LONDON BOROUGH OF HILLINGDON

HEALTH AND SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

2005/6

Interim Report

HILLINGDON PRIMARY CARE TRUST'S FINANCIAL DEFICIT

Members of the Committee

Cllr Catherine Dann (Chairman)
Cllr Janet Gardner
Cllr Shirley Harper O'Neill
Cllr Phoday Jarjussey
Cllr John Major
Cllr Andrew Vernazza
Cllr Michael White (Vice-Chairman)

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Chairman's foreword

Many of us will have seen the media coverage of the increasing financial problems of many NHS Trusts across the country, and in particular the potential impact on patients of measures to address these. Indeed, during this review we heard with concern that our local Primary Care Trust (Hillingdon PCT) is one of the worst financially performing Trusts nationally, projecting a deficit of up to £31 million for 2005/6. This review is therefore both relevant and timely for the Committee in our role of scrutinising local NHS organisations to ensure local people, particularly the vulnerable, have access to the services they need.

In examining this issue in relation to Hillingdon PCT, I have sought further information over why the deficit was allowed to grow to such an extent and whether sufficient financial monitoring was in place. I am anxious to ensure that the measures proposed to address the deficit do not have a detrimental impact on Hillingdon residents, in particular the most vulnerable sections of our population. The NHS has received increased spending in recent years and it would be worrying if improvements were threatened and waiting lists extended.

Finally, I would like to thank all those who contributed to the Committee's review, including the Officers who advised the Committee and provided evidence. I commend this interim report and the recommendations to the Cabinet of Hillingdon Borough Council and the Board of Hillingdon PCT. A full report will be published in the new year once the Committee has considered further evidence.

Cllr Catherine Dann

INTERIM REPORT

Background

1. Hillingdon Primary Care Trust (PCT) is the lead local health organisation in Hillingdon. It is responsible for ensuring Hillingdon residents have access to a range of primary care services and holds the NHS budget for commissioning health services from hospitals and other providers to meet the needs of people living in Hillingdon.

2. The Committee first identified the PCT's financial situation as a subject for a major review back in June 2005. We originally intended to undertake this review in early 2006. However, as the deficit worsened, and new measures were proposed to address the situation, the Committee decided to undertake this review as soon as possible, and seek clarification over the potential impact on Hillingdon residents.

Terms of Reference

3. Our review sought to investigate:

    - The origins of the PCT's large deficit
    - Proposed and potential solutions to the deficit
    - The impact of such actions on Hillingdon residents, especially the most vulnerable
    - The impact and risks to the Council's Social Services
    - Lessons on how such a situation can be avoided in the future

Evidence

4. The Committee held two evidence gathering sessions as part of this review.

5. At our meeting on the 11th October, the Committee took evidence from Andrew Morgan, Hillingdon PCT Chief Executive, and Elaine Kerr, Hillingdon PCT Director of Commissioning and Performance Management. The Committee sought information on the origins of the deficit, and particularly the impact of the decision to cease purchasing 'non-urgent' elective activity.

6. At our following meeting on the 29th November the Committee again took evidence from Andrew Morgan and Elaine Kerr, and also David McVittie, Hillingdon Hospital NHS Trust Chief Executive. The Committee received a written submission from North West London Strategic Health Authority. We used this session to seek further information on the origins of the deficit and information on the revised recovery plan. Social Services Officers advised the Committee of their initial concerns about the impact of the revised recovery plan.

7. The Committee heard that the PCT failed to meet its statutory duty to keep within its revenue resource limit for the financial year 2004/5, recording a deficit of £13.47 million. Without additional funding from central government or a change in local policy, activity, or cost levels, we heard that the financial situation is likely to worsen.

8. Indeed, the first five months of 2005/6 showed an overspend of £7.925 million, with a forecast year-end overspend of £23.983 million. However, we heard that the overspend was forecast to rise to over £31 million if unidentified savings are not delivered, and action is not taken to address the situation.

9. The Committee heard that on the 20th September 2005 the PCT Board decided to cease purchasing non-urgent elective activity in an attempt to address the growing deficit. Senior Officers at the PCT examined the practicalities of implementing this decision, and at their next meeting on the 29th November 2005 the PCT Board agreed not to implement their earlier decision. Instead, the Board adopted a revised financial recovery plan.

10. The Committee heard that in November 2005 the Audit Commission published a Public Interest Report on the financial situation at Hillingdon PCT. In this report, the District Auditor expressed his concern that the financial situation was not improving, and made six recommendations. In his final recommendation the District Auditor recommended that *'The PCT needs to continue to engage and seek the support of the public and stakeholders in the planned changes to local health services'*.

11. Annex 2 contains extracts from the decisions sheets of our evidence gathering sessions.

Interim Findings

12. The Committee initially proposed to consider a draft full report at their meeting on the 13th December 2005. This would then be sent to Cabinet and relevant NHS bodies in the New Year. However, at our last meeting on 29th November, it become apparent that the PCT could not yet provide the Committee with the information required to produce a full report on the impact of the recovery plan.

13. The Committee learnt that Social Services Officers have yet to receive sufficient detail from the PCT that would enable them to fully understand the impact of the recovery plan. However, we heard the initial views of Social Services Officers that the size of the financial deficit, and the timescale for correcting it, suggest implementation of the recovery plan will be extremely difficult to achieve without a potentially detrimental impact on vulnerable Hillingdon residents.

14. The Committee also noted with concern the High Level Health Impact Assessment undertaken by the PCT (included in annex 1, appendix 5 as part of the recovery plan). This concurs with the concerns of Social Services Officers and suggests that the recovery plan is likely to affect vulnerable groups disproportionately and widen health inequalities in the Borough.

15. Through our ongoing work, the Committee understands that the PCT and Council work together closely to provide health and social care services for vulnerable people in Hillingdon. In addition to the impact on vulnerable people referred to above, we heard that the recovery plan is likely to affect Social Services provision and expenditure. In particular, the Committee notes the concerns of Social Services Officers about the impact of the recovery plan on several multi-agency plans including those covering long-term conditions, falls, delayed discharges, intermediate care, and integrated care. We heard that the proposed measures could also impact upon integrated PCT and Council mental health services.

