Proposed 5 year clinical and financial plan

Introduction

The Trust's financial problems stem from the major investment into the estate, to replace inadequate and inappropriate Victorian workhouse buildings with a purpose built hospital facility. The business case was approved by the Trust's Commissioners, the Strategic Health Authority, the Department of Health and the Treasury. After identifying all possible savings, additional revenue consequences of around £20m were recognised, and the three local PCTs signed side letters to the contract agreeing to contribute their proportionate share towards meeting these additional costs.

The delivery of this business plan has been compromised since these decisions were taken by the many changes that have taken place since then. Funding the outstanding additional estate costs of £20m (at 2006/07 prices) have remained a challenge for the Trust. This was recognised when McKinsey's undertook their review of PFI sites which required national support, and resulted in a planning assumption that the Trust should receive £13m per year to contribute towards the excess costs. The Trust has been working with commissioners to find ways to close the remaining £7m gap (obviously now higher than this due to inflation), and has been generously supported non-recurrently since the new hospital opened in 2010. Going forward, this is not an arrangement that commissioners are prepared to continue, and so a new solution is needed. This will also support the Trust's intention to achieve financial sustainability.

Over the course of building, commissioning and operating the new estate, there has been a constant tension between the Trust and its commissioners about supporting the excess PFI costs (albeit non-recurrently), whilst at the same time also being expected to pay for the full PbR effect of extra activity. This has been particularly pertinent because both elective and non-elective demand has increased significantly at the Trust since the new buildings opened. This has led to a number of difficult, year-end compromise agreements being reached, with neither party really satisfied, with unhelpful repercussions for future working relationships.

The point has now been reached when it may be better to put aside these sorts of arrangements and normalise transactions based upon tariff rules. This would enable financial sustainability to be achieved if the 30% marginal rate paid for increases in non-elective activity could be re-based to recognise the impact of opening the new hospital. There is a powerful and effective argument that can be presented to support this.

The case for not applying the 30% marginal rate

It is understood that the rationale behind the 30% marginal rate policy was to deter provider organisations from attempting to inflate activity and therefore

maximise income. This theory has now been widely discredited, and it is generally accepted that this has not been the driver behind increasing levels of non-elective activity. The impact of this policy has been most challenging for any trusts which have seen non-elective activity increase significantly, but has been most difficult for trusts which have experienced increases well outside the normative range. The recent document "NHS England: Improving Accident and Emergency Performance (Gateway reference 00062)", described the massive pressures facing Accident and Emergency departments resulting from the national, aggregate rise in attendances of 5.9% over the past five years. By comparison, this Trust has experienced an increase of 25% over three years, which equates to a rise of attendances from 85,000 to well over 100,000 in 2013/14, and has resulted in an increase in admissions from 49,000 to a projected 57,000. It might be argued that the 30% marginal rate policy is not applicable in situations like this anyway. From a business case and sustainability point of view, it means that the contribution to overheads and semi-fixed costs that this activity should be making is lost. In the Trust's case, 70% of a substantial income figure has not been available, which would have made significant contribution to closing the funding shortfall against the estates overhead cost ("the PFI gap"). Nor have these sums been made available to the Trust's commissioners to help with the non-recurrent support previously provided, as the money was retained by the Strategic Health Authority for other uses.

