Strategic Plan Document for 2013-14

Warrington and Halton Hospitals NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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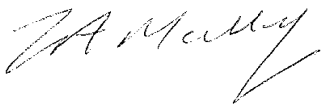

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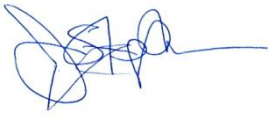

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Executive Summary

The **2013 to 2016 strategy** set the Trust's priorities and provides a framework for assessing the relative merits of service development and improvement opportunities. Based on feedback from governors, members, patients and the public, we have developed a vision and strategic priorities that we want to deliver over the next three years.

Nationally, it remains a challenging agenda for the NHS in difficult economic times with a number of policy developments that have impacted on the shape of the health service. The main impacts being:

- Greater emphasis on quality, safety, governance and risk following the Francis Enquiry.
- A shift in performance management to patient experience and outcomes.
- Moving care closer to home and away from acute settings.
- Financial pressures in the system (national and local)
- The reconfigured commissioning landscape.
- An Increased number of providers and therefore greater competition.
- A continuation to drive savings out of the system.
- Increased patient voice and choice.
- Population growth and an ageing population.

Notwithstanding these challenges, our local focus is very much on safety, quality and continual improvement to services to continue to achieve the delivery of **'High Quality, Safe, Healthcare'.** .

The overarching **Strategic priority** is to restructure the Trust's delivery of healthcare which will be delivered through three reform priorities.

Reform of Emergency Care	Reform of Elective Care	Development of Community Based Care
To support the reconfiguration of services and the management of non-elective demand, a whole system basis approach is being taken to transformation. This will provide enhanced assessment systems and rapid intervention to provide alternatives to hospital admission and reduced length of stay (LOS).	*To support the reconfiguration of services and the management of elective demand, a whole system basis approach is being taken to transform services. The Trust will increase the utilisation of the Halton Hospital Campus for elective care which will release capacity on the Warrington site for the management of non-elective activity providing an opportunity to increase elective capacity and income growth from peripheral areas.*	*As part of the Trust's growth strategy; we will develop full pathway care to facilitate the active management of demand by maintaining patients in the community. This will cover outreach services for long term conditions, frail elderly, out patients based services, dementia and accelerated discharge.*

The delivery of the strategic priorities will be achieved through:-

- ***The Trust will*** become the primary provider for services to the frail elderly through the development of primary care led step-up / step-down facilities on the Warrington site.
- ***The Trust will*** become the primary spinal provider to the peripheral areas across Cheshire to the Shropshire boarders.
- ***The Trust will*** build its elective orthopaedic market expanding into peripheral areas.
- ***The Trust will*** work with partner organisations on joint sustainability initiatives (Countess of Chester NHS Foundation Trust; St Helens and Knowsley Hospitals NHS Trust).
- ***The Trust will*** develop integrated care solutions with Bridgewater Community NHS Trust.
- ***The Trust will*** work with commissioners and partners to redesign of urgent care delivery.
- ***The Trust will*** continue to embed the 'Quality Improvement and Patient Safety Strategy' which underpins the Trust's strategic objectives and draws together the initiatives to deliver a clear plan of how the Trust will provide excellence in the quality of our patient care.
- ***The Trust will*** work with Clinical Commissioners to deliver the reform agenda and their commissioning intentions.
- ***The Trust will*** maintain financial stability, and support service improvement from capital and revenue investments from resources generated from service development, productivity and efficiency gains.
- ***The Trust will*** implement phase 1 of the Estate Strategy for rationalisation and optimisation of non-clinical buildings and those with higher levels of backlog maintenance. This will include migration of secondary care services to community facilities**.**
- ***The Trust will*** commit to developing Service Line Management to ensure that the Trust fully understands its performance, and organises its services in a way that engages clinicians and puts them at the forefront of improving the experience and outcomes for patients, improved care for patients and maximises productivity and efficiency of their services.
- ***The Trust will*** implement the IM&T Strategy through the development of the tools, systems and culture we need to deliver and allow the Trust to meet the twin national challenge of providing information to our patients by 2015 and moving to paperless by 2018.

Summary of key financial data

In 2012/13, the Trust delivered an underlying surplus of £980k (£1,109k deficit including restructuring and impairment cost) and achieved the planned Financial Risk Rating of 3 and liquidity rating of 4. For elective (5.9%) and out-patient (1.5%) activity the Trust performed above plan with a marginal underperformance for Emergency activity (-0.9%).

The overarching financial strategy is to support the strategic priorities and maintain a financial risk rating of 3 (applying the current risk rating criteria) over the planning period. The financial strategy builds on our 2012/13 performance, reflects the commissioned services signed up to in contracts and addresses the anticipated efficiency challenge. An annual surplus of £1.2m (£0.9m underlying after excluding £0.6m non-recurrent restructuring costs and £0.9m income associated with donations and grants) will be achieved in 2013/14 and an underlying surplus will be maintained over the planning period. The capital investment plan provided is risk prioritised and set at a level which provides some headroom and improvement in liquidity over the planning period. The Trust has no planned capital borrowing going forward which provides further flexibility and opportunity for securing additional resources to support strategic change, including the implementation of the Estates and I&MT strategies. At this stage no borrowing requirement has been identified as required to deliver the three year plan presented**.** This may change as the detailed business cases for these strategies' are developed. Where it represents value for money, the Trust will seek private sector investment.

Section 1 - Approach to the Delivery of High Quality Safe Healthcare

The business strategy articulates how the Trust is progressing on the achievement of its vision of delivering '**High Quality, Safe, Healthcare'**, taking into account the pressures and opportunities within the healthcare sector. The Trust has launched a framework for the next 5 years that will enable the delivery of the challenges and opportunities in a sustained and uniform manner. This approach is 'Quality, People Sustainability' (QPS) and allows staff to focus on what is expected in order to deliver the best possible outcomes across those 3 critically important areas. QPS was launched in April 2012 this framework will be the golden thread throughout the Annual Plan and this is the key enabler to support of the reform of the organisational culture.

High Quality, Safe Healthcare Quality	EXCELLENCE FOR OUR PATIENTS	High Quality, Safe Healthcare People	CARING FOR OUR STAFF	High Quality, Safe Healthcare Sustainability	HERE FOR OUR COMMUNITIES
EFFECTIVENESS	-Reducing Harm -No Avoidable Deaths -Managing Risk	WORKFORCE	-Competency -The Right Numbers -European Working Time Directive Compliant -Modernising Medical Careers -'Fit' to work -Terms and Conditions	GOOD GOVERNANCE	-Compliance and Regulation -Board Assurance -Board Effectiveness -Governors and members
SAFETY	-Improving Outcomes -Evidence Based -Research, Development, Audit, Innovation -Right Care, Right Place, Right Time	ENGAGEMENT	-Communication -Accountability -Employer of Choice -Loyalty and Discretionary Effort -Values and Behaviours	FINANCIAL VIABILITY	-QIPP -Contracting / Service Line Management -Reconfigurations and Collaborations -Estate Utilisation -Information Technology
EXPERIENCE	-Customer Care/ Personalisation -No Decision About Me, Without Me -Access -'The Basics' (warm, safe, clean, fed, cared for).	LEADERSHIP	-Talent Management -Leadership Development -Education, Training and Development	PROFILE AND PERCEPTIONS	-Good Corporate Citizen -Marketing -Commercial Development -Growth and Expansion -Diversification -Charitable Funds

Delivery of the vision will be achieved through the Trust's Strategic Priorities. The Trust's overarching strategic priority is to restructure the delivery of healthcare, through:- Reform of Emergency Care; Reform of Elective Care and Develop Delivery of Community Based Care. To achieve the restructuring of the healthcare delivery the Trust's infrastructure and sustainability priorities will be to explore strategic partnerships and acquisitions, maintain productivity and sustainability, implement estates and IM&T strategies.

