Mid Cheshire Hospitals NHS
NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
9.30am on Monday, 5 December 2016
In the Board Room, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led by	Page No
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	**-**
2.	**Patient or Staff Story** *(to note)*	I	Director of Nursing & Quality **09.32**	**-**
3.	**Board Members' Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.40**	**-**
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 7 November 2016 *(attached) (to approve)*	A	Chairman **09.42**	**n/a**
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman **09.45**	**3**
6.	**Annual Work Programme** **2016/17 Work Programme** *(attached) (to approve)*	I/A	Chairman **09.47**	**4**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 NHS Providers Conference** **7.2 Celebration of Achievement**	I	Chairman **09.50**	**-**
8.	**Governors' Items** (*to note a verbal report*) **8.1 Annual Planning Event – 23 November 2016**		Chairman **09.55**	**-**
9.	**Chief Executive's Report** (*to note a verbal report*) **9.1 Cheshire & Wirral LDSP Joint Chair and CEO meeting** **9.2 Contract Dispute 2016/17** **9.3 Executive Director Away Day** **9.4 Cheshire & Mersey Providers CEO meeting**	I	Chief Executive **10.00**	**-**

Item No	Title of Item	Action	Led by	Page No
10.	**CARING**			
	10.1 **Quality, Safety & Experience Report** *(attached)* *(to note)*	I/D	Director of Nursing & Quality 10.25	5
11.	**SAFE**			
	11.1 **Draft Quality Governance Committee notes from the meeting held on 14 November 2016** *(attached)* (*to note*)	I	Committee Chair 10.50	n/a
	11.2 **Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note/discussion*)	I/D	Deputy Chief Executive/ Medical Director 10.55	-
12.	**RESPONSIVE**			
	12.1 **Performance Report** *(attached)* (*to note*)	I/D	Director of Finance 11.00	38
	12.2 **Draft Performance & Finance Committee notes from the meeting held on 24 November 2016** *(to follow)* (*to note*)		Committee Chair 11.10	-
	12.3 **Legal Advice** *(verbal)* (*to note*)	I	Chief Executive 11:15	-
13.	**WELL-LED**			
	13.1 **Annual Plan Submission** *(attached)* *(presentation - to follow)*	I/D	Director of Finance 11.20	n/a
	13.2 **Draft Transformation and People Committee notes from the meeting held on 10 November 2016** *(attached)* *(to note)*	I	Committee Chair 11.35	n/a
	13.3 **Visits of Accreditation, Inspection or Investigation** (*verbal*) (*to note*)	I	Chief Executive 11.40	-
	13.4 **Carter Gap Analysis** *(attached) (to note)*	I/D	Chief Executive 11.45	61
	13.5 **Cheshire and Merseyside STP** *(attached) (to note)*	I/D	Chief Executive 11.55	66
14.	**EFFECTIVE**			
	14.1 **Consultant Appointments** *(verbal)* (*to note*)	I	Deputy Chief Executive/ Medical Director 12.05	-
15.	**Any Other Business (verbal)**	I/A/D	Chairman	
16.	**Time, Date and Place of Next Meeting** **To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on Monday, 9 January 2017**	I	Chairman	

Resolution: To exclude the press and public from the meeting at this point on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. The press and public are requested to leave at this point.

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
2016/11/7.1.4	07-Nov-16	Update on the role of Nurse Practitioner following the end of consultation	Alison Lynch			Dec-16	Open

Board of Directors Workplan 2016 /17

Item	Board of Director Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*June*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive Report	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
CQC Registration biannual Report				x						x							
Nursing and midwifery staffing comprehensive report								x									
Patient Survey Results (National)						x											
Patient Quality Safety and Experience Report	x	x	x	x	x	x	x	x	x	x	x	x					
Staff Survey												x					
CQC Comprehensive Inspection Action Plan				x							x						
Safe																	
Health & Safety Update to Board													x			~~x~~	
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Effective																	
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account	x																
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal	x			x			x			x							
Corporate Trustee															x		x
	~~x~~																
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan (Extraordinary BoD Meetings)	x	x										x					
Annual Report & Accounts		x	x														
Audit Committee		x	x			x		x		x		x					
Board Assurance Framework		x			x			x			x						
Top 5 Risks		x			x			x			x						
														~~x~~		~~x~~	
																x	
Trust Strategy	x																x
Trust Strategy Update	x			x			x			x							
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment													x				
Corporate Goverance Handbook		x															
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Board Sub-Committee Annual Review			x														
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board Report December 2016

Quality: Safety and Experience

(October 2016 data)

This report provides an overview of performance relating to safety and experience in October 2016.
Key messages for October are:

- There was one serious incident reported in month, this was a medication incident
- The Trust's HSMR is 106.5 and places the Trust 99 out of 137 Trusts
- The Trust is achieving its aim to have a SHMI at or below 1.0 from April 2015
- No MRSA Bacteraemia cases have been reported in month
- No avoidable Clostridium Difficile cases have been reported in month. The target continues to be achieved.
- 25 complaints were received, which is the same as the previous month
- The Trust's NHS Choices Star rating is currently 4.5 stars for Victoria Infirmary, and 4 stars for Leighton Hospital

Please note that the incident data for the CCICP has now been included in the report following the partnership commencing on the 1 October 2016.

Board Papers – Quality, Safety & Experience Section: December 2016

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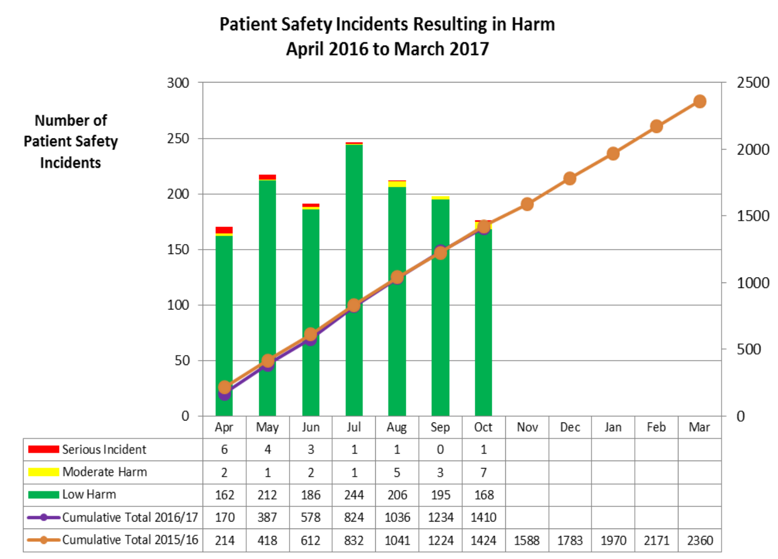
Quality & Safety Section:

Description **Aggregate Position** **Trend** **Variation**

Patient Safety Incidents resulting in harm.

This chart demonstrates the total number of reported patient safety incidents which resulted in harm.

For this financial year to date:
97.4% (1373 incidents) have resulted in low harm
1.5% (21 incidents) have resulted in moderate harm
1.1% (16 incidents) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
🟥 Serious Incident	6	4	3	1	1	0	1					
🟨 Moderate Harm	2	1	2	1	5	3	7					
🟩 Low Harm	162	212	186	244	206	195	168					
Cumulative Total 2016/17	170	387	578	824	1036	1234	1410					
Cumulative Total 2015/16	214	418	612	832	1041	1224	1424	1588	1783	1970	2171	2360

The Trust's aim is to reduce the number of harm incidents by the end of January 2018 in comparison to the previous financial year.

The aim was achieved in month.

Degrees of Harm

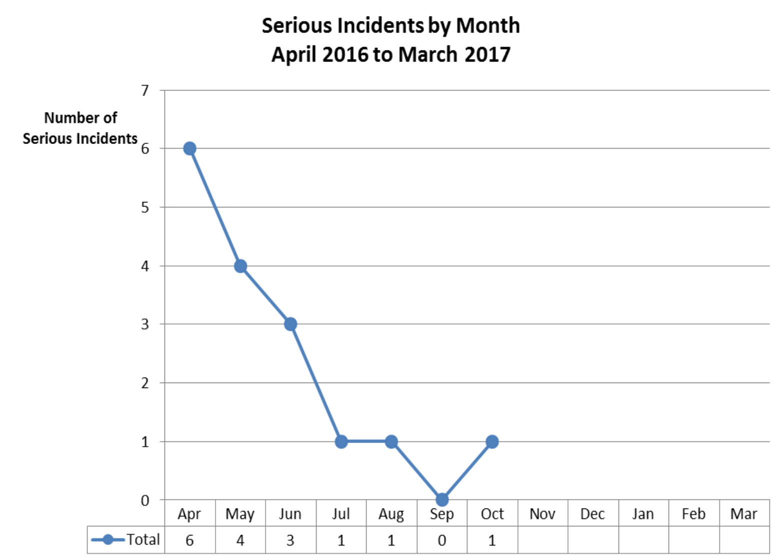
Serious Incidents.

This chart demonstrates the number of incidents that have resulted in serious harm.

One serious harm incident was reported in October 2016.

16 serious incidents have been reported for this financial year to date.

- 7 x Stage 3 pressure ulcers
- 3 x Patient falls resulting in fractured neck of femur
- 2 x Stage 4 pressure ulcer
- 1 x Delay in follow up appointment
- 1 x Medication Error
- 1 x Never Event wrong size implant inserted
- 1 x Treatment regime



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	6	4	3	1	1	0	1					

The Trust's Sign Up To Safety aim is to have no serious incidents and a zero tolerance on Never Events by the end of January 2018.

The aim is not currently being achieved.

Serious Incidents

Description

Pressure Ulcer (PU) Incidents including avoidable pressure ulcers.

Aggregate Position

For this financial year to date:

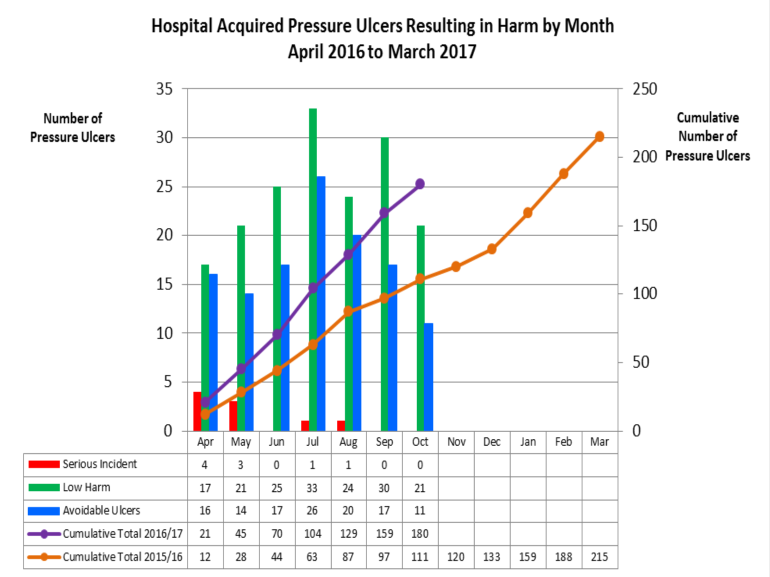
- 95% (171 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU)
- 5% (9 PU's) have resulted in serious harm (defined as a patient that has developed a stage 3 or 4 PU)

In October 2016, 11 avoidable PU's were reported, as shown by the blue bar on the chart.

Improvement actions include:

- Launch of the 'React to Red' safety collaborative in May 2016. A number of projects are underway as part of the collaborative on a cohort of wards
- Secondment of a band 6 into the role of the Skin Care Nurse for a three month period.
- The role of the Skin Care Nurse will involve reviewing PUs and focussing on Wards / Departments who require intense educational support.
- They will be rolling out the successful elements of the React to Red collaborative across the Trust; this will include the Pressure Ulcer Cross, the Positional Boards outside the bays and the implementation of the Positional Charts at the end of every bed space.
- A full time substantive band 7 Tissue Viability Nurse will be commencing in the Trust in December 2016.

Trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
🟥 Serious Incident	4	3	0	1	1	0	0					
🟩 Low Harm	17	21	25	33	24	30	21					
🟦 Avoidable Ulcers	16	14	17	26	20	17	11					
Cumulative Total 2016/17	21	45	70	104	129	159	180					
Cumulative Total 2015/16	12	28	44	63	87	97	111	120	133	159	188	215

Variation

The aim in the Trust's Quality & Safety Improvement Strategy and Sign Up To Safety Campaign is to have no avoidable hospital acquired PU's by the end of January 2018. The aim has not yet been achieved.

Pressure Ulcers

Board Papers – Quality, Safety & Experience Section: December 2016

Description | **Aggregate Position** | **Trend** | **Variation**

Patient Falls Incidents.

For this financial year to date:

- 62% (291 falls) have resulted in no harm
- 35.6% (167 falls) have resulted in low harm
- 1.7% (8 falls) have resulted in moderate harm
- 0.6% (3 falls) have resulted in serious harm

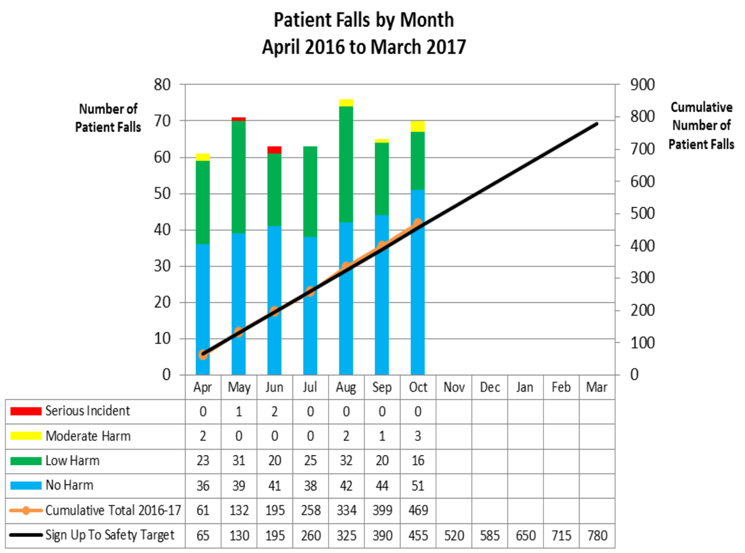
All patient falls are reviewed by the Patient Falls Prevention Group on a monthly basis.

Improvement actions include:

- The Falls Safety Collaborative was launched on 1st April 2016
- A number of projects are being trialled as part of the collaborative on a cohort of wards

Over the past 3 years we have reduced falls by 29.4%.

Patient Falls by Month
April 2016 to March 2017



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
🟥 Serious Incident	0	1	2	0	0	0	0					
🟨 Moderate Harm	2	0	0	0	2	1	3					
🟩 Low Harm	23	31	20	25	32	20	16					
🟦 No Harm	36	39	41	38	42	44	51					
Cumulative Total 2016-17	61	132	195	258	334	399	469					
Sign Up To Safety Target	65	130	195	260	325	390	455	520	585	650	715	780

The Trust's aim within the Sign Up To Safety Campaign is to reduce inpatient falls by 10% by January 2018.

The Sign up to Safety aim was not achieved in month.

Patient Falls

Medication Incidents.

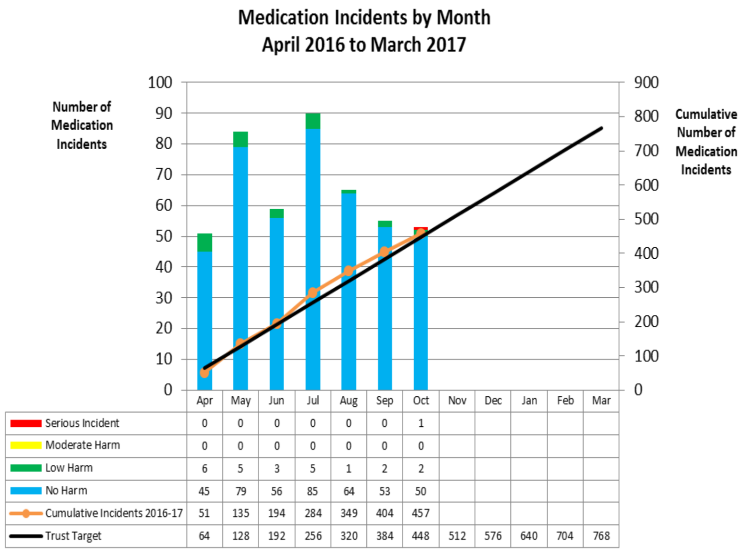
For this financial year to date:

- 94.5% (432 medication incidents) have resulted in no harm
- 5.3% (24 medication incidents) have resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0.2% (1 medication incidents) have resulted in serious harm

Improvement actions include:

- Introduction of ward based medicines safety audit monthly monitoring

Medication Incidents by Month
April 2016 to March 2017

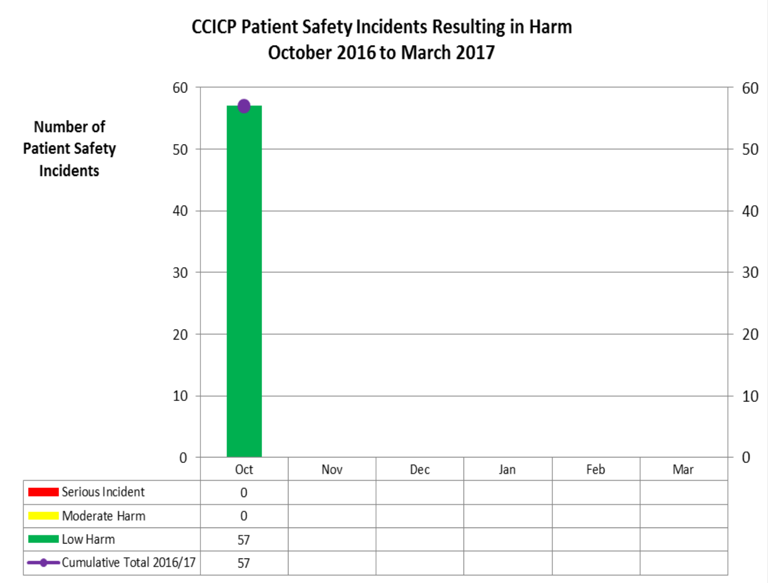
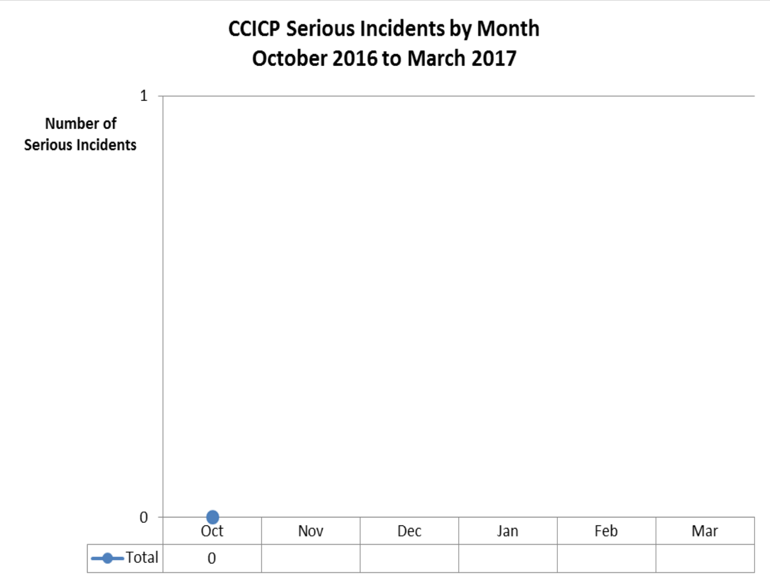


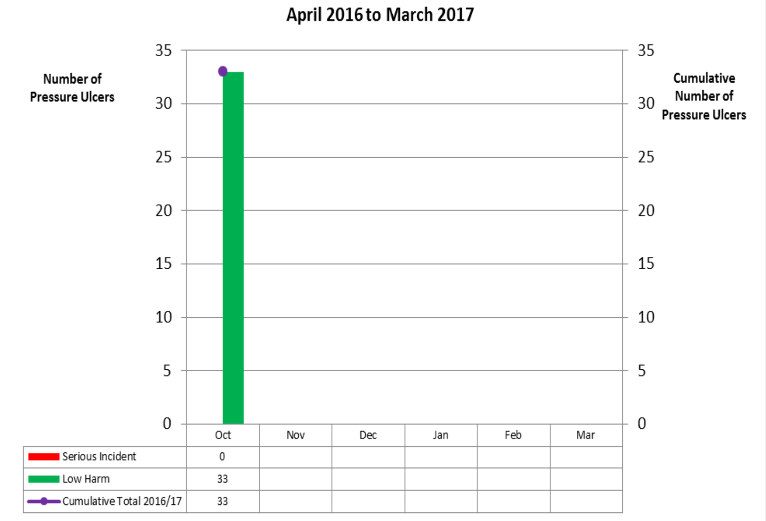
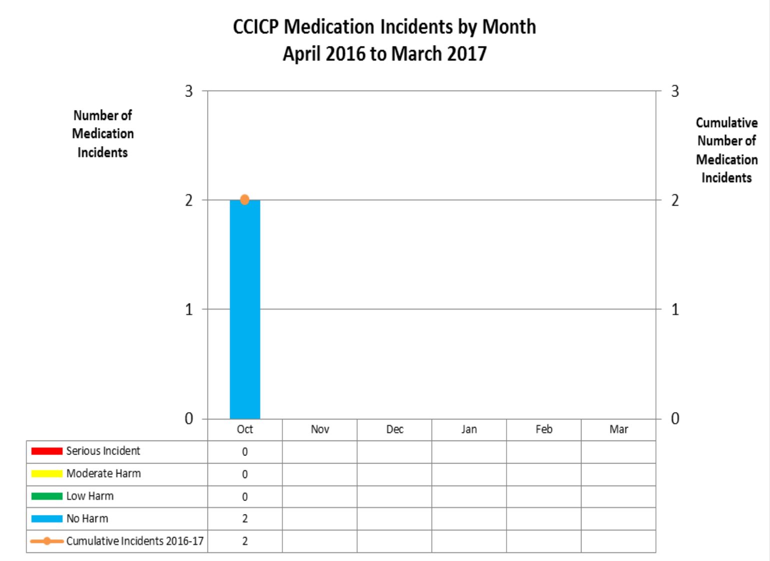
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
🟥 Serious Incident	0	0	0	0	0	0	1					
🟨 Moderate Harm	0	0	0	0	0	0	0					
🟩 Low Harm	6	5	3	5	1	2	2					
🟦 No Harm	45	79	56	85	64	53	50					
Cumulative Incidents 2016-17	51	135	194	284	349	404	457					
Trust Target	64	128	192	256	320	384	448	512	576	640	704	768

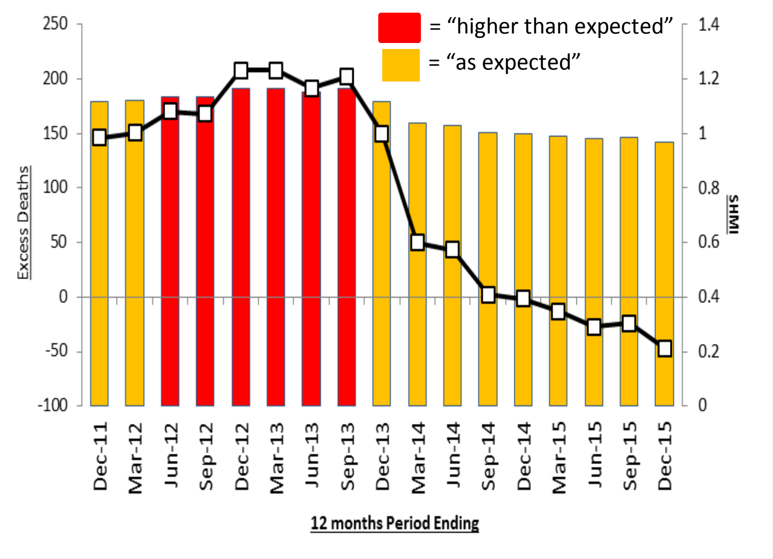
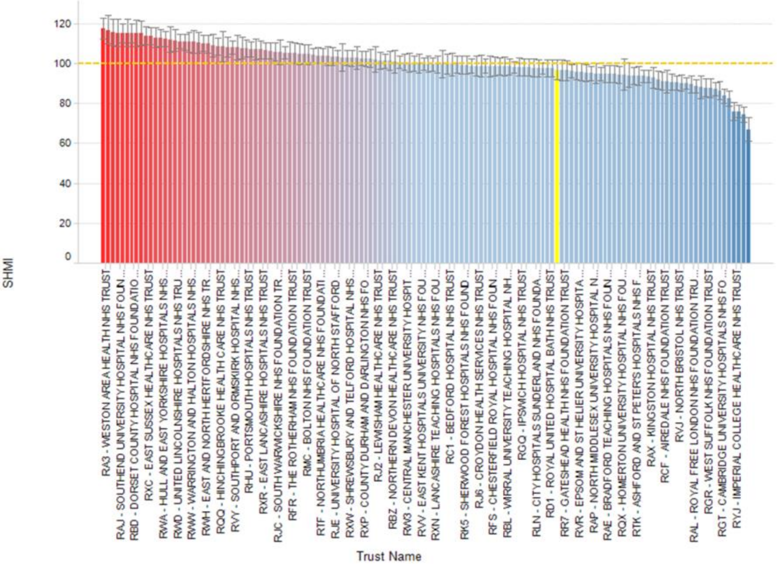
The Trust's aim is to reduce medication incidents by 5% by the end of January 2018 in comparison to the previous financial year.

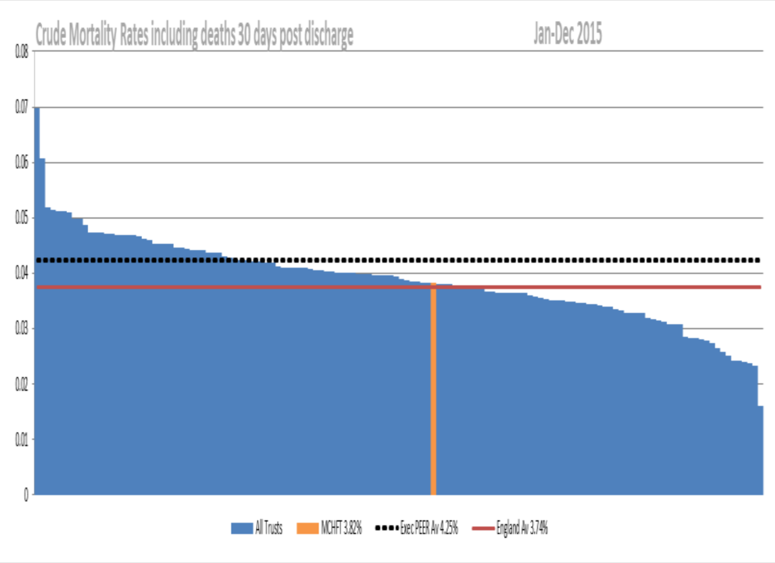
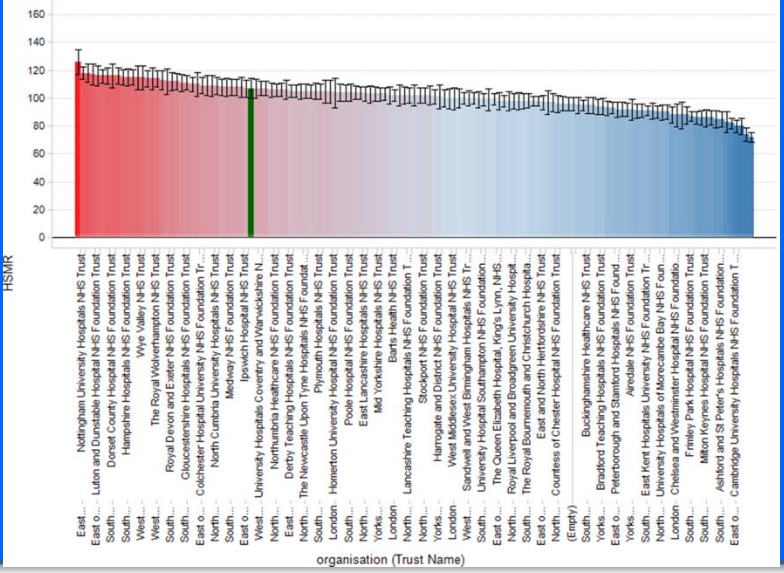
The aim was not achieved in month.

Medication Incidents

Description	Aggregate Position	Trend	Variation
CCICP Patient Safety Incidents resulting in harm. .	This chart demonstrates the total number of reported patient safety incidents which resulted in harm. From October 2016 when the partnership commenced: 100% (57 incidents) have resulted in low harm 0% (0 incidents) have resulted in moderate harm 0% (0 incidents) have resulted in serious harm		CCICP aims to be agreed. CCICP Degrees of Harm
CCICP Serious Incidents.	This chart demonstrates the number of incidents that have resulted in serious harm. No serious incidents have been reported since October 2016 when the partnership commenced:		CCICP aims to be agreed. CCICP Serious Incidents

Description	Aggregate Position	Trend	Variation
CCICP Pressure Ulcer (PU) Incidents including avoidable pressure ulcers.	From October 2016 when the partnership commenced: • 100% (33 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU) • No stage 3 or stage four PU's have been reported	 CCICP Developed in Care Pressure Ulcers Resulting in Harm by Month April 2016 to March 2017	CCICP aims to be agreed. **CCICP Developed in Care Pressure**
CCICP Medication Incidents.	From October 2016 when the partnership commenced: • 100% (2 medication incidents) have resulted in no harm • 0% (0 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm	 CCICP Medication Incidents by Month April 2016 to March 2017	CCICP aims to be agreed. **CCICP Medication Incidents**

Description	Aggregate Position	Trend	Variation
Summary Hospital-Level Mortality Indicator (SHMI).	The chart demonstrates the Trust's Summary Hospital-Level Mortality Indicator (SHMI) and calculated "excess deaths". For the period January 2015 to December 2015, the Trust's SHMI is 0.9684 and "as expected"		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2015. The aim is currently being achieved. SHMI
Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 0.9684 for the time period January 2015 to December 2015 and places the Trust 41 out of 136 Trusts.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016. The aim is currently being achieved. SHMI by Trust

Description	Aggregate Position	Trend	Variation
Crude Mortality.	The chart benchmarks the Trust's crude mortality rate for the period January 2015 to December 2015 against an executive peer and England average. The Trust (3.82%) is currently below the executive peer average of 4.25% but above the England average of 3.74% and places the Trust 62 out of 136 Trusts.		The Trust's aim is to continually reduce its crude mortality rate. . **Crude Mortality**
HSMR by Trust.	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the green bar. The Trust's HSMR is 106.5 (January 2015 to December 2015) and places the Trust 99 out of 137 Trusts.		The Trust's aim is to have an HSMR <100. **HSMR by Trust**

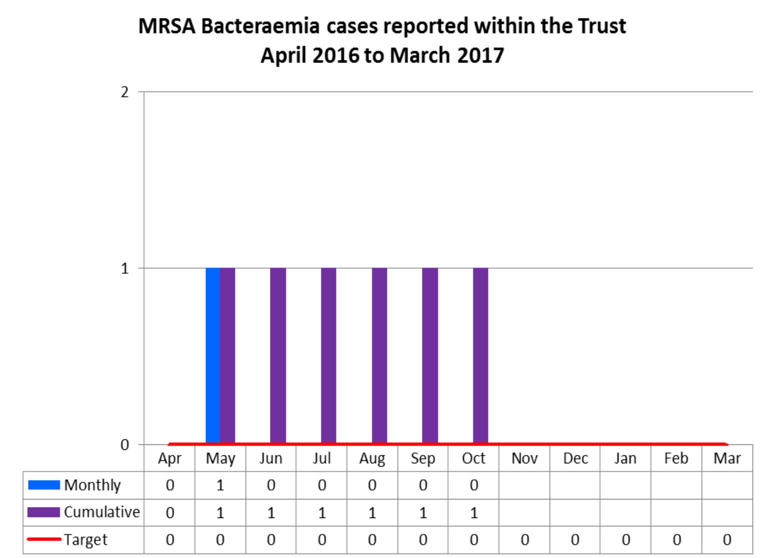
Board Papers – Quality, Safety & Experience Section: December 2016

Description	**Aggregate Position**	**Trend**	**Variation**

MRSA Bacteraemia Cases.

In this financial year there has been one confirmed MRSA bacteraemia case reported.

This was a contaminant case and lapses in care have been addressed via the root cause analysis process.



**MRSA Bacteraemia cases reported within the Trust
April 2016 to March 2017**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	1	0	0	0	0	0					
Cumulative	0	1	1	1	1	1	1					
Target	0	0	0	0	0	0	0	0	0	0	0	0

The target for MRSA Bacteraemia is zero in 2016/17.

The target has not been achieved.

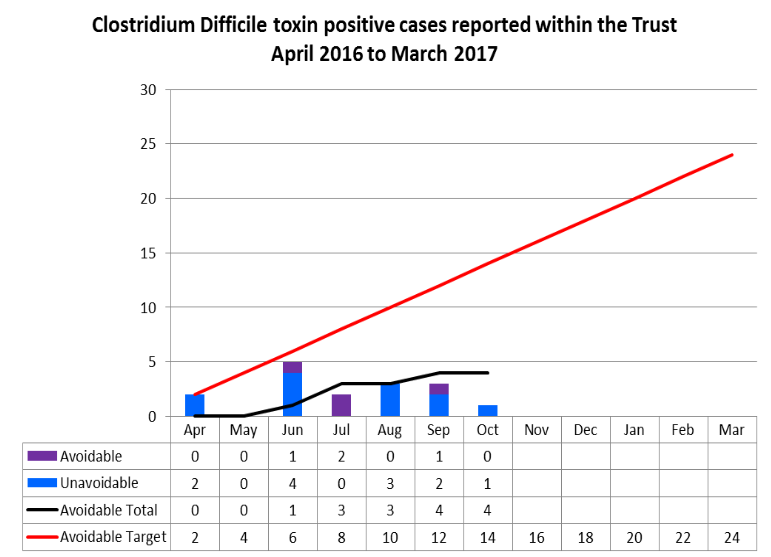
MRSA

Clostridium Difficile toxin positive cases.

In October 2016, no avoidable cases were reported.

Actions arising from review of the Clostridium Difficile cases include:

- Ward Managers to reinforce the importance of accurate stool chart documentation
- Ward staff to attend the weekly Clostridium Difficile Infection meetings to support ownership at a ward level
- Matrons to lead on formal RCA process for all avoidable and unavoidable cases of Clostridium Difficile



**Clostridium Difficile toxin positive cases reported within the Trust
April 2016 to March 2017**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	0	0	1	2	0	1	0					
Unavoidable	2	0	4	0	3	2	1					
Avoidable Total	0	0	1	3	3	4	4					
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	24

The target is less than 24 avoidable cases of Clostridium Difficile in 2016/17.

The target has been achieved.

Clostridium Difficile

Description

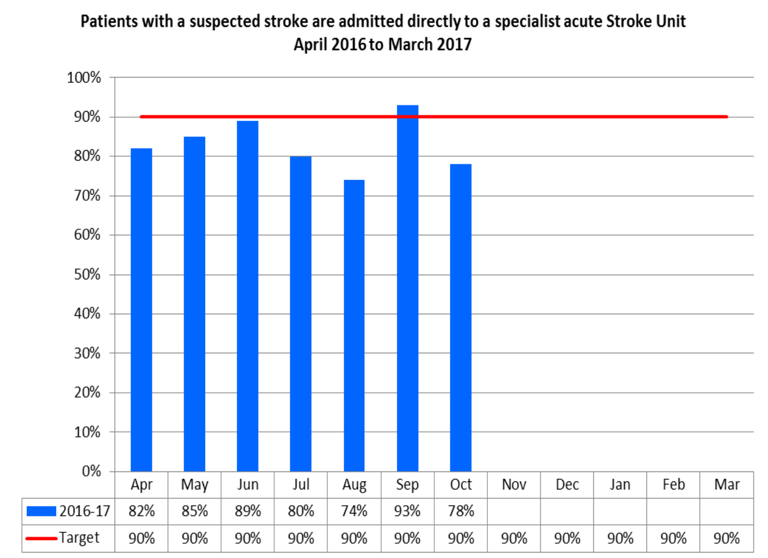
Patients with a suspected stroke admitted directly to a specialist acute stroke unit

Aggregate Position

In October 2016, 28 out of 36 patients (78%) were admitted directly to the stroke unit. Improvements in practice aimed at delivering the target include:

- An agreed pathway with UHNM was implemented on the 4 July 2016
- Bi-weekly teleconferences are being held between UHNM and MCHFT to discuss operational and clinical issues
- Clinical Meeting to be held to discuss the new pathway and any actions and or amendments required
- An individual patient review is held for each patient where the pathway was not fully adhered

Trend


Patients with a suspected stroke are admitted directly to a specialist acute Stroke Unit
April 2016 to March 2017

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	82%	85%	89%	80%	74%	93%	78%					
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

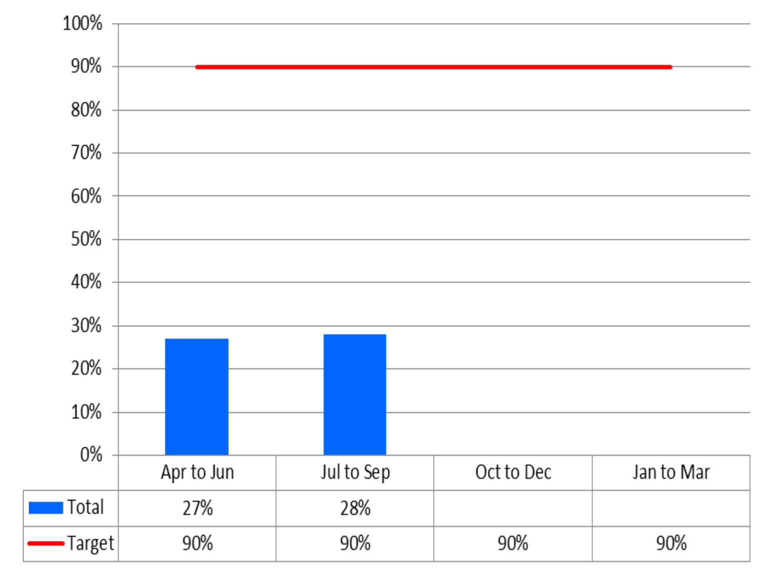
Variation

As part of the Sentinal Stroke National Audit Plan (SSNAP) the Trust aim for 2016/2017 is 90% of suspected stroke patients to be admitted directly to the stroke unit.

The target was not achieved in month.

Stroke

Description	Aggregate Position	Trend	Variation
National CQUIN – Health & Wellbeing Part 1a The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1a the Trust must introduce a Health & Wellbeing initiative from two options provided. The Trust has chosen option 2. - Introduce a range of physical activity schemes for staff. Include an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour - Improving access to physiotherapy services for staff. A fast track service for staff suffering from musculoskeletal issues to ensure staff are reviewed in a timely manner - Introduce a range of mental health initiatives for staff. Offer support to staff such as stress management courses, line management training, mindfulness courses and counselling services	For quarter 2, progress against the action plan is required, although there is no funding allocated to quarter 2. The Health & Wellbeing steering group monitors progress against the action plan and the group agrees the frequency of meetings to monthly. Actions taken to date include: - Relaunch of the green walking route. - Completion of the Race to Rio virtual walking challenge. - Participation in the Cheshire & Warrington Team Games.	The CQUIN target for Health & Wellbeing Part 1a is to have implemented the initiatives as agreed in the plan and actively promoted these initiatives to staff. The target was achieved in month. **National CQUIN – Health & Wellbeing Part 1a**
National CQUIN – Health & Wellbeing Part 1b The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1b the Trust must provide healthy food for NHS staff, patients and visitors - Banning price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS) - Banning advertisement on NHS premises of sugary drinks and foods high in HFSS - Banning sugary drinks and foods high in HFSS from checkouts - Ensuring that healthy options are available at any point including those for staff working night shifts	For quarter 2, progress against the action plan is required, although there is no funding allocated to quarter 2. The Health & Wellbeing steering group monitors progress against the healthy eating plan. Actions taken to date include: - Agreement that no foods HFSF will be promoted within the Trust by in-house catering, the RVS or League of Friends. - Only healthy options have been promoted since 1st June 2016. - All confectionary has been moved away from till points. - National data collection return was completed and returned within the required timescales.	The CQUIN target for Health & Wellbeing Part 1b is to have implemented all four outcomes as outlined in the CQUIN. The target was achieved in month. **National CQUIN – Health & Wellbeing Part 1b**

Description	Aggregate Position	Trend	Variation	
National CQUIN – Health & Wellbeing Part 1c The financial value for this CQUIN is £396,107.	To achieve the CQUIN target for Health & Wellbeing Part 1c the Trust must improve the uptake of flu vaccinations for front line clinical staff by December 2016. Providers will be expected to submit cumulative data monthly over four months on the ImmForm website.	The flu group meets monthly to plan delivery of the annual flu campaign. Led by the Deputy Director of Nursing & Quality, the group comprises of Matrons from across the Trust who act as flu leads for their respective areas. The Trust has organised 100 peer to peer vaccinators to help ensure MCHFT reaches the 75% uptake level by the 31st December 2016. The campaign commenced on Monday 3 October 2016.	The CQUIN target for Health & Wellbeing Part 1c is to achieve an uptake of flu vaccinations by front line clinical staff of 75% by 31st December 2016. The target was achieved in month.	**National CQUIN – Health & Wellbeing Part 1c**
National CQUIN – Sepsis Emergency Departments 2a Part 1: Screening The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for Sepsis Screening 2a Part 1, a random sample of 50 sets of notes are reviewed each month to ensure all patients presenting in emergency departments are screened for sepsis as part of the admission process, where this is appropriate. Actions for improvement include: • A full time permanent sepsis specialist nurse has been appointed to the Trust • The revised sepsis pathway in line with NICE guidance has now been launched across the Trust. • Each area has nominated sepsis programme and a education programme has commenced		The CQUIN target for Sepsis Part 2a Part 1 is for >90% of eligible patients to be screened for sepsis by the end of quarter four of 2016/17. The target was not achieved in month.	**National CQUIN – Sepsis Emergency Departments 2a Part 1**

Description **Aggregate Position** **Trend** **Variation**

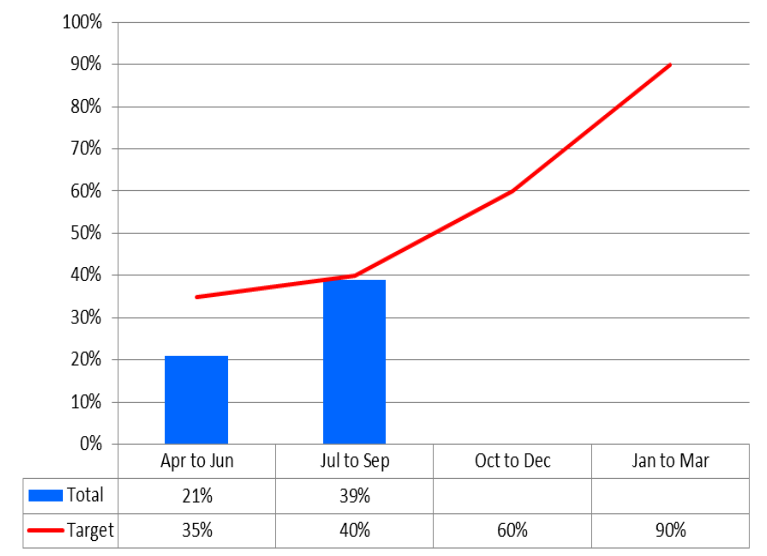
National CQUIN – Sepsis Emergency Departments 2a Part 2: Antibiotic Administration

The financial value for this CQUIN is £118,832.

To achieve the CQUIN target for Sepsis Antibiotic Administration 2a Part 2, a random sample of 30 sets of notes, where clinical codes indicate sepsis, are reviewed each month to ensure patients receive antibiotics within 60 minutes of arrival at hospital and an empiric review within 3 days of the prescribing of antibiotics.

Actions for improvement include:

- A full time permanent sepsis specialist nurse has been appointed to the Trust
- A sepsis trolley has been provided to the ED team to support timely administration of antibiotics



	Apr to Jun	Jul to Sep	Oct to Dec	Jan to Mar
Total	21%	39%		
Target	35%	40%	60%	90%

The CQUIN target for Sepsis 2a Part 2 is for 90% by the end of quarter 4.

The target was not achieved in month.

