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NHS
Warrington and Halton Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 2

Wednesday 27 June 2018
1.45pm-2.30pm
Trust Conference Room, Warrington Hospital

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NHS Warrington and Halton Hospitals NHS Foundation Trust

A G E N D A

Warrington and Halton Hospitals NHS Foundation Trust. Agenda for the Board of Directors Board Meeting, held in Public Part 2 Wednesday 27 June 2018 – 1.45pm -2.30pm Trust Conference Room, Warrington					
AGENDA REF	**ITEM**	**PRESENTER**	**PURPOSE**	**TIME**	
	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	13.45	Verbal
BM/18/06/53	Minutes of previous meeting held 24 May 2018, Part 1A and part 1B	Steve McGuirk, Chairman	Assurance		Encs
BM/18/06/54	Actions + matters arising	Steve McGuirk, Chairman	Assurance		Encl
BM/18/06/55	Briefing on outcomes of the RCS invited Service Review	Simon Constable Executive Medical Director/Deputy CEO	Assurance	13.50	Report
BM/18/06/56	Re-submission of Operational Plan 2018-19	Andrea McGee Director of Finance + Commercial Development	Decision	14.15	Report
	Any other business and close			14.30	
	Next meeting to be held on Wednesday 25 July 2018				

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Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1a) on Thursday 24 May 2018
Trust Conference Room, Warrington Hospital

Present	
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating officer
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Anita Wainwright (AW)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Director of HR + OD
Jason DaCosta (JDaC)	Director of IM&T
Alex Crowe (AC)	Medical Director and Chief Clinical Information Officer
Lucy Gardner (LC)	Director of Transformation
John Culshaw (JC)	Head of Corporate Affairs
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Observing	
Norman Holding	Lead Governor
Cllr Chris Loftus	Halton Borough Council
Apologies	
Steve McGuirk (SMcG)	Chairman
Pat McLaren (PMcL)	Director of Community Engagement
Mel Pickup (MP)	Chief Executive

Agenda Ref BM/18/05/	
BM/18/05/32	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: None were noted
BM/18/05/33	**CNST (CNST) Incentive Scheme** T Cooper, Head of Midwifery provided an overview to the Board on evidence to be submitted as evidence of progress against the 10 maternity safety actions. Compliance will result in anticipated reduction of 10% off the annual CNST payment. - The Trust is declaring compliance against all 10 safety actions. - In relation to point 8 to achieve above 90% compliance for training, the Board were advised that maternity multidisciplinary training day compliance and e-learning compliance figures when added together are above the 90% compliance target. The Trust will be able to submit additional evidence of completed training to the end of June to support this. - In relation to point 9, Trust Safety Champions, KSJ confirmed that the QAC had supported the appointment of Board Champion (M Bamforth), Executive (Chief Nurse) Governance Lead Obstetrics, Champion (Dr E Hassan), Midwifery Safety Champion (Head of Midwifery) with TC and Dr EH members of both the QAC and Patient Safety + Clinical

	Effectiveness Committees. The evidence had been approved by Commissioners. - **The Board approved formal sign-off of the submission of evidence to allow for any additional evidence to be included to the end of June.**
BM/18/05/34	**Guardian of Safeworking Quarterly Report (January-March 2018) and Annual Report April 2017-March 2018** The Medical Director highlighted the following for the Board to note: - An increase in exception reports reported in the period January-March 2018. There had been 107 completed reports covering 130 incidents, all submitted by FY1s. - The 130 incidents were submitted from a total of 24 trainees and 20 Educational Supervisors. Additional hours worked related to writing of prescriptions to support safe handover and discharge of patients. Where Drs had worked additional hours, this had been taken as time in lieu as opposed to compensatory payment to reflect propensity to work additional hours. The trainees have their own personal responsibility to ensure they do not exceed their maximum hours allowed. This trend could be explained by the Trust's continued need for full capacity and additional bed utilisation. There will be preparatory work for winter contingency in order to minimise this occurrence. - To a query raised by MB, MC commented that the Trust has completed documentation where Trainees had 'opted out' and exceed their maximum additional hours. The Trust can only be accountable for activity within the Trust and has no control if trainees choose to work elsewhere in addition to the Trust. In addition Education Supervisors have a role to play in monitoring this and discussions are progressing on how Educational Supervisors performance can be monitored. AC and MC to discuss outside of the meeting. - In response to a query raised by AW regarding the Collaborative Bank for locums and if this could be a mechanism to manage instances of trainees exceeding their maximum hours, MC informed the Board that the Collaborative Bank is still in development and its effectiveness depends on who signs up to the arrangements. - JNE referred to 'predictable' gaps due to vacancy and annual leave which could be planned, AC concurred, adding that this data is based on responses to fill the gaps. Acute Medicine admissions data is to be analysed to identify trends and benchmark with other mitigations, looking at different models of care. This will be monitored and reported through the Workforce Committee. - The report also included an analysis of all exception reports raised in the period 1 April 2017-31 March 2018 indicating 339 exceptions raised, related to 418 separate episodes, 217 had been closed and 122 reported as outstanding. Positive engagement with trainees which reflects the increased activity and continued positive engagement through the Drs Forum which is Chaired by AC, supported by MT, KC and HR colleagues to review metrics and identify gaps. Gaps within Acute Medicine, Specialist Medicine and T&O and work progressing to identify where Physician Associates could be used in these areas, developing measures to support this. - In relation to query raised by MB regarding exception reports, MC and AC advised this is primarily F1s. Exception reports from lead employers are received and the MIAA audit demonstrated issues with late notification from lead employer which is a regional issue. The newly appointed Head of Medical Staffing will lead on this work to ensure improved and timely reporting. • **The Board noted the report and AC to provide feedback to Guardian as requested in**

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	relation to Educational Supervisors, acknowledgement of changes and late notification. - As requested at the last Board, AC provided a briefing regarding Junior Doctor Rota and additional hours worked, especially as a result of the handover period not within the scheduled rota resulting in additional 30 minutes extra every time in order to complete a safe handover for patients and staff. This issue has now been resolved. - AC advised that the actions taken to date within the paper had been positively received at various forums, including Junior Doctors Forum. CBUs continue to work with Junior Doctors to develop and support their educational experience with improved monitoring systems, monitoring training and access to educational opportunities, including monitoring of ward cover. - Care of Elderly Medicine had been reviewed by HEE and monitoring reduced due to quality of portfolios provided. - Further visit from HEE on 29 June, AC reassured the Board that action plans are in place to address identified issues. - AC added that findings from all ward observation visits are triangulated at various forums to provide a holistic picture and negate duplicated action plans. - 'Electronic tool' as part of handover working successfully supported by an identified clinician. • **The Board noted the report.** • **The Board to receive report following HEE visit on 29 June 2018.**
BM/18/05/35	**Minutes of the meeting held 28 March** Date to be amended to read 28 March 2018. C Evans to be noted as present at the meeting. Page 5, paragraph 3, CEO Report. Last sentence to read .. at present anticipated period of 6 months for relocation of the following services: ….. Page 6, last paragraph, BM/18/003/23 CQC Update. To read … There was a discussion relating to other Trusts partnering with 'outstanding CQC Trusts' as also happened with Keogh Trusts some years ago. Discussion also had regarding funding and consideration on whether CBU team members could be released for some time to focus solely on the CQC Action plan. Page 7, BM/18/03/24 Working Capital Loan. To read …. AMG reported the terms for the £14.2m loan had been extended to November 2018. With these amendments, the minutes of 28 March 2018 were agreed as an accurate record of proceedings.
BM/18/05/36	**Actions and Matters Arising** Actions closed since the last meeting were noted, BM/18/03/27 F2SU report, BM/18/01/07 IPR Dashboard, BM/18/04/14 Engagement Dashboard and outstanding actions reviewed.
BM/18/05/37	**Chief Executive's Report** Executive Medical Director provided an update to Board on pertinent issues since the last Board meeting: - Kendrick Wing Fire. Impact on patients had been managed well despite a significant impact on clinical and administrative teams who had been displaced from their locations as a result. A Fire Response Steering Group is now established to oversee associated work. The Trust had received formal confirmation from NHS Resolution for liability to buildings and contents from the Trust's primary insurers which will allow commencement

	of interim work to allow relocation of staff back to their place of work where appropriate. - Halton Healthy New Town. Steering Group continues to meet to develop strategy and plans to develop the Halton site. The CEO of Halton Council (DP) as the Senior Responsible Officer is working closely with the Trust to prioritise access to any STP monies and developing a capital bid for submission. DP had written formally to the NHS CEO regarding support and the importance of developing a sustainable health and social care system for our patients. - Warrington. Aspirations remain for development of a new hospital with on-going discussions with the local authority. A high level capital bid had been prepared for submission to the STP outlining the both organisations intentions to explore collaborative working arrangements and the CEO is due to meet with local MP H Jones to discuss. - SC acknowledged the challenging lengthy winter period with the closure of some escalation beds only last month. Plans are being developed to ensure that demands for next winter can be met which will be supported by the Frailty Unit and close working with partner agencies to ease pressure. - ECIP team have recently looked at pathways within the Trust and provided positive feedback especially in relation to assessment schemes and ambulance handover times. - SC was pleased to report that the Trust had recently been visited by HRH Princess Anne, the Princess Royal to the Maternity Unit recognising the excellent work of this unit. - A Pulse Check and Leadership Audit is due to be launched next month to engage with staff to develop workstreams to focus on all the quality domains which will support the recommendations within the CQC action plan. - The 'Start the Year' conference will take place in June and the Trust has a number of events to celebrate the NHS 70th birthday. - SC asked that thanks are formally recorded for staff directly affected as a result of the recent Fire, at a crucial time in the year, when preparing end of year documentation.
BM/18/05/38	**Chairman's Report** No issues were highlighted.
BM/18/05/39	**Integrated Performance Dashboard M1** The report was taken as read and each Director highlighted key areas for the Board to note. Quality Dashboard The Chief Nurse highlighted areas to note **relating to the Quality KPIs:** - 8 Red indicators reported in April, a reduction of 2 in month. Following 2018/19 KPI refresh the number of Quality indicators increased from 24 to 26. - The 7 indicators which were Red in March and remain Red in April. - Incidents – the Trust has 176 open incidents which are over 40 days old. - Safety Thermometer – The Trust achieved 96.4% for Adults, 100% for Children, 80% for Maternity against a 95% target, a deep dive to understand variance is to be undertaken. - Healthcare Acquired Infections – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance. KSJ advised this had occurred on a different ward and that a RCA is being undertaken to understand the cause, findings will be reported to Quality Assurance Committee. - Friends & Family Test - for in-patient and day case reporting 94% in April (target 95%) against a decrease from March of 96%. - F&FT - A&E + UCC achieved 85% in April (target of 87%) improvement on March from

