

1. Introduction

1.1 The purpose of this paper is to:

- Establish the context and evidence base for sustainable cost improvement delivery;
- consider the current process for delivering sustainable cost improvement plans;
- propose changes to the process for delivering sustainable cost improvements plans with immediate effect;

2. Structure of Report

2.1 This report is a discussion document for Executive Directors. Following discussion and amendment, the report will be shared with Divisions to maximise engagement. The document will then be issued to the appropriate Governance Committees of the Trust for approval.

2.2 The Report will consist of:

- An Executive summary for Governance and Strategic Committees
- This detailed report for Executive Directors and supporting departments
- A presentation for use at a launch event for Divisions and subsequent planning event for Services and Support Services.

3. Executive Summary

3.1 The key messages from this paper are:

- The Trust intends to manage Cost Improvements through Divisions wherever possible
- Cost improvement Plans are one of a number of performance issues that Divisions will be assessed against and held to account for
- Performance Management will be rigorous and balanced and high performance will be recognised with increased autonomy and increased delegated authority
- Poor performance will be addressed through remedial action plans and Divisions will be helped to develop these. Continued poor performance will be addressed through reduced autonomy and removal of delegated authority
- The Trust expects Divisions to plan, record, manage and deliver schemes below certain materiality levels
- The Trust will routinely report a small number of key material schemes through a small central team
- Delivery of Cost Improvements will be assessed in the context of “run rate”. A cost improvement reduces the rate of underlying expenditure or increases the underlying contribution from income and we will be clear about what constitutes a cost improvement
- A key challenge for the Trust is constructively engaging the whole workforce in the identification of cost improvement plans
- Cost improvement is an absolute necessity to fund services on a sustainable basis. Improvements in systems and processes and delivery of services that are safe and timely will result in cost improvements

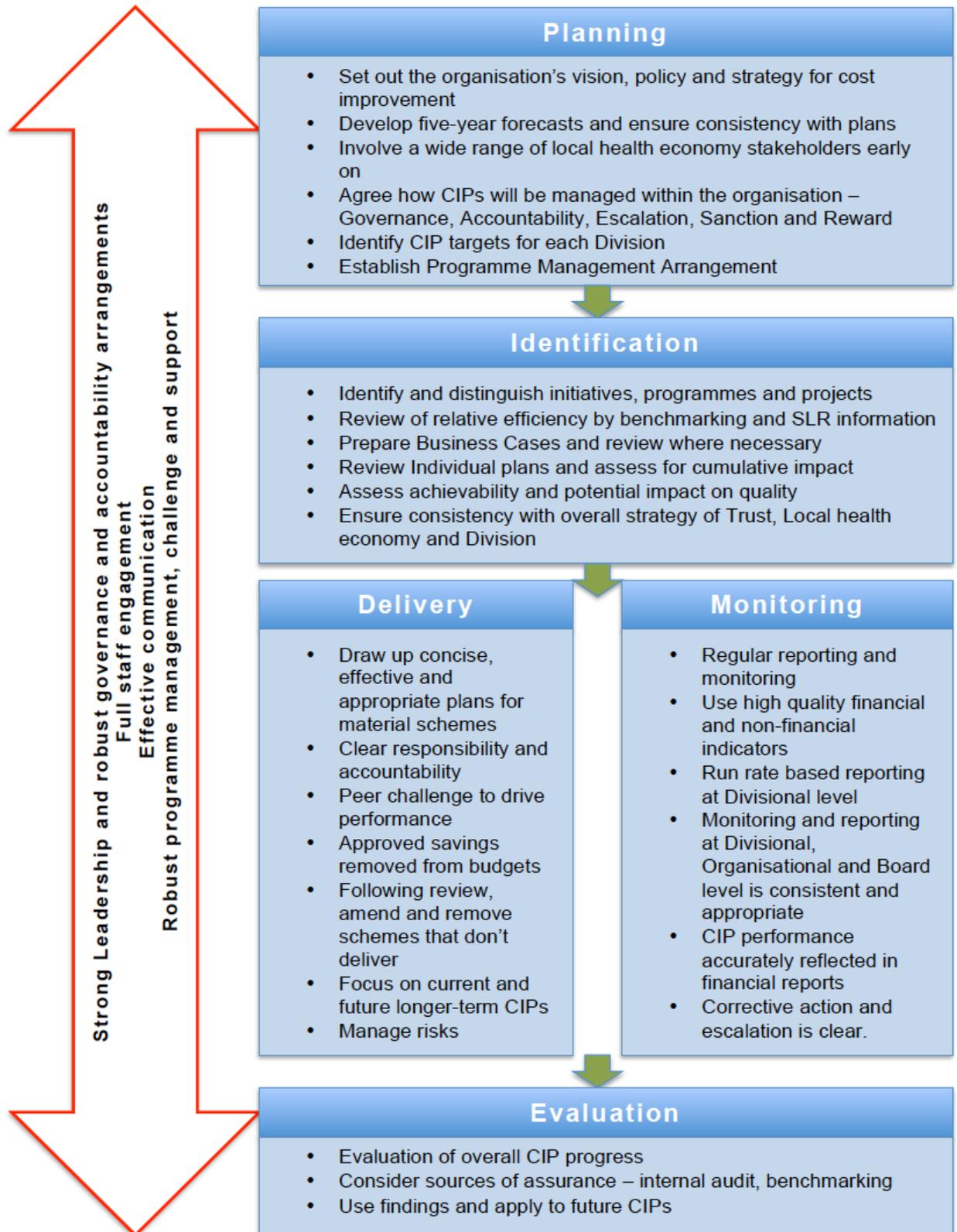
- The Performance Management Framework of the Trust provides assurance on delivery of cost improvements. The Divisional Boards operationalise delivery and ensure benefit realisation
- Cost improvement plans set out the opportunity to deliver savings and the delivery of the tasks associated with those plans ensure benefits are realised by Divisions
- Delivery of CIP is an integral part of the delivery of forecast or planned expenditure against which accountable officers will be appraised
- Divisions will be expected to undertake Quality Impact Assessments that will continue to be assessed by the Medical and Nurse Director who retain the right to reject plans or require further assurances as to the safety and quality impact of plans.
- Planning and identification of schemes is a continuous process that will be facilitated by a number of workshop events through the year. Schemes can be submitted throughout the year for future year delivery
- The costs of delivery of schemes should be transparently and realistically included in project plans and the net benefit only will be recognised in plans

