# Development of a Cost Improvement Programme for Manx Care.

# 2021/2022.

June 2021

Isle of Man Department of Health and Social Care & Manx Care

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## Acknowledgement and Further Information

MIAA would like to thank all Manx Care staff for their co-operation and assistance in completing this project.

This report has been prepared as commissioned by Manx Care. If there are any queries regarding this project please contact Keith Bowman (07770 971 007) to discuss.

# 1. Introduction

We understand that in recent years forecasted budgets have been overspent, driving the need to instil a focus on continuous efficiency improvement and significant cost saving delivery to achieve financial resilience. Alongside the Transformation Programme which will reshape how services are delivered, sits a significant Cost Improvement Programme to ensure best value for money for all services.

The establishment of Manx Care provides an opportunity to drive forward improvements to achieve long term financial resilience while improving patient care. This report presents a comprehensive plan for a 2021/22 Cost Improvement Programme (CIP) to deliver against these objectives.

# 2. Executive Summary

## 2.1 Objectives

MIAA was commissioned to provide independent advice and guidance to:

- To produce an initial headline plan and summary list of opportunities to reduce the projected overspend in 2020/21, benchmarking existing service delivery areas against best in class.
- To develop a focused, evidence-based CIP programme for 2021/22; developed with engagement of clinicians and other staff to ensure the delivery of achievable, realistic and sustainable cost savings;
- Design and identify the governance, infrastructure and resources required to oversee, monitor, and deliver the programme.

## 2.2 Overview

The review considered a range of opportunities for saving money, reducing spend, improving efficiency and throughput, reducing demand or a combination of approaches. The focus of the Cost Improvement Programme (CIP) for 2021/22 has been on identifying annual in year saving plans to deliver 'quick wins'. A total of £2,990,256 has been identified which represents prudency and achievability.

To secure the savings opportunity as fast as possible, dedicated project governance and on the ground delivery support has been identified, complemented with subject matter expertise. This investment is calculated to be £375,000, which would accelerate the delivery of £2,615,256 in net savings.

Four 4 focus areas were identified to form the focus for 2021/22 CIP delivery plan; the rationale being these areas had the greatest opportunity for quick wins and cash out in year savings. They are:

- CIP 1: Secondary Care Medicines
- CIP 2: Primary Care Medicines
- CIP 3: Procurement
- CIP 4: Workforce

This report outlines the opportunities and delivery plan for each of the 4 workstreams. Each section starts with the findings of this review and key recommendations. The section follows with a CIP saving opportunities summary, assumptions and rationale, priority actions for the first 30 days and finally a delivery plan to provide an idea of the timescales to savings delivery. Several opportunities were identified by Manx Care leads, and these have been incorporated into the overall plan, providing the structure and a single plan for swift progression and accelerated delivery.

Further opportunities have been identified in care delivery processes, particularly within elective and non-elective care. Opportunities in these areas align more with efficiency improvements. Whilst a reduction in activity or improvement in efficiency will deliver greater value and in time, savings, the timescale for these opportunities did not lend themselves to the CIP plan for 2021/22.

It is recommended that these opportunities are taken forward this year to establish the robust basis for future savings and improved financial resilience. A proposed delivery plan for these opportunities is presented the sections below which detail 2 'Value based Workstreams'; Elective Care and Non-Elective Care (see sections 9 and 10).

MIAA have also presented a summary of the investment required to help support this work and accelerate the delivery of savings. This paper also presents recommendations for the governance resources and structures required (see Appendix D).

Supporting this report are a suite of documents that provides further detail and context and includes:

- Long list of opportunities with high, medium and low savings potential with supporting evidence base, assumptions, benefits and key metrics, (a summary has been provided in Appendix B).
- The final cut CIP plan for 2021/22 (See appendix A).
- Comprehensive action plan (Gantt Chart) some of which is summarised below in each section.

- Detailed summary of findings, evidence base and plans for each of the 4 key areas: Secondary care medicines, primary care medicines, procurement, and workforce.
- Suite of slides for each of the 6 'deep dives' summarising the evidence on the opportunities presented together with outputs and discussion notes
- A comprehensive report on the governance and structures required to take forward the CIP programme and oversee delivery.
- Proposal from MIAA for further support to drive forward some of this work if required.

# 3. Overview of Approach

A strategic approach, underpinned by robust governance, in combination with service transformation would provide the potential for greater long-term financial sustainability, more cost-effective service delivery, best value for money and an improved patient experience.

The following section presents a summary of the steps taken to develop the 2021/2022 CIP plan

## 3.1 Phase 1 Developing a Long list of CIP Opportunities

**Interviews with Key Stakeholders:** a series of interviews were conducted in order to get a sense of the challenges that were being experienced, understand local context, areas of potential opportunity and where improvement work might be already taking place or completed. The aim was to link together with transformation work to avoid duplication. See Appendix C for a list of individuals consulted.

**Data and Benchmarking:** used to identify areas of opportunity, informed by either high-spend or low efficiency or compared to England equivalent health systems. Data availability was a challenge in some areas and therefore many assumptions were made. Where possible, comparisons were made to England performance.

**Case Studies:** opportunities delivered by health systems and commissioners from across England were used to inform savings and potential opportunities. An evidence base of case studies was used to support assumptions. Opportunities were benchmarked against England CCG populations to calculate potential scale of opportunity for Manx Care.

**Development of a long list of opportunities:** informed by conversations with Executive Leads, Clinical Directors and other key staff, supported by data analysis and benchmarking to inform potential areas of improvement, comparing data, where available, to England averages. Finally, the list was informed by a library of case study examples of work that has been delivered successfully in England health systems. The CIP Long List is a mix of transformational opportunities and quick wins were proposed as required to address the challenges identified (see Appendix B for a summary).

## 3.2 Phase 2 Opportunity Qualification and CIP Plan for 2021/22

The focus of Phase 2 was to narrow the focus into several high priority areas, following engagement and qualification with relevant stakeholders, to ensure the identified opportunities had a likelihood of CIP delivery in 2021/22 and to shape the identified CIP savings opportunities into discrete projects with ownership and input from each area of focus.

**Deep Dive Workshops:** Six Deep Dive sessions with key staff from the following areas were held in order to drill down into more specific areas of focus as follows:

- Procurement
- Workforce
- Primary Care Medicines
- Secondary Care Medicines
- Elective and Tertiary Care
- Non-Elective & Emergency Care

**Workshop objectives:** The objectives were to review the long list of identified CIP projects and gain front line staff ownership, glean insights into feasibility, timescales and risks, barriers and mitigations to delivery, to agree a realistic delivery plan for 2021/22, and understand the investment required in terms of project management, clinical or technology to make it happen.

**Finalised Short List:** Following the workshops, four key areas were agreed would form the main focus of the 2021/22 CIP plan: Procurement, Workforce and Primary and Secondary Care Medicines. The final cut list is a realistic savings plan of shortlisted projects with the potential and indeed likelihood of cash out delivery in year.

# 4. 2021/22 CIP Programme Overview.

The finalised short list includes the following opportunities and associated savings:

| Key Focus Area | Opportunity | Saving |
|---|---|---|
| Secondary Care Medicines | Biosimilar Switches | £53,204 |
| | Sugammadex | £6,441 |
| | Capsaicin patches | £28,980 |
| | DOACs (anticoagulant primary care rebate) | £102,631 |
| | Nobles Pharmacy Stockholding | £300,000 |
| | Blueteq High-cost Drug Management System | £100,000 |
| | Sub Total | **£591,256** |
| | Investment (Programme management and SME) | **£100,000** |
| | **Net Savings** | **£491,256** |
| Primary Care Medicines | Reducing prescribing for Vitamin B Compound Strong, Oral Vit B 12, Bath and shower emollients and Eye preparations | £155,000 |
| | Low clinical value prescribing cessation | £250,000 |
| | Stoma Appliances | £57,000 |
| | Stopping 3rd party Ordering (Repeat Medication) | £94,000 |
| | Sub Total | **£556,000** |
| | Investment (Programme management and SME) | **£60,000** |
| | **Net Savings** | **£496,000** |
| Procurement | NHS Supply Chain and supplier alignment on Non-Pay Spend | £600,000 |
| | Improved Contracting Arrangements | £250,000 |
| | Pilot stockholding reduction and centralised purchasing. | £25,000 |
| | Tertiary Care Transportation Contract Review | £518,000 |
| | Sub Total | **£1,393,000** |
| | Investment (Programme management and SME) | **£90,000** |
| | **Net Savings** | **£1,303,000** |
| Workforce | Reduction in locum Spend | £200,000 |
| | Review of Agency Framework and On Call Unit Costs | £150,000 |
| | Maximum Use of Bank where possible | £100,000 |
| | Sub Total | **£450,000** |
| | Investment (Programme management and SME) | **£60,000** |
| | **Net Savings** | **£390,000** |
| **SUB TOTAL** | | **£2,990,256** |
| **CIP Investment to accelerate delivery:** Workstream support | | **£310,000** |
| **TOTAL** | | **£2,680,256** |

# 5. CIP 1: Secondary Care Medicines

## 5.1 Key Findings and Recommendations

- Pharmacy is understaffed and therefore under pressure, which risks delivery of identified opportunities. Resource investment should be identified to support reporting and delivery of secondary care pharmacy projects in order to ensure delivery without compromising clinical or service quality.
- The availability of management information to best support ongoing identification of savings opportunities and tracking of delivery could be improved. An expanded suite of reports should be developed to support this work; potentially through commissioning EMIS Health (Ascribe) - The pharmacy system provider.
- Delivery of medication spend opportunities is reliant on changes in prescribing habits, formulary changes and or patient switches, which requires the right governance and structures with effective clinical engagement, input and oversight and effective cross-system collaboration, which must be established. The financial justification for switch decisions must also align with a clinical justification, ensuring no negative impact on patient outcomes.
- The establishment of a cross-system medically led multi-disciplinary Integrated Medicines Optimisation Group should be considered to provide this governance and oversee a cross-specialty high-cost and biosimilar drugs usage review and recommendations. A review and approvals process for biosimilar drug switches should incorporate specialist clinician input.
- The potential for implementing a prior approval process for high-cost drug prescribing, should be explored to ensure clinical appropriateness and cost-effectiveness of prescribing. Use of a system such as Blueteq, has been successfully implemented in many NHS organisations saving an average of 2% of annual high-cost drug spend through ensuring appropriate prescribing of high-cost drugs. If implemented, system implementation should consider the governance required for consistent application of policy adherence, to ensure parity of access and transparency, to support Board objectives.
- The Pharmacy department at Nobles Hospital currently has a high level of stockholding compared to England equivalents, driven partly due to Noble's location which presents challenges around procurement and delivery of orders, concerns of Brexit and fragility of the supply chain and the impact of COVID-19.

Holding high stock costs money, space, and poses a risk of wastage and therefore a reduction in stockholding should be delivered without compromising quality of care; striking the right balance between just in time and more effective and optimal supply chain management as part of a post COVID-19 recovery plan. In terms of ensuring continuity of access to procurement advice and thus achieving best value for money, Nobles Pharmacy should contribute annually to the services of the NW Regional Pharmacy Procurement.

- Consider the opportunity to install a pharmacy robot to improve stock management, reduce stockholding and improve dispensing efficiency in line with the benefits achieved by many other hospital pharmacies.
- Work to date to initiate treatment naïve and to switch existing patients prescribed biologic drugs onto the 'biosimilar' version should continue, aiming to achieve at least 80% uptake in line with achieved rates in UK hospitals.
- A more restrictive policy and controls for anaesthetic drug, Sugammadex (to reverse neuromuscular blockade) should be explored as a priority.
- A more restrictive policy and controls for Capsaicin patches (pain management) should be considered in line with UK regions who have either not approved it at all or permit restricted usage only within a comprehensive pain service. In addition , pain management drug usage and spend in primary care is higher per head of population than England, which suggests that improvements to pain management services or better management of patients waiting for orthopaedic procedures might deliver value and improved patient outcomes.
- Opportunities for switching some patients, where deemed clinically suitable, onto the best value anti-coagulant (DOAC) should be explored to leverage primary care rebate and reduce annual spend for some appropriate patients.
- Expansion of the use of pharma-funded homecare services for high-cost drugs should be explored to release resource needed for patient training (self-inject).
- Investment in additional pharmacist resource to expand medicines reconciliation on admission and at discharge would enable support for delivery of the savings identified as well as improving the quality of care for patients.
- Consider repatriating to Nobles Pharmacy, high cost / value HS10 Prescriptions that are initiated in hospital, but dispensed by community pharmacy for savings through reduced drug costs. Use of HS10s is also open to abuse and should be reviewed to ensure the right controls are in place to ensure best and appropriate use.
- The most common item prescribed by hospital consultants and dispensed in the community is Diazepam; this a high spend item in IoM but not so in England, which may indicate abuse of the drug and should be investigated further.