	81%. KSJ reassured the Board that action plans are in place to address F&FT response rate - A reduction in Mixed Sex Breaches reported, 16 in March reporting 7 in April. - Total Falls & Harm Levels – There was 1 incident resulting in severe harm in month. - Safer Surgery indicator had moved from Green to Amber in month - Medication Safety indicator had moved from Red to Green in month reporting no incidents of harm in April. - NICE Compliance and Complaints indicators had moved from Red to Amber. The Board noted the significant effort to reduce the number of complaint cases over 6 months old in line with the complaint backlog improvement target. The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Quality Assurance Committee highlighted the approval of the Maternity Champions as discussed earlier in the meeting. The Chief Operating Officer highlighted areas to note **relating to Access and Performance KPIs:** - 7 indicators rated Red in April a decrease from 9 in March. - Improvement noted in both A&E and Ambulance Handover. CE provided further update on A&E performance to date for May (month to date) at 90.74% and Ambulance Handover times 14-20 May of 26 minutes. - Cancelled Ops on the day (not offered an appointment within 28 days), 7 reported in April, 6 were due to the damage of equipment in the Fire but patients had now been rebooked for treatment. - Diagnostics - additional Red indicator this month, achieved 98.6% which is associated with lack of capacity for Cardiac CT scans. Additional capacity is being sourced externally with Royal Liverpool Hospital alongside development of a business case for additional support and equipment. CE assured the Board a recovery plan is in place to support improvement. The Director of Finance + Commercial Development highlighted areas to note **relating to Finance + Sustainability KPIs:** - 5 Red indicators reported in April, a reduction of 2 in month. Following 2018-19 KPI refresh the number of FSC indicators increased from 9 to 10. - Capital Programme is ahead of plan and no concerns highlighted to the Board. - Better Practice Code (BPPC) deteriorating, currently 29%, position is discussed and reviewed monthly at the FSC in addition to aged creditor payments. - Use of Resources score of 3 due to agency over-spend of £0.8m which is £0.1m (13%) above agency ceiling of £0.7m. AMG advised that a Use of Resources Assessment is to be undertaken in year with indicators identified against all indicators within the IPR where Use of Resources applies to allow correlation of information. - 2 indicators had moved from Red to Amber, financial position, deficit of £2.8m in line with plan and cash balance of £1.2m. Approval of a further Working Capital Loan will be requested later in the meeting to maintain liquidity and meet the Trust's financial statutory obligations.

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Key Issues Report – Finance and Sustainability Committee 21 March + 18 April 2018

The Key Issues Reports were taken as read and Terry Atherton, Chair of FSC Committee provide reassurance to the Board that the financial position of the Trust is debated and discussed in detail at FSC with any matters for escalation to Board noted in the Key Issues Report and that there were no additional matters to highlight to the Board.

The Director of Workforce and OD highlighted areas to note **relating to Workforce KPIs:**

- CBUs now report to the Workforce Committee with exception reports relating to sickness absence, PDR and RTW indicators with recovery plans to address non-compliance. Some issues had been identified where RTW had taken place but not recorded appropriately electronically and where staff had returned to work at the end of March, outstanding annual leave had had to be taken resulting in some RTWs not completed in month.
- Assurance had not been provided to WF Committee by CBUs which will be escalated to Trust Operational Board on 29 May.
- Sickness Absence (4.88% in April) correlates with the busy periods within the Trust, predominantly due to MSK and stress. Staff are supported through a number of routes, including Occupational Health, Mental Health Stage Training and general raising awareness of support available for staff.
- Agency spend - MC reported that activity undertaken with the Trust had been discussed at FSC which was in the main due to continuation of escalation beds providing a direct correlation with use of bank and agency. Approval for use of staff outside of the framework was by the Chief Nurse or HRD.
- The Board were asked to note that the Pay did not decline in line with activity in April as figures included assumed pay inflation uplift of 2% in line with A4C with back pay to 1 April 2018 if approved. In addition there were a number of job planning arrears payments in month.
- MC was pleased to report that 84% of Medical Job Plans had been signed with an additional 11 due to be signed off on 23 May.
- MB asked regarding the number of clinical supervision sessions undertaken and MC advised that some staff had undertaken this. A mapping exercise to develop a framework is to be completed to agree roll-out Trust wide which will include Mentorship framework with Nurses to support revalidation. The Framework will enable identified staff to undertake 1:1 and face to face supervision.

- **MC to obtain external absence data to benchmark against the Trust. Post meeting note: Difficult to obtain external data. MC to provide split of all absences categories including stress to JNE outside of the meeting.**
- **The Board noted the Key Issues report of the Workforce Sub Committee held 17 April**

(c) Key Issues Report – Audit Committee 26 April 2018

The Key Issues Reports were taken as read and Ian Jones, Chair of Committee reported:

- Audit Committee approved changes to the SORD to reinstate £5k delegated authority for Ward Managers, which will be presented today for Board ratification.
- Approval of the Annual Report, Quality Strategy, final accounts and associated year end documentation for sign-off, which will be presentation today for Board ratification.

	The Board noted the report.
BM/18/05/40	**Spinal Services Update** The Executive Medical Director reported progress to date. The Trust had received the Royal College of Surgeons final report which had been jointly commissioned by the Trust, Commissioners and NHSE. The report has not been produced and written for intended publication due to the personal identifiable information it contains of both patients and staff. Under Duty of Candour, Data Protection Regulations and the wish for transparency, the 3 organisations are seeking legal advice from their legal teams to ensure that in the event the report appears in the public domain no breaches in data protection and duty of candour occur as a result. NHSE are to produce a legal redacted version and the first priority for the Trust priority is to the families when the final report can be shared. SC advised that the recommendations and learning will be through the C&M Spinal Network. Under this auspice, the aspiration is for a single specialist service for all service provision with 2 workstreams, one for cancer and deformity surgery and one for spinal trauma for all C&M patients. Service provision at WHH remains suspended, with patients being repatriated to The Walton Centre; 2 consultants continue to providing consultancy advice at WHH. • **The Board noted the report.**
BM/18/05/41	**Annual SIRO Report** The Director of IM&T highlighted key areas for the Board to note: - The Trust is fully compliant with all data protection, cyber security, IG and information security regulations and is fully prepared for the GDPR launch on 25 May. - Firewalls, anti-virus and patch servers have all been updated and applied with Windows 10 providing enhanced security. - The Trust has appointed an IT Security Manager following an internal restructure who will work alongside the IG Manager. - The Trust achieved Significant Assurance following the IG Toolkit Audit. Data following the NICE guidance and clinical coding audit could not be verified as the audit was on-going in these 2 areas. - Information Sharing Agreements established through BCF funding to allow safe sharing and transformation of data between identified partners/agencies. Audit of these agreements will continue to ensure full compliance. - New software to be installed to enable tracking and assistance by asset managers to verify contracts. - Confirmation of launch date for new IG Toolkit awaited which the Trust will self-assess against. **The Board noted the report and the assurance provided relating to the Trust IT systems.**
BM/18/05/42	**CQC Action Plan Update Report** The Chief Nurse highlighted key points for the Board to note: - 230 actions of on the CQC Action Plan reported in March has increased to 260, as due to work commencing, additional actions have been determined. For example some actions are 'to review' or 'to audit' and therefore further actions had been identified. - At the time of writing this report (16th May 2018) 198 actions are due to be completed by end May. To date the Governance Department and Executive Leads have received and