Section 2 - Strategic Context and Direction

The strategic context reflects the challenges posed by the complex **commissioner and competitor landscape** that the Trust operates within.

Commissioner Landscape

The Trust is located on two hospital sites across two health economies as the main provider to two Clinical Commissioning Groups (CCGs) in Warrington and Halton. Service provision is being reviewed in partnership with the commissioners to meet the differing needs of their local populations, as profiled below:-

ONS =Office for National Statistics Representing		Warrington CCG	Halton CCG
		26 GP Practices; Population size 202,700	17 GP Practices; Population size 125,700
Activity Profile per 1000 pop	*Outpatient*	✓Low 148 (179 ONS Cluster, national 188) Outpatients appointments	✗high 193 (179 ONS Cluster, national 188) Outpatients appointments
	Elective Admissions	✓Below average 109 (116 ONS Cluster, national 123)	✓Average 132 (133 ONS Cluster, national 123)
	Urgent Activity	✗High 133 (100 ONS Cluster, national 123) non-elective admissions	✗High 154 (100 ONS Cluster, national 123) non-elective admissions
Health Outcomes	*High Prevalence*	Coronary Heart Disease, Dementia, Depression, Chronic Kidney Disease	Coronary Heart and Chronic Obstructive Pulmonary Disease (COPD), Diabetes
	Poor Outcomes	Under 75 mortality from cancer and cardiovascular disease Emergency admissions of alcohol related liver disease Unplanned hospitalisation	Under 75 mortality from cancer, respiratory and cardiovascular disease Emergency admissions ambulatory sensitive conditions Unplanned hospitalisation
Demo-graphics	*Population Projections*	Average growth 1% p.a. (twice the rate in the North West).	Average growth 0.3% p.a.
	Ethnicity	6.9% belong to an ethnic minority group (11.6% North West)	2.5% belong to an ethnic minority group (11.6% North West)
	Deprivation	47th Worst out of 325 Local Authorities, scores have remained stable	27th Worst out of 325 Local Authorities, scores have remained stable
Commissioning Intentions	*Commissioning Plan*	10 programmes including: planned care, acute children's, long term conditions and frail elderly.	Integrated commissioning strategy including integrated partnership working, and an increased focus on dementia services.
	Particular initiatives which may impact on or provide opportunity to the Trust	The redesign of urgent care model (to reduce admissions), pre-operative assessments in the community and integrated children's services. Introduction of integrated neighbourhood teams. Geriatrician led care home support.	Review of provision: urgent care (at Halton) pathology; musculoskeletal; maternity service review; primary eye care and assessment; orthoptic delivery in schools and community based provision including ENT assessment, gynaecology, and DVT. Review of AQP for termination of pregnancy. Pathway redesign including COPD and diabetes, community MDT redesign

Provider Market

The Trust is in an increasingly competitive market being situated close to a number of major population centres such as Liverpool, Salford, Chester and Manchester each served by at least one local acute provider. There are numerous hospital providers serving populations of c300k with a turnover of £200-300m. Reference costs are relatively low on the patch (at or below 100). The Trust therefore has a number of potential competitors within the vicinity that could impact on its traditional activity base.

The Trust's **key competitors** in the locality for current and planned business are:

Main Competitor(s)

Reference Cost Index (RCI)

St Helens and Knowsley NHS Trust – *(Turnover £237m, RCI 103, Population 350k, beds c700)*

Whiston Hospital offers acute care with St Helens providing some day case, outpatient and intermediate care. The trust is looking to secure additional market share to ensure the longer term viability of its PFI developments. A number of partnership projects have taken place between the Warrington and Halton NHS FT and this hospital e.g. pathology, stroke services.

Bridgewater Community Healthcare NHS Trust – Provide a full range of community based services including; healthcare maintenance, therapy, rehabilitation and public health services. Some impact particularly in relation to services which have community involvement from the Trust e.g. Sexual health, community rehab models etc.

Cheshire

Countess of Chester NHS Foundation Trust - A medium sized district general hospital *(turnover £171m, RCI 95, Population 445k, beds 600)* with a catchment area that competes along the M56 corridor. The hospital is partnering services with Wirral Hospitals NHS FT. Located on the English/Welsh boarder the Trust is subject to activity risks due to repatriation to Wales.

Mid-Cheshire Hospitals NHS Foundation Trust- A medium sized district general hospital with a catchment area that borders the local catchment area.

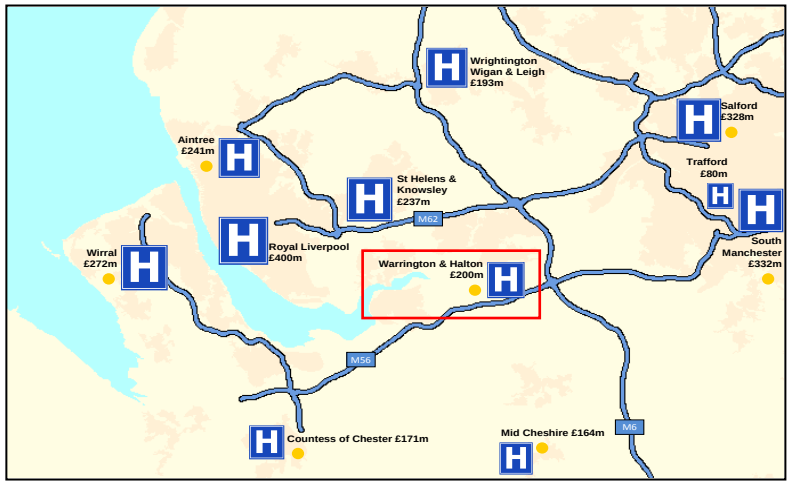
Spire - Stretton

Independent Hospital based in Warrington with commissioned capacity from the Trust's main commissioners. The Trust utilises additional capacity as a contingency.

Manchester

Wigan Wrightington and Leigh NHS Foundation Trust *(turnover £193m, RCI 102, beds 758)* - The main acute site is based in Wigan with a specialist orthopaedic centre based in Wrightington Competes with the Trust for market share to the north of Warrington in (Newton, Golbourne, Lowton and Culcheth).

Salford Royal NHS Foundation Trust - Large teaching hospital with full range of secondary care, plus tertiary services. Neurological long term care facility. Competes with the Trust for market share along M62 corridor to the East of the M6



Liverpool

Aintree Hospitals NHS Foundation Trust *(turnover £241m, RCI 102, Population 330k, beds 712)* - University Teaching Hospital with full range of secondary and some tertiary services. Regional centre for Head and Neck centre. This trust represents a greater direct threat to St Helens and Knowsley and Royal Liverpool.

Royal Liverpool and Broadgreen University Hospitals NHS Trust *(turnover £400m, RCI 102, beds 780)* - University Teaching Hospital which provides a full range of secondary and tertiary services.

Royal Liverpool Children's Hospital NHS Foundation Trust (Specialist) Main centre for children's services within Liverpool. The trust has a very strong brand identity across Cheshire and Merseyside and competes across all areas of paediatric care.

