East Sussex Financial Recovery Action Plans

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A1. East Sussex Hospitals Trust

Ref.	Action	Target	Responsible	Date
	Apply 3% CRES to all Directorates	£000		
	To include a review of purchasing, fees and charges, local CRES, review good practice list, staffing including agency management and antibiotic drugs.			
	▪ Surgery	884	Jim Davey	31.3.05
	▪ Anaesthetics	679	Jim Davey	31.3.05
	▪ Medicine	909	Joanna Smith	31.3.05
	▪ Children's Services	194	Sally Smith	31.3.05
	▪ Obs & Gynae	288	Sally Smith	31.3.05
	▪ Other Acute Services			
	▪ Hospital Directors	20	G Griffiths/A Stenton	31.3.05
	▪ Outpatients	99	David Neale	31.3.05
	▪ Pharmacy	43	Ian Bourns	31.3.05
	▪ Non Emergency Ambulance	34	G Bryant	31.3.05
	▪ Pathology	309	Ken Murphy	31.3.05
	▪ Radiology	223	Lorraine Lea	31.3.05
	▪ Facilities	430	David Philliskirk	31.3.05
	▪ Management Services			
	▪ Management & Admin	44	G Griffiths/A Stenton	31.3.05
	▪ Medical Director	123	David Scott	31.3.05
	▪ Finance	152	David Townsley	31.3.05
	▪ Planning & Information	10	David Townsley	31.3.05
	▪ Human Resources	94	Monica Green	31.3.05
	▪ Professional Nursing & Therapies	165	Cathy Stone	31.3.05
	Total CRES saving	**4,700**		

A1. East Sussex Hospitals Trust

Ref.	Action	Target	Responsible	Date
	Central Savings	£000		
	▪ All Saints closure (50% of net savings)	1,000	Graham Griffiths	31.3.05
	▪ Activity Increases	1,000	GG/AS/DT	31.3.05
	▪ Outpatient Drugs	600	H McIntyre/I Bourns	31.3.05
	▪ Reimbursement charges/ reduced LoS and capacity	1,000	G Griffiths/A Stenton	31.3.05
	▪ Outpatient management	500	A Stenton	31.3.05
	▪ Increase in OATS income	200	Gary Bryant	31.3.05
	▪ MRI lease	200	David Townsley	31.3.05
	Total Central Savings	**4,500**		
	Additional recurrent and non recurrent savings – Still to be identified	**1,600**		
	Additional savings and issues currently under consideration to contribute to savings still to be identified;			
	▪ Review of Contract Management			
	▪ Payment by results			
	▪ Horder Centre activity/contract			
	▪ Reconfiguration			
	▪ Star chamber approach			
	▪ Capital charges review			
	▪ Capitalisation of expenses			
	▪ Asset lives review			
	▪ Non recurring savings			
	Total Options identified	**10,800**		

A2. East Sussex County Healthcare

Ref.	Action	Target	Responsible	Date
5.3.2	Eliminate the referral of patients to the private sector as ECRs.	£683,000	S.Jones	Ongoing
	Continue with the policies and procedures commenced in 2003/4 eg application of new admission and discharge policies, bed management procedures, and controls on authorisation of potential ECR referrals.			
5.3.2	Reduce the spend on specialist mental health referrals (OARs)	£1,100,000	S.Jones	Ongoing
	Progress business case for additional medium secure beds.		R.Hackett	Jan 2005
	Provide 6 medium secure beds for women by converting existing facility.		R. Hackett	May 2004
	Achieve shorter lengths of stay in specialist private facilities by the active intervention of case managers employed by the Trust.		R. Hackett	Ongoing
	Develop specialist residential and community services for women (full year use of beds opened in November 2003).		R.Hackett	Ongoing
	Implement new contract with local provider of PICU beds.		J. Wilson	July 2004
	Pursue cost and volume contracts with preferred providers of eating disorder and mother & baby services.		R.Hackett	June 2004
5.3.2	Reduce the use of agency nurses	£150,000	J.Woollett	Ongoing
	Continue with the monitoring, vacancy controls, recruitment initiatives, & staff attendance management procedures introduced in 2003/4.		J. Woollett	Ongoing
	Develop NHS bank staff resources		J. Tolofson	Ongoing
5.3.2	Reduce the use of locum doctors	£621,000	H. Naliyawala	Ongoing
	Continue the plans developed in 2003/4, to recruit permanent staff and restrict the use of locums			
5.3.2	Service modernisation	£300,000	S. Jones	Sept 2004
	Greater use of crisis response and home treatment services leading to fewer inpatient stays.			