Much more important than the economic impact of this policy is the potential effect on patient care. This Trust has absorbed over 20,000 additional Accident and Emergency attendances, and 8,000 additional admissions resulting in the need for 30,000 additional bed days equating to around 90 additional beds. However, capacity is largely fixed, so on general and acute wards occupancy levels have increased, and increased to the point where something has to change. The most damaging aspect of this policy has not been that it has suppressed the generation of a contribution to overheads, but that it has resulted in staff on wards and other direct support departments being required to absorb unsustainable increases in workload without any additional workforce capacity. For the most part, the additional non-elective activity compromises frail, elderly, sick patients with multiple co-morbidities, who have long lengths of stay, are difficult to discharge, and are very dependent upon the care of nurses. This policy specifically precludes providing any funding to manage these vulnerable patients and thus places a huge burden on the organisations trying to manage this workload, whilst at the same time also delivering on very challenging savings requirements. Most importantly, it places huge stresses on the staff themselves and creates risks to the quality and safety of services delivered. In the wake of the Francis enquiry, the Keogh review, and clear evidence that staffing levels play such a major part in delivering safe care, it is disappointing that this policy is still retained. The Trust is seeking recognition that in cases of extreme rates of non-elective activity growth, and in the interests of patient safety, the policy is not applied and that activity is remunerated at full tariff. These sums are already in the system and a decision could be taken to deploy them in a different way, if it were considered important.

Delivery of safe services into the winter

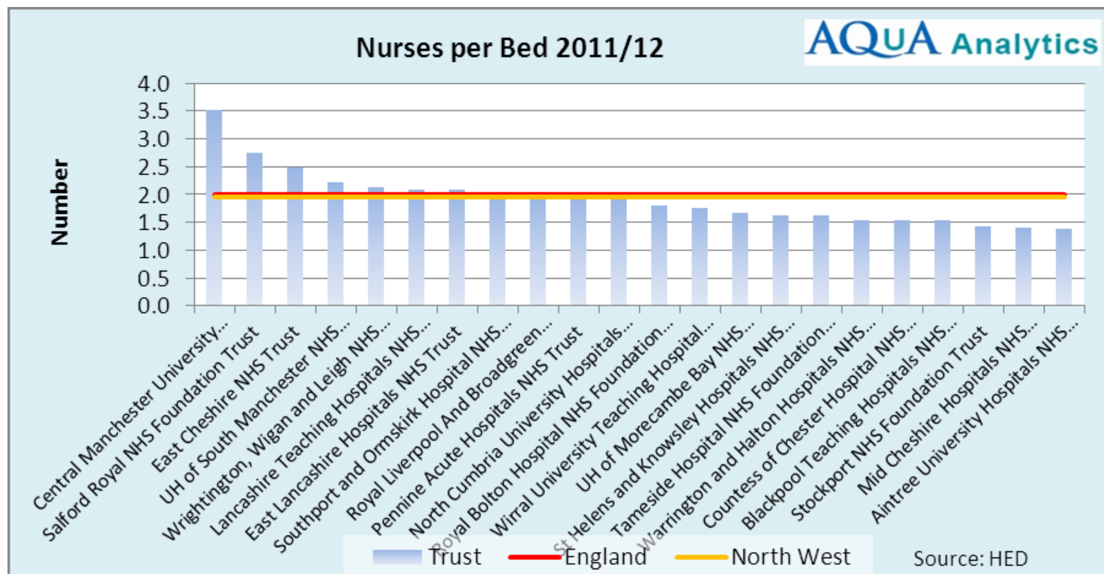
What would the Trust do with this money if made available? The most important challenge facing the Trust is maintaining high quality, safe care and a good patient experience. As mentioned earlier, the Trust has already exceeded reasonable bed occupancy levels and realistically cannot absorb any further activity into the winter. Nurse staffing levels have had to be increased, despite a lack of funding and this has increased financial pressure. The Accident and Emergency department has been overwhelmed at times, and last year's Q3 and Q4 Accident and Emergency performance fell just short of 95% (although achieved for the year over all). The Trust recognised that something major has to change before next winter, as service delivery will become compromised. So, the Trust management invited in the Emergency Care Intensive Support Team and sat down with senior clinicians to devise a plan.

