The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 3 August 2017 at 9.00am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.00
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.00
3.	**Announcements**		J Ord	To Note	9.00
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6 July 2017	Enclosure 1	J Ord	To Approve	9.00
	4.2 Action Sheet 6 July 2017	Enclosure 2	J Ord	To Action	9.05
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.10
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	9.20
7.	**Patient Safety and Quality**				
	7.1 Clinical Strategy	Enclosure 4	P Harrison	To discuss and agree	9.30
	7.2 Pathology Outline Business Case	Enclosure 5	D Wake	To approve	9.45
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	To note assurances & discuss any actions	10.00
	7.3 Chief Nurse Report – Infection Control	Enclosure 7	S Jordan	To note assurances & discuss any actions	10.10
	7.4 Nurse/Midwife Staffing Report	Enclosure 8	S Jordan	To note assurances & discuss any actions	10.15

8.	**Finance and Performance** 8.1 Finance and Performance Committee Exception report 8.2 Performance Report	 Enclosure 9 Enclosure 10	 J Fellows P Bytheway	 To note assurances & discuss any actions To note assurances & discuss any actions	 10.25 10.35
9.	**Any other Business**		J Ord		10.45
10.	**Date of Next Board of Directors Meeting** 9.30am 7 September 2017 Clinical Education Centre		J Ord		10.45
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		10.45

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th June, 2017 at 9:30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Paul Harrison, Medical Director
Siobhan Jordan, Interim Chief Nurse
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
Paul Bytheway, Chief Operating Officer
Jonathan Fellows, Non Executive Director

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Dr Mark Hopkin, Associate Non Executive Director
Liz Abbiss, Head of Communications
Roger Callender, Deputy Medical Director (Item 17/074.5)
Amanda Gaston, Head of Service Improvement (Item 17/075.3)

17/067 Note of Apologies and Welcome
9.50am

Diane Wake, Chief Executive had sent apologies.

17/068 Declarations of Interest
9.51am

The Medical Director's standing declaration was noted and it was confirmed that this did not conflict with any items on the agenda requiring any decision.

Dr Mark Hopkin confirmed that he was a GP and Clinical Lead at the CCG and it was confirmed that this did not conflict with any items on the agenda requiring a decision.

There were no other declarations of interest.

17/069 Announcements
9.51am

None to note.

17/070 Minutes of the previous Board meeting held on 1st June, 2017 (Enclosure 1)
9.51am

The minutes of the previous meeting agreed by the Board as a true and correct record of the meetings discussion and could be signed by the Chairman.

17/071 Action Sheet, 1st June, 2017 (Enclosure 2)
9.52am

17/071.1 Corporate Risk Register

Corporate Risk Register Report to be presented at the next Board meeting.

Corporate Risk Register Report to be presented at the August Board meeting.

All other items on the action sheet were either complete or for a future meeting.

17/072 Patient Story
9.54am

The featured patient had been diagnosed with incontinence in 2008 and had been treated by the Continence Team at the Trust since 2011. The patient had a lot of praise for the care provided, particularly by one member of the Continence Team.

The Board noted that the patient had an issue with the Continence Nurse arriving at her home in uniform. The Chief Nurse has discussed the issue with nursing staff, who confirmed that they like to wear a uniform. It was agreed that in individual cases such as this, efforts would be made to disguise the fact that they were a nurse, such as wearing a coat for example. Mrs Becke, Non Executive Director, suggested that the Trust could look further at this particular team and how visits were undertaken.

The Head of Communications confirmed that the Division are investigating the breakdown in communication around referrals mentioned in the story. Mr Hopkins remarked how pleased he was that one person had taken on the lead co-ordination role. Whilst there had been others who could have communicated more promptly the fact that one person, and in this case, the best person was able to navigate the patient through the system demonstrated the ethos of the Multi Disciplinary Teams in practice.

The Chairman and Board noted the story.

17/073 Chief Executive's Overview Report (Enclosure 3)
10.12am

The Medical Director presented the Chief Executive's Overview Report, given as Enclosure 3, including the following highlights:

- Friends and Family Test: The roll out of the text messaging service continued and was having a positive impact on the number of patients engaging with this survey.

- Visits and Events: A summary of the meetings and visits undertaken by the Chief Executive during the previous month.

- MCP: To be covered on the Private agenda given the commercial sensitivities of the procurement process underway by the CCG.

- Fellow of the Royal Pharmaceutical Society: The Chairman confirmed that she will send a letter of congratulations on behalf of the Board, in recognition of this member of staff's dedication and hard work.

- Clinical Fellow Placements for Pharmacy Staff: The Chairman confirmed that she will send a letter of congratulations on behalf of the Board.

The Chairman asked about the Fellow appointments in Pharmacy. The Board noted the expectation that staff will return to the Trust at the end of the placement. Their roles are currently being back-filled.

The Chairman and Board noted the report.

17/074 Patient Safety and Quality

17/074.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
10.18am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 4.

The Board noted the following key areas from the Committee meeting:

- The outcomes of the continued weekly audits on compliance with the National Patient Safety Agency Alert for Naso Gastric Tube Placements were received by the Committee. Insufficient assurance remained to change the frequency to quarterly audits and a report will be provided to the next meeting.

- The Committee received a report from the Surgery Division on three recent incidents within Ophthalmology. The quality of this service will continue to be a focus of the Committee. The Committee endorsed the actions proposed by the Chief Executive to ensure that the short term capacity challenges were managed.

- The Committee approved its revised Terms of Reference reflecting the extended membership for this Committee.

- The Quality Improvement Board (QIB) Report to be received by the Committee in July.

The Chief Nurse added that there had been significant debate around serious incidents and ensuring that learning is embedded.

The Chairman and Board noted the report, assurances received, additional capacity for Ophthalmology, ratified the Terms of Reference for the Committee and noted that the QIB report will be presented to the Committee at the end of July.

QIB report to be presented to the Clinical Quality, Safety, Patient Experience Committee at the end of July.

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17/074.2 Chief Nurse Report – Infection Prevention and Control Update (Enclosure 5) 10.05am

The Chief Nurse presented her report, given as Enclosure 5.

The report detailed infection prevention and control issues, including the following key highlights:

- MRSA: The Board noted the Trust's positive performance in this area, with no cases identified this year.

- CDiff: The Trust continues to do well, with a total of 5 cases to date. An independent review is currently taking place examining opportunities for further good practice.

- TB: A second patient had been treated in the Trust. This patient was isolated and treated as appropriate.

- Infections in the organisation - Neonatal incidents. The Board noted that the cases were not linked and that agreed actions will be delivered.

The Board noted that the Infection Prevention and Control Committee frequency had changed to a monthly meeting.

The Medical Director further confirmed the Neonatal incidents were not linked.

The Chairman and Board noted the report and the actions being taken. The Board noted the positive performance in relation to MRSA and C-Diff and the position regarding TB and Neonates and the external review of infection control process.

17/074.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
10.29am

The Chief Nurse, presented the monthly Nurse/Midwife Staffing Report given as Enclosure 6.

The Board noted the following key issues:

- Staffing Review being undertaken. This has been concluded for Surgery. Neonatal review will be concluded the following day and then work will be undertaken across Medicine. Results to date indicated the need to increase the substantive nursing workforce.

Mrs Becke, Non Executive Director, commented that the Trust, like many others had encountered difficulty in recruiting nursing numbers. The Chief Nurse confirmed that a number of actions are being put in place, including approaching Graduates and a nurse recruitment lead established.

The Director of Finance and Information stated that the Trust must ensure that it is not in a position where additional nurses are recruited but the spend on agency staff does not reduce.

The Medical Director advised that we have to maximise our ability to attract staff.

The Board discussed strategies for recognising the contribution of our staff and showing them that they were valued. It was agreed that Long Service Awards should continue to be used but with more timely events.

Mr Atkins, Non Executive Director, endorsed the actions around nurse recruitment and agreed that staff may not choose to work at the Trust if there was a higher patient to nurse ratio than in other hospitals.

The Chairman and Board noted the report and the staffing review underway. The Board recognised the need to focus on both recruitment, and incentives for retention and the need for the Trust to continue to look for opportunities to grow and sustain the clinical workforce.

17/074.4 Workforce and Staff Engagement Committee Summary Report (Enclosure 7)
10.51am

Mr Atkins, Committee Chair, presented the Workforce and Staff Engagement Committee Summary Report given as Enclosure 7.

The Board noted the following key issues:

- The Committee received the Corporate Workforce risks. Some updating was required to ensure that all staff groups were reflected within the actions to address the risks.

- The amended Committee Terms of Reference representing the extended membership of the Committee were presented and approved.

- Assurance was provided around the expected full use of the apprenticeship levy.

- KPIs were presented. There was concern around the time taken by management to shortlist candidates for interview. This improvement need will be monitored at divisional performance meetings.

- The Workforce Plan was presented to the Committee.

- A number of policies were ratified.

The HR Director raised the key performance targets and the importance of managers improving shortlisting timeframes. The Chairman stated that the Board expected to see a dramatic improvement in this position in time for the next Workforce Committee meeting.

The Chairman and Board noted the report and assurances provided and ratified the Terms of Reference which had been tabled.

The Workforce Committee actively seek assurance in relation to the expected improved timescales for managers shortlisting for interview at their next meeting.

17/074.5 Mortality Report (Enclosure 8)
10.57am

The Deputy Medical Director presented the Mortality Report given as Enclosure 8.

The Board noted the following key issues:

- The mortality indices were detailed in the first part of the report. The Chief Operating Officer confirmed that an admission audit had been undertaken in assessment areas and there will be cases that are not now classed as admissions. This needs to be taken account within the future calculation of mortality ratios.

- The Board noted that every death is reviewed to establish all the facts, the outcomes of which are recorded. This approach aligned with good practice which enabled any learning to be shared.

- The Mortality Tracker was tabled on page 11 of the report. The Board noted the amber and red areas and that these were mostly in Oncology and Haematology. Mr Callender, Deputy Medical Director, confirmed that these areas are reviewing deaths. Dr Hopkin, Associate Non Executive Director, commented that there was no excuse for audits not being undertaken. The Chairman asked if reviews are being undertaken how this could be reflected on the tracker.

Mr Callender confirmed that he would adjust the report and tracker to ensure all reviews are reflected in the report. Mr Callender confirmed that more detail will be included on level 2 reports and around learning in future reports

The Chairman asked if there were any concerns that should be taken from the report and asked to see more detail on how learning is being embedded.

The Medical Director confirmed that our mortality review system fortuitously had been developed ahead of the new NHS guidance and positioned us well compared to other Trusts.

Mr Miner, Non Executive Director, commented that the report was complex and could have areas of clarity on issues, risks and actions. He asked for assurance from the Medical Director this would be possible in future reports. The Medical Director confirmed that there were no areas of concern identified and that the report content and format would be adjusted as indicated by Mr Callender earlier.

Dr Wulff, Non Executive Director, confirmed that the report reflects the difficulty of distilling information at this level. The Chairman suggested that the next Clinical Quality, Safety, Patient Experience Committee look at the report at its meeting. The Medical Director confirmed that the new draft policy around the review of deaths will be presented at the next Committee meeting.

Mr Atkins, Non Executive Director, asked for further assurance, as figures in the report were aggregated. The Medical Director stated that due to the small numbers it would not be valuable to disaggregate the figures.

The Medical Director confirmed that the work is also being undertaken looking at end of life care and the links between primary and secondary care. The Chief Nurse confirmed that work is also being undertaken around DNA CPRs and this should link into the work on end of life care.

The Chairman and Board noted the report and the discussion regarding its future format.

Draft policy on the review of deaths to be presented to the next Clinical Quality, Safety, Patient Experience Committee.

17/074.6 Health, Safety and Fire Assurance Report (Enclosure 9)
11.33am

The Chief Operating Officer presented the Health, Safety and Fire Assurance Report given as Enclosure 9.

The Board noted the following key issues:

- Health and Safety audit results were outlined in the report.
- Work is being undertaken to ensure all policies are updated and staff understand their roles in their delivery / adherence.
- The Board noted that COSHH adherence is a challenge for the Trust.
- Fire training was detailed within the report and a new process is in place providing greater flexibility on how the training can be accessed.
- Medical Devices compliance remains a challenge. Work to be completed within the next 2 weeks. There are also some issues with the asset register and access to equipment. Mr Atkins, Non Executive Director, asked how the situation arose. The Board noted that this had previously been a PFI contract non compliance issue and work is ongoing to bring this in-house.
- Staff Muscoskeletal and stress absences now links in to a CQUIN target and support to prevent and enable better working environments were underway.
- Incident data: There were issues relating to sharps training and poor compliance with policy.
- The Trust's Fire Safety workplan was included within the report for approval.

The Chairman asked about the independent review on the cladding of the building. The Chief Operating Officer confirmed that initial feedback suggested that specification of the cladding was not problematic and that all cladding on site allows at least 60 minutes of protection.

The result of the full independent review would be reported to the regulators and the Board.

The Chairman and Board noted the report, assurances received and approved the fire safety work plan.

17/074.7 Charitable Fund Committee Report (Enclosure 10)
11.41am

Mr Atkins, Committee Chair, presented the Charitable Fund Committee Summary Report given as Enclosure 10.

The Board noted the following key issues:

- The Committee received a report from the Fundraising Manager for 2016/17.
- The 2016/17 Fundraising Plan ended the year with a £21k deficit against the fundraising target, but there is confidence that this year's plan can be achieved.

- The total fund balance stood at £2.4m and the general funds balance was £208k.
- Income to date was ahead of plan.
- 4 Bids were approved and 1 bid was deferred for the use of charitable funds.

The Board noted that the Charity Fundraiser will now report to the Head of Communications as strengthening this link should improve the success of fundraising campaigns.

The Chief Nurse commented that staff appreciate the support of the Committee.

The Chairman and Board noted the report, actions underway and assurances provided.

17/075 Finance and Performance

17/075.1 Finance and Performance Committee Exception Report (Enclosure 11) 11.45am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 11.

The Board noted the following key issues:

- Agency spend was not falling as planned and this puts receiving the STF money at risk.
- Performance Targets: A&E, Cancer and Diagnostics were discussed given the recent performance of the Trust and the Board noted that all 3 areas have action plans in place to improve performance.
- MCP Procurement: Deloitte have been engaged by the CCG to identify the risk impact of the MCP and what costs will be left with Trust post the MCP process. The Board noted that there was a potential for significant stranded cost and this could destabilise the Trust.
- The Board noted the discussions with Summit regarding their Estate management performance.
- The revised Terms of Reference were referred to the Board for ratification .
- The business case for increased staffing within ED was reviewed and approved. This will need to be circulated to the Board for final approval due to the value of the case.

The Chief Operating Officer confirmed that Cancer standards for the quarter were likely to be breached. There had been difficulties with recruitment into Pathology specialties but the Trust had secured additional sessions to provide a more stable Histopathology service. Breaches should reduce during July.

Diagnostics had seen a number of challenges over the last 12 months, including a higher number of referrals and some down time for CT and MRI scanners. Ultrasound was the biggest area of demand as the service was seeing an extra 700 extra referrals in a month. The Trust was increasing sessions and using locums to support the service. A mobile CT scanner will be on site from 6th July and it was now forecast the target would be reached by August, 2017.

ED had seen an increase in activity month by month. A programme of work had started to look at preparing for winter. The Trust had seen a decrease in delayed transfers of care but an increasing number of attendances with an average take of 300 patients per day (up from 270 last year). The Trust is on trajectory to deliver the A&E target from July, 2017. The Board noted that the Trust had a high ambulance conveyance rate compared to some other areas, which added to the demand on A&E services.

The Chief Operating Officer confirmed that there had been no mixed sex breaches since May 2017.

The Chairman and Board noted the report, actions underway, risks to delivering forecast performance and ratified the Terms of Reference.

17/075.2 Performance Report
12.05pm

The Performance Report was attached as an Appendix to the Finance and Performance Committee Report and performance had been discussed within the previous item.

17/075.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 13)
12.06pm

The Head of Service Improvement presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 13.

The Board noted the following key highlights:

- There had been slippage in May and the Trust was £146k behind its CIP plan. The Trust was mitigating the majority of this slippage across the rest of the year. A £10k gap was predicted at year end.

- The Pathology Managed service contract is a risk to the plan and the forecast had been rephrased and is included within the revised forecast outturn.

- Agency spend was also a risk and slide 3 showed the trajectory against the reduction plan.

- Detail on the CIP divisional performance was included in the report.

- The Trust is working with frontline staff to gather further ideas for transformation schemes and is re-launching the Ideas Forum.

- The Quality Impact Assessment panel had met and approved 29 schemes with 11 schemes remaining. More panel meetings had been arranged.

The Chairman and Board noted the report and performance at month two of the business year.

17/076 Any Other Business
12.13am

There were no other items of business to report and the meeting was closed.

17/077 Date of Next Meeting
12.13am

The next Board meeting will be held on Thursday, 3rd August, 2017, at 9.00am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 6 July 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/041.7	Corporate Risk Register and Assurance Report	The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.	ET	6/7/17	Corporate Risk Register Report to be presented at the next Board. Deferred to September Board due to timings.
17/074.1	Clinical Quality, Safety, Patient Experience Committee	Maternity Review report to be presented to the Clinical Quality, Safety, Patient Experience Committee at the end of July.	DWu	25/7/17	On Agenda
17/074.5	Mortality Report	Draft policy on the review of deaths to be presented to the next Clinical Quality, Safety, Patient Experience Committee.	PH	25/7/17	On Agenda
17/074.4	Workforce Committee	Improvements to be seen in relation to timescales for shortlisting for interview by the next Workforce Committee meeting.	AM	29/8/17	
17/052.3	Complaints and Claims Report	Future reports to contain correlation with incidents and examples of learning.	GP	7/9/17	
17/063.5	Guardian of Safe Working Report	Assurance to be presented to the Board around the exception reporting process in 3 months time.	BE	7/9/17	
17/063.6	Trust Annual Plan Objectives 2017-18	Appropriate maternity elements specific to Dudley to be included in the Annual Plan. Text regarding the MCP to be amended in light of timescales.	LP	7/9/17	
17/074.6	Health, Safety and Fire Assurance Report	The full result of the independent review to be reported to the regulators and the Board.	PB	7/9/17	

17/063.3	Research and Development Report	Research and Development Strategy to be produced and presented to Board. R&D newsletter to be made available to Community staff.	JN JN	7/12/17 7/12/17	
17/063.9	Organ Donation Report	Tissue and organ donation data to be included in future OD Annual Reports. General Practice to be included in the Organ Donation week arrangements for September. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	JN/RE/RU SJ	7/12/17 Sept 17 November Meeting	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 3rd August 2017

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Friends and Family Test (FFT)
- Visits and Events
- Trust News
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Effective, Responsive, Caring**
	Monitor	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

RECOMMENDATIONS FOR THE BOARD: The Board are asked to note and comment on the contents of the report

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – August 2017

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Friends and Family test (FFT)

Response rates:

Table 1 below provides the FFT response rates over time including June 2017. It is pleasing to see that all areas have seen an increase - Emergency Department has seen an increase from 13.6% in May to 17.1% in June and is consistently achieving scores above the national average 12.5% (April '17). Likewise, the response rates for inpatient areas have shown continued improvement with an increase from 30.8% in May to 32.8% in June 2017 compared to the national average response rate of 25.5%.

Table 1 – Response rates over time

Area	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Emergency Department	8.4%	10.7%	5.0%	5.0%	3.7%	4.3%	13.1%	15.4%	18.6%	15.4%	13.6%	17.1%
Inpatients (inc. day case)	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.9%	18.1%	18.3%	28.7%	30.8%	32.8%
Community	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.5%	1.2%	1.2%	1.1%	0.9%	2.1%
Outpatients	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	2.4%	1.9%	1.7%	1.5%	1.9%	2.3%

Actions continue to support improved response rates in all areas. An FFT awareness day was held on 6th July which included an interactive stand in Russells Hall Hospital main reception and am FFT roadshow that visited community sites across the Borough.

Recommended percentage rates:

In May 2017, all areas achieved a recommended percentage that was equal to or better than the national average with the exception of ED who achieved 78.7% compared to the national average of 87% (May '17) and Inpatients who achieved 95.6% compared to the national average of 96% (May '17). See table 2.

Table 2 –Recommended percentage rates over time

Description	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Community – Recommended %	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94.0%	94.4%	97.8%	97.3%	94.0%	96.0%	97.4%
ED – Recommended %	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76.0%	81.0%	75.0%	76.6%	78.7%
Inpatients – Recommended %	97.0%	94.6%	96.6%	96.6%	97.9%	95.0%	97.9%	95.8%	97.3%	97.3%	96.4%	95.6%	96.5%
Maternity – Recommended %	98.9%	96.0%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99.0%	98.8%	97.8%	98.2%
Outpatients – Recommended %	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95.0%	94.1%	96.2%	95.3%	95.2%	91.6%

Visits and Events

7th July Dementia Carer Voices Presentation
12th July Black Country Alliance Board
13th July Visit to Dudley Rehabilitation Services
13th July Birmingham University Chancellor's Dinner
17th July Meeting with NHS Improvement
18th July Meeting with Wyre Forest GPs
19th July A&E Delivery Board
19th July Senior Medical Staff Committee
20th July Annual Members Meeting
21st July Presentation for Winning Leaflet Design at Holly Hall Academy
26th July Partnership Board
27th July Trust/Summit Board to Board Meeting
27th July Visit by Margot James MP
28th July Operational Medical Director Interviews
28th July Attendance at Vascular MDT
31st July Visit by Ian Austin MP
2nd August Visit to the Undergraduate Centre

Trust News

Dudley Emergency Treatment Centre

Work on the £2.6 million purpose-built extension next to our Emergency Department starts on 31st July. The new facility will improve patient flow and will be open In November 2017. Having the two services in one place will also allow us to work even more closely with clinicians from primary care and enable more efficient streaming between the two services.

The new building will house a new UCC waiting area, eight UCC treatment rooms, as well as a new ED waiting area. Building work starts on 31st July 2017 and, during the work, some temporary arrangements will be in place: **Temporary waiting area** The ED waiting area will move at 3am on Tuesday 8th August to a temporary building located in the area currently used for EAU ambulances by the corridor to cardiology.

Guest Community Imaging Hub

A brand new £3.5 million imaging suite with state-of-the-art technology is being built at Guest Outpatient Centre for patients who need an MRI or CT scan. The new facilities will be able to handle almost 20,000 extra scans a year, reduce waiting times for patients and allow patients to have a scan closer to their homes.

All patients referred for an MRI or CT scan by their GP will no longer have to visit Russells Hall Hospital or Corbett Outpatient Centre but will, instead, go to Guest.

We are spending £2 million to adapt the existing building and the remaining £1.5 million is to be spent on the equipment. The new kit allows us to have the very best equipment to maintain a high quality service. To manage the extra number of patients attending Guest, an extra 22 car park spaces are being provided for staff and visitors.

Building work is due to begin in August and will last three months. The suite is expected to be fully operation by 1st November 2017.

Children's Welcome Booklet Design Competition

The communications team ran a very successful competition with our most local school Holly Hall Academy for design students to design the front cover of our new Welcome booklet for the children's Ward and ran an online vote on facebook and Twitter to decide the winner. The winner is Lily Piddington, aged 14, from Holly Hall Academy in Dudley.

Charitable Fundraising

We are in the running to receive a huge £4,000 cash grant from the TESCO Bags of Help initiative. Please support us – your vote does count!

You can vote for us during July and August using the blue token given to you at the checkout each time you shop. If you're not given a token, please do ask for one! Tesco community funding scheme sees grants of £4,000, £2,000 and £1,000 – all raised from the 5p bag levy – being awarded to local community projects. So, if we get the most votes that's £4,000 towards our 'Children in Hospital' appeal which could really improve the environment in which our children may spend some of the scariest times of their young lives.

Three groups in every Tesco region have been shortlisted to receive the cash award and shoppers are being invited to visit Tesco stores to vote for who they think should take away the top grant.

Voting is open in all Tesco stores throughout July and August. Customers can cast their vote using a token given to them at the check-out in store each time they shop.

The Tesco Express stores where you can vote for us are:

Pensnett High Street
Dudley Highland Road Esso
Goose Pub Kingswinford
Gornal Dudley
Kingswinford Esso

The Big Push

Our wheelchair campaign with the local Dudley News is gathering pace with over £3,000 having been donated already. The first batch of new wheelchairs have been delivered and reports are already coming in of how easy they are to use and steer. We are really excited to have the support of the Dudley News to give the campaign such profile.

National NHS News

More than 80,000 NHS posts vacant, says report

More than 86,000 NHS posts were vacant between January 2017 and March 2017, figures suggest. Statistics from NHS Digital shows the number of vacancies climbed by almost 8,000 compared to the same period in 2016. Nurses and midwives accounted for the highest proportion of shortages, with 11,400 vacant posts in March 2017. The data included job adverts published on the NHS Jobs website between February 2015 and March 2017.

NHS 'does not need more money to improve'

The NHS does not necessarily need more money to improve care, the outgoing Chief Inspector of Hospitals in England, Prof Sir Mike Richards, says. Sir Mike said there were more cost-effective ways of running the service, such as ending the use of what he called "very expensive" agency nurses.

Overnight Maternity Services in Two Towns Suspended

Overnight Maternity services in two Devon towns have been suspended for at least three months because of "staff vacancies and unforeseen sickness absence", health bosses say. The Royal Devon & Exeter NHS Foundation Trust said services at its birth centres in Honiton and Okehampton were suspended last Thursday because of patient safety concerns, which it said was its "top priority", and would remain so until it had "safe staffing levels".

NHS Plans to Scrap Homeopathy Treatments

NHS England has announced plans to stop doctors prescribing homeopathy, herbal and other "low value" treatments. It hopes to save almost £200m a year by ending what the head of the service called a "misuse of scarce" NHS funds. Prescriptions for conditions including diarrhoea, thrush, acne and acute pain are among those up for review. Consultation is out now on what should be scrapped.

Hospital Asbestos 'a ticking time bomb'

The number of people who could contract cancer from asbestos poisoning in London's hospitals is a "ticking time bomb", it has been claimed. BBC London has found 94% of hospitals in the capital contain asbestos.

Contaminated Blood Scandal Inquiry Announced

A UK-wide inquiry will be held into the contaminated blood scandal that left at least 2,400 people dead, the Prime Minister has confirmed. A spokesman for Theresa May said it would establish the causes of the "appalling injustice" that took place in the 1970s and 1980s. Thousands of NHS patients were given blood products from abroad that were infected with Hepatitis C and HIV.

Use of WhatsApp in NHS 'widespread', say Doctors

Doctors and nurses are using WhatsApp and Snapchat to share information about patients "across the NHS", health professionals have told the BBC. GP Alisdair MacNair said he was aware of a number of medical groups using WhatsApp to discuss patients. Use of internet-based messaging apps to send patient information is banned under current NHS guidelines.

Regional NHS News

More than 70 Extra NHS beds in new £65m Hospital to be Built at the QE

A new £65 million hospital providing more than 70 new beds for NHS patients is set to be built on the site of Birmingham's Queen Elizabeth Hospital.

The development will also include 66 beds for private patients and will include a new Radiotherapy Unit and access to state-of-the-art Operating Theatres.

The deal is a tie-up between University Hospitals Birmingham NHS Foundation Trust (UHB) and the HCA Healthcare UK company.

West Midlands Ambulance Changes 'putting lives at risk'

Cannock Chase has now been left with no response or standby points for ambulances after the last one, at Delta Way, was removed.

Councilor George Adamson, leader of the District Council, said the move was 'making people in Cannock Chase second-class NHS citizens' and also warned lives were being put at risk.

NHS England Commits to Faster Ambulance Response to Critical Cases

Up to 750,000 more calls per year will get an immediate response, and the changes will remove long waits suffered by millions of patients, including reducing lengthy waits for the frail and elderly, according to NHS England. They result from the world's largest clinical ambulance trial. Academics at Sheffield University found that the changes are safe, with no safety issues identified in more than 14 million 999 calls handled during the 18-month trial.

Almost 800 Patients Left Waiting in Ambulances

Figures from West Midlands Ambulance Trust reveal 795 patients waited between 45 minutes to an hour from January to March 2017, for handover to Birmingham City Hospital, County Hospital Stafford, New Cross Hospital, Dudley's Russells Hall, Sandwell Hospital and Walsall Manor.

Amazon Echo among the Tech being Funded by NHS to improve Social Care

Amazon Echo is just one of the digital ideas being tested out, as a result of NHS Digital's decision to give 16 Councils up to £50,000 each to spend on technology to improve Social Care. Hampshire Council is seeking to trial the use of the Amazon Echo, a voice-activated home audio speaker, on 50 people who are using Adult Social Care services.

Grenfell Tower Fire: Wolverhampton's New Cross Hospital Cladding Fails Safety Test

Trust chiefs have confirmed a sample from the Heart and Lung Centre at the hospital has failed a combustibility test.

Bosses said they will work with the fire service to ensure the site remains safe – but the cladding will be removed in the future.

Patients will continue to be treated at the Centre, which was built in 2004.

More than £8 million Spent on Private Ambulances in Shropshire

Figures from a Freedom of Information request to Shropshire Clinical Commissioning Group has revealed that it spent £3,146,427 on the ambulances in the last financial year alone.

Information, provided by the CCG, which looks after health services across Shropshire, reveals it has an ongoing contract with private ambulance provider Medical Services Limited (MSL).

2,000 People Alive Thanks to Organ Donors

The number of people living in the West Midlands currently known to be alive thanks to organ transplants has reached 2,106.

This figure is revealed by NHS Blood and Transplant, whose annual Transplant Activity Report shows the UK-wide number of people alive thanks to transplants has reached the milestone figure of 50,000.

In the West Midlands, the number of people on the Organ Donor Register has increased by 25 per cent over the past five years.

Relax English Language Test for Foreign Nurses, say Hospital Execs

Hospital bosses have called for the English language test for foreign nurses to be relaxed after just three of 118 Filipino applicants at one NHS Trust passed.

Managers at Walsall Manor Hospital in the West Midlands said their chronic staffing shortfall could be solved “overnight” if watchdogs slackened standards, however patient safety campaigners have demanded the existing pass mark remain in place.

NHS Bed Blocking Relieved by New Mobile Phone Technology

New mobile phone technology is helping local authorities to alleviate NHS bed blocking, it was shown today, following trials around the country. The new technology can help speed up hospital discharges and prevent unnecessary re-admissions, freeing up vital beds and also reducing the cost of post-hospital care.

A three-month trial of a similar service in the West Midlands town of Dudley found a reduction in the number of people being readmitted to hospital, which was not only good news for the Telecare users but represented a saving to the NHS of £600 per averted re-admission.

Scandal of the 700,000 NHS Undelivered Medical Letters including many Belonging to Derby Patients

Thousands of undelivered medical letters have been languishing in an East Midlands NHS processing centre – including clinical notes, screening test results, treatment plans and child case notes from Derby.

Some of the child protection case documents dated back up to a decade as they had become separated from the medical records that identified the children concerned.

Thousands are Waiting more than 12 hours in West Midland A&Es

Nearly 6,000 people waited more than 12 hours in West Midland A&Es last year, with numbers experiencing 'mega-waits' up by more than two-thirds in a year.
In the first 11 months of 2016/17, between April and February, there were 5,923 unplanned attendances at Trusts across the Birmingham area that lasted more than 12 hours from arrival to admission, discharge or transfer.

Mayor of West Midlands Marks Major Milestone for "Super Hospital"

When the Midland Metropolitan Hospital opens in Smethwick, it will be the bringing together of teams who provide acute and emergency care. This was a key outcome of a public consultation about the future of local health services and will improve outcomes and safety. Although local clinicians have worked on the plans for many years before signing the long-term contract, those plans were tested against new models of care, including the Keogh Review on emergency care, published in 2013.

Demolition Work Paving Way for New ICCU

Demolition of the concrete canopy over the entrance to the former West Wing at Walsall Manor Hospital is well under way as contractors work on the first phase of a new multi-million pound Integrated Critical Care Unit (ICCU).

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to Board on 3rd August 2017

TITLE:	**DGFT Clinical Strategy**		
AUTHOR:	**Lisa Peaty** **Deputy Director: Strategy & Performance**	**PRESENTER**	**Dr Paul Harrison** **Medical Director**
CORPORATE OBJECTIVE: **SO6 Deliver a viable future**			

SUMMARY OF KEY ISSUES:

In 2013, DGFT's Clinical Strategy set out the key priorities for clinical services. This was refreshed in 2016 but, at the time of the refresh, it was recognised that a more detailed revision would be needed.

A revised Clinical Strategy has been developed within the context of the Trust's Corporate Strategy and has been guided by the Trust's existing vision, values and strategic objectives. It sets out a framework for the development of clinical services at DGFT for 2017/18 to 2020/2021, explaining why change is needed, what direction change will take and how the trust proposes to organise and develop its clinical services over the next three years. The Clinical Strategy also sets out the clinical transformation required to provide services whilst retaining a focus on safety, quality and patient experience. This will be achieved through three clinical aims which are in line with those in Trust's Strategic Plan:

1) develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible;
2) strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way;
3) provide specialist services to patients from the Black Country and further afield.

The principles of and priorities for delivery are set out for each of the three clinical aims.

The Strategy has been developed with input from clinicians, Medical Service Heads/Clinical Service Leads, Divisional and Directorate Managers and the Chief Operating Officer through:

- an assessment of the Trust's clinical Strengths, Weaknesses, Opportunities and Threats (SWOT) in light of these key drivers for change undertaken by Medical Service Heads/Clinical Service Leads and Directorate Managers in January 2017;
- a review of the outputs of the SWOT analyses in a series of workshops attended by the Chief Operating Officer, Directors of Operations, the Medical Director, Executive Directors and Non-Executive Directors in February and March 2017;
- undertaking deep dives with relevant Medical Service Heads, Clinical Service Leads and their teams supported by Directorate Managers in April 2017;
- undertaking a feasibility and impact analysis of the outputs of the deep dive exercise.

This was then reviewed by Medical Service Heads and Clinical Service Leads in April and May 2017.

Once approved, the Clinical Strategy will be:

- launched and communicated within the Trust;
- embedded through the annual business planning process, performance management processes and development of business cases.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N/A		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** ***Well led***
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR Board:

The Board are asked to approve the Clinical Strategy, subject to any amendments required.

CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*

SO1:	**Deliver a great patient experience**
SO2:	**Safe and Caring Services**
SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**

SO5:	**Make the best use of what we have**
SO6:	**Plan for a viable future**

CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves food outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and that people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

THE DUDLEY GROUP NHS FOUNDATION TRUST
STRATEGY FOR CLINICAL SERVICES 2017/18 – 2020/2021

1. INTRODUCTION

In 2013, Dudley Group Foundation Trust's (DGFT) Clinical Strategy set out the key priorities for clinical services. This was refreshed in 2016 but, at the time of the refresh, it was recognised a more detailed revision would be needed. The key vision was for DGFT to be a highly regarded healthcare provider for the Black Country and West Midlands offering a range of closely integrated acute and community based services, driven by the philosophy that people matter. The strategy set out three main aims:

a) providing the highest quality local hospital care in the most effective and efficient way;
b) providing excellent integrated services enabling people to stay at home and be treated as close to home as possible;
c) providing a series of series of specialist services across the Black Country.

Since the refresh of the Clinical Strategy in 2016, a number of factors have led to the need to review the strategy so that it continues to set out how the trust plans to develop its clinical services and the key priorities for them over the next three years. The most significant challenge for all NHS providers is the need to meet the needs of more people living longer and of more people living with more complex and chronic conditions.

This revised strategy has been developed with significant input from clinicians and sets out a framework for the development of clinical services at DGFT for 2017/18 to 2020/2021. It does not give prescriptive details of exactly what developments are required and how they will be achieved, but instead it explains why change is needed, what direction change will take and how the trust proposes to organise and develop its clinical services over the next three years.

2. STATEMENT OF INTENT/PURPOSE

This document sets out the clinical priorities for DGFT between 2017/18 and 2020/2021 and provides an overall framework for change. It sets out how DGFT proposes to develop, organise and deliver its clinical services which will ultimately lead to improved patient access, clinical outcomes and patient experience. The strategy is also driven by the Trust's commitment to quality.

3. VISION, VALUES AND STRATEGIC OBJECTIVES

The Clinical Strategy has been developed within the context of the Trust's Strategic Plan and is guided by the Trust's current vision, values and strategic objectives. The Trust's vision is:

"Trusted to provide safe, caring and effective service because people matter"

The vision is underpinned by three values:

- *Care* – provide safe, quality healthcare for every person – every time
- *Respect* – show respect for our patients, our visitors and each other at all times
- *Responsibility* – take responsibility for everything we do every day

Six strategic objectives outline how the Trust will achieve the vision:

- *Deliver a great patient experience*
- *Safe and caring services*
- *Drive service improvement, innovation and transformation*
- *Be the place people choose to work*
- *Make the best use of what we have*
- *Plan for a viable future*

It is within this context that that the Trust's clinical ambition will help drive organisational transformation and improvement between 2017/18 and 2020/2021.

Our vision: Trusted to provide safe, caring and effective services because people matter	
Our Values: Care, Respect and Responsibility	
Our Six Strategic Objectives:	
Deliver a great patient experience	**Be the place people choose to work**
Deliver safe and caring services	**Make the best use of what we have**
Drive service improvement, innovation & transformation	**Deliver a viable future**

4. OVERVIEW OF CURRENT SERVICES

DGFT is an integrated service provider offering both acute and community services to a population of 315,000 people in the Dudley Clinical Commissioning Group (CCG) catchment area (Appendix One). Services are also provided to other parts of the Black Country, West Birmingham, South Staffordshire and North Worcestershire. The Trust also provides a range of tertiary level services, some of which are accessed by patients from further afield. These include, for example, vascular surgery, endoscopic procedures, stem cell transplants and specialist GU reconstruction. In addition, the Trust provides a range of adult community services including community nursing, end of life care, podiatry, therapies and outpatient services.

5. KEY DRIVERS FOR CHANGE

DGFT is operating within a changing national and local context which needs to be taken into account when considering the development, organisation and delivery of clinical services over the next three years. The key drivers for change that impact on the direction of travel for clinical services have been considered and include:

National policy context	• NHS England's 'Next Steps on the NHS Five Year Forward View' published in March 2017 sets out the key improvements that the health economy needs to take and how they will be implemented. • DGFT will respond to the requirements of the Five Year Forward View document and ensure that it has the appropriate measures in place to take forward the actions required, some of which will be embedded within this Clinical Strategy (including implementing new models of care) • DGFT will respond to CQC standards for quality and safety, and the CQC inspection framework.
Commissioning requirements	• Dudley CCG's Commissioning Intentions for 2017/18 and 2018/19 set the direction of travel for the local health economy. • DGFT will continue to respond to both local and national commissioning requirements. • The CCG are commissioning a Multi-specialty Community Provider (MCP) which will join up services in one new organisation to integrate care in people's homes and the community and improve access to, and continuity, coordination of care through practice based Multi-Disciplinary Teams. • Some services currently provided by DGFT will be delivered through the MCP including some out-patient and community based services, intermediate care and end of life services. The MCP will require significant reconfiguration of services currently provided by DGFT.
Population changes	• The proportion of residents aged 65 and over is higher than regional and national averages (19.3%) and is projected to increase over time and at faster rate than the overall population*.