National CQUIN – Sepsis Emergency Departments 2a Part 2

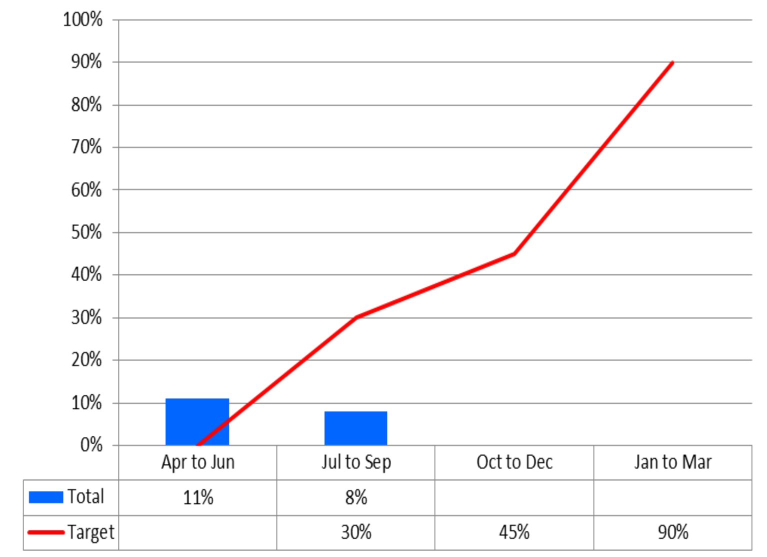
National CQUIN – Sepsis Inpatients 2b Part 1: Screening

The financial value for this CQUIN is £79,221.

To achieve the CQUIN target for Sepsis Screening 2b Part 1, a random sample of 50 sets of notes are reviewed each month to ensure all inpatients are screened for sepsis, where this is appropriate.

Actions for improvement include:

- A full time permanent sepsis specialist nurse has been appointed to the Trust
- The revised sepsis pathway in line with NICE guidance has now been launched across the Trust.
- Each area has nominated sepsis programme and a education programme has commenced



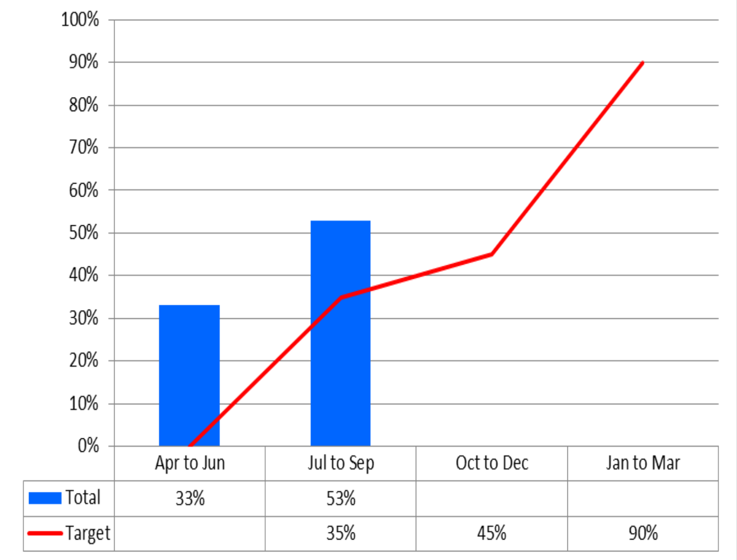
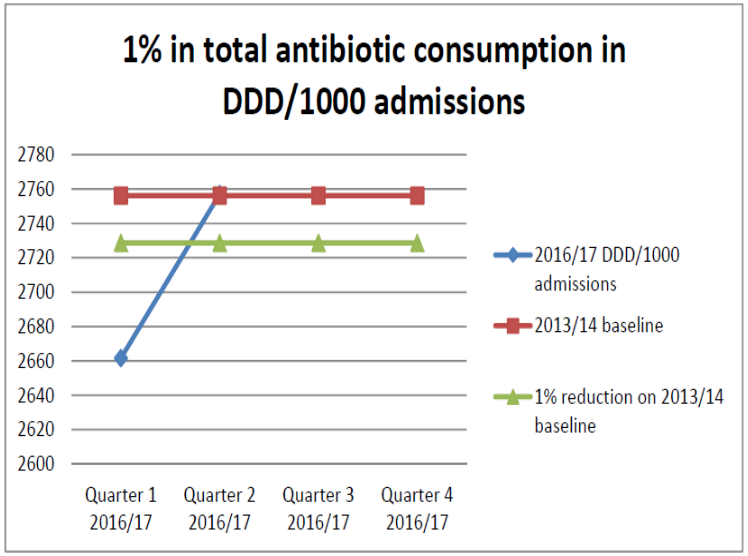
	Apr to Jun	Jul to Sep	Oct to Dec	Jan to Mar
Total	11%	8%		
Target		30%	45%	90%

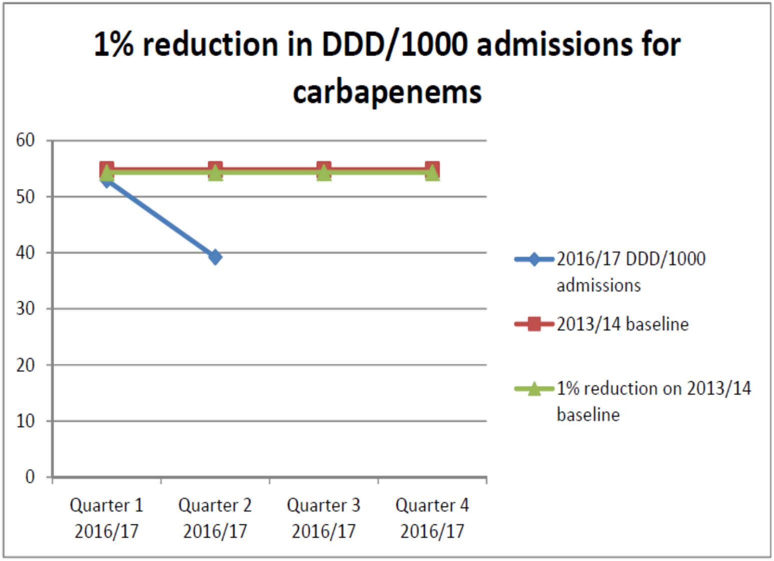
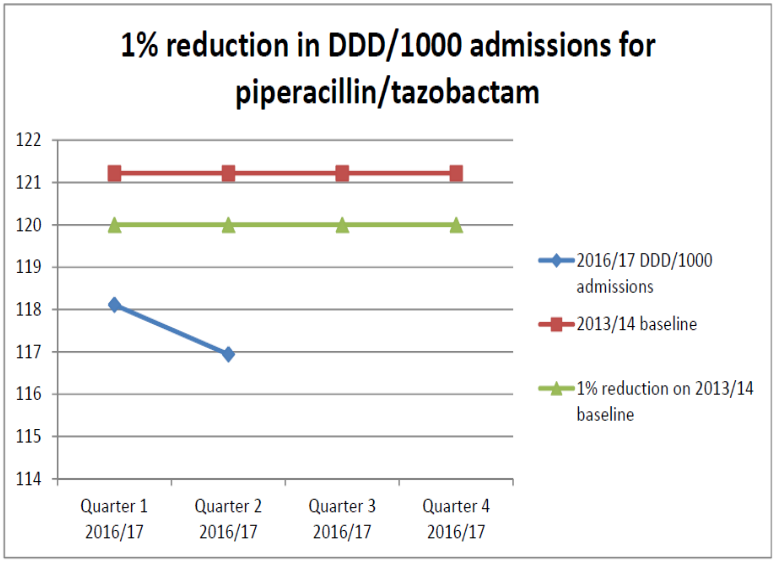
The CQUIN target for Sepsis Part 2b Part 1 is for >90% of eligible patients to be screened for sepsis by the end of quarter four of 2016/17.

The target was not achieved in month.

National CQUIN – Sepsis Inpatients 2b Part 1

Board Papers – Quality, Safety & Experience Section: December 2016

Description	Aggregate Position	Trend	Variation
National CQUIN – Sepsis Inpatients 2b Part 2: Antibiotic Administration The financial value for this CQUIN is £118,832.	To achieve the CQUIN target for Sepsis Antibiotic Administration 2b Part 2, a random sample of 30 sets of notes, where clinical codes indicate sepsis, are reviewed each month to ensure patients receive antibiotics within 60 minutes of identification of sepsis and an empiric review within 3 days of the prescribing of antibiotics. Actions for improvement include: • The revised sepsis pathway in line with NICE guidance has now been launched across the Trust. • Each area has nominated sepsis programme and a education programme has commenced		The CQUIN target for Sepsis Inpatients 2b Part 2 is for >90% of eligible patients to receive antibiotics within 60 minutes of identification of sepsis and empiric review within 3 days by the end of quarter four of 2016/17. The target was achieved in month. **National CQUIN – Sepsis Inpatients 2b Part**
National CQUIN – Reduction in antibiotic consumption Part 3a1 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a1, the Trust must have a reduction of 1% or more of total antibiotic consumption per 1,000 admissions. Quarter 2 data suggests an increase in the total antibiotic consumption to a similar level to the baseline 2013/14 data. However quarter 1 and 2 demonstrate cumulatively a > than 1% reduction in total oral antibiotic consumption, in line with the CQUIN requirements. This picture is similar to that of other Trusts in the North West region.		The CQUIN target for antibiotic consumption Part 3a1 is for a reduction of 1% or more in total antibiotic consumption per 1,000 admissions. The target was achieved in month. **National CQUIN – Antibiotic consumption Part 3a 1**

Description	Aggregate Position	Trend	Variation
National CQUIN – Reduction in carbapenem consumption Part 3a 2 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a 2, the Trust must have a reduction of 1% or more of carbapenem consumption per 1,000 admissions. Quarter 1 data has now been reported on the National database and mirrors the quarter 1 data provided in the previous reports which used local data. Using local data as a comparison for quarter 2 this in on target with 54.82 being the baseline and 39.23 being the DDD/1000 admissions for quarter 2 2016/17		The CQUIN target for antibiotic consumption Part 3a 2 is for a reduction of 1% or more in carbapenem consumption per 1,000 admissions. The target was achieved in month. **National CQUIN – carbapenem consumption Part 3a 2**
National CQUIN – Reduction in piperacillin-tazabactam consumption Part 3a 3 The financial value for this CQUIN is £79,221.	To achieve the CQUIN target for antibiotic consumption Part 3a 3, the Trust must have a reduction of 1% or more of piperacillin-tazabactam consumption per 1,000 admissions. Quarter 1 data has now been reported on the National database and mirrors the quarter 1 data provided in the previous reports which used local data. Although quarter 2 National data is not yet available, early indication suggests that the target is met.		The CQUIN target for antibiotic consumption Part 3a 3 is for a reduction of 1% or more in piperacillin-tazabactam consumption per 1,000 admissions. The target was achieved in month. **National CQUIN – piperacillin-tazabactam consumption Part 3a 3**

Description

National CQUIN – Empiric review of antibiotic prescriptions Part 3b

The financial value for this CQUIN is £79,221.

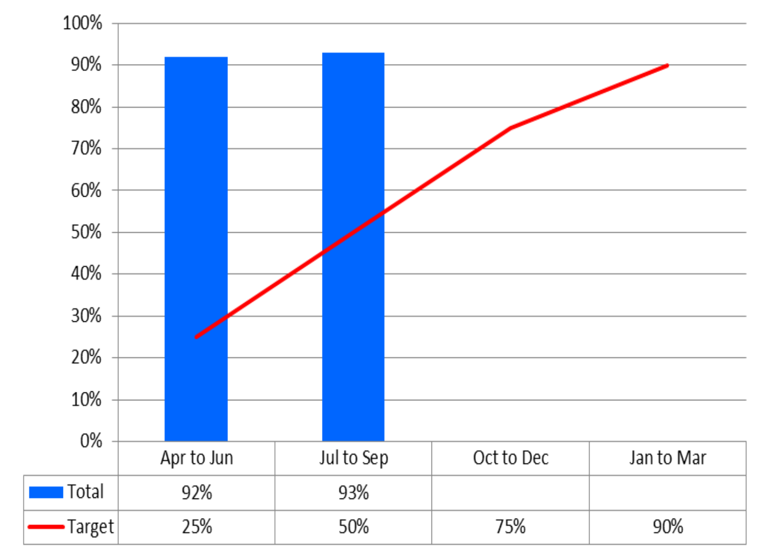
Aggregate Position

To achieve the CQUIN target for empiric review of antibiotic prescriptions Part 3b, a local audit of a minimum of 50 antibiotic prescriptions must be undertaken from a representative sample across all sites and wards.

150 prescriptions were audited across all wards at MCHFT in quarter 2.

An empiric review was documented in the medical notes within 72 hours of commencing treatment for 93% of audited prescriptions for antibiotics in quarter 2.

Trend



	Apr to Jun	Jul to Sep	Oct to Dec	Jan to Mar
🟦 Total	92%	93%		
— Target	25%	50%	75%	90%

Variation

The CQUIN target for empiric review of antibiotic prescriptions Part 3b is for an empiric review to be performed for at least 90% of cases in the sample.

The target was achieved in month.

National CQUIN – Empiric review Part 3b

Description **Aggregate Position** **Trend** **Variation**

Safety Thermometer - Harm Free Care.

In October 2016 97% of patients received harm free care as measured by the Safety Thermometer.

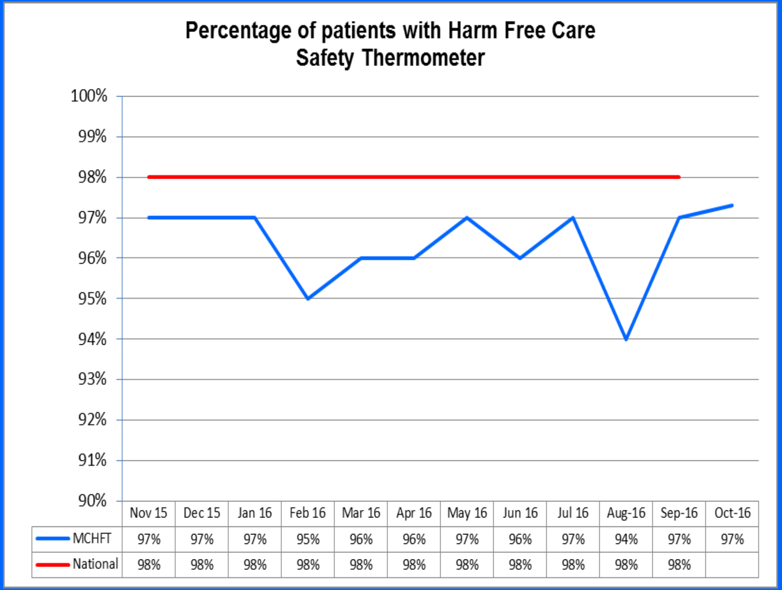
The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward assisted by the Divisional Senior Nursing Teams.

Data is collected on the following each month:

- Hospital Acquired Pressure Ulcers
- Community Acquired Pressure Ulcers
- Patient Falls (Including in and out of hospital falls)
- Urinary Tract Infections
- Catheters
- Venous Thromboembolism (VTE) Risk Assessment
- VTE Prophylaxis
- Hospital Acquired VTE
- Community Acquired VTE

Actions taken include:

- Review of data at appropriate Trust Groups
- Production of ward level Safety Thermometers to aid local improvements



	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug-16	Sep-16	Oct-16
MCHFT	97%	97%	97%	95%	96%	96%	97%	96%	97%	94%	97%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	

>95% of patients to receive harm free care as monitored by the Safety Thermometer.

Harm Free Care

Description	Aggregate Position	Trend	Variation
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.9% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **October 2016 95.9%** September 2016 95.3% August 2016 95.8%	The lowest staffing levels during the day were on Ward 9 at 87.2%. **Registered Staff Day Time**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	99.6% of expected Registered Nurse hours were achieved for night shifts.	Trend **October 2016 99.6%** September 2016 98.4% August 2016 98.8%	The lowest staffing levels during the night were on Ward 12 at 94.6% **Registered Staff Night Time**

Description	Aggregate Position	Trend	Variation
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	95.4% of expected HCA hours were achieved for day shifts. The NICU staffing is low for unqualified staff, particularly on the day shift. This is predominantly due to sickness. However, assurance can be provided that clinical care has not been compromised during October 2016 and the staffing data collated via Badgernet identifies that the acuity and staffing levels on the ward were appropriate for 91% of all shifts in October 2016.	Trend **October 2016 95.4%** September 2016 100% August 2016 101.2%	The lowest staffing levels during the day were on NICU at 24.3% **Support Worker Day Time**
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	103.8% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **October 2016 103.8%** September 2016 106.8% August 2016 105.1%	The lowest staffing levels during the night were on NICU at 64.5% **Support Worker Night Time**

Ward Name	Main Specialties	Day				Night				Day		Night		Care Hours Per Patient Day			
		Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHT		43796.9	41984.5	31225.6	29785.2	25069.3	24957.2	16848.1	17487	95.9%	95.4%	99.6%	103.8%	15451	4.3	3.1	7.4
AMU	Gen. Medicine	2011.3	1962.3	1519	1482.5	1898.8	1837.5	1519	1482.3	97.6%	97.6%	96.8%	97.6%	887	4.3	3.3	7.6
CAU	Paeds	2736.5	2736.5	1006	1006	1460.5	1460.5	391	391	100.0%	100.0%	100.0%	100.0%	487	8.6	2.9	11.5
Critical Care	Gen. Medicine	4124.5	4124.5	473.5	473.5	2565	2565	0	0	100.0%	100.0%	100.0%	-	266	25.1	1.8	26.9
Elmhurst	Rehab	871.5	871.5	2232	2232	775	775	1550	1562.5	100.0%	100.0%	100.0%	100.8%	892	1.8	4.3	6.1
Ward 1	Gen. Medicine	2181.3	2031.3	1162.5	1068.8	1519	1470	759.5	771.8	93.1%	91.9%	96.8%	101.6%	799	4.4	2.3	6.7
Ward 10 SAU	Gen. Surg	1500	1432.5	930	892.5	580.7	580.7	290.4	571.4	95.5%	96.0%	100.0%	196.8%	319	6.3	4.6	10.9
Ward 10 SSW	Gen. Surg & Urology	1701	1629	992	1008	635.5	635.5	317.8	317.8	95.8%	101.6%	100.0%	100.0%	646	3.5	2.1	5.6
Ward 12	Gen. Surg & Gynae	2227	2091	1984	1888	953.3	902	635.5	615	93.9%	95.2%	94.6%	96.8%	943	3.2	2.7	5.8
Ward 13	Gen. Surg	2272	2128	1984	1896	953.3	922.5	635.5	635.5	93.7%	95.6%	96.8%	100.0%	934	3.3	2.7	6.0
Ward 14	Gen. Medicine	1704	1536	1488	1488	744	744	1116	1128	90.1%	100.0%	100.0%	101.1%	972	2.3	2.7	5.0
Ward 15	Trauma & Ortho	2234.5	1970.5	1984	1840	953.3	922.5	635.5	717.5	88.2%	92.7%	96.8%	112.9%	951	3.0	2.7	5.7
Ward 18	Gen. Medicine	1391.3	1366.3	1550	1575	759.5	759.5	759.5	833	98.2%	101.6%	100.0%	109.7%	769	2.8	3.1	5.9
Ward 2	Gen. Medicine	1793.8	1762.5	1550	1468.8	759.5	967.8	1139.3	1163.8	98.3%	94.8%	127.4%	102.2%	966	2.8	2.7	5.6
Ward 21B	Rehab	1304	1226	1813.5	1813.5	775	775	775	775	94.0%	100.0%	100.0%	100.0%	739	2.7	3.5	6.2
Ward 23	Obstetrics	1238	1231.7	785.3	747.3	764.7	764.7	764.7	752.3	99.5%	95.2%	100.0%	98.4%	596	3.3	2.5	5.9
Ward 26	Obstetrics	3211	3211	557.3	557.3	2725.7	2725.7	382.3	382.3	100.0%	100.0%	100.0%	100.0%	155	38.3	6.1	44.4
Ward 4	Gen. Medicine	1704	1698	1860	1800	744	744	1488	1500	99.6%	96.8%	100.0%	100.8%	816	3.0	4.0	7.0
Ward 5	Gen. Medicine	2452.5	2352.5	1550	1487.5	1519	1494.5	759.5	759.5	95.9%	96.0%	98.4%	100.0%	966	4.0	2.3	6.3
Ward 6	Gen. Medicine	2042.5	1961.3	1937.5	1812.5	1519	1470	759.5	820.8	96.0%	93.5%	96.8%	108.1%	827	4.1	3.2	7.3
Ward 7	Gen. Medicine	1746.3	1671.3	1550	1606.3	759.5	747.3	1139.3	1396.5	95.7%	103.6%	98.4%	122.6%	967	2.5	3.1	5.6
Ward 9	Trauma & Ortho	1686	1470	1488	1440	635.5	635.5	317.8	451	87.2%	96.8%	100.0%	141.9%	542	3.9	3.5	7.4
NICU	Paeds	1663.9	1520.8	829	201.7	1069.5	1058	713	460	91.4%	24.3%	98.9%	64.5%	12	214.9	55.1	270.0

Ward Name	Main Specialties	Safety Thermometer Results			
		Hospital Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		1.35% (11)	0.61% (5)	0.12% (1)	0.61% (5)
AMU	Gen. Medicine	0% (0)	10% (3)	0% (0)	3.33% (1)
CAU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	12.5% (1)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SAU	Gen. Surg	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SSW	Gen. Surg & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 12	Gen. Surg & Gynae	0% (0)	3.12% (1)	0% (0)	0% (0)
Ward 13	Gen. Surg	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	3.12% (1)	0% (0)	3.12% (1)	3.12% (1)
Ward 15	Trauma & Ortho	6.25% (2)	0% (0)	0% (0)	0% (0)
Ward 18	Gen. Medicine	4% (1)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	4.55% (1)	0% (0)	4.55% (1)
Ward 21B	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	3.12% (1)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	3.12% (1)	0% (0)	0% (0)	0% (0)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	3.85% (1)	0% (0)	0% (0)	0% (0)
DN – Danebridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eaglebridge	District Nursing	1.69% (1)	0% (0)	0% (0)	0% (0)
DN – Evening Service	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	4.76% (2)	0% (0)	0% (0)	0% (0)
DN – Grosvenor / Hungerford	District Nursing	0% (0)	0% (0)	0% (0)	2.06% (2)
DN – Middlewich / Sandbach	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Rope Green / Church View	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
Intermediate Care	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)

Experience Section:

Indicators	YTD 16/17	Last four months			
		Jul-16	Aug-16	Sep-16	Oct-16
Complaints received by month	176	21	29	25	25
Complaints being reviewed by the Ombudsman		3	5	6	6
Closed complaints by month	187	27	15	29	24
Contacts raising informal concerns	600	82	68	72	76
Compliments received in month	885	112	110	106	171
Number of new claims received in month	27	7	0	3	3
Number of claims closed	18	3	4	1	1
Number of inquests concluded	7	3	0	1	1
NHS Choices - Star Ratings (Leighton)		4	4	4	4
NHS Choices - Star Ratings (VIN)		4.5	4.5	5	4.5
NHS Choices - Number of new postings	60	10	14	7	11
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		6%	8%	7%	4%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		93%	95%	90%	95%
F&FT Response Rate Inpatients and Daycases		18%	20%	20%	20%
Proportion of positive responses Inpatients and Daycases		98%	98%	99%	98%
F&FT Response Rate Outpatients		5%	5%	4%	4%
Proportion of positive responses Outpatients		93%	94%	94%	96%
F&FT Response Rate Maternity - Birth		17%	22%	16%	16%
Proportion of positive responses Maternity - Birth		100%	98%	97%	100%
F&FT Response Rate Community (CCICP)					10%
Proportion of positive responses Community (CCICP)					96%

*ED = Emergency Department; MIU = Minor Injuries Unit; UCC = Urgent Care Centre

Description **Aggregate Position/Description** **Trend**

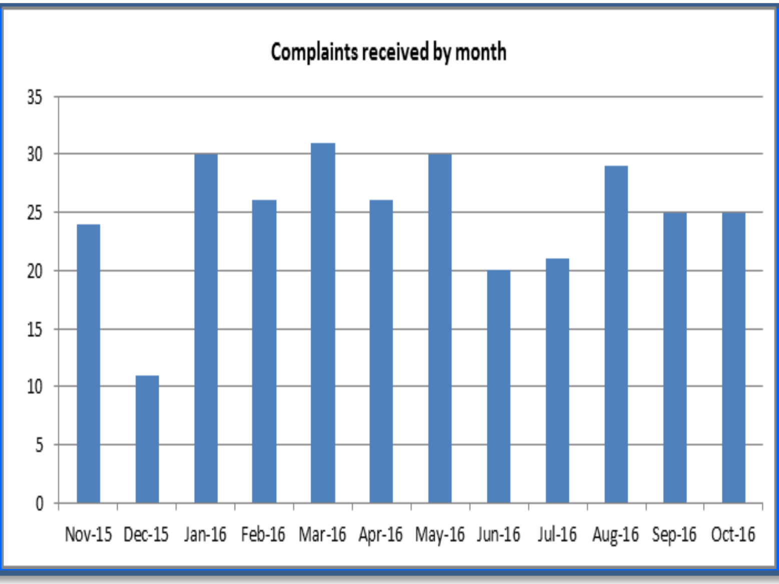
Monthly Trust complaints received by the Trust

25 complaints were received in October 2016 which covered 67 categories. The highest categories were:

- Communication
- Staff Attitude
- Other Medical issues

Highest 3 areas receiving complaints/issues were:

- General Surgery Medical Staff: 6 complaints/13 issues
- Emergency Department: 3 complaints/6 issues
- Ward 13: 2 complaints/5 issues



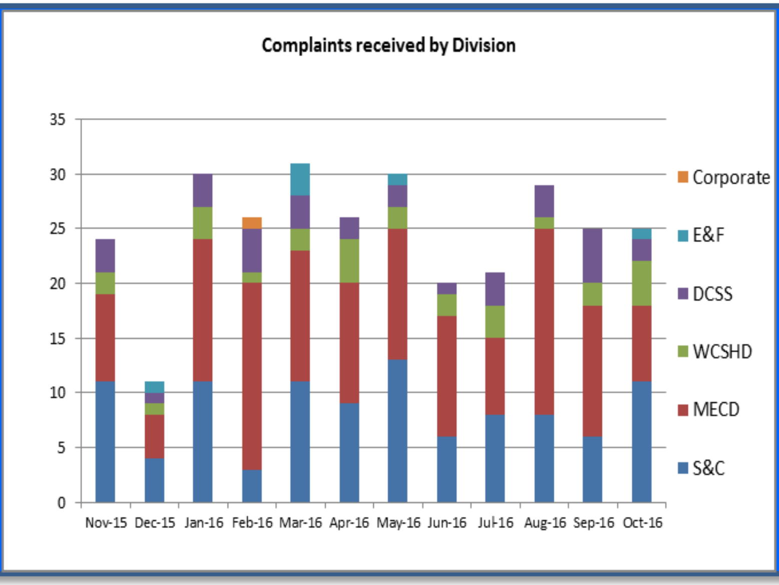
Formal Complaints

Number of formal complaints by Division

This graph shows the breakdown of complaints by month for each division.

S&C: 11
DCSS: 2
W&CD: 4
MECD: 7
E&F: 1

Examples of complaints for October 2016:
S&C – Post –operative care provided
DCSS – Communication re clinics at VIN
W&CD – Standard of care from paediatric team
MECD – Care delivered in the ED



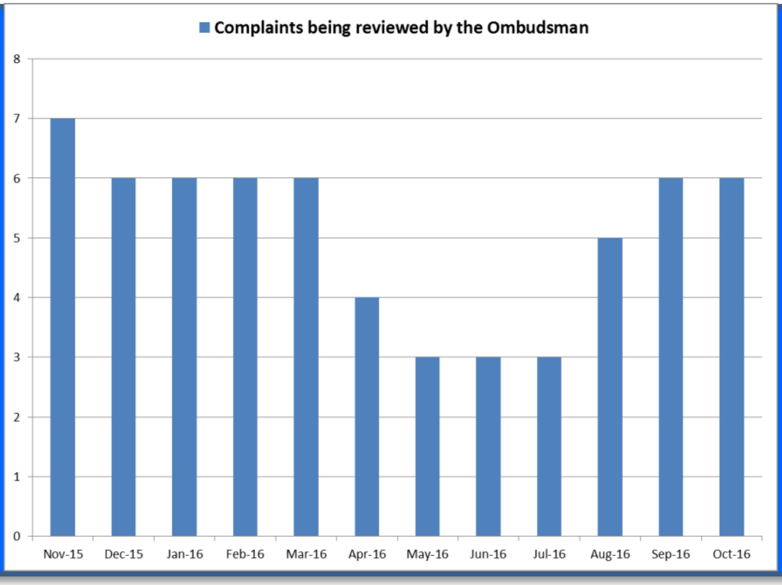
Formal Complaints by Division

Description | **Aggregate Position/Description** | **Trend**

Complaints being reviewed by the Public Health Service Ombudsman

In October 2016 there are currently 6 PHSO cases open.

- 4 are being investigated by the PHSO
- 1 the Trust is awaiting final sign off
- 1 the Trust has returned comments following an external review and is awaiting an update from the PHSO

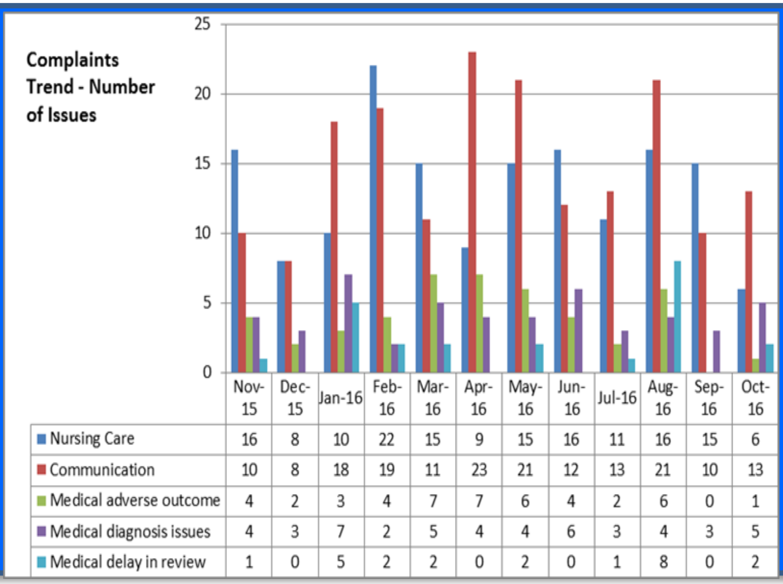


Ombudsman

Complaint Trends and number of issues

The main trends in October 2016 were:

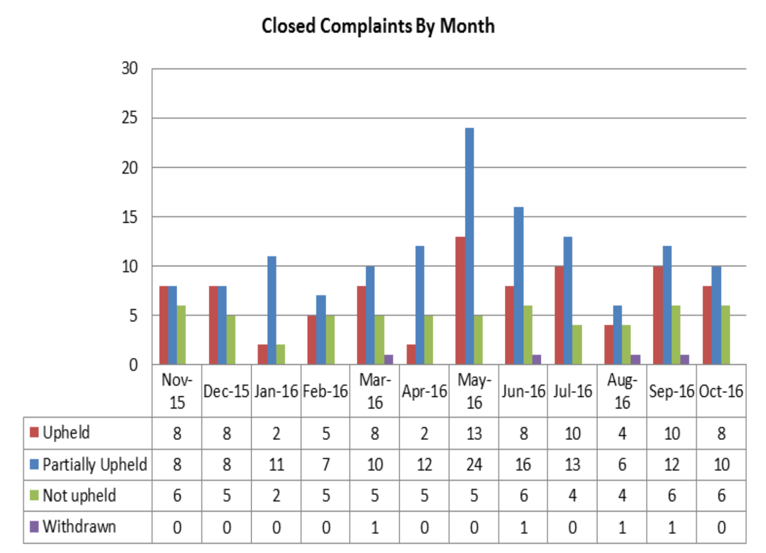
- Communication: 9 complaints/10 issues
- Other Medical: 8 complaints/10 issues
- Staff Attitude: 6 complaints/10 issues



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Nursing Care	16	8	10	22	15	9	15	16	11	16	15	6
Communication	10	8	18	19	11	23	21	12	13	21	10	13
Medical adverse outcome	4	2	3	4	7	7	6	4	2	6	0	1
Medical diagnosis issues	4	3	7	2	5	4	4	6	3	4	3	5
Medical delay in review	1	0	5	2	2	0	2	0	1	8	0	2

Complaint Trends

Description	Aggregate Position/Description	Trend
Closed Complaints	24 complaints were closed in October 2016	



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
🟥 Upheld	8	8	2	5	8	2	13	8	10	4	10	8
🟦 Partially Upheld	8	8	11	7	10	12	24	16	13	6	12	10
🟩 Not upheld	6	5	2	5	5	5	5	6	4	4	6	6
🟪 Withdrawn	0	0	0	0	1	0	0	1	0	1	1	0

Closed Complaints

Closed Complaints by Division

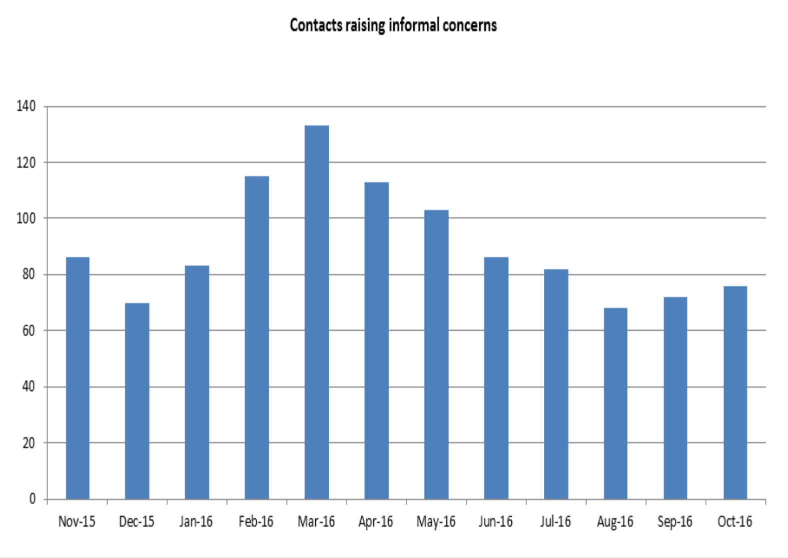
The Table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld or partially upheld.

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Sub-Total
Medicine and Emergency Care	4	4	1	0	9
Surgery and Cancer	3	3	4	0	10
Diagnostics & Clinical Support Services	0	2	0	0	2
Women's and Children's	1	1	1	0	3
Estates & Facilities	0	0	0	0	0
		Total closed			**24**

Complaints closed by division

Department Division	Specialty	Department	Details Of Complaint	Outcome Details	Lessons Learned	Incident Link ?

Tables removed under Section 40 of the Freedom of Information Act.

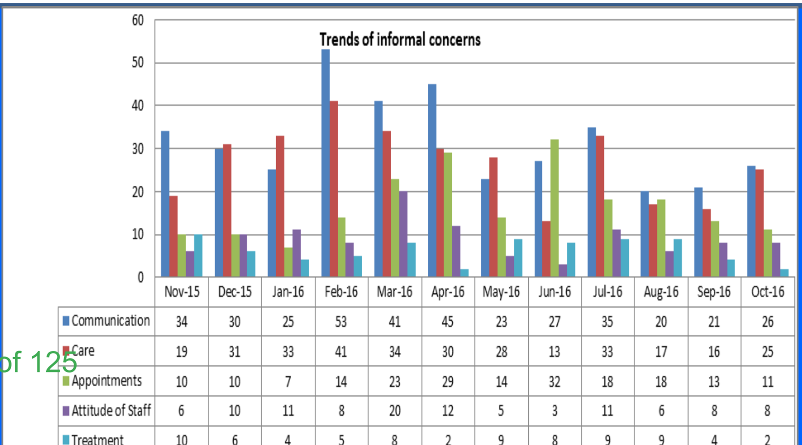
Description	Aggregate Position/Description	Trend	
Informal Concerns Numbers	The number of contacts raising informal concerns for October 2016 was 76, 4 more than the previous month. The Division of Medicine and Emergency Care has received the largest number of issues with 30 contacts raising concerns.		Informal Concerns Feedback

Informal Concerns Trends

Communication was the highest trend for informal concerns in October 2016, with 15 of the issues raised belonging to the Surgery and Cancer Division, 8 of which belong to Ophthalmology.

Of the 25 issues relating to care, 13 belong to the Division of Medicine and Emergency Care with 12 pertaining to medical care. Three of the 13 issues belong to the Emergency Department.

Of the 8 issues relating to attitude, 3 belong to the Diagnostics and Clinical Support Services Division physiotherapy



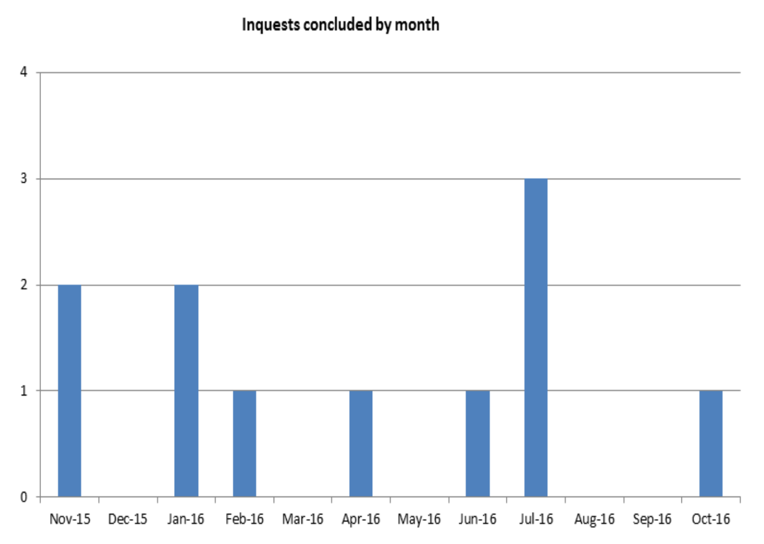
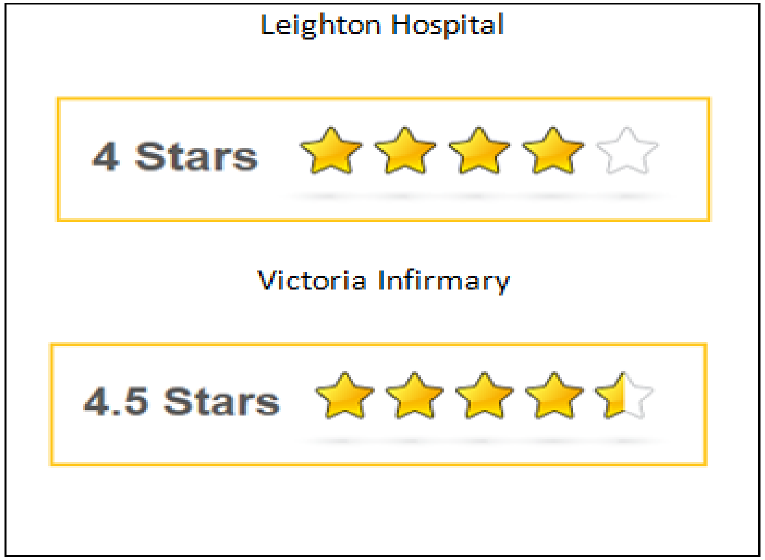
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Communication	34	30	25	53	41	45	23	27	35	20	21	26
Care	19	31	33	41	34	30	28	13	33	17	16	25
Appointments	10	10	7	14	23	29	14	32	18	18	13	11
Attitude of Staff	6	10	11	8	20	12	5	3	11	6	8	8
Treatment	10	6	4	5	8	2	9	8	9	9	4	2

Informal Concerns

Trends

Description	Aggregate Position/Description	Trend
New claims received	Paragraph removed under Section 43 of the Freedom of Information Act.	Chart removed under Section 43 of the Freedom of Information Act Claims
Claims closed with/without damages	Paragraph removed under Section 43 of the Freedom of Information Act.	Chart removed under Section 43 of the Freedom of Information Act. Closed Claims

Description	Aggregate Position/Description	Trend
Value of claims closed by month	Paragraph removed under Section 43 of the Freedom of Information Act.	Chart removed under Section 43 of the Freedom of Information Act. **Value of Claims**
Top five claims by Specialty	Paragraph removed under Section 43 of the Freedom of Information Act.	Chart removed under Section 43 of the Freedom of Information Act. **Top 5 Claims by Specialty**

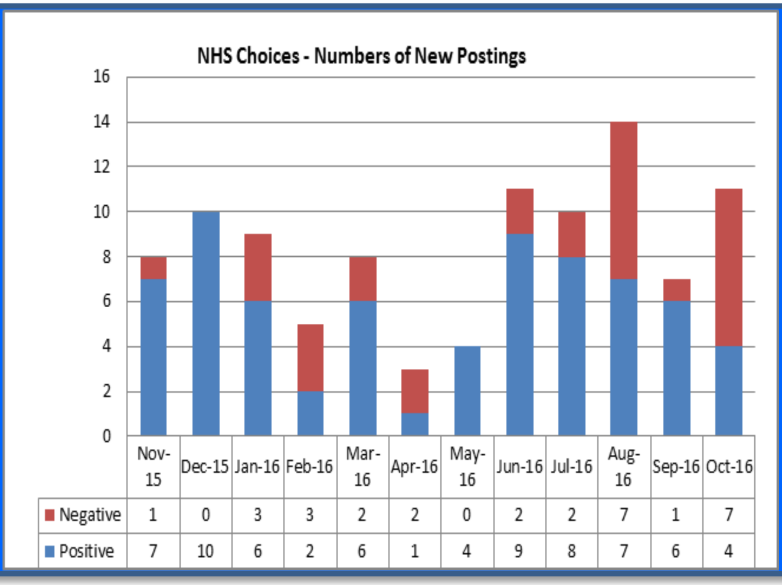
Description	Aggregate Position /Description	Trend	
Number of Inquests concluded by month	1 inquest was concluded in October 2016 and an accidental conclusion was returned. This related to a patient fall on a ward and all actions identified through the RCA have been fully completed.		**Inquests**
NHS Choices Star Ratings	Leighton Hospital is rated at 4 stars. Victoria Infirmary, Northwich is rated at 4.5 stars. The above ratings are based on 181 postings received to date. All postings in October were for Leighton Hospital	 Leighton Hospital 4 Stars Victoria Infirmary 4.5 Stars	**NHS Choices – Star Ratings**

Description **Aggregate Position /description** **Trend**

NHS Choices postings

There were 11 postings on NHS Choices in October
Examples of feedback included:

Macmillan Cancer Centre - The whole process was speedy and efficient in a caring environment. A first class service
Treatment Centre - My case was dealt with very professionally and quickly
ECG - Just wanted to say thank you again for all the team being so reassuring and helpful
Children's ward - Leighton is operating within acceptable levels and as such the care and attention is not where it needs to be for service users to feel confident in their treatment and care



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
🟥 Negative	1	0	3	3	2	2	0	2	2	7	1	7
🟦 Positive	7	10	6	2	6	1	4	9	8	7	6	4

NHS Choices - Postings

The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

In October 2016 the Trust has scored the following positive response scores :

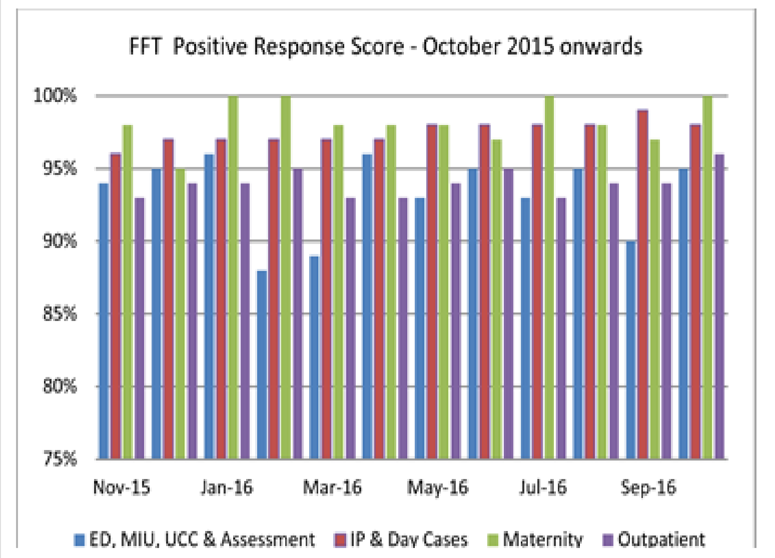
Inpatients and day cases – 98%

Emergency care /Assessment areas – 95%

Outpatients - 96%

Maternity – 100%

In total 2338 responses were received and 97% of patients would recommend our hospital services.

