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Clinical Commissioning Group

Governing Body

27th May 2016

Financial Recovery Plan

Agenda Item 12 Paper 7	
Author:	Antony Collins, Turnaround Director
Executive Lead:	Ralph McCormack Interim Chief Officer
Relevant Committees or forums that have already reviewed this paper:	Council of Members; Clinical Cabinet; Finance and Performance Cttee
Action required:	To AGREE
Attached:	2016/17 Financial Recovery Plan
CCG Strategic objectives relevant to this paper:	Strategy implementation Financial balance
Risk	Significant risks on risk register re financial balance, QIPP and control of acute spend
Compliance observations:	**Finance:** Subject of report
	Engagement : No specific issues
	Quality impact: The potential impact on service quality is assessed where significant changes are made to commissioned services or the commissioning / decommissioning of services.
	Equality impact: The potential impact on protected groups under equality and diversity legislation (and the CCG's own policies) is assessed where significant changes are made to commissioned services or the commissioning / decommissioning of services.
	Privacy impact: No specific issues
	Legal: The CCG is under a statutory duty to break even.

EXECUTIVE SUMMARY	
The purpose of this report is to summarise the CCG's approach to financial recovery in 2016/17 and to seek the agreement of the member practices.	
Date of paper	5th May 2016
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16/17 Financial Recovery Plan

April 2016

NHSE submission

Improving care together across Surrey Downs

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1.CCG context and historic financial performance

Surrey Downs Clinical Commissioning Group was authorised on 1st April 2013. The CCG achieved a surplus of £72k in 2013/14 with an overspend in acute care, primary care and programme costs offset by underspends in mental health, estates charges, continuing healthcare and running costs.

The CCG's submitted financial plan for 2014/15 comprised an allocation of £333.2m, a total spend of £329.9m and a surplus of £3.3m. The plan included £10.8m for QIPP schemes of which £3.3m was unidentified and highlighted as a dependency for achieving the surplus.

From early in the year the CCG Executive Team flagged to the Governing Body and NHS England the risks to delivery of this position including rising acute over-performance, a transfer of £4.7m of recurrent allocation to NHS England in respect of specialised commissioning, and a £1.4m increase in the costs charged to the CCG by NHS Property Services.

At the September 2014 Governing Body meeting, the CCG revised its forecast position to a £200k surplus. At M8, as a result of high levels of acute over-performance in the preceding months, the CCG revised its forecast out-turn to an £11.4m deficit in year and put itself into financial turnaround. The final position for 2014/15 is summarised below and in the bridge analysis on p.21:

- 2014/15 deficit of £10.7m (£14.1m adverse to budget)
- Overspend v budget driven by:
  I. £13.2m underlying overspend on Acute services
  II. £4.7m specialised commissioning budget transfer (including spec. comm. total Acute variance is £18.0m)
  III. £1.4m increase charge on property services above CCG funding allocation (£4m above amount charged 13/14)

1.CCG context and historic financial performance

- Adverse variances to budget above were offset by £5.4m of underspend - Mental Health (£1.0m), Community (£1.0m), Primary Care (£0.8m) and Reserves (£2.6m)

- The favourable reserves variance included unspent investments of £5.1m, unidentified QIPP that was not achieved of £3.3m and a CHC refund of £0.8m

- Acute overspend was principally driven (£9-10m) by unbudgeted non-elective and elective activity growth. The residual is missed QIPP.

- The key underspent programme areas were IAPT £0.5m (Mental Health), prescribing costs £0.8m (Primary care) and an underspend on investments of £5m (included in reserves, offset by net of unidentified QIPP and CHC refund).

2.Bridge 2014-15 plan to 2014-15 outturn

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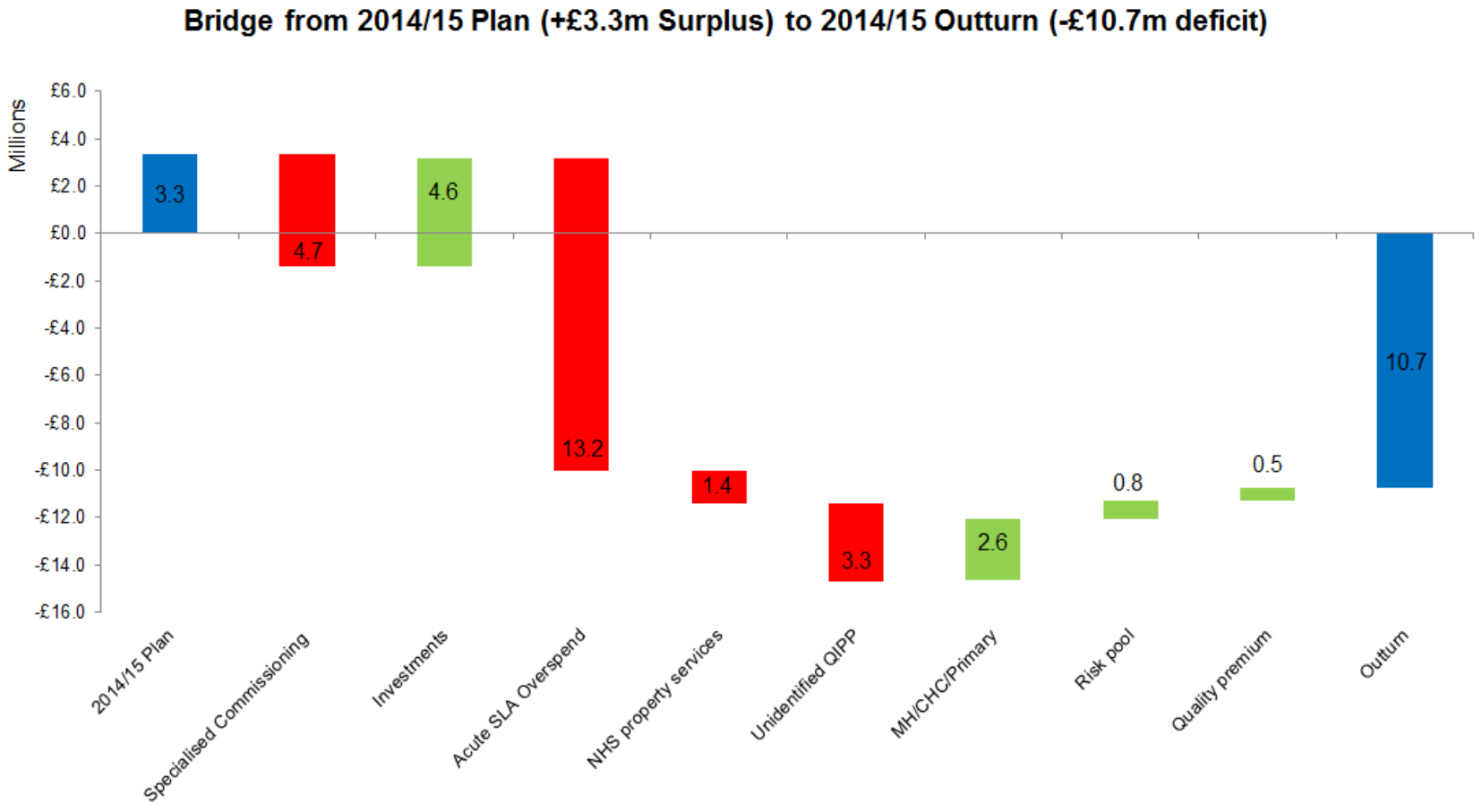

2a. Principal aspects of 2014/15 acute spend growth

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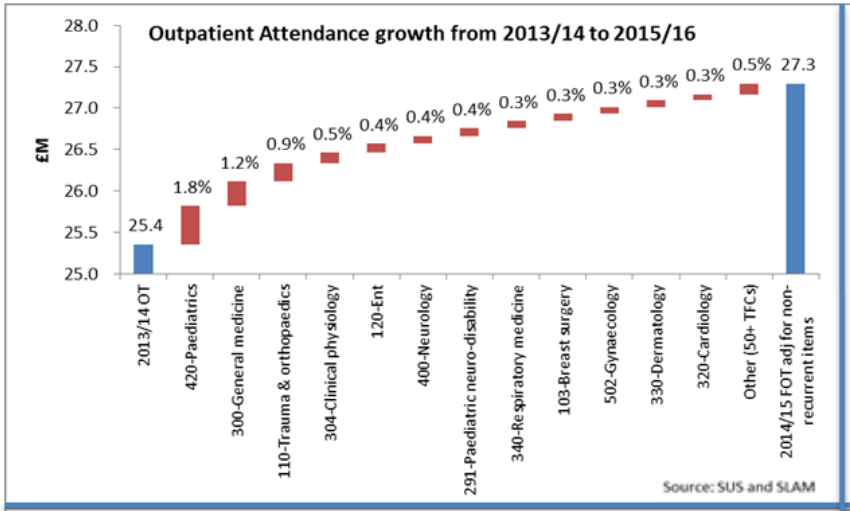
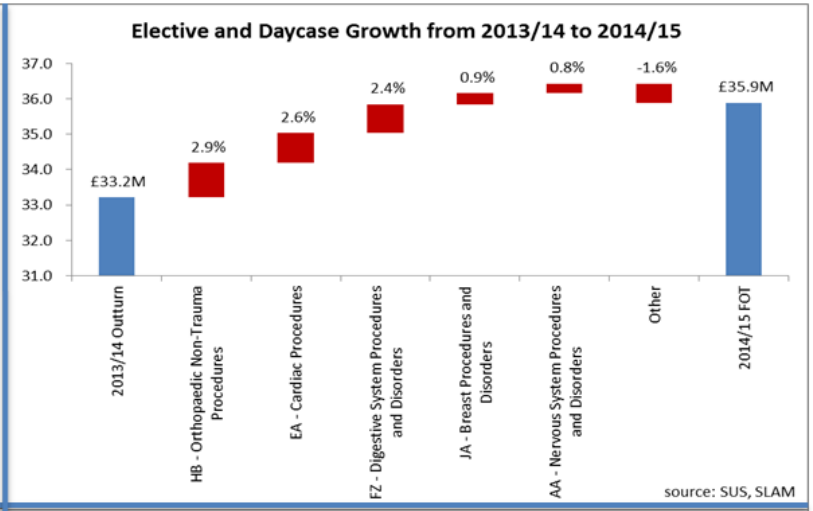
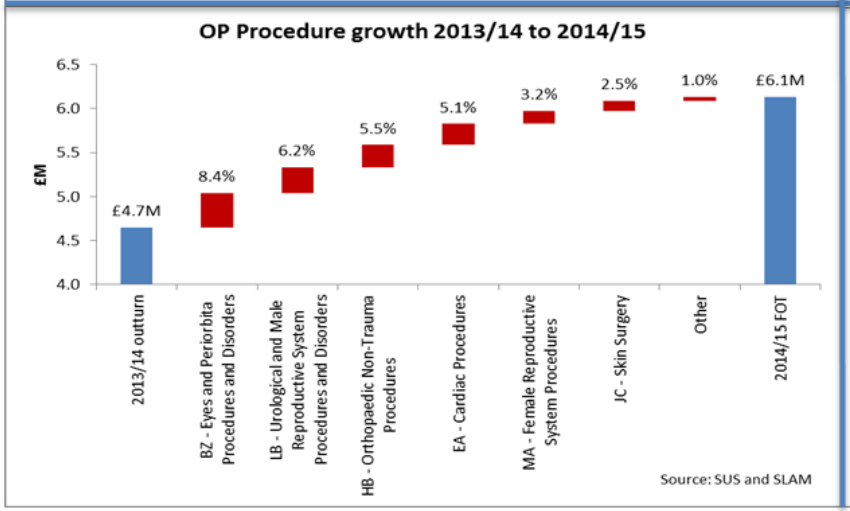
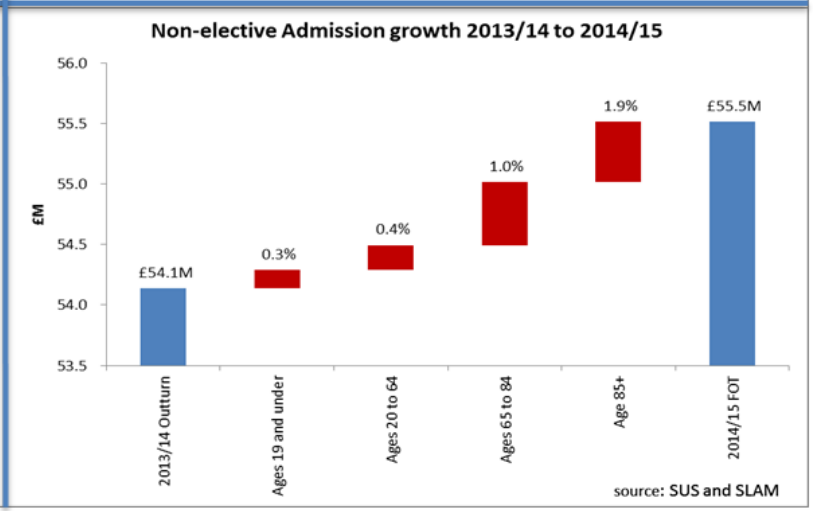
At the previous meeting, NHSE requested that the CCG break out the specialty level growth drivers of the aggregate 6.2% in 2014/15, of which 5% was assessed to be recurrent going into 2015/16. These analyses are shown below.









3.Our Overall Strategy

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Sustainability of the local health economy is a considerable challenge. Epsom and St Helier NHS Trust and its main commissioners have held a cumulative £17 – 20m deficit for the last 4 – 5 years, moving periodically between the acute and community sectors. ESTH has a forecast £29m deficit, in addition to the CCG's forecast £18m deficit and with a £3.9m income triangulation gap between Trust and CCG plans. Community services locally are provided by a £30m social enterprise, with 90% of income derived from SDCCG. The Epsom/SW London system has been subject to almost continual strategic review and unsuccessful efforts to reconfigure.

The CCG therefore requires a strategy which achieves system-wide cost control and long term sustainability.

Key elements of this strategy are:

I. **Primary care leadership and ownership for all service change**

II. **Acute, community, GP and social care integration in supporting the frail elderly backed by a single capitated payment across all providers**. The CCG's 65+ population is already at 19.7% and is set to increase further over the next five years, with significant growth in the 80+ population. A&E performance has been sustained to date through robust capacity management but pressure on the acute bed base is growing. The CCG's strategy mobilises community hubs bringing together key partners, under GP leadership.

3.Our Overall Strategy

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III. **Pragmatic approaches to managing urgent care demand that do not duplicate cost**. The locality is well served by A&E sites. A&Es are seen as places of safety where care is guaranteed. The CCG will accept increased attendance at A&E sites but will improve the multi-disciplinary support to those sites and options to stream presenting patients into the most appropriate service, frequently a primary care professional linking closely with the general practice list-holder.

IV. **Managing elective care conditions outside acute hospitals for longer.** The CCG area has not inherited from successor organisations, some of the tried and tested approaches to managing elective care demand used elsewhere. Historically compliance with referral management initiatives has been hard to secure. The CCG will support GP networks to deliver alternative models to consultant-led secondary care, but with financial incentives clearly linked to GP compliance with the agreed pathways.

V. **Provider integration and market consolidation**. Delivering the above requires close working between GP networks, acute care and community care. Given provider sustainability challenges, the CCG is looking for increasingly close working and, providing that long-term financial projections for a merged organisation were affordable, would support the organisational integration of community and acute care in the local area. Independent sector providers of elective services will either transition into operating as part of GP Networks, or will be asked for price improvements beyond national tariff deflators to demonstrate their value to the local system (as per the CCG's negotiation with its AQPs).

4.The Financial Recovery Plan

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The Financial Recovery Plan (FRP) outlines Surrey Downs CCG's current status and workstreams, which will move the CCG to a sustainable financial footing, plus ensuring quality for Health Care services. In mid-2015 the CCG faced challenges of:

- financial deficit,
- a change in leadership team
- being placed under NHSE Directions.

Along with these challenges, the CCG was delivering year one of its FRP which mandated its largest annual QIPP saving to date (£12.8m 15/16).

Year two of the FRP had set a QIPP target of £19.6m. The projects that will produce these savings needed to be identified, scoped and planned for during year one of the FRP, along with delivering the current £12.8m QIPP target.

Up until this point the QIPP did not have the profile, structure and emphasis it needed to achieve target savings.

The current QIPP portfolio was largely generated from a standing start in Q1 15/16. The original planned target was £12.8m, which was considered too ambitious and was revised to £9.8m in October 15.

The following pages explain;

- the Overall 15/16 forecast outturn and observed growth
- the 15/16 QIPP plan and forecast outturn
- overall 16/17 financial plan and activity growth
- CCG response to 16/17 key challenges
- the 16/17 QIPP planning process
- the latest 16/17 QIPP schemes
- the latest 16/17 values and governance processes for delivery of these schemes and
- actions from recent reviews

4a.2015/16 Plan Overview

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I. Revenue allocation of £327.6m (2014/15: £332.2m), adjusted for:
   - Removal of non-recurrent 2014/15 funding (£3.7m)
   - Activity transfers to Surrey County Council (£0.8m, GUM)
   - Winter funding £1.7m (2014/15: £1.8m in non-recurrent)
   - Transfer of Whole System Partnership funding of £4.2m into baseline as part of BCF
   - Baseline funding increase of +£4.3m
   - £10.7m brought forward deficit
   - Recurrent effect of £7.7m cumulative specialised commissioning transfers in 2013/14 and 2014/15

II. Excluding the brought forward deficit, the 2015/16 revenue allocation is £338.3m

III. Programme costs of £348.2m (2014/15: £336.0m), including:
   - Removal of non-recurrent or transferred activity
   - £7.5m payment for the protection of Adult Social Care as a part of BCF (impacts deficit)
   - Transfer in of Whole System Partnership costs of £4.2m as a part of BCF (no deficit impact)
   - Underlying activity increase of +5.0%, based on 2014/15 actual growth of +6.2%, adjusted for -1.2% non-recurrent effects
   - Net provider efficiency and cost inflation according to DTR/ETO elections
   - QIPP savings of £12.8m (4%)
   - Investments of £4.1m (2014/15: £0.5m) into Community Multi Specialist Providers and rapid response focussed on emergency admissions and readmissions avoidance

IV. Cost contingency of £1.6m (0.5%) is included

V. Running costs of £6.4m (2014/15: £6.9m), -10% reduction

VI. In-year deficit of -£17.9m (2014/15: -£10.7m), or -£28.6m including the brought forward deficit

£M	Allocation	Programme Costs	Running Costs	Contingency	Surplus/ (deficit)
2014/15 outturn	**332.2**	**336.0**	**6.9**		**-10.7**
Non-recurrent allocation adjustment*	-3.7	-3.2			-0.5
Transfer to public health (GUM)	-0.8	-0.8			0.0
Winter resilience into baseline	1.7	1.7			0.0
+1.4% inflationary uplift	4.3				4.3
2014/15 deficit	-10.7				-10.7
ETO tariff adjustment	0.5				0.5
Whole Systems Partnership BCF)	4.2	4.2			0.0
Running cost savings			-0.6		0.6
Efficiency		-8.3			8.3
Inflation		6.2			-6.2
Growth		13.8			-13.8
QIPP		-12.8			12.8
Protection of ASC (BCF)		7.5			-7.5
Investments		4.1			-4.1
2015/16 contingency at 0.5%				1.6	-1.6
Other	0.0	-0.1	0.1	0.0	0.0
2015/16 plan	**327.6**	**348.2**	**6.4**	**1.6**	**-28.6**
2015/16 underlying (excl. B/F deficit)	*338.3*	*348.2*	*6.4*	*1.6*	*-17.9*

* QP -£0.5m, Winter -£1.8m, RTT -£0.8m, GPIT -£0.8m, Overseas visitors +£0.1m

BCF	
Included in 2014/15 baseline	4.7
Whole Systems Partnership	4.2
Protection of ASC	7.5
Total	**16.4**

4b. Principal activity comparators used in developing the 2015/16 plan

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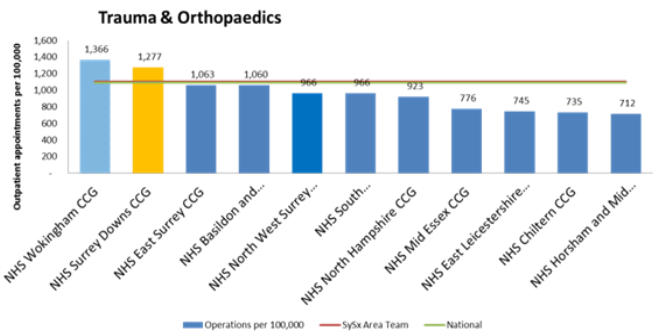
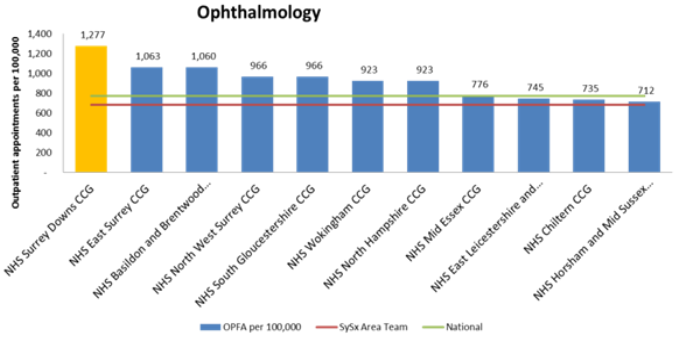
At the previous meeting, NHSE requested that the CCG set out some of the key comparators used to set its priorities for 2015/16. These are set out below. For the outpatient spend, the yellow highlights in the table indicate specialties targeted in 2015/16. The high rate of surgical procedures has been addressed through both primary care referral thresholds and demand management and the prior notification system for restricted procedures. Surrey CCGs are also continuing to restrict procedures of limited clinical effectiveness with new thresholds for joint replacement agreed at the November Priorities Committee meeting.