16. The Committee have therefore asked Social Services Officers to present a report with more information on these concerns having consulted with the PCT further. To enable this information to be gathered, we have asked to receive this report at our meeting on the 12th January 2006.

Recommendations

17. Although it is still too early to understand fully the impact of the recovery plan, it is clear that it is likely to have a detrimental effect on vulnerable Hillingdon residents. We have therefore agreed to produce this interim report so that it is available to Cabinet for their meeting on 20th December. In particular, the Committee draw Cabinet's attention to the potential impact on Social Services expenditure when considering the budget proposals for 2006/7.

The Committee have therefore agreed the following urgent recommendations:

<u>Recommendation 1</u>

That in light of the evidence received by the Health & Social Care Overview & Scrutiny Committee, Cabinet note:

1. **the seriousness of the financial situation at Hillingdon PCT**
2. **the possible negative impact on vulnerable Hillingdon residents of actions proposed by Hillingdon PCT to address the financial deficit**
3. **that Social Services Officers have not yet received the information they need to understand the impact of the proposed actions on Social Services expenditure and provision**

Recommendation 2

That Cabinet asks Officers to continue to work with colleagues at the PCT about the uncertain risks to services for vulnerable people and any consequent impact upon local authority expenditure so that, in line with the recommendations of the Audit Commission's Public Interest Report, the Council is fully involved and consulted in NHS planning to address the financial deficit

Recommendation 3

That Cabinet take up this issue, particularly the concerns about the impact of the recovery plan on vulnerable Hillingdon residents with the relevant regional and national NHS bodies

ANNEX 1: HILLINGDON PCT'S FINANCIAL RECOVERY PLAN

2005/06 BUDGET AND REVISED RECOVERY PLAN

Decision ☒ **Discussion** ☐ **Information** ☐

IMPACT ON STRATEGIC DIRECTION: An affordable plan needs to underpin the LDP in order for the PCT to continue to provide and commission current services, improve the quality and access of these services, deliver the NHS Plan targets and meet the PCT's key priorities and objectives.

FINANCIAL IMPACT: The Strategic Health Authority has approved a budget shortfall for 2005/06 for the PCT of £12m. Assumptions and details of the repayment of the 2004/05 deficit are included with the main body of this report.

IMPACT UPON SERVICE USERS: This is not yet quantifiable and is dependent upon the actions that the Board decides to take to restore financial balance.

IMPACT UPON STAFF: The current financial difficulties will mean the continued operation of the Cost Control Group and savings targets being set against budgeted establishments. This may affect the ability to fully recruit to all vacancies, resulting in additional pressure on existing staff, and lower morale.

IMPACT UPON INTERNAL PARTNERS: N/A

IMPACT UPON EXTERNAL PARTNERS: There could be unwelcome effects for all the PCT's partners

IMPACT UPON EQUITY: Not yet quantifiable.

IMPACT UPON PCT OBJECTIVES:
This action would enable the PCT to move closer to being able to deliver financial balance, a statutory responsibility.

PCT Objectives:

1. To improve access to health and healthcare
2. To develop new and innovative ways of delivering services and alternative models of care, particularly for those with long term conditions
3. To improve the user experience and develop the capacity of patients, carers and the wider public to be involved in the delivery of healthcare and managing their own health
4. To improve the health of the population through identifying unmet health need, reducing inequality and influencing the wider determinants of health

To ensure the delivery of these objectives the PCT has further enabling objectives.

- To develop partnership working
- To build an organisation that is learning and developing
- To deliver within existing resources, ensuring best value at all times
- To deliver national programmes to enable change

ANY OTHER CRITICAL INFORMATION: The PCT has a statutory duty to break even and live within its resource limit.

2005/2006 BUDGET AND REVISED RECOVERY PLAN ITEM 9

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SUMMARY

This paper:

- Summarises the opening Budget of Hillingdon PCT for 2005/06
- Outlines the risks and the current projected outturn for 2005/06
- Proposes further action necessary to reduce the forecast deficit by means of a Revised Recovery Plan

RECOMMENDATIONS

Board is requested to:

1. Note the Financial Out-turn for 2004/05 and its impact on the Opening Budget Position.

2. Note the 2005/06 Opening Budget and associated risks

3. Approve the revised recovery plan.

TERMS/ACRONYMS USED IN THE REPORT

SHA	Strategic Health Authority
AWP	Allocation Working Paper – notices from Department of Health advising of funding changes
NSCAG	National Specialist Commissioning Advisory Group
SLA	Service Level Agreement

Background

1. The PCT's financial position for 2005/06 has been routinely reported to the Board this financial year. However the financial deficit has been steadily deteriorating and it has been necessary to revisit the recovery plan presented to the Board in May 2005.

2. As reported at the last Board meeting the 2004/05 annual accounts have been audited and the PCT had a deficit of £13.47m. The reasons for the financial pressures and the measures taken up to 31st March 2005 have been well documented by the PCT at previous Board Meetings, the final deficit was only achieved by £2.9m of non recurrent measures. Therefore the underlying deficit for 2005/06 is £15.27m. The table at Appendix 1 summarises the position.

3. The increase in the 2004/05 projected deficit from £6.5m (in January 2005) to £13.47m means that the two year recovery plan contained in the Board paper 2004/05 – 2006/07 Financial Recovery Plan presented to the January Board needs to be updated as it only addressed the £6.5m problem and also the

recovery plan as presented to the Board in May 2005 only addressed a deficit of £9.3m and did not identify all the savings at that time required to meet Financial Balance.

4. The Strategic Health Authority subsequently in recognition of the actual 2004/05 deficit have advised the PCT to work to a Control Total of a £12.m deficit this year rather than expecting the PCT to achieve Financial Balance. This deficit will be the first call on 2006/07 growth funding.

