
At Birmingham Women's Hospital
We Will
• be friendly polite and helpful
• listen to you
• be welcoming and caring and professional
• keep you informed and explain what is happening
• treat everybody equally with dignity and respect
• treat you the way you would like to be treated
• be committed to getting you an answer

Operational Plan Document for 2014-16

Birmingham Women's NHS Foundation Trust

1. EXECUTIVE SUMMARY

1.1 Introduction

Birmingham Women's NHS Foundation Trust provides a range of health care services to women and families across the West Midlands and further afield.

We treat 50,000 people a year, carry out 3,000 operations and test 50,000 genetic samples. More than 8,000 babies were born under our care last year, making our maternity unit one of the busiest in the country.

We are proud to be one of only two Trusts in the country which specialises in providing care for women and families. We provide a full range of gynaecological, maternity and neonatal care as well as a comprehensive genetics service. Our fertility centre is one of the most successful in the country and our fetal medicine centre which provides care for the unborn baby and women during pregnancy receives referrals from across the region and further afield.

We strive to put patients at the centre of everything we do. We want patients to have an excellent experience and to feel involved in their care. Our waiting times are low and we achieve high standards for cleanliness, food, privacy and dignity.

Birmingham Women's Hospital aims to continue to be a leading provider of a specialist range of services. To achieve our vision we plan to redevelop the hospital site so we can improve our services and the way we deliver them for many years to come.

1.2 Current Position

The Trust currently enjoys an excellent clinical record, with Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards level 3, British Urogynaecology accreditation, exceptionally low infection rates and genetics laboratory re-accreditation with ISO15189 standards achieved. It has also achieved stable financial position with many years of small surplus and expects to maintain a Continuity of Service Risk Rating of 4.

However, in line with a number of other NHS organisations the Trust is facing significant challenges to continue to meet and exceed the expectation of its patients and achieve the necessary level of cost reductions to meet the financial expectations over the next 2 years.

1.3 Commissioners

The Trust has two main commissioners NHS England and Birmingham South Central CCG which between them account for over 80% of the Trust's income. Finance and activity matrices have been agreed with these organisations and contracts are expected to be signed before 1st April 2014.

Birmingham South Central CCG contracts on behalf of the CCGs in the Birmingham Area and is anticipated to meet its financial targets for 2013-14. However, it needs to achieve its QIPP target

in line with other CCGs. The CCG is taking a collaborative approach in line with other CCGs in the area.

1.4 Quality Plans

The Trust set itself previously 3 main quality targets. These are:-

- To improve the detection rate of intrauterine growth restriction (IUGR) to 35%
- Achieve multiple pregnancy rates at or below the target of 12%
- Increasing the percentage of nursing and midwifery time spent delivering direct care.

The Trust has detailed plans for both monitoring these targets and any clinical risk associated with the service. The Trust is not aware of any concerns of CQC. The second intelligent monitoring data report for the Trust published this month conforms that the Trust remains in the lowest risk category, Band 6. An unannounced routine inspection carried out by CQC in October 2013 concluded that the Trust met all the Standards inspected.

1.5 Operational Requirements and Capacity

The Trust has detailed objectives in order to achieve its four strategic objectives which are:-

- To deliver an excellent experience that exceeds our patients' expectations
- To consistently deliver clinical and laboratory outcomes that place us amongst the top hospitals
- To develop an exceptional organisation where people achieve their potential
- To work with our partners to maintain and develop our service, academic and research standing.

The Trust has identified an increase in its workforce of approximately 100 WTE in 2014-15 funded via a variety of bringing in-house previously outsourced services, new services specifically funded and increases to current services funded from the contractual round. There is no anticipated change to the number of beds the Trust will require to deliver this plan.

1.6 Productivity, Efficiency and Cost Improvement Plans

The Trust has identified £3.6 million worth of cost improvement plans for 2014-15 and these schemes have been developed in detail. Over 80% of these schemes are considered low or medium risk of achievement, i.e. plans are well advanced for their delivery.

It has been identified that an additional £4 million worth of CIPs will be required to ensure the Trust meets its financial plan in 2015-16. A list of CIP areas for 2015-16 has been identified. Detailed plans to deliver these schemes will be worked through in detail starting from April 2014.

The actions taken in 2013-14 have given the Trust an important platform for delivering this challenging agenda. In particular:-

- A Trust wide review of models of care in order to ensure that the Trust has a clear understanding of how services are and will be delivered in the future

- Review of SLAs, in particular Information Technology, Pharmacy, Procurement and Occupational Health. The Trust has changed supplier for all these services over the last 12 months and the benefits of the new suppliers are anticipated over the coming year.