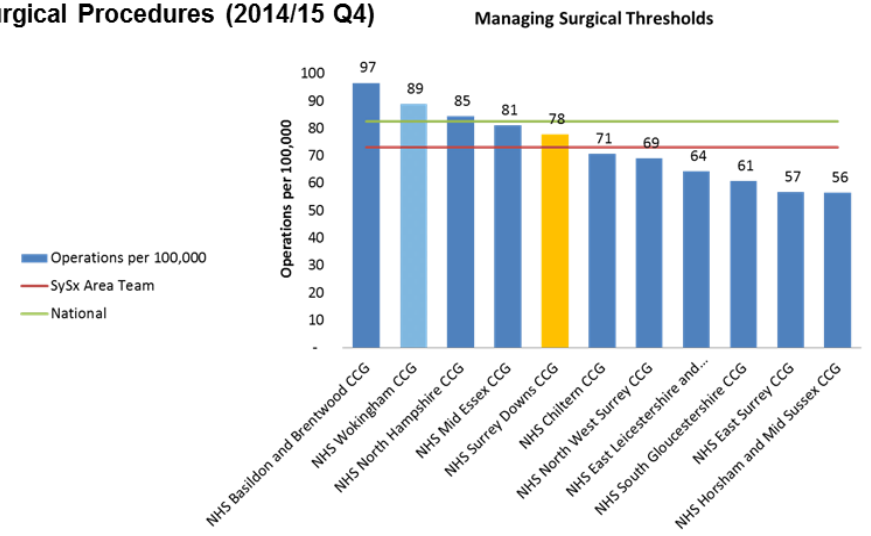
Outpatient appointments (2014/15 Q4)

Top 10 Opportunities
T&O
General Medicine
General Surgery
Urology
Ophthalmology
Paediatrics
Dermatology
Cardiology
Audiological Medicine
Pain Management

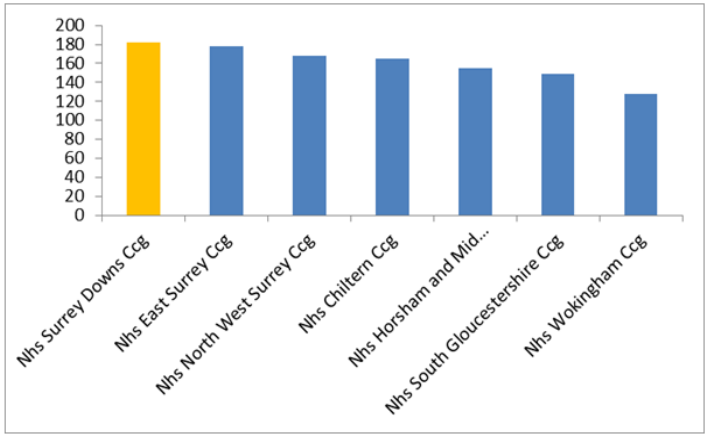




Surgical Procedures (2014/15 Q4)



Non-elective spend per head (2014/15 FY)



4c. Moving from 5% to 2% planned growth

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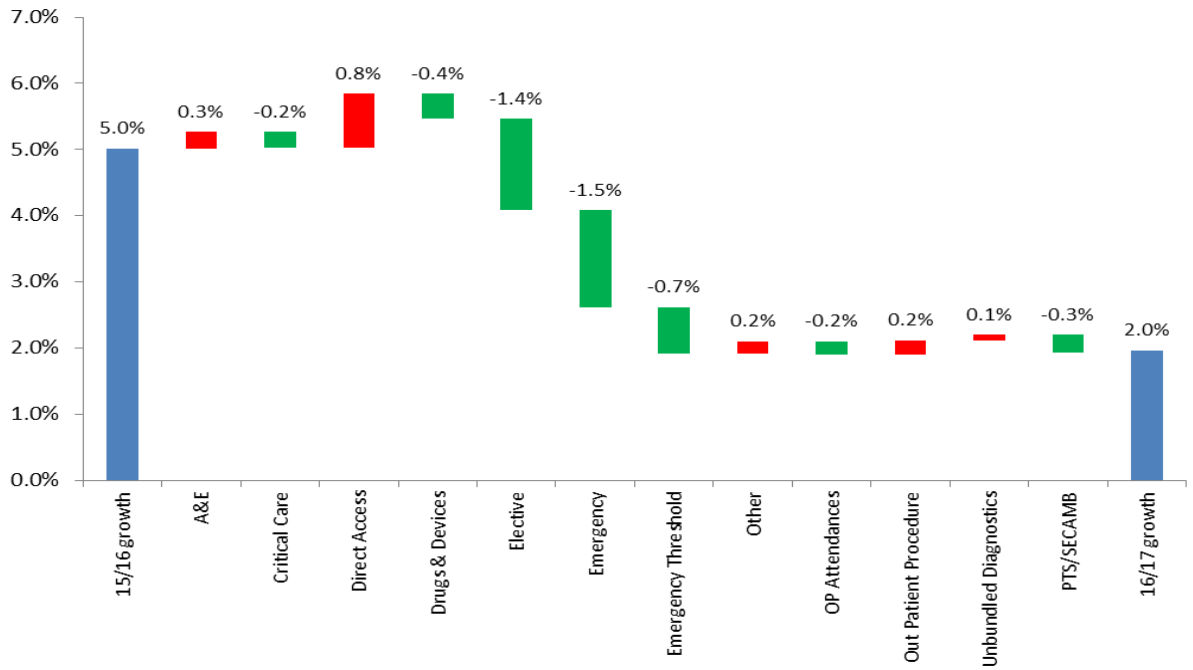
The CCG has been tracking its overall rate of acute growth by Point of Delivery and speciality throughout the year. It is now possible to illustrate, based on current growth rates, an indicative picture of which PODs are likely to reduce their growth sufficiently to allow the CCG to enter next year planning confidently for a 2% underlying acute growth rate across the year. This is illustrated in the chart below which shows how the change in growth rate by POD bridges from this year's 5% assumption to a 2% assumption next year.

Non-elective growth has slowed significantly in Q2 and early Q3 in comparison to the rate observed last year, with the CCG returning to the 2 – 3% growth rates typical of other CCGs. At the moment, elective PODs are showing low growth. However this partly reflects in year underperformance at the Elective Orthopaedic Centre (EOC) which is now attempting to 'catch up' in Q3 and Q4. At the same time, the drop in referral rates (see next slide) should deflate the outpatient growth rate further and may compensate for any changes in elective caused by the EOC.



Elective 1.4% breakdown by chapter	
FZ - Digestive System Procedures and Disorders	1.1%
HC - Spinal Surgery and Disorders	0.2%
AB - Pain Management	0.1%
BZ - Eyes and Periorbita Procedures and Disorders	0.2%
MA - Female Reproductive System Procedures	0.1%
JC - Skin Surgery	0.1%
S - Haematology, Chemotherapy, Radiotherapy and Specialist Palliative Care	-0.1%
EA - Cardiac Procedures	-0.2%
CZ - Mouth Head Neck and Ears Procedures and Disorders	-0.1%
LB - Urological and Male Reproductive System Procedures and Disorders	-0.2%
HB - Orthopaedic Non-Trauma Procedures	-2.5%
Grand Total	**-1.4%**

4d.Moving from 5% to 2%- reductions in referral rates

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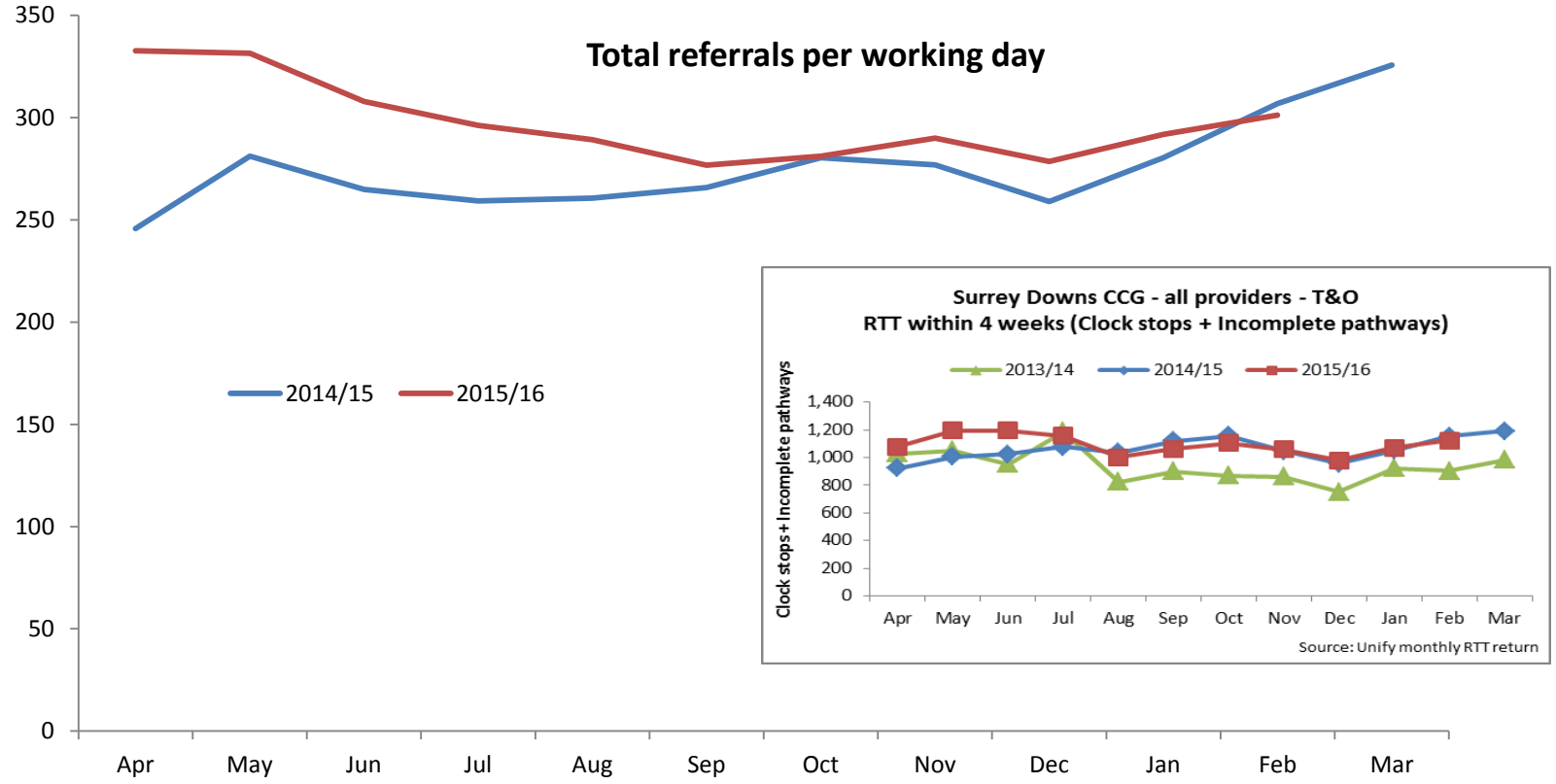
Whilst growth in elective areas was high in Q1, this reflected Q4 referrals prior to the initiation of any demand management initiatives. Since the mobilisation of many aspects of the CCG's 2015/16 plan, referral growth has dropped from 95 referrals per working day over 2014/15 (April) to below both 2014/15 and 2013/14 levels by October. Referral levels have now stabilised and appear to be rising slowly however February had an additional working day. The CCG continues to actively monitor referral performance. T&O referrals, a major outlier on comparator benchmark data for the CCG, have now dropped below the 2014/15 comparator.



4e. 15/16 Growth Rates

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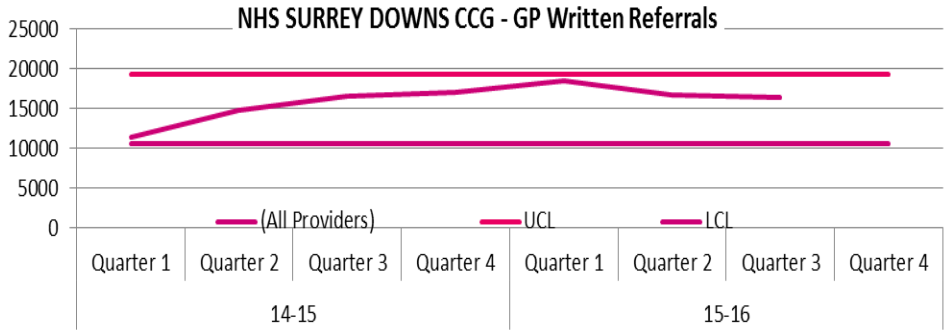
- Growth in GP referrals has reduced from a peak in Q1 with negative growth in a number of months in Q2 and Q3; as demonstrated by the Provider Quarterly Activity Return (QAR)



- Based on various sources shows a blended 15/16 underlying activity growth rate of 3.4% to 4.1% however financial growth is currently at 0.3%
- Activity and finances have not moved in tandem with activity growing in all PODs however case mix has mitigated the financial impact

- The CCG has calculated a blended activity rate at 4.1% which reflects the relative costs of the PODs (see table below)
- The CCG has calculated indicative 2016/17 growth based on demographic ONS projections and observed 15/16 non-demographic growth.

	Growth rate			
	£	Activity		
	SLAM M9 YTD	SLAM M9 YTD	SUS FY (15/16 FOT)	Weight (%)
EL and DC	-0.2%	3.6%	3.4%	30.7
NEL (w credits)	-5.7%	3.5%	2.7%	32.9
A&E (Type 1 only)	9.8%	1.1%	0.4%	7.0
OP Attendances	6.4%	6.1%	N/A	28.8
OPFA	8.1%	6.2%	5.9%	12.3
OPFUP	5.0%	6.1%	5.1%	15.5
Observed/blended growth rate	**0.3%**	**4.1%**	**3.4%**	

4f. 5 year predicted growth rate projections by POD (no QIPP)

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- The CCG's non-demographic activity growth rate has slowed markedly
- This change in growth rate is a result of demand management programmes
- It is expected that QIPP programmes as supported by the Right Care approach will start reducing the observed non-demographic growth which is unusually high in outpatients
- Impact on the demographic growth will be affected by the CCG's prevention programmes and Right Care interventions however its impact will likely be realised in future years

	14/15	15/16	16/17	17/18	18/19	19/20
EL and DC	**3.7%**	**3.4%**	**3.4%**	**3.5%**	**3.5%**	**3.5%**
demographic	1.4%	1.0%	*1.0%*	*1.1%*	*1.1%*	*1.1%*
non-demographic	2.3%	2.4%	*2.4%*	*2.4%*	*2.4%*	*2.4%*
NEL	**8.3%**	**2.7%**	**2.7%**	**2.9%**	**2.9%**	**2.8%**
demographic	1.5%	1.5%	*1.5%*	*1.7%*	*1.7%*	*1.7%*
non-demographic	6.7%	1.2%	*1.2%*	*1.2%*	*1.2%*	*1.2%*
A&E (Type 1 only)	**4.1%**	**0.4%**	**0.4%**	**0.5%**	**0.5%**	**0.5%**
demographic	1.1%	1.0%	*1.0%*	*1.1%*	*1.1%*	*1.1%*
non-demographic	3.0%	-0.6%	*-0.6%*	*-0.6%*	*-0.6%*	*-0.6%*
OPFA	**7.8%**	**5.9%**	**5.9%**	**6.1%**	**6.0%**	**6.0%**
demographic	1.4%	1.3%	*1.3%*	*1.5%*	*1.4%*	*1.4%*
non-demographic	6.4%	4.6%	*4.6%*	*4.6%*	*4.6%*	*4.6%*

N.B: Observed, *Predicted*
Demographic growth based on healthcare demographics and ONS projections
Non-demographic growth based on observed growth rates
Elective and Day case non-demographic growth adjusted for Epsomedical
Source : SUS and ONS

4g. 15/16 QIPP Programme (Month 12)

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At month 12 Surrey Downs CCG delivered the £9.8m QIPP programme. This is a marked improvement on the QIPP savings delivered in 2014/15

PMO QIPP Projects Summary Dashboard

MONTH 12

CATEGORY	NAME	Clinical Director / Lead	Executive Lead	Programme Lead	YTD Plan £	YTD Actuals £	YTD Variance £	16/17 FYE £
PLANNED CARE	MSK	Dr Natalie Moore	James Blythe	Oliver MCKinley	649,581	533,170	- 116,411	909,000
	Dermatology	Dr Natalie Moore	James Blythe	Oliver MCKinley	232,370	166,684	- 65,686	
	Practice Peer Review	Dr Natalie Moore	James Blythe	Oliver MCKinley	635,622	888,764	253,142	
	AQP Price Review	N/A	James Blythe	James Blythe	725,000	454,250	- 270,750	184,000
	RSS	N/A	James Blythe	Oliver MCKinley	179,835	174,861	- 4,974	16,000
	POLCE - Prior Notification	Dr Natalie Moore	James Blythe	Oliver MCKinley	684,000	684,000	-	
	Diabetes	Dr Natalie Moore	James Blythe	Oliver MCKinley	146,389	159,319	12,930	
INTEGRATION	15/16 Community Hubs	Dr Simon Williams	James Blythe	Tom Elrick	1,000,000	1,307,000	307,000	
CHC	CHC Contracts	Claire Fuller	Steve Hams	Lorna Hart	914,000	996,417	82,417	180,000
OTHER (CONTRACTING/BAU)	Medicines Management	Helen Marlow	Steve Hams	Helen Marlow	618,552	769,822	151,270	96,000
	Pharmaceutical Commissioning	Liz Clark	Steve Hams	Liz Clark	242,000	216,100	- 25,900	
	Estates	N/A	Matthew Knight	Julian Wilmhurst-Smith	368,500	385,250	16,750	
	PTS	N/A	James Blythe	Tom Elrick	59,000	64,900	5,900	59,000
	Improving Contracting	N/A	Matthew Knight	Moyra Costello	3,000,000	3,042,720	42,720	
	Other	N/A	Executive	Executive	358,734	-	- 358,734	
	TOTALS				**9,813,583**	**9,843,257**	**29,674**	**1,444,000**

4h. 15/16 M12 Outturn

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£M	2014/15	2015/16			
	Act	Act	Bud	Var to Bud	Var 14/15
Acute (incl SRG)	211.4	213.1	210.7	-2.4	-1.7
Mental Health	24.1	24.7	25.3	0.6	-0.6
Community	29.1	27.0	27.5	0.5	2.1
CHC	22.9	21.9	22.1	0.1	1.0
Primary Care	45.3	46.2	46.6	0.4	-0.9
Other (B)	2.7	13.8	14.1	0.3	-11.1
Corporate	7.0	6.2	6.4	0.2	0.8
Reserves	0.5	3.8	4.1	0.3	-3.3
1% uncommited	0.0	0.0	0.0	0.0	0.0
TOTAL	**342.9**	**356.7**	**356.7**	**0.0**	**-13.8**
Allocation (A)	**332.2**	**338.8**	**338.8**	**0.0**	**6.6**
In year Surplus / Deficit	-10.7	-17.9	-17.9	0.0	-7.2
Cumulative surplus Deficit	-10.7	-28.6	-28.6	0.0	-17.9

Key points

- 2015/16 outturn as per plan
- Main acute providers overspent by £6.9m offset by planned headroom £3.6m and other acute underspends / benefits of £0.9m to give a net overspend of £2.4m
- Overspend of £2.4m in acute offset by underspends in other programme areas e.g. Mental Health £0.6m (IAPT £0.4m and SaBP £0.2m), Community £0.5m (NHS Property Services) and Primary Care £0.4m (Prescribing)
- QIPP achievement reported was £9.8m (versus original plan of £12.8m). QIPP underachievement impacted acute programme
- Included a £1.7m Surrey Collaborative contribution (M11)

5. 16/17 Plan and 5 year indicative model

5a.Assumptions in 2016/17 plan and indicative 5 year model

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Area	Assumption
Tariff	• 1.6% in 2016/17, thereafter Monitor assumptions applied
Growth	• 2.0% in 2016/17 and 17/18, 2.4% thereafter (Acute) • Between 3.0% and 5.2% from 2016/17 onwards, including tariff and growth (Non-Acute)
Allocation	• As per formal communications Jan 2016 (3 years fixed, 2 year indicative)
BCF	• 2015/16 position rolled forward – total £16.4m each year (of which £7.5m for Adult Social Care is incremental to the deficit position 2015/16 and thereafter)
Compliance with Business Rules	• The current plan is not compliant with business rules in so far as: i) a deficit is forecast in 2016/17 instead of a 1% surplus ii) the plan does not model for the incremental £10.8m allocation over and above the policy funding to be used to fund the historic deficit (although from 2017/18 onwards most of the increased funding goes to the bottom line)
1% uncommitted	• Added 2016/17 onwards as an additional recurring cost pressure (equate to £3.5m – £3.7m) per annum i.e. over and above any existing investments
QIPP	• Remains as per FRP (£19.6m in 2016/17, £16.0m in 2017/18) • Of the £19.6m 2016/17, £16m is fully identified (either full year effects of 2015/16 QIPP or new incremental schemes) • Further work is on-going to identify £3.6m gap
ETO, GPIT, CAMHS	• ETO, GPIT and CAMHS are cost pressures from 2016/17 onwards (previously funded through non recurrent allocation adjustments, now assumed to be funded in baseline 1.4%)
Epsom	• Additional acute costs

