

TO: West Gloucestershire Primary Care Trust Board

FROM: Amanda Fisk, Director of Performance & Corporate Development

DATE: 14th July 2005

SUBJECT: FINANCIAL RECOVERY PLAN 2005/06 – PERFORMANCE MONITORING REPORT

1.0 BACKGROUND

- 1.1 The PCT has developed a financial recovery plan (FRP) in response to the deterioration in the financial position during the latter half of 2004/05. The financial recovery plan for 2005/06 currently stands at £13.7M.
- 1.2 Performance management arrangements have been designed based on regular reviews by the Director of Service Delivery and the Director of Performance & Corporate Development with individual project managers, a monthly Directors FRP meeting and a formal report on progress to PCT Public board meetings.

2.0 CHANGES/UPDATES SINCE THE LAST BOARD MEETING ON 19TH MAY 2005

- 2.1 Members have already been informed of the report on our FRP processes provided by Chris Spry, critical friend to the Strategic Health Authority (SHA).
- 2.2 The SHA has assessed West Gloucestershire PCT as a “Challenged Organisation”, along with six other Trusts across Avon, Gloucestershire and Wiltshire, on the grounds of financial performance. Monthly review meetings have been scheduled with the SHA and PCT Chief Executive and Directors of Performance and Finance. Clarification is awaited as to whether the new performance meetings with AGW will replace the role previously fulfilled by Chris Spry.
- 2.3 The first “Challenged Organisation” performance meeting with the SHA was held on the 5th July 2005. Discussion at the meeting covered key service delivery targets, especially performance against plan to achieve the maximum six month (inpatients) and 13 weeks (outpatients) waiting times by December 2005. Focus is required on the plans for the Gloucestershire health community to achieve the new cancer treatment waiting times targets. The rest of the meeting focused on the status of the PCT Recovery Plan, with a review of individual demand management schemes and the overall status of our savings plans contained in the risk assessment. In overall terms satisfaction was expressed about the plans for demand management and the project management arrangements associated with delivery. A letter is anticipated confirming the outcome of the meeting, and a key date will be the September meeting, when significant progress against delivery of the FRP is expected.

- 2.4 A letter has been sent to the Chief Executive from Sir Nigel Crisp, Chief Executive of the NHS and the Department of Health, reconfirming his responsibility as Accountable Officer to deliver financial recovery. A similar letter has been sent to the Chair of the PCT by the Secretary of State for Health.
- 2.5 The Department of Health and SHAs are referring PCTs to the Modernisation Agency report on "Ten High Impact Changes" which was published in September 2004. This sets out evidence of approaches undertaken by Trusts who are delivering improved care for patients whilst reducing costs. Each organisation has been asked to consider whether all of the high impact changes have been implemented in the PCT and in the provider services commissioned. Gloucestershire Hospitals NHS Foundation Trust as the provider of the majority of secondary care services for the PCT population scores well in the report, for example having increased day case rates and reduced cancelled operations. However, the outcome of the report will be reviewed with colleagues from GHT in order to identify any further areas for improvement and cost reduction.
- 2.6 Local Delivery Plan (LDP) allocations and new allocations for 2005/06 have continued to be reviewed at the monthly FRP meeting, with a view to earmarked funds being allocated to FRP savings where possible.

3.0 STATUS OF FRP PROJECTS AT THE END OF MONTH 3

- 3.1 An updated schedule, showing progress on individual FRP savings projects is enclosed at Appendix 1. The projects currently carrying a red risk assessment for achievement are highlighted. A further set of projects is currently at the development/scoping stage, where it is anticipated that detailed implementation plans are ready to be drawn up. At that stage new schemes will be transferred to the list of FRP projects. The risk analysis is attached at Appendix 2 and the overall FRP trajectory for non-elective admissions to GHT at Appendix 3.

3.2 Update on Chronic Disease Management/Case Management.

- 3.3 Case managers have now started selecting patients and several of the early implementer sites are already actively working with case loads of five patients. Increases in case load are progressing to plan and all case managers will have a full case load of approximately 30 patients by the end of September 2005. There is a good level of engagement with the Social Services operational teams and discussions are underway with Allied Health Professionals to agree their input to the case management patients. GHT is engaged with the project and has been supporting the provision of information on cohorts of patients who will be case managed. Within the PCT a senior manager who has recently returned from maternity leave has joined the project management team which has added further support and expertise to the project.
- 3.4 The financial impact in terms of the savings trajectory has been revised in line with the phasing of the project towards a full case load by September 2005. This has led to a reduction in the anticipated savings for a full year effect of £448,000, making the anticipated savings from case management £1.474K in 2005/06. It is still anticipated that the project will pick up pace and produce greater savings in 2006/07. The risk analysis summary attached as Appendix 2 has been amended accordingly.

4.0 EMERGENCY ADMISSIONS/UNSCHEDULED CARE

4.1 Background

During 2004/05 there was a 6.8% growth in non - elective admissions to Gloucestershire Hospitals Foundation NHS Trust (GHT) over 2003/04 outturn, compared with a planning assumption of 2.8% growth. This resulted in additional cost to the PCT of £1.6M. and was a major cause of the overall PCT overspend of £3.1M at year end.

