Report to West Middlesex Hospital NHS Trust Board

TURNAROUND PROGRAMME

‘Securing Our Future’

22nd March 2011

Agenda Item

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Turnaround Programme 2011-13</th>
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<tbody>
<tr>
<td>Report by:</td>
<td>Rakesh Patel</td>
</tr>
<tr>
<td>Author</td>
<td>Glenn Anley / Andrew Murphy/Rakesh Patel</td>
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PURPOSE OF THE REPORT:

To outline the Trust programme to achieve the requisite cost improvement over the two years from April 2011.

KEY POINTS:

- In line with the rest of the public sector the West Middlesex University Hospital NHS Trust (WMUH) and the local health economy face a considerable financial challenge over the next spending review period to 2014/15.
- Cost reduction measures of around £22 million will be required over the next four years. This paper outlines the savings identified for the two years from April 2011.
- Cost improvements have been identified in line with the national ‘Quality, Innovation, Productivity and Prevention’ (QIPP) agenda.
- Cost savings of £19.7m are required over the two years from April 2011, of which £12.2m must be delivered in year one.
- Advanced plans are in place to deliver a total of £15.3m, of which £11.9m will be delivered in year one.
- Further opportunities of £3m cost reduction have been identified and a further £2.7m of contribution from NHS income.
- The Board can be assured that:
  - Robust performance management and governance arrangement are in place to ensure delivery
  - The plans have been rigorously tested both in terms of deliverability and any potential adverse consequences
  - There are appropriately detailed plans in place for all initiatives
  - There is complete synchronicity with budget setting
- The Trust is on course to deliver break even in 2010/11

RECOMMENDATIONS:

Approve the Turnaround Programme plan and note the risks, particularly around income in year two.
**Implications:**

**Link to Strategic Objectives**
- Low overheads
- Efficiency and productivity
- Generating surpluses to invest in services

**Financial**
- £19.7 million over 2 years

**HR**
- Significant workforce change

**Policy**
- QIPP,
- NHS White Paper ‘Liberating Ideas’,
- NHS Operating Framework 2010/2011

**Staff Involvement**
- Matrix working across the organisation
- Staff consultation on changes
- Celebrating Success

**Risk Register**
- Corporate Risk Register
- Business Unit / Departmental Risk Registers

**Contents:**

1. Background and National Context
   1.1. Overview
   1.2. Structural Reform across the NHS
   1.3. NHS Efficiency
   1.4. NHS Funding Gap

2. NHS Operating Framework 2011-12
   2.2. Key announcements
   2.3. Long Term Financial Model

3. Developing the Turnaround Programme
   3.1. Turnaround Review Process and Risk Reduction
   3.2. Turnaround Process Matrix

4. Trust Wide Overview

5. Business Unit Highlights
   5.1. Medical Division
   5.2. Surgical Division
   5.3. Women’s and Children’s Division
   5.4. Clinical Support Services Division
   5.5. Corporate Directorates

6. Projects Overview
   6.1. Clinical Administration
   6.2. Beds
   6.3. Procurement and Materials Management
   6.4. Nurse skill mix and staff review

7. Managing the Change
   7.1. Workforce Change
   7.2. Governance
1. Background and National Context

1.1. Overview

Record levels of investment in the NHS are coming to an end whilst demand continues to rise. Nationally the NHS has been tasked with identifying £15 to £20 billion (up to 20% of current expenditure) in efficiency savings by the end of 2014/15. These savings must be realised if the NHS is to meet the challenges presented by an aging population, and the continued increased costs of health innovations. This efficiency challenge also comes at a time of radical structural change across the NHS in England. The government’s healthcare reforms will see 152 primary care trusts and 10 strategic health authorities abolished, with GP consortiums responsible for commissioning in future. In addition, from April 2011 commissioners will be able to purchase treatment from any willing provider whether this is in the NHS, private healthcare or charity.

Changes to NHS prices combined with the rapid slow-down in the growth in NHS funding will create a growing financial pressure on all acute healthcare providers.

The WMUH will need to identify and deliver improvements in productivity and efficiency in order to realise ongoing savings without sacrificing clinical or service quality.

The Trust has identified a requirement to deliver 15% savings over 4 years. This equates to around £22 million.

As a result of the wider challenges facing the organisation the Trust has committed to delivering the majority of this savings requirement over the next two financial years.