Liverpool Heart and Lung NHS Foundation Trust Chest - Specialist centre for heart surgery in Cheshire and Merseyside. The commissioning intentions to repatriation of Elective PCI work has led to a competitive response.

Walton Centre for NHS Foundation Trust - Specialist centre for neurological conditions in Cheshire and Merseyside. Marginal impact with some DGH work being referred.

Clatterbridge Centre for Oncology NHS Foundation Trust - Specialist centre for cancer services in Cheshire and Merseyside. Marginal impact with some DGH work being referred to the specialist unit.

Market analysis

Analysis of the profile of activity highlights the opportunities available to increase market share or capitalise on alternative income streams.

Planned Admissions

- 4 year planned admission trend growth; Royal Liverpool 46.5% , Wrightington, Wigan and Leigh FT (WWL) 41.8%, Countess of Chester 33%, St Helens 6%
- The 2 dominant providers are Royal Liverpool Trust 21.7% and WWL 19.4% market share.
  - WHHFT 8.3%
  - St Helens 4.5%, Countess of Chester 11.9%. St Helens appear to be focusing on acute service delivery with Countess and WHHFT spreading evenly across acute and elective inpatient activity.
- Private provider growth in NHS activity Spire Liverpool 3277 admissions and Spire Cheshire 1789.

WHHFT have double the activity of St Helens representing an opportunity but also a threat from WWL and Royal Liverpool.

Finished Consultant Episodes (FCE)

- 4 year FCE trend
  - WHHFT achieved a 2% growth.
  - St Helens Trust achieved 2% growth.
  - Countess of Chester has had significant growth at 11%.
- No one provider dominates the FCE market share, most providers have 10-15% share (WHHFT 10.9%) with turnover between £200m to £250m (excludes specialist trusts)
- All providers provide a full range of DGH services

Opportunity for rationalisation due to service duplication.

Emergency Admissions

- 4 year market emergency admission trend has been a reduction in admissions.
  - WHHFT has experienced a rise of 3%.
  - Mid Cheshire experienced an 18% reduction.
- Emergency admission market share:
  - WHHFT 12.5%,
  - St Helens Trust 14.89%, Countess of Chester 9.3%, Royal Liverpool 12.1%.
- No one organisation is dominating the market.
- It is an expensive model of delivery and difficult to deliver 7 day working.

Extend collaborative working

Length of Stay (LOS) not case mix adjusted

- LOS ranges from 1.8 to 2.6 days. WHHFT LOS is 2.1 days, St Helens c2.2 days. *WHHFT is in line with competitors.*
- 4 year trend in LOS
  - The largest reductions at Royal Liverpool and WWL. This may be due to the reduction in emergency admissions and increase in planned.
- WHHFT has reduced LOS by 0.1 day over the period compared to 0.2 days in St Helens and 0 days in Chester.

Explore opportunities to reduce LOS further.

Day Cases

- 4 year trend in day case growth:
  - WHHFT 6.2%
  - Royal Liverpool 23.5%, Countess of Chester 18.6%, St Helens 26.2%.
- Day case market share:
  - WHHFT 10.3%
  - Royal Liverpool, WWL, Wirral have the highest shares equalling 41% in total, St Helens 10.5%.

Market opportunity for WHHFT to grow day case activity.

A&E

- 4 year market growth WHHFT 9%, St Helens 12%, no other organisations had significant growth.
- A&E is evenly spread across the providers with St Helens the highest at 15% and WHHFT at 13%.

There is opportunity to work with commissioners on integrated pathways and alternatives to A&E.

Out Patients (New)

- Royal Liverpool has a 18.8% market share (due to tertiary services)
- WHHFT, St Helens and Countess have c10.5% market shares.
- Over the last 3 years Outpatient attendances has declined by 01.6% in Royal Liverpool. Significant increases in St Helens 5.4% and in Chester and WWL.

There is opportunity for WHHFT to increase market share through developing relationships with GPs and CCGs in addition to increasing market footprint across the current boundaries.

Out Patients (Follow-up)

- Royal Liverpool has c20% market share of follow-up attendances. St Helens has 10.9% share and WHHFT 11.3%.
- Over the last 3 years St Helens (10%) and Chester (19%) have experienced growth in follow up in line with new attendances.
- WHHFT (5%) and Royal Liverpool (8%) have reduced follow-up attendances.

Commissioning intentions require reduction in follow-up rates which provides opportunity to increase new attendances through increased capacity and reduced waiting times.

The commissioning landscape and provider market assessment has identified:-

Commissioners

- The need for the Trust to work with the CCG's to deliver the reform agenda and respond to their commissioning intentions and local population needs.
- The need to review the provision and location of services and pathways in response to the disease prevalence and differing local population needs across the two CCG's. Develop services to meet the longer term growth in the Warrington population.
- A requirement to reform the provision of urgent care in response to high local demands.
- The opportunity to maximise the promotion of self-funded activity covering procedures no longer commissioned by the NHS e.g. varicose veins.

Competitors

- There are strong drivers for collaboration recognising that the health economy is relatively efficient and generally at or below reference cost index; all of the trusts are in close proximity servicing similar population numbers with a full range of DGH activities.
- The timescales for the foundation trust programme in respect of both St Helens and Knowsley Hospital NHS Trust and Bridgewater Community NHS Trust will impact on any collaborative working.
- There are market opportunities around our key catchment areas such as the Vale Royal area through expanding the range of services provided out of the Halton site (including the newly acquired Cheshire and Mersey Treatment Centre (CMTC) musculoskeletal facility) and increasing competition with the Countess of Chester Hospital.
- As a key influencer of choice, GPs will need to be fully aware of our services as well to maximise these opportunities. "Choice" decisions are widely influenced by the GP and personal/family experience but location remains the key personal determinant of choice. Clear information on reputation, quality and waiting times is increasingly important for potential patients.
- There is opportunity to increase the efficiency of service provision in terms of reduced length of stay and reduced new to follow-up rates which provides capacity and market opportunity.

The strategic context and direction has informed the Trust's strategic priorities and Clinical Strategy as summarised in **Sections 3 and 4**.

Section 3 – Strategic Priorities

The overarching **Strategic priority** is to restructure the Trust's delivery of healthcare which will be delivered through:-

- **Reform of Emergency Care**
- **Reform of Elective Care**
- **Develop Delivery of Community Based Care**

