BUSINESS CASE TEMPLATE

NEW CONSULTANT COLORECTAL SURGEON

Division/Department	**Digestive Diseases – Unplanned Care**		
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Date	**03/09/ 2019**		

1	**Background & Rationale for Change** *Provide an outline of what you want to do, highlight the issues with the status quo and identify the risks of not proceeding with the proposal.* *Aim for 500 words*

General surgery is currently failing to meet RTT targets, 14 day, 31 day and 62 day cancer targets for both upper and lower GI, and as a CBU are also failing to meet the surveillance and urgent endoscopy demand; of which general surgery contribute to covering. This inability to meet these targets has been contributed to by a number of factors:

<u>Endoscopy</u>

The Endoscopy unit is currently struggling to meet the competing demands for 2ww cancer, routine and surveillance backlog; this is then having a negative effect on General surgery ability to provide definitive treatment in a timely manner, leading to long RTT waits.

<u>General surgery workforce</u>

The extraordinary unforeseen demands on the existing workforce time for a number of reasons:

1. Temporary and permanent sickness resulting in a loss of 25% of our consultant workforce
2. Major gaps in the junior rotas at registrar, SHO and house officer level. These gaps have resulted in the existing flexible component in peoples job plans being used up to cover these gaps and we therefore have no capacity to pick up the shortfall.
3. The CBU has been unable to undertake premium rate working within Bradford Hospitals Trust because of issues with payment and pension and tax.

The CBU has implemented the following actions to improve the current position:

- Outsourcing activity to Yorkshire Clinic for GS theatre cases; this contract ceases end June 2019
- Outsourcing Endoscopy to and Eccleshill; this contract has now ceased
- Review of all GS clinic templates to ensure constitency across the specialty
- Increased management and oversight of backfill
- Utilisation of 80% of General surgery allocated theatre capacity
- Use of theatre booking tool to maximise list utilisation and increase numbers on lists
- Short term locum cover

The CBU proposes to appoint a new full time consultant colorectal surgeon. This person will not directly bring in new activity but will work to reduce the backlog of work and improve almost every target on which we are measured. This person will work within the current template in outpatients, theatres and endoscopy and will not produce any new demands on those sessions or indeed on any other aspect of the estate. The post timetable will consist of 2 Endo lsits, 2 theatre sessions and 1 OPD.

The specialty is in contact with a highly desirable colorectal surgeon who is ready and available and wants to come to Bradford. This individual in question also has an interest in the subspecialty of pelivc floor, we currently offer this service however its becoming increasingly busy and run by a stand alone surgeon. The MDT is full and the CPF clinic is fully booked for the next 5 months. As pelvic floor surgery becomes increasingly more specialised and after the national 'mesh crisis' we are finding increasing numbers of tertiary referrals particularly from Airedale . At present the single handed consultant is seeing approximately 5-10 referrals / month from Airedale (either the colorectal or gynae team). The Pelvic Floor Society have produced guidelines on what is required for a unit to receive full accreditation. We currently fall short of their

requirements in terms of the number of dedicated clinics and surgeons.
The candidate was interviewed last year for the last appointment but at that stage was not quite ready. We will lose this individual if we don't act quickly.

2	**Proposed Outcomes & Benefits Realisation** *What will be achieved? Provide a **realistic** assessment of outcomes for patients and the Trust. Show how the proposal will improve quality. Say how the proposal will improve delivery of performance and/or financial targets. Don't forget to **clearly justify the investment** (benefits do not have to be financial). Remember there will be a post implementation review and the DGM and DCD will be held to account - so be realistic about what the proposal can achieve.* *Aim for 350 words*

The filling of this post will achieve a number of measureable outcomes.

