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NHS
Croydon
Clinical Commissioning Group

Draft Improvement and Recovery Plan Summary

8 December 2016

Longer, healthier lives for all the people in Croydon

Contents

Executive Summary

Our vision is that all the people in Croydon have longer and healthier lives.

Through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners, we will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services

Introduction

Based on forecast performance at Q1 2016/17, Croydon CCG was placed in SPECIAL MEASURES in July 2016. These measures require that the CCG produce and implement an Improvement and Financial Recovery Plan, improve governance and develop leadership for the CCG that is consistent with the shared management arrangements required to support implementation of the STP.

The purpose of this document is to set out our plans to deliver (i) financial recovery (breakeven in 2017/18) and (ii) a sustainable financial position over a five year period (in line with the South West London Sustainability and Transformation Plan), alongside improving the safety and quality of care and transforming services to deliver better patient outcomes in Croydon, within the funds available.

This plan responds to these directions and builds upon the strategic work which we have already started and has been prepared in line with the strategic principles of our vision for the healthcare of Croydon, which includes:

- Ensuring people are seen in an appropriate setting;
- Having active case management within each care setting; and
- Improving efficiency within each care setting
- Commissioning care within the resources available to the Croydon population

We have had a number of recent successes

Our plan builds upon the work which we have already started. We have had a number of recent successes and have made significant progress, including:

- Improved mental health performance (IAPTS, CAHMS, early intervention);
- Improved pathways for specific conditions;
- Improved public and patient involvement, notably contacts with over 2,800 people in FY16/17;
- Improved financial position including delivery of over £35m in QIPP over the past three years;
- Refocused our existing staff resources on financial recovery;
- Finalised arrangements to engage additional financial recovery / turnaround capacity to help us deliver our Financial Improvement Plan.

However we know and understand the size of the challenges that we continue to face

Our overriding ambition is to deliver our healthcare vision for Croydon whilst becoming financially sustainable.

We recognise the following key challenges which we continue to face in seeking to achieve this aim:

- Our financial challenges are multi-faceted, with our key challenges being:
  - the reduced expectation for future growth in allocations and the increase in provider tariffs have significantly altered the timeline for achieving financial balance – i.e. financial balance by 2017/18 and achievement of 1% NHS business rules by 2018/19.
  - the benchmarked opportunity is significantly lower than the QIPP challenge required to deliver the Financial Improvement Plan.
- Improving the quality of service – particularly CHS's delivery of the 4 hour A&E target and meeting the waiting time target for patients with suspected cancer starting treatment within 62 days following urgent GP referral;
- As part of enhancing our mental health provision to patients, we need to continue reduce the reliance on inpatient services, and develop out of hospital care including IAPT;
- Across GP practices, there are significant variations in referrals made by GPs to secondary care. Reducing these variations is vital.

Executive Summary

We are committed to delivering sustainable financial performance

We intend to be in compliance with NHS Business Rules of a 1% surplus by 2018/19 and to achieve this goal, we intend to deliver decreasing financial deficits and achieve financial balance in the intervening years. We expect that we will be able to deliver on this by the following key steps being taken:

- An enhanced financial recovery/turnaround approach has been adopted
- Reliance is placed on the 5 year allocations announced in January 2016 and the business rules in place for 2017/19 .
- Delivering increased QIPP plans based on benchmarking (which is continually being refreshed);
- Additional support from RightCare to understand its benchmark position and how to unlock the opportunity
- Delivering a range of expenditure reduction / decommissioning initiatives as initiated in 2016/17.
- Working with the SWL CCGs and Providers to deliver the transformation in out of hospital care, planned care, prevention and managing long term conditions as contained in the Sustainability and Transformation Plan and,
- Reducing variation in Primary Care that presently exists across the borough.
- Introducing Outcome Based Commissioning (OBC) for over-65s – this is presently planned for 2016/17, developing the work we have already started around Transforming Adult Community Services ("TACS") and building upon the financial benefits already being achieved;
- Increasing the implementation pace of our transformation programme for Adult Mental Health Services and Older Adult Mental Health Services and our prevention, self-management and shared decision making programme
- Developing further our primary care and out of hospital strategy and our Learning disabilities transformation plans.

We recognise the enormity of the challenges ahead and the need to respond. We have already taken steps to deliver our plan and have had some successes to date. This document sets out details of how we aim to deliver our Financial Improvement Plan.

We understand the importance of working with our stakeholders to achieve our ambitions

Strong clinical engagement is critical to the commissioning and delivery of high quality health care services that meet the needs of the local population. We pride ourselves on the value of the collaborative relationships that we are part of as well as individual ones which have allowed us to build strong partnerships especially where we face a common interest. We are members of:

- Joint Commissioning Board with the Local Authority;
- The South West London CCG Collaboration;
- The Transforming Croydon (Chief Executive Group);
- The Transforming Care Board (Croydon Sub-STP); and
- The System Resilience Group.

We have a solid relationship with our main acute and community provider, Croydon Health Services (CHS) with acute services predominantly provided at Croydon University Hospital. The CCG and CHS have worked together on progressing and developing joint QIPP schemes and continue to do so (supported by an Executive monthly joint QIPP meeting) .

The South London and Maudsley (SLAM) is the main Mental Health provider to Croydon CCG, along with a number of other CCGs across South East London. We have strong engagement with them and a developing relationship.

In addition the CCG and Croydon Council have been working towards an innovative approach that incentivises providers to achieve improved outcomes. In the context of health and social care in Croydon, we see Outcomes Based Commissioning as the mechanism for significantly improving health and wellbeing outcomes for the over 65s, as well as driving efficiency and promoting the integration of health and social care services.

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1. Where are we now?

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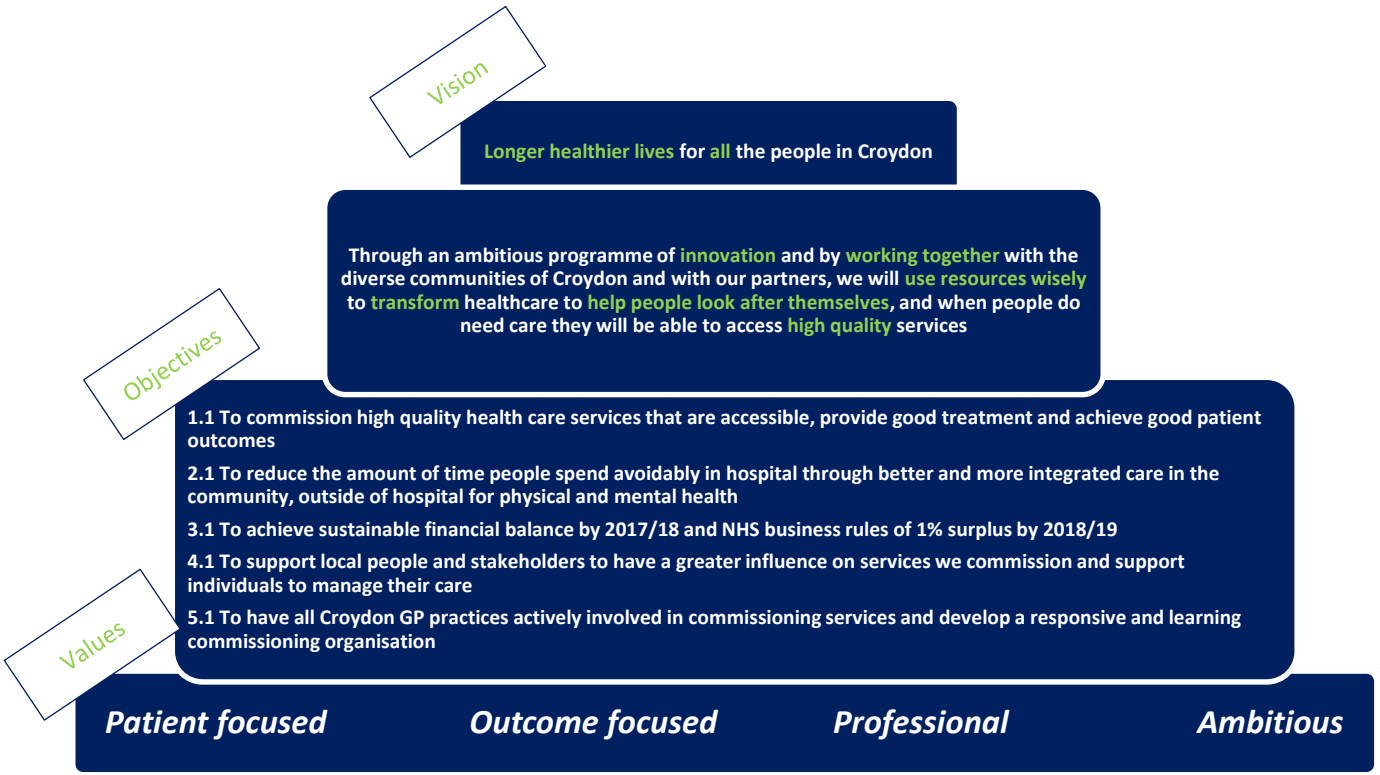
Strategic Vision and Goals

Following a wide-reaching engagement process with a variety of stakeholders, we have reconfirmed our vision and developed organisational values. In addition we have revised our objectives for 2016/17. The strategic direction of travel has been confirmed and we will finalise the outcomes over the coming months.



This vision and strategy is a product of understanding the needs of our population and the service challenges that we face. Croydon's population is growing by 1% per year, with particular increases in younger people and with older people living longer. Given this, our priority areas that we aim to deliver on are:

1. Reducing potential years of life lost through amenable disease;
2. Ensuring patients are treated in the right place;
3. Children and young people reach their full potential;
4. Early detection and intervention; and,
5. Positive patient experience.

The principles upon which we will deliver these priorities and indeed all areas we commission are that:

- Prevention is better than cure;
- When someone does become ill, self management is the best option;
- When a person does need treatment they are seen in the right place at the right time; and,
- There is shared decision making between the patient and the health professional.

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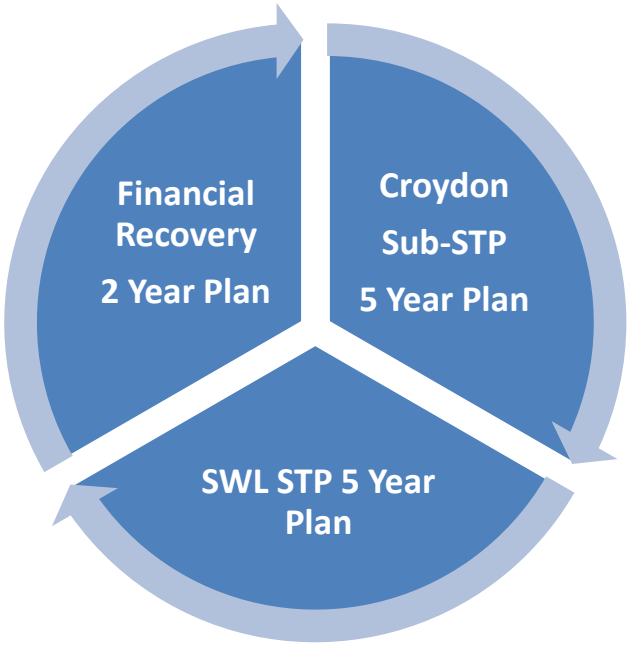
Strategic Alignment of Financial Recovery and the SWL STP



1

Financial Recovery Plan (2 Year)

The Croydon Financial Recovery Plan is based on analysis of the historic, current and forecast position to ensure that the agreed actions are put in place to help the CCG reach the targets it has set.

2

Croydon Sub-STP 5 Year Financial Plan (5 Year)

The 5 Year Financial Plan (2016/17 – 2020/21) consists of a number of measures and will provide a clear framework with which to successfully reach the financial and quality targets set for the CCG over the 5 year period.