5b. Bridge 2015/16 FOT to 2016/17 Plan

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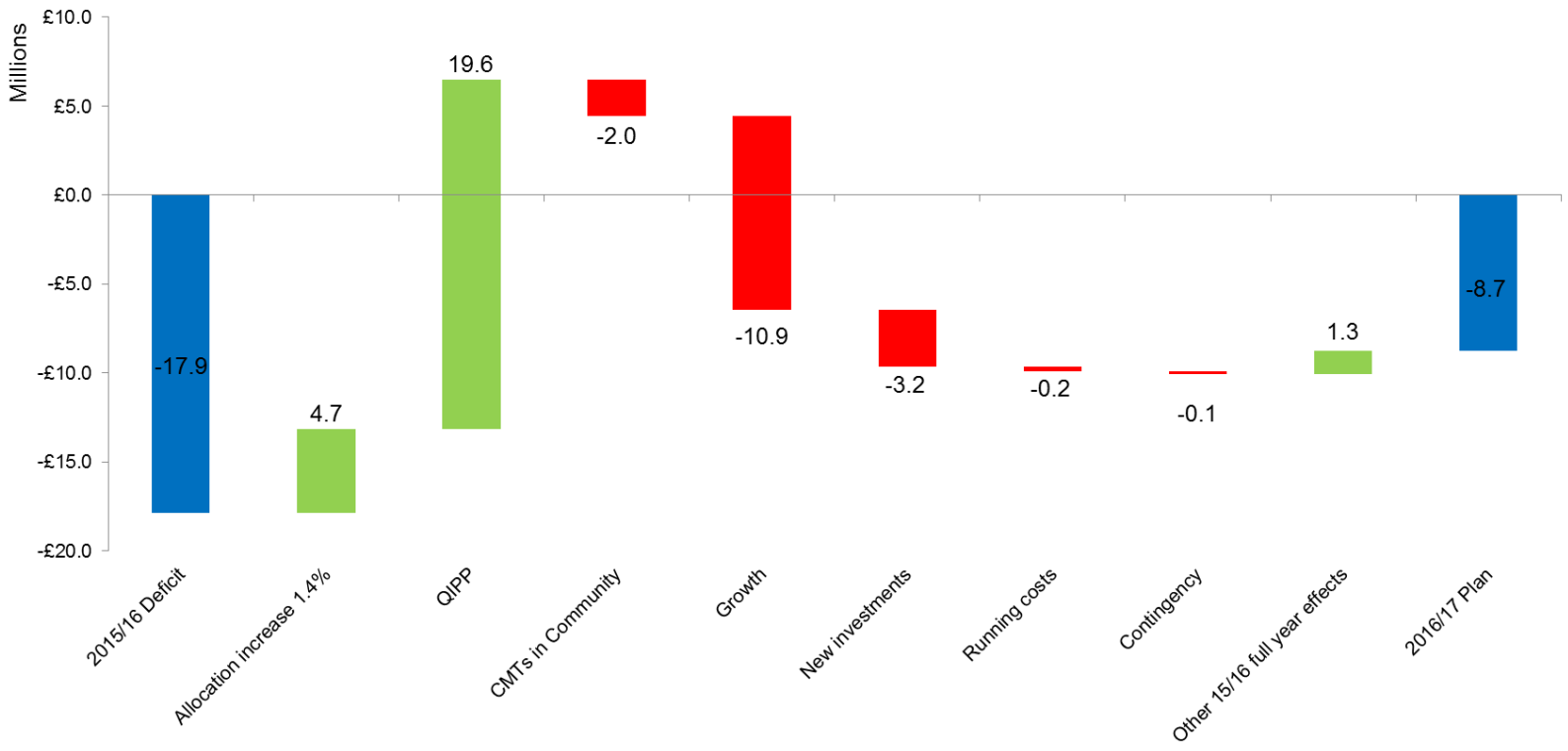
Bridge from 2015/16 FOT (-£17.9m Deficit) to 2016/17 Plan (-£8.7m Deficit)



5c. Reconciliation between FRP and 2016/17 plan

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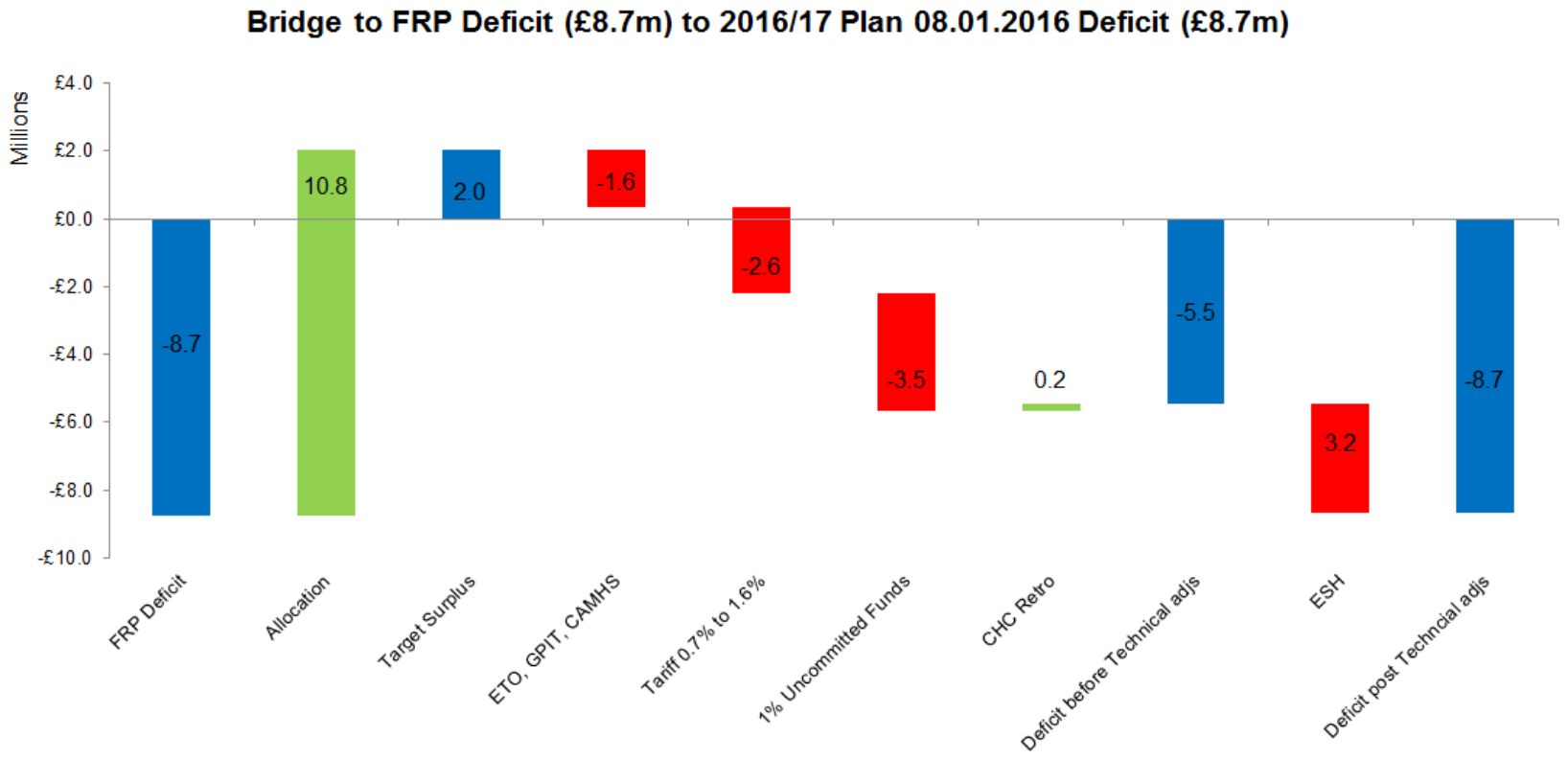

5d. 2016/17 plan and 5 year indicative view

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SURREY DOWNS CCG - 5 YEAR VIEW (PRELIMINARY)						
£M	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	Fct	Plan	Plan	Plan	Plan	Plan
Allocation gross (i)	338.2	354.1	361.1	369.9	379.2	395.4
Prior year deficit b/f	-10.7	-28.6	-37.3	-33.4	-25.3	-13.2
Allocation adjusted	327.5	325.5	323.8	336.5	353.9	382.2
Acute (A)	210.0	210.1	200.5	198.6	198.3	204.4
Mental Health	25.3	25.6	26.2	27.0	27.7	28.8
Community	27.9	27.1	26.8	27.2	27.5	28.2
CHC	21.8	21.3	22.7	24.1	25.3	27.1
Primary Care	46.3	46.5	49.6	53.4	56.7	61.6
Other	13.6	13.9	13.8	13.9	13.9	13.9
Corporate	6.4	6.4	6.4	6.4	6.4	6.4
Investments	4.2	6.9	6.1	6.0	5.9	5.8
Contingency	0.6	1.6	1.6	1.6	1.6	1.6
1% Uncommitted	0.0	3.5	3.5	3.6	3.7	3.9
TOTAL	356.1	362.8	357.2	361.8	367.1	381.8
QIPP included in above	-9.8	-19.6	-16.0	-10.8	-8.0	-6.0
QIPP as % of gross allocation	2.9%	5.5%	4.4%	2.9%	2.1%	1.5%
BCF included in above	-7.5	-7.5	-7.5	-7.5	-7.5	-7.5
Acute Growth assumption included above	5.0%	2.0%	2.0%	2.4%	2.4%	2.4%
Acute Tariff Deflator / Inflator (net) (ii)	-1.0%	1.6%	0.3%	0.0%	0.0%	0.9%
Non-Acute Growth assumption	4.9%	3.1%	5.1%	4.6%	4.6%	4.7%
Surplus (Deficit) B/F	**-10.7**	**-28.6**	**-37.3**	**-33.4**	**-25.3**	**-13.2**
Surplus (Deficit) In year	**-17.9**	**-8.7**	**3.9**	**8.1**	**12.0**	**13.7**
Surplus (Deficit) To Date	**-28.6**	**-37.3**	**-33.4**	**-25.3**	**-13.2**	**0.4**
Target Surplus in year		***2.0***	***8.2***	***8.6***	***9.2***	***11.3***
GAP		*-10.7*	*-4.3*	*-0.5*	*2.9*	*2.4*
Target surplus calculation						
FRP Surplus / Deficit	*-17.9*	*-8.7*	*0.1*	*0.0*	*0.0*	*0.0*
Allocation to deficit	*0.0*	*10.8*	*8.2*	*8.6*	*9.2*	*11.3*
Target Surplus		***2.0***	***8.2***	***8.6***	***9.2***	***11.3***

(i) As per notified allocations Jan 2016. Note allocation in 2016/17 is adjusted (increased) by £1.7m to reflect non-recurrent surrey collaborative allocation adjustment. An equivalent amount of cost has been included (against acute, ESH) and it is assumed the cost is recurring over the 5 year period

(ii) As per monitor guidance

5e. Movement on non-programme spend (excl. running costs) 2015/16 to 2016/17

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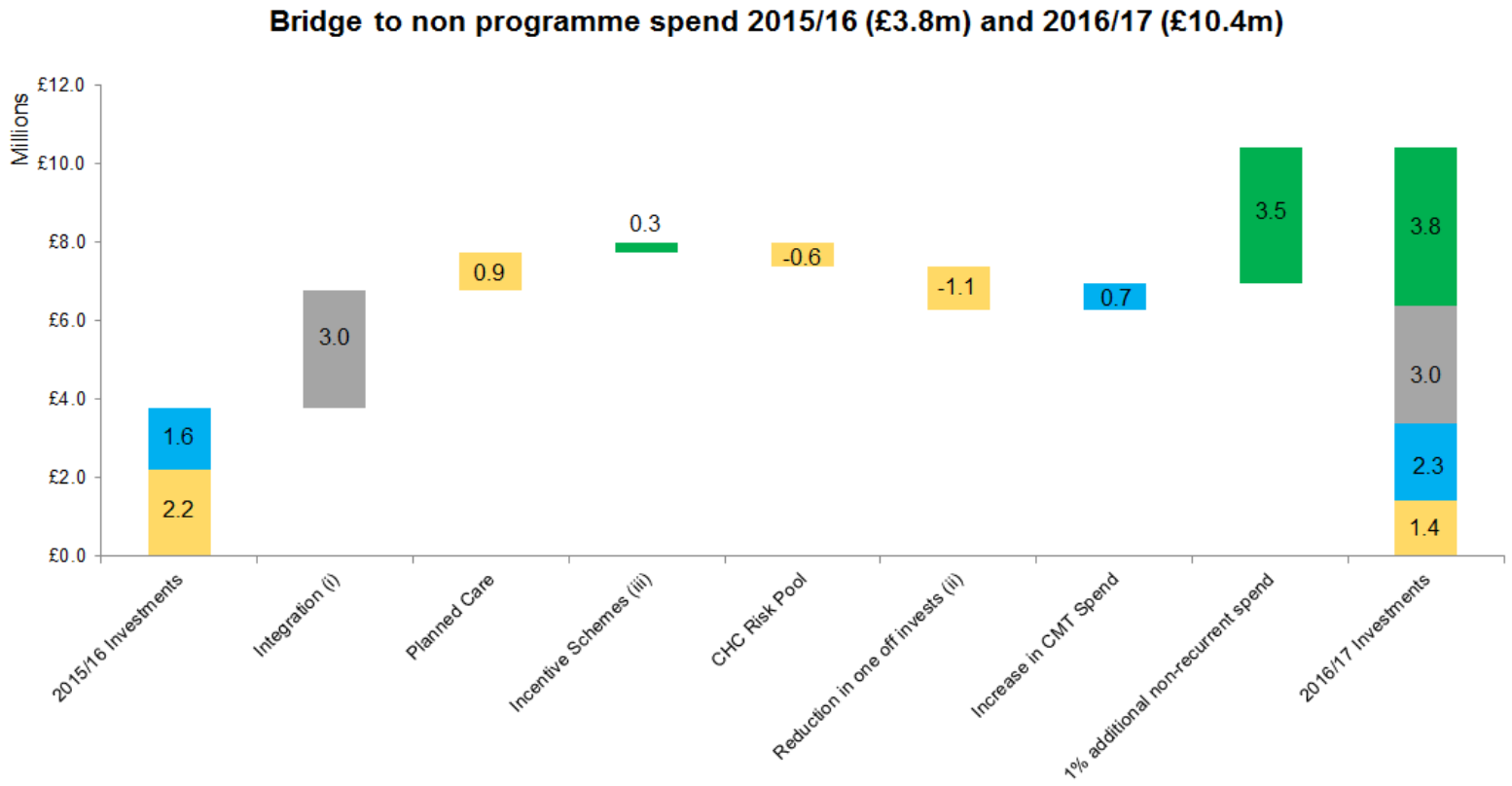


(i) Integration investment - will become committed if a block contract is agreed with EGH for 2016/17
(ii) Lower 'one offs' in 2016/17 when compared to 2015/16 e.g. PPL, SWL Partnership, CADU
(iii) RSS, Prescribing

Committed, Non Recurrent
Committed, Recurrent
Non Committed, Recurrent
Non Committed, Non Recurrent

6. CCG Response to the 16/17 Challenge

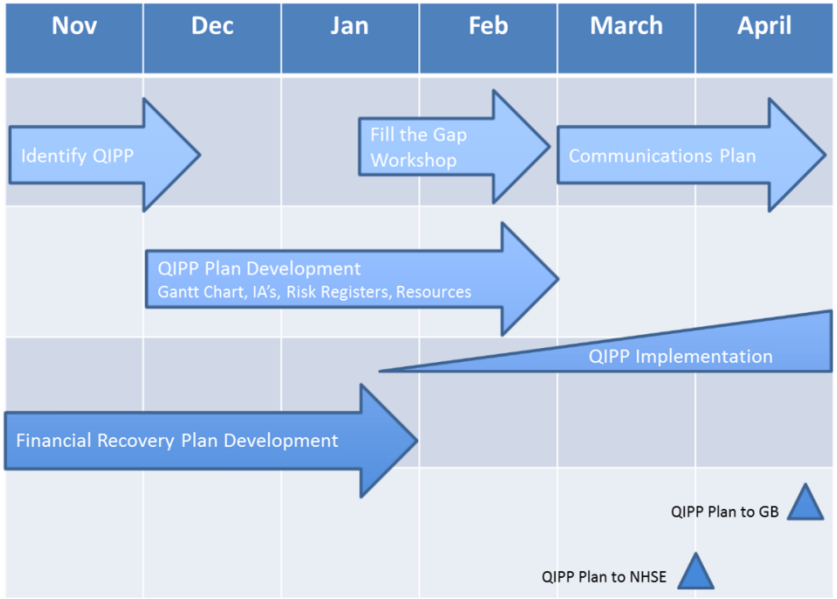
PwC were commissioned to provide a review of the CCG's capacity and capability. This identified the need to improve these areas for QIPP delivery to achieve the significantly larger 16/17 requirement.

To address this the CCG took the following actions

- Created and recruited to a new Executive structure
- Appointed a Turnaround Director in October 15.
- Set-up Programme Boards for each workstream.
- Strengthened the capacity and skills of the PMO.
- Retrospectively produced key project documentation for existing projects to enable effective portfolio management.
- Designed and implemented project governance processes.
- Introduced a formal reporting and monitoring structure for QIPP through the PMO.
- Appointed an experienced interim PMO Director in April 16

6a. 16/17 Planning Process

For 16/17 SD CCG started the QIPP planning process much earlier than in the previous year. The timescale below shows the key stages of QIPP development.



In December 2015, almost £15m of potential QIPP had been identified, these schemes moved into detailed planning.

The planning process included;

- comparison exercises with NEW Devon and West Berkshire CCGs
- the Deloitte benchmarking from 2015
- and local intelligence.

Following the appointment of the new interim Chief Officer in January 16, a senior team workshop was held to identify further schemes to "Fill the Gap".

A further £1-4m of potential QIPP was identified and these proposals are being scoped. A further £1m of schemes have now been added to the planned total which is now just over £16m

Further events to identify additional QIPP schemes will be held. These will include a second "Fill the Gap" workshop which will be held in late May. Additionally, SD CCG will also be reviewing New Care Model Vanguards, the Primary Care Home Model Rapid Test sites and the Better Care Exchange to identify additional opportunities. This will ensure all possible opportunities have been exhausted.

Furthermore, the 3 CCGs in the Surrey Heartlands STP are collaborating on QIPP planning.

6b. QIPP Project Descriptions

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Programme	Project	Description
Planned Care	Ophthalmology	Setting up direct referral from optometrists into appropriate community and acute providers for the following services; cataracts, suspected wet AMD, glaucoma intraocular pressure and visual field.
	Musculosckeletal (pain management & rheumatology)	To change pain management pathways in order to divert activity from secondary care to community.
	Cardiology	To provide an integrated community cardiology service for patients in the SD CCG area, to shift activity from the acute setting into the community and bring services closer to the patients home.
	ENT/Audiology	A community-based ENT and Audiology service to diagnose and treat a range of ENT and Audiology conditions, and manage relevant follow-up activity .
	Dermatology	A Tele-dermatology service, providing patients with timely access to diagnosis and treatment within the primary care setting.
	Gynaecology	To focus on the development of the referral forms, email advice & guidance, reducing direct referrals from GPs to secondary care and RSS as a more focal point in the triage of referrals coming through.
	Planned Care Urology	To develop a new urology pathway for a more integrated service across Surrey Downs CCG area and reduce the rate of hospital admissions.
	Planned Care Neuro	To develop a new neurology pathway for a more integrated service across Surrey Downs CCG area, to reduce the rate of hospital admissions.
	Planned Care Gastro	To develop a new gastroenterology pathway for a more integrated service across Surrey Downs CCG area, to reduce the rate of hospital admissions.
	All referrals for 1st OP via RSS	To create a system where all First outpatient appointments are managed via the RSS and we do not pay for any that are not and to explore the potential to pay on RSS data and not Provider.
	Email advice and guidance	To Implement a system for primary care clinicians to access a prompt, remote advice from consultants working in acute trusts and local providers.
	POLCE on prior approval	To ensure that patients receiving any of the procedures listed within the List of Procedures with Restrictions and Thresholds policy (TNRF 2) have met clinical thresholds assessed by the provider, and to prevent procedures being undertaken that the CCG has not commissioned.
	All C2C activity directed to RSS (BAU Contracting)	To direct all Consultant to Consultant referrals via RSS assurance all referrals follow CCG pathways and meet appropriate criteria and that activity in secondary care is that which is commissioned by CCG.
	Hips and Knees	To implement Shared Decision Making tools (SDM) to uphold revised thresholds for surgery on hips and knees, for patients that present with one or more factors that could lead to poor post operative outcomes.
Other	Medicines Management	The Medicines Management team identify and implement opportunities to support medicines optimisation initiatives that improve quality, safety and patient outcomes, whilst providing value to the NHS.
	Medicine Management (Drop list)	Reduction in the prescribing of certain medicines identified as drugs of limited therapeutic value , NICE do not do's or not recommended for prescribing in local guidelines (DROP list).
	Pharmaceutical Commissioning	The Pharmaceutical Commissioning develop and implement initiatives that effectively manage escalating specialist drugs costs, including the redesign of
	Managed entry of biosimilar etanercept	To start all new patients on biosimilar etanercept (cheaper drug), which should be available from Q1 16/17. and a switch programme will be implemented for existing patients. Savings are anticipated through drug cost reduction and patients uptake.
	Tocilizumab IV switching to SC homecare self-administration	To Switch patients currently receiving Tocilizumab via intravenous infusion to sc injections delivered via homecare (in patients who can self-administer) and to manage budget transfer back to CCG from NHS England through work together with CSU contracting managers.
	Mental Health - Dementia	To develop a dementia discharge pathway.
	Community (small contracts)	Savings opportunities being identified from various small community contracts.
Urgent Care & Integration	Integration Programme (Inc. Community Hub)	To develop Epsom locality-specific models of integrated community services that will avoid non elective admissions and thus deliver savings.
	East Elmbridge & Dorking Integration Programme (Inc. Community Hub)	To develop Dorking, East Elmbridge locality-specific models of integrated community services that will avoid non elective admissions and thus deliver savings.
	Falls Management	To re-specify current falls service, provided by CSH (Surrey) with clear KPIs included, this will form part of the Community Hubs. The new service will deliver savings through a reduction in fracture clinic activity and DEXA scans and, in the longer term, a reduction in hip fractures.
	A&E Admission Avoidance	Capturing benefits from community hub integration programme.
	CHC Contracts	Management efficiency of NHS contracts with CHC service providers to assure that patients are placed appropriately for the best value contract price by a review of placements and renegotiation of individual service user placement agreements (ISUPAs).
	Neuro Rehab Review/ Reprocurement	A regional procurement across Hampshire, West Sussex and Surrey for Continuing Healthcare Acquired Brain Injury (ABI) and Neuro Rehab placements in specialist facilities to manage high cost low services though negotiation with the top 25 providers.
	Fast Tracks outsourcing	CHC proposes to outsource fast track procurement process through a block contract to improve process and alignment of End of Life packages supporting patients to achieve their preferred place of care and death.
Enabling Programme	Estates	To reduce the cost of ownership of the Community Estate via various cost reduction methods (i.e. efficient use of space, rent negotiations and an improved management of costs).
	Running Costs Savings	Establishment and agency cost savings
	Improving Contracting	CSU PBR and contractual data validation claims and challenges

6c. Project Leadership

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Experience tells us that large QIPP programmes need a depth of project leadership to succeed, especially where there is significant interim presence in the team at start up, as continuity can be impacted when the interims (highlighted with * below) are replaced. The interims contracts are normally extended in 3 month blocks. Substantive recruitment is underway on all these roles.

