits realisation from the systems reform agenda (R1)		
6.Actively market new facilities including the private patient Highgate Hill Treatment Centre to maximise income (R1 & R4)		Ref action 11
7. Effectively implement additional Cost Improvement Programme. (R1)		500
8. Close regular monitoring and discussions with PFI contractor to resolve issues quickly and speed up work. (R2 & R3)		
9.Continue to develop day surgery service in current facilities through efficiency in theatre use. (R2)		630
10. Plans in place to commission new facilities in a 6-week period once handed over. (R3)		
11. Explore alternative use of additional day case facilities by NHS/private sector. (R4)		*
12. Continue to have effective discussions with commissioners aiming to have SLAs in place by end March 06 (R5)		*
13. Implement marketing strategy (R5)		*
14. Implement changes to address issues raised by GPs patients eg hospital environment, communications (R5)		*
Total marketing and business strategy*		4,280
15.Use outcome of clinical risk assessment and patient surveys to inform capital programme (R6)		

16. Continue development of the site strategy to address major investment requirements (R6)			
17. (Carry out a cost/benefit analysis of screening of all inpatients (R7)			
18. Increase number of side rooms and improve fixtures and fittings (R7)	720	740	
Total potential mitigations	**720**	**7,150**	

This risk assessment indicates a potential additional financial risk in 2006/07 of almost £3.m, most of which relates to lower than planned income under PbR and risk relating to hospital acquired infection affecting throughput. The following year, when the new day treatment unit opens, this risk income increases over £9m when the day treatment unit comes on stream. Mitigating action is expected to reduce this exposure to approx £2m in both years.

6.4 The Day Treatment Centre

The principal source of mitigation in 2007/08 is the exploration of alternative uses for the expanded capacity in the day treatment centre. The details of this exercise will be shared with stakeholders when sufficiently advanced. The main opportunities identified so far are as follows:

6.4.1 Increasing Whittington day case activity, in some cases as a collaborative venture with other providers

- Ophthalmology }
- Colposcopy } est. 3,500 cases
- Private patients }

6.4.2 Partnerships with the private sector

- Bariatric (obesity surgery)
- Cosmetic surgery

These examples are not exhaustive and all options are being carefully risk assessed as well as analysed in economic and financial terms. In addition the Trust will actively promote the existing day case services, drawing the Whittington's expertise and commitment and the benefits of "choose and book".

6.5 Evaluation of impact of business and marketing strategy

The quantification included in mitigation analysis is indicative at this stage but considered to be realistic in the light of current evidence available. Further detail will be available in the final business plan.

7 IMPLEMENTATION AND MONITORING ARRANGEMENTS

7.1 Implementation

7.1.1 Timetable / Project Plan

An outline programme for implementing the contents of this plan is set out below.

Figure 28: PSP Implementation Programme

Finalise Financial Model	March 2006
Agree SLA proposals	March 2006
Finalise detailed 06/07 Directorate objectives & plans	April 2006
Trust Board Approval	May 2006
Commence PSP in-year monitoring	July 2006
PSP 6 month review	November 2006
Review 06/07 SLAs; draft 07/08	January – February 2007
Develop detailed financial plan 07/08	January – March 2076
Issue 06/07 SLA proposals	February 2007
Develop 06/07 budget	January – February 2007
Develop 06/07 Directorate objectives & plans	November 2006 – March 2007
Agree & sign-off budgets	March 2007
Agree 06/07 Directorate objectives & plans	March 2007
Agree SLAs	March 2007
Trust Board approval	May 2007

7.1.2 Role of the Board

The development of the Trust's longer term strategy and business plan has hitherto been supervised by the Business Strategy Committee established as a sub-committee of the Trust Board. This Committee was also used as the vehicle for developing the 2005/06 PSP with the local PCTs and the SHA..

Following the trust's expression of interest in becoming a Foundation Trust in wave 3A, this committee has been superseded by a shadow FT Project Board. The membership of this comprises the chairman and vice-chairman of the Trust, the Chief Executive, Finance Director and Director of HR/Corporate Affairs.

Consistency of the Trust's plans with the local health economy will be discussed with the PCTs and SHA at the Trust's regular meetings with the SHA Chief Executive and Finance Director.

7.2 MONITORING

7.2.1 Information

The Trust is in the process of designing reporting schedules which will improve its capacity to monitor implementation of the plan. Reports which integrate activity, workforce and financial information have been developed to assist in decision-making at divisional level.

Projects have already been established to develop the financial reporting regime and this will extend to the detailed reporting under PbR. The Finance Department has recently been restructured to strengthen its capacity in respect of NHS income reporting and cash flow management.

7.2.2 Performance Management

Internal performance management at an executive level is via a weekly Executive Team meeting and a formal monthly meeting of the Management Board. The monthly reports are scrutinised by the Finance & Performance Committee which is a sub-committee of the Trust Board. The Trust Board receives the reports every other month along with the notes of the discussion at the FPC.

7.2.3 Review Meetings with the SHA

Regular meetings have been held during the development of the PSP. The future programme of review meetings will be integrated with the FT Diagnostic Programme.

7.2.4 The Role of the Board

The Trust has recently reviewed its decision-making structures to ensure that effective and appropriate mechanisms for scrutiny and performance management are in place. The Finance & Performance Committee will undertake detailed monitoring in-year of the PSP. Any remedial action required will be documented and monitored through the same process.

The Trust Board will be responsible for ensuring the alignment of the strategic service plan and PSP, and the economic value and affordability of further investment in the Trust's facilities.