Appendix 4

PROJECT DOCUMENTATION

BUSINESS CASE

Operations Management Review

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Authors: Pete Jones
Richard Henderson
Tina Richardson

Owner: Director of Operations

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1.0 Executive Summary

1.1 The East Midlands Ambulance Service (EMAS) NHS Trust Integrated Business Plan (IBP) focuses on the Trust's long term future as an organisation which is "committed to providing all our patients with access to high quality clinical care and services to ensure the best experience and clinical outcome".

1.2 This document has been written in the context of the Trust's aspirations and sets out a business case for introducing a revised operational management structure at divisional level across EMAS which is fit for purpose, capable of delivering key Trust objectives and represents value for money.

1.3 The recommended outcomes incorporated within this paper apply exclusively to the A and E operational infrastructure and can be summarised as follows:

1.3.1 Rationalise the number of divisions from 5 to 3

1.3.2 Disestablish divisional headquarters A and E management structure and replace with a new divisional HQ management structure.

1.3.3 Disestablish current frontline Operational Support Manager (OSM) and Paramedic Team Leader (PTL) management functions and replace with a new locality management structure.

1.3.4 Identify support services required by divisions.

1.4 Initial costings indicate that adoption of the proposed structure will realise £2million recurrent pay savings in management costs per annum once embedded.

1.5 The proposal is quite radical and directly affects approximately 200 substantive operational management posts across the Trust; consequently there will be robust processes in place to ensure full engagement and consultation throughout. For this reason full implementation of the recommendations will commence June 2012 for an 11 month period. (see section 11)

1.6 Implementation of the new structure will result in approx 46 fewer substantive managerial posts The majority of affected managers are HPC registered; consequently the risk in terms of redundancies is minimal. Those clinically qualified managers who exit the process without securing a preferred post will receive appropriate support and be offered suitable alternative employment within the A and E directorate commensurate with their competencies.

1.7 The critical measures of success will be:

- Improved patient outcomes
- Delivery of performance within a constantly changing healthcare environment
- Financial viability which is responsive to market forces.
- High quality services and a culture of continuous improvement which provides a unique selling point to commissioners and reinforces the EMAS brand.
- Having a management team that can transact the change and deliver on both performance, financial and quality targets

1.8 The remit of this paper is confined to divisional A and E operational staff who have a line management responsibility or specialist accountability within the divisional management team.

2.0 Introduction and Rationale for Change

2.1 In 2006 Northamptonshire Ambulance Service, Lincolnshire Ambulance Service and East Midlands Ambulance Service merged to form East Midlands Ambulance Service NHS Trust.

2.2 The current operational management structure was agreed by the Trust Board and designed to provide a period of stability and consistency pending assimilation of the 3 former ambulance services and harmonisation of policies and procedures. The Trust achieved the required response targets for the period 2006 to 2009, but the focus was entirely on performance as opposed to quality of care.

2.3 East Midlands Ambulance Service failed to achieve national ambulance response targets for the period 2009/10 and 2010/11 for Category A8 and B19 calls. In addition EMAS has also faced significant challenges in meeting clinical quality standards and maintaining a healthy financial balance.

2.4 In response to sub standard performance, EMAS undertook a review of the General Manager function at divisional level and this was completed in June 2010. The General Manager post was disestablished and replaced by a more strategically focused Assistant Director of Operations role. The original plan was to conduct a full review of all operational management functions and implement changes by April 2012, but this was deferred due to concerns regarding potential detrimental impact this may have on operational performance. It was recognised at the time that changes at middle and junior management level were required in order to maximise the value of changes implemented at higher levels within the organisation. Whilst EMAS was achieving core response targets, albeit at the expense of other essential activities such as training, staff development and quality it was prudent to act cautiously to offset any potential destabilisation which may occur due to a radical overhaul of management at middle and frontline level. However, the incompatibility of the current structure with the needs of a modern ambulance service have been exposed by the Trust's poor

performance over the last two years and failure to address the situation may jeopardise the future viability of EMAS as an autonomous organisation.

2.5 It is clear that sub standard performance is unacceptable to a Trust which aspires to achieve Foundation Trust status and deliver the highest quality care possible. Success can only be achieved by ensuring that Trust strategic objectives are translated into positive outcomes by focused, motivated and proficient managers.

2.6 There is overwhelming evidence across all divisions to demonstrate that the existing operations structure is very expensive yet consistently failing to deliver core Trust strategic objectives across a range of criterion. The current divisional management structure is not clinically focussed and in urgent need of review primarily because frontline managers are frequently required to perform two job roles due to performance pressures – manager versus operational responder. This results in policies and procedures being inconsistently applied, failure to support staff in a timely and appropriate manner and lack of pro active response to sub standard performance within individual areas of responsibility.