- The introduction of new technology e.g. kiosks in gynaecology, K2 community and antenatal modules, Badgernet (neonatal), Documentum (in genetics), a data warehouse and EPR system in Maternity. These systems are all anticipated to have qualitative as well as quantitative benefits to the Trust.

- Other Capital investments such as Next Generation Sequencing, New PACS environment, voice recognition software, and scanners are also expected to deliver qualitative and quantifiable benefits.

- New Business Development Opportunities e.g. miscarriage service, expansion of genetics testing, maternity domino service and increases in existing services provided e.g. fertility (either NHS or Non-NHS), Early Pregnancy Assessment Unit (EPAU)

1.7 Financial Plan

The Trust's financial plan will continue with the delivery of small net Income and Expenditure surpluses over the next 2 years. This will mean the Trust will maintain a Continuity of Service Risk Rating of 4 for the 2 years covered by this plan. A level 4 is maintained in both the Liquidity Ratio and the Debt Financing Ratio.

Income is expected to grow in line with commissioner plans and the agreed contracts for 2014-15. The Trust also benefits in 2014-15 from a significant reduction in CNST costs.

1.8 Conclusion

The Trust has a strong record of excellent clinical achievements as well as achieving a stable financial environment. There are a significant number of challenges that the Trust faces in continuing these achievements in line with other NHS bodies. This plan details how the Trust will tackle these challenges and set itself up for the longer term.

2. OPERATIONAL PLAN – THE SHORT TERM CHALLENGE

2.1 Commissioning Landscape

The Trust has two main Commissioners, NHS England West Midlands (NHSE) and Birmingham South Central Clinical Commissioning Group (BSC CCG).

2.2 BSC CCG

This CCG contracts for its patients for Maternity, Gynaecology and Reproductive Medicine and this equates to approximately 50% of the Trust's income. The CCG acts as a lead commissioner for the Trust and negotiates terms and conditions of the contract on behalf of other CCGs within the area, i.e. Birmingham Cross City CCG, Sandwell and West Birmingham CCG, Solihull CCG. Other CCGs within the West Midlands are invited to share these arrangements under an Associate Commissioner arrangement.

The CCG has a QIPP target which is in line with other CCGs nationally and in 2013-14 is anticipating to deliver its financial plan of a 1% surplus. The CCG has already made some (£375K) non-recurrent funds available to the Trust to support its choice agenda within Maternity and intends to invest a further £375K non-recurrently in 2014-15.

In order to deliver the QIPP challenge the CCG in its Commissioning Intentions has indicated that it "will be working with Trust colleagues, within the framework of the Joint Clinical Commissioning Groups (JCCGs), to develop sustainable and locally owned initiatives that will deliver the required efficiencies and maintain quality services".

The key principles around which the CCG is commissioning are as follows:-

- The contract is clinically lead
- There is a consistent approach across the health economy
- Recognise the issues that impacts on both the commissioner and provider to develop a mutually workable solution in a difficult financial environment.
- Plan for constrained resources and minimal growth
- Deliver the QIPP and CIP challenge
- Apply the tariff to service provision

- The CCG expects to pay no more than the national average reference cost price for locally priced services.

- Any change in contracting, counting and coding arrangements is subject to agreement and a six month notice period.

- The contracts will be consistent with Pbr guidance.

- The 2014/15 Standard National Contract will be used.

- It is assumed that provider inflation related pressures and advances in technology are covered by the national tariff inflation calculation.

- The CCG will continually look to improve standards to data and information associated with the contract.

2.3 Birmingham Cross City CCG Fertility Services

Birmingham Cross City CCG has recently put a tender out for tier 3 fertility services that are currently provided by the Trust (Income approximately £300K). The exercise is in conjunction with Walsall CCG (with whom the Trust does not currently have a contract for this service).

The Trust has put in a bid to supply either one or other or both CCGs with this service in 2014-15. The result of the tender will not be known until May 2014. The Trust's plans have assumed that it will continue to provide services to Cross City CCG but not to Walsall CCG. If the Trust were to lose the Cross City CCG tender the capacity freed up would undertake additional private work that it currently does not undertake but is aware of the demand.

2.4 Better Care Fund

The Trust has been in discussion with BSC CCG in relation to the Better Care Fund and is keen to support initiatives that the CCG and its partners across Birmingham propose in relation to utilising this funding. However, at this time it has been agreed with BSC CCG that there are no specific areas for the Trust to utilise the fund and therefore there is no impact identified within the plan. The Trust will continue to support the CCG and other partners and stakeholders to optimise the use of this fund.

2.5 Redditch and Bromsgrove Services

The Trust is involved in, along with other providers, discussions lead by Redditch and

Bromsgrove CCG, regarding the services currently provided by the Royal Alexandra Hospital in Redditch.

The Trust has not made any contingency for any changes in activity within this area, either in terms of income or expenditure and will continue to engage with all interested parties to support the CCG in its plans for providing high quality healthcare services in this area.