Programme	Project	Executive Lead	Clinical Director	Programme Director	Project Manager	PMO Manager
Planned Care	Ophthalmology	James Blythe	Dr Natalie Moore	Oliver Mckinley	Michelle Heller	Saima Sandhu
	Musculoskeletal (pain management & rheumatology)			Oliver Mckinley	Andrea Ching*	Saima Sandhu
	Cardiology			Oliver Mckinley	Linda Balzanella*	Saima Sandhu
	ENT/Audiology			Oliver Mckinley	Ross Emmens	Saima Sandhu
	Dermatology			Oliver Mckinley	Ross Emmens	Saima Sandhu
	Gynaecology			Oliver Mckinley	Gareth Jones	Saima Sandhu
	Urology			Oliver Mckinley	Ayisha Jessa*	Saima Sandhu
	Neurology			Oliver Mckinley	Linda Balzanella*	Saima Sandhu
	Gastroenterology			Oliver Mckinley	Ayisha Jessa*	Saima Sandhu
	All referrals for 1st OP via RSS			Oliver Mckinley	Majorie de Vries	Saima Sandhu
	Email advice and guidance			Oliver Mckinley	Majorie de Vries	Saima Sandhu
	POLCE on prior approval			Oliver Mckinley	Majorie de Vries	Saima Sandhu
	Hips and Knees			Oliver Mckinley	Majorie de Vries	Saima Sandhu
	All C2C activity directed to RSS (BAU Contracting)			Oliver Mckinley	Contracts Team	Saima Sandhu
Other	Medicines Management	Steve Hams*	Dr Andreas Pitsiaeli	Kevin Solomons	Helen Marlow	Maria Bruce
	Pharmaceutical Commissioning			Sarah Watkin	Liz Clark	Maria Bruce
	Managed entry of biosimilar etanercept			Sarah Watkin	Liz Clark	Maria Bruce
	Anti-TNF interval extension for Rheumatoid Arthritis			Sarah Watkin	Liz Clark	Maria Bruce
	Mental Health – Dementia	James Blythe	Dr Simon Williams	Tom Elrick*	Deborah Russell*	Maria Bruce
	Community (Small Contracts)			Julian Wilmshurst-Smith	Julian Wilmshurst-Smith	Quentin Symington*
Integrated Care	Integration Programme (Inc. Community Hub)			Tom Elrick*	Stephanie Isherwood	Jane Chalmers*
	Other Integration Programme (Community Hub)			Tom Elrick*	Stephanie Isherwood	Jane Chalmers*
	A&E Admission Avoidance			Tom Elrick*	Stephanie Isherwood	Jane Chalmers*
	Falls Management			Tom Elrick*	Kirsty McMurray	Jane Chalmers*
Continuing Healthcare	CHC Contracts	Steve Hams*	Dr Claire Fuller	Lorna Hart	Stuart Brown	Maria Bruce
	Neuro Rehab Review/ Reprocurement			Lorna Hart	Stuart Brown	Maria Bruce
	Fast Tracks outsourcing			Lorna Hart	Stuart Brown	Maria Bruce
Enabling Programme	Estates	Matthew Knight	n/a	Julian Wilmshurst-Smith	Julian Wilmshurst-Smith	Saima Sandhu
	Running Costs Savings			n/a	Dan Brown	Quentin Symington*
	Improving Contracting			n/a	Moyra Costello	Quentin Symington*

6d. 16/17 QIPP Programme

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Programme	Project	2016/17 Gross Savings £k	Risk Rating	2016/17 Risk rated Savings £k	2061/7 Service Delivery Costs £k	QIPP Net Savings 16/17 £k	2015/16 QIPP Savings FYE £k	QIPP Total Savings 16/17 £k
Planned Care	Ophthalmology	961	80%	769	- 310	459	-	459
	Cardiology	571	80%	457	- 244	213	-	213
	ENT/Audiology	613	80%	490	- 210	280	-	280
	Dermatology	524	80%	419	- 269	150	-	150
	Gynaecology	105	80%	84	-	84	-	84
	Urology	251	80%	201	- 125	76	-	76
	MSK	-	100%	-	- 552	- 552	909	357
	AQP prices review	-	100%	-	-	-	184	184
	Referral Service	-	100%	-	-	-	16	16
	Neurology	108	80%	86	- 53	33	-	33
	Gastroenterology	111	80%	89	- 66	23	-	23
	C2C activity directed to RSS	321	80%	257	- 120	137	-	137
	Email advice and guidance	381	80%	305	- 12	293	-	293
	Planned Care reprocurement costs (reserves)	-	0%	-	944	944	-	944
	Thresholds :Hips and Knees	413	80%	330		330	-	330
	POLCE on prior approval	2,053	80%	1,642	-	1,642	-	1,642
Other	Medicines Management	1,130	80%	904	-	904	96	1,000
	Medicines Management - Drop down	188	80%	150	- 67	83	-	83
	Medicines Management - Extended Provider challenge	188	80%	150	-	150	-	150
	Commissioning (Acute claims and challenges)	313	80%	250	-	250	-	250
	Mental Health Dementia	344	80%	275	-	275	-	275
	Community (Small contracts)	188	80%	150		150		150
	Managed entry of biosimilar etanercept	175	80%	140	-	140	-	140
	Anti TNF interval extension : Rheumatoid Arthritis	53	80%	42	-	42	-	42
Integrated care	Epsom Integration Programme (Inc. Community Hub)	4,875	80%	3,900	-	3,900	-	3,900
	Dorking & East Elmbridge Integration Programme (Inc. Community Hub)	815	80%	652	-	652	-	652
	A&E Admission Avoidance	65	80%	52	-	52		52
	Falls Management	241	80%	193	-	193	-	193
Continuing Healthcare	CHC Contracts	1,013	80%	810	-	810	180	990
	Neuro Rehab Review/ Reprocurement	262	80%	209	- 4	205	-	205
	Fast Tracks outsourcing	232	80%	186	- 1	185	-	185
Enabling Programme	Estates	463	80%	370	- 85	285	-	285
	Running Costs Savings	250	80%	200	-	200	-	200
	Patient transport	-	0%	-	-	-	59	59
	Improving Contracting	3,000	67%	2,000	-	2,000	-	2,000
Total		**20,203**	**78%**	**15,762**	**- 1,174**	**14,588**	**1,444**	**16,032**
Target Savings								**19,600**
Savings Gap								**3,568**

This Table details all the QIPP projects that are planned to deliver savings in 2016/17.

This shows plans in place to deliver £16m of the target £19.6m savings, including £1.4m FYE of existing 2015/16 schemes. There are projects under development to address the £3.6m gap (see page 23 “pipeline initiatives”)

Savings totals have been subject to ongoing revision and challenge through the PMO’s assurance process including POD development, PID development and clinical assurance and challenge through the CCG Executive and Governing Body.

N.B. 1 £944k is a CCG investment fund earmarked for re-provision costs, to avoid a double count of funds it nets off the £2.118m “service delivery costs” above to £1.174m

6e. 16/17 QIPP Programme : Further Pipeline Initiatives

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The table below lists further QIPP initiatives currently being worked up, which have not yet been through the internal assurance process. The first table below shows projects under development that will potentially deliver savings of £1.6m in 2016/17.

Programme	Pipeline : Other Under Development Schemes	Net Benefits (Most Likely) £k	Worst case £k	Best Case £k
	Hip and Knees : Phase 2	**420**	252	546
	Avastin off Licence Ophthalmology	**250**	110	333
	A&E Admission Aviodance phase 2	**67**	40	87
	Further Integration (Non Epsom NEL) Phase 2	**829**	497	1,078
	Totals	**1,566**	**900**	**2,044**

The second table below are less developed schemes that have the potential to deliver a further £2m of savings which brings the total potential savings delivery in 2016/17 to the target £19.6m

Programme	Pipeline : Other possible Schemes	Net Benefits (Most Likely) £k	Worst case £k	Best Case £k
	Respiratory Community service	400	176	533
	Pathology	350	154	467
	Community services contracting	400	220	520
	Out-patient procedures	300	154	467
	Smoking and Obesity	552	243	718
	Totals	**2,002**	**947**	**2,704**

The QIPP identification process will continue through 16/17, with quarterly workshops, to fill the 16/17 gap and start the 17/18 QIPP programme.

6f. Phasing of 16/17 Programme

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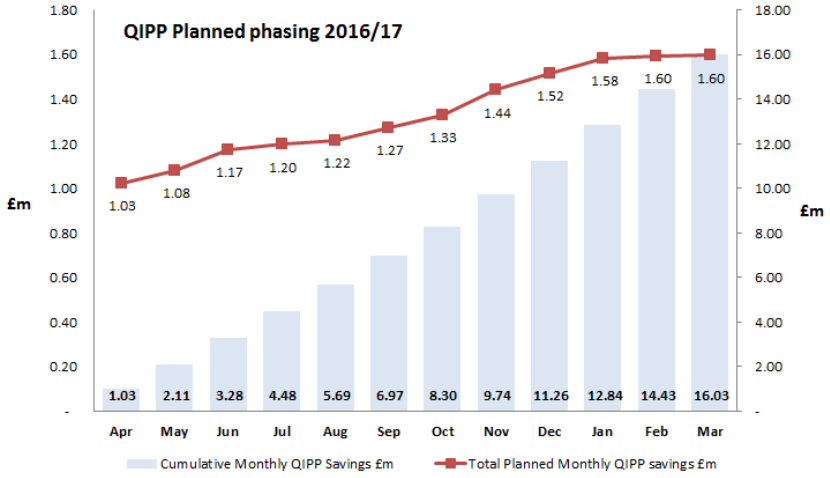
The graph above shows the planned phasing of the 2016/17 savings delivery, which starts in April at £1.03m and rises to £1.6m by March 2017.

The monthly QIPP run rate at M12 15/16 will be £1.1m, (of which over £0.9m is recurrent).



7. Leadership and Governance

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Clinical Leadership

The Executive Committee has provided clinical sign-off for all 15/16 projects. From April, clinical sign-off of new projects will be provided through the newly established Clinical Cabinet.

Transformation projects have a dedicated GP lead, who participates in programme boards to inform the design and delivery process.

The newly appointed Clinical Directors will provide clinical oversight and support through project lifecycle. Clinical Directors will represent their designated workstream at Clinical Cabinet meetings to enable informed and fluent discussions and decision making.

The CCG has also appointed an Interim Director of Clinical Performance and Delivery.

Improved Governance

Based on feedback from the PwC work, Governance Reviews and NHSE Directions; the Turnaround Director has revised the CCG's processes and procedures for Programme management. These changes have included;

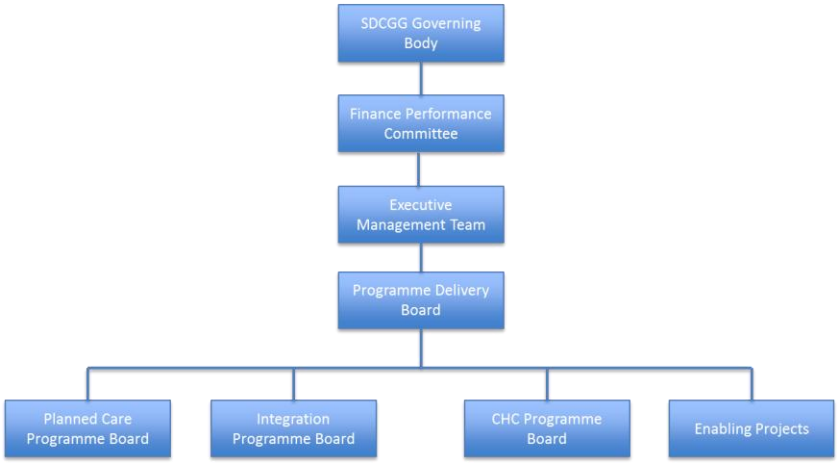
- More formalised and robust reporting
- Made PMO reporting more independent – "critical friend style"
- Streamlined the project approval process and adapted it to fit into the CCG's new governance structures
- Developed the PMO manual, which details the new way of working, governance structure and provides guidance and tools for project managers.
- Introduced integrated project workbooks to ensure consistent process across all work streams
- Introduced a single page summary dashboard for each project
- During planning and implementation Impact Assessments (quality, equality, privacy and procurement) will be conducted and monitored by the relevant professional Leads.
- The inclusion of key performance indicators for each project.

N.B. for further detail please refer to Appendix D for corporate governance.

8. Programme Structure

Overview

In Q3 15/16 the CCG moved to strengthen the governance of its programme delivery structure. QIPP programme delivery is now overseen by the structure below;



FPC

The FPC is the Governing Body (GB) sub-committee that has oversight of the QIPP programme and reports to the GB on performance. In addition to the normal finance report, the Turnaround Director attends and provides a report on QIPP at both FPC and GB.

PDB

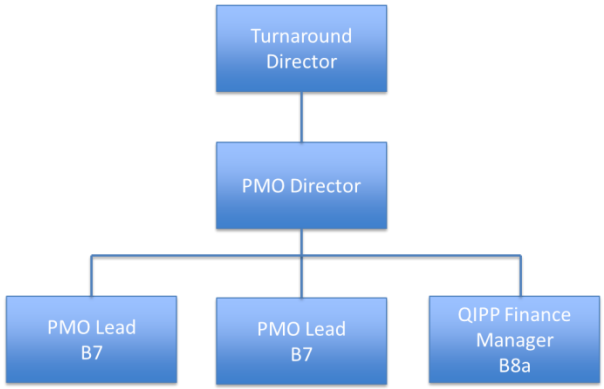
The PDB meets weekly and comprises all executive team and key project staff. It monitors progress of 15/16 delivery and generation of 16/17 QIPP plans and delivery. It also reviews the Programme risk register (see appendix C) and ensures impact assessments compliance. From April 16 the newly appointed Clinical Directors for Planned Care (Dr. Natalie Moore) and Integration (Dr. Simon Williams) will attend PDB

Programme Boards

The transformational programmes (Planned Care and Integration) have monthly programme boards. These monitor the progress of individual projects, generate new QIPP proposals and plans and provide reports to the PDB.

PMO

The PMO has been restructured to improve capacity and capability, which now reports directly to the Turnaround Director. Each project also has a dedicated PMO Lead. The new structure comprises;



9. Tracking Methodology

All QIPP planning and monitoring documents have been brought together into one integrated MS Excel workbook, to facilitate efficient tracking. The workbooks comprise;

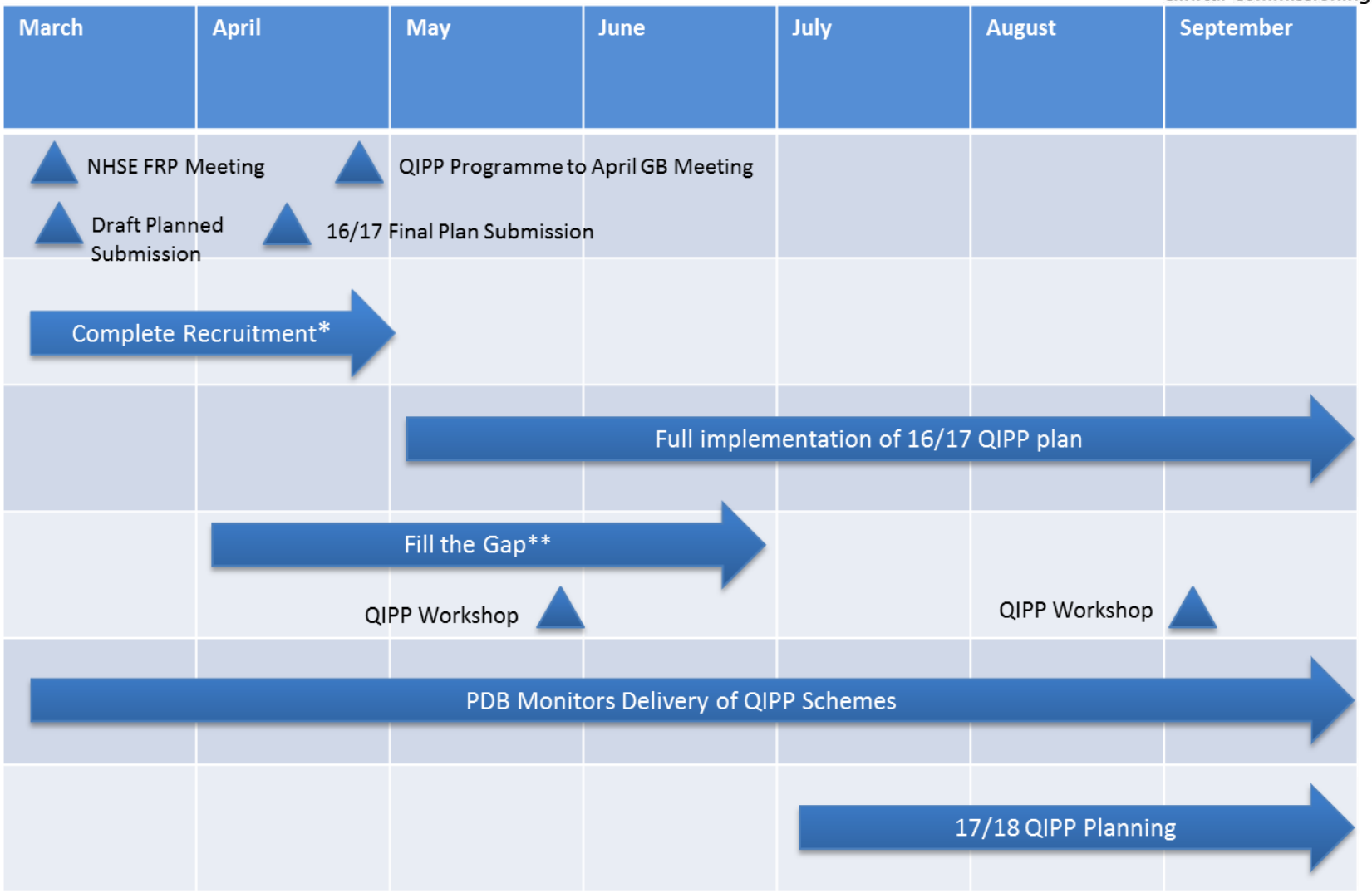
- Summary dashboard report
- Milestone tracker
- Financial/KPI tracker
- Risk register
- QIA/EQIA/PIA/Procurement

These workbooks form the basis of the monthly assurance process. An example of current project workbook: cardiology, is included in appendix E.

The CCG has recently decided to transition to using Microsoft Project software for its project planning. Training for the team took in March. Whilst the outline milestone plans have been written in Excel, the detailed implementation plans will be transferred to Project, which will provide greater detail and better reporting.

10. Next Steps

NHS
Surrey Downs
Clinical Commissioning Group



N.B. * Complete recruitment to substantive posts in planned care, integration and PMO teams plus completing the appointment of Clinical Directors to each team.

N.B. ** Continue to research and develop new QIPP schemes to the "Fill the gap" currently identified in meeting the planned QIPP target.

11. Appendix A – Project Outline Documents

Project Name:
Planned Care Dermatology Service Review

Project Manager: Ross Emmens

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

Delivery of a community based Dermatology service, providing patients with timely access to diagnosis and treatment, managing dermatological conditions and appropriate within the primary care setting. The service will improve access to Dermatology services, enabling a reduction in waiting times and improved patient experience. It will allow GPs to manage patients without the need for secondary care referral, and within a shorter timeframe.

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£419	£683
Costs £k -	-£269	-£389
Net Savings £k	£150	£294

Comments:

Project Benefits

Measureable Benefits

- Reduction in outpatient referrals to acute providers
- Patient centred case management - (Evidence of active and continual patient
- and carer involvement in the review and redesign of service provision,
- reported through patient surveys to the commissioner)
- Increase in clinical outcomes for patients (e.g. PROMS)

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Savings Assumptions

- A more cost effective community based service will reduce hospital Dermatology Out patient activity by up to 50% over the next two years. (This is based on the outcomes of a Bristol tele dermatology pilot scheme)

Benefit Delivery Tracking Methodology:

- Monthly Acute (SLAM) data for outpatients

Project Constraints & Risks

- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Communications, Finance, BI
- Sustainability of secondary care
- Uncertainty of what the market could provide locally

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Case for change sign off		X				
Milestone 2 - Business case submission		X				
Milestone 3 - Business case sign off		X				
Milestone 4 - Market warming event		X				
Milestone 5 – Service specification sign off			X			

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

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Project Name:
Planned Care ENT & Audiology Service Review

Project Manager : Ross Emmens

Programme Lead: Oliver Mckinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- The outcome of the service review is to commission a community-based ENT and Audiology service to diagnose and treat a range of ENT and Audiology conditions, and manage relevant follow-up activity within the service before final discharge back to the care of the patient's own GP, or onward referral to secondary care where necessary. The service will provide patients with timely access to diagnostics and treatment, providing a 'one-stop' service where possible and appropriate, and will be delivered by a range of appropriately trained and accredited clinicians

Project Benefits

Measureable Benefits

- Reduction in outpatient referrals
- Patient centred case management - (Evidence of active and continual patient and carer involvement in the review and redesign of service provision, reported through patient surveys to the commissioner)
- Increase in clinical outcomes for patients (e.g. PROMS)

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Comms, Finance, BI
- Sustainability of secondary care
- Uncertainty of what the market could provide locally

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£490	£1,256
Savings £k -	-£210	-£488
Net Savings £k	£280	£768

Comments:

Savings Assumptions

- Reduction in FOP, FU, – reduce avoidable demand and change setting of care
- Reduction in costs of FOP., FU , OPPR & Diagnostics

Benefit Delivery Tracking Methodology:

- FOP, FUP, OPPROC

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 - Case for change completed	X					
Milestone 2 - Business Case Submission		X				
Milestone 3 – Business Case Sign Off		X				
Milestone 4 – Service Spec sign off		X				
Milestone 5 – (High level) Implementation process to begin		X				

Project Name:
Planned Care E-referral and Guidance

Project Manager: Majorie de Vries

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

1. Implement a system for primary care clinicians to access a prompt, remote advice from consultants working in acute trusts and local providers.
2. To support GP's to make better referrals by minimising unnecessary referrals.
3. Delivering the potential trigger for more urgent referrals
4. Offering Primary Care educational opportunities by discussing patients symptoms with consultant if unsure about definitive diagnoses

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£305	£36
Costs £k -	-£12	-£3
Net Savings £k	£293	£33

Comments:

Project Benefits

Measureable Benefits

- Save money by reducing inappropriate referrals
- FOP appointments right place, right clinician, first time

Unquantifiable Benefits:

- Improve Patient Care
- Strengthen links between primary care and secondary care clinicians
- Improve quality of service delivery
- Improved data and quality reporting
- Alignment of provider(s) towards common outcome goals

Savings Assumptions

- Based on the East of England and Wandsworth schemes a 5% reduction in Out patient appointments across the 7 specialities within the scope of the email advice and guidance has been modelled.

Benefit Delivery Tracking Methodology:

- Monthly hospital (SLAM) outpatient data triangulated with referral data

Project Constraints & Risks

Appropriate level of support staff
Consultants do not engage
Consultants not signed up onto E-Referrals (SMART card access)
KPI of 72 hours respond time to GP request not reached
Backup plan if consultant is on annual leave – how to transfer the information
Primary Care becomes agitated at a potential perceived increase in Primary Care workload.