(1) Improve patient experience and safety
(2) The RTT position will improve
(3) The cancer 14, 31 & 62 day targets will improve
(4) There will be reduction in non-cancer endoscopy waits for urgent and surveillance cases
(5) There will be repatriation of work to the BRI and a vast saving in the cost of such work going out of the organisation some of which will hopefully appear in the cost improvement programme.
(6) Eradicate the need for locum cover in this area
(7) Participate in acute on call commitments

The appointment of another surgeon will also free up the burden on the existing workforce and increase their ability to work flexibly. The knock on in improvement and quality of care for patients will follow if only in reducing the amount of time patients have to wait for urgent cancer care.

Impact on Performance and Capacity & Demand projections:

Endoscopy:

- Current levels of planned capacity were compared to predicted demand using the NHSI IST model for Endoscopy. This showed a weekly shortfall against the mean and a significant shortfall against the 65th and 85th percentiles. The use of flexible backfill sessions, premium rate sessions and the independent sector is needed to prevent further deterioration in performance but will not clear the existing backlog of patients waiting.
- The model suggests that this post alongside an additional Consultant Gastroenterologist would provide sufficient capacity to meet demand at the 65th percentile. This specific role contributes 1/3rd of the additional capacity for Endoscopy. Improvement to less than 2 weeks wait time for Fast Track Endoscopy would be realised in 14-15 weeks from the post commencing.

General Surgery:

- Increased Fast Track (straight to test) capacity provided by this role will set weekly capacity at the 65th percentile and provide more resilience to flex capacity when demand is high. Clearance of the existing backlog above the sustainable waiting list size for Lower GI cancer two week waits will take 14-16 weeks from the post commencing.
- Alongside the improved Endoscopy turnaround this should support improvement against the 62 day standard with 85% achieved within a similar timescale.
- The current RTT position is largely weighted to an admitted backlog problem. The additional theatre coverage will help this position but it will take 40 weeks for full clearance. The increase in outpatient activity will have an immediate impact on reducing a tail of long waits but will require a similar timescale to bring the average waiting times down to a sustainable level.

2a	**EPR Impact** *Please detail any impact or potential impact that your proposal may have on EPR or vice versa. Please indicate the considerations you have undertaken to assess this impact*

No impact on EPR. The new post holder will receive the required training as part of their induction to utilise Cerner.

3	**Financial Implications** *Complete the financial summary below using the information you have developed with Finance. You must meet the financial targets unless there is a compelling case re quality and safety*

The fixed income contractual arrangements mean that the standard financial template cannot be completed until the funding arrangements are confirmed. Please see Appendix 1 – Financial Background for more details.

The CBU is forecasting a bottom line overspend of £0.64m for 2019/20 and as a consequence does not have any internal funding to invest in this proposal.

The revenue costs of the proposal are £0.7m per annum. The tariff value of the work is £0.88m per annum. However, £0.8m of this tariff value relates to the Host CCGs and would therefore not be recovered under the terms of the fixed income agreement. The Trust must seek prior Host CCG approval to avoid committing to £0.7m of recurrent costs with only £0.08m of non-Bradford CCG funding to offset this.

It is assumed that the part year effect of these costs in 2019/20 (based on a 1 October start date) would be £0.35m and the part year tariff value would be £0.44m. With £0.04m of non-Bradford CCG funding, the Trust may propose to the Host CCGs that it requires £0.3m of funding to offset the direct costs in 2019/20 (rather than the full £0.4m tariff value) . The CCGs may then commit to increasing the contract recurrently by £0.8m in 2019/20.

If the CCGs agree to cover the costs of the service expansion only, this will be net neutral to the Trust and CBU. The CBU will continue to forecast a £0.64m overspend in 2019/20, however the service pressures would be resolved in a financially neutral way.

In the absence of external funding, if the CBU or Trust wish to fund this proposal internally (effectively doing this work for the CCGs free of charge), this would necessitate a £0.7m increase to the recurrent CIP target.