1.2. Structural Reform across the NHS

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Dec 2010</td>
<td>NHS Outcomes Framework published provisions in Health Bill to strengthen local democratic legitimacy</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>Plans to increase the number of co-operatives and mutual’s in the NHS, details to be published in the Public Service Reform White Paper</td>
</tr>
<tr>
<td>Apr 2011</td>
<td>Separate PCT commissioning from service provision &amp; divest community services</td>
</tr>
<tr>
<td>Apr 2012</td>
<td>Strategic Health Authorities abolished</td>
</tr>
<tr>
<td>Nov 2012</td>
<td>NHS Commissioning Board established Enhanced role for local authorities in integration of health and care and influencing NHS commissioning</td>
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1.3. NHS Efficiency

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 2010</td>
<td>Quality, Innovation, Productivity and Prevention (QIPP) national update</td>
</tr>
<tr>
<td>Apr 2012</td>
<td>Monitor launched as NHS economic regulator</td>
</tr>
<tr>
<td>Nov 2012</td>
<td>NHS Commissioning Board makes allocations to GP consortia for 2013/14</td>
</tr>
<tr>
<td>Apr 2013</td>
<td>Full responsibility for commissioning given to GP consortia Monitor responsible for setting efficient prices Primary Care Trusts abolished</td>
</tr>
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</table>
1.4. NHS Funding Gap

The October 2010 Spending Review settlement means the NHS will receive a 1% real term increase in funding each year for the four years to 2014/15. An aging population, increasing demands for care, health technology developments, inflationary pressures and the costs of implementing government policy will create a shortfall in funding between the required and actual funding allocation. This will create a projected £10 to 15 billion funding gap across the NHS by 2014.

2. NHS Operating Framework 2011-12


The Operating Framework sets out a framework for the NHS during the 2011/12 financial period. This will be a year of significant transition for the NHS and outlines the scale of the challenge faced by the national health economy.

2.2. Key announcements:

- **Reductions to running costs:** The Operating Framework refers to reductions in the “overall running costs of the new NHS superstructure,” which will decrease by one third by 2014/15. This means the scale of cuts required is equal to £1.7bn worth of “running costs” across the NHS.

- **Primary Care Trust funds:** PCT’s will withhold 2% of their annual allocation to “create financial flexibility and headroom to support change.”

- **Productivity challenge:** The NHS faces an emerging spending gap projected to reach £15-20 billion by the end of 2014/15. NHS Trusts must meet this by delivering significant improvements in productivity.

- **NHS Tariff Reduction:** National tariffs will be reduced by 1.5% overall between 2010/11 and 2011/12. This figure is achieved through the reduction of all tariffs by 1%, setting tariffs below the national average level and off setting pay and price uplifts by approximately 2%.

- **Competition:** From April 2011 the national tariff will become a maximum reimbursement rate for treatment rather than a fixed price allowing for price competition among NHS providers.
2.3. Long Term Financial Model

Long term financial modeling enables the organisation to focus strategic decisions in line with the financial outlook.

The Turnaround programme forms an integral part of the Trust’s medium term financial plan.

In developing the plan, the Trust has made a number of assumptions based on national guidance on items such as tariff deflator, pay and non-pay inflation and contingency. Local cost pressures have also been included.

Income assumptions are based some of the following:

- North West London Sector QIPP plans
- Discussions with commissioners
- Local knowledge based on historic trends
- National and local KPIs

As shown in the table (Right), the Trust is planning to deliver a surplus of £1.3m in 2011/12 and £0.3m in 2012/13. In order to achieve this, Cost Improvement Plans of £12.2m and £7.5m are required in 2011/12 and 2012/13 respectively.

The required cost improvement plans will be made through a combination of savings delivered through the Turnaround programme and cost reduction following the decommissioning of services. The Trust is able to reduce costs by £1.0m and £0.5m in 2011/12 and 2012/13 respectively following the decommissioning of services.

