Trust Structure and Divisions

Ben Gray
Assistant Director – Strategy, Planning and Integration

About me

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The Rotherham NHS Foundation Trust

- Assistant Director of Strategy, Planning and Integration
- Joined the NHS on the National Graduate Training Scheme – specialising in Finance
- Operational Management – Guys and St Thomas', ICHT and Doncaster and Bassetlaw Hospital
- Management Consultancy

- Help the organisation work out what it needs to do in the short/medium term (planning) and the longer term (strategy) and then help deliver this.
- A external focus of the role, recognition the increasingly integrated approach within the NHS (Integration)

act

What we'll cover today

- The Types of Provider Trusts in the NHS
- A Look Inside an Acute Trust
- The Rotherham NHS Foundation Trust

A Trust Structure

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Provider Trusts within the NHS

There are four main provider Trust groups within the NHS. :

- Acute / Hospital (Secondary Care)
- Community
- Mental Health
- Ambulance

The lines between these four groups have continued to erode

- Mental Health and Community (RDASH)
- Acute and Community (Rotherham)

There are around 220 Trust's across the four Groups in England.

Primary Care Networks may take on some Community Services

A Trust Structure

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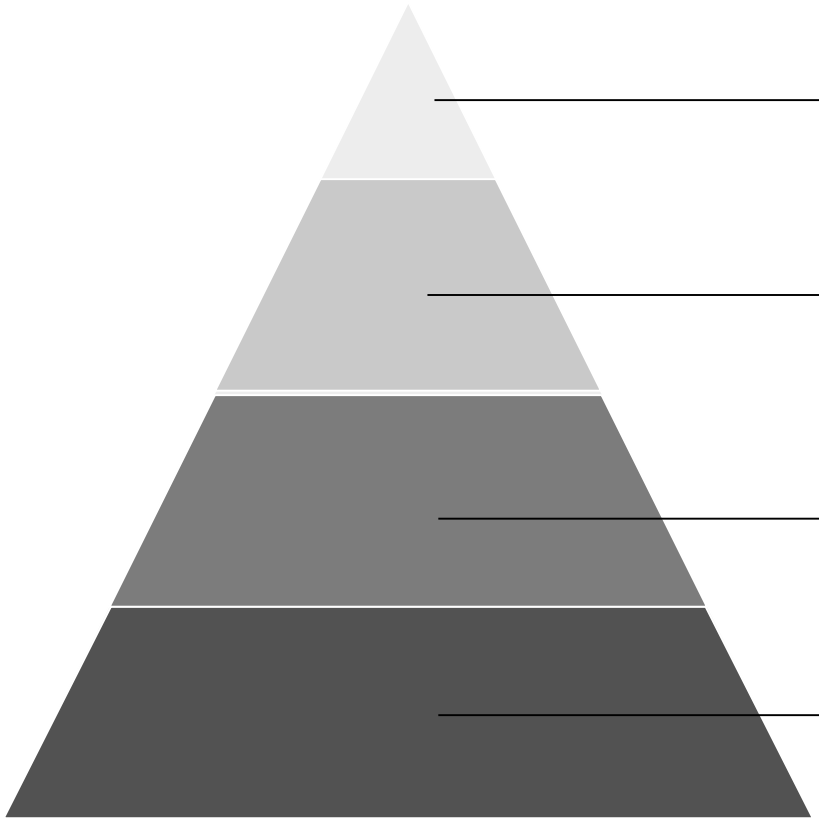
Looking inside an Acute Trust



Board of Directors

Trust Executive Team / Executive Directors

Divisional / Care Group Teams

Service Teams

Board of Directors

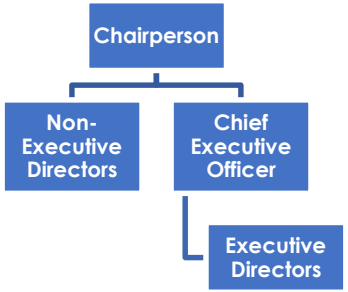
Council of Governors are responsible for assuring the performance of the Board of Directors by holding the Non-Executive Directors to account

Council of Governors made up of:

- Public Governors
- Staff Governors
- Partner Governors

Assurance Committees are chaired by a NED and ensure the Board of Directors receives assurance (positive or negative)across all areas of the Trust's business

The Board of Directors is responsible for the operational management of the Trust and, with the participation from the Council of Governors, sets the strategic direction of the Trust.