- Seven day working

  The plan that was devised has the support of clinicians across the Trust, and is a radical redesign proposal, which will reduce time patients spend in Accident and Emergency, improve many non-elective pathways, and deliver full on site seven day Consultant presence, with all day time admissions reviewed by a Consultant within four hours. The major benefits of the proposal will be to improve the quality of care, reduce mortality and morbidity, reduce length of stay releasing capacity, deliver best practice evidence based care for ambulatory patients and reduce multiple transfers and handovers of care for patients. The anticipated quality improvements are substantial and significant, and this is also the only proposal currently available which will enable delivery of the four hour target this winter. Some of the proposed changes (particularly to Accident and Emergency) have already been implemented on the basis of goodwill from the staff, and have demonstrated that despite record breaking levels of activity, 97% of patients have spent less than four hours in Accident and Emergency. The proposal has been turned into a business case, and presented to commissioners, seeking their support and investment. Time is running out for a decision to be taken, so the Trust has advertised the necessary posts, in the hope of a successful outcome. A copy of the business case is attached for reference.

- Increasing nurse staffing levels

  The other Trust priority for the investment of any contribution from the 70% unpaid tariff is to invest in improved nurse staffing levels. Comparative data (see below) shows that the Trust is in the lower half in terms of nurses per bed compared to other Trusts in the North West.



However, the Trust has a much greater proportion of non-elective patients than others, has a very deprived population with much co-morbidity, and has very high percentage occupancy and growing demand. For all of these reasons, and in the wake of the lessons learned from the Francis report, a further review has been undertaken of nursing staffing levels across the Trust. The result of this was a recommendation that the Trust should increase staffing by 95 nurses, to ensure that safe, high quality services can be maintained. Once again, this has been submitted to commissioners as a business case for reinvestment of some of the 70% unpaid tariff. In the meantime, increased nurse staffing numbers have been authorised on all wards at financial risk to the Trust.

A short term solution for clinical and financial sustainability

The Trust's proposal for delivering on its short term clinical and financial imperative is to achieve agreement that all activity will be remunerated at full PBR rates, including non-elective activity. The planned surplus would also be reduced to a minimum acceptable level, releasing internally generated savings for reinvestment. Taken together, these sums would release around £12m to invest in the schemes described. This would encompass funding the outstanding PFI debt (£6.7m), redesigning emergency care services to enable the delivery of the four hour target in the winter (£1.9m) and increasing nurse staffing levels on wards (£3.5m). Financial schedules shown later in the document also cover the impact in 2014/15. So, largely through the re-use of resources that should be already somewhere in the system, the Trust could achieve the following improvements:-

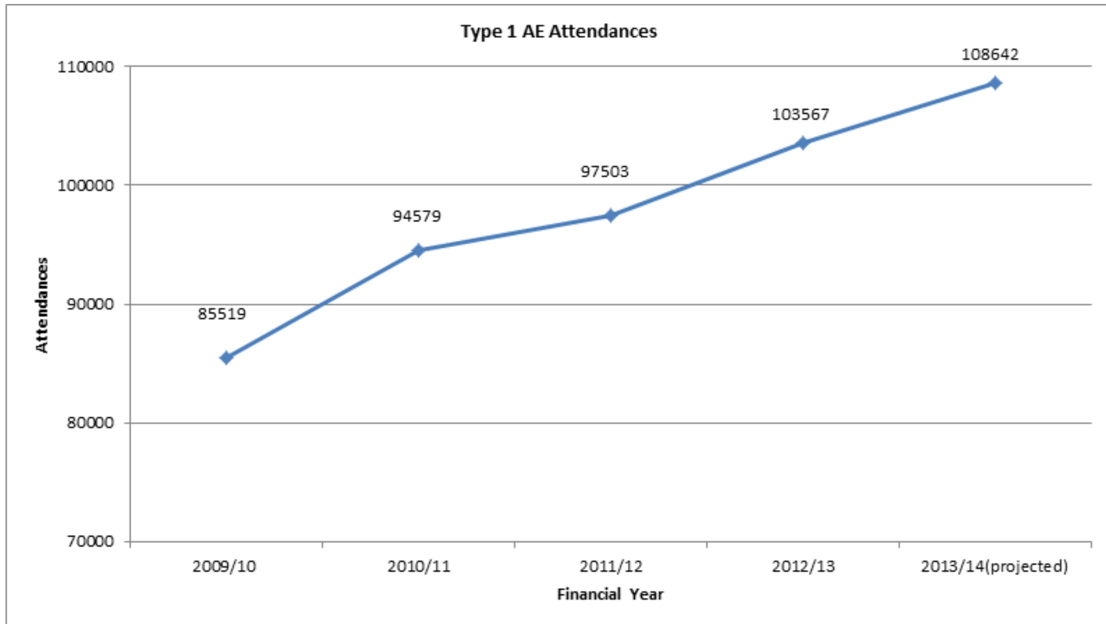
- Improve safety and quality
- Reduce mortality and morbidity
- Achieve the four hour Accident & Emergency target.

