TB (10/18) 020

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	2019/20 Investment Decisions		
Sponsoring Executive	Dinah McLannahan, Acting Director of Finance		
***Report* Author**	Dave Baker, Director of Partnerships and Innovation		
Meeting	Trust Board	**Date**	4th October 2018

1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

The Board is familiar with a strategy over two years of reducing expenditure in 2018-19 and of localising services and expanding income in 2019-20. Work continues collaboratively with partners to put the latter arrangement in place as we aim to grow our local income to £300m as part of the longstanding Midland Met strategy agreed in 2014-15.

The Board may wish to discuss the engagement of GPs in this localisation of services and the delivery risks we face in improving productivity.

The paper represents a delivery plan for approximately half of the growth anticipated.

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan		Public Health Plan	**X**	People Plan & Education Plan	**X**
Quality Plan		Research and Development		Estates Plan	
Financial Plan	**X**	Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

HLP Board / Clinical Leadership Executive

4. Recommendation(s)

The Board is asked to:

a.	NOTE the recruitment plans articulated for surgery
b.	CONSIDER in November's Board the income yield as against further cost reduction

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		Risk Number(s):					
Board Assurance Framework		Risk Number(s):					
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	Service specific in December

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 4 October 2018

2019/20 Investment Decisions – briefing paper (part one)

1.0 Executive Summary

1.1 The Trust is working closely with GP colleagues. This work has confirmed a longstanding belief that services could be provided in our organisation, locally to residents, for which presently care takes place elsewhere, outside SWB. This narrative was imagined in 2014-15 when we developed the Midland Met FBC with the local CCG. The subsequent years have not shown a transfer to our teams, as we have held but not materially waiting times, and as our administrative processes have remained not always referrer friendly. As such the time we have before 2022 gives us a second chance to deliver the agreed health economy strategy.

1.2 Surgical services are leading the way in developing more accessible services. Our very short wait knee and hip surgery models are a headline to a wider improvement, which our 23-hour units are assisting with. Despite demand rises, we would expect to enter 2019 RTT compliant in every discipline. This paper sets out the recruitment needed to grow services significantly from April 2019. This learns lessons from deferred improvements in 2019-20 when decisions to proceed were delayed.

2.0 Overall Context

2.1 The Sandwell and West Birmingham integrated care strategy is based upon the creation of integrated and optimised care chains in each of the two places that are focussed upon delivering improved outcomes whilst improving the wider determinants of health and caring for the whole person (physical and mental health);

2.2 Inherent within the success of the integrated care system and the Midland Metropolitan Hospital are:

a) The continuity of care for our population at a Sandwell and at Western Birmingham level;

b) The reduction in local "economic leakage" from the Sandwell and West Birmingham system to other systems. This has been previously been identified as being ~£50m per annum, although some of this relates to specialist work that has been, and is best left delivered at a specialist centre. Revised estimates now suggest that the opportunity is closer to £18m.

3.0 Financial Strategy

3.1 In response to a review by GE Finnamore, the Trust and CCG agreed to work more closely together to achieve the long term clinical and financial sustainability of the system.

3.2 Clinically, there is a huge recognition of the need to develop a sustainable workforce model. Financially, a two year strategy (2018/20) was developed that looked to:

a) reverse the economic leakage by £22m (margin) over 2 years,
b) deliver cost improvement plans of £37m over 2 years;
c) deliver QIPP of £16m over 2 years;
d) deliver commercialisation opportunities of £12m over 2 years;

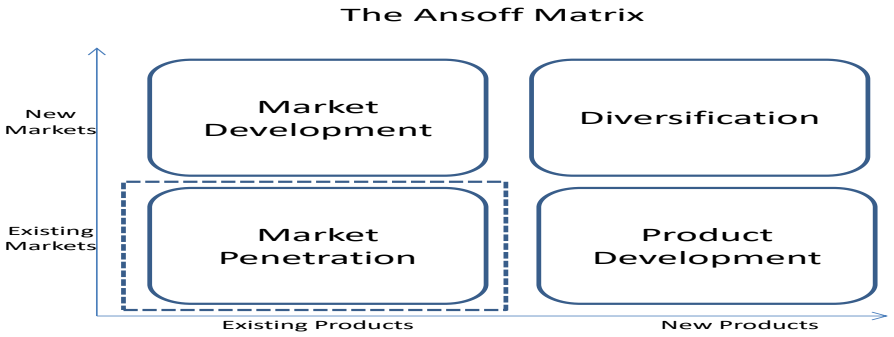
3.3 In practical terms this meant that the SWB CCG allocation of funds to the Trust would rise from £264m to £273.8m in 2017/18 and then from £273.8m to £300m in 2019/20. Midway through 2018/19 this plan is on track with the CCG seeing an increased throughput at the Trust and reduced levels at nearby organisations. This process ramps up in 2019/20.

