Primary care trusts (PCTs) – Enhancing performance

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INTRODUCTION

INTRODUCTION

LESSONS LEARNT

PCT Workshops organised by the National Programme Office for Turnaround ("NPO") and held with PCT management, General Practitioners, SHA Turnaround Directors and specialist advisors have led to the identification of a number of lessons learnt and good practices in Turnaround. With additional input from policy leads, this guide encapsulates those lessons and practices and updates the original PCT Lessons Learnt document issued in April 2006.

There is no single reason why organisations find themselves in financial difficulty. However, there are **weaknesses** common to most underperforming organisations (be they Acute Trusts or PCTs), e.g.:

- **Failure to implement CIPs** early enough, with a lack of consideration for the lead times and dedicated resources (whether internal/external) required;
- **Lack of detailed implementation plans**, with the recycling of old failed plans or unrealistic plans applied;
- **Limited engagement** with clinicians or GPs and sometimes poor relationships with providers in general;
- **Lack of accountability** and/or responsibility within the organisation to deliver the plan; and
- **Poor inter-organisational relationships** between PCTs and providers

However, the dynamics of PCT turnaround can be more complex than those of the Acute Trust, with a lack of direct control over associated GPs and how the majority of the PCTs resources are utilised, as well as the additional complexity in the arrangements for lead commissioning and risk sharing. This may be compounded in certain instances by the loss of individual organisational accountability, historic weak or absent leadership, poor financial controls and/or the absence of reliable financial and operational information.

INTRODUCTION

Challenges within the operating environment

- Baseline assessments, 'Fitness for Purpose' assessments, advisors, turnaround plans and reconfigurations have been demanding of staff energy levels;
- There are still concerns that there is insufficient resource and capability at Commissioning Director level in particular;
- Mixed implementation of PBC; DH suggested approach vs. local modification vs. an overly bureaucratic process;
- Some challenging commissioning relationships with Acute and Foundation Trusts ("FTs"). Coding needs to be scrutinised, along with the SLAs, by the PCT. Varying degrees of established working practice exist at the PCT and this requires a consistent approach and training of coding staff at the Trust;
- Disruption caused by reconfiguration needs careful management from PCTs;
- Mediation and arbitration with FTs is different to that with Acute Trusts, with limited to no access to supporting data.

Whole Health Economy

The benefits of a total health economy view far outweigh the costs, despite the fact that the parties can sometimes appear to have conflicting objectives. A robust collaborative and contractual relationship is essential, though there remain a number of challenges to overcome:

- PCTs need to work on coherence between FT planning and governance and their own arrangements
- Data flow is sometimes too slow – decisions risk being made without real time information;
- Difficult for PCT to control and 'manage' short term demand; it takes some three to six months for any significant impact;
- Drivers to reduce cost can appear non-compatible (e.g 18 week wait);
- The local implications of the national pricing model;
- Investment in community preventative measures might not, at times, seem justifiable given short term financial pressures. However, a lack of investment in preventative measures will likely increase future demand for health services.

THIS GUIDE

- The first section of the guide takes the user through what a successful turnaround looks like and some of the key priorities. It then sets out 'Quick Wins' that can give short and medium term financial returns and provides case studies of a sample of successful approaches to PCT turnaround. The last part of this section summarises key lessons learnt from some of those success stories from the April version of this document.

- The second section details the construction of a successful turnaround programme identifying the support needed and the key activities within the four main steps to Turnaround. It pays particular attention to the analysis of the issues, most notably around the challenging area of commissioning.

- Finally, it covers the necessary interface with stakeholders, particularly GPs, and the roles of the SHA and the SHA TDs.

1. DEVELOPING FINANCIAL STRATEGY AND ACTION PLAN

- WHAT DOES A SUCCESSFUL PCT TURNAROUND LOOK LIKE?
- PCT TURNAROUND PRIORITIES
- QUICK WINS
- TURNAROUND CASE STUDIES
- SUMMARY OF LESSONS LEARNT – APRIL 2006

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (1 of 7)

OVERVIEW

A number of PCT workshops have been held in order to capture suggested approaches to implementing turnaround in these organisations. The attendees at these events have comprised PCT management, the SHA TDs, a sample of GPs and turnaround advisers on the ground working within PCTs.

The focus for these discussions has been around the key elements of a successful turnaround in the short-to-medium term. The overriding conclusion is that the suggested solutions, with significant savings attached, are achievable over this timeframe. However, realistic goals and timeframes are essential to the turnaround process, where the relevant KPIs should be used in monitoring the delivery of the identified actions, and these actions must be continually refined as part of an iterative process.

Set out below is a summary of the main points made by the above attendees on the successful turnaround of a PCT organisation. These relate to:

- Commissioning;
- Coding;
- Management Teams and Systems;
- Provider Services;
- Stakeholders;
- Demand Management; and
- Whole Health Economy.

In the following section we provide a selection of lessons learnt from PCT organisations that are currently in the turnaround process.

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (2 of 7)

COMMISSIONING

This represents the most likely area to deliver significant savings focussed on managing elective and non-elective activity. This will be achieved through:

- Directly using practice and GP based data with individual GPs to achieve changes in referral behaviour partly through PBC; and
- Ensuring that the relevant Acute Trusts are fully involved so that this is not simply a cost shifting exercise.

At the same time, in a similar fashion to the US system, PCTs will need to develop three critical steps:

1. Pre-approval systems when appropriate;
2. Admission avoidance mechanisms where clinically appropriate; and
3. Post-verification systems

To date, there has generally been more successful progress on the first two steps, which can be classified as ‘demand management’.

- Intelligent use of the data enables coding problems to be identified, furthering the need for verification systems.
- Contracting is growing in importance; a national framework contract may not be the solution- who will it benefit?
- Coding is growing in importance.

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (3 of 7)

Four primary areas have been highlighted as requiring focus:

- **Planning**: with GPs involved throughout this process with the setting of challenging but realistic targets;
- **Contracts**: executed at the beginning of the financial year with Trusts and GPs. Contractual obligations may yield significant windfall savings. These may include high cost/low volume contracts (mental health, learning disabilities and complex cases) and reviewing care criteria and how these are applied. Other procurement contracts, including leases or 'arrangements' with other providers such as local authorities, may yield material one off savings;
- **Information management**: providing effective, timely data analysis and information to GPs and Trusts; and
- **Accountability**: holding the trusts and practices responsible for poor performance to account.