CBU Forecast - No Investments

	2019/20			2020/21		
Service	**Income**	**Cost**	**Net**	**Income**	**Cost**	**Net**
Plan	39,935	-24,328	**15,607**	39,935	-24,328	**15,607**
Actual	40,072	-25,101	**14,972**	40,072	-25,101	**14,972**
Variance	**137**	**-773**	**-635**	**137**	**-773**	**-635**

Scenario 1 - Recover CCG Funding for Costs of New Service Only

	2019/20			2020/21		
Service	**Income**	**Cost**	**Net**	**Income**	**Cost**	**Net**
Gastroenterology	210	-210	**0**	419	-419	**0**
Colorectal Surgery	348	-348	**0**	696	-696	**0**
Total	**558**	**-558**	**0**	**1,115**	**-1,115**	**0**

Scenario 2 - No Host CCG funding, only Tariff from Non-Bradford CCGs

	2019/20			2020/21		
Service	**Income**	**Cost**	**Net**	**Income**	**Cost**	**Net**
Gastroenterology	27	-210	**-183**	53	-419	**-366**
Colorectal Surgery	40	-348	**-308**	84	-696	**-612**
Total	**67**	**-558**	**-491**	**137**	**-1,115**	**-978**

CBU Forecast - Investments with Full External Funding

	2019/20			2020/21		
Service	**Income**	**Cost**	**Net**	**Income**	**Cost**	**Net**
Plan	39,935	-24,328	**15,607**	39,935	-24,328	**15,607**
Actual	40,630	-25,659	**14,972**	41,187	-26,216	**14,972**
Variance	**695**	**-1,331**	**-635**	**1,252**	**-1,888**	**-635**

CBU Forecast - Investments with No Host CCG funding, only Tariff from Non-Bradford CCGs

	2019/20			2020/21		
Service	**Income**	**Cost**	**Net**	**Income**	**Cost**	**Net**
Plan	39,935	-24,328	**15,607**	39,935	-24,328	**15,607**
Actual	40,139	-25,659	**14,481**	40,209	-26,216	**13,994**
Variance	**204**	**-1,331**	**-1,126**	**274**	**-1,888**	**-1,613**

4 Strategic Context

How does the proposal assist in the achievement of the Trust's objectives and/or delivery of the divisional annual plan

Aim for 150 words

The approval of this business case will assist in delivering the CBU annual plan, assist the Trust in meeting local and national objectives:

- Improve cancer, DMO1 and RTT targets by investing in additional workforce capacity
- Reduce premium rate activity therefore supporting plan to achieve financial balance
- Support delivery of JAG accreditation related to timeliness and waiting times of procedures

- Partake in the delivery of the acute service and will help to bolster and support the ability of the business unit to deliver an efficient acute service.

Strategically the organisation must recognise that 50% of the current surgical consultant workforce is aged over 52 and will retire over the next 8 years and we need to prepare for that major change now.

5	**Option Appraisal** *Set out available options (including "do nothing"), appraise each option setting out the advantages and disadvantages of each. With regard to the "do nothing" option ensure that you are clear on the potential impact to the Trust of maintaining the status quo.* *Clearly identify the preferred option and why it is the best one. This should relate back to the sections above i.e. what the problem is and how the preferred option is the best way of solving it.* *Aim for 500 words*

The preferred option is to appoint a new consultant colorectal surgeon to improve our delivery of our existing workload. Alternative options would be

(1) Keep our workforce as we are and try and improve our position against the various targets by trying to work efficiently and by increasing premium rate working. As mentioned previously, there is no option in terms of premium rate working at the moment as people simply will not take this up. All surgical job plans are currently on 11PA's, there is little room for manoeuvre in increasing the job planned activity. Whilst we fully intend to make cost improvements in how we deliver work, we do not envisage major improvements in terms of being able to get people to do more.

(2) The option to do nothing will only result in the RTT position plateauing and not reaching its target. Further deterioration of the 14, 31 & 62 day cancer targets and the continuing problem of an almost impossible endoscopy workload.

