NHS Peterborough

Leader of your local NHS

Peterborough Turnaround Plan

Draft for Board approval

19 May 2010
Main document

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Sections

- **Looking backwards – How we got here**

- Looking forwards – Turnaround Plan

Where we are now

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- Understanding of the size of challenge
- Understanding of the underlying factors
- Turnaround plan
- System Transformation Board
- Public and stakeholder engagement

What was NHS Peterborough deficit in 2009/10

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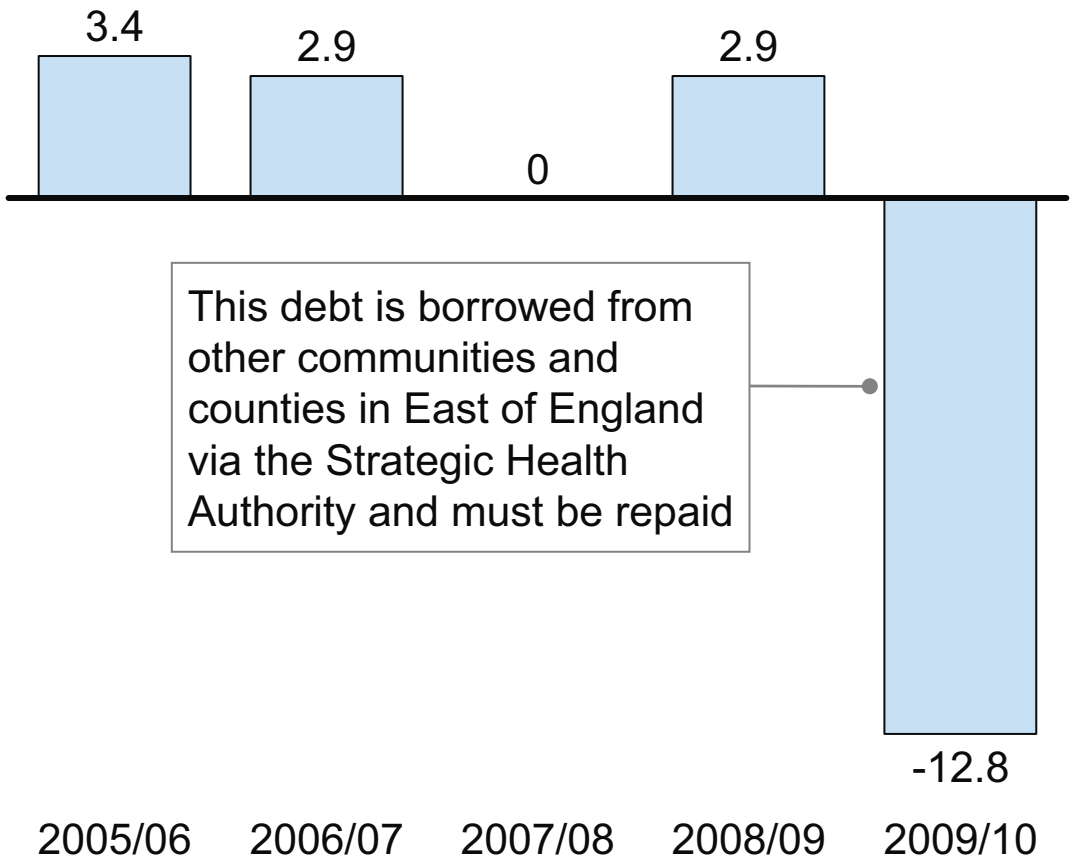
Spend vs. revenue resource limit, £m



PCTs must ensure system spending matches resources as:

- This is a statutory legal requirement
- Other communities and counties in East of England will not bankroll Peterborough
- ***With 95% of PCT spend passed to providers, PCT debt is a system issue***

