



Phase One: Summary Report

January 2012

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1. Introduction

Purpose of the Report

- This is a summary report of the service transformation, quality improvement and efficiency opportunities identified in phase one of the Transforming for Excellence Programme, which took place between October and November 2011. The full report was signed off by the Bedford Hospital NHS Trust Board on 30 November 2011.
- The Trust has now launched phase two of the Transforming for Excellence Programme, which will see the detailed scoping and implementation of schemes identified in phase one.

Background and Context

- The NHS faces its greatest financial challenge in delivering £20bn efficiency savings by 2013/14. This sees Trusts across the country having to make significant financial savings through improved productivity and efficiency, and a reduction in costs.
- All Trusts also have to manage a reduction in income due to the reduced national tariff (price) for procedures and care undertaken in hospital, and an unfunded two-and-a-half per cent rise in inflation. This alone means around a four per cent reduction in income (about £5m for Bedford). All Trusts must also respond to local Primary Care Trust Quality, Innovation, Prevention and Productivity (QIPP) plans, which sees significant work and income moved out of hospitals and into community settings (up to £7m for Bedford).
- To meet these challenges, and to end each financial year with a small surplus (necessary if Bedford are to become an NHS Foundation Trust) Bedford Hospital will have to make at least £20m of savings by the end of 2013/14.
- To make the efficiency savings Bedford needs, there will need to be a shift from being an average performing Trust into being in the top ten per cent of Trusts in the country.
- This report outlines how Bedford Hospital can make the savings it needs, whilst improving quality and productivity; ensuring a sustainable future for the Trust.

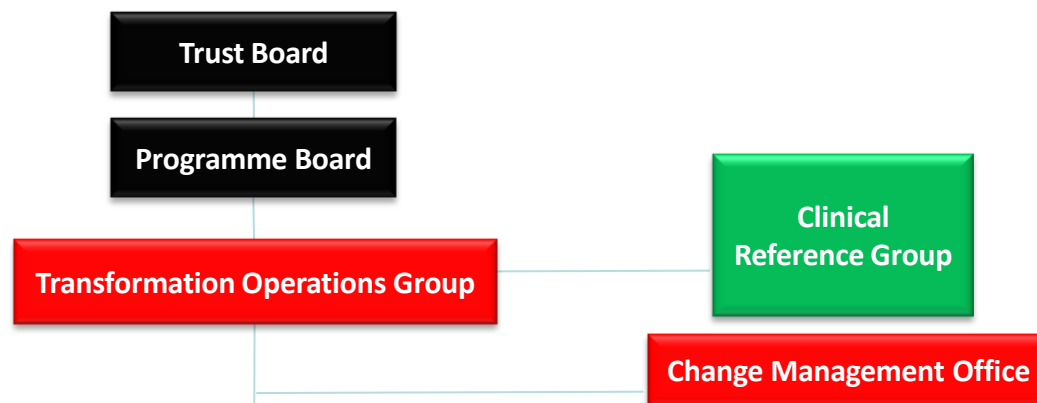
More information

- For more information or if you need any clarification on issues raised, or help in understanding what some of the terminology or phraseology means, please contact tfe@bedfordhospital.nhs.uk

2. Phase One Programme Structure

The below diagram illustrates the *first phase* Transformation Programme structure and staffing.

Four workstreams and a programme governance structure were set up to steer the process and validate key findings. The workstreams comprised **Clinical Effectiveness, Services and Strategy, Clinical Support Services** and **Controls**. A fortnightly **Programme Board**, chaired by the CEO, oversaw the work of a dedicated steering group, the **Transformation Operations Group** (TOG), that met weekly and was co-chaired by the Medical Director and the COO. Workstream membership comprised an executive sponsor, clinical chair and multidisciplinary representation to ensure full stakeholder engagement. A **Clinical Reference Group** (CRG) was also set up to test the findings of the programme and support wider dissemination of the programme 's key messages.