2.7 The current Divisional Operations Structure (Figure 1 page 8) is very traditional and hierarchical. There are too many layers of command which lead to ambiguity, duplication, delayed decision making, and blurred accountability. In addition, existing job descriptions allow too much scope to adapt roles to meet local requirements which do not necessarily support strategic aims and objectives.

2.8 A number of enablers/drivers have arisen over the last year which further reinforce the case for change and should assist in the successful implementation of the proposed structure, as follows:

- New Trust Board appointments to substantive posts at Chair, Non Executive, Chief Executive and Director of Operations should provide a period of stability to support the review process and ensure it is embedded effectively across the Trust.
- Financial recession and the requirement to operate within a reduced financial envelope.
- Government policies in relation to future healthcare provision.
- EMAS centralised resource management centre (RMC) which will assume all responsibility for roster management across EMAS by April 2012 (Notts, Leics, Derbys, Northants - January to March, Lincolnshire - April) This will free up frontline management capacity which can then be diverted to support the clinical quality agenda.
- EMAS estates strategy which is focused on rationalising the existing estates infrastructure to accommodate the revised hub and spoke profile which will be overseen by locality managers and will commence implementation during 2012.
- Loss of the PTS contract is a significant factor that will have a significant impact on the current A and E operational infrastructure in terms of

estates required to facilitate staff and fleet and a reduction in A and E management time required to maintain PTS service delivery at local level (fleet and logistics).

- Foundation Trust aspiration requiring the development of localised autonomous business units which are accountable for the delivery of strategic aims.
- Advances in technology aiding the communications between Trust HQ and remote sites, single CAD nullifying former historic divisional count boundaries
- Improved CAT A performance for the period 2011/12, thus minimizing the risk of destabilising operational performance during period of restructure with additional change to clock start being considered from April 2012.
- Improved demand management within EOC due to NHS Pathways, HAR, HAT.
- Revised frontline service delivery model to be rolled out between 2012 to 2014 which will match resources to demand in terms of activity and skill mix and fleet requirements required, ie. Urgent care crews which are on duty when required and level out batching of GP urgents.
- New A and E contracts which will focus more on payment by results.
- Performance management framework, KPIs and KLOEs which are now embedded at divisional level and will be implemented at frontline management level in line with the revised structure.
- Development of CCGs which will require local engagement to support future commissioning.

3.0 Current Divisional Operational Structure – Estates and Support Services

3.1 Divisions

3.1.1 EMAS currently operates across 5 divisions **(see Appendix 1)** – Nottinghamshire, Leicestershire/Rutland, Derbyshire, Northamptonshire and Lincolnshire. The divisional breakdown is historical and based on former county ambulance services. There is no operational requirement to retain 5 divisions and the use of county titles fuels a staff culture of divisional identification, often dating back to pre merger days, which detracts from the modern EMAS brand name.

3.2 Service delivery is supported via a combination of centralised and localised support services as follows:

- Finance – each division is currently supported by a nominated finance manager who also has corporate responsibility for reporting on financial performance.

- ICT – This is provided centrally by the ICT department based at Beechdale. The service is covered by SLA agreements to cover response arrangements both in and out of hours.

- Fleet maintenance – this is provided by the Trust's fleet department based at Alfreton. The SLA provides comprehensive maintenance cover for all divisions with the exception of Lincolnshire. Lincolnshire outsources maintenance to All Truck but does have some scope to request support from fleet where vehicle breakdowns impact on core cover. Lincolnshire also has a mobile fleet engineer to attend to repairs which can be managed on site.

- Human resources – HR is led strategically at trust HQ with HR managers available at divisional level to provide support and advice to divisional managers.

- Education – Education is led strategically at trust HQ with training facilities located at Bishops Court (Lincoln), Beechdale (Nottingham), Meridian (Leicester).

- Risk and Safety – R and S has recently been centralised with designated contact persons to support divisions.

- Clinical Governance is led centrally and embedded via the clinical quality manager post at divisional level

- Estates/logistics is managed centrally but Lincolnshire has developed a logistics cell to monitor stores ordering and equipment maintenance to ensure that it is cost effective and within budgetary limits. Future logistics modelling may be required to identify gaps in cover and potential for localised procurement which offer value for money.

- Resourcing – The Resource Management Centre will go live across all divisions by April 2012. Lincolnshire currently operates a local resource cell at divisional HQ which will cease from the start of 2012/13. The RMC will also assume responsibility for the management of logistics once embedded.