What is the size of the management action required

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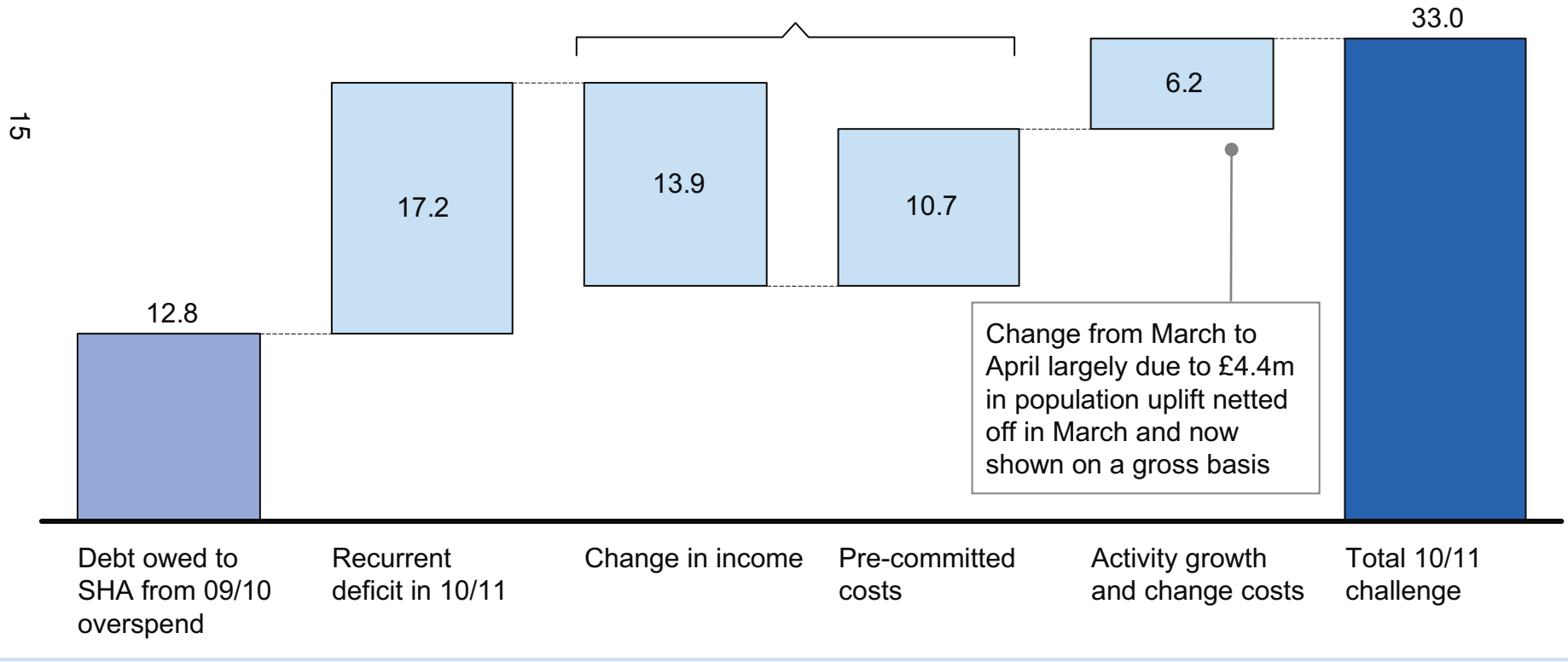
1. In 2009/10, the deficit was £12.8m due to multiple overspends
2. The recurrent value of the 09/10 over-spend is £17.2m in 10/11
3. PCT receives growth money that is offset by pre-committed costs
4. PCT also needs to fund rising population and "non recurrent change"
5. In total, the impact before interventions is £33m which reconciles to £27m in March



SOURCE: NHS Peterborough Financial plan 2010, PCT Finance team, team analysis

Which are the contributing factors to the financial challenge

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- Costs exceed income in many areas
  - 12% growth in 09/10 in acute
  - 8% spend growth in 09/10 in community services
- Extensive NHS infrastructure and broad range of services in Peterborough
- Rising usage of healthcare services
- Variation in care provided to local people and high non elective (emergency hospital) activity

How is our Organization Health

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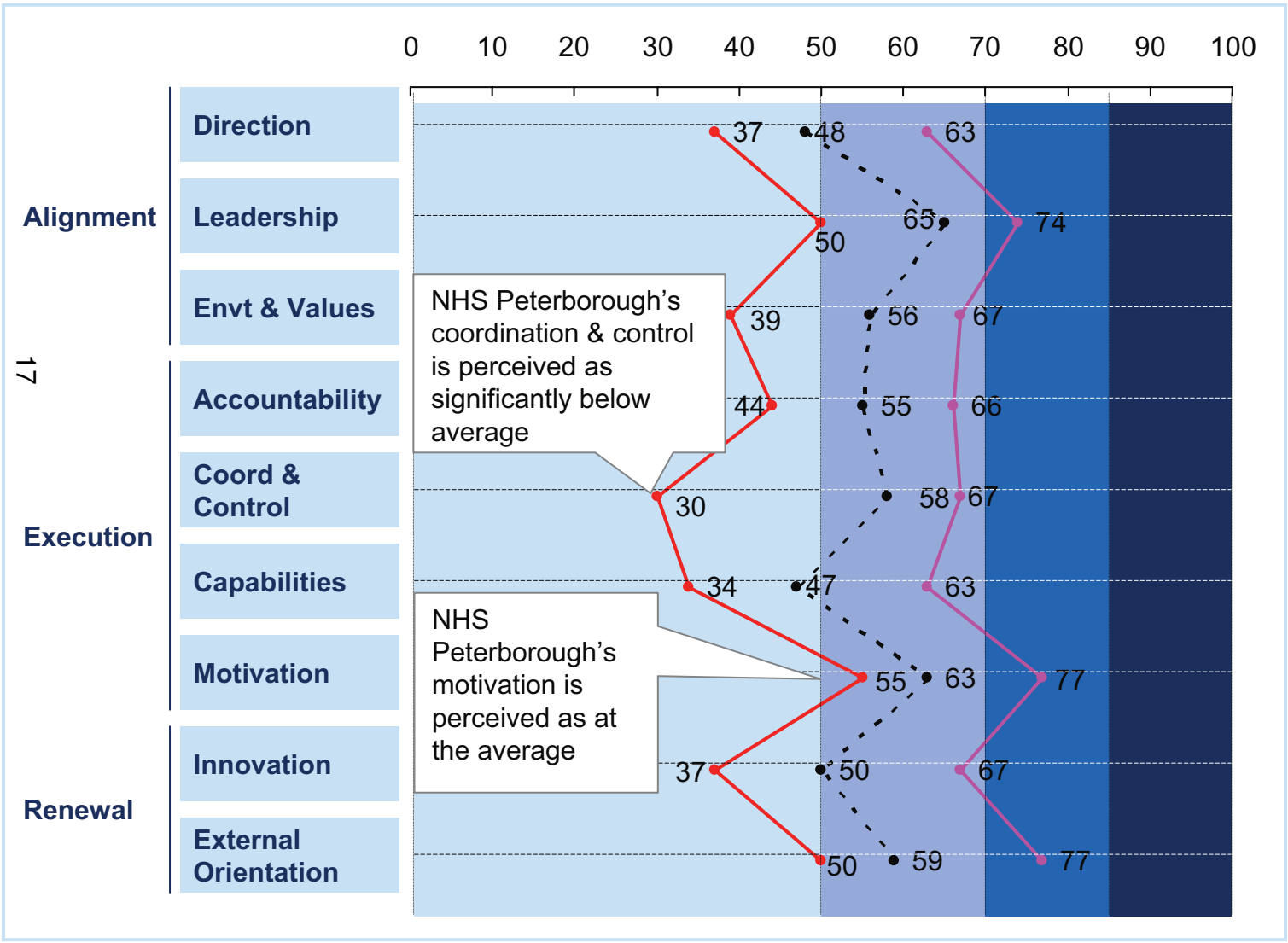
% of respondents agreeing or strongly agreeing