2.6 Current Contractual Position

The Trust has agreed the Service and Activity Matrix and CQUINS for 2014-15 with BSC CCG for these services and the contracts have been signed by this Trust. Plans of 2015-16 for the CCGs are much less evolved therefore detailed projections regarding activity. Therefore these plans assume that activity in 2015-16 will be in line with 2014-15 contracts.

2.7 NHS England (West Midlands Local Area Team)

NHS England contracts for Neonatal, Fetal Medicine, Genetics and some specialist elements of Maternity and Gynaecology services. This accounts for approximately 31% of the Trust's income. NHS England is anticipating a significant overspend against plan in its Specialist Service Commissioning, and the West Midlands element of this deficit is anticipated to be approximately £42m (as at February 2014). The redefining of rules between CCGs and Specialist Service Commissioning (the Identification Rules) has not impacted on the Trust.

As part of its drive to reduce expenditure in line with its planning assumption NHS England has a Financial Sustainability programme with all providers, focussed on better value through:

- a two-year programme of productivity and efficiency improvement in service delivery which will commence during 2014/15 and will focus on converging local tariff pricing to match the most efficient services, with support and reward in line with commitment to levels of ambition, and shared ownership of risk;

- agreed improvement goals to ensure that efficient services form part of lean, patient-focused pathways, and that treatment is commissioned by default in the most cost effective setting, adopting and spreading best practice across provider services;

- securing the benefits of more widespread use of best value prices for drugs and devices with increased transparency of billing;

- strategic collaboration with providers and other partners to achieve prevention and earlier intervention in specific services;

- reducing the future burden of demand for prescribed services by managing demand and reducing rates of admission and readmission.

The Trust has agreed the Service and Activity Matrix and CQUINS have been signed for 2014-15 with NHS England (West Midlands). This includes payment at full price for the over activity in neonatal services and genetics undertaken in 2013-14. It is assumed that genetics services will once again (similar to the last 3 years) continue to increase and that the Trust will continued to be paid at marginal rate for the first year with subsequent years being paid at full price. Therefore increases in 2015-16 are assumed in this service in 2015-16 but not for other services.

2.8 Other Commissioners

In 2013-14 the new maternity pathway tariff was introduced as a method of payment for maternity services. In Birmingham it was agreed amongst the main providers that the Trust who received the community booking would be the lead provider and receive the payment for that element of the pathway and if other Trust (not the lead provider) were to provide services to the woman then the provider recharges the lead provider for these services.

As a specialist maternity provider the Trust sees significant numbers of patients who have their community booking with other providers. This equates to over £1 million for both Heart of England NHS Foundation Trust and Sandwell and West Birmingham NHS Foundation Trust. BWH is approaching both of these Trusts to explore the advantages of holding a contract for this work to formalise the agreement now the activity levels are understood and definitions agreed and tested.

2.9 Quality Plans

The Trust is highly proud of the excellent clinical record.

For the year 2014-15 our three main priorities will be in line with the Priorities for 2013-14:

- To aim to improve the detection rate of intrauterine growth restriction by a further 5% compared to the quarter 4 actual outturn;
- To achieve a multiple pregnancy rate at or below the target of 11%;
- To increase the percentage of nursing and midwifery time spent delivering direct clinical care from the benchmark figure**.**

PRIORITY 1 – To aim to improve the detection rate of intrauterine growth restriction (IUGR) to 35%.
Perinatal mortality has long been recognised as being high in the West Midlands, whilst this is partly accounted for by the population we serve a recurrent theme in our investigation of perinatal deaths is the failure to detect fetal growth restriction. In light of this we have in the past and continue to give a high priority to the detection of IUGR.

This last year we have implemented all the planned initiatives in our previous report. The initiatives we have put in place have enabled us to increase our performance on this important

indicator. Over the past year, we have consistently had an IUGR detection rate greater than 35%. Our new target will be an increase of 5% over 2014-15 on the detection rate from Quarter 4, which is not yet available.

We have increased the numbers of midwives able to provide growth scanning. Practice is audited regularly demonstrating that progress has been made in staff understanding that growth scanning needs to continue beyond 36 weeks gestation and stopping serial scanning at 36 weeks in now a rare occurrence.

In addition to babies found to be below the tenth percentile, we have also chosen to include and report cases where there were clinical indications of growth restriction such as static growth, oligohydramnios and abnormal Doppler studies.

We have continued to strive for further improvement in this area and are developing the following initiatives:

- Rolling out of software to midwives performing growth scans so they are aware of their individual detection rates.
- Ultrasound images taken during growth scanning being reviewed by the Consultant Lead for the Day Assessment Unit.
- Work to consider the new Green Top Guideline from the Royal College of Obstetricians and Gynaecologists and how implementation of the recommendations may enable us to enhance our performance in the detection of IUGR further.