### Income and Expenditure Plan

<table>
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<tr>
<th></th>
<th>2011/12 £m</th>
<th>2012/13 £m</th>
</tr>
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<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical income</td>
<td>130.4</td>
<td>130.4</td>
</tr>
<tr>
<td>Other income</td>
<td>12.3</td>
<td>9.9</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>142.7</strong></td>
<td><strong>140.3</strong></td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>(129.9)</td>
<td>(128.3)</td>
</tr>
<tr>
<td>Non-Operating Expenses</td>
<td>(11.5)</td>
<td>(11.7)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(141.4)</td>
<td>(140.0)</td>
</tr>
<tr>
<td><strong>Surplus</strong></td>
<td>1.3</td>
<td>0.3</td>
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</table>
3. Developing the Turnaround Programme

As it became clear that the Trust, in line with other providers, would need to save in the region of 15% over 4 years, the Trust Board agreed that the approach needed to take account of a number of factors:

- It is unlikely that a traditional ‘salami slicing’ savings programme would be successful
- Clinical frontline services must be prioritised over non-clinical support expenditure
- Emphasis should be placed upon making savings by reducing waste, improving productivity and enhancing value for money

To ensure adequate focus on developing the programme and preparing the organisation for significant change, and in recognition of the scale of the challenge, the Board appointed a Turnaround Director, (Andrew Murphy of Kingsgate Interim, Advisory and Investment), in September 2010.

The Turnaround programme was launched by the Chief Executive in September 2010 with a series of staff meetings emphasising the key principle underpinning the programme: “better for patients, better for costs”.

It was recognised that the necessary change could not be achieved without the active involvement of staff at all levels. A key part of this has become the “celebrating success” scheme. A matrix approach to developing initiatives was adopted, where corporate areas and clinical business units were asked to generate ideas around the following challenges:

- Improved rosta management
- Reduction in agency usage
- Increased use of specialist nursing
- Enhanced role for support workers.
- Review of medical staffing numbers and grades based upon an assessment of service, teaching and other requirements, roster changes, moving to team based job plans etc.

- Best practice review
- Bed management review
- Visual management on wards
- Productive model ward project
- IP pathway & DC improvement (protocol based)
- Emergency surgical review
- Enhanced recovery after surgery
- Reduction in delayed discharges
- Increasing proportion of surgical time
- Ensuring all lists run to time
- Ensure all theatre lists are optimally booked
- Better pre-operative assessment to reduce cancellations on day of operation
- Reducing DNAs
- Rationalising staffing patterns to match demand
- Review of utilisation of outpatient services, reducing DNAs
- Pathway based reviews of outpatients and diagnostics applying lean methodology

- All non-clinical staff

- Rigorous performance management

- Ongoing programme achieve reductions in waste, unit cost and volume used
- Reduce demand for blood products by speeding up physical access
- Ongoing programme based upon reducing waste, unit cost and volume used
- Reduction in demand based upon protocols and regular clinical audit
The Board’s early commitment to make greater savings in non clinical areas (thereby reducing the pressure upon clinical areas) has led to the development of plans to reduce staff costs in corporate directorates by 30%. In addition plans are being finalised to save 38% in other administrative areas across the Trust.

An ‘Away Day’ was held in November 2010 to work through each ‘initial challenge’ in more detail. Following this, each clinical area produced a draft cost improvement programme in December 2010. These plans were thoroughly scrutinised and the financial gap closed by means of priority budget setting sessions in late December and early January. Project plans were worked up for these initiatives in January 2011 and again scrutinised in detail by the Director of Finance and Turnaround Director in February 2011 prior to being included in the final cost improvement plan. The implementation timeline and financial value of each plan has accordingly been rigorously scrutinised and can therefore be seen as risk adjusted.

These final plans are being incorporated into the budget setting process so that there is a complete correlation between agreed budgets and the cost improvement plan.

The overall programme will be performance managed and reported by:

- Corporate area
- Division
- Theme
  - Clinical administration
  - Beds
  - Back office
  - Procurement and materials management
  - Clinical productivity and value for money
3.2. Turnaround Process Matrix

Board Themes:
- Clinical Administration
- Beds
- Back Office
- Procurement & Materials Management
- Clinical Productivity and Value for Money

Examples:
- Clinical Services Productivity
- Clinical Services VFM
- Cost Control / Avoidance
- Non-Clinical Staff Productivity and VFM

Categories Examples:
- Management cost reduction
- Ward Development
- Medicines Management
- Clinical Administration
- Medical Staffing

QIPP Examples:
- Back Office
- Clinical Support Rationalisation
- Pathology
- Planned Care

Department Examples:
- Radiology
- IT
- Outpatients
- Theatres
- Pharmacy
- Histopathology
4. Trust Wide Overview

The Trust has identified a total of £15.4m of cost improvements for the two years from April 2011. This is against a requirement of £19.7m, based upon the activity contracts with PCTs. Given the process that the organisation has been through to identify, test and hone the improvement plans, the Trust Board can be assured that with appropriate management action, the full £15.4m will be delivered.