Comparison against other PCTs need to consider that other PCTs may not have been in similar financial distress as NHS Peterborough

SOURCE: NHS Peterborough PCT, Opportunity For Improvement Survey, 12th-16th April'10, survey received by 168 people response rate of 85%

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How did we approach it

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▼ May 14-today

Validate existing initiatives and develop new

	Initiate mobilization	Baseline validation	Identify potential	Develop options; assess impact on providers	Derive implication on existing plans	Produce high-level turnaround plan
Agree savings plan	Kick off ▪ Set up workstreams ▪ Align approach with Directors, ADs, Chair, PEC chair	▪ Close 2009/10 accounts and firm up baseline ▪ Understand 2010/11 growth	▪ Benchmark Peterborough against peers (ONS, national, SHA) ▪ Review "earmarked" spending	▪ Validate existing initiatives against opportunity ▪ Prioritize and develop big ticket initiatives to close gap ▪ Develop options for Peterborough to close gap, including debt repayment and assess implications on providers ▪ Determine changes to PCT strategy promises, if any		▪ Draft plan and refine with Executive ▪ Review plans with Board for sign off ▪ Discuss SHA proposed plan and link to QIPP ▪ Launch specific projects e.g., referral management
Develop ability to deliver	▪ Set up one- on-ones with leadership and clinicians ▪ Formal and informal briefing meetings with providers and local partners	▪ Understand – Organisational structure – Governance – Organisational health (inter-views, focus group, survey)	▪ Interpret findings	▪ Develop options for organisational structure, and governance arrangements ▪ Set up delivery mechanisms (PMO process, including director responsibilities, tools and resource work streams) ▪ Set up series of System Transformation Board meetings		▪ Design proposed organisational and governance changes ▪ Create rapid delivery pace supported by System Board and PMO

