ISLE OF WIGHT HEALTHCARE NHS TRUST
ISLE OF WIGHT PRIMARY CARE TRUST

RECOVERY PLAN 2005/06

1. Local Delivery Plan 2005/06

1.1 At the Board meetings on the 27th April, 2005, the HCT and PCT Boards approved the 2005-2008 Local Delivery Plans. Both Boards agreed that, in order to meet their statutory duties to breakeven and to support the development of the new organisation from April 2006, the emphasis for the LDP must be on a shared approach to 'fixing the money'.

1.2 The Island received growth funding of circa £14.5m, this has been used to repay overspends and brokerage, eradicate underlying deficits, fund tariff increases to providers in line with SHA guidance, and fund services to ensure we meet key NHS Plan targets.

1.3 It was agreed, as part of the shared approach to 'fixing the money', that whilst the HCT and PCT remain separate organisations, we would develop a joint Recovery Plan.

1.4 The Recovery Plan has been developed jointly based on the LDP submission approved on the 27th April, 2005, attached as appendix 1 and 2. A further submission will be required on the 18th May, 2005 to take account of the 2004/05 outturn position, and the Recovery Plan will be amended as appropriate.

1.5 Based on the LDP, the current joint Recovery Plan is circa £9.8m.

2. Budgets 2005/06

2.1 At the Board meetings on the 27th April, 2005, the HCT and PCT Boards approved the 2005/06 Budgets for both the HCT and PCT. These budgets had been developed in line with the Local Delivery Plan as follows:

- Increase budgets for tariff uplifts
- Adjust budgets for short-fall on pay reform
- Reduce budgets by 1.7% efficiency savings associated with the tariff uplift
- Increase budgets for investments to deliver NHS Plan targets.

2.2 The efficiency savings (£2.5m) and pay reform (£1.5m) have been built into the opening budgets. As part of the budget setting process, budget holders are required to develop plans to show how they will deliver their budgets including the CRES, pay reform and any other in-

year cost pressures. Performance against budgets will be monitored through the monthly performance review meetings, monitored by the Joint Financial Control Board and reported to both Boards in the Performance Reports.

2.2.l The Mental Health & Learning Disabilities Care Group have developed their recovery plan, which involves significant service redesign in order to meet the many challenges facing the Care Group this year.

The Care Group Board has agreed the following approach in order to support the Care Group in meeting the challenges and their recovery plan:

- The implementation of the Recovery Model, as a method of increasing capacity in the service;
- The review and revision of eligibility criteria across the service - to manage demands by reducing the number of people accessing the service and the length of time for which services are provided;
- The reduction of inpatient beds across Adult and Older Adult Services (by approximately one third of our current bed numbers) to release resources.

The MH&LD Management Team has agreed a model of service delivery to reflect the above and have built the recovery plan on the extent to which this model would free up resources to support both the financial deficit and the service development agenda.

The recovery plan is outlined in appendix 3 and Board approval is required in order to take forward the recommendations.

2.3 The Prescribing budget has been set a recovery plan of £1.15m which, given the success in 2004/05 and recent prescribing changes and medicines management initiatives, we are confident we can deliver. Performance will be monitored by the Medicines Management Collaborative Committee, monitored by the Joint Financial Control Board and reported to both Boards in the Performance Reports.

2.4 Tariff uplifts relating to non-pay have not been issued to individual budgets and will be used to support the Recovery Plan (£200k). Following a review of joint investment budgets, a further £250k has been put to the Recovery Plan.

2.5 In summary, against a £9.8m Recovery Plan target, £5.45m (see below) has already been included in budgets and will be monitored in the normal way. Whilst not wanting to understate the challenging nature of these plans, both the HCT and PCT have good track records

for delivering CRES and there is robust performance monitoring arrangements in place to ensure they are delivered.

	£m
CRES	2.5
Pay Reform	1.5
Prescribing/Medicines Management	1.15
Non Pay	0.2
Joint Investment	0.25
Total	**5.6**

3. Corporate Recovery Plan

3.1 Through the Budget setting and LDP process, £5.6m of the £9.8m Recovery Plan has been found, and plans now need to be developed and approved by the Boards for the remaining £4.2m.