Strategic Priorities – Restructuring the Delivery of Healthcare

	Reform of Emergency Care	Reform of Elective Care	Develop Community Based Care	
Rationale	*To support the reconfiguration of services and the management of non-elective demand, a whole system basis approach is being taken to transform services. This will provide enhanced assessment systems and rapid intervention to provide alternatives to hospital admission and reduced length of stay (LOS).*	*To support the reconfiguration of services and the management of elective demand, a whole system basis approach is being taken to transform services. The Trust will increase the utilisation of the Halton Hospital Campus for elective care which will release capacity on the Warrington site for the management of non-elective activity providing an opportunity to increase elective capacity and income growth from peripheral areas.*	*As part of the Trust's growth strategy; we will develop full pathway care to facilitate the active management of demand by maintaining patients in the community. This will cover outreach services for long term conditions, frail elderly, out patients based services, dementia and accelerated discharge.*	Rationale
Key Initiatives	▪ Manage the impact of the 111 service (anticipated growth in AE attendances). -Further implementation of the Acute Medical Unit (AMU) scheme. -Continued appointment of the acute physicians ▪Review of the clinical model (2014/15). ▪Combine minor injuries and GP front end into a new location. ▪Implementation of the A&E transformation project. ▪Consolidation of complex discharge processes (task team, integrated discharge team, rapid response). ▪Implementing urgent care at Halton. ▪Complete award refurbishment (dementia ward). ▪Respond to Halton CCG's obstetrics and gynaecology commissioning intentions.	▪Repatriation of Percutaneous Cardiac Intervention (PCI). ▪Further transfer of elective work to Halton. ▪Collaboration for rotas over larger footprint e.g. Ophthalmology, Urology. ▪Review viability of JAG accreditation for Halton site. ▪Review outpatient clinics, increase provision at Halton. ▪Transfer of light orthopaedic trauma to CMTC. ▪Delivery of CMTC Orthopaedic business case. ▪Establish future strategy for oral surgery and maxillofacial. ▪Transfer out of vascular activity as part of the regional solution.	▪Joint working with Bridgewater Community Healthcare NHS Trust including:- ▪Integration of GUM and Sexual Health services in the community. ▪Appoint a Joint 'Head of Integrated Care'' ▪Support admission avoidance programmes:- -Case management e.g. frail complex elderly. -Management and maintenance of long term conditions neighbourhood schemes. -Roll out of the nursing home support initiative ▪Introduction of the: -Dementia Strategy. -End of Life Strategy. ▪Review and implementation of Children's services in the community. ▪Management of readmissions including a telephone follow-up service.	Key Initiatives

To achieve the restructuring of the healthcare delivery the Trust's **infrastructure and sustainability priorities** will be to:-

	Productivity and Sustainability	Strategic Partnerships & Acquisitions	Developing an Estates Strategy	IM&T Infrastructure	
Rational	*Maintain financial stability, and generate investment potential through productivity and efficiency gains. Increase market share through the development of the Trust's reputation to deliver 'High Quality Safe Healthcare'.*	*Explore strategic partnerships and acquisitions to ensure successful delivery of the Quality, Innovation, Productivity and Prevention (QIPP) agenda.*	*Development of an Estates Strategy to achieve the strategic priorities. This will support the sustainability agenda, through rationalisation and partnership working.*	*Establish a robust IM&T infrastructure to increase clinical efficiency and effectiveness.*	Rational
Key Initiatives	▪Financial stability. ▪Service Line management development supported by Patient level costing. ▪Marketing Strategy and Growth initiative:- increase including opportunity for community service contracts over the planning period. ▪Efficiency and productivity opportunities. ▪Review of Facilities Management Services including Catering. ▪Energy efficiency and carbon reduction strategy.	▪Work in collaboration with local partners and commissioners to identify productivity gains. ▪Explore formal partnership arrangements with:- - St Helens and Knowsley Hospital NHS Trust - Countess of Chester Hospital NHS Foundation Trust - Bridgewater Community Healthcare NHS Trust ▪Partnership for the delivery of :- -Pathology Services. -Integrated sexual health services. -Cardiology PCI. -Vascular pathways. -Trauma network solutions. -ENT - on-call partnership across Cheshire.	▪Implementation of Phase 1 Estate Strategy. Estate rationalisation and optimisation of non-clinical buildings and those with higher levels of backlog maintenance. -Reduce total operating expenditure of the facilities management services. -Provide low cost non clinical accommodation. Maximising the ratio of clinical to non- clinical accommodation. -Maximise estate utilisation. -Reduce backlog maintenance. -Release surplus land. -Maximise the utilisation of community facilities. -Maximise the contribution of the CMTC building. ▪The Phase 1 strategy will provide the platform for the on-going estate development in years 2 and 3.	▪IM&T Strategic Direction – review of configuration of IM&T services: -Connecting people with information as we move from PCs to Tablets. -Move to paperless by implementing an EPR to replacing paper with electronic notes to support quality care -Consolidate down and optimise our current systems with new ways of working and investing benefits to reduce our costs. -Introduction of a clinical portal (overview screen to consolidate medical results). -Re-procure Patient Administration System -Re-procure Picture Archiving Communication (PACS) and radiology Information System	Key Initiatives

Section 4 - Clinical Strategy

The delivery of the Strategic Priorities: Reform of Emergency Care, Reform of Elective Care and Development of Community Based Care, outlined in Section 3 are supported by the Trust's clinical strategy plans. A review of the Trust's **Clinical Strategy** is being completed focusing on: local Specialty Based Service Developments and external Health Economy Collaborations with Partners key new developments include:-

Specialty Based Review

- *Becoming the primary provider of services for the frail elderly population.*
- *Becoming the specialist provider of urgent care at Halton.*
- *Becoming the primary provider of specialist spinal services to an extended catchment through Cheshire to Shropshire.*
- *Expansion of elective orthopaedic service provision.*
- *Service line management implementation*
- *Clinical sustainability assessment incorporating Service Line reviews.*
- *Market assessment*
- *Migration of secondary care services to community facilities including:- Sexual Health; Breast Screening; Paediatrics; Ophthalmology*

Health Economy Collaborations with Partners

- *A review of the sustainable configuration of services through the health economy 'Clinical Summit'.*
- *Support the high level review of the configuration of acute services, as part of the commissioner led Merseyside Collaborative.*
- *Completion of joint sustainability programme development with:-*
  - *The Countess of Chester NHS Foundation Trust including the transfer out of Vascular Services.*
  - *St Helens and Knowsley Hospitals NHS Trust on Pathology provision.*
- *Development of service integration plans with Bridgewater Community Healthcare Trust.*
- *Development of primary care led step-up / step-down facilities on the Warrington site.*
- *Redefine emergency care emphasis from front end GP provision to primary ambulatory care site (ward A1).*

Clinical workforce redesign solutions have been developed for the Acute Medical Unit, Surgical Assessment Unit and the redesign of hospital 24:7. Clinical sustainability will be maintained through a range of specialty level actions.

The Trust is facing a number of clinical workforce pressures:

Key workforce pressures	Mitigation / Actions
•Significant shortage of junior doctors including A&E, surgery and Trauma and Orthopaedic. Availability of acute physicians (new specialty)	Appointment of Trust grade doctors, increased reliance of middle grades.
•Working time and out of hours cover compliance. Including Labour ward cover 60hour increasing to 96 hour. Impact on service provision of the transfer of Vascular services.	Expansion of hospital out of hours and critical care outreach nursing to deliver clinical care.
•Compliance with the national 'Carter Review' for pathology services.	Collaborative working with St Helens and Knowsley Hospitals NHS Trust and Countess of Chester hospital e.g. pathology, ENT, Thrombolysis, urology.
•Sustainability of small specialties	

Clinical Leadership, Development and Engagement

As part of the Strategic Change programme the Trust has committed to developing **Service Line Management (SLM)** to ensure that the Trust fully understands its performance, and organises its services in a way that engages clinicians and puts them at the forefront of improving the experience and outcomes for patients, improved care for patients and maximises productivity and efficiency of their services.

To support this work, the Trust has joined the McKinsey Hospital Institute in their Accelerated Service Line Management Programme so that it can benefit from the professional input provided by McKinsey consultants and the peer learning with the participant trusts.

A structured approach over the next 3 years will be used to achieve the implementation of SLM. Leading the roll out is the Medical Director, and Director of Finance.

Workforce Planning

The overarching workforce strategy is supported by a range of redesign initiatives to ensure on-going sustainability, quality and service delivery.