PRIORITY 2 – Achieve multiple pregnancy rates at or below the target of 12%.
The multiple pregnancy rate is defined by the number of pregnancies with more than one fetal heart identified on ultrasound scan following in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) as a percentage of the total number of pregnancies from IVF and ICSI for the given time period.

Multiple pregnancy is a major risk factor for perinatal mortality and morbidity. In recent years the Human Fertilisation and Embryology Authority, HFEA have set a target for the rate of multiple births. This rate has been decreasing year on year and from this year will remain static at 10%. A problem of assessing service changes against a multiple birth rate is that there will be a significant time lag between changes in the processes of assisted conception and birth.

At the present time the additional target we have set ourselves is the rate of multiple pregnancies which is more stringent and also more timely in that changes in practice will result in changes in multiple pregnancy rates before the necessary time delay prior to delivery and hence multiple birth. The multiple pregnancy rate will always be higher than the multiple birth rate due to the higher pregnancy loss rate in women with multiple pregnancies. Since May 2013, we have consistently achieved a mean multiple pregnancy rate of less than 12% In the coming year we aim to decrease our multiple pregnancy rate further to 11% or below whilst maintaining our excellent pregnancy rates.

PRIORITY 3 – Increasing the percentage of nursing and midwifery time spent delivering direct care.
This is an important measure for the Trust. It assures us that despite the many and varied tasks nurses and midwives carry out during their busy day, that direct patient care remains their focus. It is audited on a monthly basis using a “time and motion study”. A proforma which was

developed nationally as one of the tools for the Productive Ward, is completed, and calculates the percentage of time spent on “direct or indirect care”. This is a recognised audit tool developed for this purpose.

Evidence shows that higher percentages of direct care improve:

- Efficiency of care
- Patient experience
- Safety and reliability of care
- Staff well-being and satisfaction with the job they do

Our target for direct clinical care is 60%

The Trust has been working to improve this percentage continuously and has been successful at increasing this percentage steadily throughout the year.

There has been a Trust wide review of the time spent delivering direct care undertaken by the Director of Nursing and Midwifery and assisted by the Heads of Nursing and Midwifery. This has been adopted as a generic Nursing and Midwifery metric and will be measured each month by each area for 2014-15.

2.10 Assessment of Clinical Risks

Currently the Trust has identified indicators to assess the key clinical risks within the organisation which are published and monitored on a weekly basis. These are:-

- MRSA bacteraemia (no instances for over 2 years)
- Clostridium Difficile (no instances for over 3 years)
- Inadvertent bowel or bladder damage during gynaecological surgery
- Unexpected returns to gynaecology theatre
- Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present
- Inborn babies that require therapeutic hypothermia for presumed peripartum hypoxia
- Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved
- Inborn births before 25 weeks where the neonatal consultant was not present at the resuscitation when required to be present by the Trust’s early care guideline
- Incorrect laboratory report released by genetics laboratories
- Reports to SABRE from blood bank

This information (along with last year’s comparator figure) is reviewed monthly at the Trust Management Board and the Patient Outcomes Committee (a sub-Committee of the Board chaired by a Non-Executive Director).

2.11 Cost Improvement Programme

The Cost Improvement Programme will be formally reviewed by the Director of Nursing and Midwifery and the Medical Director in order to ensure that the schemes do not lead to an unacceptable level of clinical risk. This information is then updated and reviewed regularly at the Patient Outcomes Committee throughout the year to ensure the position has not changed.

2.12 CQC Inspection

The Trust had a planned unannounced CQC inspection visit over a weekend in October 2013. The inspectors particularly considered the following Standards :

- Care and welfare of people who use services
- Safety, availability and suitability of equipment
- Staffing
- Assessing and monitoring the quality of service provision

The report confirmed that the inspectors considered the Trust fully meet all these Standards. The Trust is currently in Band 6 Risk Category as confirmed by the Intelligence Reports published by CQC to assess the risk level of each Trust. The Trust is not aware of any concerns that the CQC have at this time.

2.13 The Trust Response to Francis, Berwick, Keogh, Cavendish and Clwyd Reviews

The Trust has undertaken a review and mapping exercise against all the recommendations contained in the Reviews mentioned above. These where reviewed by the Patient Outcomes Committee and discussed and approved by the Board of Directors. The Trust has identified whether or not it currently complies with each of the recommendations with appropriate actions plans where appropriate.

These documents can be found on the Trust website and will be reviewed on a regular basis.

2.14 Operational Requirements and Capacity

In order to achieve the challenging financial and quality agenda the Trust has developed a clear set of objectives, which are directly linked to the Trust's Strategic Objectives which are annual reviewed and refreshed.