Communication

How we mobilize the organization

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Working group	Membership[1]	
1 Planned care & acute contracting	▪ Exec - Sarah Shuttlewood ▪ AD - Jacqui Collins ▪ Clin/Pro - Dr Sanath Yogasundran ▪ ACM - Dr Mark Kroese, Dr Andy Liggins, Andrea Patman, Dr Malcolm Bishop, & Matthew O'Grady Marshall	▪ Finance: Caroline Hall ▪ Contract: Jacqui/Chris Daff ▪ Performance: Mathew ▪ HR: Christine Pattissan ▪ Consultancy support
2 Unplanned care/ urgent care	▪ Exec - Peter Wightman & Paul Whiteside ▪ AD - Richard Mills ▪ Clin/Pro - Dr H Mistry, Dr.Mike Caskey ▪ ACM - Sue Oakman, Andrea Patman, Dr Richard Withers, Tim Bishop or Denise Radley, Alison Reid, Jacqui or Sarah	▪ Finance: Caroline Hall ▪ Unplanned Care: Kyle Cliff ▪ Performance: Noor/ Chris Gillings ▪ HR: Christine Pattisson ▪ Consultancy support
3 Mental health & LD	▪ Exec - Denise Radley ▪ AD - Ray Legge ▪ Clin/Pro - Sue Clarkson ▪ ACM - Kathryn Woods, Ralph Middlebrook	▪ Finance: Cheryl Osborn ▪ Contract: Paul Raymond/ Jacqui Collins ▪ Performance: Alison North ▪ HR: Christine Pattisson ▪ Consultancy support
4 Community services. CC care, LTC	▪ Exec - Dr Andy Liggins ▪ AD - Richard Mills/ Jessica Slater[2] ▪ Clin/Pro - Dr Van Den Bent, Paul Kitney[2] ▪ ACM - Sue Mitchell, Tim Bishop, Paul Kitney[2]	▪ Finance: Sue Cuthbert/ Cheryln Osborn[2] ▪ Contract: Tony Lacey ▪ HR: Christine Pattissonn ▪ Consultancy support
5 Primary care & prescribing	▪ Exec - Dr Richard Spiers ▪ AD - Andrea Patman ▪ Clin/Pro - Dr Kevin Brinkhurst ▪ ACM - Dr Mike Caskey, Ron Smith, Diane Siddle, Sarah Shuttlewood	▪ Finance: Sue Cuthbert ▪ Contract: Diane Siddle/ Jacqui Collins ▪ Performance: Chris Gillings ▪ HR: Christine Pattissan ▪ Consultancy support
6 Corporate	▪ Exec - Rob Yeomans ▪ AD - John Bain ▪ Clin/Pro - Dr Neil Modha ▪ ACM - Chris Palmer	▪ Finance: Donna Shade/ Hazel Allerton ▪ Contract: Jacqui Collins ▪ Performance: Chris Gillings ▪ HR: Angela Hartley ▪ Consultancy support

Time commitment
- **2 weekly meetings**
- **Daily catch up with key members**
- **Core members 30-40% of time**
- **Clinical leads invited to meetings/ briefed weekly**

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1 'Exec' = Executive Lead, 'Clin' = Clinical Lead, 'Pro' = Professional Lead, 'ACM' = Additional critical members
2 Continuing care sub-group

How we ensure the robustness of the plan

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- **Clear accountability and governance from the beginning**
  - Each work stream has met a minimum of twice per week led by an executive lead working alongside a clinical lead
  - Tight turnaround discipline has been in place with daily conference calls to clear any blockages to progress
  - Weekly turnaround oversight meetings
  - Range of meetings with partners, staff and stakeholders.

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- **External expertise** has been deployed to assist in developing a robust Turnaround Plan and challenge assumptions

- Plan reviewed against the **PCT Strategic Plan** to ensure that major priorities in lifestyle, inequalities, vulnerable people and access are supported within a lower spending envelope

- Opportunities in the Plan have been validated using a **benchmarking exercise** to compare Peterborough spending with best practices

- **Equality impact assessment** undertaken by each of the Delivery Boards shows that while plans have the potential to impact vulnerable groups, plans have been established in all of the groups to manage this transition

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What is our plan

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1	**Stop over-spending**	▪ Stop overspending, and spend less than our income so we make savings to clear debt and at same time, invest in some areas ▪ Need to continue to meet health and social care needs, whilst regaining financial control quickly
2	**Consistent, safe, good value care**	▪ Ensure we deliver on consistent standards of care to patients, by reducing variation in referrals to hospital, common approach to dental check ups, similar primary care costs per patient, and minimising waste in prescribing and medicines
3	**Use NHS local services appropriately**	▪ Keep GPs as the primary place of care with consistent approaches to referrals, meaning fewer unnecessary outpatient appointments, less unnecessary surgery, and fewer hospital follow ups ▪ Tighter controls on hospital spending and higher cost services
4	**Simplify options and reduce duplication**	▪ Improve access to GPs ▪ Reduce alternative points of access that duplicate GP or hospital care ▪ Improving out of hours provision by linking to GPs
5	**Shift from bed to home based care**	▪ For Learning Disabilities increase use of intensive care teams that help people stay at home and reduce hospital use ▪ Bring back people receiving high cost care out of area ▪ Improve value for money and productivity whilst shifting focus towards helping people with long term conditions and keeping people safe at home and avoiding unnecessary hospital or residential care
6	**Cut running and management costs**	▪ Cut waste and cost across management in the PCT and providers ▪ Move out of poorly used and poor condition premises to make best use of newer and better facilities