OTHER COMMISSIONING

Insufficient benchmark information currently exists in relation to other commissioning, outside of that undertaken with trusts. However, a number of areas have been highlighted as potential opportunities for realisable savings such as:

- Development of volume and performance metrics for Mental Health Providers;
- Substituting community Mental Health Services only if offset by mental health spending (such as CBT);
- Closely reviewing continuing care placements, charges and changes in criteria which increase costs for general nursing home care; and
- High cost cases such as those associated with Mental Health Services.

It is, however, important that none of these cost saving activities jeopardises necessary care.

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (4 of 7)

CODING

Ensuring Secondary Services are accurately coded will allow a PCT to plan with greater precision around activity levels. We note however, that in some instances, increased activity levels identified in a trust have been attributable to more accurate coding, rather than as a result of actual increases in activity.

MANAGEMENT TEAMS AND SYSTEMS

The right people and processes are critical for the successful turnaround of the financially troubled PCTs.

Any managerial shortcomings must be addressed with clear recommendations to the SHA CE on the appropriateness of the existing personnel and business processes to deliver the turnaround. The main contributors to turnaround in the management team include the Chief Executive, Director of Finance, Commissioning Director, Medical Director and PEC Chair.

Reviewing the delivery chain to de-layer management processes, in particular where excess capacity exists, is imperative in refocusing on the reporting and challenge activity which contributes to the Local Delivery Plan and preparation of Turnaround Plans.

Some organisations may need to consider decommissioning some of the services it provides, where there is a noticeable weakness in the incumbent management teams or the systems that cannot be dealt with quickly and effectively.

Some of the benefits associated with reorganisation of management teams are listed below:

- New teams in place appear stronger with a natural transfer of knowledge from one organisation to another;

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (5 of 7)

MANAGEMENT TEAMS AND SYSTEMS *cont'd*

- Potential additional cost savings through synergising work-stream initiatives and streamlining operations;
- The balance of power is shifting away from the SHA and towards the PCT to manage it's own SLAs; and
- Management teams should not wait for the one inspirational individual to come on board, rather secure quick wins with the existing team.

PROVIDER SERVICES

Intermediate Beds are an option used in some areas as a way in which to undertake the staged exit of patients from the hospital and back to their homes. Their benefits and cost effectiveness should be considered, bearing in mind specifically:

- These beds can be more expensive for the health economy than hospital beds; and
- There is an associated critical mass/ size associated with these services.

Other areas of provider services which may present opportunities for additional financial savings include:

- District Nursing: re-designing some of these services;
- Health Visitors: re-examining the services provided;
- Community Diagnostics: applied as low cost alternative to outpatient/A&E investigations; and
- Assessment Units: providing real time assessments as to whether GP heralded admissions can be more effectively applied elsewhere within the health community.

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (6 of 7)

STAKEHOLDERS

Working with GPs may require appropriate incentives to be granted, for example, from the reimbursement of investment costs. Other incentive schemes for GPs to support local initiatives that lead to sustainable improvements in services offer further opportunities for cost savings. This allows PCTs to focus resources and plan services appropriately to assist in the efficient use of funds at a local level.

Peer pressure through league tables and the provision of performance data (as outlined on page 21) appears an effective initial measure in getting GPs engaged - on a practice by practice basis - prior to or in conjunction with the use of financial incentives.

This is a complex relationship (GPs and PCT) in which both better value from GPs needs to be achieved as well as engaging them in the PBC agenda. The PBC plans form an important part of the Commissioning plan.

In addition to the potential savings realised through improved referral behaviour, engaging GPs throughout the turnaround process will allow a PCT to derive significant savings from its prescribing budget. This should be coupled with effective controls across Primary Care being put in place where required.

Provider Trusts may also be impacted by PCT actions and, in the context of the NHS as a whole, this relationship also requires management through effective engagement with clinicians and senior management teams.

Other important Stakeholders include local MPs and councillors. In particular they should be engaged when proposals for service reconfiguration are being put forward.

WHAT DOES A SUCCESSFUL TURNAROUND LOOK LIKE (7 of 7)

DEMAND MANAGEMENT

In relation to the effective control of activity levels associated with a PCT's commissioning activity, outlined below are the key areas of focus in managing this demand:

- 'Front end' to A&E referred to as Urgent Care Centres;
- Elective Services: referenced to CAS & CAT referral thresholds, being applied to all types of practitioners (not just GPwSI);
- 'Frequent Flyers'/LTC Patients: leveraging off the information derived from Community Matrons, case management processes, partnerships with the local ambulance trust and the management of nursing/residential home patients;
- Low priority treatments: where clinical engagement in the community is used in undertaking these services in a more effective manner, both in terms of services and value for money; and
- Contracting and coding has grown in importance where PCTs and Trusts must again operate towards a congruent goal. PCTs should seek to take the lead in commissioning SLAs, taking a more active role in agreeing and signing SLAs that meet the needs of the organisations involved.

WHOLE HEALTH ECONOMY

- Matched expected activity and income v expenditure.
- PCTs and Trusts communicating and working together to achieve a congruent goal. This may require a change in mindset, and behaviours.
- Local providers are positioned as second only to GPs as the main stakeholders requiring management.
- The SHA is instrumental in facilitating the way forward.

PCT TURNAROUND PRIORITIES

HOW SHOULD A PCT PRIORITISE?

PCTs should look into the following seven areas to help strengthen commissioning:

- ✓ Arrangements with GPs to minimise unnecessary referrals;
- ✓ Maximise day case and minimise in-patient activity;
- ✓ Agree protocols with providers to limit follow-up treatment;
- ✓ Arrangements with consultants to minimise unnecessary consultant to consultant referrals;
- ✓ Introducing generic prescription exercises to minimise the use of branded medicines;
- ✓ Use the indicative unbundled tariffs published for 2007/08 to help redesign the pathways of care; and
- ✓ Model contracts to ensure proper provider behaviour.

‘QUICK WINS’ – **THOSE WHICH CAN HAVE THE FASTEST FINANCIAL RETURNS**

ELECTIVE

- **Contract Management**

There are often items in SLAs that PCTs aren't obliged to pay for, but habitually have done so. These need to be identified and then eliminated. A detailed review of contracts/ SLAs often reaps dividends (and of course helps for following year).

- **Low priority treatments**

Stop (or severely constrain) all low priority treatments through use of an elective filter and/ or not paying for them at Trust level (except through pre-approval).

- **Reduce number of follow ups appointments/ agree contractual ceiling**

This has benefits for the Acute Trust as well; patients going up to hospital unnecessarily also benefit by fewer appointments. It does require a rapid review facility where patient can be seen quickly if problems arise after discharge – there is a need to agree a limit between new and follow up for these cases (i.e. not completely new patients but may not have been seen for some while). Get telephone or email access to consultants.