3.2 The Joint Management Team (JMT) has met to discuss the Corporate Recovery Plan and a number of key themes have been developed and agreed. Lead directors have been identified for each area, together with a savings target. Each lead will now, subject to Board approval, develop an action plan to ensure that the savings are delivered.

3.3 Local Delivery Agreement

The Local Delivery Agreement (LDA) consists of six major programmes which support the Recovery Plan, as follows:

- Unscheduled care (s3.9)
- Scheduled care (s3.8)
- Long term condition management (s3.7)
- Transfer of care/alternatives to admission (s3.6)
- Demand management (s3.6)
- Medicines management and prescribing (s2.3)

3.4 Redundancies

The Strategic Health Authority (SHA) and Workforce Development Confederation (WDC) recently issued each organisation within the SHA a workforce reduction control total, i.e. PCT 8 and HCT 108. In this way, the SHA expects organisations to reduce costs as our workforce is a major component (70-80%) of our cost base, and deliver all our targets.

Therefore, further redundancies will have to be identified in addition to budget holders CRES or other Recovery Plan schemes.

In order to facilitate this, the WDC and SHA have established a change fund of £10m, which is partly available on a per capita basis (£400k for the IOW) and partly on a bids basis.

It is envisaged that these redundancies will, in part, be as a result of bringing corporate/non clinical functions together across the PCT and HCT.

Lead Director	Graham Elderfield
Support Director	Terence Hart
Target Savings	£1m part year
	£2m full year

3.5 **Estate Rationalisation**

A number of Estate rationalisation schemes are currently being developed in support of the Capital Programme (56 St. Johns Road, Ventnor Clinic and Cowes Clinic), the Mental Health & Learning Disabilities savings plan (The Gables) and the Emergency & Medicine savings plan (outlying ambulance stations).

In addition, further plans are now being considered to relocate services from Ryde, Arthur Webster and Pyle Street. Services would be relocated either in primary care facilities such as GP Practices, Social Services facilities, or on other healthcare premises such as St. Mary's.

Plans are also being developed to locate all PCT/HCT headquarters staff on the St. Mary's Hospital site, thus releasing the Whitecroft site.

In addition to capital receipts from any associated land sales, it is anticipated that there will be an ongoing revenue savings made by reducing overheads.

Lead Director	Sheila Paul
Support Directors	Camilla Lambert/Lynda Blue
Target Savings	£750k part year
	£1m full year

3.6 **System Reform**

Implementation of the Ten High Impact Changes across the PCT and HCT should deliver savings. However, given that we have only invested the minimum to deliver targets, have little or no headroom to cover the required closure of 2 theatres at the HCT, and have an average bed occupancy of 98% at St. Mary's, it is envisaged that the implementation of measures such as improving day case rates currently 66% to 70%, improving demand management (PCT), improving discharge management (HCT), introducing hotel beds and developing avoidance of admission schemes will enable the PCT and HCT to meet targets, and will contribute to the Recovery Plan through

the avoidance of additional investment to meet cost pressures and by reducing costs.

Lead Director	Sheila Paul
Support Directors	Helen Shields/Andrew Watson/ Camilla Lambert/Jane Wilshaw/ Terence Hart
Target Savings	£500k

3.7 **System Redesign**

It is recognised that we cannot go on delivering the current level of services in the same way as we currently do and continue to make savings, i.e. we cannot continue to cut budgets and simply ask people to do more. Instead, we must redesign the way in which services are delivered. There are a number of schemes in place to transfer services from Secondary Care to Primary and Community Care, and these need to be further developed and expanded.

There are concerns over our ability to recruit consultants and GPs in the short to medium term and this concern, together with the cost of locums, has led to the HCT Medical Director and the PCT PEC Chair looking to develop alternatives to Consultant and GP projects and a 'locum free' hospital scheme.

Lead Director	Helen Shields
Support Directors	Sheila Paul/Jane Cusden/Jane Wilshaw/Andrew Watson/Mark Denman-Johnson
Target Savings	£750k part year £1m full year

3.8 **Service Provision**

The current position is neither affordable nor sustainable, neither the PCT nor the HCT can continue to meet the targets and achieve financial balance as services are currently configured. Whilst service redesign and modernisation are necessary for both financial and clinical reasons, the scale of the changes required means that they cannot be fully implemented in time to support the financial position in the short to medium term. The 'Single Point of Access' project is a good example of this.