Project Difficulty	Tick	Rationale
High	X	System compliance
Medium		
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Service Specification developed		X	X			
Milestone 2 - Stakeholder Engagement, detailed plan to be developed			X	X		
Milestone 3 - Contractual impacts considered, mitigations and actions implemented			X			
Milestone 4 – Financial Modelling completed and tested			X			
Milestone 5 – Training & Education on new pathway			X			
Milestone 6 – Ongoing Comms & Engagement			X	X	X	X

Project Name:
Planned Care All First Outpatient Appointments via RSS

Project Manager : Majorie de Vries

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- To create a system where all First outpatient appointments are managed via the RSS and we do not pay for any that are not
- Explore the potential to pay on RSS data not Provider

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£257	£36
Costs £k	-£120	£20
Net Savings £k	£137	£16

Comments:

Project Benefits

Measurable benefits:

- Reduction in avoidable demand based on research, experience and benchmarking
- Increase in clinical outcomes for patients (e.g. PROMS)

Unquantifiable benefits:

- Patients are seen in the right place, right clinician, first time
- Improved data and quality reporting
- Alignment of provider(s) towards common outcome goals

Savings Assumptions

- An increase in the Out patient 1st referrals via the referral service from 65% to 95% will reduce inappropriate hospital appointments. by 1,600 in 2016/17

Benefit Delivery Tracking Methodology:

- Monthly tracking of referral rates and Hospital Out patient data

Project Constraints & Risks

- Capacity within support function
- Sustainability of secondary care
- Stakeholder Engagement
- NHS Standard Contract Restraints - if a patient is referred they must be seen – could be outside of RSS

Project Difficulty	Tick	Rationale
High	X	System agreement; NHS Standard contract restraints
Medium		
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Capacity, Demand & Financial Assumptions Tested	X					
Milestone 2 – Legal Advice	X					
Milestone 3 - Contractual impacts considered, mitigations and actions implemented	X					
Milestone 4 – Stakeholder Engagement, detailed plan to be developed		X	X	X		
Milestone 5 – Training & Education on new pathway		X	X			
Milestone 6 – Wider Comms & Engagement strategy			X	X	X	X

Project Name:
Planned Care Ophthalmology Service Review

Project Lead: Michelle Heller

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Lead: Nicola Hamilton

Clinical Director: Natalie Moore

Project Objectives

- To engage existing providers to understand current issues and identify proposed solutions to improve pathways across primary, community and acute care
- To engage with local patients, carers and the public to understand their views and experiences of existing services as well as their views of how services could be improved in future
- To produce a case for change highlighting key aspects of service review
- To develop a business case and new service specifications where appropriate
- To implement new services (once approved by CCG Executive)
- To develop standardised primary care referral guidelines and implement within primary care.

Project Benefits

Measureable Benefits

- Defined ophthalmology patient pathways
- Reduction in avoidable demand based on research, experience and benchmarking
- Improved clinical outcomes for patients (e.g. PROMS)

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Availability of GP Clinical Leadership
- Stakeholder Engagement
- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Comms, Finance, BI
- Sustainability of secondary care

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits (£k)	£769	£894
Costs (£k) -	£310	£382
Net (£k)	£459	£512

Comments:

Savings Assumptions

- Reduction in inappropriate outpatient attendances (first/follow-up/procedures)
- Reduction in inappropriate emergency attendances and admissions

Benefit Delivery Tracking Methodology:
FOP, FUP, OPPROC

Project Milestones

	16/17			
	Q1	Q2	Q3	Q4
Milestone 1 – Implement new services	x			
Milestone 2 – Seek approval from CCG Executive on progressing to phase 2 of the business case	x			
Milestone 3 – Review benefits realisation		x		

Project Name:
Planned Care MSK –pain management and Rheumatology

Project Manager : Andrea Ching

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Lead: Nicola Hamilton

Clinical Director: Natalie Moore

Project Objectives

- To engage existing providers to understand current issues and identify proposed solutions to improve pathways across primary, community and acute care
- An analysis of the potential options for service re-modelling e.g. suggested pathway improvements/changes, etc.
- To develop a new pathway which will deliver efficiencies across all services s that are integrated across self-care, primary, community and specialist care.
- A full mapping of the existing pathways, identifying key issues/bottlenecks, inter-relationships, as well as data analysis (ideally mapped by each stage of the pathway)
- To reduce the activity in secondary care by diverting to a community setting
- Define service with a view to procurement.

Project Benefits

Measureable Benefits

- Reduction in secondary care activity
- New defined clinical pathways
- Improvement in clinical outcomes (PROMs, waiting times etc.)
- Financial savings.
- Improvement in reported patient experience

Unquantifiable Benefits:

- Clear picture of services commissioned and tangible benefits realisation
- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Dependency on changes in workforce practice

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits (£k)	£909	£0
Costs (£k) -	£552	£0
Net (£k)	£357	£0

Comments:

Savings Assumptions

- Reduction in outpatient attendances (first/follow-up/procedures)
- Reduction in inappropriate emergency attendances and admissions

Benefit Delivery Tracking Methodology

- Reduction in first and follow-up outpatient attendances.
- Patient experience survey

Project Milestones **16/17**

	Q1	Q2	Q3	Q4
Milestone 1 – Implement new services	x			
Milestone 2 - Progress to procurement of newly defined service with locality roll out		x		
Milestone 3 – Begin procurement exercise –service commencing 1/4/17		x		

Project Name:
Planned Care Gastroenterology Service Review

Project Manager : Ayisha Jessa

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- To engage existing providers to understand current issues and identify proposed solutions to improve pathways across primary, community and acute care
- To engage with local patients, carers and the public to understand their views and experiences of existing services as well as their views of how services could be improved in future
- To produce a case for change highlighting key aspects of service review
- To develop a business case and new service specifications where appropriate
- To implement new services (once approved by CCG Executive)
- To develop standardised primary care referral guidelines and implement within primary care.

Project Benefits

Measureable Benefits

- Defined gastroenterology patient pathways
- Reduction in avoidable demand based on research, experience and benchmarking
- Improved clinical outcomes for patients (e.g. PROMS)

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Availability of GP Clinical Leadership
- Stakeholder Engagement
- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Comms, Finance, BI
- Sustainability of secondary care

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits (£k)	£89	£132
Costs (£k) -	-£66	-£76
Net (£k)	£23	£56

Comments:

Savings Assumptions

- A 20% reduction in Gastroenterology outpatient attendances over the next two years

Benefit Delivery Tracking Methodology:

- Monthly hospital (SLAM) outpatient data (FOP, FUP, OPPROC)

Project Milestones	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Recruitment of GP Clinical Lead CAG & PAG Engagement		X				
Milestone 2 - Stakeholder Engagement – Clinical Advisory Group established			X			
Milestone 2 - Stakeholder Engagement – Patient and Carer Advisory Group established			X			
Milestone 3 - Current state, issues and proposed solutions documented				X		
Milestone 4 – Primary Care Guidelines signed off by Executive				X		
Milestone 4 – Case for Change approved				X		
Milestone 5 – Business Case developed (if appropriate)				X		
Milestone 6 – Service Specification developed (if appropriate)					X	
Milestone 7 – Implement new services (if appropriate)						X

Project Name:
Lifestyle Thresholds for Surgery: Hips and Knees

Project Lead: Asim Foroze

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Natalie Moore

Project Objectives

The aim of the programme is to implement Shared Decision Making tools (SDM) to uphold revised thresholds for surgery on hips and knees, for patients that present with one or more factors that could lead to poor post operative outcomes. This will supported by the provision of evidence based lifestyle interventions to enable patients to come within the new thresholds for surgery as well as improving their health & well-being. The programme will also consider the use of other methods to manage conditions in primary care e.g. pain management which, along with lifestyle intervention will reduce the number elective surgeries required for hips and knees, and those are that are still required after intervention will benefit form shorter recovery time, releasing hospital bed days.

Project Benefits

Measureable Benefits

- Reduction in Length of Stay following surgery
- Reduction on spend in elective procedures
- Reduction in inappropriate procedures
- Increase PROMS score
- Increased uptake of lifestyle interventions

Unquantifiable Benefits:

- Patients will be empowered to make decisions on their care
- Reduction in NEL activity possible
- Integration agenda better working with public health/primary care
- Patients maintaining healthier lifestyles before and after surgery

Project Constraints & Risks

- This scheme was attempted by the previous PCT and Governing Body members have already raised concerns – However this is a new approach around SDM.
- Reliance on uptake of the SDM tools by patients and clinicians to ensure that revised pathways are used to prevent early or inappropriate referral to secondary care.
- Lead in time for benefits delivery may be significant as patients are typically listed for surgery 6 – 8 weeks prior to treatment and referred 11 – 16 weeks prior to treatment. Enforcing new priorities committee standards and engagement in the Right Care deep dive may bring forward some benefits.
- Acute clinical buy in/rejection – this has not been included in commissioning intentions to date and was rejected by Surrey Priorities Committee following engagement with orthopaedic surgeons on this issue.
- Savings may not be sustained and there may be a significant non-recurrent effect as patients complete programmes and enter surgery.

Project Difficulty	Tick	Rationale
High	X	The programme has previously failed to get off the ground due to lack of buy in, patient pressure to access surgery, a number of procurements exercises may need to be undertaken.
Medium		
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£330	£150
Costs £k	£0	£0
Net Savings £k	£330	£150

Comments:

Savings Assumptions

The FYE saving assumes achieving on average a 7% reduction in primary knee and hip replacements (excluding revisions) from the £7.15m estimated total expenditure for 2015/16 .This is based on a clinical assessment of the new eligibility / threshold criteria.

Benefit Delivery Tracking Methodology: Reduction in spend in relevant HRGs

Project Milestones

	16/17			
	Q1	Q2	Q3	Q4
Milestone 1 – Validate cost/savings assumptions				
Milestone 2 - Appoint project manager	11/04			
Milestone 3 - Design proposal for Governing Body approval	31/05			
Milestone 4 – Public consultation	30/06			
Milestone 5 – Implementation for new referrals from this date		01/07		
Milestone 6 – No procedures outside threshold funded from this date		30/9		

Project Name:
Prior Notification to Prior Approval

Project Manager : Majorie de Vries

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- Providers will be required to seek funding approval before delivering certain services or procedures to patients, which will enable the CCH to control activity
- The CCG will be able to challenge providers where prior approval is not sought and also challenge any activity outside of the agreed policy
- There will be a transparent system for monitoring compliance that is agreed to by the provider
- The CCG will be able to ensure that NHS- funded treatments are effective and evidence based
- There will be a clear process in place for approving / refusing treatment by using the effective prior approval document

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits (£k)	£1,642	£0
Costs (£k) -	-£0	-£0
Net (£k)	£1,642	£0

Comments:

Project Benefits

Measureable Benefits

- Reduction in PoLCE procedures based on research, experience and benchmarking
- Increase in clinical outcomes for patients (e.g. PROMS)
- Patient centred case management

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for IFR team
- Management of new contracting models
- Alignment of provider(s) towards common outcome goals

Savings Assumptions

- The savings are based on clinicians reviewing April to September 2015/16 activity to determine the volume of expected exceptions versus approvals for each listed prior approval procedure, this has been sense checked against the findings of the West Berkshire experience

Benefit Delivery Tracking Methodology:

- Blueteq

Project Constraints & Risks

- Capacity and capability within the current IFR Team
- Cost due to increase in capacity of the IFR Team
- Capacity and Capability in Support Teams , Comms, Finance, BI
- Approval from secondary care
- Availability of Clinical Leadership
- Stakeholder Engagement
- Policy being contractually enforced
- OPCS codes match up with Blueteq/trust data collection
- CSU being able to challenge POLCE successfully

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Provider Engagement		X	X			
Milestone 2 - Stakeholder Engagement, detailed plan to be developed		X	X			
Milestone 3 - Contractual impacts considered, mitigations and actions implemented		X	X			
Milestone 4 – Financial Modelling completed and tested		X	X	X		
Milestone 5 – Training & Education on new pathway			X	X		
Milestone 6 – Ongoing Comms & Engagement			X	X	X	X

Project Name:
Planned Care Urology Service Review

Project Manager : Ayisha Jessa

Programme Lead : Oliver Mckinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- To explore the hand offs between various stages, identify any potential inefficiencies and variation across inpatient and outpatient activity, as well as scope the effectiveness of wider support services and the potential to deliver care in alternative settings
- To develop a new pathway which will deliver the efficiencies within all services s and are integrated across self-care, primary, community and specialist care.
- To develop standardised primary care referral guidelines and thresholds.

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£201	£307
Costs £k -	-£125	-£175
Net Savings £k	£76	£132

Comments:

Project Benefits

Measureable Benefits

- Reduction in avoidable demand based on research, experience and benchmarking
- Increase in clinical outcomes for patients (e.g. PROMS)
- Patient centred case management

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Savings Assumptions

- A 20% reduction in Urology outpatient attendances over the next two years

Benefit Delivery Tracking Methodology:

- Monthly hospital (SLAM) outpatient data (FOP, FUP, OPPROC)

Project Constraints & Risks

- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Comms, Finance, BI
- Sustainability of secondary care
- Clinical Leadership
- Stakeholder Engagement

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – CAG & PAG Engagement		X	X			
Milestone 2 - Stakeholder Engagement, detailed plan to be developed		X	X	X		
Milestone 3 - Contractual impacts considered, mitigations and actions implemented		X				
Milestone 4 – Financial Modelling completed and tested	X	X	X	X		
Milestone 5 – Training & Education on new pathway				X		
Milestone 6 – Ongoing Comms & Engagement					X	X

Project Name:
Planned Care Community Cardiology Services

Project Manager : Linda Balzanella

Programme Lead: Oliver McKinley

Project Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- To provide an integrated Community Cardiology Service for patients in the SD CCG area, to shift activity from the acute setting into the community and bring services closer to the patients home.
- To implement a standardised patient pathway for Community Cardiology Services ensuring care is provided in the most appropriate setting.
- To minimising acute episodes of care and ensure care is provided by appropriate clinicians in the right place, first time.

Project Benefits

Measureable Benefits

- Application of best practice care pathways
- Reduction in secondary care referrals
- Reduction in unnecessary diagnostics / interventions
- Improved patient experience and patient outcomes through optimum care pathways
- Overall system wide efficiency savings through consolidation of fragmented service e.g. reduction in repeat treatments / OP appointments / investigations etc.
- Improved secondary care efficiency = reduction in cost per treatment

Unquantifiable Benefits:

- Clear picture of services commissioned and tangible benefits realisation
- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- GP take-up of scheme
- Capability of mobilisation period
- Clinical Leadership
- Stakeholder Engagement

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£457	£169
Costs £k -	-£244	-£96
Net Savings £k	£213	£73

Comments:

Savings Assumptions

A 20% reduction in Cardiology outpatient attendances over the next two years

Benefit Delivery Tracking Methodology:
Monthly hospital (SLAM) outpatient data (FOP, FUP, OPPROC)

Project Milestones

	15/16	16/17			
	Q4	Q1	Q2	Q3	Q4
Milestone 1 – EE mobilisation	X	X			
Milestone 2 - Service Specification agreed	X				
Milestone 3 - GPHP Proposal to Exec Team (9th Feb)	X				
Milestone 4 – GPHP mobilisation	X	X	X		
Milestone 5 – GPHP Service Specification agreed		X			
Milestone 6 – Training and Education on new pathway					
Milestone 7 - On-going Comms and engagement				X	X

Project Name:
Planned Care Neurology Service Review

Project Manager : Linda Balzanella

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- Provision of a more integrated neurology service across Surrey Downs CCG area.
- To reduce the rate of hospital admissions

Benefits

Measureable Benefits

- Defined service referral guidelines
- Reduction of inappropriate referrals into neurology services
- Increase in community based services
- Efficiencies and productivity:
- Minimisation of duplication and waster, in particular, the inefficient use of consultant time supporting multi-site inpatient and surgical services;
- Single waiting list management, providing equality of access
- Reduction in the use of locum doctors through consolidating the medical teams, improving clinical continuity and reducing staffing costs
- More efficient sharing of best practice, driving up standards
- Increased knowledge and education regarding the referral process

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Capacity and capability in Service Redesign Team
- Capacity & Capability in Support Teams , Comms, Finance, BI
- Sustainability of secondary care
- Availability of Clinical Leadership
- Stakeholder Engagement

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£86	£131
Savings £k -	-£53	-£75
Net Savings £k	£33	£56

Comments:

Savings Assumptions

- A 20% reduction in Neurology outpatient attendances over the next two years

Benefit Delivery Tracking Methodology:

- Monthly hospital (SLAM) outpatient data (FOP, FUP, OPPROC)

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – CAG & PAG Engagement		X	X			
Milestone 2 - Stakeholder Engagement, detailed plan to be developed		X	X	X		
Milestone 3 - Contractual impacts considered, mitigations and actions implemented		X				
Milestone 4 – Financial Modelling completed and tested	X	X	X	X		
Milestone 5 – Training & Education on new pathway				X		
Milestone 6 – Ongoing Comms & Engagement					X	X

Project Name:
Planned Care Gynaecology Review & Redesign

Project Manager: Gareth Jones

Programme Lead: Oliver McKinley

Executive Lead: James Blythe

Clinical Director: Dr Natalie Moore

Project Objectives

- To develop a new pathway which will deliver the efficiencies within all services and are integrated across self-care, primary, community and specialist care.
- To reduce variation across Surrey Downs CCG local population
- To develop standardised primary care referral guidelines and thresholds.

Project Benefits

Measureable Benefits

- Reduction in avoidable demand based on research, experience and benchmarking
- Increase in clinical outcomes for patients (e.g. PROMS)
- Patient centred case management

Unquantifiable Benefits:

- Improved data and quality reporting
- Development of skills and capabilities for large-scale elective care redesign and management of new contracting models
- Alignment of provider(s) towards common outcome goals

Project Constraints & Risks

- Availability of clinical leadership
- Sustainability of secondary care
- Stakeholder Engagement

Project Difficulty	Tick	Rationale
High		
Medium	X	CCG owns project, resources and capability restraints
Low		

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£84	£0
Costs £k -	-£0	£0
Net Savings £k	£84	£0

Comments:

Savings Assumptions

- A reduction in Gynaecology Out patient activity over the two years due to community & GP education and training

Benefit Delivery Tracking Methodology:

- Monthly hospital (SLAM) outpatient data (FOP, FUP, OPPROC)

Project Milestones

	15/16		16/17				17/18			
	Q3	Q 4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – CAG & PAG Engagement	X	X								
Milestone 2 - Stakeholder Engagement, detailed plan to be developed		X	X	X						
Milestone 3 - Contractual impacts considered, mitigations and actions implemented		X	X							
Milestone 4 – Financial Modelling completed and tested		X	X	X	X					
Milestone 5 – Training & Education on new pathway				X	X	X				
Milestone 6 – Ongoing Comms & Engagement					X	X				

Project Name:
Managed entry of biosimilar etanercept

Project Manager: Liz Clark

Programme Lead: Sarah Watkin

Executive Lead: Steve Hams

Clinical Director: Dr Andreas Pitsiaeli

Project Objectives

- Managed entry of biosimilar etanercept which should be available from Q1 16/17.
- Savings cannot be calculated until CMU price becomes available and patient numbers at ESHUT are confirmed
- Envisaged all new patients will start on biosimilar and a switch programme will be implemented for existing patients.

Project Costs & Savings

	In year 16/17	FYE 17/18
Benefits £k	£140	£0
Cost £k -	-£0	£0
Net Savings £k	£140	£0

Comments:

Project Benefits

Measureable

- Containment of anti-TNF spend – ability to treat more patients with same financial envelope.
- Possibility of treating small number of clearly defined patients with destructive rheumatoid arthritis earlier in the pathway to prevent long-term joint damage and associated social & healthcare costs.

Unquantifiable

N/A

Savings Assumptions

- Based on a 40% annual price saving on drug costs for up to 81 patients

Benefit Delivery Tracking Methodology:

- Tracked by pharmacy per patient

Project Constraints & Risks

- Currently CMU drug price unknown – expected to be announced in February 2016 price will be up to 35% lower than previous drug.
- Product launch subject to MHRA approval process so may be delayed
- Budget in with NHS England for ESHUT patients for biologic medicines.

Project Milestones	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1	Monthly review with finance and commissioning director					

Project Difficulty	Tick	Rationale
High		
Medium		
Low	x	*proven capability, clinician engagement in place, biosimilar principles in place, just need to have the budget back from NHS E.*

Project Name:
Community Integration Programme

Project Manager : Stephanie Isherwood
Programme Lead: Tom Elrick

Executive Lead: James Blythe

Clinical Director: Dr Simon Williams

Project Objectives

- 3 locality-specific models (Dorking, East Elmbridge, Epsom) of integrated community services that will avoid non elective admissions and thus deliver savings. The models will be co-developed by the key providers in each area: the GP Networks, Community Providers, Mental Health Service Providers, Adult Social Care Services, Acute Hospitals, and third sector providers. The integrated community models will also include the Quality Care Homes and Falls Service projects as well as relevant elements of the End of Life Care, Mental Health and Dementia workstreams.
- These locality models will build on the current Community Medical Team (CMT)/ Community Multi Speciality Provider (CMSP) model.
- The degree of integration across the individual providers and the contracting arrangements with Surrey Downs CCG will differ by locality.
- **Epsom:** It is expected that a single provider organisation, Epsom Health & Care, will exist in the Epsom locality, comprising a workforce from each of the core providers, and with which the CCG will contract directly. The Epsom model is likely to include the new CADU service opened at Epsom Hospital in November 2015.
- **Dorking:** are proposing a Primary Care Home model. To date this has been developed as part of their unsuccessful Vanguard bid with CSH but they are looking to include SCC and potentially SABP through the business case development task for this programme. Dorking are seeking a mandate to proceed from the Governing Body on 29th January 2016.
- **East Elmbridge:** it is expected that each core provider will continue to contract separately with the CCG via contract variation to the existing contracts, as currently. The expectations of and KPIs for each provider will, however, be consistent.

Project Benefits

Measurable:

- Reduce the number of non-elective admissions
- Reduce the length of stay of frail and elderly patients admitted to an acute or community hospital
- Reduce the number of readmissions
- Improve the long-term health and wellbeing scores of patients
- Patient Experience

Unquantifiable:

- Improve interprofessional communication

Project Constraints & Risks

- The 15/16 CMT/CMSP model and supporting elements (IT, Estates) may not be fully implemented by end March 2016 resulting in the starting point for 16/17 and associated savings being delayed.
- Agreement of the contracting model for Epsom Health & Care may delay the start of the new model in Epsom locality.
- CCG is not able to mandate change or implementation. This is mitigated this through the way we are engaging and the way in which the governance is set up.