	reviewed 129 reports - Robust evidence seen for 88 reports due by end May 2018, which can be signed off compliant. 41 have been reviewed requesting further evidence. - Due to the complexity of the evidence provided, MIAA will undertake an audit of compliance against actions and report findings through the Quality Assurance Committee. - A 'mock' CQC inspection is planned in July to include external partner agencies. - Date of the CQC Well-Led inspection is still awaited. - KSJ referred to the Fundamental breach analysis and advised that it is anticipated this will move to Green when evidence/assurance is given that sustained action plans are in place. - KSJ reassured the Board that progress against actions and mitigating actions are reported through CQC / G2G Steering Group which is Chaired by either the CEO or Chief Nurse, , attended by professional and Executive leads to allow issues to be escalated immediately. - In response to queries raised by JNE relating to premises / cleaning and training, KSJ advised that in relation to cleaning/premises, more instances were identified in radiology than in other areas and other kit incidences. Checks had been made against a number of areas, identifying that audits had not taken place and gaps had not been identified during internal audits. In response to training, KSJ reported that each of the CBUs have been asked to provide compliance reports for mandatory training. Professional nursing teams had completed safe guarding and MCA and training is through both electronic and face to face training. Where identified, there will be individual practical training for staff. • **The Board noted the update report and progress against the action plan which continue to be monitored and reported at CQC Getting to Good Group and Quality Assurance Committee.**
BM 18/05/43	**Quality Strategy** The Chief Nurse highlighted key points for the Board to note which had been developed following the Quality Strategy Day earlier this year. Draft copies had been discussed and reviewed at Audit, Quality Assurance and Patient Safety Clinical Effectiveness Committees. - KSJ advised that roles have been created and staff identified to fill the roles within the Quality Academy, from existing resources. This had not incurred any additional cost. - ToR had been agreed, and a Trust wide communication will be agreed ahead of the launch of the Quality Academy in June. - KSJ is developing training plans with AQUA and the Improvement Agency. - The Quality Academy will support the CQC and G2G action plans. • **The Board noted the report and approved the Quality Strategy.**
BM 18/05/44	**Working Capital Loan Resolution + Working Capital Loan approval** The Director of Finance & Commercial Development asked the Board to delegate authority to the Director of Finance & Commercial Development to obtain revenue support and sign loan agreements up to a maximum value of £24,444, which relates to the deficit plan for the year as detailed within the report. **The Board:** • **Approved the terms of and the transactions for the Working Capital Loan.** • **Approved authorisation by the Chief Executive Officer to execute the Finance Documents relating to uncommitted interim revenue support loans to the value of £24,444k to which it is a party on its behalf; and** • **Approved authorisation by Director of Finance & Commercial Development, on its**

	behalf, to despatch all documents and notices (including, if relevant, any Utilisation Request) to be signed and/or despatched by it under or in connection with the Finance Documents up to which it is a party. • **Confirmed the Borrower's undertaking to comply with the Additional Terms and Conditions.** All are in accordance with the Trust's Scheme of Reservation and Delegation and Schedule 1 of an Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) agreement.
BM 18/05/45	**Quarterly Response to Lord Carter** The Director of Finance & Commercial Development highlighted areas to note which indicate compliance against the recommendations within the Lord Carter Report. As discussed earlier, future reports will include Use of Resources progress against the Use of Resources workstream as part of the Getting to Good, Moving to Outstanding programme and be presented as 1 full report to avoid duplicate monitoring and report. • **The Board noted the report.**
BM 18/05/46	**My Choice** The Director of Finance & Commercial Development highlighted areas to note: - PLCP process proposed to retain existing capacity and continue to provide services through the NHS with treatments available at the Trust, which will expand patient choice for safe and clinically effective services and enable to the Trust to retain capacity. Therefore income from My Choice will be directly invested into front line care for our NHS patients. Referral would be by GP or clinician and critically patients would follow the exact same pathway as the NHS patient, the only exception being they would self fund. The Board was re-assured by AMG that this is not privatisation of services but offers patients choice for services no longer funded as they are categorised as of lower clinical priority. - A FAQ summary has been developed and services to be included have been reviewed and agreed following engagement with the Trust's clinicians via the Medical Cabinet and CBUs. The anticipated launch is June/July supported by a clear communication plan. - AMG advised that the financial elements (finance SOP, Lorenzo SOP and operational SOP) of the initiative had been supported at the Finance and Sustainability Committee on 23 May. - Following discussion, the Board emphasised the importance of ensuring a clear and consistent message is agreed. Queries were raised regarding potential reputational messages with the public and commissioners, the need to understand demand and clinical benefit to patients. • **The Board noted the update and agreed a 'soft' launch with commissioners and GPs prior to any external launch.** • **The Board asked that outcomes from the 'soft' launch be reported to July Trust Board prior to wider external launch of My Choice.**
BM 18/05/47	**Engagement Dashboard** In the absence of PMcL, the Board noted the report and asked that any comments be provided to PMcL.
BM 18/05/48	**Strategic Risk Register (SRR) +Board Assurance Framework (BAF)** JC reported 4 new risks had been added to the Risk Register, Information Governance, GDPR,

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	Medical Devices, G2G/CQC Action Plan. The Register had been reviewed at Quality Assurance Committee on 2 May and Finance & Sustainability Committee on 23 May. - The Committee were asked to note updates on existing risks since the last Board, upgrades continue relating to cyber security. 4 SI falls reported in April, plans in place to monitor and mitigate risk. - 2 risks had been removed following approval at Quality Assurance and Patient Safety and Clinical Effectiveness Committee relating to blood administration and review of paediatric urgent and emergency care. • **The Board noted the report and approved the changes/amendments to the Strategic Risk Register.**
BM 18/05/49	**Finance + Sustainability Committee (FSC) Chairs Annual Report** The Board noted and approved the FSC Chairs Annual Report with the amendment to the Executive Lead as Andrea McGee, Director of Finance + Commercial Development. • **The Board ratified the FSC Chairs Annual Report and FSC ToR and Cycle of Business.** **Audit Committee (AC) Chairs Annual Report and Cycle of Business** • **The Board ratified the AC Chairs Annual Report and Cycle of Business**
BM 18/05/50	**Trust Operational Board Cycle of Business** The Board ratified the Trust Operational Board Cycle of Business
BM 18/05/51	**Scheme of Reservation and Delegation ((SORD) + Standing Financial Instructions (SFIs)** The Director of Finance + Commercial Development summarised proposed amendments within the report for Board approval: - Revised delegated limits following the changes to the restructure of operations. - Reinstatement of £5k delegated authority for Ward Managers. - Changes to professional services consultancy contracts to comply with NHSI directives. - There are no changes to the SFIs • **The Board approved the changes to the SORD.**
	The meeting closed to convene Part 1 b Year End meeting of the Public Board **Next meeting to be held: Wednesday 25 July, Trust Conference Room**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1b) on Thursday 24 May 2018
Trust Conference Room, Warrington Hospital

Present	
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating officer
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Anita Wainwright (AW)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Director of HR + OD
Jason DaCosta (JDaC)	Director of IM&T
Alex Crowe (AC)	Medical Director and Chief Clinical Information Officer
Lucy Gardner (LC)	Director of Transformation
John Culshaw (JC)	Head of Corporate Affairs
Karen Spencer (KS)	Head of Financial Services
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Apologies	
Steve McGuirk (SMcG)	Chairman
Pat McLaren (PMcL)	Director of Community Engagement

Agenda Ref BM/18/05/	
BM/18/05/53	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed the CEO.Apologies: as above. Declarations of Interest: None were noted
BM/18/05/54	**Recommendation to Adopt Audited Annual Report and Accounts including:** **Annual Report.** The Chair asked the Board to note the Going Concern Disclosure (Page 11) which had been submitted to the Audit Committee on 22 May. Going Concern of the Trust had been discussed at a number of Committees throughout the year. The Audit Committee supported this disclosure and recommended approval for sign off by the Trust Board. **Annual Governance Statement.** This had been submitted to the Audit Committee on 22 May. The Audit Committee supported recommended approval for sign off by the Trust Board. **Quality Account Report 2017-18.** This had been submitted to the Audit Committee on 22 May. The Audit Committee approved in principle subject to the Stakeholder commentaries being received and included. The Audit Committee had discussed the Independent Auditors 'Limited Assurance' opinion

	within the Council of Governors report. They discussed and noted the data quality relating to RTT concerns. Last year a sample of case notes (25) had identified 10 errors. This year's audit of sample cases notes had identified 5 errors. The Audit Committee had requested full compliance for 2018-19 for this indicator. **Annual Accounts** The Board noted the 'Qualified Opinion' due to the Trust's overall financial position, year end report of £14.6m. The Board formally recorded thanks to the Finance Team, recognising their efforts in producing the report, in difficult circumstances due to office relocation as a result of the fire within the Finance Department in March. • **The Board formally approved the Audited Annual Report and Accounts for 2017-18 for sign-off by the CEO, Deputy Chairman and DoF.**
BM/18/05/55	**Self Certification Compliance with the Trust Licence 2017** A Certificate of Compliance had been issued in November from NHSI. At the time of writing the report, the Trust does not consider itself to be in breach of is provide license and declares continued compliance. Periodic monitoring will continue and any material changes report to the Audit Committee. • **The Board noted the report and continued full compliance with its Provider License conditions and Certificate of Compliance.**
	The meeting closed to convene Part 2 of the Trust Board meeting. **Next meeting to be held: Thursday 25 July, Trust Conference Room**

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BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/06/54	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27 June 2018

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/05/39 c	24.05.2018	IPR Dashboard – Workforce Indicators	Split of all absences categories including stress to be provided to JNE oustside of the provide to JNE outside of the meeting.	**Director of HR and OD**	June 2018		June 2018 Informaiton shared with JNE	

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/04/49	26.04.2017	Proposal to change Trust Name	Process to commence to incorporate 'teaching' element into its Brand.	**Director of Community Engagement**	On-Going		24.5.17. This process has commenced. 20.9.17. Shared at Annual Members meeting in Sept.. 31.1.2018. awaiting outcome of Chester University application to become a Medical School on 7 March 2018. Anticipated GMC approval September 2019 following GMC visit in September 2018,. 31.3.2018. work to progress to change to W&H Teaching Hospitals.	