These objectives are as follows:

- To deliver an excellent experience that exceeds our patients' expectations;

- To consistently deliver clinical and laboratory outcomes that place us amongst the top hospitals;
- To develop an exceptional organization where people achieve their potential;
- To work with our partners to maintain and develop our service, academic and research standing.

Objective 1 – To deliver an excellent experience that exceeds our patients' expectation

Productivity, Efficiency and VFM	• To improve the Trust's IT capacity • To enhance the neonatal pathway with a focus on family centred care • To increase overnight accommodation for parents in maternity and neonatal services, improving its quality and facilities • To develop enhanced services for recently discharged babies • To expand the portfolio of genetics laboratory tests • To increase neonatal cots above 39 • To ensure the development and delivery of a clear estates strategy to deliver the strategic vision • To provide electronic reporting to internal and external customers of pathology services • To develop support an appropriate Laboratory Information Management System to maximise efficiency of our laboratory services
Service Transformation	• To become a leading organisation in providing *care closer to home* models in maternity services, e.g. home births, Domino service, community inductions, community scanning • To continue to redesign services in gynaecology based upon ambulatory care, day case and outpatient services • To develop one stop ambulatory care environment for gynaecology to provide care and treat services and expanding emergency care • To continue to develop community gynaecology services • To use innovative technology including telemedicine,

	interactive hub based tools and IT to deliver an efficient services base
Patient Experience	• To create a culture of two way communication involving all patients in their care – 'no decision without me' • To focus on areas that show least patient satisfaction to improve patient care year on year • To continue to examine different methods to capture patient experience and feedback • To maintain a culture in which customer care is seen as a critical part of achieving an excellent outcome for patients and which responds to and reflects the diversity of our patient base • To actively embrace the 'patient revolution' • To ensure that patients always have information to make choices and are treated with dignity, honesty and respect • To ensure equity of access to high quality laboratory tests for all patients and providers
Objective 2 – To consistently delivery clinical and laboratory outcomes that place us amongst the top hospitals	
Maternity & Radiology	• To continue to proactively develop the Regional Fetal Medicine Centre as a quaternary centre in the UK, seeking technology enabled opportunities to expand the service e.g. Downs Screening provision and turnaround • To continue to work towards meeting the Safer Childbirth Standards/Birth Rate Plus, e.g. consultant presence, caseload numbers, midwives to birth ratio
Gynaecology & Fertility	• To continue to develop complex and tertiary urogynaecology where the market exists • To become the pan city hub for the provision of fertility, fertility preservation and menopause services • To increase pregnancy rates through continuous scientific and medical review, at the same time as maintaining multiple pregnancy rates within the reduced national targets

Genetics & Pathology	• To be a leading edge genetics service for service delivery, automation, new technology and skill mix • To work towards being the first choice laboratory for any national Genomic Technology development • To continue to develop the perinatal pathology service as a tertiary centre in the UK • To develop an integrated blood sciences laboratory providing haematological, microbiological and clinical chemistry services round the clock
Neonatology	• To strive towards meeting and exceeding the quality standards in national Neonatal Toolkit • To become further recognised as an exceptional Perinatal Centre developing and increasing neonatal surgery capacity and related patient outcomes
Trust wide	• To ensure that the Trust continues at the leading edge of quality, demonstrating this openly and publicly to all our stakeholders • Ensure that the Trust's brand is appropriately defined and then marketed • To ensure that the Trust fully takes on the leadership role in areas where we are excellent

Objective 3 – To develop an exceptional organisation where people achieve their potential

- To develop the leadership capability of the Trust at all levels, being clear about what great leadership is and our expectations
- To continue to develop the *Together We Can* approach to staff engagement and increase both activity and coverage. Striving to become an exemplary organisation in terms of staff engagement, involvement and innovation
- To continue to achieve a financial risk rating of 3 or better under Monitor's new arrangements
- To generate the financial resources required to enable the strategy to be delivered. Use external funding sources only

	where clearly they can be seen to deliver long term affordability and value for money • To increase the wellbeing of staff as measured by relevant KPIs • To improve the attendance of staff, investing in occupational health and staff support services • To be a destination employer for professionals in genetics, health care science, neonatal care, maternity care, gynaecology and support services • To redesign the clinical workforce, working with a most appropriate skill mix, variety of contracts and support structures • To ensure our workforce is widely trained in equal opportunities and that it reflects the diversity of both the community we serve and the wider labour market • To increase the capacity/efficiency of services by maximising use of multi-disciplinary teams and autonomous roles • To be the leading regional education and training centre for junior doctors, undergraduate medical, nursing, scientific and midwifery students for our disciplines • To be a leading genetics training centre of healthcare scientists, technologists, counsellors and clinicians • To be a leader in midwifery and related research • To maximise the contribution and opportunities provided by our members and governors
Objective 4 – To work with our partners to maintain and develop our service, academic and research standing	
With commissioning organisations	• To build strong and effective relationships with the new commissioning bodies, e.g. NCB and CCGs
With Universities	• To develop a Birmingham Institute of Genomic Medicine bringing together education, clinical, laboratory and academic genetics capability • To increase national and internal prominence for clinical, academic and research capability in obstetrics, fetal medicine and gynaecology