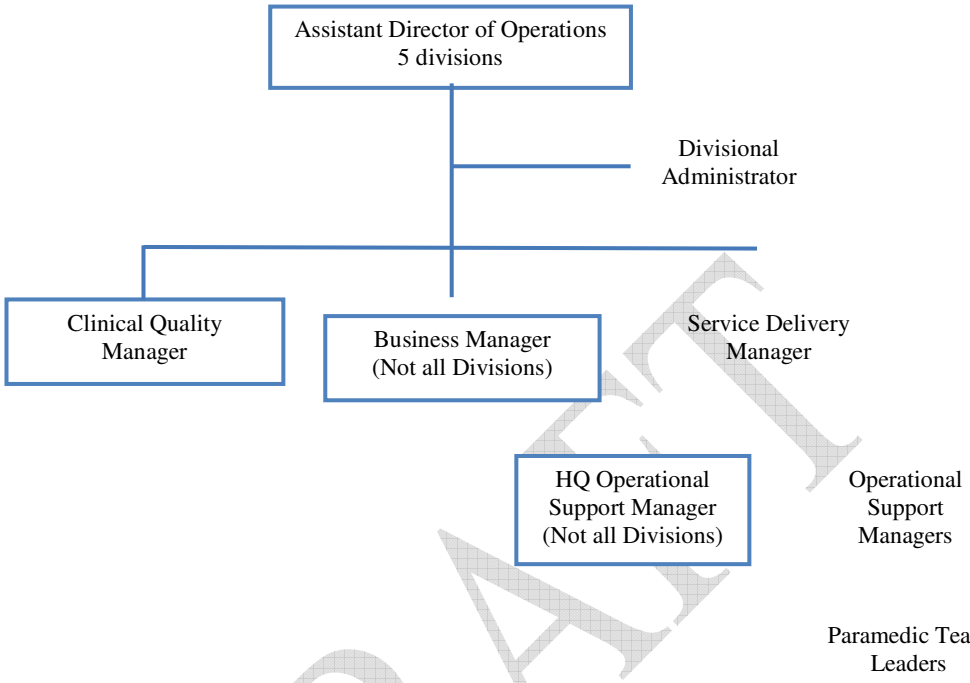
3.3 Current Divisional Configuration **(see Appendix 1)**

4.0 Current Divisional Operational Management Structure – (see Figure1)

4.1 The substantive roles at divisional HQ are ADO, SDM, CQM, BDM and HQ administrator.

4.2 The substantive posts at frontline operational level are OSM, PTL and locality administrators

Figure 1: Current EMAS Divisional Operations Structure



- **Service Delivery Manager – Band 8A**

  The SDMs operate on a Monday to Friday basis and are responsible for Service Delivery across the geographical area of their division. Currently each division of EMAS has one substantive A&E Service Delivery Manager. Two of the Divisions (Lincolnshire and Nottinghamshire) are supported by an OSM based at Headquarters. The delivery of the PTL and OSM roles varies significantly between different divisions and this has resulted in an inconsistent approach to operational delivery. The SDM role is currently too focused on performance and tactical matters consequently there is little capacity to operate at a more strategic level in developing services and implementing service improvements. The core functions will be integrated into the revised structure.

- **Business Manager (Lincs, Leics, Notts and Derby) – Band 8A**

  The Business Manager is responsible for development and management of cost improvement plans specific to the division, strategic plans in relation to estates, CIP, workforce plans and links to other directorates within EMAS. The business manager function operates differently across all divisions consequently this role needs to be reviewed and the core functions integrated into the new operational structure.

- **Clinical Quality Manager – Band 8A**

  The Clinical Quality Manager is accountable for delivering the Trust clinical strategy and delivering against the requirements of the clinical performance indicators.

- **Divisional Administrator – Band 3**

  The divisional administrator provides support to the ADO at divisional HQ.

- **Operational Support Managers – Band 7**

  The OSMs are accountable for operational delivery within their area of responsibility including staff and budget management issues. Within each division, the OSM is often responsible for groups of staff across numerous stations, or one specific station. Currently the OSM role is predominately undertaken by Paramedics although the Trust still has two Ambulance Technicians within the OSM structure. There is inconsistency in the out of hours cover by OSMs in the different divisions and the focus is primarily on achieving response targets. The core functions will be integrated into the new operational structure.

- **Paramedic Team Leaders – Band 6**

  The PTLs are responsible for delivering a range of functions including roster administration, staff management, clinical supervision, performance development reviews, observed practice, etc. They operate on a 24 hour basis within teams configured to the size of their area of responsibility. Normal team configuration is based upon a model of one team leader to 12 - 15 members of operational staff working a 12 or 8 hour rota configuration. The PTLs are frequently moved between managerial and operational roles at the discretion of Emergency Operations Centre dispatchers, to meet call demand. Although the ratio of 1 PTL to 12 - 15 members of staff should be sufficient, operational factors greatly influence the ability of the PTL to deliver Trust KPIs. The core functions will be integrated into the new operational structure.