The assumed income position for 2011-12 has worsened by around £1.5m as contracts have been finalised in the second week of March 2011. This mainly results from differing assumptions around the impact of seasonality, the likely level of income growth, and the reductions in the number of procedures carried out because of changes in guidelines. It is recommended that the Trust sets an income plan at the revised contract level, and therefore adjusts the cost reduction requirement by £1.5m to £19.7m. Of this, £12.2m is required to be delivered in year one.

The Board will recall that there are advanced plans in place to deliver £10.6m in year one. This has been supplemented by advancing the implementation of a number of schemes to increase savings in year one. This includes full implementation of the Clinical Administration Project and, most notably, advancing the closure of a ward from April 2012 to June 2011. These measures combined will deliver a total of £11.9m in year one.

The overall two year gap increases from £2.9m to £4.3m.

It is important to highlight the relative savings made across different work groups in the trust, as this reinforces the Trust Board commitment to minimise the impact of savings on front line clinical services. For instance, the 7% reduction in nurse costs in the wards is enabled by a planned overall reduction in Administrative and Management posts of 35%.
**Saving Profile:**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Clinical Services Productivity &amp; Value for Money</td>
<td>5,212</td>
<td>997</td>
<td>6,209</td>
</tr>
<tr>
<td>Back-office</td>
<td>1,553</td>
<td>800</td>
<td>2,353</td>
</tr>
<tr>
<td>Clinical Administration</td>
<td>1,491</td>
<td>745</td>
<td>2,236</td>
</tr>
<tr>
<td>Procurement &amp; Materials Management</td>
<td>789</td>
<td>38</td>
<td>826</td>
</tr>
<tr>
<td>Beds</td>
<td>1,263</td>
<td>224</td>
<td>1,487</td>
</tr>
<tr>
<td>Decommissioning</td>
<td>1,000</td>
<td>500</td>
<td>1,500</td>
</tr>
<tr>
<td>Other</td>
<td>650</td>
<td>150</td>
<td>800</td>
</tr>
<tr>
<td>Total</td>
<td>11,958</td>
<td>3,454</td>
<td>15,411</td>
</tr>
<tr>
<td>CIP Requirement</td>
<td>12,200</td>
<td>7,500</td>
<td>19,700</td>
</tr>
<tr>
<td>Variance</td>
<td>(242)</td>
<td>(4,046)</td>
<td>(4,289)</td>
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**Closing the gap**

<table>
<thead>
<tr>
<th>Bridging the gap</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Total</th>
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<tbody>
<tr>
<td>Gap</td>
<td>-242</td>
<td>-4,046</td>
<td>-4,288</td>
</tr>
<tr>
<td>New cost reduction initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back office (further 15% reduction in corporate areas)</td>
<td>50</td>
<td>600</td>
<td>650</td>
</tr>
<tr>
<td>Procurement &amp; Materials Management</td>
<td>200</td>
<td>600</td>
<td>800</td>
</tr>
<tr>
<td>Medical Staff Review</td>
<td>150</td>
<td>300</td>
<td>450</td>
</tr>
<tr>
<td>Specialist Teams review</td>
<td>100</td>
<td>100</td>
<td>200</td>
</tr>
<tr>
<td>Additional Departmental initiatives</td>
<td>250</td>
<td>250</td>
<td>500</td>
</tr>
<tr>
<td>Income initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS income contribution @18% (having increased surplus)</td>
<td>1,400</td>
<td>1,400</td>
<td></td>
</tr>
<tr>
<td>Higher trustwide margins (1%) - service line improvement</td>
<td>1,300</td>
<td>1,300</td>
<td></td>
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<tr>
<td>Total initiatives</td>
<td>750</td>
<td>4,550</td>
<td>5,300</td>
</tr>
<tr>
<td>Contingency</td>
<td>-500</td>
<td>-500</td>
<td>-1,000</td>
</tr>
<tr>
<td>Variance</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
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</table>

Having brought forward £1.3m of plans from year two, the year two gap has increased to £4m, giving an overall gap of £4.3m. In order to close this gap there are a number of areas being investigated:

**Back office**

This would involve targeting a further 15% saving in corporate back office functions. A full review will be undertaken in April 2011 to ascertain the most effective way of making such a reduction. This will not delay implementation of established plans in this area.