- **Implement chosen elective pathway to avoid admissions/streamline care**

This should have the effect of reducing appointments e.g. DVT, Lower Limb clinic, Cardiac, Orthopaedics, Paediatrics.

- **Out of area treatments**

Especially mental health. Consider repatriation into area or negotiate with more cost effective supplier.

- **Shifting minor surgery away from the hospital**

This can lead to significant savings; >£0.5m not impossible.

‘QUICK WINS’ – **THOSE WHICH CAN HAVE THE FASTEST FINANCIAL RETURNS**

NON-ELECTIVE

- **Emergency Filter- i.e. reducing unnecessary admissions**

Put in place an emergency filter - different filters are required for in hours and out of hours. PCT running front end of the A&E. Care is needed to ensure system is set up to fulfil PCT (and patient) aims rather than hospital aims. Some weaker systems have been set up with consequent leakage/ contra effects.

One PCT has a policy of getting the hospital to ring practices (in hours) before any patient is admitted via A&E. They have a very low admission rate.

- **Case Management**

Variable, although sometimes very successful implementation. Use community matron "model"; this may mean using existing PCT staff (e.g. district nurses). Use PARR tool (DH sponsored tool for Patients at Risk of Rehospitalisation) or similar. Critically need to link with practices and social services on the ground (i.e. this is getting case managers to respond).

‘QUICK WINS’ – **THOSE WHICH CAN HAVE THE FASTEST FINANCIAL RETURNS**

PCT (IN HOUSE PROVIDER SERVICES / HQ)

• **Review of in-house provider services**

Resource planning to optimise best use of staff. Ensure in house services are delivering strategic aims (including avoiding admission).

Where relevant (i.e. community hospitals) look for hand over time between shifts, reducing from 1.5hrs to 1hr is perfectly feasible.

• **HQ costs**

Aside from consolidating senior and other staff

- Stop all temp contracts/agency staff (twice the price of full time NHS staff) except where absolutely necessary for patient care;
- Reduce lease cars except where totally necessary; and
- Limit mobile phones except for staff working alone.

• **S28 Capitalisation**

Section 28 is joint commissioning with the Local Authority – review the rules and their application; it is permissible to use capital to pay for Section 28, thereby releasing other funds for FRP. In any case, should review Section 28 in context of savings plan as often outdated.

‘QUICK WINS’ – **THOSE WHICH CAN HAVE THE FASTEST FINANCIAL RETURNS**

PRIMARY CARE

• **Prescribing**

Some organisations still have much to gain in this category of spend, especially looking at drugs started in hospital and inappropriately continued in the community. Accurate downloads are available from PPA. Look at recent productivity measure from NHS Institute.

- Generic prescribing rates generally;
- Statins (ensure simvastatin generic) - especially watch statins started in secondary care;
- Antidepressants;
- PPIs.

CASE STUDY 1 – Nov 2006

Kensington & Chelsea PCT (1 of 2)

"TEN THINGS THAT HAVE WORKED"

1. ***GP private income*** – if a GP receives more than 10% of their income from private sources, the PCT is able to claim back a proportion of overheads originally paid to the practice.
2. ***Prescribing*** – reducing the proportion of high cost Statins and branded drugs that are prescribed can have a significant impact on prescribing costs.
3. ***Acute data validation*** – particularly around ensuring coding is correctly input by the Acutes.
4. ***Nursing homes*** – by reviewing the occupancy at their homes, they identified that there was over-capacity at both sites, as well as them being over-staffed at particular times of the day, when compared to comparable businesses in the private sector.
5. ***Reducing handover time*** – by slightly changing working practices to reduce handover time between shifts, from 1.5hrs to 30mins had a significant impact.
6. ***Reviewing care plans*** – this should be done regularly to ensure they are still appropriate for the needs of individual high-cost patients who in some cases may need to be moved to other facilities.
7. ***Charitable donations*** – looking into the details of how donations can be used within the wider PCT care spectrum.
8. ***Headcount*** – looking at ongoing requirements of agency/bank staff, particularly post initial appointment. Overall headcount reduction achieved mainly through natural wastage and cancelling vacant position, though also some redundancies.
9. ***Site rationalisation*** – consolidating two administrative offices into one, reducing costs and improving internal communication.
10. ***Mobile phones*** – reviewing their issue and usage on a case by case basis to ensure they are actually justifiable.

CASE STUDY 1 – Nov 2006

Kensington & Chelsea PCT (2 of 2)

CHALLENGES

- Turnaround is usually seen as a negative thing, but this needs to be reframed and be open to change and challenge. It should be at the core of the organisation.
- A challenge is maintaining the energy and enthusiasm for turnaround in the organisations, so keeping sight of what has already been achieved is very important.
- Also a danger of being counter-strategic, with the pressure to cut district nurses etc actually conflicting with a need for capacity in primary/community care.
- Another challenge is demonstrating the positive (or at least not negative) impact on diversity/quality of services/equality of care etc.
- Finally, ‘demand management’ should not be seen as reducing demand, especially by GPs, but rather making it more efficient.

CASE STUDY 2 – Nov 2006

Surrey PCT

IMPLEMENTATION 'QUICK WINS'

- All areas of expenditure need to be examined.
- GP engagement and Board ownership is critical to success.
- Each workstream needs an executive lead that is regularly held to account and project mangers for day to day management.
- CEO / TD must regularly review progress with executive leads.
- Activity based KPIs need to be developed as PCT expenditure reporting is too slow.
- KPIs need to relate to the outputs of specific projects (e.g. community matron workload) AND to those factors that incur expenditure (emergency admissions).
- Information is key to success and must be of sufficient quality and timely basis to facilitate effective decision making and monitoring.

IMPLEMENTATION 'QUICK WINS'

- Locality boards provided a mechanism to monitor progress with GP clusters (PBC).

PROBLEMS ENCOUNTERED

- Initially, they were not 'joined-up' with the Trust.
- Meaningful analysis is challenging as the analytical function was not integrated within the PCT.
- Commissioning and Finance were not always integrated in their approach.
- Keeping momentum post August, particularly when key staff members were uncertain about their future in a newly merged organisation.

CASE STUDY 3 – Apr 06

Wandsworth Teaching PCT (1 of 2)

BACKGROUND

- Wandsworth Teaching Primary Care Trust ended the financial year 2004/05 with a deficit of £8.3 million.
- The deficit arose as a result of pressures in both the commissioned services and services provided by the PCT.
- The forecast in-year deficit for FY2005/06 is £1.2 million, bringing the cumulative position to £9.5 million.
- For the financial year 2006/07 the Trust is forecasting the achievement of in-year financial balance position.