- **Locality Administrators – Band 4**

  The locality administrators provide support where hubs currently exist by coordinating stores ordering, vehicle servicing and fulfilling generic administration functions.

5.0 Proposed Divisional Operations Management Structure – (see figure 2)

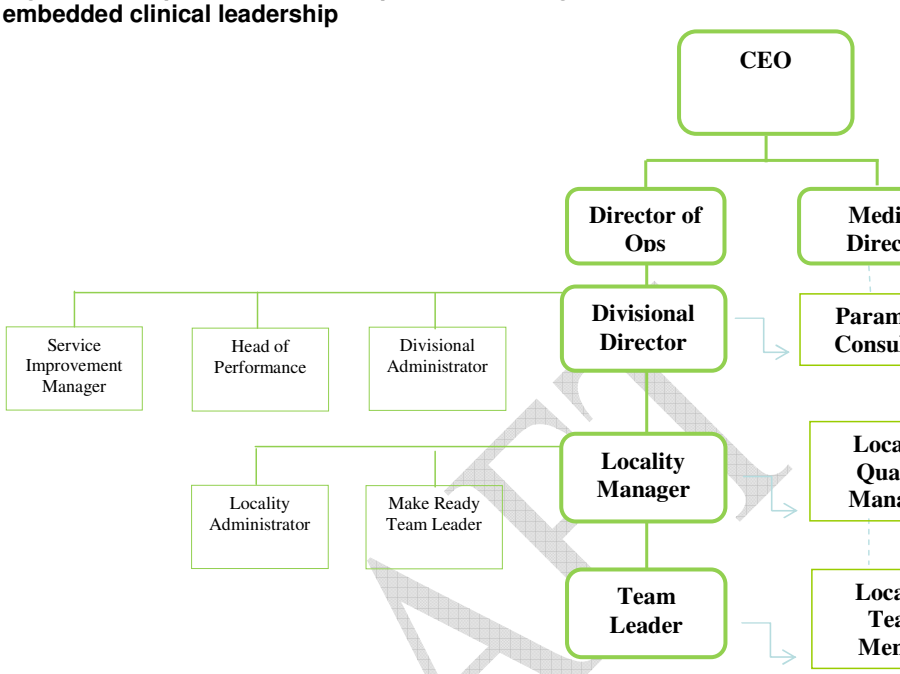
5.1 The proposed divisional operations management structure has been designed to incorporate key supportive management behaviours, as identified in the 'Health Audit Results: Summary Report 2010.[1] This proposal offers a structure where managers are able to promote increased work engagement, improved attitudes to patients, and reduced staff stress by providing clinical and managerial leadership from the front line and embedding leadership competencies into the workforce.

5.2 The proposed structure **(Figure 2)** will be streamlined and ensure a consistency in approach to operational delivery which will contribute to achieving trust targets whilst ensuring longer term financial viability. There will be a robust selection process to ensure that the recruitment and selection process is equitable and appointed staff meet the required competences.

5.3 Once in place the proposed structure will provide the required platform to implement further changes required to meet the Trust's revised service delivery model for the period 2012 to 2014 regarding operational staffing skill mix, whole time equivalents and DCA/FRV ratio.

[1] Zeal Solutions (2010) Organisational Risk Assessment, A Report for East Midlands Ambulance NHS Trust, Health Audit Results Summary Report.

Figure 2 – Proposed Divisional Operations Management structure – with embedded clinical leadership



5.4 Proposed Process for implementing new structure
(See **Item 11** for timescales)

5.4.1 The new structure will be implemented via a phased approach to ensure ongoing stability of core Trust functions during the transitional process. Revised roles and responsibilities will migrate to the new structure in line with devolved autonomy of budgets, service line reporting and local clinical accountability. This section provides an overview of actions to be taken, outcomes and anticipated timescales.

5.4.2 Rationalise from 5 to 3 divisions as follows:

- Lincolnshire – divisional boundary to retain status quo and be titled East Division
- Nottingham/ Derbyshire to merge and be titled North Division.
- Leicestershire/Northamptonshire to merge and be titled South Division.

5.4.3 The revised divisional titles will reinforce the EMAS brand identity across the whole organisation and remove local variations in custom and practice which date back many years following the merger of the former county ambulance services.