**Procurement and Materials Management**

The original two year target for this area was £2m set against total non-pay expenditure of £44m. The procurement department are initially targeting a reduction in the £12m consumable spend. There will be a Chairman and Non-executive review of the procurement plans in March/April 2011. Following this the target will be reassessed.

**Medical staff review**

The secured savings plan involves reducing non-clinical staffing levels by about 30% and most clinical areas by 7%. However the established plan only reduces medical staff expenditure by about 2%. A further £450k reduction would increase the overall percentage to 3.5%. This will be achieved by a trust wide review of medical staff cover arrangements and more closely matching job plans and operational arrangements to contract.

**Specialist Team review**

A team based multi-disciplinary review will take place across April and May 2011 to establish the most effective way to maintain quality whilst reducing costs by changing skill mix between and within professions.

**Additional Departmental initiatives**

Each Division and department will be allocated a further modest savings target based upon relative budget.

**Income contribution**

It is difficult to envisage cash releasing cost reduction over the first two years of more than about £17m (just under 12% of turnover). Any greater reduction would adversely impact the balance between fixed and variable costs. It is therefore the case (in line with the Commissioners strategy) that about £2.7m will be required as a contribution from additional income. This will require explicit commissioner sign-off.
5. Business Unit Highlights

5.1. Medical Division

2-Year Savings Identified - £4.1m

Saving profile:

- Year 1 = £3.3m
- Year 2 = £0.8m
- Staffing Reduction = 62.52 wte

£482k - Medical Staffing: This will be achieved by a combination of:

- Tight control of locum and agency medical staffing costs at a Divisional level
- Permanent disestablishment of a number of posts across the Division enabled by changes in practice
- Taking full advantage of opportunities to affect skill-mix changes

£806k - Nurse Staffing: A skill mix review across the medical areas will deliver significant savings by aligning staffing levels and competencies to closely match the needs of our patients. Changes to the nursing rotas have been agreed by the ward sisters, matrons and director of nursing and will begin in April 2011.

£350k - Site Management and Discharge Team: These services are being reorganised in order to place resources and decision making as close to the patient as possible. The change enables investment in frontline staff, the extension of the critical care outreach team to 24hr per day, whilst maintaining a lean central bed management team.

£483k - Trust Wide: Drugs and Pathology: demand management strategies will support a 10% reduction in pathology requesting and 5% reduction in blood product testing.
5.2. Surgical Division
2 Year Savings Identified £2.4m

Saving profile:

- Year 1 = £2.2m
- Year 2 = £0.2m
- Staffing Reduction = 37.8 wte

£287k - Beds: A five day short stay surgical ward will be created on Richmond ward. The ward will open Monday 07:30 and close Friday 21:00. This will reduce existing pay and non pay costs. Associated processes will be revised to support this model of care.

£687k - Theatres & Outpatients: Improvements in productivity and output in surgical theatres and outpatients clinics will support overall reductions in both theatre sessions and outpatient clinics. This will reduce existing pay and non pay costs.

£130k - Out of Hours Arrangements: Creating a single ‘on call’ rota for Senior House Officers in surgical specialties from the currently separate, General Surgery and Orthopaedics rotas.

£565k - Staffing Review: A skill mix review across all wards in the divisions will deliver significant savings by standardising shift patterns and changing skill mix.

£280k - Non Pay: A multitude of smaller non pay projects will deliver savings through innovative process improvements. In Cancer Services a secure Imaging Exchange Portal has been created to enable images to be shared between organisations reducing the need for courier services.
5.3. Women and Children Division
2 Year Savings Identified £1.1m

Saving profile:

- Year 1 = £1.0m
- Year 2 = £0.1m
- Staffing Reduction = 6.8 wte

£426k - Skill Mix Review:
Significant savings are being delivered in maternity services by changing midwifery skill-mix, standardising shift patterns, and changing from Registrar to Consultant on-site cover.

A skill mix review of the Queen Marys Maternity Unit, Starlight Paediatric ward and Sunshine Day Unit, Special Care Baby Unit (SCBU) and Genito-Urinary Medicine (GUM) service will deliver significant savings by a combination of changed skill mix and standardised shift patterns.

