SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 4th April 2019

Operating and financial planning for 2019-20

1. Overview

1.1 The finances of our future are simply a means to an end. The budgets that we discussed in January and have embedded at directorate level provide for us to:

- Invest in key staffing priorities, such as 40% more training spend, new roles in frailty and in domestic abuse, and support for our accelerator programmes
- Invest in new equipment to replace existing kit as well as to bring on line more scanners and take forward service relocations in support of Midland Met
- Support staffing establishments that have never more than a 2% vacancy rate by recruiting more and retaining better
- Expand by more than a hundred staff the scale of our planned care services, delivering the Imaging Sustainability plan the Board agreed in November
- Making £4m of non-pay cost savings through better purchasing both locally and in the national supply chain towers delivered by SCCL

1.2 The Trust continues to seek to diversify its portfolio of income. However, we will freeze prices to visitors and staff in the coming year. Our car park plans see us create new facilities in 2020. Our catering services have successfully grown business in 2018-19 and expect to continue to do in 2019-20. These change use not price. Within research and development, we are looking to continue the huge progress of recent years, but with a new focus on commercial studies, given the peaking of NIHR grants. Success in this endeavour is a six figure risk within the plan, which can be managed in year. Responsibility for delivery is with the medical director. Educational spend is increased, with the commitments made by the Board in October, and the decision by the executive to put further funds into training, even though we have distinctively delivered the levy in 2018-19. Learning generally within the Trust is a priority for us, as we get ready for the new Aston Medical School intake in 2020, and seek to deliver our **we**learn programme in 2019-20. This responds to a longstanding intention to spread knowledge more effectively across the Trust. That intention is the theme of our upcoming public annual general meeting.

1.3 Based on the work done since our 2020 vision, we continue to strive to secure our Safety Plan commitments for every single inpatient every single day, led by our Chief Nurse. Our Quality Plan focus in Q1 remains on Sepsis and amenable mortality. By the end of Q1 we will set a trajectory for every part of the Quality Plan by quarter over the coming

eighteen months. Notwithstanding that we have agreed some quality priorities for the year ahead as follows:

(a) Ensuring safe and resilient systems of care through deploying better IT infrastructure, embedding Unity, and maintaining safety plan compliance
(b) Improving quality of care for patients by tackling Sepsis more effectively and reducing amenable mortality in line with our long term Quality Plan
(c) Mobilising the opportunities of our new digital infrastructure to both tackle medication errors in our care system and to ensure that Making Every Contact Count is a mainstream part of every care experience
(d) Supporting improved acute care by implementing strong people management improvements, addressing configuration issues in advance of Midland Met, and ensuring seven day service compliance from 2020

In addition to this, we want to implement in full our CQC improvement plan, and help each service to move towards a Good rating. This will require us to deliver our own Well-Led plan as well as to address the specific raised by the 2017 and 2018 inspections. This is the only remaining quality issue within our undertakings process, with the work on incident reporting having been concluded with the successful external review reported to the Board in January.

1.4 The Board has established an 8 weekly People and OD committee with the specific intention of increasing the pace of improvement in the management of our people in the organisation. Ground-work has been laid during 2016-18 with the introduction of our Aspiring to Excellence PDR programme, improvements in mandatory training, and the delivery of several phases of our Accredited Manager work. The challenge in coming quarters is to make sure that the depth and spread of improvement reaches each directorate, with ward sickness rates reduced, roster management improved, and vacancy level cut in line with the plan agreed at the Board in February. The new People Plan PMO is a vehicle through which a drumbeat of constant improvement is to be achieved, both in terms of quantity, and quality. No more than 140 of our 7000 roles should be absent long term sick in any given month, and every employee will have access to a face to face briefing conversation with their manager every single month. Our **we**connect ambition seeks to take engagement ratings from NHS average (3.7) to upper decile (4.0). The primary accountability for success sits with every single line manager, but the director of People and OD will take responsibility for securing that success, moving the HR function from a reactive, transactional model, to one anticipating the future needs of the organisation's principal asset.

2. Demand and volume of care

2.1 As in prior years, commissioners have funded an expected level of growth in demand associated with population changes. In addition, we have agreed an interim settlement to counting and coding changes pending a full unwind of historic notified changes from

2020-21. As presently considered this would grow the Trust's income further, albeit waiting list funded volumes would reduce as presumed non-recurrent. The most likely start point for 2020-21 therefore is between £305-£310m with Sandwell and West Birmingham CCG. £75m is expected to come from Birmingham and Solihull CCG.