A2. East Sussex County Healthcare

Ref.	Action	Target	Responsible	Date
5.3.2	Reduce level of expenditure on drugs	£113,000	H. Naliyawala	Ongoing
	Agree protocols with primary care; restrict the use of anti-dementia drugs.			
5.3.2	Procurement savings	£142,000	M.King	June 2004
	Part of the Surrey Sussex initiative			
5.3.2	Income generation and facilities schemes	£275,000	M.KIng	June 2004
	Extra income from catering services, and various schemes to reduce energy and building costs.			
5.3.2	To be identified	£150,000	C. Fincham	June 2004

A3. Bexhill & Rother PCT

Ref.	Action	Target	Responsible	Date
PCT FRP	Continue to maintain GP prescribing expenditure at 1.8% below national average	233,000	Gill Ells	31/03/05
PCT FRP	De-commission non-NHS activity	110,000	Peter Finn	31/05/04
5.4.3	Identify areas for and make PCT productivity improvements in provider functions (community, therapies and inpatient facilities)	85,000	Mary Jones/Val Houlton	30/06/04
5.4.7	Collaborate cross PCT to deliver such services as risk management, controls assurance, infection control etc so that best practice is assured and organisational savings achieved (£35k). Repatriate resources from previous hosted shared services (some already identified) and locally deliver service more cheaply (£30k).	65,000	Vanessa Harris/Rick Stern/Val Houlton	31/05/04
5.4.8	Work with Health Economy Medicines Committee to deliver PCT share of expected cross county savings.	65,000	Gill Ells	31/03/05
5.5.1	Participate pro-actively in East Sussex Supply Chain Review Group and a) identify and b) force out procurement savings opportunities for PCTs.	98,000	Vanessa Harris	31/05/04
6.2.1 & 6.2.2	Analyse GP referral patterns and put in place capacity and systems demand management to reduce the number and cost of acute admissions and elective activity.	185,000	Peter Finn	31/05/04
6.2.3 & 6.2.4& 6.2.5	Implement cross LHE plans to reduce costs of: hospitalisation, expenditure on specialist contracts and non- mental health OARs.	160,000	Peter Finn	31/05/04
	TOTAL	1,001,000		

A4. Eastbourne Downs PCT Organisational savings Prescribing

	Action	Target	Responsible	Date
4.3	Prescribing Target saving	£950k		
	• FRP brainstorm meeting followed by discussion with prescribing leads and GP Forum		CH	April/ May
	• Compare 2003/4 costs with cluster		CH	April
	• Compare annual increases over last 4 years with national and SHA averages		CH	April
	• Review financial recovery actions to date		CH	April
	• Review East Sussex prescribing top tips		CH	April
	• Review Audit Commission prescribing advice		CH	April
	• Identify quality-linked prescribing by practice and compare with benchmarks		CH	April
	• Agree further detailed action plans		CH/JV/GB	May
	• PCT: GP prescribing target agreement		DM/JL	May
	• Practice–based pharmacy support		DM/JL	May
	• Develop nurse prescribing capacity		JL/NC	May
	• Review outcomes of national medicines management programmes.		JL	May
	• Agree wholesale drugs switch and input support to practices to implement		JL	June
	• Review role of medicines management team and assess collaborative opportunities with other PCT team; refocus capacity on priorities.		JV	June

A4. Eastbourne Downs PCT Productivity

Ref.	Action	Target	Responsible	Date
5.4.3	Provider services			
	• Apply 2% CRES to all provider services	£200k	JV	1 April
	• Achieve 98% reference costs	£200k	JV	April 05
	• Accurate data collection to be in place by 1 May.		JV	1 May
	• Case load and case mix analysis ▪ Link to demand management plans with particular link to Chronic disease management service changes (Lead RB) ▪ Link to nGMS and practice nurse workload wherever Practice is willing to participate. (Lead JV) ▪ Link to patient pathway project (lead JV) ▪ Link to delayed transfers of care projects (lead JV)		Clinical Leads and Therapy heads LDMs Paul Trevethick& Sophie Clark David May & LDMs Sophie Clark Sophie Clark/ Sylvia Newson	1 June
	• Mode of delivery determined e.g ▪ Home - qualified practitioner assessment and intervention ▪ Home - Qualified Practitioner assessment and trained intervention with qualified supervision ▪ Home - trained intervention ▪ Clinic - qualified assessment and intervention ▪ Clinic - qualified assessment and trained intervention with qualified supervision ▪ Clinic - trained intervention ▪ Group - qualified intervention / trained intervention ▪ Group - trained intervention ▪ Information and advice – telephone – direct access telephone – planned access written		JV with Clinical Leads and Professional Heads	1 June
	• Skill–mix based upon case analysis and mode of delivery		LDM / clinical leads and Therapy heads	1 June