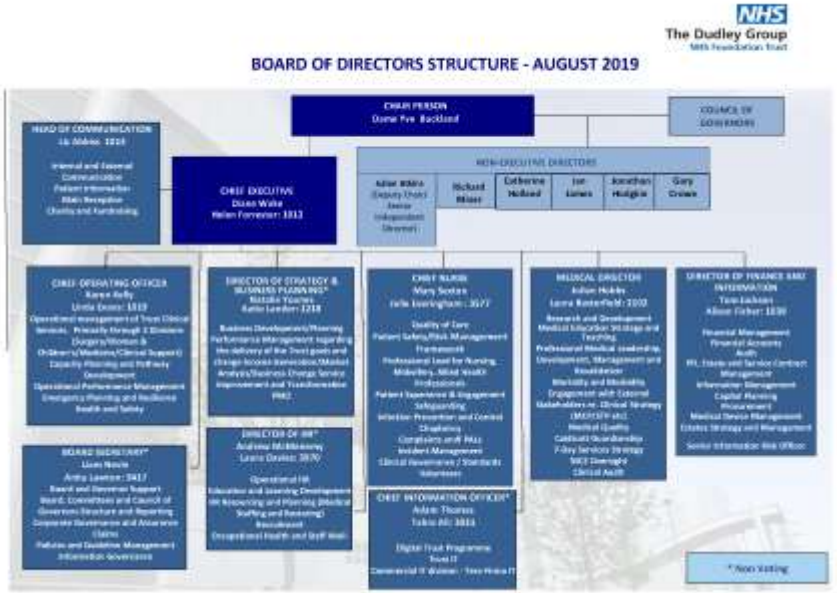
At least 6 non executive members including the Chairperson (must always make up more than half of the board)

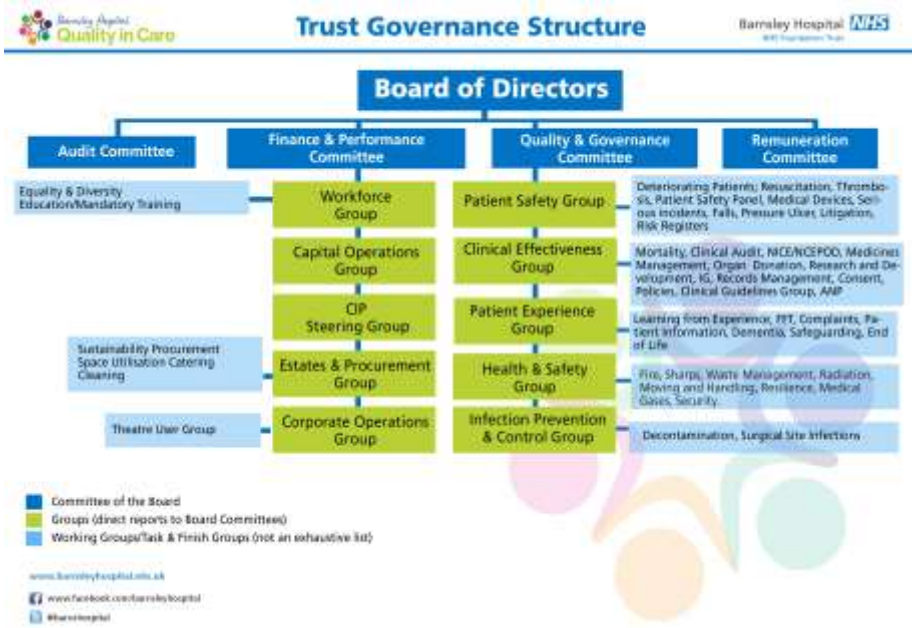
Executive members must include:

- Chief Executive
- Finance Director
- Registered medical practitioner or dentist
- Registered nurse or midwife