	• To further develop neonatal academic activity and raise the profile of the Unit • To develop stronger academic links with the University of Birmingham, further supporting the development of pathology related research
With groups and clusters of public sector organisations	• To understand our wider inter-dependencies and manage these to achieve the best outcomes for patients • To lead the Maternity Capacity review on behalf of Birmingham & Solihull, focusing on a vision of integrated women's and newborn care • To drive discussions around services for families in Birmingham • To create an effective, influential lobby for appropriate tariffs • To influence the development of the new learning, education and development infrastructures i.e. through the West Midlands Local Education and Training Board and the Birmingham Local Education Training Committee.
With private and third sector organisations	• To increase private patient services in gynaecology and fertility services • To continue to build relationships with the genomic biotechnology industry • To explore further private and third sector partnership potential • To maximise the fundraising and publicity opportunities afforded by the Birmingham Women's Charities
With other single NHS provider organisations	• To evaluate a joint estate and organisational solution with local NHS organisations • To develop single number, single cot locator in partnership with BCH • To develop enhanced care pathways with UHB with an initial focus on interventional radiology and emergency gynaecology and urology • To continue maximising new opportunities and existing partnerships with other local providers

These objectives will be used to drive the quality and financial agendas and provide the bedrock of the Trust's future plans.

2.15 Staffing

The proposed financial plan includes allowance for an increase in WTE from 1450 to 1545. The main reasons for the increase in staffing levels are listed below:

- ICT staff to support the service previously outsourced
- Midwifery staffing to support the newly commissioned home birth team
- Neonatal staff to support the move towards BAPM standards
- Midwifery staff to support the move towards Birthrate plus standards
- Genetics staff to support the increase in activity.

A significant amount of the pay CIPS are related to skill mix changes and variable pay (i.e. bank, agency, overtime etc.) and therefore are not anticipated to significantly reduce the headcount of the organisation.

2.16 Bed Capacity

The Trust is anticipating that the bed and cot capacity will remain at its current levels. However, the Trust is in negotiation with NHS England regarding the potential increase in NNU cot capacity over the current number of 39, in order to allow the commissioners to meet the demand identified in the new-born capacity review for Birmingham and Solihull, undertaken in 2013/14.

3. PRODUCTIVITY, EFFICIENCY AND COST IMPROVEMENT PLANS

3.1 Cost Improvement Programme

The cost improvement programme has been built up from schemes identified by each Clinical Directorate or department. These were then discussed by the Management Board (Executives and Clinical Directors) in order to agree a final position. All income schemes are net of expenditure relating to that scheme and are included within the contracting position. Below is a summary of all the schemes, including the split for recurrent and non-recurrent CIPs as well as those for Income, Pay and Non-pay, and can be summarised as follows:

Directorate	Income	Pay	Non-Pay	Total	Recurrent	Non-Recurrent	Total
Maternity	174,400	218,000	576,764	**969,164**	830,564	138,600	**969,164**
Neonatal	199,260	383,141	134,322	**716,723**	271,723	445,000	**716,723**

Gynae.	443,959	29,066	95,189	**568,214**	553,148	15,066	**568,214**
Genetics	361,814	441,430	178,392	**981,635**	485,031	496,604	**981,635**
Corporate	35,000	23,500	298,789	**357,289**	328,189	29,100	**357,289**
	1,214,433	**1,095,137**	**1,283,456**	**3,593,026**	**2,468,656**	**1,124,370**	**3,593,026**
	34%	**30%**	**36%**		**69%**	**31%**	**100%**

It should be noted that Directorates do not have the same percentage of CIPs compared to budget, with Neonatal and Genetics Directorates having a greater percentage than the corporate departments (including facilities) and Gynaecology. Approximately 50% of the maternity CIP relates to the achievement of CNST level 3. This is to recognise the different level of opportunities to identify savings across the Trust as well as the different levels of Capital Investment for each of the Directorates.

3.2 Key CIP Risk

2014-15

Each of the CIPs has individually been given a level of risk with those identified as low risk being highly expected to be achieved, those at a medium risk being expected to be achieved with some agreed actions, and those CIPs identified as high risk being achievable but with a significant level of management.