	• Locality plan to develop workforce and delivery as determined by analysis		LDM	30 June

A4. Eastbourne Downs PCT Productivity

Ref.	Action	Target	Responsible	Date
5.4.4	• Chronic Disease Management Services – develop plans to establish CDM service in first instance ensuring that sufficient service is in place to activate commissioning savings as identified in demand management project.		LDMs with clinical leads Sophie Clark & Paul Trevethick	
	• Patient Pathway Project – using Mary Jones and Debbie Parker as advisors develop patient pathway plan for Eastbourne that replicates service now working at Conquest hospital.		Sophie Clark and Older peoples team	
	• Ensure that all new existing and new intermediate care services are working at 98% cost reference and are realising expected impact on acute bed occupation		Elaine MacDonough	
	• Develop systems and processes for admission to acute care and discharge from acute care that ensures optimum lengths of stay .			
	• Best Value review using LA Best value principles for ▪ Family intensive support service ▪ Children Therapy service. • If indicated by review prepare output specification for tendering exercise		Alison Smith Alison Smith / Paul Trevethick	30 June 31 July
	Review management structure	£100k	Gina Brocklehurst	30 May
	Total productivity	£500k		

A4. Eastbourne Downs PCT Decommissioning/demand management

Ref.	Action	Target	Responsible	Date
6.2.1	GP referral rates	**£200K**		
	• Identify variances in referrals by speciality including emergency • Produce Age standardised rates • Absolute numbers of referrals by GP		RB	30 April
	• Develop with practices plans to reduce referrals by 5% • Provide information to GPs • Visit all GP practices • Develop action plan based around localities		RB include JV and LDMs	31 May
	• Roll out plan		RB	30 June
6.2.2	Elective implications of reduced referrals			
	• Identify impact by specialty of action plan on admissions		RB	31 May
	• Agree impact on SLA		JV/CH	30 June

A4. Eastbourne Downs PCT Decommissioning/demand management

Ref.	Action	Target	Responsible	Date
6.2.3	Hospitalisation rates	**£400k**		
6.2.3.1	• Manage demand for unscheduled care • work as part of new unscheduled care service	-	JV	1 April 05

6.2.3.2	• Move minor surgery to primary care
	  • Action plan
	  • Implementation
		£100K	PT	
				30April
				30 June

6.2.3.3	• Falls
	  • Action plan
	  • Implement plan
	• Stroke
	  • Action plan
	  • Implementation
	• Heart Failure
	  • Action Plan
	  • Implementation
	• Dermatology
	  • Action plan
	  • Implementation
	• Respiratory
	  • Action plan
	  • Implementation
	• Diabetes
	  • Action plan
	  • Implementation
	• Agree changes to SLA
		£100K
		
		£50K
		
		£100K
		
		£50K
		
		-
		
		-
			RB / Older people team
			
			RB / Older people team
			
			PT / Older people team
			
			RB / John Clarke
			
			RB / older people team
			
			PT
			
			PT
				
				15 May
				1 Sept
				
				30 May
				30 Sept
				
				15 May
				1 Sept
				
				15 May
				30 Sept
				
				31 July
				31 Oct
				
				31 July
				31 Oct
				
				Ongoing

6.2.3.4	• Establish mechanism for staff to bring new ideas		RB	30 May

A4. Eastbourne Downs PCT Decommissioning/demand management

Ref.	Action	Target	Responsible	Date
6.2	Review of independent sector contracts	£1,000k		
	• Identify target contracts		CH	April
	• Agree basis for Contract negotiation		JV	30 April
	• Obtain legal advice to assess likely cost of early termination of contract etc		JV	30 April
	• Complete contract negotiation		JV	June
	• Agree and sign new Contract		JV	Sept
	• Complete physical changes to support reconfigured services		JV	Dec

A4. Eastbourne Downs PCT Decommissioning/demand management

6.2.4	Priorities and Placement Process			
	• Agree panel process • ensure sign up from LHE		PT/RB	20 April
	• Implement new processes		PT/RB	30 May
	• Eliminate treatments of limited value		PT	30 May
	• Monitor and report		PT/RB	1 Sept
6.2.5	Non Mental Health OARs			
	• Ensure all placements go through a panel		JV	April
	• Review all current placements		SN	on going
6.2.6	Specialist Commissioning	**£180K**		
	• Establish numbers and value by speciality		PT	30 April
	• Ensure all referrals through panel (or agreed protocol)		RB/ PT	31 May
	• Develop plans with secondary sector for repatriation		RB / PT	31 July
	• Implement plans		RB / PT	30 Sept
	Total decommissioning	£1,780k		