## 5.2 Secondary Care Medicines CIP Savings 2021/22

| Opportunity | CIP Description | CIP Saving |
|---|---|---|
| Biosimilars | • Further 33% switch from Humira to Amgevita to achieve 80% biosimilar uptake<br>• 40% switch from remaining Remicade to Remsima<br>• 100% switch from Mabthera IV to Truxima | £53,204 |
| Sugammadex | 50% reduction in usage | £6,441 |
| Capsaicin patches | 50% reduction in usage | £28,980 |
| DOACs | Switching patients from Apixaban to Edoxaban generating a £236.60 saving per patient per year. Edoxaban has been identified as a potential first-choice treatment if clinically appropriate. | £102,631 |
| Nobles Pharmacy Stockholding | A stock management improvement team to explore reducing stockholding and improvements to supply chain management. | £300,000 |
| BluTeQ High-cost Drug Management System | High-Cost Drug system to monitor expensive treatments ensuring they are prescribed in line with local policy and NICE guidelines. Costs: £6,000 one off for implementation and training, plus £10,000 annual. | £100,000 |
| **Gross Savings** | | **£591,256** |
| **Investment** | 1. Pharmacist expertise SME (£60,000)<br>2. Project Management (£40,000) | **£100,000** |
| **Net Savings** | | **£491,256** |

## 5.3 Assumptions

- **Biosimilars** – savings based on data on the top 250 lines, further opportunities may present through further analysis of all medication lines.
- **Sugammadex** – assumes 50% of current spend can be reduced without impacting patient care through improved controls
- **Capsaicin patches** - assumes 50% of current spend can be reduced without impacting patient care through improved controls. Capsaicin patches are £200 per patch - £1000 per patient treatment. The £60K annual spend has increased 14% in last 2 years. Some UK regions have not approved it and others only with restrictions within a pain service. A more monitored and restricted policy on use could deliver savings.

Lidocaine patches restrictions might have led to increased usage and therefore a need for a holistic examination of pain services as part of this work.

- **DOAC**s – Assumes switching a proportion of patients on existing DOAC to Apixaban DOAC at a cost saving per year per patient switched of £236.60 (due to a 29% primary care rebate in place). Assumes 40% of patients will be clinically suitable to switch. Further opportunities for switching Warfarin patients to DOACs will also deliver long-term value (through stroke prevention) and should be explored alongside this project.
- **Nobles Pharmacy Stockholding** – Current position is a stockholding of £1.8M which is 60 days on average. The UK average is 30 days. Reducing this by 10 days will deliver a £300,000 one off cash saving.
- **Blueteq -** savings assume 2% can be saved on high-cost drug spend, in line with savings achieved by other health systems in England.

## 5.4 Further Opportunities to be scoped further

Repatriated Hospital HS10 prescriptions Hospital prescriptions that are dispensed in community pharmacy. These drugs are likely to be more expensive when dispensed in primary care. There are opportunities for bringing some prescriptions back to Nobles where drug costs are lower.

Savings potential is to be confirmed.

## 5.5 Priority Next Steps – first 30 days

- Commission EMIS Health (Ascribe ) to create bespoke reports, if needed.
- Establish a cross-system medically led multi-disciplinary integrated Medicines Optimisation Group
- Design and create the governance with clinician input to oversee and assess cross-specialty high-cost drugs usage, restriction, and switches.
- Identify the required resource, Workstream Lead and SRO
- Sign off the 2021/22 workplan and savings.
- Create a dashboard to monitor progress with the 2021/22 workplan.
- Agree the teams, meetings and involvement needed to progress the various projects.
- Identify investment needed and inform the CIP Programme Board, develop the necessary business cases.
- Produce or commission the required management information and BI resources needed to inform work

## 5.6 Secondary Care Medicines Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Stockholding Reduction** | | | | | | | | | | |
| Agree a realistic and achievable stockholding reduction | | | | | | | | | | |
| Explore implementing a pharmacy robot in order to improve stock management and dispensing efficiency | | | | | | | | | | |
| Line by line stock line review to establish high risk drugs and associated stockholding | | | | | | | | | | |
| Amend the reordering parameters needed to deliver savings | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| **Biosimilars and High-Cost Drugs** | | | | | | | | | | |
| Establish a cross-system medically led multi-disciplinary integrated Medicines Optimisation Group (IMOG) and agree membership and TORs | | | | | | | | | | |
| Establish a clinician review of all biologic drugs across the key specialities and assess suitability for biosimilar use. | | | | | | | | | | |
| IMOG to review High-Cost Drugs and Biosimilar savings plan and agree clinical criteria for switching and policies requiring development | | | | | | | | | | |
| IMOG to review High-Cost Drugs list for further savings opportunities | | | | | | | | | | |
| Review patients and identify those suitable for switching | | | | | | | | | | |
| Develop and agree a policy for anaesthetic drug Sugammadex to restrict use and put the necessary controls in place, to deliver savings | | | | | | | | | | |
| Develop and agree a policy for Capsaicin patches to restrict use and put the necessary controls in place, to deliver savings | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Anti-Coagulant Switches** | | | | | | | | | | |
| Develop and agree the business case for DOAC switches and identify resource for patient reviews | | | | | | | | | | |
| Develop and agree a policy for DOAC switches, to deliver savings | | | | | | | | | | |
| Review patients for clinical suitability for Edoxaban | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| **High-Cost Drug Approval System (Blueteq)** | | | | | | | | | | |
| Explore use of Blueteq for restricting high cost drugs and develop a business case | | | | | | | | | | |
| Commission and deploy Blueteq | | | | | | | | | | |
| Confirm with Treasury whether NICE TA drugs will be funded on IoM | | | | | | | | | | |
| Develop the required policy to support prior approvals (using Blueteq) for high-cost drugs and communicate to clinicians | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| **HS10s Prescription Repatriation** | | | | | | | | | | |
| Review HS10 prescriptions dispensed in community for repatriation into Nobles Pharmacy | | | | | | | | | | |
| Explore whether additional controls are needed to govern HS10 prescribing at Nobles hospital | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| **Pharmacy Re-admission Prevention** | | | | | | | | | | |
| Develop a proposal and explore funding streams for a reablement service | | | | | | | | | | |
| Design the service and agree the criteria for assessment of high-risk patients | | | | | | | | | | |
| Implement PharmOutcomes as a conduit for primary - secondary care information transfer | | | | | | | | | | |
| Launch the service. | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |

# 6. CIP 2: Primary Care Medicines

## 6.1 Key Findings and recommendations

- A lot of focus and effort has been put into reducing spend on high-cost items, switching patients to lower cost alternatives, however this can be a challenge to maintain. Data analysis has shown that a number of drugs previously stopped by the primary care medicines optimisation team are still being initiated, and, in some patients prescribing has resumed and is increasing for previously 'dropped' drugs. These drugs present further savings opportunities. Previously stopped drugs should be monitored by prescriber so that any necessary reminders to prescribers can be made and steps taken, where appropriate, for effective enforcement of policies. A collaborative work plan with GP engagement will support effective policy development, communications, and policy adherence.
- The Isle of Man spends £912,000 on medication which are deemed to be of low clinical value or items to support self-care which can be purchased readily through high street outlets, such as supermarkets as well as community pharmacies. A policy to not routinely prescribe these items should be explored in line with similar work across England health systems with consideration given to avoiding detrimental impact to high-risk patients. This would require a policy change from DHSC, close engagement with GPs and effective support for patients to self-care.
- Prescribing volumes are rising year on year mirroring the experience across many areas of England. Some of this increase will be driven by general practice repeat prescribing systems and wastage. Implementing greater control over the repeat prescribing process should be explored for viability on Island and for its potential to reduce annual primary care spend.
- There are currently no shared care arrangements in place between Nobles Consultants and GPs which may impact the quality of care for some patient cohorts. Cross-system policies should be explored across various high-risk areas with the necessary budgetary alignment.
- Recent significant increases in spend on stoma appliances should be explored for opportunities to reduce spend through a combination of improved long-term patient follow-up to identify unresolved clinical issues, potential inappropriate prescribing and the implementation of policies to restrict certain accessories with limited clinical value such as deodorants and underwear.

## 6.2 Primary Care Medicines CIP Savings 2021/22

| CIP Opportunity | CIP Description | CIP Saving |
|---|---|---|
| Vitamin B Compound Strong | Primary care pharmacy team to manage stopping the majority of these items being prescribed by GPs | £155,000 |
| Oral Vit B 12 | | |
| Bath and shower emollients | | |
| Eye preparations | | |
| Low clinical value prescribing | £912,000 was spent in 2019/20 on medication with low clinical value or items for self-care. Savings through reducing these items that can be provided on a prescription. | £250,000 |
| Stoma Appliances | Stoma appliances and accessory spend is increasing YoY. Opportunities to deliver long term follow up for patients to ensure prescriptions are appropriate and items meeting patient's clinical needs. | £57,000 |
| Stop 3rd party Ordering | Several England CCGs have delivered significant savings through controls places on regular repeats. | £94,000 |
| **Gross Savings** | | **£556,000** |
| **Investment** | • SME (£20,000)<br>• Project Management (LCVP, Stoma and 3rd Party Ordering) (£40,000) | **£60,000** |
| **Net Savings** | | **£496,000** |

## 6.3 Assumptions

- **Vitamin B Compound Strong** – A proportion of savings, based on existing Medicine's Optimisation Team's workplan
- **Oral Vit B 12** – A proportion of savings, based on existing Medicine's optimisation Team's workplan
- **Bath and shower emollients** – A proportion of savings, based on existing Medicine's Optimisation Team's workplan
- **Eye preparations** – A proportion of savings, based on existing Medicine's Optimisation Team's workplan
- **Low clinical value prescribing** – A proportion of savings allocated to 2021/22. The savings are predicated on DHSC finalising a policy to support prescribing

cessation. Total annual spend is £910,000. The £250,000 savings target, reduced from £340,000) considers timescales to delivery and the challenges with removing prescribing for some high risk patients or patients with long term conditions.

- **Stoma Appliances** – Total annual spend for 2020/21 was £570,000, which was a 7% increase in spend was observed from the previous 12 months. Savings adjusted to equate to 10% reduction in spend.
- **Stop 3rd party Ordering** - Annual primary care spend in 2020/2021 (ePACT2), was £15,680,738. CCGs who have implemented restrictions on 3rd party repeat prescription ordering, have made significant savings (e.g. Coventry & Rugby identified 8% waste). A 3% saving would deliver £470,000. Due to delivery timescales, assumed 20% of total savings in 2021/22.

## 6.4 Further Opportunities to be scoped further

**Readmission prevention** through medicines reablement. Following patient identified high risk (+ 75 years), community pharmacist domiciliary visit within 7 days of discharge.

**Establish an IoM formulary:** Explore the potential to implement a locally revised Pan Mersey formulary and implement a range of mechanisms to improve the adherence to formulary.

**Primary Care prescribing incentive schemes** with GPs Accelerate the DHSC business case currently being developed for money to pump prime incentive scheme.

**Primary Care Rebate schemes** should be explored for saving opportunities for example:

- Cyanocobalamin (Orobalin) as part of a vitamin B12 policy
- Enoxaparin (Inhixa)
- Pramipexole and Pipexus
- Melatonin (Slenyto) considering the expansion of 'licensed' melatonin.

**Shared care prescribing protocols** between GPs and hospital teams. Needs to be explored as a medically led project together with pharmacy support.

## 6.5 Priority Next Steps – The first 30 days.

- Identify Resources, Workstream Lead and SRO.
- Formulate the 2021/22 workplan for the primary care workstream.
- Sign off the 2021/22 workplan and savings.
- Create a dashboard to monitor progress with the 2021/22 workplan.
- Agree the teams, responsibilities, meetings, and involvement needed to progress the various projects, with clinical input.
- Establish a system wide Integrated Medicines Optimisation Group.
- Establish a joint working group with DHSC on development of a policy on LCV medicines.
- Identify investment needed to deliver programme.
- Implement required tracking of current and historical drug switches progress and associated savings.
- Agree the enforcement approach and responsibilities for prescribers who consistently prescribe against agreed policies.
- Establish a cross system group to look at Stoma care and prescribing.
- Create a team with representation from GPs, Primary Care Medicines optimisation and Finance to review arrangements for prescribing incentive scheme and model financial impact and risks.