5.4.4 The configuration of each division factors in rurality and geographical spread consequently the recommended ratio of locality hubs and staff per locality varies as detailed below:

East Division revised profile

- 474 frontline staff – skill mix and number to be reviewed in line with new service delivery models (2013/14)
- 2,646 square miles
- 3 million population
- DCA 69, FRV 40 – to be rationalised in line with new service delivery models (2013/14)
- 5 locality hubs – 5 teams per hub
- 100 staff per locality hub, 20 staff per team
- Estates to be rationalised in line with estates strategy. (2012/14)

North Division revised profile

- 866 frontline staff – skill mix and number to be reviewed in line with new service delivery models (2013/14)
- 1,866 square miles
- 1.5 million population
- DCA 105, FRV 59 – to be rationalized in line with new service delivery models (2013/14)
- 5 locality hubs – 9 teams per hub
- 180 staff per locality hub – 20 staff per team
- Estates to be rationalised in line with estates strategy (2012/14)

South Division revised profile

- 567 frontline staff – skill mix and number to be reviewed in line with new service delivery models (2013/14)
- 1,784 square miles
- 1.3 million population
- DCA 81, FRV 63 – to be rationalized in line with new service delivery models (2013/14)
- 4 locality hubs – 2 x 5 teams and 2 x 8 teams per hub
- 115 staff per locality hub – 20 staff per team
- Estates - to be rationalised in line with estates strategy (2012/14)

5.4.5 The number of localities and hubs will eventually be predicated upon an analytical piece of work which has been commissioned from an external provider. This baseline review is due for completion within the next 4 months and will further underpin the rationale incorporated within this business case. The model has been designed to factor in any variables

arising from the baseline review. Therefore, the number and location of hubs can be flexed accordingly.

5.4.6 Divisional support function

It is proposed that each division will require corporate resources through either centralised or de-centralised support functions to ensure that key deliverables are achieved.

5.4.7 There will be 3 layers of operational units within the Trust operational directorate, as follows:

- Divisions which will manage hubs, work as accountable autonomous units with service line reporting and contribute to strategic and policy development.
- Hubs which will provide workforce support and coordinate logistics, fleet and supplies where this is devolved locally. Hubs will be responsible for the delivery of IPC via deep clean and make ready support services. Make ready/deep clean services are currently under review but interim arrangements will be in place, overseen by the Make ready team leader role, to ensure KPIs are achieved in accordance with statutory and mandatory requirements. It is envisaged that responsibility for logistics, stores ordering and stock control will be an integral function of any future "make ready" model.
- Spokes which will be satellite facilities from which response teams and frontline manager will operate. Spokes will be equipped with rest facilities and IT links for local and central communication.
- A flexible 4th layer of operational units may also be in place in the form of fixed (modular) and mobile standby sites to support the SSM deployment plan.

5.5 Divisional HQ Management Structure – *(see section 6 for roles and responsibilities of new posts)*

5.5.1 Disestablish the following posts:

- Assistant Director of Operations – 5 posts
- Service Delivery Manager – 5 posts
- Business Manager – 4 posts

5.5.2 Rationalise current Clinical Quality Manager from 5 to 3 Divisional Quality Managers.

5.5.3 Establish new posts as follows:

- Divisional Director – 3 posts
- Head of Performance HQ – 3 posts
- Paramedic Consultant – 3 posts
- Service Improvement Manager – 3 posts

- Divisional Quality Manager

5.5.4 Review additional support required:

- Divisional admin – 3 posts

5.6 Locality Hub Management Structure

5.6.1 Disestablish the following posts:

- Operational Support Manager – 30 posts

5.6.2 Increase Administration posts from 12 to 14

5.6.3 Establish new posts as follows:

- Locality Manager – 14 posts

5.7 Phases one and two will result in a net reduction of **18** WTE management posts with an increase in administration post of **2** WTE.

5.8 Locality Hub and Spoke Management Structure

5.8.1 Disestablish the following posts:

- Paramedic team leaders (PTLs) – 144 posts

5.8.2 Establish the following posts:

- Team Leader – 90 posts
- Locality team Supervisor –30 posts

5.8.3 Phase three will result in a net reduction of **30** whole time equivalent frontline management posts

6.0 Roles and Responsibilities of new structure with indicative bandings

6.1 The **Divisional Director** (band 8D) will be responsible for delivery of key targets in terms of performance, quality and budgetary management – see attached JD.

6.2 The **Paramedic Consultant** (band 8D) will be responsible for all clinical matters.

6.3 The **Head of Performance HQ** (band 8b) - primary roles and responsibilities will be as follows:

- All back office functions
- Strategic overview

- KPI frameworks
- Ensuring divisional performance is reviewed against core Trust targets.
- Interface between directorates
- Interface between key internal and external stakeholders.

6.4 **Divisional Administrator** (band 4) will provide support to the Divisional Director.

6.5 The **Service Improvement Manager** (Band 7) will be responsible for overseeing the implementation of all service improvements and data collation to support service line reporting. Specific core functions will be:

- Co-ordinating the implementation of Service Improvement initiatives across divisional hubs.
- Project management – CIP, contract management etc.
- Business development support
- Evaluating service improvement initiatives, including cost/benefit analysis.