A5. Hastings & St Leonards PCT

Ref.	Action	Target	Responsible	Date
5.4.7	Prescribing – Workstreams identified to achieve savings targets – Budget reduced at budget setting	285	 GD KE	 31 March 04 30 April 04
	TOTAL PCT Savings schemes	**285**		

5.4.2	PCT providing productivity improvements	35	 DP / KE / TW KE	 30 April 04 30 June 04
5.4.3	Further PCT providing improvements - Identify areas within PCT budget for all “providing” reductions - Benchmark with other PCTs prior to submission of 2003/4 reference costs	105		
5.4.7 – LHE	Support Services Collaboration - Budget reduced at budget setting - Preliminary discussions with Bexhill - Wider discussions across the LHE	77	 PCT Dirs	 31 Mar 04 30 June 04
5.4.8 – LHE	Secondary / Primary Prescribing – Budget reduced at budget setting – Work with LHE partners to ensure successful initiatives	77	GD (through ESPrescribing Group)	 30 April 04 31 Mar 05
5.5 – LHE	More effective Non Pay Procurement – Budget reduced at budget setting – Work with LHE partners to ensure successful initiatives	96	Through ES procurement group	 30 April 04 31 Mar 05
	Total Productivity Improvements	**390**		

Decommissioning schemes which should be developed on a LHE basis. However PCT needs to underpin achievement through developing PCT specific schemes in parallel.				
6.2.1 - LHE	Outpatient GP referrals	69	PF	May 2004
6.2.2 – LHE	Elective activity implications	141	PF	July 2004

East Sussex Financial Recovery Action Plans

Ref.	Action	Target	Responsible	Date
6.2.3 – LHE	Lower rates of Hospitalisation – Decide areas to investigate – GP referrals, Specialties, Procedures, Diagnosis – including varicose veins, backs – Produce activity data to inform process – Develop pathways / protocols – Ensure all stakeholders are signed up to changes – Implement pathways / protocols	74	PF	Sept 2004
6.2.4 – LHE	Lower use of Specialist contracts – Ensure appropriate referral / panel arrangements are in place	51	PF	May 2004
6.2.5 – LHE	Non Mental Health OARS – Ensure appropriate referral / panel arrangements are in place	62	PF	May 2004
6.2.6	Commissioning reduced activity – Develop plans for areas (including non acute activity – Mount Denys, Sanctuary, Laureston) to review – Review impact of decommissioning v reserves – Produce relevant data to inform decisions – Develop pathways / protocols – Ensure all stakeholders are signed up to changes – Implement pathways / protocols	500	PF Board PF DP (Primary care development Working Group)	26 Apr 04 26 Apr 04 May 2004 July 2004 Sept 2004
	Total Demand Management / Activity Decommissioning	**897**		
	TOTAL H&StL PCT Savings Required	**1572**		

A6. Sussex Downs & Weald PCT

Ref.	Action	Target	Responsible	Date
Org.	Prescribing: continuation of the measures commenced in 2003/04. The plan for 2004/05 focuses on: • Practices being offered direct assistance. Experience with this over the last 12 months with pilot practices has both improved prescribing quality and reduced expenditure by focussing on waste and the management of generics; • Double dose project – community pharmacies providing information to practices on individual prescriptions where expenditure can be reduced without reducing clinical care; • Development of practice based repeat prescribing guidelines and active audit of Practices; • Pharmacist led repeat prescribing reviews particularly with Practices with patients in nursing residential homes; • Focussed work with patients on multiple therapy to assist compliance and review medication; and • In addition the PCT will work with its neighbouring PCTs and Acute Trusts to manage the introduction of new therapies and ensure prescribing interface is well managed.	£333k	Mike Salter	Ongoing from 2003/04
Org. & 5.4.3	Following a zero-based budget setting approach and service reviews, detailed plans will be put in place for services to be delivered within existing resources. General Managers are currently working with finance staff to agree start budgets for 2004/05, however, at this point in time it should be noted that these will probably mean the continuing restriction on bed availability within the community hospitals. Setting budgets within recurrent baselines will require the implementation of new service models which are currently being developed in each of the localities. Progress on this is likely to be phased and current restrictions enforced to generate non-recurrent savings to balance with the Full Year Effect as planned in 2005/06. This level of savings is in line with StHA expectations of 5% savings where reference costs are above national averages in order to bring all organisations down to 98%. This savings target is above the 1% mandatory efficiency saving of £165,000, which will be required to manage any non mandatory cost pressures.	£776k	Jackie Brown, Brenda Darking, Flowie Georgiou, Eva Merry	May 2004
Org.	It is planned to save £100,000 on other corporate areas of the PCT budget in line with the original East Sussex Financial Recovery plan. These have yet to be identified.	£100k	Helen Aldis	May 2004