Therefore, we need to take urgent and temporary action in the short term, whilst in parallel putting in place schemes such as the 'Single Point of Access' to deliver recurring balance. This means the reduction and/or withdrawal of services, changing referral/access protocols and reducing the standard of some services. The services currently

identified are private physiotherapy and bringing it back to the NHS, allergy, asthma, pain clinics, maxillofacial.

Lead Director	Helen Shields
Support Director	Sheila Paul
Target Savings	£1m

3.9 Out of Hours/Unscheduled Care

Currently, out of hours services are provided through NHS Direct and through IDOC, with emergency secondary care provided through Ambulance and A&E. Plans are being developed to reconfigure these services, including the control room. This will involve renegotiating contracts for 2005/06 but will support the 'Single Point of Access' project in the longer term.

Lead Director	Jane Cusden
Target Savings	£200k

3.10 Corporate Efficiencies

JMT discussed a corporate approach to areas such as hospitality, recruitment advertising, travel, managing absence, etc. It is envisaged that this will support budget holders delivering their individual CRES targets.

4. Summary

Target **£9.8m**

Area	**Lead**	**£m**
CRES	ALL	2.50
Pay Reform	ALL	1.50
Prescribing/ Management	SP/CL	1.15
Non Pay	Achieved	0.20
Joint Investment	Achieved	0.25
Redundancies	GE	1.00
Estate Rationalisation	SP	0.75
System Reform	SP	0.50
System Redesign	HS	0.75
Service Provision	HS	1.00
Out of Hours	JC	0.20
Total		**9.80**

5. Risks

The key risks for the Recovery Plan are as follows:

- Deliver key targets
- Achieving savings and reshaping the workforce to ensure that pay reforms are cost neutral
- Prescribing
- Achieving plans in primary and community care which have offset the requirement for investment in secondary
- Agreeing Service Level Agreements and contracts within the financial envelopes set out for each provider within the LDP framework

6. Conclusions and Recommendations

6.1 The HCT and PCT Boards are asked to approve the Recovery Plan outline in Section 4, so that detailed action plans can be developed and monitored and where necessary, urgent and temporary action will be taken.

6.2 The HCT and PCT Boards are asked to approve the Recovery Plan of the Mental Health & Learning Disabilities Care Group outlined in section 2.2.1 and detailed in appendix 3.

6.3 The monitoring and management of the overall Recovery Plan will be through the Joint Financial Control Board, chaired by Graham Elderfield, Chief Executive Officer for the PCT and HCT.

6.4 Progress reports will be presented to the HCT and PCT Boards each month, and shared with the SHA and both Internal and External Audit.

LYNDA BLUE
Director of Finance
IOW HCT and PCT

17 May 2005
LB/lm

Lead Commissioner Name	Helen Shields
Trust Name/PCT Name (as appropriate)	IWPCT

		2005-06			2006-07			2007-08		
PCTs (please complete):										
Commissioning spend e.g. on provider SLAs										
Other expenditure										
Trusts (please complete):										
Income from NHS SLAs										
other income										