How we expect providers to help

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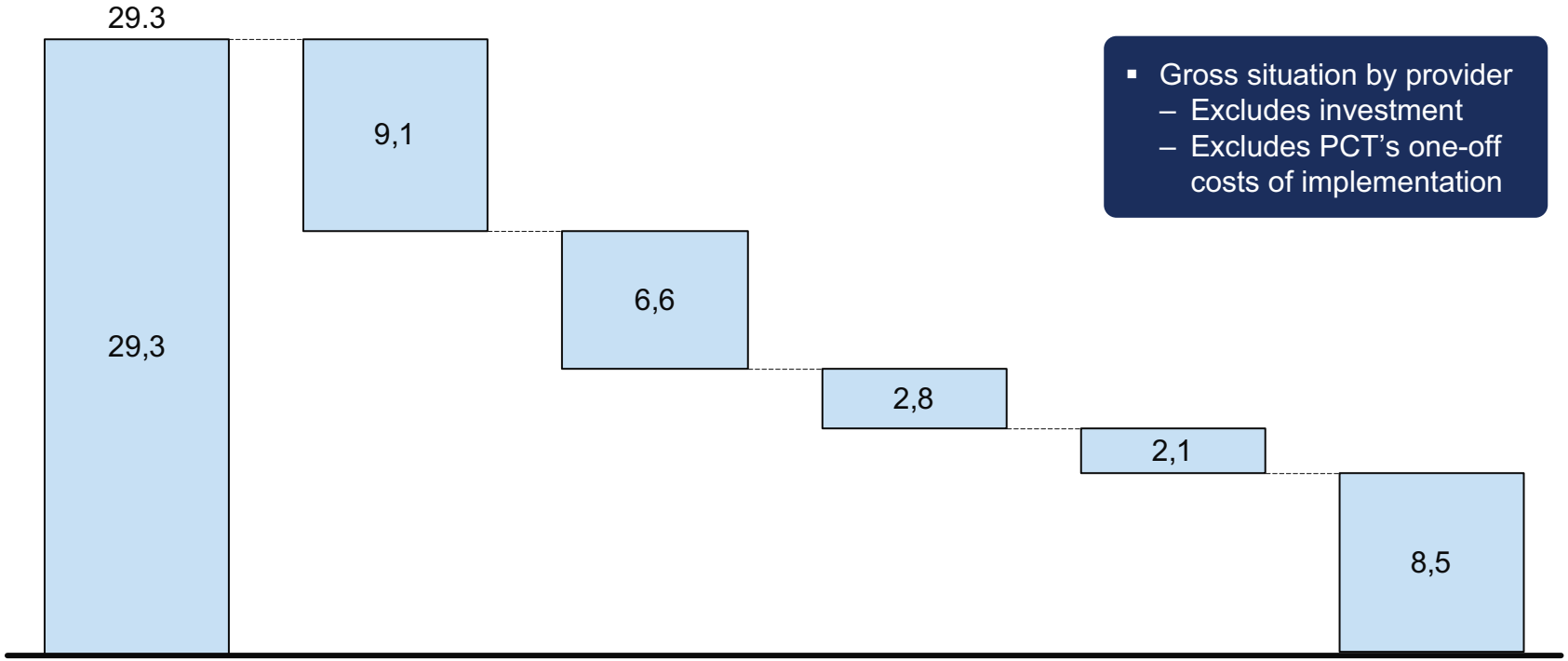
Gross savings before risk adjustment, 2009/10 vs 2010/11 £m



- Gross situation by provider
  - Excludes investment
  - Excludes PCT's one-off costs of implementation

	PSHFT	PCS	Cambridgeshire & Peterborough NHS FT	GPs	Others – mainly PCT corporate, placements and prescribing
Provider income from NHS Peterborough 09/10	£88m	£67m	£28m	£23	N/A
% of 09/10 income	10.5%	9.9%	10.0%	9.1%	N/A

SOURCE: NHS Peterborough 2009-10 Outturn, Working groups Turnaround plan, team analysis

What will be the anticipated savings in 2010/11 if we signed the contracts at expected values

