Isle of Wight Primary Care Trust
Isle of Wight Healthcare NHS Trust

JOINT RECOVERY PLAN

Update Paper – July 2005

Introduction

The Isle of Wight Health Economy has tackled the Recovery Plan in two main ways. The first is through the identification of efficiency savings in the Care Groups and Directorates, and the second is through Service Transformation, which is reflected in our Local Delivery Agreement (LDA).

Within the Isle of Wight joint LDA we have set out action plans across six key areas of Service Transformation:

- Unscheduled Care
- Scheduled Care
- Long Term Condition Management
- Transfers of Care / Alternatives to Admission
- Demand Management
- Medicines Management and Prescribing

These action plans also address the 10 High Impact changes. The LDA will be coming to the Boards in September for final approval.

In order to achieve the Joint Recovery plan of £9.8m across the Isle of Wight Health Economy, some very difficult decisions will need to be taken. Many areas where there has been scope to improve efficiency have been addressed and it is difficult to achieve recurrent efficiency savings without impacting on patient services. However through areas such as effective vacancy control, bank usage and restructuring of teams, target savings will be achieved.

Some of the ambitious plans for Service Transformation, as set out in the LDA, will take more than one year to deliver. However these will achieve more significant recurrent savings. Where possible through service transformation patients will either notice benefits in administration and care or there will be minimal direct patient impact. However, there are also some areas where, if financial balance is to be achieved in year, it is now inevitable that there will be some reduction in the current high standards and levels of provision. The impact of changes may also be felt in partner organisations and these need to be clearly set out and agreed.

The Joint Management Team has now put forward proposals for consideration. In some instances we now need agreement to proceed with proposals, in others we need agreement in principle to proceed with working up the proposal in more detail for final decision.

Gillian Baker

Outpatient Follow-ups Reduction

Many patients are given follow up appointments which they do not need because they are well, with no complications. A number of specialties have already reduced follow ups, however the approach is not consistent. The proposal is to extend the number of circumstances where patients will not be given a follow up but will be given advice on what to do should they be concerned. This may range from contacting their GP, to arranging an appointment with their consultant.

Recommendation – for approval to proceed now

Categorisation of patients

Patients in many specialties are classified as 'urgent, soon or routine'. Some specialties now have 'urgent' and 'in turn'. This should be rolled out to all specialties as it will reduce bottlenecks.

Recommendation – for approval to proceed now

NHS Direct

NHS Direct supply two services:

NHS Direct Core Service £253k. This is a non negotiable amount paid for the service. We are currently exploring other areas who have opted out of this service and provide it locally. Should this be possible the service would be brought in house at a reduced rate.

NHSD Out of Hours Service. This is a negotiable service costing £324k that we can serve notice on. We are exploring options of how the service can be delivered locally.

Recommendation

1. *Approve in principle giving notice for Core Service April 2006.*
2. *Give notice to NHSD in October for OOH Services*

Low Priority Procedure Policy

The Low Priority Procedure Policy has been recently updated. However further work will be undertaken reviewing policies from elsewhere and reflecting work undertaken by the Clinical Priorities Forum across Hampshire and the Isle of Wight. Further procedures will therefore be recommended as low priority.

Recommendation – for approval to continue to tighten up the policy

Extra Contractual Requests

The PCT is increasingly receiving requests for treatments outside of existing contracts and Service Level Agreements. Although some funding is set aside for this, the majority of funding is committed within contracts. The PCT Reference Panel

is therefore having to turn down a number of patients who wish to be treated outside of existing contracts or for treatments not considered by providers as part of their main services.

Recommendation – to support the PCT Reference Panel in limiting choice to existing contracts and Service Level Agreements wherever appropriate.

Joint Investment Budget (JIB)

The PCT has traditionally had a JIB to support schemes that need small amounts of pump priming funding or are time limited projects that are developed jointly with partners including the voluntary sector. Although described as 'joint', funding only comes from the PCT. No new schemes received investment in 2004/5 apart from those already committed. A number of schemes will be ceasing by the end of 2005/6. Anticipated saving £250k.

Recommendation – for approval to cease JIB when current schemes cease and to not approve any new schemes

Patient Travel

The PCT currently pays the ferry costs for patients travelling for radiotherapy and renal dialysis. The PCT does not pay travel costs for any other patient group and any patient on income support will get financial help from the Benefits Agency. No other PCT we are aware of pays patient travel in this way.

Patients travel was considered as part of HealthFit and options were considered to try to make this more equitable within budget. This has not been possible. It is therefore felt to be inequitable to continue to support two groups of patients and not others, although it is acknowledged that travel off Island is a burden for all patients.

Anticipated saving in full year £90k

Recommendation – that notice is given now to terminate the scheme by April 2006 and that alternative support is sought for patients facing financial hardship.

Manor House

The PCT currently contributes £234k to the Manor House in Southampton which last year equated to £106 per day. This is a facility for patients to stay overnight in Southampton when they are receiving outpatient radiotherapy treatment.

The PCT is not funded in its baseline for this type of expenditure, which is not the direct purchase of healthcare. We know of no other PCTs that fund this type of facility.

Recommendation – that notice is given to the Manor House in September 2005 and consideration is given to more cost effective support.

Rationalisation of Estate

The Trust currently has a number of buildings which would realise significant capital gains and associated revenue savings such as utilities if sold. It is proposed, therefore, to sell the following buildings and relocate the services:

- Shackleton House (Ryde), Dementia impatient unit.
  Relocation to be agreed.

- Suffolk Towers (Ryde) Health Centre.
  Services to be relocated within Ryde outpatients, remainder to be agreed.

- Orchards (Freshwater) Adult Mental Health day service.
  To be relocated within locality.

- 102 Carisbrooke Road (Newport), Island Drug Advisory Service
  Relocation to be agreed.

- Kestrals (Newport) Adult Mental Health Rehabilitation Unit.
  Relocation to be agreed.

Recommendation - the Trust proceeds with securing suitable alternative accommodation for services and markets the properties.

Extension of Primary Care Prescribing Platinum Points Scheme

Primary Care currently has both primary and secondary care targets; England and SHA average spend respectively. It is suggested that a new tertiary target of the Dorset and Somerset SHA average spend per patient is set. If this were to be achieved by all practices this would save an additional £3.016m. A further payment of £1.00 per patient to practices would cost a maximum of £137k. Payment would be proportional at 1% move towards target.

Recommendation – for approval to proceed now with introducing a tertiary target.

Lynda Blue	Gillian Baker
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