4. Context

4.1 **Figure 1** is a framework for Sustainable Cost improvement derived from the Monitor and Audit Commission report of that name published in January 2012. The framework has been adapted and added to reflect greater:

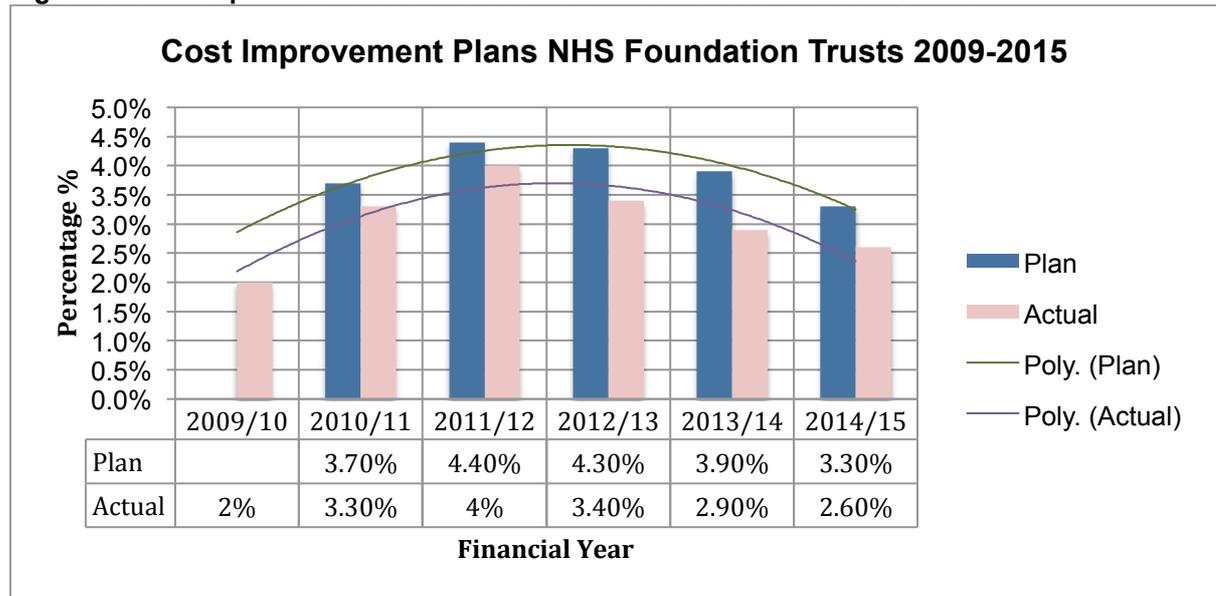
- focus on escalation, sanction and reward
- pragmatism about the materiality of schemes
- weight to reporting delivery through run rate monitoring.