## 6.6 Primary Care Medicines Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Primary Care Best value prescribing** | | | | | | | | | | |
| Develop the required policies to support drug switches and do not prescribe items and communicate to GPs | | | | | | | | | | |
| Establish the ongoing tracking of 'dropped' / no longer prescribed medicines | | | | | | | | | | |
| Agree the enforcement approach and responsibilities for prescribers who consistently prescribe against agreed policies | | | | | | | | | | |
| Establish an IoM formulary | | | | | | | | | | |
| Communicate the formulary to GPs | | | | | | | | | | |
| Work with ScriptSwitch to remind GPs to prescribe within policies | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **Low clinical value prescribing** | | | | | | | | | | |
| Establish a joint working group with DHSC on development of a policy on LCV medicines | | | | | | | | | | |
| Produce the communications material, needed to support and educate both GPs and patients | | | | | | | | | | |
| Robust workplan to support GP engagement | | | | | | | | | | |
| Agree high-risk patient categories for which prescribing should continue | | | | | | | | | | |
| Review and agree the red flag conditions where a prescription may be required, and the patient not directed to self-care | | | | | | | | | | |
| Careful communications and engagement to patients and GPs. Ensure joined up working with DHSC. | | | | | | | | | | |
| Careful consideration of the barriers and political support required in the face of potential negative public feeling. Ensure joined up working with DHSC to support the change. | | | | | | | | | | |
| Create the monitoring tool to enable adherence to policy to be tracked and agreed how it will be enforced. | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Stoma Appliances** | | | | | | | | | | |
| Establish a cross system group to look at Stoma care and prescribing | | | | | | | | | | |
| Undertake an audit of patient's stoma prescriptions to understand whether there is any over prescribing and ensure quantities are in line with national guidance | | | | | | | | | | |
| Consider opportunities for collaborative working with industry | | | | | | | | | | |
| Develop and agree a policy for stopping prescribing of accessories which do not add clinical value (in line with England guidance) e.g., deodorants, lubricants and underwear. | | | | | | | | | | |
| Consider options for redesign of care to provide more effective long term follow up for patients | | | | | | | | | | |
| Where investment is needed, develop a business case as part of the CIP gateway process. | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **Stop 3rd Party Ordering** | | | | | | | | | | |
| Examine current approach to 3rd party ordering for repeat medication | | | | | | | | | | |
| Explore opportunities to develop policies to restrict ordering or new service approaches, such as a telephone repeat ordering service that will reduce waste in unnecessary ordering of repeat medication | | | | | | | | | | |
| Where investment is needed, develop a business case as part of the CIP gateway process. | | | | | | | | | | |
| Implement the new service approach | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **Shared care prescribing protocols - GPs and hospital.** | | | | | | | | | | |
| Create a team to review shared care arrangements with relevant pharmacy, GP and hospital clinical leads | | | | | | | | | | |
| Identify one or two areas and the clearly defined patient cohorts where shared care arrangements can be explored through the Integrated Medicines Optimisation Group.. | | | | | | | | | | |
| Develop the necessary cross system policies | | | | | | | | | | |
| GP engagement: communicate policies widely to prescribers in Nobles and community (incl. GPs) | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Consider the budgetary alignment needed to support shared care and action any required changes in close liaison with finance. | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| Primary Care prescribing incentive schemes with GPs | | | | | | | | | | |
| Create a team with representation from GPs, Primary Care Medicines optimisation and Finance to review arrangements for prescribing incentive scheme and model financial impact and risks | | | | | | | | | | |
| Develop a policy to govern the prescribing incentive scheme | | | | | | | | | | |
| Communicate policy with GPs | | | | | | | | | | |
| Identify any risks and barriers | | | | | | | | | | |
| Identify the data requirements in order to monitor and track adherence to policy and trigger incentivisation payments | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |
| Primary care rebate schemes | | | | | | | | | | |
| Track other primary care rebate schemes for suitability for savings | | | | | | | | | | |
| Review current list of drugs with PCRs at the D&T and agree the drugs where it makes sense that prescribing should be switched to make best use of the savings. | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |

# 7. CIP 3: Procurement and Contracting

## 7.1 Key Findings and Recommendations

- A significant number of opportunities have been identified within procurement. Opportunities presented are a mix of cash out in year quick wins and more transformational development which will lead to significant further longer-term savings for which the groundwork will need to laid this year as part of a wider move toward drive for efficiency and good use of resources.
- In addition to savings opportunities for what Manx Care purchases and how it manages its supply chain, there are also opportunities to reduce usage, wastage, and specification at the point of care and thus a need to communicate to and educate front line staff on improved stewardship of resources.
- There is a fragmented supplier base which is not effectively leveraging best value contracts and supply routes. Perceived 'Island Factors' have increased purchasing costs and led to overordering and a perceived political pressure to use IoM suppliers, which might not be the most cost-effective supply route.
- Decentralised purchasing (at departmental level) and multiple stockholdings is increasing procurement effort, stockholding and spend.
- Manual ordering processes is increasing effort, limiting data availability needed to make best value procurement decisions and may lead to duplication and errors.
- The procurement function should be centralised into a team with the right skills and ordering removed from departmental level, where possible. A single point of ordering will achieve greater stock control, improved stock and supply chain management, and greater standardisation.
- Investing in an electronic purchase to pay ecommerce system across all areas will improve efficiency, improve data availability, prompt payment of suppliers and reduce errors.
- Introducing a materials management system to high turnover areas (e.g. intensive care, operating theatres) with appropriate stock and accrual levels will reduce stockholding.
- Introduce an annual procurement workplan to record projects and savings opportunities with annual cost reduction targets.
- Invest in a price benchmarking tool to understand cost-effectiveness of procurement and opportunities for added value.
- Introduce Multi-Quote free of charge service to achieve compliant routes to market by obtaining competitive quotes.

- Standardisation of equipment will provide for economics of scale, compatibility, reduced training requirements.
- Review On Island purchasing to better understand potential savings. Many Isle of Man providers, are simply a middle man to off Island providers and don't add any value. Opportunities should be explored across food, consumables, cleaning products, equipment maintenance, admin and medical staffing agencies, to ensure best value is being achieved. Introduce Contracts and local purchasing agreements where there is no formal agreement in place.
- Establishment of a Contracts Database for contracted goods and services and a separate Contracts Database for the Maintenance of Equipment.
- Redesigning tertiary care models presents the best opportunity for cash releasing savings, for example, moving pre-op assessments and follow ups back to Island. Repatriation of off island activity will deliver reduced air fares, escort costs as well as reduce spend with tertiary providers. Virtual outpatient development will save money when applied to tertiary care as this will avoid transfers. Consideration should be given to the location for the virtual care and whether best in patients' own home or within Nobles, in consideration that there are times when having a medic present with the patient is required and beneficial.
- Tertiary Care contracts should therefore be reviewed for opportunities for savings and cost avoidance through repatriation of activity and changes to established default practice where patients are transferred to England hospitals, implementing redesigned, shared, or virtual care models. An analysis of all Off Island activity, SLAM data and tertiary contracts should be reviewed to better understand what is being contracted for and used and therefore the scale of the opportunity this presents.
- A renegotiation of transport contracts should be undertaken in conjunction of this work to align contracted transport activity with projected off island care models. The opportunity for having tertiary provider clinicians coming to the island to see many patients, rather than patients travelling to England may be more cost-effective and should be avoided.

## 7.2 Procurement CIP Savings 2021/22

| Opportunity | CIP Description | CIP Saving |
|---|---|---|
| NHS Supply Chain and supplier and product alignment on Non-Pay Spend | Significant opportunity for increasing the amount of spend that is pushed through NHS Supply Chain and building an improved and proactive and productive working relationship with the NHS SC business manager. | £600,000 |
| Improved Contracting Arrangements | Review of existing contracts for savings opportunities, through a mix of approaches, outlined below. Contract non-contracted spend. | £250,000 |
| Pilot stockholding reduction and centralised purchasing. | Savings opportunities through addressing current inefficiencies in stores management and fragmented ordering processes. | £25,000 |
| Tertiary Care Transport Contract Review | Re-procurement exercise for off Island transportation, delivering cash releasing savings on current budget | £518,000 |
| **Gross Savings** | | **£1,393,000** |
| **Investment** | • SME Procurement and contracting expertise (£50,000)<br>• Project management (£40,000) | **£90,000** |
| **Net Savings** | | **£1,303,000** |

## 7.3 Assumptions

**Pilot stockholding reduction and centralised** purchasing Assumed a pilot in one area before roll-out hospital-wide. Explore a hospital-wide stock amnesty to reduce waste and share short shelf-life products.

**Tertiary Care Contract Renegotiation** Savings of £268k (difference between current budget and current contractual agreement), plus a stretch target with further potential savings of £250k giving a total of £518,000. Care delivery contract reviews with tertiary providers may identify further opportunities.

**NHS SC and Contract Arrangements.** Many of the savings have already been identified by the MIAA review team.

## 7.4 Future Savings Opportunity

E-Commerce Purchase to Pay System: Explore opportunity for integrated procurement and purchase to pay system.

Treasury has plans for new single accounting system, but it has been reported that the proposed AX system not easy to use and error prone, therefore the deployment of a health-specific system that interfaces well with accounting system should be explored and a decision reached on the best route for Manx Care.

## 7.5 Priority Next Steps – The first 30 days.

- Identify Resources, Workstream Lead and SRO
- Formulate the 2021/22 workplan for the Procurement workstream
- Sign off the 2021/22 workplan and savings.
- Agree the teams, meetings and involvement needed to progress the various projects.
- Establish a Medical Devices Committee or Product Evaluation User Group, with clinical input
- Identify Clinical Procurement Representatives for advice on product switches and other procurement decisions that may impact patient care.
- Identify investment needed to deliver programme
- Create a dashboard to monitor progress with the 2021/22 workplan.
- Implement required tracking of progress with procurement, supplier and contract changes and associated savings.

## 7.6 Procurement CIP Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Create a Centralised Procurement Function** | | | | | | | | | | |
| Create a centralised procurement function and strategy (and investment) to govern the transition. | | | | | | | | | | |
| Explore options for centralising procurement, develop a strategy and proposed departmental structure, roles and functions | | | | | | | | | | |
| Produce a business case for the centralised procurement function and associated IT (e.g. purchase to pay system) required for this to operate effectively | | | | | | | | | | |
| Create Purchasing Procedures Manual/Guide for each stage of the procurement process | | | | | | | | | | |
| Implement the strategy and identified actions | | | | | | | | | | |
| **NHS Supply Chain – supplier and product alignment on Non-Pay Spend** | | | | | | | | | | |
| Identify a Manx Care – NHS SC liaison / relationship owner | | | | | | | | | | |
| Proactive management of the significant opportunity to increase the amount of spend pushed through NHS Supply Chain. Build an improved and proactive and productive working relationship with the NHS SC business manager. | | | | | | | | | | |
| Establish and schedule ongoing meetings with NHS SC | | | | | | | | | | |
| Ensure monthly meetings with NHS SC happen to review savings opportunities and progress supply chain consolidation | | | | | | | | | | |
| Create a process for NHS SC's multi-year Aggregation Scheme and align IoM purchasing with key dates | | | | | | | | | | |
| Switch suppliers where best value can be obtained via a different supply route. | | | | | | | | | | |
| Create IoM Government Select Lists covering 'standard' areas such as paper, stationery | | | | | | | | | | |
| Explore NHS SC levies and escalate to DHSC for resolution if necessary | | | | | | | | | | |
| Explore alternatives to NHS supply chain for pricing advantages | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Improved Contracting Arrangements** | | | | | | | | | | |
| Review of all existing contracts for savings opportunities, through a mix of approaches, as recommended. Contract non contracted direct supplier spend. Combine same supplier spend into annual/multi-year contracts. | | | | | | | | | | |
| Establish a Contracts Database for contracted goods and services and a separate Contracts Database for the maintenance of equipment. | | | | | | | | | | |
| Action the recommended savings opportunities as identified during the review. | | | | | | | | | | |
| Introduce interim local pricing agreements for Non-Contracted Spend | | | | | | | | | | |
| Create an Inflationary Avoidance Guidance to mitigate annual inflation increases | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **E-Commerce Purchase to Pay System** | | | | | | | | | | |
| Explore opportunity for integrated procurement and purchase to pay system. | | | | | | | | | | |
| Review Treasury's single accounting system, the AX system for suitability for Manx Care (reports of it being hard to use and error prone) and explore alternatives e.g., deployment of a health-specific system that interfaces well with accounting system. | | | | | | | | | | |
| Develop an options appraisal and business case for any investment required for a new system detailing required investment and benefits in efficiency and financial savings. | | | | | | | | | | |
| Implement the selected system (procure system, if required) | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **Tertiary Care Transportation Re-Procurement** | | | | | | | | | | |
| Review contracted activity with off island providers | | | | | | | | | | |
| Explore repatriation of activity and opportunities for reducing spend through shared care, or virtual care models | | | | | | | | | | |
| Use revised activity projections to inform transportation re-procurement. | | | | | | | | | | |
| Conduct transportation re-procurement | | | | | | | | | | |
| New contract in place with revised arrangements and spend. | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |

# 8. CIP 4: Workforce

## 8.1 Key Findings and Recommendations

- The Isle of Man has had long standing difficulties in recruitment, and high number of clinical posts remain vacant which are filled using locum and bank staff. Locums has been the default model over many years, however work to expand the use of bank staff has paid dividends.
- Many of the recruitment challenges stem from the Isle of Man's location, and this has worsened with the COVID-19 pandemic and associated border closures. Despite these constraints, there is a need to address the high spend and the associated high usage of locums used to plug substantive posts that remain vacant.
- Care is very consultant delivered, which provides for significant opportunities for more cost-effective skill mix used to deliver pathways of care and should be considered as an alternative to or to augment recruitment. All vacant posts should be reviewed to better understand whether they remain relevant and explore alternatives to recruitment such as training or skill mix redesign, ensuring each member of staff is operating at the top of their license.
- Prioritise remaining vacancies and undertake renewed recruitment focus, exploring R&R premia, international recruitment, use of specialist head-hunters and aligning Manx Care with Clinical Research Network Northwest Coast; bringing research opportunities and making posts more attractive.
- Create a central team to manage and approve locum and bank use to increase monitoring and control.
- Implement medical director or other senior leader approvals for bank and locum use.
- Implement a policy of 'Bank First', before booking locums to fill vacant shifts where possible.
- Finalise an SOP and communicate to staff.
- Establish a framework of preferred locum agencies with pre-agreed renegotiated pricing as a means of reducing the unit rate paid, number of agencies used, and volume of invoices paid.
- Implement agency-provided portals, or alternatives, to enable better control, collect valuable management information and facilitate a move to lowest contracted rates rather than high 'spot rates'.
- Reducing LOS and resulting reconfiguration of the acute bed base will drive down the need for clinical resources and this should factor in any service redesign business case.