Board of Directors
Executive Team
Divisional Team
Service Team

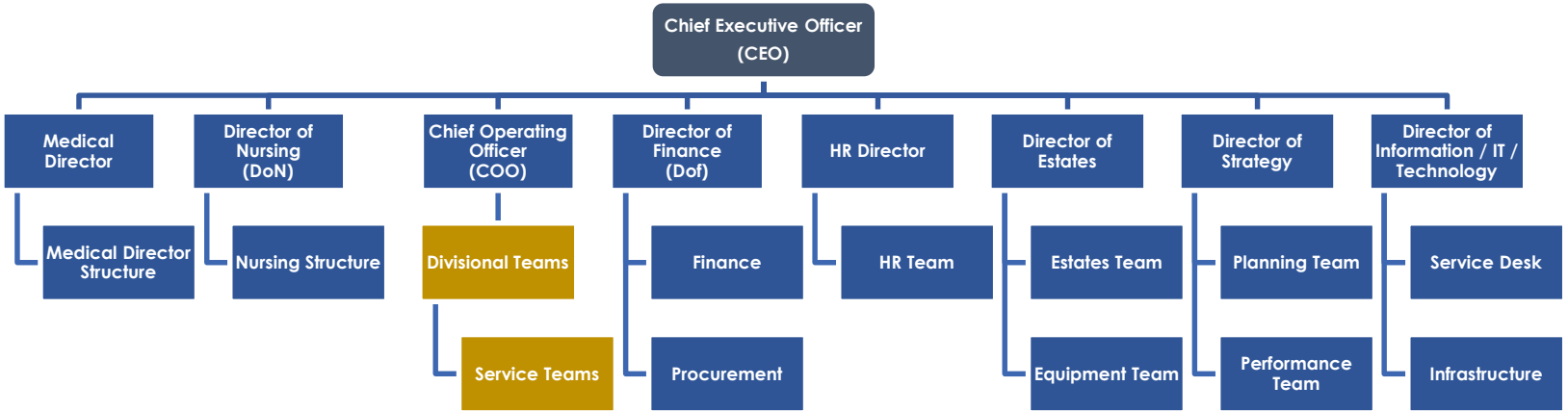
Examples


NHS
The Dudley Group
BOARD OF DIRECTORS STRUCTURE - AUGUST 2019
CHAIR PERSON
Dame Pye Backland
CHIEF EXECUTIVE
Diana Wake
Helen Forrester: 1313
NON-EXECUTIVE DIRECTORS
Richard Moser
Catherine Holland
Jon James
Jonathan Hodgkin
Gary Crowe
CHIEF OPERATING OFFICER
DIRECTOR OF STRATEGY & BUSINESS PLANNING*
CHIEF NURSE
Mary Seston
MEDICAL DIRECTOR
DIRECTOR OF FINANCE AND INFORMATION
BOARD SECRETARY*
DIRECTOR OF HR*
CHIEF INFORMATION OFFICER*
* Non-Voting


Barnsley Hospital
Quality in Care
Trust Governance Structure
Barnsley Hospital NHS
Board of Directors
Audit Committee
Finance & Performance Committee
Quality & Governance Committee
Remuneration Committee
Equality & Diversity Education/Mandatory Training
Workforce Group
Capital Operations Group
CIP Steering Group
Estates & Procurement Group
Corporate Operations Group
Sustainability Procurement Space Utilisation Catering Cleaning
Theatre User Group
Patient Safety Group
Clinical Effectiveness Group
Patient Experience Group
Health & Safety Group
Infection Prevention & Control Group
Deteriorating Patients; Resuscitation; Thrombosis, Patient Safety Panel, Medical Devices, Serious Incidents, Falls, Pressure Ulcer, Litigation, Risk Registers
Mortality, Clinical Audit, NICE/NCEPOD, Medicines Management, Organ Donation, Research and Development, IG, Records Management, Consent, Policies, Clinical Guidelines Group, AHP
Learning from Experience, PET, Complaints, Patient Information, Dementia, Safeguarding, End of Life
Fire, Sharps, Waste Management, Radiation, Moving and Handling, Resilience, Medical Gases, Security
Decontamination, Surgical Site Infections
Committee of the Board
Groups (direct reports to Board Committees)
Working Groups/Task & Finish Groups (not an exhaustive list)

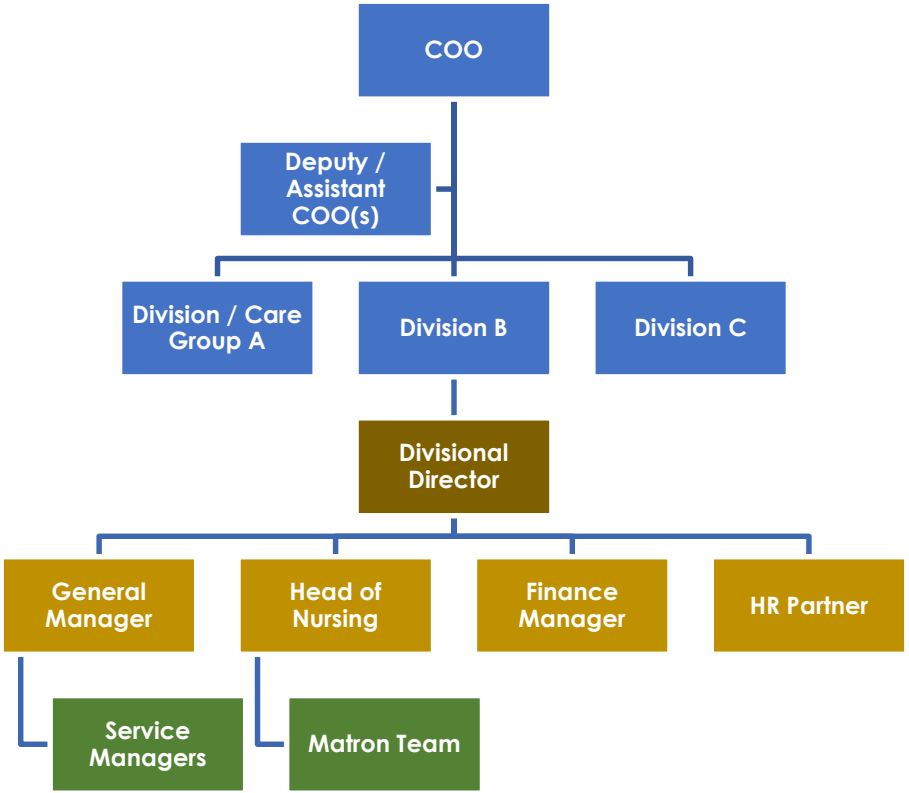
Executive Team

- A Trust Executive Team run the Hospital on a day to day basis.
- They are responsible – through the CEO – to the Board of Directors