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BM/17/01/12	25.01.2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	**Director of Community Engagement**	25 July 2018		7.7.2017. Deferred to Part 1 Board on 26 July 2017. 26.7.17. Deferred to Part 1 Board 25 October. 23.01.2018. Deferred to February Board 31.3.2018. Deferred to after July Executive Time Out on 6 July.	
BM/18/03/22	28/03/2018	Learning from Experience Summary Q3 Report	A presentation slide deck to be available to the Board as opposed to the report, as the report is discussed in depth at Quality Committee.	**Chief Nurse**	25 July 2018		14.06.2018. To be presentd to July Board meeting.	
BM/18/01/01	31.01.2018	Partnership with King Edward Memorial Hospital Mumbai	Update Report to November Trust Board	**Medical Director**	28 November 2018			
BM/18/05/34 ii	24.05.2018	HEE visit 29 June	Report following the visit on 29 June	**Medical Director**	26 September 2018			

RAG Key

	Action overdue or no update provided		Update provided and action complete
	Update provided but action incomplete		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/06/55**
SUBJECT:	**Royal College of Surgeons Invited Review of Spinal Surgery at Warrington and Halton Hospitals**
DATE OF MEETING:	**27th June 2018**
ACTION REQUIRED	**For discussion**
AUTHOR(S):	Prof Simon Constable Executive Medical Director and Deputy Chief Executive
EXECUTIVE DIRECTOR SPONSOR:	Prof Simon Constable Executive Medical Director and Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	Complex/specialised spinal surgery is commissioned by NHS England. Non-complex/non-specialised spinal surgery is commissioned by local commissioners. WHHFT is now part of discussions with all spinal providers in Cheshire and Merseyside regarding the provision of a high quality, single spinal surgery service for the region, with the intention of keeping access for patients as local as possible.
EXECUTIVE SUMMARY (KEY ISSUES):	On 22nd September 2017, following an executive safety review panel, the Trust took the decision to voluntarily suspend all spinal surgery at WHH pending completion of an comprehensive internal investigation. The decision was taken following four serious (but unrelated) incidents. The incidents involved different pathologies, different indications for surgery, different operations and subsequently different post-operative complications. All index cases had been subject to a multi-disciplinary team process. On 27th September 2017 NHS Warrington CCG issued a formal suspension notice. The Trust, NHS Warrington CCG and NHS England Specialist Commissioning jointly commissioned an independent expert review from the Royal College of

	Surgeons through the RCS Invited Review Mechanism. A desktop review of documents and interviews were undertaken over two days by the RCS team on 2nd and 3rd November 2017, followed by subsequent further document reviews. In summary, the RCS findings included that the 'hub and spoke' relationship with The Walton Centre had not been functioning sufficiently well to ensure it was capable of providing the necessary reassurance in relation to clinical decision-making. This was one of the key recommendations by the Chair of the Clinical Reference Group (CRG) in 2015. Moreover, outcome data was not uploaded systematically into the British Spine Registry. The Trust did make efforts to implement the CRG recommendations and all action points pertaining solely to the Trust were introduced. However, it is accepted that a more structured approach from the outset would have better allayed any concerns from commissioning partners. The report does not conclude that any direct harm flowed from any suggested deficiency in full implementation of the CRG recommendations. The Trust would like to emphasise its regret and sincere apologies to those patients and families whose serious incidents prompted the suspension of the service. It also extends its apologies to the many patients who have been inconvenienced as a result of the ongoing suspension and the need for them to be transferred to alternative providers. The Trust has made significant progress since the suspension of its spinal service in improving its processes, learning from investigations, investing in training and development and standardising the processes for Multi-Disciplinary Team meetings. It has further worked to improve its complaints and serious incident management including a significant reduction in the complaints backlog and invested in a dedicated, specialised investigation team, with two medical leads and expertise in human factors. The RCS report commended the Trust on its new *Learning from Deaths* Policy and new governance structure

	surrounding mortality and morbidity meetings and the enhanced 72 Hour Review investigation process. The Trust is appreciative of the guidance provided by the RCS in suggesting a future 'road map' for the recommencement of services should the Trust and its commissioners wish to do so. However it has become clear that the future of spinal surgery at the Trust is only viable through operating as part of a revised specialist 'hub and spoke' model, similar to that operated for vascular and cancer services; a stand-alone WHH service is not a recommended option. As a healthcare system, commissioners and the Trust are working together to ensure that the report's recommendations are fully considered and incorporated as part of this wider context of spinal surgery services for Cheshire & Merseyside. The joint intention is to maintain access for patients to spinal surgery services as close to home as possible.	
RECOMMENDATION:	Spinal surgery services at the Trust will remain suspended pending the outcome of ongoing work being led by NHS Improvement's 'GIRFT' team. Alternative providers remain in place to take WHH patient referrals for the immediate future. The recommendations of the report will need to be shared with the C&M Spinal Surgery Network such that the learning can be taken forward and the future governance arrangements can meet or exceed those specified by the RCS.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

TRUST BOARD

SUBJECT	RCS Invited Review of Spinal Services	AGENDA REF:	BM/18/06/55

BACKGROUND/CONTEXT

1.1 Complex spinal surgery was first commissioned at Warrington & Halton Hospitals NHS Foundation Trust (WHH) by NHS England in 2014. Subsequent concerns emerged with regards to the waiting time for those patients undergoing complex/specialised spinal procedures. In response to this, an external review was undertaken by Mr Ashley Cole (Chair of NHS England's National Clinical Reference Group) who put forward various recommendations in May 2015 to assist with the integration of a 'hub and spoke' partnership arrangement between the Trust and The Walton Centre NHS Foundation Trust (TWC). The aim of this partnership was to ease the waiting time burden of those patients awaiting complex surgery and to better develop the means and processes necessary to be able to safely perform complex procedures at Warrington. In essence, Mr Cole's recommendations were for the:

- Development of a regional MDT where complex cases could be discussed with TWC
- Development of a pro-forma, with patient selection criteria, for cervical and lumbar disc replacement procedures
- Warrington management team to support the service long term
- Establishment of a network on-call arrangement for spinal emergencies
- Orthopaedic trainees to gain emergency spinal experience at TWC
- Information leaflets to be produced to give patients realistic expectations for outcomes and potential complications
- Arrangements to ensure that patient waiting times remain below 18 weeks
- Patient Reported Outcome Measures to be shared with the British Spine Registry
- Patients to be able to access TWC pain management programme.

1.2 On 22nd September 2017, following an executive safety review panel, the Trust took the decision to voluntarily suspend spinal surgery at WHH pending completion of a comprehensive internal investigation (including Root Cause Analysis methodology – RCA). The decision was taken following four serious unrelated incidents. The incidents involved different pathologies, different indications for surgery, different operations and subsequently different post-operative complications. The index cases involved three lead consultant surgeons. All index cases had been subject to an MDT process.

1.3 On 27th September 2017 NHS Warrington CCG issued a formal suspension notice to include all outpatient activity, with a short term exemption to allow patients requiring follow up appointments to be seen by their surgeons, pending a safe transfer to alternative providers. Alternative providers were sought and their care safely transferred.

1.4 The Trust, NHS Warrington CCG and NHS England Specialist Commissioning jointly commissioned an independent expert review from the Royal College of Surgeons through the *RCS Invited Review Mechanism*. A desktop review of documents and interviews were

undertaken over two days by the RCS team on 2nd and 3rd November 2017, followed by subsequent further document reviews. The report arrived in February 2018.

1.5 The three commissioning parties undertook a joint factual accuracy check and corrections (some of which were factually incorrect or needed clarification) and this was returned to the RCS. The RCS subsequently responded thus: *Whilst the review team sought to reflect all available information accurately, it is appreciated that further information may be held by the parties who commissioned the review and it is, therefore, for you to consider the report in the context of any additional information held.*

KEY ELEMENTS

RCS Invited Review Findings

In summary, the RCS Invited Service Review findings were that:

2.1 The Trust had not demonstrated clear, documented evidence of implementation of Mr Cole's recommendations from 2015;

2.2 The spinal clinicians should have led on the implementation of the report's recommendations, there had not been a coordinated response from them to the report's recommendations;

2.3 There had been unsatisfactory outcomes for data collection for patient outcomes from 2015 and the completion of service pro-formas;

2.4 The 'hub and spoke' relationship with TWC had not been sufficiently embedded to ensure the development of a satisfactory network arrangement, capable of providing the necessary reassurance in relation to clinical decision-making and the safety of the service;

2.5 There was a lack of senior direction in implementing the Cole recommendations which indicated weaknesses in the leadership of the service, stemming from a lack of clarification in the expectations of individual roles;

2.6 There were deficiencies in the governance processes which had meant that serious incidents had come to light via third parties, rather than Trust systems, and fundamental shortcomings in patient care had been overlooked;

2.7 Records of discussion at the Trust's local MDT were inadequate. The review team heard that the meetings had not been long enough and that discussions had been too brief;

2.8 The clinical decision making at the local MDT meetings were a concern, as by using disc replacement as the primary solution, more patient-focused alternatives had not been considered. The surgeons were too keen to offer surgery in lieu of more conservative measures;

2.9 This approach to surgery represented a marked difference between the Warrington surgeons and TWC, which had inhibited the development of an effective partnership;

2.10 Greater efforts to overcome differences in mind-set between the Trust and TWC should have been made. Warrington surgeons' attendance at the regional MDT meeting had been pointless without meaningful discussion of their referred cases;

2.11 There was concern about the lack of discussion for disc replacement patients as the team uncovered a failure at a senior level to have learnt from particular clinical incidents, which could have perpetuated similar errors in clinical judgement and adverse patient outcomes;

2.12 There was a disconnect between the Warrington surgeons and Trust management which had contributed to their independent management of certain patients, which had compromised patient safety;

2.13 The unusual formation of the team had hampered its cohesiveness;
2.14 The need for further investment in the service.