## 8.2 Workforce CIP Savings 2021/22

| Opportunity | CIP Description | CIP Saving |
|---|---|---|
| Reduction in locum Spend | Vacancy review, recruitment opportunities, skill mix and training and better controls | £200,000 |
| Review of Agency Framework and On Call Unit Costs | Develop a framework agreement with preferred provider with negotiated reduced rates. Place controls in the application of the framework and ensure approvals mechanisms in place. | £150,000 |
| Maximising Use of Bank where possible | Maximise use of bank over use of locums where possible, though improved rostering, communication with staff and implementing a robust and centralised approvals process. | £100,000 |
| **Gross Savings** | | **£450,000** |
| **Investment** | SME (£20,000)<br>Project Management (£40,000) | **£60,000** |
| **Net Savings** | | **£390,000** |

## 8.3 Assumptions

- **Locum Spend** Assumed spend can be reduced from the current position through implementing the actions to control use of Locums, fill vacancies and explore skill mix opportunities.
- **Agency Framework** A reduction on the per unit agency spend which will reduce overall spend from current position of £8,371,926.
- **Maximising Bank Use** Assumed a proportion of locums spend will revert to bank at reduced rates.

## 8.4 Future savings opportunities

Establish a technology-driven gateway process for raising, approving, and making bank shifts available to staff. Explore whether use of health roster would be suitable for this purpose, or an alternative system is required. Consideration should be given into the return on investment for an e-rostering system to streamline the approvals process.

## 8.5 Priority Next Steps – the first 30 days.

- Identify Resources, Workstream Lead and SRO
- Formulate the 2021/22 workplan for the Workforce workstream
- Sign off the 2021/22 workplan and savings.
- Agree the teams, meetings and involvement needed to progress the various projects.
- Identify investment needed and inform the CIP Programme Board, develop the necessary business cases for approval .
- Commence vacancy post reviews

## 8.6 Workforce CIP Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Reduction in locum Spend** | | | | | | | | | | |
| Set a specific target in 21-22 to covert a number of locum posts to substantive posts and quantify the impact in £-saved to give focus and energy and enable success to be recognised. | | | | | | | | | | |
| Create a centralised team to oversee a recruitment drive for long standing and urgent vacancies. Revisit advertising, consider R&R premia for some posts, and explore international opportunities | | | | | | | | | | |
| Review all open vacancies to ascertain how long they have been vacant for, whether still required or whether alternatives to recruitment are possible, such as training, skill mix or care pathway redesign. | | | | | | | | | | |
| Review junior doc, grades, numbers, banding, training vs non training posts and how funded | | | | | | | | | | |
| Recruitment team to consider establishing links with C&M CLRN to be part of research projects to make posts more attractive. | | | | | | | | | | |
| Deliver recruitment drive with focus on prioritised posts. | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |
| **Review of Agency Framework and On Call Unit Costs** | | | | | | | | | | |
| Establish a team to oversee this work, with input from HR, Clinical, procurement, contracting and finance | | | | | | | | | | |
| Review all workforce contracts with agencies and the contracted rates and rates paid | | | | | | | | | | |
| Oversee a procurement exercise to create a framework with pre-agreed rates, and an agreed short list of preferred providers. | | | | | | | | | | |
| Identify opportunities for implementing agency provided portals (or alternatives) for process management and in order for valuable usage and control data, and to facilitate a move to contracted rates rather than high 'spot rates' | | | | | | | | | | |
| **Savings accrue** | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | | |
| Centralisation, Monitoring and Controls for Bank and Locum Use | | | | | | | | | | |
| Centralise the bank and approvals process by identifying the resource, process and structure required. | | | | | | | | | | |
| Review existing process for locum and bank approvals and how this differs across each division / departments | | | | | | | | | | |
| Appoint a medical staffing lead to develop better monitoring and control of junior doctor rotas and locum and bank use. | | | | | | | | | | |
| Implement a Bank first policy | | | | | | | | | | |
| Review Health Roster and compare with alternative technology | | | | | | | | | | |
| Agree the optimal approvals system | | | | | | | | | | |
| Develop a revised Locum and Bank SOP and associated approvals process and communicate to staff | | | | | | | | | | |
| Savings accrue | | | | | | | | | | |

# 9. Value-Based Workstream 1:` Elective Care

## 9.1 Key Findings and Recommendations

- Hospital-based services on the Isle of Man have a higher proportion of planned care than in other healthcare systems
- High referral rates and high demand have been reported for many specialities - up to 3 years for some specialties.
- The high volume of hospital-based care exacerbates long waiting times and breaches of specific quality targets.
- High DNA rates in many specialties, significantly above England averages.
- Historically , there has been high rates of delayed discharges, (2019 Ind Review)

There are various approaches that present opportunities for increasing efficiencies, throughput, reduce waiting times and improve the quality of care provided. However, these are unlikely to deliver cash out CIP due to the IoM funding model. Nevertheless, a focus on improving these areas will establish a robust platform for long term sustainability and better long-term value for money.

Furthermore, addressing the backlog, may avoid spend in other areas such as a patients' worsening condition while waiting may increase their overall cost of care. Reducing demand, avoiding hospital admissions etc, may reduce procurement effort and consumable spend and reduce the spend on locums.

A whole system approach should be taken to evaluating opportunities to understand the real value they may deliver downstream and any benefit or unintended negative impact on other services.

## 9.2 Redesign Opportunities

- **Reducing Waiting Times:** There are long waiting lists in some areas, and it is recommended that waiting lists be reviewed to understand whether all patients waiting still require the procedure or can be optimised waiting, introducing lifestyle change or alternative care models. The approach taken with the MSK First Contact Practitioners should be explored in other areas of high demand.
- **DNA Rates:** Opportunities for reducing areas of high DNA rates should be explored such as reviewing the amount, timing and content of patient communications. Use of SMS systems or enabling better patient choice when booking could be explored.
- **New to Follow up ratios**: Data highlighted high ratios in Diabetes and Rheumatology, both specialties have a high reliance on GPs and therefore more integrated and collaborative working between hospital consultants and GPs may deliver improvements.

- **Advice and Guidance** Systems which connect GPs with a relevant consultant prior to referral should be explored as a means of ensuring referrals are appropriate, alternatives to a hospital referral are explored and unnecessary delays avoided. Implementing advice and guidance with Tertiary care providers may be an opportunity to reduce demand and avoid unnecessary patient transfers off island.
- **Virtual Care Systems:** Redesigning the traditional outpatient model so that for certain medical specialties their outpatient appointment is carried out virtually, without the need for patients to attend an outpatient appointment in person. Evidence from England has shown that that 50-70% of outpatient appointments could be conducted virtually. This would require significant cultural change amongst clinicians and patients, underpinned by robust technical solutions. However, this has been achieved successfully in many health systems, accelerated in the past year following COVID-19 constraints.
- **Procedures IP to Day case:** There is appetite to move more inpatient procedures to day case and outpatient procedures, particularly in Orthopaedics, basing clinical decisions on the British Association of Day case Guidelines. Doing so at Manx Care will increase throughput and reduce waiting times for some specialties. However, challenges in space, capacity and equipment will need to be explored in order to facilitate this. The use of Ramsey hospital for high volume high throughput procedures and ambulatory procedures could be explored, however this would require up front funding and sufficient equipment procured. A business case should be developed to explore the costs and benefits further.
- **Procedures of Limited Clinical Value (POLCV):** DHSC is examining POLCV from political and policy development point of view. In order to move to restrict procedures of limited clinical value, an agreed framework and set of policies should be developed in conjunction with DHSC. Following the policy, work must commence on the mechanisms for ceasing the work, robust communications and engagement with GPs to stop associated referral activity. A prior approvals process should be implemented to govern policy enforcement, using systems to manage the authorisation process for example Bluteq could be explored. It is recognised that the lack of procedure level data will hamper understanding on the business case opportunity. However, steps could be taken now to start to collect relevant data, such as the using new coding team to create an alert system going forward.

## 9.3 Value-based Opportunity Summary

| Opportunity | Description | Benefits | Costed Value est. |
|---|---|---|---|
| Outpatient Efficiency Improvement | Create capacity and improved efficiency through work to Reduce DNAs and improve 1st to Follow Up rates | • Enhanced Patient Experience<br>• Reduction in DNAs which improves clinic utilisation<br>• Utilises clinician time more effectively<br>• Better cost effectiveness of care | £124,000 |
| Advice and Guidance | Utilising consultants to provide pre-referral guidance to referring GPs. An advice service which allows a referrer to request advice from a provider (e.g. a consultant) before or instead of making a referral. Explore model initially with tertiary providers to avoid off Island transfers. Future Island -wide roll out.<br>Technology deployment to support the advice process e.g., Consultant Connect. | • Preventing unnecessary referral<br>• Improved quality of care and patient management<br>• Improved demand management<br>• Improved outpatient utilisation | £124,000 |
| Virtual Care systems | Redesign the traditional outpatient model so that a percentage of current outpatient attendances are held virtually without a physical in person outpatient appointment. | • Reduced time to diagnosis<br>• Reduced time from referral to first definitive treatment<br>• More efficient use of clinical time<br>• Reduced patient travel<br>• Reduced total healthcare expenditure<br>• Reduced outpatient costs per unit of demand (i.e. referrals)<br>• Reduced Consultant locum expenditure | £310,000 |

| Opportunity | Description | Benefits | Costed Value (est.) |
|---|---|---|---|
| Procedure Reviews (IP to DC and POLCV) | **IP – DC:** The British Association of Day Surgery published guidelines detail the proportions of activity for surgical procedures that should be undertaken as OPP rather than as DC. Review rates of day cases in line with BADS recommendations and investigate potential for expanded basket of procedures suitable for DC and or Op Procs from current position.<br>**PLCV:** Review procedures with limited clinical value, develop policies and restrictions to reduce activity and demand. Review procedures based on NHS E guidance and POLCV toolkit. Agree procedures to avoid / reduce and develop a POLCV policy and monitoring mechanism. | • Preventing unnecessary spend on procedures for which there is limited evidence of efficacy.<br>• Improved patient experience and care quality.<br>• Improved access and utilisation of outpatient department and theatres<br>• Preventing unnecessary admissions and associated spend<br>• Increased throughput to ease long waits for surgery.<br>• Reduced overall cost of care.<br>• Waiting list reduction as throughput is increased | **IP – DC:** £150,000<br>**POLCV** £150,000 |
| **Gross Value** | | | **£858,000** |
| **Investment** | SME (£20,000)<br>Project Management (£40,000)<br>Technology (pilot) (£85,000) | | **£145,000** |
| **Net Value** | | | **£713,000** |

## 9.4 Assumptions

**Outpatient Efficiency Improvements**

- £124 per outpatient appointment saved.
- 1000 DNAs prevented or outpatient appointments avoided would deliver £124,000

**Advice and Guidance**

- England evidence - only 30% of patients needed a referral following A&G
- Savings based on the number of saved first attendances multiplied by the specialty FA cost per First Outpatient appointment (assume £124)
- 1000 outpatient appointments avoided would deliver £124,000 – more if an off island tertiary appointment is avoided.