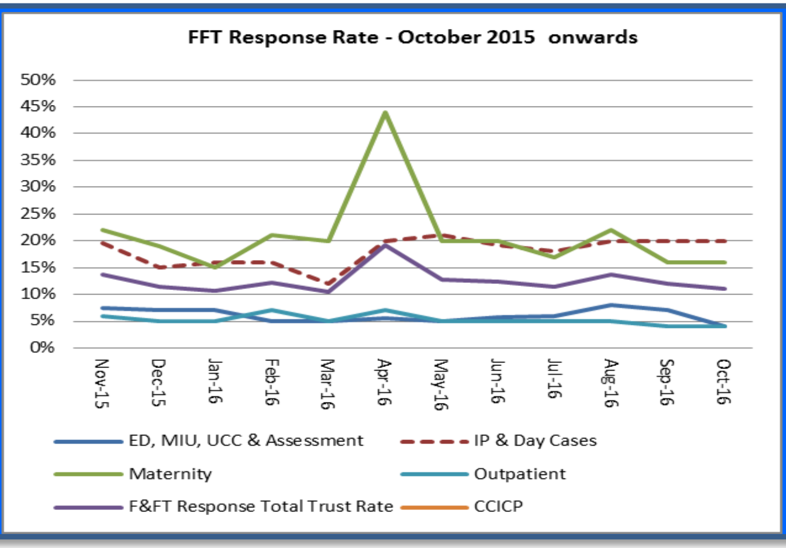


Family & Friends Test

Description **Aggregate Position** **Trend**

Number of responses received for IP, Day Case, ED, maternity compared to eligible patients

August-16 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	4%	256	242
Inpatients & Daycases	20%	864	847
Maternity	16%	42	42
Outpatients	4%	1176	1126
CCICP	10%	223	215

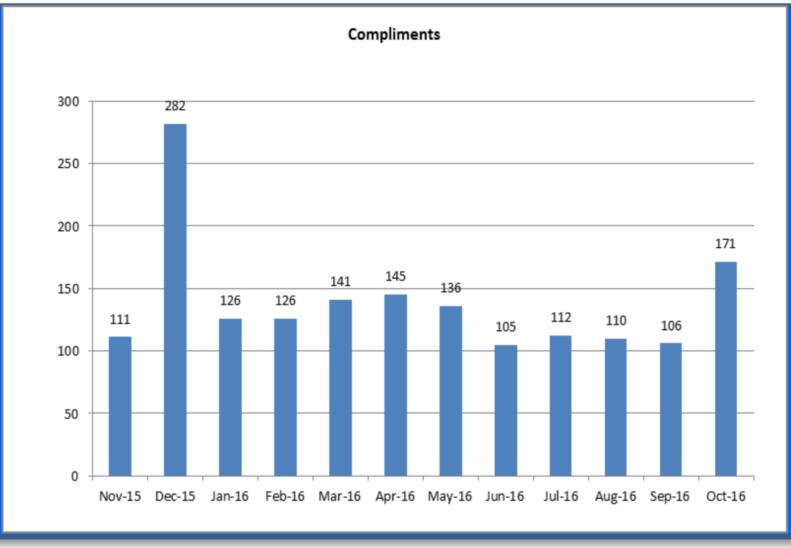


Family & Friends Test

Compliments received

There were 171 compliments/thank-you's received for October 2016.

My son was seen for a dislocated shoulder in the emergency department. I would like to express my extreme gratitude for the professionalism shown by the nurse, and the treatment of my son, who was in great pain due to his injury. The staff member treated him with respect, explained his status and helped relieve the pain as much as possible. Thank you for the help, care and empathy.



Compliments

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board of Directors Performance Report

October 2016

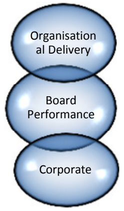
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

The MCHT Monthly Performance Report has been developed to integrate key domains of Quality and Safety, Performance and Corporate into one consistently presented report. It has been developed to provide an over arching view of performance against Trust priorities as set out in the NHS Improvement Compliance Framework, NHS Operating Framework, CCG CQuIN and Annual Plan.

The Monthly Performance Report will focus upon delivery of service improvements within 3 key domains:



The delivery of the service improvements within the 3 key domains are also reflected in the Board Assurance Framework which identifies where the organisation has insufficient assurance in delivering the strategic objectives of the organisation.
Within this Performance Report the indicators within each domain are presented on a summary page with the current month and year to date performance given. All indicators are measured against a NHS Improvement, national, peer or locally agreed target. A further analysis of all measures within each domain is then provided with supporting trend information and narrative. Performance against each indicator is rated as either red/green against the year to date or single month/quarter target as appropriate. Supporting narrative is provided on an exception basis.

This report is an evolving summary of overall Trust Performance, therefore measures, targets and reporting periods will be refined over time. A supporting and more detailed quality and safety report will be presented separately. This is also under further review.

Tracy Bullock
Chief Executive

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	Capital Summary	17
	State of Financial Position	18
	Cash position and Working Capital	19
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Headline Measures

Organisational Delivery

Indicator	Standard	YTD	Oct-16
Cancer			
Urgent referrals seen in 2 wks (%)	93.00%	97.88%	98.60%
No of Patients Seen		5,518	712
No of Breaches		117	10
62 day from urgent GP (%)	85.00%	92.70%	93.88%
No of Patients Seen		425	49
No of Breaches		31	3
62-day wait for first treatment from NHS Cancer Screening Service referra	90.00%	94.48%	100.00%
No of Patients Seen		73	12
No of Breaches		4	0
Unplanned Activity			
A&E <4hrs Standard (%)	95.00%	89.40%	89.21%
A&E Attendances LH & MIU (% to plan)		102.18%	104.15%
A&E Attendances LH & MIU (Vol)		48,854	7,024
Planned Activity			
Incomp Pathways <18wk (%)	92.00%	94.00%	93.49%
>6wk Diagnostic Waits (%)	1.00%	0.45%	0.63%
Total Patients Waiting for a First Outpatient Appointment			6,842

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		3.03%
Turnover Rolling 12 Month		10.24%

Corporate

	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	4	2	4	0.80	0.91
Liquidity	4	4	4	-23	-27
I&E Margin	3	2	3	-0.32%	-0.32%
Distance from Financial Plan	0	1	2	0.00%	0.00%
Agency Spend	1	2	1	0.00%	-0.47%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Scheme Total (£000's)	1,934	1,956	22	3,315	3,370	55
Revenue Generation Scheme total (£000's)	1,902	1,389	-513	3,690	2,409	-1,280
Commission Contact Income SC & VR (£000's)	88,705	91,703	2,998			
Contract Income (£'000) Net of Drugs	105,790	106,783	993			
Pay to Budget (£000's)	-83,943	-84,189	-246			
Non Pay to Budget (£000's) Net of Drugs	-30,677	-32,820	-2,143			
Agency Trajectory (£000's)	-3,770	-4,042	-272			

Exec Summary

In October, the Trust delivered 4 of the 5 NHS Improvement performance indicators (as revised in the Single Oversight Framework); the compliance indicator not met was the A&E 4-hour waiting time target, where performance in month was 89.2% against a national target of 95% and an STF trajectory target of 92%. October 2016 saw another very busy month in A&E with activity up almost 9% compared to the same month in 2015, with over 7,000 attendances.

The Trust achieved the RTT 18 week referral target for incomplete pathways, however missed the 90% target for admitted patients, with performance at 89.6%. The Trust also failed to deliver the RTT target for non-admitted patients, delivering 91.4% against the 95% target.

In Diagnostics, 0.63% of patients waited longer than 6 weeks in the October reporting period.

Cancer services continue to perform strongly across all key performance indicators, with all services performing consistently above target.

Outpatient DNA rates for October were below 6%, and the OP waiting list is below 7,000, both reflecting the lowest levels in over a year.
In Inpatient care, an increase in elective LoS and continued high rates of delayed disharges saw pressure on medical beds, resulting in an increase in medical outliers to 8, the highest rate since March.

The UoRR metric introduced this month is 3, primarily a result of the override resulting from the Liquidity rating of 4. The liquidity rating is a result of working capital equivalent to -17 days of operating expenditure, prior to the support of the working capital facility provided by NHSI.

The Trust's normalised I&E position is a surplus of £574k against a planned deficit of £147k The main areas resulting in this better than planned position, excluding drugs offsets and Community Services are Other Income £0.5M, Pay £1.2M, Non-Pay (£1.0M) and Depreciation £0.2M.

The variance on South Cheshire & Vale Royal contract is a result of significantly different planning assumptions relating to growth.

The position assumes receipt of the STF monies, equating to £3.5M year to date, there are risks associated with achieving criteria for the remainder of the year, particularly around the A&E performance trajectory.

The Trust is meeting its CIP target but will not deliver the Revenue Generation due to gaps in the clinical workforce.

The Trust is currently £272k behind its Agency spend trajectory which for the full year is £6.2M being £3.5M less than 2015/16.

NHS Improvement Framework

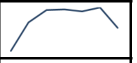
Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to met the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard.	🟥
Finance & Resource	Poor levels of overall financial performance (avg score of 3 or 4). Very poor performance (score of 4) in any individual metric. Potential value for money concerns.	🟥

The Trust Operational trigger rating continues as RED as a result of the 3 quarters failure of a primary target. The A&E target has been failed in the previous two quarters as well as October 2016.

The Trust has a Use of Resource rating of 3 cumulative and is forecasting a rating of 3 for the full year. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the liquidity rating as a result of our underlying low cash balance for which the Trust is receiving targeted support in the form of a working capital facility. The Trust is better than plan for its I&E margin ytd but is expected to meet its control total plan by year end. The Agency trajectory target is currently not being met with a worsening position in October.

Operational Performance

	Current YTD														
	Target	**Actual**	**Apr 16**	**May 16**	**Jun 16**	**Jul 16**	**Aug 16**	**Sep 16**	**Oct 16**	**Nov 16**	**Dec 16**	**Jan 17**	**Feb 17**	**Mar 17**	**Monthly Trend**
Maximum 6 week wait for Diagnostic procedures	1%	0.45%	1.22%	0.49%	0.18%	0.16%	0.21%	0.11%	0.63%						
All Cancers: 62-day wait for first treatment from urgent GP referral (%)	85%	92.70%	91.49%	96.55%	89.47%	92.81%	89.76%	95.24%	93.88%						
All Cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral (%)	90%	94.48%	94.74%	77.78%	100.00%	92.31%	90.00%	100.00%	100.00%						
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	94.00%	94.65%	94.80%	93.95%	93.99%	93.52%	93.50%	93.49%						
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	89.40%	89.78%	85.57%	87.46%	88.86%	93.12%	92.17%	89.21%						
A&E STF Trajectory			88.0%	89.0%	92.0%	95.0%	95.0%	95.0%	92.0%	92.0%	92.0%	93.5%	92.0%	92.8%	

Financial & Resource

		Unit	**YE Plan**	**YE Forecast**	**YE Rating**	**YTD Plan**	**YTD Actual**	**YTD Rating**
Financial Sustainability	Capital Service Capacity	0.0x	0.80	0.91	4	1.01	2.15	2
	Liquidity	days	-23	-27	4	-17	-17	4
Financial Efficiency	I&E Margin	%	-0.32%	-0.32%	3	-0.26%	0.47%	2
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	2	0.00%	0.73%	1
	Agency Spend	%	0.00%	-0.47%	1	0.00%	9.04%	2
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

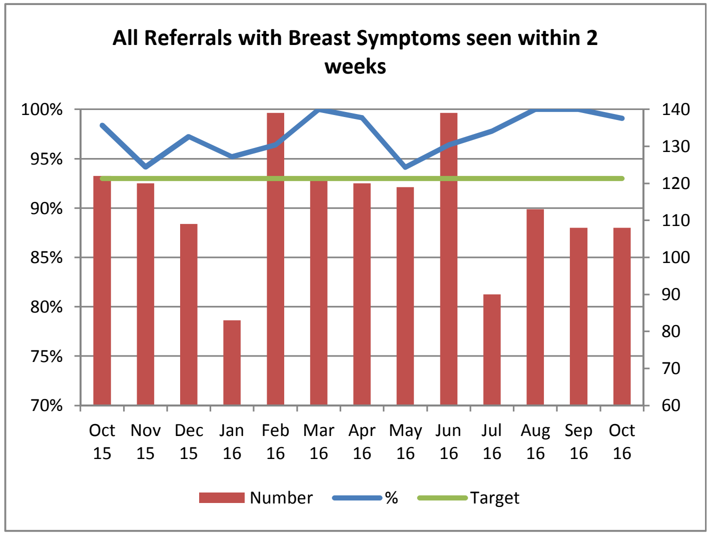
	Current YTD		Rolling 13 months													
	Target	Actual	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
Urgent GP referrals seen within 2 weeks (% to Target)	93%	97.88%	97.45%	97.31%	96.68%	96.01%	98.15%	96.61%	97.09%	97.55%	96.86%	98.20%	98.55%	98.25%	98.60%	
Number of Referrals		*5518*	*666*	*633*	*663*	*576*	*702*	*708*	*755*	*774*	*795*	*666*	*685*	*687*	*712*	
Number of Breaches		*117*	*17*	*17*	*22*	*23*	*13*	*24*	*22*	*19*	*25*	*12*	*10*	*12*	*10*	
% seen within 7 days		*49.4%*							*41.6%*	*37.2%*	*48.6%*	*65.6%*	*63.8%*	*58.7%*	*64.6%*	

62 day wait for 1st treatment from urgent GP referral for suspected cancer (% to Target)	85%	92.70%	92.59%	96.00%	93.08%	90.83%	96.15%	93.41%	91.49%	96.55%	89.47%	92.81%	89.76%	95.24%	93.88%	

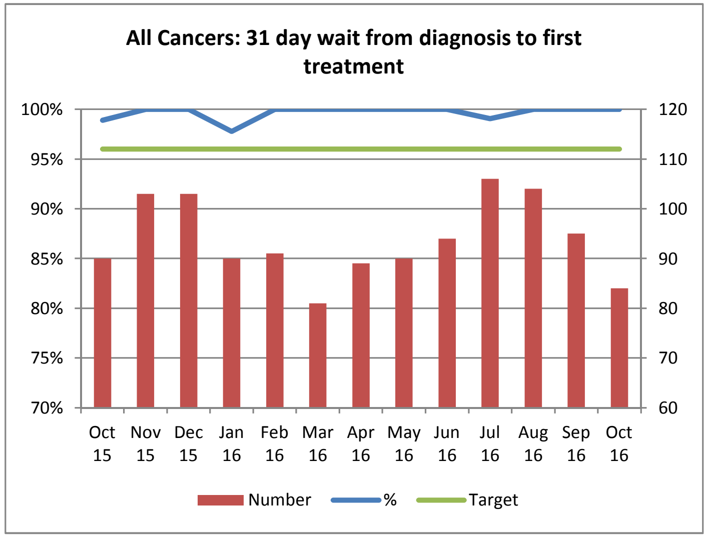
Commentary

The Trust continues to perform strongly against the national cancer targets, with all performance targets being met consistently.

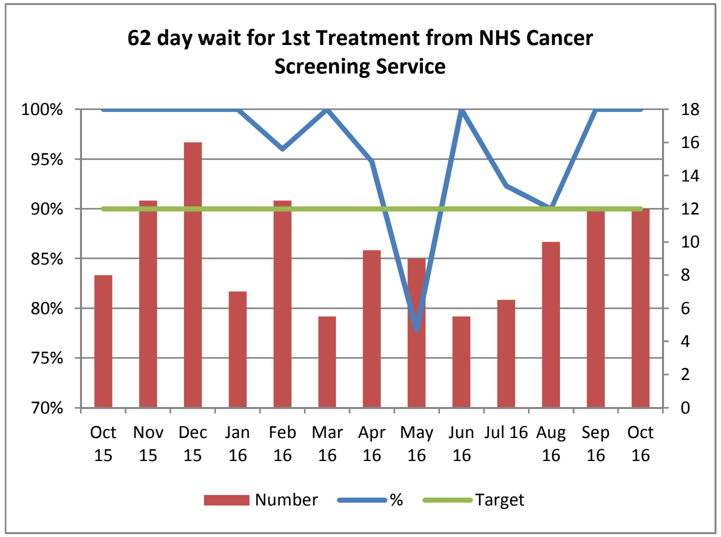
Primary Measures



All Referrals with Breast Symptoms seen within 2 weeks

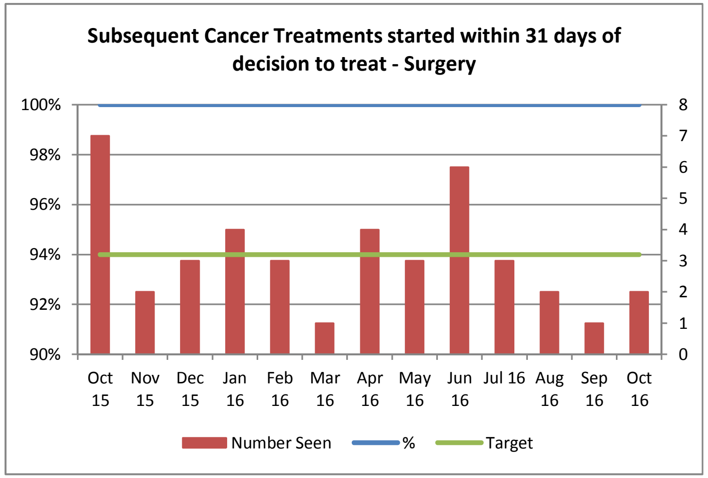


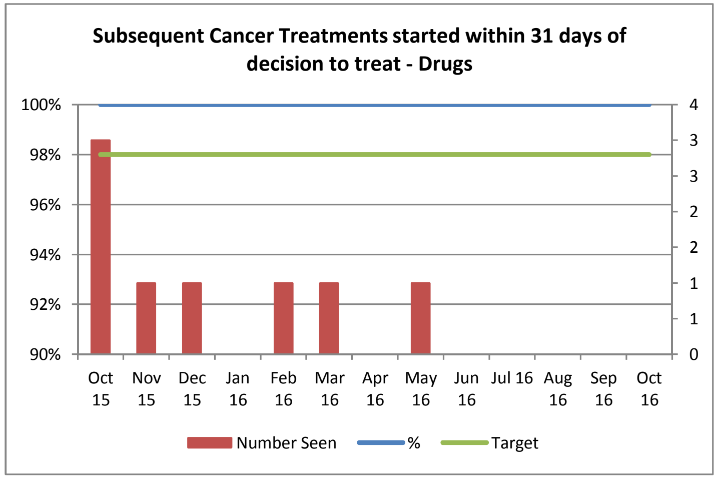
All Cancers: 31 day wait from diagnosis to first treatment

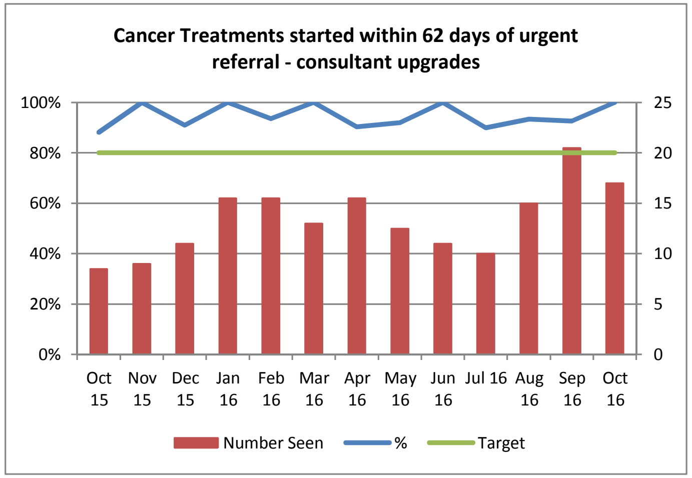


62 day wait for 1st Treatment from NHS Cancer Screening Service

Operational Delivery: *Cancer Pathway*

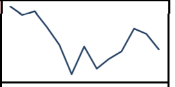




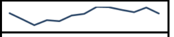


Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months													
	Target	Actual	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
A&E - >4 hr wait time from arrrival to admission/ transfer/ discharge (% to Target)	95%	89.40%	97.41%	95.72%	96.43%	93.46%	90.10%	84.52%	89.78%	85.57%	87.46%	88.86%	93.12%	92.17%	89.21%	
No. of 4hr breaches		*5,512*	*179*	*305*	*245*	*463*	*696*	*1,215*	*709*	*1,128*	*934*	*854*	*503*	*571*	*813*	

	Plan	Actual	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
A&E Attendances Leighton & MIU (% to Plan)		*102.18%*	*92.1%*	*97.6%*	*86.1%*	*98.3%*	*101.7%*	*102.2%*	*99.2%*	*106.3%*	*101.7%*	*99.7%*	*100.2%*	*104.1%*	*104.1%*	
A&E Attendances Leighton & MIU (No.)	*47,812*	*48,854*	*6,446*	*6,495*	*6,366*	*6,565*	*6,522*	*7,215*	*6,533*	*7,454*	*6,995*	*7,207*	*6,826*	*6,815*	*7,024*	

A&E Attendance Case Mix (Leighton)	*Major*		*57.83%*	*60.6%*	*61.8%*	*64.7%*	*62.6%*	*61.8%*	*58.3%*	*59.6%*	*54.8%*	*56.6%*	*58.0%*	*59.6%*	*57.6%*	*59.0%*	
	Minor		*36.58%*	*35.2%*	*32.7%*	*30.0%*	*32.1%*	*31.8%*	*34.3%*	*34.9%*	*38.1%*	*37.9%*	*36.6%*	*35.6%*	*37.7%*	*35.0%*	
	Resus		*3.29%*	*2.5%*	*3.6%*	*3.0%*	*3.8%*	*4.2%*	*4.8%*	*3.5%*	*4.6%*	*3.5%*	*3.4%*	*2.5%*	*2.3%*	*3.1%*	
	Unknown		*2.30%*	*1.7%*	*1.8%*	*2.2%*	*1.5%*	*2.2%*	*2.7%*	*2.0%*	*2.5%*	*2.0%*	*2.0%*	*2.3%*	*2.3%*	*2.9%*	

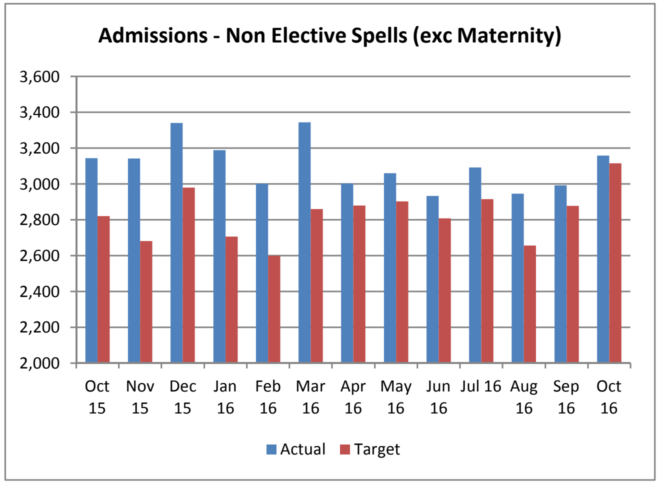
Commentary

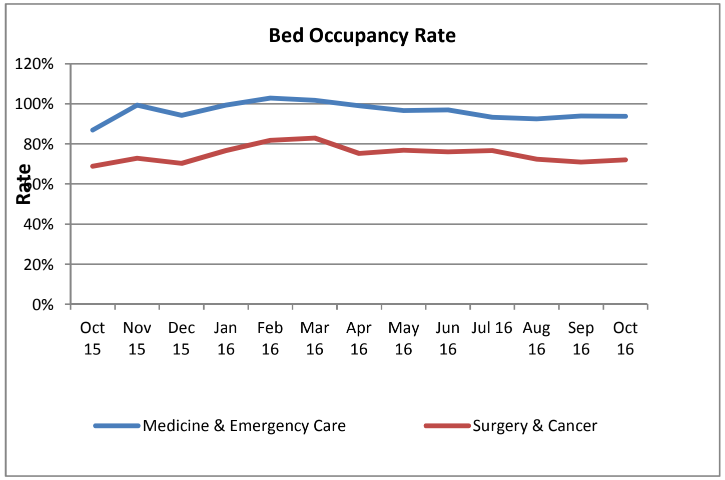
The Trust has failed to achieve the 4-hour A&E target since January and the department is under continued pressure. We have seen a 9% increase in attendances in October 2016 compared to the same month in 2015, and ambulance attendances continue to rise, with October seeing the highest number of arrivals in 6 months. The Trust has an Emergency Department Action Plan in place which is addressing some of the key issues affecting A&E performance, including staffing, case mix, flow and discharge.

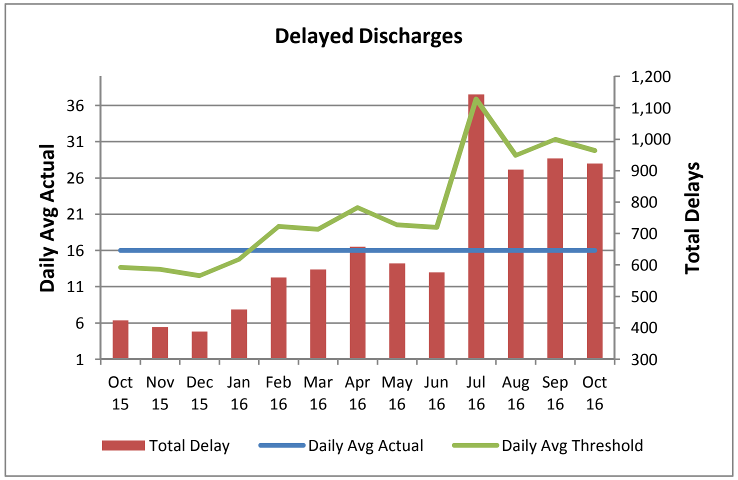
Non-elective admissions continue to be above planned levels, although there are indications that this increase may be slowing. Flow through the hospital is compromised by high levels of delayed discharges, with daily average levels consistently above 25. The main challenge here for delayed transfers of care (DTOC) is available of social care beds.

October has seen a rise in medical outliers as a result of an increase in Elective LoS and the continued challenges around delayed discharge of patients.

Primary Drivers

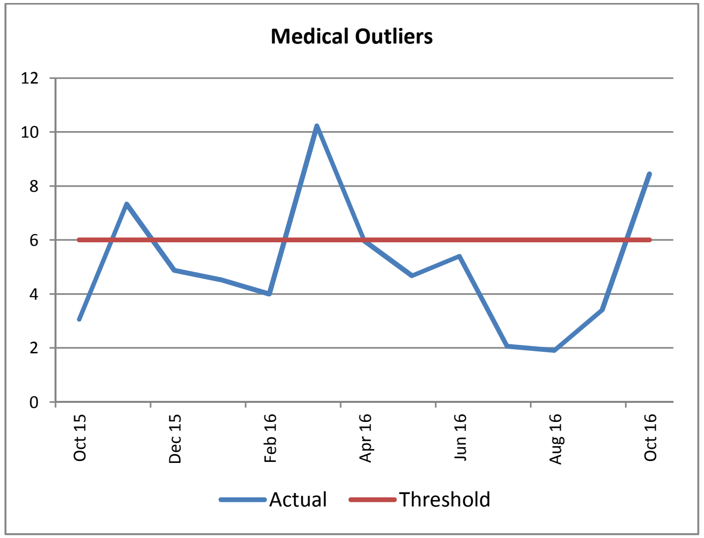


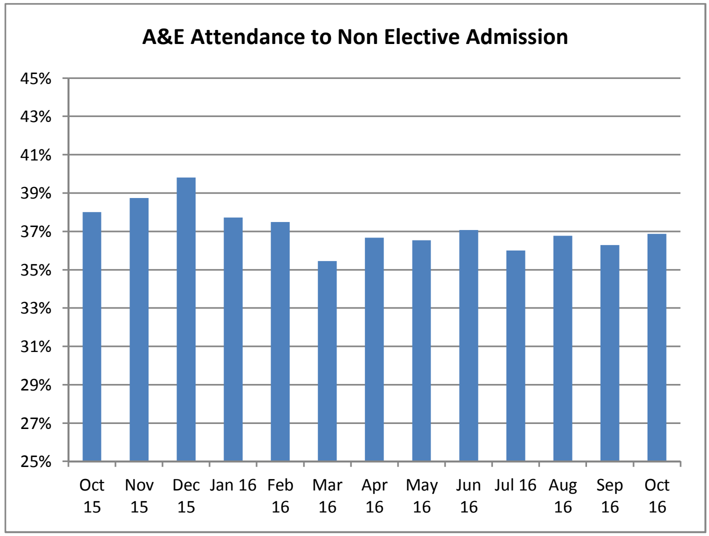


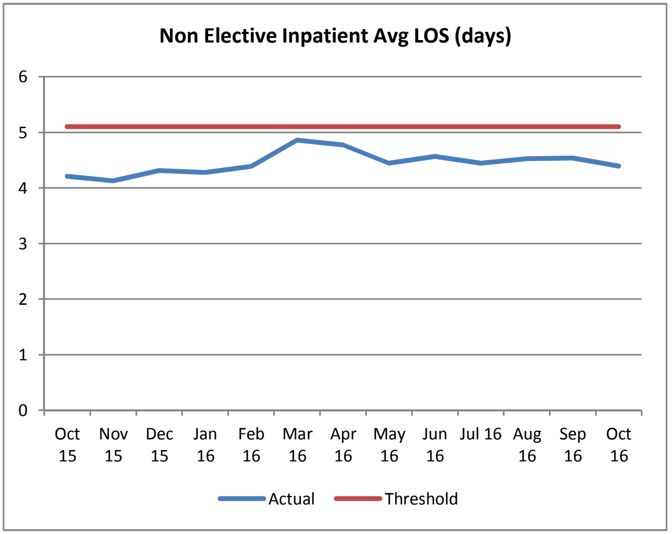


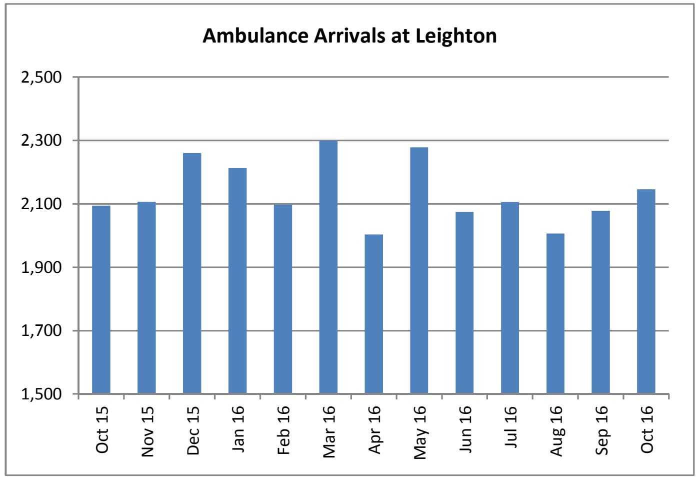
Operational Delivery: *Unplanned Activity A&E*

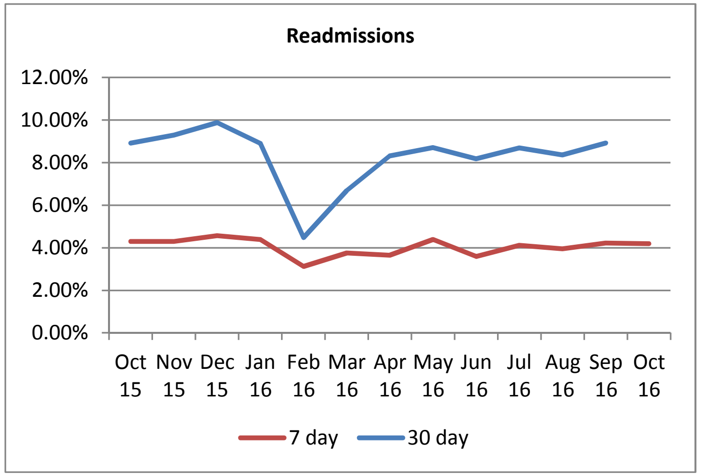
Secondary Drivers

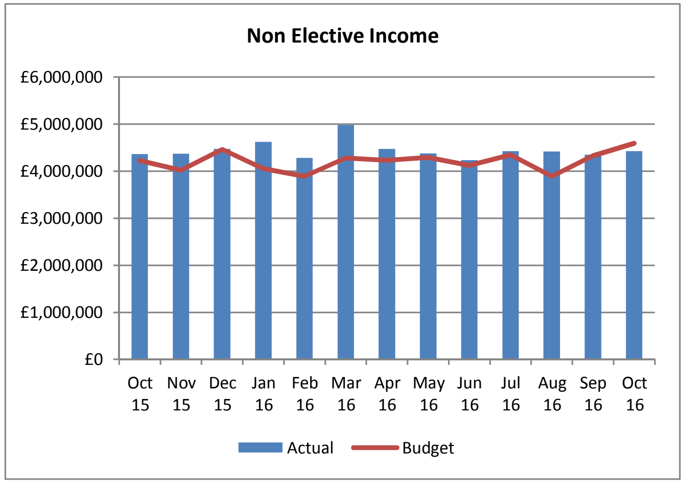

Medical Outliers


A&E Attendance to Non Elective Admission


Non Elective Inpatient Avg LOS (days)


Ambulance Arrivals at Leighton


Readmissions


Non Elective Income

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months													
	Target	Actual	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	94.00%	95.04%	94.61%	94.79%	94.67%	95.16%	94.56%	94.65%	94.80%	93.95%	93.99%	93.52%	93.50%	93.49%	
Total 18 Weeks		*115,984*	*14,682*	*14,483*	*14,346*	*14,365*	*15,096*	*15,435*	*17,025*	*16,956*	*17,358*	*17,158*	*16,688*	*15,923*	*14,876*	
No. > 18 Weeks		*6,959*	*728*	*780*	*747*	*766*	*730*	*839*	*910*	*882*	*1,050*	*1,032*	*1,081*	*1,035*	*969*	
Diagnostic Waiting Time	1%	0.45%	1.45%	0.38%	0.44%	0.65%	0.33%	0.98%	1.22%	0.49%	0.18%	0.16%	0.21%	0.11%	0.63%	
Total Number of Waiters		*34,419*	*3,587*	*4,708*	*4,289*	*3,846*	*4,588*	*3,678*	*5,588*	*7,121*	*6,149*	*4,358*	*3,806*	*3,767*	*3,630*	
Waiters of 6 Weeks +		*156*	*52*	*18*	*19*	*25*	*15*	*36*	*68*	*35*	*11*	*7*	*8*	*4*	*23*	
Total Patients Waiting for a First Outpatient Appointment			7,371	7,162	7,248	7,150	7,790	8,302	8,774	8,892	8,918	8,853	8,327	7,669	6,842	
Longest Wait Time (weeks) - under development																

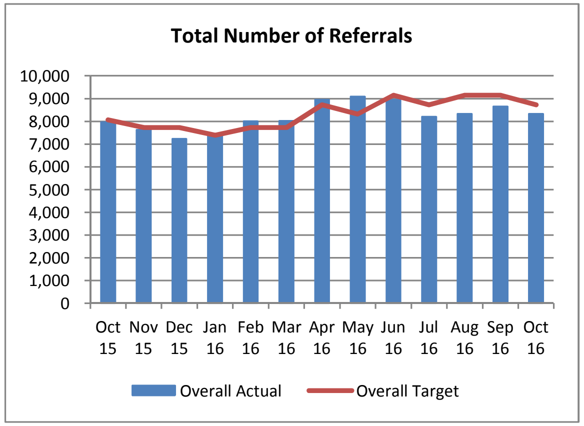
Commentary

The Trust continues to face significant challenges in maintaining performance against its 18 week referral to treatment pathways. The Incomplete pathways target continues to be met, with the position remaining static for the past three months at 93.5%. However in October the Trust did not achieve the target for Non-Admitted or Admitted pathways, with performance at 91.4% (T: 95%) and 89.6% (T: 90%) respectively.

Referrals remain on or slightly below plan, and with strong sustained levels of outpatient activity the OP waiting list continues to reduce, with the total number of patients awaiting a first OP appointment below 7,000 for the first time in over a year. Whilst the Trust has delivered the diagnostic wait time in the majority of prior months, it is noted demand for MRI, CT and Ultrasound is increasing and there is a constraint with providing the clinical resources required to meet demand.

The Trust is delivering its planned levels of elective activity despite continued pressures from unplanned activity resulting in cancelled operations and less than planned levels of theatre efficiency, as well as significant challenges resulting from extended patient discharge times.

Primary Drivers

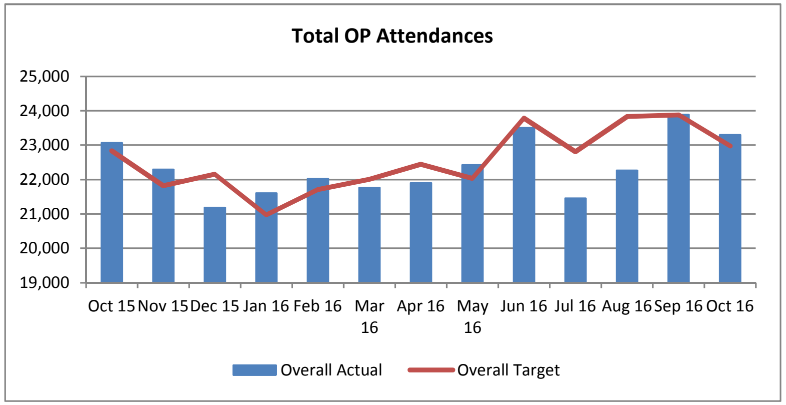


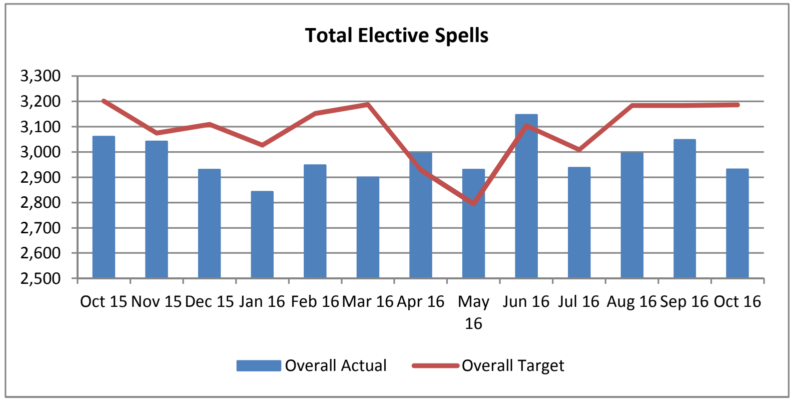
Referral Breakdown

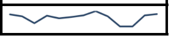
	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
GP Actual	5,047	4,837	4,453	4,793	5,136	5,048	5,762	5,622	5,586	5,055	5,035	5,383	5,063	
GP Target	5,295	5,072	5,072	4,849	5,072	5,072	5,505	5,243	5,767	5,505	5,767	5,767	5,505	
% to Target	95.3%	95.4%	87.8%	98.9%	101.3%	99.5%	104.7%	107.2%	96.9%	91.8%	87.3%	93.3%	92.0%	
Other Actual	2,913	2,789	2,788	2,643	2,872	2,980	3,196	3,465	3,370	3,151	3,297	3,275	3,263	
Other Target	2,777	2,656	2,656	2,535	2,656	2,656	3,222	3,069	3,376	3,222	3,376	3,376	3,222	
% to Target	104.9%	105.0%	105.0%	104.3%	108.1%	112.2%	99.2%	112.9%	99.8%	97.8%	97.7%	97.0%	101.3%	
Total Actual	7,960	7,626	7,241	7,436	8,008	8,028	8,958	9,087	8,956	8,206	8,332	8,658	8,326	
Total Target	8,072	7,728	7,728	7,383	7,728	7,728	8,728	8,312	9,143	8,728	9,143	9,143	8,728	
% to Target	98.6%	98.7%	93.7%	100.7%	103.6%	103.9%	102.6%	109.3%	98.0%	94.0%	91.1%	94.7%	95.4%	
GP % of Total	63.4%	63.4%	61.5%	64.5%	64.1%	62.9%	64.3%	61.9%	62.4%	61.6%	60.4%	62.2%	60.8%	

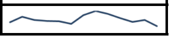
Operational Delivery: *Planned Activity*

Primary Drivers



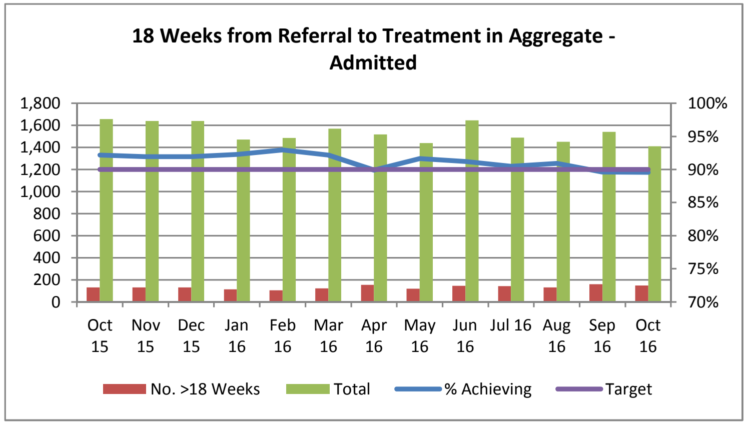


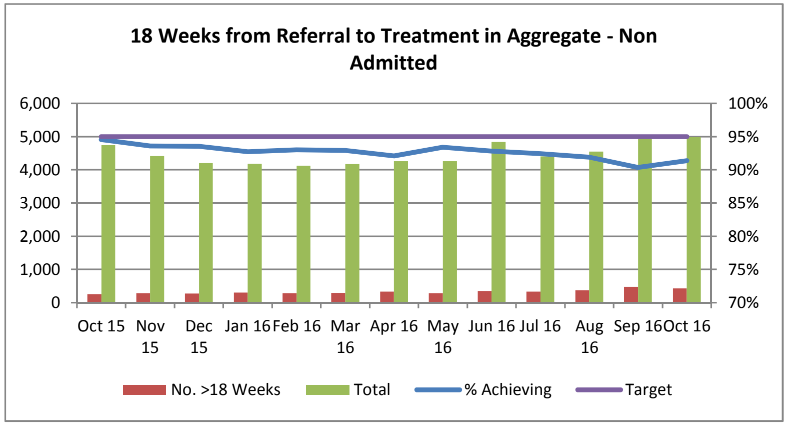
OP Attendance Breakdown	YTD	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
New Actual	28,549	7,342	6,906	6,506	6,651	6,767	6,890	7,253	7,240	7,556	6,576	6,880	7,644	7,449	
New Target	28,752	6,996	6,693	6,724	6,405	6,683	6,710	6,970	6,693	7,329	7,002	7,333	7,337	7,081	
% to Target	99.3%	104.9%	103.2%	96.8%	103.8%	101.3%	102.7%	104.1%	108.2%	103.1%	93.9%	93.8%	104.2%	105.2%	
F U Actual	62,376	15,728	15,391	14,680	14,951	15,255	14,877	14,652	15,190	15,952	14,882	15,392	16,249	15,853	
F U Target	64,739	15,839	15,128	15,430	14,567	15,028	15,293	15,478	15,342	16,457	15,807	16,498	16,540	15,894	
% to Target	96.3%	99.3%	101.7%	95.1%	102.6%	101.5%	97.3%	94.7%	99.0%	96.9%	94.1%	93.3%	98.2%	99.7%	
Total Actual	90,925	23,070	22,297	21,186	21,602	22,022	21,767	21,905	22,430	23,508	21,458	22,272	23,893	23,302	
Total Target	93,491	22,835	21,821	22,154	20,972	21,711	22,002	22,447	22,035	23,786	22,809	23,831	23,876	22,975	
% to Target	97.3%	101.0%	102.2%	95.6%	103.0%	101.4%	98.9%	97.6%	101.8%	98.8%	94.1%	93.5%	100.1%	101.4%	
New % of Total	31.4%	31.8%	31.0%	30.7%	30.8%	30.7%	31.7%	33.1%	32.3%	32.1%	30.6%	30.9%	32.0%	32.0%	