£365k - Non Pay: A number of smaller non pay projects will deliver savings through innovative process improvements. Improvements in medicines management, procurement and pathology will all support reductions in expenditure. Examples include the negotiation of cheaper combined tests in sexual health and the removal of the antenatal PET panel to encourage appropriate requesting of imaging.
5.4. Clinical Support Services Division

2 Year Savings Identified £3.4m

Saving profile:

- Year 1 = £2.4m
- Year 2 = £1.0m
- Staffing Reduction = 104 wte

£120k - Out of Hours Arrangements: Converting the current on-call system to a five day shift system in line with nursing staff. The current system of Radiographer cover out of hours has been in place for over 20 years. Rationalising the clinical support required will deliver savings and reduce the need to provide on-call payments.

£221k - Medical Staffing: The demand management strategy will see the pathology and radiology test budgets devolved to the clinical directorates. Successful reductions in clinical demand across the organization will facilitate a corresponding reduction in Imaging Programmed Activities (PA’s). These are planned for year two, following changes in demand.

£40k - Phlebotomy Service: Incorporating the phlebotomy activity into the wards existing workforce capacity through workforce redesign.
5.5. Corporate Directorates

2 Year Savings Identified £2.1m

Saving profile:

- Year 1 = £1.4m
- Year 2 = £0.7m
- Staffing Reduction = 50 wte

£2.1m - Workforce Review: Each Corporate area has carried out a review of future structure, staff numbers and skill mix required for the future. As a whole this delivers a reduction in cost of 30% over two years.

Many of the changes will be enabled by strengthening the ability of clinical front-line areas to manage their own affairs, by devolving responsibility and authority.

In addition savings will be made by improving systems and processes, and by ensuring that non-value added activities are minimised.

Careful planning, communication, implementation and evaluation will ensure that all core back office functions are maintained with continuity of service assured.
6. Projects Overview

6.1. Clinical Administration

2 Year Savings Identified £2.2m

Saving profile:

- Year 1 = £1.5m
- Year 2 = £0.7m
- Staffing Reduction = 83.6 wte

In 2010/11 the West Middlesex Hospital will spend £6.14 million in pay for Administrative & Clerical (A&C) staff in clinical divisions, employing around 240 wte staff. There are real opportunities to improve value for money within this support function, whilst at the same time addressing the quality issues that the current inefficient and duplicative processes have for both our patients and the Trust itself.

Staffing levels will reduce over time, with the £2.24 million saving equating to around 84 wte band 4 staff. However, taking into account the staff who will have left for various reasons by April 2011, the vacancy freeze which has been in place since October 2010 and the contribution of non pay savings, the actual reduction is likely to be in the region of 60 wte staff.

The project is split into 5 main sub areas, each of which is described below. An informal month long consultation at the start of the project enabled consultants and other key stakeholders to highlight the inefficiencies, inequalities and frustrations apparent in the current systems. Away days for detailed processes mapping have been held with key representatives.

These have been supplemented with scoping meetings with potential technology suppliers and Trusts that have already implemented new processes, in order to validate assumptions. The design phase is due to complete by April 2011 with the publication of the consultation paper, and detailed implementation plans for each main work stream will follow.

Central Administration

Covering the current booking and reception roles, this work stream aims to reduce the inefficiencies related to, amongst others, multiple bookings (currently a quarter of all appointments are re-arranged), a slow referral grading / acceptance process and individual reception desks. Bookings for all elective outpatient areas (with the exception of maternity and sexual health) will be made centrally, working to one streamlined process. A centralised reception desk, supplemented with self check-in technology allowing for sub 10 second check in, will assist the fast, efficient flow of elective and outpatients into and out of the hospital, and the convenient centralisation of all administrative processes for the patient.

This work stream also covers the ward administration function.

Letter Management

Covering the current medical secretarial role, the letter production aspects of the function will be supplied via a digital dictation system that is integrated with the Trust PAS systems. This will eliminate the intensive manual merge process that is required with the current dictation service used in some specialties. The PA-type role, which was clearly the most valued aspect relayed during the initial interviews, will be extended with band 5 and 4 staff linked to specialties (or specialty clusters depending on activity demand) to provide a service both to the consultant team and patients who require assistance moving through the system. A managed
mail service will be implemented to further reduce the manual burden on our secretarial staff, enabling letters to be printed, stuffed and posted for less than the current cost of postage.