	• The 60+ age group is projected to increase by 32.9%; the 75+ by 67.9% and the population aged 85+ by 171% between 2012 and 2037*. • DGFT will transform clinical services so that they meet the needs of an increasing aging population, and by doing so reduce unplanned admissions, readmissions, length of stay and delayed transfers of care.
Changing patterns of illness and disability	• 20% of people living in Dudley have a long term illness or disability. This is worse than the national average*. • 71.3% of people aged 75 years or above have a long term illness or disability*. These percentages are projected to increase further. • DGFT will transform clinical services so that patients with long term illness or disability receive the right care in the right place in the right time.
Constraints on financial resource at a time of increasing demand	• DGFT will seek to implement further efficiencies through its Cost Improvement Programme where costs are reduced whilst quality is retained or improved. • DGFT will continue to support implementation of Lord Carter and RightCare approaches to redesigning pathways and services to ensure greater efficiency and improved quality, patient experience and outcomes.
Technological changes	• Technological changes and clinical developments resulting in new therapeutic options, changed clinical pathways and the potential to transform care.
Digital transformation	• An Electronic Patient Record will be implemented from 2018/19 to support the transformation of clinical services. This will change the way clinicians work and improve the care patients receive through greater effectiveness, efficiency and safety.
Workforce	• A sustainable workforce with recruitment and retention of suitably skilled staff is critical to the delivery the Clinical Strategy. • There are national and regional shortages of many staff groups including radiographers, consultants in certain specialties, nurses and junior medical staff. These impact on the ability of DGFT to recruit to some posts. • DGFT has a clear focus on managing the current resource alongside sustained recruitment campaigns to reduce the vacancy rate.

*Source: Dudley JSNA 2014.

An assessment of the Trust's clinical Strengths, Weaknesses, Opportunities and Threats (SWOT) in light of these key drivers for change has been undertaken at an organisational level to inform the review of the Clinical Strategy (Appendix Two). In addition, SWOT analyses have also been completed by Medical Service Heads/Clinical Service Leads and Directorate Managers for each clinical specialty. The outputs of the SWOT analyses were reviewed in a series of workshops attended by the Chief Operating Officer, Directors of Operations, the Medical Director, Executive Directors and Non-Executive Directors.

6. CLINICAL SERVICES IN 2020/2021

DGFT is committed to maintaining its current range of clinical services provided that these services continue to be clinically and financially viable. The development of the MCP and the Black Country Sustainability and Transformation Plan (STP) means that transformation and re-shaping of services are inevitable to ensure they are viable. The key drivers for change indicate the Trust will need to deliver better outcomes and better patient experience at a lower cost.

This Clinical Strategy sets out the clinical transformation that is required to provide services in a different way to meet these challenges. This will be achieved whilst retaining a focus on safety, quality and patient experience through three clinical aims which are in line with those in Trust's Strategic Plan. DGFT will:

1) develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible;
2) strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way;
3) provide specialist services to patients from the Black Country and further afield.

Clinical support services (pharmacy, imaging, pathology and therapies) underpin the delivery of the priorities listed under each of the three aims. DGFT recognises that these services also need to develop so that they can fully support the new models of care and the developments outlined below.

Aim One: develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible

Principles

Treating patients as close to home as possible is both desirable to the patients themselves but also often makes sense financially for the health system. As a current provider of both hospital and community services, DGFT is well placed work with commissioners, primary care and social care to increase the community resources needed to look after more people at or near home instead of in hospital. DGFT has a unique opportunity to transform care in line with the aspirations of the MCP. DGFT will:

- work closely with partners to develop models of care, redesign relevant pathways and transform services to provide accessible and coordinated integrated care in the community so that people can be treated at home or as close to home as possible;
- lead on the development of multi-disciplinary teams to ensure that patients receive proactive, co-ordinated care in line with their care plan;
- deliver the majority of care for long term conditions and older people at or near home, keeping visits to hospital and hospital stays to a minimum;
- continue to have hospital and community services integrated with social care and primary care services with people's needs at the centre whilst improving co-ordination of care between care settings;
- be amongst the best for the safety, quality, patient experience and outcomes for the services the Trust provides.

Priorities for delivery for the next three years:

Service/Initiative	Rationale	Time Horizon (years)
Reconfigure services in line with the MCP model	The MCP will require development of accessible integrated community services provided by multidisciplinary teams, including Respiratory, Rheumatology, palliative care, diabetes, elderly care and Neurology. For some specialties (e.g. end of life services, Frail and Elderly Care) this will build on work already underway to develop and implement community models. This will also require reconfiguration of services provided at Russell's Hall Hospital, Guest Outpatient Centre and Corbett Hospital. The trust will develop a bid for the MCP in conjunction with Birmingham Community Health and Care Trust and Dudley GPs. DGFT will also continue to develop community clinics outside of the auspices of the MCP where contracted to do so by other organsiations (e.g. Wyre Forest, South Staffordshire).	1
Develop a more integrated clinical model for therapy services by enhancing community provision	Therapies are already provided in both community and acute settings, but increases in demand and waiting times mean that therapy pathways and delivery across acute and community settings need to be redesigned. Community therapy services will be aligned with the MCP delivery model.	1
Development of the Qutenza Pain service	This service provides management of neuropathic pain associated with post-herpetic neuralgia through application of a specialist pain relief patch. Nurse-led clinics in the community will be developed in line with the principles of the MCP. DGFT are the only provider of this service in the Black Country and plan to extend their reach within and beyond the Dudley area.	2
Expansion of community ENT clinics (including Audiology) (Stourbridge Health Centre)	Demand for this service is increasing due to an aging population. This requires an increase in audiology support to improve patient flow through one stop clinics to enable more patients to be seen in the community and prevent an increase in Referral to Treatment Time.	1 to 2

Address Ophthalmology demand and capacity	The Trust will continue to develop Ophthalmology services in line with its existing Ophthalmology Plan.	2
Develop domiciliary non-invasive ventilation service and difficult asthma clinics	This is a new service which DGFT is developing in discussion with Dudley CCG. It is currently provided by regional centres. Non-invasive ventilation could be provided as part of community respiratory services. DGFT provide a difficult asthma service as part of a regional network. Plans are in place to develop the model of delivery and increase the number of patients seen.	1 to 2
Improve access to Neurology (including Neurophysiology)	Capacity issues mean that plans are in place to expand the capacity of this service, repatriate activity and improve quality. Appointment of nurse specialists is already in progress. There is a STP work stream developing a regional model for delivery of Neurology services with specialisms based at some Trusts. DGFT will develop its services in line with the implementation of the preferred STP option.	2 to 3
Improve care coordination	Improved care coordination will decrease the number of hospital attendances/readmissions through the appointment of Care Coordinators and development of integrated and coordinated services, including Multi-disciplinary Teams in line with the MCP.	1

The implementation of the Clinical Strategy will need to be flexible enough to respond and adapt to the changes associated with the ongoing procurement and implementation of the MCP and the Black Country and West Birmingham STP.

Business cases will developed for each of the initiatives above.

Aim two: strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way

Principles

DGFT will continue to provide and strengthen hospital-based services for the population of Dudley and beyond with as much of the pathway as possible based out of hospital in line with the following principles:

- maintain a range of hospital-based services and expanded those in which the Trust excels and has a competitive advantage;
- ensure an appropriate balance between urgent, inpatient and day-case services;
- ensure timely access to meet 'referral to treatment' standards to clearly defined pathways;
- take a lead in developing 24/7 high quality and sustainable local hospital services in the Black Country and beyond;
- be amongst the best providers for safety, quality, patient experience and outcomes of hospital care.

Priorities for delivery for the next three years:

Service/Initiative	Rationale	Time Horizon (years)
Improve access to Emergency/Urgent Care	Demand for urgent and emergency care is continuing to rise and pathways require redesign to continue to deliver best practice. The current staffing and skill mix will be reconfigured as part of the redesign. There is also a need to develop and implement sustainable ambulatory care services in line with partners. Medical and Surgical Ambulatory Emergency Care services have outgrown their space and require additional room.	1 to 2
Redesign of paediatric services to improve patient flow	Redesign is needed to deliver required standards and deliver clinical sustainability across the Paediatric Assessment Unity, inpatient and community paediatric services. Community paediatrics may be impacted by the MCP, although some consultant led community clinics are planned. Specialist paediatric services will also be developed (e.g. paediatric endoscopy). Access to outpatient services will also be improved through appointments of further Consultant Paediatricians and development of Clinical Nurse Specialists.	1 to 2
Expansion of orthodontics service	This is a 'high demand and high volume' service which requires recruitment of consultant staff to shape and lead its development and growth.	1
Review provision of Plastics/skin cancer services	There is pressure on capacity to achieve cancer standards in this service at a time where there is also increasing demand for general plastic surgery. A review of provision and the workforce requirements to meet this rising demand will be undertaken to support expansion of this service.	1
Review SHDU/ICU provision	A review of Surgical High Dependency Unit and Intensive Care Unit provision will take place with the view of potentially reconfiguring the current estate and workforce to deliver improved efficiency and quality.	2 to 3
Develop a model to support Acute Oncology service	The Acute Oncology service is currently provided in collaboration with the Royal Wolverhampton Trust. A review of the existing service will determine future need and service configuration.	1

Redesign and development of Cardiology services	New NICE guidelines and increasing demand mean that the Cardiology service requires redesign. This includes the development and growth of the current service for cardiac imaging and device therapy. Clinical workforce and equipment requirements and developments across the Black Country will be addressed as part of this work.	1 to 2
Develop MSK services	The musculoskeletal pathway will be redesigned with partners, implementing a process for triage and pathways based on best practice guidelines.	1 to 2
Further develop access to seven day services	DGFT will work with appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care. DGFT will work with other local trusts to support the expansion of on call Interventional Radiology Services.	1

The implementation of the Clinical Strategy will need to be flexible enough to respond and adapt to the changes associated with the ongoing procurement and implementation of the MCP and Black Country and West Birmingham STP.

Business cases will developed for each of the initiatives above.

Aim three: provide specialist services to patients from the Black Country and further afield

Principles

DGFT provides a range of specialist services including vascular surgery, endoscopic procedures, stem cell transplants and specialist GU reconstruction. Although the Trust is always seeking to innovate and develop best practice, it does not plan to become a predominantly tertiary hospital. However, the Trust will work to build on its strengths and become a leading hospital in the Black Country and beyond providing a range of specialist services in line with the following principles. DGFT will:

- deliver specialised services in line with national best practice standards and expanded those in which the Trust excels and has a competitive advantage;
- consider specialist commissioning opportunities on a case by case basis;
- consider opportunities presented through the appointment of new clinicians who come with special skills or expertise;
- be amongst the best for safety, quality, patient experience and outcomes for specialist care.

Priorities for delivery for the next three years:

Service/Initiative	Rationale	Time Horizon (years)
Expand paediatric hypospadias surgery	Paediatric hypospadias surgery is a specialist procedure provided by DGFT to patients from across the UK. Salvage procedures are also undertaken. There is potential to expand activity as the number of surgeons performing this procedure elsewhere is reducing.	1 to 2
Expand Genito-Urinary reconstruction surgery	DGFT provides a specialist penile reconstruction service with a national reputation for which there is high demand and long waiting times. Further growth through the increased provision of service from a second Consultant, with some potential to expand into penile cancer work.	2 to 5
Provide temporomandibular joint (TMJ) arthroscopy	This service is not currently provided by DGFT. The introduction of a new service using existing consultant expertise to serve patients from Dudley and beyond is planned. This could reduce the number of MRI scans undertaken.	1 to 2
Redesign and expand the Vascular Hub	DGFT currently provides the Vascular Hub for the Black Country and there has been a growth in demand over last three years with the consultants now operating in Walsall to address shortages of consultants in outpatient settings. The service standard specification requires delivery of 24/7 Interventional Radiology and the hybrid theatre to be built which would expand capacity for additional surgical activity generally and support retention of Vascular Hub status.	2 to 3
Expand specialist endoscopic procedures for Zenker Diverticulum and full thickness endoscopic resection	DGFT currently provides specialist endoscopic procedures for patients from across the UK which are performed in only a few other Trusts nationally. DGFT will continue to develop and expand this service.	1 to 2
Improve stroke services	DGFT plans to retain its Hyper Acute Stroke Unit status and will redesign pathways to improve services further, including supporting the development of rehabilitation beds in the community to free up capacity in hospital through earlier discharge. A model for the Black Country is being considered as part of the STP.	1 to 2
Expand the Level 3 Bariatric Service	This specialist commissioned service with a MDT is in place, but increasing demand means that the Trust needs to increase capacity and grow this service	1 to 2

	further.	
Develop the pathway for Level 3 Haematology	DGFT provides the Level 3 Haematology service for the Black Country, although some Trusts are still utilising historical referral pathways. The incidence of myeloma and lymphoma is rising due to age related conditions leading to an increase in demand for the service. Expansion of the service will require additional staffing.	1 to 2

The implementation of the Clinical Strategy will need to be flexible enough to respond and adapt to the changes associated with the ongoing procurement and implementation of the MCP and Black Country and West Birmingham STP.

Business cases will developed for each of the initiatives above.

An overview of the initiatives within the Clinical Strategy is provided in Appendix Three.

7 UNDERPINNING STRATEGIES

The Clinical Strategy should be read in conjunction with the following strategies which will support and enable implementation.

Quality Improvement Strategy	Nursing & Midwifery Strategy	Workforce Strategy
The Quality Strategy was refreshed in January 2017 and sets out the Trust's approach to continuous improvement. It outlines an annual plan for improving quality of care. The key quality priorities are: • Patient experience • Infection prevention & control • Pressure ulcer prevention • Nutrition & hydration • Medicines The strategy also articulates the Trust's safety priorities and additional key quality initiatives and standards.	The Nursing & Midwifery Strategy (2016-2019) describes how the Trust will develop nursing and midwifery services to deliver high quality care to patients. The Strategy develops the 'six Cs' of the national nursing and midwifery strategy and the ten commitments of 'Leading Change' and outlines what needs to be done to deliver these locally.	Implementation of this Clinical Strategy is dependent on the continued retention, recruitment and development of clinical staff and leaders with the right skills and experience, as well as the non-medical workforce required to support developments in medicine and surgery. The Trust refreshed its Workforce Strategy in 2015. It outlines the key actions that the Trust will take place to ensure that it has a workforce with the capacity and capability to meet the Trust's aspirations, in particular to deliver safe and effective patient care.

Digital Strategy	Estates Strategy	Patient Experience Strategy
The Trust's Digital Strategy, particularly the implementation of the Electronic Patient Record, will support this Clinical Strategy.	The Trust's Estate Strategy 2013-2018 focuses on maximising the use of resources on all sites to organise and manage acute care in an optimum pattern to provide safe and efficient services. Detailed capacity planning has been used to model demand for services at the hospitals. Implementation of this Clinical Strategy, particularly in relation to the development of the MCP will require a review of how the Trust utilises its estate.	The current Patient Experience Strategy (2014-2017) underpins the Clinical Strategy. A plan is in place to review the Patient Experience Strategy to underpin the on-going improvement of the patient experience.

Research and Development Strategy	Marketing Strategy	Risk Management Strategy
The Trust's revised Research and Development Strategy will support the Clinical Strategy.	The Trust's Marketing Strategy will support this Clinical Strategy.	Published in 2015, the Trust's strategy for managing risk identifies accountability arrangements, resources available and provides guidance on what may be regarded as acceptable risk within the organisation.

8 IMPLEMENTING THE CLINICAL STRATEGY

The Clinical Strategy will help inform the Trust's Annual Operational Plan which will outline the high level actions that are required to implement the priorities outlined above. In addition, clinical divisions will use this Strategy and the Annual Plan to frame their own Divisional and Directorate annual plans. Progress will be monitored through monthly divisional performance meetings and a programme of updates to Trust Board.

Business cases will provide detail on specific actions, changes and developments that are to be implemented. The trust will track progress through existing governance mechanisms.

9 COMMUNICATION OF THE CLINICAL STRATEGY

DGFT will ensure that staff and external stakeholders are clear about the Clinical Strategy and what it means for patients and services by using existing communication channels, both trust-wide and within specific divisional structures.

10 EQUALITY IMPACT ASSESSMENT

DGFT is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way staff are treated reflects individual needs and does not discriminate against individuals or groups on any grounds. The Strategy has been screened using the Trust's Equality Impact Screening Tool and is considered to have a positive impact on all equality groups.

Appendix One: Current Dudley Group Foundation Trust

CORBETT OUTPATIENT CENTRE

Outpatient Services
Bespoke OP Specialties including:
- Cardiology
- Dermatology
- Gastroenterology
- Geriatrics & Elderly Care
- Gynaecology
- Neurology
- Neurology
- Physiotherapy
- Plastic Surgery nurse-led
- Renal Medicine
- Respiratory
- Rheumatology nurse-led
- Trauma & Orthopaedics
- Urology
- Wheelchair Services

Diagnostic
Radiology (X-ray, Ultrasound scanning, DEXA bone scanning)
Phlebotomy

Day Treatment
1 Day Case Surgery Unit
1 Anaesthetics Theatre
Podiatry

Other
Pharmacy

BRIERLEY HILL HEALTH & SOCIAL CARE CENTRE

Community Midwifery, Podiatry, Leg Ulcer , OPAT, Physio, Phlebotomy , Sexual Health

HALESOWEN HEALTH CENTRE

Ophthalmology, Leg Ulcer, Podiatry, Physio, Sexual

RUSSELLS HALL HOSPITAL

693 Acute Inpatient Beds,
28 Adult Inpatient Wards, 8 Maternity Wards, 14 Critical Care Beds,
22 Neonatal Cots, 37 Paediatric Beds, 26 Coronary Care Beds,
101 Adult Acute Assessment Spaces

Outpatient Services
Bespoke OP Specialties including:
- Accident & Emergency
- Anaesthetics
- Breast surgery
- Cardiology
- Cardiology
- Clinical Genetics
- Clinical Pathology
- Dermatology
- Dermatology
- Dermatology
- Diabetic Medicine
- Ear Nose & Throat
- Endocrinology
- Gastroenterology
- General Surgery
- Geriatrics & Elderly Care
- Gynaecology
- Haematology
- Immunology
- Medical Assessment
- Medical Oncology
- Midwife Obs
- Neurology
- Obstetrics
- Ophthalmology
- Oral Surgery
- Orthodontics
- Paediatrics
- Pain Management
- Plastic Surgery
- Pre Assessment Clinics
- Rapid Access
- Renal Medicine
- Respiratory
- Rheumatology
- Stroke Medicine
- Surgery Colorectal
- Transient Ischaemic Attack
- Trauma & Orthopaedics
- Trauma (Fracture)
- Urology

Emergency / Elective Surgery / Day Case
8 Main Theatres
1 Trauma Theatre
1 Emergency Theatre
1 Angio Suite
4 Day case Theatres
1 Treatment Room
2 Maternity Theatres
2 Obstetric Theatres

Diagnostic
Phlebotomy
Radiology (X-ray, MRI and CT scanning)

Urgent Care
UCC provided by Malling Health
Emergency Department
AEC

Other
Trust Headquarters
Chaplaincy Service
Pharmacy
Undergraduate Centre
Action Heart

Day Treatment
Day Case Surgery Unit
Elective Medical Unit
Podiatry

GUEST OUTPATIENT CENTRE

Outpatient Services
Bespoke OP Specialties including:
- Cardiology
- Dermatology
- Gastroenterology
- General Surgery
- Geriatric & Elderly
- Stroke
- Immunology
- Neurology
- Pain Management
- Physiotherapy
- Psychology
- Renal Medicine
- Respiratory
- Rheumatology
- Urology,

Diagnostic
Radiology (X-ray and Ultrasound)

Other
Pharmacy

Kidderminster Hospital/Hume Street

Outpatient Services
Bespoke OP Specialties including:
- Renal, ENT, General Surgery, Neurology, Gynaecology

SEDGLEY HEALTH CENTRE (LADIES WALK)

Community Midwifery, Podiatry, Dermatology,

TIPTON DIALYSIS CENTRE

Renal Dialysis

Sedgley, Coseley and Gornal | Dudley and Netherton | Kingswinford Amblecote & Brierley Hill | Stourbridge, Wollescote and Lye | Halesowen and Quarry Bank

Audiology, Blood Borne Virus, Chronic Obstructive Pulmonary Disease, (COPD) respiratory nurse service, Care Home Practitioner Service, Community Ear, Nose and Throat (ENT), Community Response Team, Continence Service, Contraception and Sexual Health, Dermatology, Diabetes Specialist Team (Primary Care), Dietetics, District nursing, Dudley Rehabilitation Service, Heart Failure, Intermediate Care, Leg Ulcer clinic, Macmillan Community Palliative Care Team, Macmillan, Outpatient Parental Antibiotic Therapy (OPAT) and oncology outreach, Palliative Care Support Team (Joint Agency), Physiotherapy – Musculoskeletal, Physiotherapy Service, Orthopaedic Assessment Service, Podiatric surgery, Podiatry, Tissue Viability , .

Appendix two: clinical services SWOT analysis

Strengths:	Weaknesses:
• One main CCG Commissioner • Track record of delivery of targets and quality, good infection rates • Good mortality rates • Relatively positive financial position for most specialties • NHS Choices Feedback is positive • Loyal and stable staff base • Loyal local patient base • Trust is co-terminus with local authority • Integrated services – including community services • Improving & successful quality accounts • Good mortality tracker • Urgent Care pathway development • Improving reputation nationally (clinically and organizationally) • Development of tertiary/specialist services/procedures • Skilled clinical workforce • Supportive and proactive management	• Relationship with CCG • PFI pressures/retained costs • Increasing nursing establishment – cost pressure & recruitment pressure • Inability to address agency cap • No clear workforce strategy • Clinical leadership/medical engagement • Outpatient processes, capacity & patient experience • Relationship with CCG & Social Care in dealing with delayed transfers of care • Lack of succession planning • The lack of theatre availability and staffing limiting ability to expand • Recruitment and retention in key areas and posts • Capacity of supporting services (e.g. imaging, pathology) • Space – flexibility & capacity (e.g. endoscopy, out patients, audiology, ophthalmology) • Maintaining patient flow (e.g. ED, AEC, LOS, imaging, Peadiatrics) • Delivery of seven day services in some specialties (e.g. IR) • Limited exploitation of research and development opportunities
Opportunities:	**Threats:**
• MCP development – partnership with BCHC and local GPs • Opening of the Midland Metropolitan Hospital • Improved relationship with CCG - clinical relationships are key to this • Community services consolidation/re-design • Improve integration (MSK, therapies, Renal/Diabetes/Cardio/Vascular) • Maximising targeted private patient income, where the opportunities arise • Improved utilisation of Guest & Corbett • Re-design of Frail and Elderly services • Collaboration with other Black Country providers Repatriate activity • Gain share of markets outside Dudley (e.g. Wyre Forest, South Staffs) • Non-consultant led clinics (ENT, Ophthalmology, GUM, Renal, Respiratory) • Outsourcing or working in collaboration with other organisations for services (Pathology/back office) • EPR • Better advertising/expansion of specialist services (Gastroenterology, Urology) • Development of one stop clinics (Vascular,	• NHS political agenda post-election • The challenge of meeting increasing standards/expectations vs the economic climate • Impact of the opening of The Midland Metropolitan Hospital • Competitor providers • Lack of collaboration with other provider units – duplication of services/efforts • Re-alignment of specialist services into fewer providers e.g. Stroke, Renal, Vascular • Demographic & lifestyle changes (Frail & elderly, Stroke, Cardiology, Diabetes) • Increase in complexity of patient conditions • Ageing staff profile • Increase in demand with reduced or static resources/workforce capacity • Reduced money in the national and local health economy, including pressures on social care allocations • Infrastructure in diagnostics to meet accreditation standards • Relationship/performance with the PFI partner as contractual arrangements tighten • Continued increase in costs with tariff reduction • Nurse/midwife/pharmacist training pipeline • Junior doctors' contract • Degree of disruption caused by MCP

Cardiology) • Using un-used skills (skin lesions, TMJ, HIV Renal) • Hybrid theatre – creating capacity • Carter benchmarking • Use of prescribing pharmacists & nurse prescribers • Maximising benefits offered by RightCare & GIRFT • New technology / procedures (e.g. in endoscopy, penile procedures) • New medicines (e.g. Respiratory, Hematology, Neurology, Rheumatology) • Medical Training Initiative • Maximising Research and Development opportunities	• Shortage of medical workforce – Radiologists, Orthodontics, ED & ITU consultants, junior staff • Emerging therapies and ability respond • Termination/non-renewal of existing contracts (e.g. GUM)

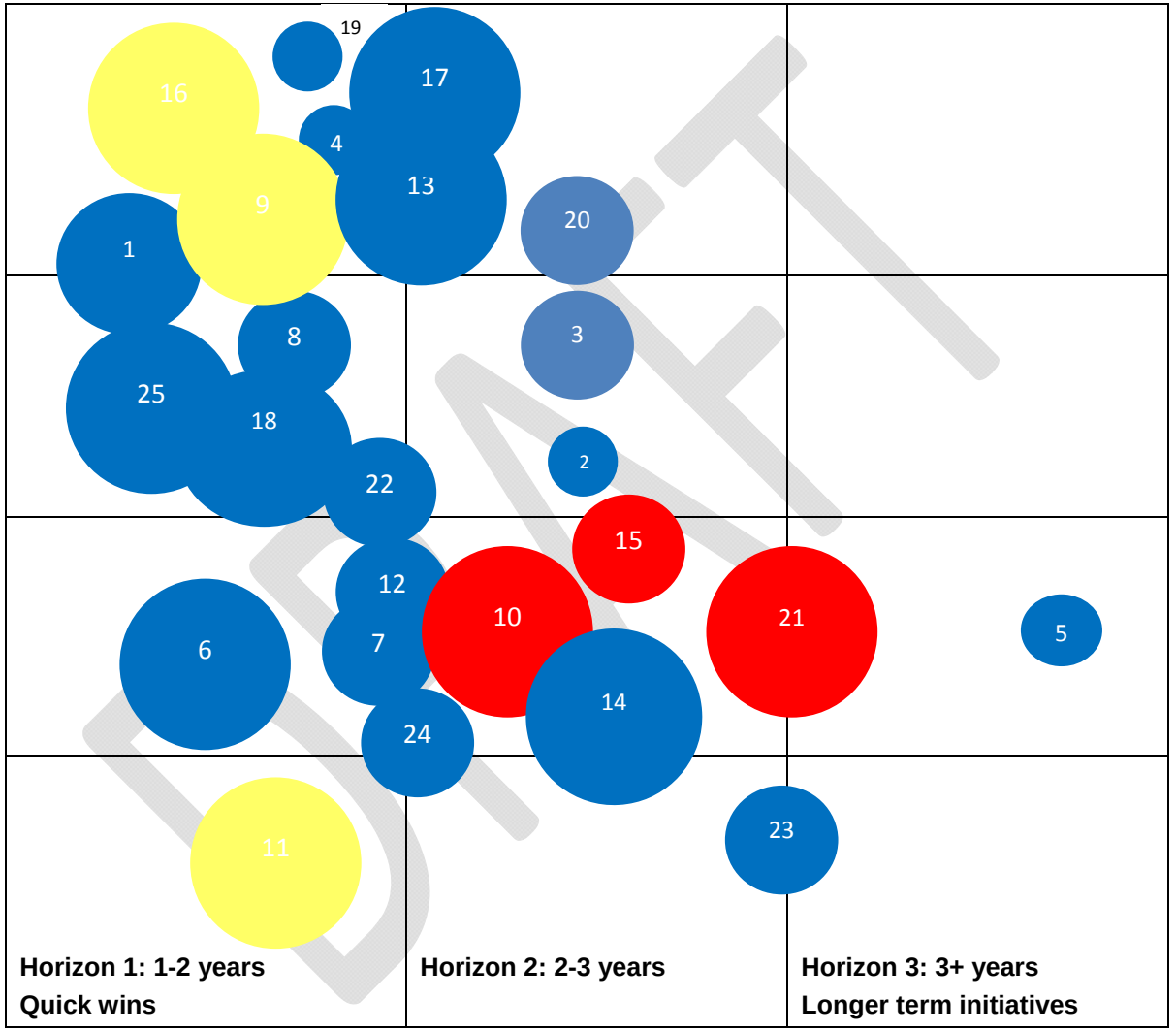
Appendix three: overview of Clinical Strategy

Feasibility: 4 (High)
Already commenced
Low cost, Low risk,
Sole provider
Capability not an issue,
Few workforce issues,
Little competition

3

2

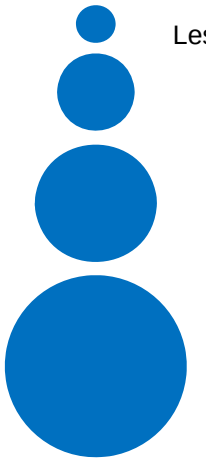
Feasibility: 1 (Low)
High cost, High risk
Multiple providers
Significant competition
Capability an issue
Workforce issues



Colour of bubble:

Blue: Internal to trust
Yellow: Vertical integration (MCP)
Red: Horizontal integration (STP, national)

Size of bubble reflects relative attractiveness of initiative (e.g. positive/negative impact, cost, quality improvement, reputation, capacity to deliver, workforce)



Less attractive

More attractive

1	Develop MSK Services
2	Expand the Level 3 bariatric service
3	Development of the Quetenza pain service
4	Expand paediatric hypospadias surgery
5	Expand GU reconstruction service
6	Develop a model to support Acute Oncology service
7	Expansion of community ENT clinics (including Audiology)
8	Review of provision of plastics/skin cancer services
9	Develop Community NIV service
10	Improve stoke services
11	Develop a more integrated clinical model for therapy services
12	Redesign paediatric services to improve patient flow
13	Redesign of Cardiology Services including cardiac imaging & device therapy
14	Improve access to Emergency/Urgent Care
15	Improve access to Neurology
16	Reconfigure services in line with the MCP model
17	Develop the pathway for Level 3 Haematology
18	Further Develop access to seven day services
19	Develop Difficult Asthma service
20	Address Ophthalmology demand and capacity
21	Redesign and expand the vascular hub
22	Expand specialist endoscopic procedures
23	Review Surgical High Dependency Unit/Intensive Care Unit provision
24	Provide TMJ arthroscopy service
25	Expansion of orthodontics service

COMPLIANCE MONITORING CHECKLIST Lead	**Tool**	**Frequency**		**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
Examples of key aspects to include are given below:						
Key elements of the strategy	Chief Executive and Directors	Developed framework	Quarterly	At CQSPE	Identify actions required and delegate individuals to take forward	Communications Department to publicise Annual Report Reports to Monitor
Business Plans	Director of Operations Executive Directors	Outcomes explicit in plans	Quarterly	Trust Board	Identify actions required and delegate individuals to take forward	Annual Report Reports to Monitor
Quality Targets	Chief Nurse/Medical Directors Executive Directors	Quality Account	Quarterly	At CQSPE	Identify actions required and delegate individuals to take forward	Communications Department to publicise Quality Account /Report published
Progress on implementation and impact on performance	Chief Executive and Directors	Outcomes explicit in plans	Monthly	Divisional Monthly Performance Meetings	Identify risks and actions required and delegate individuals to take forward	Communications Department Annual Plan Quarterly report
Progress on individual clinical schemes	Chief Executive, Directors and Non-executive Directors	Outcomes explicit in plans	Monthly	Trust Board	Identify risks and actions required and delegate individuals to take forward	Communications Department Annual Plan Quarterly report

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to Board 3 August 2017

TITLE:	**Pathology**		
AUTHOR:	Mark Newbold / Terry Whalley - BCP Transitional Management Team	**PRESENTER**	Diane Wake – Chief Executive
CORPORATE OBJECTIVES **SO 3 – Drive service improvement, innovation and transformation** **SO 5 – Make the best use of what we have** **SO 6 – Deliver a viable future**			

Introduction

The Black Country Pathology (BCP) Transitional Management Team, formerly the BCP Steering Group, has been meeting monthly since September 2016 to discuss the opportunities that could be realised by creating a single managed pathology service from the four Trust services that are currently operating. Whilst all members understand and acknowledge the concern caused by large scale change, there has been a consistent and firm view that the creation of a unified service offers a real opportunity to address some of the critical challenges that are being faced by pathology services across the NHS. Foremost amongst these are recruitment and retention of key staff, and the ability to maintain and develop quality of service in the face of financial constraints.

While the Outline Business Case (OBC) concentrates, quite rightly, on the technical detail, it is important to view this process as a positive and exciting one, aimed at creating a new service that is strong and sustainable, focused on quality, and fit for the future. It must be a service that is attractive to high quality staff, fully integrated with all other clinical services across the locality, and set fair to move quickly to implement new scientific developments as they become available.

The success of any pathology service is dependent on the expertise and commitment of the staff, who provide far more than a simple technical 'results' function. Pathology is an integral part of all patient-facing clinical services and this close relationship must be maintained if the proposed approach is to be successful. Accordingly, we are proposing that:

- the governance arrangements facilitate equitable input from all Trusts
- a medically-led Clinical Reference Group is created to oversee service quality and the delivery against the 'no worse than now' promise and 'better than the best of us' aim.
- the next stage (production of Target Operating Model and Full Business Case) includes considerable staff and stakeholder involvement as the detail of the new service is developed and agreed.

Outline Business Case (OBC)

The OBC reaffirms the finding from the Strategic Outline Case, that there are significant benefits to be achieved by creating a Black Country Pathology Service that operates from a single large hub, supported by three Emergency Service Laboratories (ESLs) on the other acute hospital sites.

The BCP would be set up as an Arms Length Organisation, hosted by one Trust but owned equitably and run jointly by the four Trusts. The senior members of the single management team, and the Chairs of the Clinical Reference and Operational Reference Groups, should be drawn from all Trusts to ensure balance, with the Clinical Reference Group playing the pivotal role in ensuring clinical service users are able to monitor and influence the quality of the services and functions provided. The single management team will report to Trust Boards via the BCP Strategic Board that comprises of Trust Directors (one clinical and one non clinical from each trust) and an independent Chair.

The BCP will include a commitment to deliver services and meet turnaround times 'no worse than now' and an aspiration to go beyond the best among us. Detailed transitional planning will include consideration of what is done now that is valued to assure this. The preferred approach offers an estimated saving in excess of £65m against a currently projected overall pathology spend of circa £708m over the next 10 years. This incorporates and goes beyond the savings projected within the long-term financial model (£44m), many of which depend on high levels of collaboration and rationalisation of working to achieve.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	NHS I	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	Y		

RECOMMENDATIONS FOR THE BOARD

The Board is asked to consider the Outline Business Case, and approve the recommendations to

- Establish a Black Country Pathology Service, which will be equitably and jointly owned by all 4 Trusts.
- Commence a transition phase to create a Black Country Pathology Service based on a

single hub / ESL model that is expected to be fully operational by end of 2018.

- Begin process of recruiting BCP Clinical and Operational Director roles that will drive this work forward.
- Commit to enabling expenditure for next period of activity as defined in attached summary.
- Produce a detailed Target Operating Model (TOM) and Full Business Case (FBC) that will be completed in time for consideration at Trust Board meetings in October 2017.

Outline Business Case (OBC)

Report into the development of a consolidated Black Country Pathology Service

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Walsall Healthcare NHS
NHS Trust

The Dudley Group NHS
NHS Foundation Trust

The Royal Wolverhampton NHS
NHS Trust

Foreword

Review of options for an efficient and high quality Black Country Pathology Service

This is a critical time for NHS pathology services both nationally and locally.

At present almost 130 NHS Trusts and Foundation Trusts provide their own pathology services, many of which are competing for increasingly scarce staffing resource and based on outdated operating models which are in urgent need of investment in premises, IT and equipment. At a national level, NHS Improvement are looking for an increase in ambition and pace for the consolidation of pathology services across the NHS, based on strong international and NHS evidence that consolidation and modernisation of pathology services can provide strong and sustainable services that offer both increased quality and efficiency.

At a local level the four Black Country Trusts each operate their own laboratory service, and the Black Country Pathology Steering Group has been formed to examine how a single management team for the four services might achieve similar benefits locally. There is considerable commitment to working as a single service, with the aim of developing a successful and sustainable pathology service that continues to provide high quality services in the locality. Clearly there are a number of options and opportunities that require examination, and this report details the appraisal of seven operational options.

Trust Boards have committed to a service led by a single management team that is neutral with respect to site and organisation, and accountable to an Oversight Group derived from executive and non-executive directors of the four Trusts. This is a very positive step, which places the responsibility for shaping the services in the future with the existing laboratory teams, and this report provides the first piece of analysis that will inform the next steps for the management team. This Strategic Options evaluation includes strategic, economic, financial, commercial and management considerations, and utilises both the expertise of the current pathology management teams and the best data available from locations across the NHS where similar processes have been undertaken.

This report provides clear direction to the Steering Group and points to some exciting opportunities for the Black Country services. I very much look forward to progressing with the establishment of our single management team and utilising the findings in this report to develop a full business case for Trust Board consideration later in 2017.

Mark Newbold

Independent Chairman Black Country Pathology Steering Group

Content

Content

EXECUTIVE SUMMARY

Executive Summary

Introduction and Recommendations

This Outline Business Case (OBC) presents a detailed analysis of the potential benefits for patients, staff, primary care and hospital clinicians of a new operating model for pathology services across the Trusts - a single hub and spoke model, with a single operating and governance model under a hosted arrangement.

The Black Country Pathology Service (BCPS) project began 6 months ago with the development of a Strategic Outline Case (SOC), which identified four preferred options out of a long list of 8. It was decided at the end of that stage that a Hub and Spoke (essential services laboratories or ESLs) model was likely to produce the best quality, patient, operational and financial benefits. This OBC has been developed to assess the potential benefits that a consolidated model would bring to all parties involved..

This OBC follows the Treasury guidance and recommendation on developing Business Cases and brings together the potential benefits and the recommendations for approval by each Trust Board during August and September 2017. If the OBC is approved, the months of September, October and November will be spent developing a detailed transition timeline, plan, activities and gateway reviews where the Trusts would be able to assess the progress of the project.

The Executive Summary brings together:

• **The Strategic Case** for change to the current operating model;

• **The Economic Case** which sets out the results of the appraisal of the new operating options and describes, in detail, the preferred Target Operating Model and its benefits;

• **The Financial Case** which quantifies the annual revenues and costs and investment required for the Target Operating Model and shows the impact (compared to the current model) for each Trust;

• **The Commercial Case** sets out the proposed governance, managerial and commercial arrangement for the Target Operating Model and the organisational form which it could take; and

• **The Management Case** which describes the implementation planning required and the risks to be managed to move the BCPS Trusts forward, were they to agree to establish a single pathology entity in line with the new Target Operating Model.