3

SWL Sustainability and Transformation Plan (5 Year)

There is a close relationship between the STP and the 5 Year Financial Plan (2016/17 – 2020/21); many of the opportunities identified in the 5 Year Financial Plan are closely linked to the STP themes, and going forward the STP will help deliver further areas of potential QIPP improvement.

Croydon's demographic & characteristics

Croydon has a unique set of demographic characteristics which shape its local health economy.

Croydon CCG commissions over £475m of local healthcare services for 376,000 people. This already sizeable population is forecast to grow by 13.8% by 2030, with particular increases expected among both Croydon's younger and older populations:

- There was a 13.4% increase in already high birth rates between 2004 and 2014;
- Estimates suggest that the number of people aged over 85 will increase by 48% on existing levels by 2029.

Alongside this, deprivation (and the extent to which it varies between wards) is a key issue within the borough. Croydon is currently the 17th (out of 33) most deprived population in London (Indices of Deprivation, 2015).

Croydon's population is extremely ethnically diverse. Over 50% of the borough's population are from Black, Asian or minority ethnic groups. In addition to English, a number of other languages are widely spoken in Croydon, such as Tamil, Polish, Gujarati and Urdu. This evidently has implications for the delivery of healthcare in the borough.

Factors which impact the local health economy of Croydon

A city in its own right
Croydon is officially classed as part of Outer London. However, if it were to be regarded as a stand-alone city, it would be the 8th largest in the UK. It has its own thriving business district and receives a large daily influx of commuters from central London and the surrounding area. This flow of people creates its own stresses on local healthcare services.

The Home Office
The principal administrative office of this government function is based in Croydon. The implication of this is that Croydon receives a large number of new migrants (including unaccompanied refugees and asylum-seeking children) on a daily basis. This in turn places additional stress on the local health economy – new migrants commonly have no access to a GP and so are more likely to attend a hospital in the first instance should they need medical assistance.

Nursing and care homes
Croydon, in comparison to the rest of London, has a disproportionately high number of nursing and care homes. The borough contains 4% of London's population, but has just over 9% of London's nursing and care homes – more than twice the rate expected. Elderly people moving to nursing or care homes within Croydon from outside of the borough are required to register with a Croydon GP. This influx of elderly, vulnerable patients who require a greater level of care also places unique demands on the local health economy.

Our key challenges

Croydon CCG's overriding challenge and ambition is to maintain and improve safety and quality of care in Croydon, transforming services to deliver better patient outcomes and delivering financial sustainability.

Financial position - CCG
Our financial challenges are multi-faceted. The 5 year allocations announced in January 2016 included £16m additional funding. Funding for healthcare in Croydon in 2016/17 still reflects underfunding of -3.71%, or £18m. Given this is within the acceptable range of plus or minus 5%, no further additional funding outside of growth funding is expected. The CCG has delivered £35.5m QIPP since its inception in 2013/14.

Based on forecast performance at Q1, Croydon CCG was placed in special measures in July 2016. These measures require that the CCG produce and implement an Improvement and Financial Recovery Plan, improve governance and develop leadership for the CCG that is consistent with the shared management arrangements required to support implementation of the STP.

Financial climate - external
The challenging financial position of Croydon Health Services ("CHS") and Croydon Council has impacted the CCG's operations. The unique health economy: the concentration of nursing/care homes, the high immigrant population levels, and housing pressures, has exacerbated this.

Performance
The 16/17 annual recovery target for the 4 hour A&E waiting time for CHS is 93.8%. As of July 2016 (month 4), the Trust's performance stands at 94.2%, and 93.4% year-to-date, against a national standard of 95%. Under performance against the trajectory in the summer months will mean that as we move in to Winter, delivering the annual target will become increasingly challenging.

In Planned Care, diagnostic tests waiting times were 96.8% in July 2016, a year-to-date average of 97.1%, below the national target set of 99%.

Demand for services and utilisation of resources
For acute hospital services There are significant variations in referral rates made by GPs to secondary care, which the CCG has addressed through a number of initiatives. This includes spot peer review (which has worked well to date) and identifying practices with high referral rates to actively work with them. Our Multi-Disciplinary Teams ("MDT") teams have also been working across practices and we have been monitoring utilisation of these teams by practices. The aim of which being to improve the coordination of care and management of long-term conditions.

For mental health services Croydon CCG has historically had a low baseline of service provision with increasing pressures being asked of those services. The CCG experienced a significant increase in the number of inpatient occupied bed days in 15/16, which created a £2.8m cost in 16/17. An urgent review was commissioned to understand the drivers of the inpatient performance. The principal finding was that the increase in bed days, was driven by an increase in the length of stay.

Patient experience
Across health and social care in Croydon, people are reporting a poorer experience than that received elsewhere. In the Access to GP Services survey, respondents reported that:

- 40% of people in Croydon believed they waited too long to see a GP, compared to 34% nationally.
- For those people with a long term condition, 57.7% felt supported to manage their condition, against an average of 64.4% in England.

Pace of Transformation Required
Given the current financial challenge and the need to deliver our recovery plan at the required pace, we recognise that further resources, particularly in finance and QIPP programme management are needed to support the existing team. In the short-term, we recognise that complementary skills and experience in delivering financial recovery will also be critical.

Benchmarking analysis

We have used benchmarking as a tool to identify areas where efficiency savings could be made. As well as commissioning a benchmarking report from PwC in March 2015 (see Appendix 3 for further detail), we have also used the RightCare programme (see below) to identify further opportunities.

The NHS RightCare focus is:

- To expose and tackle unwarranted variation with a view to securing value.
- To develop clinical programmes to identify value opportunities.

Each CCG is clustered with 10 CCGs who have the most similar population and a rigorous benchmarking methodology applied on quality, outcomes and spend data, to highlight those clinical programmes where the CCG appears to be an outlier and therefore most likely to yield the most improvements to clinical pathways and policies. The comparator is also used against the average of the best five performers in the similar CCGs. Croydon's most similar CCGs are:

NHS Barking and Dagenham CCG	NHS Brent CCG	NHS Greenwich CCG	NHS Hillingdon CCG	NHS Barnet CCG
NHS Waltham Forest CCG	NHS Enfield CCG	NHS Haringey CCG	NHS Lewisham CCG	NHS Merton CCG

Headline opportunity areas for your health economy

Overall, benchmarking has highlighted good performance in some areas (Prescribing and Primary Care – see Appendix 3), as well as highlighting potential opportunities (Inpatient non-elective) for us to improve. To close the gap highlighted previously in this report, we need to target all areas for improvement, whilst noting that some areas may be more productive than others.

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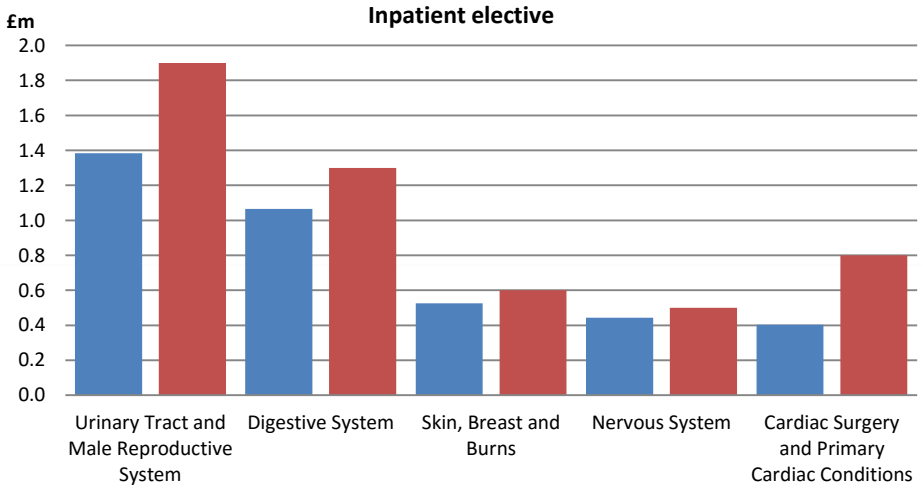
Benchmarking analysis - Acute

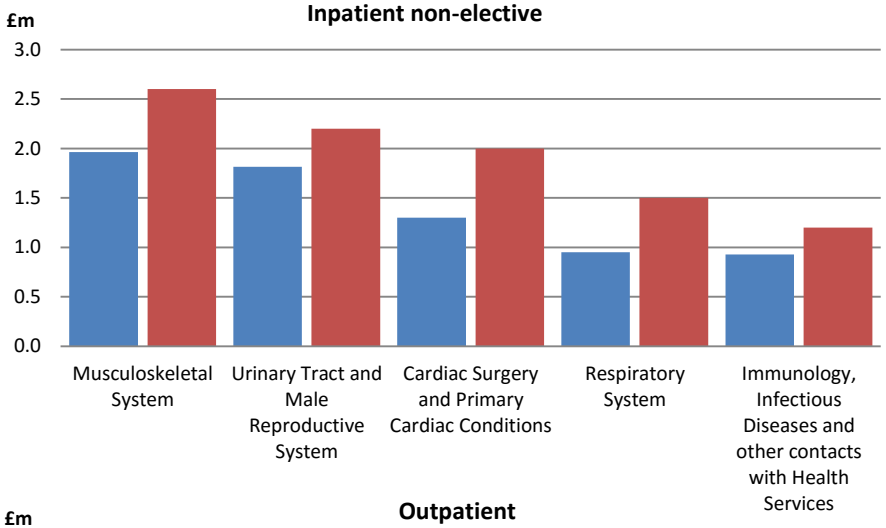
Acute benchmarking against our peers

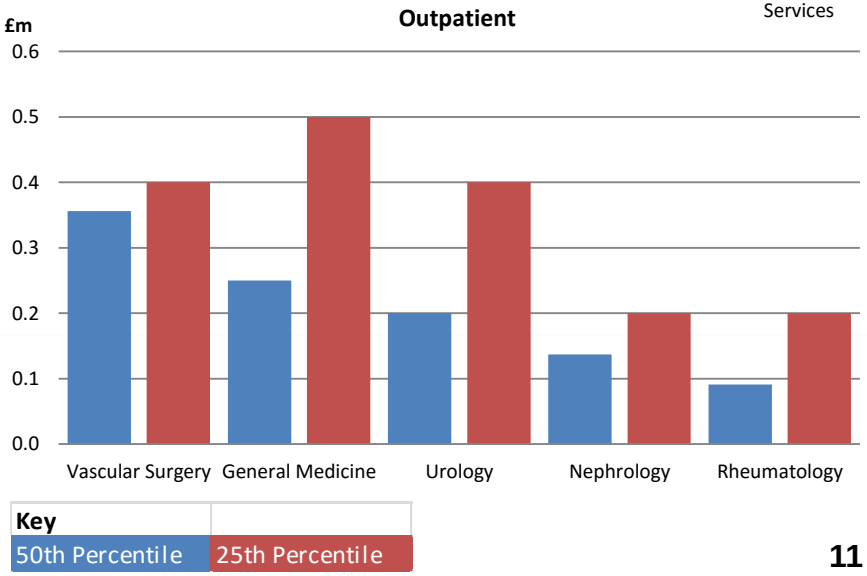
Benchmarking has recently been updated and savings of £16.1m (50th percentile) have been identified. The following table and charts summarise the disease chapters where the highest potential savings are available at 50th and 25th percentile.

Care Type	2014 Savings opportunities (£m)	Savings delivered in 2014/15 (£m)	2015 Savings opportunities 50th Percentile (£m)	2015 Savings opportunities 25th Percentile (£m)
Inpatient non-elective	5.5	2.8	9.7	15.7
Inpatient elective	7.4	3.51	3.8	7.6
Outpatient	1.4	1.72	1.0	1.8
A&E care	0.7	0.14	1.5	2.5
	15.1	**8.17**	**16.1**	**27.6**

Note that the 25th percentile values shown in the charts correspond to the top 5 disease chapters at the 50th percentile level, therefore does not imply that these are the top 5 under the stretch scenario.