ACTIONS REQUIRED

The Trust's Response

3.1 Foremost are the patients and their families whose serious incidents prompted the suspension of the spinal service and the commissioning of the RCS Invited Review. The Trust acknowledges that while nothing can change the outcome, it would like to unreservedly apologise for failing these patients.

3.2 The Trust further apologises to the many patients who have been inconvenienced as a result of the continued suspension and their transfer to alternative providers, the frustration that this must have caused has not been underestimated.

3.3 As a healthcare system we fully acknowledge the findings of the RCS Invited Review and are working together to ensure that the findings are addressed, lessons are learned and shared, practice and procedures changed and that the governance of the service achieves the highest possible levels.

3.4 The Trust did make efforts to implement Mr Cole's recommendations and all action points pertaining solely to the Trust were introduced. However, it is accepted that a more structured approach from the outset would have better allayed any concerns from commissioning partners and would also have allowed the Trust to clearly evidence what steps had been taken to the RCS Review Team.

3.5 The report does not conclude that any direct harm flowed from any suggested deficiency in full implementation of the Cole recommendations.

3.6 The Trust is appreciative of the 'road map' set out by the report's authors and recommended actions to support the recommencement of the service, if the Trust and Commissioners wish to do:

- *The RCS report recommends that the Trust first address the patient-safety issues highlighted prior to considering the resumption of non-complex spinal surgery. It is advised that this will require a redefined hub and partner arrangement, better investment with improved governance processes and consideration be given to making all locum appointments substantive ones.*
- *Once non-complex surgery is safely resumed satisfactorily for a period of one year, further thought can then be given to how to safely re-commission complex spinal surgery*.

3.7 Both the Trust and commissioners consider that the future of the Trust's spinal service is within a renewed 'hub and spoke' arrangement with a senior partner organisation able to provide the support and clinical governance oversight commensurate with a specialised surgical service. TWC has subsequently not been designated as an orthopaedic spinal hub site by the North West Regional Spinal Network; the Trust does not consider a stand-alone WHH service as a feasible option.

3.8 The Trust has been working with local commissioners, specialised commissioners and other spinal service providers in the development of a single spinal service for Cheshire and Merseyside, overseen by NHS Improvement's Getting It Right First Time (GIRFT) team. The aim is the development of a specialised hub (or hubs) in Liverpool with local access preserved for the people of Cheshire through spoke sites for non-complex activity - which could include WHH. An executive-led steering group has been established and there are two major work streams examining patient pathways for spinal trauma as well as cancer and deformity work.

3.9 Spinal surgery services at the Trust will remain suspended pending the outcome of these discussions on the future delivery of specialist spinal services across Cheshire and Merseyside and alternative providers remain in place to take WHH patient referrals for the foreseeable future.

3.10 The Trust intends at all times to be as open and transparent as possible about the findings of the RCS invited review report; acknowledging that it is bound, in law, by the Data Protection Act relating to the privacy and rights of individuals.

4 Subsequent actions

4.1 Cognisant of its legal responsibilities under the Data Protection Act to protect the information relating to individuals, the Trust requested an independent review by solicitors. This was subsequently undertaken by NHS England's solicitors.

4.2 The independently redacted report has now been received in a number of versions as follows:

I. Redacted document obscuring all patient and staff identifiable data – this is for use by all three commissioning parties for reporting to their Boards/Governing bodies.
II. Four Patient-Unique documents obscuring all patient and staff identifiable data except for data relating to that patient's case review (index case).
III. Original report – to be held by the Trust alone and to be provided to CQC/HM Coroner if/as required.

4.3 The process of providing these reports to those affected patients/families is a priority and commenced 19th June 2018 in writing followed by appointments.

4.4 External expert opinion has been obtained in relation to the four serious incidents. Communication with the families and, in some instances, their legal representatives is ongoing.

4.5 A selection of further complaints received concerning the Trust's spinal services has also been subject to independent review. We have selected nine complaints to be reviewed from the past three years, to ensure that we have appropriate external scrutiny. Of these nine cases, at the time of writing this document, seven investigations have been concluded, with one case being escalated to a Serious Incident and six of the cases concluding that there were no failings. The Trust is working with its legal team and NHS Resolution to expeditiously resolve those complaints, where issues have been identified, for the benefit of the affected families. In addition to these complaints, a further 42 informal concerns via the Trust's Patient Advice and Liaison Service and nine formal complaints have been received from patients in relation to issues surrounding the suspension of the service and the transfer to other providers.

4.6 Since the suspension of the service, the Trust has reported a further two Serious Incidents relating to historic spinal surgery at WHH; therefore there are six Serious Incidents that have

now been reported in total; these two historic cases had already been flagged by the Trust at the time of the RCS review. Families of the two additional cases have been contacted and are being supported by the Trust through the investigation process.

4.7 The Trust has also met with HM Senior Coroner for Cheshire to advise him of the two closed inquests in which clinical failings have since been identified.

4.8 The following actions have been undertaken to date within the Trust as learning from the investigations undertaken into the care of the patients:

- The Trust has undertaken a review of its pre-operative policy and processes and further strengthened these, and the Trust has also trained and re-trained staff via a specialist clinical skills provider in pre-operative clinics.
- The Trust is adopting the national NEWS 2 policy, and the policy has been developed and training is currently being cascaded across the Trust to support implementation.
- Work is being undertaken within the Trust to review and standardise the processes for Multi-Disciplinary Team meetings and learning from the spinal serious incident investigations have supported this; a Trust-wide Patient Safety Summit is planned for autumn 2018 in order to share the wider learning for issues identified across all surgical specialities.
- There has been significant work undertaken with regards to complaints management and serious incident management within the organisation including: significant reduction in the complaints backlog; training provided to staff on conducting investigations; a review of the 72 hr review processes and the implementation of the Trust's *Learning From Deaths* Policy. A dedicated specialised investigation team, with two medical leads and expertise in human factors, has been established.
- The RCS report commended the Trust on its new *Learning from Deaths* Policy and new governance structure surrounding mortality and morbidity meetings and the enhanced 72 Hour Review investigation process. The Trust was already implementing improved governance policies, systems and procedures and these are now working to good effect. All unexpected deaths are now reported as serious incidents, as per national serious incident framework, and are subject to an RCA investigation.
- Spinal outcome data is being uploaded into the British Spine Registry.
- All clinical staff involved in all of the serious incident cases have reflected on their practice and subsequent HR and support processes have been put in place as appropriate.

5. Supporting staff and patients / families

5.1 Those families affected have had a copy of their patient-unique RCS report shared with them in accordance with the Trust's commitment to openness and candour. Family Liaison Officers have been appointed in each case.

5.2 It is acknowledged that this is likely to be a very difficult report for those families to read and therefore the Trust has invited each family to a meeting to discuss the report and its findings and to offer any additional support where possible.

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CONCLUSION/RECOMMENDATIONS

6.1 The Trust would like to emphasise its regret and sincere apologies to those patients and families whose serious incidents prompted the suspension of the service. It also extends its apologies to the many patients who have been inconvenienced as a result of the ongoing suspension and the need for them to be transferred to alternative providers.

6.2 The Trust is appreciative of the guidance provided by the RCS in suggesting a future 'road map' for the recommencement of services should the Trust and its commissioners wish to do so. However it has become clear that the future of spinal surgery at the Trust is only viable through operating as part of a revised specialist 'hub and spoke' model, similar to that operated for vascular and cancer services; a stand-alone WHH service is not a recommended option.

6.4 As a healthcare system, commissioners and the Trust are working together to ensure that the report's recommendations are fully considered and incorporated as part of this wider context of spinal surgery services for Cheshire & Merseyside. Our joint intention is to maintain access for patients to spinal surgery services as close to home as possible.

6.5 Spinal surgery services at the Trust will remain suspended pending the outcome of ongoing work being led by NHS Improvement's 'GIRFT' team. Alternative providers remain in place to take WHH patient referrals for the immediate future.

SAC

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/06/56**	
SUBJECT:	**Operational Plan Resubmission**	
DATE OF MEETING:	27 June 2018	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Jane Hurst Deputy Director of Finance (Strategy)	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	SO4: To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust submitted the 2018/19 Operational Plan to NHSI on 30 April 2018. NHSI has now provided feedback on the plan and given the Trust the opportunity to resubmit the plan on 20 June 2018. The feedback requires the Trust to consider all points raised with the Trust Board. This paper sets out the changes made to the Operational Plan 2018/19.	
RECOMMENDATION:	The Trust Board is asked to discuss and note the changes made to the operational plan.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/18/06/77
	Date of meeting	20 June 2018
	Summary of Outcome	Noted and supported for discussion at Trust Board on 27 June 2017
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Section 41 – confidentiality	

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Warrington and Halton Hospitals NHS Foundation Trust

Trust Board

SUBJECT	Operational Plan Resubmission	AGENDA REF:	BM/18/06/56

1. PURPOSE

The Trust submitted the 2018/19 Operational Plan to NHSI on 30 April 2018. NHSI has now provided feedback on the plan and given the Trust the opportunity to resubmit the plan on 20 June 2018. The feedback requires the Trust to consider all points raised with the Trust Board. This paper sets out the changes made to the Operational Plan 2018/19.