Appendix 1 provides a detailed appraisal of options and outlines the financial complexity

6	**Demand, Capacity & Resource Implications**
6.1	**Demand** *Include detail regarding any changes to activity numbers. Confirm whether commissioner support is gained (if it has not then you will need to submit a paper to the Service Development Group)* *Aim for 250 words*

As stated previously this job is not intended to bring in new work but to drain the lake of activity that we need to do to improve our targets. A full time consultant appointment would produce 220 more elective surgical operations per annum and at least 720 points of endoscopy per annum. This work is currently done outside the organisation at a huge cost. As there is no new activity involved there is nothing to discuss with the commissioners.

6.2	**Capacity** *Will there be any changes to physical capacity requirements (Theatres, outpatients, beds, diagnostics, equipment etc.) as a result of the proposal?* *Aim for 250 words*

Currently we utilise 80% of our allocated footprint in theatres and with this appointment we would want to drive that towards 95%. There is no need for additional space in outpatients, currently there is flexibility with our outpatient footprint and also there is a large amount of virtual clinic and virtual ward work done which we plan to expand without a need for further physical capacity and support staff. This new job would not require any further estate in terms of diagnostics and beds as it is dealing with the work that we already have. Indeed the perception is that it would improve our efficiency with the management of our acute workload and the bed base. This position would work within the existing equipment framework that we have and there would be no perceived increase in demand for new theatre equipment.

6.3	**Resources and Estates Considerations** *Will there be a need for additional resources (including non-recurrent resources such as project management) from other divisions or departments* *Aim for 250 words*

This consultant appointment will be supported by the existing secretariat which over the years has become extremely efficient particularly since the introduction of EPR and there will be no need for any new secretarial support. In terms of office space, the individual will go into the existing consultant surgeon's office and there is no demand for further resource in this area.

7	**Implementation Plan** *Description of action, responsibility, date to complete. Bear in mind that there will be an ongoing implementation review designed to ensure that Business Case is progressing as planned*

Objective	Description of Action	Lead	Date to complete
Approval by unplanned care group	Submit completed business case	LL	TBC
Approval by Business case review board (BCRB)	Submit business case	LL	TBC
Recruit to post	Submit recruitment Approval	JCM	TBC
Commence interview process		JCM	TBC

Signatures	
CBU Clinical Director	**Mr John May**
General Manager	**Louise Lacy**
Finance Manager	
Finance Manager – Capital *(if capital funding is required)*	
Director of Estates and Facilities *(if applicable)*	
Date:	

Appendix 1.

Below is an explanation of the detailed options and the financial complexity related to the new contract

1. Do Nothing Position

1.1. As at Month 3 freeze date, the General Surgery service is broadly delivering its overall 2019/20 contracted activity levels with the Host CCGs (block contract), with over and undertrades against different points of delivery offsetting each other.

1.2. The specialty's trading position against the non-Bradford commissioners is below plan, with very substantial % undertrades against the majority of points of delivery.

1.3. Performance against access standards, notably Cancer and DM01 is a major cause for concern. More work must be done, resulting in an even greater activity overtrade, if performance against these key standards is to improve.

1.4. Elective Inpatient activity for all commissioners is 24% above plan (44 cases at month 3, projected 147 cases by year end).

1.5. Daycase surgical and endoscopy activity for all commissioners is 20% below plan at Month 3 (121 cases) and is predicted to be 25% below plan by year end (648 cases).

1.6. Outpatient activity is marginally ahead of plan.

1.7. Non-Elective activity is broadly on line with plan.

1.8. In previous financial years, the General Surgery service has supported its capacity with PRA sessions and sub-contracting work to private providers, neither of which are options in 2019/20.

1.9. In contrast to the current Gastroenterology proposal, the General Surgery service does not need to seek external funding for an underlying overtrade.

1.10. The proposal instead is to increase capacity to address an underlying undertrade with the non-Bradford CCGs and a capacity problem.

Table 1 – Do Nothing Forecast for 2019/20

	Colorectal		
	Plan	**Forecast**	**Variance**
Contract Income			
Host CCGs	20,728	20,731	3
Fixed Income Adj	-784	-787	-3
Other Commissioners	6,312	5,886	-425
Total Income	**26,255**	**25,830**	**-425**
Expenditure	**-12,164**	**-13,406**	**-1,242**
Net Impact on BTHFT	**14,091**	**12,425**	**-1,667**

1.11. The "do nothing" income forecast for General Surgery is a £3k overtrade with the Host CCGs and a £425k undertrade with the non-Bradford CCGs.