2005/06 Budget

Opening Position

The table at Appendix 2 summarises the use of the growth funds and therefore the opening financial position for the PCT in 2005/06. This shows an opening deficit of £23.6m. It has already assumed the £1m savings on provider services continue.

The PCT to arrive at an opening deficit of £12m has taken the following action:

1. Made the Prescribing savings in 2004/05 of £1.8m recurrent
2. In order to agree SLA's with NHS Trusts the PCT has had to agree to additional funding of £2.2m.
3. The PCT expects the delivery of the £12m savings presented to the Board in May.

At the next Board meeting details of the revenue budgets with savings targets will be provided.

Risks

Listed below are the main risk areas which would reduce our ability to meet the control total. In future Finance Performance reports there will be an update on these risks.

1. The PCT may have to provide further additional funding in order to reach agreement of the outstanding SLA's.
2. Additional costs as a result in the change to the payment system for out of area treatments which has moved from being top sliced from allocations at the start of the financial year based on historical data, to a system whereby the PCT pays for actual activity at each Trust quarterly. The PCT has set aside £1m for these payments based on the 2004-05 deduction.
3. Additional costs as a result of an increase in A&E and unplanned admissions.
4. There is a high risk that the PCT will not manage the ECR expenditure back to budget.
5. There is a risk that prescribing inflation will be greater than the 1% forecast.
6. There is a risk that the PCT will not deliver the £12m savings targets.
7. The funding retained for Agenda for Change is based on Department of Health guidance, however until more staff are assimilated it is difficult to judge whether the reserve is adequate.

2005/06 In Year Position and Requirement for a Revised Recovery Plan

1. As reported to the Board at month 5 the PCT had only identified savings of £5.8m with £7.2m unidentified and was projecting a year end over-performance of £11.8m giving a total year end deficit of £31m. The SHA have confirmed that the PCT must meet its control total.

2. In order to meet the control total the PCT Management Team has developed a revised recovery plan, which is attached at Appendix 3. A risk analysis column has been included and each lead has undertaken an assessment of the risk of not achieving the required savings by 31st March 2006. Managers are currently working up the savings that this plan will deliver in 2006/07 and for the next board a paper will be presented outlining the 2006/07 and onwards financial position of the PCT.

3. An Health Impact Assessment has been undertaken led by the Director of Public Health and details of the assessment process, panel members and outcome is attached at Appendix 4.

4. The PEC has met to discuss the Revised Recovery Plan.

5. The Revised Recovery Plan shows total savings of £24.9m which includes £5.8m from the original recovery plan. Items from the original recovery plan are in Bold Italics with where necessary a revised savings target following the latest review. This level of savings delivers the SHA requirement of meeting the £12m control total.

6. At future board meetings the actual savings to date and a commentary on progress will be provided.

7. This Revised Recovery Plan is presented to the Board for approval.

APPENDICES

Appendix 1 – Analysis of Opening 2005/06 underlying deficit
Appendix 2 – 2005/06 Use of Growth Funding
Appendix 3 – 2005/06 Revised Recovery Plan
Appendix 4 – Assessment Process for Health Impact Assessment of 2005/06 Revised Recovery Plan
Appendix 5 – High Level - Health Impact Assessment on 2005/06 Revised Recovery Plan

BACKGROUND DOCUMENTS

Budget papers/Recovery Plan previously presented to Board on 25 January 2005 and 12 May 2005

APPENDIX 1

Analysis of Opening 2005/06 underlying deficit

	2004/05 £m
Underlying Deficit from 2003/04	5.00
Additional Commissioned Services (SLA's) over and above growth	3.17
Opening Deficit	8.17
Action Taken during 2004/05 to produce balanced budget	
Recurrent Vacancy Target on Provider Services	-1.00
Unidentified Savings	-7.17
Total Savings	-8.17
Therefore Opening underlying deficit	7.17
Additional In Year pressures	
Mental Health ECR's/Continuing Care	3.60
Slippage on unidentified savings	6.40
Mental Health Provider Budgets	0.77
SLA Over-performance	7.40
	18.17
Covered by Non Recurrent Measures	
Slippage on Developments	-2.90
Prescribing Savings now made recurrent	-1.80
	-4.70
2004/05 Reported Deficit	13.47
Therefore Underlying Deficit for 2005/06	15.27

APPENDIX 2

2005/06 use of Growth Funding

	2005/06 £'000s	Notes
Growth and Inflation Funding		
Recurrent Growth Allocation	20,327	8.55%
Return of 03/04 deficit over-recovery	34	
Return of Revenue Brokerage	750	
Charges against growth Funding		
Repayment of 04/05 deficit	-9,235	
Contribution to New Pharmacy Contract	-1,423	National Requirement AWP(05-06)HA06
Change in cost of Capital Adjustment	-597	AWP(03-04)PCT24 . last of 3 year annual adjustment applying to all PCT's for a Department of Health error in calculating growth Funding
GMS increase in Negative adjustment for removal of Practice Staff from PCT Budgets and transferring into nGMS contract	-216	AWP(04-05)PCT18
NHS Estates Revaluation	-589	AWP(05-06)HA05. Mismatch between the funding to the PCT's for NHS Estates revaluation and the amounts which they are permitted to recover from/charge to Trusts
Shortfall on Payment by Results adjustment	-352	All PCT's share an element of this and is the difference between activity transferring to PBR at local and National Tariff
NSCAG Adjustments	-499	Reductions to all PCT's baselines following transfer of services for lysomal storage disorders, forensic CAMHS and pancreatic transplantation etc.
Total Net Source of Funding	**8,205**	
Other Calls on Growth		
Contractual pay and non pay funding – Commissioned and Managed Services	-11,606	5.44% for NHS Trusts, 2.5% Non NHS Providers, 1% Prescribing
Recurrent underlying deficit from 04/05	-15,270	As per Appendix 1
Less Reduction in Mental Health ECR expenditure	3,090	
Increase in Enhanced Service in Primary Care	-380	AWP(05-06)PCT15
Increase in Continuing Care Costs	-1,650	Includes £500k in respect of 03-04
GMS Pressures	-1,680	Includes Computer, Premises and QOF
Other Commissioning Adjustments	-2,048	Includes Renal, Cancer etc
Agenda for Change	-900	
LIFT	-1,030	Impairment