	Parenthesis	2005-06			2006-07			2007-08		
		Recurring	**Non-Recurring**	**Total**	**Recurring**	**Non-Recurring**	**Total**	**Recurring**	**Non-Recurring**	**Total**
Underlying Recurrent Deficit	-	**1,512**	**0**	**1,512**	**-68**	**0**	**-68**	**0**	**0**	**0**
Prior Year's Deficit Repayment	-	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**
Repayment of Brokerage	-	**-1,000**	**0**	**-1,000**	**0**	**0**	**0**	**0**	**0**	**0**
Plus Growth (equal to line 02 DH template)	+	**13,295**	**814**	**14,109**	**15,594**	**414**	**16,008**	**19,431**	**428**	**19,859**
TOTAL AVAILABLE ADDITIONAL RESOURCES		**13,807**	**814**	**14,621**	**15,526**	**414**	**15,940**	**19,431**	**428**	**19,859**
Baseline Generic Pressures										
Pay awards	+	3,484	0	3,484	3,819	0	3,819	3,949	0	3,949
Pay drift - will be zero	+	0	0	0	0	0	0	0	0	0
Agenda for Change	+	1,791	0	1,791	1,884	0	1,884	1,712	0	1,712
Consultant Contract	+	416	0	416	456	0	456	472	0	472
Capital Charges	+	228	0	228	250	0	250	258	0	258
New capital investment	+	455	0	455	499	0	499	516	0	516
Estate revaluation	+	341	0	341	374	0	374	387	0	387
Non pay inflation	+	633	0	633	694	0	694	717	0	717
Clinical negligence	+	91	0	91	100	0	100	104	0	104
Hospital drugs - general	+	385	0	385	422	0	422	436	0	436
Hospital drugs - NICE	+	648	0	648	710	0	710	734	0	734
GMS contracts	+	42	0	42	46	0	46	47	0	47
FHS drugs (incl NICE)	+	1,193	0	1,193	2,282	0	2,282	1,352	0	1,352
Local Cost pressures not included above	+	111	0	111	122	0	122	126	0	126
Total Baseline Pressures	+	**9,818**	**0**	**9,818**	**11,658**	**0**	**11,658**	**10,811**	**0**	**10,811**
Investment in Key Targets										
Cardio-Vascular Disease	+	50		50	590	0	590	284	0	284
Cancer	+	415	149	564	704	0	704	935	0	935
Suicide prevention	+	286	153	439	486	170	656	400	179	579
Public Health (Life Expectancy, Infant Mortality, Smok	+			0	502	190	692	497	228	725
Access	+	467		467	1,622	0	1,622	3,262	0	3,262
Drugs Misuse	+			0	60	0	60	60	0	60
Long term conditions	+	539		539	145	0	145	1,200	0	1,200
Improving Patients Experience	+	344		344	58	0	58	50	0	50
MRSA	+			0	0	0	0	0	0	0
NPFIT (include all new IM&T spend)	+	0		0	359	0	359	382	0	382
Total Investment in Key Targets	+	**2,101**	**302**	**2,403**	**4,526**	**360**	**4,886**	**7,070**	**407**	**7,476**
Other Investments										
Workforce - not included above	+			0	0	0	0	0	0	0
Local Targets	+			0	0	0	0	0	0	0
Cols			540	540	0	0	0	0	0	0
Out of Hours		314	130	444	0	0	0	0	0	0
Specialist Services		317	24	341	450	0	450	550	0	550
LSD Specialist services		203		203	0	0	0	0	0	0
Underlying Deficit IWHCT		3,693		3,693	0	0	0	0	0	0
Other Investments		1,745		1,745	1,215	54	1,269	3,402	21	3,423
2004/05 Overspend IWHCT			3,000	3,000	0	0	0	0	0	0
Total other investment	+	**6,272**	**3,694**	**9,966**	**1,665**	**54**	**1,719**	**3,952**	**21**	**3,973**
TOTAL ADDITIONAL EXPENDITURE	+	**18,191**	**3,996**	**22,187**	**17,849**	**414**	**18,263**	**21,833**	**428**	**22,260**
NET CHANGE IN SPENDING		**-4,384**	**-3,182**	**-7,566**	**-2,323**	**0**	**-2,323**	**-2,402**	**0**	**-2,402**
Efficiency on Provider SLAs 1.7% tariff adjustment - PCTs only to complete	+	**2,011**	**0**	**2,011**	**2,200**	**0**	**2,200**	**2,273**	**0**	**2,273**
Efficiency on prescribing 0.5%- PCTs only to complete	+	**117**	**0**	**117**	**123**	**0**	**123**	**129**	**0**	**129**
Recovery Plans Contribution	+	**2,188**	**3,250**	**5,438**	**0**	**0**	**0**	**0**	**0**	**0**
Overall Surplus/(Deficit) - MUST BE BREAK EVEN IN LINE WITH AGREED LDP	+/	**-68**	**68**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HEALTH AUTHORITY

Lead Commissioner Name	IOW PCT
Trust Name/PCT Name (as appropriate)	ISLE OF WIGHT HEALTHCARE NHS TRUST