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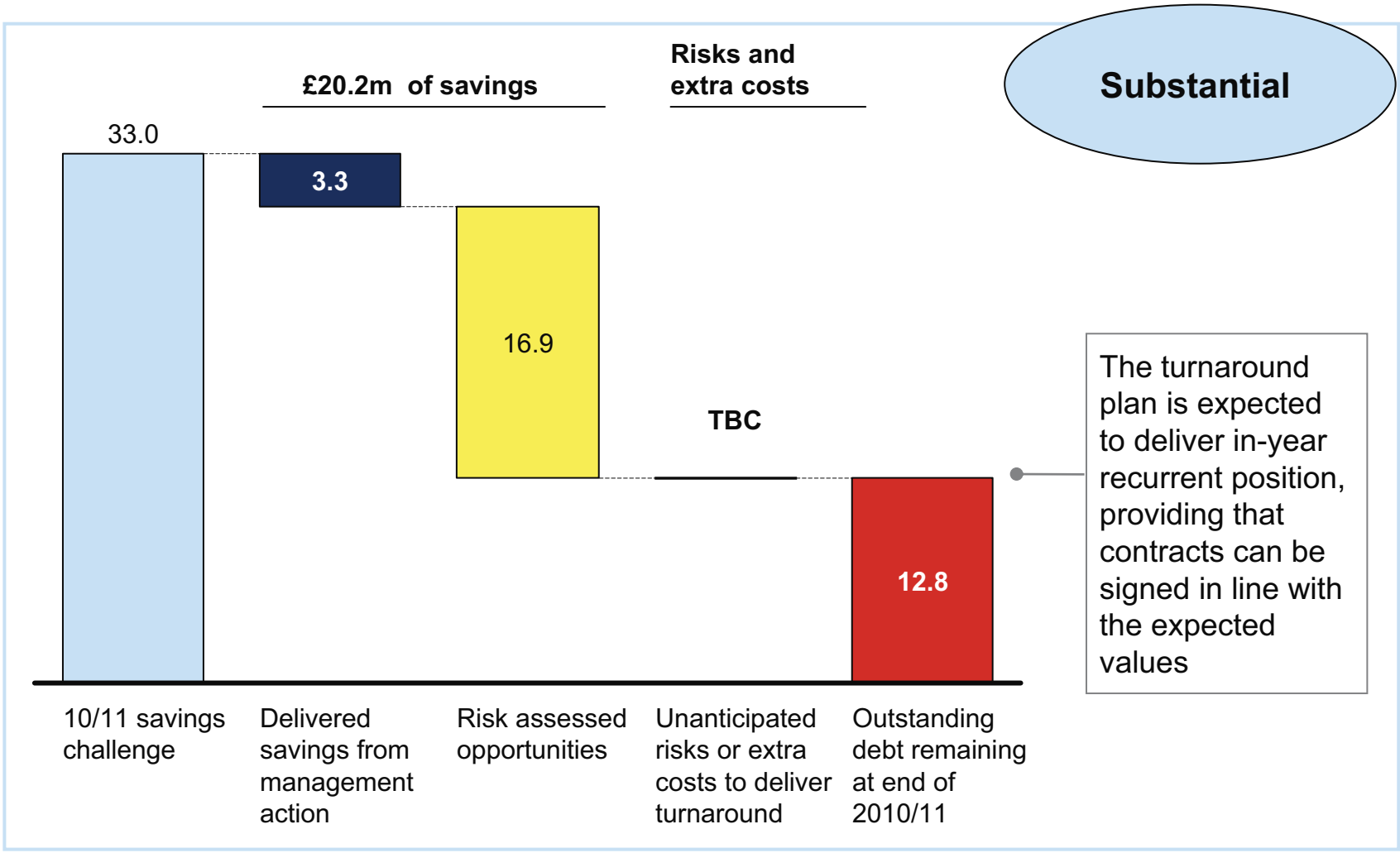
Current plans for 2010/11, Net savings, £m



SOURCE: Financial plan May 2010, PCT Finance team, working groups team analysis

How we have involved the public and stakeholders

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What we have heard from you

- Considerable agreement with the areas identified for potential efficiency improvements

- The main concerns were
  - People should get the care they need when they need it
  - Plan should not disadvantage vulnerable groups

- Action to improve health and prevent illness, including promotion of messages and support for self-care

- A sense of wanting to move forward, but
  - Need for stronger assurance that there would be closer monitoring and control
  - Continuing with NHS Peterborough good practice of involving services users, carers and professionals

How we have incorporated into the plan

- Delivery Board for the Health Improvement
- Financial control processes being strengthened
- Frequent monitoring of the delivery through the Programme Management Office (PMO)
- Delivery boards plans include continuing stakeholders and partners engagement

How are we going to organise for the System-wide delivery

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Delivery Boards	Major projects	Executive lead	Lead Clinicians
1. Primary Care	▪ GP contracts/payments, incl. hard budgets ▪ Referral management ▪ Prescribing ▪ Dental ▪ Rationalize walk- in OOH	▪ Dr. Richard Spiers	▪ Dr. Mike Caskey (TBC) ▪ Paul Van der Bert (TBC) ▪ Kevin Brinkhurst (TBC)
2. Acute Care ▪ **Unscheduled** ▪ **Planned**	▪ Acute Contract ▪ Ambulance redirection ▪ MSK ▪ Ophthalmology ▪ Dermatology ▪ MOSS ▪ Specialist commissioning ▪ A&E / WIC / CCC	▪ Sarah Shuttlewood ▪ Paul Whiteside	▪ Mike Caskey (TBC) ▪ Paul Van dem Bert (TBC) ▪ Dr. H Mistry (TBC)
3. Community & Older People	▪ Community Contract ▪ Older People ▪ Nursing homes and residential placements ▪ LTC programmes??	▪ Peter Wightman	▪ Dr. Mike Caskey (TBC) ▪ Paul Van dem Bert (TBC) ▪ Dr. H Mistry (TBC)
4. Mental Health	▪ Contracting and reducing unit costs ▪ Shifting pathways from acute to community ▪ High costs placements (LD, MH, CHC)	▪ Denise Radley	▪ Sue Clarkson (TBC)
5. Children and maternity	▪ Maternity pathway redesign ▪ Paediatrics pathway redesign	▪ TBD	▪ Dr Sanath Yogasundran (TBC)
6. Corporate ▪ **Back Office** ▪ **Infrastructure**	▪ Estate rationalisation ▪ Management structure ▪ PCT support costs ▪ Gateway review	▪ Rob Yeomans	▪ Dr Neil Modha (TBC)
7. Health Improvement	▪ Smoking ▪ Obesity ▪ Substance misuse	▪ Dr. Andy Liggins	▪ TBD