2. EXECUTIVE SUMMARY

NHSI feedback on the operational plan is minimal. The feedback has been reviewed and the following changes have been made. The revised plan is attached as Appendix 1. Key changes include:-

- The Trust has signed up to control total of £16.9m deficit
- Change in A&E Trajectory has been revised to show anticipated winter dip in performance as seen in 2017/18 (see page 3, Appendix 1)
- Reference to the plans in place for patients with length of stay longer than 21 days (see page 4, Appendix 1)
- An additional income table (see page 10, Appendix 1)

In addition in line with the feedback the Trust has reviewed the workforce plan to ensure it is safe, realistic and will deliver forecast activity (see page 9, Appendix 1)

NHSI required sign off of the revised plan via a finance template signed by both the Chief Executive and Director of Finance on behalf of the Board. This was submitted per deadline on 20 June 2018.

3. RECOMMENDATIONS

The Trust Board is asked to discuss and note the changes made to the operational plan.

Andrea McGee
Director of Finance and Commercial Development

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington & Halton Hospitals NHS Foundation Trust
Narrative to update 2018/19 Plan

Status: Draft
Version: 3
Date of Submission – 20 June 2018

Contents

Activity Planning

The Trust's activity and income assumptions underpinning the 2018/19 revised plan are based on the 2017/18 forecast outturn, adjusted for tariff deflation, demand changes, and service changes. The demand and capacity modelling is being undertaken and the plans have been shared to make sure that they are aligned with the Commissioners planning assumptions. This will ensure the activity plans are sufficient to deliver key operational standards, in particular accident and emergency (A&E), referral to treatment (RTT), incomplete, cancer, and diagnostics.

The plan includes growth assumptions in line with the national assumptions with exception of outpatients as highlighted in the following table.

POD	Activity				£				
	17/18	18/19 Plan	Variance	Variance %	17/18	18/19 Plan	Variance	Variance £	National %
A & E	112,929	114,866	1,937	**1.72%**	13,370,518	13,450,720	80,202	**0.60%**	**1.10%**
Elective	35,747	36,135	388	**1.09%**	33,476,563	33,994,456	517,893	**1.55%**	**3.60%**
Non Elective	35,393	37,091	1,698	**4.80%**	62,154,357	61,042,980	-1,111,377	**-1.79%**	**2.30%**
OP	315,985	312,490	-3,495	**-1.11%**	33,082,229	33,522,239	440,010	**1.33%**	**4.90%**

2017/18 A&E trajectory was as follows:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	91%	92%	92%	92%	92%	92%	91%	91%	91%	91%	91%	91%
Actual	91.4%	92.8%	90.4%	92.8%	94.4%	90.9%	89.5%	87.8%	83.8%	85.6%	83.8%	82.0%

Current plans set a proposed A&E trajectory for 2018/19 as follows:

Performance	**Y1 M01**	**Y1 M02**	**Y1 M03**	**Y1 M04**	**Y1 M05**	**Y1 M06**	**Y1 M07**	**Y1 M08**	**Y1 M09**	**Y1 M10**	**Y1 M11**	**Y1 M12**
	Plan	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
*Revised A&E %**	**85.0%**	**85.9%**	**86.9%**	**87.8%**	**88.8%**	**89.7%**	**90.0%**	**85%**	**85%**	**85%**	**83%**	**83%**

*The above plan assumes inclusion of walk in centre data in line with previous years. Month 8 to month 12 has been revised in line with the feedback from NHSI.

The contract discussions with the Lead Commissioners have led to agreeing a block contract for 2018/19. The revised financial control total and PSF allocation has led to a review of the operational plan and acceptance of the new control total of £16.881m deficit. The Trust is working with local Commissioners to produce a three year plan to improve the financial position of the local health economy.

In the spirit of working together the Lead Commissioners have not included QIPP and the Trust has not included any income CIP in the 2018/19 plan. The Trust and Commissioners have agreed to progress working within the Capped Expenditure Process (CEP) and are investigating how a block contract might work for the health economy.

The Trusts CIP will continue to focus on productivity in theatres and outpatient clinics; this will be linked to demand and capacity modelling and shared with the Commissioners. The Trust and CCG's continue to work together along with other partners across the Accountable Care Partnership (ACP) to provide quality sustainable care.

Capacity planning includes focus on length of stay this includes weekly focus and escalation through Length of Stay Meeting and all wards maintain a delays action plan for patients over 21 days LOS. The Trust is working to reduce over 21 days LOS in line with recent guidance.

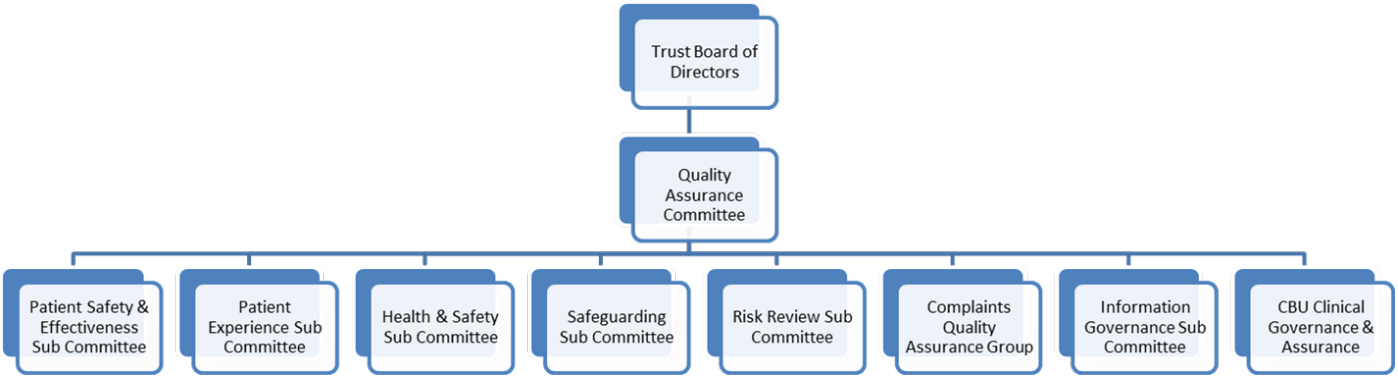
Quality Planning

Section 1: Approach to Quality Governance

Kimberley Salmon-Jamieson (Chief Nurse) -named executive lead for quality improvement

The Trust reviewed its Quality Strategy in 17/18, focusing on key improvements against Lord Darzi's domains of quality; patient safety, clinical effectiveness and patient experience. The strategy was developed in partnership with staff, and partner organisations, and takes into account feedback from the Trust's regulators. The quality priorities defined for the Trust include reduction in avoidable harm, commitment to learning, commitment to ensuring positive outcomes for patients by delivering evidence based practice and ensuring that the patient's voice is heard in everything we do. The Quality Account describes the programme of quality and safety improvement for 2017/2018 and sets out the quality indicators and priorities for 2018/19.

The Trust has reviewed and strengthened its quality governance structure and reporting lines. Each speciality has a clinical governance and quality assurance meeting, reporting through to the Clinical Business Unit (CBU) Clinical Governance Quality Assurance meeting. Each CBU reports its governance updates to the Trust Quality Assurance Committee. The Trust Quality Assurance Committee reports to the Board of Directors and is responsible for overseeing quality governance processes in the Trust, and is also the designated Committee responsible for risk. The reporting Sub Committee of the Trust Quality Assurance Committee are outlined below.



The Trust's processes relating to Quality Governance is aligned to the CQC Fundamental Standards, which is integral to the development of a Quality Performance Assessment Framework. The revised governance arrangements described above have further strengthened ward to Board reporting. In order to discharge its responsibilities, the Quality Assurance Committee has the following Sub Committees reporting to it

- Patient Safety & Clinical Effectiveness Sub Committee
- Patient Experience Sub Committee
- Health & safety Sub Committee
- Safeguarding Sub Committee
- Risk Review Sub Committee
- Complaints Quality Assurance Group
- Information Governance Sub Committee
- CBU Governance & Assurance meetings

The Trust appointed a Director of Governance and Quality, reporting to the Chief Nurse and matrix working across the Medical Director/Deputy Chief Executive to drive strategic quality governance issues and lead the development of a new Quality Academy to align quality with organisational development and transformation.

Below is the model which is being adopted to promote continuous improvement within the Trust.

This model is one which there is more effective use of shared resources, matrix working across portfolios, to ensure continuous improvement this needed to be articulated, in order to move forward.
The Quality Academy has been approved and will launch in April 2018, the priorities being:

- Key enabling arm to deliver support the delivery of the Trust Clinical and Quality Strategies.
- Training people in QI methodology to give staff the empowerment, tools and training to improve the care they give to patients.
- Encouraging innovation and increasing R&D profile within and outside the Trust.
- Supporting WHH to move toward best practice- benchmarking ourselves against best in class – therefore using effective knowledge management.