Risk Profile	Low	Medium	High	Total
Maternity	540,717	192,447	236,000	**969,164**
Neonatal	141,463	535,260	40,000	**716,723**
Gynaecology	46,911	370,303	151,000	**568,214**
Genetics	237,112	744,523	-	**981,635**
Corporate	51,189	85,100	221,000	**357,289**
	1,017,392	**1,927,633**	**648,000**	**3,593,026**
	28%	**54%**	**18%**	

2015-16

In order to achieve the required level of CIPs approximately £4 million worth of schemes will need to be identified. So far detailed schemes of approximately £1m have been identified, although a significant number of other opportunities are currently being developed, but are not sufficiently understood to fully quantify

These schemes focusing in the following areas will be drawn up in detail during 2014-15 to ensure a robust detailed financial plan is available for 2015-16. This process will start in April 2014 to ensure the maximum opportunity is available to do any preparatory work before the CIP is expected to deliver.

- Income generation from NHS and Non-NHS schemes (Business Development Group). These CIPs will be income net of costs of implementation.

- Efficiency improvements utilising developments in IT infrastructure, including wi-fi, community midwifery IT module (already purchased), badgernet neonatal system, advanced bed management and EPR for Maternity. These CIPs will be both pay and non-pay.

- Efficiency improvements following developments in capital infrastructure, e.g. automated kiosks, voice recognition software, genetics liquid handling station. These CIPs will be both pay and non-pay.

- Review of SLAs, in particular Information Technology, Pharmacy, Procurement and Occupational Health. The Trust has changed supplier for all these services over the last 12 months and the benefits of the new supplier are anticipated to start over the coming year with a full year effect in 2015-16.

- Review of the ante-natal and post natal pathways, including benchmarking of length of stay.

- Increase numbers of births due to the Domino Service and expansion of the home birth service

- Introduction of new services in gynaecology from recruitment undertaken in 2014-15, such as 7 day working in EPAU, Termination of Pregnancy Service (TOPS) and miscarriage service.

- Increase in fertility provision through a move to 5 day egg collection, better utilising the current estate.

- Expansion of the portfolio of genetics laboratory tests e.g. Clinical Exome service, whole genome sequencing and bioinformatics analysis across all referrals. In addition the genetics service would expand Cardiac and Endocrine specialist services to regional services.

- Introduction of a community neonatal team.

3.3 The Financial Plan

3.3.1 Current Financial Position

The Trust has continued to make small net surpluses over approximately the last ten years and

this will continue in 2013-14. The Trust had a previous Risk Rating of 3 and a now has a Continuity of Service Risk Rating of 4, and no external borrowing outside Public Dividend Capital. This stable financial environment has been brought about by a combination of increasing income growth through the development of new services and the regular delivery of cost improvement programmes. The Financial Plan sees these trends extending into 2014-15 and 2015-16.

The Trust has also continued to maintain a Continuity of Risk Rating of 4 throughout the year, although the liquidity ratio has been put under pressure due to phasing of Capital expenditure, the Debt Ratio is expected to remain stable as the Trust only has borrowings of Public Dividend Capital.

This trend is expected to continue throughout the 2 year period under consideration (although not for the longer term trend) as the financial plan is for approximate breakeven with income and expenditure statement and a Capital expenditure plan which utilises the opportunities from non-cash items in the I&E and any funds that were not spent in the 2013-14 Capital programme as well as part of the anticipated surplus in 2013-14.

3.3.2 Assumptions

The key financial assumption are listed below:

- Pay rises of 1% for all staff without incremental point increase
- Tariff prices are based on the published Monitor prices;
- All other income has been considered individually on a line by line basis.
- Provider-to-provider income is based on Month 9 invoices excluding transitional payments received in 2013-14.
- SLAs with other NHS bodies are considered to remain priced on an individual basis with SLAs with pay as the main cost having a 1% increase. SLAs where there are known issues are individually budgeted for.
- CNST costs have reduced by £818K, of which £417K relates to the move to level 3 and is shown as a maternity CIP and the remaining is shown in the baseline position and relates to the Trust's claims history.
- CIPs in 2013-14 that have been delivered non-recurrently have been excluded;
- Non-pay is based on forecast outturn for 2013-14, with changes made for non-recurrent items and price increases where known.
- National Genetics Education Development Centre will transfer out the Trust on 1st April.

- Depreciation includes any increases for known capital expenditure and revaluations are assumed to confirm the Net Book Value amounts;

- Activity is based on forecast outturn for 2013-14.

- Contract income is based on offers from the CCG and NHS England with agreed variations only included – other income generation schemes are included as Cost Improvement Programmes.

- Contingency is set at £450K

For 2015-16 the key financial assumptions are :

- Pay rises of 1% for all staff

- Additional 0.7% employer pension contributions.