Board of Directors
Executive Team
Divisional Team
Service Team

Divisional Structure



- Each Trust Structure will be slightly (or sometimes significantly) different.
- Historical Influences / restructures / personalities etc
- Number often dependant on the size of the Trust and/or support within each division (flat v tall structure)
- Divisions usually built around Medical Specialities – i.e. Medicine, Surgery, Family Health etc
- Divisional Directors usually report into the Chief Operating Officer
- 'Dotted Lines' to Head of Nursing / Medical Director / Professional Leads etc

Board of Directors
Executive Team
Divisional Team
Service Team

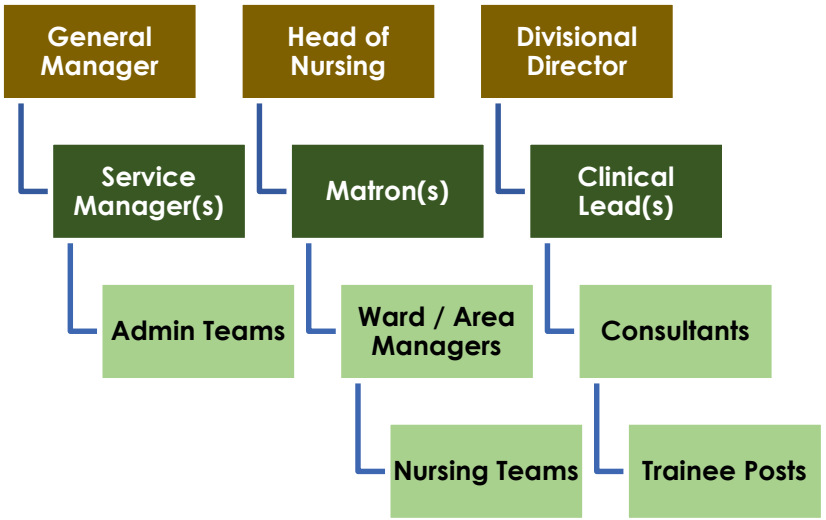
Divisional Roles and Responsibilities

- Divisional Teams Lead the Division – and will have the autonomy to do this – along with the accountability. The larger the hospital, often the more 'independent' they are
- Responsible for all the services within them, making sure they provide high quality, safe services that achieve there performance targets and are financially sustainable
- Will performance manage the services
  - Operational Performance
  - Clinical governance meetings / SI investigations etc
  - Finance / CIP
  - Etc
- They try and think more medium / longer term than the service teams – leading on planning and strategy for the services within the division
- Expected to work collaboratively across the teams – similar to a Trust Executive Team

Questions / Challenges

- What is the right grouping of services for a Division? Why does it matter?
- Traditional Structures v New idea

Service Teams



Leadership Teams

- Day to Day leadership and problem solving
- Work collaboratively across the service(s)
- Staff and Performance Management

Service Teams

- Provide the service(s)

Admin: Booking Clerks, Rota Managers, PA's etc

Nursing: Ward Teams, Specialist Nurses, unit managers

Questions

- What defines a service?
- How do cross cutting services/functions (i.e. pain team, Outpatients) get managed?
- How do you engage with the service leadership?

Treatment Function Codes

- 94 Main Speciality Codes
- 182 Treatment Function Codes

- Speciality Codes are medically driven – maintained by a medical body
- Each consultant is assigned to a main speciality on appointment
- Most activity returns made by Acute Hospitals are by Treatment Function Code

	Code	Description
Spec	100	General Surgery
Spec	101	Urology
TFC	104	Colorectal Surgery Service
TFC	109	Bariatric Surgery Service
Spec	110	T&O
Spec	300	General Internal Medicine
Spec	301	Gastroenterology
TFC	307	Diabetes Service
Spec	320	Cardiology
TFC	328	Stroke Medicine Service