1.12. The service's expenditure forecast even before any additional investment is an overspend of £1.242m, resulting in a combined bottom line overspend of £1.7m.

2. Proposal for Additional Resource to address Backlog and Recurrent Demand

2.1. The CBU is seeking funding for an additional consultant surgeon, anaesthetist sessions, related support staff and non-pay resources to meet this demand.

2.2. The service's modelling suggests that an additional consultant will provide capacity for 113 additional Elective Inpatient procedures, 110 Surgical Daycases and 224 additional Daycase Endoscopies, together with 699 new outpatient appointments and 592 follow up outpatient appointments *in a full year.*

2.3. Capacity and demand modelling carried out by the Performance Team suggests that this is the minimum amount of additional capacity required to clear the backlog and keep pace with the increased demand.

2.4. The tariff value of this level of additional work would be £885k on a full year basis, of which £800k relates to the host CCGs (fixed income contract) and £85k relates to other CCGs on PbR contracts.

2.5. Because the specialty is delivering is overall contract with the Host CCGs, if this work is carried out by BTHFT without gaining prior funding approval from the CCGs, it will forgo the £800k from the host CCGs and receive only the £85k from the non-Bradford commissioners.

2.6. On the assumption that a new consultant appointment would start work on 1 October 2019, the modelled activity impact of the proposal for 2019/20 is a part year effect increase of 57 Elective Inpatients, 55 Surgical Daycases, 112 Endoscopies, 252 new outpatient attendances and 107 follow ups.

2.7. The cost of delivering this activity[1] is estimated to be £700k for a full year and £350k for 6 months in 2019/20.

[1] Consultant, medical secretary, diagnostics, pathology, consumables etc.

2.8. The tariff value of this work for 6 months would be £420k. If there is no prior agreement with the Host CCGs, the Trust will receive only £40k to pay for the additional work.

2.9. The impact of recruiting an additional consultant on the General Surgery service's financial position without agreement from the Host CCGs to pay for additional work is summarised in Table 2.

Table 2 – Impact of Recruiting New Consultant without Host CCG Agreement

	2019/20			2020/21		
	Plan	**Forecast**	**Variance**	**Plan**	**Forecast**	**Variance**
Contract Income						
Host CCGs	0	373	373	0	801	801
Fixed Income Adj	0	-373	-373	0	-801	-801
Other Commissioners	0	40	40	0	84	84
Total Income	**0**	**40**	**40**	**0**	**84**	**84**
Expenditure	**0**	**-348**	**-348**	**0**	**-696**	**-696**
Net Impact on BTHFT	**0**	**-308**	**-308**	**0**	**-612**	**-612**

2.10. Proposed Action 1

2.10.1. **The Trust should approach the Host CCGs to seek recurrent funding approval for the sums required to support the appointment of an additional consultant to deliver the additional activity specified and the consequent improvements in Access Standards.**

2.10.2. **The proposal should be based on the actual unfunded costs of delivering the increased activity, rather than the tariff value. In this instance, the Trust would require £308k in 2019/20 and £612k recurrently to be added to the General Surgery fixed income contract.**

2.10.3. **This would result in the CCGs paying the Trust 83% of tariff for these additional Electives, Endoscopies, Daycases and Outpatients.**

2.10.4. **It is to be anticipated that the Commissioners will find this proposal to be unaffordable and outwith the terms of the fixed income contract. In this scenario, the Trust should be prepared to ask the CCGs to find an alternative provider for the projected 209 excess Elective cases and (and associated Outpatients) in 2019/20. The Trust may need to close the door to new referrals.**

3. Alternative Approach – Fund Internally

3.1. If the CCGs cannot commit to increasing the external funding for the proposed additional capacity, and the Trust wishes to invest in the additional capacity without a funding stream, this would either need to come from existing CBU budgets, a re-purposing of existing reserves or an increase to the CIP target.