Several major system changes occurred over 2004/05 which individually cannot be attributed to the rise in emergency admissions, but in combination with the others are likely to have had an impact. The most significant are:

- Transfer of primary care out of hours services to the PCT in December 2004
- The move to a 98% target for achieving a maximum 4 hour wait in A&E
- The impact of the Payment by Results financial regime.
- The move of Gloucestershire Royal Hospital into new buildings, including the move from the Medical Admissions Unit (MAU) to the Acute admissions Unit (AAU) in the new GRH building.

The financial recovery plan (FRP) savings programme for 2005/06 is £13.7M. The three largest areas of savings through demand management are £1.5M for chronic disease management (through the case management programme) (11% of total), £676k for out of hours/inreach/A & E diversion schemes (5%) and an unidentified savings category of £3.4M (£2.6M non- recurring) (25%).

4.2 Financial Context

The contract with GHT has been set for 2005/06 with a 3.8% level of growth above 2004/05 outturn, (excluding FRP). For the purposes of our planning assumptions, we have therefore prepared for the level of non-elective activity experienced between October and December 2004 to be sustained, with 3.3% growth on top of that. After FRP savings plans have been factored through the actual growth in activity equates to 1.2%.

The area of greatest risk to the PCT is a further increase in growth in the use of emergency care services – primary care out of hours, ambulance and A & E/casualty services – where this leads to an increase in non-elective admissions. However, this is also the area of greatest opportunity for the PCT, as any reduction in non-electives with GHT below our planning assumptions is a financial saving. Some of the key costs with GHT in 2005/06 are:

Service Area	Cost per patient	Total proposed contract (£)
GRH A&E (standard attendance)	£61	£3.6M
Community Hospital MIU attendance	£35	£747K
Non Elective admissions	£1,667 (average taken from 2004/05)	£33.6M

Rehabilitation	£193 per bedday	£9.2M
----------------	-----------------	-------

4.3 **Outcomes from the clinical audit on patients admitted to GRH as emergencies in December 2004**

A preliminary report on the findings from the audit review of non elective admissions to GHT has been produced. Further joint analysis with GHT is planned. As might be expected, significantly higher numbers of patients were admitted from the Gloucester area than the Forest of Dean. Approximately a third of zero length of stay admissions were due to presenting problems described as “ongoing problems” (these are patients who could be expected to have a chronic disease) and about a third of patients in the out of hours and weekend audit self-referred.

4.4 **Current PCT plans in progress to reduce non- elective admissions**

There are several projects and plans underway to reduce patient demand for emergency services:

- i) PEC clinical strategies – the three strands of the PEC clinical strategy are chronic disease management, unscheduled care and outpatients and diagnostics. PEC members are leading groups to establish service development plans for each area. The focus is on the patient pathway and access to appropriate services.
- ii) FRP project on case management – savings target of £1.5M
- iii) FRP projects on A & E diversion (based on moving the Gloucester city primary care out of hours centre into GRH), enhancing the role of the GRH inreach team and skill mix changes in all the PCT primary care out of hours centres from GPs to nurses. – savings target of £676k

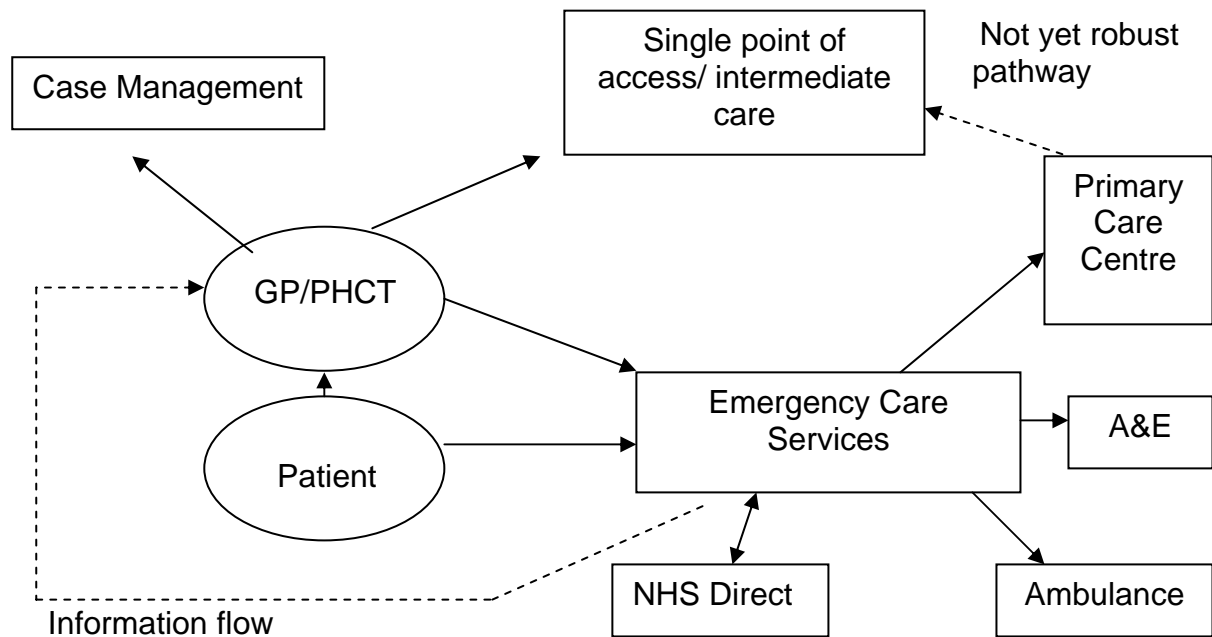
4.5 **Engagement of GP practices – current arrangements**