Project Difficulty	Tick	Rationale
High	X	Multiple providers, 3 locality models, dependencies across other programmes, integrated model and new contracting arrangements
Medium		
Low		

Project Costs & Savings

	16/17	17/18
Benefits £	£4,552	Tbc
Costs £	£0	Tbc
Net Savings £	£4,552	tbc

Comments: 16/17 is evolution to locality designed and developed models. Models will be designed across January/ February 2016 with view to implementing from 1st April 2016. Gross savings indicated are in line with the original business case (August 2015) although until the locality plans are developed this is only directional.

Savings Assumptions

Savings are from NEL admission avoidance.

- 16/17 estimate from original business case (Aug 2015) is 5-7% which is in line with the stretch targets proposed by Deloittes. However, savings will be refreshed as part of locality business case development which will be drawn together in a single business case by mid March 2016.

Benefit Delivery Tracking Methodology:

- Locality providers will report vs KPIs articulated in the contract variations

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Completion of the 15/16 phase one CMT/CMSP model in all 3 localities (enables benefit delivery from 1/4/16)		x				
Completion of the locality business cases		29/2				
Sign off the 3 locality business cases for the 16/17 models		18/3	29/4			
Implementation of 16/17 model			x	x		

Project Name:
Integrated Falls Service

Project Manager : Kirsty McMurray

Programme Lead: Tom Elrick

Executive Lead: James Blythe

Clinical Director: Dr Simon Williams

Project Objectives

An evolution of the current falls service into the new Integrated Falls Service which will form part of the Community Hubs. The current service, provided by CSH(Surrey), will be re-specified with clear KPIs included. The new service will require no incremental investment but will deliver savings through a reduction in fracture clinic activity and DEXA scans and, in the longer term, a reduction in hip fractures.

Operational Approach:

- Work closely with ED, fracture clinics, and acute and community inpatient teams to identify patients with prior fractures and agree processes to refer these to the Integrated Falls Service
- Work closely with GP practices to develop processes for case finding the potential non fracture osteoporosis patients from chosen cohort
- Collation of guidelines and other support materials for clinicians and patients
- Update training and education resources around osteoporosis and fragility fractures

The IFS will consist of two primary elements :

- Triage – patients who have had a fall with or without fracture or injury can be referred to the IFS. This includes those patients occupying beds in either acute or community hospitals, patients in the Emergency Department, patients at home or patients in residential care. Healthcare professionals can refer the patient to the IFS for review and advice. The IFS will assess the patient to determine the risk of further falls and injury. The IFS will provide the referring clinician with advice on how best to manage the patient, including preparation of the patients home environment, safety advice and use of aids.
- Care Delivery – the IFS will have a patient case load, focused on those who are at highest risk. Such patients will receive regular assessment visits from the IFS team, with nursing and physiotherapy input to improve the patients general mobility and safety.

Project Benefits

Measurable

- Improve clinical outcomes and benefits by bringing care closer to home
- Reduction in unnecessary hospital outpatients activity
- Improving patient compliance
- Improve secondary prevention in patients with osteoporotic fractures as well as non-fracture but high risk patients
- Improve healthcare access and outcomes for difficult to reach patients

Unquantifiable:

- Improve interprofessional communication

Project Constraints & Risks

- Duplication of patient counts (and therefore savings) for fracture clinic with MSK pathway – this is currently being worked through between the Planned and Urgent & Integration programme leads

Project Difficulty	Tick	Rationale
High		
Medium		
Low	√	Recontracting of current service

Project Costs & Savings

	16/17	17/18
Benefits £k	£193	£0
Costs £k	£0	£0
Net	£193	£0

Comments*:*

The pioneer Glasgow model showed a 3.6% reduction in number of hip fractures over 10 years. Using that experience and applying it for 5 years, Combining the hip fracture reductions and the Outpatient savings, the Integrated Falls Service can potentially make a cumulative efficiency savings of £1,160k over next 5 years.

Savings Assumptions

- **15%** Estimated reduction in Fracture clinic activity due to IFS Review
- **30%** Estimated reduction in DEXA scans due to IFS Review
- Based on evidence from Crawley CCG

Benefit Delivery Tracking Methodology:

- Via contractual KPIs

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Initial meeting with CSH to define new service		X				
Co-develop service spec incl KPIs with CSH		x				
CSH to develop transition plan and agree with CCG		x				
Agree joint Comms plan for new service for primary care, comm hosps, Acutes		x				
Complete impact assessments		x				
New service starts, benefits realised			1/4/16			
Evaluation of service (3 months in)				x		

Project Name:

Community Estate

Project Manager: Jules Wilmshurst-Smith

Executive Lead: Matthew Knight

Clinical Lead: Not required

Project Objectives

To reduce the cost of ownership of the Community Estate through:

- More efficient use of space, through consolidation of services and potentially leading to the disposal of properties.
- Improved management of costs, eg, reduced FM costs including new NHS PS FM contract (~10%) and utilities.
- Reduction in Rent for Cedar Ct site NLT May 2016

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£370	£0
Costs £k -	-£85	£0
Net Savings £k	£285	£0

Comments:

Project Benefits

Measurable Benefits:

- Reduced overall FM costs (£££)
- Reduced Rent Cedar Ct – 9 month free rent (£££)
- Site Closure – Ashtead at M6 (£££)

Unquantifiable benefits:

- Consolidated CSH Services, e.g. to Leatherhead Hospital

Savings Assumptions (Best case)

- FM savings 10% of budget
- Cedar Ct Rent assuming 9 months free rent from Apr 16
- Close Molesey Open Cobham - £0 (cost neutral)
- Close Ashtead and Banstead to LH Hospital.

Project Constraints & Risks

Benefits heavily dependant on NHS PS for:

- Re-procurement of Regional FM contract by March 2016.
- Re-gearing/ new lease for Cedar Ct wef May 2016
- Community Hospital Review delays CSH (and other provider) service consolidation options. (Closure of Molesey outweighed by Cobham costs)
- NHS 2015/16 costs still to be confirmed. Savings identified are based on NHS PS cost profile 2014/15. We have recently received new baseline from PS that shows a potential £0.5m reduction in 2015/16 costs – this is yet to be confirmed . If the CCG uses the 2015/16 baseline for 2016/17 FOT then QIPP available will be reduced.)

Benefit Delivery Tracking Methodology:

- NHS PS cost data provided at M6 & YE

Project Difficulty	Tick	Rationale
High	Tick	CHR and NHS PS dependencies.
Medium		
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
NHS PS New FM Contract			X			
CHR Option Agreed		x				
Cobham Host Lease agreed		x				
Cedar Ct Lease Agreed		x				
Ashtead disposal (to NHS PS)				x		

Project Name:
Neuro rehab / ABI CHC

Project Manager : Stuart Brown

Programme Lead: Lorna Hart

Executive Lead: Steve Hams

Clinical Director: Dr Claire Fuller

Project Objectives

- Surrey Downs CCG hosts CHC across Surrey. Highly specialist Neuro rehabilitation is part of the CHC budget but is not specifically aligned to the CHC eligibility criteria. Historically CHC hosts this budget in Surrey as it does in other parts of the Country. Patients that are funded within this category require specialist Neuro rehab outside that which is offered through community or acute contracts. The provider market is high cost low volume.
- This initiative seeks to develop a common specification for specialist Neuro rehab to ensure parity and consistency of quality and price for Continuing Healthcare across; Hampshire, West Sussex and Surrey CCGs. To provide a clear and consistent

Project Benefits

Quantifiable Benefits

- Consistency of service across the region using a single service specification and contract therein.
- Achievement of economies of scale by buying and services at this level (Market Management)
- Patient satisfaction will be measured through patient surveys using qualitative questions

Unquantifiable Benefits

- Parity of offer

Project Constraints & Risks

Market engagement, consultation and price negotiation

- Slippage due to complex governance processes – working across multiple CCGs outside of Surrey

Project Difficulty	Tick	Rationale
High	√	*co-dependency with CGs across the south east*
Medium		
Low		e.g. *proven capability, resources in place, CCG owns the process*

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£209	£61
Costs £k -	-£4	-£2
Net Savings £k	£205	£59

Comments:

Savings Assumptions- to be confirmed

- 5% reduction in £3.0m budget (tbc). Full year effect is split 75%/25% across 16/17 and 17/18

Benefit Delivery Tracking Methodology:

- Quarterly reconciliation of budget line
- Development and roll out of patient satisfaction survey.

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Provider Engagement events		x				
Benchmarking for pricing matrix		x				
Agree pricing matrix			x			
Go live (apply matrix to contracts				x		

Project Name:
Fast Track Outsourcing

Project Manager : Stuart Brown

Programme Lead: Lorna Hart

Executive Lead: Steve Hams

Clinical Lead: Dr Claire Fuller

Project Objectives

- Surrey Downs CCG hosts CHC across Surrey. CHC funds patients approaching the end of life with a fast track referral and placement in a nursing home, hospice or with a package of care through a domiciliary care agent.
- To improve process and alignment of End of Life packages of care and placements for patients and carers by supporting patients to achieve their preferred place of care and death. CHC proposes to outsource fast track process after the verified assessment to a provider(s) to broker to placement / package of care.

Project Benefits

- Consistency and assurance of service delivery across fast track patients
- Patient satisfaction
- Market management through a brokerage service

Project Constraints & Risks

- Market engagement , consultation and price negotiation
- Slippage due to complex governance processes
- Competing priorities with other programmes

Project Difficulty	Tick	Rationale
High		
Medium	√	Procurement project
Low		

Project Costs & Savings

	16/17	17/18
Benefits £k	£185	£0
Costs £k -	£0	£0
Net Savings £k	£185	£0

Comments:

Savings Assumptions- to be confirmed

- 8% reduction of £2974k fast track budget. Full year effect is split 50%/50% across 16/17 and 17/18

Benefit Delivery Tracking Methodology:

- Quarterly reconciliation of budget line

Project Milestones	15/16		16/17				17/18			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Market engagement	x									
Develop service specification		x								
Procurement process		x	x							
Contract Award			x							
Mobilisation				X						
Go live				x						

Project Name:

Medicines Management – Drop List

Project Manager : Helen Marlow

Programme Lead: Kevin Solomons

Executive Lead: Steve Hams

Clinical Director – Prescribing

Project Objectives

- Reduction in the prescribing of certain medicines identified as drugs of limited therapeutic value , NICE do not do's or not recommended for prescribing in local guidelines (DROP list)
- To provide tools and resources for GPs to implement a reduction in prescribing of medicines on the DROP list
- Promotion of self-care and reduction in CCG spend on medicines patients can buy OTC from their pharmacy

Project Costs & Savings

	In Year 16/17	FYE 17/18
Benefits £k	£150	£0
Costs £k -	-£67	£0
Net Savings £k	£83	£0

Comments:

Project Benefits

Measureable Benefits

- Reduction in medicines spend without damaging patient outcomes

Unquantifiable Benefits:

- Formal mandate to GPs to be able to say no on certain medicines
- Encouraging better use of pharmacies which in turn might lead to patients being prepared to use their pharmacists for more services?

Savings Assumptions

- Although this will go across all patient cohorts, by the very nature of the medicines involved, this will not impact a huge number of patients

Benefit Delivery Tracking Methodology:

- Reduction in medicine spend as tracked by MM team

Project Constraints & Risks

- Requires GP and patient engagement to reassure patients
- Capacity required in GP practices to implement the change and manage patient concerns
- Patient ability to afford purchase OTC
- Clear communication on why we are doing this to avoid Daily Mail over-reaction

Project Difficulty	Tick	Rationale
High		
Medium	X	Patient and GP engagement
Low		

Project Milestones

	15/16		16/17			
	Q3	Q4	Q1	Q2	Q3	Q4
Milestone 1 – Agree medicines to be included on DROP list		X	X			
Milestone 2 - Financial modelling completed and tested-		X	X			
Milestone 3- CAG & PAG Engagement			X			
Milestone 4- Patient Engagement and detailed communications plan to be developed			X	X		
Milestone 5 – Implementation tools developed to support practices				X		
Milestone 5 – Dissemination and implementation in GP practices				X	X	X
Milestone 6 – Ongoing Comms & Engagement						

12. Appendix B – FRP Actions

12a. FRP actions from 3rd December 2016 regional review

NHS
Surrey Downs
Clinical Commissioning Group

	Action	Response
1	Footprint. For the purposes of 2016/17 planning it was agreed Surrey Downs is in the Surrey Unit of Planning, noting there are three local health economies based around patient flows to Epsom, Kingston and SASH. This may be refined for the 5 year plan expected to be submitted in spring/summer 2016. Action: Surrey Downs	Done 7th December
2	Kings Fund decision making framework. POD/PID/BC process overseen by FPC is consistent with this.	The CCG's project initiation, approval and oversight process run by the Project Delivery Board and overseen by the Finance and Performance committee embodies this approach
3	AQPs. Action: MK to contact Clinical Commissioners to determine if local issues are replicated nationally	NHSCC not aware of any specifics. Informal follow up with NHSCC finance forum.
4	Community Services. Action: Contact Patricia Davis at Dartford Gravesham & Swanley CCG for details of their procurement	We are aware of DG&S procurement and the recent legal challenge. Once available, lessons learned will be incorporated into SD's community procurement.
5	Surrey Downs local financial positions for primary care and specialised commissioning. Action: Contact Sarah McDonald at NHSE for details [Update 6/1: NHSE advising CCGs of positions in advance of planning submissions]. Update: in national guidance.	The CCG is above target funding. Inclusion of primary care and specialised reduce Distance from Target in 2016/17 from 2.92% to 2.58%. By 2020/21 the reduction is from 2.15% to 2.04%.
6	QIPP: Continue to review plans to cover £5m gap, including potential benefits still to accrue from mobilisation of right care. Action: Surrey Downs.	See QIPP slides.
7	NHSE monitoring: Responsibility moved from regional to sub-regional team per J Howells letter of 3/12/15. To note.	Noted.

12b. FRP actions from 5th February 2016, local finance review

NHS
Surrey Downs
Clinical Commissioning Group

	Action	Response
1	Plan to be submitted at a deficit of -£7.5m (-£9.5m below headline business rules before adjustments)	Done (see assumptions and bridge)
2	QIPP to be maintained at FRP level of £19.6m for 2016/17	Noted
3	Re-work latest view of 2015/16 underlying growth rate	See slide 15
4	Calculate "do-nothing" view of non-elective growth and costs to compare to the integration business case	See slide 16
5	Provide overarching 2015/16 to 2016/17 bridge and a detail bridge of investments between periods - of current 2015/16 investments what is recurring and rolls forward into cost base 2016/17?	See slide 24
6	Potential £2m Epsom cost to bridge to £102m overall is included	Confirmed.
7	East Surrey – share budget reconciliation template	Done.

12c. FRP actions from 3rd March 2016, local finance review

NHS
Surrey Downs
Clinical Commissioning Group

	Action	Response
1	15/16 QIPP table – Slide 16 - please insert details of clinical leads	See slide 17
2	16/17 QIPP programme – Slide 20 – FYE of 15/16 QIPP was challenged – paragraph required around treatment of schemes spanning years. Also clarity required around the risk assessment process that arrives at the QIPP values presented – we agreed that the sums presented had been abated for risk.	See slide 29
3	Final document to include an example of your QIPP tracker	See slide 62
4	Produce updated detailed FRP document akin to that presented in December	16/17 FRP - Version: April 2016

13. Appendix C – QIPP Risk Register

13. QIPP Risk Register

NHS
Surrey Downs
Clinical Commissioning Group

RISK IDENTIFICATION & MITIGATION											RISK ASSESSMENT				
Title of risk	**Risk Area**	**Executive Risk Owner**	**Risk Manager**	**Main responsible committee**	**Risk Description:** *"There is a risk that…"*	**Source of risk** *(where does this come from)*	**Potential effect of the risk** *(what might happen)*	**Assurance** *(What do we know)*	**Gaps in assurance** *(What don't we know)*	**Controls** *(what can we do)*	**Date of latest scoring**	**Likelihood Score**	**Impact Score**	**Net Score**	**TREND** *(change since last report)*
Planned Care : work capacity	Resources	Director of Commissioning & Strategy	OMckinley	PDB	New planned care projects cannot be planned, mobilised and implemented due to planned care team working at full capacity on current projects	Need to develop and deliver additional projects	Unable to deliver current projects on time and to mobilise new projects in a timely manner	Additional capacity is required if new projects are required in 2016/17	Whether we have the budget for extra resource.	Put a request to PDB/ Exec for an extra resource.	06/04/2016	2	2	4	Improving
Community Hubs (15/16 element)	Delivery/Project Plan	Chief Finance Officer	TElrick	PDB	Stakeholders using various IT systems which are configured differently will prevent access by clinicians to each other's systems.	CSU IT resource	Creates operational inefficiencies	SECSU have proven that they are unable to deliver this work. CSH have agreed to manage the implementation via new Dir IM&T with Jo Pritchard as CSH/GPHP SRO.	Revised Plan. CSH confident solution can be enabled for 31 Mar 16.	SECSU were originally asked to enable work. Despite constant pressure and escalation no action - so CSU support has been terminated. Working with CSH as planned alternative solution.	04/02/2016	3	3	9	Static
Community Integration Programme (16/17 element)	Benefits & Costs	Interim Deputy Director of Commissioning	TElrick	PDB	Insufficient alignment between SDCCG and providers within Epsom Health & Care impacts the conclusion and sign off of the integrated business case.	Delayed business case due to model of care not being finalised, finances not aligning with CCG FRP submission and provider alliance misalignment.	Epsom 5YFV plan will not be realised in 2016/17 impacting on patient services, QIPP for 16/17 and credibility of overall strategy.	Strategic outline case and supporting draft finance have been shared. MCP to test provider alliance readiness is to be issued 2/3.	How the provider alliance is going to be able to achieve the investment/ benefit balance.	CCG can continue to facilitate discussions with and between providers.	01/03/2016	2	4	8	Improving
Community Integration Programme (16/17 element)	Governance	Interim Deputy Director of Commissioning	TElrick	PDB	Governance arrangements for delivery of Community Integration Programme are insufficient for Commissioner's oversight, monitoring of patient quality and QIPP savings delivery.	New 'federated' operating model for delivery of programme does not allow for sufficient CCG oversight.	CCG is unable to influence or monitor delivery of savings and patient quality	Business cases will be reviewed by CCG governance. There is an existing Integration Group. Dorking and East Elmbridge recognise the need for CCG oversight. Epsom has an existing programme board with CCG attendance.	This structure worked during design phase - however for implementation phase of programme, governance needs to be reviewed and agreed.	Review delivery governance and propose refinement to existing structures along with new Terms of Reference for all 3 localities. Possibly set up a Clinical Quality Reference Group as an oversight vehicle.	29/03/2016	4	4	16	Static
QIPP 16/17	Finance	Interim Chief Officer	RMcCormack	PDB	The CCG's 'control' total QIPP will not be achieved	Insufficient number of approved QIPP schemes to meet the full 16/17 target	Fail to achieve control total.	The CCG has a number of approved schemes which are already underway and underpin significant QIPP total. However, there remains a number of identified schemes that are not yet authorised - work underway to get these approved.	Capacity to design and authorise the projects.	Further work is planned at Head of Service and Executive level to advance these opportunities as soon as is possible.	29/03/2016	2	5	10	Static

14. Appendix D – Improving Corporate Governance

14. Improving Corporate Governance

NHS
Surrey Downs
Clinical Commissioning Group

The CCG has undertaken a number of actions in response to the NHS England commissioned PwC review of its capacity and capability in August 2015 and the CCG commissioned reviews by Grant Thornton and OECam which were reported to the Governing Body in October 2015. On the basis of these the CCG has, as of April 2016:

- **Successfully completed an executive restructure.** Current position:

  i. Interim Chief Officer
  ii. Interim Turnaround Director
  iii. Interim Director of Clinical Performance & Delivery
  iv. Substantive Director of Commissioning and Strategy
  v. Substantive Chief Finance Officer

- **Completed a governance restructure** with new Governing Body and committees in place, and constitution about to be formally signed off by NHS England

- **Streamlined and more effective Governing Body –** reduced from 24 to 14 members but still retaining clinical majority.

- **4 Committees:** Remuneration & Nominations; Audit; Finance & Performance; and Quality. Primary Care Committee has ceased with new arrangements to be put in place for co-commissioning status once Directions are discharged and primary care capacity in place.

- Executive Committee with blurred accountability now replaced by **Executive Management Team** with clear responsibilities.

- **New Clinical Cabinet** to act as the central 'hub' for clinical commissioning (CCG business and delegation will be transacted through the Executive Management Team)

- **Revised role for localities** to ensure greater leadership, communication and engagement with locality membership practices

- **210 Internal and External Governance review recommendations completed** with small number of remaining issues transferred to new committees

- **GB Induction programme and leadership programmes developed** focusing on both individual leadership roles (clinical and non clinical) and development of the Governing Body as a whole

- **External support to major OD programme** just commenced designed to ensure that the CCG makes best use of senior managers and gets leadership and ownership of FRP and transformation in place throughout the organisation.