ACTIONS TAKEN TO DATE

- The PCT set up a recovery board and employed an external turnaround specialist to review all services in Wandsworth, whether provided or commissioned by the PCT, to ensure value for money, effectiveness and efficiency.
- The PCT formulated a three year strategy to recover its position which features five main initiatives:
  - Creating a new internal structure for the PCT;
  - Making services as efficient as possible;
  - Trying to save money on leases and properties;
  - Controlling spend in all non-pay areas; and
  - Attaining increased value for money from commissioned services.

CASE STUDY 3 – Apr 06

Wandsworth Teaching PCT (2 of 2)

CURRENT POSITION

- Currently the PCT is undergoing a staff restructuring process which will result in the removal of jobs mainly within management, administration and clerical positions. These reductions are being achieved through a combination of natural wastage, a reduction in agency staff and redundancies, though efforts are being made to minimize the last.
- In the current financial year (2006/07), Wandsworth Teaching PCT will contribute £10.8 million of its £360 million budget to a London-wide reserve. As a result, in the coming year, this PCT will be restricting the increase in commissioned activity to the rate of inflation. The PCT is working with GPs, the local authority, acute hospitals and other local partners to look at different ways of commissioning services and in some cases commissioning closer to home to ensure the needs of the population are reflected. It will continue to seek further efficiencies.

LESSONS LEARNT SO FAR

- The lessons learnt to date include the need for an accurate assessment of the size of the initial financial problem and close monitoring of it thereafter.
- In addition ensuring full board ownership of both the financial deficit position and the solutions identified throughout the recovery process have been imperative.
- This has been reinforced by good communication lines and an open culture throughout the organisation regarding the problems and the required solutions; this has assisted the organisation in securing all round support for the turnaround process.

CASE STUDY 4 – Apr 06

Rotherham PCT (1 of 2)

BACKGROUND

- This organisation was formed on 1 April 2002 from the consolidation of five organisations:
  - Three Primary Care Groups;
  - Small Health Authority; and
  - Priority Services NHS Trust.
- At this time the LDP identified a £6m financial deficit.
- Furthermore, the inherited culture was one of control by a few people and "managers" had little responsibility for the use of resources.

ACTIONS TAKEN TO DATE

- Budget setting processes were introduced to engage individuals responsible for managing resources: for example, prescribing advisors involved in prescribing budget setting.
- Targets were and continue to be set which incorporate the associated risk. Where individuals identify as a risk, the requirement for more resources the availability of these resources should be confirmed.

CASE STUDY 4 – Apr 06

Rotherham PCT (2 of 2)

CURRENT POSITION

- The PCT has lent £4m to another organisation in South Yorkshire and has generated a surplus of over £1m. The team of directors and non-executives at the PCT is still the same team. There is clear responsibility for the management of resources, with Directors held to account by the Chief Executive in regular meetings that incorporate a review of the financial position. The culture promoted by the PCT is one of responsibility, accountability, continuous improvement and one where individuals "do and learn".
- All financial information is shared throughout the organisation. As indicated above a systematic review of the financial risks associated with this information is continually undertaken.
- Action plans are put in place to manage these risks. Managerial resources are targeted as the main financial risks - for example, a team of general managers, finance staff, data analysts and commissioning managers was put in place to manage Payment by Results based contracts. All papers that go to the Board have a financial section.

LESSONS LEARNT SO FAR

- The following key lessons have been highlighted:
  - Focus attention on the critical risks;
  - Establish clear outcomes and actions required to deliver them;
  - Ask lots of questions, listen, engage and communicate with Primary Care professionals and other local organisations;
  - The devil is in the detail: trends, comparators and good analysis of the main risk areas are essential in understanding the potential for change;
  - Manage variations in individual practices and from their respective plans/contracts;
  - Have contingency plans to address/mitigate "in year issues";
  - Maintaining a belief that "it can be done" is essential. If the senior managers and directors do not believe it can be done then there is little chance of success; and
  - Communicate, communicate and communicate again in an open manner with staff.

CASE STUDY 5 – Apr 06

District Nurse Productivity Improvement (1 of 2)

BACKGROUND

- As part of a whole health economy cost reduction programme various provider service functions were assessed for cost effectiveness. A number of assessment methods (such as shadowing, diary analysis, time logs and interviews) indicated that the quantity of patient visits per nurse per day could be increased by reducing the time spent on indirect activities.

ACTIONS TAKEN TO DATE

- Group sessions were held to discuss findings and identify areas of indirect work that could be reduced.
- Volunteers were tasked to investigate meeting attendance, paperwork and ‘grace & favour’ activities.
- Other individuals investigated IT access / training, having fewer but larger nurse teams and a single point of referral for all requests.
- Extensive consultation was held with key stakeholders.
- Reassurance was given that fewer nurses could maintain service levels through greater productivity.

CASE STUDY 5 – Apr 06

District Nurse Productivity Improvement (2 of 2)

CURRENT POSITION

- The planned decrease in establishment of 1 in 5 whole time equivalents (c.20% of the District Nurse Budget) has been achieved within nine months through attrition.
- There was a considerable drop in morale of nurses and this contributed to further unplanned attrition.
- However the remaining nurses and management have been able to sustain service levels, with new staff recruited in order to stabilise the service at the revised planned establishment level.

LESSONS LEARNT SO FAR

- The key learning points arising from the above are as follows:
  - In order to make material realisable savings organisations need to be bold and “take the plunge”;
  - New ways of working need to be in place and secure before (or as) headcount is reduced; and
  - Open, frank dialogue with key stakeholders early in the change process, particularly with GPs, is essential to gaining a critical mass of support.

CASE STUDY 6 – Apr 06

Demand Management of Non-Elective Hospital Admissions (1 of 2)

BACKGROUND

- A dedicated ‘Locality Management’ team was piloted to provide a range of rapid response options in community care and to coordinate case-management for patients with chronic conditions.

ACTIONS TAKEN TO DATE

- The scale of admissions prevention possible was estimated from an analysis of "frequent flyers" in the locality and reasons for admission. The Locality Management function comprised a single point of referral and a range of care options including 24x7 Intensive Care at Home*, access to community beds and a ‘hot line’ to Local Authority Home Care services.
- No additional costs were incurred in establishing the Locality Management team (*this service was established prior to the pilot).