The Primary Care Development Managers (PCDMs) are sent information on patients (by practice) with the highest number of multiple admissions – ‘frequent flyers’. This is used by the primary healthcare teams, with some involvement of GPs, to identify patients who would be suitable for the new case management project.

The GPs in the North Forest commissioning cluster (Practice Based Commissioning budget holders) are comparing practice data with GHT data on emergency admissions with a view to identifying alternative pathways for patients. There is a requirement for the cluster to contribute to the PCT FRP savings before incentives can be realised.

The Chief Executive is due to lead a series of meetings in each patch, for GPs, primary healthcare teams and community staff, accompanied by other director colleagues.

4.6 Patient flows and information sources



5.0 USING INFORMATION TO TAKE ACTION, IN COLLABORATION WITH GLOUCESTERSHIRE HOSPITALS TRUST AND GLOUCESTERSHIRE AMBULANCE TRUST

5.1 A large amount of information is already available to the PCT in order to track non-elective activity. Some of this provides “real time” information which it will be helpful to monitor in conjunction with colleagues from the Gloucestershire Hospitals Trust and the Gloucestershire Ambulance Trust. Further data sets are available on daily admissions to GHT by practice, frequent flyers referred to previously, admissions identified by key long term condition groups and information is provided to the Forest of Dean commissioning cluster. It is also possible to break down the number of emergency admissions by practice/per 1,000 patients and by per cost per registered patient.

5.2 Action plan to stem the flow of emergency admissions

5.3 A series of actions are underway or planned to respond to the multi-factorial causes of the increase in the rise in emergency admissions seen in the latter half of 2004/05. Underpinning the action plan are the three key elements of data analysis, identifying interventions and delivering sustainable change. The actions are as follows:-

- i. A planned workshop between PCT and GHT clinicians and managers to look at the outcomes from the audit of patients admitted in December 2004. The purpose is to take stock of the information presented and to identify key pathways or blockages which warrant further attention. Following this a joint final report will be issued and shared with the healthcare community.
- ii. Escalation arrangements to be agreed between the Gloucestershire Hospitals Trust, the Gloucestershire Ambulance Trust and the PCT, using real time data on system pressures to agree appropriate responses when there are significant pressures in the system.
- iii. A meeting to take place between the Gloucestershire Hospitals Trust lead A&E Consultant and Director of Service Delivery and the PEC Chair and Director of Performance to look urgently at the feasibility of moving from an out of hours Primary Care Centre (as planned to be co-located at GRH from August 2005) to a 24 hour Primary Care Centre, with the PCT managing

- patient flows at the point of entry. Detailed implementation plans will need to be drawn up.
- iv. Connections to be made to the other streams of activity (some existing FRP plans) aimed at reducing emergency admissions, such as enhancing the In-reach Team, increasing intermediate care services and improving patient assessment and discharge processes.
 - v. Practice engagement – meetings in the PCT patches are due to be rolled out from late July 2005. These will be used as the basis for examining more closely with primary healthcare teams the overall spend per practice (e.g. on prescribing) and usage of secondary care services by the practice population, particularly as emergency admissions.
 - vi. Based on the county Reforming Emergency Care Group, to establish a PCT level of multi-agency/professional working, particularly to pick up the outcomes of the PEC clinical strategy work on unscheduled care. Such a forum would oversee service improvement and workforce changes across the urgent care network.

6.0 SUMMARY OF ACTIONS TO INCREASE THE ACHIEVEMENT OF THE FRP

The following areas, referred to above, will receive additional effort and focus in order to achieve the FRP:

- Using slippage on LDP allocations and new allocations where possible.
- Using patch-based discussions to review levels of expenditure by GPs on prescribing and use of secondary care services by patients. To agree actions plans with GPs and patch teams to respond to high levels of service use and expenditure.
- Maximising opportunities to stem the flow of emergency admissions, particularly moving to 24 hour management of the GRH primary care centre/A&E reception.
- Turning demand management schemes at scoping stage into implementation plans.

7.0 RECOMMENDATIONS

PCT Board members are asked to:

- note the contents of the report
- note the change to the savings trajectory for the Chronic Disease Management programme
- note the plan of action for stemming emergency admissions.
- note the summary of additional actions and increased effort to achieve the FRP