Figure 1: Sustainable Cost Improvement Planning



4.2 Monitor publishes the most consistent and accessible information on planned Cost Improvements as a percentage of expenditure. **Figure 2** shows the planned and actual delivery of cost improvements for the period 2009-2015. It is clear from the data that there is a decreasing level of planned savings since 2011/12 and 2012/13. The gap between delivery and plan is generally 0.5-1% which is equating to a delivery rate of 80%-90% of plan. When the Trust sets its plans for the future we need to consider this trend and allow for the attrition rate between actual and plan.

Figure 2: Cost Improvement Plans and Actuals for Foundation Trusts 2009/15



5. Proposed changes to the process for delivery of Cost Improvement Plans

5.1 There are a number of key principles that drive this proposal:

- the Cost Improvement programme will be managed as close to Divisions as possible and individual schemes will be managed at Divisional level as a default position
- there will be a small central team to support Divisions and to monitor the delivery of agreed tasks and to ensure that the interfaces between projects are well managed
- Where it is clear that schemes span multiple Divisions or where Divisions believe that they are not able to manage the scheme locally a central scheme structure will be established – for example, self-rostering
- Schemes will, as far as possible follow care pathways and be self contained within Divisions, for example outpatients, pre-operative care and post operative care will be managed within the Trauma, Surgery and Anaesthetics Division
- Plans will assume a percentage of non-delivery (20%)

- RAG ratings will be clear and transparent and undertaken by Divisions
- The financial control sheets will be redesigned by the Finance team working with the project team
- The definition of Cost Improvement will be clear and transparent at the outset of the planning year
- documentation will be owned by Divisions but shared across open platforms
- existing documentation will be used as far as practically possible but will be amended based on Divisional feedback
- there will be a materiality level and reporting will be minimised and localised for schemes below that level
- performance against CIP Plans will be managed through the Performance Management review framework
- high performance will earn autonomy and increased delegation
- poor performance will be addressed through remedial action plans and continued poor performance will result in escalation and reduced autonomy and delegated powers
- the remedial action planning process will be supportive
- Divisional Planning and delivery will be supported through the Business Partner structures

Infrastructure

- 5.2 The Trust has separated Cost Improvement Planning from Strategic Planning with the fixed term appointment of a Director of Financial Recovery.
- 5.3 A temporary structure will be built for CIP planning for a six-month period. A small central function will develop the CIP plans and plan the transition to a permanent structure within the Trust.
- 5.4 The small central function will undertake the CIP Planning function of the Trust in conjunction with the Divisions. Divisions will lead Identification and Delivery. The Corporate services will incorporate monitoring within the routine reporting of the Trust. This will be supplemented by key scheme reporting (most critical 10-15 schemes) to Board. The key scheme reporting will be coordinated by the central function.
- 5.5 Evaluation will be coordinated by the central team but will utilise existing assurance processes and providers such as internal audit.
- 5.6 The central team will be resourced through interim and temporary staff for the initial six-month period while substantive structures are reviewed and implemented in Operations and Finance. The central team will consist of the Director of Financial Recovery, a senior programme manager and a programme administrator.

- 5.7 Programme management or subject specialists for specific schemes will be funded through individual schemes and will, as far as possible, be embedded into the Division responsible for delivery. In the event that cross-divisional programme management is required the central team will provide short-term management support.