A Trust Structure

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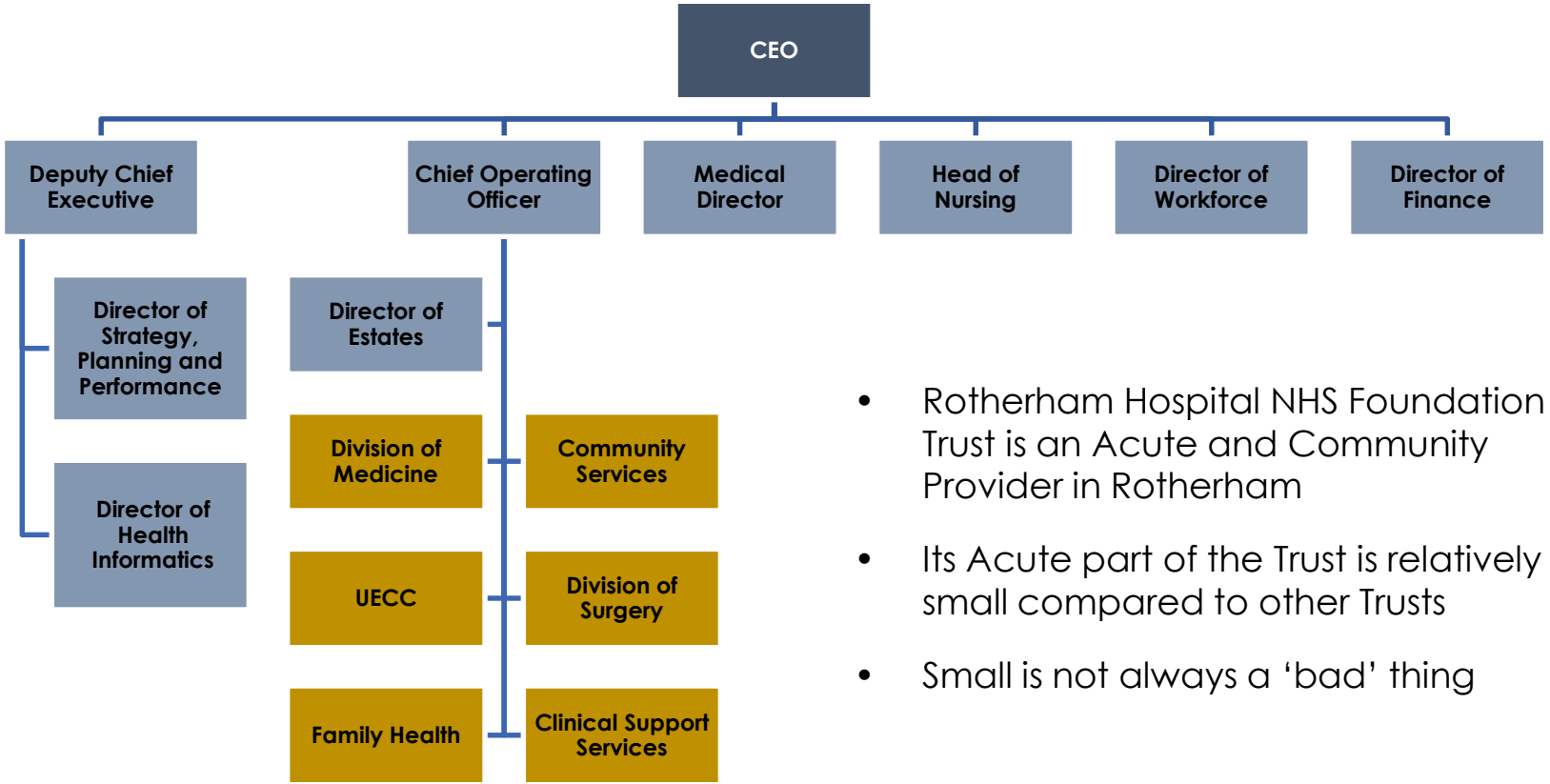
The Rotherham Hospital NHS Foundation Trust



- Rotherham Hospital NHS Foundation Trust is an Acute and Community Provider in Rotherham
- Its Acute part of the Trust is relatively small compared to other Trusts
- Small is not always a 'bad' thing

THANK YOU

Any questions

Trust Finances and Efficiency Requirements

Ben Gray
Assistant Director – Strategy, Planning and Integration

What we'll cover today

- A general introduction to acute finances
- Historic spending and efficiency requirements
- A introduction to efficiency programmes

Acute Finances

- A general introduction to acute finances
- Historic spending and efficiency requirements
- A introduction to efficiency programmes