- Deliver 7 day consultant cover
- Reduce length of stay
- Reduce occupancy
- Improve nurse staffing ratios
- Implement more appropriate pathways of care and reduce admissions
- Reduce transfers and handovers of care
- Reduce the numbers of medical outliers in surgical beds and therefore disruption to the elective surgical programme resulting in cancellations
- Close the PFI funding gap

This is such a substantial and critically important list of improvements, that the Trust would encourage earnest consideration of this proposal. With the clear evidence of increasing activity pressure, the Trust has carefully devised these plans engaging with staff across the organisation in a genuine attempt to transform service delivery, further improve quality and above all, protect patient safety.

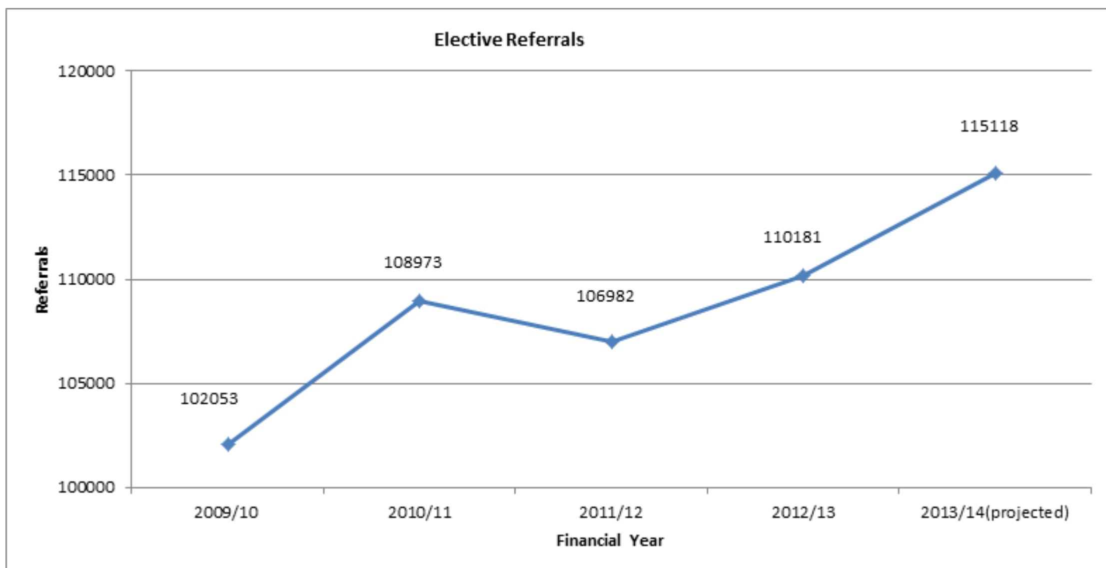
The medium term

From the time that the first Tripartite Formal Agreement was produced, it has always been acknowledged that part of the Trust's underlying structural financial problem was the unusual elective/non-elective split. According to benchmarks, the Trust has the highest percentage of non-elective patients in the country, and this has a major impact on income. Even without the anomaly of the 30% marginal rate on increased non-elective activity, remuneration for the older, more complex, longer length of stay non-elective patients generated smaller margins (contribution to overheads) than elective cases. The plan was that the Trust should work with commissioners and community partners to reduce non-elective activity and use the released capacity to increase electives, thereby increasing income and delivering financial sustainability. For many, complex reasons, this has not been successful and non-elective activity has continued to grow (see below).