Recommendations & approvals

Trusts are asked to consider and review this OBC and recommendations below:

i. The differential over 10 years between the preferred model (Hub and three ESLs) and its variant is only £3m derived from the lower capital required. However, from a clinical and quality point of view the single hub option would still be the preferred option. It should be noted that a financial sensitivity run on both models in relation to the capital development costs indicated that the Hub and 3 ESL option provides a marginal higher saving.

ii. It is recommended that the Trust boards approve the commencement of the transition phase with a number of gateways on the way which should be defined during August , September and October, such as: confirm access to funding, confirm appointment of management team, etc.

1. Strategic and Economic Case
   - All Trusts to confirm the need for change and unsustainability of current delivery model.
   - Confirm that all Trusts are signed up to deliver the described benefits to patients, staff and stakeholders.
   - Agree that all pathology activity under the Base Case models will be managed by the new service.
2. Financial Case
   - Support the Financial Case as presented and its assumptions for the new TOM.
   - Approve the initial recommendations for shareholder distribution methodology and the implication for sharing of risks and rewards including transition costs.
   - Approve the investment required in the next three months for the development of a detailed transition plan, HR plan, Hub design and operational design as part of Gateway 1.
   - Support the commitment to consolidate services at RWH with the extension of the Hub as preferred option.
   - Support the development of the final agreement amongst the parties over the next three months and as part of gateway 1. This would include full agreement on shares, payment mechanism, revenue treatment, downside scenarios, CCG price standardisation and other key commercial terms.

Executive Summary

Recommendations & approvals

Trusts are asked to consider and review this OBC and recommendations below:

- Commit to the principles of the pricing mechanism where each test is paid for using a consolidated list of test prices.
- Support the pricing principle where the profit margin on Private Patient income is always retained by the Trusts and the same for GP income is retained by the Trusts for the first two years after the opening of the Hub.

3. Commercial Case
   - Establish an Arms Length Organisation (ALO) to operate the BCPS hosted by RWH.
   - Support the ALO to be governed by the principles set out in the Heads of Terms (HoTs) using a Scheme of Delegation including the Reserved Matters set out in this OBC.
   - Support the commercial principles set out in the Commercial Case but reserve the right to agree the detail once the partnership agreement if fully developed for Gateway 1..
4. Management Case
   - Agree to the appointment of a Clinical and Operations Director for BCPS to lead the transition period and plan development.
   - Agree to the development of a detailed transition plan for implementation with a number of Trust Gateway reviews for approval. The plan is to be ready by the end of October 2017 so implementation can start in November 2017.

Engagement

Over the last 3 months period there has been significant engagement with a wide variety of stakeholders to take the project to this point, specifically:

- BCPS Oversight Group: Formed by the CEOs and Clinical Directors the group has met on a monthly basis to assess progress and evaluate options.
- BCPS Steering Group: Formed by three representatives from each Trust including the laboratory manager, the clinical lead and a divisional management representative, the group has met once a month to discuss the detail of the business case and have been involved in the development of analysis.
- Clinical Workshops: Workshops have been held at each hospital site with clinical leads from each laboratory to discuss solutions to key clinical risks and the requirements for the operating model.
- Directors of Finance: three workshops have been held with DoFs to discuss key commercial and financial terms.
- Finance managers: engagement with finance leads from each Trust to capture and validate financial information used for financial modelling.
- HR Leads: engagement with each HR Lead from each Trust to understand the risks and start the development of a HR Plan for BCPS.
- Suppliers – we have also engaged with key existing suppliers who have provided (informally) cost estimates for reagents, Managed Equipment Services, IT and logistics to help underpin the new Target Operating Model.

Over the next few months, until October 2017, it is recommended that the engagement continues with the groups above to finalise a detailed project implementation plan and finalise the commercial agreement. At this point, staff engagement and communications should stepped up with the support of HR Leads.

Executive Summary

Strategic Case

Since the publication of the second phase of the Carter review in 2008, “Report of the Second Phase of the Review of NHS Pathology Services in England”, limited progress had been made in the implementation of new operating models that were able to provide cash releasing savings. The creation of NHS Improvement in 2016 has seen a re-examination of the central drive for consolidation in pathology. The mounting pressure on the finances of each Trust together with the new policy for consolidation has created a climate were collaboration amongst Trusts is seen as the way forward to achieve the sustainability of pathology services.

The ability to develop a sustainable pathology service is the key drive for collaboration. Most Trusts in England are seeing increasing pressure on laboratory operations from demographic changes (having to do more with less funding – average year on year growth of at least 5%) but also from staffing levels. Recruitment of specialist technical staff and pathologists is becoming an issue that is beginning to have an impact in the turn around times of specialist services like anatomical pathology and the development of new clinically relevant services. Certain staff groups are becoming more difficult to recruit and retain, these staff tend to be attracted by those laboratories or partnerships that are more forward thinking, offer a wider test repertoire and sites, and can offer wider opportunities for training and development. Isolated pathology services are unlikely to be able to attract and retain best candidates. This is already evident in some of the vacancies that the Trusts within the BCP service have not been able to fill, including some key clinical positions.

This requires the need to accelerate the collaboration of pathology services to radically improve the efficiency and size of laboratories linked to the implementation of radical reconfiguration of services, the adoption of world class technology and the ability of the pathology services to support better preventative medicine, long term conditions management and enhanced primary care capability.

The BCP service has been created with the aim to explore how pathology services can be best delivered for the local economy from a clinical quality and financial sustainability point of view. While some areas of the country have begun to make progress towards achieving the STP and Carter objectives for pathology (these are highlighted in the Strategic Case), the Trusts within BCP currently have been operating its services independently and delivering increased activity volumes year on year, while achieving the required CIP savings imposed by the Trusts. This is an unsustainable model that given all the strategic pressures has now reached the point where something has to be done to ensure the safe continuity of the services.

Economic Case

The economic case covers the analysis of a long list of options from a qualitative point of view to produce a short list of options that were analysed financially.

To ensure the sustainability and quality of BCPS service and deliver the required level of savings a number of options were considered, during the SOC (Strategic Outline Case), as to what should be the optimal operating model from a clinical quality and financial sustainability view point. However, the key economic driver is not the actual annual savings but the long term quality and sustainability of the service and the retention of current income, including the GP Direct Access revenue.

Executive Summary

Economic Case

The SOC highlighted 4 preferred options of which the Oversight Group ruled that due to the quality and financial benefits of the Hub and Spoke this is the main option that should be explored in the OBC with an ESL+ variant and compared against the baseline.

Current "As Is" Pathology Services

The facts concerning the existing Pathology services across the BCPS Trusts confirm its significance. The combined pathology services:

- Deliver approximately 25 million tests per annum;
- Have experience in consolidation through the consolidated Cytology service across all BCPS Trusts; and
- Employ approximately 679 staff (including consultants) of which 497 are Bands 2 to 8 employed in the laboratory.

The service currently faces a number of challenges to its sustainability in the form of annual volume increases, difficulty in recruiting for certain grades and requirement to achieve annual savings. For this purpose a new Target Operating Model (TOM) has been developed.

New Target Operating Model

The following table summarises the target operating model. Key features are:

- Creation of a clinically led joint service, owned by the four Trusts and for the support of the four Trusts and its users;
- Clinical staff to work on where required by clinical activity;
- Hub and Spoke model to achieve economies of scale;
- GP collections, TATs and service quality maintained or improved through potential additional collections (costs included);

	Service Description	Turn Around Times (TATs)
Integrated Hub	• The Hub will incorporate maximum automation and an optimum workforce profile; • Work performed here is sub-acute and/or specialist and/or screening. The default position would be that all work is performed here, unless there is specific reason for it not to be – i.e.. Turn Around Times (TAT), clinical proximity, etc; • The Hub will allow opportunity for commercial development and expansion, including research and development; • Main Hub facility to be located at Royal Wolverhampton Hospital (New Cross site); and • Work performed at the Hub will include Research and training of staff with specific facilities available for this purpose, including consultant offices.	• Routine work – >4 hours • Specialist work - >6 hours
Essential Services Laboratories (ESLs)	These laboratories will service the clinical needs of local acute sites. These will be based at current laboratories which will be reconfigured. They will provide: • Tests required for acute care with TATs which cannot be serviced by the Hub, but which can be delivered from an ESL lab, e.g. CSF, frozen sections, A&E support; and • Tests on samples which cannot be transported to the Hub.	• 20 mins – 4 hours
Point of Care/Near Patient Testing	In areas within Acute Hospitals which require faster TATs than are available from laboratories.	• 5 mins – 20 mins

Executive Summary

Economic Case (continued)

- Common IT LIMS with links to other key systems within the Trusts, including a digital pathology solution to facilitate MDT support and reporting;
- Implementation of common equipment platforms. TOM takes into consideration the new MES contract at Dudley assuming no savings are derived from it;
- Hub extension at New Cross Hospital: costed extension and design for hub extension that would allow for all BCPS specialties to be consolidated, including space for consultant offices; and
- Creation of one team of consultant pathologists, that would work where clinical activity demands it, under one single clinical governance framework and leadership, providing continued support for MDTs.

Area	Benefits Required	How the TOM will deliver it	BCPS Objective
Patient Benefits (inc. Clinical Quality and Research)	• Reduced waiting times for patients for all tests including cancer and specialist diagnosis; • Consistency and speed in the way in which results are reported, via IT which are seamless with customer's systems; and • Support for R&D at the forefront of pathology Speedy access to clinicians for support and diagnosis.	• Co-location of staff from all disciplines would allow for multidisciplinary teams that would ensure relevant expert can report on the results, avoiding transport costs, delays and reducing duplication. This would also allow for speedy access to relevant expertise; and • This pool of experts has the potential to attract R&D funding and would allow for greater training opportunities for staff.	Deliver improved quality and outcomes for users of the service and patients, including improved TATs Deliver Clinical and Research excellence.
Workforce and Skill Mix	• Standardised working practices across all sites; • Centralised workforce and management; • Changes in skill mix and economies of skill and scale; • Cross skilling of staff across disciplines; and • Reduce staff costs.	• A common workforce that has the same standard processes and a common management team would allow for greater integration and support across all sites; and • A single management team will reduce management costs and increase opportunity for reinvestment.	Ensure a more effective, integrated and efficient service.
Equipment, IT Logistics and consumables	• Investment in transport and logistics; • Greater efficiency in procurement and distribution processes leveraging economies of scale; and • Opportunity to share facilities across disciplines to reduce costs.	• Integration of equipment and platforms with common suppliers will increase purchasing power and deliver economies of scale benefits; and • New common IT system would allow faster reporting to primary care and other users, including digital pathology.	Ensure a more effective, integrated and efficient service which delivers greater value for money.
Flexibility and resilience	• A Hub will be flexible enough to accommodate increased volume of work; • A dedicated Hub will be able to accommodate advances in technology/equipment; • A model based on a Hub with supporting Essential Lab sites has more resilience; and • Cost reduction to allow financial benefits to be both shared with customers and retained for investment.	• Integration would increase resilience through the use of spare capacity across sites; and • A Hub Laboratory would provide flexibility to increase capacity and manage test demand fluctuations, adapting to future needs creating a more sustainable service overall.	Ensure long term sustainability of the service.

Executive Summary

Financial Case

The financial evaluation has been carried out by assessing the impact that each cost driver would have on the overall cost of pathology to the Trusts. Savings are shown at the end of this executive summary. The analysis has confirmed the initial estimates provided in the SOC. While there has been an increase in the calculated transition/investment costs as a result of a more accurate evaluation of refurbishment and build requirements, there has been an increase in the savings derived from staff and non-pay. It should be noted that the design of the ESLs has been carried out with a conservative approach and therefore the numbers provided are achievable and could derived in greater savings during implementation.

- Staffing costs: staffing numbers required and skill mix were calculated based on hourly evaluation of volumes at the Hub and ESLs (using activity volumes submitted by the Trusts).
- Equipment costs: Total savings for equipment are achieved through economies of scale. This has taken into consideration current contracts in place and therefore no savings are applied to the costs from DGFT.
- Logistics: additional logistics costs were added to the models as required to cope with the additional sample movements.
- IT costs: It costs have been included and priced to reflect the required capital investment in a new IT LIMS with links into hospital system, ordercomms and other required links
- Transition investment: various levels of capital and non capital transition costs were considered and added to the totals during the transition period.

Summary of savings

The implementation of a new TOM would, including the investment required in transition would exceed the requirements of the Trusts for the achievement of CIPs as well as exceed the savings that have been planned in the LTFM.

The implementation of the TOM would ensure the long term sustainability of the service and support the quality improvements required.

Executive Summary

Commercial Case

The commercial case provides details of the agreements reached on key commercial terms and which will form the basis of the partnership agreement (PA). Key commercial terms agreed are:

- It is proposed that the service is set up as an Arms Length Organisation (ALO) and hosted by one organisation with the Host being the Hub (RWH) or an alternative Trust if it can provide a more effective service.
- BCPS to be subject to the list of reserved matters agreed in the Appendix 2 and the standing orders of the host Trust.
- Partnership to be managed by the BCPS Strategic Board which will be formed by two representatives from each Trust (one clinical and one executive member) with all Trusts having equal voting rights.
- Appointment of an Executive Management Team for BCPS formed by a finance director, operations director and clinical director.
- Establishment of user clinical steering committee to provide oversight on clinical quality and contract management committee to provide oversight on SLAs.
- All partners to commit to a term of 10 years to allow the recovery of investment.
- Shareholding to be calculated based on activity volumes by Trust times a price. These shares would only be recalculated once volume at one Trust changes by ±8%.
- Funding to be accessed through the application submitted to the development fund (resolution in early July) or through the ITFF as per the head of ITFF guidance.
- Staff to TUPE transfer to the Host.
- Revenues: each Trust would retain current revenues from commissioners and external sources. Each Trust would be responsible for managing their relationship with its commissioners and clients. New clients joining the partnership would do so by contracting directly with the BCPS service through the host Trust.
- Sharing of benefits an liabilities: these would be done in accordance to the shareholding at the time.

Management Case

The management case provides an overview of the next steps for the establishment of the the partnership. It is recommended that work on the transition begins in August 2017 to achieve an implementation date of December 2018. Key phases for the transition are:

1 – Appointment of Executive Management Team and selection of BCPS Strategic Board members;

2 – Gateway 1 (FBC): set up to transition plan by October 2017 with detailed HR plan, detailed finance plan and construction plan (FBC);

3 – Gateway 1 (FBC): Completion of commercial agreement and finances, including clarification on route to access capital (FBC);

4 – Gateway 2: Design of Hub and ESL layouts for construction and refurbishment, including detail quotes from builders;

5 – Gateway 3: Operational processes design: design of detailed operating processes for the Hub and the ESLs;

6 – Gateway 4: Procurements: Development of procurement documentation and running of procurement processes, including detailed procurement costs;

7 – Implementation of IT and Equipment;

8 –Validation of equipment, IT and transfer of services across sites: this would also include early transfer of activity where possible to achieve quick wins;

9 – Project implementation review and steady state: review of project implementation and official start of steady state.

STRATEGIC CASE

1

At a Glance

NHS Improvement National Programme	NHSI is currently undertaking a national review of pathology services with the aim of ensuring that consolidation takes place in England. The aim of the review is to create no more than 30 hubs across England as per the recommendations of the 2008 Lord Carter review. This means that working across STPs is a necessity as well as the consolidation of services in the Hub and Spoke models. It is likely that Trusts not moving forward with this strategic aim will be forced to collaborate to achieve savings.
NHSI and NHS Five Year Forward Review - 2015	This joint paper from the NHS national leadership states that **NHS providers should achieve savings** and be more proactive in the way they engage with other NHS organisations and the private sector. NHSI have issued a number of letters to Trusts and STPs with timelines and submission requirements for consolidation plans for Pathology and Back Office.
BCP Service sustainability	A key driver for the creation of the BCP collaboration was to explore options that would ensure the sustainability of the service from a financial, clinical and operational point of view. Some of these sustainability pressures are clearly manifested on the need to realise cash releasing savings but also the difficulty of recruiting and retaining qualified staff. Over time, as large laboratory collaborations develop in England the retention of qualified staff by smaller isolated laboratories is likely to become significantly harder as employees look for the challenges and variety that large laboratories with multiple disciplines can bring.
Lord Carter Coles Report	Supporting this, Lord Carter Coles has produced a report into the efficiency of NHS Trusts in England and Wales. This report recommends that **NHS Trusts look at the operational efficiencies that can be achieved through collaborations and new models of service delivery** such as consolidation and Lean thinking.
Financial and efficiency pressures	BCP is also suffering other pressures derived from the need to deliver more tests (changes in demographics and an increase in chronic conditions are increasing the number of tests delivered every year) with less financial resources as Trusts are required to reduce cost to balance their budgets. As a result of the current worsening financial position of the Trusts, **BCP will be required to achieve a higher level of savings year on year in the future.** This is no longer sustainable in the long term without collaboration or changes to the operating model.
Best use of spare capacity	Within the BCP partnership, RWH has invested in a new fully automated hub facility and Dudley and Walsall entered new equipment contracts with suppliers. This has created spare capacity with the group of Trusts that could be utilised to achieve efficiencies and savings.
Pressure from neighboring Trusts	Currently the risk of other Trusts developing a service that could pose a threat to the sustainability of the Trusts within BCP is low as all initiatives in the Birmingham area are still at an early stage of maturity. This poses an opportunity to the BCP Trusts to lead the way in the reconfiguration of services within the STP and develop an innovative and flexible service that can secure its future sustainability.
Opportunities	The creation of the BCP collaboration would allow for the sharing of resources in a way that can favour the development of the service. Key areas of development that would benefit all BCP partners, include the development and growth of the BCP reference chemistry service and the optimisation of services in a large Hub through the use of the latest automation technology. The service would also be able to better address the challenges emerging from the STP clinical reconfiguration of services, R&D and clinical sustainability.

Strategic Case

1.1 Strategic Context

1.1.1 National Context – Department of Health (DH) strategy

Since the publication of the second phase of the Carter review in 2008, "Report of the Second Phase of the Review of NHS Pathology Services in England", Trusts have increasingly looked at their option to achieve the proposed savings and quality improvement. However, limited progress has been reported across England on Trusts in achieving the creation of the proposed Hub and Spoke models for the consolidation of services

At the time the Carter review was published, the economic downturn was just starting. The publication of the review in 2008 has been followed by 8 years of austerity and public finance restrictions where the financial position of Foundation Trusts has deteriorated but also the financial position for non-foundation Trusts.

During this period of austerity, Trusts have been required to achieve annual savings to balance the budgets, and to start looking at the alternative models for service delivery.

This has translated into pressures for pathology departments to achieve year on year savings while coping with limited investment in facilities, equipment, IT and logistics and having to deliver more tests as a result of changes in test ordering and demographics.

The NHS Chief Executive Officer published in 2014 his "NHS five year forward view" for the NHS, where he seeks to address these population and demand changes through the proposal to change the way healthcare is delivered in the UK. This report encourages Trusts to look at the scale and scope of services they deliver and how these could be best delivered, including collaborations to deliver services and new organisational forms. The report has certainly inspired changes in the way "Integrated Care" is delivered but also the opportunity to think how other services can be provided.

Following this, a number of CCGs across England have started to engage further with their pathology services providers to understand what part pathology can play in the patient pathway and how it can support essential initiatives such as admission avoidance and providing greater levels of care in the community.

In December 2014, a report from Sir David Dalton (CEO, Salford NHSFT) to Jeremy Hunt entitled "Examining new options and opportunities for providers of NHS care: the Dalton Review", noted the importance of developing new organisational forms and service models to facilitate the transformation of services and improvements in Quality and Efficiency.

NHS Improvement initiative (NHSI)

The creation of NHS Improvement through the merger of Monitor and the TDA has given pathology consolidation a new focus.

The lack of progress achieved over the last 8 years and the need for Trusts to achieve efficiencies has prompted NHSI to create a new drive for consolidation. NHSI policy is currently looking into supporting Trusts across England in their consolidation efforts.

As per the recommendation from Lord Carter, it is expected that less than 30 Hubs and Spokes will be created in England: this will clearly require consolidation of services across STPs. The new drive to encourage Trusts to collaborate will look into supporting those initiatives that have currently developed plans and made progress so savings can be realised early. On the other hand, those Trusts that have no plans or are not willing to collaborate are likely to be pushed towards a recommendation on who to consolidate with in order to achieve savings for the health economy.

Overall, the current guidance from NHSI and the Department of Health points towards greater flexibility for NHS FTs and NHS non-FTs to create new alternative organisational forms and operating models that would allow the creation of sustainable services for the community and save costs. Trusts will be supported on their consolidation efforts while Trusts without plans are likely to be put under recommendation for consolidation with neighbouring initiatives.

Strategic Case

1.1.2 Summary of UK Initiatives

The following page provides a summary of all the UK initiatives and their status, classified as per their commercial model chosen.

Organisation	Partners	Size	Scope	Model	Organisational Form	Staff	IT and Equipment
Thin Joint Venture							
SPS Facilities and SPS Analytics LLPs	iPP Facilities; iPP Analytics, Taunton and Somerset NHS FT and Yeovil District Hospital NHS FT	£15m annual turnover 6.8m tests	Whole service	External hub with consolidated 99% Microbiology, 85% Blood Sciences and Cytology 2 Essential Services laboratories (ESLs)	LLPs with customer contracts with Trusts and supply agreement with iPP	TUPE to iPP	Latest automation (tracks, Kiestra and GE digital pathology) New integrated LIMS
Pathology First Analytics and Pathology First Facilities LLPs	Basildon and Thurrock Hospital; Southend Hospital and iPP	£25m per year and 13.2m tests	Whole service including phlebotomy	External Hub and 2 ESLs same as above	LLPs same as above	TUPE to iPP	Latest automation (tracks, Kiestra and GE digital pathology) New integrated LIMS
HSL LLP	TDL; UCLH and Royal Free Hospital (as a customer)	£120m per year 62m tests	Whole service	New on site Hub and ESLs	LLP	TUPE to TDL	Plan for single integrated LIMS and latest automated platforms
Thick Joint Venture							
Christie Pathology	Christie Pathology and iPP	£6m annual turnover 2.8m tests	Whole service	One laboratory at the Christie	LLPs with customer contracts with Trusts	TUPE to JV	No change to IT or automation
Viapath	Kings Hospital; Guys and St Thomas Hospital and Serco	£80m and 35m tests	Whole service	Currently undergoing a consolidation project for a Hub and Spoke	LLP same as above	TUPE to JV	Implementing integrated LIMS and consolidation with latest automation (Track at Kings)

Strategic Case

Organisation	Partners	Size	Scope	Model	Organisational Form	Staff	IT and Equipment
Trust Led Developments and Managed Networks							
Pathlinks	Boston Hospital, Grantham Hospital, Grimsby Hospital, Lincoln Hospital and Scunthorpe Hospital	£48m and 20m tests	Whole service	Laboratories deliver all the tests for certain specialties with specialties being distributed across all Trusts	No entity created	Remain with their Trusts	Under integrated iSoft system. No consolidated automation
Gateshead	Gateshead hospital	£12m investment in new pathology building on site (NHS grant and Roche)	Whole service	Centralised consolidated Hub and ESLs as required	No entity created, division within Gateshead hospital	Remain with their Trusts	Single LIMS and equipment platforms across all sites
TPP	6 Trusts East of England + PHE	£90m and 32m tests (£5m loss – because of lack of consolidation implementation)	Whole service	2 Hubs and 6 spokes although it has recently been announced that the partnership is reviewing its form in 2017	NHS Hosted organisation. From **5th of May 2017 it has split into two separate entities**	Plan to TUPE to Cambridge and PHE	Exploring implementation of single LIMS and equipment platforms
SWL	St Georges; Croydon and Kingston Hospitals	£50m and 18m tests	Whole service	Hub at St Georges and spokes	NHS Hosted	TUPE to St Georges;	Procuring single LIMS and equipment
NWL	4 NW London Trusts	£105m and 54m tests	Whole service	External Hub and spokes	To be NHS Hosted by imperial	TUPE transfer to imperial	Exploring procurement options

These initiatives show that there are a number of successful models across the UK. The MES + option where a Trust contracts additional services (such as refurbishment of facilities) with an equipment supplier has been successfully implemented across many Trusts in the UK. The facilities management option where a private developer builds and finances a laboratory block has not been tested in pathology (other than by the private sector) but has however been tried many times in NHS programmes such as the Local Improvement Finance Trusts (LIFT) projects for Primary care.

Strategic Case

1.2 Local need for change

The Black Country Pathology (BCP) service is formed by four Trusts looking to collaborate to optimise the use of resources. These Trusts are: The Dudley Group NHS Foundation Trust (DGFT), The Royal Wolverhampton NHS Trust (RWH), Sandwell and West Birmingham Hospitals NHS Trust (SWBH) and Walsall Healthcare NHS Trust (WHT).

- **Sustainability of services and CIPs:** A key reason for the creation of the BCP Service (BCPS) is to ensure the sustainability of the service. From a financial point of view the pressures that all Trusts in England are facing will translate in to the need for pathology services to achieve ongoing savings and CIPs. In addition, NHS Improvement as highlighted in the previous section, will be looking to push for collaboration to happen in England to release cash.

- The BCPS is also facing other operational pressures such as the increase in activity volumes year on year. This is a particularly acute problem in blood sciences with increases of 5-8% year on year. Including Histopathology where the increases in difficulties in recruiting clinical staff put the ability to report within agreed targets at risk.

- However, the consideration of future sustainable models by BCPS will also bring some positive solutions for some of the current local issues affecting sustainability:

- **Recruitment**: The creation of a strong service that is attractive to new high quality recruits would ensure the ability to have the right clinical leadership over the long term. The creation of a strong service would enhance the attractiveness of employment for new technical and clinical candidates.

- **Flexibility**: the drive to create Accountable Care Organisations (ACOs) as well as to move more hospital services into the community is beginning to have an impact on the redesign of pathways and the role that diagnostics play within the pathway. Pathology departments are beginning to get asked to have greater flexibility on their delivery models to allow for increases in the amount of Point of Care Testing (PoCT) offered as well as changes in nature of the interaction with clinicians. A joined team and workforce for BCP would allow it to increase its flexibility in dealing with requests arising from the Black Country Alliance and other initiatives within the area.

- **Service quality:** while all laboratories within the BCP service provide a high level of quality and care, the operational pressures that the services are phasing, coupled with pressures from the market, especially around recruitment challenges, there are some areas of the service that are seeing quality standards at risk. These areas are likely to be at risk in the future (e.g.: histopathology) unless a new TOM is implemented to address these risks.

Strategic Case

1.3 Strategic need for Change

The plans for the long term sustainability of the BCP service have to address not just the local needs of the Trusts but also the impending demands that national strategy and drivers are likely be imposing on the service.

Driven by national policy, financial pressures and local population pressures there are a number of impending needs for change:

- **NHSI:** NHS Improvement have indicated that there will be a number of directives issued to push Trusts towards collaboration and reform of operating models in Pathology. This means that by 2017 all Trusts would be required to consider the best options for their pathology service within the STP. **STPs** are being asked to collaborate and consolidate services across the STP footprint to achieve the required level of savings. Within the Black Country area, Trust boards have asked all pathology departments of the 4 member Trusts to start developing options and plans for a collaboration.
- **Technological requirements**: RWH have developed a new dedicated laboratory facility with potentially enough capacity to deliver the routine Blood Sciences and Microbiology for the current BCP partners with minimal capital investment required (detailed capacity analysis required as view formed during initial site visit by LTS). The facility also has the option to be extended to accommodate specialist work. The equipment (automated track) has spare capacity. DGFT has recently entered into a MES contract with Roche for the replacement of their technology creating some spare capacity for routine work.
- **Facilities:** RWH opened a new laboratory block with capacity to accommodate additional work and expand for additional services. SWBH are currently updating and upgrading their laboratory facilities. DGFT and WHT currently operate from PFI facilities, this could potentially impact some of the options regarding the analysis of stranded costs.

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- **Market openness and competition:** new competitors have entered the market and created efficient consolidated service models that allows them to push the boundaries on quality and cost to gain market share. These are both from the private sector (SPS, Pathology First, HSL, Synlab) and from the public sector (Gateshead Pathology, NHS Pathology – Frimley Park). These are explored in the strategic section of this report.
- **New ISO 15879 quality requirements** the move from CPA accreditation to the new ISO standards has meant that greater pressures are put in the service in order to maintain quality standards and accreditation. This requires additional staff time focused on quality as well as a high standard for the facility and equipment.
- **Increases in demand**: changes in demographics and long term conditions are increasing demand on services on an annual basis, which requires the laboratory to be optimised to be able to do more with the same or even less when financial pressures are taken into account. Across the BCP Trusts annual activity increases of 5-10% in volume for different disciplines.
- **Savings and sustainability** the deteriorating financial situation at the Trusts requires all departments to contribute towards the financial sustainability of the Trusts. For pathology this means that there is a requirement to control costs and meet budgets.
- **Clinical Sustainability:** Recruitment of clinical staff to provide a clinically led service is likely to become more challenging for those organisations that cannot offer the variety of work to develop specialism, and the ability to work for a forward looking, dynamic and flexible organisation.

Strategic Case

1.4 Opportunities, Threats & Barriers

Threats

The current NHSI initiative, the Model Hospital and the ongoing review of hospital efficiency being developed by Lord Carter will push hospitals to rethink the way pathology and other clinical support services are delivered. The financial positions of BCP Trusts will increase pressures to rethink how services are delivered to achieve efficiencies

In addition, private providers are likely to get stronger as hospitals and CCGs continue with the tendering of pathology services, which could in the future have the potential to threaten the sustainability of local pathology services.

Opportunities

The above threats would also create an opportunity for a pathology service that is already set up and operating with efficient costs and spare capacity. Certain Trusts are likely to look for partners to support pathology. In addition, a service that can provide access to Specialist Testing may see growth opportunities in this area.

Barriers to change

- **Differing Trust objectives:** trust objectives are focused away from pathology due to the financial, cancer pathway and A&E challenges (amongst others). As such pathology is not given sufficient consideration as a way to deliver change;

- **Protectionism**: A number of Trusts fear the domino effect of losing pathology through centralisation as a precursor to reducing their wider front line clinical services;

- **Staff reluctance to change**: There is often some reluctance among staff to change to a new model of delivery of pathology services, particularly where the potential delivery model is outsourcing;

- **Resources** required to develop new models: In many pathology laboratories there is insufficient staffing, with the difference made up largely by agency staff. This, coupled with ever increasing accreditation and regulatory requirements, means that there is often insufficient time in order to effectively scope and plan for changes in service;

- **IT platforms**: Different IT platforms, and the inability of these to communicate can cause significant impediments to consolidation. There must be common IT platforms across the consolidated sites;

- **Equipment platforms**: The same can be seen with equipment platforms – through the consolidation there should be in place a process to move to common equipment platforms;

- **Lack of engagement of clinical teams** and clinical users to determine an urgent test repertoire required at each site: There is a general resistance towards moving tests off site. In many occasions this can be used as a blocker which can partly be overcome through clinical engagement;

- **Agreement on a commercial** method to maintain Trust external income: If no agreement is reached between the parties then the consolidation will not take place – external income is a significant part of the pathology service delivery;

- **Lack of local leadership and skills:** a large pathology consolidation project will require a set of specialist skills, clinical skills and senior management engagement to develop the target operating model and agree the commercial terms between the parties.

Strategic Case

1.5 Clinical and Quality Benefits

BCPS is an opportunity for staff to be part of a world class service with the potential to innovate and expand the range of services, which in turn will benefit patients. Integration has already been successfully implemented by the BCPS partnership as shown in Appendix 6.

Clinical and quality benefits can be predicted based upon the experience of other networks and the experience within the Black Country of the centralised Gynae Cytology service. The centralised gynae cytology service formed in 2013. The initial concerns of staff quickly evaporated as they realised that by sharing expertise they could create something better than any of the individual sites could previously. The service that they created is nationally recognised and has maintained excellent turn-around times always being ranked within the top 5 labs in the country.

- **For patients**

A fully accredited (ISO 15189), faster, more reliable and more cost effective service, delivered by improved logistics (increased collections from GP surgeries), less requirement to send samples to other labs, and improved IT connectivity across the Black Country enabling seamless care as patients move between providers.

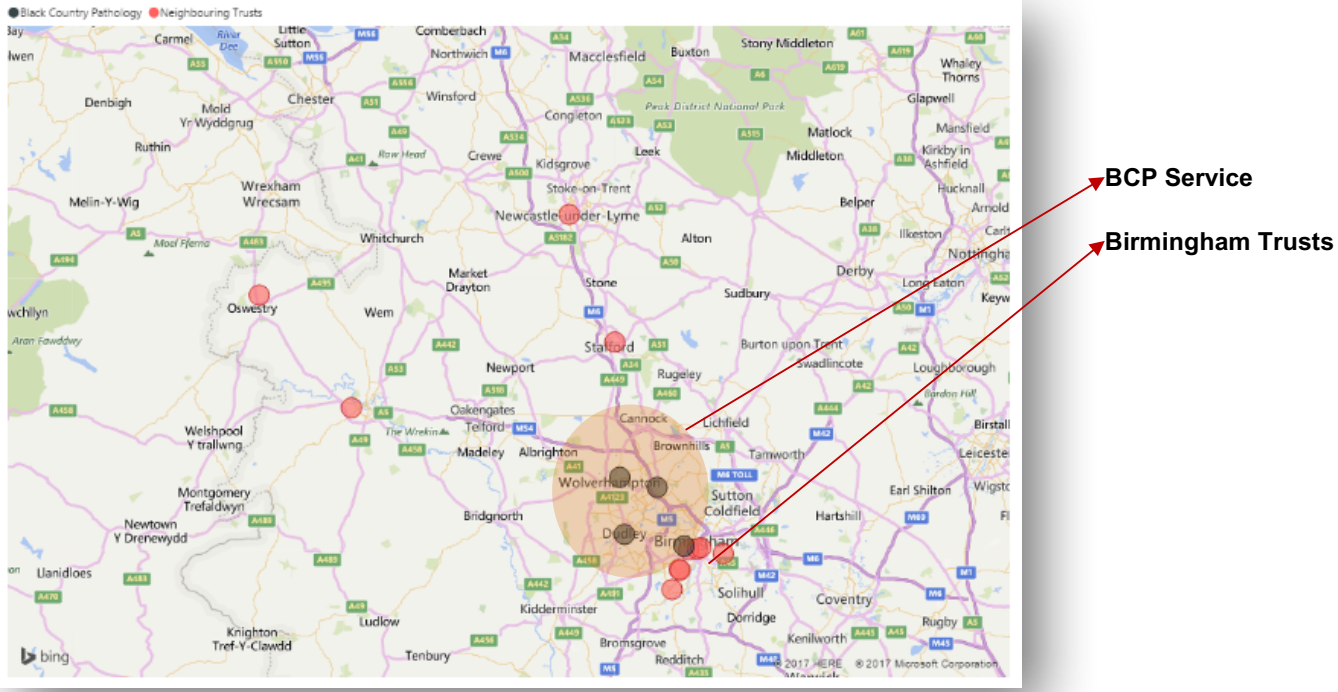
- **Staff**
  - Better utilisation of staff resources – there are currently national shortages of pathology Consultants and scientific staff,
  - Improved ability to recruit and retain staff
  - Succession planning and workforce development
    - More opportunities for development of staff
    - Improved training opportunities
  - Pooling of best practices from all sites resulting in an exemplar service
  - Staff working out of a purpose-built, state of the art building
  - Critical mass of staff enabling provision of 24/7 services for departments such as microbiology which currently cannot do this across four sites
  - Critical mass of Histopathologists enabling specialist reporting of all samples
- **Equipment**
  - Ability to always access the latest equipment and technology eg microbiology track and digital imaging for histopathology
  - Avoids duplication of equipment across sites
- **Test repertoire**
  - Larger repertoire of tests available to clinicians with resulting benefits for patients
  - Sustainability of service
  - Improved ability to recruit and retain staff
  - State of the art building
  - Latest equipment and technology
- **R&D**
  - Critical mass to enable BCPS to be at the forefront of research and development, providing better outcomes for patients.
  - Provide an opportunity to consolidate and expand other services that are of benefit to patients and users such as POCT and phlebotomy.
- **Improved user satisfaction**
  - GPs – improved number of collections per day, less chance of patients needing to be recalled for repeat tests due to samples exceeding the 4 hour delivery window,
  - Hospital users – The ESLs will be able to focus of hospital patients without the distraction of the GP work.

Strategic Case

1.6 Geography and competition

Currently BCP is surrounded by a number of Trusts and private organisations that have either created consolidated pathology models or are in the process of doing so. These organisations are looking to expand their collaborations and services. The map below shows how BCP is currently surrounded by the Birmingham Trusts to the South and a couple of isolated Trusts to the North and Northwest.

These organisations have already started to approach CCGs and other Trusts to form collaborations and gain additional activity, posing a threat (though not immediate) for the current BCP GP Direct Access revenue. The map below provides an overview of some of the hospital sites surrounding the BCP partnership



Strategic Case

1.7 Conclusions

The recommendation from National Policy, NHSI, Trust finances, initiatives in the market, changes in requirements from commissioners, changes in the way that pathology services need to be delivered and status of competitors and private providers have created a perfect storm of external threats for pathology services that are not able to adapt to the market and create a sustainable service. In addition, there are a number of internal drivers that are pushing BCP Trusts towards the need for change to address this. These are likely to have significant impact on KPIs in the future if not addressed. The pathology service is also likely to be asked to achieve increasing levels of savings in order to help the Trusts to return or maintain financially sustainable positions. The key change drivers are summarised below:

National Change Drivers

- Forward View and NHSI recommend that Trusts look at alternative ways of delivering services, increasing collaboration between Trusts and with private sector. There is growing pressure to collaborate within the local STP driven by NHS Improvement.
- Pathology services need to adapt to commissioner needs and become an integral part of the new care models such as ACOs, care closer to home, PoCT, IT connectivity and access to results, etc.
- Demand for services will continue to increase with more tests having to be delivered.
- NHS finances will continue to put pressure on pathology services to achieve large cost reductions. Doing more with less, in collaboration within STP footprints

BCP Drivers

- Service Long term Sustainability is key for each of the Trusts. All Trusts in the BCP service are currently under financial pressure which is likely to increase the demands on the pathology services to implement cash saving initiatives.
- The sustainability of the service will also be impacted by the ability to recruit the right clinical and technical staff. It has been proven around the country and in the BCP area that smaller isolated services are finding it increasingly difficult to recruit and retain staff.
- The creation of the BCP service would allow the Trusts to have access to a wider pool of resources, increasing resilience and the flexibility of the service.
- The creation of an NHS partnership may encourage other Trusts to join at a later date as well as the repatriation of send away tests and development of the service.

Market Drivers

- A number of private providers have now consolidated their positions in the UK market and will be looking for expansion of opportunities through the outsourcing of services at Trusts where pathology services cannot achieve financial sustainability.
- In the same way, a number of NHS organisations have been able to implement new operating models (Gateshead, Surrey Pathology Services), achieving savings and gaining market share through contracts with other Trusts, Mental Health Trusts, Community Services Trusts and CCGs.
- New engagement models are emerging (different types of JVs, private set ups and NHS developments) providing Trusts with the opportunity to be creative in the way that the required efficiencies can be achieved.