Acute Finances

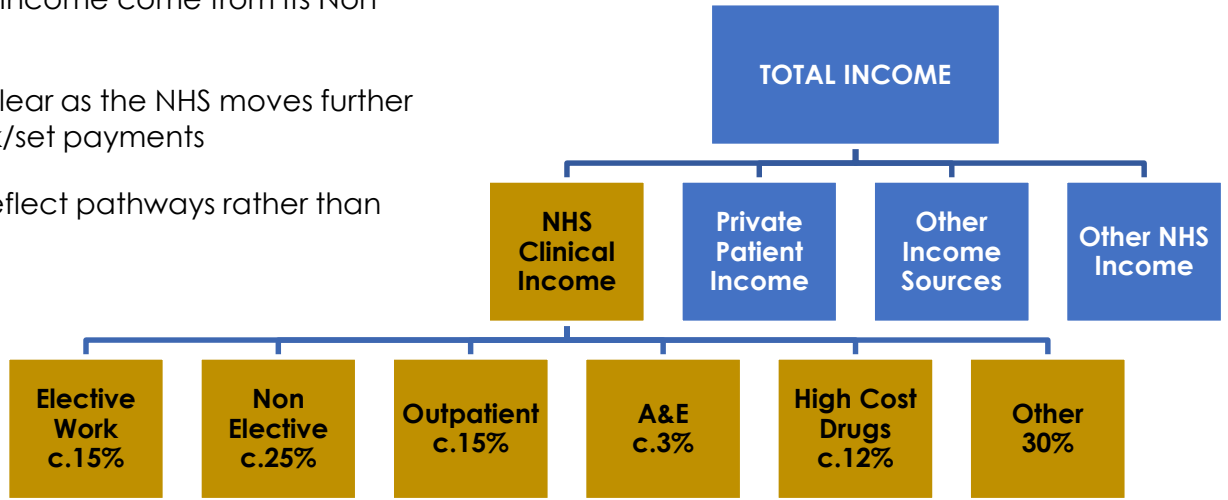
What do you think the yearly spend for a hospital such as Sheffield Teaching Hospitals is?

£1,203,960,000 in 2019/20

Employs c.17,000 staff

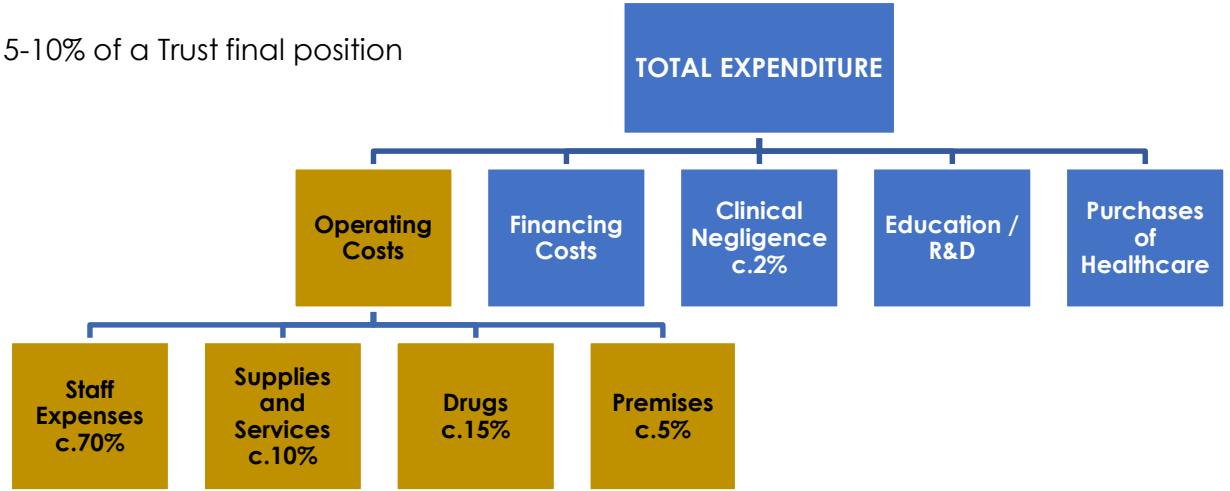
Where does a Trust get its money from?

- While it depends on the organisation, NHS Clinical Income will always be the main source of income for an Acute Trust
- Significant proportion of a Trust's income come from its Non Elective Work (c.25-30%)
- The exact split is becoming less clear as the NHS moves further away from Tariff income to block/set payments
- Some payments are starting to reflect pathways rather than elements of it



Where does a Trust spend its money?

- Staffing cost are by far the largest expense of any Acute provider at around 70%
- Clinical Negligence costs are a significant amount of money for Trusts
- Financing costs could be around 5-10% of a Trust final position