CASE STUDY 6 – Apr 06

Demand Management of Non-Elective Hospital Admissions (2 of 2)

CURRENT POSITION

- From a population of 24,000 the pilot was given a goal of reducing un-planned admissions amongst "frequent flyers" by 5%. In practice a 6% reduction has been achieved, verified on a case-by-case basis by the acute hospital.
- The savings achieved in one year were realised from 90 avoided ‘blue-light’ admissions for conditions that averaged 7.5 day length of stay and £1.5k tariff.
- Scaled across the whole PCT this scheme could deliver commissioning (and net PCT) savings of c.£1.4m.
- Furthermore the savings opportunity to the Trust could come from the removal of 18 beds and the resource associated with this removed capacity.

LESSONS LEARNT SO FAR

- The key learning points arising from the above are as follows:
  - Conclusive analysis and evidence, verified by clinicians, is essential in winning support for the pilot trial of such work;
  - Strong implementation team is required comprising GP, Community Matron, Social & Caring Services and Head of Intensive Care at Home nursing; and
  - No whole economy savings will be realised without proportional scaling down of acute services.

SUMMARY OF LESSONS LEARNT – APRIL 2006

Graphic below summaries the lesson learned from a sample of PCTs at varying stages in their turnaround process

DIAGNOSIS / ANALYSIS

Financial Review

- Achieving recurrent balance should be the first priority (S&Y PCT)
- Accurately assess the size of the financial problem and monitor on an ongoing basis (W PCT)
- Action should be taken to quickly respond to financial variances from plan (S&Y PCT)
- Manage variations in individual practice performance against plans (R PCT)
- Seek to manage demand effectively by changing the nature of local services provided (S&Y PCT)

Analysis and monitoring

- Getting underneath the detail is critical - trends, KPIs and key risks
- Focus on the in-month financial performance identifying issues earlier (S&Y PCT)
- Have contingency plans to mitigate "in year issues" which may arise (R PCT)
- Focus attention on the critical risk areas
- Monitor trends and conduct analysis of the main risk areas (R PCT)

STAKEHOLDER ENGAGEMENT

Accountability

- Full Board ownership of the financial situation and solution is critical (W PCT)
- Management must take timely and decisive action at an early stage. Supervision is needed by the SHA (H PCT)
- Management needs to be focussed on the financial position of the PCT (H PCT)
- "Can-do" attitude from senior staff is critical (R PCT)

Stakeholder Management

- Challenge, engage and communicate with Primary Care professionals and other local organisations (R PCT)
- Avoid disputes at SHA and Trust level and when it does occur it should be dealt with quickly (S&Y PCT)
- Adopt an open culture to encourage communication throughout the organisation (R PCT, W PCT)
- Using external specialists can provide impetus, structure and project mgt skills required (S PCTs)
- Time spent dealing with resource management and financial issues should not be underestimated (S PCT)

DEVELOPING PLANS

Available Savings

- Accept that most Action plans may not result in an immediate impact/cost reduction (S PCTs)
- Excess bed days, admission avoidance, GP prescribing savings should all be explored (S PCTs)
- Downward pressure on elective activity through PBC represents a key opportunity (S PCTs)
- A robust approach to contracts and SLAs with partners and providers is required (S PCTs)

R PCT – Rotherham PCT *S&Y PCT – Selby and York PCT* *H PCT – Hillingdon PCT* *W PCT – Wandsworth PCT* *S PCTs – Sheffield PCTs*

2. AN APPROACH TO PCT TURNAROUND

- DIAGNOSIS/ANALYSIS
- DEVELOPMENT AND REVIEW OF OPTIONS

TURNAROUND SUPPORT

EXTERNAL AND INTERNAL SUPPORT

PCT's have existed in their current form and function for approximately five years and, given their complexity, are still at a relatively early stage in their evolution. There is relatively limited experience of PCT organisations having achieved turnaround and financial recovery across England. Furthermore, it is clear that the process in preparing a credible, robust and sustainable turnaround plan requires a high degree of analysis and must be appropriately tailored to the needs of the organisation.

Where a PCT was ranked as a category 1 or 2 (as part of the 'Baseline Assessment' work) or as a "High Priority" (as part of the August enlargement of the Turnaround Cohort), the use of external turnaround support was necessary in undertaking the required analysis and assisting in the establishment of a stable platform of operation. This support took the form of turnaround directors and/or external advisors.

However, particularly because of pressure from 'outsiders', there is a danger that a resulting turnaround programme is considered as a 'bolt on' to the day-to-day operations of an organisation and not as an integral part of it's functioning.

Board members and senior management within the PCT, must ensure the engagement of all key decision makers and stakeholders. Without this level of engagement the turnaround plan is likely to fail. Where senior management is unable to ensure that engagement, management changes should be considered.

AN APPROACH TO TURNAROUND (1 of 2)

TURNAROUND APPROACH – THE MAIN STEPS

Outlined below are some key steps to a successful turnaround of a PCT (once the appropriate support is in the place):

- **Diagnostics/Analysis**: accurately ascertaining the magnitude of the financial difficulties and deficit, coupled with clear financial controls, and transparent key performance indicators ("KPIs");
- **Development and Review of Options**: where clear stretched saving targets are identified and reinforced by the engagement of all key stakeholders (Management, GPs, Trusts and Operational Staff);
- **Developing Financial Strategy and Action Plan**: development of prioritised actions into a detailed implementation plan with key milestones (i.e. key events), phased activities, clear timescales/interdependencies and full sustained stakeholder buy-in;
- **Implementation**: delivering the plan with the continued development of the above steps as part of an iterative process.

We summarise over the page the details under these headings.

AN APPROACH TO TURNAROUND (2 of 2)

The following diagram summarises the main steps to Turnaround, typical timeframes, actions and outputs involved:

POTENTIAL TIMESCALES

3 – 4 WEEKS	4 – 8 WEEKS

STAGE

DIAGNOSIS / ANALYSIS	DEVELOPMENT AND REVIEW OF OPTIONS	DEVELOPING FINANCIAL STRATEGY AND ACTION PLAN	IMPLEMENTATION

ACTIONS

• Dedicated (external) resource • Board level accountability • Short term cash and I&E measures in place • Detailed analysis of financial and operational performance to date	• Stretch targets and clear focus • 'Delivery Chain' from front line • to Board level • Initial assessment turned into prioritised actions • Engagement with key stakeholders	• Milestones, timescales, interdependencies and detailed activities identified Improving data streams • Managing stakeholders • Empowering clinicians	• Return to devolved accountability • Build on turnaround (e.g. better use of data, improved stakeholder engagement, recognise clinical leadership) • Additional activities identified

OUTPUTS

• Report on robustness of performance and financial targets inherent in the Service Plans and identifying savings options available	• Stakeholder agreement on prioritised options to assist the PCT to achieve recurrent financial monthly run rate balance	• A focused phased implementation plan with clear governance and accountability	• Improved readiness to manage and sustained delivery of Turnaround Plan • Tracking delivery: monitoring, reporting and challenging the delivery of plans

DIAGNOSIS / ANALYSIS

- KEY AREAS OF FOCUS IN PERFORMING ANALYSIS
- COMMISSIONING:
    - ELECTIVE
    - OUTPATIENTS
    - NON-ELECTIVE
- DATA SOURCES

DIAGNOSIS & ANALYSIS

OVERVIEW

PCTs are expected to assess all the services they commission, including those they directly provide, to ensure they are in line with value for money as well as equity and quality. They are expected to use appropriate benchmarking information to assess the performance of services against good practice.