6.6 The **Locality Quality Manager** (Band 8A) role will be consistent with the current Clinical quality manager role. These managers will work across the "Hub & Spoke" model assigned as a ratio of 1:2 hubs.

6.7 The **Locality Manager** (Band 8B) will be responsible for managing the hub and spokes within his/her designated area. Locality Managers will work Monday to Friday office hours and will be expected to contribute to an on-call system.

The post holder will be expected to hold a clinical qualification and deliver the following roles: (*this list is not exhaustive)*

- Full hub and spoke management including staff and vehicular assets
- Responsible and accountable for full Infection Prevention Control/H&S compliance within their stations
- Budgetary management
- Staff welfare management including attendance management
- Planning of essential education.
- Local community/partnership engagement
- Stakeholder engagement across Primary Care Trusts, Clinical Commissioning Groups, Acute Trusts. etc.
- Development and delivery of the estates strategy with support from divisional HQ and Trust HQ.
- Development and delivery of workforce plans which meet the Trust's workforce strategies.

6.7.1 The Locality Manager will be closely supported by the TL/LTM roles and a Locality Administrator and directly accountable to the divisional director.

6.8 The **Locality Administrator** (Band 4) will be responsible for daily administrative functions that support system and process delivery. The Locality Administrator role will include administration tasks that were previously undertaken by the PTL. Locality Administrators will not be expected to perform clinical roles and there will be no requirement to contribute to on-call systems.

6.9 The **Locality Team Supervisors (LTM)** (Band 6) will be responsible for integrating clinical quality into all frontline functions. Primary roles and responsibilities will be as follows:

- Plan and perform individual staff practice reviews (includes PDR)

6.9.1 The LTM will report directly to the Divisional Quality Manager and will remain within the operations directorate. The LTM will operate on a shift basis to allow sufficient supervision and assessment of all clinical staff. They will not ordinarily be expected to work during the night.

6.9.2 The ratio of Locality team Supervisor to locality hub will be based on each LTM responsible for conducting practice reviews for 60 staff. For more detailed calculations **see Appendix 3.**

6.10 The **Team Leader** (TL) will work within the operations directorate undertaking local management roles within the scope of the post holder's job description. It will not be a requirement of the TL role to undertake clinical supervision/observed practice of staff or have responsibility for any of the areas assigned to Clinical Supervisors. The TL role will be responsible for the delivery of staff Performance Development Reviews with clear feedback provided from the Clinical Supervisors on individual staff assessments. The TL will respond to incidents providing on-scene Bronze command

The TL will operate on a shift basis providing 24/7 line management support to staff. They will not be expected to undertake clinical supervision but will undertake the role of an incident manager and scene-supervisor as required. Protected time to fulfil core functions to be determined.

6.10.1 The ratio of TL to frontline staff will be 1:15/20 depending on geographical spread.

6.10.2 Over the lifespan of the 5 year plan the number of WTE TL will reduce from 90 to 82 in line with the Trust's workforce plan, which anticipates an overall reduction in operational staffing. The TL working arrangements will enable 30% response capability and 70% supervisory management time.

7.0 Benefits

7.1 Operationally the proposed structure will be robust resulting in core management functions being consistently applied with the overall aims of:

- Achievement of KPIs in relation to the Trust's performance management framework and clinical strategies.
- Delivery of the cost improvement programme (CIP) to support financial balance.
- Cost effective and LEAN operating model with reduced management overheads.
- Clear lines of accountability and role clarification for operational delivery.
- Clear leadership to operational staff resulting in positive culture changes.
- Job satisfaction to post holders
- Potential to reduce unnecessary staff costs by reducing reliance on overtime and reduction of on call payments.
- Increased relief capability due to rationalisation of posts and redeployment of some managers to full time operational roles.
- Increased managerial availability to perform management functions and engage with stakeholders – internally and externally.
- Improved communications across the Trust.

7.2 Enhanced focus will be on clinical excellence and quality as opposed to the current emphasis on performance targets. Quality in Leadership is key to success. Talent Management applies through a coaching and mentoring framework as well as a "two up" developmental model.

7.2.1 "Two up" development relies on identification of talent and potential in future leaders and developing that capability up to two levels above the individual's current level. There is a need for a specified and comprehensive framework that controls the Talent Management system.