**Virtual Care**

- Assume 10% of new and 25% of FUs can be delivered digitally / virtually.
- 5000 appointments delivered virtually in Y1
- Technology and hardware costs of £40,000
- Virtual appointments cost c.£62 vs. c.£124 per appointment.

**Impatient procedures & POLCV**

- Average day case cost is £698 against average elective inpatient case £3,375 (likely an overestimation) The Kings Fund
- Assume £1000 saving per switch from IP to DC.
- Assume 45 procedures avoided through PLCV policies in Y1
- 150 switches in Y1 would deliver £150,000 saving

## 9.5 Elective Care Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Advice and Guidance** | | | | | | | | | | |
| Identify a clinical champion to support engagement and help shape design, steer implementation and support ongoing delivery. | | | | | | | | | | |
| Work with clinicians and key stakeholders to identify clinical areas of opportunity. | | | | | | | | | | |
| Understand the resource implications for the service, ensuring that adequate time is allocated in clinicians' job plans. | | | | | | | | | | |
| Assess IT solutions and procure | | | | | | | | | | |
| IT infrastructure is in place to deliver A&G. | | | | | | | | | | |
| Establish a clear process to enable clinicians to review and respond to A&G requests within agreed turnaround times. | | | | | | | | | | |
| Establish monitoring and governance. Agree escalation routes for delays in responses. | | | | | | | | | | |
| Identify the specialists and administrative support needed to deliver and coordinate the service. | | | | | | | | | | |
| Benefits accrue | | | | | | | | | | |
| **Virtual Care** | | | | | | | | | | |
| Establish a Manx Care project team, with clinician input | | | | | | | | | | |
| Develop and agree the project plan and PID | | | | | | | | | | |
| Metrics for Measuring Success | | | | | | | | | | |
| Review tertiary care contracts for opportunities to move certain activity to virtual | | | | | | | | | | |
| Agree and engage with a tertiary provider (contract lead) on this opportunity and willingness to engage on a joint project | | | | | | | | | | |

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Review the evidence base and hospital data to identify opportunities for virtual appointments, to inform assumptions about the scale of opportunity for virtual appointments, and in which specialties | | | | | | | | | | |
| Understand the current process of care delivery and explore options for redesign incorporating virtual appointments as well as advice and guidance. | | | | | | | | | | |
| Agree the appointment types that would be suitable for non face-to-face delivery | | | | | | | | | | |
| Estimate of the number of OP appointments for people that could be amenable to virtual provision | | | | | | | | | | |
| Identify technology, develop business case and roll out plan. | | | | | | | | | | |
| Develop Specification | | | | | | | | | | |
| Procure system | | | | | | | | | | |
| Implement alternative appointments | | | | | | | | | | |
| Benefits accrue | | | | | | | | | | |
| **Procedures Review** | | | | | | | | | | |
| Senior Stakeholder engagement and establish project to discuss and agree outline approach | | | | | | | | | | |
| Agree financial and other benefits and delivery plan | | | | | | | | | | |
| Set up joint working group to focus on developing alternative approaches for specific procedures identified | | | | | | | | | | |
| Initiate agreed action plan from working group | | | | | | | | | | |
| Scope and agree technology, equipment, infrastructure, estates etc required. | | | | | | | | | | |
| Establish first wave of procedures that can be switched to OPP rapidly, and undertake this conversion | | | | | | | | | | |
| Agree second wave of procedures that require more complex work to relocate | | | | | | | | | | |
| Initiate second wave of procedure relocation | | | | | | | | | | |
| Track benefits | | | | | | | | | | |

| Benefits accrue | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **PLCV** | | | | | | | | | | |
| Establish a joint Manx Care & DHSC project team, with clinician input | | | | | | | | | | |
| Develop and agree the project plan and PID | | | | | | | | | | |
| Agree KPIs and success criteria | | | | | | | | | | |
| Agree a long list of procedures under review by the project team - use NHSE list as a starting place. | | | | | | | | | | |
| Agree the data collection approach and structures required to track referrals for restricted procedures. Work with BI to develop a monthly report on PLCV procedures to track increases / decreases in numbers. | | | | | | | | | | |
| Review referral rates for each procedure by GP surgery / referrer - implement a data collection approach where the data isn't readily available. Where possible review numbers of patients on waiting lists for procedures under review | | | | | | | | | | |
| Analyse and agree a set of priority 'high impact' procedures for focus for Phase 1. | | | | | | | | | | |
| Develop a policy for each restricted procedure. | | | | | | | | | | |
| Review the benefit of bringing in Blueteq for the prior approval of certain procedures before a referral takes place. | | | | | | | | | | |
| Develop referral templates around the agreed restricted procedures and understand current processes and agree areas for further development. | | | | | | | | | | |
| Soft launch of project with GPs. | | | | | | | | | | |
| Develop / update referral templates, processes and available information for referrers to support GPs and patients for each priority procedure to enable effective restriction. | | | | | | | | | | |
| Develop patient information around priority restricted procedures. | | | | | | | | | | |
| Launch comms plan of updated information etc. with GPs, MSK physios and other relevant HCPs. | | | | | | | | | | |
| Identify alternative support for some patients denied procedures. | | | | | | | | | | |
| Consider how to best manage patients on a waiting list for a restricted procedure. | | | | | | | | | | |
| Benefits accrue | | | | | | | | | | |

# 10. Value-based Workstream : Non-Elective Care

## 10.1 Key Findings and Recommendations

A review of Urgent Care in 2016, determined the current service model was unsustainable. There are opportunities to better manage demand for emergency and ambulatory non-elective care services. Reducing non elective demand, while not delivering in year cash releasing savings, will nevertheless over time reduce staff, possibly result in closing beds.

Even temporary or seasonal closures would deliver an impact on locum staff, reduce agency spend, reduced rehab requirements, releasing community physios for other MSK conditions and avoid costs from waiting list initiatives. Therefore, any business case for reducing demand for non-elective care should consider wider / downstream benefits and impact on other services. Investment in the front end of the system will release capacity at the back end and whole life' costs and the long-term system value should be considered when developing a business case.

## 10.2 Redesign Opportunities

**Falls Prevention and Frailty Services**

- IoM's +65 population high & increasing with over 65s representing almost 22% of the population (2016). This compares to the England average of 18%. A 2018 review of medical care reviewed medical admissions in patients +70 years and found that a quarter of patients had fallen at home.
- Falls are the number one reason for ambulance conveyance to hospital in IoM. Community service provision should be explored to enable those at risk of falls to be identified and services aligned to prevent falls. The arrival of two new geriatricians to Manx Care in August presents a timely opportunity to revisit care and explore redesign opportunities to reduce falls and ambulance transfers through improved frailty identification and prevention through more community support. Example opportunities include AMP frailty in-reach and outreach, identifying and signalling patients at high risk of falls, strength and balance training to address age-related loss of bone density and muscle strength.
- Long term outcomes for elderly patients and long-term cost of care associated with a fall are important considerations, as environment is critical for outcomes. A hospital admission can have long term impact, increasing dementia and resulting in long term care needs and significant increased system costs. These issues should factor into any business case and decision making.

**Ambulatory Care – Zero Length of Stay**

- Overall, Ambulatory Care provision is good and there have been good examples of work done on Island such as cellulitis, DVT and chest pain. However, there are opportunities for early specialist input and redesigning ambulatory care to make improvements. Data shows approximately 200 avoidable admissions and consideration should be given to particular patient cohorts that could be managed differently to prevent admission.
- There is a requirement for a minimum of three ambulances to maintain a safe and effective service across the Island. Therefore, work to reduce transfer rates may not achieve any cost out savings.
- However, reducing transfers will improve patient's quality of care and impact the whole pathway costs associated with the transfer and any admissions that results, such as long LOS, consumable costs and locum spend, and these should factor into any business case.
- It is recognized that redesign opportunities must ensure safe and effective care, when avoiding a hospital admission and ensure an effective balance is struck.
- There is the potential for improved process for CDU for dealing with patients needing observation, taking these patients out of the general medicine referral process. There is also the potential to expand Ambulatory clinic in AMU. Where investigations are required e.g. radiology, there is the opportunity to send patient's home with an appointment to return for investigation, rather that admit patient for investigation.
- Consideration should be given to development of an Ambulatory surgical hot clinic e.g. for patients with abdominal pain, sending patients needing surgery and imaging home to return for treatment in few days. This would move patients to semi-elective list which would reduce demand on surgery and CEPOD lists.
- The opportunity for using NHS England's 111 service, or similar, to deflect A&E attendances and better signpost patients and this should be explored.
- To inform this work, more granular data on the reason for admission, or AMU discharges analysis is required to inform decisions on what alterative care arrangements are needed. A survey / case note review may provide give sufficient information upon which to base decisions.
- It is recognized that physical space is a constraint that needs to be resolved before care can be redesigned.

## 10.3 Value-based Opportunity Summary

| Opportunity | Description | Benefits | Costed Benefit (est.) |
|---|---|---|---|
| Ambulatory Care / ZERO Length of Stay | Review of emergency admissions to identify:<br>(1) the reasons for the 'decision to admit' and if the admission was for clinical reasons;<br>(2) the timescales and interventions leading up to the attendance and subsequent decision to admit<br>(3) determine whether an alternative pathway could have avoided the admission.<br>(4) Develop new pathways based on review. | • Preventing unnecessary admissions<br>• Improved quality of care for patients who would avoid an admission.<br>• Improved utilisation and access through avoiding unnecessary admissions. | £150,000 |
| Frailty Services and Falls Prevention | Quality improvements to elderly care. E.g. falls prevention, home support and advice, community rapid response. To improve clinical pathways and provide a proactive and consistent approach to the identification and management of people who are frail and at risk of falls. | • Preventing unnecessary emergency admissions<br>• Improved quality of life for patients<br>• Improved quality of care<br>• Better throughput of A&E, through preventing unnecessary admissions | £192,300 |
| **Gross Value** | | | **£342,300** |
| **Investment** | SME (£20,000)<br>Project Management (£40,000) | | **£60,000** |
| **Net Value** | | | **£282,300** |

## 10.4 Assumptions

**Ambulatory Care**

- A cost per emergency admission is £1500
- There have been 3956 medical admission with a 24 hour length of stay, which equates to 18% of medical admissions.
- Avoiding an admission in 5% of this patient cohort, would deliver a £300,000 saving.
- Assume 50% of savings in Year 1.

**Falls and Frailty :**

- £3846 cost of an emergency falls-related admission
- Reduction in 100 emergency admissions can be achieved
- Assume 50% of savings in Year 1.

## 10.5 Non-Elective Care Delivery Plan

| Key Actions | Month | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Ambulatory Care** | | | | | | | | | | |
| Establish the project team, with clinician input<br>Develop and agree the project plan and PID | | | | | | | | | | |
| Quantify current discharge within 24 hours. Explore data for HRG groups. | | | | | | | | | | |
| Undertake initial data analysis to inform project. Where data isn't available undertake a survey / case note review to inform decisions | | | | | | | | | | |
| Audit the number of patients in Ambulatory Care for each of the priority clinical indications. | | | | | | | | | | |
| For each priority area:<br>• Understand reasons for admission<br>• Needs analysis<br>• How best to prevent the admission?<br>• Where if in not hospital? | | | | | | | | | | |
| Agree the KPIs / success criteria - what are the target admission reductions? | | | | | | | | | | |
| Work with BI to develop a monthly report on AMB admissions to track numbers, and other agreed KPIS | | | | | | | | | | |
| Agree the redesigned care pathways | | | | | | | | | | |
| Scope the alternative care mechanisms to be established and agree the specification | | | | | | | | | | |
| Explore CDU for dealing with patients needing observation or investigations, taking these patients out of the general medicine referral process. | | | | | | | | | | |
| Explore expansion of AMU | | | | | | | | | | |
| Explore establishment of an ambulatory surgical hot clinic for patients that need treatment few days (move to a semi-emergency list - reducing emergency demand and CEPOD lists | | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Implement new service provision | | | | | | | | | | |
| Explore a 111 service to deflect A&E attendances and better signpost patients | | | | | | | | | | |
| Benefits accrue | | | | | | | | | | |
| Falls / Frailty | | | | | | | | | | |
| Establish a cross system Frailty Team, | | | | | | | | | | |
| Appoint a Frailty Clinical Lead | | | | | | | | | | |
| Identify the Data needed to inform project. Undertake initial data analysis. Where data isn't readily available, consider audit or case note review. | | | | | | | | | | |
| Establish a vision for Frailty and Falls on IoM | | | | | | | | | | |
| Explore the building blocks / interventions and services needed to deliver the vision | | | | | | | | | | |
| Agree a Phase 1 to be delivered first | | | | | | | | | | |
| Agree the frailty outcomes, success factors and targets to be achieved | | | | | | | | | | |
| Agree the 21/22 net £ impact | | | | | | | | | | |
| Implement an electronic Frailty Index (eFI) with GP practices (if not already in place) to identify all individuals over 65 years who are living with moderate to severe frailty | | | | | | | | | | |
| Benchmark existing care processes to NHSE Frailty Optimal Design Pathway | | | | | | | | | | |
| Identify the interventions needed, investment required and the impact. | | | | | | | | | | |
| Use the PHE and falls prevention costing tools to understand ROI from proposed interventions | | | | | | | | | | |
| Implement new service provision | | | | | | | | | | |
| Benefits accrue | | | | | | | | | | |