Choose & Book	-340	
Surplus/(Shortfall)	**-23,609**	

Hillingdon Primary Care Trust – Revised Recovery Plan **Appendix 3**

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
2	General & Acute SLA's	Refocus Health & Social Care Community to reduce inappropriate emergency Hospital Activity, attendances and admissions at all Trusts. This includes Specialist Services	14,025			Recurrent	AM/EK	High	Nov-2005	Mar-2006
3	General & Acute SLA's	Look at increasing use of West Herts and Ealing rather than Hillingdon Hospital to reduce spend on emergency admissions	15			Recurrent	EK	Medium	Oct-2005	Mar-2006
4	General & Acute SLA's	Review Waiting lists	25			Recurrent	EK	Low	Oct-2005	Mar-2006
5	***General & Acute SLA's***	***Referral Incentive Scheme & GP validation of inpatients and daycases***	***30***			***Recurrent***	***EK***	***Low***	***Jul-2005***	***Mar-2006***
6	***General & Acute SLA's***	***Reduce follow ups at Hillingdon Hospital***	***671***			***Recurrent***	***EK***	***Low***	***Jun-2005***	***Mar-2006***
7	***General & Acute SLA's***	***Orthopaedic GP Panel to reduce referrals and work up alternative pathways***	***80***			***Recurrent***	***EK***	***Low***	***Oct - 2005***	***Mar-2006***

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
8	***General & Acute SLA's***	***Establish GP panels for authorising consultant to consultant and A & E referrals at hospital trusts***	***130***			***Recurrent***	***EK***	***Low***	***Apr-2005***	***Mar-2006***
9	***General & Acute SLA's***	***Establish GP panels for authorising all GP referrals***	***50***			***Recurrent***	***EK***	***Medium***	***Oct - 2005***	***Mar-2006***
10	***General & Acute SLA's***	***Develop alternative services to Secondary Care in the North for Dermatology***	***5***			***Recurrent***	***EK***	***Low***	***Oct - 2005***	***Mar-2006***
11	***General & Acute SLA's***	***Reduce admissions for chronic obstructive pulmonary disease***	***80***			***Recurrent***	***EK***	***Low***	***Sep-2005***	***Mar-2006***
12	***General & Acute SLA's***	***Introduce Emergency Care Practitioners***	***60***			***Recurrent***	***EK***	***Medium***	***Jan-2006***	***Mar-2006***
13	***General & Acute SLA's***	***Reduce direct access to secondary care dentistry***	***25***			***Recurrent***	***EK***	***Low***	***Jun-2005***	***Mar-2006***
17	General & Acute SLA's	Delay in investing in new services	140			Non-Recurrent	JB	medium	Oct-2005	Mar-2006
19	General & Acute SLA's	Adjustment to other Trusts recovery plans	63			Non-Recurrent	JB	Low	Oct-2005	Mar-2006
29	***General & Acute SLA's***	***Low Priority Treatments - reduce secondary care activity for Minor Skin Procedures***	***263***			***Recurrent***	***EK***	***Low***	***Jun-2005***	***Mar-2006***

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
30	***General & Acute SLA's***	***Low Priority Treatments - cease commissioning Homeopathy***	***52***			***Recurrent***	***EK***	***low***	***Apr-2005***	***Mar-2006***
31	***General & Acute SLA's***	***Low Priority Treatments - Orthodontics to be provided only in exceptional circumstances***	***60***			***Recurrent***	***EK***	***Low***	***May-2005***	***Mar-2006***
32	***General & Acute SLA's***	***Alternative care pathways - reduce Arthroscopy by providing alternative clinic***	***172***			***Recurrent***	***EK***	***Low***	***Apr-2005***	***Mar-2006***
33	***General & Acute SLA's***	***Alternative Care Pathways - introduce GPwSI clinics in the community to manage heart failure***	***120***			***Recurrent***	***EK***	***Low***	***Apr-2005***	***Mar-2006***
34	***General & Acute SLA's***	***Alternative Care Pathways - introduce new pathway for cataracts with Optometrists***	***15***			***Recurrent***	***EK***	***Low***	***Nov-2005***	***Mar-2006***
35	***General & Acute SLA's***	***Alternative Care Pathways - develop new pathway for unexplained headaches***	***37***			***Recurrent***	***EK***	***Low***	***Nov-2005***	***Mar-2006***
41	General & Acute SLA's	Payment towards PFI scheme no longer required	65			Non-Recurrent	AM	low	Oct-2005	Mar-2006
51	***General & Acute SLA's***	***Provide chemotherapy in the Community through Primary Care IV Nurse Specialist***	***25***			***Recurrent***	***PT***	***High***	***Oct-2005***	***Mar-2006***

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
52	***General & Acute SLA's***	***Provide Complex Wound Management / Tissue Viability Clinic to reduce hospital attendance and bandage costs***	***100***			***Recurrent***	***PT***	***High***	***Sep-2005***	***Mar-2006***
53	***General & Acute SLA's***	***Develop a Practice based Diabetes model***	***233***			***Recurrent***	***PT***	***Medium***	***Jul-2005***	***Mar-2006***
56	General & Acute SLA's	Move surgical lists to private providers at reduced rates for January-March 06	350			Recurrent	EK	High	Jan-2006	Mar-2006
57	General & Acute SLA's	Establish suspended outpatient appointments at secondary care hospitals for patients with diagnosed conditions. Prevents urgent treatment at the commencement of an acute phase and by-passes A & E (similar to COPD pilot).	40			Recurrent	EK	Medium	Jan-2006	Mar-2006
58	General & Acute SLA's	Introduce panels for all Providers to authorise tertiary and Consultant to Consultant referrals from secondary care hospitals	50			Recurrent	EK	High	Jan-2006	Mar-2006
59	General & Acute SLA's	Re-establish local breathlessness clinic and link to pulmonary rehab	14			Recurrent	EK	Medium	Jan-2006	Mar-2006
	Total Savings General & Acute SLA's		**16,995**							

