

WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

Financial Recovery Plan 2005/06 onwards

1 Overview of the PCT's Financial Position

1.1 Background

West Gloucestershire PCT was established in April 2002.

In 2002/03 the PCT achieved financial balance and was awarded two stars for performance for that year.

In 2003/04 the PCT exceeded its resource limit by £159k (total budget approx £200m). £515k brokerage was secured to achieve this position. The PCT was awarded three stars for performance in 2003/04.

1.2 Foundation Status and Payment by Results

In April 2004 Gloucestershire Hospitals Trust achieved Foundation Trust status and this introduced an accelerated Payment by Results regime for the PCT, covering around 80% of services commissioned from the Trust. In February 2004 the PCT Board indicated that whilst it supported foundation status it was concerned as to whether the PCT was sufficiently robust to be ready for the challenges associated with foundation status and Payment by Results.

The expanded form of Payment by Results applicable to Foundation Trusts has brought particular challenges for local PCTs. This has included the requirement to fund any growth at full national tariff (where previously tolerances and marginal costings would have been applied), the application of national tariff prices for new activity (which are higher overall than local prices given the Trust's historically low average reference costs), and increased data recording/quality (which can increase the costs in any given year even where there has been no real growth in activity).

Payment by Results can also skew some of the potential 'incentives' traditionally associated with demand management. As an example, day case procedures come under the same price as their inpatient equivalent, and there is therefore no longer any direct financial incentive to the PCTs to significantly increase day case rates. Similarly, outpatient appointments with extended scope physiotherapists (recorded as 'consultant responsible') are now charged at the same rate as those seen by the consultant ('consultant led'). The significance of these issues has been highlighted within other health communities, and nationally.

As a Foundation Trust, GHT receive transitional funding to support the difference between the cost of baseline activity at national tariff and the lower HRG price that the

Trust would otherwise have received in SLAs with the Gloucestershire PCTs. In 2004/05, this support was £5m countywide. The funding is a real addition to the Gloucestershire health economy as a consequence of FT status; although there is no direct benefit to PCTs, the funding pays for cost pressures with the Trust that they would otherwise have sought from PCTs in SLA negotiations. In 2005/06 the support will be approximately £21m.

1.3 PCT Allocations

The PCT allocations announced on 9th February 2005 show the following for our PCT:-

2005/06 closing distance from target	2006/07 increase	2007/08 increase	2007/08 closing distance from target
- 0.5%	9.1%	9.9%	- 1.3%

The 2007/08 increase is significantly more than the national average, and will assist in consolidating recurrent balance by 31st March 2008.

1.4 Local Delivery Plan/Financial Position 2004/05

In 2004/05 the PCT's Local Delivery Plan required a savings plan of £7.3m. £2.2m recurring was achieved through 1% CRES reduction from all budgets leaving £5.1m to find. Saving plans were developed for 2002/03 which included £2.7m recurring on demand management which would reduce the spend with GHT, £1m (non recurring) on slipping planned developments, £400k recurring on service reduction with the balance of £1m to find. It was originally envisaged (April 2004) that further non recurring saving schemes to make up the balance would be found by September 2004. Some non recurring measures have been taken but these have proved insufficient to meet the balance.

At the end of September it did appear that the PCT's plans to achieve financial balance were going reasonably well and in particular the intention to underspend the GHT contract by £2.7m looked to be well on track. From November to January, the growth in emergency admissions led to a deteriorating financial position, with the GHT contract heading for break even. A graph illustrating the link between spend on the GHT contract and the PCT's overall financial position is included in the monthly finance report.

Other pressures in 2004/05 have included Service Level Agreements for some out of county providers (about £0.8m overspend), GP Contract and Out of Hours services (about £1.3m overspend) and private sector placements (about £0.5m overspend) (individual patients normally mental health and learning disabilities).

As at month 12, it is expected that the PCT's forecast outturn will lead to a commitment to repay £4m in 2005/06.

1.5 Managing Demand/Increase in Emergency Admissions

In relation to the rising numbers of emergency admissions considerable analysis has been undertaken to understand the 2004/05 activity, but there does not appear to be a simple explanation. Planned growth for non electives in 2004/05 was 3.4%. Demand management schemes were put in place to contain non elective growth to 1.01%. At the end of December performance in year was 0.8% above this planned level. At the year end actual growth is now likely to be nearer 4% above plan i.e. about 5% in total.