| CIP Number | Area | CIP Opportunity | CIP Description | CIP Saving |
|---|---|---|---|---|
| 1 | Secondary Care Meds | Biosimilars | Switching patients to best value biosimilar, where clinically appropriate to do so. | £53,204 |
| 2 | Secondary Care Meds | Sugammadex | 50% Reduction in usage | £6,441 |
| 3 | Secondary Care Meds | Capsaicin patches | 50% Reduction usage (limited clinical value) | £28,980 |
| 4 | Secondary Care Meds | DOACs | Switching patients from Apixaban to Edoxaban treatment where clinically appropriate, generating a £236.60 savings per patient per year. | £102,631 |
| 5 | Secondary Care Meds | Nobles Pharmacy Stockholding | A stock management improvement team to look at reducing stockholding and improve supply chain management. | £300,000 |
| 6 | Secondary Care Meds | BluTeQ High-cost Drug Management System | Enables monitoring of expensive treatments ensuring they are prescribed in line with local policy and NICE guidelines. | £100,000 |
| 8 | Primary Care Meds | Vitamin B C Strong | Primary care pharmacy team to manage stopping the majority of items prescribed by GPs | £20,000 |
| 9 | Primary Care Meds | Oral Vit B 12 | Primary care pharmacy team to manage stopping the majority of items prescribed by GPs | £70,000 |
| 10 | Primary Care Meds | Bath and shower emollients | Primary care pharmacy team to manage stopping the majority of items prescribed by GPs | £35,000 |
| 11 | Primary Care Meds | Eye preparations | Primary care pharmacy team to manage stopping the majority of items prescribed by GPs | £30,000 |
| 12 | Primary Care Meds | Low clinical value prescribing | £912,000 was spent in 2019/20 on medication with low clinical value or items for self-care, which shouldn't routinely be prescribed. Reducing the items that can be provided on a prescription. | £250,000 |

| CIP Number | Area | CIP Opportunity | CIP Description | CIP Saving |
|---|---|---|---|---|
| 13 | Primary Care Meds | Stoma Appliances | Stoma appliances and accessory spend is increasing YoY. Opportunities to deliver long term follow up for patients with regular reviews to ensure prescriptions are appropriate and items meeting patient's clinical needs. | £57,000 |
| 14 | Primary Care Meds | Stop 3rd party Ordering – Option for centralised ordering hub | Several England CCGs have delivered significant savings through controls placed on regular medication repeats. | £94,000 |
| 20 | Procurement and Stock management | NHS SC and supplier and product alignment Non-Pay Spend | Significant opportunity for increasing the amount of spend that is pushed through NHS Supply Chain and building an improve and proactive and productive working relationship with the NHS SC business manager. | £600,000 |
| 23 | Procurement and Stock management | Contract realignment various opportunities | Extend duration of existing NHS SC contracts beyond current 12 months - renegotiate associated contract value savings<br>Renegotiate out of date Medical - Engineering Contracts and manage centrally<br>Multiple contracts are in place with same provider.<br>Ultrasound equipment maintenance<br>Reduce contract coverage and terms | £250,000 |
| 28 | Procurement and Stock management | Pilot stockholding reduction and centralised purchasing | Huge savings opportunities through current inefficiencies in stores management and ordering processes. Pilot in one high spend area before wider roll out.. | £25,000 |
| 29 | Workforce | Reduction in locum Spend | Vacancy review, recruitment opportunities, skill mix and training and better controls | £200,000 |
| 30 | Workforce | Review of Agency Framework and On Call Unit Costs | Develop a framework agreement with preferred provider with negotiated reduced rates. Place controls in the application of the framework and ensure approvals mechanisms in place. | £150,000 |
| 31 | Workforce | Maximising Use of Bank where possible | Maximise use of bank over use of locums where possible, though improved rostering, communication with staff and implementing a robust and centalised approvals process. | £100,000 |

| CIP Number | Area | CIP Opportunity | CIP Description | CIP Saving |
|---|---|---|---|---|
| 32 | Tertiary Care | Renegotiation / tender for patient transportation | Re-procurement to be complete September 2021, no savings will accrue until tender complete. Opportunity to move away from the block contract to variable contract more in line with reduced patient numbers | £518,000 |
| 33 | Elective Care | Outpatient Efficiency Improvement | Create capacity and improved efficiency through work to Reduce DNAs and improve 1st to Follow Up rates | *£124,000 |
| 34 | Elective Care | Advice and Guidance | Utilising consultants to provide pre-referral guidance to referring GPs. Explore model initially with tertiary providers to avoid off Island transfers. Future Island - wide roll out.<br>Technology deployment to support the advice process e.g., Consultant Connect. | *£124,000 |
| 35 | Elective Care | Virtual Care | Redesign the traditional outpatient model so that a percentage of current outpatient attendances are held virtually without a physical in person outpatient appointment. | *£310,000 |
| 36 | Elective Care | Inpatient procedures to DC / OPP | Review rates of day cases in line with BADS recommendations and investigate potential for expanded basket of procedures suitable for DC and or Op Procs from current position. | *£150,000 |
| 37 | Elective Care | Private Patient Unit | DHSC – accelerate getting the PPU up and running, channel income from waiting lists. Large outlay year one and revenue to flow down the line.<br>Potential for 3rd party to run and profit share. | TBC |
| 38 | Elective Care | POLCV | Agreeing a list of procedures that will be 'restricted' and approvals needed before patient is referred. Requires policies developed by DHSC, who are currently exploring. | *£150,000 |
| 39 | Emergency Care | Zero Length of Stay | Review of emergency admissions with short LOS Determine whether an alternative pathway is needed to reduce the number of emergency admissions. CEPOD lists. | *£150,000 |
| 40 | Emergency Care | Frailty and falls prevention | Opportunities through AMP frailty in-reach and outreach, signalling patients at high risk of falls e.g. strength and balance training to address age relates loss of bone density and muscle strength. | *£192,300 |

The CIP Long List included the following identified Opportunities:

| Elective Care Schemes | Emergency Care |
|---|---|
| • Advice and guidance<br>• Virtual care<br>• 1st to follow up improvement<br>• POLCV /prior approvals for restricted procedures<br>• Inpatient procedures to DC / OP procs | • Rationalisation of services<br>• Zero length of stay<br>• Frailty & falls prevention<br>• High intensity users |
| **Primary Care Prescribing** | **Secondary Care Prescribing** |
| • Primary care rebates<br>• Appliances<br>• Low clinical value medicines<br>• DOACs | • Homecare optimisation<br>• Patient's own meds<br>• Stockholding<br>• Biosimilars, high-cost drugs and Blueteq |
| **Workforce** | **Back Office / Procurement** |
| • Locum/Agency spend<br>• Review of agency contracts<br>• Centralised rostering | • Supply chain optimisation<br>• NHS Supply chain and contracts review<br>• Use of England frameworks<br>• Invoice duplication<br>• Purchase to pay process digitisation. |
| **Tertiary Care** | **Intermediate / Community Care** |
| • Repatriation of some off Island tertiary care<br>• Reduced use of off island escorts<br>• Prior approvals<br>• Virtual care models to avoid transfers | • Community IV, injections<br>• Oral Surgery |

# Appendix C

## Interviews, Meetings and Workshops

The following key individuals were interviewed and or were engaged with, in this work.

Our thanks go to all.

| Name | Title |
|---|---|
| Annmarie Cubbon | Head of Primary Care |
| Andre Risha | Clinical Director, Surgery, Theatres, Critical Care and Anaesthetics. |
| Andrew Foster | Chair 'Manx Care' |
| Angela Murray | Chief Operating Officer refer sub responsibilities re Adult Social Care Contracting, Community, Hospital |
| David Segal | Primary Care @ Scale Lead |
| Dr Gareth Davies | Clinical Director for Emergency Medicine |
| Dr Ishaku Pam | Clinical Director for Medicine and Consultant Geriatrician |
| Dr John Thomas | Consultant Physician and Geriatrician |
| Dr Lakshman Paudyal | Deputy CD for Medicine |
| Dr Mick Fleming | MHS Matron (apologies) |
| Dr Patricia Crellin | MHS Clinical Director |
| Gareth Davies | Ambulance & Paramedic Services |
| Jackie Lawless | Director of Finance |
| James Watson | General Manager Care Group 1 |
| Joanna Chadwick | Deputy Pharmaceutical Advisor |
| John Snelling | Director of Primary Care (and GP) |
| Jon Green | Transformation Senior Lead |
| Juan Corkill | GP Representative |
| Kathryn Magson | Interim Chief Executive |
| Lyz Howard | Matron for Medicine |
| Marc Jubb, | Business Manager, Unscheduled Care |
| Maria Bell | Pharmaceutical Adviser |
| Martin Hamm | Ambulance & Paramedic Services |
| Mick Fleming | Acting Head Mental Health |
| Oliver Radford | Director of Operations, Manx Care |
| Partha Vaiude | Clinical Director, Integrated Cancer and Diagnostics Services |
| Paula Primrose | Exec Director Financial Advisory |
| Richard Wild | Chief Information Officer (RW) |
| Robbie Corrin | Programme Office Manager |

| Name | Title |
|---|---|
| Ross Bailey (RB) | Mental Health |
| Sally Shaw | Director of Social Care |
| Sarah Hepburn | Interim Chief Pharmacist |
| Siva Balasubramanian | Clinical Director, Surgery, Theatres, Critical Care and Anaesthetics. |
| Sreeman Andole | Medical Director |
| Steve Crowe | Head of Ambulance & Paramedic Services |
| Steve Doyle | Pathology Manager |
| Stuart Hemmingway | Matron, Clinical Director, Surgery, Theatres, Critical Care and Anaesthetics. |
| Tammy Hewitt | Head of Commercial and Business Enterprise |
| Teresa Cope | CEO 'Manx Care' |
| Theresa Faragher | Cancer Operational Manager |
| Toby Irving | PPL Transformation Finance |
| William Cowie | GP Rep for negotiating with the Department |

## CIP Governance Overview

Successful delivery of the CIP Programme requires board oversight, senior leadership accountability and stakeholder engagement, underpinned by a strong governance structure that is widely understood and used to approve projects, track delivery, identify, manage and monitor implementation risks and unblock and resolve issues. An ongoing Manx Care CIP programme should be developed in line with the following principles.

- Ensure projects are aligned to strategic plans, and have multi-disciplinary stakeholder involvement in identifying, shaping, developing, and implementing plans
- Savings projections be supported by a clear evidence base, data and where possible benchmarking information
- Project will have clearly defined patient cohorts and / or project scope and parameters
- Savings and other quality benefits tracked with appropriate key indicators and metrics agreed at the outset
- The CIP process will be underpinned by robust governance, scrutiny and effective stakeholder communications

A communications plan should be used to involve and engage with a wide range of internal and external stakeholders. The communications plan will ensure clear message regarding the organisational importance of CIP is well understood throughout the organisation as well as highlighting the importance of the need for monitoring the potential impact on quality, focussing on quality will drive increases efficiency and save money.