Workstreams

	Service Reviews / Strategy	Clinical Effectiveness	Clinical Support Service	Controls & CIP
EY Leads	Craig Porter	Jackie Fawkes	Ben Morgan	Jessie Turner
Executive Sponsor	Director of Strategy/ Chief Operating Officer	Medical Director	Director of Nursing	Director of Finance
Nurse / Consultant Lead / Chair	Associate Medical Director Specialty Medicine	Associate Medical Director Surgery	Associate Medical Director Clinical Support/ Associate Director of Nursing	Associate Medical Director Women and Children
Nurse/AHP lead	Lead OHP/ Lead Infection Control Nurse	Matron (Medicine)	Matron (Surgery)	Deputy Director of Nursing
Management Lead	Deputy COO	Deputy COO	ADO Elective CBUs	ADO Non Elective CBUs
Change Management Office Lead				
Specialist input & sign off	Consultant Anaesthetist (Deputy Medical Director)	Associate Medical Director Acute Medicine	Heads of Service	Head of Financial Management / Associate HR Director

3. Where and How Savings Have Been Identified

2011/12 to 2012/13 Forecast

Workstream	Total (£)
Clinical Effectiveness	
Theatre utilisation	718,000
Bed reconfiguration (improved models of care)	1,560,000
Medical workforce planning (job plans)	624,000
Outpatient clinic (efficient running, reducing new-to-follow up ratio)	597,000
Endoscopy (improved models of care)	168,500
Radiology (improved models of care)	255,000
Trust wide small efficiency schemes	1,210,000
S CBU small efficiency schemes	70,000
W&M CBU small efficiency schemes	20,000
AM CBU small efficiency schemes	-
SM CBU small efficiency schemes	200,000
CS CBU small efficiency schemes	20,000
Total	5,442,000
Clinical Support Services	
Workforce management (linked to bank, agency and locum)	1,291,000
HR (e.g. salary sacrifice tax relief schemes)	361,200
Procurement (standardisation)	229,000
IM&T (systems and data quality)	806,800
Estates and support services (e.g. services on a single site)	322,000
Pharmacy and medicines management	302,250
Total	3,312,250
Controls	
Bank, agency and medical locum spend	750,000
Overseas visitors	100,000
Annual leave management	140,000
Discretionary non-pay	200,000
Total	1,190,000
Total	9,944,250 *
	*(rounded figure)

This table provides a headline of where savings have been identified, without detailed explanation. The next pages provide some context, but not a detailed breakdown. If you have questions on the contents of this table, please email tfe@bedfordhospital.nhs.uk

The **Clinical Effectiveness Workstream** focused on reviewing the efficiency of six key service areas identifying a total of £5.44m saving. It also includes 18 small efficiency schemes identified with a value of £1.52m.

Opportunities identified include:

- Increase of theatre utilisation, productivity and capacity enabling repatriation of outsourced activity.
- Reduced length of stay and increased provision of ambulatory emergency care enabling a reduction in beds across the Trust.
- Large number of paid consultant programmed activities above the standard ten per full time equivalent; flexible element of consultant and staff grade/associate specialist doctor capacity to respond to service requirements.
- Reduction in outpatient clinics through reduced new to follow up ratio, DNAs, improved capacity planning.
- Opportunity within endoscopy to deliver all activity within core scheduled hours and stop reliance on additional lists paid at a premium.
- Need to increase reporting capacity within radiology department, particularly with an anticipated increase in demand in 2012 due to second permanent CT scanner.
- 54 meetings and clinical area walk rounds were held that generated identification of 18 small efficiency schemes based on a review of the five CBUs.