2.2 In addition our plan for 2019-20, as indicated in Board discussions and papers since Q3, and referenced back to the Midland Met FBC 15/16, sees a major localisation of planned care. This is based on local GPs choosing SWB based services. This has the merit of offering care continuity, and care across a range of conditions. It will require the Trust to work ever more closely with GP practices, and to offer services that meet the needs of their patients. The risk that this collaboration services unmet local need continues to sit with commissioners, until such time as the capitated budget proposed by the Trust is enacted in the HLP ICP. The Trust has proposed to the STP, and to regulators, that live referral data sharing is put in place across all systems such that any net referral growth can be managed, or at least visualised in situ.

2.3 The table below summarises the changes viewed against this year's likely outturn position. A broadly flat expectation is set, with the exception of planned care outpatients, inpatients (El) and daycases.

- Daycase increases in volume of 29%
- Elective increases of 21%
- Outpatient changes of 12% (the Trust will be reimbursed for follow up outpatients from SWB CCG in relation to its new patient volumes)

	2018-2019		2019-2020			
Point of Delivery Group	Annual Plan	Forecast Outturn	Annual Plan Base	Localisation	RTT	Annual Plan Total
A&E	218,762	219,887	221,127	0	0	221,127
DC	40,195	36,752	41,240	5,195	1,116	47,552
EL	6,804	6,309	6,533	1,074	0	7,607
Emergencies	55,187	55,810	55,239	0	0	55,239
Maternity	19,597	18,596	18,749	0	0	18,749
Outpatients	664,597	676,655	691,500	45,244	24,273	761,017
Community	690,478	693,564	666,278	0	0	666,278
Other	3,868,650	4,031,131	4,168,733	8,514	0	4,177,247
Total	5,564,270	5,738,703	5,869,399	60,028	25,389	5,954,816

2.4 The phasing of change has been modelled, as the changes reflect in part reduction in existing waiting lists, and the treatment of existing patients, in the first six months of the year. Referral changes will drive growth in the latter part of the year, with an allowance made for Unity 'downtime'.

2.5 Our November Board meeting considered the balance of productivity gains and additional staff required to deliver this localisation plan. We continue to operate to that plan, with hires made since. It is not expected that that plan will require us to bust the agency ceiling which we have undertaken to meet to NHSI.

3. Our expenditure plan

3.1 The budget setting approach that we are taking adjusts by normalisation roll-over budgets. It invests for agreed developments, recognising those on a full year basis. Quantified cost reductions are deducted from this plan. Pension changes are excluded in line with national guidance. Pay awards are not localised until we are confident of their allocation. Non-pay inflation is provided for against actual indicated increases. At present no allowance has been made for any pricing changes post EU Exit by suppliers.

3.2 We have set phased plans in our budgets, which take account of recruitment as outlined in the Board's People Plan PMO paperwork. They also take account of summer/winter ward phasing. The latter is held centrally whilst we work through the most appropriate way to manage additional winter demand. The Trust is exploring becoming the national pilot site for work to manage acute medical admissions from care homes in a different way. That has the potential to offer a better solution to acuity than simply funding additional beds. At the time of writing a number of winter beds remain open, which is a funding risk to Month 1.

3.3 The phasing of central non-pay savings and of technical matters was challenged at the Finance and Investment Committee. The intention is to phase these gains from month 7 to month 12, rather than holding them in Q4 as in prior years. This is consistent with the forecast for year-end typically used at the baseline for NHS wide planning.

3.4 The cash plan for the Trust in 2019-20 has been considered and agreed by the Finance and Investment committee. It maintains the plans first agreed in the Midland Met OBC and FBC, which invests in ensuring local care be delivered through Sheldon and BTC, and through the refurbishment of the Sandwell Treatment Centre. It includes the creation of a GP practice at Sandwell, which was committed to at the time of the public consultation on changes to acute care over a decade ago. Planning permission for that change has now been granted and it is progressing, with first building work taking place in 2019. It is possible that loan facilities will be needed in 2019-20, but only if we fall behind with our income and expenditure reduction plans.

3.5 The largest additional investment made in 2019-20, when compared to historic plans, is in growing the scale of our IT department, and expanding investment in our IT resilience. No long-term funding model for IT is agreed, and in line with prior Board papers it is possible that outsourcing will see a capital to revenue transfer in following years. Proposals on what services will be provided by a commercial partner will return for consideration during Q1.

3.6 The budgets do provide sums sufficient to continue to support the Black Country Pathology service. Currently no increased investment is considered for the infrastructure of the STP, likewise our ICP. Provision would need to be made in kind, or maintained at outturn levels, or found from reserves. The last partnership board of the STP agreed that the proposed collective budget could not yet be agreed, as many partners resiled from the proposed investment in new posts.