A6. Sussex Downs & Weald PCT

Ref.	Action	Target	Responsible	Date
5.4.7	Collaboration: East Sussex lead to submit.	£97k		
5.4.8	Prescribing: £520k of savings have been identified by the East Sussex Health Economy Medicine Committee chaired by Fiona Henniker. See A7 below.	£97k		
5.5.1	Procurement: savings apportioned to arise in respect of Sussex Downs & weald PCT from the Surrey & Sussex Procurement initiative tabled by Barry Elliot.	£103k	Alistair Hoptroff	May 04

A6. Sussex Downs & Weald PCT

Ref.	Action	Target	Responsible	Date
6.2.1	Outpatient GP Referrals: improved productivity/demand management based upon East Sussex LHE savings as modelled for East Sussex Hospitals Trust. These have been extrapolated to provide targets for our main acute commissioning.	£77k	Alistair Hoptroff	June 04
6.2.2	Elective activity implications: improved productivity/demand management based upon East Sussex LHE savings as modelled for East Sussex Hospitals Trust. These have been extrapolated to provide targets for our main acute commissioning.	£157K	Alistair Hoptroff	June 04
6.2.3	Hospitalisation rates: improved productivity/demand management based upon East Sussex LHE savings as modelled for East Sussex Hospitals Trust. These have been extrapolated to provide targets for our main acute commissioning.	£83k	Alistair Hoptroff	June 04
6.2.4	Specialist Contract: The PCT, along with all PCTs from the former ESBH HA, are to work with AAW PCT to reduce the demand for Specialist activity.	£65k		
6.2.5	Non Mental Health OARS: The PCT, along with all PCTs from the former ESBH HA, are to work together to reduce the demand for Non Mental Health OARS and are considering creating a single Funding Panel to review cases across the LHE.	£78k		
6.2.7	Further savings amounting to £78k has yet to be identified whilst a review of Non NHS commissioning is undertaken.	£78k		
	1% CIP on Provider Services – cost pressures outside mandatory to be contained within baseline funding.	£165k		
	TOTAL SAVINGS AS PER LDP SUBMISSION	**£2,209k**		

A7. **Local Health Economy initiatives**

	Action	Target	Responsible	Date
5.4.7	Functional collaboration	£375k		
	• Review all shared and hosted services		RS/GB/TW/FH	tbc
	• Identify and implement savings			
5.4.8	Prescribing			

	Prescribing: £520k of savings have been identified by the East Sussex Health Economy Medicine Committee chaired by Fiona Hennicker.
	
	• Task and finish group set-up to review lipid lowering drug prescribing, £150k
	• Task and finish group set-up to review EBIXA (Memantine) prescribing, £60k
	• Task and finish group set-up to review Proton Pump Inhibitor and NSAID prescribing policy, £100k
	• Proposals to changes in three drugs in secondary care which will impact on Primary care Prescribing to be submitted to the May Drugs & Therapuetic Committee (potentially significant savings), £t.b.c.
	• Recruiting to facilitator pharmacist post to support Task and finish groups. Interim paper by PCT Prescribing Advisors
	• Shared care protocols
	• Task and finish groups to be established for:
	  • Beta-interferon (including specialist commissioning), £40k
	  • Antibiotic Prescribing, £120k
	  • Clopidogrel prescribing, £50k
		£520k	
			
			Ian Browne
			Jed Hewitt
			Jackie Lamberty
			
			Mike Salter
			Fiona Hennicker
			t.b.c.
			
			t.b.c.
			t.b.c.
			t.b.c.
				
				Sept. 04
				June 04
				
				July 04
				
				June 04
				
				July 04
				t.b.c.
				
				t.b.c.
				t.b.c.
				t.b.c.