		2005-06			2006-07			2007-08		
PCTs (please complete):										
Commissioning spend e.g. on provider SLAs										
Other expenditure										
Trusts (please complete):										
Income from NHS SLAs		86,066			92,912			98,143		
other income										

	Parenthesis	2005-06			2006-07			2007-08		
		Recurring	**Non-Recurring**	**Total**	**Recurring**	**Non-Recurring**	**Total**	**Recurring**	**Non-Recurring**	**Total**
Underlying Recurrent Deficit	-	**(3,693)**		**(3,693)**	**0**		**0**	**0**	**0**	**0**
Prior Year's Deficit Repayment	-		**(1,500)**	**(1,500)**	**0**	**0**	**0**	**0**	**0**	**0**
Repayment of Brokerage	-	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Deficit funding		**3,693**		**3,693**			**0**			**0**
Prior Year's Deficit funding			**3,000**	**3,000**			**0**			**0**
Plus Growth (equal to line 02 DH template)	+	**4,954**		**4,954**	**4,647**		**4,647**	**4,907**		**4,907**
Investment funding		**1,340**	**622**	**1,962**	**586**	**170**	**756**	**95**	**179**	**274**
TOTAL AVAILABLE ADDITIONAL RESOURCES		**6,294**	**2,122**	**8,416**	**5,233**	**170**	**5,403**	**5,002**	**179**	**5,181**
Baseline Generic Pressures										
Pay awards	+	2,540	0	2,540	1,839	0	1,839	1,942	0	1,942
Pay drift - will be zero	+	0	0	0	0	0	0	0	0	0
Agenda for Change	+	1,344	0	1,344	973	0	973	1,028	0	1,028
Consultant Contract	+	334	0	334	242	0	242	255	0	255
Capital Charges	+	172	0	172	125	0	125	132	0	132
New capital investment	+	345	0	345	250	0	250	264	0	264
Estate revaluation	+	258	0	258	187	0	187	197	0	197
Non pay inflation	+	482	0	482	349	0	349	369	0	369
Clinical negligence	+	71	0	71	51	0	51	54	0	54
Hospital drugs - general	+	295	0	295	214	0	214	226	0	226
Hospital drugs - NICE	+	493	0	493	357	0	357	377	0	377
GMS contracts	+	n/a	0	0	0	0	0	0	0	0
FHS drugs (incl NICE)	+	n/a	0	0	0	0	0	0	0	0
Cost pressures costs above funding		1,871		1,871	60		60	63		63
Local Cost pressures not included above	+	83	2,000	2,083	0	0	0	0	0	0
Total Baseline Pressures	+	**8,288**	**2,000**	**10,288**	**4,647**	**0**	**4,647**	**4,907**	**0**	**4,907**
Investment in Key Targets										
Cardio-Vascular Disease	+	0	0	0	0	0	0	0	0	0
Cancer	+	220	0	220	305	0	305	95	0	95
Suicide prevention	+	286	153	439	74	170	244	0	179	179
Public Health (Life Expectancy, Infant Mortality, Smokin	+	0	0	0	0	0	0	0	0	0
Access	+	767	0	767	0	0	0	0	0	0
Drugs Misuse	+	0	0	0	0	0	0	0	0	0
Long term conditions	+	91	0	91	58	0	58	0	0	0
Improving Patient Experience	+	344	0	344	0	0	0	0	0	0
MRSA	+	0	0	0	0	0	0	0	0	0
NPFIT (include all new IM&T spend)	+	0	0	0	0	0	0	0	0	0
Total Investment in Key Targets	+	**1,708**	**153**	**1,861**	**437**	**170**	**607**	**95**	**179**	**274**
Other Investments										
Workforce - not included above	+	0	0	0	0	0	0	0	0	0
Local Targets	+	0	0	0	0	0	0	0	0	0
Other - Critical care/ amb A4C	+	184	469	653	149	0	149	0	0	0
Total other investment	+	**184**	**469**	**653**	**149**	**0**	**149**	**0**	**0**	**0**
TOTAL ADDITIONAL EXPENDITURE	+	**10,180**	**2,622**	**12,802**	**5,233**	**170**	**5,403**	**5,002**	**179**	**5,181**
NET CHANGE IN SPENDING		**(3,886)**	**(500)**	**(4,386)**	**0**	**0**	**0**	**0**	**0**	**0**
Efficiency on Provider SLAs 1.7% tariff adjustment - PCTs only to complete	+	**0**	**0**	**0**		**0**	**0**		**0**	**0**
Recovery Plans Contribution	+	**3,886**	**500**	**4,386**	**0**	**0**	**0**	**0**	**0**	**0**
Overall Surplus/(Deficit) - MUST BE BREAK EVEN IN LINE WITH AGREED LDP	+/	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