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Financial performance - benchmarking

The below table shows the results of the benchmarking commissioned in March 2015 and illustrates where benchmarking has led to savings and RAG ratings of how we believe we have performed

Care Type	Annual spend (£m)	Benchmarked Performance*	Unexplained Variance at 50th percentile £m
Acute			
Inpatient non-elective	80.9	☹	9.7
Inpatient elective	44.0	😐	3.8
Outpatient	20.4	☺	1.0
A&E care	12.8	😐	1.5
Sub-Total Acute	**158.1**	☹	16.1
Prescribing	40.0	☺	0.8
Continuing Care	20.0	☺	-
Mental Health	52.0	😐	Secondary Beds
Primary Care (NHSE)	50.0	☺	-
			16.9

***Key**

- ☺ Favourable against Benchmark (low QIPP opportunity)
- 😐 Adverse against benchmark (moderate QIPP opportunity)
- ☹ Significant adverse against benchmark (high QIPP opportunity)

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Key Drivers of the 'Do Nothing' Plan

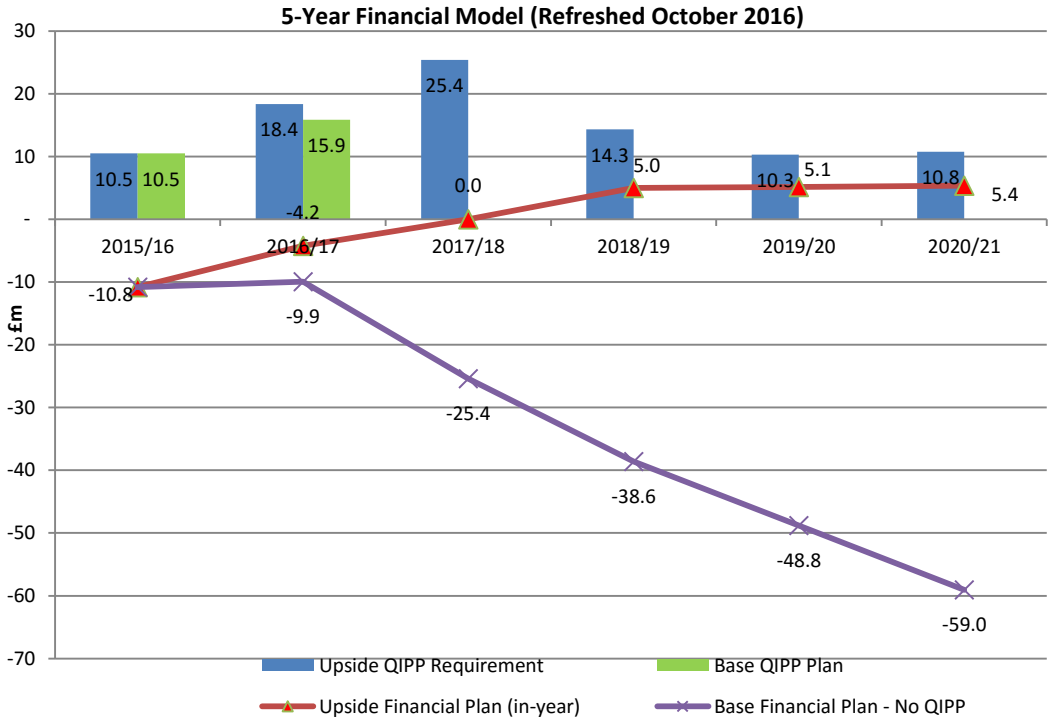
We are aiming to deliver in-year financial balance by 2017/18. On route to that, we are forecasting to deliver a financial deficit for 2016/17 of £9.9m. The graph opposite compares this plan with the impact of not delivering QIPP schemes – 'doing nothing'. This shows the importance of our delivering the annual QIPP schemes.

The key assumptions underpinning the forecast can be seen in Appendix 2, however a summary of key assumptions are:

- Allocation growth (programme) – 5.86% in 2016/17, 2.57% - 2.86% in 2017/20 and 4.65% in 2020/21;
- Gross provider efficiency (Acute) – 2.0%;
- Provider inflation (Acute) – 3.6% in 2016/17, 2.2% in 2017/18, 2.3% in 2018/19 and 2.4% thereafter;
- We anticipate OBC to begin realising financial benefits (over 65 QIPP) from 2017/18; and,
- QIPP savings (under 65s) are net of investment costs and savings assumed to realise in full.

Our focus for 2016/17

Given our successes in 2015/16, our organisational focus for 2016/17 is:



Implement

- Outcomes based Commissioning for over 65s
- Urgent Care Strategy

Implement at greater pace

- Prevention, self-management and shared decision making
- Mental Health Transformation

Develop and Implement

- Learning Disabilities Transformation plans
- Primary Care and Out of Hospital Strategy
- Obesity plan

2. Delivering Financial Recovery (2 years)

Our Financial Recovery approach

Croydon CCG is currently in Special Measures as a result of its forecast financial performance. It has therefore undertaken a wide range of measures in order to improve its financial position:

- Tightening of existing financial controls.
- Radical shift in emphasis from clinically-led QIPP to expenditure reduction initiatives and some decommissioning (see subsequent pages).
- External baseline review of (i) financial position, (ii) expenditure reduction opportunities and (iii) governance.
- Development of Financial Recovery Action plan to ensure continued grip across financial control, QIPP delivery, contract management and GP engagement.
- Secure additional financial recovery / turnaround capacity to support the organisation to respond to the challenge.

The following financial controls are also in place

- Recruitment - all recruitment to vacant posts is subject to a business case.
- Agency staff - all agency costs must be contained within agreed staffing budgets and comply with the agreed financial caps for each grade.
- All budget underspends revert to the control of the Chief Officer.
- All discretionary non-pay expenditure requires Director level approval.
- Any contract over-performance payments to be agreed by Chief Finance Officer and Director of Commissioning, on recommendation of Head of Contracting.

Subject to the outcome of the Well-Led Governance Review, further changes may be proposed to strengthen governance arrangements.

It should be noted that the specific management response to the actions arising from the Independent Financial Review are embedded in the plan, and specifically addressed in the appendices.

QIPP – Introduction

This section details how we take QIPP schemes through from idea generation to implementation, the governance processes in place and the current performance and risk across the QIPP Programme .

The CCG has a strong record of identifying and delivering its QIPP programme financial benefits in full. To ensure delivery of our QIPP programme, we have developed governance arrangements supported by a QIPP Programme Management Office ("PMO").

Our 2016/17 programme focuses on whole system redesign across a number of key areas including Cardiology, MSK and Urology. These areas of focus were identified where Croydon CCG appears to be an outlier on spend relative to peer CCGs identified using RightCare methodology.

In previous years, initiatives have focused on making a sustainable quality and financial impact across the entire pathway starting with prevention through to treatment in secondary care. One of our key transformational schemes, Transforming Adult Community Services (TACS), has delivered a number of initiatives (risk stratification, MDT, rapid response and intermediate care) to support older people in the community, restricting admissions within the hospital and reducing length of stay. Many of these initiatives were started in 2015/16 or earlier and 2016/17 will expand and build on their success.

Context

Croydon CCG's original 5 Year Plan forecast a deficit of £12.8m for FY16/17. This included the base QIPP programme savings of £7.0m.

In April 2016, NHSE requested that a further 2% QIPP (£8.6m) be identified in 2016/17, to bring the deficit down from £12.8m to £4.2m. This increased the amount of savings required in the year to be £18.4m.

In response to this, the CCG assessed the opportunities available and identified further areas of expenditure reduction.

Through the arbitration process on the SLAM contract, it was clear that a further £2.8m would have to be saved from Mental Health budgets to cover the cost of increasing adult mental health admissions and length of stay, hence this mitigated a new risk, rather than improve the deficit position.

The CCG has now identified the full additional £11.4m (£8.6m 2% plus £2.8m MH) and this is summarised below.

The programme for 2016/17 therefore has four distinct elements:

1.	Base QIPP Programme	£7.0m
2.	Wave 1 Expenditure Reduction	
	Stretch the TACS Programme	£1.4m
	Mental Health Restructuring	£2.8m
	Expenditure Reduction 1 (ECIs/Top 5%/Variation/Prescr Waste)	£1.5m
	Sub-Total	**£12.7m**
3.	Wave 2 Expenditure Reduction (incl NR)	£4.7m
4.	Wave 3 Expenditure Reduction	£1.0m
	Total	**£18.4m**

Our historical performance is summarised below:

Year	13/14	14/15	15/16	16/17
Target	£14m	£11m	£10.5m	£18.4m
Plans	£19m	£12.24m	£11.5m	£17.4m
Delivered	£14m	£11m	£10.5m	n/a

Expenditure Reduction initiatives we are not taking forward

The required pace of change has meant that the CCG has explored a variety of options to reduce expenditure. These have been assessed against a set of criteria (see Appendix 4) in order to ascertain whether the option is viable for further investigation. The criteria is centred on the ease of implementation vs the financial benefit. Based on the results of this assessment, some of the options tabled have not been considered. Below we have outlined a selection of these.

Expenditure Reduction Initiative	Rationale
Reducing investment in the Better Care Fund (BCF)	Withdrawing funding would impact the delivery of the OBC model for the over 65s. It would reverse the CCG's ability to reduce non-elective admissions in the short and long-term, at the detriment of patient care and increased cost to the NHS.
Referral to treatment: increasing waiting times for outpatients, diagnostics and elective surgery	Extending waiting times for a number of appointments and treatments would have a significant short term impact on patient care.
Reducing GP hubs in the borough from four to three	The public has recently been engaged on this model and based on the outcomes of this, this would not be help to achieve the CCG's objectives for the redesign of Urgent Care.
Reducing funding to Child and Adolescent Mental Health Services (CAMHS)	Given the preventative impact that these services have in reducing mental health in later life, the CCG decided against making savings from this initiative.
Reducing investment around Outcomes Based Commissioning (OBC)	Although the CCG will seek to minimise costs as far as possible, the OBC is a crucial way of making the local health and social care economy sustainable in the longer term.