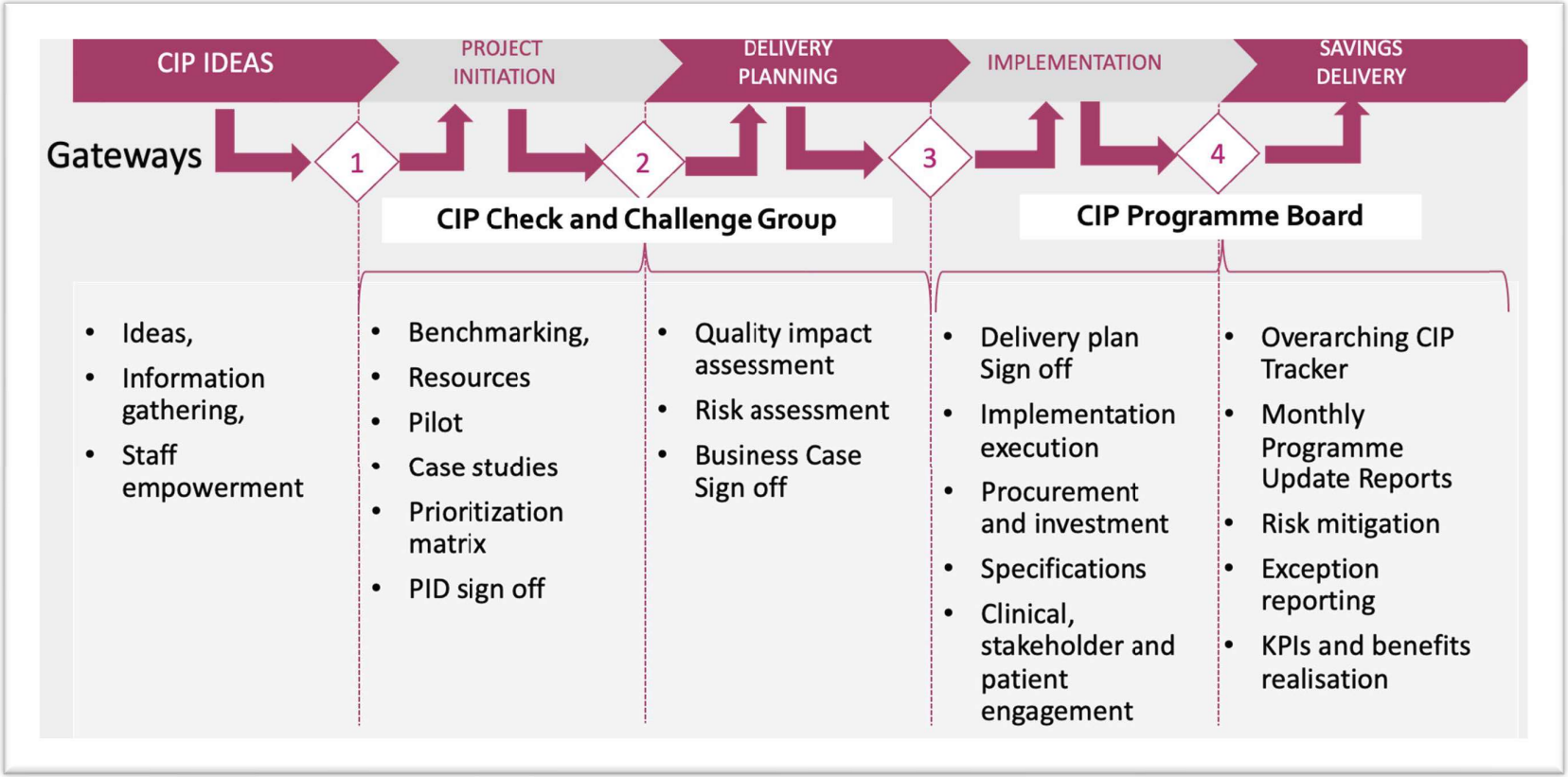
## CIP Programme Stages

A series of gateways should be implemented to provide opportunities for review and scrutiny as CIP projects move from ideas through to maturity and onto delivery, ensuring they meet basic requirements before the projects commence.

Decisions on which ideas are taken forward should be subject to a degree of scrutiny at an early stage to ensure they are robust, realistic and achievable. Early scrutiny will remove any projects with potential to negatively impact quality of care or are unlikely to be delivered, before too much time and resources have been committed.

# Appendix D

## Approach to Governance




Documentation will support each stage, ensuring formality, a consistency of decision making and an audit trail.

## **Gateway 1:** Project Identification and Project Initiation

CIP Identification: CIP should not be considered as a one-off annual exercise but a continual planning process that aims to improve the quality of care that is delivered whilst delivering efficiency improvements and cost savings. A range of measures should be implemented across the system to ensure that staff throughout Manx Care at all levels are engaged with and empowered to suggest opportunities for consideration by the CIP programme.

A project initiation document (PID) will be developed and approved, following generation of CIP ideas, that provides a high-level summary of the projects, its costs, savings and other benefits. Projects that are unlikely to deliver or are not consistent with Manx Care's strategic objectives can be rejected at this stage before too much time and resources have been expended.

Gateway 1: Gateway 1 approves the Project Initiation document, , once the potential project has been clearly defined. Regular CIP Check and Challenge meetings should be used as the forum for this gateway to ensure these areas of scrutiny have been addressed.

## **Gateway 2:** Business Case Development

Business Case Development. A detailed business case with full costing and accompanying quality impact assessment and risk assessment will be developed for CIP project that have a requirement for investment for example, investment in technology, new services or resources required for delivery.

Gateway 2: Will oversee validation of CIP projects, ensuring a review and approval of the detailed business case, including a full costing and accompanying quality impact assessment and risk assessment.

Regular CIP Check and Challenge sessions should be used as the forum for this gateway to ensure these areas of scrutiny have been addressed. Regular CIP Check and Challenge meetings should be used as the forum for this gateway to ensure these areas of scrutiny have been addressed.

## **Gateway 3: Delivery Planning**

Implementation Planning: A comprehensive delivery plan should be developed for all projects prior to commencement of implementation.

Gateway 3: The CIP Programme Board should be used as the forum for this gateway to ensure these areas of scrutiny have been addressed.

## Implementation

The following structures will be put in place to govern effective implementation.

- Delivery Plans
- Project Status Updates will be produced to enable oversight and review of CIP project to understand those that are on track and those that are underperforming.
- Risk management, a CIP risk log will be maintained by the PMO. Quality will be monitored continually, as an essential part of this risk management process.
- CIP Tracker will be maintained, providing an overview of the entire CIP programme.
- KPIs a range of appropriate key performance indicators (KPIs) will be developed for each project and used to monitor success in addition to savings, such as patient experience, patient safety, clinical outcomes and efficiency measures.
- Quality impact assessments should be developed together with the delivery plan and used as an aid to monitor CIP project's quality impact during delivery.
- Exception reports will be used to track, communicate and escalate underperforming projects and ensure mitigations are documented and implemented.

## Gateway 4:

Governs exception reporting, for projects where there has been slippage or underperformance against plans. The CIP Programme Board should be used as the forum to review exception plans and to review and sign off of mitigation plans to ensure delivery.

# Advisory support:
# Cost Improvement Plan 2021/22: Procurement

## Manx Care

Terms of Reference

June 2021

Reference: ADV_2021_063

# 1 Introduction

1.1 This paper sets out the work undertaken to date with Manx Care, the savings identified and recommendation for the future development and delivery of the procurement function.

1.2 MIAA and our Associate specialist Linda Bailey (MCIPS) would like to thank all colleague stakeholders in ManxCare for their time, co-operation and input in progressing our work to support the Cost Improvement Plan opportunities. relating to Procurement.

# 2. Work to date:

## 2.1 Meetings

| Contact and Outcomes |
|---|
| NHS Supply Chain Representative for Equipment Purchases |
| Assessment completed/actions applied<br>• Outlined Multi-Trust Aggregation benefit<br>• Shared the MTA Calendar Dates<br>• Ran through NHSSC current equipment Framework Agreements.<br>• NHSSC talked through their procurement offering for supporting on Tenders/Quotes/Evaluations/Supplier Days etc.<br>• Followed up with previous Case Studies.<br>• Meeting held 1st June with NHSSC & IOM Leads<br>Contact details – Francesca Cullen (NHSSC)<br>Business Development Manager, North West & Northern Ireland<br>E mail: francesca.cullen@supplychain.nhs.uk<br>Mobile: 07714041726<br>Status: Engagement completed and regular meetings now in place between NHSSC and Manx Care leads. |
| NHS Supply Chain Representatives for Maintenance Contracts. |
| Assessment completed/actions applied<br>• Outlined NHSSC benefits for new Maintenance Contracts<br>• Outlined benefits for multi-year contracts<br>• Explored opportunities to switch to 3rd party providers.<br>• Bring together same supplier contracts on to one main contract.<br>• Evaluate current contract level of cover – Fully comprehensive/comprehensive.<br>• Engaged with IOM MEAM & third party maintenance provider.<br>• Initial meeting with IOM reps held on 27th May 2021.<br>• Medical Engineering and 3rd Party Maintenance Provider have produced MaintenanceContracts schedule. |

- NHSSC have requested my support with chasing IOM on expired contracts.
- Introductory Meetings with NHSSC & IOM Leads have now taken place.

Contact Details: Lynne Wyard (NHSSC)
Buyer Maintenance
E mail: Lynne.Wyard@supplychain.nhs.ukTelephone 01133854816

Mobile: 07446875552

Status: Engagement completed and regular meetings now in place with NHSSC and Manx Care leads. Savings have been achieved and on-going.

NHS Supply Chain Account Manager (Appointed Mid June 2021)

NHS Supply Chain Director Logistics

Assessment completed/actions applied

- opportunities to rationalise product ranges.
- Switch appropriate supplier direct spend wherever possible.
- Consider opportunities to standardise products.
- Evaluate the 25 areas of Nationally Contracted products with a view to switch.
- Assessed opportunities to move to "Top Proven Savings Switches".
- Assessed opportunities for most economical UOI.
- Assessed most economical price banding.
- Consider current carriage charges (renegotiate or change)
- Understand invoicing arrangements with regards to under-charging.
- Introduced regular meetings with NHSSC and IOM leads
- Meeting to be arranged with Director of Logistics (on his return from leave)
- Meeting taken place with new NHSSC Account Manager on 14/6/21.

Contact details: Brij Valambhia (NHSSC)
Customer Relationship Manager Supply Chain Coordination Limited
Management Function of NHS Supply Chain
E mail: brijesh.valambhia@supplychain.nhs.uk
Tel: 07725 110989

Status: Engagement completed and regular dialogue now taking place with future meetings to be arranged.

## 2.2 Analysis: Direct Supplier Spend

| Approach |
| --- |
| • Look at IOM Suppliers – any opportunity to improve pricing, switch to NHSSC.<br>• Identified Contracts with Non-contracted suppliers.<br>• Analysed Theatre spend with view to new contract arrangements for General Surgery andEye Surgery products. |
| **Options/Action** |
| • Implement interim local purchasing agreements.<br>• Move spend to manufacturers, cutting out agents.<br>• Take out the "nice to have" items or add on (embroidered uniform, reduce product specification, rationalise product ranges)<br>• Move office furniture to NHS Framework providers<br>• Support IOM with alternative suppliers<br>• Support IOM with other procurement providers Framework Agreements |
| **Recommendations** |
| • Mini Competition of the Radiology PACS via the NHSSC Framework Agreement (several meetings have been held and extension of existing service with Phillips now in place)<br>• A switch from local agreement with 4Ways Healthcare for X-Ray reporting to compliant route via Shared Business Service to 4Ways Healthcare delivering savings & efficiencies plus credit back based on value of spend.<br>• Future mini-competition of X-Ray Reporting Service by way of mini competition via Shared Businesses Framework.<br>• Radiology Contrast Media agreement be switched from local arrangement to SBS Framework Agreement.<br>• The purchase of new Phaco equipment to be via NHSSC Framework.<br>• Switch Johnson & Johnson direct spend via NHSSC.<br>• Improved pricing obtained on breast reconstruction surgery products, recommend multi year contract be set up.<br>• Recommend switching ResMed Ltd & Phillips spend on Sleep Therapy Products to Remserve. Ltd. (Data needs verifying and usage confirming. |

## 2.3 Exploration of procurement arrangements Jersey and Guernsey Healthcare Providers

| Guernsey (Population 64,000). |
|---|
| • Meeting held 11/6/21<br>• Non-Pay Healthcare Budget is £70M<br>• Main healthcare service provider is off island – Southampton<br>• The aspiration is to spend on Guernsey where possible with a desire to increase this spend due to Covid.<br>• Use NHSSC however the spend is low (circa less than £1M)<br>• Contact details: Shelley Nicholls<br>Procurement Manager<br>Mobile: 07838 257883<br>Email: shelley.nicholls@gov.gg<br>• Contact details: Helen Ridgwick<br>Procurement Director<br>Email: helen.ridgwick@gov.gg |
| Jersey (Population 108,000) |
| • Meeting held on 27/5/21<br>• Non-Pay Healthcare Budget is £169M<br>• Aspiration is to keep spend on Jersey where possible.<br>• Use NHSSC – currently spend approx. £2M and believe the on-cost to be approx. 10%.<br>• Don't use NHSSC for maintenance of equipment as they are contracted to a third party provider who manages all maintenance expenditure.<br>• Contact details: Gareth Hudson<br>• Interim Senior Category Manager – Covid Response Commercial Services, Chief Operating Officer, Govt of Jersey<br>Email: G.Hudson@gov.je<br>Mobile:+44(0)7890 537462 |

## 3 Impact: Future implication for CIP

3.1 Four maintenance contracts have been switched to date that were due for renewal over to multi- year deals keeping with the same providers. This has delivered **£58,051** saving.

3.2 A further **£621,750** of potential savings has been identified covering 20 separate projects. Please refer to Appendix A: 'Procurement Savings Tracker'.

3.3 It sets out against each project listed

- the end users involved and their contact details.
- the procurement providers contact details and the appropriate Framework Agreement reference numbers and company details.
- Some projects to do not have a savings figure yet confirmed as this will be dependent on supplier choice and outcome but will be in addition to the £621,750 identified.