MENTAL HEALTH AND LEARNING DISABILITIES

MAY 2005

Introduction

The Mental Health and Learning Disabilities development and recovery plan is based on an innovative service redesign that is underpinned by the principles of recovery, retraining and redeployment, and reduction of inpatient provision – and which is supported by a retention and recruitment plan in relation to specialist posts. Despite anticipated income streams this financial year, some redundancies may be inevitable in the service restructure, but no compulsory job losses are anticipated.

The Model

Having considered a range of options, and recognised the difficulty in achieving a consensus, the following model is now considered to be the most viable.

Diagram ONE represents the agreed model and depicts the various funding streams to support the Care Group's position. Overall, it is anticipated that in addition to bridging the £1m gap this year, the model will facilitate the re-investment of some £750,000 in service developments – some in support of the new inpatient provision and some in support of community services for Adults and Older Adults.

The model is based on a controversial "stretching" of admission boundaries –

- The development of a new inpatient service on the Halberry site, to accommodate a cross diagnostic range of Older People with either organic conditions or functional disorders – for assessment and acute treatment.
- The development of a reduced provision on Osborne Ward, to meet the needs of Adults in the acute phase of illness, and a small number of Older Adults whose needs would be appropriately met in this environment.
- The development of a new 12 bed low secure facility in Sevenacres, based on Seagrove plus the high dependency unit, to accommodate current patients and 4 mainland placement returnees.
- The reduction in rehab beds at the Kestrels to accommodate 2 nurse staffed crisis beds.

Clearly, there is a huge amount of work still to be done in developing a practical/realistic implementation plan. There are serious clinical and management reservations about the feasibility of this model and these are not being under estimated.

The safe and successful redesign of services along these lines will not be achieved without the full cooperation and support of our partner organisations. Specialist Secondary Healthcare services cannot be developed in isolation, and careful responsible reprovision of services for this vulnerable client group (specifically older people with dementia) must be agreed with PCT and LA colleagues during the implementation period.

All efforts will be made to engage fully with staff, services users and carers, and capacity to develop and deliver the project plan will also need to be supported; this will include working closely with the medical staff and commissioners to enable best use of their resources. There are no plans to reduce medical cover within the service in this model.

Funding Streams (See Diagram TWO)

Service redesign supports the two main funding streams underpinning recurrent resolution of the financial position:-

- Bed closures will release resources in the order of £700k (fye) from 06/07, and bring in spending capacity of nearly £300k this financial year.
- Mainland placement returnees accommodated in the newly developed low secure unit will result in a significant contribution to the Island Health economy, and in excess of £500k fye 06/07 to the Health Trust (£228k this financial year).

Clearly such radical redesign will take time to implement safely, and allowing an appropriate timeframe to implement the plan requires a one-off subsidiary element this year to support the position:-

- The anticipated capital receipt in relation to the sale of the Shackleton building will be in the order of £500k.
- A timely and comprehensive bid to WDC in respect of the service restructuring, leading to a contribution to the position of some £400k this year.

Approved recurrent LDP funding for this year (approximately £300k) will ensure that community support will effectively underpin bed reductions, and plans are already progressing well in this respect.

The combined effect of these funding streams will enable the progression of many much needed service developments in line with National and Local targets. The Summary (diagram TWO) gives an indication of resource allocation this year and next year, and demonstrates the provision for progress towards all major targets – though EIP remains a high risk without additional LDP support in 06/07.

Next steps

Formal approval of the model will be via the Healthcare Trust/Primary Care Trust board meetings on the 25th May 2005, with some bed reductions being achieved by the 1st of October 2005, mainland placements returning in October 2005 and further bed reductions by the 1st April 2006.