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
15	GMS/PMS	Delay Practice Premises Investment until White Paper on out of Hospital Care available	275			Non-Recurrent	PT	Medium	Oct-2005	Mar-2006
16	GMS/PMS	Validation of Quality and Outcome Framework payments	250			Non-Recurrent	PT	high	Oct-2005	Mar-2006
	Total Savings GMS/PMS		**525**							
1	Non NHS Providers	Continuing Care - negotiate block contracts and tighten contracting and assessment processes.	600			Recurrent	EK	Low	Oct-2005	Mar-2006
38	Non NHS Providers	Partnership Fund (Voluntary Sector)	15			Recurrent	HP	low	Oct-2005	Mar-2006
50	Non NHS Providers	Decommission Intermediate Care Beds	163			Recurrent	JV EK	High	Oct-2005	Mar-2006
55	***Non NHS Providers***	***Reduce expenditure of Joint Commissioning client groups***	***50***			***Recurrent***	***EK***	***High***	***Apr-2005***	***Mar-2006***
	Total Savings Non NHS Providers		**828**							
14	Other Budgets	LIFT	40			Non-Recurrent	BW	Low	Oct-2005	Mar-2006
24	***Other Budgets***	***Vacancy control and other savings measures within Chief Execs Office/Corporate Services***	***65***			***Recurrent***	***AM***	***Low***	***Apr-2005***	***Mar-2006***
25	***Other Budgets***	***Vacancy control and other savings measures within Public Health & Healthy Hillingdon***	***183***			***Recurrent***	***HP***	***Low***	***Apr-2005***	***Mar-2006***

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
26	***Other Budgets***	***Vacancy control and other savings measures within Finance***	***83***			***Recurrent***	***JB***	***Low***	***Apr-2005***	***Mar-2006***
27	***Other Budgets***	***Vacancy control and other savings measures within Human Resources***	***72***			***Recurrent***	***MS***	***Low***	***Apr-2005***	***Mar-2006***
28	***Other Budgets***	***Vacancy control and other savings measures within Estates & Facilities***	***20***			***Recurrent***	***BW***	***low***	***Apr-2005***	***Mar-2006***
36	***Other Budgets***	***Heathrow HCU***	***800***			***Recurrent***	***AM HP***	***low***	***Apr-2005***	***Mar-2006***
37	Other Budgets	Health Promotion	15			Recurrent	HP	low	Oct-2005	Mar-2006
39	Other Budgets	Further 10% reduction in Headquarters functions	500			Recurrent	AM	medium	Oct-2005	Mar-2006
42	***Other Budgets***	***Partnership Funding***	***82***			***Non-Recurrent***	***HP***	***low***	***Apr-2005***	***Mar-2006***
43	***Other Budgets***	***Vacancy control and other savings measures within Primary Care Support/Locality management***	***129***			***Recurrent***	***PT***	***Low***	***Apr-2005***	***Mar-2006***
44	***Other Budgets***	***Vacancy control and other savings measures within IM&T***	***105***			***Recurrent***	***GC***	***Low***	***Apr-2005***	***Mar-2006***
54	***Other Budgets***	***Operational Services - Re-designing Services/Invest to save (incl. CDC SLA reduction)***	***100***			***Recurrent***	***SC***	***Medium***	***Apr-2005***	***Mar-2006***
	Total Savings Other Budgets		**2,194**							

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
45	Prescribing	Part year savings from Prescribing contract	250			Recurrent	PT	High	Oct-2005	Mar-2006
46	***Prescribing***	***Primary Care - Nursing & Residential homes team working to reduce poly-pharmacy***	***100***			***Recurrent***	***PT***	***Medium***	***Oct-2005***	***Mar-2006***
47	***Prescribing***	***Primary Care Prescribing – changing to cheaper drugs through a revised incentive scheme***	***640***			***Recurrent***	***PT***	***medium***	***Jul-2005***	***Mar-2006***
	Total Savings Prescribing		**990**							
18	Provider	Mental Health - Second Tranche of Savings	900			Recurrent	CK	High	Oct-2005	Mar-2006
20	***Provider***	***Vacancy Control within community nursing and Clinic administration***	***500***			***Recurrent***	***PT***	***Low***	***Apr-2005***	***Mar-2006***
21	***Provider***	***Savings following renegotiation of Continence products contract***	***25***			***Recurrent***	***PT***	***High***	***Nov-2005***	***Mar-2006***
22	***Provider***	***Vacancy control and other savings measures within Therapies***	***330***			***Recurrent***	***JV***	***low***	***Apr-2005***	***Mar-2006***
23	***Provider***	***Vacancy control and other savings measures within Mental Health***	***591***			***Recurrent***	***CK***	***High***	***Apr-2005***	***Mar-2006***
40	Provider	Capture Savings from Projects by reworking secondments	75			Non-Recurrent	JV	High	Oct-2005	Mar-2006

Ref No	Budget Heading	Specific Action	Required Savings to 31st March 2006	Year to Date Achieved	Savings 2006/07	Recurrent/ Non Recurrent	Lead	Risk Assessment	Timescale	
		£'000	£'000	£'000	£'000				Start Date	Finish date
48	Provider	Second Tranche Vacancy freeze for all community services	900			Recurrent	JV PT SC	High	Oct-2005	Mar-2006
49	Provider	Change of use of 6 beds at Northwood & Pinner to provide continuing care	72			Recurrent	PT	High	Oct-2005	Mar-2006
	Total Savings Provider		**3,393**							
		Totals	24,925	0	0					