- **Separation of functions** between clinicians helping to drive change and contributing to integration and transformation (Clinical Cabinet), and others responsible for assurance and constructive challenge (Governing Body and principal committees)

Follow Up Work

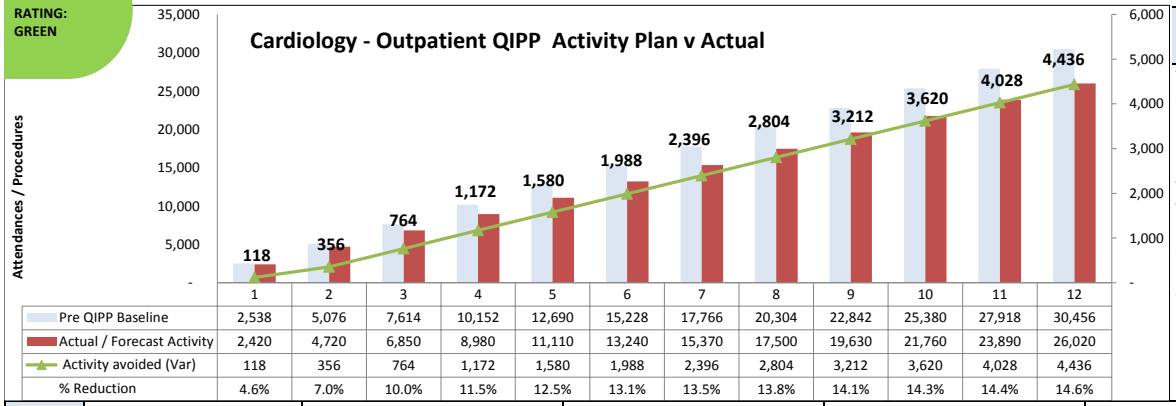
- OECam commissioned to come back in the Autumn to see what progress the CCG has made in terms of impact of new Governance arrangements
- Continued review of Governance through quarterly assurance meetings with NHS England

15. Appendix E – Example Workbook: Cardiology

Updated by: Linda Balzanella	Date Updated: 19.04.16

PMO PROJECT RATING: GREEN

PLANNED CARE : CARDIOLOGY DASHBOARD | **REPORTING PERIOD : Quarter 1**



	1	2	3	4	5	6	7	8	9	10	11	12
Pre QIPP Baseline	2,538	5,076	7,614	10,152	12,690	15,228	17,766	20,304	22,842	25,380	27,918	30,456
Actual / Forecast Activity	2,420	4,720	6,850	8,980	11,110	13,240	15,370	17,500	19,630	21,760	23,890	26,020
Activity avoided (Var)	118	356	764	1,172	1,580	1,988	2,396	2,804	3,212	3,620	4,028	4,436
% Reduction	4.6%	7.0%	10.0%	11.5%	12.5%	13.1%	13.5%	13.8%	14.1%	14.3%	14.4%	14.6%

Executive Sponsor Commentary

The projects are locality based. The Service Specification for SMN Ltd has been sent to the provider and cirulated internally for inclusion within the NHS Contract. The service did not 'go live' on 7th April due to the request for documentation from contracting. Triaging is scheduled to start by the end of April.
The Service Specification for the GPHP Ltd service has been circulated internally (01.04.16) for final comment. Go live date agreed as beginning of May. A meeting has been arranged with GPHP Ltd to discuss mobilisation of the new service.

KEY MILESTONES

Period	March week beginning 28th	April week beginning 4th	April week beginning 11th	April week beginning 18th	April week beginning 25th
SMN Ltd Service Specificaiton finalised, sent to provider, contracting and internal departments.	→				
SMN Ltd Service - clinical 'go live' 7th April. Rescheduled for end of April.					⇢
GPHP Ltd - Comments received from GPHP Ltd, Final draft service spec circulated to senior management with GPHP Ltd comments for agreement and comments		→			

KEY: MILESTONE COMPLETED → | MILESTONE NOT COMPLETED ⇢ | START OF BENEFITS DELIVERY ☺ | KEY DECISION POINT ◆

FINANCE

£k	Apr-16	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar-17	YTD	16/17 Total
Monthly Planned Savings (000k)	£3	£6	£12	£12	£12	£24	£24	£24	£24	£24	£24	£24	£0	£213
Actual/Forecast (000k)	£3	£6	£12	£12	£12	£24	£24	£24	£24	£24	£24	£24	£0	£213
Savings - (Var + behind plan)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

KPI Performance

First Appointment Waiting Times - Patients will be seen for their first appointment within 2 to 4 weeks of the referral being received

Status (RAG)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	16/17 Total
Planned	80%	85%	90%	95%	98%	98%	98%	98%	98%	98%	98%	98%		
Actual													-	
Variance														

KPI Quality

Service User Experience - % complaints per month < 1.5%

Status (RAG)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	16/17 Total
Planned	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%		
Actual														
Variance														

Project Finance Delivery Summary and Activity Tracker

Programme Name	0
Project Name	0
Executive Sponsor	0
	0
Project Lead	0

Reporting Month:	

	Project Cost or Savings Values (as per Summary Sheet)		Year to date financial performance (£000's)				Apr-16 (£000's)		May-16 (£000's)		Jun-16 (£000's)		Jul-16 (£000's)		Aug-16 (£000's)		Sep-16 (£000's)		Oct-16 (£000's)		Nov-16 (£000's)		Dec-16 (£000's)		Jan-17 (£000's)		Feb-17 (£000's)		Mar-17 (£000's)	
	Full Year Recurrent	**Part Year**	**Actual**	**Budget**	**% Achieved**		Actual / Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget	Actual/ Forecast	Budget
Recurrent Savings	**0**	**456**	**456**	**456**	**100%**		7	7	13	13	26	26	26	26	26	26	51	51	51	51	51	51	51	51	51	51	51	51	51	51
Non-Recurrent Savings	**0**	**0**	**0**	**0**																										
Total Savings	**0**	**456**	**456**	**456**			**7**	**7**	**13**	**13**	**26**	**26**	**26**	**26**	**26**	**26**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**
Revenue Costs	**0**	**-244**	**-244**	**-244**			-3	-3	-7	-7	-14	-14	-14	-14	-14	-14	-27	-27	-27	-27	-27	-27	-27	-27	-27	-27	-27	-27	-27	-27
Total costs	**0**	**-244**	**-244**	**-244**			**-3**	**-3**	**-7**	**-7**	**-14**	**-14**	**-14**	**-14**	**-14**	**-14**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**	**-27**
Net (Cost) / Savings	**0**	**213**	**213**	**213**			**3**	**3**	**6**	**6**	**12**	**12**	**12**	**12**	**12**	**12**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**	**24**
							1%		3%		6%		6%		6%		11%		11%		11%		11%		11%		11%		11%	

ACTIVITY

				Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Activity	KPI description	Status	Actual / Forecast	2,420	2,300	2,130	2,130	2,130	2,130	2,130	2,130	2,130	2,130	2,130	2,130
			Pre QIPP Baseline	2,538	2,538	2,538	2,538	2,538	2,538	2,538	2,538	2,538	2,538	2,538	2,538
			Monthly Variance	118	238	408	408	408	408	408	408	408	408	408	408

Project Milestone Tracker

Community Cardiology and Diagnostics Service	0
Oliver McKinley / Linda Balzanella	0
James Blythe	0

Please note mobilisation plans have been attached and are being updated on a weekly basis with each locality group

Legend:
- (purple) Other Internal Department Taking Forward
- O – Original milestone due date, not yet due. This is the starting position for all milestones
- OC – Original milestone, Completed on time.
- OCL – Original milestone, Completed late.
- OM – Original milestone, target date for completion missed

Milestone Description The date which the action is to be completed in (week commencing)	Milestone Owner	PMO Comments Notes on achievement / slippage	Dec-15 01-Dec-15	08-Dec-15	15-Dec-15	22-Dec-15	29-Dec-15	Jan-16 05-Jan-16	12-Jan-16	19-Jan-16	26-Jan-16	Feb-16 02-Feb-16	09-Feb-16	16-Feb-16	23-Feb-16	Mar-16 01-Mar-16	08-Mar-16	15-Mar-16	22-Mar-16	29-Mar-16
SMN Ltd Community Cardiology and Diagnostic Service																				
SMN Ltd - Draft Mobilisation plan for comment and to agree	Linda Balzanella	Mobilisation plan to be drafted and agreed with SMN Ltd as a working document									O	OC	OC							
SMN Ltd - Service specificiation comments	Linda Balzanella	Attended meetings to discuss service spec, chased response. Response received 15.02.16						O	O	O	O	OM	OM	OCL						
SMN Ltd - To provide evident of CQC certificates, adult safeguarding, SOP, IG Toolkit etc.,	Linda Balzanella	SMN Ltd have sort legal advise and disagree with contracting re documentation requirement. Contracting are now taking this forward.										O	O	O	O					
Community Cardiology Scheme Sign Off																				
Service spec to be worked up and agreed	Linda Balzanella	Awaiting agreement and sign off by RW and SW									O	O	O	O	O	O	O	OM	OM	OCL
Service spec sent to contracting	Linda Balzanella / Lillian Nigrelli	Draft sent to contracting; contracting speaking direct to SMN Ltd re supporting documentation. Final version has been delayed due to internal signatures														O	O	OM	OM	OCL
Service Spec sent to SMN Ltd	Linda Balzanella	Service spec delayed due to internatl signatures. Due to be signed 24.03.16															O	OM	OM	OCL
Mobilisation																				
SMN Ltd Mobilisation of proposed triage service start date	Linda Balzanella	The start date of the service has been delayed due to the requirements of documentation from contracting. Triaging is due to start end of April			OC							OC			OC	OC			OC	OM
SMN Ltd Community Cardiology Clinic Proposed start date	Linda Balzanella	The start date has been delayed as above. The clinic start date is scheduled for two weeks after the start of the triage service.																		
Service Provision to be monitored on a weekly basis for activity etc., during rollout, then weekly and monthly when happy with the uptake and provision.	Linda Balzanella / Dr A Kapoor	23.03.16 Mable Wu advised that KPIs will not be collated by BI team and will be responsibility of provider. A matrix sheet has been sent to the provider for this purpose.																	OC	
GPHP Ltd - Community Cardiology and Diagnostic Service																				
GPHP Ltd - Epsom locality proposal to Exec Team	Oliver McKinley / Linda Balzanella	Proposal agreed 09.02.16											OC							
To discuss and draft the Service Specificataion	Linda Balzanella / Jonathan Evans	Comments received from provider re service spec and final version to be circulated internally												OC	OC					
Draft Service spec to be circulated to department inhouse for input and through GPHP Ltd to members.	Linda Balzanella / Jonathan Evans	Feedback received from GPHP Ltd, final draft with GPHP comments from previous spec sent to senior management for input and comment																		OC
Documentation																				
GPHP Ltd - Final service specification to be presented for SD CCG agreement	Linda Balzanella / Oliver McKinley	Service specification with CCG senior management for agreement and sign off																OM	OM	OCL
Certification and supporting documentation from GPHP Ltd to be forwarded to contracting for the contract to be issued and service spec imbedded	Linda Balzanella	Relient on GPHP Ltd sending the necessary documentation																		
Contracting issue contract for signing to GPHP Ltd	Linda Balzanella / Lillian Nigrelli	Relient on GPHP Ltd sending the necessary documentation																		
Mobilisation																				
GPHP Ltd - Mobilisation of triage service	Meeting to discuss mobilisation plan; weekly meetings agreed with provider to monitor the progress and roll out.	Start date agreed for beginning of May 2016. Weekly meetings discontinued for provider to concentrate on documentation to support the contract. Meeting arranged for 19.04.16												OC	OC					
GPHP Ltd - Roll out of Community Cardiology and Diagnostic Clinic	Linda Balzanella / Jonathan Evans	JE advised roll out from beginning of May 2015 - to advise of roll out..																		
GPHP Ltd - Reduced rate for Epsom takes effect	Linda Balzanella / Jonathan Evans	To be confirmed																		
Monitoring																				
Service to be monitored on a weekly basis for activity, DNA etc., during roll out, then fortnightly and when happy with uptake and service monthly there after.	Linda Balzanella / Jonathan Evans	Agreed with GPHP																		
Communication and Engagement																				
Ongoing communication and engagement to ensure takeup of clinic	Linda Balzanella / Providers	Both GPHP and SMN Ltd have taken this forward within their Federation meetings																		
Meeting with SMN Ltd re comms and support	Linda Balzanella / Sue Platts	Article to be placed in GP Newsletter; Comms adding to SD CCG extranet; Gareth working with Sue re GRIP													OC					
Meeting with GPHP Ltd re comms and support	Linda Balzanella / Jonathan Evans	Have met with CS comms to produce article for the GP weekly newsletter as per SMN Ltd., and comms to PAG members.												O	O	O	OC			

Milestone Description	Apr-16 05-Apr-16	12-Apr-16	19-Apr-16	26-Apr-16	May-16 03-May-16	10-May-16	17-May-16	24-May-16	Jun-16 31-May-16	07-Jun-16	14-Jun-16	21-Jun-16	28-Jun-16	Jul-16 05-Jul-16	12-Jul-16	19-Jul-16	26-Jul-16	Aug-16 02-Aug-16	09-Aug-16	16-Aug-16	23-Aug-16	30-Aug-16
SMN Ltd Community Cardiology and Diagnostic Service																						
SMN Ltd - Draft Mobilisation plan for comment and to agree																						
SMN Ltd - Service specificiation comments																						
SMN Ltd - To provide evident of CQC certificates, adult safeguarding, SOP, IG Toolkit etc.,																						
Community Cardiology Scheme Sign Off																						
Service spec to be worked up and agreed																						
Service spec sent to contracting																						
Service Spec sent to SMN Ltd																						
Mobilisation																						
SMN Ltd Mobilisation of proposed triage service start date				O																		
SMN Ltd Community Cardiology Clinic Proposed start date	OM	OM				O																
Service Provision to be monitored on a weekly basis for activity etc., during rollout, then weekly and monthly when happy with the uptake and provision.																						
GPHP Ltd - Community Cardiology and Diagnostic Service																						
GPHP Ltd - Epsom locality proposal to Exec Team																						
To discuss and draft the Service Specificataion																						
Draft Service spec to be circulated to department inhouse for input and through GPHP Ltd to members.																						
Documentation																						
GPHP Ltd - Final service specification to be presented for SD CCG agreement																						
Certification and supporting documentation from GPHP Ltd to be forwarded to contracting for the contract to be issued and service spec imbedded																						
Contracting issue contract for signing to GPHP Ltd		OM																				
Mobilisation																						
GPHP Ltd - Mobilisation of triage service			O																			
GPHP Ltd - Roll out of Community Cardiology and Diagnostic Clinic					O	O	O	O	O	O	O	O	O									
GPHP Ltd - Reduced rate for Epsom takes effect																		O				
Monitoring																						
Service to be monitored on a weekly basis for activity, DNA etc., during roll out, then fortnightly and when happy with uptake and service monthly there after.						O	O	O	O	O	O	O	O	O		O		O		O		O
Communication and Engagement																						
Ongoing communication and engagement to ensure takeup of clinic																						
Meeting with SMN Ltd re comms and support																						
Meeting with GPHP Ltd re comms and support																						

Milestone Description	Sep-16 06-Sep-16	13-Sep-16	20-Sep-16	27-Sep-16	Oct-16 04-Oct-16	11-Oct-16	18-Oct-16	25-Oct-16	Nov-16 01-Nov-16	08-Nov-16	15-Nov-16	22-Nov-16	29-Nov-16	Dec-16 06-Dec-16	13-Dec-16	20-Dec-16	27-Dec-16	Jan-17 03-Jan-17	10-Jan-17	17-Jan-17	24-Jan-17	Feb-17 31-Jan-17	07-Feb-17	14-Feb-17	21-Feb-17	28-Feb-17	Mar-17 07-Mar-17	14-Mar-17	21-Mar-17	28-Mar-17
SMN Ltd Community Cardiology and Diagnostic Service																														
SMN Ltd - Draft Mobilisation plan for comment and to agree																														
SMN Ltd - Service specificiation comments																														
SMN Ltd - To provide evident of CQC certificates, adult safeguarding, SOP, IG Toolkit etc.,																														
Community Cardiology Scheme Sign Off																														
Service spec to be worked up and agreed																														
Service spec sent to contracting																														
Service Spec sent to SMN Ltd																														
Mobilisation																														
SMN Ltd Mobilisation of proposed triage service start date																														
SMN Ltd Community Cardiology Clinic Proposed start date																														
Service Provision to be monitored on a weekly basis for activity etc., during rollout, then weekly and monthly when happy with the uptake and provision.	O				O				O					O				O				O					O			
GPHP Ltd - Community Cardiology and Diagnostic Service																														
GPHP Ltd - Epsom locality proposal to Exec Team																														
To discuss and draft the Service Specificataion																														
Draft Service spec to be circulated to department inhouse for input and through GPHP Ltd to members.																														
Documentation																														
GPHP Ltd - Final service specification to be presented for SD CCG agreement																														
Certification and supporting documentation from GPHP Ltd to be forwarded to contracting for the contract to be issued and service spec imbedded																														
Contracting issue contract for signing to GPHP Ltd																														
Mobilisation																														
GPHP Ltd - Mobilisation of triage service																														
GPHP Ltd - Roll out of Community Cardiology and Diagnostic Clinic																														
GPHP Ltd - Reduced rate for Epsom takes effect	O				O				O					O				O				O					O			
Monitoring																														
Service to be monitored on a weekly basis for activity, DNA etc., during roll out, then fortnightly and when happy with uptake and service monthly there after.		O			O				O					O				O				O					O			
Communication and Engagement																														
Ongoing communication and engagement to ensure takeup of clinic					O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Meeting with SMN Ltd re comms and support																														
Meeting with GPHP Ltd re comms and support																														

GPHP Ltd Mobilisation Plan					Feb-16					JE A/L	Mar-16				LB A/L	Apr-16			May-16					Jun-16				Jul-16				Aug-16					
Ref.	Area	Actions	Lead	Comments	01.02.16	08.02.16	15.02.16	22.02.16	29.02.16	07.03.16	14.03.16	21.03.16	28.03.16	04.04.16	11.04.16	18.04.16	25.04.16	02.05.16	09.05.16	16.05.16	23.05.16	30.05.16	06.06.16	13.06.16	20.06.16	27.06.16	04.07.16	11.07.16	18.07.16	25.07.16	01.08.16	08.08.16	15.08.16	22.08.16	29.08.16	05.09.16
1	PMO	GPHP Proposal agreed at Executive Team - subject to requirements listed in the box below	Linda Balzanella	Requirements included within this mobilisation plan																														
2	Exec Team Requirements	James to send letter to GPHP re Exec Team Requirements.	Linda Balzanella	James sent letter to GPHP re Exec Team requirements																														
		Contract 'risk sharing', needs to clarify and justify the model, 12 month pilot project with review. If the scheme continues basline for savings will remain the same, except to reflect national efficiency and inflation. (National Acute tariff).	Linda Balzanella / Ollie McKinley	JE has requested a workup of the model. OMc has been working with QS to provide final workings. 19.04.16 JE request final working -																														
		To clarify how the proposal will work re the 24 hour BP monitoring currently provided by practices and avoid duplication of tests.	Saul Galloway / Jonathan Evans	JE to clarify with Saul and feedback. GP practices to continue providing the service under Primary Care Standard																														
		To clarify how and what the system is for the Direct Access Dart i.e. ECGs from Epsom to the GPHP Ltd service.	Saul Galloway / Jonathan Evans	JE to clarify with Saul and feedback																														
		To clarify the referral flow into and out of the service	Saul Galloway / Jonathan Evans	JE to clarify and feedback re EMIS Clinical System? Referral route for onward referrals to secondary care and patient choice																														
2		Exec Team requirement - to ensure secondary care referrals are sent via RSS (detail within Service specficiaiton)	Linda Balzanella	Currently Jon Wong referrs directly into his team, Exec Team want assurance these will now go through RSS. 19.04.16 JE still in discussions																														
2		To agree service model with GPHP	Linda Balzanella	JE to feedback. To clarify premises current system re referral to RSS and patient choice																														
3		Input from Governance to ensure quality and performance monitoring	Linda Balzanella	Draft spec to be worked up further and sent to EC and MW																														
		Deadline for Service Specification to be signed off	Linda Balzanella	Work in progress; dependent on GPHP Ltd and turnaround of internal departments. Current with Exec team																														
4		To work along side GPHP Ltd to agree a realist 'go live' date	Linda Balzanella	Anticipated start date 3 months from PID (beginning May)																														
		To work along side GPHP Ltd to agree roll out plan / mobilisation timescales to full uptake of the service	Linda Balzanella	JE to discuss practice roll out with Saul and feed back. Work in progress																														
5	Contracting	Service specificiation sent to various internal departments	Linda Balzanella	LB feedback received from GPHP, document to be worked up further and circulated for internal comment.																														
6		Send out approved service specification and contract to GPHP Ltd for signature and return	Lillilan Nigrelli / Paula Asberry	Contracting working with GPHP Direct.																														
7		Service specification incorporated within NHS Standard Contract	Lillilan Nigrelli / Paula Asberry																														
		Contract sent to GPHP Ltd for signing and return	Lillilan Nigrelli / Paula Asberry																														
		GPHP Ltd - contract signed, dated and returned to CDCCG, prior to go live date	Saul Galloway / Jonathan Evans																														
9	Governance	GPHP Ltd to evidence register as a provider of Cardiology services with the CQC	Jonathan Evans / Saul	JE taking forward																														
10		GPHP Ltd to evidence register named clinical responsible person with CQC	Jonathan Evans / Saul	JE taking forward																														
11		GPHP Ltd to provide a range of policies to SDCCG as assurance of safeguarding, infection prevention and control, consent, chaperoning, etc. and safer recruitment policies.	Jonathan Evans	Contracting working with GPHP Direct.																														
12		GPHP Ltd to provide copies of the standard operational policies to SDCCG as assurance of how the service will run and be managed operationally.	Jonathan Evans																														
		GPHP Ltd to provide copies of Statement of Purpose Part 2 (SOP); IG Toolkit Assessment Summary Report; Litigation cover; Indemnity Insurance etc; DBA Compliance etc.	Jonathan Evans																														
13		GPHP Ltd have NHS.net accounts for their staff and clinical personnel working as part of the service.	Jonathan Evans	JE to feedback																														
14		GPHP to ensure reporting matrix is inplace for 'go live' date of the service	Jonathan Evans	KPI matrix included in service specification to be issued.																														
		KPIs and monitoring of the service to be agreed	Linda Balzanella																														
15	IT	To ensure the Community Cardiology Service systems are in place to receive and triage referrals electronically through EMIS web;	Jonathan Evans	JE to advise																														
16		Clarification re IT flow to and from service	Jonathan Evans	JE to advise																														
17		To upload all Community Cardiology referral pathways and guidelines on GRIP	Linda Balzanella	02.03.16 LB meeting with Gareth. Contact forwarded to Gareth																														
18	Comms and Engagement	To meet with CCG Comms team and discuss comms and engagement for go live and after established service.	Linda Balzanella	LB met with comms and feedback to OMc re clarification funded. Comms drafting documentation																														
19		To develop a Community Caridology section on SDCCG website to assist patients/carers/public in accessing Community Cardiology services																														
20		To ensure communications to GP practices to advise of the new Community Cardiology Service and referral route. Possible presentation at Network meeting, inclusion in weekly GP Practice newsletter.	Linda Balzanella / Comms	To be included in GP weekly newsletter prior to 'go live'																														
21	Acute Trust	To advise Epsom Hospital of the new Community Cardiology Service provision	Jonathan Evans / Linda Balzanella	Moyra has been advised. GPHP have met with Epsom																														
			Linda Balzanella	LB met with MC to advise																														
		To advise Contracting of proposed movement from acute trust to community services.																														
22	Training	To identify and provide education sessions to GPs within the Epsom Locality area	GPHP	Educations sessions after go live date to be agreed JE																														
23	Operational	Ensure prescription pads / medicines management specific to Community Cardiology clinic is in place	Linda Balzanella /Jonathan Evans	JE to advise re current and proposed service. Medicines Management contact: Helen Marlow. 19.04.16 JE is still in discussions with GPHP																														
24		GPHP Ltd to ensure adequate equipment is available and the rooms are clincially suitable for patient consultation	Jonathan Evans / Saul Galloway	19.04.16 JE sourcing equipment																														
25		To ensure Performance Matrix is in place for timely reporting of KPIs	Linda Balzanella / Jonathan Evans	KPIs contained in Service spec - awaiting final sign off from Exec Team																														
26		Confirmed names of staff members and clinicians to SDCCG	Jonathan Evans	JE to complete Contract Supporting Documentation List and provide documentation as required																														
27		To ensure copies of staff and clinician qualitifications / certification are forwarded to SDCCG for assurance	Jonathan Evans																														
28		To confirmed 'go live' dates for Community Cardiology clinic and phased roll out	Jonathan Evans / Saul Galloway	As previous																														
		To confirm date of move to new service for staff, consultant and GPwSI	Jonathan Evans	JE to advise																														
29		Escalation points / red flags	Jonathan Evans / Saul Galloway	Confirmation received and included within service specification. Meeting with Gareth re GRIP																														