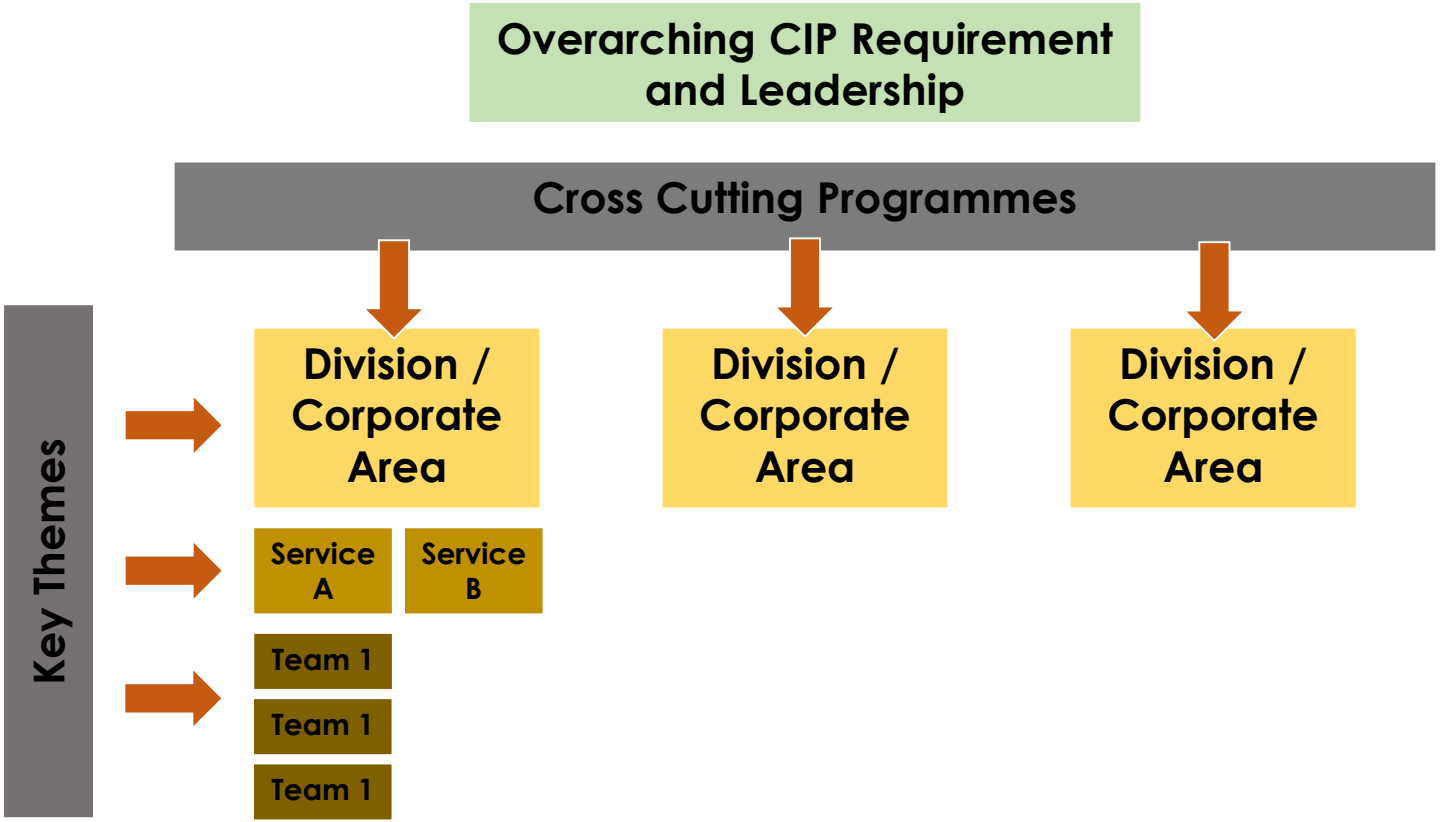
Why does a Trust need a efficiency programme

- In 2019/20 (this year), the plan was for a Tariff uplift of 2.4% and a efficiency factor of 1.1%.
- Therefore a minimum of 1.1% efficient was needed to maintain the status quo
- However, what about improvements?
  - Invest in quality
  - Invest in new, better services?
  - Investments to reduce 'gaps in services'
  - New requirements

	20/21	21/22	22/23	23/24
Pay	2.9%	2.8%	2.1%	2.1%
Tariff Drugs	0.6%	0.6%	0.6%	0.6%
Capital	1.8%	1.9%	2.0%	2.0%
Other	1.8%	1.9%	2.0%	2.0%
Overall	**2.4%**	**2.4%**	**2.0%**	**2.0%**
Efficiency Factor	**(1.1%)**	**(1.1%)**	**(1.1%)**	**(1.1%)**
Tariff Uplift	**1.3%**	**1.3%**	**0.9%**	**0.9%**

- However, activity is also increasing. This needs to be paid for.
- Commissioners will try to limit activity growth, reduce spend on acute services (QIPP)
- This could be anything from 2-4% reduction in income for Trusts – but costs cannot always be removed with this – so additional efficiency needed.
- Usually, a 'deliverable' efficiency programme may be between 2-5% of clinical income – though can be lower and higher (often dependant on national funding)
- NHS Long Term Plan – 1.1% for all Trusts, 0.6% additional if in deficit.