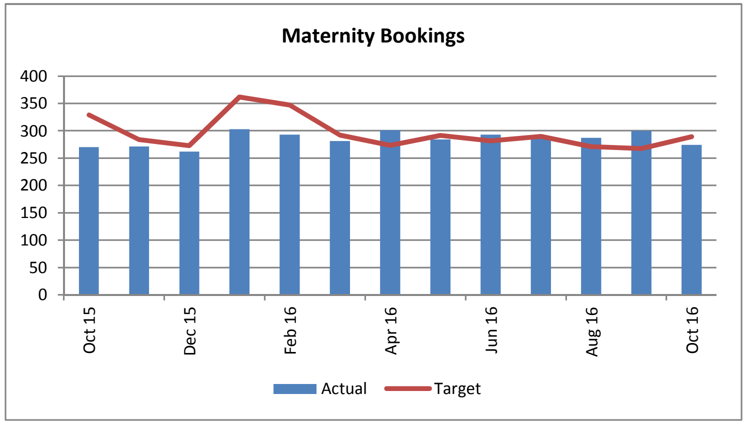
Elective Spells Breakdown	YTD	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
I P Actual	1,226	395	340	278	288	289	274	356	313	313	294	298	302	332	
I P Target	1,430	409	392	392	377	394	394	348	332	365	348	365	365	352	
% to Target	85.7%	96.7%	86.8%	70.9%	76.4%	73.4%	69.6%	102.2%	94.4%	85.7%	84.4%	81.6%	82.7%	94.4%	
Daycase Actual	10,685	2,665	2,701	2,652	2,555	2,659	2,625	2,638	2,617	2,834	2,643	2,697	2,746	2,599	
Daycase Target	11,130	2,792	2,682	2,717	2,649	2,758	2,793	2,580	2,462	2,738	2,660	2,818	2,818	2,834	
% to Target	96.0%	95.5%	100.7%	97.6%	96.5%	96.4%	94.0%	102.2%	106.3%	103.5%	99.4%	95.7%	97.5%	91.7%	
Total Actual	11,911	3,060	3,041	2,930	2,843	2,948	2,899	2,994	2,930	3,147	2,937	2,995	3,048	2,931	
Total Target	12,561	3,201	3,074	3,109	3,026	3,152	3,187	2,928	2,794	3,103	3,008	3,183	3,183	3,186	
% to Target	94.8%	95.6%	98.9%	94.2%	94.0%	93.5%	91.0%	102.2%	104.9%	101.4%	97.6%	94.1%	95.8%	92.0%	
I P % of Total	10.3%	12.9%	11.2%	9.5%	10.1%	9.8%	9.5%	11.9%	10.7%	9.9%	10.0%	9.9%	9.9%	11.3%	

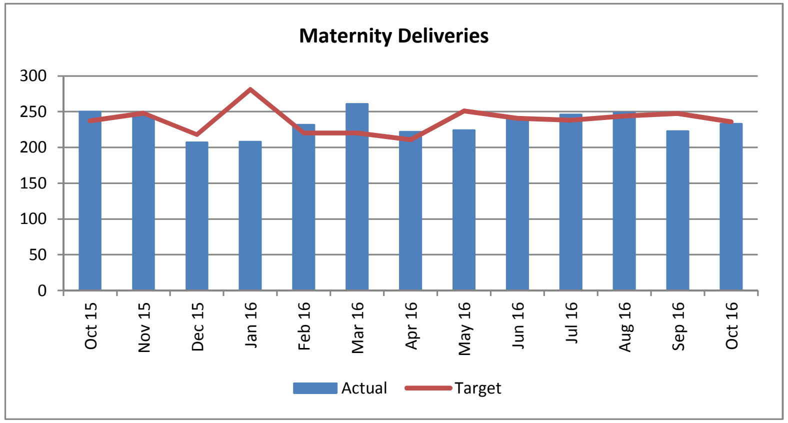
Operational Delivery: *Planned Activity*

Primary Drivers



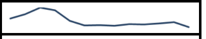


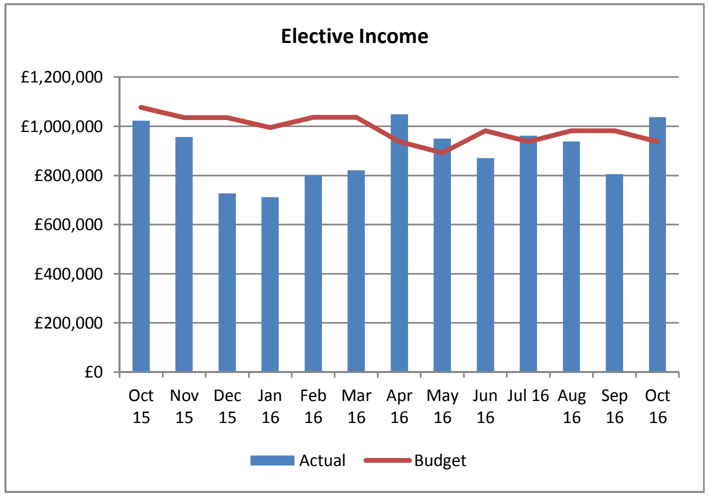


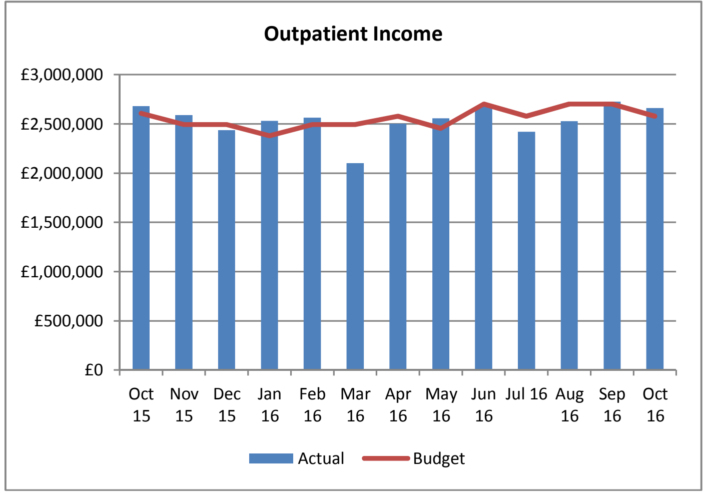


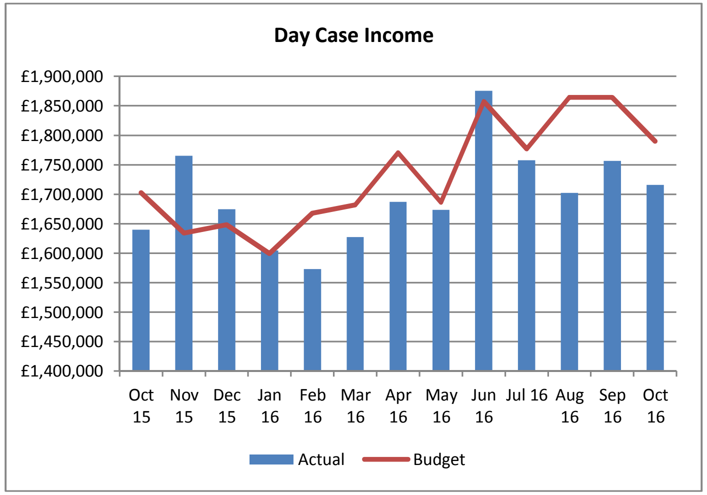
Operational Delivery: *Planned Activity*

Secondary Drivers

			Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		86.8%	99.4%	94.2%	99.3%	102.8%	101.7%	99.0%	96.6%	97.0%	93.2%	92.5%	94.0%	93.7%	
	Surgery & Cancer		68.9%	72.8%	70.3%	76.7%	81.7%	82.8%	75.2%	76.9%	76.0%	76.7%	72.4%	71.0%	72.0%	
Elective Inpatient Avg LOS (Days)			2.3	2.5	2.3	2.5	3.0	3.7	2.5	3.1	2.6	3.2	3.2	2.7	3.3	
Delayed Transfers of Care (MFFD)		16.00	14	13	13	15	19	19	22	20	19	37	29	31	30	
Medical Outliers			3	7	5	5	4	10	6	5	5	2	2	3	8	
Readmission (Emergency Re-admissions after Planned Surgery)																
** reported from 16/17.*	30 Day Rate		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.94%	2.97%	3.24%	2.77%	2.91%	3.15%		
One month delay	7 Day Rate		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.15%	1.21%	1.33%	1.65%	1.01%	1.16%	1.29%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.71%	1.50%	0.69%	1.72%	1.56%	2.07%	0.84%	1.57%	1.09%	1.40%	0.98%	1.48%	1.17%	
Theatre Efficiency																
	Main Theatres		77.1%	74.0%	74.6%	71.6%	68.6%	72.2%	74.0%	71.7%	77.3%	74.9%	79.6%	76.6%	77.6%	
	TC Theatres		71.9%	70.8%	70.6%	70.3%	69.8%	71.7%	70.0%	73.0%	71.7%	72.3%	74.4%	74.6%	77.2%	
DNA (OP Efficiency)			7.29%	7.97%	9.02%	8.57%	6.92%	6.16%	6.24%	6.11%	6.39%	6.34%	6.47%	6.72%	5.92%	
Hospital Cancellation Rate (OP Efficiency)			4.65%	5.19%	4.80%	4.12%	4.60%	5.48%	5.93%	4.75%	4.87%	5.19%	5.99%	5.01%	5.36%	







Financial Performance: Income & Expenditure Position

	Month			Year to Date			Forecast	Base Budget 2016/17 £'000
	Plan Oct (£'000)	Actual Oct (£'000)	Variance Oct (£'000)	Plan April to Oct (£'000)	Actual April to Oct (£'000)	Variance April to Oct (£'000)	2016/17 (£'000)	
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	940	1,065	125	6,637	6,612	-25	10,757	11,460
Non-Elective	4,595	4,437	-158	29,809	30,712	903	50,570	53,215
Maternity	1,018	975	-43	7,200	7,145	-55	11,294	12,138
Day cases	1,821	1,777	-44	12,397	12,169	-228	19,457	21,748
Outpatients	2,588	2,673	85	18,245	18,073	-172	29,161	31,340
A&E	666	708	42	4,723	4,861	137	7,642	7,887
Other NHS	4,924	6,751	1,828	34,570	34,149	-421	53,493	58,989
Total NHS Clinical Revenue	**16,551**	**18,386**	**1,835**	**113,582**	**113,720**	**139**	**182,374**	**196,777**
Other Operating Income	1,855	2,044	189	12,964	13,626	662	22,093	22,302
TOTAL OPERATING INCOME	**18,406**	**20,430**	**2,024**	**126,546**	**127,346**	**801**	**204,467**	**219,079**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,019	-13,309	-1,290	-83,943	-84,189	-246	-136,210	-146,239
Drugs	-1,587	-1,235	352	-10,790	-9,274	1,516	-15,249	-18,709
Clinical Supplies	-1,452	-1,327	125	-10,666	-10,220	446	-16,862	-18,415
Non Clinical Supplies	-217	-321	-104	-1,519	-1,615	-96	-2,536	-2,610
Other operating expenses	-2,239	-3,238	-999	-15,494	-17,455	-1,961	-26,817	-26,422
TOTAL OPERATING EXPENSES	**-17,514**	**-19,430**	**-1,916**	**-122,412**	**-122,753**	**-341**	**-197,674**	**-212,395**
EBITDA	**892**	**1,000**	**108**	**4,134**	**4,593**	**460**	**6,792**	**6,684**
Non Operating								
Non Operating Income								
Interest & Asset disposal	4	2	-2	28	18	-10	37	47
Non-Operating Expenses								
Depreciation & Finance Leases	-445	-391	54	-3,203	-2,931	272	-4,937	-5,651
PDC Dividend Expense	-158	-158	0	-1,106	-1,106	0	-1,787	-1,900
Net Surplus/(deficit) before Exceptional Items	**293**	**453**	**160**	**-147**	**574**	**722**	**106**	**-820**
Provision against Contract dispute	0	-184	-184	0	-1,193	-1,193	-2,184	0
Reversal of 15/16 unused bad debt prov	0	0	0	0	1,050	1,050	1,050	
Charitable Income	0	0	0	43	343	300	343	0
Net Surplus/(deficit) after Exceptional Items	**293**	**269**	**-24**	**-104**	**774**	**879**	**-685**	**-820**

The Trust delivered a £0.8M surplus position against a planned deficit of £0.1M.

The transfer of Community Services (CS) on the 1st October is consolidated into the actual position in month and will impact on individual variances as the budget has not yet been allocated. The impact of community services is assumed to be cost neutral overall.

Contract income includes £2.2M of CS, the underlying variance is £2.2M worse than plan cumulative. Key variances include Non- elective income and drugs.

Other Income includes £0.2M of CS, the underlying variance is £0.5M better than plan cumulative as a result of training and nhs recharge variances.

Pay includes £1.4M of CS, the underlying variance is £1.2M better than plan cumulative as a result of underspends in medical pay from unfilled vacancies.

Non-Pay includes £1M of CS, the underlying variance is £0.9M better than plan cumulative as a result of high cost drugs (income offset), clinical supplies and Other (outsourcing).

The forecast position remains to achieve plan, however risks remain in respect of achievement of CQUIN, the impact of winter pressures and the contract dispute.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(70)	(461)	(225)	(30)	(13)	(491)	(308)
Endoscopy	Endoscopy	3,625	0	(41)	(1,643)	(142)	(737)	197	1,245	14
General Surgery Directorate	General Surgery	9,647	61	(779)	(4,649)	334	(971)	124	4,088	(321)
Head & Neck Directorate	Head & Neck	3,067	246	(53)	(1,349)	221	(441)	15	1,524	183
Macmillan Cancer Centre	Macmillan Cancer Centre	340	945	131	(461)	7	(755)	(120)	69	18
Ophthalmology	Ophthalmology	7,587	38	148	(2,287)	193	(2,273)	(116)	3,065	225
Orthopaedic Directorate	Orthopaedics	12,070	161	(324)	(3,517)	108	(2,173)	(189)	6,542	(406)
Theatres & TC	Theatres & TC	0	212	10	(4,229)	(93)	(1,689)	(202)	(5,706)	(285)
Urology Directorate	Urology	3,642	52	399	(1,562)	46	(198)	15	1,933	460
Surgical and Cancer Division	**Surgery & Cancer**	**39,977**	**1,716**	**(578)**	**(20,158)**	**448**	**(9,265)**	**(289)**	**12,270**	**(419)**

The Surgical Division is £419k worse than budget as at Month 7. The key variances are General Surgery and Orthopaedic income worse than plan as a result of consultant vacancies in General Surgery and lower elective activity in Orthopaedics. Pay is better than plan as a result of medical vacancies and non-pay is worse than plan as a result of drugs costs in MacMillan, which is offset by income and surgical supplies costs in Orthopaedics and Theatres.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	18	18	(1,202)	117	(68)	(38)	(1,253)	97
Accident & Emergency Dir	Emergency Department	7,597	421	476	(3,407)	154	(677)	(59)	3,934	571
Anaesthetics & Critical Care	Anaesthetics & Critical Care	3,648	35	(9)	(4,571)	(38)	(751)	(197)	(1,638)	(244)
Medical Directorate	General Medicine	23,209	145	111	(13,188)	58	(2,685)	146	7,481	316
Urgent Care Centre	Urgent Care Centre	606	0	0	(202)	59	0	(1)	404	58
Emergency Services Division	**Medicine & Emergency Care**	**35,060**	**619**	**596**	**(22,570)**	**351**	**(4,180)**	**(149)**	**8,928**	**797**

The Medicine & Emergency Care Division is £797k better than budget as at Month 7. The main variances are better than plan on income in A&E and the Medical specialties as a result of higher non-elective admissions than plan. Pay is better than plan as a result of medical vacancies and non-pay is worse than budget as a result of drug costs which are part offset by income.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	23	23	(767)	1	(101)	9	(844)	34
Gum clinic	GUM clinic	0	0	(3)	0	0	(37)	(37)	(37)	(40)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	9,853	51	(415)	(4,998)	5	(855)	134	4,051	(277)
Paediatric Directorate	Paediatrics	6,681	67	479	(4,243)	130	(631)	(60)	1,874	549
Women and Childrens Division	**Women and Children**	**16,534**	**141**	**84**	**(10,007)**	**136**	**(1,625)**	**46**	**5,044**	**266**

The Womens and Childrens Division is £266k better than budget as at Month 7. The key variances are better than plan on income as a result of non-elective admissions in Paediatrics being higher than expected, offset by IVF income in Gynaecology being worse than plan. There are no significant variances on the Pay and Non-pay lines.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(184)	(1)	(10)	9	(193)	8
Dermatology	Dermatology	1,209	14	(36)	(724)	63	(191)	2	309	30
ECG department	ECG	244	41	20	(573)	57	(47)	(2)	(335)	75
Elmhurst	Elmhurst	1,163	71	(31)	(888)	(36)	(267)	48	78	(18)
Integrated Discharge	Integrated Discharge	0	0	0	(244)	(5)	(3)	(0)	(246)	(5)
Medical Records Department	Medical Records Department	0	(0)	(0)	(958)	(58)	(131)	(27)	(1,090)	(85)
Outpatients	Outpatients	0	142	44	(302)	7	(42)	(10)	(202)	41
Pathology Directorate	Pathology	6,992	2,301	(325)	(5,593)	217	(5,196)	411	(1,497)	304
Pharmacy Departments	Pharmacy	1,560	150	(582)	(1,738)	50	(1,633)	526	(1,660)	(6)
Radiology Directorate	Radiology	2,237	448	233	(3,432)	(111)	(1,530)	106	(2,277)	228
Therapeutic Departments	Therapies	0	174	(21)	(1,128)	(27)	(432)	(8)	(1,385)	(55)
Victoria Infirmary Northwich	Victoria Infirmary Northwich	1,228	34	(23)	(991)	(43)	(158)	17	113	(49)
Diagnostics and Support Divisi	**Diagnostics and Support**	**14,633**	**3,374**	**(720)**	**(16,754)**	**114**	**(9,639)**	**1,071**	**(8,387)**	**465**

The Diagnostics Division is £509k better than plan as at Month 7. The key variances include worse than plan on income as a result of Pharmacy drugs pass through costs lower than expected (offsetting cost underspend). Pay is worse than plan in Radiology as a result of locum costs for consultant vacancies and agency costs for radiographer vacancies being offset by underspends in Pathology and Pharmacy from vacancies. Non-Pay is better than plan as a result of drugs costs being lower than anticipated in Pharmacy and Pathology.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	0	0	(277)	3	(100)	(7)	(377)	(4)
Catering Directorate	Catering	0	799	49	(860)	(82)	(766)	(11)	(826)	(44)
Estates Departments	Estates Departments	0	272	(27)	(926)	(47)	(3,584)	68	(4,239)	(6)
Hotel Services	Domestics	0	2	(1)	(799)	(38)	(10)	(6)	(807)	(45)
Laundry Services Departments	Laundry	0	711	9	(643)	(57)	(394)	52	(326)	5
Security	Security	0	986	46	(408)	28	(301)	(46)	277	28
Site Services	Porters	0	4	(2)	(1,571)	43	(50)	(5)	(1,617)	36
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**2,775**	**74**	**(5,485)**	**(150)**	**(5,204)**	**47**	**(7,914)**	**(29)**

The Estates and Facilities Division is £29k worse than plan as at Month 7. The main variances include worse than plan on pay as a result of agency costs in Laundry, Estates and Catering. Non-pay is better than plan as a result of lower than expected Utilities charges.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	0	0	(774)	21	(118)	9	(892)	30
Computer Services	Computer Services	0	364	27	(735)	46	(1,038)	(124)	(1,409)	(51)
Finance & Information	Finance & Information	0	35	16	(1,622)	6	(348)	30	(1,935)	53
Human Resources	Human Resources	0	280	1	(1,229)	22	(258)	102	(1,207)	125
Risk Manangement & R&D	Risk Management & R&D	0	294	(21)	(871)	31	(29)	26	(606)	36
Quality Assurance Departments	Nurse Management	0	291	255	(1,625)	(205)	(4,940)	(20)	(6,274)	30
Trust Central Expenditure	Trust Central Expenditure	4,001	3,736	(2,547)	(747)	264	546	1,430	7,534	(850)
Other Departments	Other Departments	74	172	297	(237)	43	(368)	(176)	(359)	163
	Corporate	**4,075**	**5,173**	**(1,972)**	**(7,841)**	**228**	**(6,553)**	**1,276**	**(5,149)**	**(464)**

The Corporate Division is £464k worse than plan as at Month 7. The key variances are income on Trust Central as a result of the STF and CQUIN schemes non-achievement against plan and the provision against the contract dispute. Pay and Non-Pay are better than plan as a result of vacancies and investment slippage.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Community Div Management	Div Management Community	2,247	55	2,302	(48)	(48)	(700)	(700)	1,554	1,554
Community Dietetics	Dietetics	0	1	1	(23)	(23)	(4)	(4)	(27)	(27)
Community GP Out of Hours	GP Out of Hours	0	0	0	(196)	(196)	(48)	(48)	(244)	(244)
Community Intermediate Care	Intermediate Care	0	23	23	(271)	(271)	(129)	(129)	(378)	(378)
Community Nursing/Tissue Vblty	Community Nursing	0	27	27	(343)	(343)	(52)	(52)	(368)	(368)
Community Paediatrics	Community Paediatrics	0	1	1	(101)	(101)	(14)	(14)	(115)	(115)
Community Therapies/Wheelchair	Community Therapies	0	65	65	(391)	(391)	(97)	(97)	(423)	(423)
Community Services	**Community Services**	**2,247**	**171**	**2,418**	**(1,374)**	**(1,374)**	**(1,045)**	**(1,045)**	**(0)**	**(0)**

Community Services has transferred to the Trust as at 1st October and the Trust is currently in the process of validating the establishment and non-pay spend and to allocate budgets to directorates. The effect is assumed to be cost neutral in Month 1 (7) as it there is not yet the clarity of the underlying cost position. The £44k adverse position reported above is the result of internal recharges that need to be established to recognise the Trust will no longer received recharges from ECT for staff that have TUPE'd.

	Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
EBITDA	**112,527**	**13,968**	**(98)**	**(84,190)**	**(247)**	**(37,511)**	**957**	**4,792**	**616**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	Final Actual (£'000)	Final Variance (£'000)
NHS South Cheshire CCG	99,749	58,071	59,542	1,471
NHS Vale Royal CCG	52,588	30,634	32,161	1,527
NHS Eastern Cheshire CCG	7,439	4,337	4,589	252
NHS West Cheshire CCG	2,872	1,679	1,858	180
NHS North Staffordshire CCG	2,037	1,189	1,101	-88
Specialist Commissioning Group	7,344	4,296	4,765	469
NHS Commissioning Board	1,510	881	887	6
OTHER CCGs	2,236	1,304	1,314	10
Overseas Visitors Chargeable	0	0	0	0
NON-CONTRACT ACTIVITY	1,916	1,121	1,123	2
NON CCG SPECIFIC TARGETS	17,885	10,069	5,186	-4,883
TOTAL	**195,577**	**113,582**	**112,527**	**-1,054**

The South Cheshire and Vale Royal contracts are significantly over-performing their contract values. This is the result of a material difference in the predictions of growth adopted by the Trust and the CCGs. This difference is reflected in the Non-CCG Specific target line.

Other commissioners are not showing any significant variances as this point.

In addition, a provision has been made against the commissioner contract dispute showing in the Non CCG specific Actual.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,967	3,480	3,470	-11
Adult & Neonatal Critical Care	8,042	4,715	4,626	-90
Urgent Care Centre	1,007	588	588	0
Community Paediatrics	1,298	757	757	0
Direct Access Services	9,418	5,503	5,810	307
Unbundled Radiology	3,982	2,323	2,325	2
High Cost Drugs	13,357	7,792	5,744	-2,048
Screening Programmes	1,473	859	859	0
Audiology	909	530	633	103
IVF	945	552	181	-370
CQUIN	3,914	2,283	1,670	-614
STF	6,500	3,792	3,521	-271
Community Services	0	0	2,247	2,247
Other	2,392	1,395	525	-870
TOTAL	**59,205**	**34,570**	**32,956**	**-1,614**

Other contract income is showing £1.6M worse than plan, CS accounts for £2.2M and the underlying variance is therefore £3.8M.

An analysis of the key service lines identifies that this is primarily the result of High Cost Drugs where expenditure (and therefore recovery) predictions have not yet been seen related to new drugs and changes in use. In addition, the provision agains the contract dispute is recognised in other and is £1.2M.

Direct Access is better than plan whilst IVF is worse than plan. CQUIN is worse than plan due to the contract agreement and the failure of the Sepsis CQUIN.

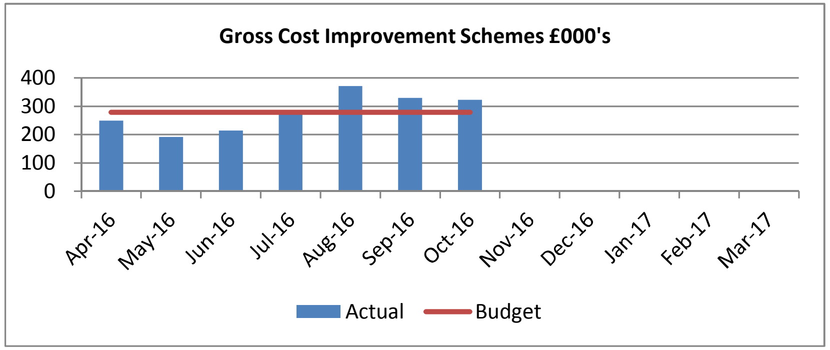
STF is less than plan due to the failure of the A&E improvement trajectory.

Other includes the contract dispute provision and variations in year.

Financial Performance: Cost Improvement Programme

Cost Improvement Schemes

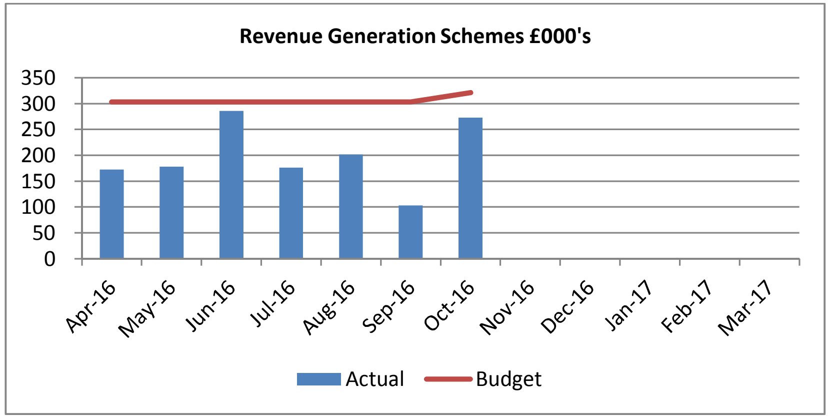
Scheme Category	YTD Target	YTD Actual	YTD	FY Target	FY Forecast	FY Variance
Access & Flow	642	642	0	1,100	1,100	0
Drugs	175	175	0	300	300	0
Non-Pay Efficiency	136	163	27	234	293	60
Nursing Agency	611	610	-0	1,047	1,047	0
Pathology Efficiency	165	165	0	282	282	0
Pay Savings	13	13	0	23	23	0
Procurement	193	188	-5	330	325	-5
TOTAL (£'000)	**1,934**	**1,956**	**22**	**3,315**	**3,370**	**55**



The Cost Improvement Programme is achieving plan ytd and is forecast to acheive the full year target.

Revenue Generation Schemes

Scheme Category	YTD Target	YTD Actual	YTD	FY Target	FY Forecast	FY Variance
Best Practice Tariff	245	149	-96	420	298	-122
Bowelscope QIPP	287	154	-133	856	269	-587
ENT QIPP	18	0	-18	106	0	-106
General Surgery QIPP	72	30	-42	123	81	-42
Income Generation	282	403	121	484	653	169
Ophthalmology QIPP	34	6	-29	59	30	-29
Orthopaedics QIPP	395	293	-102	676	383	-294
Other Income	129	68	-60	221	138	-83
Other QIPP	91	41	-50	145	57	-88
Outpatients QIPP	175	96	-79	300	224	-76
Theatres QIPP	175	150	-25	300	277	-23
TOTAL (£'000)	**1,902**	**1,389**	**-513**	**3,690**	**2,409**	**-1,280**



Revenue Generation schemes are £0.5M worse than plan cumulative as a result of not achieving the expected level of Best Practice Tariff improvement, this is related to a vacancy in the medical team who would be responsible for medical review of Fractured Neck of Femur patients. In addition, delays in accreditation are affecting the role out of Bowelscope at partner sites.

Financial Performance: Capital Report

WHOLE PROJECT PROPOSED PLAN	APPROVED	SCHEME	BROUGHT FORWARD	2016/17				2017/18	2018 +	TOTAL FORECAST
				MONITOR ANNUAL PLAN	CUMULATIVE ACTUAL	BETTER/WORSE THAN BUDGET	FORECAST	FORECAST	FORECAST	
ROLLOVER SCHEMES FROM 15/16 CAPITAL PROGRAMME										
60	60	CAR PARK BARRIERS	0	60	0	60	60			60
2404	2404	MRI SCANNER	1836	126	122	4	126			1962
310	310	OPHTHALMOLOGY OUTPATIENTS	24	286	286	0	286			310
		OTHER ROLLOVERS 15/16		0	-35	35	-35			-35
NEW WORKS										
50	50	BISTRO & 2 OFFICES		50	0	50	50			50
35	25	BLOCK ME CONVERT TO OFFICES		35	0	35	35			35
25	35	BLOCK MF CONVERT TO OFFICES		25	0	25	25			25
		DR'S MESS INTO RMO'S		42	0	42	42			42
11		MATERNITY		11	0	11	0			0
COMPLIANCE ISSUES										
6673	6673	ASBESTOS REMOVAL	5397	60	25	35	122	100	300	5919
7500	2544	WARD REFURBISHMENTS & FIRE COMPARTMENTATION	0	1950	1229	721	2544	2849	8952	14345
CLINICAL DEVELOPMENT										
850		3RD CT ENABLING		450	0	450	0	850		850
70		CENTRALISED POAC		60	0	60	121			121
50		ED RAPID ACCESS BAYS		50	18	32	61			61
1500	1500	MRI SCANNER 3RD BUILD		750	0	750	0	1500		1500
335	335	OPHTHALMOLOGY OUTPATIENTS - PHASE 2		50	25	25	201	134		335
98	98	SEXUAL HEALTH CLINIC		98	100	-2	98			98
ENABLING										
1500	250	DESIGN TEAM & PAINTERS	833	146	183	-37	283	250	750	2116
IM&T ROLLOVER SCHEMES FROM 15/16 CAPITAL PROGRAMME										
26		ASCRIBE HANDOVER	10	13	0	13	13			23
42	42	DAWN	27	15	0	15	6			33
1223	693	INFRASTRUCTURE	605	22	-1	23	22			627
31	31	INTERSITE CONNECTIVITY	6	25	19	6	25			31
458	329	RADIOLOGY INFORMATION SYSTEM	230	100	36	64	228			458
72	72	STORAGE DATA ARCHIVING	21	51	8	43	51		300	372
1170	420	VOICE OVER IP	42	120	0	120	466	77		585
336	336	OTHER ROLLOVER IT SCHEMES 15/16	312	0	3	-3	3			315
IM&T NEW SCHEMES										
600		CLINICAL PORTAL		0	0	0	0	1200		1200
1000		EDMS		0	0	0	0	1956		1956
244		E-HANDOVER		0	0	0	0	256		256
65		INTERFACING		25	11	14	65	40	80	185
75		IT APPLICATIONS		57	0	57	75	75	150	300
25		NET CALL / CALL CENTRE		25	0	25	25			25
30		PCTI / DOCMAN		30	0	30	24			24
350		ROSTERING SYSTEM		0	0	0	350			350
150		UPS		75	0	75	0	150		150
30		WIRELESS UPGRADE		0	0	0	30			30
ADDITIONAL										
80	80	DISHWASHER		80	45	35	80			80
7	7	ECG SLEEP SYSTEM		7	7	0	7			7
		MEC SOFTWARE FOR CARDIAC MONITORS			16	-16	16			16
LEASING ARRANGEMENTS										
3000	500	MEC EQUIPMENT		0	0	0	500			500
		3RD CT SCANNER		0	0	0	600			600
		3RD MRI SCANNER		0	0	0	800			800
		ACCESS CONTROL		0	0	0	100			100
		LAUNDRY FINISHING	70	0	0	0	70			140
		OPHTHALMOLOGY EQUIPMENT	150	0	0	0	150			300
		REPLACEMENT CT SCANNERS		0	0	0	600			600
DONATED										
		BUILDIINGS								0
		EQUIPMENT		0	28	0				0
BACKLOG MAINTENANCE										
1075	422	MAINTENANCE	334	290	242	48	396	175	525	1430
6833	1054	GENERAL PROVISION	1711	655	221	434	1054	2250	4500	9515
38393	**18270**	**TOTAL PROGRAMME**	**11608**	**5839**	**2587**	**3280**	**9775**	**11862**	**15557**	**48802**

The capital programme is less than anticipated by £3,280K which is mainly due to the following General Provision £434K, Ward Refurbishment £721K, Third CT Scanner enabling £450K, Third MRI Scanner £500K, Voice Over IP £120K a number of IT Schemes £362K

Accruals have been made for Theatres £90K, Ward 11 refurbishment £263K , Rapid Access Bay 18K and Ward 16 Refurbishment £6K

Financial Performance: Statement of Financial Position

	Plan Apr to Oct (£'000)	Actual Apr to Oct (£'000)	Variance (£'000)	Forecast 2016/17 (£'000)
Assets				
Assets, Non-Current	**83,900**	**77,487**	**-6,413**	**80,878**
Assets, Current				
Trade and other Receivables	8,505	11,011	2,506	6,001
Other Assets (including Inventories & Prepayments)	5,491	4,679	-812	4,933
Cash and Cash Equivalents	4,048	2,519	-1,529	2,868
Total Assets, Current	**18,044**	**18,210**	**166**	**13,802**
ASSETS, TOTAL	**101,944**	**95,697**	**-6,247**	**94,680**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-390	-404	-14	-885
Loans Commercial Current	-2,680	-5,170	-2,490	-2,895
Trade and Other Payables, Current	-15,194	-10,785	4,409	-13,951
Provisions, Current	-146	-118	28	-231
Other Financial Liabilities	-6,691	-8,776	-2,085	-7,573
Total Liabilities, Current	**-25,101**	**-25,251**	**-150**	**-25,535**
Net Current Assets/(Liabilities)	**-7,057**	**-7,041**	**16**	**-11,733**
Liabilities, Non Current				
Finance Lease, Non Current	-5,079	-3,287	1,792	-3,038
Loans Commercial Non-Current	-7,691	-5,200	2,491	-5,623
Provisions, Non-Current	-1,755	-1,645	110	-1,575
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-14,525**	**-10,132**	**4,393**	**-10,236**
TOTAL ASSETS EMPLOYED	**62,318**	**60,314**	**-2,004**	**58,909**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	75,157	75,157	0	75,157
Retained Earnings	-22,551	-25,063	-2,512	-26,469
Donated asset reserve	0	0	0	0
Revaluation Reserve	9,709	10,220	511	10,221
TOTAL TAXPAYERS EQUITY	**62,315**	**60,313**	**-2,002**	**58,909**
TOTAL FUNDS EMPLOYED	**62,315**	**60,313**	**-2,002**	**58,909**

This mainly due to the capital programme being less than anticipated by £3,280K which is mainly due to the following General Provision £434K, Ward Refurbishment £721K, Third CT Scanner enabling £450K, Third MRI Scanner £500K, Voice Over IP £120K a number of IT Schemes £362K. In addition the plan was produced before the final position for 2015/16 was established which meant the opening balance was £1,614K in the plan more than the actual position which is mainly due to the revaluation completed at the end of 2015/16. The remainder relates to Finance leases of circa £1,277K where the lease has now been assed as an operating lease and not a finance lease. This includes the replacement MRI Scanner.

Trade Receivables mainly relates to the plan for Trade Receivables being produced before the final position for 2015/16 was established which has meant that the opening balance was £1,354K in the plan being more than the actual position in 2015/16. This was due to an adjustment for a bad debt of £1,450K at the year end. The main outstanding debts are the over performance for South Cheshire CCG £1,573K, Vale Royal CCG £758K, NHS England £390K, Public Health £212K which is offset by a £1.0M provision against the outstanding contract dispute.

Other Assets is less mainly due to delays in new operating leases and invoices for IT Maintenance and Radiology Maintenance contracts.

Trade and Other Payables - Trade Creditors are less than anticipated due the Trusts Working Capital Facility being higher than anticipated allowing an increase in the number of creditors being paid.

Other Liabilities are higher than expected due to an invoice or Health Education England £541K raised early, deferred Vanguard Income £51K and return to practice income £48K. Accruals are higher due to an accrual for the new Community Services contract of £1,000K anticipated costs.

Loans are higher than anticipated due to the Trust receiving a higher than anticipated Working Capital Facility and drawing down £997K more than anticipated in the plan and in the plan it was assumed that £1,500K was paid back. This has not happened due to the delay in the payment in the over performance invoices.

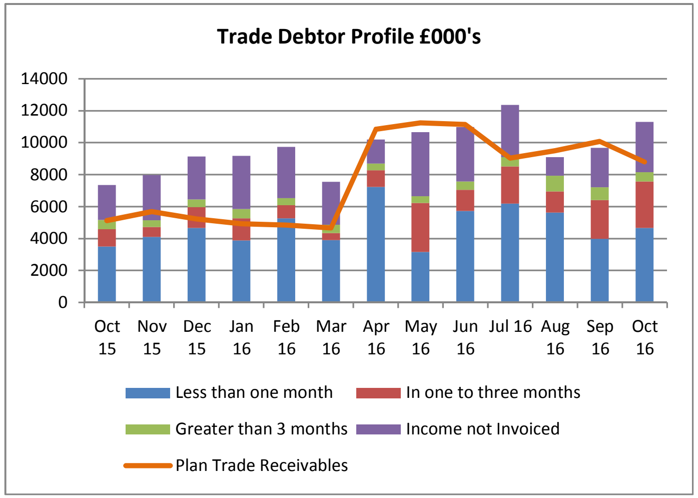
Retained earnings is lower than anticipated due to the closing figure for 2015/16 in the plan being lower than the final position in 2015/16 as a result of the revaluation.

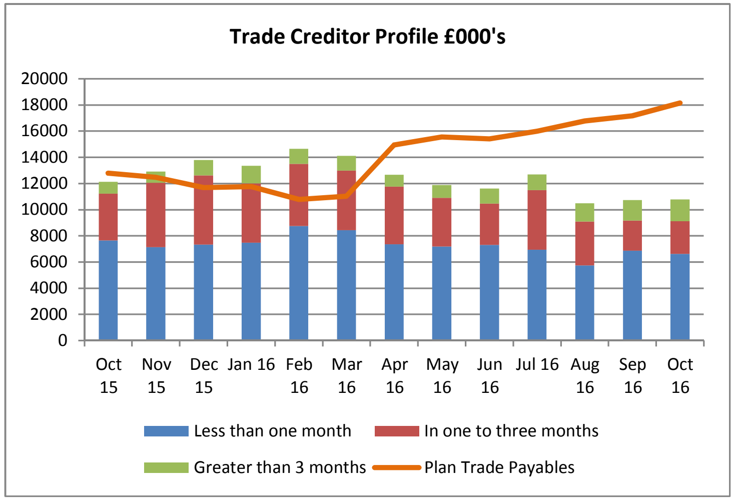
Financial Performance: Cash Position and Working Capital

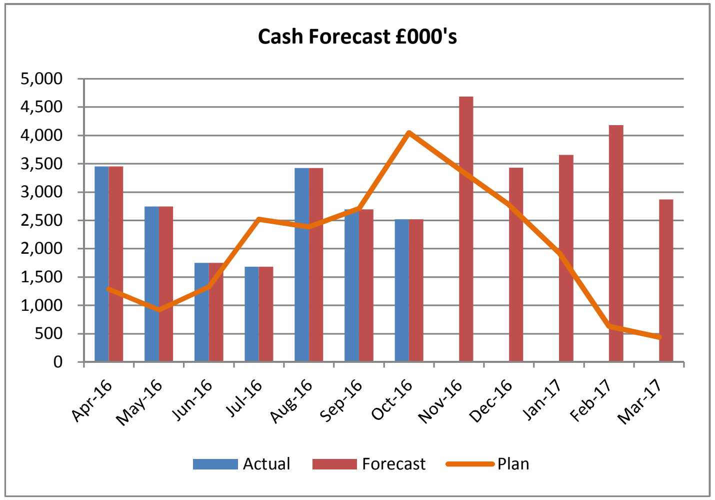
	Plan Apr to Oct (£'000)	Actual Apr to Oct (£'000)	Variance
Surplus/(deficit) after tax	**-405**	**774**	**1,179**
Non-cash flows in operating Surplus/(deficit) total	3,272	2,900	-372
Operating cash flows before movements in working capital	**2,867**	**3,674**	**807**
Increase/(Decrease) in working capital Total	1,001	-3,665	-4,666
Net cash inflow/(outflow) from operating activities	**3,868**	**9**	**-3,859**
Net cash inflow/(outflow) from investing activities total	-5,097	-3,004	2,093
Net Cash inflow/(outflow) before financing	**-1,229**	**-2,995**	**-1,766**
Net cash inflow/(outflow) from financing activities Total	4,512	4,749	237
Net increase/(decrease) in cash and cash equivalents	**3,283**	**1,754**	**-1,529**
Opening cash balance	**764**	**764**	**0**
Closing cash balance	**4,047**	**2,518**	**-1,529**

Cash is £1,529K worse than anticipated.

This is mainly due to a higher than anticipated drawdown of the working capital facility, the deferred repayment of £1,500K working capital facility offset by the impact of trade creditors lower than expected, the delay in payment of over-performance invoices. In addition there is an underspend on the capital programme, however this is offset by the delay in the drawdown of capital


Trade Debtor Profile £000's


Trade Creditor Profile £000's


Cash Forecast £000's

Finance: *Staff Costs*

Headline Measures

		Rolling 13 months £000's													
	YTD £000's	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
Pay Budget	83,948	11,348	11,360	11,157	11,637	11,443	11,980	11,964	11,866	12,055	11,964	12,056	12,024	12,019	
Pay Actual	82,772	11,432	11,477	11,492	11,568	11,655	12,214	11,755	11,794	11,934	11,783	11,689	11,925	11,892	
Variance	1,175	-84	-117	-336	69	-212	-235	208	72	121	181	367	99	127	
% to Budget	*98.6%*	*100.7%*	*101.0%*	*103.0%*	*99.4%*	*101.9%*	*102.0%*	*98.3%*	*99.4%*	*99.0%*	*98.5%*	*97.0%*	*99.2%*	*98.9%*	

Nursing Staff % to Budget	99.9%	99.8%	101.0%	105.3%	99.4%	103.5%	107.1%	99.9%	104.9%	99.6%	99.2%	98.1%	98.9%	98.6%	
Medical Staff % to Budget	94.0%	101.4%	98.9%	99.1%	96.8%	97.4%	100.8%	92.4%	87.6%	94.4%	94.3%	90.1%	98.4%	100.6%	
Other Staff % to Budget	101.5%	102.9%	103.9%	104.8%	102.5%	105.4%	98.2%	105.0%	102.8%	102.0%	101.1%	101.2%	100.2%	98.0%	

Commentary

figures exclude Community Services until a budget has been derived

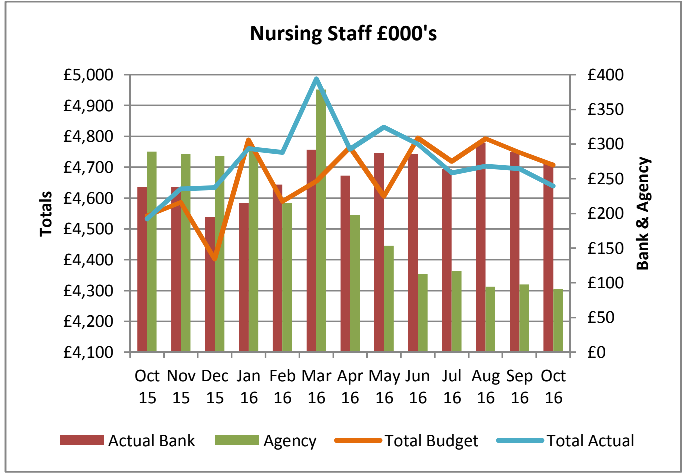
Pay is better than budget by £1.2M as at Mth 7. There are significant underspends on medical pay but this lessened in Months 6 & 7 , Nursing pay is on plan and other pay is over by £0.4M due to the vacancy target not being allocated to individual staff groups.

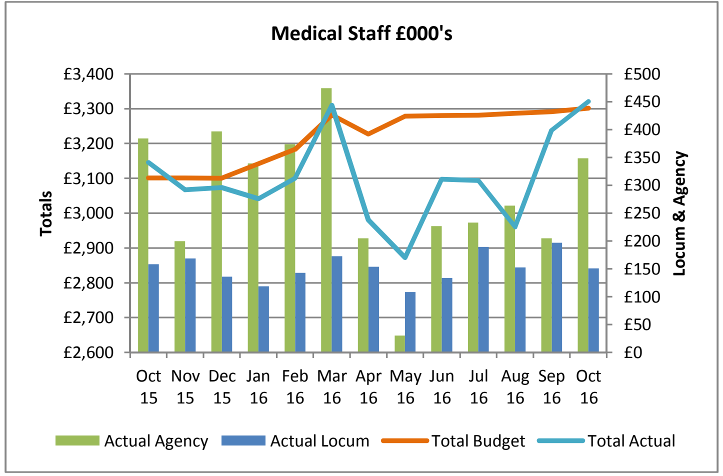
Nursing vacancies have continued to be high since January with the closure of the winter capacity coinciding with the start of the new financial year where additional investments have been approved. Nursing Agency spend has had a sustained reduction since April, however, bank use over establishment for HCAs continues to support one to one patient supervision.