7.3 Financial savings due to the reduction in management overheads – *please see **Appendix 4** for detailed financial modelling for implementing the new structure compared with the existing structure)*

8.0 Risks

8.1 Any proposed changes present associated risks and these need to be balanced against the identified benefits. The potential and actual risks that have been identified as a consequence of this business case are as follows:

- Recruitment/Selection process may impact on management engagement.
- Resistance to change from staff
- Possible operational impact (short-term)
- Reduced visibility of senior managers out of hours.
- Disestablishment of current management roles will result in existing post holders at risk and potential period of instability pending new roles being recruited to.
- Opposition from staffside to implement the framework
- Ability to recruit staff with the required skills
- Failure to implementation proposed structure within planned timeline

- The capacity of support services to direct and facilitate the plan of transition
- The cost of the transition plan outweighs the benefits of the cost improvement plan. Detailed financial modelling
- The size of the divisions are not equitable and the ration of staff to managers could be disproportionate.

8.2 All risks will be mitigated by ensuring that staff affected by this proposal are fully supported throughout the process with an emphasis on timely and ongoing communications. The process will also be open and transparent to ensure the rights of individuals are respected in compliance with Trust policies and procedures.

9.0 Benefits Realisation

9.1 The proposal will be supported by a formal review process to ensure that the revised management structure delivers against agreed KPIs – qualitative and quantitative. These will relate to the overarching strategic objectives of the Trust in terms of performance, clinical quality, financial balance and risk and governance.

9.2 It is anticipated that the proposed structure could be in place by January 2013, but the benefits should start to be realised as soon as posts are recruited to, dependent on individual knowledge and experience.

9.3 Benefits in terms of role clarification and accountability will be immediate.

9.4 Improvement in staff morale and sickness absence due to timely access to management support is a benefit which cannot be underestimated. This proposal is very people focused since achievement of Trust aims and objectives is reliant on motivated staff who feel valued, empowered and supported.

10.0 Cost and Timescale

10.1 It is envisaged that the Trust will appoint a full time Project Manager to oversee implementation of the key deliverables outlined within this paper. The Project Manager will perform a dual function as follows:

10.1.1 Impartiality to ensure that the Trust does not inadvertently breach HR regulations. This is particularly relevant to this business case since most managers will be affected by the restructure; consequently use of existing operations management may present a conflict of interest.

10.1.2 To deliver action plans and identify workstream to ensure that key milestones are achieved and provide regular updates to the lead director regarding progress and any risks which may impact on delivery.

10.1.3 Indicative costs for the Project Manager are based on 9 month fixed term contract and circa £30k.

10.2 The proposed new model will be delivered within the existing management cost envelope.due to the disestablishment of some positions to offset new roles. There may, however, be some non recurring or time limited costs related to redundancies or protected pay in the event of staff being unsuccessful in securing new posts or being deployed to suitable alternative posts. In addition there may be some cost efficiency savings due to reduced unsocial hours pay and redeployment of managers to operational roles which will increase relief and reduce overtime requirement. Details regarding MARS availability or early retirement are not available at time of writing this paper.

10.3 Cost per annum of existing divisional management structure compared with proposed structure can be found in appendix 4 – financial modelling.

10.4 There are no anticipated capital costs or start up costs as hub sites are already in place or being factored into the Trust's overarching estates strategy.

11.0 Timescales – October 2012 to March 2013

11.1 October 2012 – Consultation starts for a three month period with all affected staff.

11.2 December 2012 - Appoint to substantive Divisional Director and Paramedic consultant.

11.3 December 2012 – Appoint Locality Managers.

11.4 December 2012 – Appoint to Head of Performance HQ, Service Improvement Manager, and, Divisional Quality Manager.

11.5 February 2013 – Appoint to Team Leader and Locality Team Supervisor

11.6 March 2013 – Possible suitable alternative employment to frontline Paramedic substantive posts for displaced staff

11.7 Timescales provided are approximate and based on having capacity within support and operational functions to deliver internally or externally through consultancy services. i.e management presence, HR advisory and transactional functions, Recruitment, selection and education and development processes

11.8 .Based on minimum time required but may be reduced by mutual consent, notice periods may affect some transitional changes

12.0 Assumptions

12.1 The Trust estates strategy will be endorsed by the Trust Board and implemented within the required timescales.

12.2 The RMC function delivers the required aims and objectives with no additional resourcing required at divisional level to support.

12.3 SLA agreements between support services and divisions are comprehensive across all required criteria and responsive to time critical events with no additional resourcing required at divisional level to ensure delivery of key objectives.

12.4 Fleet services in Lincolnshire are currently outsourced but will need to be reviewed to ensure timely maintenance and minimise disruption due to vehicle downtime.

12.5 Project Manager will be appointed to oversee successful implementation of the proposed restructure.

13.0 Investment Appraisal

13.1 There are no funding implications to this proposal but an appraisal will be conducted to ensure the anticipated benefits are realised within agreed timescales.