Key issues	Interdependencies	Quality Impact
<ul style="list-style-type: none"> • Further clinical buy in and support for schemes. • Capacity of CBU management to deliver changes. • Availability of robust information 	<ul style="list-style-type: none"> • Service review/ASR – impact on beds, theatres, outpatients, diagnostics requirements • Repatriation of outsourced surgical activity – beds • Capacity across clinical areas – bank and agency spend • Capacity across clinical areas – medical workforce planning 	<ul style="list-style-type: none"> • Reduced on the day cancellations in theatre, positive impact on patient experience • Right care, delivered in right place at the right time will improve patient experience

The Clinical Support Services Workstream identified a total of £3.31m saving.

- The biggest opportunity relates to workforce management at £2m (£750k of which is included in controls). This is based on a structured approach to reducing current non-contracted (bank, agency, locum) pay expenditure of £3m by 66%. This will be delivered through the implementation of controls, suppliers/individual negotiation, better use of existing enabling technology and holding staff to account for bank/ agency use. The Trust should be able to deliver 75% of the savings within the next two years.
- The Trust has a mixed record of successfully delivering IM&T projects, contract management and implementing efficiency schemes relating to back-office functions. Schemes are often identified but subsequent execution results in lower than anticipated benefit realisation. Key reasons for this are that, relative to peers, the Trust's back-office functions are lean and potentially underinvested; secondly, functions do not work together as effectively as they could do; and, finally, enforcement of policy and governance across the Trust and performance management could be further improved. Poor data quality adds to limitations in capability.
- The Trust should seek to identify areas where appropriate collaborative, shared service or outsource agreements could deliver benefits. This is the only viable route through which to drive further savings in clinical support services whilst also improving systems and processes and growing expertise.

Key issues	Interdependencies	Quality Impact
<ul style="list-style-type: none"> • Further clinical buy in and support for schemes • Capacity of management to deliver changes 	<ul style="list-style-type: none"> • Efficiencies through improved workforce management are linked to wider service change and bed reconfiguration 	<ul style="list-style-type: none"> • Quality implications should be carefully considered in collaborative, shared service or outsource assessments.

The **Controls Workstream** focused on cost reduction through tighter management of discretionary pay and non-pay expenditure. Processes and opportunities to support immediate cost reduction opportunities have been agreed through a controls transformation group.

Focus has been on medical, nursing and non-clinical staff pay control for locum, agency, bank and overtime spend, supported by longer term opportunities such as re-negotiation of nursing and medical locum agency charge rates.

Additional opportunities have been identified by managing annual leave accrual and non-pay expenditure by undertaking a residual budgetary process.

Key issues	Interdependencies	Quality Impact
<ul style="list-style-type: none"> Ensuring robust engagement with all staff groups Patient safety remains paramount and must not be compromised 	<ul style="list-style-type: none"> With all elements of the Transformation Programme 	<ul style="list-style-type: none"> Bank and agency process needs to ensure patient safety and service levels are maintained

Other key issues

- The Trust is currently forecast to spend £7.9m on non-contracted pay expenditure for 2011/12, of which £3m is above establishment.
- A focus on immediate pay and non-pay controls has been acknowledged and revised. Processes are being implemented to support achievement of the financial year end ambition set by the Executive Team and Trust Board.

4. More Information

More Information

This is a summary report covering key aspects of the work and findings from phase one of the Transforming for Excellence Programme.

If you have any questions on this report, or if you need clarification on any point or term used, please email tfe@bedfordhospital.nhs.uk

Ernst and Young (EY) Disclaimer

This report is based on inquiries of, and discussions with Trust management and clinical teams and analysis of Trust data

- *EY did not seek to confirm the full accuracy of the data or the information and explanations provided by Trust management and clinical teams*
- *EY work was limited in scope and acknowledged that more detailed procedures could reveal issues that the analysis so far has not*
- *The work EY has done does not constitute an audit, a review or other form of assurance in accordance with any generally accepted auditing, review or other assurance standards, and accordingly EY does not express any form of assurance*
- *The report, developed with the support of EY, is intended solely for the information and use of the management of Bedford Hospital NHS Trust (BHT) and is not intended to be and should not be used by anyone other than BHT without the Trust and EY's specific permission*