Less Savings already included in Original Recovery plan to get to Control Total of £12,026	5,785
Therefore Total New Savings	19,140
Savings Required to bring down to Control Total = 31,002-12,026	18,976
Surplus	**-164**

Italics = Carried forward from original recovery plan

Key:

AM – Andrew Morgan	EK – Elaine Kerr	CK – Catherine Knights	GC – Geoff Cross	JB – Jackie Briscoe
PT – Penny Thorpe	JV – Joan Veysey	BW – Barbara Wood	SC – Siobhan Clarke	HP – Hilary Pickles
MS – Mel Smith				

Appendix 4

RAPID 'HIGH LEVEL' HEALTH IMPACT ASSESSMENT

1. BACKGROUND

Hillingdon Primary Care Trust is drawing up a Recovery Plan to meet the control total required by the SHA. This is for endorsement at the public Board meeting on the 15th November. Although there is also a recovery plan for the longer term, the focus for now is on the savings required by the end of March 2006.

Whilst acknowledging the over-riding need to ensure that the health needs of patients and the local community continue to be met, it is recognised that the proposed actions included in the Recovery Plan may have an negative impact on the health of the population as well as on partners within the local health economy.

With this in mind the Director of Public Health agreed to undertake a rapid 'high level' Health Impact Assessment (HIA) to identify, as far as posible, the potential negative impact of the proposals put forward on the health of the local population. The methodology being suggested mirrors that used recently within Hounslow.

2. WHAT IS HEALTH IMPACT ASSESSMENT?

Health Impact Assessment can be defined as a combination of procedures or methods by which a policy, programme or project can be assessed regarding the effects it may have on the health of a defined population.

More specifically its purpose is threefold:

- To assess the potential health consequences of policies, programmes and projects, whether positive or negative, on a population and different groups within a population;

- To influence decision makers by assisting them in the consideration of the implications and trade-offs of their decisions;

- To improve the quality of public policy decision making through evidence-based recommendations to enhance *predicted* positive health impacts and minimise any negative ones on health, well being and inequalities that might arise or exist.

Rapid Health Impact Assessment is one of several methods of HIA and represents a way of analysing the potential health impacts of a policy in a short time frame.

3. DEFINING THE PARAMETERS OF THE RAPID 'HIGH LEVEL' HIA

3.1 The aim of this rapid 'high level' HIA was to produce, within half a working day, a rapid assessment of the impact of Hillingdon PCT's proposed

Recovery Plan on the health of the population. The version of the plan used was that dated 4th November 2005.

The Recovery Plan is wide ranging and includes a total of 59 proposals. across the following areas of big expenditure:

- Non-NHS providers
- General and Acute SLAs
- GMS/PMS
- Provider Services
- Commissioning
- Prescribing
- Other budgets

3.2 Methodology

3.2.1 Given the rapid nature of the approach to be adopted and the need to keep the process as 'high level' as possible, the aim was to use existing knowledge about the health needs of the local population in conjunction with 'intelligence' received from commissioning/project leads, as appropriate, to assess the potential impacts of the savings proposals on the Hillingdon population as well as deprived or vulnerable groups within the population.

The assessment process was challenging given the brevity of the descriptions provided for the majority of the savings proposals, especially around the big savings on general and acute SLAs and on mental health.

The issue of the impact of the Recovery Plan on meeting national and local targets was not considered as part of this process, as this will be considered separately. Likewise, the feasibility of the proposals and risk that they will not be delivered was not covered within the HIA. The emphasis was on the savings required in 2005/6 and the HIA was undertaken assuming that each item delivered the savings identified.

3.2.2 Validity and reliability of the process

Both the validity and the reliability of the process to be adopted needs to be addressed. This is of particular concern since the outcome of the impact assessment will become public. This is not without political risks, if the Board proceeds with proposals that are judged to have adverse impact on health, vulnerable groups or to widen inequalities. The alternative, of not reaching financial balance, needs also to be taken into account. The HIA will be only part of the information available to the Board when decisions are made.

3.2.3 The Assessment Process

In general HIA focuses on how a community's health is determined by a range of economic, social, psychological, environmental, access to services, policy and organisational influences. This HIA focussed on the potential impact of the PCT's financial savings 'policy'. The acting Director of Public Health in Hounslow performed a very rapid literature review which did not identify any useful HIA tools which have been used to assess the potential negative health impacts of a health commissioning organisation's savings plans on their local population. Consequently, an attempt was made to construct a local tool. This was used in Hounslow with success, with

Hillingdon's DPH as part of the assessment panel. The Hounslow acting DPH assisted Hillingdon PCT with its process. The outcome of both Hillingdon and Hounslow processes will be compared and any learning applied.

3.2.4 **The Assessment Tool:**

Because of time constraints, it was not feasible to undertake a rapid HIA of each of the many proposals. As such the following approach was adopted:

- The savings proposals were placed into groupings. Each grouping of proposals were then considered by the assessment panel; with the caveat that if the panel were unhappy with the groupings being suggested, then these could be unpicked.

- Health Impact: The Assessment Panel was first asked to consider whether the potential health impact of each of the groups of savings proposals were high, medium or low. In doing this, it was assumed that the proposal had the success needed to reach the savings total that had been identified

  The definitions for high, medium or low health impact were as follows:

  a) **High Risk:** A 'significant health risk' to a small proportion of the population, but a 'low risk' to a large proportion of the population.

  b) **Medium Risk:** A 'low risk' to a small proportion of the population and a 'minimal risk' to a large population;

  c) **Low Risk:** A Minimal risk to a small proportion of the population or 'no risk' or 'risk unknown' but likely to be very small

- Vulnerable/Deprived Groups: The Assessment Panel were then asked to consider whether the savings proposal affects vulnerable/deprived groups disproportionately. The Assessment Panel had to answer either yes or no to this question;

- Health Inequalities: The Assessment Panel then considered what potential effect the savings proposals would have on health inequalities. The options here were for an increase, a decrease in health inequalities or no effect.