Scheme Management

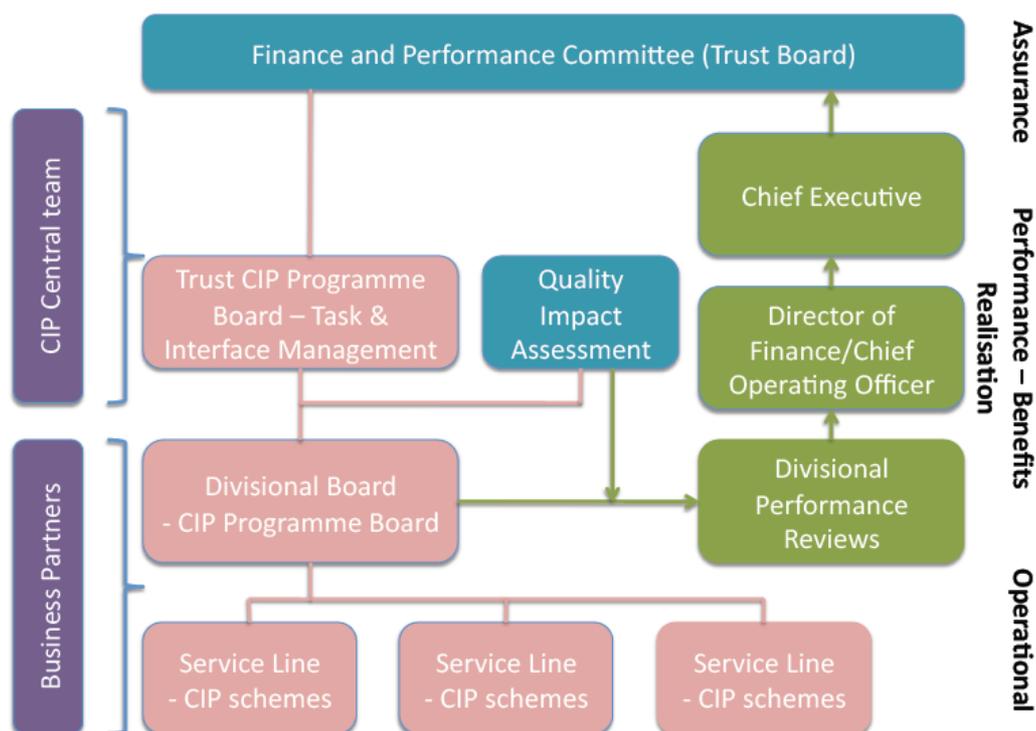
- 5.8 All schemes under £50,000 will be managed directly by the Divisions. The schemes will be deducted directly from opening budgets at the start of the year and according to the directions of the Divisions. This will not be through the use of negative unidentified budget lines. Divisions will then be monitored routinely on run rate. The Trust may aggregate all Divisional schemes under £50k on one set of Programme documentation to facilitate external reporting.
- 5.9 Schemes over £50,000 will be subject to programme plan documentation and will be monitored through the Governance structure noted below.
- 5.10 The Trust will routinely report the top 15 schemes in detail, which it is anticipated will account for in excess of 50% of the value of the programme.
- 5.11 Each scheme will be sponsored by a senior manager/executive who will be held to account in the Divisional Performance Management meetings. The sponsor is responsible for appointing a project manager for the scheme who is responsible for the day-to-day management of the scheme.

Governance and Accountability

- 5.12 It is proposed to retain the majority of the existing documentation suite for management of CIP schemes but to work with Divisions to streamline the process.
- 5.13 It is proposed to change the current reporting, governance and escalation processes. **Figure 3** sets out the proposed structure. Each scheme will, as far as possible, be managed at service level. The accountable officers will be within Divisional structures building on the existing resources for project management and service improvement. The Business Partners from core services such as Finance, Information and Human Resources will support the operational identification and delivery of schemes.
- 5.14 Divisional Boards will be responsible for ensuring delivery of the schemes, for the identification of key performance indicators and the measurement of progress against those metrics.