Over the life of the plan the Trust will utilise a programme of '**Competency Based Workforce Planning'**(CBWP) a 'bottom up' activity which will enable the Trust to plan for the job roles required, and can afford, in order to meet the needs of their patients. It is a technique that uses competencies along with locally collected data about the amount of time undertaken by staff in different areas of competence to generate a model of the required workforce to deliver the required service. Cost efficiencies should be generated as a result of implementation of workforce skill mix, whilst maintaining patient contact time and quality standards.

Year 1 (2013/14)

- Increase divisional business unit accountability.
- Implement Structure Changes:-
  - *Create a single line of accountability - Divisional Medical Director (DMD).*
  - *Recruit DMD's*
  - *Establish divisional triumvirate (DMD, General Manager, Head of Nursing)*
  - *Develop / Train leadership teams*
- Revise meeting structure to drive divisional expectations:-
  - *Introduce monthly Executive: Divisional Business Unit meetings.*
  - *Development of KPI dashboards*

Year 2 (2014/15)

- Extend development
- Increased specialty level service line management

Year 3 (2015/16)

- Through performance delivery the development of autonomous divisional business units.

Clinical participation and leadership*: an assessment of our current state; exposure for our clinicians and managers to organisations that have successfully introduced and embedded SLM.*

People*: a review of the likely candidates for key positions in the new structure; what are we looking for in these individuals as SLM will be a new way of working; gap analysis that will identify strengths and weaknesses in the current team; proposals for how we close that gap (in the current team, and to ensure that we 'grow our own', and can attract the best to the positions).*

Governance*: Clear roles and responsibilities and decision making processes.*

Planning*: clear operational, budget, CIP and activity plans agreed.*

Structure: *of service lines and directorates*

Performance Management*: compliance against regulator, national, commissioner and financial targets.*

Engagement*: a communication programme to ensure that all key stakeholders are identified and served.*

Section 5 - Clinical Quality

The Trust has formally adopted the **Quality Improvement and Patient Safety Strategy** and the **Patient Experience Strategy** to ensure that it has an established mechanism to develop quality and safety initiatives across the organisation and that there is clear performance monitoring reported on patient safety, effectiveness of clinical services and the patient experience.

Quality is a core and standing item of each Trust Board agenda and it receive a monthly report on the performance of a range of safety, effectiveness and experience measurements in the Quality Dashboard. The Trust Board are able to see the progress made against improvements to quality, safety and experience and use information gathered from other sources (e.g. risk register and safety walkabouts) to triangulate the information that is presented .

To deliver on the quality and patient safety initiatives, the Trust has a series of multi-professional quality improvement groups. These lead the different changes to practice as well as developing appropriate measurement tools. Wherever possible, measurement tools are based on nationally agreed metrics in order to benchmark Trust practice against that of the wider health community. This is further supported by the Trust's action plans in response to national enquiries such as Francis to ensure robust maintenance and delivery of services and quality.

The Trust's '**Quality Improvement and Patient Safety Strategy'** underpins the Trust's strategic objectives and draws together the initiatives to deliver a clear plan of how the Trust will provide excellence in the quality of our patient care. It sets out the Trust's quality priorities to guide our strategies and plans and ensures a coherent approach and sets standards, for assuring and continuously improving the quality of our services and patient experience. The strategy:-

-Clearly sets out our quality and safety priorities to guide our plans.

-Ensures a coherent approach to setting priorities for continuously improving the quality of all our clinical services, for patients, staff and families.

-Sets out how we will measure our quality and patient safety performance to support quality assurance and improvement.

-Supports the delivery of national priorities and commissioner requirements for the provision of quality healthcare

-Provides a framework to both support and motivate our staff to deliver the highest possible quality care providing staff with an environment where the pursuit of continuous quality improvement is both encouraged and required.

-Complements our existing clinical governance arrangements in the Quality and Clinical Governance Sub Committee work plan and patient safety work via the Leading Improvement in Patient Safety (LIPS) project and ensuring that quality is our underpinning principle.

The Trust defines quality as safe, effective care that provides the best patient experience. Our patients can expect that:

SAFE	Care that is intended to help is free from avoidable harm .
EFFECTIVE	Care is evidence based care that supports and encourages recovery and ensures the best possible patient outcomes and experience.
EXPERIENCE	Care provides patients with the most positive experience possible, i.e. patient centred and provided in high quality, safe therapeutic environments

The Trust's Quality Improvement and Patient Safety Strategy build on these themes further and details the aspirations for Warrington and Halton Hospitals. The strategy is underpinned by the following strategies and frameworks: Nursing Strategy; patient experience strategy; risk management strategy; medical clinical governance framework; end of life strategy; delivering high quality care through high quality people strategy.

Key Initiatives

The Strategy is in the second year of a three year programme which will be reviewed annually to ensure the approach, direction, targets remain valid. Detailed action plans have been developed to underpin all elements of the Strategy which will be subject to regular monitoring and progress reporting. A biannual report will be presented to the Quality and Clinical Governance Sub Committee and an annual report to the Board of Directors, Council of Governors and other key partners to demonstrate progress and achievements.

The Trust is striving for year on year improvements to the quality of our clinical services, achieve better patient outcomes and improve the experience of care; furthermore to identify risks, reduce harm and reduce mortality. This will be achieved through the implementation of local, regional and national requirements including Commissioning for Quality and Innovation (CQUIN), responding to national enquiry requirements e.g. Francis and by having:-

SAFE CARE		EFFECTIVE CARE		PATIENT EXPERIENCE	
No avoidable deaths	-HSMR/ SHMI lower than 100. -Embed the Clinical Quality group work on reducing mortality.	Care Bundles	Effective Care will focus on three clinical conditions (that result in high patient numbers of admissions) and agree and implement best practice care bundles that support care and recovery, producing clinical guidelines linked to evidence based pathways. This targeted focus on high volume diagnosis supports the overall quality improvement in respect of readmissions and reducing mortality and morbidity. -Agree one high volume condition per division. -Agree and then implement best practice care. Continued implementation of national Dementia CQUIN: Dementia Screening; Dementia Risk Assessment; Referral for specialist diagnosis.	Excellence in Patient & Staff Experience	Promote a positive experience by providing high quality, safe therapeutic environments, maintaining compassionate and respectful care. Ensure easy access to care at the right time by: ▪Delivery of national targets for access. ▪Year on year improvement of patient survey responses to hospitals 'patients want to be treated by'. ▪Introduction of the friends and family test. •Year on year improvement of staff survey response to whether staff would recommend their hospital to patients. •Increased utilisation of patient stories. •Governors ward rounds. •Continued improvement on same sex accommodation. •Timely response to and learning
Reducing Harm	Implementation of the national CQUIN for the 'NHS Safety Thermometer (CQUIN) to achieve:- -Continued reduction in the number of hospital acquired grade 2, 3 & 4 pressure ulcers that are avoidable. -Continued reduction in the number of incidents causing severe or catastrophic harm. -Reduce the number of UTIs associated with indwelling catheters (within the hospital setting). -Reduce the number of VTE (hospital acquired). -Reduce the no. of medication errors associated with insulin and other diabetic medicines. -Prevent NPSA 'never events'.	Critical Care High Impact Innovations	High risk critical care has 95% compliance to the high Impact Interventions (best practice care bundles) supporting care and recovery in: -Ventilator bundle compliance -Urinary catheter insertion bundle compliance -Urinary catheter on-going care bundle compliance -Peripheral cannula insertion compliance -Peripheral cannula on going care bundle compliance -CVC insertion compliance bundle -CVC on-going bundle compliance		
		Deteriorating Patient	High Level Early Intervention for Deteriorating Patients -Compliance with colour coded Modified Early Warning System (MEWS) patient observations. -High level compliance of patients who have a MEWS score recorded twice as a minimum. -High level compliance of patients who had a MEWS score trigger and a timely action is documented. -High percentage of wards using SBAR (Situation Background Assessment Recommendation - recognised tool that improves communication between clinical staff) for deteriorating patients (requesting urgent clinical review).	Health Promotion	-Increasing patient's knowledge of local Public Health Issues through early intervention and awareness.