- Tariff deflator of 1.9% in line with Monitor projections

- Non-pay increases of 3% in line with Monitor projections

- NHS activity will be as planned for Maternity, Gynaecology, Fetal medicine, Fertility, Neonatal and Genetics. The contract will reflect the 2014-15 outturn position with activity being paid at marginal rates will be paid at full cost in 2015-16.

- The genetics contract will continue to have a threshold of 5% paid at 50% marginal rates in 2015-16 and this threshold will be reached.

- CNST premiums will remain at 2014-15 levels.

Using these assumptions the Trust anticipates that it will achieve a Continuity of Service Risk Rating of 4 for all quarters in 2014-15.

3.3.3 Income

The Trust has aligned its plans with those of BSC CCG and NHS England for 2014-15 and the figures included in the plan are based on the agreed contract. Other income is based on 2013-14 anticipated outturn. For 2015-16 the commissioners have not shared with the Trust detailed financial plans and therefore the Trust is not in a position to comment on whether these plans align or not.

Increases in activity for 2015-16 are either based on long-term trends e.g. genetics, or based on known demand that is currently being treated outside the NHS (e.g. fertility, TOPS)

3.3.4 Capital Plans

The Trust anticipates its capital expenditure to be approximately £5.6 million. £0.9m relates to schemes that where funded in 2013-14, but have not yet completed and this funding is therefore being utilised in 2014-15. For 2015-16 the Trust is assuming that any VITA costs not utilised in 2014-15 will be moved into 2015-16 to fund these elements of the project. The remaining schemes can be summarised into the various departments as follows.

This can be broken down as follows:

	Agreed 14/15
Directorate	**£'s**
Corporate - Informatics	75,000
Corporate - ICT	900,000
Corporate - VITA	1,600,000
Facilities	700,000
Maternity	300,652
Gynae	133,752
Neonatal	122,484
Pathology	125,400
Genetics	492,000
	4,449,288

	Agreed 15/16
Directorate	**£'s**
Corporate - ICT	1,000,000
Facilities	850,000
Maternity	322,000
Gynae	129,000
Neonatal	107,430
Pathology	410,000
Genetics	705,000
	3,523,430

3.3.5 Financial Risk

The key financial risks to the Trust are the following:-

Key Income Risks 2014-15

The key risk is that activity levels anticipated are not achieved and this would result in a drop in income in most services. There is also the possibility that the Trust will undertake greater activity than anticipated, although it should be noted that in genetics this would take the Trust above the currently agreed cap and would not automatically attract payment and in maternity the Trust would not accept additional activity if this was not felt to be clinically safe.

As the activity is based on the forecast outturn for most areas (except for those areas where there is historically very strong growth) this risk is deemed medium rather than high.

Key Pay Risks
An increase in sickness would lead to the Trust needing to utilise additional bank expenditure to ensure the service quality did not decline. This is a high risk with a 1% increase in expenditure leading to approximately £200,000 increase in cost.

As incremental progression has not been funded, this assumes that the Trust will replace higher graded staff with staff on a lower scale point. This is in line with Agenda for Change (A4C) Terms and Conditions and has historically been the case. However if the turnover of the Trust declines this may lead to a cost pressure. A 10% reduction in staff turnover would lead to approximately £70,000 incremental drift costs.

Key Non-Pay Risks
There is a risk that prices increase at a faster rate than anticipated e.g. in energy costs or drug prices.

There are specific risks relating to the SLAs regarding Anaesthetics and Hearing Screening (£150K) which are still being negotiated.

Risks to the Financial Plan 2015-16
The risks identified for the 2014-15 plan will also apply to 2015 -16 plan, although the income risks can be assessed as higher as for obvious reasons negotiations regarding that year are far less advanced. In addition there are additional risks that NHS England will change the current rules regarding service funding mechanisms or prices that will be to the detriment of the Trust.

The key risk will be the non-delivery of CIPs, particularly in 2015-16.

The Trust will therefore mitigate this risk by focusing on identifying the detail of the 2015-16 cost improvement plan, focusing in on the areas listed above. However the Trust will base its plan on the foundations which have been laid in 2013-14. Particularly:

- Review of models of care in order to ensure that the Trust has a clear understanding of how services will be delivered in the future undertaken as part of the VITA project to refresh the Trust's estate in the medium term.

- Review of SLAs, in particular Information Technology, Pharmacy, Procurement and Occupational Health. The Trust has changed supplier for all these services over the last 12 months and the benefits of the new supplier are anticipated over the coming year.

- The introduction of new technology e.g. kiosks in gynaecology, K2 community and antenatal modules, badgernet (neonatal), Documentum (in genetics) and a data warehouse. These systems are all anticipated to have qualitative as well as quantitative benefits to the Trust, and have either been introduced or are anticipated in the next 6

months.

- Other Capital investments such as Next Generation Sequencing, New PACS environment, voice recognition software, ultra sound scanners.