The following key questions/points should be considered during the analysis:

- How well is elective demand managed and how efficiently is it being delivered;
- How well are emergency admissions managed;
- How are A&E attendances impacting admissions;
- How well is primary care performing, in total and by practice;
- How well managed is the prescribing spend;
- Are the provider functions impacting the level of unplanned emergency admissions and/or impacting other organisational spending;
- What are the other opportunities to reduce other overhead and direct spending costs;
- Where is spending most out of line with national trends;
- Are utilisation trends different by provider; and
- Are there any opportunities to deliver better value for money on other commissioning.

The following pages set out the detailed questions to be addressed under the above categories.

KEY AREAS OF INVESTIGATION (1 of 5)

How well is demand managed and how efficiently is it being delivered?

Commissioning of Secondary Services

- What has been the trend over time in elective, emergency, maternity and other FCEs/admissions?

Electives

- How does the percentage of day cases (versus inpatient) compare to national benchmarks?
- What has been the trend in GP referrals over time in total and by speciality?
- How does the level of first outpatient appointments by speciality compare to national averages?
- How does the ratio of follow up consultations per first appointment by speciality compare to national averages?
- How do conversion ratios from referral to outpatient assessment to operative procedure vary over time and compare with peers?
- Are there any community services for assessment and treatment (clinical assessment unit -CAS or clinical assessment and treatment unit - CATS) and if so are they cost effective?
- Are there standard referral protocols used by all GPs for elective referrals?
- Has the PCT stopped funding low priority treatments?

KEY AREAS OF INVESTIGATION (2 of 5)

How well are emergency admissions managed?

- What has been the trend in over 2 day Length of Stay?
- What is the age profile for admissions?
- What are the main reasons for admissions?
- Is there an assessment unit? What is the percentage of admissions to that unit? What proportion of emergency admissions occurs during the period covered by the out of hours provider, benchmarked against the peer group or England average?
- What is the emergency utilisation rate for the DH ambulatory care sensitive marker conditions?
- How is the relationship between Social Services and PCTs managed, particularly with regard to the management of unplanned emergency admissions and continuing care thereafter?

How are A&E attendances impacting admissions?

- How does the age of the attendees compare to the age profile of the population?
- What percentage of attendances is due to GP heralded (referred) attendances and for what reason? Could these be handled in the community? What are the levels of inappropriate admissions? What are the levels of repeat admissions?
- What percentage of A&E attendances convert to admissions?
- What is the most common source of attendances (nursing homes, for example)?
- Is there any substitute activity to avoid A&E attendances for minor injuries, such as Walk-in centres or other Urgent Care centres?

KEY AREAS OF INVESTIGATION (3 of 5)

How well is primary care performing, in total and by practice?

- How does the GP WTE per weighted average population compare to national averages?
- How strong is primary care provision (QoF scores for example)?
- How do practices compare to each other? (Profile of practices for referral activity, prescribing activity, frequent flyers, GP referred A&E attendances etc)
- Access to diagnostics – is there direct access to diagnostics and lab (or do these become admissions or outpatient referrals?

How well managed is the prescribing spend?

- How does spending per weighted average population compare to national average?
- How does spending per AstroPU (prescribing unit of measure) compare to national average?
- What is the level of generic drug prescribing ratio and how does it compare to national averages?

KEY AREAS OF INVESTIGATION (4 of 5)

Are the provider functions impacting the level of unplanned emergency admissions and/or impacting other system spending?

- What is the cost and use of intermediate care beds (step up versus step down; are beds cheaper than acute trust costs)?
- What is the spending on District Nursing and Health Visitor spending per weighted average population? What are their major activities?
- Is there a risk stratification programme? What actions have been implemented to manage the highest risk population and what has been the impact?
- What proportion of high risk patients, with unplanned admissions, are under active case management by the PCT provider services?
- What proportion of patient caseloads in the PCT provider services relate to patient who are not at high risk of avoidable unplanned admission?

What are the opportunities to reduce other overhead and direct spending costs?

- Management cost analysis
- Facilities cost analysis

KEY AREAS OF INVESTIGATION (5 of 5)

Where is spending most out of line with national trends?

- What is the spending by major category (trend over time) including: primary care, acute care, prescribing, mental health and learning disabilities, community care, provider services, PCT administration, and other?
- What is the comparison of historical activity to capitation based budgets in respect of Practice Based Commissioning?

Are utilisation trends different by provider?

- What has been the historical and current year utilisation compared to SLA agreed volumes by provider?

Are there any opportunities to deliver better value for money on other commissioning?

- What is the Mental Health spending per weighted average population compared to the national average?
- What is the Learning Difficulties spending per weighted average population compared to the national average?
- Are there many high cost cases for Continuing Care?
- What are the other major sources of spending?

DIAGNOSIS & ANALYSIS - COMMISSIONING

COMMISSIONING

With regards to commissioning, the following points should be considered:

- *Level of operative interventions/procedures;*
- *Number of elective FCEs responsible patients for the 20 most common procedures;*
- *Level of elective referral rates;*
- *Level of cancellations;*
- *Level of referrals;*
- *Level of outpatient follow ups;*
- *Level of emergency admissions by frequent flyers;*
- *Patients arrival at hospital; and*
- *Average occupied bed day rate.*

The following pages set out a number of questions to be addressed under the above categories.

COMMISSIONING - ELECTIVE (1 of 3)

What is the level of operative interventions/procedures?

- What is the variation in number of operative interventions / procedures (where actual is above the national average) against thresholds/benchmarking?

What are the total number of elective FCEs responsible patients for the 20 most common procedures?

- What are the levels of surgery currently being undertaken that could be shifted into Primary Care?
- Is there appropriate use of endoscopy services? Set a number of requirements that need to be met before sending a patient to undergo endoscopy tests?
- What are the least clinically effective treatments and can they be reduced?
- Can unnecessary pre-operative admissions be reduced?

What is the level of elective referral rates?