3.2. Taking the General Surgery specialty's forecast income and expenditure position for 2019/20 at face value, it appears that the specialty in isolation cannot afford to invest the required £308k in 2019/20 due to the forecast £1.7m overspend.

3.3. Table 3 shows the General Surgery income and expenditure forecasts with and without the proposed investment.

Table 3 – General Surgery Forecast Income & Expenditure with and Without the Investment

Do Nothing Forecast I&E

	Year to Date			Forecast 19/20			Steady State - Forecast 20/21		
Activity Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Contract Income	6,462	6,368	-94	26,255	25,830	-425	26,255	25,830	-425
Expenditure	-3,265	-3,576	-310	-12,164	-13,406	-1,242	-12,164	-13,406	-1,242
Net Contribution	**3,197**	**2,792**	**-405**	**14,091**	**12,425**	**-1,667**	**14,091**	**12,424**	**-1,667**

Proposed Investment

	Year to Date			Forecast 19/20			Steady State - Forecast 20/21		
Activity Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Contract Income			0		40	40	0	84	84
Expenditure			0		-348	-348	0	-696	-696
Net Contribution	**0**	**0**	**0**	**0**	**-308**	**-308**	**0**	**-612**	**-612**

Forecast after Proposed Investment

	Year to Date			Forecast 19/20			Steady State - Forecast 20/21		
Activity Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Contract Income			0	26,255	25,871	-385	26,255	25,914	-341
Expenditure			0	-12,164	-13,754	-1,590	-12,164	-14,102	-1,938
Net Contribution	**0**	**0**	**0**	**14,091**	**12,117**	**-1,975**	**14,091**	**11,812**	**-2,279**

3.3.1. Table 3 demonstrates that investing in the proposed service expansion without external Host CCG funding would cause the specialty's overall forecast overspend position to deteriorate by £308k in 2019/20 and £612k in 2020/21. The forecast overspends would increase to £2m and £2.3m respectively.

3.3.2. In the new organisational structure, budgetary performance is managed at the CBU bottom line level rather than the specialty level. However, the Gastroenterology service's forecast underspend is inadequate to offset General Surgery's forecast overspend, meaning the CBU does not have any spare funds to invest in new posts in either specialty.

3.4. Alternative Action – Fund Internally via CIP Target Increase

3.4.1. **In the context of the CBU's overall financial position, the only options to fund this post internally would be to increase the Trust's CIP target by £308k in 2019/20 and £612k in 2020/21.**

3.4.2. **The Trust Senior Leadership Team has delegated authority to increase the Trust's CIP target by a cumulative maximum £500k.**

9. Benefits Realisation Table

Each benefit must be clear and measurable, have an owner, have a current baseline value and measurable target and have a deadline date. ***Remember*** *– there will be a post implementation review and DGMs and DCDs will be held to account for achieving the benefits stated.*

Benefit to Measured	Owner	Baseline Value	Target Value	Method of Measurement	Measurement Dates	Risks & Mitigation
18 weeks RTT for admitted and non-admitted	LL		Treat all patients in 18 weeks, reduce/eradicate over 40+	Daily RTT tracking. Weekly CBU access meeting	weekly	18 weeks RTT for admitted and non-admitted
Cancer access targets	LL		Treat all patients within 2ww, 31 and 62 day pathway	Daily Cancer tracking. Weekly CBU access meeting	weekly	Cancer access targets
Endoscopy utilisation and productivity	LL/SLJ		Utilise all available endoscopy sessions daily	Weekly utilisation meeting	Weekly	Endoscopy utilisation and productivity
Reduction in premium rate activity provided by sole practitioner currently	LL			Monthly finance budgets		Reduction in premium rate activity provided by sole practitioner currently (Dr Mundre)
Weekly CIP monitoring	weekly					Weekly CIP monitoring