5.5.1	Procurement	£1,357k		
	• Identify saving opportunities from Procurement Board work		All	tbc
	• Renegotiate or move contracts		All	tbc
	• Monitor and review		All	tbc

Risk management and contingency plans

R1. East Sussex Hospitals Trust

Ref	Action/Issue	£000	Risk
	CRES Efficiency Improvement and Central Savings	11,500	There is a risk around the Trust's ability to deliver savings of £11.5m (7%), in order to achieve recurrent financial balance and repay the £2.5m deficit from 2003/04.
	Consultant Contract		There is a risk of mismatch between the cost of implementation and the available funds
	Agenda For Change		The amount set aside by PCTs may not be sufficient. Pilot sites have found the costs of implementation to be high, and not allowed for in the calculation.
	Junior Doctors' Hours		It is not certain whether rotas can be staffed at the appropriate banding. Also, there is a risk that working practices cannot be changed quickly enough to sustain costs.
	NICE Drugs		The level of mandatory uplift may be less than the cost pressures estimated by Pharmacy.
	Payment by Results		There is a risk that the Trust will under perform against the 48 HRGs and lose funding. Conversely, we may over perform in other areas but not be paid as levels are within tolerances or that if the Trust over performs on the 48 HRGs that the PCT may not have enough resources to pay for the overperformance.
	Patient Choice		This initiative may lead to a loss of income within the local health economy, an element of which would be attributable to the Trust.
	Delayed Transfers of Care		Unless levels reduce substantially, the Trust's ability to deliver significant efficiency improvements and increased levels of elective activity, along with a reduction in agency staff costs, will be impaired.
	All Saints' Hospital Closure		There is a risk that slippage in the closure programme could delay achievement of the planned savings.
	Managing Emergency Care		It remains to be seen whether the opted out Out of Hours service will increase the level of emergency referrals to the Trust.
	Ambulance Service		It is not yet clear whether the mandatory cost pressures funding includes sufficient uplift to pay for PTS contracts.

R2. East Sussex County Healthcare

R3 Bexhill & Rother PCT

Workstream	Savings Target	Risk Assessment	a) Risk Analysis justification b) Scheme substitution if workstream fails
Prescribing	£233k	low	a) PCT succeeded in managing prescribing costs down in 2003 - 04. It already has work in place to continue to keep these costs down in 2004 - 05. b) n/a
Non NHS decommissioning	£110k	low	a) PCT has already identified contracts that can be withdrawn/reduced to realise savings target in year. b) n/a
5.4.3	£85k	med	a) PCT is confident some efficiency savings can be found in provider services but there are constraints within PCT's capacity both to identify and deliver these. b) Combination of vacancy freeze/gapping in provider function.
5.4.7	£65k	med	a) PCT has already identified some potential for collaborative working with Hastings PCT. In addition some repatriation of previously hosted services may permit more cost effective joint working with Hastings PCT. b) Impose vacancy freeze/gapping target on PCT management function.
5.4.8	£65k	med	a) It should be possible to achieve greater prescribing financial efficiency through a LHE medicines committee. This approach has been successful in other areas of the country. However, it was difficult to implement locally in 2003 - 04 so a different approach might be needed. b) Impose further savings target on GP prescribing.
5.5.1	£98k	high	a) The PCT has a small purchasing/supply budget (excl. prescribing), it is not confident significant savings can be achieved in 2004 - 05. b) To be identified.
6.2.18 6.2.2	185k	high	a) Much work to be done to analyse GP referral patterns and variances. Although it should be possible to influence this area it may take some time to prepare and implement. b) To be identified (although if PCT has achieved all above workstreams it will break even in 2004 - 05).
6.2.3 6.2.4 6.2.5	£160k	high	This requires close working across LHE and wider Surrey/Sussex area. Influence over specialist commissioning costs has been difficult to manage in the past and although the PCT has managed down non-MH OARS in 2003 - 04 it is always vulnerable to unplanned needs arising in year e.g AB1. b) as (b) above.

R4. Eastbourne Downs PCT

Ref	Action	Target	Risk	H/M/L	Contingency
4.3	Prescribing	£950k	Lack of capacity in pharmacy team	M	Focus resource on financial priorities
			Lack of commitment from prescribers	M	Consider use of incentives
5.4.3	Productivity – Provider Services	£400k	Cost controls may have adverse impact on services	M	Review detailed plans carefully and monitor performance
			Estate constraints may delay implementation	M	Complete estate strategy
5.4.4	Productivity – management structure	£100k	Cost reductions may require redundancy (cost)	M	Review detailed plans carefully and monitor performance
			Cost reductions may have adverse impact on services	L	Review detailed plans carefully and monitor performance
			Cost reductions may have adverse impact on statutory duties	M	Review detailed plans carefully and monitor performance
6.2.1	GP referral rates	£200k	Decrease in referrals may not be achieved	L	Work closely with practices
6.2.3	Hospitalisation rates	£400k	Lack of capacity to develop plans	L	Focus resource on plans
			Delay in transferring services	L	Focus resource on plans
6.2	Independent sector contracts	£1,000k	Providers not willing to negotiate	L	Consider alternative uses of contracts
6.2.6	Specialist commissioning	£180k	Unforeseen difficulty in demand management	M	Focus resource on this issue