- 5.15 Cost Improvement plans will be assessed as part of the standard performance management framework of the Trust. There will be monthly performance management reviews with Divisions where Divisions will be assessed against the key performance pillars of Quality and safety, Governance, operational performance and Finance (including CIP).
- 5.16 Divisional Performance Reviews will be escalated and de-escalated according to performance. High performing Divisions will be reviewed quarterly, standard review intervals will be monthly. Divisions facing performance challenges will meet with the Chief Operating Officer and Director of Finance to develop supported recovery plans. Divisions that are unable to deliver recovery plans will meet weekly with the Chief Executive and will be required to attend the Finance and Performance Committee of the Trust Board to report progress against remedial action plans.
- 5.17 The Trust will develop further incentives for high performance that reflect the principles of earned autonomy and enhanced delegated powers. A further extension of the £50,000 materiality level for high performing Divisions may be one area to be considered.
- 5.18 The Cost Improvement Programme Board is responsible for ensuring that the tasks for delivery of CIPs are being undertaken and will monitor run rate for delegated schemes and specific tasks for key schemes. The Board is also responsible for ensuring that interfaces between schemes are properly managed and recognised by all scheme leads.
- 5.19 The existing Quality Impact Assessment process is maintained and will feed the performance management function through Executive Directors.
- 5.20 Scheme identification will be through Divisional Boards and will be supported with workshops. The initial workshops to develop a 2015/16 plan will be a full day in duration and will involve Service leads and Clinicians supported by all the support services of the Trust. Divisions will work in Divisional groups in close proximity and will be able to access support services throughout the day to support plan development. The Executive Directors will provide advice and feedback to focus Divisions on schemes that are consistent with the Trust strategy. Executive Directors will also assist Divisions in assessing the risks to delivery of outline schemes to ensure that productive time is spent on plans that are deliverable.

Figure 3: Proposed Governance Structure



Definitions

5.21 There are a number of areas of definition that the Trust needs to agree and specifically, these relate to:

- RAG Rating tolerances
- What is a Cost Improvement

5.22 It is assumed that if schemes are rated as Green then 100% achievement against operational and financial targets will be delivered. It is assumed that amber schemes will be anything less than 100% of the operational and financial targets set at plan. Red schemes will achieve less than 80% of planned targets. Black schemes will not achieve in year and will be closed in that year.

5.23 RAG rating will be treated as a control measure. Divisions will RAG rate their own schemes. If a scheme is RAG rated as Black, Red or Amber then the Division needs to identify mitigation and alternatives. Assurance that schemes are progressing and that the RAG rating of Divisions is reasonable is achieved through the Performance Management meetings. If Divisions are not effectively rating schemes then this will be managed through performance management.

5.24 A cost improvement is any action that reduces the underlying spend of the organisation or increases the underlying income of the organisation as measured by run rate. Reductions in expenditure should not be system driven such as changes in fines as these will be accounted for

in baseline budgets. Increases in income will not include Patient Treatment Income for existing services, which will be accounted for in annual capacity plans and in changes to national tariffs. New service developments which have been subject to Business Case will be recognised if a clear contribution is identified.

Delivery of savings

5.25 Most Cost Improvement Plans identify savings in generic and “safe” terms. The Trust is clear that the Cost Improvement Programme will seek benefits in the following areas:

- **Reduction in pay costs** – this will be through reductions in variable and non-permanent pay expenditure which includes Agency spend, enhanced or premium payments to staff, Bank expenditure and a reduction in the average cost per whole time equivalent through careful and appropriate skill mix management. In order to reduce pay costs in the longer term we will have to reduce the numbers of beds that we provide. Bed reductions must be managed on the basis of whole wards and we will have to consolidate bed reductions in order to close wards. We will also have to reduce the number of theatres we need to maintain by consolidating lists and maximising productivity in those we retain.
- **Reduction in non-pay costs** – a real terms reduction in the amount we spend on goods and services, which will require us to reduce the quantities we use and to standardise the number of products we use in order to reduce the price per unit we pay. We must also ensure we buy good quality products in flexible volumes to ensure we minimise waste but optimise the price per unit.
- **Reduction in the site area** – we need to use the premises and sites we have to an optimum level and therefore free space that we can dispose of in order to reinvest the proceeds in sites and equipment that make us even more efficient
- **Ensure we receive income for all the things we do and be clear about those things that make us a profit and those things that cause losses** – we must code and record what we do correctly to ensure that we have the best quality information available to demonstrate the work we have done. We should ensure that we do things right first time and use the additional time this allows us to do more for the same cost. We will seek to maximise the profitable activity that we do ourselves but will be open and transparent in our planning to enable our partners to plan for the work that they can do to support the health system. We will also be clear about those areas of work where we incur losses and where other providers may be better placed to deliver.
- **Outsourcing** – where there is persuasive evidence that someone else can deliver a better quality, more cost effective service or process than we can ourselves we will outsource services but we will be clear about which services are considered strategically critical and therefore not safely outsourced and we will also ensure

that our own services are supported to determine whether or not they can deliver similar or better quality and costs standards as part of any evidence gathering process.