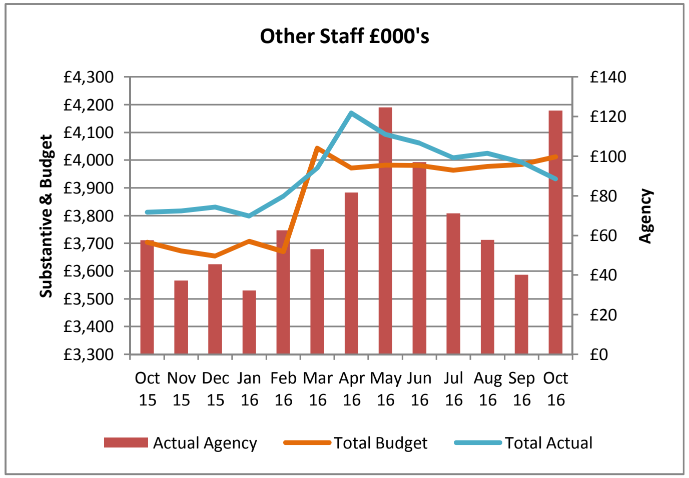
Medical pay is underspent against budget (£1.4M) as a result of consultant and junior doctor vacancies being unable to be filled with substantive or acceptable locum arrangements .

The Agency trajectory is failing in month by £0.2Mand cumulatively by £0.3M. Earlier lower medical agency costs are offset by increased spend in Gastroenterology and Endoscopy and new pressures Radiography and Therapy Services.

Primary Drivers

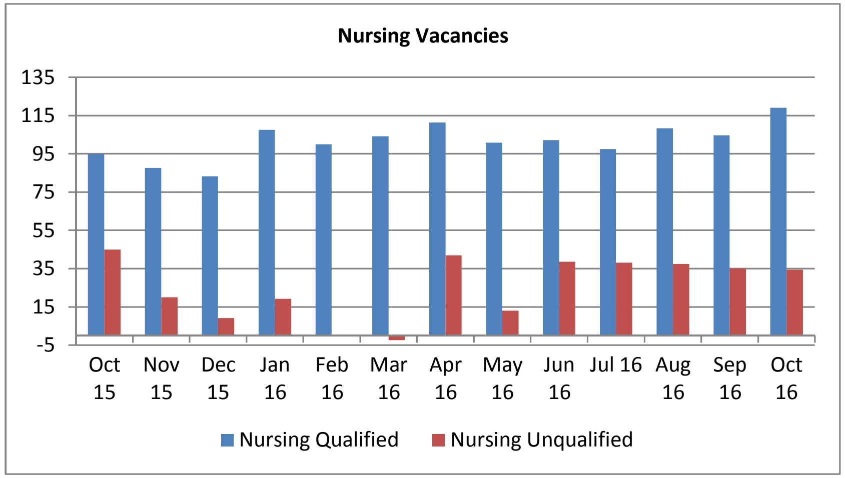


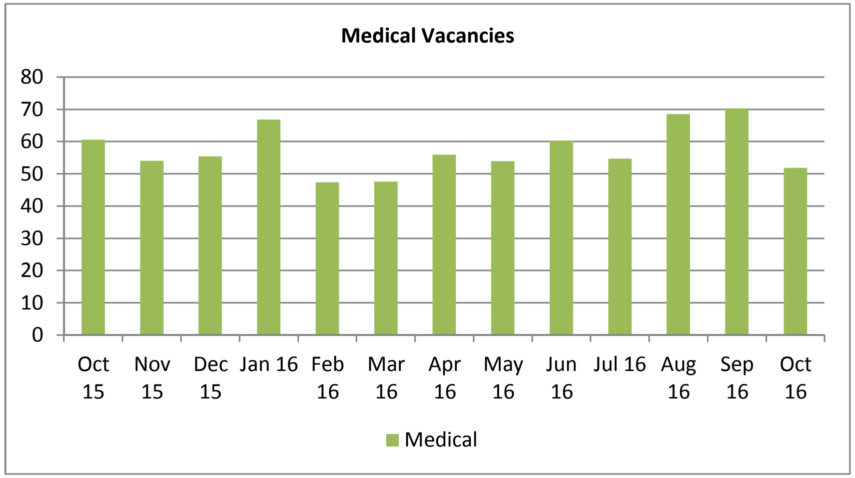




Finance: *Staff Costs*

Secondary Drivers





Agency Trajectory

	YTD	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
Plan	-3,770	-556	-556	-557	-595	-595	-593	-539	-572	-561	-515	-563	-525	-495	
Actual	-4,042	-942	-691	-861	-784	-795	-1,079	-638	-416	-570	-611	-568	-540	-699	
Variance	-272	-386	-135	-304	-189	-200	-486	-99	156	-9	-96	-5	-15	-204	

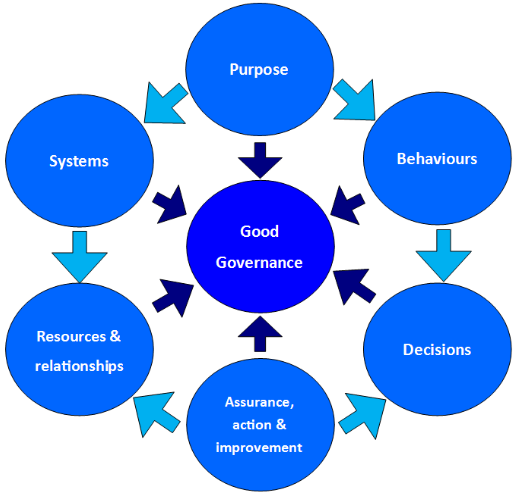
	Rolling 13 Months													
	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Monthly Trend
Sickness Rate (Rolling 12 mths)	3.86%	3.75%	3.63%	3.50%	3.40%	3.34%	3.26%	3.17%	3.16%	3.13%	3.08%	3.04%	3.03%	
Total Leavers	32	27	28	41	30	29	28	24	41	36	31	39	34	
Turnover (Rolling 12 mths)	11.45%	11.56%	11.40%	11.33%	11.36%	11.34%	11.28%	10.92%	11.04%	11.01%	10.61%	10.23%	10.24%	

Mid Cheshire Hospitals NHS Foundation Trust

Gap Analysis / Action Plan
Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations

Template, Monitoring and Escalation

Good Governance Institute Body of Knowledge


Purpose
Systems
Behaviours
Good Governance
Resources & relationships
Decisions
Assurance, action & improvement

Document owner: *Mark Oldham*
Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations
March 2016

1. Purpose of this document

The purpose of this document is to outline the monitoring and escalation process for any gap analysis / action plan / after action review undertaken at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT).

2. Process for monitoring and escalation of gap analysis / action plan / after action review (see flowchart on page 3)

The Trust standard template (see page 4) will be completed by the identified lead

Any gaps in assurance will be rated as follows:

Key (National Guidance):	🟩 **Compliant CLOSED**	**Partial – Compliance**	🟥 **Non – Compliant**
Key (Audits):	🟩 **Adherence > 90%**	**Adherence 80% - 89%**	🟥 **Adherence < 79%**

The completed template will be submitted to the named committee responsible for that area. The actions and timescales will be monitored by the named committee.

Timescale breaches for urgent actions with potentially serious implications require immediate escalation to the relevant Board sub-committee

If a timescale breaches by 2 months, the Chair of the named committee will escalate the breach to the reporting committee (e.g. Operational Integrated Governance Committee) or, where appropriate, to the relevant Board sub-committee (e.g. QuEST)

If a timescale breaches by 4 months, the Board sub-committee will consider escalation to the Board of Directors.
The identified lead is responsible for ensuring that all actions are completed within the timescales agreed in conjunction with the person responsible for the action.

PROCESS FOR MONITORING AND ESCALATION OF ACTION PLAN / GAP ANALYSIS / AFTER ACTION REVIEW

Trust standard template completed by identified lead

Template submitted to the named committee responsible for that area

Actions and timescales monitored by the named committee

Timescale breaches for any action potentially resulting in major or catastrophic harm (as defined on the risk matrix) requires immediate escalation to the Chair of the relevant Board sub-committee

If a timescale breaches by 2 months, named committee Chair to escalate to reporting committee (e.g. Operational Integrated Governance Committee) or where appropriate the relevant Board sub-committee (e.g. QuEST)

If a timescale breaches by 4 months, the Board sub-committee considers escalation to the Board of Directors

The identified lead is responsible for ensuring that all actions are completed within the timescales agreed in conjunction with the person responsible for the action

Mid Cheshire Hospitals NHS Foundation Trust Template for Gap Analysis / Action Plan / After Action Review

RAG:	**Compliant CLOSED**	**Partial - Compliance**	**Non - Compliant**

INTRODUCTION:

Please write brief statement introducing the purpose of the gap analysis/action plan

Ref	Standard/Process/ Issue/Gap Identified	Action Required	*RAG Rating	Responsible Lead	Timescales (by end of):	Responsible Committee	Progress / Closure Date & Evidence (embed evidence into document)
Recommendation 11: Trust Boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and co-ordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community. Delivered by:							
11.1	Trusts completing the area plans as per the 2016/17 planning guidance	1. CEO / Exec representation at all LDP meetings 2. MCHFT to contribute to LDP SOC to influence wider STP 3. CEO to contribution to STP on behalf of the Board 4. MCHFT to influence / lead programmes of work 5. LDP / STP to be regular Board / BAD agenda		Chief Executive	Ongoing 31 May 2016 30 June 2016 Ongoing Monthly	Trust Board	Trust Operational Plan complete Mid Cheshire Strategic Outline Case concluded by Deloitte

Ref	Standard/Process/ Issue/Gap Identified	Action Required	*RAG Rating	Responsible Lead	Timescales (by end of):	Responsible Committee	Progress / Closure Date & Evidence (embed evidence into document)
		item 6. Trust Strategy to be reviewed post STP submission 7. BAF to be reviewed post STP submission			31 December 2016 31 August 2016		
Recommendation 14: All acute Trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved. Delivered by:							
14.1	Chairs and Chief Executives preparing their Boards, including their non-Executive Directors, to use the Model Hospital and anticipate the introduction of the Integrated Performance Framework.	1. Model Hospital updates to be provided at BADs 2. Best practice to be obtained from pilot hospitals (CoCH) 3. Board subcommittee (QGC) to escalate progress on speciality reviews and any issues identified 4. Review actions on publication of the Integrated Performance Framework		Chief Executive	As guidance is released Underway & ongoing First review in July 2016 & thereafter on publication of dashboards On publication	Trust Board	

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Sustainability and Transformation Plan	
Author:	STP CEO Provider Group	
Executive Lead:	Tracy Bullock, Chief Executive	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

Link to Strategic Objectives:		***Link to Domain:***	
Quality, Safety & Experience		Safe	
Strong Progressive FT	x	Effective	
Organisational Delivery	x	Caring	
Workforce Development & Effectiveness		Responsive	x
Fit for Purpose Infrastructure	x	Well-Led	x
Emergency Preparedness			

Link to Board Responsibility:	Performance	
	Accountability	x
	Strategy	x
	Implementation	
Action Required:	Decide	
	Approve	
	Note	x
	Recommend	
	Delegate	

Positive Benefit:	To manage demand in the healthcare system.
Risk:	
To be published on Trust Website –complete version	**Y** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	**N** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	5 December 2016

Cheshire & Merseyside
Sustainability and Transformation Plan
21 Oct 2016 version 3.3

2,571,170

people

32%

Live in most deprived areas

8.3%

Aged 75+ (UK ave. = 7.8%)

12

CCGs

20

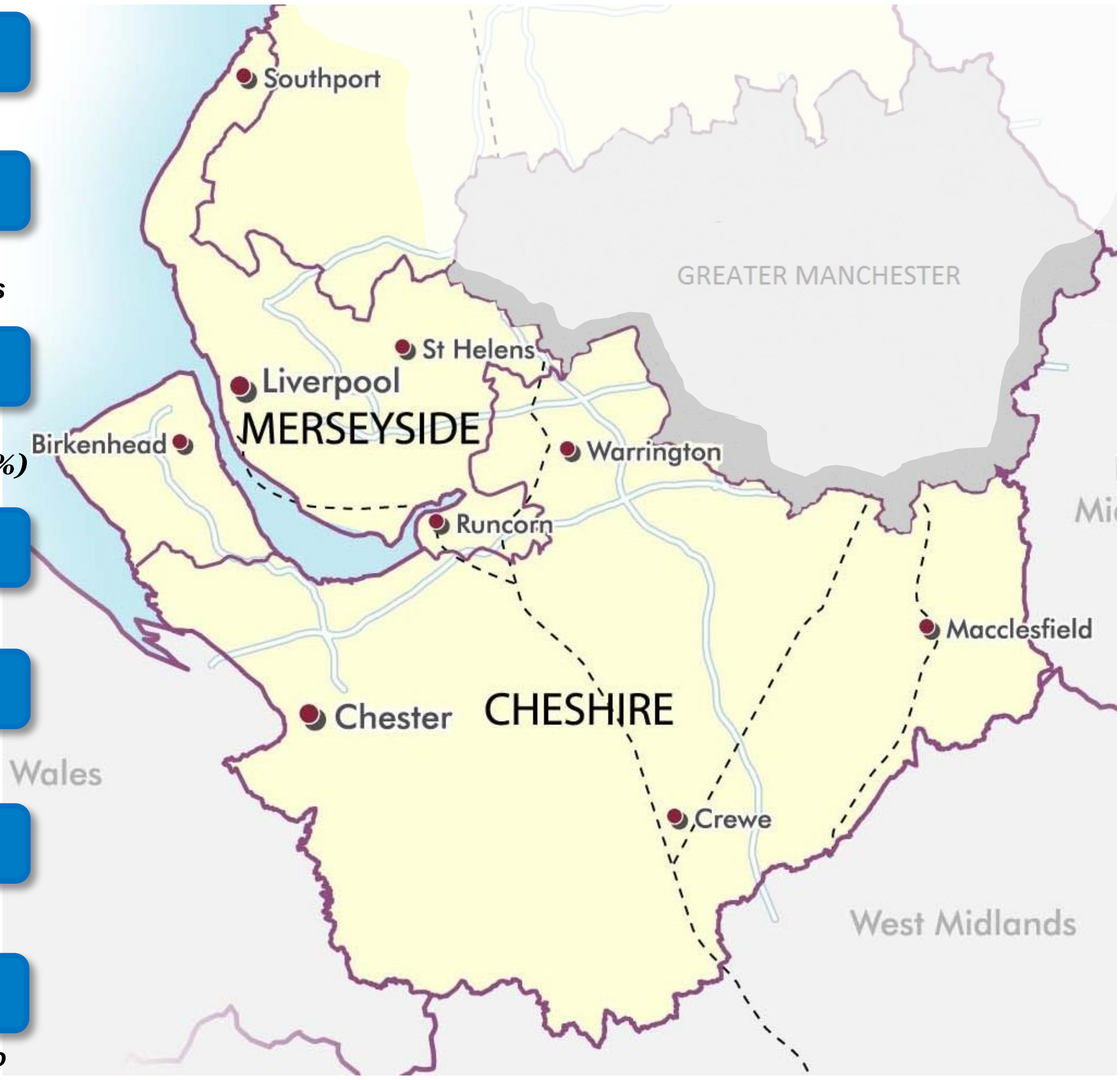
Providers

2nd

Largest STP

2

Proposed Devo footprints



Key information

Name of footprint and no: Cheshire & Merseyside; No. 8

Region: North

Nominated lead of the footprint including organisation/function: Louise Shepherd, Chief Executive, Alder Hey NHS FT

Contact details (email and phone): louise.shepherd@alderhey.nhs.uk **–** 0151 252 5412

Organisations within footprints:

CCGs – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington

LAs: Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral

Providers: Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust

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Foreword

Partners across Cheshire and Merseyside have been working together over the last 4 months to develop further the blueprint we set out in June to accelerate the implementation of the 5YFV for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together, otherwise we will fail to support the needs of our Communities into the future. This document summarises the plans developed to-date to address these challenges across all our different communities in Cheshire and Merseyside and fall into 4 common themes:

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;
- designing an acute care system for our communities that meets current modern standards and reduces variation in quality;
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes;

Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole Region in the future.

Executive Summary

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- ***high rates of diseases associated with ageing, including dementia and cancers;***
- ***high rates of respiratory disease;***
- ***early years and adult obesity;***
- ***high hospital admissions for alcohol;***
- ***poor mental health and wellbeing; and***
- ***high rates of teenage conceptions.***

Furthermore our analysis confirmed that across the region there are significant service and financial challenges, either at individual organisational level or across whole economies. Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our Communities. At the same time, there are significant pressures on health and social care budgets. Both these issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery. Continuing with current models of care provision will result in a gap in our finances of £908m by 2021 across the Region if we do nothing. This challenge has narrowed from the £999m in our June submission, reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create sustainable, quality services for the population of C&M. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

We have devised a portfolio of 20 programmes, each with clear objectives, scope and emerging governance structures – some are further ahead than others in developing their detailed plans.

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

Maximising opportunities

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

The key themes we are pursuing

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations.

Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

1 - Our starting point

Our previous submission in June demonstrated a sound understanding of our issues, and a clear strategy for going forward

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- *high rates of diseases associated with ageing, including dementia and cancers;*
- *high rates of respiratory disease;*
- *early years and adult obesity;*
- *high hospital admissions for alcohol;*
- *poor mental health and wellbeing; and*
- *high rates of teenage conceptions.*

Furthermore our analysis confirmed that across the region there are significant financial challenges, either at individual organisational level or across whole economies. *The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be* ***£908m.*** This challenge has narrowed from the £999m in our June submission, to £908m driven by the gap now reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

Clearly C&M isn't going to sit back and 'do nothing'. In addition to the work already underway within our three Local Delivery Systems (LDS) we identified the strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

1. **Improve the health of the C&M population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
    - *Promoting physical and mental well being*
    - *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*
2. **Improve the quality of care in hospital settings** (previously referred to as 'Reducing variation & improving quality in support of hospital reconfiguration') by:
    - *Reducing the variation of care across C&M;*
    - *Delivering the right level of care in the most appropriate setting*
    - *Enhancing delivery of mental health care*
3. **Optimise direct patient care** (previously referred to as Productive back office and clinical support services collaboration) by
    - *Reducing the cost of administration*
    - *Creating more efficient clinical support services*

After the existing LDS plans were modelled we forecast a surplus of £49m by 2021. However, these plans required further analysis and challenge to convert them from sound ideas into robust plans.

Our work since June has been focussed on the development of these 'sound ideas' into 'robust plans'.

We have created a portfolio structure that brings together twenty distinct, but interrelated programmes of work. Each of these programmes has developed clear objectives, is in the process of agreeing its governance model and are developing their plans for delivery. Each is at a different stage of maturity and this STP submission reflects this.

Our strategic STP programmes aim to provide guidance and clear principles about how we will tackle four key issues across the STP footprint:

1. Improving the health of the C&M population
2. Improving the quality of care in hospital settings
3. Optimise direct patient
    a) Reduced administration costs
    b) Effective clinical support services

These programmes are supported by eight clinical programmes looking to improve the way we deliver:

4. Neuroscience;
5. Cardiovascular disease (CVD)
6. Learning disabilities
7. Urgent Care
8. Cancer
9. Mental Health
10. Women's & Children's
11. GPs and primary care

There are five programmes that support and enable the above programmes:

12. Changing how we work together to deliver this transformation.
13. Finance
14. Workforce
15. Estates and facilities
16. Technology, including Digital
17. Communications and Engagement

Delivery of these programmes is at LDS level, each of which has a programme of work delivering improvements locally:

18. North Mersey
19. The Alliance
20. Cheshire and Wirral

The overarching purpose of these programmes is to deliver on our purpose of creating sustainable, quality services for our population.

2 - Our Cheshire & Merseyside strategy

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create **sustainable, quality services for the population of C&M**. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

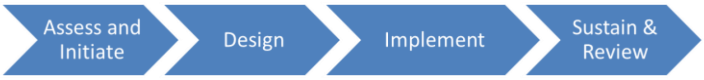
Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

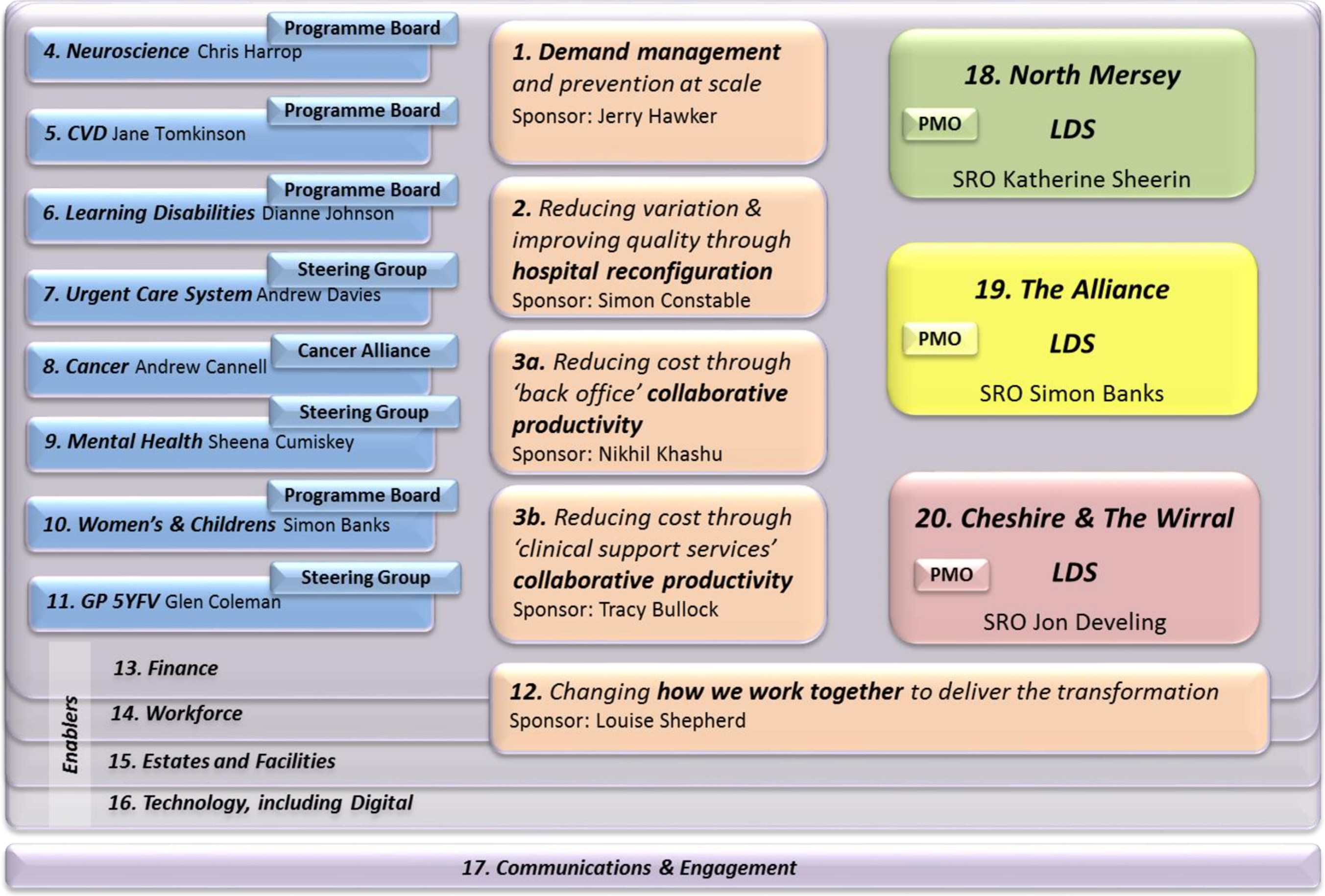
Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

Doing the right things

The 20 programmes that form our delivery portfolio have been chosen as a direct consequence of the issues faced by C&M, and with a clear end goal in mind. These were noted in Section 1 and are regularly communicated by way of the graphic below:

Each programme is at a different point of maturity, and this is reflected in the later sections of this plan. As with any portfolio this is not unusual and there is no reason to get them all to the same place. However, there is an overarching process that each programme will go through and that the PMO will use to help assess progress.


Assess and Initiate
Design
Implement
Sustain & Review


Programme Board
4. Neuroscience Chris Harrop
Programme Board
5. CVD Jane Tomkinson
Programme Board
6. Learning Disabilities Dianne Johnson
Steering Group
7. Urgent Care System Andrew Davies
Cancer Alliance
8. Cancer Andrew Cannell
Steering Group
9. Mental Health Sheena Cumiskey
Programme Board
10. Women's & Childrens Simon Banks
Steering Group
11. GP 5YFV Glen Coleman
1. Demand management and prevention at scale
Sponsor: Jerry Hawker
2. Reducing variation & improving quality through hospital reconfiguration
Sponsor: Simon Constable
3a. Reducing cost through 'back office' collaborative productivity
Sponsor: Nikhil Khashu
3b. Reducing cost through 'clinical support services' collaborative productivity
Sponsor: Tracy Bullock
18. North Mersey
PMO
LDS
SRO Katherine Sheerin
19. The Alliance
PMO
LDS
SRO Simon Banks
20. Cheshire & The Wirral
PMO
LDS
SRO Jon Develing
Enablers
13. Finance
14. Workforce
15. Estates and Facilities
16. Technology, including Digital
12. Changing how we work together to deliver the transformation
Sponsor: Louise Shepherd
17. Communications & Engagement

2 - Our Cheshire & Merseyside strategy

Clarity on responsibility

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

There are no budgets or quality standards held at STP level. Changes will directly impact organisations at level 1, with level 2 LDS plans providing oversight of progress, and, over time, a consolidated view of performance measures.

We have been really clear on the role of people at STP level, ensuring we are not duplicating effort.

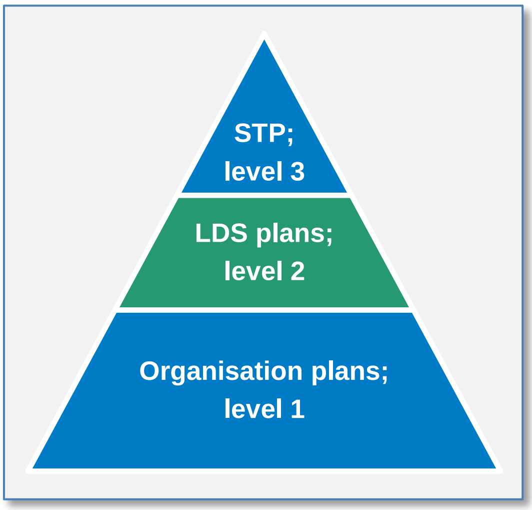
Level 1 STP has a focus on:

- **Economies of Scale** – what can be done at STP to create additional economies
- **X-LDS learning** – how can each LDS learn from each other
- **National benchmarking** – how is the STP doing compared to national benchmarks
- **STP wide system design** – design once, deliver locally – e.g. ACO/ACS framework
- **Governance** – agreeing and managing an STP wide approach
- **Assurance** – provision of assurance to STP lead, and ultimately NHSE
- **Performance** – responsibility for meeting and reporting against STP wide control totals
- **Communications and engagement** – consistent delivery of overarching key messages

Level 2 LDSs also have a clear role to play:

- **Locality strategy** – how this works in the LDS
- **Detailed delivery plans** - development and delivery of LDS plan
- **Monitor progress** – regular monitoring of plan
- **Reporting to STP** – progress reporting to STP
- **Financial control** – managing impact on finances across LDS.

At Level 1 the responsibility is well known around meeting financial and quality standards. Currently it is only at Level 1 that a budget can be impacted. Level 1 organisations also have a clear responsibility to manage communications within their organisation and to their Boards/Governors.



Maximising opportunities

Our approach to delivering improvements is that opportunities will be designed and delivered at the highest level of our triangle.

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

The emergence of an STP plan doesn't reduce the focus on organisational delivery at level 1 or their need for financial balance.

2 - Our Cheshire & Merseyside strategy

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

Managing a portfolio of 20 programmes is a significant undertaking and the dependencies between them need to be effectively managed.

Managing dependencies across the portfolio

With twenty programmes of work there are many interdependencies that need to be carefully managed, such as:

- Effective management of demand on our healthcare system will influence the future configuration of where and how services are delivered;
- Future hospital service configurations will be driven by clear clinical strategies that place patients at the heart of any redesign;
- Very few changes can be made without the implicit inclusion of the Workforce, Estates and IM&T programmes

Section 6 will look in more detail at how the STP will deliver the transformation required.

STP Interventions

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.

Our challenges

Demand for health and care services is increasing

Cheshire and Merseyside face different challenges as a consequence of its geography and demographics. There is therefore unacceptable variation in the quality of care and outcomes across C&M

The C&M system is fragmented resulting in duplication and confusion

The cost of delivering health and care services is increasing

Our priorities and areas of focus

Improve the health of the C&M population,

1a. improving the provision of physical and mental care in the community (i.e.outside of hospital)

- Agree framework to deliver via ACOs
- Managing demand across boundaries
- Joint commissioning and delivery models
- Community risk stratification
- GP Federations, Primary Care at scale

1b. Promoting physical and mental well being

- Addressing primary prevention & the wider determinants of health
- Pan C&M Alcohol Strategy
- Pan C&M High BP Strategy

Improve the quality of care in hospital settings

2a. Reducing the variation of care across C&M

- Common standards, policies and guidelines across organisations at C&M level
- Standardised care across pathways

2b. Delivering the right level of care in the most appropriate setting; and enhancing delivery of mental health care

- Common standards, policies and guidelines across organisations at C&M level
- SOPs and high level service blueprints for specialist services

Optimise direct patient care

3a. *Reducing the cost of administration*

- Optimised workforce, reduced agency usage
- Consolidated Procurement functions – an integrated Supply Chain Mgmt. function

3b. *creating more efficient clinical support services*

- Consolidated clinical support services

The impact of our plans

- Reduction in A&E attends and non-elective admissions
- Reduced elective referrals
- Reduced emergency bed days, and length of stay
- Reduced re-admissions
- Early identification and intervention
- Delivery of care in alternative settings
- Increased use of capitation-based and outcomes-based payments

- Improved clinical outcomes and reduction in variation
- Improved performance against clinical indicators

- x-organisation productivity and efficiency savings
- Reduced duplication
- Reduction in temporary staff dependency

Governance and Leadership - Changing how we work together to deliver the transformation

Programme Delivery Structure

Communications and Engagement

Enablers – IM&T; Estates; Workforce

2.1 - Improve the health of the C&M population

Introduction

We previously referred to this programme as 'Demand Management' and 'Prevention at Scale'.

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

What are the objectives

- To maximise the benefits that C&M can gain from the improvement to its population's health.
- To provide the guidance and principles upon which the work around demand management and prevention will be delivered at LDS level.

Why is this programme important?

The current challenges makes integration and consolidation across organisational boundaries a necessity. The NHS five year strategy sets out the ambition for this and local government leaders are keen to take a leading role in the integration agenda. Leading health economies are moving in this direction and they are delivering real reductions in hospital admissions; better population health through prevention; and 10-20% cost savings.

Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. It allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals.

Another important feature of the population health PIDs that have been developed is that as well as supporting the development of benefits over the next 5 years directly (from reduced hospital admissions / attendances etc), they will also play a crucial role in supporting the sustainability of the current STP. For example, by not addressing the real behavioural problems that excessive drinking can run the risk of creating future problems and dilute the positive impact that the current set of interventions are expected to have.

What is the scope of the work

Improving the provision of integrated primary and community, health and social care (i.e. Out of Hospital)

1. A substantial range of schemes & interventions which can be broadly categorised as Prevention, CCG Business efficiencies (QIPP) and new Out of Hospital initiatives.
2. Promoting physical and mental well being to reduce the need for people to access care.
3. Developing an STP wide methodology and structure for tackling unwarranted variation in demand for care services and enabling effective delivery of the first two objectives.

What is the structure of the programme?

1. Three STP prevention schemes will be delivered at LDS Level::
   - Alcohol Harm Reduction
   - High Blood Pressure
   - Antimicrobial resistance
2. Three high impact areas help manage demand, delivered at LDS level:
   - Referral management
   - Medicines management
   - CHC
3. Development of integrated primary and community, health and social care
4. Create a framework for the development and implementation for Accountable Care approaches (name of the chosen vehicle may be different but they are nationally known as ACOs)

The first phase of the programme has focussed on helping each LDS develop their plans and to verify the opportunity. This will now be taken forward at LDS level leaving the work at STP to focus on creating a framework to support development of ACOs and supporting the accelerated implementation (delivery) of high impact demand management initiatives (e.g. Right Care).

How will the change be lead?

Sponsor:	**Jerry Hawker**
Members:	Eileen O'Meara (CHAMPS WG DPH Lead) Alliance – Leigh Thompson/Colin Scales Cheshire & Wirral – Tracy Parker-Priest North Mersey – Tony Woods Local Gov't – TBD Andrew Davies, Urgent Care CCT

2.1 - Improve the health of the C&M population

Current Position

Management of demand

There is a strong symmetry across all three LDS plans and a further opportunity to share best practice and reduce inter-LDS variation. NHS England's referral management audit (template) suggests significant variation across three of the LDSs with respect to implementation of the eight high impact changes.

The high impact change areas being adopted across the LDSs include:
- Medicines management (**£66.6m**)
- Referral management – implementation of eight demand management high impact changes for elective care (**£61.5m**)
- Implementation of Right Care (**£42.5m**)
- Continuing healthcare (**£16m**)

(indicative values)

These are predominantly flagged as business as usual efficiencies within CCG plans.

Prevention

Three population based prevention projects have been developed to support reductions in Alcohol abuse / harm, blood pressure and antimicrobial resistance (AMR).

The first two have identified benefits including reduced hospital admissions & “whole system impact” where appropriate (e.g. prevention of alcohol related violence). AMR will produce more long term impact.

All are key to the longer term sustainability of the STP i.e. doing nothing runs the risk of increasing our challenge post 2021.

The blood pressure team have identified a number of benefit scenarios associated with the level of increases in diagnosis rates. The table below shows the low end estimated net benefits i.e. based on a 5% increase BP diagnosis being achieved – these could be as high as £9.1m if the higher rates are achieved of 15%.

Delivery plans for these projects are noted overleaf

Prevention	Alcohol	Blood Pressure	Total benefit (2021)
Gross benefit	£13.65m	£9.5m	**£23.15m**
STP investment required	£2.45m	£2.5m	**£4.95m**
Net benefit at LDS level • C&W • Alliance • NM	 £4.7m £3m £3.5m	 £2.8m £2m £2.2m	 **£7.5m** **£5m** **£5.7m**
Total STP net benefit (2021)	**£11.2m**	**£7m**	**£18.2m**

2.1 - Improve the health of the C&M population – alcohol prevention and High Blood Pressure Plans

Alcohol Prevention Project	Milestones
STP demand reduction (alcohol) steering group	• Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations • Detailed business case worked up • Develop and continue to risk register • Develop and implement a stakeholder engagement and communications • Establish a data/outcomes working group
Enhanced support for high impact drinkers	• Develop multi-agency approaches to support change resistant drinkers' • Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals • Review pathways and commission outreach teams
Large scale delivery of targeted Brief Advice	• Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff offering brief advice and referring to local specialist services as required. • Ensure screening and advice for Making Ever Contact Count includes evidence based alcohol IBA, and brief interventions such as high BP, smoking cessation, diet and physical activity.

Effective population level actions	• Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards.
	• Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
	• Ensure local partners collaborate to ensure efficient use of data and considerations of improvements, including:
	  • Targeting interventions to prevent violence and reduce alcohol-related harm
	  • Targeting police enforcement in hotspot areas
	  • Use of intelligence in the license review process and targeting alcohol licencing enforcement

High Blood Pressure Project	Milestones
STP demand reduction (BP) steering group	• Detailed business case write up • Risk register write up • Stakeholder engagement and communication plan developed
System Leadership approach	• System leadership approach is ensured in the delivery of the C&M strategy • Systematic triangulation and review of cross-sector patient safety measures is embedded into strategy dashboard
Population approach to prevention	• Develop healthy local policy
BP awareness raising campaigns	• Link with community pharmacies, community partners and voluntary sector partners and inform patients and communities of key messages
Making Every Contact Count at scale	• Roll out MECC across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners
Blood pressure equipment	• Increase availability of BP machines and Ambulatory Blood Pressure Monitoring to meet local need
Primary care education and training programme	• Develop education and training programme that utilises Sector Led Improvement principles
Medicines Optimisation	• Increase uptake of Medicine Use Reviews and New Medicines Services on antihypertensive medicines

2.1 - Improve the health of the C&M population – antimicrobial resistance

Project	Milestones
Ensure every Trust, Community Trust [including non-medical prescribers] and CCG has an AMR action plan	• Obtain assurances that every trust has an AMR action plan • Obtain assurances that every trust has an Antimicrobial Stewardship Committee

Implement back up prescribing for the treatment of upper respiratory tract infections	• Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach
	• Audit post implementation:
	  • Establish whether implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners is required. Consistency can be achieved by harmonising access to GP records.
	  • Prior to implementation, establish whether Healthwatch should be involved.

Engagement	• Pharmacy:
	  • Ensure consistent messages are given by all prescribers and all pharmacists.
	  • Ensure pharmacies support the AMR strategy as appropriate
	• Care Homes:
	  • Establish whether the Care Home Hygiene Award Scheme needs scaling up

Ensure AMR awareness, stewardship and training is delivered to all prescribers, non-medical prescribers and health care workers	• Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training • Ensure that training addresses and meets the PHE Antimicrobial prescribing and stewardship competencies
Support public facing media campaigns to aid and inform about Antimicrobial Resistance	• Local authorities and CCGs engage with any national or international AMR campaigns and plan local activities to promote the initiative
Implementation of AMR and Stewardship education at the primary and secondary level	• Utilise the free ‘e-Bug’ resource produced by PHE in all schools to encourage a generational change in the attitude to the use of antibiotics
Identify a dedicated Community Microbiologist function to support AMR Stewardship	• Ensure protected sessions are available and establish whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community
Identify an Antimicrobial Stewardship Lead GP	• Establish how this resource can be identified and secured, assuming that the role doesn’t exist already
Ensure that every secondary care trust is implementing PHE Start Smart – Then Focus toolkit	• Obtain assurances that every trust has implemented the tool kit, including a ward-focused antimicrobial team
Ensure that every GP Practice is implementing TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) (best practice recommendations)	• Obtain assurances that every GP Practice has implemented the tool kit
Ensure every Trust and CCG has an Antimicrobial Pharmacist and ensure that they are provided with sufficient protected time to fulfil this role	• Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist
Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	• Primary and secondary care formularies should dovetail • Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance

2.1 - Improve the health of the C&M population

Development of ACOs

ACO's are one option for supporting the development of a standardised care model for non-acute care across the C&M Footprint that includes Primary, Community, Mental Health & Social Care with a view to driving & managing demand and pursuing population health management. We might want to look at this as a way of enhancing care for medically unwell and frail patients in particular, by integrating organisational arrangements, sharing clinical and financial risk across the system

Ambition - There is significant variation in the progress made on developing ACOs across the STP; most are at an elementary stage. St Helens has made the most progress having commissioned advisors to consider the options for an accountable care management system. Further work is required in most localities to fully define the vision and outcomes.

Care Model - Greater focus could be paid on ensuring primary care is at the centre of care models and ACOs are built on GP registered lists. Additionally, processes to engage primary care need to be determined. In parts of the system there is some ambition to build the ACOs around multispecialty community providers. The connection between ACOs and already established/proposed care models in some areas needs to be clearer e.g. the Caring Together programme in Eastern Cheshire.

Delivery Model - There is significant variation in the form of ACOs being proposed and developed across the STP. For instance, in some areas an 'accountable care management system' is being developed whilst in others a 'partnership' is envisioned. In almost all areas there is no defined operating model agreed and no delivery plans in place for implementation.

Capabilities - Learning should be shared as much as possible by those areas who are leading in the development of their ACOs. The process to understand the capabilities required for the successful implementation of an ACO is in place in some areas. Further work is required on the approach to sharing accountability amongst partners include risk and gain sharing.

There needs to be a real focus on the development of an STP wide framework to help design the right ACO model for each locality.

Each locality is at a different state of maturity – the potential plan below is an indicative view of the process and timeline that a more mature locality might aspire to.

1. Improving the health of the C&M population	**Oct-Dec 2016**	**Jan-Mar 2017-2018**					Output ◆ Details of work ▭
ACOs* *or other variations thereof	Design framework for development of an ACO C&M framework for ACOs agreed ◆	Complete readiness assessment	Agree the ACO concept with providers and commissioners	Develop the target operating model, business plan and financial case	Establish contracting and commercial arrangements	Build and implement ACO	

Plans

There are a number of next steps to follow on from the work:

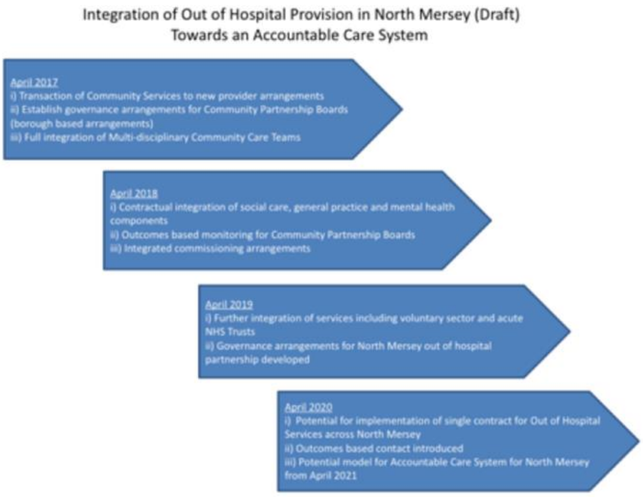
- Need to agree the relevant priorities of the projects and the associated investments.
- There is an immediate need to agree how benchmarking intelligence will be provided and utilised by end November.
- Each LDS should review existing plans against business intelligence to strengthen activity and financial modelling and assure schemes against benchmarked evidence to ensure that plans are targeted appropriately, by end November.
- The STP should identify a way to support each LDSP to stress test its business efficiencies (QIPP) schemes due to the significant financial variation, by end November.
- Develop a framework document to provide structured support to fast track potential exemplar ACOs and provide STP wide guidance and principles.

Much of this is to be delivered as part of the LDS plans, and features in their delivery plans, highlights of which are overleaf.

2.1 - Improve the health of the C&M population

Each LDS has plans that will tackle demand, enhance prevention, bring care closer to home and radically improve out of hospital care, the highlights of which are shown below. Full details are in each LDS plan that is within the supporting documents. By providing coordination, guidance, standards and clear principles, LDS's will learn from each other and C&M will achieve greater economies of scale.