SAFE CARE		EFFECTIVE CARE		PATIENT EXPERIENCE	
Reducing Harm	-Continued reduction in relation to the number of Health Care Associated Infections (HCAI) (MRSA and clostridium difficile) in line with mandated targets. -In partnership with key stakeholders, to ensure sustained focus on embedding robust safeguarding arrangements for vulnerable adults and children. -High level compliance with the clinical nurse indicators (CNI) measuring quality and record keeping of essentials of nursing care. -Ensure discharge summaries to GPs provide good quality information and meet contractual obligations.	Readmissions	The Trust will reduce readmissions: - Monitor via the Quality and Clinical Governance Sub Committee the process of managing and monitoring compliance with all relevant NICE and NCEPOD guidance. - Review and act on all high level enquiries via the Quality and Clinical Governance Sub Committee.	Communication and Discharge	•Introduce 'always events' - what we must do to ensure the quality of care. •Improve the way in which we plan and prepare patients for a safe discharge from hospital: -Contact if patients had fears on leaving hospital. -Details on side effects of medications taken home. -Phone all patients following discharge. •Achieve an improvement in the priorities included within the Patient Experience Strategy (i.e. engagement and increasing the patient's voice in operating services).
		End of Life Care	The Trust will provide high level quality care at end of life via: - Compliance with 'Route to success in end of life care; achieving quality in Acute Hospitals', (National End of Life Care team). In addition compliance with the Quality Standards for End of Life Care for adults published by NICE November 2011 via the Trusts end of life care strategy.		
		Advancing Quality	- Ensure compliance with targets set for Advancing Quality compliance with best practice for patients with the following conditions: Acute Myocardial Infarction (AMI);Hip and knee replacement; Stroke; Heart failure; Pneumonia.		

To enable the Trust to meet these commitments we will have in place clear structures and processes at all levels of the organisation.

Key Risks To Delivery of the Quality Strategy	Mitigation
-Operational pressures and capacity of the workforce to implement and maintain the changes required.	-Through the integration of effective reporting structures from within divisions through to the Quality and Clinical Sub Committee to the Governance Committee and onto the Trust Board.
-Failure to reduce the level of harm events.	-By clearly defining at every level within the organisation, individual objectives, responsibilities and accountabilities for Quality Improvement and Patient Safety management by including them within personal development plans. By providing relevant training at all levels as an integral element of the Trust's training and development plans.
-Failure to provide a robust response to the Francis action plans.	-By empowering all staff to report risk and to register their concerns about unsafe practice through an open and fair culture supported by effective Human Resources and Risk Management policies and procedures.
-Failure to maintain the required momentum for the delivery of the plans.	-Introduction of a new senior nursing structure.
-Delivery challenge of Clinical Commissioning of quality indicators.	-Detailed action planning to respond to initiatives.
	-By providing the necessary leadership development throughout the organisation as part of the Delivering High Quality Care through High Quality People (Human Resources and Organisational Development Strategy 2008 – 2013) to empower and enable staff to play their part in realising QPS.

Section 6 - Productivity and Efficiency

The Trust has developed a 1-3 year Cost Improvement Plan (CIP) that is based on the following principles.

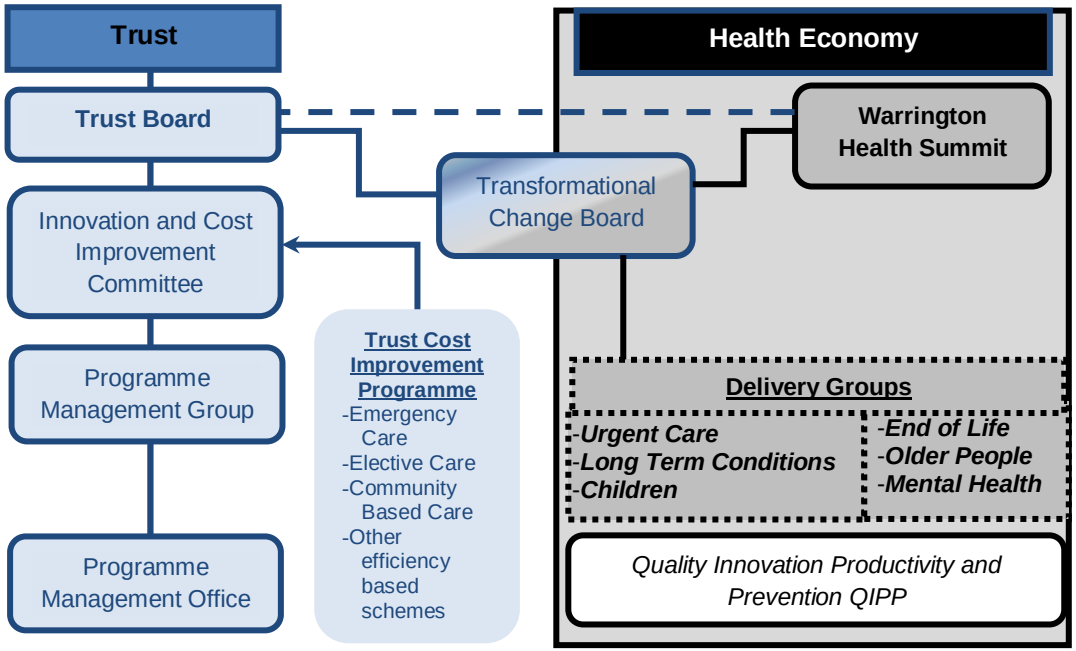
- The delivery of a minimum of £9m per annum.
- It links directly to and supports delivery of the Annual Plan targets (3 years).
- The CIP programme is linked directly to both supporting and enabling the Trust's Strategic Objectives and is therefore built as an integral part of the major transformation plan.
- Clinical and managerial partnership is integral to the delivery of the plan through the operation of the Innovation and Cost Improvement Committee (ICIC) which reports directly to the Trust Board and has executive, non-executive, clinical and operational management membership.
- The links between 'savings' and 'investment' is transparent and demonstrable.
- Programme management principles and resources have been established to support delivery, and to improve Trust performance and line accountability. The Trust have introduced a Programme Management Office (PMO) to support the delivery and monitoring of the CIP.
- Benchmarking of schemes against other NHS organisations to determine additional opportunities including review of Audit Commission reports and reviews with other trusts e.g. 'Delivering a Substantive Cost Improvement Programme' – Audit Commission and Monitor 2012; 'Back Office Functions Benchmarking' - NHSNW Consortia.

<u>Governance Arrangements</u>

Trust specific and health economy wide schemes have been developed to achieve the delivery of a sustainable CIP programme. The figure opposite summarises the governance arrangements. The Trust's Chief Executive established the Transformational Change Board to operationalize the implementation of the change programmes.

In terms of the health economy arrangements, key parties (clinical and managerial) from across the acute, community, mental health, social care and commissioning organisations are working in partnership to deliver an integrated 'Quality, Innovation, Productivity, and Prevention (QIPP) programme, the overall objective being to ensure we are getting patient care right first time, meaning better care and better value through the reduction of waste and errors and the prioritisation of effective treatments.