## 4 Recommendations

4.1 In addition to the recommendations in 2.2 above, the following steps should be progressed immediately by Manx Care to maximise potential cost out opportunities:

- Purchasing Procedures Manual
- Product Evaluation User Group
- Identify Clinical/Nursing evaluation support.
- Introduce zero inflationary avoidance guidance.
- Invest in suitable resource to cleanse the direct spend data into the template format required to enable bench mark comparisons (using specialist software) to identify and secure ongoing savings and efficiencies.

# Appendix A: Procurement Savings Tracker

| Total CIP | | | | | Supplier | | Spend | | | | Delivery | | | | | | | | | | £679,801 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Procurement CIP Reference | Area | CIP Opportunity Name | Opportunity Description | Assumptions | Supplier (Pre-Saving) | Supplier (Post Saving) | Annual Spend Pre-Savings | Projected Annual Spend Post Savings Delivery | Annual / Recurrent | Other Benefits | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | CIP Saving |
| 1 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | Cannon Medical Ltd | Cannon Medical Ltd | | | | | | | £12,670 | | | | | | | | **£12,670** |
| 2 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | GE Medical Systems Ltd | GE Medical Systems Ltd | | | | | | | £5,182 | | | | | | | | **£5,182** |
| 3 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | Med Imaging Ltd | Med Imaging Ltd | | | | | | | £8,856 | | | | | | | | **£8,856** |
| 4 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | Siemens PLC Healthcare | Siemens PLC Healthcare | | | | | | | £31,343 | | | | | | | | **£31,343** |
| 5 | Radiology | **PACS** | Undertake mini competition against NHSSC PACS Framework Agreement. Currerntly up to a maximum of 12 month extension in place with Phillips. | Approx. 5% saving per annum for 10 year agreement. | Phillips Healthcare | Unknown | £226,000 | £214,700 | | | | | | | | | £113,000 | | | | **£113,000** |
| 6 | Endoscopy | **Maintenance Contract** | Switch to 3rd party provider | Approx £90K off current spend for 5 year contract. New contract to commence June 2023 | Olympus Medical Ltd | Althea Ltd | | | | | | | | | | | | | | | **£90,000** |
| 7 | Surgery | **New Equipment Purchase** | Use of NHSSC Framework and MTA | Approx 10% off purchase price of 36 MP70 replacement monitors | Phillips Healthcare | Phillips | TBC (dependant on model purchased) | | | | | | | | | | | | | | **£0** |
| 8 | Theatres | **Orthopaedic Impants** | New Contract | Approx 5% discount off current spend | Styker Uk Ltd | Stryker UK Ltd | £408,913 | £388,468 | | | | | | £20,445 | | | | | | | **£20,445** |
| 9 | Theatres | **Energy Devices** | Renegotiate pricing on harmonic scalpel | Minimum of 10% saving by contracting | Johnson & Johnson | Medtronic Ltd | £286,000 | £257,400 | | | | | £28,600 | | | | | | | | **£28,600** |
| 10 | ManxCare Wide | **Top Proven Switches** | Switch current products to alternative proven switch | Range of products offering between 7 - 30% discount | NHSSC | NHSSC | TBC | | | | | | | | | | | | | | **£0** |

# Appendix A: Procurement Savings Tracker

| Total CIP | | | | | Supplier | | Spend | | | | Delivery | | | | | | | | | | £679,801 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Procurement CIP Reference | Area | CIP Opportunity Name | Opportunity Description | Assumptions | Supplier (Pre-Saving) | Supplier (Post Saving) | Annual Spend Pre-Savings | Projected Annual Spend Post Savings Delivery | Annual / Recurrent | Other Benefits | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | CIP Saving |
| 11 | ManxCare Wide | **25 Nationally Contracted Products** | Switch to alternative tried & tested products | Range of products saving between 5 - 20% off current price | NHSSC/Direct Supplier | NHSSC | TBC | | | | | | | | | | | | | | **£0** |
| 12 | Radiology | **Off Site X-Ray Reporting** | Re-negotiate current pricing | Put Contract in place via SBS Framework plus opportunity for 4% cash back based on multi year contract £27K) | 4 Ways Healthcare | 4 Ways Healthcare | £678,000 | £644,206 | | | | | | £33,905 | | | | | | | **£33,905** |
| 13 | Radiology | **Off Site X-Ray Reporting** | Re Project 12 - Award Multi Year Contract | Obtain further 4% cash back based on multi year contract.in addition to Project 13 saving | 4 Ways Healthcare | 4 Ways Healthcare | | | | | | | | £27,120 | | | | | | | **£27,120** |
| 14 | Theatres | **Eye Surgery - IOL's** | Re-negotiate current pricing | New Contract, anticipate 7% saving | Alcon Eye Care | Alcon Eye Care | £124,000 | £115,320 | | | | | | £8,680 | | | | | | | **£8,680** |
| 15 | Radiology | **Maintenance Contract** | Ultrasound Equipment - Switch to 3rd party provider | Anticipate minimum 10% saving | | | TBC | | | | | | | | | | | | | | **£0** |
| 16 | Theatres | **New Equipment Purchase** | Use of NHSSC Framework and MTA - Phaco Machines (Eye Surgery) | Anticipate minimum 10% saving | TBC | TBC | | | | | | | | | | | | | | | **£0** |
| 17 | Theatres | **New Equipment Purchase** | Use of NHSSC Framework & MTA - Anaesthetic Machines | Anticipate minimum 10% saving | TBC | TBC | | | | | | | | | | | | | | | **£0** |
| 18 | Theatres | **Breast Surgery(Mesh)** | Renegotiate pricing on Stratis mesh. Paying £2667 each potential new price £1960. | Saving per item = £707. | Healthcare 21 | Healthcare 21 | Need annual useage | | | | | | | | | | | | | | **£0** |
| 19 | ManxCare Wide | **NHSSC** | Switch direct supplier spend to NHSSC | Provides compliant route to market, economic unit of issue plus price paid reductions. | Various suppliers | NHSSC | Recommend investment to cleanse date will deliver circa £300K saving | £300,000 | | | | | | | | | | | | £300,000 | **£300,000** |
| 20 | ManxCare Wide | **NHSSC** | Top Savings Recommendations | | NHSSC & Various Suppliers | NHSSC | TBC | | | | | | | | | | | | | | **£0** |

# Appendix B:
## Savings Tracker Notes

| Total CIP | | | | | £679,801 | Note |
|---|---|---|---|---|---|---|
| Procurement CIP Reference | Area | CIP Opportunity Name | Opportunity Description | Assumptions | CIP Saving | |
| 1 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | **£12,670** | Completed |
| 2 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | **£5,182** | Completed |
| 3 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | **£8,856** | Completed |
| 4 | Radiology | **Maintenance Contract** | Switch to Multi-Year deal | Achieved | **£31,343** | Completed |
| 5 | Radiology | **PACS** | Undertake mini competition against NHSSC PACS Framework Agreement. Currerntly up to a maximum of 12 month extension in place with Phillips. | Approx. 5% saving per annum for 10 year agreement. | **£113,000** | Kathleen McDowall<br>Radiology Manager<br>M: +44 (0) 7624 218730 • T: +44 (0) 1624 650432<br>E: kathleen.mcdowall@gov.im NHSSC:John Lambert<br>Medical IT Buyer<br>Email:john.Lambert@supplychain.nhs.uk<br>Mobile: 07730206350<br>Landline: 0113 385 4887 |
| 6 | Endoscopy | **Maintenance Contract** | Switch to 3rd party provider | Approx £90K off current spend for 5 year contract. New contract to commence June 2023 | **£90,000** | NHSSC: Lynn Wyard<br>Email:Lynne.Wyard@supplychain.nhs.uk<br>Telephone 01133854816<br>Mobile 07446875552 |
| 7 | Surgery | **New Equipment Purchase** | Use of NHSSC Framework and MTA | Approx 10% off purchase price of 36 MP70 replacement monitors | **£0** | NHSSC:Francesca Cullen<br>E:francesca.cullen@supplychain.nhs.uk<br>M:07714041726 |
| 8 | Theatres | **Orthopaedic Impants** | New Contract | Approx 5% discount off current spend | **£20,445** | Lynn Reid, Theatre Mgr |
| 9 | Theatres | **Energy Devices** | Renegotiate pricing on harmonic scalpel | Minimum of 10% saving by contracting | **£28,600** | Lynn Reid, Theatre Mgr |
| 10 | ManxCare Wide | **Top Proven Switches** | Switch current products to alternative proven switch | Range of products offering between 7 - 30% discount | **£0** | Neil Davidson<br>General Manager Operations Division<br>T: +44 (0) 1624 650847<br>E: neil.davidson@gov.im<br>NHSSC Brij Valambhia<br>Customer Relationship Manager<br>Email:brijesh.valambhia@supplychain.nhs.uk |

# Appendix B:
## Savings Tracker Notes

| Total CIP | | | | | £679,801 | |
|---|---|---|---|---|---|---|
| Procurement CIP Reference | Area | CIP Opportunity Name | Opportunity Description | Assumptions | CIP Saving | Note |
| 11 | ManxCare Wide | **25 Nationally Contracted Products** | Switch to alternative tried & tested products | Range of products saving between 5 - 20% off current price | **£0** | Neil Davidson<br>General Manager Operations Division<br>T: +44 (0) 1624 650847<br>E: neil.davidson@gov.im<br>NHSSC Brij Valambhia<br>Customer Relationship Manager<br>Email:brijesh.valambhia@supplychain.nhs.uk<br>Tel.: 07725 110989: |
| 12 | Radiology | **Off Site X-Ray Reporting** | Re-negotiate current pricing | Put Contract in place via SBS Framework plus opportunity for 4% cash back based on multi year contract £27K) | **£33,905** | ManxCare -Kathleen McDowall<br>Radiology Manager<br>M: +44 (0) 7624 218730 • T: +44 (0) 1624 650432<br>E: kathleen.mcdowall@gov.im SBS Rep:Sarah Findlay<br>Category Manager<br>Tel: 07933389868 |
| 13 | Radiology | **Off Site X-Ray Reporting** | Re Project 12 - Award Multi Year Contract | Obtain further 4% cash back based on multi year contract.in addition to Project 13 saving | **£27,120** | As per Project 12. |
| 14 | Theatres | **Eye Surgery - IOL's** | Re-negotiate current pricing | New Contract, anticipate 7% saving | **£8,680** | ManxCare Lead Karen Patterson,Team Leader ENY.Ophthalmics & Maxillio-Facial.<br>Karen.patterson@gov.im |
| 15 | Radiology | **Maintenance Contract** | Ultrasound Equipment - Switch to 3rd party provider | Anticipate minimum 10% saving | **£0** | NHSSC: Lynn Wyard<br>Email:Lynne.Wyard@supplychain.nhs.uk<br>Telephone 01133854816<br>Mobile 07446875552 |
| 16 | Theatres | **New Equipment Purchase** | Use of NHSSC Framework and MTA - Phaco Machines (Eye Surgery) | Anticipate minimum 10% saving | **£0** | ManxCare Lead Karen Patterson,Team Leader ENY.Ophthalmics & Maxillio-Facial.<br>Karen.patterson@gov.im NHSSC:Francesca Cullen E:francesca.cullen@supplychain.nhs.uk M:07714041726 |
| 17 | Theatres | **New Equipment Purchase** | Use of NHSSC Framework & MTA - Anaesthetic Machines | Anticipate minimum 10% saving | **£0** | NHSSC:Francesca Cullen<br>E:francesca.cullen@supplychain.nhs.uk<br>M:07714041726 |
| 18 | Theatres | **Breast Surgery (Mesh)** | Renegotiate pricing on Stratis mesh. Paying £2667 each potential new price £1960. | Saving per item = £707. | **£0** | **Lynn Reid, Theatre Mgr - Pricing taken from comparison with other Trusts prices.** |
| 19 | ManxCare Wide | **NHSSC** | Switch direct supplier spend to NHSSC | Provides compliant route to market, economic unit of issue plus price paid reductions. | **£300,000** | Neil Davidson<br>General Manager Operations Division<br>T: +44 (0) 1624 650847<br>E: neil.davidson@gov.im<br>NHSSC Brij Valambhia<br>Customer Relationship Manager<br>Email:brijesh.valambhia@supplychain.nhs.uk<br>Tel.: 07725 110989: |
| 20 | ManxCare Wide | **NHSSC** | Top Savings Recommendations |  | **£0** | Neil Davidson<br>General Manager Operations Division<br>T: +44 (0) 1624 650847<br>E: neil.davidson@gov.im<br>NHSSC Brij Valambhia<br>Customer Relationship Manager<br>Email:brijesh.valambhia@supplychain.nhs.uk<br>Tel.: 07725 110989: |