R5. Hastings & St Leonards PCT

RISKS	Gross Value £'000	% Chance	Financial Impact £'000
Commissioning			
1. Increases in activity over the contracted levels for the 48 HRGs expected on a cost per case basis	250	40%	*100*
2. The late development of PCT introduced demand management measures around GP referrals and unscheduled admissions meaning that acute activity is still undertaken	1000	50%	500
3. Specialist activity increasing either locally or in other districts covered under the risk sharing arrangements	200	50%	100
4. Late development of alternative continuing care provision either through contract negotiation or development of local services meaning that non mental health OARs continue to overspend.	100	50%	50
Implementation of nGMS			
a) The requirement to make the enhanced services floor amount available may put pressure on other areas of the PCT budget.	250	40%	*100*
b) The cost of providing OOH services may exceed current estimates.	100	40%	*40*
c) The anticipated quality aspiration points of our GPs may be significantly greater than the level or resources funded nationally.	150	60%	90
d) In order to achieve the aspiration points there is a knock on increase in prescribing costs greater than that anticipated	200	40%	*80*
e) Essential replacement of GPs IM&T systems in advance of the availability of the nationally funded solutions would incur additional costs.	100	50%	50
Prescribing			
a) Costs of prescribing can not be contained within the budget uplift	300	40%	*120*
b) Slippage on prescribing savings identified	100	30%	*30*
Providing			
a) A 5% improvement on the providing function is not achieved	100	40%	*40*
Continuing Care			
a) Actual expenditure is greater than the historic levels of claims.	500	20%	*100*
Funded Nursing Care			
a) Insufficient resource available for funding nursing care in nursing homes	250	30%	*75*
TOTAL POTENTIAL RISKS (*ITALICS – IGNORED AS BELOW 50%)*			**790**

<table>
<tr><td>CONTINGENCY PLANS</td><td>Financial Impact
£'000</td></tr>
<tr><td colspan="2">Robust Recovery Plans
Efforts will need to go into ensuring that the recovery plans are as robust as possible, that there is a reporting mechanism and that the schemes deliver the planned level of savings. This action will reduce the risks and the need for contingencies.

However, if the risks do occur then there are a couple of areas where the PCT's Board may decide to reduce the potential risks facing the PCT, by reducing the following specific areas of resource :</td></tr>
<tr><td>Health Inequalities
The PCT has been given additional growth of approx. £700k, over other PCTs within Surrey and Sussex, in order to address the Health Inequalities within the population. The Financial Recovery Plan prepared in November 2003 proposed that 50% of this growth be used in the recovery plan and the Board decided that the other 50% of those resources should be used to develop other services. This remaning element would need to be used to offset any risks.</td><td>350</td></tr>
<tr><td>Access
The amount set aside under this heading covers several areas of commissioning risk
1. Historically, Specialist Service SLAs and OARS have overspent against their budget, and demand for this area of service continues to increase. Part of the savings included in the recovery plans proposed assumes that both areas will be able to reduce expenditure below budget levels.
2. The PCT's SLAs has an element of exposure to "Cost per Case" activity, i.e. if activity increases the providers would expect additional payment. The recovery plan assumes the introduction of measures to ensure that demand is managed within the levels of activity agreed with providers.
3. The PCT's SLAs also have an element of exposure to increases in commissioned activity over tolerance levels.
The Board have been already been asked to consider the use of this contingency to reduce the level of savings and therefore risks.</td><td>395</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Non recurring savings
Every year there appears to be elements of non recurring savings, which can't be included within the plans, but offsets some of the risks which materialise. The PCT will need to assume that there will be non recurring savings identified to offset any risks which materialise.</td><td>200</td></tr>
</table>

R6. Sussex Downs & Weald PCT

1. Implementation of nGMS

Guidance from the StHA had previously indicated that the nGMS allocation together with existing, remaining, budgets is sufficient to meet the costs of the new GMS contract. However, the PCT has identified some specific risks:

a) The requirement to make the enhanced services floor amount available may put pressure on other areas of the PCT budget. Previously, the PCT had identified through a national data collection exercise that identified that the 2003/04 floor was not being met. A commitment was given to correct this through the LDP together with the national growth expectation. Since this time, the definition of enhanced services has been revised so that current spend on areas such as nurse prescribing, counselling and physio are now excluded. The sum allowed for in the LDP has been increased to meet 50% of the revised gap, but in order for the floor spend to be met in 2004/05 services will need to be identified for transferring from secondary care and a comprehensive review of non NHS services will be undertaken. Following further guidance options for recommissioning services will be reviewed together with a review of Out Of Hours arrangements to ascertain how best this may be managed.