Which actions have we taken to strengthen the organisation and support the delivery

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- Establishment of Programme Management Office with a tight reporting cycle
  - Weekly Delivery Board performance management
  - Monthly reports to the Board
  - Daily status meetings
- Directors accountabilities for each Delivery Board
- Align budgets to ensure strong financial control
- Clinical engagement in all Delivery Boards
- Continue staff, public and media communications and engagement
- Develop plan to tackle “Organisation Health” issues

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What are the details of the Plan by Delivery Board (1/2)

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Delivery Boards	Major projects	Description
1. Primary Care	▪ GP contracts/payments	▪ Stop 2-3 GP APMS contracts, reduce variability (higher and lower) in rates & reimbursements per patient to GP practices, LES cessation and capping, and reduction of C&B
	▪ Referral management	▪ Work with GPs to route referrals appropriately and implement ACS programme
	▪ Prescribing	▪ Therapeutic switches, patent expires, incentive schemes, specials
	▪ Dental	▪ Increase check up frequency from 6-8 to 12-16 months, reduce re-visits within 5 months
	▪ Rationalize walk- in OOH	▪ Define walk-in/OOH model and renegotiate contract
2. Acute Care ▪ **Unscheduled** ▪ **Planned**	▪ Acute Contract	▪ Contractual targets e.g. readmission rates, invoice validation, non-PBR spend review and reduced tariff for short stays with no procedure, MOSS[1] pathway compliance
	▪ A&E / WIC / CCC	▪ GP triage at front A&E, OOH/Walk-in provided by GPs, redesign OP & urgent pathways
	▪ MSK, Ophthalmology, Dermatology	▪ Pathway redesign to enhance usage of community services
	▪ Specialist commissioning	▪ Renegotiate unit costs of some specific services and better management of activity, including MH SCH medium secure
3. Community & Older People	▪ Community Contract	▪ Reduce corporate overheads and improving productivity of adult and children services
	▪ Older People	
	▪ Nursing homes& residential care	▪ Renegotiate contracts, review entitlements based on criteria, Frail and Elderly people
		▪ Optimize the number of nursing homes and optimize day care services
	▪ LTC programmes	▪ Build on work done as part of the LTC programme

What are the details of the Plan by Delivery Board (2/2)

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Delivery Boards	Major projects	Description
4. Mental Health	▪ Contracting ▪ Shifting pathways to community ▪ High costs placements	▪ Rebase the Community Services based on actual activity ▪ Rationalise inpatient services and rebase contract based on actual activity ▪ Commission a specialist Intensive Community Support Service ▪ Optimise high cost placement commissioning
5. Children and maternity	▪ Maternity redesign ▪ Paediatrics redesign	▪ Redesign services to bring non elective admissions to top quartile performance
6. Corporate ▪ **Back Office** ▪ **Infrastructure**	▪ Estates ▪ Mgmt structure ▪ PCT support costs ▪ Gateway review	▪ Stop leases & sell non-clinical space not used/underutilised ▪ Rationalization of management structure, freeze consultancy costs, and expenses ▪ Review of ASP contracts in IT, mobiles, etc. ▪ Technical review of budget lines for non contractual commitments e.g. vacancies. Plus implementation of new financial control of expenses

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Further savings opportunities are under consideration but have not been included in the Turnaround plan

What are the anticipated savings over the next 3 years if we signed the contracts at expected values

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Delivery Boards	Major projects	Net savings, 2010/11. £m	Risk adj., Reduction[1] %	Risk adj. net savings, £M 2010/11	Forecast net savings, £M 2011/12	2012/13
1. Primary Care	GP contracts and payments	1.0	31%	0.7	1.9	2.0
	Referral management	0.4	25%	0.3	0.8	0.8
	Prescribing	0.7	18%	0.6	1.3	1.7
	Dental	0.3	25%	0.2	0.4	0.4
	Rationalise walk-in/OOH	1.1	20%	0.8	1.8	1.8
2. Acute Care ▪ Unscheduled ▪ Planned	Acute Contract	3.4	0%	3.4	3.3	3.3
	A&E/ WIC/ CCC	1.8	25%	1.3	2.8	2.8
	MSK	-0.02	50%	-0.01	0.3	0.3
	Dermatology	0.1	50%	0.04	0.1	0.1
	Ophthalmology	0.1	50%	0.03	0.1	0.1
	Specialist commissioning	0.4	25%	0.3	0.8	0.8
3. Community & Older People & Learning Disabilities	Community contract	1.5	15%	1.3	4.7	4.7
	Older people	0.6	15%	0.5	1.0	1.2
	Nursing home & residential place.	0.2	15%	0.2	0.2	0.2
	LTC programmes	1.4	38%	0.9	2.2	2.7
4. Mental Health	Contracting and reducing unit costs	1.7	7%	1.6	2.4	2.4
	Shifting pathways from acute to community	0.6	0%	0.6	0.8	0.8
	High costs placements (LD, MD, CHC)	2.7	29%	1.8	4.0	4.8
5. Children and maternity	Maternity pathway redesign	0.3	50%	0.2	0.4	0.4
	Paediatrics pathway redesign	1.0	18%	0.8	1.6	1.6
6. Corporate ▪ Back Office ▪ Infrastructure	Estates rationalisation	0.4	13%	0.3	0.8	0.9
	Management structure	0.8	0%	0.8	2.0	2.5
	PCT support costs	0.6	10%	0.5	0.6	0.7
	Gateway review	3.3	0%	3.3	1.7	1.7
	Total	**24.0**	**17%**	**20.2**	**35.8**	**38.4**