- Can clinically driven thresholds be used to reduce the number of elective referral rates?
- Could the establishment of community based services (e.g. optometry led triage service) result in a reduction of secondary care referrals; conversion rates are generally static?
- Which GPs are referring the largest number of patients into secondary care?
- Which consultants are referring to other consultants within the hospital?

What is the level of cancellations?

- Are SLAs sufficiently robust that the financial burden for cancellations of procedures by Acute Trusts does not lie with the PCT?

COMMISSIONING - OUTPATIENTS (2 of 3)

What are the level of referrals?

- What are the number of new outpatient attendances, by the 20 most common specialities, where the source of referral is consultant?
- What are the 20 most common GP to consultant written referrals? Possible use of the New Zealand referral scoring systems – clinically driven scoring system where GPs may refer a patient into secondary care upon achieving a measured threshold, thus minimising uncertainty on the GP's behalf.
- Has the PCT established a CAS?
- What are the first outpatient attendances by provider (non A&E consultant referral, A&E referral, GP referral, dental referral, Prosthetist/Self/Community referral, other)?
- What is the Trauma & Ortho GP referral rate per 1000 weighted population by practice (pre-approval and avoidance)?
- Is it possible to reduce the number of consultant to consultant referrals by introducing a 'no onward referral' clause for conditions that are unrelated to the initial referral?

What is the level of outpatient follow ups?

- How do the number of outpatient follow up attendances broken down by speciality, benchmark against higher performing PCT's?
- Can the the number of ophthalmology glaucoma follow up appointments be reduced by arranging for follow ups to take place in the community?

COMMISSIONING – NON ELECTIVE (3 of 3)

What is the level of emergency admissions by frequent flyers for the 20 most common Primary Diagnoses?

- Can the level of emergency admissions associated with management of long term care conditions be reduced through the promotion and improved use of demand management initiatives? Can the use of front-of-house specialist nurses reduce admission rate?
- Are there opportunities to increase the utilisation of facilities within the community hospitals resulting in reduced admissions to secondary care providers?
- Can case management be developed to support at-risk patients more actively in the community? Promotion of the development of intermediate care services can help prevent hospital admissions.
- Are care plans still appropriate and fit for purpose or do they need to be reviewed/revised?

How are patients arriving at the hospital?

- By what means do A&E attendances arrive at hospital? Gaining an understanding with the Ambulance Trusts may help redirect patients into primary care.
- What percentage, by speciality, of emergency FCEs responsible patients have a spell LoS of zero?

What is the average occupied bed day rate at the Community Hospitals?

- How does the bed day rate benchmark against higher performing Community Hospitals and private care?

DATA SOURCES (1 of 2)

When considering financial recovery and undertaking a diagnosis of a PCT, there are a number of potential data sources which could be used. These data sources will facilitate the work required in undertaking the analysis suggested on the preceding pages. The table below lists some of these data sources:

DATA SOURCE	DATA DESCRIPTION	WEBLINKS
Department of Health – **Hospital Episode Statistics (HES)**	Various. HES is a national statistical data warehouse containing a wide range of healthcare analysis for the NHS. Examples of types of data available through HES: – Admissions – elective/emergency (by age/type/length of stay/day case/bed days etc)	Main HES home page: http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en Link to datasets: http://www.hesonline.org.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=96
Healthcare Commission	1) Performance benchmarking - Benchmark graphs and the collation of performance data on PCTs. It is possible to view particular areas of performance (clinical, patient, capacity & capability) or indicators. Examples of types of data available: – Access to GPs; – Access to a primary care professional; – Waiting times; – Total time in A&E; and – PCT commissioning of NHS deliverables. 2) PCT clusters – Comparing PCTs in similar groups or 'clusters'. For the purposes of comparison and analysis benchmarking against other similar PCTs is possible.	List of indicators and results: http://ratings2004.healthcarecommission.org.uk/Trust/Indicator/indicators.asp?trustType=4 Descriptions of indicators: http://ratings2004.healthcarecommission.org.uk/Downloads/pctlist.pdf

DATA SOURCES (2 of 2)

DATA SOURCE	DATA DESCRIPTION	WEBLINKS
Department of Health – **Primary Care Access Survey**	Detailed patient access to GPs across the UK.	http://www.dh.gov.uk/PolicyAndGuidance/PatientChoice/WaitingBookingChoice/WaitingBookingChoiceArticle/fs/en?CONTENT_ID=4079186&chk=NldfeQ
NHS Employer Website	Provides information on handling redundancies and the restructuring of the workforce. Also provides guidance to support the management of employee communication and consultation, which is required in applying the proposed change process resulting from CPLNHS ("Commissioning a Patient-Led NHS").	Website: http://www.nhsemployers.org/ CPLNHS: http://www.nhsemployers.org/practice/practice-708.cfm
Department of Health – **Programme Budgeting**	Details NHS expenditure, including primary care services, to programmes of care based on medical conditions. Provides details of PCT spending patterns. Organisations can examine the health gain to be obtained from investment to help inform understanding about equity and how patterns of expenditure map to the epidemiology of the local population.	Website: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/ProgrammeBudgeting/ProgrammeBudgetingArticle/fs/en?CONTENT_ID=4117327&chk=CfJL4u
The Information Centre - Review of Central Returns (ROCR)	Various. The Review of Central Returns (ROCR) This process ensures that central collections of information are appropriate for their purpose and minimises the burden on the NHS of submitting the data. This site references various types of data collected and contact details for further information.	Approved data collections: http://www.ic.nhs.uk/rocr/approved/04114167.pdf/file One-off data collected: http://www.ic.nhs.uk/rocr/approved/Oneoff.pdf/file

NB: Before drawing any conclusions using the data found in these or other data sources, it is advised that the appropriate assumptions are explored and care and discretion be applied as there may (for example) be year on year fluctuations due to changes in policy/guidance, organisational changes, adjustments required for any shortfalls in number of returns received from organisations etc.

DEVELOPMENT AND REVIEW OF OPTIONS: *Stakeholder Engagement*

- ENGAGING STAKEHOLDERS
- PERSPECTIVE FROM GENERAL PRACTITIONERS
- ROLES OF THE SHA AND SHA TDs

ENGAGING STAKEHOLDERS

KEY PCT STAKEHOLDERS

PCTs work with a variety of stakeholders to serve people who rely on a mix of services. Good engagement with all of these around any proposals for change is essential.

In other words, a PCT cannot deliver a successful turnaround in isolation. Staff and staff side representatives, the SHA, GPs and practices, local acute and mental heath providers and the media need to be briefed up front and on an ongoing basis and local authorities, social care groups and voluntary bodies engaged.

Bringing and keeping GPs and major providers on board is essential, as they play a critical part in achieving the solution.