- Political Significance: Finally, the Assessment Panel was asked whether or not they believed the political significance of the savings proposals to be significant or not.

- Prioritising Panel Responses: Once the Assessment Panel completed its deliberations the groupings of savings were sorted according to their level of significance, in order to identify those groups with the highest level of significance.

- The next step for the Assessment Panel was to consider what the PCT could do to maximise the positive health impacts and minimise

the negative impacts of the groups of savings proposals which scored 3 and over.

The full description of the items is in the recovery plan version 4.0 (Appendix 3)

TABLE 1: HPCT FINANCIAL RECOVERY PLAN - HEALTH IMPACT ASSESSMENT TEMPLATE

Proposal No.	Proposed service change	Health Impact High Medium Low/Unknown	Does this affect vulnerable/ deprived groups disproportionately? Yes No	What effect will this have on health inequalities? Increase None Decrease	Is this of high political significance? Yes No

FOOTNOTE: *<u>Vulnerable/Deprived Groups</u> - Eg. Black and minority ethnic communities; Irish communities; women; young people; children; students; lesbian and gay communities; disabled people; mental health service users; people with learning difficulties; older people; refugees and asylum seekers; faith groups; rough sleepers; people living in poor housing; people living in deprived communities; Other*

This health impact assessment tool was initially and piloted in Hounslow and then used in an assessment there on the 25th October. The same tool was then applied in Hillingdon on the 7th November.

4. The Assessment Panel

4.1 Because of the short time available, panel members were found from those available to clear their diaries at such short notice. Since the mix of individuals on the Hounslow panel worked well, individuals were nominated to match more or less the same make-up.

4.2 The following constituted the HIA Panel:

-	Public Health	Hilary Pickles
-	Commissioning	Elaine Kerr, Terry Kelly
-	PEC GP	Patrick Andrews
-	Provider/primary care	Penny Thorpe, Lesley Johnson
-	Finance	Jackie Briscoe
-	Non-Executive Directors	Malcolm Ellis
-	Diversity	Margie Lindsay
-	External – Acting DPH Hounslow	Sharon Daye

Meeting record: Caroline Bowles

4.3 The Assessment Panel reached a consensus on each assessment.

5. Outcome

5.1 The outcome of the assessment is as in Appendix 5. Some items on the original list had to be split for assessment. The assessment was undertaken in numerical order, but the Appendix is presented with the overall scores revealed and items ranked according to the score. The highest ranks were for those that were judged to have the most adverse impact on health, affecting vulnerable groups, increasing inequalities and with adverse political impact.

5.2 The second tranche of mental health provider savings, and the complete freeze on community services were in this group. There was insufficient detail to enable the group to advise on mitigating action, but it was recommended that both these areas should be looked at in more detail, with the savings broken down into constituent parts. This could then form the basis for subsidiary health impact assessments. Mental health savings, especially the new tranche item 18, could then be for discussion with the receiving trust for these services, since they would be responsible for the carry-over impact the following year. Item 48, the freeze on provider services, was judged to affect a service that had already been cut back and was about to enter the most testing time of year anyway. The situation here may need to be reassessed weekly.

5.3 Item 2c, admission avoidance scored 4, on the basis that if it delivered the level of savings required in the plan, this would be a major proportion of the currently available service. Less effective saving delivery would have meant a score that might appear more acceptable. This item was not alone in its score being sensitive to the degree of effectiveness in savings delivery

6. Next steps

The outcome of this assessment will be used to inform the Board decision on the recovery plan. It is intended that in both Hounslow and Hillingdon those who took part in the process will be asked for their views, and the Boards asked about what influence if any it may have had to their decision-making process. The process will then be written up to enable it to be shared more widely.

Hilary Pickles
Director of Public Health
7th November 2005

Proposed service change	Health Impact	Does this affect vunerable/deprived groups disproportionally?	What effect will this have on health inequalities?	Is this of high political significance?	Total
	High	Yes	Increase	Yes	
	Medium		None		
	Low/Unknown	No	Decrease	No	
mental health provider functions	High	Yes	Increase	Yes	5
community vacancy freeze,	High	Yes	Increase	Yes	5
G & A SLAs admission avoidance	Medium	Yes	Increase	Yes	4
Gen & acute SLAs: scheduled care	Medium	No	Increase	Yes	3
first tranche mental health savings	Medium	Yes	Increase	No	3
vacancies in therapies	Medium	Yes	Increase	No	3
GP panels to reduce referrals	Medium	No	None	Yes	2
vacancies community nursing & continence	Medium	Yes	None	No	2
decommission intermediate care beds	Medium	No	None	Yes	2
G & A SLAs: reducing hosp capacity	Low/Unknown	No	None	Yes	1
Specialist commissioning	Low/Unknown	No	None	Yes	1
delay premises improvements	Low/Unknown	No	None	Yes	1
joint commissioning	Low/Unknown	No	None	Yes	1
non-NHS providers: continuing care	Low/Unknown	No	None	No	0
unscheduled care: attendance avoidance	Low/Unknown	No	None	No	0
SLA review, use W Herts/Ealing	Low/Unknown	No	None	No	0
reduce follow ups at THH	Low/Unknown	No	None	No	0
GP validatn, devp alternative services	Low/Unknown	No	None	No	0
introduce ECPs	Low/Unknown	No	None	No	0
Reduce hospital dentistry, OMFS investment	Low/Unknown	No	None	No	0
LIFT spend	Low/Unknown	No	None	No	0
GMS/PMS scrutiny of payments	Low/Unknown	No	None	No	0
NWL recovery plan, & Paddington basin	Low/Unknown	No	None	No	0
vacancy control + savings 0f Headquarters	Low/Unknown	No	None	No	0
low priority treatments	Low/Unknown	No	None	No	0
alternative care pathways	Low/Unknown	No	None	No	0
HCU reimbursement	Low/Unknown	No	None	No	0
health promotion, partnership fund	Low/Unknown	No	None	No	0
Further savings on HQ functions	Low/Unknown	No	None	No	0
prescribing	Low/Unknown	No	None	No	0
N& P beds, access & capacity	Low/Unknown	No	None	No	0
Reduce SLAs and develop community services	Low/Unknown	No	None	No	0
redesign operational services	Low/Unknown	No	None	No	0
private providers for surgical lists	Low/Unknown	No	None	No	0
Reduce COPD admissions, breathless clinic	Low/Unknown	No	Decrease	No	-1