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QIPP – Wave 1 Programme (£12.7m)

Base QIPP programme 2016/17 year to date position at month 4 (July)

Project	Project Manager	Project Sponsor	M4 YTD actual (£000)	M4 YTD plan (£000)	Variance (£000)	2016/17 plan (£000)	2016/17 forecast outturn (£000)	Variance (£000)	Project RAG status
Mental health reprioritisation	Jennifer Francis	Mike Sexton	827	927	-100	2,781	2,781	0	A
TACS	Ivan Okyere-Boakye	Mike Sexton	749	784	-35	2,352	2,352	0	G
Prescribing	Janice Steele	Mike Sexton	709	800	-91	1,200	1,200	0	G
Learning Disabilities	Sue Culling	Elaine Clancy	-16	166	-182	1,016	1,016	0	G
Overseas visitors (charges exempt)	Marion Joynson	n/a	0	0	0	500	300	-200	A
Top 2% complex patients	David Roskam	Mike Sexton	0	0	0	500	500	0	R
Respiratory	Nick Clinch	Stephen Warren	-80	155	-235	465	221	-244	A
Cardiology	Nick Clinch	Stephen Warren	203	0	203	446	446	0	A
Reduced variation	Helen Goodrum	Mike Sexton	0	0	0	400	400	0	A
Adult Continuing Care	Michaela Quinn	Stephen Warren	-210	-210	0	370	370	0	G
End of Life Care	Lucky Hossain	Stephen Warren	102	111	-9	350	350	0	G
Trauma & Orthopaedics	Oliver Paul	Stephen Warren	0	0	0	320	160	-160	A
ECIs	Jimmy Burke	Paula Swann	0	0	0	300	300	0	R
Falls and Bones Yr 3	Oliver Paul	Elaine Clancy	-137	100	-237	300	156	-144	R
Fetal medicine	Mike Sexton	n/a	0	0	0	300	300	0	G
Prescribing (waste)	Helen Goodrum	Mike Sexton	0	0	0	300	300	0	G
High Cost Drugs (bio-similars)	Philippa Blatchford	Mike Sexton	65	67	-2	200	120	-80	G
In Health Diagnostics	Aarti Joshi	n/a	67	67	0	200	200	0	G
Mental Health	Jennifer Francis	Mike Sexton	67	67	0	200	200	0	G
Anti coagulation	Paula Halfhide	n/a	16	64	-48	191	0	-191	R
Digestive System	Jill Anderson	Elaine Clancy	0	0	0	184	92	-92	R
Neuro Rehab	Michaela Quinn	Stephen Warren	18	36	-18	180	90	-90	A
Urgent Care	Jack Edge	Paula Swann	18	36	-18	180	35	-145	R
Diabetes - transactional	Paula Halfhide	n/a	38	47	-8	140	115	-25	G
Urology	Jill Anderson	Stephen Warren	-115	35	-150	106	53	-53	A
Paediatrics Asthma	Jane McAllister	Stephen Warren	-47	34	-81	103	103	0	R
Urgent Care recharges	Jack Edge	n/a	0	33	-33	100	100	0	A
Procedures not carried out	Aarti Joshi	n/a	8	30	-23	90	90	0	R
Epilepsy	Nick Clinch	Elaine Clancy	17	24	-8	73	73	0	G
Reduced Direct Access Diagnostics	Jill Anderson	Paula Swann	30	18	12	55	25	-30	A
Termination of Pregnancy	Paul Cooper	n/a	0	0	0	45	45	0	A
Tendancy to Fall	Oliver Paul	Elaine Clancy	0	0	0	-80	-80	0	G
NETA	n/a	n/a	-296	-400	104	-1,200	-1,200	0	n/a
		TOTAL ('000s):	**£2,031**	**£2,992**	**-£960**	**£12,667**	**£11,213**	**-£1,454**	

Wave 2 - Expenditure Reduction

Identification of further savings

To address the £5.7m gap between the £9.9m deficit submitted to the governing body and the £4.2m deficit requested by NHSE, a list of possible savings opportunities, including decommissioning have been drawn up and reviewed at key meetings, including:

- Business Planning
- QIPP Operations Board
- Senior Management Team
- Clinical Leaders Group.

Each proposal was scored based on the impact of the programme versus the appetite to take it forward, with 1 meaning "unthinkable to implement" to 5 meaning "has merit to review current ways of working".

As a result of these meetings, further expenditure savings were identified "Wave 2 Expenditure Reduction" (see next slide), that will have an in-year impact. These included a mix of some transactional, as well as some transformational and decommissioning. A further "Wave 3" of expenditure reductions have been identified and are in the scoping stage.

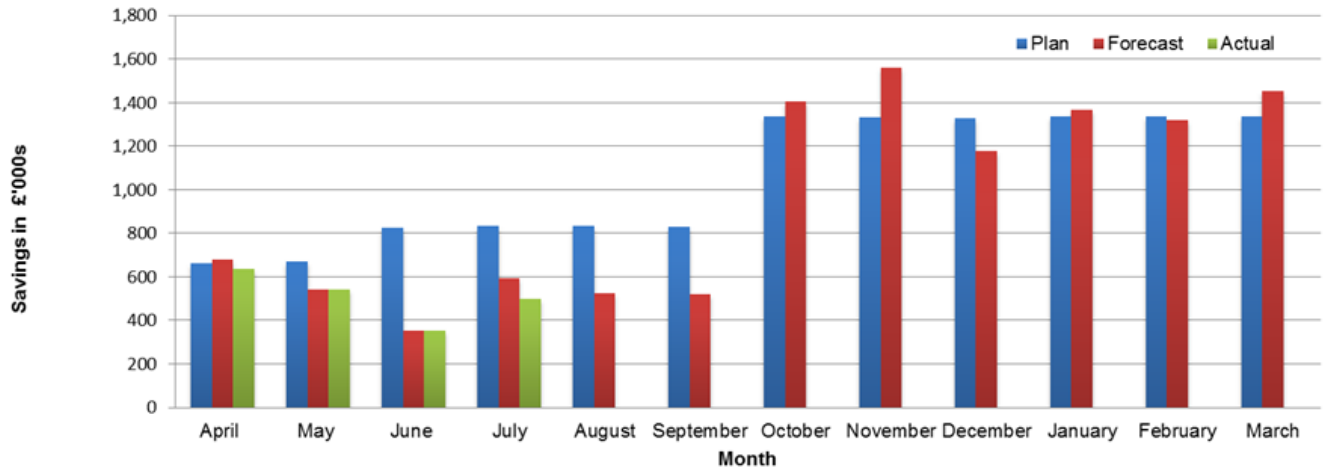
Wave 2 projects financial risk

The Wave 2 projects currently carry greater risk a due to their early stage of development.

Projects	RAG rating	Collective planned value of projects ('000s)	Percentage of programme	RAG adjusted value of outturn ('000s)	RAG M3
6	R	£2,293	49%	£688	£1,600
9	A	£1,275	27%	£765	£0
8	G	£1,138	24%	£1,024	£0
23		£4,706	100%	£2,477	£1,600

Position to date

These are expected to realise a phased delivery of £3.2m in the second half of the financial year. A further £1.5m of non-recurrent savings (in the form of uncommitted quality premium funds and a significant reclaim from Specialised Commissioning) has been identified.



Wave 2 Expenditure Reduction

Wave 2 2016/17

In working up these initiatives the CCG undertook a scoping and prioritisation exercise. A combination of clinical and administrative intelligence was gathered alongside information from other CCGs and contributions of national best practice examples from PwC.

To establish an objective measure of priority for the long list of initiatives identified, the CCG used an assessment tool to rate initiatives against:

- Patient benefit
- Clinical benefit
- National priority
- Local priority
- Stakeholders
- Buildings and equipment
- Workforce
- Service delivery
- Financial benefit

A composite score provides a measure of each project's potential financial contribution compared against its ease of implementation. This is shown on the next slide, with the most desirable projects in the lower right hand quadrant.

This methodology will be used for the newly identified Wave 3 initiatives and in the development of the 2017/18 QIPP Programme.

Wave 2 Project	#	2016/17 FYE (£000)	2016/17 PYE (£000)	Ease of implementation consolidated score*
CSU	1	400	400	23
CReSS	2	300	100	35
PDDS underperformance	3	200	200	21
LIS's	4	500	250	27
OBC Running Costs	5	200	100	23
Voluntary Sector (MH)	6	100	25	31
Interims	7	300	300	21
Prescribing - Emollients	8	150	75	30
Prescribing - Over the Counter	9	220	55	33
Prescribing - staggered dispensing	10	200	200	43
Prescribing - Vitamin D	11	200	100	33
Prescribing - Lidocaine	12	57	57	26
Prescribing - Liothryonine	13	40	10	28
Prescribing - Travel Immunisations	14	56	14	22
Prescribing - Gluten free	15	80	0	34
Greenbrook / Caterham Dene repatriation	16	600	100	31
Moorfields	17	300	200	35
Evergreen	18	800	400	26
SLaM cost per case (Tony Hillis Unit)	19	100	100	24
Surrey & Borders	20	400	100	38
Waiting List review - acute	21	87	43	31
Outpatient Services & Demand Management	22	3000	200	40
TOPS	23	137	137	21
Paediatric SALT	24	80	40	25
Roving GP	25	0	0	36
Fertility & IVF Services	26	700	0	50
Intermediate Diabetes	27	500	0	24
Increase uptake of Personal Health Budgets	28	50	0	22
Specialised Commissioning challenge (non-recurrent)	29	N/A	1100	24
No new investment in Quality Premium schemes (non-recurrent)	30	N/A	400	29
		£ 9,757	£ 4,706	

Wave 3 – In development

Wave 3 - Potential initiatives				Financial Benefit		
#	Title	Description	Next step	FYE (£000)	2016/17 PYE (£000)	2017/18 (£000)
B2	PDDS	Funding reduction of 2% (i.e. reduce budget to £1.8m)	Scoping	200	200	200
B5	Review all non-mental health community services	Seek assurance on value for money (VfM) on each community service. Assume a 5% savings on re-procurement for any service unable to demonstrate VfM	Scoping	200	0	200
B7	IAPT services	Review and recommission IAPT and counselling Services	Scoping	500	0	500
B8	Review access to New Oral Anti-coagulation (NOAC) drugs	Review NOAC v Warfarin cost effectiveness with a view to restricting prescribing of NOACs if value for money cannot be demonstrated.	Scoping	TBC	TBC	TBC
B9	Review prescribing of medicines of marginal clinical efficacy	Review prescribing for items of limited clinical efficacy such as baby milk	Scoping	TBC	TBC	TBC
B11	Apply threshold to therapeutic interventions	Restrict access to surgical treatment where evidence base/NICE guidance suggests co-morbidities will limit clinical effectiveness	Scoping	TBC	TBC	TBC
B12	Review cost & clinical effectiveness high cost drugs	Apply an ECI approach to non-specialist commissioned high cost drugs - reviewing cost effectiveness and restrict where value for money cannot be establish	Scoping	TBC	TBC	TBC
B14	Review access to elective caesarean section	Limit access to elective caesarean sections to those required on defined clinical grounds only. Studies have indicated 2.5% of caesareans are on maternal request. Forecast spend on elective caesarean for 2016/17 = £1.2m	Scoping	30	8	30
B15	RAMU	Review to establish return on investment. If good value for money cannot be established consider decommissioning	Scoping	TBC	TBC	TBC
B17	Voluntary sector contracts	Review all contracts to ensure services commissioned only cover CCG constitutional duties.	Scoping	500	125	500
B21	Decommission intermediate gynaecology Service	Serve notice on contract (held with BMI) immediately with no reprovision with an alternative	Scoping	400	100	400
B22	Decommission Respiratory hot Clinic		Scoping	330	83	330
				£2,160	**£516**	**£2,160**