PERSPECTIVE FROM GPs

OVERVIEW

GPs represent one of the primary stakeholders for a successful PCT turnaround.

The consistent view from GPs interviewed on the ground and from the limited workshops undertaken highlights the limited amount of effective information available to them in relation to their own performance versus their peers. This specifically relates to the provision of quality indicators and comparable data on the levels of referrals, utilisation and benchmarking which PCTs have a responsibility for providing under PBC. Thereafter the provision of this information needs to be reinforced by focussed follow-up meetings with GPs.

Interestingly a number of GPs agree with the assertion that GPs that are perceived as delivering a high quality service are more inclined to make higher levels of referrals than their peers. This is not to suggest that referrals should be reduced at the expense of patient care. Rather this highlights the need for referrals to be more carefully considered to ensure their appropriateness. It underlines the need to provide useful comparative data to GPs within their specific locality.

GPs that have engaged with organisations as part of the turnaround process have also highlighted the savings available from improved prescribing methods. Prescribing represents an area where good information already exists and therefore, represents an opportunity for PCTs, in conjunction with their local GPs, to obtain immediate savings - for example in relation to drugs coming off patent.

PBC, by ensuring the most appropriate type and level of care is provided to the patient, can be a major factor in bringing about a successful turnaround at a PCT.

ROLES OF THE SHA AND SHA TDs

ROLE OF THE SHA:

- The role of the SHA should focus on some additional areas:
  - Key role in the development of commissioning plans for PCTs
  - Due to the complexity and difficulties in creating an effective commissioning organisation in a health system, the SHA will need to provide sufficient resource and guidance to the process.
  - The SHA should be an effective and proactive facilitator of potential commissioner/provider disputes
  - Performance managing organisation to ensure effective working as part of the local health economy
  - Continue to take the lead on turnaround with organisations, including the use of turnaround directors to their full effect.
  - SHA's should endeavour to take on the role of the SHA TD and integrate it fully into the SHA's senior management team. The role of the TD has been detailed on the following slides.

ROLES OF THE SHA AND SHA TDs

ROLE OF THE SHA TURNAROUND DIRECTORS:

- As part of the infrastructure to support the delivery of turnaround, private sector Turnaround Directors were appointed to each of the eleven SHA Transitional Patches (which were to become ten SHAs). In summary, the role of the SHA TDs is to:
  - Manage and co-ordinate the turnaround initiatives of organisations within the SHA and to facilitate the preparation and delivery of comprehensive turnaround plans;
  - Ensure there is no trade off between achievement of financial targets and delivery of national clinical service priorities;
  - Support SHA management in assessing and managing the performance and delivery of turnaround resources within challenged organisations and the appointment, where necessary, of local Turnaround Directors, and/or external advisors;
  - Agree turnaround action plans with challenged organisations (and ensure formal SHA approval) before submission to the National Programme Office for Turnaround ("NPO");
  - Liaise with 'Fitness for Purpose' leads to help ensure the project is carried out effectively and that the turnaround programme aligns with the longer term future of the organisation;
  - Help coordinate, review, monitor and scrutinise the performance and delivery of turnaround resources within challenged organisations;
  - Ensure that fortnightly progress reports are received from Turnaround Cohort organisations on time, completed in full and thoroughly reviewed and commented on before submission to the NPO (in line with the strict NPO reporting timetable);
  - Ensure completion of regular and ad hoc reports / information requests from the NPO;
  - Bring to the attention of the NPO, at the earliest opportunity, the identification of organisations with deteriorating financial performance and/or the need for turnaround support; and
  - Ensure that savings plans and pressures are viewed under a health economy approach.

ROLES OF THE SHA AND SHA TDs

SHA TURNAROUND DIRECTORS – Reviewing Implementation Progress:

- SHA TDs are in regular contact with Turnaround Cohort organisations and their Turnaround Directors (or equivalent). This entails prioritised visits to turnaround organisations (and in particular 'High Priority' organisations) to review, scrutinise and challenge progress and the delivery of the required savings.

- Whilst the general approach and precise modus operandi of these meetings is at the discretion of the SHA TDs it is envisaged that they would need to include, but not be limited to, the following in order to satisfy the typical insights required by the NPO:
  - Detailed discussion and explanation of fortnightly Progress Reports.
  - Meetings with Programme Office managers (or equivalent) and TDs/external advisors (if applicable).
  - Ad hoc meetings with medical and operational representatives from specific savings workstreams.
  - 'Spot checks' - Review and basic validation of supporting documents used to underpin fortnightly Progress Reports e.g. financial schedules, project plans, Gantt charts.

DEVELOPMENT OF TURNAROUND PLANS:

- Overall it is crucial to highlight that turnaround plans are owned and developed by the organisations themselves with, in some instances, local external support.
- External support has come in the form of advisers from the larger accountancy and consultancy groups and from independent Turnaround Directors.

ACKNOWLEDGEMENTS AND GLOSSARY OF TERMS

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SHA Turnaround Directors

The National Programme Office for Turnaround

Hillingdon PCT
Kensington & Chelsea PCT
Rotherham PCT
Selby & York PCT
Sheffield PCTs
Surrey PCT
Wandsworth PCT

(NB – All job titles are those at time of contribution)

GLOSSARY OF TERMS

A&E	**Accident and Emergency**
CAS	**Clinical Assessment Unit**
CAT	**Clinical Assessment and Treatment Unit**
CBT	**Cognitive Behavioural Therapy**
CE	**Chief Executive**
CIP	**Cost Improvement Plan**
CPLNHS	**Commissioning a Patient Led NHS**
DH	**Department of Health**
DVT	**Deep Vein Thrombosis**
FD	**Finance Director**
FCE	**Finished Consultant Episodes**
FRP	**Financial Recovery Plan**
FT	**Foundation Trust**
GP	**General Practitioner**
GPwSI	**General Practitioners with a Special Interest**
HA	**Health Authority**
HES	**Hospital Episode Statistics**
KPI	**Key Performance Indicator**
LDP	**Local Delivery Plan**
LoS	**Length of Stay**
LTC	**Long Term Care**
NHS	**National Health Service**
PARR	**Patients at Risk of Rehospitalisation**
PBC	**Practice Based Commissioning**
PCT	**Primary Care Trust**
PEC	**Professional Executive Committee**
PPA	**Prescription Pricing Authority**
PPI	**Proton Pump Inhibitor**
QOF	**Quality Outcomes Framework**
ROCR	**Review of Central Returns**
SHA	**Strategic Health Authority**
SLA	**Service Line Agreement**
TD	**Turnaround Director**
WTE	**Whole Time Equivalent**