North Mersey



Integration of Out of Hospital Provision in North Mersey (Draft)
Towards an Accountable Care System

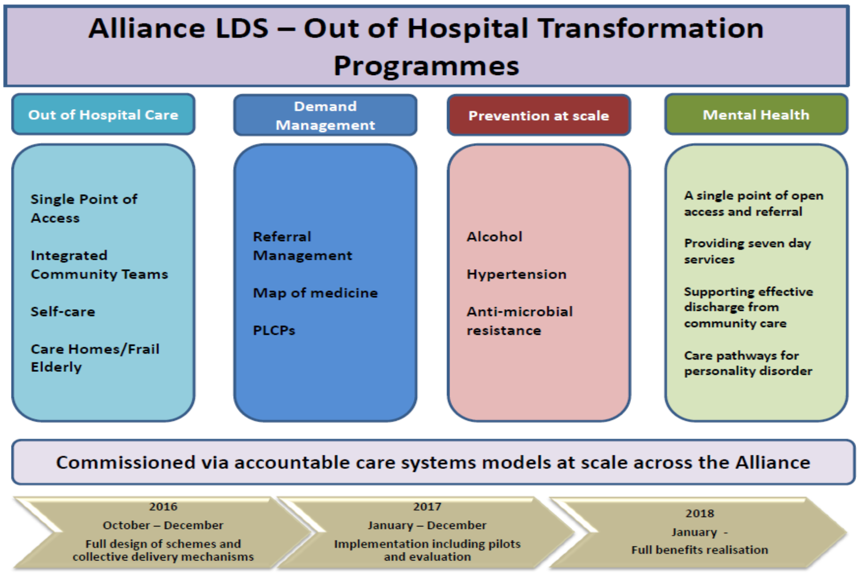
April 2017
i) Transaction of Community Services to new provider arrangements
ii) Establish governance arrangements for Community Partnership Boards (borough based arrangements)
iii) Full integration of Multi-disciplinary Community Care Teams

April 2018
i) Contractual integration of social care, general practice and mental health components
ii) Outcomes based monitoring for Community Partnership Boards
iii) Integrated commissioning arrangements

April 2019
i) Further integration of services including voluntary sector and acute NHS Trusts
ii) Governance arrangements for North Mersey out of hospital partnership developed

April 2020
i) Potential for implementation of single contract for Out of Hospital Services across North Mersey
ii) Outcomes based contact introduced
iii) Potential model for Accountable Care System for North Mersey from April 2021

The Alliance



Alliance LDS – Out of Hospital Transformation Programmes

Out of Hospital Care	Demand Management	Prevention at scale	Mental Health
Single Point of Access Integrated Community Teams Self-care Care Homes/Frail Elderly	Referral Management Map of medicine PLCPs	Alcohol Hypertension Anti-microbial resistance	A single point of open access and referral Providing seven day services Supporting effective discharge from community care Care pathways for personality disorder

Commissioned via accountable care systems models at scale across the Alliance

2016
October – December
Full design of schemes and collective delivery mechanisms

2017
January – December
Implementation including pilots and evaluation

2018
January -
Full benefits realisation

Cheshire & Wirral

The core C&W ambitions by 2020/21 are:

- Implement Cheshire and Merseyside Wide Prevention strategies in Hypertension, Alcohol, and AMR.
- Implement Cheshire and Wirral wide prevention strategies for Respiratory conditions and Diabetes.
- Implement Cheshire and Merseyside Wide Neurology, Cancer and Mental Health Programmes.
- Implement a Gain Share agreement with NHSE for specialised commissioning
- Embed integrated community teams by 2017/18 that include General Practice, Social Care and Community Services that will manage demand effectively throughout Cheshire and Wirral.
- Implement high impact demand management initiatives identified by NHSE through our current and ongoing QIPP Programme.
- Implement measures to reduce CHC expenditure by £8m
- Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)
- Continue to implement and optimise the benefit of sharing clinical information through the Cheshire (and Wirral) Care Record.
- Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral.

2.2 - Improve the quality of care in hospital settings - overview

Introduction

We previously referred to this programme as 'Reducing variation and improving quality to support hospital reconfiguration'.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity. There is a strong need for a service line-by-service line review of the current acute care model, in order to generate the evidence and data required to inform an explicit decision to be taken on the locations of acute provision based through analysis of future patient flows.

What are the objectives

- To maximise the quality of care delivered in hospital settings.
- To provide the guidance and principles upon which work around hospital services will be delivered at LDS level.

Why is this programme important?

There is a wide variation of the quality of care across C&M – this is not acceptable and our population should expect the same quality service and outcomes wherever they live in C&M.
Hospital care is expensive – we should only be treating people in hospital when it is evidenced that their outcomes will be better by treating them there.
Improving care is at the forefront of our STP ambitions, and delivering effective, safe and efficient care in hospital settings is a core principle.

What is the scope of the work

There are two STP Level projects:

1. Technical solutions for the C&M system:
    - Critical decisions developed by specialist and technical expertise which exists already in the clinical networks or Vanguards for new models of care (e.g. Urgent and Emergency Care and Women's and Children's Health)
    - Agree the best clinical models across C&M and their detailed specification, which will include access issues, consideration of co-dependencies and the un-intended consequences. This will be underpinned by the very best evidence base and specialist expertise.
    - Pilot to then be expanded through all the specialities.
2. Reducing variation in outcomes
    - Clinical effectiveness is at the heart of the programme to reduce variation in clinical practice and outcomes across C&M.
    - Existing programmes of work such as Advancing Quality (AQ) and Getting it Right First Time (GIRFT) will be strengthened, standardised and harmonised.
    - Intra-hospital as well as inter-hospital variation will be considered
    - Workforce issues through people as well as processes will be standardised or harmonised at STP level to manage system as well as cultural issues through the assistance of Health Education England, the North West Leadership Academy and the Advancing Quality Alliance (AQuA).
    - An overarching principle will be achieving even modest improvements at scale over the whole C&M and reducing the variation that exists.

How will the change be lead?

Sponsor:	**Simon Constable**
Members:	Alliance - Ann Marr Cheshire & Wirral - David Allison N Mersey - Steve Warburton/Fiona Lemmens Local Gov't - **TBD** Andrew Davies, Urgent Care CCT Simon Banks, Women & Children's CCT

2.2 - Improve the quality of care in hospital settings – delivery plans

To date, this thinking has largely been driven at the LDS level with little consideration of hospital reconfiguration across the C&M-wide footprint.

However, we believe there is benefit and the financial imperative to undertake this thinking at C&M level to deliver a consistent clinical service across the STP footprint.

We recognise that the current acute configuration within this footprint is unsustainable. This is perhaps most evident in Cheshire. The number of tertiary providers in Merseyside presents an atypical challenge and opportunity as well.

Given the importance and sensitivity of this area, our first task is to instigate a service by service review of the acute care model.

This will be a single programme of work that will run in parallel to the emerging LDS-led reviews and work undertaken by the NW Specialised Commissioning team.

Our view is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside’s strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core.

The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by March 2017 (subject to further discussion and agreement).

Work is underway with AQuA to identify from an international and national evidence base the areas in which reduced variation would give the maximum potential in addressing the quadruple aims of the 5YFV across the whole of C&M. The output of this work is expected in late 2016. In addition one of the early scoping pieces of work across the STP through the local delivery systems is to identify where there are already plans implemented or in train to reduce variation and/or implement hospital reconfiguration, to ensure that outputs and outcomes are known, understood and assessed and adopted at pace and scale utilizing a range of clinical, managerial, patient and other change agents and supporting systems that are already in place.

The engagement strategy for this workstream is critical to its success in delivering against the quadruple aims of the 5YFV. The approach, with the appropriate level of programme management support and resource to oversee the progress of engagement, is to utilize existing networks of clinicians across primary and secondary care, other staff across the health and care system, and patients and carers to create a dialogue in the design of the priority work programmes (utilizing the intelligence identified above as an input) and identify, at a range of levels, change agents who have experience and are motivated to influence at a range of levels. So in addition to the necessary scoping of areas of focus for this workstream both in terms of existing improvement work in the STP area, and national/ international evidence base, we will undertake a piece of scoping around the existing engagement fora in order to enable face to face discussion about areas of focus. We see the STP Clinical Congress as a key engagement mechanism for clinical engagement along with existing networks of clinicians, particularly at and within LDS level. We will also, in conjunction with the STP workstream area around ways of working, explore the possibility of digital collaborative platforms to maximize engagement.

This review will focus on how acute provision will synergistically work within the construct of a demand management system (and potential ACO-driven environment), as well as embracing new technology such as tele-tracking to create individual control centres capable of having visibility across multiple providers who exist in a networked way. The review will consist of 2 phases of work as shown below:

Nov - Jan

Phase 1 – Evidence generation & research

- Agree methodology & plan
- Formalise governance (clinical and non-clinical)
- Carry out service line reviews
- Capture and organise evidence

Jan - Apr

Phase 2 – Analysis & outputs

- Design options for future acute care provision
- Build strategic outline case for each option including benefits and RoI
- Agree method for option selection
- Prepare for review
- Create delivery roadmap

2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

North Mersey

A more granular plan is included in the NM LDS plan. built from well established plans described in 'Healthy Liverpool'.

	One year	Three years	Five years - 2021
Hospital Service Reconfiguration	OBC for Royal Liverpool & Aintree merger, including proposals for single service reconfiguration Implement Orthopaedics & Upper GI single service and single Cancer MDTs Decision on configuration of women's and neonatal services – June 17	Complete merger – April 18. Adult acute single service implementation to commence 18/19, Complete commissioner review of S&O services - March 18	Complete adult acute service reconfiguration Implement LWH reconfiguration Implement S&O reconfiguration

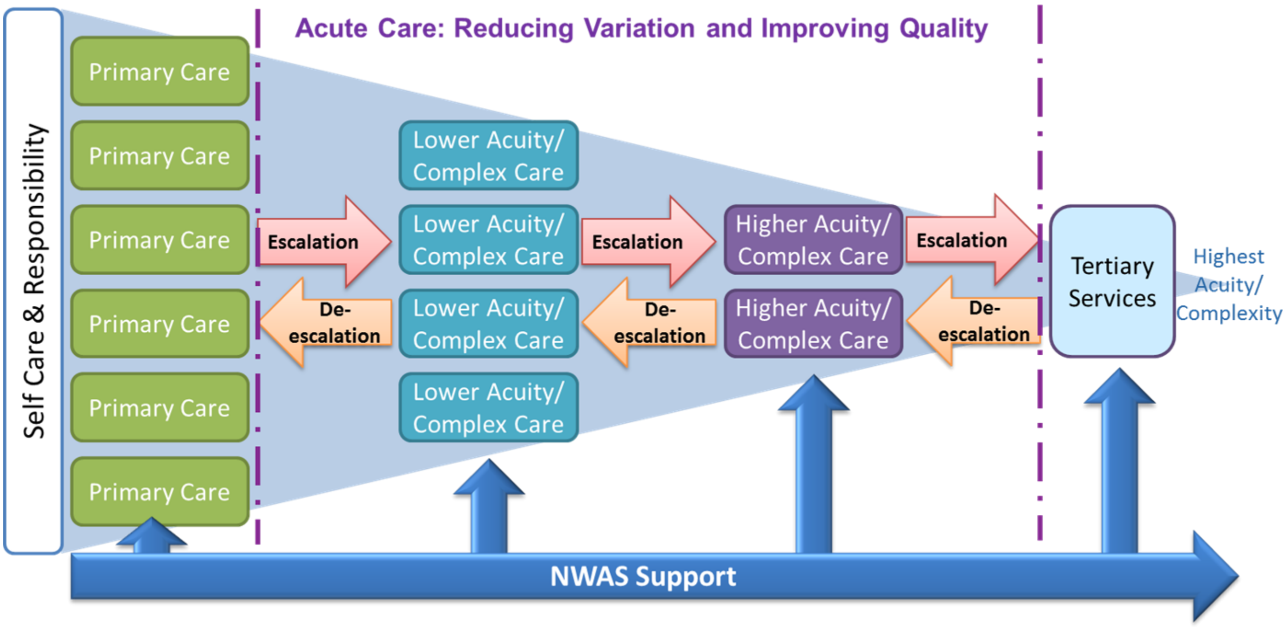
Review of Services at Southport & Ormskirk NHS Trust

NHS Southport & Formby CCG will lead a review of the services provided by Southport and Ormskirk NHS Trust, the outcome of which is to ensure long term clinical and financial sustainability and to meet the particular needs of this population. The review process will be conducted by a multi-stakeholder partnership that will develop a case for change which will inform plans for the future of these services.

- Process, Governance and Stakeholder Mapping (Jan-March 2017)
- Case for Change (April-June 2017)
- Pre-consultation engagement (July-September 2017)

The Alliance

The Alliance has developed a vision for hospital reconfiguration, and started to develop a range of options. A plan for the assessment and design of these services will be completed by December.


Acute Care: Reducing Variation and Improving Quality
Self Care & Responsibility
Primary Care
Primary Care
Primary Care
Primary Care
Primary Care
Primary Care
Escalation
De-escalation
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Escalation
De-escalation
Higher Acuity/ Complex Care
Higher Acuity/ Complex Care
Escalation
De-escalation
Tertiary Services
Highest Acuity/ Complexity
NWAS Support

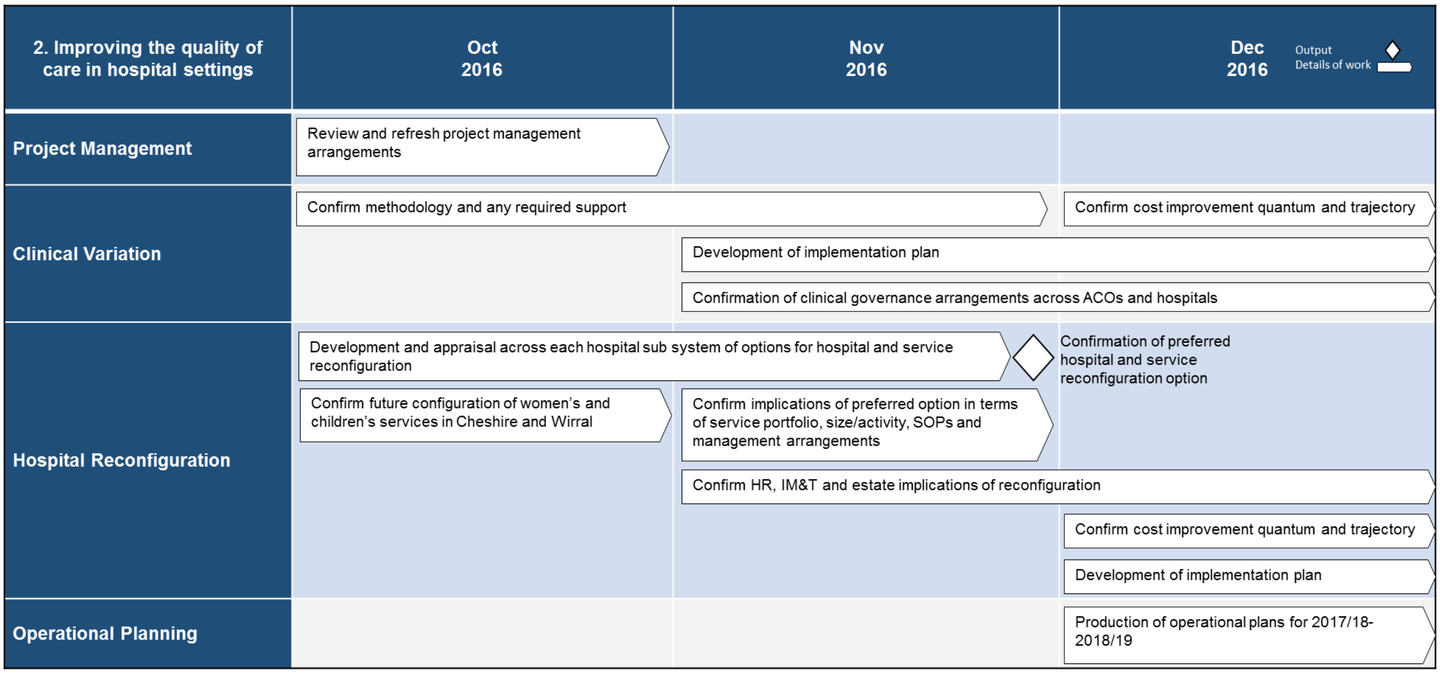
2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

Cheshire and Wirral

C&W have a short term plan to rapidly address variation and reconfigure hospital services across Cheshire and Wirral



2. Improving the quality of care in hospital settings	Oct 2016	Nov 2016	Dec 2016
			Output ◆ Details of work ▭
Project Management	Review and refresh project management arrangements		
Clinical Variation	Confirm methodology and any required support		Confirm cost improvement quantum and trajectory
		Development of implementation plan	
		Confirmation of clinical governance arrangements across ACOs and hospitals	
Hospital Reconfiguration	Development and appraisal across each hospital sub system of options for hospital and service reconfiguration	◆	Confirmation of preferred hospital and service reconfiguration option
	Confirm future configuration of women's and children's services in Cheshire and Wirral	Confirm implications of preferred option in terms of service portfolio, size/activity, SOPs and management arrangements	
		Confirm HR, IM&T and estate implications of reconfiguration	
			Confirm cost improvement quantum and trajectory
			Development of implementation plan
Operational Planning			Production of operational plans for 2017/18-2018/19

Hospital Services in Eastern Cheshire

The Caring Together programme is a well-established transformation programme within Eastern Cheshire. The programme aims to improve the health and wellbeing of the local people by implementing enhanced integrated community care supported by clinically and financially sustainable hospital services.

Extensive modelling work has been completed and indicates that transforming just one segment or service of the local health and social care economy will not be sufficient to address the challenges the economy is now facing. Instead a system-wide solution is needed. The Caring Together Programme Board met with system regulators (NHS England and NHS Improvement) on 17 October 2016 and agreed to complete financial modelling on two care model options

The two options are based on clinical and financial sustainability of hospital services at East Cheshire Trust, (and the impact on neighbouring Trusts) taking into account clinical dependencies of managing either low risk or medium to low risk patients and the impact these options have on the development of enhanced proactive community care.

The financial modelling of the two options builds on decisions already taken in 2016/17 including Dermatology Services transferred to Vernova CIC in January 2016 and Stroke Services transferred to Stockport NHS Foundation Trust in October 2016.

Options for the future of high risk general surgery are currently under review. The CCG is working with East Cheshire Trust to assess compliance of the *Healthier Together* standards from April 2017.

The modelling of Options 1 and 2 including capital requirements and potential impacts of tariff plus payments/MFF will be completed by the end of 2016 with the findings being presented to the Caring Together Programme Board and NHSI/NHSE for a final decision in early 2017.

2.3a - Optimise direct patient care – reduce the cost of administration

Introduction

We previously referred to this programme as 'Back Office'.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations. The ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.

What are the objectives

- Reduced spend in the Back Office will enable additional spend and effort to be directed towards front line services.
- Cost reduction in Back Office is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services.
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system.
- Improve links and engagement with stakeholders to ensure that reconfigured services meet both corporate and clinical need.
- Identify the required changes to ways of working and to organisational culture to enable delivery of collaboration.
- Create an engaging and rewarding place to work, operating flexibly across structures and ensuring staff are able to build a broad framework of skills and experience
- Ensure that Back Office operations are sufficiently flexible to meet changing needs of the organisations in the footprint

Why is this programme important?

The Carter Review made clear that we can no longer rely on traditional efficiencies and cost improvement programmes within single organisations.

Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. This is how real efficiencies are identified and how greater economies of scale can be delivered.

Values - Where appropriate, Back Office services will be maintained within the NHS to provide wider economic benefit to communities in Cheshire & Merseyside region.

What is the scope of the work

For all Back Office services, the ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.
The projects that will delivered are to be prioritised on the basis of deliverability, scale of benefit and time to transform.

Projects can be described in two ways:

- Transactional savings leveraging economies of scale and best in class approaches and models across the patch
- Procurement at category level, then built up to a cluster approach at LDS and then STP level

How will the change be lead?

Sponsor:	**Nikhil Khashu**
Members:	Alliance – Andrea Chadwick, WHH Cheshire & Wirral – Tony Chambers North Mersey – Aidan Kehoe Local Gov't - **TBD**

2.3a - Optimise direct patient care – reduce the cost of administration

Delivery

The ‘Plan on a Page below is a summary of the more detailed plans that are included in the Appendices.

There is a clear opportunity to create some early wins in this programme, though there are risks and challenges - he key challenge being the capability and capacity to deliver within the timescales.

The main enablers for the Back Office programme will be:

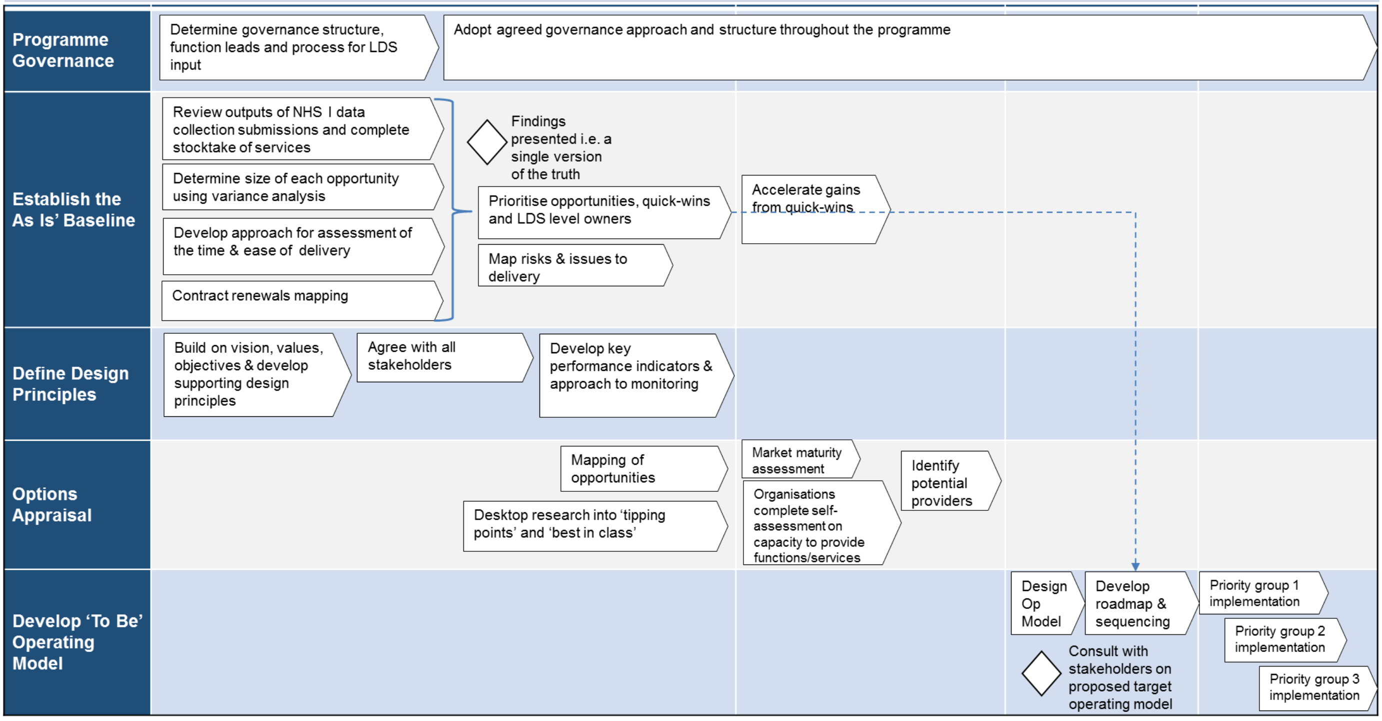
- Breaking down department or Trust silos and ensure open communication and sharing of data.
- Sharing lessons learnt and good practice swiftly and openly
- Investment in required technology and systems.
- Balanced focus across business as usual and future state development – being future focussed according to the needs of our stakeholders.

Proposed Governance Arrangements

- The existing Back Office Steering Group is to become the Back Office Programme Board
- Back Office SRO is a member of the Steering Group representing the 3 LDSs, with a remit to challenge, drive and support the LDSs in the delivery of the programme and where appropriate, escalate issues or opportunities to STP Membership Group for consideration
- LDS Back Office leads / SROs will be part of the Programme Board
- Governance at the level of the LDS leads for the functional areas will be determined as part of the next phase of work.

Immediate next steps

- Determine governance for the Back Office programme considering the structure, leads for identified function areas and process for LDS input
- Collate and analyse the organisation submissions for the NHS Improvement corporate and administrative data collection exercise
- Complete stocktake of services delivered at an organisational level
- Present findings from both of the above and gain agreement from all stakeholders on the current ‘as-is’ state



Programme Governance

Determine governance structure, function leads and process for LDS input

Adopt agreed governance approach and structure throughout the programme

Establish the As Is’ Baseline

Review outputs of NHS I data collection submissions and complete stocktake of services

Determine size of each opportunity using variance analysis

Develop approach for assessment of the time & ease of delivery

Contract renewals mapping

Findings presented i.e. a single version of the truth

Prioritise opportunities, quick-wins and LDS level owners

Map risks & issues to delivery

Accelerate gains from quick-wins

Define Design Principles

Build on vision, values, objectives & develop supporting design principles

Agree with all stakeholders

Develop key performance indicators & approach to monitoring

Options Appraisal

Mapping of opportunities

Desktop research into ‘tipping points’ and ‘best in class’

Market maturity assessment

Organisations complete self-assessment on capacity to provide functions/services

Identify potential providers

Develop ‘To Be’ Operating Model

Design Op Model

Develop roadmap & sequencing

Consult with stakeholders on proposed target operating model

Priority group 1 implementation

Priority group 2 implementation

Priority group 3 implementation

2.3b - Optimise direct patient care – efficient clinical support services

Introduction

We previously referred to this programme as ‘Middle Office, or Clinical Support Services’.

The vision is to deliver cost effective, efficient and commercially sustainable Clinical Support Services which can be transformed to deliver improved services to front line services across the STP footprint.

What are the objectives

- Reducing variations in practice / services across the STP footprint area and develop a set of standards which every service can comply with irrespective of *how* they are delivered (e.g. either via a “network” arrangement or a single managed service).
- Reduced spend by delivering increased efficiencies generated by Clinical Support Services operating differently across the C&M footprint, enabling additional spend and effort to be directed towards front line services.
- Cost reduction in Clinical Support Service areas is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system
- Reduction of on call rotas through better / increased use of digital enablers

Why is this programme important?

The Carter Review, and indeed Lord Carter’s review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if these services are consolidated on a regional basis.

Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.

What is the scope of the work

- Radiology
- Pharmacy
- Pathology

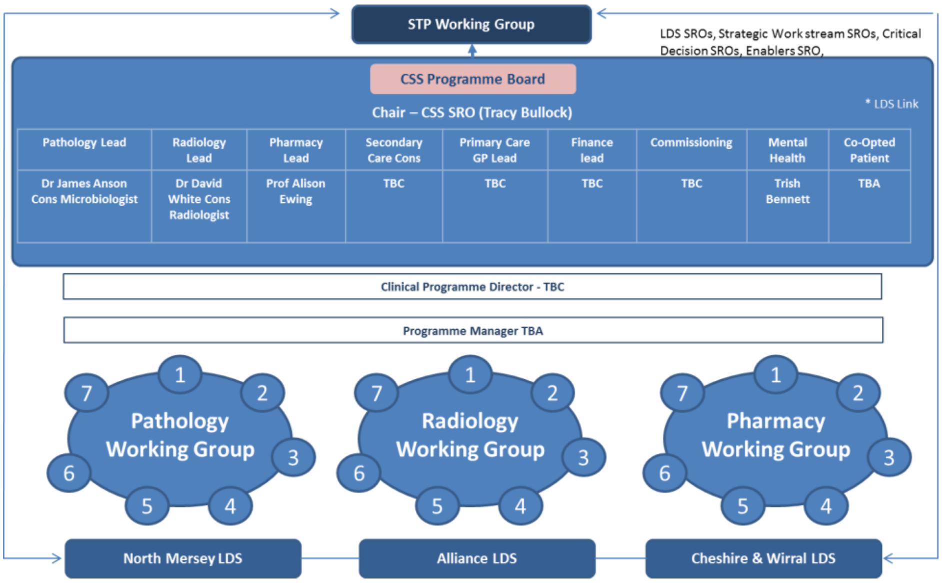
The ambition is to collaborate at STP level wherever possible and to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint

How will the change be lead?

Sponsor:	**Tracey Bullock**	
Members:	Pharmacy: Pathology: Radiology:	Karen Thomas, Prof. Alison Ewing Dr James Anson Dr Dave White

2.3b Optimise direct patient care – efficient clinical support services

Proposed Governance Arrangements



Pathology Lead	Radiology Lead	Pharmacy Lead	Secondary Care Cons	Primary Care GP Lead	Finance lead	Commissioning	Mental Health	Co-Opted Patient
Dr James Anson Cons Microbiologist	Dr David White Cons Radiologist	Prof Alison Ewing	TBC	TBC	TBC	TBC	Trish Bennett	TBA

Delivery

The principle is collaboration across the entire STP but recognising that this will be a journey starting with programme based collaboration at STP level in the first 18 months of the programme, building to full STP collaboration where appropriate between 18 and 36 months or even longer in some cases.

The 'Plans on a Page, below and overleaf, are summaries of the more detailed plans that are included in the Appendices.

3b. Optimise direct patient care: Clinical support services- Radiology	**Phase 1 Oct-Mar 2016-2018**	**Phase 2 Apr-Sep 2018-2019**
Collaborative reporting arrangements	Develop project scope and review 'as is' model Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify and evaluate options for future delivery arrangements Develop new operating model and a business case Determine investment costs required to ensure IT systems are compliant across the footprint Consult on the proposed business case proposal Examine governance and HR requirements to support proposed new model of care	
Flexible reporting arrangements – home reporting	Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify the options for future delivery arrangements Identify any infrastructure/IT costs to support/facilitate home care reporting arrangements Carry out gap analysis of how future reporting arrangements compare to current and identify potential investment costs	Increased use of honorary contracts Examine governance and HR/legal issues in support of changing practices Introduce trials of home reporting arrangements and carry out evaluation of results Expansion of home reporting across the C&M footprint
Flexible reporting arrangements- establishing 'hub and spoke' units	Consideration and development of new operating model including establishment of a central management team charged with managing requests for work/balancing demand with capacity in system Explore flexibility/use of honorary contracts to support flexible working arrangement across Trusts	Examine implications of introducing honorary contracts to allow flexible working arrangement across Trusts Establish central reporting hubs to allow group involvement in speciality reporting Consolidation and expansion of radiographer role extension
Greater collaboration around procurement	Carry out audit of equipment which is regularly purchased by type, manufacturer and value Identify when larger items are due for replacement and synchronise purchasing schedule Standardise range of equipment lines Establish a single managed service via a lead Trust/supplies team to lead the negotiations with potential suppliers about the range of items required and agree potential discounts	Commence the procurement of standard range of interventional radiology equipment Central procurement of contrast media Central procurement of imaging technology

Output ◇
Details of work ▭

2.3b Optimise direct patient care – efficient clinical support services

Delivery, cont.

3b. Optimise direct patient care: Clinical support services- Pathology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output ◆ Details of work ▭
LDS consolidation and partial centralisation (phase 1)	Alliance merger consolidate further with Warrington North Mersey LDS to complete consolidation by merger of Regional Genetic Service into LCL and examine the potential merger/centralisation of Alder Hey pathology service into LCL Cheshire and Wirral- to review collaborative models feasible between the current collaboration and CoCH & Wirral. Identify options for further consolidation/centralisation of services Identify current unsustainable services and opportunities across C&W/C&M for short term sustainability Identify IT and support system investments required vs financial/sustainability benefits Develop business cases	Develop Project Implementation Boards to implement agreed business cases
STP wide/C&M single managed service	Commence scoping of potential future strategic direction of services including development of baseline position (costs, staffing, service and performance issues) Look at demand and capacity and site options to accommodate any further centralisation options Undertake workshops and engagement sessions with key stakeholders to define a well understood and agreed set of design principles that could govern future change with specific focus on the use of increased collaborative working arrangements. Define which processes are suitable for delivery through a more consolidated function versus those that should be retained within local hospitals / LDS level	Review potential governance models that could best support an STP single managed service Review governance arrangements that could support the operation of the above solution and clarify performance of services required Review and discuss potential vision and models with stakeholders to seek buy-in and support Consider how this supports the acute service reconfiguration model which evolves from the STP work Undertake an options appraisal of the best solution and identify the relevant costs and benefits associated with this for the C&M footprint area Examine the potential for novation of contracts over time

3b. Optimise direct patient care: Clinical support services- Pharmacy	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output ◆ Details of work ▭
Medicines information	Develop project scope Identify and evaluate options ◆ CEO/STP sign off	Implement new operating model and establish and transfer services
Aseptic service	Develop project scope and clarify investment/support costs Establish 'as is' position- audit what is currently provided at each site and identify those areas that could be centralised and what would need to remain under local direction Agree vision ('to be' operating model) and establish design principles	Establish a communication plan Evaluate estate's capacity/capability to meet potential transfer of services Develop business case to support service proposal Develop stakeholder engagement plan and engage key stakeholders Finalise options Develop implementation plan Commence roll out of proposed service moves
Clinical Pharmacy Templates	Develop project scope and clarify investment/support costs Establish 'as is' position- Assess what is currently done and how pharmacists/technicians currently spend their time delivering these functions Identify what a good pharmacy service looks like Establish patient:pharmacist contact criteria eg when a patient would see a pharmacist, how long consultation should take (average) Establish criteria which would support a medicines review for a technician	Design templates for pharmacists and technicians and agree new standards of working Undertake a gap analysis- compare proposed solution with the 'as is' situation and develop a case for change Develop a shared medicines management training programme via e-learning package Staff side engagement and consultation Establish potential opportunity for improvement across the STP footprint from moving to the new operating model Set KPIs to inform performance management and to adhere to standards
Forging links with the community Pharmacy	Develop project scope and clarify investment/support costs Establish vision of the proposed future state Undertake assessment of current pharmacy dispensing arrangements across every Trust in the C&M footprint and how they are funded Explore legal implications of the proposed operating model Evaluate potential options/commercial vehicles to support the proposed venture/operating model	Develop service specification and obtain professional advice Develop tender arrangements to secure preferred partner Develop appropriate legal documentation to support the proposed commercial partnership arrangement Determine new governance arrangements Set up new commercial vehicle(s) with proposed community pharmacy partner
Formulary management and application	Review current plans/proposals being developed in C&W in short term for proposals to cover the five existing Trusts in the area Undertake assessment of staffing costs Agree, if applicable, a wider vision and target operating model prior to regional centres being established Consider proposed governance arrangements to support proposed model	Consult with stakeholders on proposed single sit solution and how this will work Implement single formulary arrangement with the advent of the Regional Medicine Optimisation Committee coming on line for the North West area

2.4 - Mental Health

Introduction

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%). One in four adults experience at least one diagnosable mental health problem in any given year. *Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.* In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people.

People with long term illnesses suffer more complications when they also develop mental health problems, increasing the cost of care by an average of 45%. For example, £1.8billion additional costs in diabetes care are attributed to poor mental health.

Two thirds of people with mental health needs are seen in primary care. Local GP registers indicate that 9 out of the 12 CCGs in Cheshire and Merseyside have a higher number of adults with depression than the England average. The number of people on Cheshire and Merseyside GP registers with severe mental illness is also higher than the England average and over 50% of Cheshire and Merseyside CCGs have been flagged for having a high prevalence rate of dementia.

Additional funding to support the transformation of mental health services will include centrally-held transformation funding and allocations via CCGs. It is assumed that an appropriate share of national monies will be made available and that this investment will rise to at least £57.9m in Cheshire and Merseyside by 2020/21. Evidence provided within the Centre for Mental Health Economic Report indicates that significant savings across the health and care system will outweigh the investment needed to deliver services.

What are the objectives

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases;
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

A C&M Mental Health Programme Board will be established to oversee nine workstreams to facilitate delivery of these key objectives. The Board will identify workstream owners and confirm timescales for delivery of all workstreams.

How will the change be lead

Sponsor:	**Sheena Cumiskey**
Members:	Alliance – Simon Barber C&W – Sheena Cumiskey North Mersey – Neil Smith / Joe Rafferty

2.4 - Mental Health

Delivery

Three priorities have been identified for early implementation:

- Eliminate out-of area-placements
- Develop integrated clinical pathways for those with a personality disorder
- Enhance Psychiatric Liaison provision across the footprint and establish Medically Unexplained Symptoms (MUS) service

The nine projects below have been developed to deliver the objectives. Detailed plans for each workstream are currently being prepared.

A Mental Health plan on a page is included overleaf to provide the headline phases of work.

Project	Impact	'Workstream'
Children & Young People's (CYP) MH	Increased number of CYP receiving community treatment; reduced use of inpatient beds; improved outcomes for children with conduct disorder leading to savings in the public sector, mainly the NHS, education & criminal justice	• Community access • 24/7 crisis & liaison • School age screening & education
Perinatal MH (PMH)	Improved identification of perinatal depression & anxiety; improved health outcomes; reduction in adverse impact on the child (which account for >70% of total long-term costs to society);	• Build PMH capacity & capability • Improve screening programmes & access to psychological therapy
Adult MH: Common MH Problems	Relieve pressure on General Practice , reduce A&E attends & short stay admissions. Target most costly 5% of patients with medically unexplained symptoms (MUS)	• Increase access to psychological therapies • Develop Medically Unexplained Symptoms Service
Adult MH: Community, Acute & Crisis Care	Reduced bed days, lower rates of relapse, reduced admissions and lengths of stay Reduced use of MH services and improved outcomes	• Early Intervention in Psychosis • 24/7 Crisis Resolution & HTT • All-age MH Liaison in acute • Increase GP screening & access • Scale up IPS employment services • Improve psychological therapies
Secure Care Pathway	Prevent avoidable admissions & support 'step-down' and ongoing recovery	• Improve pathways in & out of secure care
Health & Justice	Fewer GP consultations, hospital admissions & inpatient MH treatment	• Expand access to liaison & diversion services
Suicide Prevention	Main benefits relate to non-public sector costs relating to the individual and the family	• Suicide Prevention
Sustaining Transformation	Prevent avoidable admissions, reduce length of stay, improve community access and eliminate out-of-area placements	• Care pathways • Workforce MH
Dementia Care	Increase dementia diagnosis rates & create dementia-friendly health & care settings	• Implement commitments from PM's Challenge on Dementia 2020

2.4 - Mental Health – plan on a page

9. Mental Health		2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Enablers	Output ◆ Details of work ▭	Establish Transformation Board Identify BI capacity & capability to complete baseline assessments & provide ongoing support / delivery of schemes Confirmation of funding as per 5 YFV for MH				
Children & Young People's (CYP) Mental Health	**Community access**	Design	Implementation	Post-implementation phase. PDSA		
	24/7 crisis & liaison	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Screening of school children & provision of parenting programmes	TBC				
	Develop school based mental health curriculum (social & emotional learning)	TBC				
Perinatal Mental Health	**Build PMH capacity & capability and improve screening programmes & access to psychological therapy**	Recruitment	Full implementation	Post-implementation phase. PDSA		
Adult Mental Health: Common MH problems	**Increase access to psychological therapies**	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Develop a specialist Medically Unexplained Symptoms (MUS) service	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Provide collaborative care for long-term conditions & co-morbid MH		Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Early Intervention in Psychosis	Implementation	Post-implementation phase. PDSA			
	24/7 Crisis Resolution & HTT	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Deliver all-age mental health liaison teams in acute hospitals	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Armed forces community MH		Baseline assessment, design & implementation	Post-implementation phase. PDSA		
	Increase GP screening & access		TBC			
	Scale up IPS employment services		TBC			
	Improve access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Supported housing step-down facility		TBC			
	Improve pathways in & out of secure care		TBC			
	Expand access to liaison and diversion services		TBC			
	Suicide Prevention	Design	Implementation	Post-implementation phase. PDSA		
	Care pathways (multi-phased)	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
			Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Workforce MH		TBC			
	Implement the 18 commitments outlined in the Prime Ministers Challenge on Dementia 2020	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		

3 - Embedding the change locally

Please see separately attached LDS plans in full

LDS Plans

The previous section has described the programmes of work at the STP level, together with the LDS's contribution to them. Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

The strategic programmes that will drive transformation across C&M are not new or particular to C&M. They are issues that health economies have tackled over many years but so often failed to deliver on.

However, there is now an compelling need to deliver on these ideas that have been developing. This is reflected in the plans of the three LDSs. All three have already put in place programmes to help improve out of hospital care, to reduce the demand on our acute hospitals and to persuade people that they need to take responsibility for their own health.

Acute hospitals in each LDS have started work on aligning and sharing services, including clinical service lines, and in North Mersey, merger discussions are at an advanced stage. There is also a, mixed, history of back office collaboration and working together on city and county wide issues.

Over the following pages we have summarised the key programmes being developed in each LDS, together with their delivery plans.

The graphics below illustrate the overall alignment of LDS plans with the STP's strategic programmes:

1 Demand Management,

2 Variation and Hospital Reconfiguration,

3 a) Back Office, b) Clinical Support Services, and

4 Mental Health

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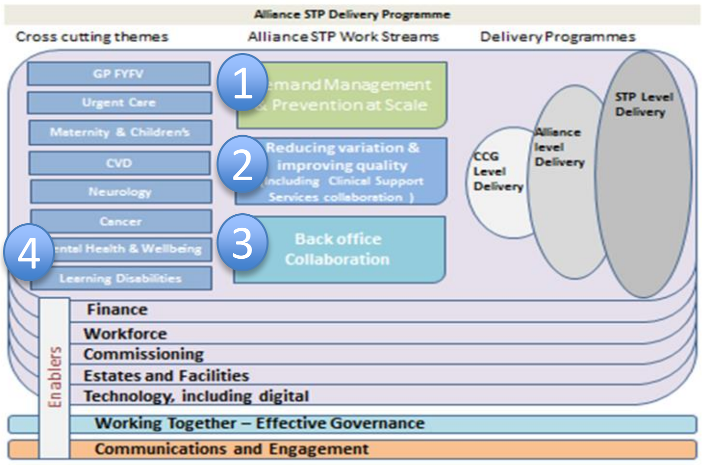
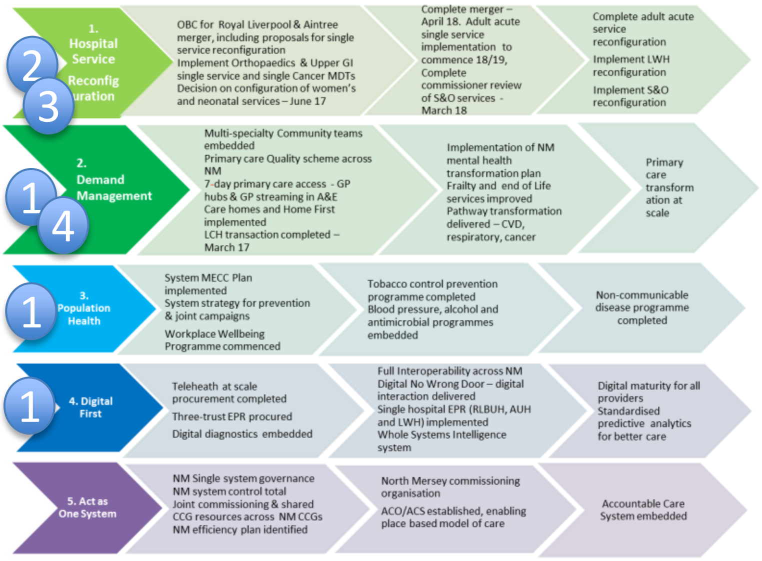

Alliance STP Delivery Programme
Cross cutting themes
Alliance STP Work Streams
Delivery Programmes
GP FYFV
Urgent Care
Maternity & Children's
CVD
Neurology
Cancer
ental Health & Wellbeing
Learning Disabilities
1
emand Management
& Prevention at Scale
2
Reducing variation & improving quality
including Clinical Support Services collaboration)
3
Back office Collaboration
4
CCG Level Delivery
Alliance level Delivery
STP Level Delivery
Enablers
Finance
Workforce
Commissioning
Estates and Facilities
Technology, including digital
Working Together – Effective Governance
Communications and Engagement



1. Hospital Service Reconfig uration	OBC for Royal Liverpool & Aintree merger, including proposals for single service reconfiguration Implement Orthopaedics & Upper GI single service and single Cancer MDTs Decision on configuration of women's and neonatal services – June 17	Complete merger – April 18. Adult acute single service implementation to commence 18/19, Complete commissioner review of S&O services - March 18	Complete adult acute service reconfiguration Implement LWH reconfiguration Implement S&O reconfiguration
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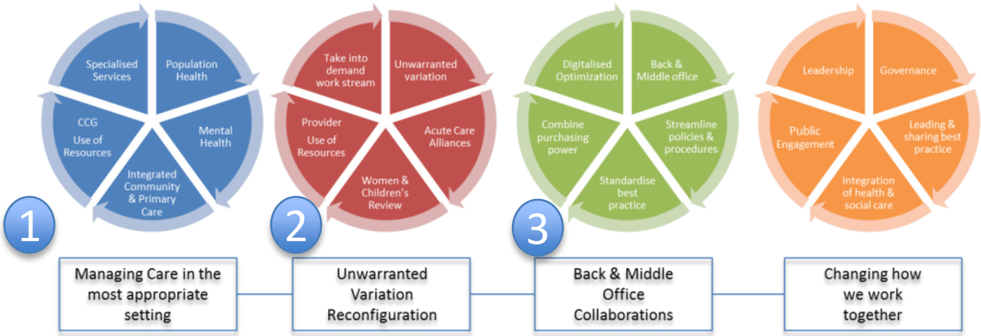
3. Population Health	System MECC Plan implemented System strategy for prevention & joint campaigns Workplace Wellbeing Programme commenced	Tobacco control prevention programme completed Blood pressure, alcohol and antimicrobial programmes embedded	Non-communicable disease programme completed
4. Digital First	Teleheath at scale procurement completed Three-trust EPR procured Digital diagnostics embedded	Full Interoperability across NM Digital No Wrong Door – digital interaction delivered Single hospital EPR (RLBUH, AUH and LWH) implemented Whole Systems Intelligence system	Digital maturity for all providers Standardised predictive analytics for better care
5. Act as One System	NM Single system governance NM system control total Joint commissioning & shared CCG resources across NM CCGs NM efficiency plan identified	North Mersey commissioning organisation ACO/ACS established, enabling place based model of care	Accountable Care System embedded

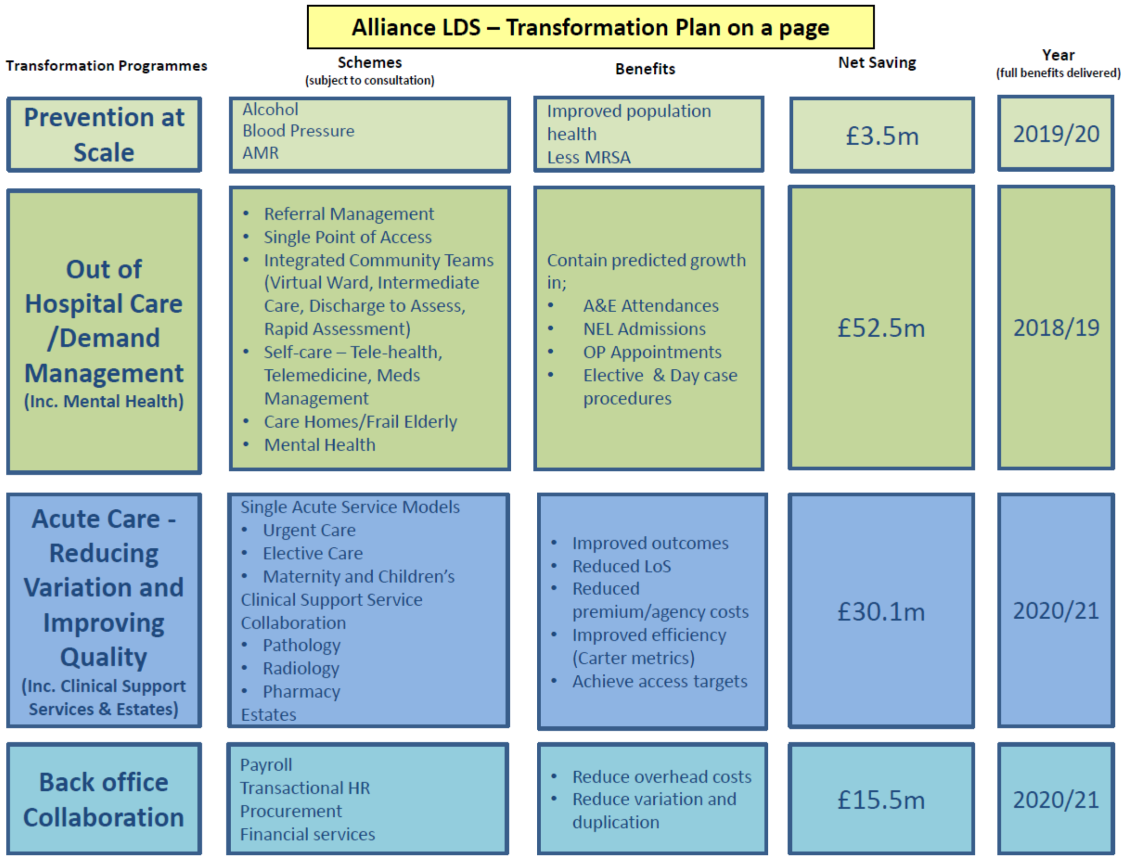

Specialised Services
Population Health
CCG Use of Resources
Mental Health
Integrated Community & Primary Care
1
Managing Care in the most appropriate setting
Take into demand work stream
Unwarranted variation
Provider Use of Resources
Acute Care Alliances
Women & Children's Review
2
Unwarranted Variation Reconfiguration
Digitalised Optimization
Back & Middle office
Combine purchasing power
Streamline policies & procedures
Standardise best practice
3
Back & Middle Office Collaborations
Leadership
Governance
Public Engagement
Leading & sharing best practice
Integration of health & social care
Changing how we work together

3.1 - Alliance approach and plans

The Alliance LDS has aligned its transformational work streams and delivery structure to mirror that of the C&M STP to ensure that delivery will be at the most appropriate level – organisational, LDS level or STP footprint.