The **Health Summit** objective is to prioritise and agree a programme of top work streams supported by detailed action focused plans which organisations can be measured against and held accountable by other Summit members for. These will be agreed on a collaborative basis to: Understand the collective financial situation



for Warrington and Halton's health and social care economy and to address the issue on a sustainable basis; and collate & scrutinise activity and performance data across the economy to implement shifts in activity to maintain high quality, effective and affordable services.
The **Transformational Change Board** objective is to provide operational and clinical leadership and support to the delivery groups. This board operationalises implementation plans and will further assess the impact of proposed changes to services or systems on patient care, policies, practices and staff resources before such changes are implemented. Members of the Transformational Change Board are responsible for ensuring that planned changes are communicated widely across all participating organisations, agencies and stakeholder groups. Clinicians are responsible for leading and gaining wider clinical engagement in the changes thereby ensuring patient/user focus remains at the centre of planning and decision making. Successful transformation delivery during 2012/13 has included the Cheshire and Mersey Treatment Centre (CMTC), Medical Assessment Unit (MAU), Surgical Assessment Unit (SAU) and GP front end, these will support and yield longer term efficiency savings

Warrington and Halton Hospitals NHS FT **Trust Board** retains accountability for the delivery of the Trust's CIP plans. The key monitoring of the CIP programme development and delivery is delegated to the **Innovation and Cost Improvement Committee (ICIC).** This is a Committee meets monthly with representation from the executive team, non-executives, operational teams, and Programme Management Group members. The key objectives of the Committee are to:

- Develop a comprehensive three year investment and cost improvement plan (CIP) programme for the Trust and give assurance to the Board that the programme supports:
  - -The strategic direction of the Trust from delivery of service and a financial perspective;
  - -Patient care and patient experience; and
  - -Public, employee and stakeholder relations.
- To review progress and ensure that the Trust is aware of and incorporates where appropriate:
  - -Industry best practice; and
  - -Key health care partner's investment and cost improvement plans
- To receive reports, PIDs, appraisal options papers and support from the Programme Management Group.
- To ensure that the programme is sufficiently testing in its approach to investment, efficiency and cost reduction and has considered the impact on quality and safety (quality impact assessment below refers);
- To explore different approaches to CIP projects and draw upon the experience and skills of the non-executive directors;
- To monitor and report back progress to the Board against the three year programme and where necessary to escalate any concerns to the Board for consideration.
- To support the cultural changes, through a communication and staff development plan that results in sustainable productivity and investment plans that support the development of quality patient services; and
- To manage the risk associated with the cost improvement programme including risk to services and financial viability.

The Trust has introduced a **Programme Management Group** (PMG) which meets every 2 weeks and reports to the Innovation and Cost Improvement Committee. Key corporate and operational departments are represented on this group including finance, information, operations, clinicians, communications and the Programme Management Office. The primary purpose of the group is to drive the CIP programme forward to deliver the associated outcomes and benefits. Members will provide leadership, resource and specific commitment to support the group and the Committee. The group will take the lead in establishing the values and behaviours required to deliver the programme, leading by example. Members of the group are individually accountable to the Committee for their areas of responsibility and delivery.

The Trust has implemented a **Programme Management Office** (PMO) function to provide professional support to the transformational and cost improvement programmes. The PMO ensures that monthly reporting processes provide the information required by senior management, and will assist clinical and operational teams with managing their proposals, schemes and performance reporting including quality KPI's, CIP and programme risk assessment.

The CIP programme has been developed in three phases:-

Phase 1 - Project Group to coordinate programme delivery and risk assessment

Establish a **Project Group** to co-ordinate the Trust in developing a 'prioritised' and 'risk' assessed programme of schemes. The programme has been developed to support a culture that results in wider Trust accountability, awareness and partnership working.

The key outcomes of the plan are:-

- Cost improvement and income generation schemes for 2013/14 that delivers a recurrent target of £9m. Based on prioritised risk assessed CIP's with phased financial plans, milestones, performance measures and a risk rating.
- Identification of high level opportunities for development in 2013/14 as part of developing the 2014, 2015 and 2016 Cost Improvement Plan.
- Investment/ 'Invest to Save' proposals for increasing the Trust's Service, Quality, Infrastructure Standards, Staff Skills and Invest to Save opportunities based on a cost benefit case. To be reviewed in year on delivery of savings above the £9m target through agreed release of the present contingency.

A communication plan across key internal and external stakeholders that seeks to engage, generate ideas for efficiency savings, outlines the context and reports and recognises progress.

Phase 2 – Joint Management / Clinical Review of the Programme

A joint **clinical/management review programme** was established to identify, agree and set up key CIP/Investment programmes linked to the Trust's Strategic Plan. This has been supported through the Trust's Clinical Advisory Group (CAG). Key Outcomes:-

-Agreement on the key 'step change' programmes and phasing for 2013/14/15

-Establishment of project leads for the programmes and Programme Management Office support.

Clinical Leadership engagement is achieved at multiple levels within the development and review of the programme. Including:-

CIP Assurance – The Medical and Nursing directors are members of the overarching committee. The Programme Management Group has representation from senior nurses. The Task and Finish Groups have medical consultant, and senior nursing representation. Transformational project sponsor groups all include a consultant and a nursing representative

CIP Development – Joint clinical and managerial visioning events have been held for Elective Care, Paediatrics, and A&E to support transformation. CIP meetings and workshop are held at divisional level. All CIP schemes have a clinical lead and are approved by the medical and nursing directors

Phase 3 – Outline Case Project Initiation Documentation

The process for developing proposals (business cases, strategic ideas, scoping documents, pilots etc.) has been enhanced in 2012/13 to ensure that the planning and budgeting of all potential CIP and innovation is robust. Scheme proposals are set down in a Project Initiation Document (PID). These PIDs are reviewed and approved by both the Medical Director and the Nursing Director before being submitted for final approval to the ICIC.

All CIP scheme leads produce a PID including:

-Financial analysis (costs, savings, productivity and efficiency gains, income generation), which is validated by management accountants;

-A quality impact assessment;

-Governance arrangements;

-Performance measures;

-Risk and issues; and

-Key milestones for delivery.

All PIDs have a nominated clinical lead that is responsible for signing off the PID and ensuring that the quality criteria for Safety, Effectiveness and Experience are taken into account.

PIDs are then submitted for formal approval by the **Programme Management Group (**PMG) and to the **Innovation & Cost Improvement Committee** (ICIC). All PIDs are approved by both the Medical Director and the Nursing Director.

Quality Impact Assessment - project plans are completed and signed off for individual CIP schemes by the lead manager and clinical lead. They are reviewed and approved by both the Medical Director and Nursing Director. Following this approval, these individual assessments are reviewed by both the PMG and the Innovation and Cost Improvement Committee for viability and quality impact. The Quality Impact Assessment is structured around patient safety, effectiveness, experience, staff, compliance and commissioning requirements. This was introduced in 2012/13 and now forms part of the standard PID documentation completed for all schemes. The PMO holds a central risk register which captures risks that are escalated from projects and CIP schemes including risks identified through the quality impact assessment. This register is reviewed by the PMG and the ICIC on a monthly basis.

CIP Performance

Delivery of CIP targets has been achieved on a recurrent basis.