NB: Adjusted for change in GPAU pathway

Meanwhile elective referrals have also increased substantially (see below), but pressures on capacity have meant that this work is often not being undertaken in an efficient way.



In the face of unsustainable service delivery pressures, the Trust has had to find a different way to respond to the huge activity demands placed upon it. This was the imperative that brought the Trust's staff together to produce the plan for the complete redesign of non-elective flows, pathways and care delivery, which has proved difficult to achieve in very many other organisations.

A consequence of the service improvements described is that bed capacity is released, which can be used to accommodate alternative activity. This would include the Trust's own elective programme (undertaken in a more cost effective way), developments and repatriation of activity, capacity needed for

collaborative working, private patient facilities, sub-acute beds, and other proposals. This creates the opportunity to generate further income, which together with other initiatives and the Trust's own savings plans provide the basis for the Trust's medium term financial plan. The key steps are as follows:

- Repatriation of local activity

  Generating additional income is crucial to ensure financial stability although the Trust recognises that this will need to be achieved within a commissioning environment of flat or falling activity in the acute sector. Local residents and GPs are generally very loyal to the Trust, evidenced by the fact that approximately 75% of St. Helens patients choose to come here for their routine elective care. In relative terms this is a high figure with a significant proportion of the remaining 25% of patients accessing routine care via neighbouring tertiary providers such as; LHCH or Alder Hey, or via private sector providers through Choose & Book.

  The Trust will continue to grow its "local" elective markets and is particularly focused upon repatriating activity which is directed into the private sector. St. Helens CCG is strongly supportive of this approach and acknowledges that the LTFM assumption of a "general growth" increase of 3% in GP referrals both this year and next year is reasonable given that referrals over the last 3 years have increased by over 8,000 in a diminishing market. Market share has increased by 5% over this time.
  The Trust recently commissioned a detailed market analysis from Deloitte in order to test that the LTFM assumptions are reasonable. This analysis identified:-

  - that there are some referral pattern inconsistencies between specialties at several local GP practices;
  - those practices where patients choose to be treated at the local private provider.

  The analysis confirmed that there are opportunities to expand market share over and above the LTFM assumption despite the expected overall market contraction. It identified C&B private sector leakage as a specific area of focus and in order to enact this change the Trust has:-

  - Developed a clinically led GP engagement plan to improve our understanding of the perception of each individual clinical service at each GP practice.
  - Introduced out-of-hours and weekend "consultant only" clinics to develop a "distinct selling point".
  - Worked to ensure that waiting times are comparable to or better than neighbouring providers, including the private sector.

  The combined impact of this is expected to deliver an additional 1% increase in GP referrals next year over and above the LTFM

assumption. Again St. Helens CCG is supportive of this approach as it expected that this additional growth will be at the expense of other providers. As such it will come from within the existing commissioning expenditure resource.

- Improving efficiency

  The Trust has developed four projects to optimise the efficiency of the service portfolio:

  Advanced Scheduling - This project recently received an award from the British Quality Foundation (BQF) for project excellence, the first time that a healthcare provider has won this award. The project involves the implementation of a hospital resource planning system that schedules and plans the patient journey using demand information. The project uses lean methodologies and includes the planning and scheduling of outpatients, AED, elective and non-elective theatres activity. To date the project has achieved remarkable results, with an 11% improvement in theatre session utilisation across both sites. This equates to an annual cost saving of at least £1.2m by the end of year 3.