ECONOMIC CASE

2

At a Glance

Options evaluation and process	The BCP Steering Group during their meeting in March decided that a long list of options needed to be evaluated on a qualitative basis in order to assess the deliverability and sustainability of the service under those Target Operating Models (TOM). While this was a subjective evaluation it provided the Trusts with an opportunity to discuss the key strengths and weaknesses of each option and assess them against the proposed evaluation criteria. It was then agreed that the shortlisted options would become the subjects of further detailed financial analysis to assess their financial sustainability. It was decided that out of the 7 options in the long list, 4 would be selected for financial evaluation with the As Is used as a baseline to compare against.
Long List of Option	The Long list of options was formed by the following: 1 – Status Quo (As Is) – including required CIP savings; 2 - Joint Outsourcing – to a private sector organisation or another Trust; 3 – Distributed Network Model – creation of centres of excellence by discipline at different sites; 4 – New External Hub + five ESLs – building of a new external hub facility; 5 – One internal Hub and three ESLs – using a current Hub as a facility for all services; 6 – two Hubs and three ESLs – duplicating specialties across two Hubs based on capacity; and 7 – MES+ – Joint equipment contract for all sites by specialty.
Evaluation of the long list	The evaluation was carried out by the BCP Steering Group Trust representatives and the Chairman of the BCP group as an independent evaluator. The five evaluation scores per option were then combined into an average to provide the following results: 1 – Status Quo (As Is) – 2.70 – 7th 2 - Joint Outsourcing – 2.88 – 5th **3 – Distributed Network Model – 2.98 – 4th** 4 – New External Hub + five ESLs – 2.78 – 6th **5 – One internal Hub and three ESLs – 3.71 – 1st** **6 – two Hubs and three ESLs – 3.25 – 2nd** **7 – MES+ - 3.07 – 3rd**
Preferred Option	Following the initial evaluation of options in the Strategic Outline Case, the BCPS Strategic Board decided that the preferred option they would wish to explore in the OBC is option 5, **One Internal Hub and three ESLs**. This option would be compared against an enhanced “As Is” model that includes CIPs and a variant on option 5 where one of the ESLs hosts reference chemistry to reduce the capital investment required.

Economic Case

The economic case will provide a summary of the current services. This will be followed by a description of each option and a description of qualitative evaluation criteria to be used for the evaluation of these options to reduce the long list to a shortlist that will undergo detailed financial analysis.

A key consideration for the modelling of the different options is that any tests with a TAT of 4 hours or more can be consolidated at a centralized laboratory.

All staffing numbers in the following pages reflect total budgeted staff and not actual, which means that vacancies are not included in the numbers in the followng pages.

2.1 Description of the current service – Blood Sciences

The current services for the BCP Trusts are provided from 5 main sites. The table below provides an overview of the levels of activity for Blood Sciences and Immunology. Areas like specialist chemistry, haematology testing, coagulation, and blood transfusion have been grouped as part of the Blood Sciences. We have assumed that direct access blood sciences, which are non urgent tests that could be considered for consolidation at a centralised facility, can be centralised. In addition, we have assumed that from the remaining Inpatient and Outpatient tests, approximately 90% of the volume would also have a non-urgent TAT. It should also be noted that current immunology tests for Walsall are sent away and not delivered in house.

	Blood sciences	Chemistry	Coag.	Haematology	Immunology	Blood Transfusion
RWH	6,204,169	5,132,736	217,716	576,048	175,968	101,701
SWB	7,967,196	6,383,868	284,244	921,708	176,652	200,724
WH	3,979,500	3,778,962	88,406		33,508	78,624
DGH	5,340,748	4,452,000	161,184	443,532	196,200	87,832

Economic Case

The table below provides a summary of the staffing levels within blood sciences and the skill mix of the staff. It should be noted that the high levels of staff at SWBH, in contrast to the number of tests performed, is the result of the provision of specialist testing and services which the other Trusts do not provide. The high levels of efficiency at RWH are the result of the implementation of the new automated laboratory facility for routine activity.

Current State Blood Sciences				
Blood Sciences	WHT	RWH	DGFT	SWBH
Band 2	-	-	6.29	3.58
Band 3	9.28	16.34	10.00	11.78
Band 4	0.08	-	-	3.94
Band 5	1.63	13.00	8.00	11.49
Band 6	15.78	17.17	22.85	37.26
Band 7	6.89	10.00	8.32	15.94
Band 8a	4.14	3.00	4.33	4.80
Band 8b	-	1.00	1.00	2.38
Band 8c	-	-	-	1.00
Band 8d	-	-	1.20	-
Total	37.80	60.51	61.99	92.17

Current State Immunology				
Blood Sciences	WHT	RWH	DGFT	SWBH
Band 2	-	-	-	2.00
Band 3	1.00	2.34	1.00	1.73
Band 4	-	-	-	
Band 5	-	-	-	2.82
Band 6	1.00	2.00	2.49	3.05
Band 7	0.80	1.00	1.00	1.60
Band 8a	-	-	1.00	
Band 8b	-	-	-	0.80
Band 8c	-	-	-	
Band 8d	-	-	-	
Total	2.80	5.34	5.49	12.00

Economic Case

2.2 Description of the current service – Microbiology

Microbiology services are delivered across all four Trust members of BCP.

	Microbiology
RWH	307,068 *
SWB	433,356
WH	261,024
DGH	345,523

* Serology included within blood sciences

Current State Microbiology				
Blood Sciences	WHT	RWH	DH	SWBH
Band 2	-	5.84	6.97	14.37
Band 3	4.06	4.00	4.00	1.80
Band 4	1.23	5.00	-	1.00
Band 5	0.42	3.00	2.00	1.50
Band 6	6.62	8.67	9.00	11.83
Band 7	2.96	4.00	3.00	5.70
Band 8a	1.00	2.00	1.00	0.94
Band 8b	-	1.00	-	1.00
Band 8c	-	-	-	-
Band 8d	-	-	-	-
Total	16.29	33.51	25.97	38.14

Economic Case

2.3 Description of the current service – Cellular Path.

The cellular pathology service is currently delivered at all the Trusts. For the purpose of modelling, the figures below do not include staffing or activity for Mortuary.

	Cellular Path.
RWH	220,000
SWB	60,216
WH	84,777
DGH	84,000

Current State Cellular Pathology				
Blood Sciences	WHT	RWH	DH	SWBH
Band 2	3.41	2.00	3.10	-
Band 3	1.00	10.00	3.86	1.63
Band 4	1.76	8.62	-	2.75
Band 5	1.27	8.00	3.50	2.23
Band 6	3.02	11.30	5.78	3.74
Band 7	3.83	7.46	2.95	4.30
Band 8a	1.00	3.00	1.00	1.00
Band 8b	-	2.00	-	-
Band 8c	-	1.00	-	-
Band 8d	-	-	-	-
Total	15.29	53.38	20.19	15.65

Economic Case

2.4 Description of the current service – Equipment & IT

The following table shows the current IT Systems and equipment used across the BCP Trusts.

	WHT	RWH	DH	SWBH
IT System	**CliniSys**	**Technidata**	**CliniSys**	**CSC-iSoft**
Blood Sciences				
Central Specimen Reception			ThermoFisher	Anglia ICE/Cerner
Blood Transfusion	Biorad	Diamed	Biorad	IBG
Clinical Biochemistry / Chemical Pathology	ROCHE	Abbott and Sebia	Orthoclinical & TOSOH	Abbott, Waters, Shimadzu, Agilent, Thermo
Haematology	Beckman Coulter	Sysmex	Siemens	Sysmex, Wersen
Immunology	Euroimmune	Thermo Fisher, Werfen and Sebia	ThermoFisher	Phadia
Cellular Sciences / Anatomical Pathology				
Cytology		Hologic	Roche	Various
Histopathology	Thermo Fisher	Leica	Roche	Various
Microbiology				
Bacteriology		Biomerieux	Becton Dickenson	Biomerieux
Molecular Microbiology	Panther	Roche	Becton Dickenson/Biomerieux	Various
Serology	Cobas	Abbott & Biomerieux	Abbott Diagnostics	Abbott
Other / Not known (Microbiology)	UF100			

Economic Case

2.5 Description of the current service – Financial Baseline

2.5.1 Total laboratory costs

	RWH	SWB	WH	DGH	Total
Pay costs	8,666,970	9,305,181	5,141,895	6,375,000	29,489,046
Non-pay costs	6,204,490	9,302,643	6,144,876	8,108,026	29,760,035
Total cost of pathology	14,871,460	18,607,824	11,286,771	14,483,026	59,249,081

Current laboratory costs equal £59.2m. Alongside this, there are c.£33.5m of income for the laboratory. Therefore the Net As Is Cost for the pathology department, the true cost of providing the hospital pathology service, is c.£25.8m.

Total income for the laboratory represents 56% of the total cost base for the laboratory.

The cost information is for the financial year 2016/17.

Economic Case

2.6 Requirements for a joint BCP Service

The following are the key requirements that any option must be able to successfully address:

- A clinically led service;
- High quality pathology service that improves the provision of services to the Trust and meets its clinical pathology requirements;
- Fit in with the strategic vision and plans of the Trusts, the NHS and the Black Country STP;
- Financial sustainability;
- Ability to improve current facilities through investment and development;
- Minimise potential costs of PFI for those Trusts where pathology is in a PFI facility;
- Ability to develop areas of the service that could provide additional revenue for the Trusts;
- Additional equipment and upgrade to current analysers (note that The Dudley Group has recently signed an MES contract to renew all their equipment);
- Ability to retain staff and improve staff morale;
- Improve and facilitate recruitment of staff;
- Provide for GP Direct Access activity;
- Ensure retention of current research and other income;
- Opportunity to expand research and development activities;
- Ability to reconfigure processes and workforce to improve efficiency;
- Ability to maintain clinical contact and clinical relationships;
- Comply with NHS guidance on collaboration for pathology services and Strategic vision;
- Provide funding for development and access to capital; and
- Desirable: Ability to develop assays for the repatriation of tests to reduce costs.

Economic Case

2.7 Outline of the options

The options that have been considered are summarised below. Further information on these models is provided in this section:

- **Option 1: Status Quo** – This option involves the four Trusts to retain the current services as they are. The option includes minor reconfiguration in the form of high level collaboration on send-aways and other unsustainable areas, together with some investment on maintenance as required.

- **Option 2: Joint Outsourcing –** This option involves the full outsourcing of the service (pay and non-pay elements) to a third party provider organisation (Viapath, HSL, iPP or an NHS organisation). This model assumes that the independent sector would be responsible to invest in the creation of a Hub and reconfiguration of ESLs. This option assumes a full transfer of risk to another pathology operator (NHS or Private) and a contract management function within the Trusts.

- **Option 3: Network Collaboration model –** This model would require the Trusts to collaborate to deliver pathology provision in a service model where specialties and activities are shared across the Trusts. The specific form would depend on local agreement but be underpinned by the consolidation of areas of testing to realise efficiencies from the consolidation of volumes and skills. As a minimum, the Trust would retain an essential services laboratory (ESL) on site but could also maintain elements of additional specialist and/or discrete provision under certain circumstances. Multiple governance arrangements also exist with regard to this model with the potential ability for the Trusts to maintain direct influence over the quality and direction of future service delivery.

- **Option 4: New external Hub and 5 five Essential Services Laboratories (ESLs) –** This option involves the consolidation of all non-urgent testing within an external Hub laboratory and the creation of 4 ESLs as a minimum, within each hospital site that requires it.

- **Option 5: One Hub and 4 three ESLs –** This option is similar to the above but the Hub is located in one of the current hospital sites, therefore reducing the need for 1 ESL.

- **Option 6: Two Hubs and 3 three ESLs –** As above although this involves the creation of two distinct Hubs and therefore reducing the need for ESLs to only 3 as the Hubs would be collocated with ESLs on current hospital sites.

- **Option 7: MES+** –.This involves the collaboration between the 4 Trusts in a joint procurement for an MES+ contract that would allow for savings in equipment/reagents as well as some potential investment to invest in the current model. It does not include any consolidation of testing other than some low volume specialties.

These options are explored in further detail in the following section.

Economic Case

2.7.1 Option 1: Status quo (baseline)

This is the option of the Trusts continuing to provide the service on their own, from the current facilities, and the staff remaining in each of the Trust's employment with minor changes. Option 1 therefore provides an opportunity to develop a baseline for the comparison of other options. As such, the Trusts retain full control of the service, both in terms of management and in terms of patient care, and retain the full benefits of the profitability of the service. However, Trusts will be required to invest in the service in order to improve capacity (dealing with year on year demand increases), including investment in the estate for backlog maintenance. While this option involves minimal changes to the current provision, it is expected that initiatives such as business process reengineering and workforce and demand alignment would be implemented to assist each Trust with its own CIP targets for savings.

This option is the most common form of pathology provision in the UK, whereby Trusts continue to own and operate their pathology service. In light of the increasing financial pressure of the NHS and deteriorating financial positions of NHS Trusts, and the reports on the service, many Trusts are coming to the conclusion that continuing to operate a pathology service "on their own" is becoming increasingly unsustainable. In addition, in July 2016, the NHSI asked all Trusts in the UK to submit their plans for STP consolidation to achieve savings.

2.7.2 Option 2: Joint/single Outsourcing

This option involves the full outsourcing of the service (pay and non-pay elements) to a private sector provider organisation (Viapath, TDL, iPP, Synlab) or an NHS organisation. While this model has the potential to provide efficiencies similar to those of the Hub and ESL models (options below), the savings to be realised by the Trusts are likely to be lower as a result of the investment recovery margin and the profit margins that would be retained by the private sector. Given that there are currently no private sector providers in the region with an established Hub, this option is likely to require a significant level of capital investment in the creation of a Hub and the refurbishment of ESLs. This option would most likely lead to the centralisation of all non-urgent activity with only ESLs left on each hospital site. All specialist testing would also be consolidated at the Hub.

The key advantage of this model would be the full transfer of risk to the private sector and the access to capital. However, it is an option that is likely to face opposition from staff and consultants. This option would see the TUPE transfer of all laboratory staff while consultants would remain employed by their Trusts. The option would require the establishment of strong clinical and operational governance procedures as well as a contract management structure to monitor the delivery of services. A key risk arising from this option is scope creep and increases in cost as a result of test activity growth and price changes, areas that would need to be carefully set up in the payment mechanism of the contract.

The procurement could be run jointly by the four Trusts or as a single organization by each Trust. A joint procurement would have the advantage of economies of scale as well as the opportunity to create a Joint Venture (JV) with the private sector. A further implication that would need to be explored at a later stage is the VAT implications and the impact on the overall financials, and the impact of any competition commission assessment of the contract.

Economic Case

2.7.3 Option 3: Network Collaboration Model

Under a distributed network, each site would continue to operate an ESL (Essential Services Laboratory) in order to provide those tests that have an urgent turn-around time. For non-urgent tests, and for GP tests, these would be distributed across the sites based on discipline. Each site would specialise in certain disciplines, and would see the activity for that discipline co-located onto that site. The option assumes the creation of a joint operational management team and joint clinical governance group..

2.7.4 Option 4: New Hub and 5 ESLs

Under this model, each hospital site would operate an ESL for the purposes of undertaking the urgent TAT work. All non-urgent turnaround-time work, and all GP (Direct Access) work would then be transferred to a new laboratory off-site from the hospital locations.

While this option allows for potentially a high level of savings through the optimization of processes in the build of a new laboratory it requires a high level of investment based on the need to either build or refurbish a facility. The likely capital requirement is in the region of £8m to £16m based on current estimates for a refurbishment or a new build for a laboratory of the size required.

There would be an additional requirement for capital for the refurbishment of the ESLs, estimated at approximately £250k per ESL. Other additional costs are likely to involve the integration of IT, implementation of common equipment platforms and additional logistics costs.

2.7.5 Option 5: 1 Hub and 4 ESLs

This model is similar to the above, however, it assumes that the Hub can be collocated with one of the ESLs within a current hospital site. This would bring the advantage of sharing resources across the ESL and the Hub and therefore maximizing workforce efficiency. Pending further analysis, this option would be deliverable with the Hub located at Wolverhampton Hospital with the need to extend it at a cost of £2 m to £4 m to accommodate reference chemistry depending on the specification of the building. It is estimated that while the laboratories at Dudley and Walsall Trusts may have some spare capacity this would only be enough to accommodate a relatively small number of tests. Sandwell and West Birmingham Trust confirmed no capacity is currently available to host the full Hub.

2.7.5 Option 6: 2 Hubs and 3 ESLs

This model assumes that the activity in the Hub would split into two smaller hubs. The idea being that it is likely to require less reconfiguration in terms of the infrastructure to create the capacity for 2 Hubs. Similar costs and capital investment issues would arise for the reconfiguration of infrastructure and increase in capacity as required to accommodate the two hubs, including the implications of reconfiguring PFI buildings. While the reduction on the number of ESLs may deliver some savings these have the potential to be offset by less efficient hubs and duplication of functions like pre-analytics.

There are two variants within this model:

3.6.1 – Mirror Hubs: both hubs perform the same type of tests and activity

3.6.2 – One Hub specialises in non-urgent testing while the other hub performs all specialist testing

Economic Case

2.7.7 Option 7: MES +

This option assumes that there is no/minor reconfiguration of actual pathology activity but an active collaboration on the procurement of same equipment platforms across all Trusts through an MES. The joint procurement would provide economies of scale savings on the MES pricing and a saving of 20% on VAT. These savings could also be applied to any of the other options where a joint procurement is put into effect.

Economic Case

2.8 Trust SWOT Analysis

All Trusts were requested to submit a SWOT analysis on behalf of their Trusts for each of the options. This SWOT analysis formed part of the BCP Steering Group discussion prior to the submission of evaluation scores. The aim was to create a common view that represented the opinion of Trusts in relation to each of the options. The summary SWOT analysis is shown in the following tables.

	Strengths	Weaknesses	Opportunities	Threats
Status Quo	• Easy to achieve • No investment required • Acceptable to staff • Least disruptive	• Little potential for saving • Does not address sustainability • Lack of sufficient size to undertake major projects • Multiple platforms for work that could be centralised and done more efficiently • Politically inept. Does not align with national strategy. Unable to meet CIP. Fails to meet NHSI plan	• Joint working gives opportunity for areas of common interest to be addressed. Sharing of best practice	• Vulnerable to privatisation • Politically not seen as doing anything • Little potential for savings based on large facility model
Joint Outsourcing	• Access to capital if required • New facility not required • Greater focus on financial savings • KPIs very strong as contract in place with provider • Transfer of operational risk to provider • Externalising the change decreases the opportunity for in-house resistance • Fall back option if DIY fails	• Perceived poor track record (Toxicology in London) • Poor track record on research • Training cuts • Local innovation may be lost • Staff resistance could be very strong • Stakeholders may have very negative views • Overcoming existing long term contracts in some Trusts very difficult unless taken on by the outsourcing organisation - may actually mean little interest is shown • Trusts do not achieve full benefit of financial savings	• One brand new organisation comes in and implements change • Opportunity to improve current areas of poor performance • Commercial benefits of private organisation • Improved marketing • Robust KPIs with users established	• Risk of staff leaving for other Trusts • Consultant staff not being part of the outsourcing is a very significant risk. This would completely change the nature of the Trust's clinically driven services • Control by Trusts only as good as specification. Could cause problems with future proofing • Cost containment in meeting contracts could mean lower service • Stakeholders with much higher expectations and increased sensitivity to our services • No plan B if private sector gives notice of termination. There is a track record of private sector providers doing this (Hinchingbrooke Hospital)

Economic Case

	Strengths	Weaknesses	Opportunities	Threats
Network Model	• Acceptable to Trusts and stakeholders • Retains high level of control • Perceived that all Trusts 'win' something • Little capital investment. Gradual move to uniform ways of operating. Increased ability to discuss areas of improvement, for example when there are skill shortages	• Poor efficiency and financials: both may be worse than the status quo • Requires considerable IT investment • Increased logistics risk • Significant clinical risk with moving samples • Poorer communication between sites/disciplines • More difficult to have shared Quality Management System (governance, assurance) • Overall big things such as single governance and quality systems across the four Trusts may not be worth the return	• PFI's are utilised • Plays to different Pathology strengths across the Black Country • Some standardisation of working practices, SLAs, KPIs etc.	• Chaos. Significant risk to patient safety • Movement of staff potentially very destabilising • Potential loss of contracts due to stakeholder dissatisfaction • May cost more • IT heavy solution required probably not justified by business plan finances • Not seen to offer the NHSI/STP solution being looked for
New Hub and 5 ESLs	• New optimised and purpose-built facility – should be efficient and effective once samples arrive • Could be centrally located and collectively owned. No one Trust 'winner'	• Requires a high level of capital (£15-20M) • This capital is not available • Expensive running costs • Not aligned with NHSI guidance on use of current capacity and facilities • Divorced from clinical services • Requires an additional ESL • Increased equipment requirement • Cost of current facilities needs to be written off • Lack of contingency within the group • Significant time required to build new facility, unlikely to be achieved by end of 2018	• Could be a financially efficient model. • Optimally planned and designed • IT and equipment platforms refurbished • Easy to introduce new technology • Opportunity to design for future expansion • Combined expertise for all disciplines • Provision of 24/7 services for Microbiology and extended working day/week for Cellular Pathology • Good opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development • Repatriation of tests due to consolidation of work	• Prime target for privatisation. Business continuity • Capital may not be forthcoming • Staff may not want to work in what is perceived as a 'factory'

Economic Case

	Strengths	Weaknesses	Opportunities	Threats
1 Hub and 4 ESLs	• Most optimal and efficient model • Maximises financial savings • Capacity already available. Low capital investment • Opportunity to consolidate all routine blood sciences and microbiology at no capital cost • Stronger governance • Standardises services across the Black Country • Successful models elsewhere (St Georges London, Imperial London, Frimley Park) • Consultant recruitment easier to a single cancer centre for Cellular Pathology. Aligns with proposed cancer network reporting. Better recruitment, training and retention of staff based on experience of other single hub networks • In line with Carter report	• Requires some investment to move all services (histology and reference chemistry) • IT solutions required • Lack of contingency within the group • No mirror lab in the event of downtime • High level transport required for sample movement across an area of 150 sq. miles • Geographical issues of Birmingham centre to Wolverhampton • Perceived by 3 Trusts as negative impact on staff (however cytology services merged successfully)	• Centralise all 'cold' work. Efficient use of resources • Easy to introduce new technology • Combined expertise for all disciplines • Provision of 24/7 services for Microbiology and extended working day/week for Cellular Pathology • Good opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development • Repatriation of tests due to consolidation of work	• Business continuity • Not enough staff to run it in the single locality
2 Hubs and 3 ESLs	• Increased resilience of services • Easier to deliver than 1 hub model and more acceptable to staff and stakeholders • Staff more likely to be retained • Two Trusts are not fighting • Allows 'mirroring' of all services for risk and capacity issues • Less transport issues • Major changes can help to achieve NHSi/STP goals locally	• May not be as efficient and effective • IT solution may be increased over 1-hub model • Duplication of equipment and services • Compared with 1 Hub and 4 ESLs: Higher level of capital investment, more difficult to agree on clinical governance and quality management system (easy to split into 2 separate organisations) • This model was used in Cambridge and failed	• Some opportunities for combined expertise for all disciplines • Some ability to extend working day and week • Some opportunities for R&D (and associated income for Trusts) • Opportunities for training and staff development and ability to attract skilled staff from both ends of conurbation • Potential for some repatriation of tests due to consolidation of work • Ability to standardise across the Black Country	• Easy to become 2 separate organisations • For long term sustainability, ultimately may need to move to 1 hub • Two Trusts fighting and negative to process • More management structure needed than single hub models • May not realise savings
MES+	• Some savings over doing nothing • Standardisation of equipment • No structural changes and little local politics from staff or stakeholders	• Less cost savings • NHSI/STP goals may not be achieved • Does not address sustainability • Two trusts have already done this with long term contracts in place. So much of the savings from this approach are already achieved	• Standardised reference ranges • Business continuity resilience • Two trusts may achieve savings	• Vulnerable to privatisation • May not be seen as compliant with NHSI/STP either locally or nationally

Economic Case

2.9 Options evaluation methodology and criteria

The evaluation of options has been carried out by the members of the BCP Steering Group in representation of their Trusts. In addition, the chairman of the BCP Steering Group produced a separate and independent evaluation of options t bring an additionally element of neutrality to the process. The evaluation process has followed a two stage approach with an initial long list of options evaluated on the basis of a qualitative desktop analysis to produce a shortlist of options. The 4 options with the highest scores will proceed to the financial evaluation developed in the financial case of this SOC.

The evaluation criteria below has been developed on the basis of the pathology service requirements to assess the potential benefits of each options and how they contribute towards meeting the Trusts objectives and needs. Each option will be scored against each of the criteria by assigning a value of 1 to 5, where 1 means that the option does not meet the evaluation criteria and 5 means that the options fully meets the evaluation criteria

	Criteria	Description	Sub-Weighting	Weighting
Patients and Clinical Quality				
1	Clinical sustainability and Quality	The option provides the right level of clinical oversight to create a consultant led service with a common clinical governance structure across all sites that is sustainable and improves quality	40%	60%
2	Patient Safety and experience	The option minimises any potential risk to patient safety, e.g. The need to have some services within a certain proximity to the patient, any necessary linked between staff, consultants (MDTs) and the patient are preserved.	30%	
3	Achievability	The service addresses the emerging needs of the pathology market and would face the lowest level of resistance by stakeholders. Evidence that other organisations have successfully implemented the model without affecting quality	15%	
4	Standardisation	The model facilitates the introduction of common procedures, common ranges, KPIs and clinical reporting across sites	15%	

Economic Case

	Criteria	Description	Sub-Weighting	Weighting
General, Financial and Governance Requirement				
5	Strategic Fit, innovation and clinical sustainability	The option would provide the greatest chance for BCP to become a sustainable organisation supporting it on the retention of current revenues and supporting the development of the service to meet the future needs of the market and service.	15%	40%
6	Potential affordability	The option would provide the best opportunity to access funding and is likely to provide a high return on investment. Capital requirements are low and therefore achievable.	25%	
7	Potential VfM	The option would provide the greatest level of savings over the long term through economies of scale	30%	
8	Facilities, IT and Eqmt Systems	The options allows the introduction of a common IT LIMS that would link all sites and common equipment platforms across all sites. Availability of estates for development of pathology	15%	
9	Control and Governance	The option would allow BCP to operate with an autonomous governance structure allowing to operate in the market and effectively respond to market forces	15%	

Economic Case

2.10 Options' evaluation results

The following table provides a summary of the evaluation scores as awarded by each Trust to provide a ranking of the options. As can be seen from the data, the preferred options for further analysis are options 5 (Hub on a current site with 4 ESLs), 6 (two hubs on current sites with 3 ESLs), 7 (MES+ contract) and 3 (network collaboration model).

Out of the 4 options shortlisted for financial analysis the single hub option with 4 ESLs is the preferred overall. It should be noted that it would be expected that the saving derived from Option 7 (MES+) would also be achieved under any of the other options by increasing the purchasing power of the BCP Trusts through a joint procurement. At this point in time, Option 2 (joint outsourcing) and option 4 (construction of a new Hub on a greenfield site) have been rejected.

The following page provides a summary of the commentary provided by each Trust with regards of each of the options.

	Weighted Score						
	1	2	3	4	5	6	7
	Status Quo	Joint Outsourcing	Network Model	New Hub 5 ESLs	Single Hub and 4 ESLs	2 Hubs and 3 ESLs	MES+
The Dudley Group NHS Foundation Trust	3.48	2.27	4.52	1.66	2.66	2.54	4.01
The Royal Wolverhampton NHS Trust	1.92	3.44	2.7	3.79	4.82	3.9	2.37
Sandwell and West Birmingham Hospitals NHS Trust	2.6	3.53	1.87	2.62	2.53	2.93	2.75
Walsall Healthcare NHS Trust	3.39	3.17	4.11	3.53	3.96	3.09	4.01
BCP Chair	2.09	1.99	1.71	2.28	4.6	3.81	2.2
Average	2.696	2.88	2.982	2.776	3.714	3.254	3.068
Rank	7	5	4	6	1	2	3

Economic Case

		Comments
1	Status Quo	• This does not deliver the change agenda • This offers a low risk model with some greater degree of coming together. Overall it is low risk with regard to clinical issues as currently they are felt to be reasonably covered. Of course it does not address future pressures in any way - for example one or more Trusts not attracting key staff e.g. Consultant Histopathologists or specialist Clinical Scientists
2	Joint Outsourcing	• Effectively privatising with risks and uncertainty around delivering service • There is no private sector presence in the Midlands and therefore they would need to build or refurbish a building for a central laboratory function. This would not be within the decision timeline • The key potentially positive aspect of this approach is externally driven change. A big risk is that Consultants are not taken into the new organisation, due to the very real issues of negotiating with the BMA etc. This scenario would totally change the nature of the SWBH service
3	Network Model	• The logistic risks are common to most of the options. The least logistic risk is in the status quo and the network • Poorest consolidation model • Overall this will need capital investment at local sites and also substantial IT infrastructure. Sample splitting to various sites could potentially be very inefficient and disruptive
4	New Hub and 5 ESLs	• There is no clarity on where or how the hubs will work and why 5 or 4 ESL's are needed as there are only 4 acute IP sites in total • Too costly and doesn't meet the timelines • The biggest model like this was the Leeds 'factory style' centralised pathology set-up in the 1990s which failed. We do not have the capital for this approach
5	1 Hub and 4 ESLs	• Query around capacity detailed in proposal document, where the hub will be and how it will work • Consolidation model which is closest to the national expectation and maximises savings • This model offers relatively low capital investment. Key issues are the practicalities of one hub for our geographical area
6	2 Hubs and 3 ESLs	• Query around capacity detailed in proposal document, where the hub will be and how it will work • Scored assuming a mirrored hub model. There may be some modifications to this model in that it is not necessary that the two hubs are an equal size • This offers a lower risk model
7	MES+	• Stepping stone to the other models • The MES approach suggests some working together has been achieved but in reality is it enough to keep the BCP idea afloat in the longer term?

Economic Case

2.11 Evaluation outcomes and preferred option

The evaluation from the Trust members of the BCP Steering Group and the chairman of the BCP indicated that the following models should be considered for financial evaluation. These options were assessed in the financial case in the SOC, with the result in the table below:

- As Is + model to be used as baseline;
- 1 – One Hub and three ESLs;
- 2 – Distributed Network collaboration;
- 3 – Two Hubs and three ESLs; and
- 4 – MES+.

In May 2017, the BCPS Strategic Board agreed that the **preferred option**, as per the evaluation carried out and described above would be the **One Hub and three ESL option**. This option is to be developed into an OBC that would allow the the BCPS Strategic Board in July to produce a recommendation for their respective Trust boards. The BCPS Strategic Board concluded that the one Hub and three ESL option would provide:

- Greatest level of standardization and quality for the service;
- Highest level of savings and economies of scale;
- Best opportunity to develop an integrated clinically led service with consultant resources supporting all the Trusts;
- Consolidated option provides the best opportunity to increase quality of the service for the long term;
- Creation of an integrated pathology service for the benefit of all Trusts.

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Economic Case

2.12 Description of preferred Target Operating Model

As per the evaluation in the previous sections, the preferred target operating model is the **single hub with three ESLs**. This model is described in the next few pages of this document. There is a scenario on this model being assessed where reference chemistry services remain at SWBH to minimise the capital requirements on the project, through the avoidance of building an extension to the RWH Hub. However, this variant would still incur capital as the services currently at City Hospital would have to be moved to a refurbished part of Sandwell Hospital.

The target operating model assumes that all tests from all disciplines that have a TAT of greater than 4 hours can be moved to the central hub facility. As such, the facility would need to extended to accommodate services and certain areas refurbished to expand their capacity. Each site would then have an Essential Services Laboratory (ESL), of which a standard description is provided. Staffing numbers have been calculated using the hourly throughput through each of the laboratories. Because of the inefficient nature of ESLs, where the focus is on rapid delivery of results, there is additional capacity at each ESL to deliver additional tests without increasing the staffing numbers. This allows for detailed scoping and adaptation of ESL requirements during the implementation phase.

Key assumptions for the implementation of the TOM are:

- **Common IT system**: implementation of a common Laboratory Information System (LIMS) to ensure the connectivity of all laboratories. This requirement has been developed with IT suppliers to understand the cost. The costs, including investment, are part of the financial evaluation. These costs provided by suppliers are the highest expected cost and likely to reduce during scoping and procurement. It system and costs include:
    - Implementation of a common LIMS at all sites;
    - Digital histopathology solution to facilitate MDTs and shared reporting;
    - Provision of bi-directional links and links with Trust systems;
    - Hub with circa 150 concurrent users and the 3 ESL with BHI and BT only and with 20 concurrent users in each ESL; and
    - Hardware required and upgrades for sites and the Hub.

As explained in the financial section all of these costs are included in the financial model as an investment or recurring annual fee. The implementation of a common IT is key for the success of the project as demonstrated by the successes of SW London pathology, SPS, Pathology First, etc and the failures of TPP and empath.

- **Common equipment platforms:** for the success of the partnership is essential the implementation of common equipment platforms. The cost of equipment has been assumed using the lowest common denominator cost per discipline to normalise equipment costs to the most efficient contract in the partnership. RWH and DGFT have recently entered into new equipment contracts and therefore the impact of savings on those Trusts has not been taken into account. It is not expected that the DGFT contract would be terminated although the cold volumes going through the analyzers maybe reduced. There are no savings expected from this contract in the financial model;

Economic Case

- **Quality**: The future service will have as a standard a requirement to be fully accredited under ISO 15189. All sites currently have their own established TAT requirements and service levels for GPs. The key assumption made on the target operating model is that the quality service levels currently provided to each user will be maintained. During the transition period these will be reviewed and target service levels set for all disciplines and users to ensure that the quality of the service is improved;
- **Sustainability and Resilience** is to be maintained at the ESLs to process and result tests 24 hours a day, seven days a week. The primary function of the ESL is to cover the BT service and urgent AE samples, as well as include frozen sections for histology and screening blood cultures for bacteriology;
- **Research and Development:** support and provision of support for R&D at the Hub based, including potential to allocate office space if required;
- **Training:** staff to be trained as multidisciplinary teams with access to a wider variety of tests and disciplines;
- **Consultant Staff:** consultants to transfer to the BCP service to work under a single clinical governance structure with office space provided at the Hub. Some consultants to work from current sites and continue to support colleagues and MDTs;
- **MDTs**: provision of MDT support at each site as required with allowance for consultant travel time built into the financial model. Introduction of digital histopathology to support MDTs;
- **Technical Staff**: laboratory staff to TUPE transfer to the BCP service;
- **Hub extension**: extension to the Hub to be built to accommodate all services, including Cellular Pathology and office space for reporting;
- **Logistics:** logistics routes to maintain current services with additional routes added to move samples to the Hub from sites and for additional GP collections where required. Additional cost of £400k per annum added to the model;
- **Point of Care Testing**: while this function is currently excluded from the business case, including this at a later stage would provide an opportunity for savings and the creation of a PoCT management team that can monitor quality and accreditation; and
- **Contingency fund**: contingency fund has been added to the model to allow for unforeseen costs.

Other financial assumptions are included in the financial case and would account for capital investment, transition team support , etc. the following pages provide a description of the TOM from a test perspective.

A detailed description of the ESL can be seen in Appendix 3

It should be note that though the TOM does not represent a radical solution (in terms of the market), it does represent an ambitious option for the Trust. The single hub solution is not new to the market, though it represents significant consolidation for the Trusts, and a radical departure from the existing model of provision for the Trusts.

Economic Case

- **Quality Baseline:**

General assumption made is that the new model will guarantee a “no worse than now” service provision and TATs. The service will continue to comply with guidance and standards set by the Royal College of Pathologists (RCPath), NEQAS, EQA schemes, ISO 15189 accreditation, NHSBT, HTA, Cancer reporting times and other relevant bodies.

The Clinical Reference Group, once established, would be responsible for overseeing this function and determining what the right levels of service should be for each clinical user. Currently all Trusts operate under slightly different quality standards which the clinical steering group will seek to standardised use the best in class amongst the Trusts as the initial standard to evaluate appropriateness for clinical care.