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

The Trust continues to be involved in a collaborative patient safety project with Stanford University (US). This is using design theory as a vehicle for quality improvement in medicines management. The Trust continues to work to ensure evidence based practice and benchmarking itself against best practice. A learning framework was developed in 2017/28 and this has been implemented throughout the year and will be further developed in 2018/19. This has involved delivery of training, development of lessons learned forums, learning debriefs and conducting learning audits.

The current 'Ward to Board' quality reporting occurs via the Quality Dashboard, Divisional Dashboard (COB) and the Trust Board Integrated Dashboard. Further work is being progressed on ward based quality metrics, ward accreditation and rolling out revised risk management processes.

Section 2: Summary of the quality improvement plan

Over the next two years the Trust will further strengthen quality improvement in line with the Trust's Quality Strategy, supporting an effective sustainable transformation plan.

National clinical audits - The Trust has robust processes in place for managing National Audits and Confidential Enquiries, which are included in the work plan for the Patient Safety and Clinical Effectiveness Sub Committees. A monthly update on clinical audit is given to Patient Safety & Effectiveness Sub Committee, reporting performance against national audits, tracking progress with internal clinical audit plans and monitoring improvements required. The Trust also complies with the mandatory reporting of this within the Quality Account.

The four priority standards for seven-day services - The Trust actively participate in the national audit of 7 day services and compliance with the standards. The Medical Director is the executive lead. The Trust takes a continuous improvement approach to the four main priorities identified as having the most impact on reducing weekend mortality – time to consultant review, on-going review, access to diagnostics and access to consultant-delivered interventions. All WHH clinical teams are asked to define their internal professional standards with reference to these priorities. It is recognised there is a need to consolidate existing improvements in provision through projects including rota redesign, the expansion of consultant shift working and the appointment of more substantive consultant physicians.

Working within the Cheshire and Merseyside STP, the three acute providers within the Alliance LDS are developing the vehicle for further improvements in quality and reducing variation through service redesign which includes further increase to the provision of seven day acute services. This is being led by the three Medical Directors.

Safe staffing - The Trust has developed a Recruitment and Retention Strategy. Patient safety is maintained at all times by senior nursing teams monitoring staffing levels daily. The staffing reports are shared with NHS Improvement (NHSI) and published online. There is an active "Freedom to Speak Up" Campaign within the Trust which offers further reassurance around staffing. Following a recent ward establishment review, the Board of Directors have recently approved a substantial business case to improve staffing on a cohort of wards.

Care hours per patient day - In line with Lord Carter's recommendations the Trust has, since April 2016, collected Care Hours per Patient Day (CHPPD). The Trust uses an electronic rostering system for effective staff utilisation, which includes a systematic evidence based acuity tool, Safe Care, to determine the number and skill mix of staff required. A 6 monthly strategic staffing review is undertaken by the Chief Nurse to monitor staffing levels in the Trust.

Better Births Review - The Trust has reviewed the report and undertaken a gap analysis to identify priorities and benchmark current performance against the recommendations. This response which identified continuity of care in the community as a key action was submitted to the Clinical Commissioning Group (CCG) in June 2016.

Improving the quality of mortality review and Serious Incident investigation and subsequent learning and action - The Trust has appointed a lead consultant with PA allocation for mortality review. The Mortality Review Group (MRG) which includes multidisciplinary representation from across the Trust and the CCG, ensure all deaths are reviewed as per the Trust's new Learning from Deaths Policy, and lessons learned are disseminated and lead to change/quality improvement in patient care. Appropriate action plans are developed identifying areas for improvement which are reviewed by the MRG and reported to the Patient Safety and Clinical Effectiveness Sub-Committee. This learning is communicated to pertinent staff to ensure the appropriate level of care is provided in

the future. Consultants involved in the peer-review process will provide feedback to the quality of their reviews ensuring the learning loop is closed.

The Trust uses the Healthcare Evaluation Data (HED) System to assess mortality data. We then compare our position nationally with regards to SHMI (Summary Hospital Mortality Indicator) and HMSR (Hospital Standardised Mortality Ratio). We evaluate areas for concern or trends which point us towards focused reviews in these particular areas.

Antimicrobial resistance - The Trust is committed to supporting this programme of work by increasing funding to provide additional hours to the role of Antibiotics Pharmacist. Work is progressing to meet the national CQUIN in terms of timely empirical treatment reviews and overall consumption reduction. The Trust has a proactive Antimicrobial Stewardship Group, undertakes quarterly point prevalence audits and conducts eight Antimicrobial Ward Rounds each week. The Trust participates in national awareness raising events e.g. Antibiotic Awareness Week. Changes to the Antibiotic Formulary will be made according to local microorganism resistance patterns.

Infection prevention and control - An overarching strategy has been developed which brings together assessment of compliance with the Code of Practice on prevention of HCAIs and more recently antimicrobial resistance. The strategy includes driving further quality improvements by implementing surgical site infection surveillance and compliance with NICE quality standards. Our robust system ensures compliance with mandatory surveillance. Infection Control is embedded across the organisation and the Trust participates in national/global awareness raising events to keep this on the agenda.

Falls- The prevention of inpatient falls is a quality improvement priority for the Trust. A trajectory of a 10% reduction is in place for 17/18 using 16/17 data as a baseline. A Trust wide falls action plan has been developed with progress monitored through the Patient Safety and Clinical Effectiveness sub-committee. A number of initiatives have commenced including weekly Harm Free Care meetings to review low and no harm falls and falls walks within clinical areas. To support the educational needs of the clinical staff, Trust wide training is available and when required focussed local training is also delivered. Any falls resulting in moderate harm or above are investigated through the Trust wide RCA process with actions plans for improvement developed.

Pressure Ulcers- The Trust is represented on the Pressure Ulcer Steering Group which assist the Cheshire and Merseyside Quality and Safety Forum in developing a consistent approach to pressure ulcer reduction across the region. The aim is to align practice across Cheshire and Merseyside, share best practice and reduce the number of grade 3 and 4 pressure ulcers by 2017. A reduction in incidence of grade 3 and 4 pressure ulcers was achieved across the region and mirrored within the Trust. Other aims of the group are to standardise practice and treatment of suspected Deep Tissue injuries (DTI). The Trust continues to be part of the regional pilot for standardised RCA documentation and collaborates actively with Edge Hill University and other Trusts in relation to this. Local initiatives for the Trust include trialling new pressure reliving mattresses, reviewing and updating documentation and improving access to pressure relieving equipment for ward and departmental staff. To support the educational needs of the staff an e-learning package for the prevention of pressure ulcers is now in place.

End of life care - The Palliative Care Team participates in national audits e.g. The Royal College of Physicians End of Life Care Audit – Dying in Hospital and will be participating in the 2017 audit. National Audit results evidenced WHH are not an outlier within our region and that we performed within the expected range.

The team is involved in regional audits within the Cheshire and Mersey Strategic Clinical Network which are presented to audit meetings and Grand Rounds. The Trust participates in a Warrington-wide Integrated Multidisciplinary Team Meeting where patients with complex palliative care needs across the hospital, hospice and community are discussed. A local Advance Care Planning Document is in development to further support patient care in their location of choice. The use of the Individual Plan of Care continues and the Trust provides training including an Intermediate Skills Course for staff to support the needs of individuals and those close to them who are dying within the hospital. Palliative Care now features on induction training for new nursing staff and it is likely that the mandatory annual updates for senior medical personnel will reflect this. The End of Life Steering Group continues to meet bimonthly and the team continues to provide a 7 day face to face service.

Patient Experience - Patient experience is an improvement priority for the Trust. An Experience of Care Strategy has been developed through involvement with patients, relatives, carers and the public to ensure high quality services are delivered to our patients. This Strategy is structured into work streams with the Patient Experience Sub Committee monitoring progress. Identified work streams include effective management of high risk complaints by introducing 72 hour review and production of a Friends and Family scorecard which indicates a positive performance by the Trust against the national average.

National CQUINs - The Trust is required to respond to a range of national and local CQUINs. For 2017/18, the CQUINS are all nationally agreed, and are two year programmes working in partnership across systems. The Trust is committed to ensuring delivery of these CQUINs to improve care across systems for patients.

Section 3: Summary of quality impact assessment (QIA) process

The Trust has an effective QIA process for service developments and efficiency plans and the governance structure surrounding scheme creation, acceptance and monitoring of implementation. The Transformation team works with staff to support the generation of new savings and improvement.

Risks are captured via the Project Initiation Document process, and sign off is required by 2 of the 3 Clinical Business Unit Triumvirate (CBU manager, Clinical Director and Lead Nurse) or the Corporate Lead for the corporate directorates. Any schemes over £100k in financial value or which have any potential impact on patients or nurse staffing are also reviewed and signed off by the Chief Nurse and the Medical Director. Schemes are assessed against their qualitative impact on patients and staff and the impact on local and national targets.

All Senior Responsible Officers (SRO) are required to identify measurable key performance indicators (KPIs) to ensure delivery of the scheme without a detrimental impact on safety or quality. Performance against KPIs is managed through a fortnightly Grip and Control meeting. Risks are identified and high risk schemes are reported to the Quality Committee. A monthly overview of all schemes is provided to the Finance and Sustainability Committee (F&SC). Schemes that impact outside of CBUs or corporate areas are reviewed at Innovation and Cost Improvement Committee (ICIC), which reports to the F&SC.