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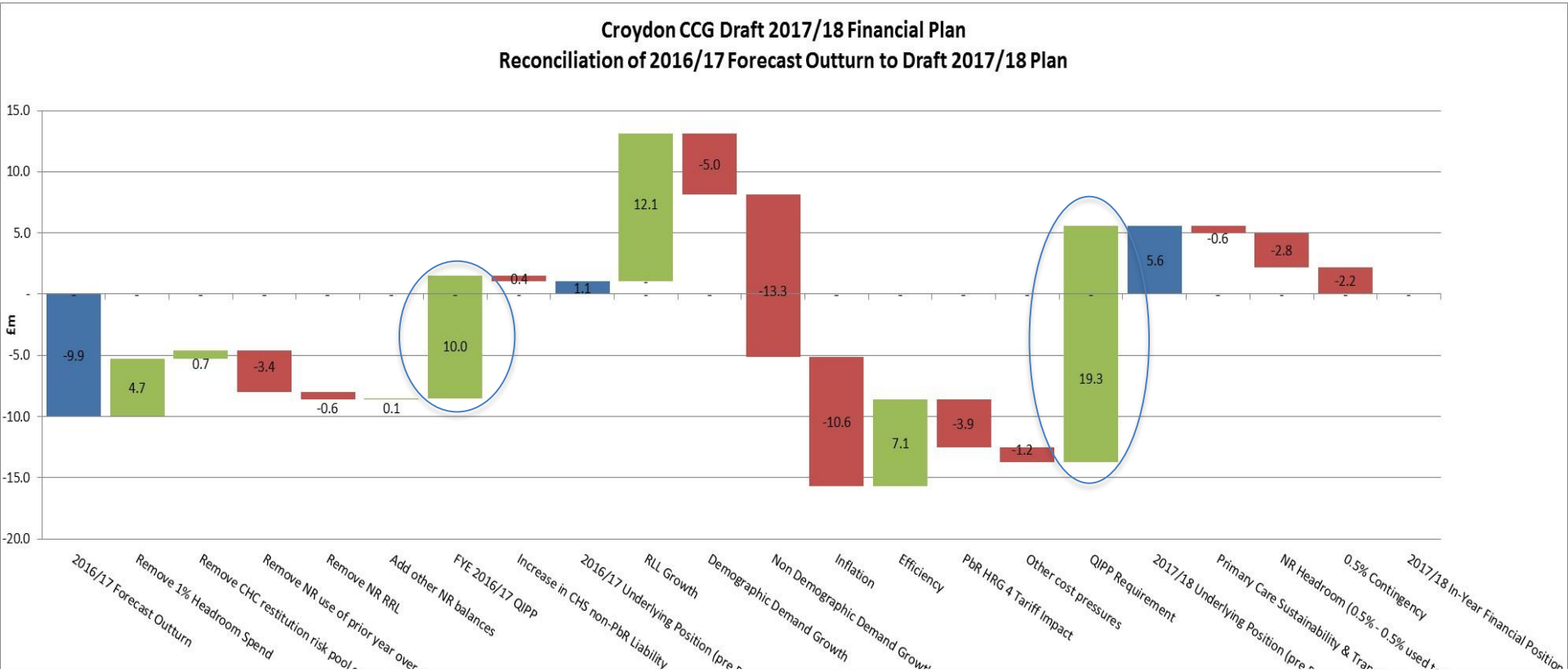
2017/18 – Financial Model
£29.3m QIPP Challenge to deliver breakeven



2017/18+ Expenditure Reduction Plans

The following table summarises the expenditure reductions plans with detail behind each line in the following tables.

Schemes	20/17/18 Additional £000s	2018/19 Additional £000s	2019/20 Additional £000s	2020/21 Additional £000s
2016/17 Wave 1	2,822	1,600	600	600
2016/17 Wave 2 + 3	7,347	2,610		
2017/18 New	14,669	10,779	6,679	6,680
To be identified	4,456	(652)	3,014	1,635
TOTAL EXPENDITURE REDUCTION	**29,294**	**14,337**	**10,293**	**8,915**
% of Allocation				

2017/18+ Expenditure Reduction Plans

2016/17 Wave 1 Schemes – Full Year Effect	20/17/18 Additional £000s	2018/19 Additional £000s	2019/20 Additional £000s	2020/21 Additional £000s
Cardiology	446			
Complex Patients	500	500		
Trauma & Orthopaedic	320			
Digestive System	184			
Urgent Care	36			
Procedures of Limited Effectiveness	300			
Prescribing Waste	600	600	600	600
Reduced Variation in Referrals/Access	400	500		
Neuro Rehab	36			
TOTAL Wave 1	**2,822**	**1,600**	**600**	**600**

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2017/18+ Expenditure Reduction Plans

2016/17 Wave 2 + 3 Schemes – Full Year Effect	20/17/18 Additional £000s	2018/19 Additional £000s	2019/20 Additional £000s	2020/21 Additional £000s
Redesign Referral Management Service	200			
Community Contract efficiency	420	460		
Fertility Treatment (incl IVF)	700			
Reduce development cost of OBC	100			
GP Local Enhanced Services	250			
Refocus Voluntary Sector Contracts	75	200		
Effective/Appropriate Prescribing	493			
Urgent Care Flows (Non local sites)	50	450		
Diabetes	500			
Paediatric Asthma	200			
Evergreen	400			
Responsible Commissioner (Surrey&Borders PLD)	300			
Outpatients	1,300	1,500		
Other	229			
Wave 3	2,130			
TOTAL Wave 2 + 3	**7,347**	**2,610**		

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2017/18+ Expenditure Reduction Plans

2017/18 New Schemes	20/17/18 Additional £000s	2018/19 Additional £000s	2019/20 Additional £000s	2020/21 Additional £000s
Strategic: A&E Attendances	900	900		
Strategic: Emergency Admissions	1,700	1,700		
Strategic: Prevention and Pubic Health	802	802	802	802
Strategic: Outpatients	2,137	2,137	2,137	2,137
Strategic: Elective Inpatients/Day Case	1,540	1,540	1,540	1,540
Medicines Optimisation	1,700	1,200	1,200	1,200
Mental Health	2,300	500		
Continuing Health Care	2,000	2,000	1,000	1,000
Learning Difficulty Placements	1,000			
Urgent Care Procurement	590			
Unidentified	4,456	(652)	3,014	1,635
TOTAL New Schemes	**14,669**	**10,779**	**6,679**	**6,680**

CCG NET QIPP Requirement: 2017/18

	Prior Year £000s	Transformation £000s	Business as Usual £000s	To be developed £000s	Total £000s
2016/17 FYE	2,522				2,522
Wave 2	5,217				3,352
Wave 3	2,130				2,130
Emergency Care/Outpatients		7,079			7,079
Prescribing/Cont Care			7,790		7,790
To be developed				4,686	4,686
Total QIPP	**9,869**	**7,079**	**7,790**	**4,686**	**29,424**
Stretch @ 20%				5,885	5,885
Total Stretch QIPP	**9,869**	**7,079**	**7,790**	**10,571**	**35,309**

Acute GROSS QIPP by POD/Trust: 2017/18

	A&E Attend. £000s	Planned Adm. £000s	Emerg. Adm £000s	Out-patients £000s	Other £000s	Total £000s
CHS NHS Trust	1,338	2,839	3,257	5,798	1,193	14,426
St Georges NHS FT	182	356	412	769	162	1,881
Kings College Hospital NHS FT	145	284	328	613	130	1,500
Guys & St Thomas' NHS FT	61	119	138	258	54	630
Epsom & St Helier NHS Trust	73	142	164	307	65	751
Moorfields Hospital NHS FT	0	0	0	100	0	100
Total	1,800	3,740	4,299	7,846	1,604	19,289

* Reinvestment is currently planned at £8,379k

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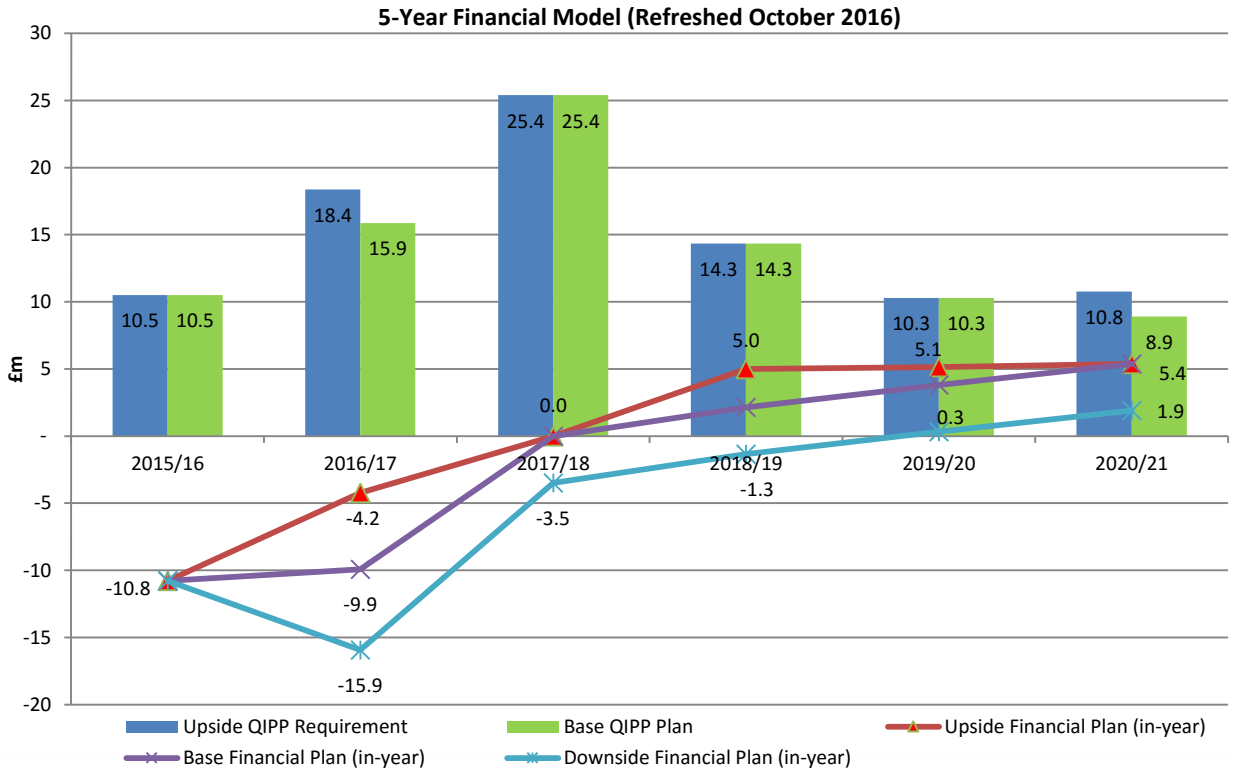
5 Year Financial Model - Sensitivity

The graph below models the upside and downside impact on our financial position, as well as the cumulative deficit over the 5 years. Details of the assumptions behind the scenarios can be found in Appendix 2.



Mitigating these scenario risks

We believe there are actions that we can take that could help us manage and mitigate (where possible) the scenario variables:

- Allocation – This is to be discussed with NHSE explaining the impact on the financial position;
- Demand growth – Continue to monitor population changes. Continue to work closely with our acute providers in monitoring and managing the acute activity; and,
- QIPP & OBC – Continue to project manage QIPP delivery. If OBC does not deliver, where possible, QIPP to be used as an alternative efficiency mechanism.

4. Delivering a Sustainable Financial Position

Our strategic approach to recovery

Below are the steps we are going to take in order to reach our goals:

Delivery of our existing QIPP stretch plans
As noted, in previous years we have had success in delivering our QIPP plans. We are continually reviewing areas where schemes can be stretched, identifying new areas where savings can be made and implementing decommissioning programmes where appropriate. Details of our current QIPP schemes are detailed on slide 22.

Roll-out of Outcome Based Commissioning for over-65s – this is presently planned for 2016/17
Details of OBC can be found on slide 36. In summary, we are driving towards an OBC contract being in place from April 2017 with an increase in financial benefits being realised from 2017/18. The level of savings will be dependent on the final scope and degree of integration the provider alliance achieves in its model of care in the first three years. Our expectation is that the scope of OBC will be broadened in future years.

Opportunities for the CCG as a result of developing our joint commissioning arrangement
We have joint commissioning arrangements with Croydon Council that includes joint commissioning for mental health, learning disabilities and children's services. It is providing a platform for joint working for commissioners across Croydon. As a result the CCG and Local Authority are now working much more effectively across CAMHS and children with Special Educational Needs.

Implementation of our transformation programme for Adult Mental Health Services
A clinical and financial strategy has been agreed that moved resources from reactive inpatient beds to proactive community support. Despite this, the CCG has experienced a rise in the demand for inpatient beds and has commissioned an independent review to ascertain the drivers behind this spike in demand and how resources can better be redirected.