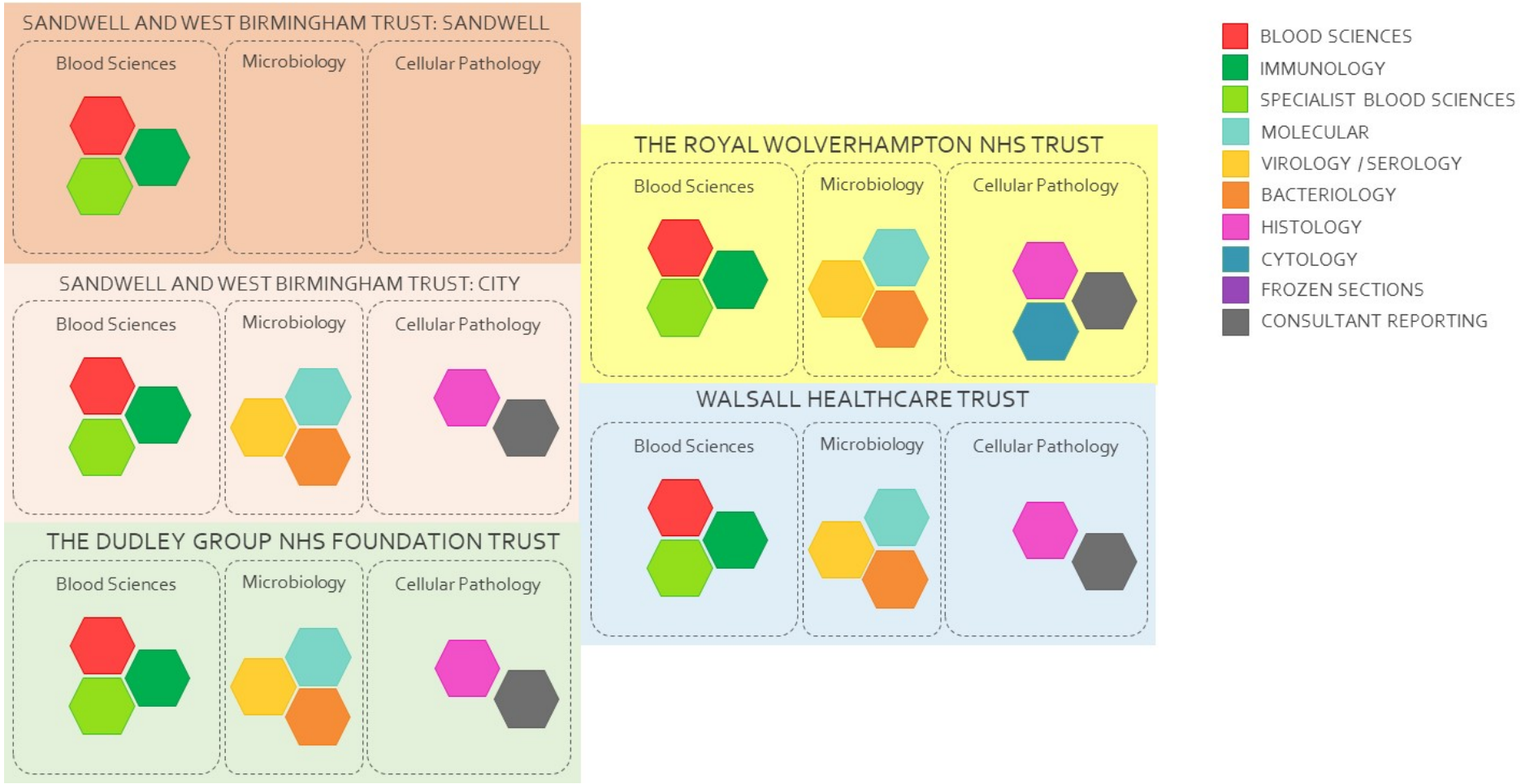
Currently all Trusts measure a range of KPIs for normal TAT reporting, complex cases and different users of the service. These KPIs are measured on a monthly basis and included within the pathology performance reporting governance. Additional quality standards such as protocols for reflex testing, further investigations, reporting of complex cases, out of hours reporting, etc, are registered within the laboratory quality manuals and handbooks and form part of the accreditation process. Examples of these KPIs are:

KPI	Trust 1	Trust 2	Trust 3
Biochemestry urgent (troponin)	RCPath 60min	60 min	60 min
Biochemistry routine (GPs)	24 hours	24 hours	24 hours
FBC urgent	RCPath 60 min	90 mins	90 mins
FBC routine	90 min	120 mins	120 mins
Histology non biopsy	RCPath 10 days	10 days	7 days
Breast biopsy	5 days	5 days	<7 days
Immunology TTG	10 days	3 days	
Anti-GBM antibodies	5 days	5 days	
MRSA screening	48 hours	48 hours	
C diff	24 hours	24 hours	
Microbiology Urines	72 hours	48 hours	
Staff mandatory training	95%		95%
Sickness absence	<5%		<3.39%
A&E TAT	90%	95%	95%
6 week wait target	0	0	0

An example of current TATs achieved and the promise that these will be maintained, improved or adjusted for best clinical outcomes and service, is available in appendix 7. It is the expectation that once the IT systems are in place, the BCPS operations and clinical directors would be able to produce a consolidated report with the quality performance of the service on a monthly basis. The following table provides an example of TATs for different users:

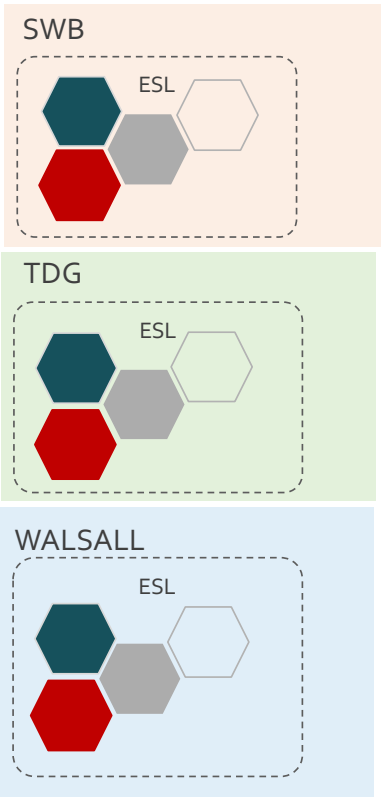
Economic Case

Current Operating Model

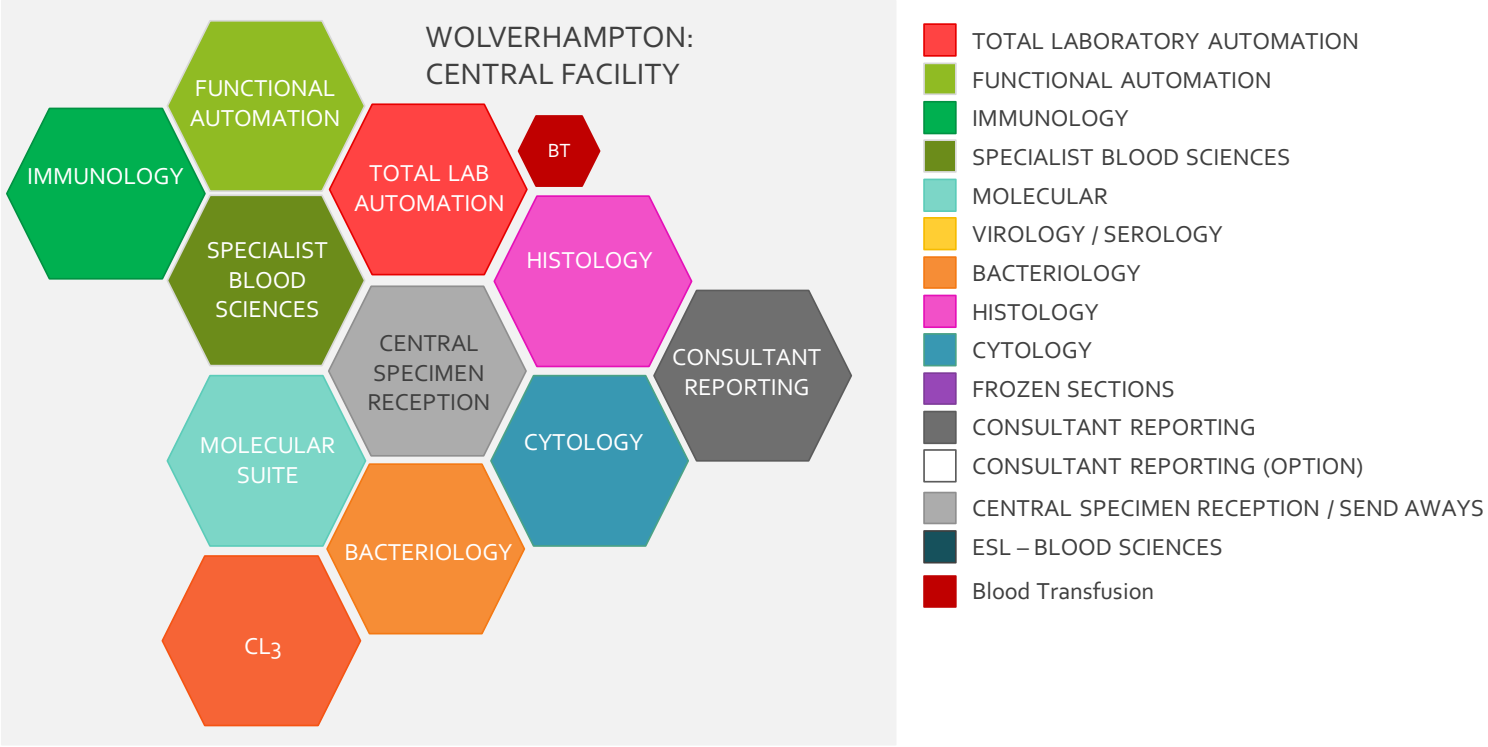


Economic Case

Single Hub and three ESLs Operating Model



Senior staff including at ESL to provide Frozen section, CSF and other urgent services

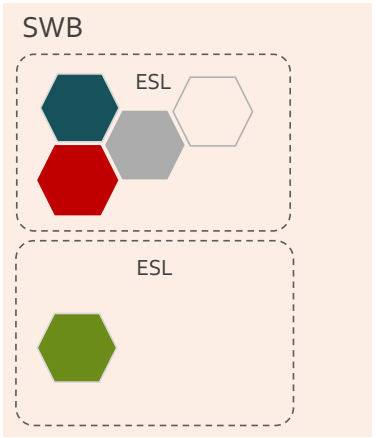


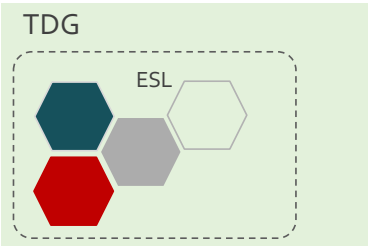
The Central Facility is currently reviewed at being at the New Cross Hospital in Wolverhampton. It would accommodate all functions across SWB, TDG and Walsall.

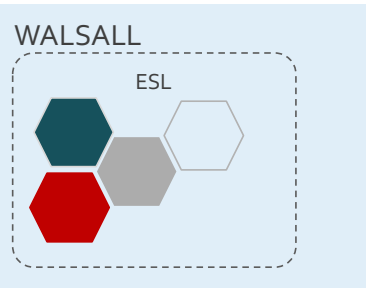
The ESL sites would consist of processing urgent blood sciences and all Blood Transfusion work. An option is to retain consultant reporting for histology at all existing sites. However, the Central Facility is currently being reviewed to have adequate space for all consultant reporting across the 4 trusts with the extension to be built.

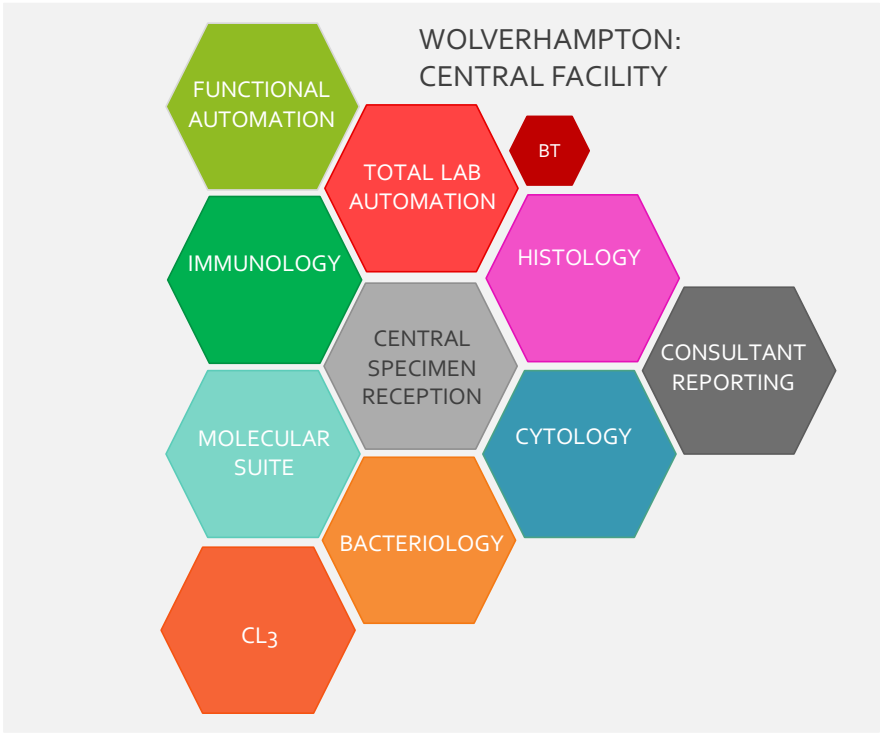
Economic Case

Single Hub Operating Model - ESL+ Reference Chemistry









Senior staff including at ESL to provide Frozen section, CSF and other urgent services

Economic Case

Central Hub Facility –Review

Based on the latest information and discussions with the architect, all activity can be centralised at RWH if the extension is to be built.

The following slides will elaborate on the below:

- The ground floor would require *medium* refurbishment to extend the automated areas
- The first floor would require *minimum* refurbishment with the addition of an additional automated line
- The second floor would require the *most* refurbishment to accommodate for the growth of histology
- The extension has been reviewed to be able to accommodate all the additional specialist blood sciences, any additional immunology, all of cytology, any additional molecular areas (if these cannot be catered into the first floor wing), as well as histology consultant offices.

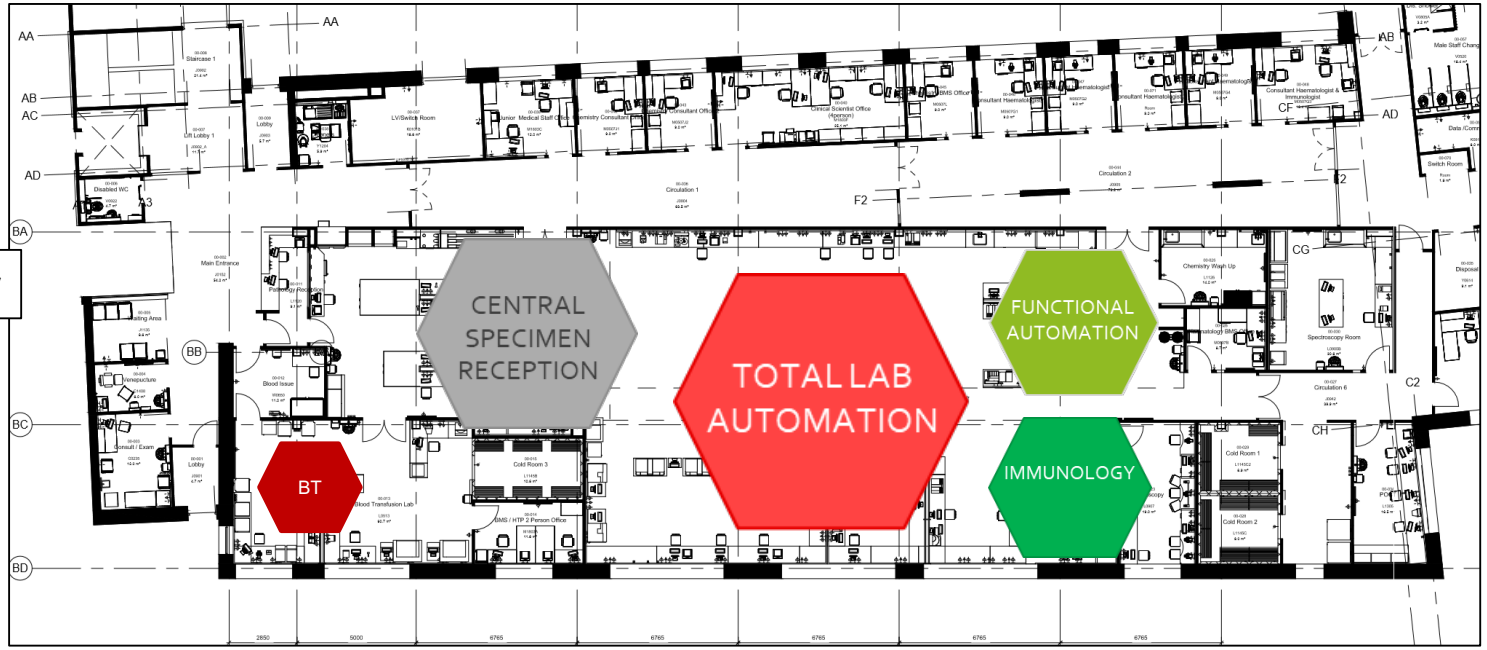
Note: The above is based on housing the required functions with regards to square meters. A detailed design would result in additional decreases in space and further accuracy for the central facility. A detailed design review could also be facilitated with the wider group of staff in engagement workshops to assure buy-in for the future service.

Economic Case

Central Hub Facility – Ground Floor Review

The Ground floor would retain its existing CSR, BT, Automation and Immunology areas. The CSR and main automated area would need to be extended. Also, the immunology area would need to be clarified further to assess the impact of growth. Any additional space for immunology or specialist chemistry is accommodated for in the extension.

Ground Floor



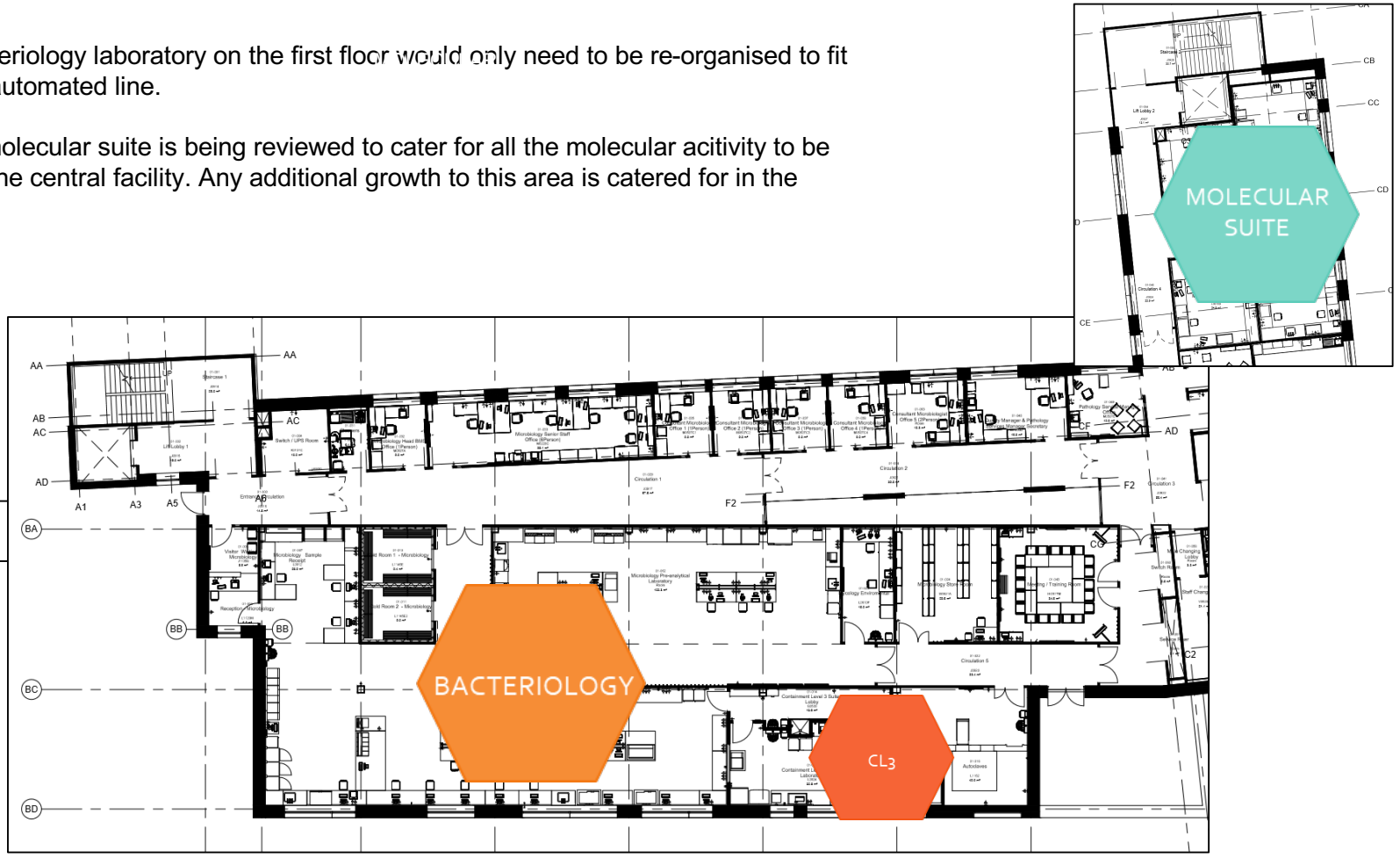
Economic Case

Central Hub Facility – First Floor Review

The main bacteriology laboratory on the first floor would only need to be re-organised to fit an additional automated line.

The existing molecular suite is being reviewed to cater for all the molecular acitivity to be processed in the central facility. Any additional growth to this area is catered for in the extension.

First Floor

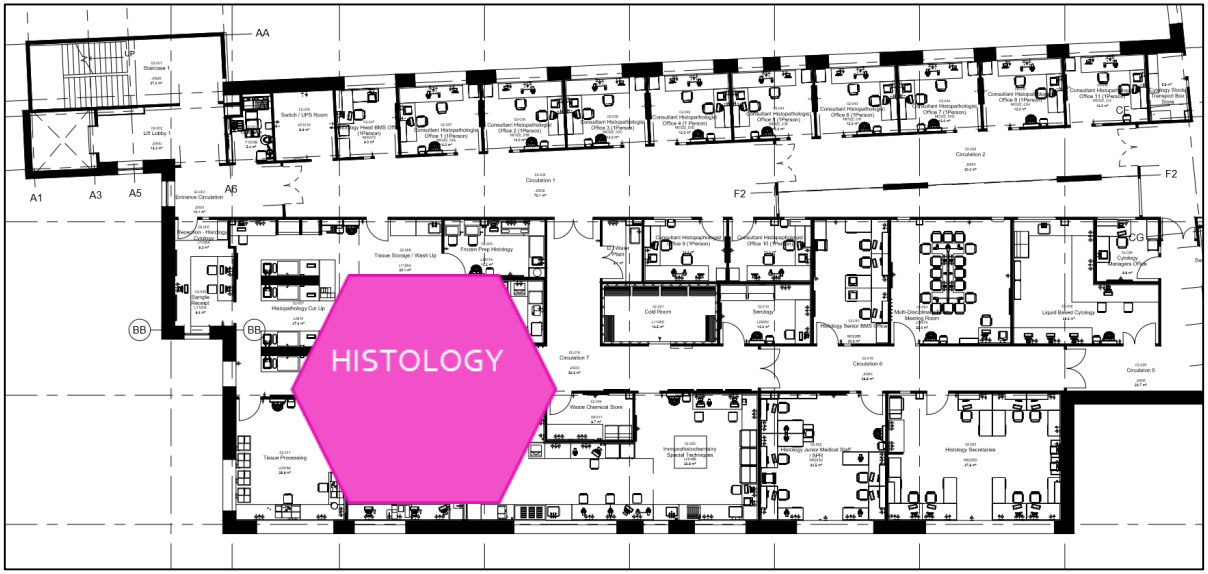


Economic Case

Central Hub Facility – Second Floor Review

The second floor would require the most refurbishment to increase the core histology area and accommodate more staining equipment. The existing space is sufficient for this. However, additional Consultant offices and Cytology may need to be moved into the extension.

Second Floor



Economic Case

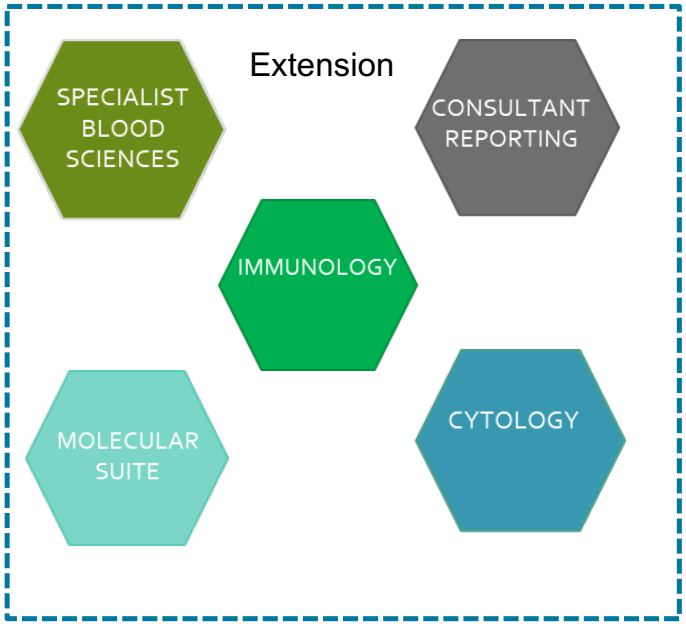
Central Hub Facility – Extension Review

The extension would have enough space for the required SQM to accommodate all additional departments and their activity. However, a detailed designed would benefit in a more optimal layout (ie. all of immunology within vicinity of the main blood science area).

If the extension would not be built, then the following would need to be considered:

- Consultant reporting to remain at existing sites
- Specialist Blood Sciences (Toxicology, Trace Metals, TPMT) to be excluded from Central Facility
- Full consolidation of Molecular work requires detailed review with Laboratory Managers

The hub extension is designed to accommodate all histology consultants and consultants for non-duplicate departments to be potentially moved to the hub. If the extension for the for the hub will not be built, then consultants would need to remain on their current site due to office space requirements.

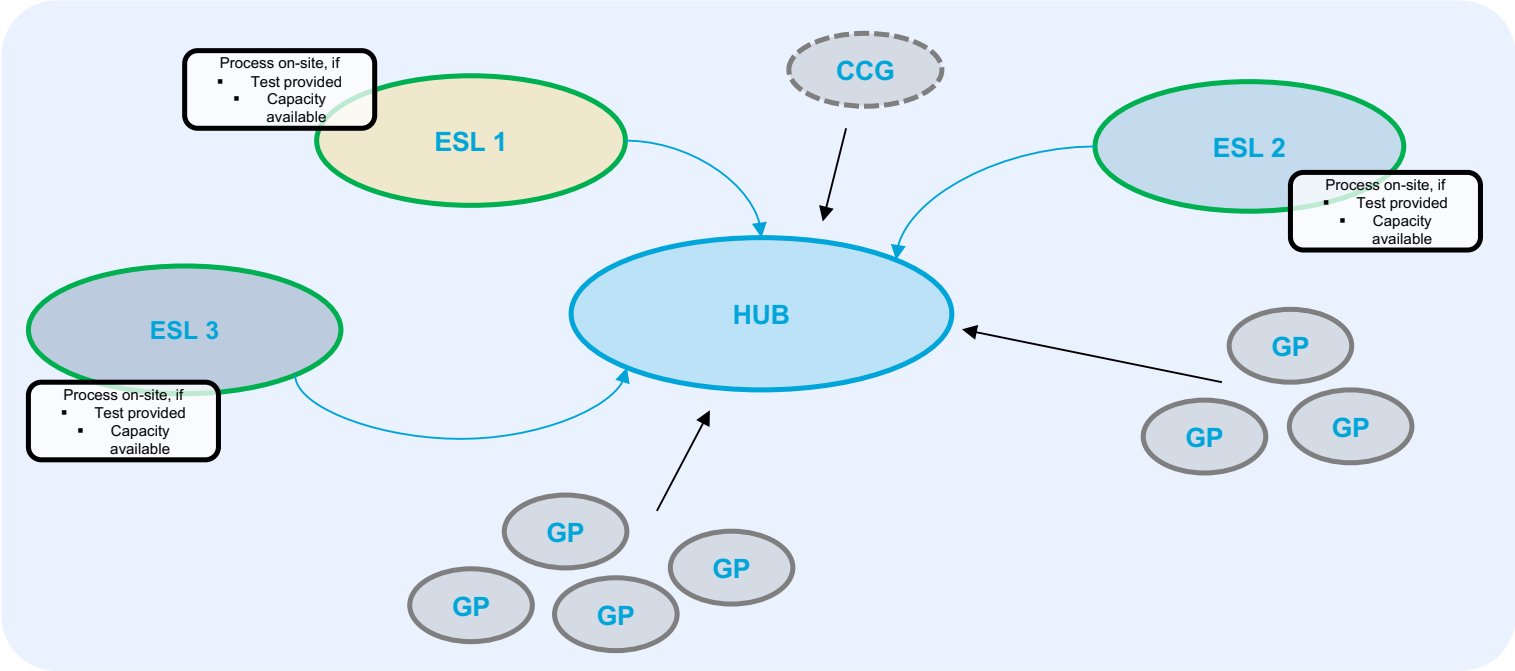


Economic Case
Logistics

The operating model is designed for all GP samples to go directly to the hub. The costs of logistics in the operating model have been increased by the cost of the trunk routes necessary to move samples from sites to the Hub. This assumes a minimum of one collection every 2 hours with the allowance for collections every hour as required. Additional contingency costs have been added in case 1 hour collections are required throughout the day from all sites. The ESL's are designed to process volume's with the following rules:

- A&E- urgent routine blood sciences sample
- Process non-urgent chemistry, haematology and coagulation *if*:
  - Test is provided within test menu
  - If capacity available to process

This allows for the efficient use of ESL resources on a 24 hour basis. The risk of processing only urgent A&E samples is under utilisation of ESL staff having to cover a 24-hour working day.



Economic Case
LIMS

The operating model envisages a single LIMS for the collaboration. This is viewed as vital for the effective operation of a single service. A single LIMS ensures that all sites are able to share data with regards to samples effectively, and will enable digital pathology, including digital histopathology, which will reduce the travel burden on staffing.

There have been a number of high-profile LIMS failures recently, and these have crippled laboratory operations. These include the decision of TPP (a recently failed pathology joint venture) to operate two LIMS concurrently. This had a significant impact on the cost of the operation and the ability to make changes. In addition, sites operating older LIMS have recently seen complete failures of their systems, including at Leeds Teaching Hospital.

In addition, the recent cyber attack on the NHS left a number of pathology services crippled, and reliant on paper for the operations of their laboratories – significantly slowing down the process, and making some testing no longer viable. As such a modern, secure, single LIMS is deemed vital for the collaboration.

FINANCIAL CASE

3

Financial Case

3.1 Introduction

The following section provides a detailed analysis of the preferred option and compares it against the baseline. Given the investment required for the expansion of the current hub facility, a new scenario has been run where all the reference chemistry activity remains at SWBH. While this scenario may avoid investing in capital it provides a higher level of clinical risk, lower quality and the option will still require capital investment as the service would need to be moved from City Hospital to Sandwell site.

These comparisons against the baseline involve measuring the cost of implementation versus the ongoing improvement in the 'run-rate' of the laboratory – annual savings that can be realised. The baseline used for comparison was based on the current costs of the laboratory as provided by the finance teams at each Trust with the application of savings and CIPs based on the long term financial models for each Trust.

For the following financial assessments, a start date of 01/08/2017 was assumed for the new service for all models.

The savings highlighted are predicted to be conservative estimates of the savings as not all non-pay cost items have been benchmarked.

The financial assessment includes a detailed evaluation and calculation of stranded costs (including the impact that changes to PFI areas may have), overheads and other non-pay areas.

The potential cost of contract terminations has been calculated, however, a termination cost would only be added when it is essential to terminate the contract and no other option, such as letting contract run to term, novation, etc., is available.

No savings are assumed for any of the options the cost of PFIs for those Trusts that have one.

Financial Case

3.2 Capital Investment and funding options

The transition period will require a <£10m capital investment requirement for the extension of Hub, refurbishment of ESLs and other transition costs. These can be obtained through:

- Application to the Carter pathology transformation fund;
- Application to the ITFF for working capital to facilitate the initial implementation of the project: it is expected that given the level of savings that BCPS would generate, the application would be successful;
- Private sector funding: cost of IT implementation could be rolled into the main IT contract to be tendered. The remaining cost for the building of the Hub extension could be obtained through the equipment suppliers or commercial borrowing/partnering.
- Trust capital programme: Allocation of costs from the Trusts' capital programmes.

ITFF funding option

A conversation with the head of the ITFF, confirmed the following aspects:

- Under normal circumstances, funding should be available, but only to the Trusts involved, not to the underlying project. So Trusts would need to downstream the funding;
- There needs to be a business case to justify the use of capital. Any loans to Trusts need to be affordable to the Trust itself. Affordability can be supported by savings, but the case needs to demonstrate this;
- Interest rates: depend on the investment and whether it's capital or not. Rough indication is equipment over 10 years at 0.5%pa and land and buildings up to 25 years at around 1%pa. Loan term is based on asset life, so a refurb might not warrant 25 years. Underlying contracts/commitments might also have an influence;
- Working capital facilities are only available to Trusts in distress, not for short term funding of a project of this nature. If the savings kick in quickly, and capital costs are already covered, ITFF could possibly look at a short term working capital loan repaid over 2 - 5 years to cover interim costs if that is more appropriate. We would need to consider how that might be split 4 ways, and whether repayment is tied in to the project or individual Trust affordability.

Financial Case

3.3 Financial modelling assumptions

For each of the main cost items in the laboratory, through our experience, and soft-market testing, we have been able to put together the following assumptions for the financial modelling. These will define the scope for cost savings, or increases, in the scenarios.

3.3.1 Cost assumptions

The following cost assumptions are applied to all the models.

3.3.1.1 Inflation

Inflation assumptions are based upon the current guidance from NHS Improvement. These are provided below:

Element	2017/18	2018/19	2019/20	2020/21
Pay costs	2.0%	1.6%	1.6%	2.9%
Non-pay costs	1.8%	2.1%	1.9%	2.0%
Corporate overheads	3.2%	3.2%	3.1%	3.1%

Source: NHS Improvement

3.3.1.2 CIP rates

Throughout the model a CIP level of 3% has been assumed on all costs. In most years, this is greater than the inflation assumption applied.

In addition, a sensitivity to the As Is position has been applied. Trusts have provided their current CIP plans for the forthcoming years. The As Is scenario, and the other scenarios prior to implementation, have been aligned to these savings to indicate the level of savings predicted through current plans. The CIP information provided by each Trust has been identified below. Where no CIP was provided, the 3% general assumption has been applied for that period.

It should be noted that the scale of the CIP savings suggest that they may be unlikely for some Trusts in the long-term without consolidation of activity between providers.

This alignment has been undertaken for the first two years until the predicted implementation date of the collaboration. CIP savings are assumed to be run-rate savings, as opposed in in-year savings. Where no pay/non-pay breakdown has bee provided, savings have been assumed to be incurred 50/50 between the categories. Non-pay savings have bee aggregated and applied as a total saving to all non-pay costs. Please note for WH the CIP on Blood Products is not included as Blood Products are not modelled as part of the combined service.

Financial Case

3.3.2 Volume growth

Activity levels have consistently risen, particularly in recent years, representing the increasing use of healthcare services in the UK, and the increasing reliance of healthcare decisions on pathology outputs.

Costs in the financial model can be classified as fixed, semi-variable, or variable, in relation to activity growth rates. Variable costs are predicted to grow at the rate activity growth (in addition to inflation and CIP growth rates). This is as their use increases directly with increases in activity. Semi-variable costs grow at a slower rate than activity growth, as they only increase partially as activity increases. Fixed costs do not increase with activity. The table below summarises the assumed variability of costs in the model.

Cost	Variability
Pay costs	Semi-variable
Reagent costs	Variable
Consumables cost	Variable
New equipment, reagent, and consumables cost	Semi-variable

3.3.3 Pay Costs

For the revised service, an new operating model has been produced to reflect the transfer of all ‘cold’ activity to a central hub facility. Based on this operating model, and the levels of activity that will subsequently be undertaken on each site, a new staffing model has been developed. The change presented is against staffing figures provided by pathology finance teams at each Trust. No change has been modelled to non-clinical AfC banded staffing.

Overall, the TOM shows reduction in staffing against the base case. It should be noted, however, that the actual financial saving is greater than this due to the model adjusting the overall grade-mix to a lower levels – thus realising additional savings. Changes in staffing levels have been modelled over a transition period where natural turnover rates, retirements and vacancies have been taken into account.

Financial Case
Single Hub Scenario

3.3.4 Non-pay Costs

Equipment, maintenance, reagents, and consumables

Similarly to pay costs, equipment, maintenance, reagents, and consumables represent one of the largest cost areas in the laboratory, and one of the largest areas for savings in collaborations. In the last few 7-10 years, market prices have fallen by around 10%. In addition, further savings can be expected in a collaboration model through lower duplication of equipment. This additional saving has been benchmarked at 15.5%. This reflects the savings on Trust contracts, where a Trust has a long term contract in place for equipment, no savings have been modelled for that contract for the remaining life of the agreement.

This saving has been confirmed through analysis of the current cost per test for the Trusts, per discipline, for their combined equipment, maintenance, reagent, and consumables cost, and predicted harmonisation of contracts to the lowest cost per test, excluding outliers.

Estates

For WH and DGH, the concern here is over the treatment of the PFI builds. As the options under consideration represent no increase in space in these labs, and only a decrease, there is no one-off change in the PFI costs assigned to the laboratory. This is as it is unclear at this stage whether the space can be re-used, and as such is assumed to still be occupied by the laboratory.

Existing estates costs are transferred to the collaboration, and recharged to the Trusts in-line with the recharge mechanism. No one-off change is assumed in these costs.

Logistics

Logistics represents the transport of samples between customers and the Trust. Under the new collaboration model there will be a new requirement to transfer samples between the hospital sites, in addition to the current transport requirements.

The model proposes no alteration to the current logistics solutions for the Trusts, and instead proposes supplementing them with additional routes for GPs and to move samples from sites to the Hub. Additional investment that more than doubles the current costs of logistics have been factored into the model.

Financial Case
Single Hub Scenario

3.3.3 Non-pay Costs cont'd

LIMS

The current LIMS providers for the organisations are summarised in the table on the right.

Two options exist for the LIMS requirement of the new pathology organisation. One option is for the combined pathology service to look to connect the existing LIMS through a middleware solution. The pathology steering group recognised that this is less than optimal, and a failure to consolidate into a single LIMS has contributed to the failure of similar collaborations, including TPP (the pathology partnership). It is also the case that this represents the highest risk solution as it presents the opportunity for the middleware to fail, as well as significant chance for the existing, and older, LIMS solutions to fail.

As such, the pathology steering group decided that the most suitable route for the collaboration would be to adopt a single LIMS that would include the implementation of a digital histopathology solution. Though likely to be the more expensive solution, it is predicted to provide the greater level of stability and interoperability for BCPS.

The capital cost of implementation includes software licences, training, and full implementation of the solution.

As such, soft market testing was undertaken for the implementation of a single LIMS for the providers. This assumes each spoke site is set at 30 concurrent users, and essential blood science and blood transfusion service only.

This value was then benchmarked against the cost of implementation of similar solutions at other providers. These indicated that the predicted annual cost was within 4% of this value, and with the capital cost 10% of the indicated value. Assumptions:

- Excludes VAT – and that any contract implementing the solution is VAT efficient.
- The capital includes spend on additional or replacement hardware for the sites.

For the financial model, the capital cost has been converted into revenue in-line with the interest assumptions provided by the ITFF. As such, for an assumed 10 year contract, the annual revenue charge has been calculated for modelling.

It is predicted that the collaboration can move 'at speed' with the procurement of the single LIMS provider given that it is possible to procure the LIMS through existing framework agreements.

Financial Case
Single Hub Scenario

3.3.3 Non-pay Costs cont'd

Tests referred out

Tests referred out are those tests which are sent outside of the Trust, and usual focus on specialist activity. For the purpose of this activity, the cost to each Trust of tests referred out to other Trusts within the BCPS group has been ignored. This is to prevent the double counting of costs – as the cost of provision of these tests is already included within the Trust that undertakes the activity.

For reference, the cost of tests referred out within BCPS, and external to BCPS are identified by Trusts in the table below:

	RWH	SWB	WH	DGH
External to BCP	£459,490	£403,462	£433,902	£516,000
Internal to BCP	£73,530	£0	£183,210	£98,031

No additional saving have been included for the tests referred out, however, savings can be expected once detailed analysis is carried out on whether tests can be repatriated or commissioned jointly.

Financial Case
Single Hub Scenario

3.3.4 Capital and Investment costs

Moving and double running costs

Under the proposed model, a new installation of equipment across both sites results in a minimal requirement for the moving of equipment. Given the transformation of the service is largely within a single laboratory site, double running and decant costs have been assessed and included, based on experience of similar movements at other laboratories. These costs are predicted to be incurred during the early part of the transition period.