1 Based on two criteria 1) Robustness of the plan and 2) Type of lever i.e level of control by the PCT

SOURCE: Working teams

What are our next steps

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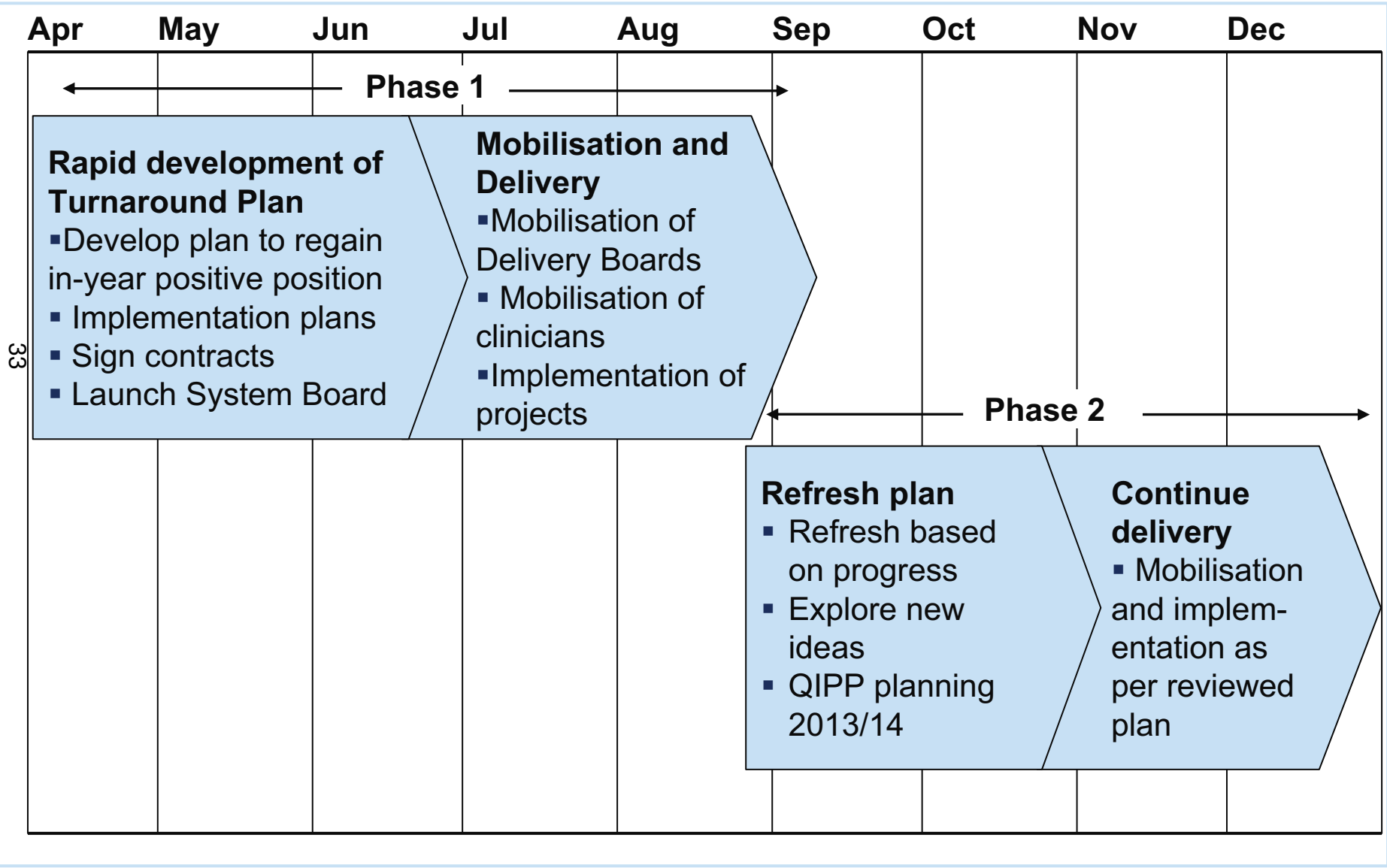

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What are we asking the Board today

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The Plan is for discussion and the Board is asked to make a decision to:

- Approve the plan in full
- Approve the plan with specific issues to changes
- Reject the plan and propose an alternative more compelling approach to addressing NHS Peterborough's financial situation