Structure of a CIP programme



A Efficiency Programme

	Plan (£000s)	Actuals (£000s)	Variance (£000s)
Bed Efficiency	1,269	0	-1,269
Cost Control	5,200	3,252	-1,948
Medical Pay & Productivity	3,653	945	-2,708
Medicines Management	1,873	2,645	772
Nursing and Midwifery	3,112	263	-2,849
Other Income - Clinical	718	4,334	3,616
Other Income - Non Clinical	5,113	3,772	-1,341
Other - Non Pay	1,988	847	-1,141
OP Efficiency	2,882	0	-2,882
Procurement	6,863	5,970	-893
Technology	2,111	319	-1,792
Theatre Efficiency	3,585	213	-3,372
Workforce – Other	2,633	10,453	7,820
Total	**41,000**	**33,013**	**-7,987**

Cost Reduction Programme (CRP) – Cost Improvement Programme (CIP) – Cost Control Programme(CC)

- Where was the money planned to be saved?
- Where was it actually saved?
- Cross Cutting Clinical Areas
  - Outpatients
  - Theatres
  - Diagnostics
- 'Other'

Efficiency Schemes

Identify – Delivery - Monitor

- **Cross Cutting Clinical Areas**
  - Outpatients (Virtual Clinics - DNA's etc)
  - Theatres (Throughput - LA/GA)
  - Diagnostics (Throughput - Modality)
  - Beds (SDECs – DCvEL)
- **Workforce (70% of Costs)**
  - Reduce Agency Spend
  - Skill Mix (Nurse endoscopists / Typists v PAs etc)
  - Automation – BI / Coding
  - Admin

Unit – Service – Divisional - Trust

- **Non Pay**
  - Procurement: Contracts - Leases
  - Clinical Supplies: New Supplier – Off Brand
  - Stationary
  - Drugs: Generics
- **Transformational Change**
  - Integrated Care
  - New technology – clinical and non clinical
  - Prevention / Proactive Care
  - 'Channel Shift'

An Efficiency Programme

There is RISK with an efficiency programme

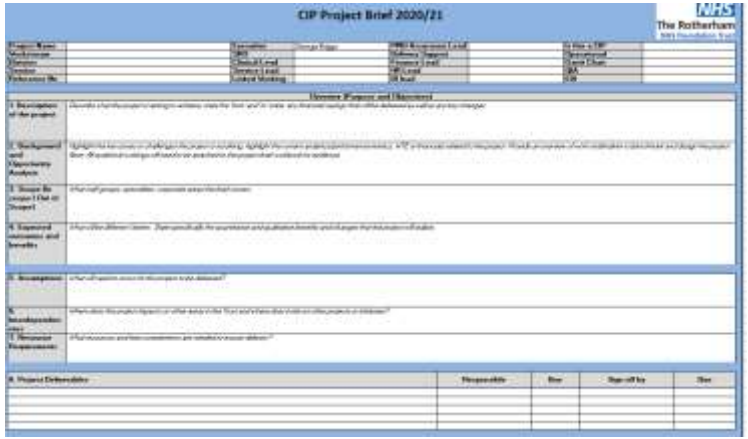
- Can you deliver what you said you would?
- Does the delivery of this CIP impact on quality of care?
- 'Swiss Cheese' approach and short-termism
- Unintended consequences
- Cost shifting

Where can we reduce costs

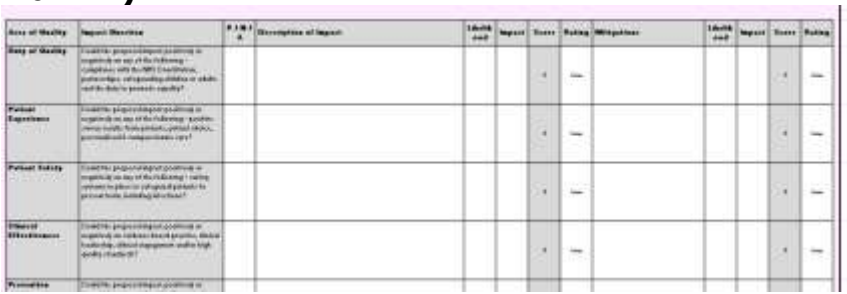
- Cost reduction
- Cost Avoidance
- Additional Income
- Run Rate v Budget

The Steps of a CIP Scheme

- **Project Mandate / PID**
  - Outline of the project
  - Scope
  - Outcomes / Benefits
  - Interdependencies
  - Resource requirements
  - Workforce impact



- **Quality Impact Assessment (Signed off my DoN and MD)**
  - Patient Experience
  - Patient Safety
  - Clinical Effectiveness
  - Prevention & Inequalities



Efficiency – Your Role

Everyone within an organisation should contribute to making it as efficient as it can be

We are spending taxpayers money and we have a obligation to spend that as well as we can

IDENTIFICATION

- You are on the front line – where most the money is spent
- What can we do better / what could we change?
- You see other organisations – fresh eyes – what did they do better?
- Trust should want to involve you / speak to you
- Impact Assessments

DELIVERY

- You may be impacted by change – how do you 'get on board'
- Influence how something is delivered / get involved
- Support colleagues who maybe don't get it / buy into it

If you get the Quality Right, efficiency usually follows

THANK YOU

Any questions