Estates investment

RWH have engaged with architects Keppie Design. Keppie have been working with the Trust, in partnership with LTS, to produce a schedule of accommodation for the new single hub at New Cross Hospital, via an extension to the existing laboratory, along with a re-organisation of the existing layout of the laboratory. Through this work, the Trust will be able to identify the level of refurbishment, as well as the nature of the extension to the laboratory required.

This work remains ongoing, and a revised draft of the schedule of accommodation, with the next phase requiring the appointment of quantity surveyors to evaluate costs. This will further refine the cost input for the model, however the current assessment is, and will remain at, a high-level.

Ahead of this, RWH have provided an indicative value for the cost of the refurbishment, and the construction of the extension. For the financial modelling, we have estimated that this value is split evenly over the four semi-annual periods from 01/04/2018 to 31/03/2020 to reflect the work being undertaken.

The work undertaken has assessed the future operating model and levels of activity. This has shown that it is practical to provide the consolidated model within one central hub facility. In order to undertake this the extension to the existing laboratory will be required, alongside refurbishment of the existing laboratory. This refurbishment is included in the price, and is estimated at light refurbishment work for 250sq.m on the New Cross Site.

Project management

For the transition of the laboratories, significant project management expertise will be required to develop the governance models, transition plans, and the legal framework for the partners. Based on experience of similar collaboration projects, we estimate this cost to be £400,000 for the partners. These have been evenly profiled across the semi-annual periods from 01/10/2017 to 30/09/2019.

Financial Case
Single Hub Scenario

3.3.4 Capital and Investment costs cont'd

Central management recruitment costs

For the new collaborative service, there will be a requirement to put in place a central management team for the service. The cost of recruitment of the senior staff is estimated at £40,000 through soft-market testing. This is predicted to be incurred in the semi-annual period 01/10/2018 to 31/03/2019.

HR Support

Given the change in services, there will be a requirement to TUPE transfer staff between the sites.

In light of this, there is likely to be significant HR support required. As such, it is assumed the support requirement from the host organisation will be two FTE senior HR staff employed full-time for a year. This cost is £133,500. This is predicted to be incurred in the two semi-annual periods from 01/10/2018 to 31/09/2019.

Contingency

In addition, a contingency fund of £400,000 per annum has been included to cover unforeseen costs.

3.3.4 Costs for the ESL+ option

These costs have been calculated following the exact same methodology as the main option. Key different between the two TOMs lies on the capital requirement for refurbishment and building of the ESL+. Initial estimates indicate that these costs are slightly lower than those of the preferred option.

Financial Case

3.4 Financial Summary of Options

3.4.1 Summary of the options

Each of the shortlisted options was modelled over a 10-year period from 2016/17 using the assumptions discussed on the previous pages. This produced a 10-year forecast for the cost of the laboratory under each of the options. The As Is model is deemed the 'base case' for the model, and the variance from this model is also presented for each of the options for easy identification as to whether the option saves money against the base case, or indeed costs more.

Presented below is the annual summary of the total cost base for the laboratory for each year modelled as well as the cost difference for each year, against the "As Is" scenario modelled. When looking at the financial outputs it should be noted that these do not reflect qualitative differences. Therefore, models that cost more may indeed result in significant qualitative improvements which justify the increase in cost.

Compared against the As Is model, it is clear that, from a purely cost perspective, all models represent a saving to the As Is Model. (a negative value in the difference equals a cost saving compared to the As Is model). Financial statements for each of the options were developed to show the profile of costs and savings.

As a result of the analysis the options that provide the largest savings are:

1 – Hub and ESL+

2 – Hub and 3 ESLs

3 – LTFM plans

4 – "As Is" with CIPs

It should be noted that the difference in savings between the Hub and ESL+ and the Hub and 3 ESLs is negligible which is likely to reduce further once the hub extension costs are fully developed by a quantity surveyor. Initial analysis through a sensitivity run on the model would indicate that the single hub and 3 ESL options may provide a higher level of savings overall if the cost of the extension remains at £2,700sqm and after value engineering principles are applied to the design. Initial estimates by LTS indicate that the price per sqm for the extension, as provided by the Trusts (£4,000 sqm), are high in comparison to benchmarks (£2,500 - £2,700 sqm).

Given there is limited difference between the annual and total cost of the One Hub and ESL+ Scenarios, it is recommended that the Trusts consider the best operating model based on the following aspects:

1. Availability of capital
2. Quality considerations – The impact on quality of a split service should be considered, and whether it is more clinically and operational preferable to have the service located on a single site.

COMMERCIAL CASE

This sets out the potential governance and management arrangements as described in the BCPS partnership agreement (PA)

4

Commercial and governance principles for a potential BCPS partnership model

4.1 Introduction

The following sections contains a summary of the proposed position for commercial terms, organisational structure and governance of the new pathology partnership. These principles have been discussed and agreed by the Directors of Finance of all the organisations in the project and/or their representatives during phone meetings and email correspondence. These terms have also been presented for review and comment to the members of the BCPS Transitional Management Team.

All organisations have agreed that at this stage they do not wish to set up a separate legal entity to establish the BCPS partnership. Therefore, the model chosen is that of an Arms Length Organisation hosted by one of the Trusts. This is the model developed in this section and all the commercial terms are arranged around this model.

A Partnership Agreement (PA)is enclosed with this OBC. This will form the basis of the agreement to be signed by the four Trusts.

This section considers the organisation and commercial principles required to to establish a potential BCPS collaborative pathology model. These have then been developed into a draft set of Heads of Terms for such a model which are divided into four sections.

1. Outline Commercial Model;
2. Governance;
3. Ownership;
4. Relationship with Customers; and
5. Organisational Form, Staffing and Corporate Services.

Each commercial principle contains initial considerations and agreed approach which was developed in discussions with the Directors of Finance. Where the agreed approach has more than one options it highlights a requirement for further discussions to complete the agreement.

The initial term proposed for the partnership is 10 years so it aligns with equipment contracts and the realisation of savings.

4.2 Outline Commercial Model

This section covers the potential commercial model for the new pathology organisation.

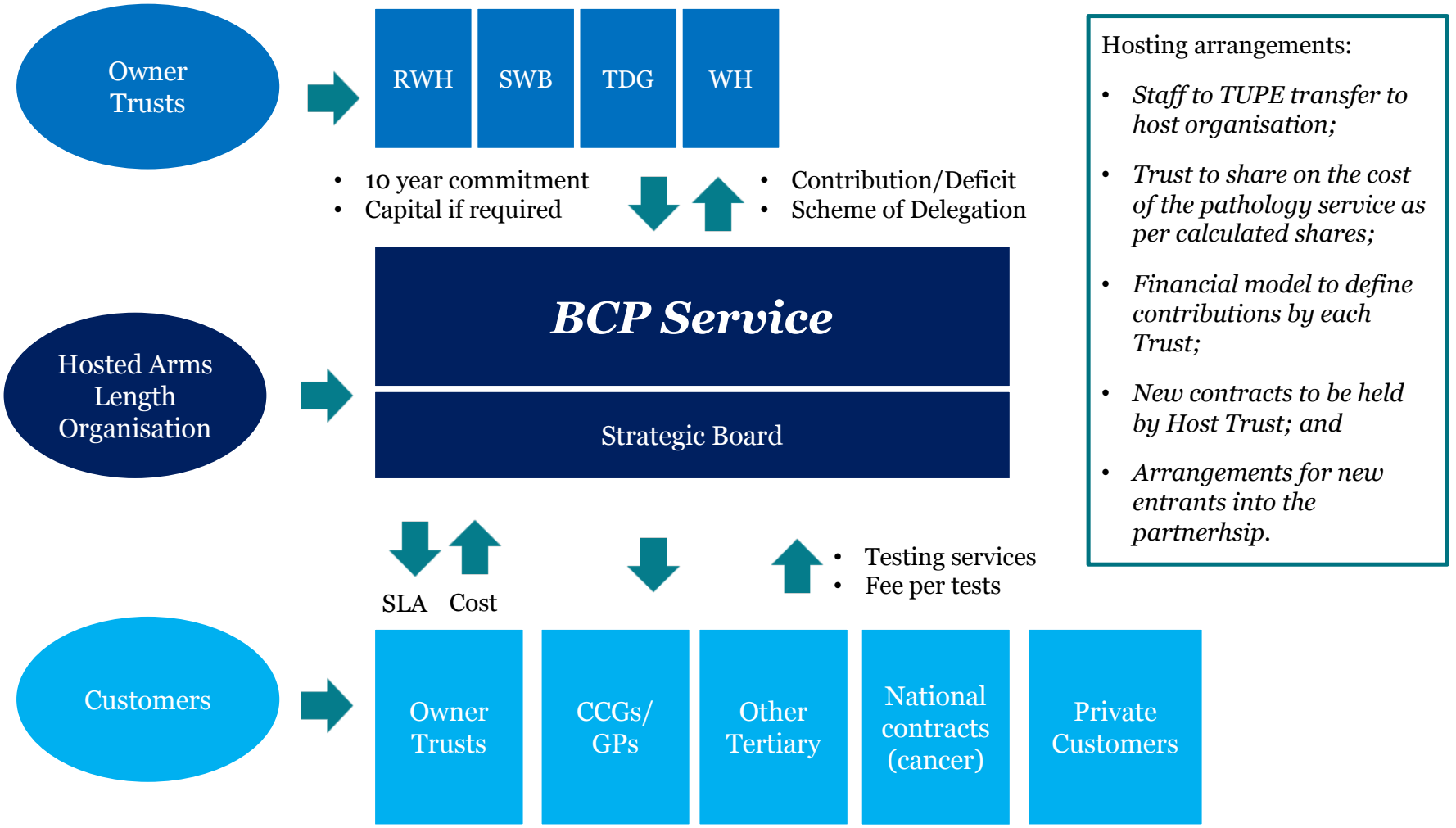
4.2.1 Operating Arrangements

The diagram in the following page summarises the operating basis for the BCPS new pathology service when fully established. It is proposed that given the complexities of setting up a new entity between NHS Foundation Trusts and non foundation Trusts, pension arrangements and costs, the partnership is set up as an arms length organisation hosted by one of the Trusts.

The entity will operate under its own Board and Executive Team, who will be accountable to the Owner Trust boards for the operation of the pathology service. It is assumed at this stage that BCP Service will not be established as a separate legal entity.

As such BCPS will have its own identity and operating flexibility which will be distinctly different for the way that pathology services are managed as part of each Trust's existing divisional management structure. It is considered important to create a new identity and operating model for BCPS because:

- This is a transformation of the pathology operations of the Trusts under a seamless management and governance structure with a single management team;
- Operationally BCPS will serve all the Trusts equally providing first class pathology services and as such needs to have its distinct identity and arms length separation from the Trusts;
- Staff will be equally and significantly engaged (in a challenging transformation) if they can identify a common loyalty to a BCPS "brand" and operational management structure which is distinct from existing arrangements within their individual Trusts;
- BCPS requires a degree of operational flexibility to set and execute its own priorities if it is to grow as a sustainable business which it is unlikely to get as part of the Trusts' divisions; and
- BCPS would be required to operate with a degree of autonomy under the standing order and scheme of delegation of the host Trust.



Hosting arrangements:

- *Staff to TUPE transfer to host organisation;*
- *Trust to share on the cost of the pathology service as per calculated shares;*
- *Financial model to define contributions by each Trust;*
- *New contracts to be held by Host Trust; and*
- *Arrangements for new entrants into the partnerhsip.*

4.3 Governance

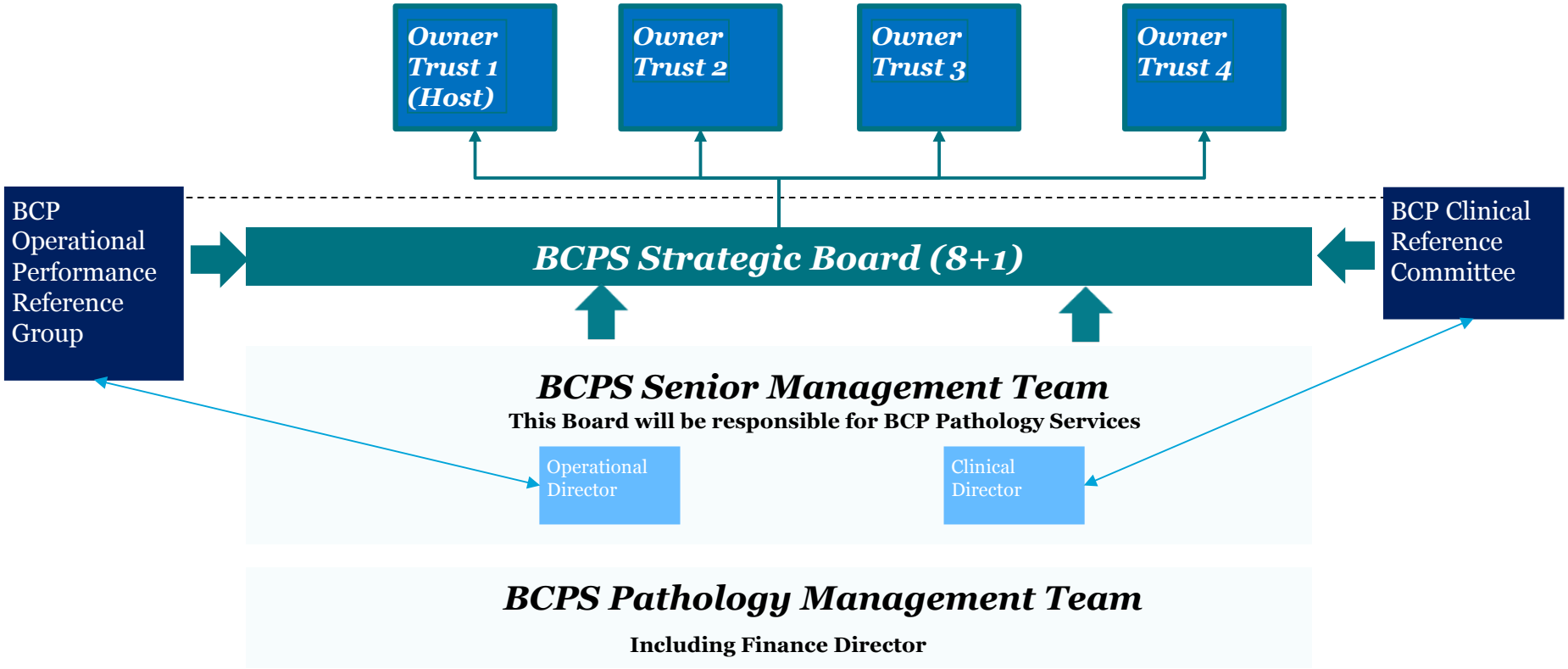
This section highlights the day to day management and control of the new organisation. The principle for the new pathology organisation is to have enough independence to make key decisions. Each owner Trust will need a level of control to assure their Board that they can strategically manage their ownership benefits and risks.

HoTs	Initial Considerations	Agreed Approach
1. ***BCPS Strategic Board***	• Initial considerations will focus on the Board role and its composition, such as: – Representation on BCPS Board; – Creation of an Executive and Non Executive team; – Management of a large business and staff responsible for finance, operational, commercial and clinical initiatives; – Size of business will require a mechanism for transparently and effectively reporting performance; – Appointment of Board members and future Board members (internal and external); – Chair appointment; and – Appointment process for independent members.	• The management remit of the BCPS Strategic Board will be in accordance with the Scheme of Delegation and reserved matters. • Trusts to appoint an independent Chair who should be independent of all Partners. Alternatively, each Trust can take it in turns to chair the board. • Unanimous agreement required for the appointment of the Chair, if no candidate available the role will rotate within the four partner Trusts. • The BCPS Strategic Board will be formed by two members of each Trust, of which at least one per Trust will be an Executive Board members of their Trust and the other will have a relevant clinical background. • Current BCP Transition Management Team to interview Directors for the BCPS Executive Management Team. • The total composition of the Board will be 9 (Chair and 2 representatives from each Trust). • Each member of the board, apart from the chair, shall have one vote. The Strategic Board will have a total of 8 votes, two from each Trust.
2. ***BCPS Executive Management Team***		• The BCPS Management Team will have responsibility for the day to day operation of the service. • The BCPS Management Team will comprise of an Operational Director and a Clinical Director (2 Executive Directors). • The Strategy, Finance and HR Directors will not need to be part of the Board, but their roles should be included in the structure of BCPS pathology. These are likely to be provided by the Host Trust. • The BCP Executive Management Team will ensure the delivery of the BCPS obligations under the SLA agreements with each Trust. • Each Trust will have an obligation to provide certain services to BCPS such facilities management, access to essential services laboratory, utilities, etc. • The Host Trust will also be responsible fro providing other support to host the organisation such as payroll, IT support and procurement and finance support.

4.3.1 Governance Principles

The diagram below illustrates the governance principles for the BCPS, The new entity will have its own board responsible for the management of the pathology service and the day to day running to the entity. The BCPS Management Board will be responsible for producing an annual business plan that will include investment requirements. This plan will then be submitted to the BCPS Strategic Board for approval and to all the Trusts for information and approval where the delegated powers are excided and confirmation from owner Trusts is required.

The BCPS Strategic Board will include a Chair and GP as non-voting members.



HoTs	Initial Considerations	Agreed Approach
3. Voting rights for Reserved Matters by the Owner Trusts	• Initial consideration will focus on the mechanism for which reserved matters are decided upon between the Owner Trusts.	• All Trusts have equal voting rights on the BCPS Strategic Board • The following is proposed: – Unanimous voting may be required for a small number of the Reserved Matters, which should be strategic in nature and not relate to operational matters; – Some Reserved Matters will be decided by Majority Voting, such a majority will be based on the agreement of at least 3 Owners or 70% of the share holding; This will ensure that no single Trust will have the majority vote or right of veto in relation to operational matters. – The final form of the Majority Voting will be determined once Ownership Shares are approved and ratified; and – The proposals as to whether a reserved matter belongs to majority or minority voting is provided in the "Reserved Matters" (See Appendix 2).
4. Scheme of Delegation	• The Owner Trusts need to 'Reserve Matters' for their own unanimous or majority decision making and the need for Trust board approval • These Reserved Matters should be critical to protecting their Owner interests and not issues of day to day operations. *Refer to Reserved Matters in Appendix 2*	• The Reserved Matters are likely to include: – Approval of the annual Business Plan and budget if it deviates from original business case by more than 5%; – Material deviation from the Business Plan or budget within the financial year; – Requests for new investment above delegated limit; – Taking on long term liabilities (e.g. large service contracts); – The appointment or dismissal of any of the executive directors of the Board; – Approving the annual clinical governance report/appraisal; – The admission of new Owners; and – Material amendments to the Partnership Agreement.

- For detailed description of reserved matters please refer to Appendix 2 of this document and the BCPS Partnership Agreement.

HoTs	Initial Considerations	Agreed Approach
5. Clinical Governance	• Initial considerations for an effective system: – The Clinical Director will have ultimate responsibility for Clinical Governance but the whole Board is responsible for effective Clinical Governance; – With BCPS hosted by a NHS Trust the Clinical Director will have to report to the Medical Director of the host Trust to ensure there is seamless, sustainable, clinical governance; and – The clinical director will also be part of the user clinical steering group.	• The Clinical Director will be responsible for clinical governance across pathology services working in collaboration with all the Trusts. • The Clinical Director will be responsible for all clinical arrangements for BCPS. • Each active laboratory will continue to receive national accreditation under the auspices of the appropriate body (CPA/ISO). • The Clinical Director should produce an annual clinical governance report for review and approval by partners. • There will be a user clinical steering committee set up who would monitor the clinical issues of the pathology service (clinical performance, clinical SOPs, introduction of new tests, etc.) • The Clinical Steering Committee will be formed by 1 clinical lead from each Trust who will be responsible for consulting with its Trusts' users. • The preferred Clinical Governance model has been discussed with the medical directors of Trusts who have confirmed that the appointment of Clinical Director is an essential requisite to achieve accreditation. This Clinical Director will then be responsible for setting up the clinical governance processes for the new entity and will also have a formal role within the Host Trust Clinical Governance processes ensuring there is regular reporting and monitoring back to the Host Trust.
6. Contact management (SLA monitoring)	• Principles for the management and monitoring of SLAs	• While the BCPS Executive Management team will be responsible for the management of BCPS a separate arrangement should be put into place to monitor SLA performance and operational remediation when required. • The contract management group will monitor SLA performance on a monthly basis and report to the BCPS Strategic Board once a month. • The contract management group will be formed by one contract manager from each Trust and the COO of BCPS • SLA KPIs and metrics will be agreed as part of the SLA development

4.4 Ownership

This section addresses the potential ownership obligations for each owner Trust which enters into a partnership to establish BCPS Pathology.
It is envisaged that a combined BCPS pathology entity will be owned by its sponsoring Trusts. A methodology needs to be agreed between the Trusts to allocate proportionate ownership "shares" between them to allow for the future distribution of surplus and losses and the sharing of start up costs (transition) and future capital calls.

HoTs	Initial Considerations	Agreed Approach
7. Obligations of Owners	• These shares will represent the proportional liability of partner Trusts. They are not equivalent to real shares as no new separate legal entity is being established. Owner shares which will be used to apportion the risks, rewards and control between the partner Trusts.	• Owner Trusts who are shareholders will take responsibility for the share of the funding and liabilities of the organisation. • There will only be a single class (type) of "share".
8. Methodology for valuing ownership "shares"	• The methodology selected to determine ownership "shares" needs to be demonstrably fair, straightforward to calculate and explain to wider stakeholders. • Conventional methods for valuing shareholders would look at the relative value or contribution that each organisation is making to the new entity. This is usually quantified as the contribution they will be giving up to the new entity.	• Income base: based on the calculation of the total income that each Trust brings to the partnership. The calculation is performed by multiplying current annual activity volumes by a set price per test (or by discipline). It has the risk of incentivising those Trusts with higher complex volumes or poor demand management and control. • Examples of the calculation are available in the "Cost Shares Methodology", Appendix 4 • Directors of Finance have proposed that the income based methodology based on activity is used. • Appendix 4 indicates the estimated current volume of shares for confirmation at Gateway 1.

HoTs	Initial Considerations	Agreed Approach
9. Commitment from owner partners and partnership term	• Entering into the Partnership Agreement will have a number of implications that all Trusts are committing to.	– The partnership is based on the creation of a joint service for the benefit of all Trusts and in which all trusts have equal say. The hosting of the BCPS and/or the location of services will be dealt with as operational matters (best value for money) and all Trusts will have an egalitarian share on the benefits created by the service. – The term of the partnership agreement will be 10 years. – At the end of the 10 year period an owner will be required to provide 12 months notice to exit the partnership. – Partners existing at the end of the term will be allowed to remain customers of the partnership. A full exit will have implications in terms of exit costs which are explored in the exit costs section. – All Trusts commit to providing the required support to BCPS, both financially and operationally. – Commitment to maintain all activity volumes within the partnership.
10. Selection criteria for the Host organisation	• Considerations for the selection of the Host organisation	– The selection of the Host organisation should be on the basis of the most advantageous set up for BCPS that would best enable the reconfiguration of services. – Key consideration should be the capacity of the Host Trust to enable and support the accounting and management of an ALO within its structure. – It should be considered the disruption to staff with TUPE transfer. This would favour the Trust with the largest numbers of staff to become the host organisation, reducing the cost and risk of TUPE transfer consultation and proceedings. – The selection of the Host organisation should be a unanimous decision by partner Trusts. – Directors of Finance have proposed that to make the management of BCPS and the provision of support better, the Hub should be the Hub at RWH. This would minimise TUPE transfer issues and ensure quick access to support services like finance and IT when needed.

HoTs	Initial Considerations	Agreed Approach
11. Exit Arrangements	• Initial considerations on the methodology and implications if an Owner wishes to leave the collaboration. Considerations include: – Owners locked in for at least [10] years Owners will not be able to trade or sell shares until end of term or break clause [if available]; – [1] year notification period for Owners who wish to exit partnership; – Penalty for an Owner for early exit; – If one Owner leaves the others have pre-emption rights to acquire their shares; and – Exit costs to be covered by the exiting party.	• Owners locked in for at least [10] years: – Owners will not be able to trade or sell shares until break clause; and – Owners who choose to terminate prior to the [6] year break clause would lose the investment and pick up any costs that are associated to early exit. • Possible exit arrangements include: – The remaining Trusts have the pre emption right to acquire the leavers share (at an agreed valuation); and – If more than [X] exit then: o If an Owner chooses to exit BCPS an equal proportion of shares will be allocated to all remaining Owners; o An Owner may increase their shareholding proportion if the other Owners do not wish to purchase additional shares; o If remaining Owners choose not to take on remaining shares a third party may be chosen to purchase the shares (majority voting will be needed); and o BCPS is wound up and its staff, assets and liabilities are divided up and transferred back to the respective Owners; or a new third party shareholder is sought [this is to avoid an unsustainable concentration of ownership. o A risk premium may be payable by any partner leaving the partnership based on the calculation in clause 6.11 in the partnership agreement. o This calculation is based on a full 12 month service fee offset by cost reductions in terms of staff transferring back to the Trust and other cost being removed from the partnership.
12. Dispute Resolution	• Dealing with poor operational performance	• Should the contract management group identify areas of non-performance, these will be notified to the BCPS Executive Management team • BCPS will put a remediation in place with the aim to rectify the problem within 3 months. • Should the problem not be rectified this will be escalated to the BCPS Strategic Board for consideration. • Following a decision of the BCPS Strategic Board, BCPS will have three further months to rectify and correct the issue. • Should the issue not be resolved it would then be escalated as per the dispute resolution procedure in clause 16 of the Partnership Agreement

HoTs	Initial Considerations	Agreed Approach
13. Annual recharges	• Consideration on how payments to the BCPS are made by each Trust to cover the operating costs.	• Prices paid by each Trust to be based on shareholding proportion of the agreed annual budget for the service (calculation based on volumes x price per test). • Shareholding to be rebased/recalculated when the volumes from one single Trust change over the course of 12 months by ±[8%] • Should volume change be within the cap and collar, then the BCPS Strategic Board has the option to agree repricing every two years.
14. Profit and Loss	• Initial considerations on the agreement on how to deal with any profit and/or losses.	• Annualised profits to be shared between Owner Trusts in proportion to their ownership share. • Losses underwritten by the Owner Trusts in proportion to their Ownership Shares.

15. Transition Costs	• Initial consideration of how implementation and transition costs are shared between the Owners. Such as:
	– Capital;
	– IT;
	– Assets;
	– Staff costs; and
	– Equipment.
		• Transition costs are shared in accordance to shares of the new entity.
		• Once the new entity is implemented any further redundancies during the transition will be shared by Owners (if they cannot be financed from the business cash flows).
		• Equipment:
		  • Transition costs will be dependent on the existing Managing Equipment Services (MES) timing of the contracts from old to new; and
		  • Owners who exit the partnership may incur costs pertaining to the termination of the equipment contracts.

16. Other transition costs	• As above	• As above

HoTs	Initial Considerations	Agreed Approach
17. Capital investment	• Considerations will be related to the Scheme of Delegation. Arrangement for investment and provision of capital, to include: – Funding obligations; – Approach to approval of investments; – Limits above which Owner Trust Board approval will be required; – Arrangements for Owners who are unable to afford the required investment; and – Ownership of new assets if the entity is a hosted arms length organisation (i.e.. still within the public sector).	• Owner Trusts to have equal investment obligations (proportionate to ownership shares). • As the entity is hosted by a Trust then all existing capital assets acquired will be owned by the acquiring Trust (Host) and in accounting terms will be consolidated between the Owner Trusts according to the shareholding. • Any capital investment, above an agreed value, will require approval from the Owners. • Investment contributions can be made in a mutually agreed form (e.g. loan with a fixed tenor, coupon and repayment period which will be the first call on operating profits before any dividend payment). • If any Owner is unable to meet its investment obligation then the other Owners will have the first right to step in and take up that investment obligation (they will probably need an adjustment to be made to shareholding to reflect the revised concentration of loss and reward) or alternative may be a loan to the new entity with agreed as fixed terms.
18. Transfer of assets	• Consideration to the treatment of currently owned assets and whether these would transfer to the partnership (BCPS) and therefore the host Trust	• All assets (equipment) that impact directly on the delivery of the pathology service will transfer to the Host at a nominal cost to be agreed with the Trust. This can then be taken into account on the share calculation methodology. • Alternatively assets can remain in the ownership of the Trust and depreciation charges consolidated as part of the cost base for BCPS • New assets and contracts will be entered into by the Host on behalf of the other Trusts.
19. Exclusivity	• Initial considerations on the exclusivity clause with partner Trusts	• Partner Trusts should enter into an exclusive pathology contact with the for a minimum of a [10] year contract. • Partner Trusts would not buy pathology services from other Trusts unless the service required is not available • New pathology contracts with new customers, national screening programmes, private sector organisations, etc. will be entered into by BCPS on behalf of all the Trusts • Entering into new contracts would require BCPS Strategic Board approval and full assement on the income and expenditure account.

4.5 Relationship with customers

This section highlights BCPS' proposed relationship with customers to secure services and revenue to the new organisation. The commercial terms for the relationship between BCPS and potential customers will be largely determined by the extent of their exclusivity and the longevity of the contract period.

HoTs	Initial Considerations	Agreed Approach
20. Customer Contracts	• Supply of services to Owner Trusts to be monitored by the Contract Management Group • Considerations include: – Methodology on how to agree on Key Performance Indicators (KPIs) in relation to internal customers (Trusts) and External (GPs and other organisations); and – Charging on commercial basis of services which could be in sourced	• As part of the preferred operating model a comprehensive set of KPIs should be set in accordance with all customer requirements and which will form part of the Trust SLAs • Charging methodologies could be: • a cost per test basis (but will need to have a demand management with customers). • Cost base contribution basis • Methodology for charging to be agreed by all Trusts
21. Customer Terms	• Initial considerations will be how to determine and define a customer. Considerations include: – Level of acceptable risk and rewards to customer; – Terms of commitment of contract with the entity (the earlier the commitment the potential greater the reward); and – Longer commitment or sharing of risk will lead to better pricing.	• Risks and rewards to be determined by the extent of the customers exclusivity and the longevity of the contract period (and whether they have contributed to any of the transitional costs). • Presume the contract will be for both on site and off site (send away) services. • Will customers provide Owners with a minimum activity guarantee for a period of time? • Negotiated levels of performance to be agreed with BCPS. • Need to determine whether reward be expressed as a "customer" discount or a share of potential future profits.

HoTs	Initial Considerations	Agreed Approach
22. Acceptance of a new Customer	• Initial considerations on the process to allocate costs to new customers. Such as: – Transition; – TUPE; – Staff changes; – Additional logistics; and – Additional IM&T and assets.	• TUPE to apply to the customer's pathology staff. • BCPS will incur additional employee liabilities. • Any staff change costs incurred as a result can either be: – Met by a new customer; and – Paid by the Owners and recovered over the contract period from the customer. • New customers coming into the new organisation will need to cover the following incremental costs (as an additional levy to their agreed test prices): – Logistics; – IT ; and – Transition.

4.6 Organisational Form, Staffing and Corporate Services

This section highlights the legal framework which will allow the delivery of the organisational model and Heads of Terms for the new organisation.

HoTs	Initial Considerations	Agreed Approach
23. Organisational form	Initial considerations on the features of the model which best fits the collaborative principles agreed by the Trust partners.	• ***Arms Length Organisation (ALO):*** this is a model that would allow non Foundation Trusts to have direct ownership of the organisation. The BCPS Pathology organisation would be set up as an ALO hosted by one of the Trusts. It would operate under a quasi autonomous regime with its own Management Board with reporting requirements to the Owners Trusts. These reporting requirements would be defined by an approved Scheme of Delegation that would be part of a contractual Joint Venture Agreement between the parties. The contract under this model can be set up in a way that would allow for the creation of new legal entity once all Owner Trusts become Foundation Trusts. NHS Trusts who are party to a Joint Venture or partnership agreement would fall under section 9 of the NHS Act and would not be legally enforceable in common law although would be enforceable under the NHS resolutions regime. An NHS Foundation Trust who is party to a NHS Joint Venture or partnership agreement can enforce its legal rights against an NHS Trust and an NHS Foundation Trust under common law. • ***Private Joint Venture:*** this model would see the creation of a separate standalone legal entity with its own Management Board. The rights of the Owners Trusts would be limited to those of share holders and as defined on the Joint Venture Agreement. Only Foundation Trusts can have direct share ownership in such a new entity, however legal advice should be sought as to whether a Foundation Trust could "hold" the share of a NHS Trust (via legal agreement) until that NHS Trust became a Foundation Trust. Such Joint Venture Agreement is enforceable under common law • ***Having considered the implications above, it is recommended that given the mix of Trusts and Foundation Trusts an Arms Length Organisation is considered which is hosted by one of the four partners.***

HoTs	Initial Considerations	Agreed Approach
24. Staff transfer and recruitment	• Initial consideration to agree approach for appointing staff to a new organisation. Such as: – Staff to remain employed by own Trust or transferred to new entity; – Approach to timing of transition of staff transfers; and – Staff TUPE transfer consultation period, including consultants. – Treatment of new recruits into BCPS	• During transition period each Trust continues to employ its own pathology staff until immediately after the new organisation becomes fully operational, with arrangements being agreed to allocate responsibility between the Trusts for matters such as: – Employment of "cross cutting" staff; – Consultation; – Interim and transitional management; – Agreement of third party contracts; – Capital expenditure; and – This reflects that until the new Hub opens it will be a largely "as is" operating model. • All pathology staff will be employed and managed by the BCPS once steady state commences. Consultant staff will transfer to the new entity to achieve the benefits of collaboration and integration. Where consultant staff have non clinical Pas these will be subject to either dual contracts of employment or SLAs with the organisation that requires the consultant support (research organisations, training institutions, etc). • During the transition period, consultant staff will remain employed by current Trusts while any new staff will be recruited under the new entity. • All staff will remain part of the NHS and in the NHS pension scheme. • All new recruits will be recruited by the Host on behalf of the Trusts with the liabilities accounted for as part of the annual budget setting and approvals process.
25. Corporate services	• Initial considerations on the corporate support needs of the new entity. Such as: – Services which should be provided by SLAs; and – Approach to recharging services.	• Owners to decide which corporate services will be provided by the entity and/or Owners Trusts. • How will on site and off site support services be provided. • Calculation of recharges by each Trust for the provision of services to enable the operation of a pathology laboratory (Hub or ESL from each site)
26. Accounting principles	• Initial considerations for the responsibility for producing trading accounts and then regularity. Such as: – Approval for accounts, budgets and forecasts financial and performance reporting. • Trusts to understand how their commitments to the entity should be consolidated.	• BCPS to produce trading accounts and financial support during transition period and steady state. • The format of the financial (and wider management) reporting to be agreed by and approved by the Owners (and capture in any future Partnership Agreement). • Accounts to be consolidated by the Host and reported to all Trusts through the BCPS Strategic Board. • As a minimum, each Trust should receive on annual basis the expected net cost of pathology to the Trust.

HoTs	Initial Considerations	Agreed Approach
27. Assets (Equipment and IM&T)	• Initial considerations on the treatment of assets, including equipment and IM&T for new organisation. Trusts should discuss: – Assets to be committed by each Trust to use by the entity; – Value and remaining life of those assets; – Party to be responsible for the replacement of obsolete assets; – Use of Managed Equipment service contracts;	• The management team of the new entity will be responsible for the management of the equipment. • Investment in equipment to be identified on the annual BCPS business plan and approved by Owner Trusts.
	– Current situation at each Trust in terms of MES; – Other contracts, leases and rentals; – Approach to determining IM&T requirements;	• During the transitional period each Owner will retain any existing MES contracts but will explore the possibility of adding the other Owners as an additional party to extend MES contracts to encompass the other Trust's equipment.
	– Investment principles for IM&T; and – Management of IM&T external contracts and maintenance.	• IM&T requirements to be determined by entity and form part of transitions/implementation plan. Responsibility for contracts and maintenance to be delegated to BCPS and host Trust.
28. Intellectual Property	• Considerations on dealing with IP during the life of the Partnership Agreement	• Any IP currently in possession of any of the Partner Trusts will remain property of the partner Trust • Any IP that is developed as part of the research and development activities of BCPS will be owned by all the Trusts. • Exploitation of new IP will be part of the responsibility of the BCPS Executive Management team and the benefits will be shared across all Trusts proportionally in accordance with their ownership shares. • At the end of the 10 year term the IP will remain property of the BCPS Trusts. Should one Trust leave the partnership it would lose the right to use the IP. Should the partnership cease to exist all together then the rights to exploit the IP will be given equally to all the partner Trusts.

Heads of Terms	NHS Arms Length Organisation	Private Joint Venture
Tax	• Normal NHS rules apply	• Capital allowances may be available. • Gift Aid can provide Owner Trusts with an opportunity to receive a tax exemption by allocating all profits (100%) to other Trusts as a charitable investment (a review needs to be conducted to understand if this is a possibility due to changing policy).
VAT	• VAT position will depend on the legal status of the arms length organisation (ALO) (i.e.. whether it has a similar VAT status to NHS Trusts or whether its legal status means that it falls to be treated under the normal VAT rules).	• Establishment of private entity will be subject to normal VAT rules. • JV would need to become registered for VAT in order to charge and account for VAT and to be able to recover any VAT on its related costs. • Trusts that make any supplies into the JV (e.g. Supplies of staff, IT, other facilities), they are likely to be required to charge and account for VAT on such supplies. • Future disposals of interest/exit by Owner Trusts can incur VAT costs (e.g. whether an exempt sale of shares) as well as in relation to any transfer of assets and/or property. • If the Owner Trusts receive any payments as a result of their interest in the JV (e.g. as a profit share/dividend) then the VAT accounting treatment will need further consideration.

Management Case

5

Management Case

5.1 Deliverability

There are a number of consolidated hubs in the UK that have managed to successfully implement a hub and spoke model. As an example, Pathology First, Southwest Pathology, Southwest London Pathology, Frimley Park and HSL are a few examples. In fact, there is expertise within BCPS in the consolidation and transfer of services albeit at a smaller scale (cytology service).

The key features learned from the successful consolidation and the lessons from those that have not been successful (TPP, Kent, Sussex, Solent) are:

- Ability to agree equitable and fair commercial arrangements;
- Clinically led service;
- Implementation of common IT systems;
- Implementation of common equipment platform;
- Refurbishment of facilities/adequate laboratory space;
- Investment in clinical engagement; and
- Investment in staff engagement and support.

5.1.1 Transition programme

To achieve the above a number of steps need to be implemented during the transition to achieve the steady state. These steps will involve:

- The establishment of governance structures
- Appointment of key transition and management personnel;
- Detailed operations modelling and site design;
- Staff and clinical engagement programme;
- Developing of funding and access to capital;
- Procurement of IT and equipment;
- Procurement and building of extension;
- Consolidation of activity to achieve early savings; and
- Transfer of staff.