b) Discussions on the Northern Consortium for Out of Hours provision are sufficiently well advanced to identify the gap between funding available and the cost of the contract. In terms of the LDP, provision has been made based on these sums, together with similar assumptions on the Southern Consortium. It is not yet clear as to whether the OOH allocation (still to be announced) will offset some of these costs, although a number of assumptions have been made and a separate risk assessment submitted to the Board.

c) The allocation for quality aspiration and achievement (still to be announced) may be insufficient to meet the likely cost. It is understood that national funding is based on an average of 770 points.

2) Agenda for Change/Consultant Contract

An amount has been set aside by the PCT (as per guidance) to fund these initiatives. However there is not enough current information to enable it to determine whether this will be sufficient.

3) National Programme for IT

Some funds have been reinstated (as per guidance) in the LDP to support the NPfIT programme. Until more details are available as to the timing of the rollout in East Sussex we are unable to quantify the risk of these being insufficient.

4) Pensions – increase in Superannuation contribution

Allocations have been made to PCTs to meet the cost of that part of the employers pension contribution previously met through central budgets. The allocation is based on annual accounts information and therefore should be adequate. The PCT has not yet been able to determine if this is the case. Allocations for nGMS and Out of Hours have yet to be confirmed.

5) Integrated Community Equipment Service (ICES)

East Sussex are currently in the process of tendering for services jointly between Health and Social Services with an expected implementation date of the 1st September 2004. Social Services have given notice to their existing supplier to terminate contract on the 31st August 2004. The revenue implications across East Sussex PCTs are significant c£850k. No provision has been made in the LDP at this stage and a handling strategy will need to be agreed by at the East Sussex Health, Social Care and Education Executive. In addition, South downs Health provide a service to the Ouse Valley area which, following the establishment of a new service and the signing of a Section 31 Agreement for the Brighton and Hove area will be unable to continue after September 2004.

6) Commissioning

a) Payment by Results
With the move towards payments by results contracts for 04/05 have to be settled using 48 HRGs. Rather than negotiate on contract over/under performance towards year-end all the 48 HRG will be settled at full cost (National Tariff). This is for all NHS contracts. There is a very real risk that if we have not purchased sufficient activity to reach waiting list targets we could have a substantial amount of funds to find.

b) Demand management
This is a significant area of the PCT agenda and the Financial Recovery plan and there are risks that until demand management measures around GP referrals and unscheduled care are implemented that acute activity is still undertaken. There are also risks if growth in demand for ambulance services is not contained as agreed in the SLA settlement.

c) Out of Area Referrals and Specialist Commissioning
These areas have historically overspent and there is a risk that the current predicted levels 2004/05 expenditure within the LDP might be exceeded.

7) Continuing Care

Whilst provisions have been created to cover the estimated cost of retrospective claims for Continuing Care, these are currently being reviewed with the StHA and it is not yet clear whether these will be sufficient in the future.

8) Other developments

It is recognised that there are a number of small developments, which due to the financial challenges have not been able to be agreed and will therefore need to be reviewed both within the PCT and with health community partners. Examples of these include restorative dentistry at BSUHT

where there are problems with the current service and diabetes where revenue will be required in order that maximum use is made of central capital funds in order to reach NSF targets.

9) Contingency Arrangements

The PCT does not hold any general or specific reserves against risks that may arise during the year.

In presenting the 2004/05 budget to the Board for approval, the risks highlighted above will be reviewed together with the measures to manage them within resources available. The measures taken during 2002/03 and 2003/04 to reduce overspends in year will also be reviewed in order to put a contingency plan in place. Measures such as vacancy control, review and limitation on bank and agency spending are still continuing from 2003/04.

Options for managing certain specific risks through use of capital funds are being explored, for example ICES, although this will need to be prioritised alongside backlog, health and safety issues across the PCT estate.

R7. Local Health Economy Initiatives

Ref	Action	Target	Risk	H/M/L	Contingency
5.4.7	Functional collaboration	£375k	Lack of clear responsibility	M	Consider delegating authority to act across organisations
5.4.8	Prescribing	£520k	Lack of agreement on incidence of saving	L	Consider risk sharing options
			Delay in recruitment of facilitator	L	Consider secondment
5.5.1	Procurement	£1,357	Lack of process to deliver savings at organisational level	L	Full participation in S&S initiative
			Delay in contract renegotiation	M	Extend scope to other contracts