Since the June submission the Alliance has gained a greater understanding of the potential service models that will transform services and achieve long term financial sustainability.

This plan represents options and models of transformation for the local health system that have been developed by the member organisations and are still subject to wider engagement and where necessary formal consultation with stakeholders.



Alliance LDS – Transformation Plan on a page

Transformation Programmes	Schemes (subject to consultation)	Benefits	Net Saving	Year (full benefits delivered)
Prevention at Scale	Alcohol Blood Pressure AMR	Improved population health Less MRSA	£3.5m	2019/20
Out of Hospital Care /Demand Management (Inc. Mental Health)	• Referral Management • Single Point of Access • Integrated Community Teams (Virtual Ward, Intermediate Care, Discharge to Assess, Rapid Assessment) • Self-care – Tele-health, Telemedicine, Meds Management • Care Homes/Frail Elderly • Mental Health	Contain predicted growth in; • A&E Attendances • NEL Admissions • OP Appointments • Elective & Day case procedures	£52.5m	2018/19
Acute Care - Reducing Variation and Improving Quality (Inc. Clinical Support Services & Estates)	Single Acute Service Models • Urgent Care • Elective Care • Maternity and Children's Clinical Support Service Collaboration • Pathology • Radiology • Pharmacy Estates	• Improved outcomes • Reduced LoS • Reduced premium/agency costs • Improved efficiency (Carter metrics) • Achieve access targets	£30.1m	2020/21
Back office Collaboration	Payroll Transactional HR Procurement Financial services	• Reduce overhead costs • Reduce variation and duplication	£15.5m	2020/21

The Alliance is still developing its programme of work and the detailed plans that explain how delivery will be effected.

In addition to the core programmes shown above the Alliance is working closely with the Clinical programmes and have clear objectives with regard Urgent Care, Women's and Children's, Elective Care and Clinical Support Services

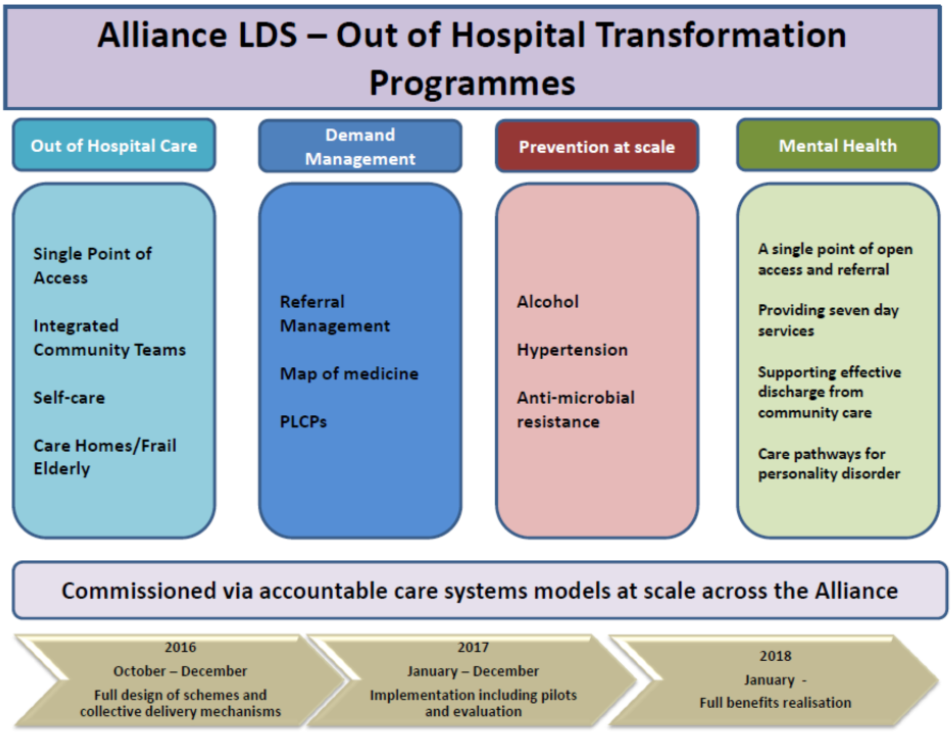
Over the page are the models and frameworks they have developed for developing improved out of hospital care and also improving the quality of acute care.

3.1 - Alliance approach and plans

Improve the health of the C&M population by:

- *Promoting physical and mental well being*
- *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*

Out of hospital care is a key component of the future vision for services across the Alliance. The individual CCGs have already started to develop plans and the challenge now is for the commissioners to come together and work collaboratively to scale up the ambition and impact of these plans to impact on the overall sustainability of the LDS. This is a complex programme of work that has 4 core elements as shown below:



Alliance LDS – Out of Hospital Transformation Programmes

Out of Hospital Care	Demand Management	Prevention at scale	Mental Health
Single Point of Access Integrated Community Teams Self-care Care Homes/Frail Elderly	Referral Management Map of medicine PLCPs	Alcohol Hypertension Anti-microbial resistance	A single point of open access and referral Providing seven day services Supporting effective discharge from community care Care pathways for personality disorder

Commissioned via accountable care systems models at scale across the Alliance

2016 October – December: Full design of schemes and collective delivery mechanisms

2017 January – December: Implementation including pilots and evaluation

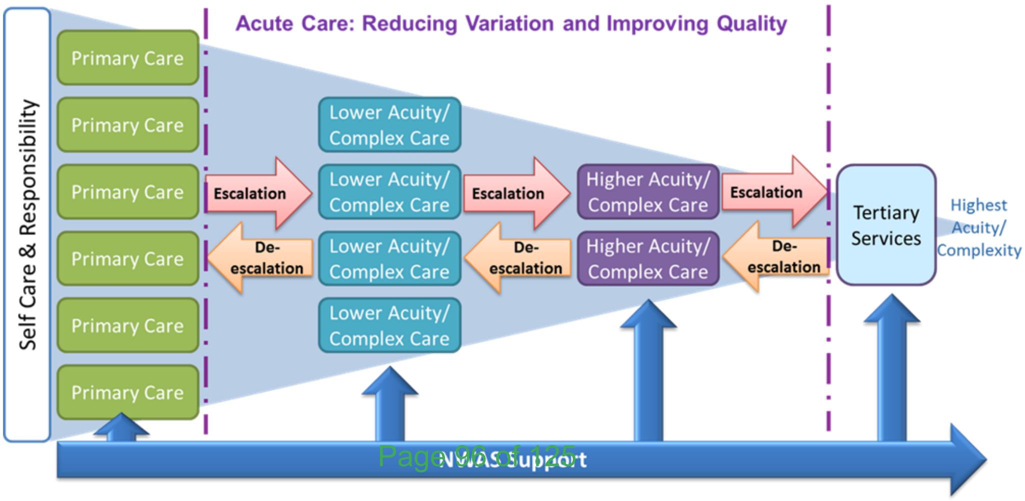
2018 January - Full benefits realisation

Improve the quality of care in hospital settings by:

- *Reducing the variation of care across C&M;*
- *Delivering the right level of care in the most appropriate setting*
- *Enhancing delivery of mental health care*

The Acute Providers will work together to develop a new model of working, including:

- More streaming of patients depending on their acuity and complexity
- The highest acuity care can be delivered on fewer sites with the appropriate facilities
- Site specialisation to suit that patient cohort with the appropriate resources and facilities
- NWAS streaming patients to the site/service appropriate to their need


Acute Care: Reducing Variation and Improving Quality
Self Care & Responsibility
Primary Care
Primary Care
Primary Care
Primary Care
Primary Care
Primary Care
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Lower Acuity/ Complex Care
Escalation
De-escalation
Escalation
De-escalation
Higher Acuity/ Complex Care
Higher Acuity/ Complex Care
Escalation
De-escalation
Tertiary Services
Highest Acuity/ Complexity
NWAS Support

3.1 - The Alliance plans - Demand management

Projects	Change Delivered	Outcomes
Quality Referral Management	Single quality referral management system across the Alliance LDS managing demand using Map of Medicine and generic pathways agreed between the acute hospital sites. Utlisation of Map of Medicine and greater scrutiny of PLCP.	Impacts Acute Outpatient Activity and Acute Elective and Day Cases Activity For Acute Outpatient: 20% activity reduction (equiv. 150,000), and £22.5m gross saving in FY202/21 For Acute Elective and Day cases: 4% activity reduction (equiv. 7,000) and £7m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Single point of access	Single clinical governance regime and infrastructure which enables access to the appropriate level of support in a variety of settings for patients and professionals in instances of unscheduled care	Impacts Acute Elective and Day Cases Activity and Acute Non Elective Activity For Acute Elective and Day Cases: 5% activity reduction (equiv. 5,000), and £5m gross saving in FY202/21 For Non Elective: 6% activity reduction (equiv. 5,000) and £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Integrated community management teams (virtual ward)	Integrated services involving social care which not only involves the work of professional teams but also integrated information systems and the sharing of patient and client information; this also supports discharge by linking into SPA - including domiciliary care and care homes.	Impacts Acute A&E Activity and Acute Non Elective Activity For Acute A&E: 4% activity reduction (equiv. 15,000), £1.8m gross saving in FY2020/21 For Acute Non Elective: 5% activity reduction (equiv. 5,000), £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Medicines Management Optimisation	Reduction in primary care medicines management spend	£4m gross saving in FY2020/21 0-1 year timeframe for benefits delivery
Telehealth and telecare	Identifying individuals to support better self care to provide them with IT equipment in their own home to monitor their conditions to reduce emergency admissions	For Acute A&E: 4% activity reduction (equiv. 15,000) and £1.8m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Rapid response/ rapid assessment	Rapid response and assessment team respond quickly to urgent requests at home, with one of the boroughs employing a community geriatrician	Acute A&E Activity: 3% activity reduction (equiv. 10,000) with £1.2m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Prevention	STP-wide strategy to reduce the prevalence of alcohol-related conditions or episodes and impact on primary and acute	

3.1 - The Alliance plans - Variation and hospital reconfiguration (1/3)

Projects	Change Delivered	Outcomes
Urgent Care System – model of care 1	S&O will consider options for new models of A&E delivery. 3 Trusts will have a Type I - 24hr A&E, but through shared rotas and federation of staff premium payments would be reduced by x% Modelling of staffing rotas and new working patterns/processes will improve productivity	Reductions in the consultant on call cover and presence Reduction in the use of locums /agency by (x%) Productivity improved through the use of best practice Alignment with commissioner interventions
Urgent Care System – model of care 2	S&O will consider options for new models of A&E delivery 3 Trusts will have a 24hr A&E High acuity patients will be transferred to the Emergency centre (for example: stroke, heart attack, compound fracture, burns, emergency dialysis, some trauma, GI Bleeds) By federating staff and remodelling of staffing rotas and new working patterns/ processes will improve productivity and reduce premium payments Alignment with commissioner demand management interventions	Accelerated flow through departments to achieve more optimal performance Reduction in the use of staff premium payments by x% Consultant presence and cover will reduce on call payment Activity transfer of x patients per year (one site) Increase in bed capacity of x y beds to freed up. Redistribution of elective activity to other centres (TBD)
Urgent Care System – model of care 3	S&O will consider options for new models of A&E delivery . 1 Trust will have a Type I - 24hr A&E, 2 trusts will re-profile opening hours with activity flowing to other 24/7 centres Alignment with commissioner demand management interventions	Reductions in the consultant cover from 3 to 2 on call covering 3 sites. Reduction in the use of locums /agency staff by x% Activity transfer of 8,700-20,000 patients per year (one site) Increase in bed capacity of 80-150 beds required/freed up. Redistribution of elective activity to other centres TBD)
Stroke Services	The Acute vision is for Whiston to be the Hyper Acute provider for the LDS support by a 1 in 8 rota. (All Trust have lost some consultant establishment recently so this needs to be address first) Single point of contact and standardise referral process All ESD teams to have equal access to discharge plans for proactive discharge planning Single CCG lead for ESD and Community for cross organisational services Development of Unified ESD and Community teams.	Single provider for Hyper Acute, support be 3 acute units and community teams Consistent approach across the Alliance Patients repatriated to local centre A x% reduction in premium payments

3.1 - The Alliance plans - Variation and hospital reconfiguration (2/3)

Projects	Change Delivered	Outcomes
Paediatric Services Review	Alignment with Vanguard Proposals for a 'Single Service' Move from 3x level 2 units to: 2x high acuity units & 1 lower acuity unit or 1x high acuity units & 2 lower acuity unit or Higher and Lower levels of Acuity **Acute Inpatient Unit – 24hrs** Paediatric A&E 24hrs GP hotline Outpatients Rapid access clinics HDU Inpatient unit Neonates: Level 1/2 Community home nursing sup. Day case surgeries Anaesthetic cover **Short Stay Unit – 12hrs** Paediatric A&E GP hotline Outpatients Rapid access clinics Neonates : level 1/2 Community home nursing sup. Day case surgeries APNPs Safe transfer to AIU	**High Quality** Resources, facilities and the care delivered in each site is tailored to the patient cohort treated ALL hospitals will be required to attain Quality and Safety standards. **Safe** Specialist consultant resources will be concentrated on the highest acuity patients Evidence shows that the more times a surgeon performs a procedure, the better the outcome. Focusing the delivery of highly specialist care in fewer locations means that our professionals will gain the volume and breadth of experience to deliver excellent quality care **Accessible** Better access to Primary care will alleviate pressure on services. Streaming the highest acuity cases to a Red Hospital means a Green hospital can deal efficiently with lower acuity demand Staffing levels will be standardised and ALL hospitals will be required to attain standards. This means quality care will be delivered in ALL our hospitals **Sustainable** This model proposed is a more effective use of EXISTING resources
Maternity Services Review	Alignment with Vanguard Proposals for a single service	
Elective Services Review & Productivity Review	Improvement in LoS benchmarked against Better Care Better Value Ward Closures based on reductions in DTOC Premium pay reductions resulting from the application of standardised care pathways Benchmark against upper quartile and within the Alliance to move to the most productive amongst peers and best in class Exploration of a Factory Model for simple high volume procedures such as: Orthopaedics Ophthalmology Plastics These could be scheduled for day case and short stay <72hrs procedures at t Treatment Centres Alignment with commissioner demand management interventions	BCBV Reduction in DTOC Reductions in Premium Payments Reduction in bed days Reduced number of delayed transfers of care Reduction in costs Alignment with commissioner demand management interventions Reduction in variation of care and outcome Higher productivity levels Improved utilisation of theatres Lower length of stay

3.1 - The Alliance plans - Variation and hospital reconfiguration (3/3)

Projects	Change Delivered	Outcomes
Sub-scale Services Review	Federate services to make them more clinically sustainable and reduce the premium payments , see above Urology; Dermatology, Rheumatology; Diabetology, Orthodontics; Respiratory Medicine; Acute Medicine, Geriatric Medicine	Clinically Sustainable Services Reduction in on-call rotas Reduction in premium payments amounts to around £4.7m Alignment with commissioner demand management interventions
Pathology	Moving from a Bi-partite arrangement between STHK and S&O to a tri-partite arrangement to include WHH	Lower unit costs Reduced investment required Increased productivity Consolidation of staffing levels 4% reduction in costs year on year
Pharmacy	Opportunity to outsource/ create a JV for outpatient dispensary Alignment with STP Review, sub regional solution likely	VAT advantages 4% reduction in costs year on year
Radiology	Alignment with STP Review, sub regional solution likely	4% reduction in costs year on year

3.2 - North Mersey approach and plans

The North Mersey plan builds upon and joins-up established transformation programmes; including *Shaping Sefton* and *Healthy Liverpool,* which was established in 2013 in response to the city's Mayoral Health Commission. The commission's ten recommendations recognised that such was the extent of poor health outcomes, and the relentless pressures on resources, that only a whole-system approach to the transformation of health and care would succeed. The commission's insight and mandate to the local NHS and partners to deliver change has given the North Mersey delivery system a three year head start in identifying and now delivering the whole system transformation plans that are set out in the Cheshire and Merseyside STP. It is represented by this 'Plan on a Page':

	One year	Three years	Five years - 2021
1. Hospital Service Reconfiguration	OBC for Royal Liverpool & Aintree merger, including proposals for single service reconfiguration Implement Orthopaedics & Upper GI single service and single Cancer MDTs Decision on configuration of women's and neonatal services – June 17	Complete merger – April 18. Adult acute single service implementation to commence 18/19, Complete commissioner review of S&O services - March 18	Complete adult acute service reconfiguration Implement LWH reconfiguration Implement S&O reconfiguration
2. Demand Management	Multi-specialty Community teams embedded Primary care Quality scheme across NM 7-day primary care access - GP hubs & GP streaming in A&E Care homes and Home First implemented LCH transaction completed – March 17	Implementation of NM mental health transformation plan Frailty and end of Life services improved Pathway transformation delivered – CVD, respiratory, cancer	Primary care transformation at scale
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4. Digital First	Teleheath at scale procurement completed Three-trust EPR procured Digital diagnostics embedded	Full Interoperability across NM Digital No Wrong Door – digital interaction delivered Single hospital EPR (RLBUH, AUH and LWH) implemented Whole Systems Intelligence system	Digital maturity for all providers Standardised predictive analytics for better care
5. Act as One System	NM Single system governance Joint commissioning & shared CCG resources across NM CCGs NM efficiency plan identified	North Mersey commissioning organisation ACO/ACS established, enabling place based model of care	Accountable Care System embedded

Each of the programmes above has a delivery plan that clearly lays out the projects that are being mobilised, the expected outputs and outcomes and forecast benefits. Overleaf are North Mersey's plans for each of these programmes

3.2 - North Mersey plans for hospital reconfiguration

Programmes	Projects	Outputs	Start Date	End date
Single service system-wide delivery for adult acute services **Plan** SOC completed OBC commenced Project plan in development	Reconfiguration of 35 adult acute services across RLBUH, AUH and LHCH, to establish single service, system-wide services. Detailed service reconfiguration plan to be set out in an Outline Business Case, currently in development	• Single service pathways across all adult acute services • Single clinical workforce for adult acute services across 3 trusts • Site rationalisation across 4 to 5 hospital sites in the city	April 2016	March 2021
Merger of the Royal Liverpool, Aintree and Liverpool Women's Hospitals **Plan** As above	Establish a single organisation from 3 NM trusts - RLUH, AUH and LWH Milestones: • Strategic Options Case – approved by boards, June 16 • Outline Business Case – to be completed June 2017 • Joint HLP and trust PMO to be established, Nov 16 Full Business Case and approval by regulators and mobilisation for a new trust by 1st April 2018	• Single trust to deliver the majority of adult acute service sin the city from April 2018	April 2016	March 2018
Reconfiguration of women's and neonatal services **Plan** Project plan completed and delivery on track (see below)	Women's and Neonatal Review. The objective is to achieve clinical and financial sustainability through a reconfiguration of the services provided by Liverpool Women's FT NHS Trust. Milestones: •Pre-consultation engagement – completed Aug 16 •PCBC – Oct 16 – completed •Assurance process – Sept – Nov 16 • Public consultation Jan17 •Decision May/June17	• Reconfiguration of services which address the clinical and financial challenges of delivering these services, as set out in the Review Case for Change • Improved access to essential co-dependent acute services, for example blood transfusion services, associated surgical expertise, diagnostics , interventional radiology etc • Increased scope for involvement in and patient benefits from research and innovation • Reduced transfers of care • Protecting the future delivery of specialist services within the city	Jan 2016	Decision: May 17
Neuro Network Vanguard **Plan** Programme plan	The programme objective is for a clinically and cost effective comprehensive whole system neuroscience service. People with neuro or spinal problems will receive the appropriate clinically effective care to assured standards, wherever they live, via local access points, and have an efficient and person centred experience.	• Integrated, high quality neuro, rehabilitation and pain pathways across Cheshire & Merseyside, delivered via a hub and spoke model of care • More care delivered in community settings	2016/17	2020/21
Southport & Ormskirk NHS Trust Review of Services	The objective is to achieve clinical and financial sustainability facilitated by a review of the services provided by Southport and Ormskirk NHS Trust. Milestones: Establish formal commissioner led major service review in a multi-stakeholder partnership. • Process, Governance and Stakeholder Mapping (Jan-March 2017) • Case for Change (April-June 2017) • Pre-consultation engagement (July-September 2017) Further milestones will follow in accordance with NHSE published "Planning, assuring and delivering service change for patients"	• Expansion of current integrated care organisation strategy. Emphasis on partnership, standardised pathways and self care in the community and primary care setting. • Reconfiguration of services which address the clinical and financial challenges, as determined by the Reviews "Case for Change" • Implementation of specialist commissioned strategy for the North West Regional Spinal Injuries Centre	January 2017	July 2018

3.2 - North Mersey plans for demand management – community 1/2

Programmes	Projects	Outputs	Start Date	End date
Integrated Multi-disciplinary Community Teams	Delivering proactive care through multidisciplinary teams operating on neighbourhood footprints of 30-50k. MDT to include general practice, community nursing, mental health, social care and a range of relevant care professionals relevant to an individuals' care.	• Reconfigured integrated multi-disciplinary teams operating on smaller neighbourhood units of 30-50k • Shared records platform • Single multi-agency assessment process (GATE Framework) • Single point of access	2015	March 2018
Primary Care Transformation	Transformation of primary care aligned to the GP Forward View and forming an essential component of the Community Model of Care Adoption of the Liverpool GP Specification across NM	• Increased integration of services across primary care • Improved workforce capacity and skill mix • Improved optimization of prescribing solutions • Standardised approach across the NM footprint	June 2016	March 2019
Primary Care Demand Management in Acute	1. Addressing activity at the front door of NM AEDs through the provision of GP streaming 2. Developing capacity and utilization of primary care through the creation of primary care hubs in the community for routine and urgent care 7 days a week	• Increased capacity to provide same day access to routine and urgent primary care 7 days per week • Urgent delivered closer to home • Increased integration of the urgent care system	Jun 2016	TBC
Effective Discharge Plan Borough specific plans in operation.	Implementation of whole system approach to support effective discharge for patients into community/home care. Focus on discharge to assess to deliver required assessments and reablement services in the patient's home (or community facility).	• Agreed pathways across whole system for discharge to home/community • Consistent protocols across the NM system • Clear system of escalation • Increase in levels of domiciliary care provision • Integration of health and social care resources • Single assessment process	Oct 2016	Mar 18
Organisational Transition **Decision October 2016 (New provider in place by April 2017)**	Transition of community services to new provider arrangements, delivering a new specification aligned to the NM community model.	• Enabler to embed the new model of care for out of hospital services • Financial sustainability	Jan 2015	Apr 17
Mental Health Plan Implement pan NM approach to Mental Health. Plan to be developed.	North Mersey Mental Health Health Transformation Board has been established. • Agreement of approach to implement new model for mental health care including: • Integration with physical health services • Implementation of new national standards/requirements Merseycare delivery of 5 year financial plan	• Integration of mental health into community model of care • Financial efficiencies	July 2016	Mar 2021
Enhanced Care Home Model **Plan** Elements in operation within South Sefton. Implementation within Liverpool from November 16.	Delivering proactive care through multi-disciplinary teams to provide regular MDT reviews in older peoples care homes. Introduction of telehealth with 24/7 access to a clinical telehealth hub	**Outputs** • Introduction of telehealth into care homes • Increase in the uptake of telehealth and telecare • MDT approach introduced • Increase in the numbers of people with a Comprehensive Geriatric Assessment	Nov 2016	Mar 2018

3.2 - North Mersey plans for demand management – community 2/2

Programmes	Projects	Outputs	Start Date	End date
Cardiology **Plan** North Mersey delivery plans in place and on-track	Whole system approach to delivering a single service delivery for cardiology services aimed at improving value from cardiology spend and improving outcomes. Six workstream areas: • Chest Pain • Cardiac Rehab • Breathlessness • Heart Rhythm • Healthy Imaging • Prevention	• Reduction in Consultant to Consultant referrals • Reduction in Outpatient appointments • Reduction in duplicate diagnostics • Reduction in inter-hospital transfers • Strengthening business continuity to support 7 day working	Oct 2015	Mar 2018
Respiratory **Plan** Plan in place but to be reviewed in line with wider North Mersey delivery arrangements	Development of a new model of integrated respiratory care with city wide delivery	• Single service pathways across all adult respiratory services. • Single clinical workforce for all adult respiratory services across the City	Jan 2016	Mar 2018
Children	Redesign of children's service infrastructure across multiple partners and sectors with a focus on integrated, community based services; primary care / general practice, community services, social care, CAMHS, education and voluntary sector. At the core is a proactive approach to health, wellbeing and care delivery, focused on children and families, utilising the Levels of Need and the Early Help tools. Prime focus on prevention and early identification of need via universal services.	• There is a clear set of objectives for this programme and a clinical blueprint is being developed to underpin the integration of teams & services.	Oct 2016	TBC
Telehealth and Assistive Technologies **Plan** Delivery plan to be reviewed in line with revised North Mersey delivery arrangements. Currently in procurement to deliver scale requirements.	• Significant scale up of the telehealth programme across North Mersey • Telehealth procurement route and specification complete; new contract enabling scale up to be implemented in December 2016 to March 2017. • Clinical technology hub embedded in community service, with amended specification.	• Full telehealth monitoring for patients with COPD, Diabetes or Heart Failure with a risk of admission above 25% and also pass the clinical suitability gateway. • Provision of 'light touch' and self care telehealth systems and apps for patients below 25% risk and for a wider range of diseases. • North Mersey wide clinical engagement and referral routes established to take advantage of economy of scale.	Apr 2016	Mar 2019

3.2 - North Mersey plans for demand management – population health

Initiatives	Projects	Benefits	Start Date	End Date
Non-communicable disease prevention strategy for North Mersey	health policy initiatives that make the healthy option the default social option.	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Jan 2017	March 2021
Making Every Contact Count (MECC)	NM MECC Plan to be developed – Dec 16 Phased implementation plan across all providers	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Sept 16	March 17
Tobacco control	Prevention programmes for young people Smokefree areas Reduce outlets selling tobacco and licencing Implementing PH guidance 48 on Smoking: acute, maternity and mental health services	Outputs • Stop smoking pathway adopted across all disciplines, which includes electronic referral to the stop smoking services • Number of staff trained • 100% of patients with recorded smoking status & given brief advice • 50% of smokers electronically referred to community stop smoking service & 50% achieve a 4-week quit Outcomes • % reduction in smoking-related hospital admissions • Improved health outcomes • Reduction in smoking prevalence	Apr 17 Apr 17 Oct 17	Ongoing Mar 18 Sept 18
Workplace Wellbeing Programme	Develop programme, charter and accreditation framework Roll out across NHS and care system first Extend to NM workplaces	Outputs Numbers of accreditations and reaccreditations achieved Evidence within 6 months of accreditation through audit of hospitals as health promoting environments e.g. • Increase in physical activity programmes at work • Increase in vending machines using healthy foods and drinks • Longer term measures - 6 months/1 year • Reduction from an agreed baseline - sickness absence, staff turnover Outcomes • Improved health outcomes • Reduced hospital admissions	Dec 16	March 18

3.2 - North Mersey plans – digital roadmap

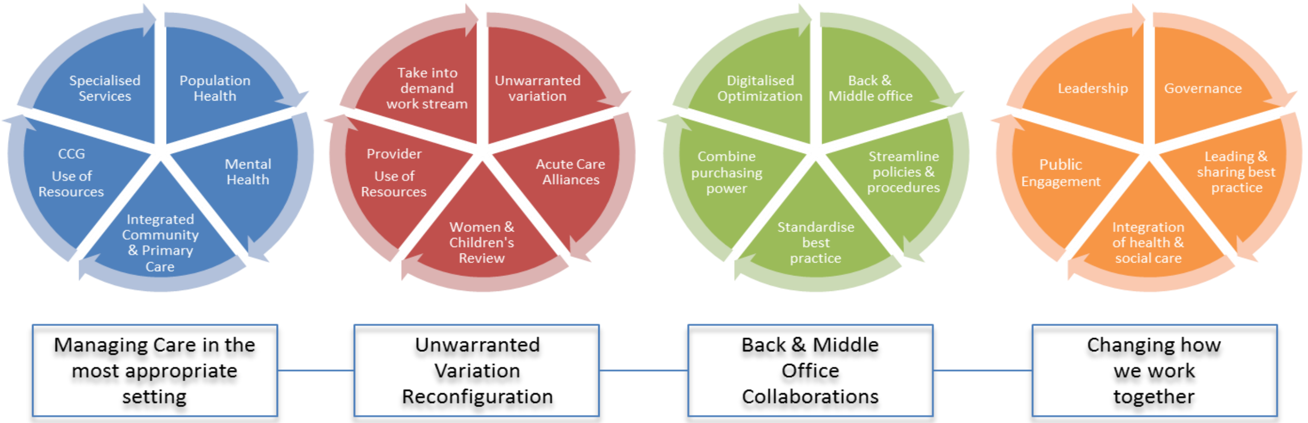
Programmes	Projects	Benefits	Start Date	End Date
Digitally Empowered People **Digital No Wrong Door & Assistive Technology** **Plan** Digital no Wrong Door plan in development Telehealth scale up in procurement phase	**Digital No Wrong Door** • Digital No Wrong Door; enabling people to interact digitally and online with the health and care system, as well as supporting population health Programmes	**Digital No Wrong Door** Outputs • A single source and platform to access information, advice and services • Online consultations with care providers and online appointments. • Use their choice of device and app to manage their care • Patients to be enabled to use assistive technology to manage their care and interact with professionals, and to access information about their own health and conditions to support them to self care. • Establish a workforce that is digitally skilled with the appropriate technology and culture to enable effective working through technology.	16/17	18/19
	Assistive Technology • Establish a range of assistive technologies that can be deployed across North Mersey in primary care, community and acute settings. This work supplements the demand management plans for deployment at scale. • Support integration and interoperability with clinical systems for improved intelligence, referral mechanisms (to increase scale and sustainability) and clinical decision making.	**Assistive Technology** Outputs • Increase in available technology • Wider range of conditions supported by assistive tech • Interoperability with clinical systems Outcomes • Further reduced emergency admissions • Improved patient experience • Improved health outcomes • Improved access to digital services	16/17	18/19
Connected Health and Social Care Economy **Plan** Plans fro all lines developed sharing agreements in place EPR procurement for 3 trusts in progress	To ensure that information is available to the right people, in the right place, at the right time Delivery of Information Sharing Framework • Digital maturity transformation of all H&S Care providers • Interoperability Programme –joining up key systems to deliver information sharing framework • Single Adult Acute Hospital EPR (3 trusts) • Maximisation of technology in Community Care Teams • Consolidated Infrastructure; enabling work across sites and better patient access **Delivered through implementation of the Merseyside Digital Roadmap**	Outputs • Every health and social care practitioner will directly access the information they need, in near real time, wherever it is held, digitally on a 24x7 basis. • Consolidated and rationalised Electronic Patient Record systems moving to a common system for out of hospital care and a common system in our hospitals with interoperability between the two. • Duplication and paper processes will be removed. • Standardised, structured, digital clinical records across all providers in the pathways of care. • No patient will need to 'repeat' their story. • All health and social care professionals record clinical information in a consistent way, digitally, at the point of care, by 2018/19. • All clinical correspondence between professionals caring for patients is sent digitally and integrated into core clinical systems by 2017/18. • Community care teams can integrate for person-centred care with technology that "just works", by 2017/18. • Individuals interact with their care services digitally should they choose to by 2018/19. • All clinicians can order diagnostic tests electronically and view share diagnostics results around a patient by 2016/17. • Single Service Teams have a single EPR to operate as a team by 2018/19.	15/16	18/19

3.2 - North Mersey plans – act as one

Programmes	Projects	Outputs	Start Date	End Date
Single-System Governance	Establish North Mersey system governance for strategic oversight, delivery of the LDS Plan and input into STP delivery. Healthy Liverpool Leadership Group to extend to NM. Financial Governance; establish governance framework for single-system accountability for managing financial risks and benefits, to achieve NM control totals and financial balance by 2021.	• Robust, embedded governance model to enable whole-system accountability and decision-making • Financial risk sharing to achieve system control total	July 16	Oct16
Commissioning Arrangements	Objective: to establish the optimum commissioning arrangements to deliver NM LDS Plan: • Establish joint commissioning programmes, with clear lead roles and resourcing across NM CCGs, Local Authorities and NHS England • New organisational arrangements for NM commissioning; reflecting Devolution and ACS plans.	• Integrated commissioning model across health and social care for North Mersey system • Single commissioner in organisational form • Place-based strategic commissioning plan for North Mersey to enable transformation	July 16	March 18
BAU Efficiency Programme - Organisational	Develop a detailed NM plan for Level 1 BAU efficiencies for: • Royal Liverpool • Aintree • Liverpool Women's • Alder Hey • Walton Centre • Liverpool Heart & Chest • Clatterbridge Cancer Centre • Merseycare • Liverpool Community Health • Liverpool CCG • South Sefton CCG • Southport & Formby CCG	• Organisational BAU efficiency plans for every NM provider • Merger of three adult acute trusts with associated efficiencies	July 16	March 2021
Collaborative Efficiency Programme – North Mersey	• Develop North Mersey plan for back office, clinical support and non-viable services • Implementation of plan – prioritised & phased	• North Mersey plan aligned for collaborative efficiencies, aligned and part of wider C&M STP plan	July 16	18/19
Accountable Care System	Explore options for the development of an Accountable Care System to support the radical step change required to manage demand and improve health outcomes. North Mersey System Control Total The North Mersey Leadership Group has agreed to explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.	• Establish an accountable care system/organisation with the right geography and scope, providing optimal model for improved outcomes and sustainability. • Whole pathways of care managed across provider and commissioner boundaries • Establish a sustainable financial model for shared benefit and risk	Oct 16	Marc19

3.3 - Cheshire and Wirral approach

We have identified four priorities to make our health and care system sustainable in the near, medium and long-term. To transform our services, we need to reduce demand, reduce unwarranted variation and reduce cost. To comprehensibly address these we must priorities the areas that we will have the greatest impact to our system. Based on our knowledge of our local challenges, and as a result of engagement across the system, we have identified the following four priorities:


Specialised Services
Population Health
CCG Use of Resources
Mental Health
Integrated Community & Primary Care
Take into demand work stream
Unwarranted variation
Provider Use of Resources
Acute Care Alliances
Women & Children's Review
Digitalised Optimization
Back & Middle office
Combine purchasing power
Streamline policies & procedures
Standardise best practice
Leadership
Governance
Public Engagement
Leading & sharing best practice
Integration of health & social care
Managing Care in the most appropriate setting
Unwarranted Variation Reconfiguration
Back & Middle Office Collaborations
Changing how we work together

Demand Management

1. Prevention £14m
2. Integrated Out of Hospital £37.9m
3. QIPP/BAU £26m
4. Accountable Care £3m
5. Specialised Services £30m

Total £110.9m

Variation / Reconfiguration

1. Unwarranted Variation and Standardisation £24m
2. NHS Provider Collaboration £8m
3. Women & Children's £2m
4. Accountable Care £3m
5. Model Hospital/BAU £107

Total £144m

Back & Middle Office

1. Back & Middle Office £3.75m
2. Streamlining £1.4m
3. Best Practice £1.2m
4. Combined P`Power £22.5m
5. Digitalisation £1 m

Total £28.8m

Ways of Working

1. Outcomes Commissioning £1m
2. Patient based need £1m
3. Systems Leadership £1m
4. Collaborative working £2m
5. Learning partnership £1m

Total £6m

The following pages provide further detail of the projects and outputs these programmes will drive. We still have a lot to do in respect of determining:

1. Capability & Capacity at STP and LDSP level
2. Full development of schemes and `business cases` including quality and impact assessments.
3. True impact of each of the Programme on each other. (Critical interdependencies /impact and activity assumptions – STP and LDSP.
4. Robust Governance driven bottom up that GBs and respective Boards and LA recognise and be part of (including local leadership groups)
5. Capital requirements need to be refined and better linked to benefits realisation.
6. Subject to the outcome of stages 1-5 above any material service changes would follow an appropriate consultation processes.