13.2 Projected recurrent annual savings are circa £2m less protected pay, redundancy or additional appointments which may be required to support divisional HQ functions.,

13.3 The benefits of approving the proposed operations structure far outweigh the consequences of retaining the status quo which has consistently failed during the last two years to deliver to the required standards.

14.0 Recommendation

14.1 The Trust Board is asked to support the business case.

14.2 The Trust Board is asked to approve the timescales for implementation.

APPENDIX 3

1.0 Formula for managers is as follows:

1.1 Locality managers – Monday to Friday with on call

- 1:5 weeks – cover Silver role
- 1:4 weeks (South Division)

1.2 Operational Supervisors – 90 WTE – ratio of 1:20 staff

- East 22
- North 41
- South 27

1.2.1 The total OS will also need to factor in Bronze response capability during the 24/7 period consequently further modelling will be conducted in each division identify gaps in cover which may pose a risk to the Trust's statuary duties under the Civil Contingencies Act and identify contingencies. Reciprocal support may be required to support divisional pressures. For example OS for the North could be deployed to the East or South division where frontline managerial support may be required, particularly out of hours.

1.3 Clinical Team Supervisors – 30 WTE

- 75% Clinical Supervision
- 25% Development /Audit

1.3.1 Total hours available per WTE per annum.

- Clinical Supervision - 1056
- Development / Audits - 352

1.3.2 The plan is to appoint 30 CTMs across the Trust, which provides the following capability:

- Clinical Supervision - 25,344 hours = 2,204 x 11.5 hour shifts
- Development / Audits – 8,448 hours.

1.3.3 Based on current frontline staffing across the Trust, which is 1,907, the above Clinical Supervision hours will provide the capacity for each supervisor (taking into account full annual leave entitlement of 28 days plus BHs, or annualised hours arrangements to facilitate up to 22hours worth of supervision per member of staff. This calculation equates to 2,204 annual Clinical Supervisions, which is 1.15 clinical supervisions per WTE.

2.0 All WTE hours calculated at 1,955 hours minus 28% abstraction = 1407.6 baseline starting hours available per WTE.

Appendix 5

	WTE	Cost Per WTE	Cost £k
Existing Structure			
Assistant Director of Operations	5	82.5	412.5
Service Delivery Manager	5	57.1	285.5
Business Development Manager	4	57.1	228.4
Clinical Quality Manager	5	57.1	285.5
Divisional HQ Administrator	5	24.4	122.0
Operational Support Manager	30	55.7	1,671.0
Paramedic Team Leader	144	52.5	7,560.0
Administration Assistants	12	24.4	292.8
Total	**210**		**10,857.7**
Proposed Structure			
Divisional Director	3	91.2	273.6
Head of Performance	3	67.7	203.1
Paramedic Consultant	3	91.2	273.6
Service Improvement Manager	3	49.4	148.2
Locality Quality Manager	7	57.1	399.7
Locality Manager	14	67.7	947.8
Operations Supervisor	90	52.5	4,725.0
Locality Team Mentor	30	52.5	1,575.0
Administration Assistants	14	24.4	341.6
Total	**167**		**8,887.6**
Saving	**43**		**1,970.1**

	WTE	Cost Per WTE
2012/13 Budget		
Assistant Director of Operations	5	80.1
Service Delivery Manager	5	60.8
Business Development Manager	4	53.6
Clinical Quality Manager	5	57.5
Divisional HQ Administrator	6	21.5
Operational Support Manager	30	56.2
Paramedic Team Leader	144	52.5
Administration Assistants	6	24.5
Total	**205**	

	WTE
Redundancy Costs (assuming 2 years)	
Assistant Director of Operations	2
Service Delivery Manager	2
Business Development Manager	4
Clinical Quality Manager	3
Divisional HQ Administrator	0
Operational Support Manager	16
Paramedic Team Leader	30
Administration Assistants	0
Total	**57**

	WTE	Cost Per WTE	Cost £k
Protection Costs			
Assistant Director of Operations	2	14.8	29.6
Service Delivery Manager	0	57.1	0.0
Business Development Manager	0	57.1	0.0
Clinical Quality Manager	0	57.1	0.0
Divisional HQ Administrator	0	24.4	0.0
Operational Support Manager	16	3.2	102.4
Paramedic Team Leader	30	11.3	678.0
Administration Assistants	0	24.4	0.0
Total	**48**		**810.0**

	WTE	Cost Per WTE
MARS Costs (assuming 12 months)		
Assistant Director of Operations	2	82.5
Service Delivery Manager	2	57.1
Business Development Manager	4	57.1
Clinical Quality Manager	5	57.1
Divisional HQ Administrator	0	24.4
Operational Support Manager	16	55.7
Paramedic Team Leader	30	52.5
Administration Assistants	0	24.4
Total	**59**	