Demand management schemes introduced in 2004/05 appear to be having some success in reducing demand for elective care. The schemes are currently being reviewed. A recent draft report from the Audit Commission (January 2005) on managing demand states that "there are indications of a step change in the strategic priority given to demand management and service redesign in the local health community". Of particular note is the Referral Management Centre introduced in the summer of 2004 where all e-referrals (other than for cancer or urgent cases) come to the PCT for review prior to being forwarded to GHT. GP referrals to GHT for 2004/05 show a reduction compared to 2003/04 and there is a similar reduction in GP referrals for trauma and orthopaedics. There is however significant growth in other referrals - e.g. allied health professionals to consultant and A&E to consultant referrals. Analysis on this is also underway.

1.6 Local Delivery Plan 2005/06

Taking account of the shortfall on Demand Management schemes in 2004/05, the PCT's opening recurrent deficit is £7.3m. In addition, based on the forecast outturn at month 12 and the application of relevant risk share arrangements, the PCT will need to repay around £4m in 2005/06. This leads to an overall savings requirement in 2005/06 of £13.7m, of which £8.1m is recurring and £5.6m non recurring. The recovery plan is based on those assumptions.

2 Financial Recovery Plan

2.1 Introduction

The PCT has taken a number of measures in 2004/05 to improve its financial position, but has now developed a financial recovery plan following the deterioration of its financial position during 2004/05, and significant challenge to achieve financial balance in 2005/06.

Following discussions with the Board and Professional Executive Committee we have identified a number of areas where we believe significant savings might be realised and project groups led by Directors have been established.

It is felt that the most significant area where continuing work is required is on managing demand, particularly by developing closer relationships with primary care colleagues to align decision making with budgetary control. The North Forest Commissioning Pilot (covering 6 GP practices) is expected to become a practice based commissioning project shortly. The existing pilot has developed close working relationships and has already been reviewing the use of diabetes, dermatology, orthopaedic and respiratory clinics to see if there are other local options that could be developed. The pilot has been operating in shadow form, and is likely to be underspent in 2004/05 on GHT Payment by Result areas.

2.2 Project Groups

The projects identified are as follows:-

- Access, managing demand, referral management and chronic disease management.
- Procurement.
- Mental health expenditure.
- NICE
- Continuing care equipment.
- Private placements.
- Out of Hours.
- Primary Care.
- Prescribing.
- Recruitment.
- Reducing provider costs.

It has been agreed that the projects working on mental health, NICE and private placements will focus on keeping expenditure within budget rather than achieving savings. The provider cost project is still finalising its plans.

Brief summaries of each of the remaining projects, and of the overall savings summary are attached. Appropriate phasing of the savings, and where relevant, front end costs of projects, will be agreed to enable proper monitoring of schemes.

Directors have been encouraged to consider all viable schemes whether or not they are achievable in the short term, and consequently the plan also has a number of measures that will take effect in 2006/07.

2.3 Other Assumptions

The plan assumes that 1.7% CRES will be achieved both on the PCT's commissioning of services, and on its own budgets.

In addition, the plan assumes a non recurring contribution of £4m from the transitional funding of £21m available to the health community to support the implementation of

Payment by Results. This is currently being discussed with Gloucestershire Hospitals Trust, and is not yet agreed.

The plan (as at 31st March 2005) has £1.7m unidentified based on "most likely" savings achievements. It is anticipated that this figure is likely to reduce when negotiations relating to the charges for 2004/05 GHT activity are completed, as there are a number of areas where activity data is under discussion, and in terms of activity projections the current GHT forecast outturn has assumed the worst case. The outcome of the discussions may affect the PCT's 04/05 outturn and also the opening 05/06 recurrent deficit. Any remaining shortfall will increase the target savings for the project groups.

2.4 Management Arrangements

Each project is led by a Director and supported by a senior manager and a finance lead, and progress will be reviewed regularly at Director meetings, and formally by monthly reports to the PEC, Board and SHA.

In the event that a particular savings scheme falls behind its agreed profile, the relevant Director will be expected to provide a revised plan for that scheme to achieve the total saving by year end, or offer a substitute scheme to make good the shortfall.

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21st April 2005