3.3 - Cheshire & Wirral plans for demand management 1/3

Projects	Change Delivered	Outcomes/Benefits
Alcohol Strategy (NHS, Local Authorities. Police, Community and Voluntary sector)	System wide interventions to reduce alcohol related harm: • Social Marketing Campaigns • Schemes to restrict high strength alcohol sale • Cumulative impact policies (reduced opening hours) • Children and Young persons interventions to reduce alcohol use. • GP Screening and life course setting approach. • 7 day alcohol care team within acute hospitals • Alcohol assertive outreach teams	• Per 100 alcohol dependent people on treatment planned reduction of 18 AE visits, 22 hospital admissions saving approximately £60k. • Cost benefit ratio £1-£200 per £1 spent • Assertive outreach services expected to return £1.86 per £1 invested. • Net benefit by 2021 estimated at £4.76m • A reduction in adverse child events.
Hypertension (High Blood Pressure)	Implementation of the Pan Cheshire Hypertension Strategy: a model of care that focuses on empowering patients and communities, enhancing the role of community pharmacies in detecting and managing high BP, and high quality BP management in primary care (including reducing variation in care).	• For Cheshire and Merseyside up to 800 heart attacks and strokes could be prevented per year through optimising blood pressure treatment alone. • If all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths. • It is estimated that a 15% increase in the adults on treatment controlling BP to <140/90 could save £120m of related health and social care costs nationally over 10 years. • Net benefit by 2021 estimated at £2.8-£3.3m
Accountable Care Partnerships/Organisations across CW plus introduction of strategic commissioner.	Building on the 4 existing Transformational Programmes, Discussions are underway to support the introduction of: • 4 ACO/Systems across Cheshire and Wirral • Budget Alignment on population outcomes • Risk Sharing Arrangements across commissioning and delivery of services as per ACO. • Delivery of new contract mechanism. • Clear operating model. • New population health management systems.	• Improved population health management. • Care will be managed in a more appropriate setting . • Better Patient and Client Experience.
Referral Management	Implementation of referral management schemes across Cheshire and Wirral.	Reduction in elective and non-elective referrals.
Primary Care Prescribing	Encourage and deliver better management of primary care prescribing (through self-care, over the counter medicines and waste associated with repeat prescriptions)	Reduction in prescribing expenditure.
Respiratory Strategy	Implement a single approach across Cheshire and Wirral to integrate Respiratory Services; • Building on the Healthy Wirral respiratory model of care (clinical registries)we will seek to develop a collaborative approach to respiratory services across Cheshire and Wirral.	Fewer hospital visits, fewer unplanned primary care visits (>1000 Emergency Admissions Avoided) • Easier and earlier access to care and support • Earlier, evidence-based treatment e.g. pulmonary rehab • Improved data sharing across Wirral health care economy • Improved diagnosis and case finding (undiagnosed population < England Avg 2.91% (<7,800)) • Consistent approach to care • Better case management • Improved targeting of services to meet population need • Earlier identification of people with certain respiratory conditions • Improved knowledge and awareness of population • Improvement of lifestyle factors e.g. reduced smoking/higher quit rates (<18 per 100,000) • It is anticipated this transformational approach to respiratory care will deliver a system saving £2m by 2021.
Diabetes Programme	Implement at scale a national evidence-based diabetes prevention programme capable of reducing not only the incidence of Type 2 diabetes but also the incidence of complications associated with Type 2 diabetes; heart, stroke, kidney, eye and foot problems. Deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.	It is forecast that over 56,000 Cheshire and Wirral residents suffer from Diabetes Mellitus and a further 99,000 residents suffering from non-diabetic hyperglycaemia. Assuming programme growth to 5000 patients, Cheshire and Wirral LDP anticipate an annual saving of over £500k per annum by 2021 with significant additional wider-systems savings resulting from a reduced incidence of diabetes.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes/Benefits
Mental Health **Delivery of the priorities set out in the 5Year Forward View for mental health and the Prime Ministers challenge on dementia (2020) Including :** • **Prevention and Early Detection** • **Better Mental Health Care for people with Physical conditions.** • **Improved services for people with severe Mental Health Conditions**	Reducing variations in clinical practice – through the development of consistent care pathways, developing standard approaches to key processes such as assessment, access, discharge and caseload review. Improving patient safety – including a commitment to 'zero suicide' Improving effectiveness – through a focus on care pathways with clear outcomes and evidence-based practice In year 1, a priority will be the establishment of fully functioning mental health liaison services across Cheshire and Merseyside, Cost of investment expected to be funded from central allocations as per planning guidance.	Better health and care outcomes for Patients and their families. Improved opportunities for community based social prescribing and enhanced employment opportunities. Reducing pressures on acute services within Hospital, Primary Care and Community setting. Enhanced primary care support for mild to moderate mental health need.
Specialised Commissioning • **A collaborative approach that will seek to address the current inequality in access for Cheshire and Wirral residents.**	The early interventional programme identified above will ensure that patients are seen and treated earlier so reducing the need for consultant to consultant referrals. In partnership with NHS England, Cheshire and Wirral will adopt an approach to reducing the £30m overspend in specialised commissioning.	Referral pathway improvement to ensure services are patient centred and outcome based. Improve productivity and value of these services.
High Impact Community Based Integrated Care Schemes: • **Integrated Community Teams** • **New Models of Primary Care** • **Long Term Conditions Management** • **Intermediate Care** • **Care Homes Support** • **Intermediate Care Development** • **Integrated Discharge Processes** • **Community Services MCP**	As detailed in the four Transformation Programmes (Healthy Wirral, West Cheshire Way, Connecting Care, Caring Together) we will expand primary and community care services. This will be done with reference to the Five Year Forward View for General Practice and the development of integrated health and social care.	• Improved Patient Experience. • Reduction in non elective admissions. • Reduction in Length of Stay. • Reduction in Delayed Transfers of Care • Shift in activity from acute to community sector.
Neurology (Cheshire and Merseyside) **The Neuro Network neurology model aims to achieve a clinically and financially sustainable integrated neurology service by enhancing the community support, clinical pathways and advice and support for primary and secondary care.** **The spinal model is to implement a whole system spinal services network, integrating the two key components of the national Spinal Transformation Project.**	Delivery of 7 day acute inpatients, specialist diagnostics, subspecialty/MDT clinics, access to neurosurgery, specialised pain and rehabilitation. DGH satellite services from visiting neurologists plus support: outpatient clinics, weekday ward consultation service, supported from the centre by: • acute referral pathways • 7 day advice line • telemedicine • second opinion/specialist neuroradiology reporting via PACS • Community nurse clinics, nurse specialist support, homecare drugs, home telemetry • GP referral pathways • ready communication between community and specialist neurology services for advice and practical help • Standards and clinical governance: common standards across network delivered services, with a single clinical governance structure, developing and using clinical outcomes as available. A network for the provision of spinal surgical procedures, managed from the centre with partner services in secondary care, working to common standards, and outcome measures, with MDT discussion of complex cases and all specialised surgery undertaken in a centre fully compliant with national specialised serviced standards. Implementation of a single whole system patient pathway through a network of all providers of spinal services, with common and audited service standards and outcome measures.	It is projected to save up to £3.2m a year recurrently by 2020-21 compared with the do nothing scenario. Hospital services reconfiguration: with its single service system wide delivery, providing a specialist centre well placed for future consolidation, and networks of specialised providers and hub and spoke models to improve collaboration across tertiary and secondary care.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes
Thresholds and Procedures of Limited Value	Following NICE guidance maximise the outcome of clinical procedures optimising the effective use of resources.	Improved utilisation of available capacity. Increased awareness of self-care. Resources will be targeted to deliver effective interventions.
Cheshire and Wirral Cancer Strategy	Targeted interventions to address areas of low screening uptake. Focus on improving the key worker arrangements for cancer patients and roll out the Recovery Package. Diagnose or exclude cancer within 28 days by creating multi-disciplinary diagnostic centres and new pathways for patients with vague cancer symptoms. Address together our capacity, workforce and organisational bottlenecks, which are preventing delivery of the 62 day cancer standards.	Seeking to improve early stage cancer detection rates, associated with better survival and lower cost impact. To limit emergency presentation rates during treatment and the follow-up costs of delivering cancer care respectively.
Operational Control Centre For Risk Stratified Population	Use technology enabled shared patient care records to identify and better coordinate care for the top 5-10% highest users of healthcare services, this will be achieved by using a centralised control facility to signpost and direct appropriate care services to those managing their conditions more effectively in the community and reducing inappropriate hospital admissions.	• Effective and personal communication with a vulnerable cohort of patients across Cheshire and Wirral in a coordinated manner. • Improved navigation of Vulnerable Patients through Health and Social Care systems. • Improved clinical outcomes for Patients. • Reduction in variation and ability to control demand.
Cheshire & Wirral Shared Care Records	Further development of Cheshire and Wirral shared care records.	• Improved patient experience by only having to tell their story once. • Less time wasted by staff tracking down important clinical records. • Reduction in repeat diagnostics and avoidable errors. • Use of near real-time data. • Enabler for key measures in all workstreams.
Implementation of Continuing Healthcare Collaborative Commissioning	• Improved joint working with local authorities and across CCGs. • Improved team metrics (reducing sickness and turnover rates).	• Planned reduction in outstanding reviews, improved experience for patients, family and carers. • Delivery of assessment targets, (i.e. 28 days). • Reducing the number of dispute cases.
New Models of Primary and Community Care	• Delivery of a range of physical and mental health initiatives designed to deliver care closer to home and reduce demand on acute services. • Introduction of new models of primary care and community care.	• Reductions in non-elective admissions. • Reductions in Length of Stay. • Reduction in Delayed Transfers of Care. • Shift in activity from acute to community sector.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
Organisational structures and system architecture	We are planning: • An integrated Cheshire & Wirral strategic commissioner. • 4 Accountable Care Systems in respective geographies that will determine the shape and form of health and social care delivery across Cheshire and Wirral. • A provider collaborative, the shape and size to be determined.	A change in the Commissioning and Provider landscape that will support : • Better patient experience • Care closer to home • Health and Social care integration • Better use of resources • Strengthen local clinical commissioning
Enhanced technology supporting care through the development of strategic alliances and relationships with subject matter experts	Technology that support s and enables the delivery of integrated health and social care services: • Single IT/ informatics platform to support management of variation • Examples such as clinical registries, patient and asset tracking, operational control centre Access to global thought leadership/ expertise in management of variation.	Effective IT and information flows across all sectors supporting the management of variation/optimum approach to management of variation.
Development of a common approach to the delivery of clinical support service	A systemic approach to: • Medicines Management • Infection Prevention Control • Pharmacy • Radiology • Pathology	Optimised clinical support services to ensure clinical, operational and financial sustainability.
Development of model care pathways	Development of care pathways (across primary, secondary and social care) for high cost/ high volume diagnoses.	Optimum management of high cost/ high volume diagnoses including: • Pneumonia/ upper respiratory tract infection • Cardiac disease • Acute abdomen • Alcohol • Ophthalmology • Orthopaedics • Dermatology Standardised care pathways. Reduced length of stay.
Improved system performance to match best decile NHS England performance	Benchmark ourselves against national metrics for: • Admissions • Overnight stays • Average Length of Stay • A&E attendances • Outpatient referrals and follow ups to match or better NHS England best decile. Participate in the NHS Right Care programme. Model impact to understand extent of overlap with other work streams.	• Management of demand in appropriate setting will produce a range of between £30-£60m. • Appropriate use of secondary care services.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
In-line with existing transformation work streams, (Caring Together) a remapping of elective and emergency care models in Eastern Cheshire	Agreed long term models for elective and emergency care in Eastern Cheshire are being developed based on strategic hospital partnerships, building on existing relationships including those with University Hospitals of South Manchester Foundation Trust and Stockport NHS Foundation Trust. A number of emerging clinical models are being developed and will form the basis of an option appraisal. Clinical modelling covers emergency care (including options to retain the A&E department or the development of an urgent care centre) and elective care. The frailty pathways being developed and will be explored to share best practice with other parts of Cheshire and Wirral.	Clinically , operationally and financially sustainable services .
In-line with existing transformation work streams, (Connecting Care) a remapping of elective and emergency care models in Central Cheshire	Agree long term models for elective and emergency care in Central Cheshire based on strategic relationship both within Cheshire and Wirral and surrounding localities so as to reflect patient flows.	Clinically , operationally and financially sustainable services .
Explore an option to consolidate elective care between the Countess of Chester Hospital NHS Foundation Trust and Wirral Teaching Hospital NHS Foundation Trust on the Clatterbridge Hospital site	Develop an options appraisal in relation to the future delivery of elective care in order to support : • Consolidation of elective care • 7 day working • Improved referral to treatment waits • Centre of excellence in recruitment and retention with potential to reduce reliance on specialised service activity flows if appropriate.	Clinically , operationally and financially sustainable services . .
Explore the consolidation of Acute Care Alliance between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust – creation of integrated low and high dependency units for women's and children's services	Creation of a clinically integrated service between providers with the consolidation of high and low dependency care as appropriate. (Women and Childrens)	Clinically , operationally and financially sustainable services .
Explore the development of Cheshire and Wirral wide clinical services at scale .	Building from the review of clinical services undertaken by the Trust Medical Directors, we will benchmark all specialities against clinical effectiveness and outcome indicators. (Advancing Quality, NHS Right Care) The emerging clinical models will also be developed in conjunction with Primary Care.	Clinically , operationally and financially sustainable services .
Specialised / 3° services	The provision of Maxillo facial services Oesophago-gastric services, plastic surgery to 3° providers in Manchester, Wirral and Liverpool	Clinically , operationally and financially sustainable services .

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Payroll Workforce, Process & Product	Across Wirral & Cheshire – • Standardise services • Streamline services • Explore the integration and centralisation of teams	A single centralised payroll will reduce duplication, improve efficiency and responsiveness, improve access for staff, reduce queries, and reduce software licensing costs.
Model Hospital & Delivery of Business As Usual Efficiencies	Model Hospital (LOS) Model Hospital (Theatre Utilisation) Model Hospital (New Opat Models) Model Hospital (Other efficiency gains)	Delivery of Provider Business As Usual efficiencies. Delivery of higher quality service for patients.
Procurement Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced cost of overheads and duplication, Improved efficiency and responsiveness, and standardised processes. Economies of scale.
Procurement Purchasing Power	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Procurement cost savings at scale. Greater purchasing power, standardisation and consistency. Compliance with Carter recommendations.
Library Service	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	More efficient service Cheshire and Wirral focus
Occupational Health	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Clinical Sustainability
Occupational Health Streamlining of Process	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication of localised management.
Recruitment Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Comms and Engagement	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Litigation service	Explore the development of an in-house legal service across Cheshire & Wirral	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Processes Transactional Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Pathology	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Automated processes scaled up to provide a service that is more cost effective and efficient and responsive so as to speed up diagnostic support.

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Capital Estates Planning and Hard Facilities Management	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Regional Estates Team Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Processing and Coding	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Utilities management approach across Cheshire and Wirral	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced overall cost of utilities. Single supplier for all organisations. Economies of scale and consistency. Intelligent energy procurement.
Teletracking	Introduce new technologies in order to undertake the tracking of Assets in support of patient care. The use of real time data will also enable the management of patient care in the most appropriate setting. This technology will be used across all 4 Hospital sites, 2 community trusts and mental health providers.	Better matching of resources and capacity to demand, reduce duplication, improve efficiency and responsiveness.
Pharmacy	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Agency Cost Reduction	Reduction in Agency Staff use by investment in substantive roles where required and using a joint strategy as 1 organisation approach	Substantive recruitment of staff in order to reduce overall agency costs by £2m, by 2021.
Clinical Commissioning Group (CCG) Business As Usual Quality Innovation Productivity & Prevention (QIPP) and Cost Improvement Programme (CIP)	Single approach to QIPP with best practice and learning being adopted across Cheshire & Wirral	Economy of scale, rapid acceleration and adoption – contribute toward year on year savings.
CCG Business as Usual QIPP Continuing Healthcare (CHC) and Funded Nursing Care (FNC)	Cost reduction from Cheshire and Wirral approach	Harnessing collaboration to reduce cost of Continuing Health Care and Funded Nursing Care Packages.

3.3 - Cheshire & Wirral plans - ways of working

Projects	Change Delivered	Outcomes
Shared Care Records	All our providers will have the ability to access shared care records in a local setting and face to face with the patient in real time. Avoiding Duplication	Improved and consistent patient care across the system Reduces cost due to patients not being lost in system.
Real time data	A single digitalised platform that we will facilitate a population health management approach. When integrated with respective risk stratification tools and the shared care records this will manage the rising risk of future patients	A preventative approach that will identify patients at risk and enable supportive intervention before the patient's needs become urgent.
Outcome based commissioning	Outcomes-based commissioning seeks to solve the issue of how financial flows and the commissioning process can best support quality and efficiency improves across the health care system.	Clear outcomes associated with all service areas, which will increase the clarity and therefore quality of provision.
Meeting patients' needs	Costs can be reduced significantly if patients are at the heart of decision making and that clinical decision making is based on outcomes with incentives aligned to doing less rather than more work.	Patients will be engaged at all levels, from shaping NHS plans to the development of services around patient need, and in decisions about their own individual care.
Clinical and Systems leadership	A new and heightened role for clinical networks, clinical leadership and multi-disciplinary working. A single Cheshire and Wirral approach to Organisational Development and cultural change with the public sector and NHS Leadership Academy and Health Education England.	Improved communication and information sharing across the system. System leaders and staff who fully support and are engaged with system leadership. Connect into the systems leadership work from Planning guidance
Collaborative working	Driving out costs where there is a benefit of procurement at scale. We will examine opportunities for integration both vertically within local systems and horizontally across providers	A system that works effectively and efficiently, driving out duplicated processes and costs.
Accountable care.	Commitment to providing accountable care, on a population health management approach in all 4 geographies within Cheshire and Wirral.	Care Systems that will focus on system benefit and change rather than organisational benefit.
CW Health & Social Care Teaching & Learning Partnership	support the creation of a sustainable local supply and the ongoing development of existing staff	workforce development to underpin national and local priorities – e.g. reception and clerical staff training and support leaders to develop system wide transformation skills

4 - Closing the Cheshire & Merseyside financial gap

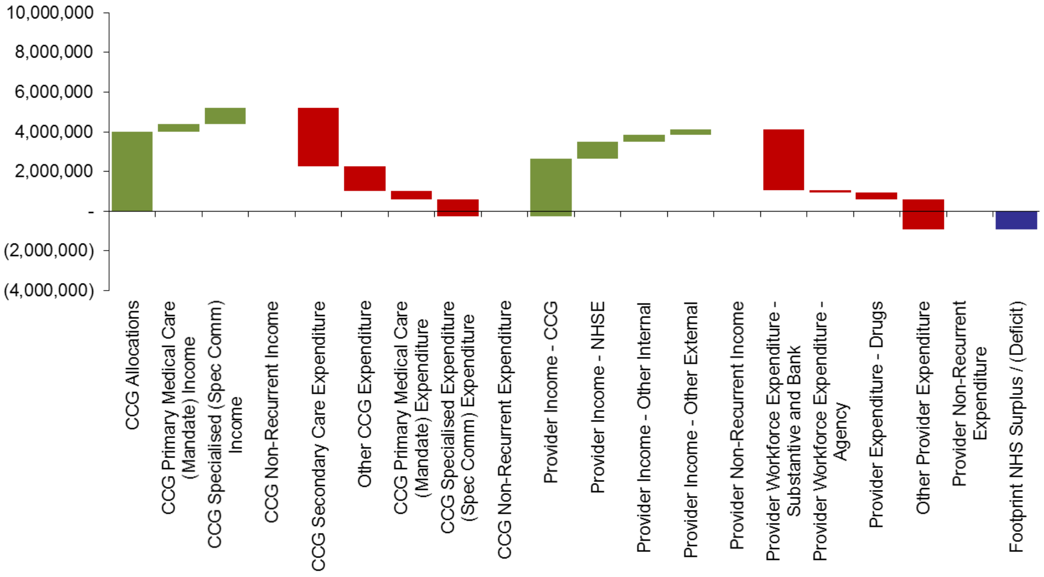
Financial Gap – current position

The ‘do nothing’ affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be **£908m**, as illustrated below. The drivers of the affordability gap is a growing population that accesses health care more often, and are – positively – living longer but often with one or more long term conditions.

This challenge has narrowed from the £999m in our June submission, to £908m driven by the following:

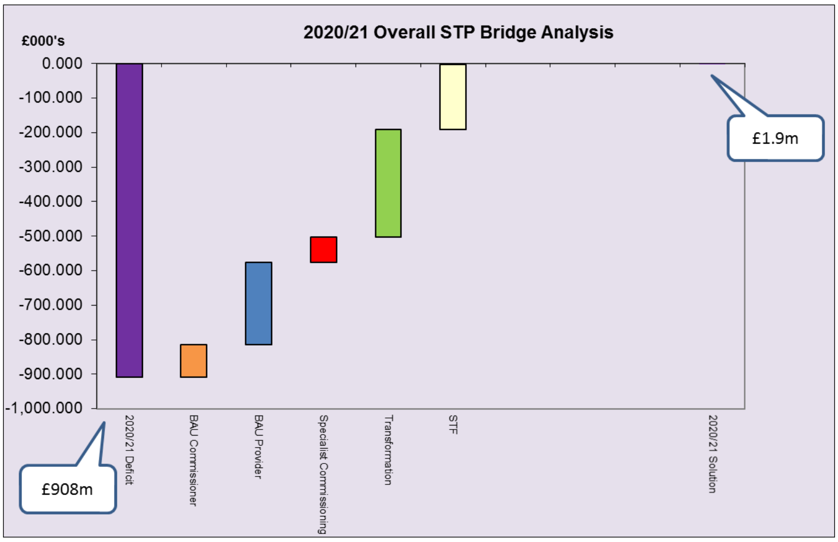
- The gap now reflects the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan
- The remaining gap now reflects the four year period 2017/18 – 2020/21

However, there is still risk associated with the delivery of organisation’s 2016/17 financial plans, which at this stage may not fully reflected within the forecast gap.



The ‘Do Something’ position

After the impact of our transformation solutions, our business as usual and specialist commissioning efficiencies, and the expected STF funding the ‘do something’ gap is £1.9m, as illustrated below:



Risks to delivery

- Whilst the plans at this stage show a balanced position there is still a significant amount of further planning required on many of the solutions before we could present them as robust and with confidence of delivery
- We will continue to pursue further solutions in order to provide a contingency for when the current plans do not deliver the levels of savings currently forecast in the plan. In particular the focus will be on extending the opportunities in the strategic programmes at STP level.

4 - Closing the Cheshire & Merseyside financial gap

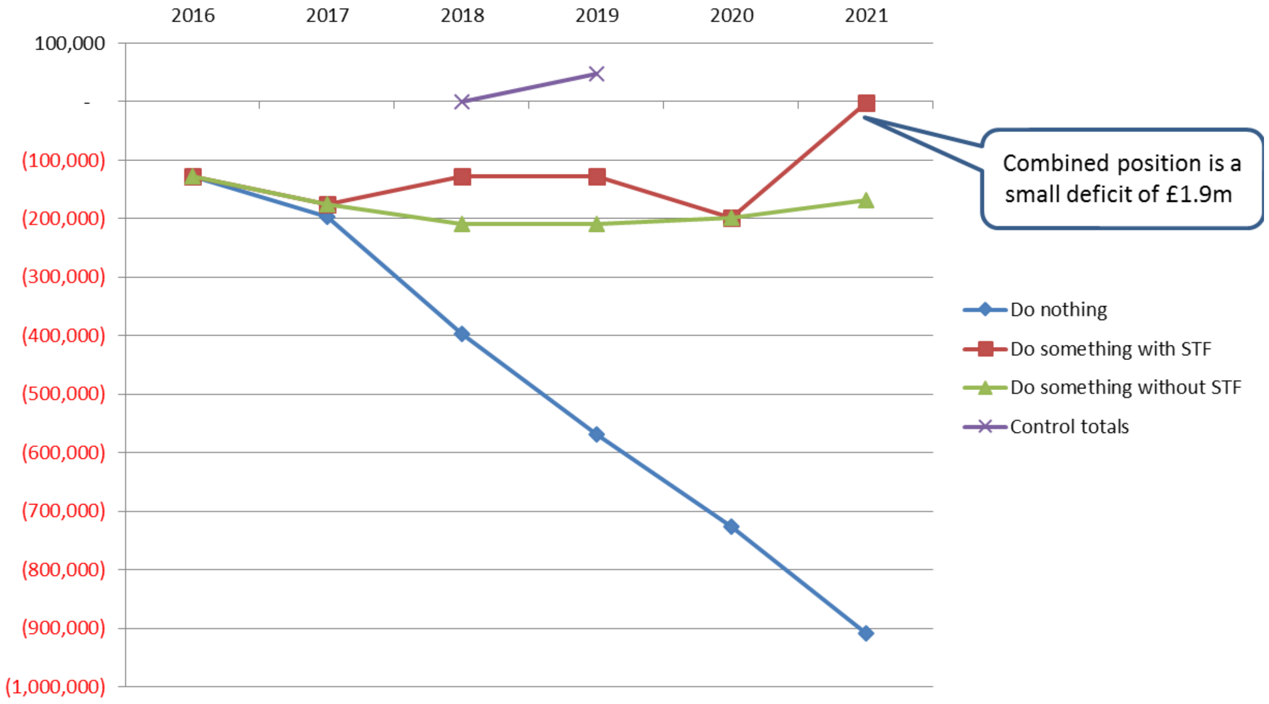
Capital

- We recognise that these plans are heavily dependent upon capital – up to £755m additional funding requirement in current plans as shown below. However we recognise there is still significant work to do before these high level requirements are turned into robust business case ready solutions. In particular to fully articulate the cost/benefits associated with the proposed investment.
- We also understand that Capital funding is extremely limited and that we will need to focus investment in those schemes that provide the most beneficial impact on our STP plans. In doing so we recognise that there may be schemes that do not get approved and the STP will therefore the benefits will also need to be reassessed.

Capital	£000s
Do Nothing	
Locally funded	726,150
Business case funding approved	150,785
Other funding source	47,634
Funding identified/approved	**924,569**
Funding not yet approved/identified	
Do Nothing	387,012
Do Something	368,232
Total funding not yet identified/approved	**755,244**
Grand Total	**1,679,813**

Pace of Change

Whilst we are forecasting balance in 2021, the profile of our solutions reflect that many of the benefits are forecast to be achieved in the latter half of the plan. Therefore the current financial plan does not demonstrate delivery of the aggregate Control Total across Providers and Commissioners for both 2017/18 and 2018/19. We will need to do further work to identify where pace can be increased, and to ensure that we are capturing all the quick wins that might be available.



Combined position is a small deficit of £1.9m

Next Steps

In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system.

5 - Delivering the change

Successful delivery of transformation this size requires:

- *Governance enabling decision making*
- *Strong leadership*
- *Robust programme management*

Governance

A successful governance structure will enable leaders to govern with confidence, making timely decisions using high quality management information

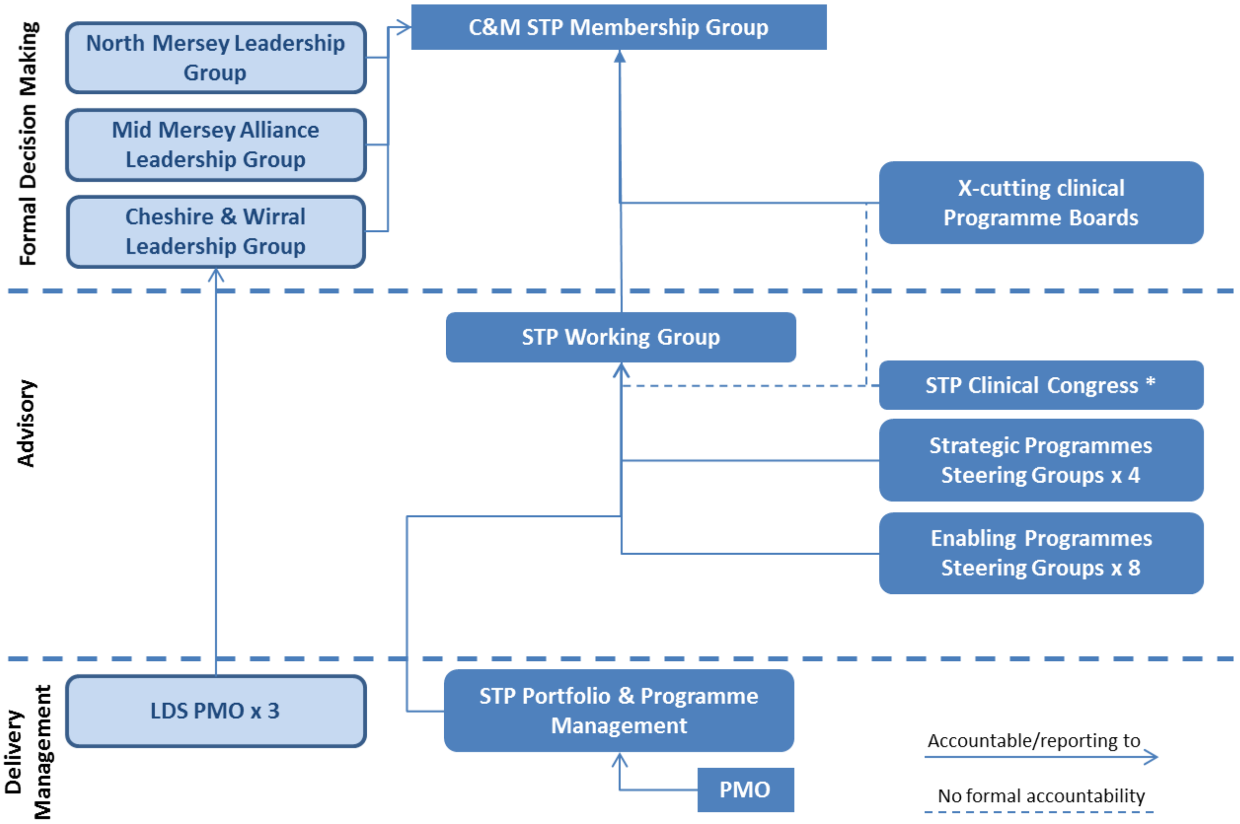
Effective governance of a programme is fundamental to successfully delivery and alignment with the STP strategy and direction, and are built on some key principles:

Each LDS already has its own Governance arrangements that will underpin the STP, and be responsible for the delivery of local programmes of work.

We will look to define governance arrangements early and comprehensively as this will create clear roles and responsibilities at all levels and allow for effective and timely decision making throughout the transformation plan.

We have drafted a Memorandum of Understanding and shared this with the STP Working Group. Once approved this will provide a sound footing to move forward from.

The current governance structure is shown below. This will be developed by the Membership Group in the short term so that Terms of Reference and membership details are agreed across C&M quickly.


Formal Decision Making
North Mersey Leadership Group
Mid Mersey Alliance Leadership Group
Cheshire & Wirral Leadership Group
C&M STP Membership Group
X-cutting clinical Programme Boards
Advisory
STP Working Group
STP Clinical Congress *
Strategic Programmes Steering Groups x 4
Enabling Programmes Steering Groups x 8
Delivery Management
LDS PMO x 3
STP Portfolio & Programme Management
PMO
Accountable/reporting to
No formal accountability

** The Clinical Congress constitutes the clinical leadership of the member organisations (medical and nursing directors) and will be led by the STP Clinical Advisory Group which is the clinical advisory group to the STP Working Group. All of the three local delivery systems, four strategic workstreams and eight cross cutting themes will have a nominated senior Clinical Lead/Sponsor who will represent their workstream, their organisation, their sector, and their local delivery system and will also be expected to take a 'holistic' clinical view across the whole STP. The STP Clinical Advisory Group will be chaired by Dr Kieran Murphy, NHSE Medical Director (C&M).*

5 - Delivering the change

The ambitions within the STP will only be delivered under strong leadership

A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network.

These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

Leadership and Organisational Development

The aim of this section is to set out the forms of leadership and leadership development required to implement, sustainably realise and maximise the impact and benefits of the Cheshire and Merseyside Sustainability and Transformation Plan for the citizens of the region. In particular, to realise the benefits of inclusive, integrated service design, delivery and on-going development, that has the potential to significantly contribute towards improved population health and the reduction of health inequalities. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always take priority over the narrower interests of individual organisations.

Context and Drivers

The context and drivers for change and new forms of leadership and leadership development within the region are both complex and diverse including factors, such as, both the national agenda, as expressed in the ‘Five Year Forward View’ and the region’s, political, economic, social, demographic, legislative, technological, geographical, physical, industrial, agricultural, commercial, educational and service sector history and current architecture, infrastructure and landscape.

The opportunities and challenges within the region’s, sub-region’s, cities, sub-cities, rural and urban environments are incredibly diverse and distinctive. However, all share the vision of a healthier population for all. A vision within which: -

- the assets and talents of local communities and populations are rigorously harnessed
- health inequalities are proactively addressed
- the promotion of health and well-being is the primary focus
- health and well-being services are integrated, resilient, culturally appropriate and sustainable

Regional Leaders

This vision requires regional leaders able to act, engage, learn, influence, challenge, develop, initiate and sustain change within differing volatile, uncertain, complex, ambiguous and diverse environments (VUCAD). We need to identify, develop, support and future proof inclusive, culturally competent leaders to become more impactful ‘place’ based, collaborative system leaders, implementing and continually developing fully integrated health and well-being strategies and services. This strategy to then support leaders to articulate and ‘live’ the ambitious Cheshire and Merseyside vision, and gain ‘buy in’ towards/for it from a range of stakeholders.

Conclusion

Twenty-first century leaders are expected to be VUCAD leaders; Cheshire and Merseyside leaders are no different. They are expected to respond to these environments by providing vision, understanding, clarity, and adaptability, to possess a VUCA approach, to fully immerse themselves in place, to work in place with individuals, groups and communities with an asset based approach, harnessing the talents of all diverse stakeholders, listening to and learning from differing perspectives, responding with agility and humility, whilst remaining personally resilient. Acting at all times as Inclusive Leaders, Cheshire and Merseyside leaders do and will work with others to ensure the successful achievement of the Cheshire and Merseyside STP, promoting innovation, creativity, entrepreneurism and inclusive, sustainable growth.

A Cheshire and Merseyside leader is and will be fulfilling an exciting, demanding, innovative and often challenging role and will need differing levels, forms and opportunities for development. This STP will work with the NHS North West Leadership Academy (NHS NWLA), and other agencies, to support the development of leaders and the region’s leadership community, spanning Cheshire and Merseyside leaders within, across and beyond organisations, systems, and place. It is recognised that the NHS NWLA’s experience developing, supporting, stretching, growing and caring for a diverse and inclusive leadership community can support the Cheshire and Merseyside leadership community in the vital role of supporting new and existing leaders to excel in role, to excel in new ‘bigger’ roles, to excel in identifying new talent and in making the region’s health and well-being services world leading.

5 - Delivering the change

Robust Programme Management

The Cheshire & Merseyside STP comprises a significant number of programmes. Programmes are about managing change, with a strategic vision and a route map of how to get there; they are able to deal with uncertainty about achieving the desired outcomes. A programme approach should be flexible and capable of accommodating changing circumstances, such as opportunities or risks materialising. It co-ordinates delivery of the range of work – including projects – needed to achieve outcomes, and benefits, throughout the life of the programme.

A programme comprises a number of projects. A project has definite start and finish dates, a clearly defined output, a well-defined developmental pathway, and a defined set of financial and other resources allocated to it; benefits are achieved after the project has finished, and the project plans should include activities to date, and both measure and assess the benefits achieved by the project.

For a portfolio of this size and complexity, the illustrative model below tells us that successful delivery is wholly dependent upon having the right set of capabilities in place. Any significant weaknesses in the capability generated to deliver projects, at any level of the programme, are likely to impact negatively upon delivery.

Resources
Capability
Delivery

The aim is to ensure that the right people are in a team and a clear and transparent project resourcing process is in place; this will mean that ways of working are understood.

Project Management

All members of the project teams must be committed to the vision and plan; moreover, impacted stakeholders should be willing to put in the additional effort required to deliver the programme. The use of milestone trackers, with enough detail to monitor on a weekly basis, and that are understood and agreed by the project lead and team, is critical.

Accountability

There must be clear accountability for project delivery of benefits (including savings) and the consequences of non-delivery understood. The work-stream lead is accountable for project delivery as delegated to them by the Executive Sponsor for each project.

Document Sharing

An intranet knowledge base should be established for the projects that comprise the programme. The use of the programme 'SharePoint' facility is an efficient and effective medium for joint viewing arrangements for documents, specifically workbooks, as well as maintaining good configuration (version) control.

The project teams will be responsible for ensuring that the latest version of the project documentation is always available on the SharePoint site. The access to the workbooks in terms of editing rights will be restricted to the Programme Assurance Framework, work stream and project team members.

Training & Development

The Programme Assurance Framework will promote exemplars of best practice project documentation. All staff completing these documents should be trained (by means of on-the-job training) during the development phase of that project.

Progress Meetings

Each project team will be expected to meet with the Programme Assurance Framework on a monthly basis. The objective of the meeting will be to gather evidence to ensure that the assurance update to the programme dashboard is based on documented evidence and is factually correct.

The conduct of the meeting will be based on a comprehensive review of the project documents as the evidence base. The progress meeting will also be an opportunity for the project to raise any issues for which the assistance of the Assurance Framework/Steering Group may be required to address to 'unblock' the route ahead.

The Programme Assurance Framework will ensure that there is a sufficiently formal process in place to ensure that any assurance reports are produced for governance meetings. This will support the embedding of an appropriate accountability framework and the provision of escalation reports, by exception, to the sub-committees; this latter process will form part of the role of the Programme Assurance Framework.

Programme Dashboard

The Programme Dashboard is intended to enable the governance bodies a more qualitative view of the development and implementation of projects. It will provide cues to focus executives on the strategic issues that require a degree of anticipation, like communications with stakeholders, or problems that need unblocking, for example questions relating to financial investment. The Programme Dashboard will also assist with the monitoring of milestones, KPIs, financial status and risks. Specifically, the dashboard reporting allows executive sponsors to review all of their projects easily, at a glance. Furthermore, it will include a responsibility matrix – given the complexity of the programme - identifying the key staff needed to deliver the project and identifies the dedicated resource required.

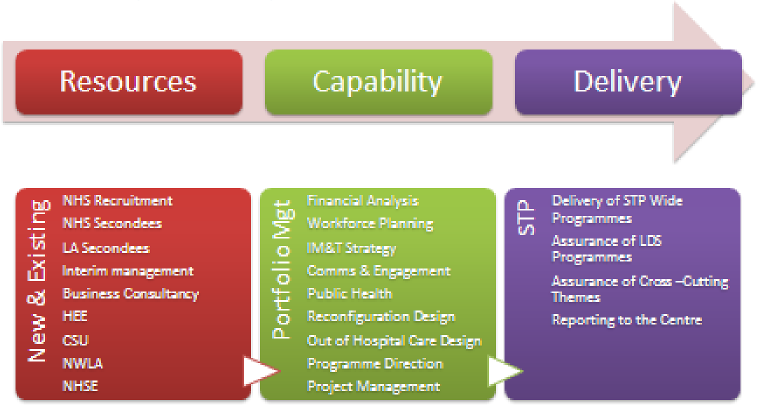
5 - Proposed resources required

The current proposals before the Cheshire & Merseyside STP Working Group are shown below. The resource and skill mix may come from a number of sources and the capability sets will need to change as programmes mature through the gated phases.

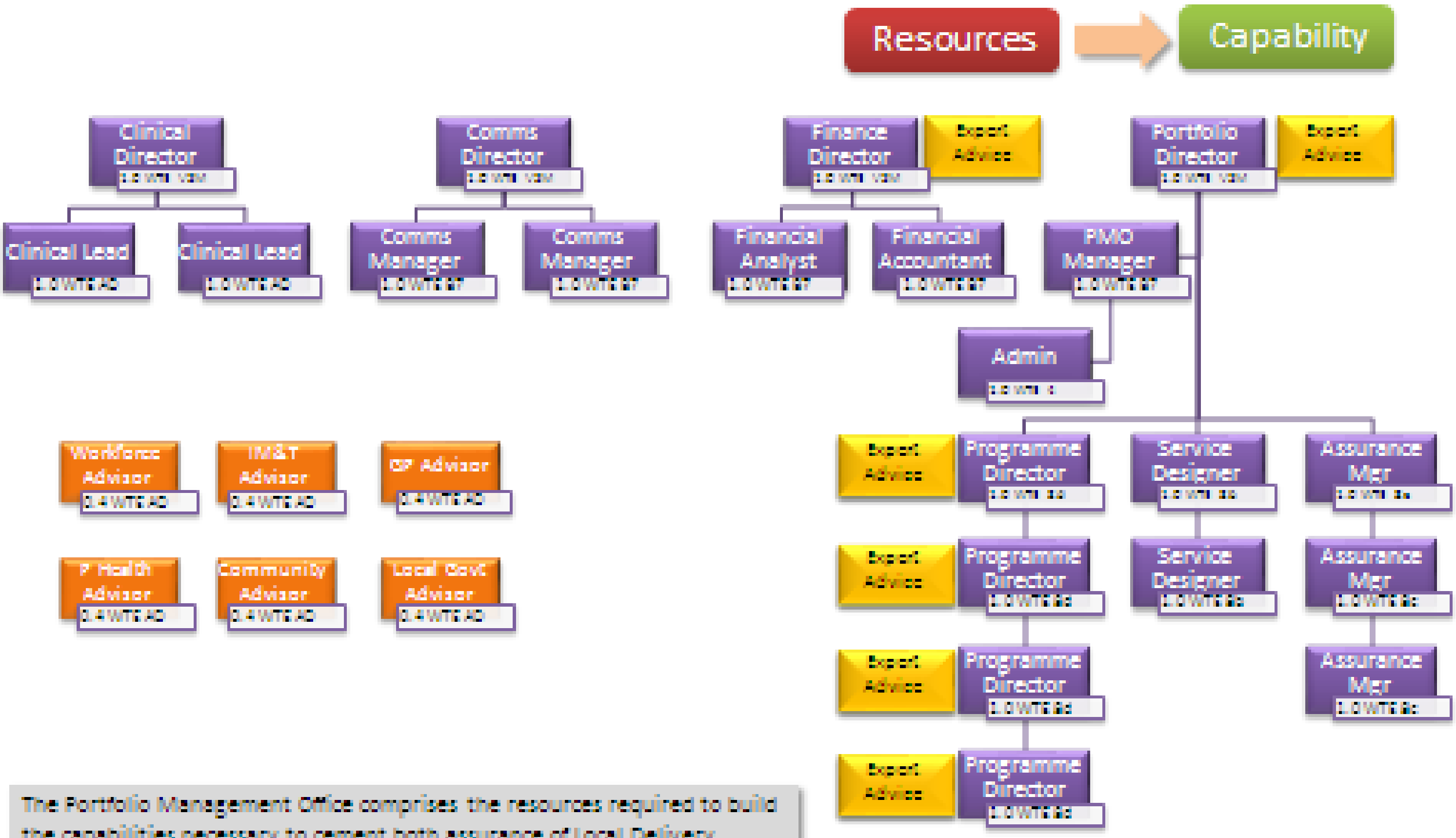
The Portfolio management Office will reside at the centre of the STP, as the engine room, meeting the demands and requests of external stakeholders while directing and assuring the programmes (as appropriate and cognisant of local governance arrangements) that fall within the agreed scope of the STP.

Similar structures will need to be agreed and mobilised, where they do not already exist, for the work of the Local Delivery Systems and each of the programmes within the Portfolio.

Delivering the change


Resources
Capability
Delivery
New & Existing
NHS Recruitment
NHS Secondees
LA Secondees
Interim management
Business Consultancy
HEE
CSU
NWLA
NHSE
Portfolio Mgt
Financial Analysis
Workforce Planning
IM&T Strategy
Comms & Engagement
Public Health
Reconfiguration Design
Out of Hospital Care Design
Programme Direction
Project Management
STP
Delivery of STP Wide Programmes
Assurance of LDS Programmes
Assurance of Cross –Cutting Themes
Reporting to the Centre

Portfolio Management Office


Resources
Capability
Clinical Director
1.0 WTE VSM
Clinical Lead
1.0 WTE AD
Clinical Lead
1.0 WTE AD
Comms Director
1.0 WTE VSM
Comms Manager
1.0 WTE 8b
Comms Manager
1.0 WTE 8b
Finance Director
1.0 WTE VSM
Expert Advice
Financial Analyst
1.0 WTE 8b
Financial Accountant
1.0 WTE 8b
Portfolio Director
1.0 WTE VSM
Expert Advice
PMO Manager
1.0 WTE 8b
Admin
1.0 WTE 4
Workforce Advisor
0.4 WTE AD
IM&T Advisor
0.4 WTE AD
GP Advisor
0.4 WTE AD
P Health Advisor
0.4 WTE AD
Community Advisor
0.4 WTE AD
Local Govt Advisor
0.4 WTE AD
Expert Advice
Programme Director
1.0 WTE 8d
Service Designer
1.0 WTE 8b
Assurance Mgr
1.0 WTE 8a
Expert Advice
Programme Director
1.0 WTE 8c
Service Designer
1.0 WTE 8c
Assurance Mgr
1.0 WTE 8c
Expert Advice
Programme Director
1.0 WTE 8c
Assurance Mgr
1.0 WTE 8c
Expert Advice
Programme Director
1.0 WTE 8c

The Portfolio Management Office comprises the resources required to build the capabilities necessary to cement both assurance of Local Delivery Systems while delivering C&M Wide (cross-cutting) programmes

5 - Proposed communications and engagement plan - subject to further work and detailed discussion, including with individual governing bodies

Introduction

Our communications & engagement strategy sets out the approach to communicating the STP across Cheshire & Merseyside and engaging in an open & honest manner, with patients, public, staff and stakeholders. Stakeholders are recognised in terms of their level of interest and influence, and the corresponding level of engagement and communication is applied to enable each audience to have the opportunity to comment on proposed changes to health service provision.

This STP is a ‘live’ document that is subject to regular revision throughout the programme, and recognises and documents the work that has already taken place and is still ongoing at a local level. Much engagement work has already taken place to support area transformation plans such as ‘Healthy Wirral’, ‘Healthy Liverpool’ and ‘Connecting Care’ and this work is currently in the process of being scoped and logged.

The plan has been developed in collaboration with the Communication & Engagement Leads for each of the three ‘Local Delivery Systems’, providing a joined up, partnership approach across the region, and utilising all available channels to reach stakeholders.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can’t happen overnight and that they shouldn’t. Some NHS care models haven’t changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

This is why we are taking time to create an STP that is worthy of consideration by the public, patients, clinicians and the wider health economy and why the STP itself is still expected to go through a number of changes and adaptations – beginning with a phase of review and revision after the 21st October.

An initial period of pre-engagement will follow this date - setting the scene, considering and communicating available options and making sure that we are having the right conversations with the right people. The conversations that we have started about this process are extremely valuable and we will continue to engage with all of our stakeholders.

Engagement & Communications Objectives

The communications and engagement strategy has a number of over-arching aims. It is based on the three LDS areas being the “engine room” for developing and implementing any plans for transforming services. At a Cheshire and Merseyside level a joint Communications and Engagement Steering Group will be established to oversee the following:

- Establish standards for communication and engagement with members of the public, NHS staff and other stakeholders, taking into account the needs of any groups of people with protected characteristics, so that local people have the opportunity to contribute to discussions about NHS services. These standards will build on existing good practice and draw on expertise from partner organisations
- Where there is a need to formally consult with the public, staff and stakeholders on options for making major changes to services, ensure that standards of best practice are adhered to. Provide peer support, advice and guidance to support this and if necessary seek external expertise
- Build on existing good practice in order to transform how the NHS engages with members of the public, staff and stakeholders for the future.

Our Local Delivery Systems

A joint calendar will be created for the three LDS areas, identifying key milestones, which will be dependent on the priorities for each area. Communications and engagement activity will be planned to support these milestones. Where appropriate this activity will take place across LDS areas.

A senior communications and engagement lead has been identified for each LDS. Each lead will be responsible for overseeing the co-ordination of activity in their LDS area, providing strategic advice and guidance to their LDS chair and delivery board and will be a member of the Cheshire and Merseyside wide communications and engagement steering group.

STP Key Messages

- All health and social organisations across Cheshire and Merseyside are committed to delivering sustainable services that deliver the best care for local people
- We need to think differently about how we deliver services to meet the changing needs of our population
- We know we need to use our limited resources wisely, to meet the demands on the system and stay within our allocated budgets. By working together we can plan our services to deliver the maximum benefit for patients

5 - Strategic Risks

Financial Sustainability challenge. Since the June 2016 submission of the Cheshire & Merseyside STP, we have taken the opportunity to commence some initial steps to create a common standard of assurance across the footprint. What we have since received in the STP Working Group is a set of high level assurance assessments, both documented and verbally, which demonstrates that our current plans are extremely unlikely to close this gap.

The size of the current gap is an estimate and more work to agree the future assurance framework is yet to be completed. However, two dimensions can be described in that: firstly, the current level of planning has no level of contingency (indicatively 25-50%) that would normally be associated with programmes of this size and complexity ; secondly, the robustness of the 'plans' and associated risks regarding measurability, capability and deliverability all serve to make us discount the current value of the whole by a figure of 30% equating to some £300m.

Decision-making. As we stated in our June submission, while there is an emerging clarity about what needs to be done to deliver system-wide change, the challenge of delivering the decisions to effect this should not be underestimated. The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities. In due course, t is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives.

Internal capacity. The issue of the capacity and capability needed to generate and coordinate detailed design and the delivery of the STP has still to be resolved. Attempting to deliver a change programme of this scale without freeing up key members of staff from other duties, or without bringing in additional resource, is destined to fail. The lack of transformation capacity and expertise released from within the system will result in momentum being lost. We are at a watershed moment and the Membership Group has recently agreed to consider all requests for capacity and skills in the light of insufficient progress being made to exploit the goodwill and discretionary efforts of all those contributing to this plan to date.

Appendices

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