**Medical Records**

Over 30 wte staff currently work within the medical records function, with a significant element of other A&C staff time taken up with managing physical records. Whilst the library function will remain separate, central bookings will take over prepping clinics. This increases their responsibility and accountability for ensuring clinics are appropriately prepared. The beginnings of a document management system, linked to the data output from the new digital dictation system is achievable within 2 years, at which point it may be possible to reduce the requirement for paper records in outpatients. Over a longer timescale there is the potential for the document management system to evolve into a Trust EPR, which will bring with it further substantial savings.

**Central Telephony**

The implementation of a centralised switchboard will improve the service we currently offer callers, with the resolution of enquiry at the earliest possible point. We will work with Ecovert, the provider of our switchboard services to find the best way to both improve customer service and cost.

A number of capital and IT-related projects will need to be implemented before the full savings can be realised and the transition process from the current systems to the new way of working will need to be closely monitored and managed. The biggest challenge is likely to be the continued engagement, acceptance and buy in of employees, particularly the consultant body who will need to be reassured that the project can deliver an improved service whilst at the same time releasing savings.

### 6.2. Beds

**2 Year Savings Identified £1.5m**

**Saving profile:**

- Year 1 = £1.3m
- Year 2 = £0.2m

The Trust has reduced the number of beds by 45 over the last 18 months, and reduced length of stay overall by around 8%. In addition the day case rate has improved during 2010/11 from 77% to 85%.

Internal analysis suggests that if we achieve upper quartile performance for length of stay we can reduce the bed base by a further 50 beds. This is supported by NHS Innovation and Improvement metrics. The Trust has also been successful in minimising the need for escalation beds over the winter of 2010/11.

The potential improvement identified will need to be realised as soon as possible within the plan. The Trust is therefore planning to close a medical ward by the end of May 2011 to coincide with the usual seasonal reduction in demand. In addition plans are in place to will reduce a surgical ward from 7 to 5 days, concentrating on pathway specific service developments to improve length of stay. To support this, each Division will be required to develop a length of stay reduction plan concentrating upon national best practice in areas such as Enhanced Recovery after surgery, Fracture Neck of Femur and long term conditions.

This is in line with our plans with our commissioners to review and reform patient pathways reducing the need for admission as well as supporting early discharge. The development of these plans will be clinically led within the strengthened Clinical Divisions.
6.3. Procurement and Materials Management

2 Year Savings Identified £0.65m

Saving profile:

- Year 1 = £0.6m
- Year 2 = £0.05m

This is against a savings requirement of £1.8million over two years. The procurement project will deliver improvements in productivity through:

Rationalisation, Standardisation and Control:

The rationalisation of service lines on the trust electronic ordering system is central to delivering savings in non pay. To date over 45,000 lines have been deactivated and restrictions have been placed on orders. A number of process controls have been implemented limiting product variation and user choice. This will ensure standard product usage facilitating average unit cost reductions through economies of scale. A simple process and procedure will be developed as part of this project to introduce new and alternative products into the organisation to meet the changing clinical requirements. Procurement continue to work with clinical staff to identify alternative cost effective products.

Contracts and Materials Management:

Savings will be delivered across the three main areas of contracting through a revised pricing strategy and ongoing supplier negotiations around maintenance, ICT, Clinical imaging and EBME contracts.

Historically the hospital has typically maintained fully comprehensive service support coverage on every maintenance contract. Cost benefit analysis will be applied to all new or expired service contracts to ensure maximum value for money is achieved. This will involve reviewing support requirements with end users and renegotiating better terms with suppliers at every opportunity. Procurement will actively seek to identify alternative suppliers and opportunities for equipment standardisation where possible.

Closing the Gap:

There is a gap of £1.1 million remaining against the procurement savings target. Procurement have reviewed seven million pounds of the twelve million pounds ‘influencable spend’ and have achieved savings of around nine percent. However, given that the review targeted the areas with greater potential for savings, there are likely to be diminishing returns as this review progresses; a reasonable estimate would be around £250k. In addition there are further opportunities in relation to maintenance and other technical issues of around £40-100k.

It is evident that the savings gap is unlikely to be closed fully with these initiatives, and a gap of £500-900k will remain.