Reducing variation in Primary Care that presently exists across the borough
The CCG has a number of initiatives in place aiming to reduce the levels of variations in primary care between practices. This includes spot peer review (which has worked well to date) and identifying practices with high referral rates to actively work with them. Our MDT teams have also been working across practices and we have been monitoring utilisation of these teams by practices. The aim of which being to improve the coordination of care and management of long-term conditions.

Working with the South-West London Commissioning Collaboration and London Commissioning System Design Group (LCSDG)
To meet the London Quality Standards and 7 day waiting, it is essential that the commissioners and providers assess SWL collaboratively to deliver structural change that enables delivery of the standards. The CCG is also fully engaged with the development of the South West London Sustainability and Transformation Plan and the South East STP for mental health and learning disabilities.

Sustainability and Transformation Plans (STP)

Objectives

- Reduction of emergency care beds by 50% (including End of Life Care).
- Reduce/Stop Outpatients including follow ups (including decommissioning).
- Prevention agenda and Self Care.
- Managing Long Term Conditions – identification and management.

Interaction of STP and QIPP

As explored in the previous slides, the base QIPP programme has delivered strong in-year cost efficiencies and with the scoping and design of Waves 2 and 3, will continue to do so into 2017/18.

Beyond this, it is vital that the CCG works across the SWL health economy to build the detail to ensure the key programmes of work identified in the STP start having an impact.

The CCG is already an active participant in STP delivery and is taking definitive action to drive STP workstreams, for example in respect of agreed prescribing initiatives.

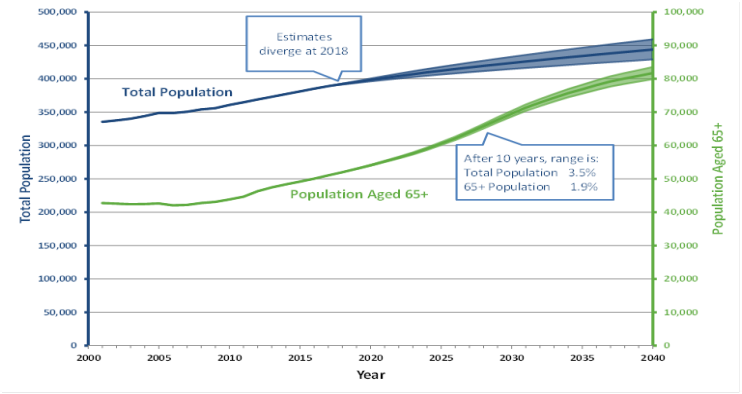
However, the CCG recognises that further work is required to implement the plans at both a local and SWL level and that the reconfiguration of services and streamlining of effort through STP implementation is key to financial sustainability for Croydon.

Outcomes Based Commissioning (OBC)

We have formed a commissioning partnership with the London Borough of Croydon where our shared aim is to provide a seamless system of healthcare and wellbeing through new innovative models of integrated care. We expect OBC to become operational in 2016/17.

Significant engagement with providers locally has meant that key providers, CHS, SLAM, our GP's, Social Care and Age Concern have come together to form an alliance, with an intended start date of 1st April 2017.

The care programme aims to deliver a new risk stratified care model for the over 65 population that is person-centred, well coordinated and best meets the needs of patients and service users on a sustainable basis. Our intention is to roll out across the whole population in line with our commissioner intentions to extend outcome-based capitation contracts.



The key delivery benefits

OBC can have several advantages to commissioners, providers and patients. These include incentivising providers to consider preventative measures which can lead to improved patient outcomes and experience, together with an overall reduction in:

- Acute spend;
- Non-elective admissions; and,
- Length of stay.

The associated financial benefits

We estimate that the savings will begin in 2017/18, building on from the work already started around Transforming Adult Community Services, End of Life Care and Falls and Bone Health. We have already agreed savings in our Older Adult Mental Health Inpatient costs in 2016/17 (£818k Gross) as a result of investment (£500k) into older adult community services which is already starting to realise a reduction in occupied bed days. A forecast of the savings for the first five years are set out below. It is worth noting that these numbers are high level estimates based on our current knowledge. We are continuing to develop our plans in collaboration with other stakeholders in order to provide firmer estimates of the likely savings.

How this will be delivered

The breadth of the scope and the requirement to develop and deliver new models of care that realise the outcomes for all older people in Croydon means that no single provider will be in a position to deliver this contract. This means that providers will agree how they will work together in new partnerships.

Key features of the contract are:

- For Year 1 there will be two contracts and budgets in place with the Accountable Provider Alliance (APA) for health and social care from the CCG and Council respectively
- After Year 1 the two contracts will be subsumed into one contract with the APA and a Section 75 agreement with a pooled budget when agreed milestones achieved
- Performance judged on the overall outcome measures of the contract, aligning the interests of the different providers
- Providers would have collective responsibility for delivering the outcomes and this will be set out in a contractual agreement between them along with the appropriate governance arrangements.
- Providers would be able to bring additional parties into the alliance to improve capability and capacity.

5. Ensuring implementation

Given the magnitude of this Plan, its implementation and delivery will require a significant change to the way Croydon CCG operates. This section details how the plan will be implemented, how the risks will be managed, and the leadership and governance structures in place to ensure that delivery of the Plan occurs.

These have been expanded on in the following section.

Engagement with stakeholders

Given the scope and scale of changes the CCG is currently undergoing, it is vital for Croydon CCG to engage fully with its local partners and stakeholders and consider all patients in any decision making processes. Croydon is committed to fulfilling its responsibilities under section 14Z2 of the Health and Social Care Act (2012) to:

"Make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them."

Before any of the projects mentioned are put into action, a series of engagement and consultations are conducted to:

- Identify patients and/or groups of patients who may be disproportionally affected by any service changes
- Assess any potentially negative (or positive) impacts on populations sharing protected characteristics (Equalities Impact Assessment)
- Gather and assess existing patient experience data, working closely with Healthwatch Croydon

Through these consultations, the CCG has identified and worked with key contacts, including the following groups:

- Mental Health service users – MIND and HereUs
- Refugee and Asylum seekers – through Croydon Voluntary Action
- BME led community groups – Asian Resource Centre, BME Forum
- Food banks - New Addington and Selhurst
- Young people with learning disabilities – People First, Wadhurst Youth Centre
- Frail older people - Age UK, New Addington Lunch Club, Shirley Neighbourhood Centre
- Parents of young children under five years old - Fieldway Family Centre, Woodlands Children's Centre
- Voluntary and Community Support organisations working in the New Addington, Broad Green, Thornton Heath and West Croydon wards

Croydon CCG recognises the need to communicate any proposals with local people, to discuss with them how the CCG wants to prioritise spend on health services, and to understand from them what they would like the CCG to prioritise.

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Financial Recovery – governance process

Once QIPP schemes are implemented, they are regularly reported to, and progress reviewed by, committees within Croydon CCG's governance framework. Key of these committees are:

Croydon Recovery Group

- Chaired by Chief Officer, attended by Directors, and Recovery Director.
- Reports to Finance Committee
- Scrutinises and challenges delivery across QIPP, Contract Mngt, GP Variation, Finance and Performance.
- Meets fortnightly (weekly initially)

QIPP Operations Board (QOB)

- QOB oversees the entire QIPP programme including oversight of risks, receiving escalation reports and challenging and supporting project teams.
- Projects are brought to QOB on a rolling basis based on current RAG status with Red schemes being recalled fortnightly, Amber monthly and Green bi-monthly (see table below for definitions including examples of rating factors).
- QOB is chaired by a Clinical Leader and supported by the CFO. The focus of discussions is on delivery against metrics and agreed actions.
- QOB is supported by the PMO team who meet at least monthly with each project manager reviewing progress, project plans, risks and issues.

PUCCG – Planned & Urgent Care Commissioning Group

- Meets monthly around business day 10 to feed outcomes into CRG.
- Its purpose is to look specifically at the management of the acute portfolio, looking at the delivery of the KPI benefit and other contractual levers, the overall financial performance against contract and the triangulation of QIPP and acute financial performance.
- The group covers the breadth of acute providers and their issues, with particular focus on CHS.
- The success of the recovery programme is highly dependent on the relationship with the main acute provider. CHS is an integrated acute and community provider and is key to the integration agenda.

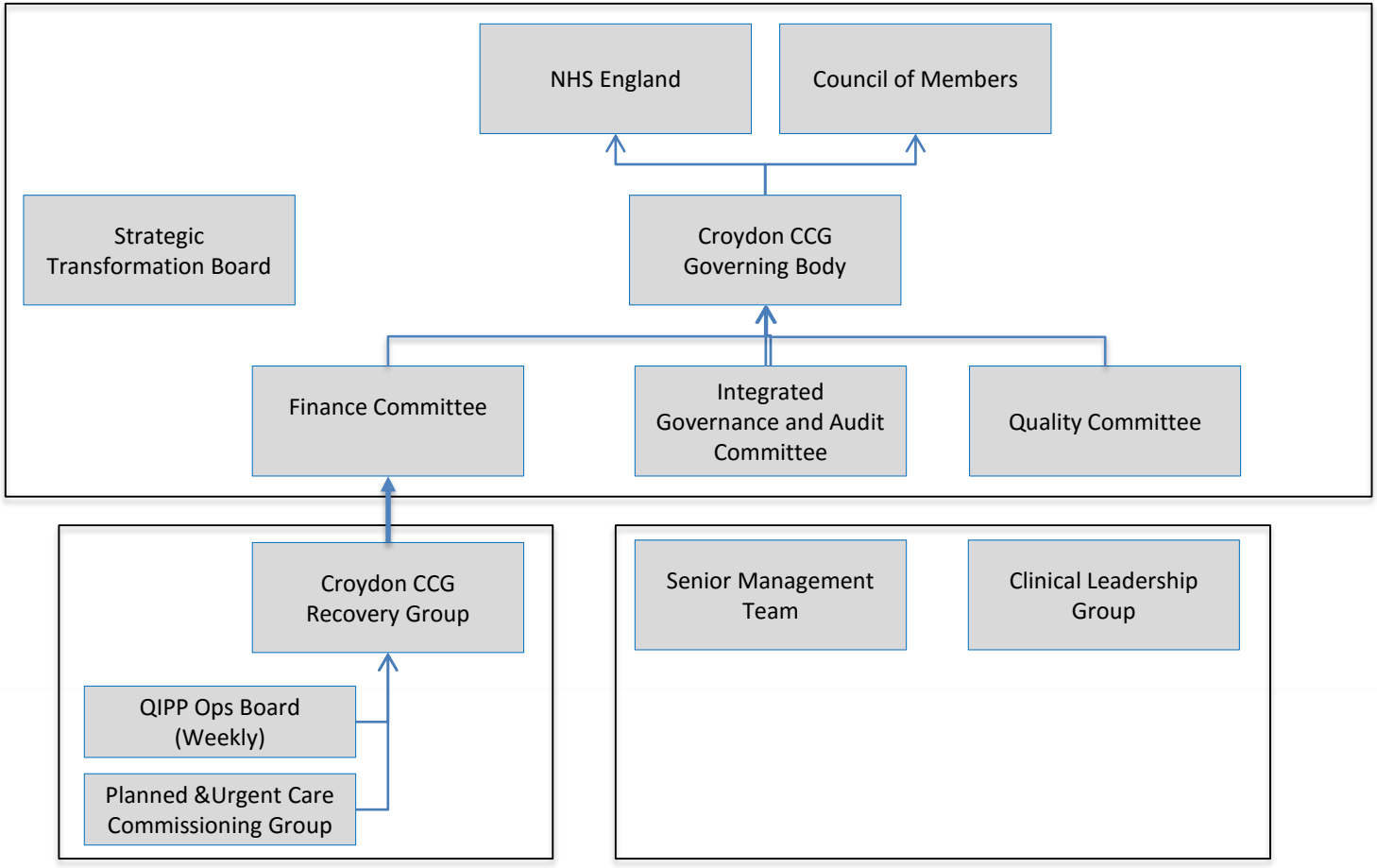
Individual project steering groups

- Each project has its own steering group that meets monthly, chaired by a CCG Clinical Lead with managerial and clinical membership from the Trust.

