NHS Haringey

OVERVIEW & SCRUTINY COMMITTEE
NHS HARINGEY – FINANCIAL UPDATE

Introduction

The purpose of this paper is to provide to the O&SC an update as to the financial position of NHS Haringey for 2010/11 onwards. The table below sets out our financial position to 2013/14 under a base case funding option.

	2010/11	2011/12	2012/13	2013/14
	£'m	£'m	£'m	£'m
Resource Limit	459.8	482.2	494.2	506.6
Expenditure	473.3	485.6	500.2	516.8
Reserves	10.4	11.5	12.6	13.7
Contingency	2.3	2.4	2.5	2.5
Less:				
Reduction in Activity	1.0	3.4	3.5	3.6
Net Polysystems Shift	2.8	3.4	4.0	4.7
Decommissioning	3.3	4.4	5.5	6.7
Admitted Patient Care	0.3	0.3	0.4	0.5
Additional Savings	23.3	10.4	12.4	15.7
Total Savings	30.7	21.9	25.8	31.2
Total Application	455.3	477.6	489.5	501.8
Surplus/(Deficit)	4.5	4.6	4.7	4.8

The key points to note are as follows:

Annual Surplus

The NHS London expectation is that a minimum surplus of 1.0% of budget is achieved. For NHS Haringey in 2010/11 this would equate to £4.5m. In addition the Operating Framework for 2010/11 sets out that all PCTs by 2013/14 should meet the requirement of at least 2% of recurrently uncommitted resource. This requirement has been reflected in our financial planning for 2010/11 onwards.

Level of Savings Required

The above table sets out the level of financial savings needed to achieve an annual surplus consistent with the NHS London planning assumptions and Operating Framework.

NHS Haringey has a need to reduce underlying cost pressures by £26m in order to breakeven in 2010/11, more in order to achieve a surplus. We are targeting productivity and efficiency gains in order to reduce costs in a way that minimizes service impact, and where there is service impact we are directing that towards positive changes that we need to take forward in order to improve healthcare for our population for example the polysystem shift. There are several main elements to our productivity and efficiency gain programme:

a) decommissioning low priority treatments. A sectorwide list has now been agreed following the model already implemented successfully in other parts of the country. We know the cost savings from implementation of this list by HRG by provider. Providers have been informed and contracts are being negotiated on this basis. We will need to implement a simple process to allow exceptional requests to be heard without allowing the non-exceptional to take over. Local GP leaders and the CEC are on board with the list and with the need to implement it successfully.
b) polysystem shift. We have examined the 7 care pathways in detail, and worked up HRG level activity and cost shifts and decommissioning changes. We have a number of new buildings suitable to support some polysystem working, in particular in Hornsey Central and Lordship Lane. We are looking at means to target quick wins in these areas in 2010/11, at the same time as introducing bigger volume changes in the east of Haringey shortly thereafter. For example we are transferring a significant amount of the Women's Services out patient activity from hospitals to local sites including the Tynemouth Road and Lordship Lane Neighbourhood Health Centres during 2010/11. We have estimated that the movement in activity will account for 60% of routine ante-natal activity and 20% of gynaecological out patients. We have also identified savings resulting from reductions in admitted patient care of £300k in 2010/11.
c) mental health services. BEHMHT has already made savings from a reduction in inpatient services and an increase in community services in 2008/09 and 2009/10 in line with the agreed service strategy across the 3 PCTs. We expect to take back the savings from this commissioned shift, and to take the benefit of further shifts in line with the roll out of this strategy in 2010/11. We are also looking to build on the short term commissioning of low secure forensic services in 2009/10 in order to reduce cost pressures in forensic services, and we are expecting to bring private sector individual high cost placements back into local services.
d) acute efficiency and productivity gains. We have identified sectorwide efficiency savings that are possible in acute providers and we expect the Acute Commissioning Agency to see these through with rigour and determination – we are also looking for NHS London support to realize these. We are not targeting unreasonable gains nor are we looking to

under commission. We have costed these efficiency and productivity gains based on current activity and unit prices: they include top quartile performance metrics in key areas such as C2C and 1st/fu outpatients, reduced drug spend especially on HCD, implementation of the Urgent Care strategy for the WiC and OOH, reducing activity down to national best practice in areas such as maternity ante and post natal, prevention of price and activity count gaming, rejection of service developments that are not self funding. Where NHS London can support these initiatives is in embedding within Trusts a climate of change, by taking a more interventionist stance to push back on income generation schemes, and through a more rigorous performance monitoring of Trusts eg reconciling provider to commissioner I&E budgeting.

e) community and primary care efficiency and productivity gains. Given the aim to upstream work, a lot of the community and primary care gains are less about cost saving and more about picking up on the extra work generated by a push back from acute and mental health, with a net reduction in cost. The providerside of the PCT has developed a number of innovative "spend to save" schemes to take work back from providers at a much lower cost and these have been through an investment review assessment and testing process. Several are about the roll out of existing pilots for example the community matron scheme, or IAPT service. Primary care contracts are being renegotiated in order to better align both to equity of service provision across the patch, but also to link better to the overarching service change programme eg in the redesignation of Enhanced Services, and in the PMS contract review.
f) back office and management cost savings. We are still waiting for guidance on management cost savings targets so have taken a Sectorwide approach to what is required. Nonetheless we have also targeted higher, and have set up a "Dragons' Den" process for our Senior Managers to feed Constant Improvement Ideas into the PCT. There are a number of savings identified already, the most significant of which is the double running of IMT services between our local support agency and CSL.

Our list of savings to be achieved through productivity and efficiency gains was presented at our February Board seminar. There was broad agreement that these are the correct areas that we should target for savings in 2010/11. The achievement of these savings would enable a break even position to be achieved in 2010/11. In addition, based upon feedback from NHS London we are also developing a Plan B list of savings with a value of approximately £7.0m. It is planned that the Commissioning Committee will approve a Plan B list of savings during March. An updated 2010/11 budget will be presented to our Board at the end of March.

Recommendation

The OS&C are asked to note this report. Further updates will be provided as requested.