6. Initial plans

6.1 Divisions met to understand expectations for the programme and to reframe the programme as described above. The event also identified a series of potential opportunities, which include the following key themes:

- Theatre Productivity – continuation and delivery of Unipart assisted schemes
- Outpatient efficiency in Surgery – an extension of the Unipart review to complete the full care pathway
- Emergency Department admissions – implementing the MCAP audit recommendations and addressing the high admission rates
- Fit for discharge spot purchasing – spot purchase of Nursing home beds to reduce medical outliers and community admission
- Managing simple discharges – quicker discharge and reduced length of stay driven by clear Estimated Dates of Discharge
- E-observations/Track and trigger – implementation of systems to monitor deteriorating patients and reduce length of stay
- High use emergency bed days – identifying the cohort of patients where 3% of patients generally consume 30% of emergency bed days
- Partnership working – to address the disproportionately high number of patients with a primary diagnosis of mental health or substance abuse or CAMHS in the acute bed stock
- E-Rostering and self-service ESR modules – to use HR systems to optimise rosters and staff management processes
- Investments – to rigorously review the investments made by the Trust where outcomes have not been evidenced and to disinvest in those schemes
- Site Rationalisation
- Non Pay and Procurement – to fully implement the world class procurement systems to maximize the value of our non-pay spend
- Hard and Soft Facilities Management – to explore all areas where the Trust benchmarks below average in comparison to other large acute providers per ERIC

6.2 The **Surgical Pathway** scheme has delivered productivity and efficiency gains at specific sites. The intention is to expand this work to the full patient pathway for surgical patients and to consider Outpatient, Pre-operative, Theatre and Post-operative care.

6.3 The Trust is undertaking significant work on patient flow in the Hospitals as part of the review of **Non-Elective pathways** including:

- Emergency Department – qualifying presentation, admission ratios
 - Discharge Planning – delayed transfers of care, Estimated Dates of Discharge, variability of discharges through week
 - Early diagnosis and senior clinical input and accelerated stages of treatment
 - Management of deteriorating patients – e-observations
 - Complex discharge planning – assess to placement and packages of care
 - The impact of high resource use patients on Trust beds, for example, multiple admissions, mental health services users, child and adolescent mental health.
- 6.4 The Trust has seen a significant increase in discretionary variable and premium pay in 2014/15 and reduction in agency and locum spending is a key aim of the **Workforce** scheme.
- 6.5 The Trust has yet to realise the full benefits of e-rostering and a number of the additional self-service and performance management modules of the Electronic Staff Record. The intention is to centralise the development of rostering rules and then to systematically roll out implementation across all ward areas on a fixed schedule to a range of staff groups.
- 6.6 The **Procurement and logistics** scheme recognises that the Trust has seen above inflation increases in non-pay expenditure, which has been partly driven by outsourcing of soft facilities services. The application of best practice and the recommendations of “World Class Procurement” is a priority for the Trust along with the implementation of the Bravo comparator tool.
- 6.8 The **Estates** Department has identified a number of site moves that will reduce Trust occupancy costs while also addressing site development plans.
- 6.9 **IT enablement** includes e-observations, single sign on, voice recognition and the Clinical Desktop. The schemes are largely clinical and it is anticipated that leadership of the schemes will be Divisionally owned.
- 6.10 The **Drugs** scheme seeks to realise savings through price and volume management. The implementation of the Blueteq systems is identified as a potential enabler of savings on pass through drug costs.
- 6.11 The outline plan assumes that the Trust will generate sufficient savings to fund project costs equivalent to approximately 10% of the planned schemes. The plan also assumes that there will be 20% attrition in delivery of schemes.
- 6.12 The Trust will also work closely with partners to identify areas of mutual gain. The Trust has agreed to share benchmark data and information

with local Commissioners to identify win/win schemes between the two organisations. This may, for example, include diversion schemes for activity where the Trust currently incurs significant losses. The Trust proposes to hold a partnership planning event in April 2015 to confirm joint plans with key stakeholders across the health economy.

- 6.13 Quality Impact Assessments are undertaken at Divisional level and the Medical Director and Chief Nurse will continue to test the impact assessments of major schemes and other selected schemes to assure the Trust of the safety and efficacy of schemes.