Delivery Criteria	RED (Risk adjust financials to 30%)	AMBER (Risk adjust financials to 60%)	GREEN (Assume 90% delivery)
Overall Project RAG	**Low likelihood of achieving project targets**	**Medium likelihood of achieving project targets**	**High likelihood of achieving project targets**
Project Complexity	• High complexity • Many stakeholders or interdependencies with engagement/ ownership still to be developed	• Medium complexity • Many stakeholders or interdependencies with evidence of joint ownership	• Low complexity • 1 or 2 key stakeholders & full engagement • Project is a contract adjustment that has been negotiated
Project Track Record on Delivery (Milestones and Financial)	• Project is still in Outline Business Case stage or still requires PID work-up • Project has a track-record of poor performance	• Project has not yet started • Project has underperformed previously	• Project has a track-record of good performance • Project is a full-year-effect (FYE) of a successful scheme
Clinical Engagement in Primary and Secondary Care (proportionate to the project)	• No active clinical engagement	• Some active clinical engagement but this needs strengthening	• High level of clinical engagement e.g. clinical steering group in place for complex projects

Governance Structure

The diagram below shows the meeting structure which supports the governance of the financial improvement plan with the ultimate aim of assuring the CCG's membership that an improved financial position is being delivered without compromising quality. There are 3 committees in place which collectively provide assurances to the Governing Body.



6. Conclusions

Since its formation in 2013, Croydon CCG has worked to reduce the deficit that had built up under its former structure, Croydon PCT, reducing the deficit from £18.2m in FY13/14 to £10.8m in FY15/16.

Croydon CCG recognises the need to continue to reduce the deficit, through a combination of QIPP, decommissioning and other cost reduction and efficiency gaining measures, whilst maintaining quality.

Croydon CCG has used a wide range of tools, including benchmarking under the RightCare programme, in order to highlight areas of inefficiency and opportunity to improve services.

The majority of the savings come from the QIPP programme. These consist of a wide range of proposals, some of which are relatively easy to implement, whilst others may be more difficult and unpopular.

Croydon CCG is determined to continue and expand on the successful work it has already started in this area in order to meet the long term financial and non-financial targets it has to achieve.

Overall, Croydon CCG is determined to deliver this Plan, and is confident that it can drive the financial recovery that will return the CCG to sustainability.

Appendices

1. Plan assumptions – Base Case

Description	Type	2015/16	2016/17 Year 1	2017/18 Year 2	2018/19 Year 3	2019/20 Year 4	2020/21 Year 5
Allocation Growth (+%)	Programme	6.84%	5.86%	2.57%	2.73%	2.86%	4.65%
Gross Provider Efficiency (-%)	Acute	-3.50%	-2.00%	-2.00%	-2.00%	-2.00%	-2.00%
	Non Acute	-3.80%	-2.00%	-2.00%	-2.00%	-2.00%	-2.00%
Provider Inflation (+%)	Acute	3.00%	3.10%	2.20%	2.30%	2.40%	2.40%
	Non Acute	3.00%	3.10%	2.20%	2.30%	2.40%	2.40%
Demographic Growth (+/- %)		1.10%	1.10%	1.10%	1.10%	1.10%	1.10%
Non-Demographic Growth (+/- %)	Acute	3.60%	2.56%	2.56%	2.56%	2.56%	2.56%
	CHC	3.90%	6.90%	6.90%	6.90%	6.90%	6.90%
	Prescribing	4.90%	3.90%	3.90%	3.90%	3.90%	3.90%
	Other Non Acute	0.00%	2.00%	2.00%	2.00%	2.00%	2.00%
QIPP Percentage (including OBC)		1.93%	3.90%	6.03%	2.60%	2.00%	2.00%
Contingency (%)		0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
Non-Recurrent Headroom (%)		0.50%	1.00%	0.50%	0.50%	0.50%	0.50%
Surplus Requirement (%)		1.00%	0.00%	0.00%	1.00%	1.00%	1.00%

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'Do Nothing' Financial Model

The Five Year Plan outlined below shows the forecast for the CCG excluding the QIPP programme. The incremental incease in the deficit each year highlights the significant challenge to deliver financial balance

	2016/17 M5 Outturn £'000	2017/18 Plan £'000	2018/19 Plan £'000	2019/20 Plan £'000	2020/21 Plan £'000
Revenue Resource Limit	**474,974**	**487,656**	**500,544**	**514,668**	**538,246**
Expenditure					
Acute services	283,702	295,589	314,169	329,570	345,688
Mental Health services	56,134	57,470	59,264	61,114	63,022
Community services	35,664	36,357	37,492	38,663	39,870
Continuing Care services	30,076	33,760	37,216	41,026	45,226
Primary Care services	8,203	7,078	7,977	8,308	8,653
Prescribing	42,922	45,081	47,354	49,742	52,251
Corporate Costs	5,334	5,095	5,115	5,135	5,155
BCF - LA Transfer	8,908	9,323	9,614	9,914	10,224
NR Funding	6,592	4,792	4,921	5,062	5,298
Cost Pressures - 0.5% on Business Rules	-	-	2,461	1,266	883
Other Reserves	- 969	7,960	3,069	3,232	10,679
Total - Commissioning services	**476,566**	**502,505**	**528,653**	**553,033**	**586,949**
Running Costs	8,339	8,372	8,405	8,437	8,470
Contingency	-	2,170	2,108	1,985	1,859
Total Application of Funds	484,905	513,047	539,165	563,455	597,277
In-year surplus/(deficit)	**- 9,931**	**- 25,391**	**- 38,620**	**- 48,787**	**- 59,031**
Cumulative surplus/(deficit)	**- 53,647**	**- 79,038**	**- 117,658**	**- 166,445**	**- 225,476**

5 Year Plan

	2016/17 M5 Outturn	2017/18 Plan	2018/19 Plan	2019/20 Plan	2020/21 Plan
	£'000	£'000	£'000	£'000	£'000
Revenue Resource Limit	**474,974**	**487,656**	**500,544**	**514,668**	**538,246**
Expenditure					
Acute services	283,702	275,821	282,900	288,937	296,658
Mental Health services	56,134	55,695	57,116	58,399	59,722
Community services	35,664	35,697	36,351	37,486	38,657
Continuing Care services	30,076	33,115	35,905	39,181	42,792
Primary Care services	8,203	6,328	6,246	6,505	6,775
Prescribing	42,922	43,388	44,376	45,414	46,504
Corporate Costs	5,334	4,995	5,015	5,034	5,054
BCF - LA Transfer	8,908	9,323	9,614	9,914	10,224
NR Funding	6,592	4,792	4,921	5,062	5,298
Cost Pressures - 0.5% on Business Rules		-	2,461	1,266	883
Other Reserves	- 969	7,960	2,869	2,914	9,375
Total - Commissioning services	**476,566**	**477,114**	**487,774**	**500,113**	**521,942**
Running Costs	8,339	8,372	8,405	8,437	8,470
Contingency	-	2,170	2,234	2,316	2,453
Total Application of Funds	484,905	487,656	498,413	510,865	532,864
In-year surplus/(deficit)	- **9,931**	- **0**	**2,131**	**3,803**	**5,382**
Cumulative surplus/(deficit)	- **53,647**	- **53,647**	- **51,516**	- **47,713**	- **42,330**

RightCare and Benchmarking to QIPP

The below table summarises the net QIPP opportunity derived from the Right Care Report (Jan 2016) and the PwC Benchmarking (see Appendix 3). The benchmarked net opportunity is £9.2m - £10.6m.

	Source (base year)	Basis of Opportunity Assessment	Gross Opportunity £m	Less MRER @ 30% £m	Gross Remaining Opportunity £m	Less 30% Reinvestment £m	Net QIPP Opportunity £m
Emergency Admissions	**Rightcare (13/14)**	**Var Best 5 CCGs**	**5.4**	**-1.6**	**3.8**	**-1.1**	**2.6**
Endocrine, nutritional, metabolic	Rightcare (13/14)	Var Best 5 CCGs	0.3	-0.1	0.2	-0.1	0.1
Neurology	Rightcare (13/14)	Var Best 5 CCGs	0.5	-0.2	0.4	-0.1	0.3
Circulation	Rightcare (13/14)	Var Best 5 CCGs	0.6	-0.2	0.4	-0.1	0.3
Respiratory	Rightcare (13/14)	Var Best 5 CCGs	1.0	-0.3	0.7	-0.2	0.5
Gastrointestinal	Rightcare (13/14)	Var Best 5 CCGs	0.8	-0.2	0.6	-0.2	0.4
Musculoskeletal	Rightcare (13/14)	Var Best 5 CCGs	0.4	-0.1	0.3	-0.1	0.2
Trauma and Injuries	Rightcare (13/14)	Var Best 5 CCGs	1.0	-0.3	0.7	-0.2	0.5
Genitourinary	Rightcare (13/14)	Var Best 5 CCGs	0.8	-0.2	0.6	-0.2	0.4
Elective	**Rightcare (13/14)**	**Var Best 5 CCGs**	**2.5**	**0.0**	**2.5**	**-0.8**	**1.8**
Circulation	Rightcare (13/14)	Var Best 5 CCGs	0.7	0.0	0.7	-0.2	0.5
Gastrointestinal	Rightcare (13/14)	Var Best 5 CCGs	0.5	0.0	0.5	-0.2	0.4
Musculoskeletal	Rightcare (13/14)	Var Best 5 CCGs	1.0	0.0	1.0	-0.3	0.7
Genitourinary	Rightcare (13/14)	Var Best 5 CCGs	0.3	0.0	0.3	-0.1	0.2
Outpatients	**PwC (14/15)**	**25th Percentile**	**1.8**	**0.0**	**1.8**	**-0.5**	**1.3**
A&E	**PwC (14/15)**	**25th Percentile**	**2.5**	**0.0**	**2.5**	**-0.8**	**1.8**
Prescribing	**Rightcare (13/14)**	**Var Best 5 CCGs**	**0.5**	**0.0**	**0.5**	**-0.2**	**0.4**
Complex patients(top 2%)-(25% of £23m)	**Rightcare (13/14)**	**Var Best 5 CCGs**	**5.8**	**-1.7**	**4.0**	**-1.2**	**2.8**
Total Max Opportunity			**18.5**	**-3.4**	**15.1**	**-4.5**	**10.6**
Adjust for Double Count Across Lines 50% of Complex Patients			-2.9	0.9	-2.0	0.6	-1.4
Total - Adjusted Opportunity			**15.6**	**-2.5**	**13.1**	**-3.9**	**9.2**