Annual CIP Target **£m**

	Plan £m	Actual £m	Variance £m
2009/10	4.9	4.9	0
2010/11	9.4	9.4	0
2011/12	12.7	11.8	(0.9)
2012/13	9.0	6.6	(2.4)

Mitigation includes: utilisation of reserves; strengthened governance to provide greater scrutiny & challenge and a specific role in resolving cross organisational issues inhibiting delivery; more detailed targets both financial and key milestones; enhanced roles & responsibilities definition; reduced income generation schemes; allocation of resources

The full year effect and recurrent savings of CIP schemes are profiled over the year. The finance team provide the PMO with a summary of progress against these monthly targets. In addition progress against key milestones is monitored through project leads and schemes providing the associated progress updates. This data is then used to produce a monthly management information dashboard for the PMG and the ICIC to review. The dashboard will summarise the overall CIP actual total, by month and by year to date, against target CIP. Any issues or major queries, particularly relating to possible delays or under-achievement of CIP, will be reported as 'Red' status to the PMG and ICIC for management action or decision. The monthly CIP summary sheet also indicates which PIDs have been approved.

A process for reporting on the status and progress of programmes/projects/schemes has been developed, based on NHS and industry best practice.

-Monthly reporting of projects and programmes identifies any issue in 3 key areas: Schedule/Delivery; Cost/Budget; Scope/Quality.
-Issues that cannot be resolved by project teams, divisional management or PMG, are escalated by an exception management process to ICIC.
-Dashboard reporting to ICIC includes a summary of the 'Red' status projects that require ICIC intervention or support. In addition to these exceptions, the dashboard includes routine summary status reports for any other specific 'key projects', as required by ICIC e.g. the major transformational initiatives.

Further Action to Ensure Future Delivery

- Wider collaborative working through developing relationships with other parties with a common purpose from the health system.
- Enhanced identification and measurement of key milestones (management actions that deliver savings) in addition to financial monitoring.
- Wider skills development in relation to project management and business improvement techniques to deliver sustainable change including e-learning modules.
- Integrated IT strategy and associated delivery through capital funding and integration with service improvement projects and schemes.
- Quality assurance star chamber to support existing robust process of assessment by medical and nursing directors.
- Wider engagement and accountability for delivery across the organisation to enable all to engage and have responsibility for CIP identification and delivery e.g. bright ideas.
- More robust profiling of monthly savings e.g. taking account of time to deliver.
- Clear delivery focus.

Section 7 - Financial and Investment Strategy

2012/13 Outturn

The Trust delivered an underlying surplus of £980k (£1,109k deficit including restructuring and impairment cost) and achieved the planned Financial Risk Rating of 3 and liquidity rating of 4. For elective and out-patient activity the Trust performed above plan with a marginal underperformance for Emergency activity.

Activity Profile

	2012/13 Activity Outturn				Planned Activity Growth (%)		
	Plan	Actual	Variance	% Variance	2013/14	2014/15	2015/16
Elective (including day case)	35,506	37,592	2,086	5.9%	2.3%❶	2%	2%
Emergency	43,493	43,118	-375	-0.9%	2.2%❷	0%	0%
A&E	99,742	102,232	2,490	2.5%	0.4%❸	1%	1%
Out-Patients	287,563	290,573	3,010	1.1%	4.5%❹	0%	0%

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

The overarching financial strategy is to support the strategic priorities and maintain a financial risk rating of 3 (applying the current definitions) over the planning period. The financial strategy builds on our 2012/13 performance, reflects the commissioned services signed up to in contracts and addresses the anticipated efficiency challenge. An annual surplus of £1.2m (£0.9m underlying after excluding £0.6m non-recurrent restructuring costs and £0.9m income associated with donations and grants) will be achieved in 2013/14 and an underlying surplus will be maintained over the planning period. The plan provides modest cash growth to provide headroom for risk and transformational change with a risk prioritised capital programme aligned to the Trust's strategic priorities of circa £4m.

Contractual activity is based on the 2012/13 forecast outturn. 2013/14 contracted growth is planned for Elective Activity (Including Day Cases) and for the following two years, growth is also planned for Accident and Emergency (1% p.a.) with no net growth in Emergency admissions. (Table above refers) Growth forecasts for 2013/14 are built into contracts agreed with CCGs.

The planning assumptions are based on increases in demand for:

- Elective ❶ – reflecting demand to achieve 18 and 52 weeks, referral increase and orthopaedic repatriation from Halton and St Helens.
- Emergency ❷ - contracted demand.
- Emergency❸ - activity being managed through transformational system changes and the impact of the 111 service on A&E after the impact of activity avoided from the implementation of A&E front end GP streaming.
- Out-patients ❹– reflective the impact on elective demand and reclassification between day case and outpatient procedures. Outpatients it is assume growth in new referrals off set by the reduction in follow up attendances.

Trust specific and health economy wide schemes have been developed to achieve the delivery of a sustainable CIP programme. In terms of the health economy arrangements key parties (clinical and managerial) from across the acute, community, mental health, social care and commissioning organisations are working in partnership to deliver an integrated 'Quality, Innovation, Productivity, and Prevention (QIPP) programme the overall objective being to ensure we are getting patient care right first time, meaning better care and better value through the reduction of waste and errors and the prioritisation of effective treatments. The Trust's Chief Executive established the Transformational Change Board to operationalize the implementation of the change programmes.

At Trust level the efficiency challenge is being addressed through two approaches:-

- Cost reduction through service review and change, workforce planning, procurement and organisational productivity and efficiency.
- Service growth to bring a contribution to support the CIP challenge e.g. repatriation for Percutaneous Cardiac Intervention (PCI) and increased orthopaedic capacity.

The Trust will manage in year slippage whilst monitoring the rolling programme to achieve the CIP requirements over the 3 years of the plan.

Key Risks to the Financial Strategy

Risk	Full Year impact £	13/14 Risk £	Mitigation
Fixed cost impact of the transfer of vascular services	£1.4m	£0.7m	-Seeking transitional support from the LAT.LAT confirmed reasonable for the Trust to assume no financial risk this year. Strong possibility that service transfer slips to start of 14/15. Trust planning 50% and then 25% transitional funding support of non-releasable costs in 14/15 and 15/16.
Non delivery of the Cheshire and Mersey Treatment Centre productivity gains	£1.7m	£1.7m	-Performance framework established. -Capacity assessment confirmed ability to deliver. -Senior team (clinical and managerial) support.
New AMU model fails to deliver length of stay and bed closure reductions.	£1.2m	£0.9m	-Revisiting the costs of the scheme. -Utilisation management report confirmed assessment of bed closures.
Contractual penalties and failure to deliver CQUIN CQUIN target may require new investment to deliver	£0.1m £0.3m	£0.1m £0.3m	-Robust performance management framework to ensure delivery. -Maximise the management of costs within existing resources.
CIP shortfall in identified schemes CIP delivery slippage risk (based on 12/13 %)	£1m. £2.3m	£1m £2.3m	-Cash / liquidity impact covered by limiting capital investment to £2m less than annual depreciation. -Performance monitoring framework in place through PMO structures. -Manpower post reduction target to increase if alternative schemes not identified (all post reductions quality impact assessed) -Investing in additional project management capacity to support the delivery of major CIP schemes -Non recurrent measures identified to buffer part impact of the implementation of recurrent schemes. PMO office established and recruited. Innovation and Cost Improvement Committee to monitor progress = subcommittee of the Board and includes two Non-Executive Directors.
Divisional financial performance	£1m	£1m	-Improved financial control over the final quarter. -Funding of financial pressures.

-Increased financial accountability introduced.