  Analysis of Capacity and Utilisation within St Helens Hospital - This analysis has identified capacity increase opportunities via the use of 3 session days and weekend working. Extension to 3 session days could increase day case capacity at St Helens by up 30 sessions with a further 24 day case theatre sessions at the weekend.

  Improving Service Line Efficiency - The Trust has rolled out Service Line Reporting, and the benefits of being able to scrutinise performance at a service and patient level are evident in the reviews currently underway.
  Using SLR and introducing Service Level Management at the Trust will deliver future productivity gains, and will ensure that individual services are appropriately benchmarked against their peers so that each area of the organisation can become best in class both in terms of clinical and financial performance.

  Clinical Director Business Development Programme - Our clinicians are a credit to the organisation and provide excellent care for our patient population, however as a means of ensuring clinical involvement and ownership of business plans being developed, a Clinical Director Business Development Programme is being introduced. This will ensure that our clinical leaders have access to the training and information required to fully understand and influence the financial as well as clinical aspects within their respective specialities.
  The combined impact of the above will enable a combination of efficiencies and service improvements that will improve the patient experience and lead to a more efficient organisation which maintains the highest standards of care.

- Enhancing Earnings

  Additional income will be generated by maximising other opportunities from our clinical and commercial income streams.

  A significant amount of work has taken place to ensure that these projects take place and it is expected that they will make an annual contribution of c£7m by year 5 of the LTFM. Examples of some of the key projects are provided below.

  Clinical Income Streams

  Collaboration Projects - the Trust has been developing collaborative projects for some time and there are numerous areas where we are working with partners both to improve services now and reduce costs over the next 3-5 years. These include:

  - Warrington & Halton Hospitals NHS Trust

    The two Trust Boards reached a formal agreement to collaborate some 15 months ago and service improvements have been made in Stroke services, Haematology and Cardiology. These have yielded c£500,000 contribution to date. The two Trust Boards have also agreed in principle to develop a shared pathology service. This will produce an annual financial saving in excess of £1.4m annually by year 3. A joint Board to Board meeting has been arranged for October to review other collaboration opportunities between the two Trusts.

  - Royal Liverpool & Broadgreen University Hospitals

    The two Trusts have recently established a joint governance structure led by the two Directors of Finance and agreed to make a joint appointment to take forward the formal collaboration programme. Immediate service improvements are planned in:-

    - Vascular and Interventional Radiology – service changes are planned from this September with a potential £600k impact across partners.
    - Plastic Surgery input to Orthopaedics – Business case recently approved for additional Consultant input to RLUH from STHK.
    - Dental – STHK looking to divest non-profitable orthodontics services to RLUH this year.
    - Renal Services –Hub and spoke model business case agreed using existing RLUH hub.
    - Sleep Laboratory – Hub and spoke business case in the final stages of development using existing RLUH hub.

  With regard to medium –longer term capacity planning, a recent KPMG report identified that short stay elective activity with a value of c£9m

may need to be relocated from RLUH as a result of their move into a smaller site. This equates to some 6,000 cases which can be accommodated at the St. Helens site. This will yield a contribution of up to £2m annually after profit sharing. Moving this activity also offers significant benefits to RLUH.

- Southport & Ormskirk Hospitals

  The two Trusts have recently agreed a joint Consultant Urologist appointment to ensure that patients in need of complex urological surgery can be offered a full MDT service based at STHK with outreach support to Southport. This agreement includes the commencement of a shared on-call service between the two Trusts.

  The Trust has also recently submitted a tender to Southport & Ormskirk Hospitals with regard to pathology services.

- Aintree University Hospital

  Discussions are at an advanced stage to develop joint services in Ophthalmology and Urology.

- Community Service Provision and Service Tender Opportunities.