Section 4: Summary of triangulation of quality with workforce and finance

Three dashboards relating to quality, finance and workforce have been integrated into a key metrics high level Integrated Dashboard. This dashboard includes metrics for quality, access and performance, workforce and finance and is reviewed by the Trust Board. The quality metrics focus on high risk issues including HCAI; fall and pressure ulcers; CQUINs including SEPSIS and Antimicrobial Resistance in addition to key patient experience metrics namely complaints and friends and family.

Integrated monitoring of performance is undertaken at CBU and divisional level via monthly review meetings, and with the Executive Team and Division at a monthly Clinical Operational Board. The performance dashboards in the Trust have been reviewed to ensure compliance and alignment with the standards expected within the Single Oversight Framework which went live in October 2016.

Workforce Planning

The Trust continues to work towards all elements of the Workforce Plan included in the Operational Plan. With regards to the People Strategy, the key elements have been updated to include attraction, retention, engagement, development and performance. The People Strategy will be refreshed in 2018/2019 in line with the internal and external context, and in consultation with the organisation. Performance against the Strategy will continue to be monitored at the Trust Workforce Committee.

The Trust remains committed to Workforce Transformation and has adopted a Population Centric Workforce Planning Model, as opposed to utilising the Calderdale Framework. Exciting and innovative work is on-going through the vanguard approach.

In relation to Safer Staffing, the Trust has adopted the approach taken with Nursing Staff for both Medical and Therapies staff and is now working to share that learning across the workforce and produce a Trust wide approach to attraction and retention.

The plan to reduce agency spend relates to the Trust plans to increase our nursing workforce by 93 wte in line with a recent business case to invest £3m in nursing following a review. The HR and OD Directorate are working closely with the Nursing Leadership Team to recruit into these posts and to develop plans to retain staff.

The Trust is introducing a number of new roles across the organisation as part of a programme of workforce redesign. The HR Business Partnering Team support Clinical Business Units with the workforce element of budget setting and are integrated into the development of business cases and service developments ensuring the workforce provision is adequate for quality and performance. The reduction in agency and increase in bank reflects the continuation from 2017/18 where we saw the schemes in place to reduce agency start to have an impact.

Financial Planning

Section 1: Financial Forecasts and Modelling

The Trust has had a challenging financial year in 2017/18 which has led to significant changes in year 2 of the two year plan. The original plan signed up to the control total for 2017/18 (£3.7m deficit) and 2018/19 (£3.6m deficit). The Trust has not been able to achieve this target in 2017/18 and this will impact on the 2018/19 plan. The main reasons have been loss of spinal work, loss of Provider Sustainability Fund (PSF) and shortfall in achieving recurrent CIP. The continued need for premium rate staff, the number of escalation beds, increased non elective activity and elective reduction for winter have also impacted on the financial performance.

The financial forecast for 2018/19 has been developed across the organisation with input from Executive Directors, CBU Managers, the Contract and Commissioning Team and Commissioners. The budget setting process has identified anticipated cost pressures and the Trust has been working with the Commissioners to finalise contract income. The draft financial plan reflects changes in national pay and non-pay inflationary pressures, operational pressures and investments necessary to ensure compliance with quality standards and performance targets.

The original control total has been revised to £16.9m deficit. The revised control total reflects CNST reduction and tariff inflation, the Trust has accepted this control total.

This plan represents a realistic assessment of anticipated performance whilst accepting the need to meet patient demand and expectation, commissioner changes, efficiency requirements and maintain and enhance patient quality and safety.

The plan sets a significant financial challenge for the Trust and local health economy. The Trust's main commissioners, Warrington CCG and Halton CCG along with the Trust have formally committed to the CEP lite process, with papers setting out the commitment agreed at the respective finance committees. The process has included a review of the current contracting methodology and block contract have been agreed. A three year plan is being developed to improve the overall financial performance of the local health economy.

This plan includes cost pressures of £21.9m which have been reviewed with the Executive team and reflects investment in nursing, medical and quality issues. The plan reflects the sustainability contract agreed with the main Commissioners but doesn't assume any activity or costs above plan. Other areas of income are based on known contracts. The Trust will continue to bid for additional income which has been achieved in previous years but not assumed. The following table shows the movement in income.

	2017/18 Plan £000's	2017/18 Actual £000's	2018/19 Plan £000's
Overseas Visitors	0	58	44
Local Authorities	1,843	2,451	1,933
Education & Training	7,693	9,511	7,693
Research & Development	0	0	0
Private Patients	106	50	152
ICR	1,287	1,074	1,135
NHS Income	206,002	205,157	207,805
Other Non NHS Income	24	445	592

The plan does not budget for fines and penalties under the sustainability (block) contract with Lead commissioners which agrees reinvestment of any financial penalties levied. Based on 2017/18 without sign up to the control total national penalties would have been c £3m. The Trust is working with Commissioners under the CEP lite framework working together to achieve a sustainable health economy.

The original forecast position included the following key assumptions which did not materialise in 2017/18:-

- The Trust delivers the control total in 2017/18
- The Trust receives all income relating to activity forecast in 2017/18
- The 2017/18 unfunded cost pressures are managed
- The Trust can deliver £10.5m CIP schemes
- The Trust receives all PSF in 2017/18

Liquidity

In 2017/18 the Trust has an audited year end position of £15m deficit with a closing cash balance of £1.2m. On this basis the Trust will owe £41.2m in revenue loans at the end of 2017/18 (£14.2m borrowed 2015/16 and £7.9m borrowed 2016/17, £19.1m borrowed 2017/18). Current Better Payment Practice Code performance based on volume is 19% for the month and 31% for the year. NHS Debtors are £4.3m and creditors £12.8m which are similar to previous years. The Trust has therefore very restricted flexibility for the management of cash or for making any improvement to the cash position.

Based on the assumptions being delivered, the Trust will require an additional working capital loan equal to the forecast deficit in 2018/19 (£16.9m). The Trust is due to pay back the 2015/16 loan of £14.2m in 2018/19 and will need to borrow to repay this loan; this has been discussed with NHSI. The total value of loans by 31 March 2019 based on existing and forecast borrowing is £58.1m. A system solution will be required to address this level of borrowing, which places an absolute requirement to work with the local health economy as per the CEP process.

Section 2: Efficiency Savings for 2017/18 – 2018/19

Productivity and Efficiency Programme

The Trust has a reference cost of 98. The Trust has incorporated £2m income into baseline plans and the block contract which will be delivered through the financial improvement and efficiency programme, predominantly through improved utilisation of theatre and outpatient services, enabling the Trust to meet RTT targets. In addition to this the Trust has a £7m CIP target and as such is targeting delivery of a total of £9m financial improvement. The £7m CIP target for 2018/19 will be stretching and require the beginnings of true system change as part of a collaborative 3 year programme. The CIP themes are structured around tactical and transformational schemes and have been allocated across categories as follows:

Scheme	Target 2017/18	Original Target 2018/19	Revised Target 2018/19
Clinical Income	£0.5m	£0.5m	£1.4m*
Non clinical Income	£0.5m	£0.5m	£0 m
Pay	£6.5m	£6.0m	£4.6m
Non Pay	£3.0m	£2.5m	£1.0m
Total	**£10.5m**	**£9.5m**	**£7.0m**

*Note – per CEP lite the Trust and Commissioners are working as agreement that QIPP / CIP schemes that will only be pursued if they improve the performance of the Local Health Economy. The clinical income we are looking to generate will not be from Warrington CCG and Halton CCG unless it is linked to repatriation of local patients.

Tactical

The Trust is planning to continue to deliver an element of savings this financial year through tighter cost control and cost reduction measures by focusing on procurement (reduced prices, product rationalisation and standardisation, collaboration and partnership working), drugs (reduced usage and prices, increased use of bio-similars), reduction in premium rates for additional clinical sessions, reduction in agency usage (to contain the spending within the ceiling and ultimately reduce it further) and income generation opportunities. 247 schemes for 2018/19 have been identified to date and progress in validating, costing and delivery planning for these schemes is being tracked on our CIP tracker.

Transformational

The Trust has committed to putting more emphasis and resource into the delivery of larger, transformational programmes of work to deliver the majority of its financial sustainability challenge for 2018/19 and beyond. These programmes are aligned to the Sustainability and Transformation Plan (STP), to our Healthy New Town programme (supported by NHSE) and to Lord Carter's priorities. All schemes will be reviewed and prioritised jointly with Commissioners as part of the CEP lite process.

Section 3: Capital Planning

The capital programme comprises site maintenance, facilities improvement, new medical equipment and technology development. Together these enable and support the delivery of the operational services. Capital resources are constrained and require prioritisation, so schemes that are essential to the provision of safe, sustainable services that offer value for money are prioritised. The process to prioritise the schemes is led initially by the Clinical Business Units informed by assessment of risk. The case for funds is then assessed and prioritised using a framework by a multi-professional team before consideration at the Finance and Sustainability Committee and approval at the Trust Board. The capital programme is funded by internally generated depreciation (£5.5m) and an element of carry forward (£1.6m) from the 2017/18 programme. The capital programme is £7.1m for 2018/19.

Summary

Given the significant financial pressure, and in setting a stretching CIP the ability to deliver the control total set will be challenging. The Trust endeavours to balance investment in quality and in delivery of performance while at the same time supporting financial sustainability. Under current contracting arrangements with pressures funded the deficit control total is £16.9m, which moves the organisation into further debt.

The Trust will continue to work with the local commissioners on a three year plan and to move to a stronger more viable position locally.