ANNEX 2: DECISIONS SHEET EXTRACTS

HEALTH & SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE
11th OCTOBER 2005

DECISIONS SHEET (EXTRACT)

3.	**Hillingdon PCT Financial Recovery Plan and Decision to Cease Purchasing Non-Urgent Elective Activity [Agenda item 2]** (Andrew Morgan & Elaine Kerr) Andrew Morgan provided his initial assessment of the financial situation at Hillingdon PCT. He told the Committee that he did not believe the existing financial recovery plan was sufficient to ensure the PCT did not breach its statutory duty to keep within its revenue resource limit for financial year 2004/5. Difficult decisions had to be taken to address the situation, and all areas of PCT expenditure were subject to consideration. Andrew Morgan and Elaine Kerr then answered a series of questions from the Committee. The Committee heard that the PCT were still working on how to implement the decision to cease purchasing non-urgent elective activity. No timetable for implementing this decision is yet available but the PCT will be working closely with Social Services and Hillingdon Hospital on this issue. Any suspension of activity would stay in place until financial balance is achieved. Elaine Kerr told Members that the PCT was always willing to share information with the Committee. Andrew Morgan told Members that he was happy for them to contact him between Committee meetings. **Agreed –** • That the Committee receive further information from Hillingdon PCT as soon as it is available, including: a timetable for implementing this decision; greater detail on the impact on patients and Social Services; and measures taken to help those patients affected by this decision. • That Members receive fuller notes of the discussion and Andrew Morgan's contact details.	**Action By:** Andrew Morgan & Elaine Kerr David Coombs

HEALTH & SOCIAL CARE OVERVIEW & SCRUTINY COMMITTEE
29th NOVEMBER 2005

DECISIONS SHEET (EXTRACT)

3.	**Major Review: Hillingdon Primary Care Trust's (PCT) Financial Deficit – 2nd Witness Session [Agenda item 2]** (Helen Robinson; Andrew Morgan & Elaine Kerr; David McVittie) The Committee heard evidence from the Strategic Health Authority, Hillingdon PCT and Hillingdon Hospital. *North West London Strategic Health Authority (SHA)* Helen Robinson presented a written submission from the SHA's Director of Finance. The Committee expressed concern about whether the SHA had been monitoring the situation at the PCT, and whether the SHA had taken any action. The Committee welcomed the weekly teleconference between the PCT and SHA but questioned why this had not happened earlier. Members stated that the deficit was the responsibility of all those who had been on the PCT Board at the time, and not just those who had now left the PCT. *Hillingdon PCT* Andrew Morgan told the Committee that the financial control at the PCT had not been sufficient in the past, and two Executive Board Members had left the PCT. Work was under way to create more detailed action plans on how to implement the revised recovery plan, and this would involve working with colleagues in Social Services and the Hospital. Measures would have to be reconsidered if the impact on Hillingdon residents was too great. Members asked to be kept updated. Andrew Morgan told the Committee that he could not guarantee that the PCT would meet the SHA control total but would do his 'utmost' to achieve the maximum £12m deficit for 2005/6. If the target was not achieved then the personal future of various people would come under discussion and the financial position for 2006/7 would be even worse. The Committee heard that a recruitment freeze was in place across the PCT. In response to Members' questions about the increase in emergency hospital admissions, the Committee heard that part of the recovery plan was to reduce the number of people passing through the Hospital and introduce alternative care pathways.	**Action By:** **Action By:**

	The Chairman expressed concern about why the deficit was allowed to grow, and the apparent lack of monitoring in the PCT. She questioned the role of the Non-Executive Directors in allowing the financial situation to worsen. Andrew Morgan told the Committee the fact that a Public Interest Report had been issued by the Audit Commission suggested that the measures being taken by the PCT were not sufficient. The Chairman stated that the whole PCT Board should have taken action to stop the deficit growing. The Committee welcomed the PCT decision not to implement the earlier decision to cease purchasing non-urgent elective care. The Chairman told NHS Officers that the people of Hillingdon should not have to suffer from the financial problems of the PCT and the action taken to address the growing deficit. John Doran suggested the Committee may like to consider the impact of the revised recovery plan on vulnerable people in Hillingdon. *Hillingdon Hospital* David McVittie presented a written submission to the Committee. He told the Committee that he did not believe the Hospital was responsible for the PCT's overspend, and the Hospital had not received a large increase in payment from the PCT. The Committee heard that the Hospital was always seeking to improve efficiency and is performing favourably with other local hospitals in relation to length of stays and spending on agency staff. The Committee concluded that although they had received a large amount of information, it was still too early to know what the impact of the deficit and the recovery plan would be on Hillingdon residents. In particular, the Committee noted the advice from Social Services Officers that it was still too early to know how the measures in the recovery plan would impact on Social Services expenditure. **Agreed –** • That the Committee receive further information from the SHA on its monitoring role, in particular why the PCT's deficit was allowed to worsen • That the SHA note, and respond to the Committee, on paragraph 32 of the Audit Commission's Public Interest Report, in which the District Auditor wrote: 'I do not believe that the PCT will be able to operate within its RRL in the short- to medium-term without additional financial support'. • That Social Services Officers present a report to the Committee for their meeting on 12th January 2006, having consulted with PCT colleagues, on the concerns they raise in paragraph five about the impact on Social Services expenditure • That Officers consider the way in which the Committee's findings	North West London Strategic Health Authority John Doran (& Andrew Morgan) Democratic

	should be reported • That the Committee receive fuller notes of the answers provided by the witnesses	Services