  The Trust does not currently provide its own therapy services and is about to complete a review of the existing service contract. St. Helens CCG has also recently commissioned a community therapy services review and it is highly likely that this service will put to tender next year. The Trust intends to compete for this tender in order to provide a holistic therapy service across the local health economy. The Trust does not currently provide community services apart from maternity and a small amount of ophthalmology and paediatrics. It views the therapy tender as an opportunity to gain a wider foothold in the provision of community services. This will create opportunities for further collaboration with or competition with existing community providers.

Plastic Surgery - plans to expand plastic surgery services in Wales are at an advanced stage. This will make a c£2.5m annual contribution by year 5.

Radiology - the Trust also has access to world class radiology equipment under the PFI scheme which allows us to offer both hospital based and community diagnostic services. This will enable the early identification of underlying conditions which will benefit both patients and the health economy as a whole. The local CCGs have already commissioned some additional community based diagnostics and commissioning plans indicate that this will be expanded.

Private Patients - The Trust does currently provide services to private patients and generates c£200,000 income. It has recently agreed an expansion plan with a number of clinicians to provide further private/cosmetic services at St. Helens Hospital. Although the local population does not generate a large volume of private practice the Trust does expect to at least double its private patient income over the next 3 years or so.

Other clinical expansion plans are at various stages of development for example:-

- Breast onco-plastics
- T&O clinical specialty developments
- Expansion of Trauma Rehab

- Commercial Income Streams

The Trust currently provides estate facilities for a GP practice on the St. Helens site and is working closely with St. Helens CCG to exploit other estates opportunities by finalising plans to:-

- Co-locate a GP practice onto the Whiston site this year
- Relocate the St. Helens WIC/MIU next year
- Introduce a primary care stream adjacent to/incorporated within the Whiston AED next year.

The Trust will continue to take advantage of any commercial opportunities in areas such as; IT, Procurement, Information Governance and Human Resources.

Financial Summary

The Trust's draft plan can deliver national targets and priorities including the ambition for the NHS to be a genuinely seven day service thereby providing resilience for emergency pathways. It addresses concerns raised from the Francis enquiry and eliminates all residual PFI cost pressures. A financial schedule is shown below demonstrating how this can be achieved through allocation of the unpaid 70% tariff monies, complemented by additional plans for collaborative working, cost improvement and efficiency savings to meet national QIPP expectations.

Financial Schedule

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Sources of Financial Contribution							
70% NEL Threshold Contribution		8,500	8,100	8,100	8,100	8,100	8,100
Additional Savings identified on 7 day working		700	4,100	4,100	4,100	4,100	4,100
Reduction in Planned Surplus		2,900	2,900	2,900	2,900	2,900	2,900
Repatriation of Local Activity			677	880	1,056	1,268	1,394
Improving Efficiency, incl advanced scheduling, SLR			2,805	3,287	3,920	3,955	3,999
Enhancing Earnings - Clinical Collaborations:	- Pathology		1065	1420	1420	1420	1420
	- Burns and Plastics			517	1,545	2,577	2,577
	- Other (incl Royal Liverpool)			1,455	4,406	4,406	4,406
Commercial Income Streams				425	1,825	1,825	1,825
TOTAL Contribution		**12,100**	**19,647**	**23,084**	**29,272**	**30,551**	**30,721**
Application of Contribution							
Emergency pathyway resiliance, incl A&E and 7 day working		(1,900)	(2,700)	(2,700)	(2,700)	(2,700)	(2,700)
Francis / Nursing		(3,500)	(3,700)	(3,700)	(3,700)	(3,700)	(3,700)
Residual PFI Gap		(6,700)	(8,700)	(8,700)	(8,700)	(8,700)	(8,700)
Total		**(12,100)**	**(15,100)**	**(15,100)**	**(15,100)**	**(15,100)**	**(15,100)**
NET contribution to Future CIP's / Increased Surplus		**0**	**4,547**	**7,984**	**14,172**	**15,451**	**15,621**

More detailed information can be provided if required.