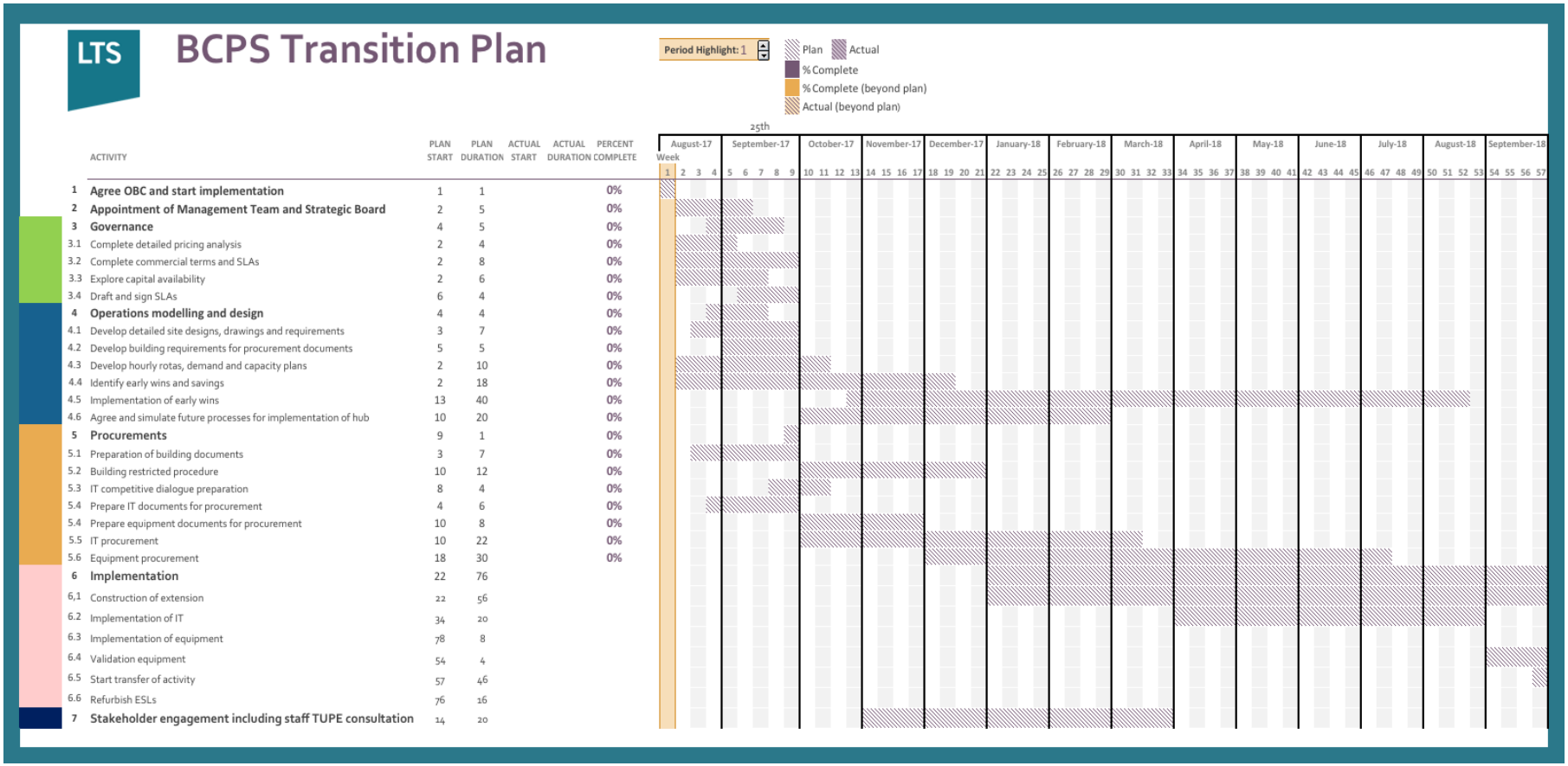
Should the Trust boards approve the OBC during July 2017 it is then expected that the implementation can start in August with the finalisation of the SLAs and agreement between the parties. At the same time, during August and September, there would be preparations for the procurements required, with expectations that the hub works can commence in second quarter of 2018. It is expected that steady state will be achieved in the first half of 2019.

5.1.2 Procurements

It is expected that three procurements will be required:

- Hub extension building works: OJEU with restricted procedure expected to start in October and finish in December 2017.
- IT Infrastructure: OJEU competitive dialogue with only one phase of dialogue. Common IT platforms and system to manage the laboratory and flow of information. Expected to start in October and finish in March 2018.
- Equipment: OJEU competitive dialogue with only one phase of dialogue Procurement to start in December 2017 and finish in July 2018. This is likely to be run as separate procurements for each pathology discipline to be able to align services and contracts across all the Trusts.

Management Case – Transition Programme



	ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
1	**Agree OBC and start implementation**	1	1			0%
2	**Appointment of Management Team and Strategic Board**	2	5			0%
3	**Governance**	4	5			0%
3.1	Complete detailed pricing analysis	2	4			0%
3.2	Complete commercial terms and SLAs	2	8			0%
3.3	Explore capital availability	2	6			0%
3.4	Draft and sign SLAs	6	4			0%
4	**Operations modelling and design**	4	4			0%
4.1	Develop detailed site designs, drawings and requirements	3	7			0%
4.2	Develop building requirements for procurement documents	5	5			0%
4.3	Develop hourly rotas, demand and capacity plans	2	10			0%
4.4	Identify early wins and savings	2	18			0%
4.5	Implementation of early wins	13	40			0%
4.6	Agree and simulate future processes for implementation of hub	10	20			0%
5	**Procurements**	9	1			0%
5.1	Preparation of building documents	3	7			0%
5.2	Building restricted procedure	10	12			0%
5.3	IT competitive dialogue preparation	8	4			0%
5.4	Prepare IT documents for procurement	4	6			0%
5.4	Prepare equipment documents for procurement	10	8			0%
5.5	IT procurement	10	22			0%
5.6	Equipment procurement	18	30			0%
6	**Implementation**	22	76			
6,1	Construction of extension	22	56			
6.2	Implementation of IT	34	20			
6.3	Implementation of equipment	78	8			
6.4	Validation equipment	54	4			
6.5	Start transfer of activity	57	46			
6.6	Refurbish ESLs	76	16			
7	**Stakeholder engagement including staff TUPE consultation**	14	20			

- It is expected that transition planning will commence in August 2017.
- Construction of the Hub extension would commence in January 2018 and last a period of 12 months including equipment installation and validation.
- Implementation of IT and Equipment would start in the second half of 2018 and completed once the Hub extension is completed. Equipment validations for accreditation may continue into early 2019 if not fully completed by December 2018.
- **Hub extension to be completed by December 2018. Current Hub to start delivery of routine services during 2018 with hub being fully operational towards the end of 2018. Detailed contingency and business continuity plans being developed as part of gateway 1**

Management Case

5.2 Project transition resources

The implementation of the transition activities will be carried out by a dedicated team under the above management structure and direct supervision by the BCPS Transition Team. It is expected that the resources required for the project from each Trust would be as follows (these are costs already included in the transition investment):

- Appointment of the BCPS Executive Management Team (2 posts);
- Financial: 1 person from the finance department to dedicate 1 day a week for three weeks to capture and validate data;
- Hub and ESL Layout design: Architect and consulting support;
- Operational process design: creation of operational processes and homogenization of processes across sites;
- Completion of of key SLAs and agreement: access to senior Trust staff and BCPS Transition Management team. Additional consulting and legal support.
- Development of IT and equipment plans, including support for potential procurements;
- Development of HR plans and engagement including support to HR departments: HR departments to allocate personnel to consultation process and analysis (1 or 2 people full time in total). Support for HR analysis and engagement;
- Total transition external support costs were included within the financial models.

5.3 Project phases

The project will involve a number of sequential and concurrent phases for the implementation of the Hub and ESL model. The following phases are expected to be part of the core programme and have dedicated management resources for implementation:

1 – Appointment of Executive Management Team and selection of BCPS Strategic Board members;

2 – Gateway 1 (FBC): set up to transition plan by October 2017 with detailed HR plan, detailed finance plan and construction plan (FBC);

3 – Gateway 1 (FBC): Completion of commercial agreement and finances, including clarification on route to access capital (FBC);

4 – Gateway 2: Design of Hub and ESL layouts for construction and refurbishment, including detail quotes from builders;

5 – Gateway 3: Operational processes design: design of detailed operating processes for the Hub and the ESLs;

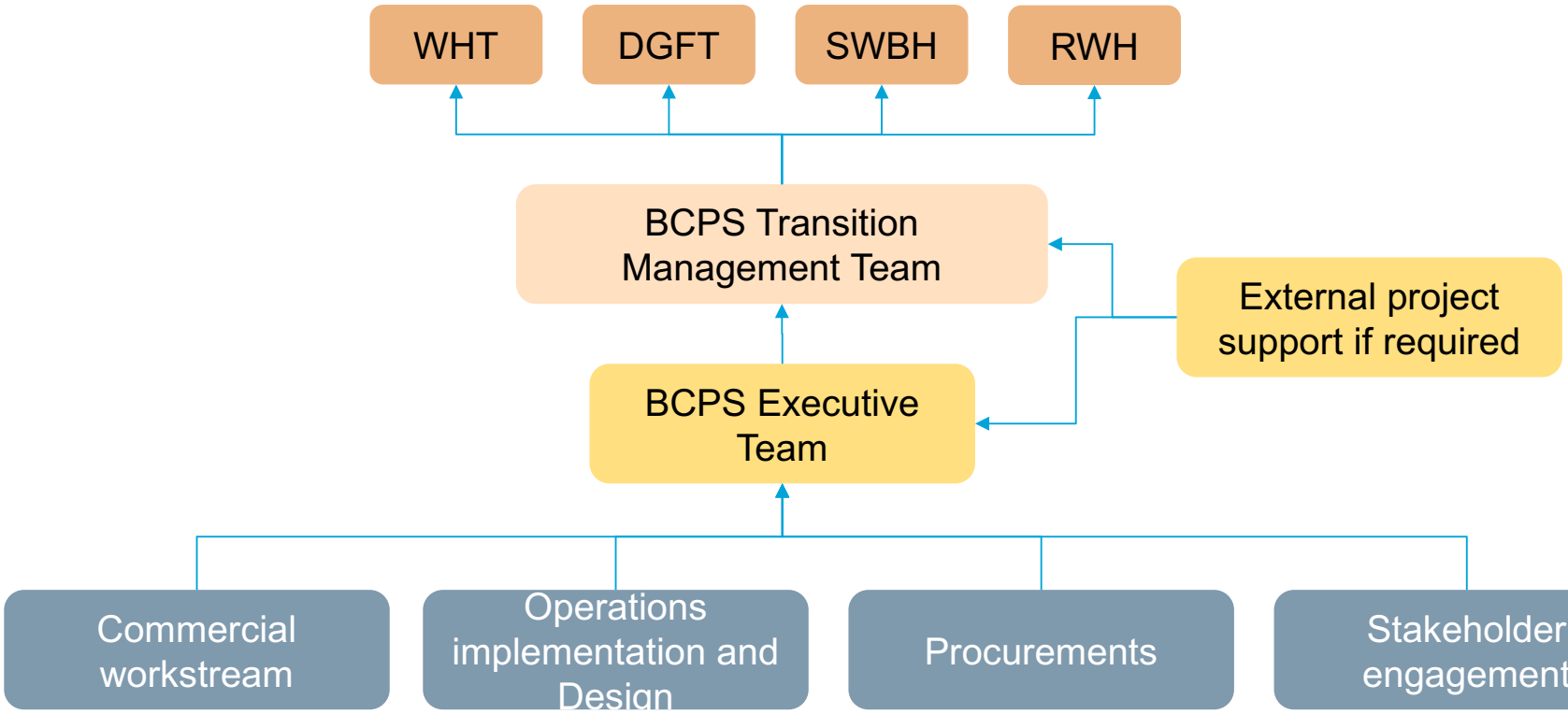
6 – Gateway 4: Procurements: Development of procurement documentation and running of procurement processes, including detailed procurement costs;

7 – Implementation of IT and Equipment;

8 –Validation of equipment, IT and transfer of services across sites: this would also include early transfer of activity where possible to achieve quick wins;

9 – Project implementation review and steady state: review of project implementation and official start of steady state.

Management Case – Transition Plan Management



- Agree governance
- Agree SLAs and KPIs
- Agree detailed pricing shareholding analysis
- Agree procurements and procurement requirements
- Identify funding

- Design facility layouts
- Design processes for Hub and ESLs
- Agree rotas and shift patterns
- Identify early wins and savings
- Develop technical requirements for procurements
- Implementation of changes

- Collect procurement information
- Equipment requirements
- Facility layouts
- IT requirements
- Manage procurement processes and negotiations

- Clinical engagement
- Technical laboratory staff engagement
- TUPE consultations
- Service user engagement
- Commissioner engagement

Management Case

5.4 Key project risks

The following table provides a summary of the key risks identified for the next stage of the project. A risk and issues register will be developed for the next phase and updated regularly for review by the BCP Steering Committee

	Description of risk(s)	Impact description	Mitigation / controls in place
1	The principles of a consolidated operating model based on arms' length governance and effective commercial partnerships are not accepted and the collaboration model continues	Lack of credibility for effective market engagement results in deferral of investments in transition, IT, equipment and logistics Staff lose confidence that genuine transformation will be delivered	OBC based on strong evidence and engagement Effective senior engagement to ensure design and delivery of governance and commercial partnerships are successful
2	Resources are not mobilised to support the workstreams and development of the TOM and associated governance and commercial arrangements. Transformation is not ring-fenced from the management of current day to day operations	Development of the TOM is high level and not bottom-up, losing credibility with technical and clinical staff Commercial agreements cannot be reached as a result of lack of key senior staff engagement	Resources identified within the Management Case. Next phase can commence immediately on approval of the OBC. Trusts to commit and nominate resources
4	Risks of legacy equipment and IT systems at each Trust aren't mitigated. Pathology and IT staff aren't engaged to review impact of current IT and equipment contracts	Loss of pathology IT service and consequent impact on hospital and GP patient services Quality and efficiency of current service compromised	Need to develop a clear understanding of current IT and equipment contracts and developed a detailed transition plan highlighting how these will be adapted to the new TOM requirements over time
5	Staff are not supportive or engaged in change	The design and implementation of the new TOM is delayed and/or compromised	Wide range of staff were engaged in the development of the target operating model Organisational Development resource to support next phase Clear and open communication with staff
6	Timeline to December 2018 is not achieved	Delay on having all services operating at the Hub by December 2018 which might impact Midlands Met hospital development	Move at pace now to commission building work and achieve timelines BCP to develop detailed contingency plan for affected services by October 2017, explore use of current facilities to accommodate specialist services and ensure business continuity

Management Case

5.5 HR Management

Management of the staffing, both in terms of legal requirements of consultation, but also in terms of staffing communication will be key. The steering group have regularly discussed staff communication, and some articles to date have been agreed and released.

In terms of the statutory requirements relating to TUPE, the HR teams have started conversations to understand and agree the route forward. This includes the collection of all policies from the Trusts around changes to staff conditions, so that a master list can be collected for formulating the consultation process.

In addition, the HR lead for Sandwell and West Birmingham has proposed the following in terms of staff support going forward, and the ongoing management of this. This is an example of the plan that all HR leads of the Trusts will be working together for Gateway review 1.

Support Programme for Pathology staff in response to proposal for 1 hub model Staff Group	Issues	Support
Medical Staff		1:1 Coaching Dealing with Change Workshop
Healthcare Scientists		1:1 Coaching Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Additional Clinical Services		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Nursing		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic
Admin and Clerical		Dealing with Change Workshop Team meetings to discuss developments and address concerns Access to HR support via monthly clinic

Appendices

Financial Modelling Assumptions

A.1

Reserved Matters will be categorised by those which need:

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
Admitting a new Owner into the new entity	Formally adopting the annual Business Plan for the new entity in respect of each Financial Year [Unanimous voting will be needed for the first 3 years of operation]
Altering the name of the new entity	Participating in any partnership or joint venture (whether incorporated or not)
Amending the Partnership Agreement or the Support Services Agreements	Entering into any contract or arrangement that is not on an arm's length basis or which is outside the ordinary course of business [Unanimous voting will be needed for the first 3 years of operation]
Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Reserved Matters will be categorised by those which need:

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
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Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Unanimous vote (all Owners)	Majority voting
Changing the nature of the Partnership's business or commencing any new business which is not ancillary or incidental to the existing business. [NB The entities business can be defined in the Joint Venture Agreement, for example: "the provision of pathology services and activities which are ancillary or incidental thereto"]	Creating or granting any Encumbrance over the whole or any part of the business, undertaking or assets of the new entity
[incurring any indebtedness or borrowings with the Owners except in accordance with the Annual Business Plan]	Making or proposing to make any material changes to the terms of employment of any employee or group of employees of the new entity which either (i) does not comply with applicable NHS policies and guidelines (e.g. Agenda for Change) or (ii) will result in the new entity exceeding its agreed staff costs budget as set out in the annual budget included within the Business Plan
[selling any significant asset or group of similar assets except in accordance with the Business Plan]	Entering into any leases or other forms of long term commitment which are material in the context of the new entity's business [except in accordance with the Business Plan]
[incurring any capital expenditure on any one item, or series of related items, which either (i) exceeds the host Trust's delegated capital expenditure cap or (ii) is not in accordance with the Business Plan and the new entity "Investment Guidance"] policy	Giving notice of termination of any arrangements, contracts or transactions which are material in the context of the new entity's business, or materially varying any such arrangements, contracts or transactions [except in accordance with the Business Plan]

Unanimous vote (all Owners)	Majority voting
Appointing or dismissing the [Chair and Managing Director of the Joint Venture], or [materially] varying the terms of employment or engagement of any such person	Instituting, settling or compromising any material legal proceedings (other than debt recovery proceedings in the ordinary course of business) instituted or threatened against the new entity or submitting to arbitration or alternative dispute resolution any dispute involving the new entity [Voting will be dependent on the legal structure. If there is any shareholding liability unanimous voting will be needed]
Disposing of the whole (or part) of the business (more than a certain value e.g. £1m pa) of the Partnership to any person	Independent assurances over financial reporting and or/ appointment of auditors
Distributing any [trading profits / surpluses] to the parent Trusts except in accordance with the agreed distribution policy set out in Partnership Agreement, or making any change to the agreed distribution policy	Working Capital Investment Limits [limits are [£X]]
	Granting any rights (by licence or otherwise) in or over any intellectual property owned or used by the new entity [scale of intellectual property is needed [£X]]
Definition of Materiality Levels	
If liability/requirement has a value of 0-3% of new entity's revenues then it will be considered non-material and the decision will rest with the Management Board	
If liability/requirement has a value of greater than 3-9% then it will be a reserved matter requiring majority voting	
If liability/requirement has a value of greater than 9% then unanimous voting will be required	

ESL Description

A.2

ESL detailed draft description

1. Biochemistry

Equipment required:

Main chemistry and immunoassay analysers

Osmometer

Blood POCT Blood gas analysers

Blood glucose/ketone meters

Tests:

Alanine Transaminase (ALT)

Albumin

Alkaline Phosphatase

[Ammonia - ideally if paediatric inpatients]

Amylase

Bilirubin (total and conjugated)

Bicarbonate

Calcium

[Chloride]

[Cortisol]

C-Reactive Protein

Creatine Kinase (CK)

Creatine Kinase (CK)

Creatinine

Digoxin

[Ethanol/Alcohol]

Gentamicin

Glucose [fluoride oxalate plasma]

Human Chorionic Gonadotrophin

Lactate Dehydrogenase (LDH)

Lithium

Magnesium

Osmolality – serum

Paracetamol

Phosphate

Salicylate

Theophylline

Total Protein

Troponin (I/T)

[Thyroid Function (free T4 & TSH)]

Urate

Urea

Desirable as high volume tests

Haematinics: Ferritin, Folate, Vitamin B12

Lipids: Cholesterol (total/HDL), Triglycerides

Carboxyhaemoglobin

Lactate

Cerebrospinal fluid (CSF)

Glucose, Total Protein

Urine

Sodium

Potassium

Urea

Creatinine

Osmolality – urine

2. Immunology services would not be required at the ESL.

3. Haematology/Blood Transfusion

FBC

Retics

PT

APTT

FIB

DD

Malaria Screen

Sickle Screen

G-6-P-D

ESR

G+S

X-match

Full provision of blood products

Kleihauer

DAT

4. Central specimen reception (small) for work sent to Hub

ESL detailed draft description

5. On-site clinics

Lipid clinics

Clinical haematology

Anticoagulation clinics

Lactose/glucose tolerance tests

Short synacthen tests

Skin prick test service

6. Other visits

Visits to support teaching & grand rounds at WHT

Visits to support service, Quality, UKAS, POCT.

Visits to support Research (ISBOS)

7. Microbiology

Blood culture analyser, plus gram and setting up sensitivities

Film array (poct to be located either in ae or bloodsciences.

8. **Frozen section facilities**

Consider Cryostat/staining facilities with ability for scanned images to be sent to Hub lab

Cryostat/staining facilities/microscope in ESL. Hub sending BMS/Path to ESL for test

Dr Deshpande raised issue of mdt's- not for an ESL

Financial data collection and excluded areas

A.3

Financial data collection and excluded areas

A financial data collection as undertaken with financial representative of the pathology departments. This financial data collection included cost, staffing, and income.

Following discussion with these individuals, the below areas were excluded from the financial data collection:

- Junior Doctors
- Phlebotomy
- Mortuary
- PoCT
- Externally funded regional trainees
- Cost of GP tubes (where a pass-through cost).

BCPS Consolidation of Services

A.4

BCPS previous experience in the consolidation of services

Background

In November 2012, The Royal Wolverhampton NHS Trust was asked to provide Black Country Single-site Gynae Cytology services from June 2013.

Cytology laboratories affected:

The Royal Wolverhampton Hospital Trust (RWT)

Walsall Healthcare NHS Trust (WHT)

The Dudley Group NHS Foundation Trust (DGFT)

Sandwell and City Hospitals NHS Trust (SCHT)

Project Structure & Reporting

An Integration Board chaired by the Director of Planning and Contracting was established, and comprised of senior decision-makers representing each organisation. Board members were charged with reporting back into existing structures within their own organisation ensuring that each organisation was engaged in the process and that local Policies and legal legislation were adhered to.

The Board was supported by various work streams covering all aspects of the new service with high level representation from the screening programme, commissioners and all Trusts including staff side representatives and unions.

A Project Manager was appointed to keep the project on track, control risks and to ensure good communication links between the work streams and the Board were maintained.

Transferring staff were kept well informed by regular feedback and in order to smooth the transition of staff into the new service a member of the RWT Human Resources Department and laboratory regularly attended each hospital to address concerns and complete the documentation required for pre-employment checks and payroll.

Post merger

Operational functioning

The service benefitted from the number of senior staff transferring into the new service this enabled the formation of smaller teams drawn from across the four organisations.

Each team included a member of RWT staff – ensuring that staff had immediate access to an experienced person from the for guidance on protocols, reporting codes, IT, workflows and the day to day working of the laboratory.

Access to, and liaison with, senior staff ensured that everyone had a named person to provide support and, from a management perspective, enabled close supervision during the transition phase.

The Cytology Manager operated an ‘open door’ policy to support staff on a range of aspects from travel, sickness policies, annual leave entitlements and work

BCPS previous experience in the consolidation of services

Access to, and liaison with, senior staff ensured that everyone had a named person to provide support and, from a management perspective, enabled close supervision during the transition phase.

The Cytology Manager operated an ‘open door’ policy to support staff on a range of aspects from travel, sickness policies, annual leave entitlements and work practices.

Senior staff were allocated areas of responsibility based on their roles at their former laboratories and they were tasked with ensuring day to day management of workflow.

As expected there was an initial minimal drop in KPI’s for the first 6 months mostly due to the requirement to honour existing staff leave commitments. This compares favourably with other cytology integrations where KPI’s generally fall off for around 2 years. KPI’s quickly recovered and the laboratory has since been able to support other organisations with their activity.

Challenges

TUPE regulations dictated that communications with affected staff should happen via their Trade Union Representatives, practically, this led to some staff feeling that the host trust were avoiding issues and being secretive. In order to allay this concern a Monthly Project Update was issued after each Integration Board; this was cascaded via board members to relevant staff. The lab held several open days for staff to have the opportunity to visit the department and ask questions.

For the host trust, uncertainty (due to TUPE regulations) around the number of staff transferring to the service until two weeks before ‘go-live’ meant that there was a potential to over provide accommodation.

There were no pre-existing IT interfaces between each of the four organisations; the development of which enabled the host to access patient histories and suggest appropriate patient management according to NHSCSP guidance.

Where are we now?

There was an expected minimal dip in meeting Turnaround Times during the first 6 months following integration due to the requirement to honour pre-existing annual leave bookings. Since this period RWT cytology has continually been in the top 10% of areas in the National performance tables (consistently achieving the 14 day TAT) and has achieved good results in CPA, UKAS and local QA visits. No patient result or management of was adversely affected.

Summary

By adopting a structured approach to the integration, and employing dedicated project management support, the move to a single-site Black Country Gynae Cytology service was achieved with no down-time, no staff turnover, minimal short term increase in turnaround times, (achieving commissioners’ targets by December 2013) and with no reduction in the quality of the service provided.

Positive feedback has been received from numerous GP practices and local colposcopy units - we have exceeded their expectations and allayed their concerns.

Quality and Performance Standards

A.5

Current Quality standards and KPIs

The following is a summary of the KPIs currently recorded by Trust. Full files are available with a full disclosure of KPIs at test level and discipline level.

June 2017

May Data - rolling 12 month

Directorates	Head Count	CPA	TOTAL KPI TATs %	Mandatory Training %*	PDR %	Sickness\ Absence %	Overall status (1-9)
BIOCHEMISTRY DEPARTMENT	(123)		83 ↑	90 ↑	92 ↑	5 ↑	8 ↑
HAEMATOLOGY DEPARTMENT	(56)		89 ↓	89 ↓	98 ↓	3 ↑	6 ↓
HISTOPATHOLOGY	(35)		74 ↓	93 ↓	91 ↓	4 ↑	7 ↔
IMMUNOLOGY DEPARTMENT	(26)		96 ↓	99 ↓	92 ↓	3 ↓	4 ↔
MICROBIOLOGY	(60)		86 ↓	91 ↑	92 ↑	3 ↑	6
GROUP MANAGEMENT/GENERAL	(7)			94 ↑	86 ↓	4 ↑	7
PHLEBOTOMY	(47)			86 ↑	94 ↓	in group ↑	7

↑ Improving ↔ No change ↓declining

Pathology KPIs	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17
AE Turnaround Targets(%)	90	90	91	92	92	92
Request Intervention Req	2100	2621	2506	2297	2560	2969
Never Events(Blood Trans, Mortuary)	0	0	0	0	0	0
MEDIAN GP courier transport Turnaround(mins)	240	222	241	250	237	258
Potassium affect(%)		6.4	5.4	5.9	5.5	4.5
6 week Waits (all test\investigations)	0	29	23	20	42	44

Discipline	Test Name	Location	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Chemistry	Albumin	ED	97%	97%	96%	91%	94%
Chemistry	Alkaline Phosphatase	ED	96%	96%	96%	90%	92%
Chemistry	ALT	ED	95%	96%	96%	92%	93%
Chemistry	Calcium	ED	95%	96%	96%	85%	92%
Chemistry	Creatinine	ED	96%	96%	95%	92%	92%
Chemistry	Potassium	ED	96%	97%	96%	93%	93%
Chemistry	Sodium	ED	96%	97%	96%	93%	93%
Chemistry	Total Bilirubin	ED	96%	96%	96%	92%	93%
Chemistry	Total Protein	ED	96%	96%	96%	92%	93%
Chemistry	Troponin I	ED	90%	86%	89%	76%	88%
Chemistry	Urea	ED	96%	96%	96%	92%	93%
Haematology	Full Blood Count	ED	95%	97%	96%	96%	95%
Haematology	D-Dimers	ED	84%	82%	83%	69%	78%

Clinical Support Services -PATHOLOGY		Baseline ()	Traj.	Quarter One (April-June)		
Governance				APRIL	MAY	JUNE
Pathology Services Group meeting		Monthly	Green Compliant,red non compliant			
Number of Formal Complaints				0	0	0
Number of Grade 4/5 Clinical Incidents				0	0	0
Number of Grade 1-3 Clinical Incidents				11	21	55
Near Misses				2	4	8
Number of SUI				0	0	0
Outstanding documents on Ipassport			Green Compliant,red non compliant			
Blood Sciences		85%			86%	56.70%
Histopathology		85%				87%
Microbiology		85%				91%
Accreditation status/Inspection bodies		Monthly	Green Compliant, amber awaiting report, red non compliant			
Blood Sciences CPA		Accredited	Accredited			
Histopathology CPA		Accredited	Accredited			
Microbiology CPA		Accredited	Accredited			
Blood Sciences UKAS ISO15189		Accredited	Accredited			
Histopathology UKAS ISO15189		Accredited	Accredited			
Microbiology UKAS ISO15189		Accredited	Accredited			
HTA license		License granted	License granted			
MHRA assessment		Current				
Turnaround Performance						
A/E (90% within 1 hour)		Target 90% within 60 Minutes. Green 90% and above, Amber 85-89%, Red below 85%				
FBC	Local target set more challenging than KPI			99	98.9	98.9
U&E				95.7	94.8	96.2
Troponin				89.3	89.6	92.4
INR				95.3	94.5	95.1
LFT				96	95.8	96.9
Inpatient	(90% within 2 hours)	Target 90% within 120 mins. Green 90%and over, Amber 85-89%, Red below 85%				
FBC				95.4	98.9	99.3
U&E				92.8	92.2	95.1
Troponin				94.7	95.6	96.9
INR				99.1	99.5	99.5
LFT				93.8	93	94.8
Histopathology						
% of all Histology reported in 7 calender days		80%	Green compliant, Red non compliant	47%	59%	55%
% of all Histology reported in 10 calender days		90%		72%	71%	74%
% of all Histology reported in 14 days		95%		86%	90%	91%
Number of cases reported after 20 days				70	43	57
Non-Gynae	80% within 7 days			88%	92%	77%
Non-Gynae	90% within 10 days			97%	96%	92%
Non-Gynae	95% within 14 days			100%		
Andrology	80% within 7 days			92%	96%	91%
Andrology	90% within 10 days			95%	96%	91%
Andrology	95% within 14 days			100%	100%	93%
No. of pregnancy remains stored for greater than 3 months		None to be stored for greater than 3 months	Green compliant, Red non compliant	0	0	0%
No. of products cremated before 1 month		None to be cremated within a month	Green compliant, Red non compliant	0%	0	0
No. of cadaver stored more than 4 weeks		None to be stored greater than 4 weeks	Green compliant, Red non compliant	1	3	3
Routine antenatal screening tests for HepB, HIV		90%	Local KPI			
Late presentation antenatal screening tests		97%				
Blood Culture contamination rates				2.88%	4.31%	3.36%
Chlamydia (molecular)		100% @10 days		100.00%	100.00%	100.00%
GC culture		100% @10 days		100.00%	100.00%	100.00%
GC (molecular)		100% @10 days		100.00%	100.00%	100.00%
Genital micros & Culture		100% @10 days		100.00%	100.00%	100.00%
Screening Programme KPI	Green KPI Met, Amber KPI parially met, Red immediate action required					
Chmalydia screening programme						
All Result Available Within 2 days				76.64%	92.95%	77.22
Positive Result Available Within 7 days				100.00%	100.00%	100%
Negative Result Available Within 7 days				100.00%	100.00%	100%
Negative Result Available Within 10 days				100.00%	100.00%	100%
Result reported as Invalid				0.33%	0.43%	0.70%
Results Reported as Equivocal				0.00%	0.00%	0.00%
Samples Not Processed (Zapped)				0.33%	0.00%	0.35%
Pathology managed aappointments						
LTT wait for appoitnment		<6 weeks is green, over 6 weeks red				
SST wait for appoitmn		<6 weeks is green, over 6 weeks red				
Skin prick test		<6 weeks is green, over 6 weeks red				

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 3 August 2017

TITLE:	**25 July 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES
SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:
The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee, specifically :- .

- that the Committee has endorsed the Trust's updated Clinical Strategy which is being presented to the Board as separate item for formal approval; and
- that the Committee has endorsed the Executive Management's decision to undertake the duty of candour conversation earlier in the SI process, namely at the point the Trust executive conclude the SI report rather than when the CCG close the RCA investigation.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	25 July 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The outcomes of the continued weekly audits on compliance with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements were received by the Committee. Whilst there had been an improvement in the latest results there remained insufficient assurance to change the frequency to quarterly audits. The Committee endorsed the proposed actions by management to expand the audit to include the Trust's community activity within future audits.
- Executive Management assurance was provided on the quality aspects of the Trust's performance in respect of key quality indicators. The Committee noted that there had been improvement within the friends and family response rates and recommended scores for all areas except outpatients recommended scores and maternity footfall (response rate for the month). The Committee asked that within future reports where a lower friends and family recommended score was achieved that the report includes information on identified themes from that months feedback with details of actions taken as a result. The Committee was updated on the proposed actions being taken to enhance the future performance reporting to the Committee that allow a broader understanding of quality performance.
- The Committee was informed that the Trust had had one grade 4 pressure ulcer and one further under investigation. The Committee were reminded that the Trust had set zero tolerance target for these. A report will be brought back on the changes brought about as a result of the RCAs on these incidents.
- The Clinical Chief Information Officer provided an update on the Digital Trust project including details of the individual digital projects underway. The Committee requested that the Trust executive work with the Clinical Chief Information Officer on ensuring a robust process is put in place for the delivery of "Point of Care testing" when delivered by agency staff.
- The serious incident report documented the Trust's continued focus on learning and improvement, supported by a separate quarterly report on learning which is shared with the CCG as part of our contractual requirement and internally with our staff to promote learning. The report provided assurance that the Trust has

complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) within two days. However, on conducting and closing 5 Pressure Ulcer SIs the two day reporting date was found to have been failed. The Trust did not close 4 investigations within the 60 day timescale this month, three relating to Pressure Ulcers and 1 relating to Falls all 4 were due to the lead managers requiring more information to be included within the RCA prior to submission. The monthly report showed that the number of incident investigations being closed by the CCG with either no questions or just one set of queries achieved the 100% target set by the Trust, but noted the numbers closed by the CCG were low this month. The number of actions not being implemented in line with the agreed RCA action plans timescales has risen slightly this month to 5 (from the 4 last month). The Serious Incident report also provided assurance regarding the Trust's engagement with families when a serious incident occurs through the reporting of the Trust's compliance with the duty of candour.

- The Committee received an update on the Trust's performance for the first quarter of 2017/18 in respect of its quality priorities. Performance had improved across all the set priorities in the first quarter but for two, MUST and Medications. The performance is below the 95% target for each indicator at 91% and 94% respectively.
- The Committee received the update in respect of medicines management and agreed the establishment of a Medicines Management sub group reporting to this Committee to be chaired by the Chief Executive to provide a focus on issues where processes are to be improved. The Committee also endorsed the Chief Executive's request that the respective divisions take action ahead of the meeting of the group on the issues of medicines security raised by the pharmacy audits recorded within this report.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of both estates and facilities. The Committee received a further update on a Never Event and the actions taken by the Trust as a result. The report also identified that work was progressing within the area of the Trust's asset register.
- The Committee received a report in respect of the End Of Life cross economy group and the work being undertaken by the Trust to ensure a successful implementation of the economy wide end of life strategy which is to be launched in February 2018.
- The Committee received a report from the Quality and Safety Group Chair, the Chief Nurse, as requested at the last meeting. The Committee was updated on the issues the Group were focusing on including the level of infection prevention and control training taking place across the Trust and the follow up of incidents in relation to transfusions. The Group Chair had also engaged with the medics to ensure that there is better attendance from medical representation from each of the divisions. To facilitate this, the group has changed the day and time it meets.
- The Committee received a report in respect of the activity of the Internal Safeguarding Board. The Committee was updated as to the actions being taken in respect of the issue of compliance with safeguarding training. The Committee was updated as to the Trust accessing offered support from NHS I in this area which would only serve to strengthen Trust processes.

- The Committee received a report on the recent Inpatient Survey Report which showed that the Trust had not improved its position. The newly appointed Interim Patient Experience Manager is taking the lead with the Chief Nurse on developing specific actions to progress improvements based on the feedback from this and other surveys. Information on progress against these actions will come back to this Committee via the Patient Experience sub group.
- Operational Divisional Management and Operational Clinical assurance was provided in respect of the actions taken to address ophthalmology delays and noted the extra resources to address these delays by November 2017. This was in accordance with the request made at the last meeting to receive more detail at the July meeting

Decisions Made/Items Approved

- The Committee endorsed the Executive Management's decision to undertake the duty of candour conversation at the point the Trust Executive conclude a SI report rather than when the CCG close the RCA investigation.
- The Committee supported the closure of 14 Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee approved 1 policy, noting that this policy will also be considered by the Audit Committee at its meeting in August.
- The Committee agreed to recommend to the Board the Trust's revised clinical strategy.
- The Committee agreed to the establishment of a Medicines Management sub group reporting to this Committee to be chaired by the Chief Executive.
- The Committee received an update from the Vascular Clinical Services Lead, on the proposed actions in respect of a recent Getting it Right First Time external review of the Trust's vascular services.
- The Committee agreed that the draft Learning from Deaths Policy should be adopted and that work should commence on the reporting of this information to future Board meetings.
- The Committee asked that one corporate risk be considered by the executive team for inclusion on the corporate risk register linked to safeguarding training and that one divisional risk be considered by the Support Services Division for inclusion on their risk register linked to pharmacy resources.
- To endorse the QIB final report going to the Board in September.

Actions to come back to Committee (items the Committee is keeping an eye on)

- The Committee requested more information on the assessment of the quality aspects where a VTE assessment has not been undertaken given the Trust's performance is below the target set for this performance measure.

- The update via the Patient Experience group in respect to the actions being taken as a result of patient feedback within national surveys.
- A report on the learning from the RCAs undertaken in respect of the grade 4 pressure ulcer.

Items referred to the Board for decision or action

The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee, specifically :- .

- that the Committee has endorsed the Trust's updated Clinical Strategy which is being presented to the Board as separate item for formal approval; and
- that the Committee has endorsed the Executive Management's decision to undertake the duty of candour conversation earlier in the SI process, namely at the point the Trust executive conclude the SI report rather than when the CCG close the RCA investigation.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors August 2017 - PUBLIC

TITLE:	Infection Prevention and Control Forum		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:
SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

For the month of July (as at 25.7.17)

- As of this date the Trust has had 9 cases of post 48 hr C. difficile so far in 2017/18 and 4 cases for July 2017.
- TB incident – This has been closed.
- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- There have been 4 MSSA bacteraemia identified in the Trust of which none are post 48 hr cases.
- There have been 16 E. coli bacteraemia identified in the Trust of which 3 are post 48 hr cases.
- No Norovirus episodes.