Updated: Week Beginning 29th February 2016

Key	
	Timescale
	Deadline Date
	Deadline Achieved
	Past Deadline

SMN Ltd Mobilisation Plan					Jan-16		Feb-16				Mar-16				LB A/L	Apr-16			May-16					Jun-16				Jul-16				Aug-16					Sep-16			
Ref.	Area	Actions	Lead	Comments	18.01.16	25.01.16	08.02.16	15.02.16	22.02.16	29.02.16	07.03.16	14.03.16	21.03.16	28.03.16	04.04.16	11.04.16	18.04.16	25.04.16	02.05.16	09.05.16	16.05.16	23.05.16	30.05.16	06.06.16	13.06.16	20.06.16	27.06.16	04.07.16	11.07.16	18.07.16	25.07.16	01.08.16	08.08.16	15.08.16	22.08.16	29.08.16	05.09.16	12.09.16	19.09.16	26.09.16
1	PMO	SMN Proposal presented to Exec Team, for agreement and sign off to the next stage.	Linda Balzanella	Proposal agreed by Exec Team subject to requirements																																				
2	Exec Team Requirements	Draft robust mobilisation plan with timescales as working document to implementation	Linda Balzanella	JE has requested a workup of the model. Quentin working up finance model																																				
3		Provider meeting to discuss pilot project and Exec team requirements	Linda Balzanella	Met with Dr Ash Kapoor to discuss next steps, timelines and draft mobilisation plan																																				
4		To clarify how the proposal will work re the 24 hour BP monitoring currently provided by practices and avoid duplication of tests.	Dr Ash Kapoor	East Elmbridge have a buddying system in place that will continue and a small incentive has been included within the costings should it be required.																																				
5		To clarify that the service will not impact on current GP practice service delivery / GP contract requirements	Dr Ash Kapoor	The service will be held at the Giggs Practice, supported by the KHFT consultant and GPwSI, an admin assistant will also be appointed to support the clinic																																				
6		To clarify the referral flow into and out of the service	Dr Ash Kapoor	LB to include within service specification																																				
7		To ensure secondary care referrals are sent via RSS (detail within Service specficiaiton)	Linda Balzanella	Discussed with Dr Ash Kapoor and included within service specficiaition																																				
8		To clarify reason for clinics to be held across two sites, and ensure that the Echo is available at all clinics.	Dr Ash Kapoor	Echo is based at Giggs practice site and the clinics will be held at this site only.																																				
9		To ensure the removal of the deadicated 3 slots allocated for chest pain.	Dr Ash Kapoor	To be removed (service spec)																																				
10		CQC status for SMN Ltd and Giggs practice to include cardiology	Dr Ash Kapoor	Dr Ash Kapoor has sort legal advice and disagrees with the supporting documentation requirement from contracting, he has been put in contact with Paula Asberry																																				
11		CQC named accountable registered officer for SMN Ltd	Dr Ash Kapoor	As above																																				
12	Service Specification	Service specification to be drafted and include agreed costs and indicative activity. Deadline for sign off beginning March	Linda Balzanella	Service specification agreed and sent to provider																																				
13		Deadline for Service Specification to be signed off	Linda Balzanella	As above																																				
14		To work with SMN Ltd to agree a realist 'go live' date and roll out/ mobilisation timescales to full uptake of the service	Linda Balzanella	Proposed triage start mid March; clinic 'go live' date 7th April. Start date delayed due to the request for documentation from contracting. Reschedule 'go live' date for end of april																																				
15		Send out approved Service specficiaition	Linda Balzanella	Contracting have awaiting documentation																																				
16		SMN Ltd return signed service specficiaiton	Dr Ash Kapoor / Sue Platts																																				
17	Contract	Service specification incorporated within NHS Standard Contract	Lillilan Nigrelli / Paula Asberry																																				
18		Contract sent to SMN Ltd for signing and return	Lillilan Nigrelli / Paula Asberry																																				
19		SMN Ltd - contract signed, dated and returned to CDCCG	Dr Ash Kapoor / Sue Platts																																				
20		SMN Ltd - data sharing agreements in place for referral flow	Dr Ash Kapoor / Sue Platts	Dr Ash Kapoor advises that Data Sharing agreements are in place with the practices, awaiting a copy for our records.																																				
21		SMN Ltd - evidence of contract agreements with service providers and staff	Dr Ash Kapoor / Sue Platts	Requested																																				
22	Governance	SMN Ltd to evidence register as a provider of Cardiology services with the CQC	Dr Ash Kapoor / Sue Platts	See comments above in ?																																				
23		SMN Ltd to evidence register named clinical responsible person with CQC	Dr Ash Kapoor / Sue Platts																																				
24		SMN Ltd to provide a range of policies to SDCCG as assurance of safeguarding, infection prevention and control, consent, chaperoning, etc. and safer recruitment policies.	Dr Ash Kapoor / Sue Platts	Some papers received, Dr Ash Kapoor has sort legal advice re the required documentation and has challenged the request from Paul Asberry, contracting are now taking this forward.																																				
25		SMN Ltd to provide copies of the standard operational policies to SDCCG as assurance of how the service will run and be managed operationally.	Dr Ash Kapoor / Sue Platts	Gareth Jones is in direct contact with SMN Ltd to take this forward re GRIP																																				
26		SMN Ltd to provide copies of Statement of Purpose Part 2 (SOP); IG Toolkit Assessment Summary Report; Litigation cover; Indemnity Insurance etc; DBA Compliance etc.	Dr Ash Kapoor / Sue Platts	Some papers received, Dr Ash Kapoor has sort legal advice re the required documentation and has challenged the request from Paul Asberry, contracting are now taking this forward.																																				
27		SMN Ltd have NHS.net accounts for their staff and clinical personnel working as part of the service.	Dr Ash Kapoor / Sue Platts	Have requested clarification																																				
28		SMN Ltd to ensure reporting matrix is inplace for 'go live' date of the service	Dr Ash Kapoor / Sue Platts	Have discussed with SP, awaiting for internal agreement.																																				
		Service spec to be agreed from a governance and monitoring perspective., prior to sign off	Linda Balzanella	Awaiting feedback from EC and MW.																																				
29		KPIs and monitoring of the service to be agreed	Linda Balzanella	KPI template sent to provider																																				
30	IT	To ensure the Community Cardiology Service systems are in place to receive and triage referrals electronically through EMIS web; and secondary care referrals sent to Leatherhead Hospital	Dr Ash Kapoor / Sue Platts	Current system NHS net alive and active; possible future system EMIS Clinic. Secondary care referrals to be sent back to GP to refer RSS																																				
31		Clarification re IT flow to and from service	Dr Ash Kapoor / Sue Platts	NHS net to be used for referral letter and communications to and from the practice / service. EMIS Clinic maybe introduced at a later stage, at this stage a data sharing agreement will be required																																				
32		To upload all Community Cardiology referral pathways and guidelines on GRIP	Linda Balzanella	Met with Gareth, meeting with Ash and Sue to advise and Gareth to take forward																																				
33		To ensure that reporting systems are in place for KPI and matrix monitoring	Dr Ash Kapoor / Sue Platts	KPI template sent to provider																																				
34	Comms and Engagement	To meet with CCG Comms team and discuss comms and engagement for go live and after established service.	Linda Balzanella	CS in Comms is taking this forward																																				
35		To develop a Community Caridology section on SDCCG website to assist patients/carers/public in accessing Community Cardiology services	Claire Small	CS is Comms is taking this forward																																				
36		To develop patient information leaflet.	Linda Balzanella / SMN Ltd / Comms	No longer required																																				
37		To ensure communications to GP practices to advise of the new Community Cardiology Service and referral route. Possible	Linda Balzanella / Comms	Message has been on hold due to the delay in the start date of the service																																				
38		Presentation at GP Network Meeting to discuss service provision, 'go live' date and roll out.	Ash Kapoor / Linda Balzanella	Met with Dr Ash Kapoor who advises that regard GP practice meetings have been held and that all practice and GPs are aware. Also on 12.04.16 attended locality meeting to advise of new service.																																				
		GP letter sent to practices re phased roll out and go live	Ash Kapoor / Linda Balzanella	This will be covered by the GP Newsletter as abover and Dr Ash Kapoor regulard Practice meetings																																				
39	Acute Trust	To advise Kingston Hospital of the new Community Cardiology Service provision	Linda Balzanella / Ash Kapoor	SMN Ltd have served notice to KHFT re the current service they provide. Contracting have been made aware and will communicate to KHFT and adjust contract accordingly																																				
40		To advise Contracting of proposed movement from acute trust to community services.	Linda Balzanella	LB met with MC re new service and contract changes.																																				
41	Training	To identify and provide education sessions to GPs within the East Elmbridge Locality area	Dr Ash Kapoor	To agree timelines with Dr Ash Kapoor when project live																																				
42	Operational	To ensure prescription pads / medicines management specific to Community Cardiology clinic is in place	Dr Ash Kapoor / Sue Platts	LB has advised Helen Marlow / and met with Sue Platts. Dr Ash Kapoor advises that the current service provides a prescription slip that then generates a prescription at the patients GP practice.																																				
43		SMN Ltd to ensure adequate equipment is available and the rooms are clincially suitable for patient consultation	Dr Ash Kapoor / Sue Platts	Services are currently provided at these premises.																																				
44		To ensure Performance Matrix is in place for timely reporting of KPIs	Linda Balzanella / Dr Ash Kapoor / Sue Platts	To finalise KPIs and matrix internally and share with SMN Ltd, Awaiting final template from MW.																																				
45		Confirmed names of staff members and clinicians to SDCCG	Dr Ash Kapoor / Sue Platts	Names provided																																				
46		To ensure copies of staff and clinician qualitifications / certification are forwarded to SDCCG for assurance	Dr Ash Kapoor / Sue Platts	Dr Ash Kapoor has sort legal advice re the required documentation for a community clinc and has challenged the request from Paul Asberry, contracting are now taking this forward.																																				
47		To confirmed 'go live' dates for Community Cardiology clinic and phased roll out	Dr Ash Kapoor / Sue Platts	The decision has been made for all GP practices to be rolled onto the scheme from commencement as there are only 8 practices in the EE locality area																																				
48		To confirm date of move to new service for staff, consultant and GPwSI	Dr Ash Kapoor / Sue Platts																																				
49		Escalation points / red flags	Dr Ash Kapoor Sue Platts	Samples of the RSS check notes have been sent to SMN Ltd awaiting clarification. Clause added in service specification																																				

Updated: Week Beginning 29th February 2016

Key	
	Timescale
	Deadline Date
	Deadline Achieved
	Taken forward by other internal department
	Past Deadline

(Community Cardiology and Diagnostic Services) RISK REGISTER

Version 6
Updated 19.04.2016

RISK IDENTIFICATION & MITIGATION													Risk Assessment					Comments
Ref ID	Title of risk	Risk Area	Executive Risk Owner	Risk Manager	Main responsible committee	Risk Description: *"There is a risk that..."*	Source of risk *(where does this come from)*	Potential effect of the risk *(what might happen)*	Assurance *(What do we know)*	Gaps in assurance *(What don't we know)*	Controls *(what can we do)*	Gaps in Controls *(what can we not do)*	Date of latest scoring	Likelihood Score	Impact Score	Net Score	TREND *(change since last report)*	
Cardiology	Proposals	Delivery/Project Plan	Director of Commissioning & Strategy	OM	PDB	Localities do not submit proposals	Planned Care	Localities do not take part in shifting acute trust activity into the community			Contact GPHP proposal re xmas		09/02/2016	4	4	16	Closed 09.02.16	Proposals received from East Elmbridge locality (SMN Ltd), anticipated 'go live' date 7th April 2016; Epsom Locality (GPHP Ltd) proposal signed off by Exec team 09.02.16 Dorking locality have engaged directly through the Director of commissioning.
Cardiology	Specification	Delivery/Project Plan	Director of Commissioning & Strategy	OM	PDB	Lack of an agreed specification with East Elmbridge	Planned Care	Many issues can still arise before mobilisation i.e. IT infrastructure, data reporting, resource, opening times...			Service specification and mobilisation plan to be agreed		18/02/2016	2	3	6	Closed 02.03.16	Feedback have been received from EE with additional comments, which are subject to internal confirmation with quality, finance, contracting and medicine management. PM has set up weekly meetings with EE to keep on track with mobilisation.
Cardiology	Communications and Engagement	Delivery/Project Plan	Director of Commissioning & Strategy	OM	PDB	Lack of stakeholder engagement including clinicians	Stakeholders (inc. patients)	The project is relient on the GP population referring patients into the scheme and patient satisfaction with the service	Clinical networks and stakeholder forums - widespread clinical and stakeholder engagement at the inception of the design process to ahcieve buy in for the model	GP referral uptake into service	Ensure timely communications and engagement plan	We can not do nothing.	09/02/2016	4	3	12		Further engagement will be required leading up to the 'go live' date of the community services
Cardiology	Finance	Delivery/Project Plan	Director of Commissioning & Strategy	OM	PDB	Non-realisation of financial or quality benefits	Benefits & Costs	Financial targets and quality benefitis are not met	Approved business case and case for change - Proposals to be scrutinised and reviewed by QIPP working groups and executive committee to ensure robust and credible business case and case for change	GP referral uptake into service	Ensure monthly contract monitoring	We can not do nothing.	09/02/2015	2	3	6		Monitoring KPIs through monthly meetings and 6 month audit and ensure GP engagement.
Cardiology	Communications and Engagement	Delivery/Project Plan	Planned Care	OM	PDB	Opposition from existing providers and other stakeholders	Stakeholders (inc. patients)	Lack of engagement and takeup	Clinical networks and stakeholder forums - widespread clinical and stakeholder engagement at the inception of the design process to ahcieve buy in for the model	GP referral uptake into service	Ensure the communications and engagement to promote the uptake of the service.	We can not do nothing.	10/04/2015	3	3	9		Ensure Comms and Engagement programme in effect.
Cardiology	Service Delivery	Mobilisation Period	Planned Care	OM	PDB	Disruption to existing services during mobilisation phase and start of new service	Change Management	Disruption to existing services	Communications and engagement plan - clear communications channels with providers of existing services to ensure awareness/involvement in new service design	Currently provide these services but in different settings	To ensure a clear mobilisation plan to go live date.	We can not do nothing.	09/02/2015	3	3	9		EE have agreed a mobilisation plan that is currently being updated. GPHP Ltd, proposal has been agreed, service specificiation and mobilisation plan to be drafted and agreed for implementation.
Cardiology	Update of Services	Service Delivery	Planned Care	OM	PDB	Resistance to change in services for patients	Change Management	Low referral rates to new service. Targets not met	Communications and engagement plan - effectively and jointly owned external communications strategy, effective stakeholder mapping and media management	The volume of the resistance.	Communication and engagement with patients.	We can not do nothing.	09/02/2015	2	3	6		Communications through provider
Cardiology	SDCCG Specialist Input	Service Delivery	Planned Care	OM	PDB	Lack of available time with internal specialists for input resulting in deadlines not being met.	Governance and Validation	The project is relient on input from internal specialists for input and advice.	To ensure that other departments are notified in a timely manner	The availability of the internal specialists	Service specificiaiton and KPIs are on hold subject to input from internal specialists	For a project steering group at the commencement of the project with input from specialists within set timescales	03/03/2016	4	4	16		It is proving to be a challenge obtaining engagement and from certain internal specialists to have input into the service specificiaiton / KPI documentation

Quality and Equality Impact Assessment Form

Please complete the form in accordance to the Guidance to Quality and Equality Impact Assessment form.

Name of the strategy/ policy/ service.	**Community Cardiology and Diagnostics Service**
Name of the person(s) completing this form	**Linda Balzanella**
Brief description of the aims of the Strategy/ Policy/ Service	As part of the planned care clinical services review, and in line with the elective care strategy for 2015/16, there are plans to review the current cardiology service provision to assess the current pathways. It is recognised that to reach the Surrey Downs ambition of having integrated cardiology services we will need to take a phased approach to the implementation of the community service; phase one will be the foundation - a responsive diagnostic infrastructure and phase two - a consultant led multi-disciplinary community specialist team that can support and treat patients close to home, sharing care across organisational boundaries as appropriate with the patient at the center of all decisions about their care. The aim is to provide an integrated Community Cardiology Service for patients in the Surrey Downs CCG area, to move procedures safely from the acute setting into the community, giving hospitals the opportunity to excel in services that only they can provide and ensure diagnostics will not be repeated with an onward referral, and bringing services closer to the patients home. To minimise acute episodes of care and ensure care is provided by appropriate clinicians in the right place, first time. A standardised patient pathway for Community Cardiology Services will be implemented to ensure care is provided in the most appropriate setting.
Which Department owns the strategy/ policy/ function	**Planned Care**

Part 1: *Please use the QEIA Matrix*

Area	Evidence	Score (impact x likelihood)
Safety of Patient Staff and Public	**Will be supported by NHS Contract implementation and Monitoring when agreed and signed**	**1**
Quality Complaints Audit	**The service is to be managed by KPIs and monitored on a monthly basis**	**1**
HR Organisational Development	**Engagement with Clinical Advisory Groups (CAGs) to support the service review. May involve rescheduling of clinics to attend.**	**2**
Adverse publicity/ reputation	**Engagement with Patient Advisory Groups (PAGs) to engage with local patients, carers and the general public as part of the service review.**	**2**
Business Objective	**As per PID**	**1**
Finance	**As per agreed proposals**	**1**
Service/ Business interruption	**The implementation stage includes the bedding in of new patient pathways and could cause some disruption to services.**	**2**
Environment impact	**Redesign bring services closer to patients and so more accessible**	**0**
Total score		**10**

Part 2:

The NHS Outcomes Framework, 2015 alongside the Adult Social Care and Public Health Outcomes Frameworks, sits at the heart of the health and care system. The NHS Outcomes Framework:

1. provides a national overview of how well the NHS is performing;
2. is the primary accountability mechanism, in conjunction with the mandate, between the Secretary of State for Health and NHS England;
3. Improves quality throughout the NHS by encouraging a change in culture and behaviour.

Part 2 of the risk assessment is showing how you have considered these factors when reviewing the risk of failing to meet with the equality and quality duties.

NHS Outcomes Framework **Could the proposal impact positively or negatively on the delivery of the five domains:**	**P/N/U**	**Evidence:**
Preventing people from dying **Prematurely**	**P**	The design of new pathways will work to reduce waiting times, with improved access into services as well as decreasing inappropriate referrals and diagnostic tests. This will also support earlier diagnosis
Equality Consideration :	**N**	**Services are for all those in need as is the current service provision**
Enhancing quality of life	**P**	Service redesign will address any issues with current service provision with the view to improve the pathway, patient & clinical outcomes.
***Equality Consideration*:**	**N**	**Services are for all those in need as is the current service provision**
Helping people recover from episodes of ill health or following injury.	**P**	Potential for first appointment and follow up appointment with diagnostic tests in the community settings without the need to go to secondary care.
Equality Consideration:	**N**	Services are for all those in need as is the current service provision
Ensuring people have a positive experience of care.	**P**	Patient engagement throughout the review and redesign to ensure services at fit for purpose and offer quality.
Equality Consideration:	**N**	**Services are for all those in need as is the current service provision**
Treating and caring for people in a safe environment and protecting them from avoidable harm.	**N**	The review has worked to NICE guidance and national pathways and models for delivering care. All providers would work to the NHS Standard contract and be contract managed to ensure compliance to clinically sound pathways.
Equality Consideration:	**N**	**Services are for all those in need as is the current service provision**
Access **Could the proposal impact positively or negatively on any of the following:** **a) Patient Choice** **b) Access** **c) Integration**	 **N** **P** **P**	**Patient choice** – GP to advise **Access** – improved access to services, community based, and locally where appropriate **Integration** – Integration primary, community and secondary care
Equality Consideration	**N**	**Services are for all those in need as is the current service provision**
Duty of Quality **Could the proposal impact positively or negatively on any of the following:** **1. Compliance with NHS** **2. Partnerships** **3. Safeguarding children**	 **N** **P** **N**	**1. Compliance with NHS Constitution** Neutral – as is currently the case **2. Partnerships** Partnerships across health economy with a planned improved communication and working together across primary, community care and secondary care. **3. Safeguarding children or adults** Safeguarding requirements in place through the contract as is currently the case, and will be written into all future contracts for contract management.
Equality Consideration:	**N**	**Services are for all those in need as is the current service provision**
Engagement and Involvement **How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:**	**P**	Stakeholders will be engaged as part of the review, future pathways and the design of the eventual service specification.
Duty of Equality **Could the proposal impact positively or negatively on any of the following protected characteristics:** **1. Age** **2. Disability** **3. Race** **4. Religion or belief** **5. Sex** **6. Sexual orientation** **7. Gender re-assignment** **8. Pregnancy and maternity** **9. Marriage and civil partnership** **10 Informal carers**	 **Y** **N** **N** **N** **N** **N** **N** **N** **N** **N**	Paediatric Patients (under 16 years of age)
Equality consideration *Please describe any additional considerations and activities which have taken place or been developed against negative impact on Protected characteristics.*	**N/A**	**NA**
HIGH RISK*:** ***If the risk is high or not meeting the requirements of the Quality and Equality Duties. ***If discrimination is highlighted through the analysis please accelerate to the executive team for further discussion.***	**N/A**	*Name of who it has been accelerated to:* *Date:*