There will be significant implications for staff across the service and the implementation of an open and equitable process to establish staff positions will be undertaken. Some staff will be redeployed and some posts may be made redundant though compulsory redundancies are not anticipated. The radical change of the service is designed to release resources to enable better ward support and extended community provision – in excess of £200,000 for Older People services specifically this year, approximately £250,000 for Home Treatment, and various additional service redevelopments.

Individuals contributing to this plan have worked hard and been remarkably flexible in their thinking; senior managers and the clinical director have been prepared to take difficult decisions with far reaching implications, and have benefited from the support of Doctors and the operational management team in doing so.

In accepting the need for this service redesign as described, it must be acknowledged that the Island demographic forecast indicates the need for expansion and investment in Mental Health and Learning Disabilities services in the medium and longer term – particularly in relation to very elderly people.

Conclusion

This is an ambitious and innovative plan and carries a degree of risk, some funding streams are fragile and actual income/savings are uncertain. Every effort will be made to maintain clear and timely communications with commissioners, staff and service users over the next important weeks and months, staff have been encouraged to take advantage of all opportunities to contribute/keep up to date.

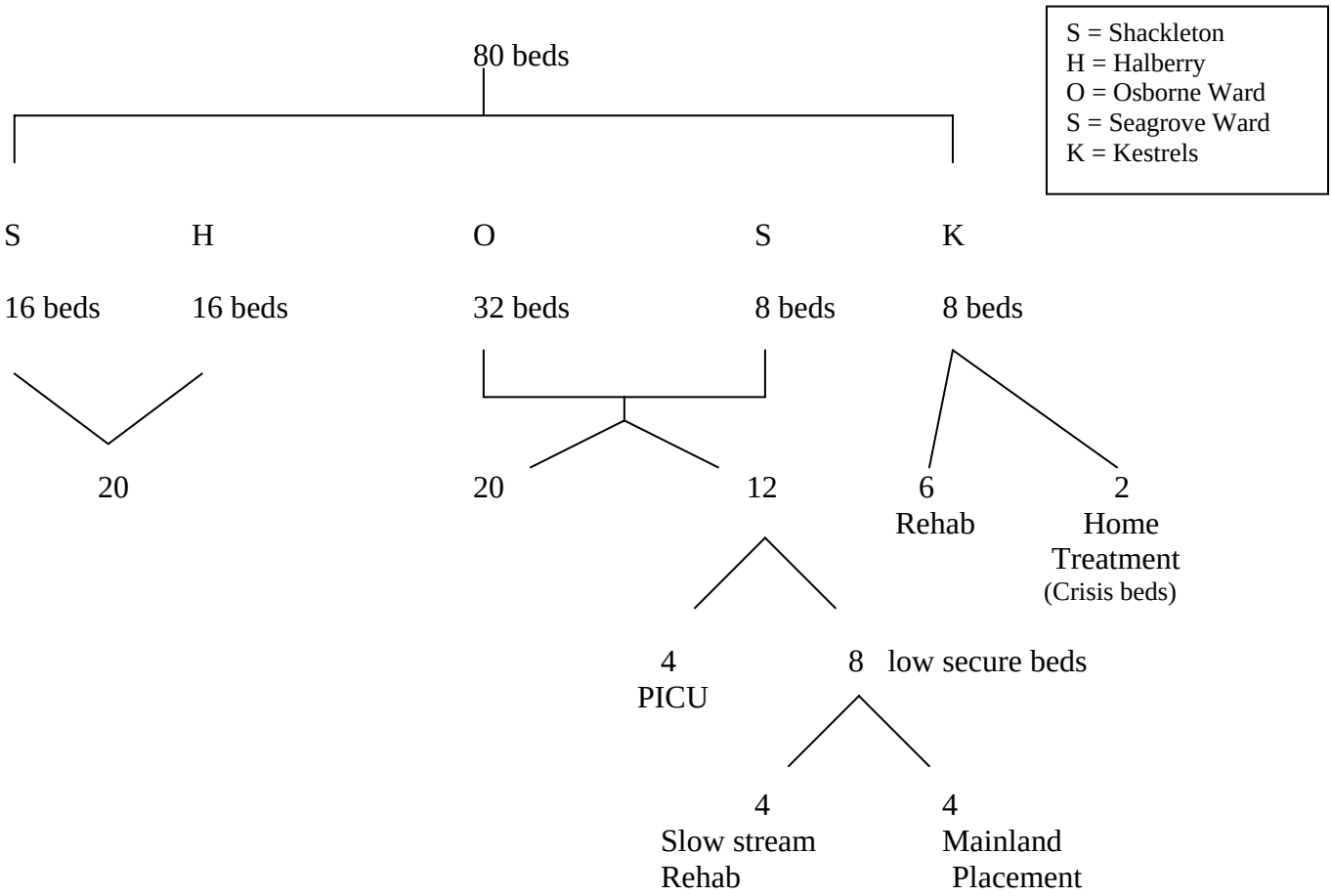
The Board is asked to approve the model of service redesign, and to support the Care Group in their efforts to implement a challenging recovery plan in the pursuit of service development and financial break-even.