3.7 We have indicated to NHS Improvement that our contingencies are sufficient to carry on a non-recurrent basis a failure risk of around £6.5m in our localisation margin plan. We do not consider that the most likely figure required, and the non-recurrent nature of the reserve reflects concern about slower than expected initiation. Around £1m of other reserves are being held for investment or unplanned slippage. 2019-20 Full Business Case for the Midland Met will ensure that we can meet our recurrent new costs and commitments. As those no longer represent 35 year contracted commitments, the prior Right Care, Right Here reserve will no longer feature in our long term financial planning.

4. Constitutional standards

4.1 Our annual plan submission to NHS Improvement requires a series of declarations and assurances to be made. These commit the Trust to delivery of national targets, notwithstanding the implication that acceptance of the control total (which we have done) might absolve us of this obligation. The Board agreed at its prior meeting that we could not commit to assurance on one of the four seven day standards prior to reconfiguration later in 2019-20. Beyond that we are only indicating deviation from the four hour standard. In line with prior discussions we have set a high bar for achievement in both BMEC and paediatric ED, and an improving trajectory in both City and Sandwell. This *excludes* the unknown and un-modelled impact of the regional "intelligent conveyancing" project with WMAS, which may introduce rises in ambulance arrivals at our sites. Our stated trajectory, which the IQPR will track against at Trust level is:

- 90% each month from September
- 88.9% for 2019-20
- April-August performance as follows: 85.2%, 86.1%, 87%, 88.5%, 89.7%

The Trust would expect some levying of fines and penalties in year associated with small numbers of MSA breaches, together with some over 30 minute ambulance waits. In contrast to prior declarations we are committing to zero 52 week breaches, and the Board will wish to track any patient dated or undated over 40 weeks on our PTL. This will take place via the Quality and Safety Committee as an exception report from the Chief Operating Officer. The overall waiting list size for the Trust will fall below 30,000 by March 2020, but we have indicated only an indicative trajectory to that improvement given our referral plans in the production plan.

4.2 We have not made provision for any other changes in national standards implied but not specified in contract documents. A long stop date of April 30th has been identified with the host commissioner, Sandwell and West Birmingham CCG, for mutual identification of any issues with this. We have only to date identified Continuity of Carer within maternity services as a potential issue. In effect the SDIPs process within the standard national contract must be finance neutral to us, and that position is endorsed by the CCG.

5. Midland Met FBC and FM delivery

5.1 As outlined in other documents, we expect to reach contract signature on the new build during summer 2019. By that time we will also have secured a partner to provide our hard FM services. The latter is proceeding on a procurement journey which has the potential to include our wider estate, and the delivery of key components of our capital programme. Governance of these decisions and changes will be overseen through the Board's Estate MPA.

5.2 At the time of writing, we are confident that we will receive a bid consistent with the OBC, and that all policy stakeholders are aligned to Preferred Bidder approval before the summer recess. This is consistent with the completion of the Early Works Contract for Midland Met. No financial provision is made within our plans for a gap between the two contracts. We continue to discuss with NHSI and national bodies how PDC payments will be accounted for in the period prior to completion of the build. Of the eight financial issues in the OBC, this was the only matter carried over to FBC, and we are confident that one of eight options will be selected in the final analysis.

5.3 The quality priorities set out above indicate the need to continue to reconfigure and develop acute care services in advance of Midland Met. This should be viewed as work to ready ourselves for the transition into the new build. It is very much to be hoped that end of 2019 all of our employees are clear both where their services will be based in 2022 and the career path open to them as individuals in that journey. Our focus on retention would be undermined if it were not clear to teams how their services and skills will be deployed when we centralise acute care services. Both 2020-21 and 2021-22 will be needed to manage the skill changes and team redeployments needed to accomplish such a huge change in our care model. That is why it is so important that we secure the hires

envisaged in our plans this year and begin to build the teams ready for the facility that we are building.

6. IT resilience and Unity

6.1 The Trust has invested time and money in work to change our IT infrastructure, change our control processes and support our IT teams. This work intensifies over the first six months of 2019-20. Additional investment in IT training has been provided and a restructure of the management of the department nears completion. The DMPA has heard of good progress with key indicators but some slippage against our turnaround plans. Resolution of all 14 Unity dependencies will be needed before we can finalise our Go Live plans.

6.2 We have been preparing for Unity Go Live for over two years. Basic training is now largely complete and we are moving on to team based local training. The introduction of the refreshed play domain in April provides a basis for developing active organisational involvement with the product. The DMPA approved Go Live criteria, pending the wider Board's view, at its last meeting. During summer 2019 we will finally move to our Unity product, and move our wider system onto an HIE platform. This is the key enabler for ICP work on patient risk stratification, and a key enabler to joining up organisations across our local system. It is the heart of our annual plan for 2019-20 and needs to match a focus on the volume changes if we are to optimise the product during 2019-20.

Toby Lewis
Chief Executive

March 31st 2019