3.4 In subsequent years it is expected that contracting will take on a different form as a CCG and Local Authority Commissioning Alliance looks to contract at a much more strategic level with Provider Alliances in each of the two places that represent all the local system providers.

4.0 Marketing Context

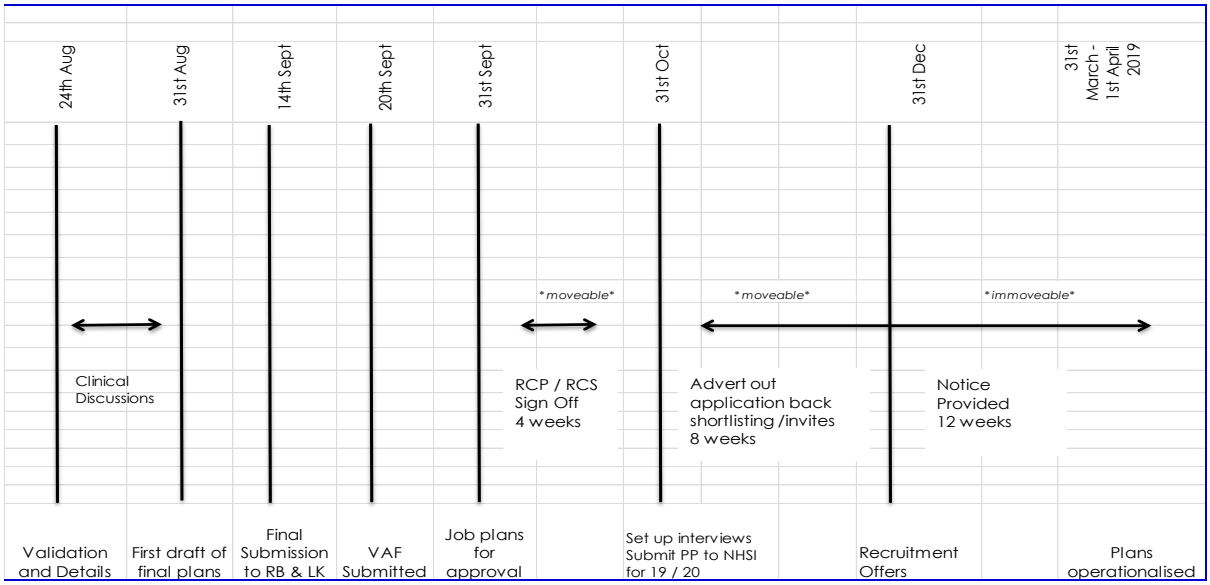
4.1 Strategically the Trust's current approach is one of market penetration of existing services based on being the most attractive provider to our population and that which our Integrated Care System is funded to provide care to. Further steps could be:

- to be more aggressive with our original plan around the scale of market penetration;
- to develop new products/services for our population where we feel that we have the skills to do so



5.0 Recruitment Plan

5.1 Our learning from the work done in advance of the 2018/19 strategy was the need to recruit early enough to drive the required levels of throughput. With this in mind a plan was agreed that allowed us sufficient time to identify and recruit the resource required.



6.0 Income, productivity and investment

6.1 The revised income opportunity now equals ~£18m. This work is grounded in detailed engagement with clinical groups. It of course represents an estimate, and is calibrated at increased but not complete referral capture.

000's	Surgery	Medicine	Imaging	PCCT	Total
Available Repatriation through PbR or Contracts	£11,500	£3,200	£1,251	£557	
Other	£1,400				Reduction in backlog in Ophthalmology
Total Income	£12,949	£3,200	£1,251	£557	£18,089

7.0 Productivity changes

7.1 Across the organisation, on the back of both shorter waiting times and greater use of patient agreed appointments, as well as better texting and email communication, teams are expecting a reduction in DNA rates. This should help us to make better use of 3.5 hour clinics. Formal reconciliation of all afternoon clinics to that expectation of a "hospital day" will take place shortly.

7.2 Our aim for theatres and other interventional facilities is to achieve 85% throughout from each list. At the same time, procedure and surgeon specific timed booking rules have been implemented to ensure that, across a 42 week year, we are optimally using our skilled teams.