Tina R Harris
Associate Director
For Mental Health and Learning Disabilities

16th May 2005

DIAGRAM ONE

Planned Bed Redesign Model to meet Care Group requirements



54 BEDS

Service developments and Resources

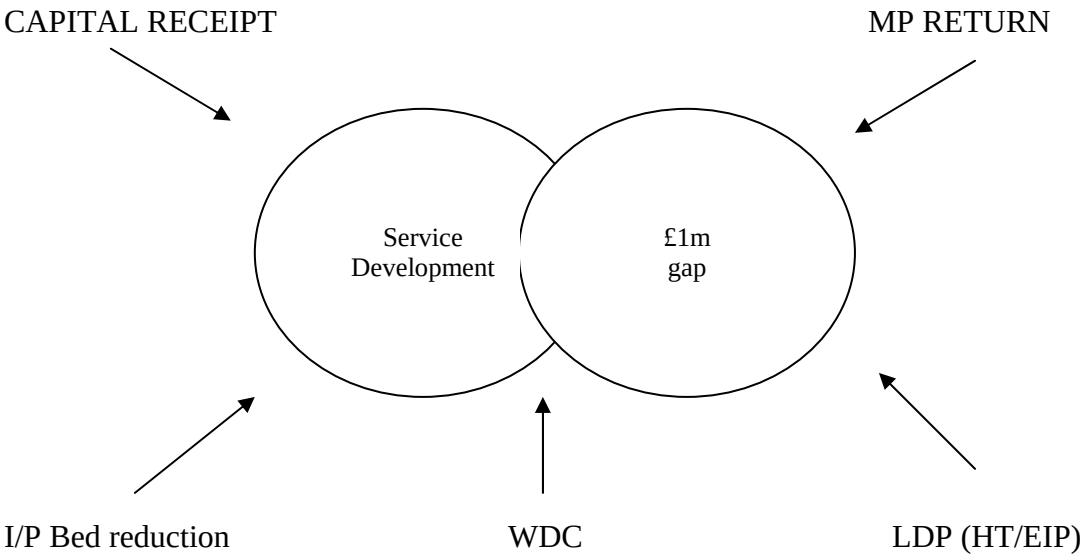


DIAGRAM TWO

Summary of 2005/06 Recovery Plan

Income	**2005/06 £000's**	**2006/07 £000's**	**Note**
Capital Receipt	500	0	1
Bed Closures	295	691	
Mainland Placements	228	548	2
WDC Bid	400	0	
LDP	286	633	
Slippage on Vacancies	100	200	
Total	**1,810**	**2,072**	
Service Developments			
Home Treatment	256	529	3
Early Intervention	30	104	4
Assertive Outreach	30	30	
Ward & Community Support	150	350	5
Low Secure Provision	140	280	
Retraining/Redeployment Costs	50	0	
Building Alterations	50	0	6
Workforce Targets	50	100	
PD Agenda	50	100	7
Total	**806**	**1,493**	
Net Saving	**1,004**	**579**	

1 Dependent on Capital to Revenue Transfer
2 Assumes 75:25 split Trust: PCT
3 As per business case
4 As per LDP
5 50% of resource released by reconfiguration of inpatients units are retained
6 Plans and estimates are required
7 Psychology input to community Teams