The Trust will therefore will need to make savings from a more radical review of the costs of large private and NHS contracts.
6.4 Nurse skill mix and staffing review

2 Year Savings Identified £1.7m

Saving profile:

- Year 1 = £1.66m
- Year 2 = £0.04m

The Trust has been able to reduce the savings requirement for nurse staffing from the global 15% to 7%, by targeting greater reductions in back-office functions. Therefore the Ward and Department Sisters and Matrons were asked to identify the best way to reduce nurse staff costs by 7% and:

- Provide a quality service
- Ensure that ward Sisters were supernumerary (to support quality)
- Where possible protect staff with a permanent contract

A core team was established in October 2011 from finance, nursing and human resources to support the Sisters and Matrons. The Matrons agreed a formula and methodology to apply to each ward and department review:

- Right skill mix for the ward
- Right numbers of nurses at any one time
- Most cost efficient shift pattern: long days, 1.5 hour breaks per long shift
- Standard “leave” budget uplift of 17%
  - Average of 38 days leave
  - 3 days study leave
  - 3 days short-term sick leave or other leave
- Sisters responsible for managing short term sickness, corporate “pot” for chronic sickness

This ensures that the Sister has sufficient budget to manage that which they have influence over, whilst a separate corporate budget is maintained to support unusual circumstances. Each Sister then reviewed their individual establishment in terms of skill mix and numbers and, once costed,

presented it, with the support of their Matron, to a panel for approval. This panel consisted of the Director of Nursing, the Turnaround Director, and representatives of both Finance and Human Resources. Once approved in terms of both quality and cost, the budget was signed by all parties. This gives the Sisters and Matrons an assured budget for 2011-12, which they are able to manage. All areas are implementing the agreed changes from the first week of April 2011 at the latest.

The total WTE figures around the change are shown below.

<table>
<thead>
<tr>
<th>WTE changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently used (including bank)</td>
<td>710</td>
</tr>
<tr>
<td>Agreed Establishments (includes surgery 5 day ward)</td>
<td>642</td>
</tr>
<tr>
<td>Permanent staff employed</td>
<td>629</td>
</tr>
</tbody>
</table>

| Overall reduction            | 68    |
| Change made by reducing bank use |       |

This demonstrates that in broad terms the change can be managed by a reduction in bank staff use. There are, however, some areas where there are changes in skill mix which will take some time to fully implement.

Matrons are able to bid for short term support from a transitional fund held corporately.

The Director of Nursing will work with the Matrons and Sisters across the coming year to ensure that, through initiatives such as the Productive Series, opportunities to “Release time to care” are materialised; further enhancing the quality of care.
7. Managing the Change

7.1. Workforce change

The majority of staff cost savings are produced from three key workforce plans:

Nurse skill mix and rosta review: Each clinical area has reviewed its skill mix and rosta arrangements against the workload of the department. This bottom up recosting of ward, theatres outpatients and midwifery staffing has produced a saving of 7% across the Trust.

Although there is a total reduction from forecast outturn expenditure to the new establishment of 80 wte, the new establishment is still greater than the number of staff in post across the organization. The change will therefore be largely achieved by reducing the use of ‘bank’ staff in the first instance and by a gradual change in skill mix as vacancies and staff turnover allow. The cost of this change has been fully accounted for.

Corporate Directorate Review: There are a large number of relatively small organisational changes involving a total reduction of 50 wte staff across the next two financial years. Almost half of these changes have been affected through the use of the NHS MARS scheme or non replacement of vacant posts. The further changes are planned across the next two financial years.

Clinical Administration Review: This is the most significant single change to the workforce across the organization involving a reduction of 80 of the 240 established posts. The details of the change are still in development and will be announced in a formal consultation document at the beginning of April 2011. In preparation for managing this change the Trust has not recruited to administrative and clerical posts since October 2010. This will create greater flexibility in making the workforce changes.

7.2. Governance

Standardised project documentation has been used throughout the turnaround programme to ensure a consistent and thorough approach. Each (excel) Project Workbook includes:

- Summary sheet with basic project information
- Quality and Safety Assessment
- Gantt chart
- Workforce plan (where required)
- Financial plan

Each project has a lead manager, with an individual named senior manager or corporate director accountable for each project.

Each of the divisions and project leads has been tasked with developing a robust governance structure involving regular structured meetings to ensure the delivery of the agreed cost improvement projects. This will be supported by wider corporate level governance arrangements that will maintain external scrutiny to ensure projects remains on target to deliver identified savings. Regular formal reviews are scheduled with the Turnaround Director. Assuming satisfactory progress against cost improvement plans these formal reviews will gradually reduce in regularity during 2011/12.

A monthly report will be provided to the Executive Board and the Finance and Performance Committee as part of the Integrated Performance Report.