8.0 As the Board might expect this gives rise to a need to expand our workforce to meet demand, having accounted for productivity changes.

8.1 We intend now to proceed recruitment at risk. We recognise that this may not succeed in time for April, but given the permissive approach nationally now to shortening elective wait times, we believe that the other risk of excess capacity is a low risk.

Group	Income 000's	Cost 000's	Overhead 000's	Notes
Surgery	£12,949	£7,434	£5,515	Excludes diagnostics at present. £171k capital required
Medicine	£3,200	£2,300	£900	High Level Costing produced requires more detailed work especially around inpatient beds impact on LOS & nursing opinion on level of resource required to deliver activity levels. Endoscopy room part of Gastro numbers requires capital investment – awaiting costings from PFI team. Average year to date diagnostic costs used to inform costing (awaiting information from Pathology/Imaging teams on exact costs and split by POD of activity). Does not include corporate, coding, overhead costs.
Imaging	£1,251	TBC	TBC	Costs to serve other Groups to be built into Group costs; £1,251m relates to Health Harmony contract for Ultra Sonography which requires more detailed assessment.

8.2 The expenditure covers an array of employees. This is important as we gear up for the future and reflects the need to make sure that we not only have a surgeon and anaesthetist available but also the wider infrastructure.

Surgical Recruitment Numbers

Roles	Full WTE	Part WTE	Total
Consultants	9	0.4	9.4
Anaesthetists	3	2.24	5.24
Fellow	1	0	1
Specialty Doctors	5	0	5
SCP Band 8A	2	0	2
CNS Band 6	0	0.2	0.2
Theatre Team Band 6	7	1.61	8.61
Theatre Team Band 5	7	1.61	8.61
Theatre Team HCA	3	1.2	4.2
Admin Band 4	5	0.5	5.5
Admin Band 3	1	0.2	1.2
Admin Band 2	0	0.2	0.2
Band 7 Nurses	0	0.14	0.14
Band 5 Nurses (Various)	3	1.14	4.14
Band 4 Nurses	0	0.18	0.18
Band 2 Nurses	1	0.6	1.6
Audiologist Band 5	1	0	1
Orthotist	0	0.2	0.2
HCA	0	0.2	0.2
Physio Band 7	0	0.66	0.66
Physio Band 6	0	0.5	0.5
Physio Band 5	1	0	1
Physio Band 3	2	0	2
OPD Pls Tech Band 4	1	0	1
Psych Band 7	0	0.37	0.37
Optometrist Band 7	1	0	1
Orthoptist Band 7	0	0.5	0.5
Orthoptist Band 4	1	0	1
Visual Functions Band 6	1	0	1
Visual Functions Band 5	1	0.5	1.5
Ward Clerk Admin – Band 2	0	0.5	0.5
8 MFFD, 6 LY2 Beds, SDU 6 Trolleys	27	0.8	27.8
Contact Centre Band 2	3	0	3
Pread Nurse	1	0	1
Booking Clerks Band 3	3	0	3
Total	**90**	**14.45**	**104.45**

9.0 Implementation

9.1 Delivery of these changes is in three parts:

- Recruitment
- Scheduling
- Execution

9.2 The project plan will be overseen corporately and led by Liam Kennedy, Deputy Chief Operating Officer. The recruitment project team will include staff from HR and finance, and will have completed all advertisements for band 5 and above roles not later than November 16th. Progress against this timeline will be reported to the Thursday's financial governance meeting chaired by the Chief Executive.

9.3 A dataset governing referrals and a waiting list pipeline sufficient to expand income by the sums listed, and also to assure the HLP Board that we are not duplicating other providers, is under development and will be ready by the same date.

9.4 The deadline to schedule April patients is mid-February, both to provide due notice, and to reflect Unity implementation dislocation.

9.5 By the time the Trust issues internal budgets for 2019-20, which will be in early January, we will have completed work on any outpatient vs. surgery phasing in Q1.

10.0 Beyond part one

10.1 We had hoped and expected to be able to present a Trustwide plan to this Board meeting. A part two plan covering PCCT, revised medicine estimates and imaging, will come to the October Finance and Investment Committee. This is consistent with work to agree 2019-20 contracting, and an aim with our principle CCG to seek to do that by the end November.

Dave Baker, Director of Partnerships and Innovation

Liam Kennedy, Deputy Chief Operating Officer

Toby Lewis, Chief Executive