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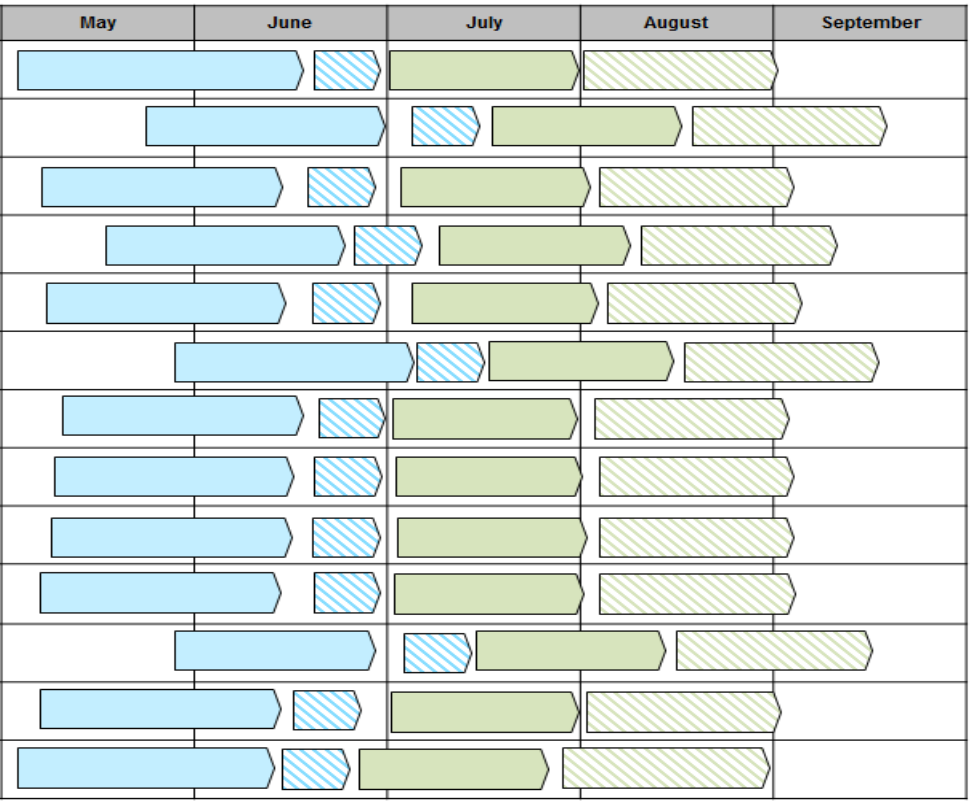
3. Value Opportunity – High Level Programme

	Clinical Lead	Project Manager
T&O/MSK/Injuries	Dr. Tom Chan	Deena Keefe/ Gerard Phillips
Complex Patients	TBC	Sam Taylor/Ivan Okyere-Boakye
Cardiovascular Disease	Dr. Farhhan Sami	Nick Clinch
Neurology	Dr. Amit Abbot	Nick Clinch
Respiratory	Dr. Yinka Ajayi-Obe	Nick Clinch
Mental Health	Dr. Bobby Abbot	Jennifer Francis
Genito-urinary	Dr. Rajeev Sagar	Pauline Stevenson
Gastro-intestinal	Dr. Tony Brzezicki	Pauline Stevenson
Outpatients	Dr. Tony Brzezicki	Pauline Stevenson
Effective Commissioning Initiatives (ECIs)	Dr. Yinka Ajayi-Obe	Jack Edge
Community Paediatrics	Dr. Mike Simmonds	Sam Taylor
End of Life Care	Dr. Ruveneko Pswarayi	Ronak Unjia
Medicines Management	TBC	Janice Steele



Key:

Opportunities: Outcomes/Spend | Outcomes | Spend

Milestones: Initial Scoping | Sign off - QOB | Prepare business case & Engage | Business case finalisation & Sign off

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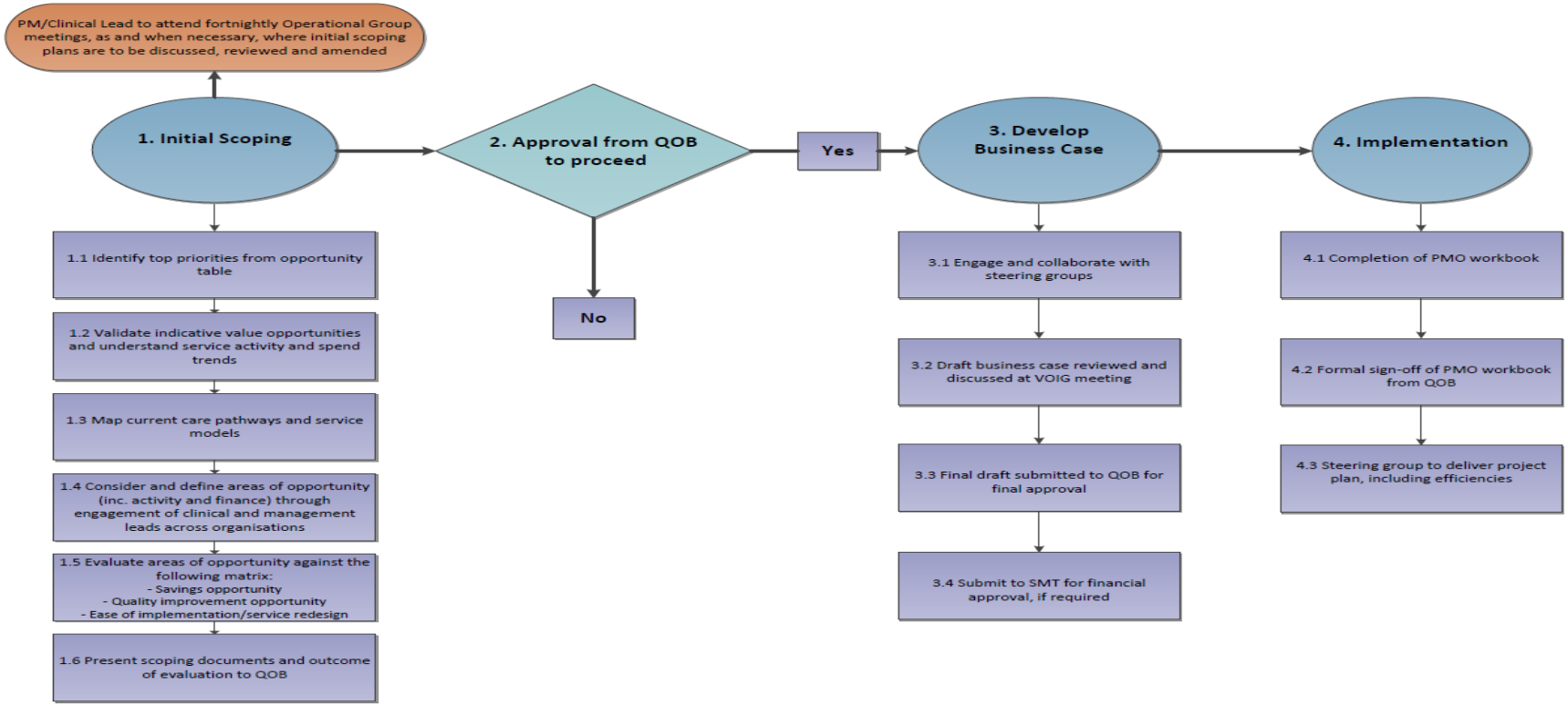
Value Opportunities Programme Step-by-Step Guide



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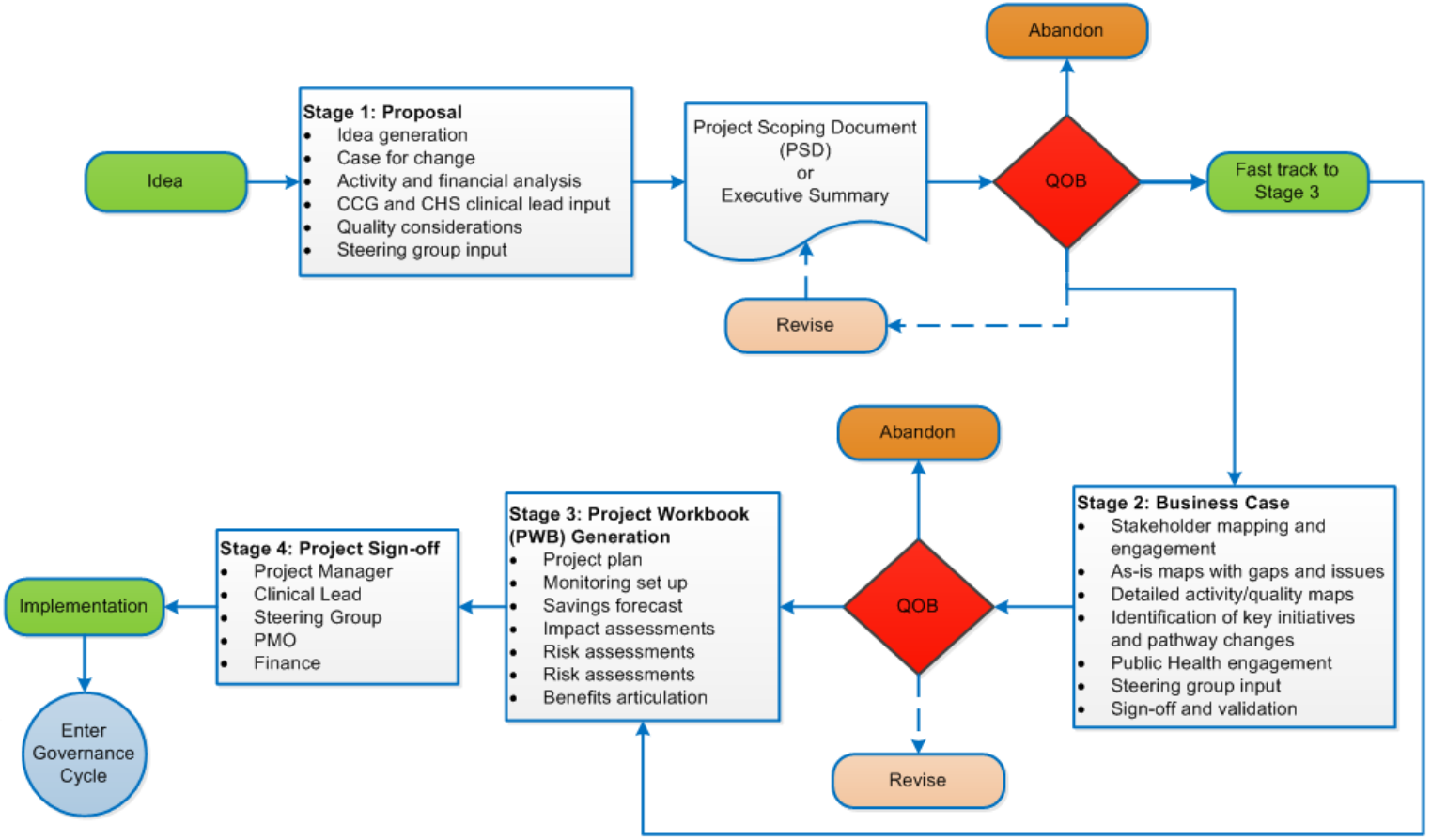
QIPP – scheme development process

The below diagram illustrates the process of developing and assessing QIPP schemes highlighting the approvals required at development stages.



7. Glossary

ACU	Acute Commissioning Unit
AQP	Any Qualified Provider
BCF	Better Care Fund
CAIMS	Community & Acute Integrated Musculoskeletal Service
the CCG	Croydon CCG
CHS	Croydon Health Services NHS Trust
CSU	Commissioning Support Unit
CUH	Croydon University Hospital
DES	Directed Enhanced Services
George's	St George's University Hospitals NHS Foundation Trust
GLA	Greater London Authority
HWBB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICO	Integrated Care Organisation
ICU	Integrated Commissioning Unit
King's	King's College Hospital NHS Foundation Trust
LAS	London Ambulance Service NHS Trust
LQS	London Quality Standards
MRER	Marginal Rate Emergency Rule
MSK	Musculoskeletal
NHSE	NHS England
OBC	Outcome Based Commissioning
ONS	Office of National Statistics
PCT	Primary Care Trust
PID	Project Initiation Document
PMO	Programme Management Office
PPI	Patient and Public Involvement
QIPP	Quality, Innovation, Productivity and Prevention
QOB	QIPP Operational Board
RAG	Red, Amber, Green Ratings
SLAM	South London & Maudsley NHS Foundation Trust
SMT	Senior Management Team
SPG	Strategic Planning Group
SWL	South West London
TACS	Transforming Adult Community Services

DRAFT

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