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe and effective care
	Monitor	**Yes**	**Details:** MRSA and C. difficile targets
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD:
To receive the report and note the contents.

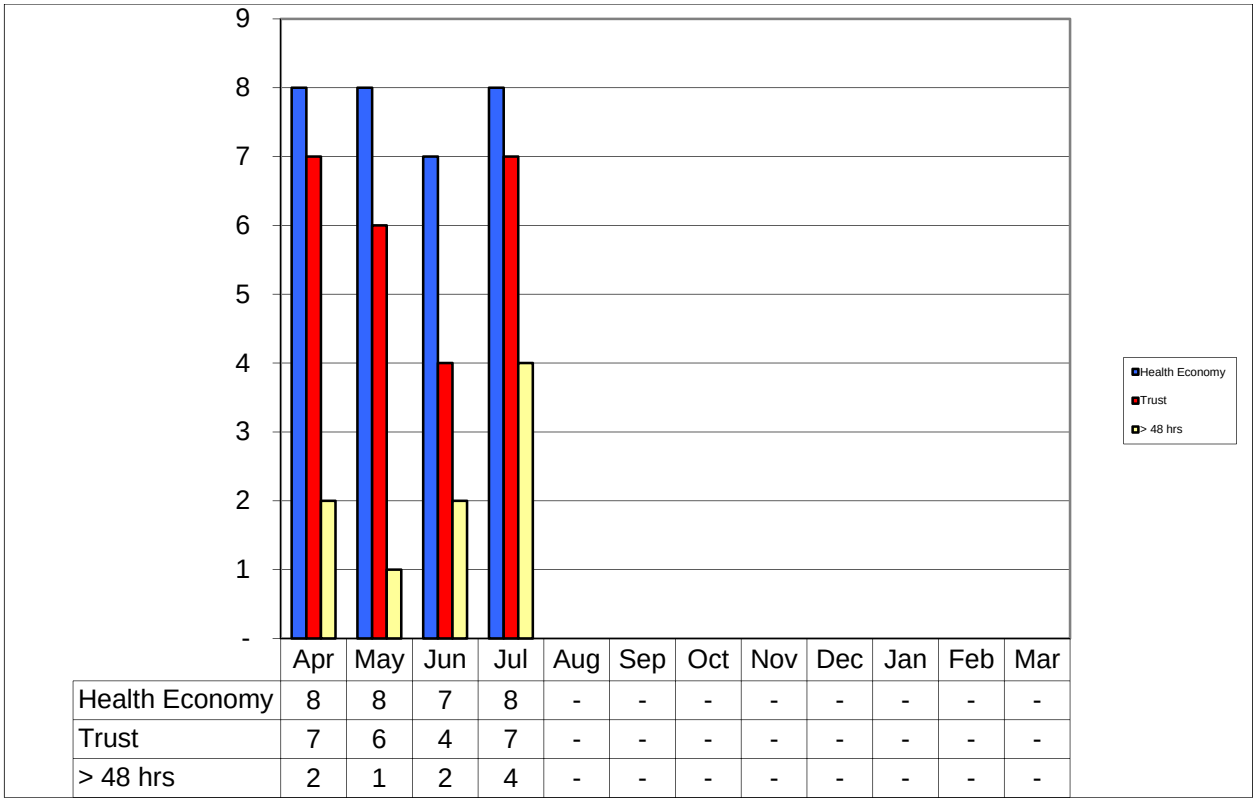
Clostridium Difficile – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (25.7.17) we have had 4 post 48 hour cases recorded in July 2017.

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues.

For the financial period 2017/18 there has so far been 9 post 48 hour case identified since 1st April 2017. There are 4 cases for July 2017 to date. Of these 9 cases 4 are lapses in care and the remaining 5 are under review. Of the 4 apportioned cases the lapses in care associated are: failure by areas to meet their mandatory IC training targets, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

There is a Trustwide C. difficile action plan in place to address issues identified by the RCA process as well as local plans for each individual case. Progress against the plan is recorded at the Infection Prevention Forum.

C. DIFFICILE CASES 2017/18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	8	7	8	-	-	-	-	-	-	-	-
Trust	7	6	4	7	-	-	-	-	-	-	-	-
> 48 hrs	2	1	2	4	-	-	-	-	-	-	-	-

TB Incident – The investigation into this has been completed and is now closed.

MRSA bacteraemia (Post 48 hrs) – There have been 0 post 48 hour MRSA bacteraemia cases since 27th September 2015.

MSSA bacteraemia (Post 48 hrs) – No post 48 hr cases for July to date.

MRSA screening – The Trust screens emergency admissions as well as appropriate elective surgical cases. The percentage of emergency admissions for June is 92.8% (last complete set of data available).

The percentage of elective admissions for June is 88.9%. Areas for improvement have been identified and work to improve figures ongoing. Although we are aware that some of the data included some patients who do not require screening. Further work is required to provide more reliable data.

E. Coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. There are 3 post 48 hr cases for July to date and enhanced surveillance is being undertaken on those cases.

Neonatal Unit – Staffing review is ongoing and is part of a large piece of work. There is progress with the hand basin element as well as the trolleys are now ordered.

Infection Control Mandatory Training – Percentage compliance as at 30.6.17 (target 90%).

Area	Clinical	Non Clinical
Corporate/Management	83%	94%
Medicine and Integrated Care	87%	92%
Surgery	88%	93.7%

There is work on going to address the Infection Control Mandatory training to ensure ward areas meet their target within a short time frame. Currently there are 2 face to face sessions available per month for ward staff, e learning is available at all times and the Infection Control Team proactively approaches wards to arrange local training.

IC Related Policies – *Cleaning Policy* – this is currently out for review.

Environment and Hand Hygiene – ICT will be working with the Trust's PFI partner to implement the revised Cleaning Policy when finalised and is currently working with Trust's Health and Safety Manager and Interserve to source and provide a comprehensive range of hand care products for all staff.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation, Public Health England.

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd August 2017

TITLE:	Monthly Nurse/Midwife Staffing Position – August 2017 report containing June 2017 data		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience
SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

The attached paper contains the actual and planned hours for qualified and unqualified staff for both day and night shifts for each area of the hospital. The fill rates and the Care Hours per Patient Day (CHPPD) are also tabled. It can be seen that in general the fill rates are generally close to but less that one hundred percent of the current establishment and there has been some improvement in these figures from January.

With regards to the staffing review:

- Phase 1 covering the Surgical Wards is now complete. The proposed increase in staffing has been discussed at the Finance and Performance Committee in July.
- Phase 2 covering Paediatrics and the Neonatal Unit is now awaiting review by the Executive Team.
- Phase 3 covering the Medical Wards is part completed.
- Phase 4 will consist of the other areas within the hospital.
- Phase 5 the Community.

Following the completion of Phase 1 the Chief Nurse and the Human Resources Director have drawn up an implementation plan to ensure effective recruitment and retention in order to have a substantive workforce providing high quality patient care.

IMPLICATIONS OF PAPER:			
RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	N	**Details**:
	Monitor	Y	**Details:**
	Other	Y	**Details**: Internal Audit

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data and the position with the ongoing staffing review.

Monthly Nurse/Midwife Staffing Position

August 2017 Report containing June 2017 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for June 2017 (Wards that have been fully or partially closed in the month are omitted). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

The report shows that the overall fill rates for the Trust are nearly 100% but this has been achieved by using the present establishments and a significant reliance on temporary staff (bank and agency). A number of factors make it unlikely that a full fill rate will always be achieved although this is the aim. These factors include long term issues such as vacancies, short term issues such as sickness and maternity leave, the unavailability of temporary staff and unexpected numbers of patients requiring enhanced care.

It can be seen that for individual wards the fill rates vary although in the main they are close to 100%. On occasion, the fill rate is over 100%. C2, the paediatric ward, is a particular exception with regards to this as the planned hours are derived from the RCN dependency tool. Each shift the planned hours are determined by the acuity of the children on the ward. Sometimes there are occasions when the fill rate of unqualified staff goes above 100%. This occurs when it is recognised that there will be a reduction in qualified staff.

The chart below shows that the percentage fill rates have been improving over the year.

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	**Unqualified Day**	**Qualified Night**	**Unqualified Night**
Jan	94%	96%	94%	99%
Feb	93%	95%	96%	99%
Mar	95%	97%	97%	100%
Apr	97%	96%	98%	98%
May	97%	97%	99%	98%
June	96%	96%	98%	99%

With regards to the CHPPD, as has been explained in previous reports this is a new indicator that can be used to benchmark the Trust.

Table 2. Care Hours Per Patient Day (CHPPD) – Overall Trust Regional Comparators

2017 Month	TRUST Nurse & Midwife	Midlands & East Median	National Median	TRUST Care Support Workers	Midlands & East Median	National Median	TRUST Total number	Midlands & East Median	National Median
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	4.8	4.8	3.73	3.1	3.1	8.28	7.8	7.9
May	4.38	N/A	N/A	3.83	N/A	N/A	8.22	N/A	N/A
June	4.36	N/A	N/A	3.58	N/A	N/A	7.95	N/A	N/A

N/A = Data not yet available (Please note April Regional/National data is new for this report)

The recently published regional and national average figures for April indicate that the Trust is below these averages for qualified staff but higher for care support workers.

As part of the staffing review being undertaken the comparative data in the Model Hospital has been considered. The examples below are for surgery as the review has just been completed for these wards.

Table 3. Care Hours Per Patient Day (CHPPD) for Surgery – Trust and Regional and National Medians

Speciality/ Staffing Type					
T AND O	**B1**	**B2H**	**B2T**	**Peer Median**	**National Median**
Total	***6.62***	7.81	7.13	6.68	7.3
Registered	3.94	***2.78***	***2.65***	3.54	3.8
HCSW	***2.68***	4.84	4.48	3.08	3.34
SURGERY	**B3**	**B4**	**B5**	**Peer Median**	**National Median**
Total	***6.94***	***6.19***	***5.47***	6.95	7.4
Registered	***3.35***	***2.83***	***3.49***	3.95	4.44
HCSW	3.6	3.36	***1.98***	2.86	2.95
UROLOGY	**C6**			**Peer Median**	**National Median**
Total	***6.15***			6.47	7.06
Registered	***3.35***			3.62	4.18
HCSW	2.81			2.81	2.81

(Peer Median is for NHSI Region) (These figures from April 2017 are the latest available)

It has to be stressed that these figures need to be interpreted with caution. For instance, the Model Hospital has only a single median figure for both paediatrics and neonates and one would expect these to be different based on the different nature of a specialist unit compared to a general paediatric ward. Also, with regards to trauma and orthopaedics the median figures are for all of these wards, the majority of which will be general T&O wards like B1

while comparing these median figures is less applicable to, say, B2 hip suite a specialised area having many elderly and patients with dementia.

All Trust figures that are less than both the peer and national median have been put into bold and italics and it can be seen that the majority of the qualified staffing (6 out of 7 areas) and many of the total staffing figures (5 out of 7 areas) are less than both medians. This is confirmed by the review's findings, which has shown staff to patient ratios less than national standards.

The Trust is just starting to use this comparative data and this will continue and become more refined as time progresses. A visit from NHSI specialists on both nurse staffing and this data is being arranged.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate and there is a continued commitment to do so. Benchmarking the Trust workforce data using the CHPPD is informative and will continue.

The staffing review which commenced in May is using data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review is structured discussions with senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It is also considering the outcome of the most recent six monthly Safer Nursing Tool exercise. The outcome of the five phases of the review (1.Surgery, 2. Neonates and Paediatrics, 3. Medicine, 4. Rest of the Hospital, 5.Community) will be reported, as agreed, to the Board of Directors as each phase is completed. The first phase outcome is being discussed at the Finance and Performance Committee in July and at the Board of Directors in August.

APPENDIX 1

Safer Staffing Summary **Jun** Days in Month 30

Ward	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Actual CHPPD Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	240	234	210	201	150	147	180	180	98%	96%	98%	100%	1,052	4.35	4.35	8.69
A3																
A4																
B1	108	104	63	60	64	64	58	56	96%	95%	100%	97%	499	3.82	2.79	6.61
B2(H)	120	116	215	197	90	88	190	182	96%	92%	98%	96%	854	2.86	5.33	8.19
B2(T)	90	90	169	160	60	60	141	138	100%	95%	100%	98%	665	2.64	5.38	8.02
B3	190	183	169	161	157	154	140	132	96%	95%	98%	94%	961	4.11	3.58	7.68
B4	180	174	222	200	150	144	169	162	97%	90%	96%	96%	1,269	2.94	3.42	6.36
B5	180	177	120	120	150	151	90	90	98%	100%	101%	100%	988	3.89	2.55	6.45
B6																
C1	180	165	314	285	150	143	199	188	92%	91%	95%	94%	1,385	2.67	4.10	6.77
C2	196	213	74	76	161	178	41	49	109%	103%	111%	120%	739	6.21	1.82	8.03
C3	184	181	390	370	163	160	393	391	98%	95%	98%	99%	1,524	2.68	5.99	8.67
C4	150	136	61	62	90	86	90	84	91%	102%	96%	93%	629	4.13	2.79	6.91
C5	180	157	240	250	150	130	179	190	87%	104%	87%	106%	1,392	2.36	3.79	6.15
C6	90	90	61	60	60	61	60	59	100%	98%	102%	98%	459	3.85	3.11	6.96
C7	180	176	131	133	120	117	132	135	98%	102%	98%	102%	1,067	3.21	3.01	6.23
C8	197	189	239	238	180	174	249	250	96%	100%	97%	100%	2,465	1.69	2.33	4.02
CCU_PCCU	210	171	41	40	150	146	2	5	81%	98%	97%	250%	688	5.52	0.78	6.31
Critical Care	320	320	59	54	318	317	-	-	100%	92%	100%		317	23.61	1.87	25.48
EAU	180	175	150	146	150	150	150	145	97%	97%	100%	97%	633	6.02	5.52	11.54
Maternity	532	523	210	204	510	498	150	145	98%	97%	98%	97%	525	19.35	7.78	27.14
MHDU	110	102	33	33	110	103	4	4	93%	98%	94%	100%	179	13.74	2.32	16.07
NNU	203	181	-	-	190	178	-	-	89%		94%		438	9.63	0.00	9.63
TOTAL	**4,019**	**3,855**	**3,171**	**3,049**	**3,323**	**3,249**	**2,617**	**2,585**	**96%**	**96%**	**98%**	**99%**	**18,728**	**4.36**	**3.58**	**7.95**

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 3 August 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary reports from the Finance and Performance Committee meeting held on 27 July 2017.

RISKS	**Risk Register**	**Risk Score Y**	**Details:** Risk to achievement of the overall financial target for the year
COMPLIANCE	**CQC**	**Y**	**Details:** CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.
	NHSLA	**N**	
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report.

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**27 July 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- The steps being taken to ensure the Trust is complaint with the new 38 Day Cancer target
- The level of information about the Trust included in the Model Hospital dashboard is being regularly reviewed to identify saving opportunities
- The Transformation Plan is forecast to deliver £12.7m at the year-end compared to the plan of £12.5, and that additional schemes are being developed to accommodate any shortfall in schemes
- The potential loss of £190,789 on CQUIN schemes was identified in 2017-18 from a total potential of £6.17m
- The Month 3 income and expenditure position was on plan and hence the STF funding for Q1 would be payable by NHS Improvement
- The cash position continues to be strong although there are a number of outstanding debts which are being pursued
- Further discussions to be undertaken with Summit Healthcare (Dudley) Limited regarding the current performance of the PFI contract
- The majority of the risks on the corporate risk register that related to the Finance & Performance Committee had been discussed at the meeting

Decisions Made / Items Approved

- None

Actions to come back to Committee

- The forecast out-turn for 2017-18 to be reviewed in more detail and reported back to the August 2017 committee meeting

Performance Issues to be referred into Executive Performance Management Process

- Review of all specialities to ensure there are no further backlog issues because of shortcomings in the partial boking outpatient process

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- All risks noted in agenda item

Items referred to the Board for decision or action

- Recommendation for approval of the increase in the establishment of the surgical nursing rotas, subject to the conditions identified in the paper to avoid additional agency costs
- To note the risks to the 2017-18 financial fore-cast out-turn and the steps being taken to alleviate
- To note the comparative information about the Trust's performance in the Model Hospital tool

Enclosure 10

The Dudley Group NHS Foundation Trust

Board of Directors on 3 August 2017

TITLE:	**Key Performance Targets Report for Month 03 (Jun) 2017/18**		
AUTHOR:	**Andy Troth** **Head of Informatics**	**PRESENTER**	**Paul Bytheway** **Chief Operating Officer**

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

SUMMARY OF KEY ISSUES:

A&E target

Was not achieved with performance in June of 93.5**%** for combined Type 1 and Type 3 activity but this was up from 92% in May. The Trust's ED department was 90.0% up from 86.6%. An improvement programme has commenced this work has identified areas of improvement to support improved length of stay, reduce bed occupancy and alternative pathways.

Cancer 62 day

The **provisional** performance figures for Cancer 62 day wait for June is 78.1% as at 19th July. While continuous validation will continue it is not expected that June will be achieved therefore Q1 will not achieve the target. The Weekly Cancer Performance meeting continues to meet and the main concern continues to be length of time for Histopathology review, along with high number of tertiary treatments being undertaken. A comparison of performance by tumour site is included in the backing pages of the report.

Referral to Treatment (18 week)

Incomplete pathways was achieved in June with a performance of 95% against a target of 92%, although performance in several specialities fell below the expected performance

Urology(90.98%) – slight improvement from last month
Ophthalmology (87.8%) – slight improvement from last month
Neurology (90.27%) – slight improvement from last month

The non-admitted measure of 95% was not achieved based on a provisional figure of 93.1%. The admitted measure was below its target of 90% at a provisional figure of 88.6%.

DM01 Diagnostic Performance

Was not achieved for June with a performance of 96.9% against a target of 99%, up from 94.3% in May. An improvement trajectory has been provided to Exec Team that does not show delivery until September, a formal weekly performance meeting has commenced with the Chief Operating Officer. The trajectory is included in the main report.

C.Diff cases

2 in month.

Mixed sex accommodation

0 breaches in month.

Never Event.

There was 1 never event recorded for June.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description**: High levels of activity could impact on the delivery of KPIs – particularly the emergency access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations**.**
	Risk Register: Y		**Risk Score: 20 (COR 079)**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of licence
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE COMMITTEE

To note the contents of the report and approve

Report of Chief Operating Officer
to the Board of Directors

Key Performance Targets Report for Month 03 (Jun) 2017/18

1. Introduction

This paper aims to present to the Committee performance against key areas, highlighting good performance and identifying areas of exception, together with the actions in place to address them.

2. Key Issues

a) A&E 4 hour wait – Page 4

The combined Trust and UCC performance was below target in June 2017 at **93.52**%. Whilst, the Trust only (Type 1) performance was **90.02**%

The split between the type 1 and 3 activity for June was:

	Attendances	Breaches	Performance
A&E Dept. Type 1	8902	888	**90.02**%
UCC Type 3	4810	0	**100.00%**

We saw an improved position within the Emergency Access Standard for the latter half of May and this has continued into June, activity continues to be high, but there were around 150 less Major's arrivals in June than in May. Both inpatient divisions have a work stream that is aiming to sustain improvement through LoS reduction and improved access to alternative pathways. This was has allowed the Trust to close its winter ward.

b) Cancer Waits

The Committee is reminded that due to the time required to validate individual pathways, the cancer waiting times in this report are **provisional only**. In addition, the reporting of patients breaching 104 days is provided 1 month retrospectively.

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for June at 78.1% as at 19th July. Continual validation is underway before the final figure is submitted.

Cancer - 104 days - Number of people who have breached beyond 104 days (May)

No. of Patients treated on or over 104 days (DGFT)	1
No. of Patients treated on or over 104 days (Tertiary Centre)	7
No. of Patients treated on or over 104 days (Combined)	8

c) Referral To Treatment (RTT)

NOTE: Bringing the extraction of data forward in month to achieve reporting deadlines means that the figures for the month are **provisional**.

The performance of the key target RTT Incomplete Waiting Time indicator remained strong, with performance of 95% in June against a target of 92%, an increase in performance from 94.7% in May. General Surgery returned to achieving target at 93.17%. Urology have not met the target in June at 90.98%, up slightly from 89.4% in May. Ophthalmology are at 87.8%, slightly up and Neurology at 90.3%, slightly up.

The Division has an assurance plan in place with a trajectory for Neurology to recover the position by the end of July 2017, which was achieved in the first week of July and Ophthalmology by January 2018. Urology plans to hit the 92% incomplete target by end of September 2017. This will require the Directorate to closely monitor the complex Mr Anderson work, but also consistently reduce the amount of 'non-Anderson' breaches to fewer than five each month. The Directorate has also identified a number of key actions which includes liaising with the CCG and optimising the pre-operative process to prevent short notice cancellations.

The admitted pathways figure was below target at 88.6% (90%), a decrease on the previous month. Non-admitted was at 93.1% below its target of 95%, a decrease on the previous month.

There were no 52-week Non-admitted Waiting Time breaches in June.

d) Diagnostic waits

The diagnostic wait target was not achieved in June with a performance of 96.9%. This was an Improvement from the May position of 94.3%. The number of patients waiting over 6 weeks has fallen significantly from the previous month, 429 to 231.

Of the 231, Non-obstetric Ultrasound accounted for 129, MRI 75, and CT 27.

A diagnostic trajectory plan has been that supports improved performance over the next months as outlined below, Junes significant deterioration has been as a result of the CT Scanner being unavailable for 7 days, coupled with increased referrals in USS. As you can see from Figure 1 the plan has identified a number of additional slots available through increased workforce and the delivery of a mobile CT Scanner that was planned as part of the Guest Diagnostic Centre project.

	Jun Actual	Jul Forecast	Aug Forecast	Sep Forecast
MRI Breaches	75	48	40	28
MRI Extra Capacity		6	6	6
CT Breaches	27	36	15	5
CT Extra Capacity		180	180	180
US Breaches	129	125	100	35
US Extra Capacity		120	345	345
Others	0	5	5	5
Total Breaches	231	214	160	73
Total Activity (denominator)	7380	7500	7500	7500
DM01 %	96.87%	97.14%	97.86%	99.02%

e) HCAI

Total No. of C. Diff cases identified after 48hrs for June was 2. (5ytd.)

	June	YTD
Total No. of cases due to lapses in care	N/A	2
Total No. of cases NOT due to lapses in care	N/A	N/A
No. of cases currently under review	3	N/A
Total No. of cases ytd.	N/A	5

There were 0 post 48 hour MRSA cases reported in month.

f) Never Events

There was 1 reported never event in Month.

g) Mixed Sex Sleeping Accommodation Breaches (MSA)

There were 0 breaches reported in month.

h) VTE Assessment Indicator

The indicator did not achieve the target in June with **provisional** performance at 93.6% against a target of 95%. This is an increase on May's performance of 92.3%. The committee will note the roll out programme of the new reporting process and this is still being embedded.

i) Stroke Medicine - Suspected High Risk TIA Assessed and Treated < 24hrs from Presentation

This KPI was met in month with a **provisional** figure for June of 93.3% (14/15) against a local target of 85%. For 2017/18 the guidance and requirements for seeing TIAs are changing, with all TIAs to be seen within 24hrs (except where the event is over 7 days prior to referral), but requirements for further assessment and treatment vary. The Indicator will be retitled to TIAs Seen within 24hrs.

j) Stroke Medicine – Swallowing Screen

This KPI was met in month with a **provisional** figure for June 77.8% (35/45) against a local target of 75%. It is to be noted that after validation the April final figure rose to meet the target, 64.5% to 76.3%.

k) Finance

The overall financial performance for Q1 was fractionally lower than plan by £0.028m. However, consolidation of Dudley Clinical Services Ltd into the Trust position results in a positive variance to £0.013m. The Trust performance against the ED 4 hour target shows an improvement against Q4 of 16/17 and a return has been completed regarding the delivery of primary care streaming. As such, the Trust fully expects to achieve the STF allocation of £1.286m for Q1. Day Case and A&E attendances remain above plan and 16/17. Emergency activity and Births are in line with plan and 16/17 but Elective and Outpatient are falling some way short. Following a concerted effort to clear the backlog of District Nursing activity, the Community activity is now over-performing against plan. Agency spend has reduced to the lowest level since November 2015 but remains higher than cap. Bank spend has increased in June (Medical staff) and WLI payments remain comparatively high. The forecast position represents a significant risk and could be between £4.487m and £5.1m over target. This would result in no further STF payments (Trust would miss out on £7.288m). A detailed review is required of the forecast position, including associated risks and potential mitigations. This is in order to decide whether to invoke the NHSI protocol for in-year forecast changes.

Liquidity is above plan at month 2 with a rating of 14.7 against a plan of 12.5. This is as a result of the stronger net current assets position compared to plan. Capital service cover is slightly lower than plan as a result of the deficit position compared to plan the Trust has reported at month 1

l) Workforce

Appraisals:

June has seen a small decrease in the percentage of appraisals undertaken, from 83.6% in May to 82.9%. Medicine & Integrated Care are red at 79.1% (below 80%) down slightly from May. Corporate/Management and Surgery are amber at 85.4% and 89.2% respectively (>80% <90%), also down slightly from May.

Mandatory Training:

Mandatory Training has fallen from 84.9% in May to 84.6% in June. The Director of HR is working with respective Divisions based on the feedback from a series of forums that were held to identify issues within the mandatory training system. Only the Nursing Surgery and Urgent Care directorates are red with 79.6% and 72.4% respectively. The Chief Executive has signalled that for the year of 2017/18 that the Trust's targets need to be met.

Sickness:

Sickness rate overall has risen from 3.8% in May to 3.9% in June. Medicine & Integrated Care are red with 4.26% and Surgery division red at 4.29%. Within the Medicine & Integrated Care division, Integrated care, Medicine Division Management and Nursing Medicine directorates are red with 4.05%, 6.92% and 5.8% respectively. Within the Surgery division; Nursing surgery, Trauma and Orthopaedics, and Theatres & Critical Care directorates are red with 5.14%, 4.89% and 4.66% respectively, all slightly higher than May.

M) Single Oversight Framework (SOF)

The Trust's self-assessment against NHSI's single oversight framework is included at Appendix 1 to this report. We are awaiting the formal NHSI assessment but we consider we would remain within segment 2.

N) Electronic Communication with Primary Care

This indicator remains below target (90%) at 76.9%. A Contract Notice has been issued by the CCG.

3. Recommendation

Finance and Performance Committee is asked to: Note the contents of the report and approve.

Paul Bytheway
Chief Operating Officer

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - June 2017

Quality & Risk			2016						2017							
Description		LYO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YEF
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		87.56%	90.2%	88.64%	89.36%	97.5%	86.54%	89.8%	79.03%	83.64%	85.71%	94.23%	96.49%	92%	94.34%	
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation		79.31%	63.64%	66.67%	83.33%	93.33%	80%	100%	66.67%	93.75%	91.67%	100%	85.71%	93.33%	93.02%	
VTE Assessment Indicator (CQN01)		94.76%	93.91%	94.5%	93.91%	95.65%	95.64%	94.64%	94.18%	92.84%	96.31%	92.3%	92%	93.58%	92.62%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - June 2017

Finance			2017				
Description		LYO	Apr	May	Jun	YTD	YEF
Budgetary Performance		£1,467k	(£72)k	(£369)k	£412k	(£28)k	
Capital v Forecast		63.7%	72.6%	52.7%	49.6%	49.6%	
Cash v Forecast		65.6%	80%	74.9%	84.1%	84.1%	
Debt Service Cover		1.77	0.57	1.06	1.45	1.45	
EBITDA		£32,776k	£871k	£2,380k	£3,412k	£6,663k	
I&E (After Financing)		£10,004k	(£980)k	£514k	£1,541k	£1,076k	
Liquidity		16.43	14.7	14.56	14.99	14.99	
SLA Performance		£1,937k	£182k	£317k	(£110)k	£388k	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - June 2017

Performance			2016						2017							
Description		LYO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		89.77%	93.34%	92.97%	92.14%	92.3%	86.08%	82.86%	77.85%	86.3%	92.46%	84.94%	86.6%	90.02%	87.21%	
A&E - 4 Hour UCC Dept Only % (Type 3)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.97%	100%	99.99%	
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)		94.16%	96.21%	95.81%	95.29%	95.51%	91.97%	90.78%	87.7%	92.31%	95.59%	91.69%	92.05%	93.52%	92.38%	
Activity - A&E Attendances		102,696	8,973	8,579	8,594	8,929	8,477	8,718	8,607	7,758	9,020	8,577	9,056	8,879	26,512	
Activity - Community Attendances		394,381	31,673	33,863	33,078	32,365	34,044	33,676	33,404	29,912	34,208	27,793	32,134	34,173	94,100	
Activity - Elective Day Case Spells		45,982	3,798	3,895	3,911	3,721	3,888	3,428	3,761	3,748	4,313	3,805	4,244	4,198	12,247	
Activity - Elective Inpatients Spells		6,029	561	482	506	540	518	454	414	440	528	473	509	492	1,474	
Activity - Emergency Inpatient Spells		60,748	5,054	5,002	4,933	5,038	5,119	5,171	5,107	4,765	5,412	4,968	5,214	5,100	15,282	
Activity - Outpatient First Attendances		125,869	9,890	10,006	10,799	10,445	11,007	9,158	10,610	10,450	12,172	8,840	12,680	12,695	34,215	
Activity - Outpatient Follow Up Attendances		310,607	25,084	25,384	26,492	25,427	27,159	23,292	26,406	24,567	26,804	21,258	26,715	26,877	74,850	
Activity - Outpatient Procedure Attendances		59,621	5,090	4,898	4,992	4,845	4,985	4,067	5,163	5,133	5,311	5,617	4,851	4,121	14,589	
RTT - Admitted Pathways within 18 weeks %		92.4%	94.2%	95%	93.2%	93.9%	92.6%	92.9%	91.4%	88%	88.5%	86.3%	88.8%	88.6%	88%	
RTT - Incomplete Waits within 18 weeks %		95.4%	97.1%	96.6%	96.1%	95.6%	95%	94.5%	94.2%	93.3%	92.8%	94.2%	94.7%	95%	94.6%	
RTT - Non-Admitted Pathways within 18 weeks %		96.5%	98%	98.4%	97.1%	95.9%	96.3%	96.3%	94.2%	94.3%	95%	93.2%	94.5%	93.1%	93.7%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		97.41%	98.96%	97.69%	98.12%	98.59%	97.38%	93.5%	92.25%	97.09%	99.29%	95.99%	94.28%	96.87%	95.7%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - June 2017

Staff/HR		2016							2017							
Description		LYO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD	YEF
Appraisals		82.9%	78.1%	78.3%	77.4%	77%	77.1%	73.9%	71.7%	75.9%	82.9%	81.9%	83.6%	82.9%	82.9%	
Mandatory Training		83.9%	77.4%	78.6%	77%	78.5%	79.6%	79.4%	78.6%	80.2%	83.9%	84.6%	84.8%	84.5%	84.5%	
Sickness Rate		4.16%	4.07%	3.73%	4.04%	4.38%	4.29%	4.28%	4.56%	4.34%	4.12%	3.45%	3.81%	3.93%	3.73%	
Staff In Post (Contracted WTE)		4,278.19	4,083.49	4,112.05	4,146.74	4,199.22	4,236.4	4,230.95	4,240.77	4,280.54	4,278.19	4,309.81	4,301.72	4,323.76	4,323.76	
Vacancy Rate		7.90%	10.75%	10.31%	9.61%	9.18%	9.09%	9.18%	8.77%	7.93%	7.90%	8.65%	8.62%	8.80%	8.80%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

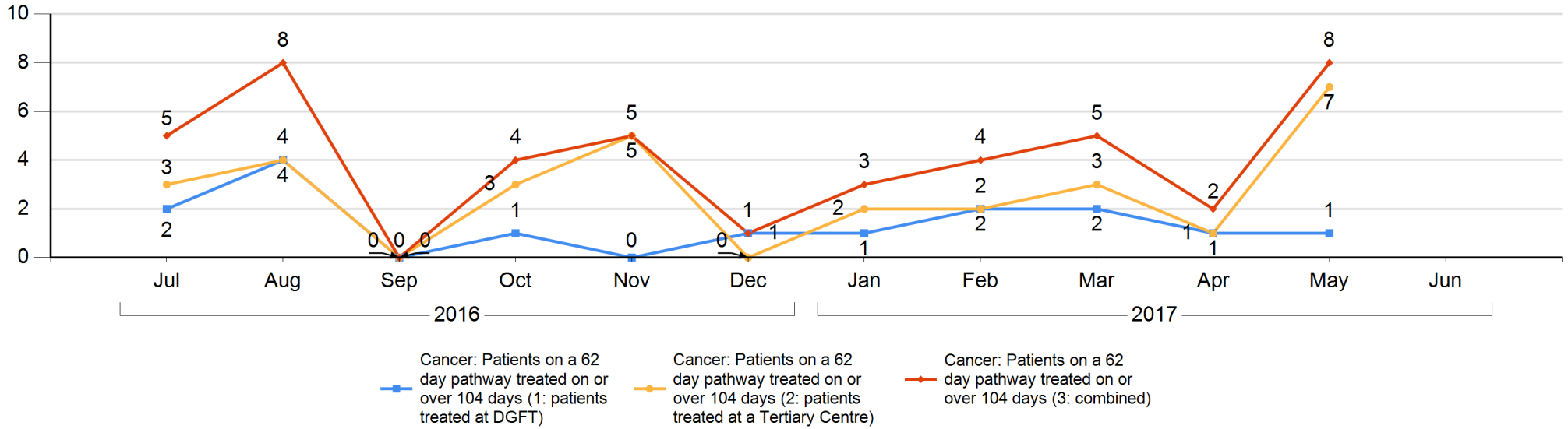
The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - June 2017

Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	98.9%	99.5%	99.1%	100%	98%	100%	92.9%	97.7%	92.7%	95.9%	**97.6%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	99.4%	-	-	-	-	-	-	-	-	-	**99.4%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	-	100%	-	96.2%	100%	90.9%	**97.4%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	94.7%	-	-	-	-	-	-	-	-	-	-	-	**94.7%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	96.9%	-	-	-	-	-	-	-	-	-	-	-	**96.9%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	-	-	92.3%	100%	100%	100%	70.6%	-	100%	84.2%	96.6%	**91.2%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	94.7%	72.7%	57.1%	100%	0%	66.7%	-	100%	48.3%	78.8%	**78.9%**

The Dudley Group NHS
NHS Foundation Trust

	2016						2017					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	2	4	0	1	0	1	1	2	2	1	1	
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	3	4	0	3	5	0	2	2	3	1	7	
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	5	8	0	4	5	1	3	4	5	2	8	



Appendix 1: Single Oversight Framework

Finance & use of resources.

Single Oversight Framework (Finance and Use of Resources)							
Area	Weighting	Metric	Definition	Score			
				1	2	3	4
Financial Sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75 - 2.5x	1.25 - 1.75x	<1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly commtted lines of credit available for withdrawal	>0	(7)-0	(14) - (7)	<(14)
Financial Efficiency	0.2	I&E Margin	I&E surplus or deficit/total revenue	>1%	1-0%	0-(1)%	<=(1%)
Financial Controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/deficit	>=0%	(1)-0%	(2)-(1)%	<=(2%)
	0.2	Agency spend	Distance from provider's cap	<=0%	0%-25%	25%-50%	>50%

Single Oversight Framework (Finance and Use of Resources)								
Area	Weighting	Metric						
			Jan	Feb	Mar	Apr	May	Jun
Financial Sustainability	0.2	Capital service capacity	3	3	3	4	4	3
	0.2	Liquidity (days)	1	1	1	1	1	1
Financial Efficiency	0.2	I&E Margin	1	1	1	4	3	1
Financial Controls	0.2	Distance from financial plan	2	2	1	2	2	1
	0.2	Agency spend	4	4	4	4	4	4

Quality of Care (safe, effective, caring &responsive) and Operational performance:

Measure	April Trust Position	May Trust Position	June Trust Position	VAR	Latest National Position	Latest National Reporting period	Ranking if Applicable
Quality Indicators							
Organisational Health Indicators - all Providers							
Staff Sickness	3.53%	3.81%	3.93%	▼	4.01%	Jul-16	54/105
Staff Turnover	8.74%	9.14%	9.26%	▼	N/A	N/A	
Executive Team Turnover							
NHS Staff Survey	Annual Report				3.83	2016	This is for Overall Staff engagement, calendar year 2015 was 3.86.
Proportion of Temporary Staff							
Aggressive Cost Reduction Plans							
Written Complaints - Rate							
Staff F & F % Recommneded - Care							
Ocurrence of any Never Event	0	0	1	▼	0	Up to end of October	
NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	0	0	–	0	Up to and including 3 March	
Acute Providers							
Mixed Sex Accomodation Breaches	5	3	0	▲	3	May	
Inpatient Scores F & F - % Positive	96%	96%	97%	▲	96%	May	127/172
A & E Scores F & F - % Positive	75%	76%	79%	▲	76%	May	131/139
Emergency C - Section Rate	19%	19%	22%	▼	17%	2015/16	95/129
CQC Inpatient / MH and Community Survey							
Maternity Scores F & F - % Positive							
Antenatal	100%	99%	96%	▼	99%	May	47/115
Birth	99%	99%	98%	▼	99%		52/129
Postnatal Community	100%	100%	100%	–	100%		1st with 63 other trusts
Postnatal Ward	98%	95%	99%	▲	95%		77/125
VTE Risk Assessment							
C Diff - Variance from plan	TBC				TBC	TBC	
C Diff - infection rate	2	1	2	▼	1	May	
MRSA Bacteraemias	0	0	0	–	0	May	
HSMR (DFI)				–	107	Mar 16 to Feb 17	As expected
HSMR (DFI) - Weekend				–	98	Mar 16 to Feb 17	As expected
SHMI					0.98	Oct 15 - Sep 16	As expected
Potential under-reporting of patient safety incidents							
Emergency Re-admissions within 30 days	7.1%	6.4%	6.3%	▲	National Reporting Suspended - Last 2 months will be provisional		
Community Providers							
CQC Inpatient / MH and Community Survey							
Community Scores F & F - % Positive	94%	96%	97%	▲	94%	May	106/142
Operational Performance Metrics							
Acute and Specialist Providers							
A & E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	91.7%	92.1%	93.5%	▲	92.1%	May	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	94.2%	94.7%	95.0%	▲	94.7%	May	
All Cancers - maximum 62-day wait for first treatment from: - urgent GP referral for suspected cancer	85.3%	78.0%	78.1%	▲	77.0%	May	115/161
- NHS Cancer screening service referral	92.3%	92.0%	100.0%	▲	100.0%	May	1st with 49 other trusts
Maximum 6-week wait for diagnostic procedures	95.99%	94.30%	96.90%	▲	94.30%	May	168/177

Arrows in the VAR column indicate whether we have seen an improvement performance from the previous month, not whether we have achieved a target or not.