Barnet Clinical Commissioning Group
Recovery Plan

Local clinicians working with local people for a healthier future

May 2013

Contents

I. Foreword, Dr Sue Sumners and John Morton

NHS Barnet CCG is committed to improving the quality and outcomes of the services we commission for the people of Barnet. We believe as a board that by tackling duplication and waste in the system we can improve patient experience and safety and reduce costs. We are embarking on some very significant and once in a generation changes in the local health system. These will have absolute synergy with what we are doing and result in an aligned primary, secondary and community service; in other words providing the right care in the right place at the right time. We believe as a board that this is what will deliver a vibrant caring and effective health care system for the people of Barnet.

The first major change is the Barnet, Enfield and Haringey clinical strategy. This will see a reduction in the range of services provided at Chase Farm Hospital in Enfield, resulting in a shift, particularly in Accident and Emergency, Paediatric and Maternity Services to Barnet Hospital, and North Middlesex Hospital in Enfield. The strategy is working with partners towards a planned move in November 2013.

This aligns Barnet & Chase Farm Hospitals trust with the CCG's strategy of supporting people in the community and avoiding unnecessary hospital admissions and reducing overall secondary care activity. There is a planned reduction in acute beds and this is being supported by services in the community and urgent clinics providing alternatives to admission.

The second major change is the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust. Barnet and Chase Farm Hospitals NHS Trust approach to managing a challenging health economy has been to increase income by increasing activity both directly and indirectly. Work in 2012/13 has confirmed that the Trust`s income for both maternity and A and E admissions was greater than indicated by the activity. The CCG is working closely with the new interim CEO and leadership team at Barnet and Chase Farm and we are already seeing a change in approach. The Royal Free health economy has over recent time been working collaboratively with commissioners to provide integrated care, for example they have both an Executive and GP Director working to reduce hospital activity. We are now working with both trusts towards a more balanced system.

Barnet and Chase Farm is not viable on an ongoing basis; once its income reduces to an affordable level which is appropriate for the catchment population, the infrastructure which has been built up will not be sustainable, hence the current option of acquisition. Acquisition would be both a transaction and a transformation. The transaction is likely to take place early in 2014, the transformation over the next three to five years. A tangible example of the potential of this transformation are the seven pathway workshops held on 30th April and 1st May 2013 where secondary and primary care clinicians from the Royal Free, Barnet and Chase Farm, and Barnet, Camden, Enfield, and Hertfordshire CCGs came together to consider Cardiology, Respiratory, Orthopaedics, MSK, Pain, Rheumatology, Hepatology, Gastroenterology and Gynaecology pathways. These workshops completed the initial design of new systems which will be much more effective at getting the right decisions made much earlier in patient journeys by senior clinicians. This will be supported by systems, including technology, to ensure that the treatment is in the right care setting. Incentives will be attached to shared achievement of outcomes and value for the speciality or disease group, rather than individual provider activity.

I. Foreword, Dr Sue Sumners and John Morton

We recognise that NHS Barnet CCG is the most challenged health economy in the new system. This is partly due to the new system design and we have an expectation that this will be recognised by NHS England and that over time there will be some re-balance. However it is largely due to the historic position which we now assume responsibility for, the mantle has passed from the PCT to the CCG. We are very clear on the reasons for this historic position and these are set out in the recovery plan.

We have the following principal areas of spend:

1. On mental health and community we set out the evidence that our spend is below or at average. These are critical areas to deliver our strategic aims, we will drive efficiency and effectiveness but we will not reduce spending in real terms.
2. In acute hospital services we spend about £43M more than other London Boroughs for the same population. This is partly for the reasons set out above and partly because GPs refer more people to hospital in Barnet than elsewhere, and there are more consultant to consultant referrals than elsewhere. This is the core of the Barnet problem and it must be addressed, this recovery plan is built on achieving this over the next three to five years.
3. We have a large primary care estate primarily based at Edgware Community and Finchley Memorial Hospitals. Barnet has two large acute hospitals, two very large community hospitals and a specialist orthopaedic hospital on the western boundary. As a new organisation we will need to spend some time considering how this estate can best be utilised to support our strategy, recognising our residents appreciate local access above most other measures. We will need to reduce estate costs, however this is likely to be over a longer period.

The CCG would prefer not to be writing a recovery plan as our first document post-authorisation; importantly the Board has confirmed its commitment to tackling financial recovery a year at a time, while developing vibrant, caring, and sustainable services for Barnet residents.

Dr Sue Sumners
Chair

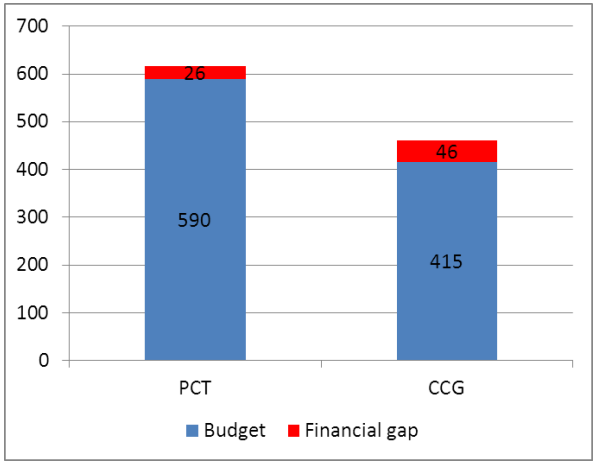
John Morton
Chief Officer

II. Executive Summary - Headlines

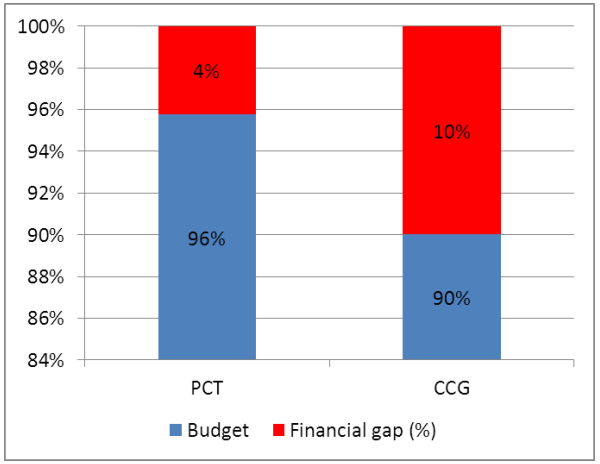
This recovery plan articulates the Barnet CCG approach to achieving financial balance. It should be read in conjunction with our Integrated Strategic Plan, available on www.barnetccg.nhs.uk.

We know and understand the size of the challenge

- The CCG forecasts a deficit in the 13/14 financial year of £46m before QIPP and any benefit from the 2% head room
- The CCG financial position is more challenging than the former PCT exit rate deficit position of £26m, primarily due to the loss of revenue allocation & increased costs totalling c£13m incurred in the transition from PCT to CCG. £9m is due to allocation differences which the CCG believes NHS England should resolve, and £3.8m is due to additional estates costs.



Budget and financial gap (£): PCT compared to CCG

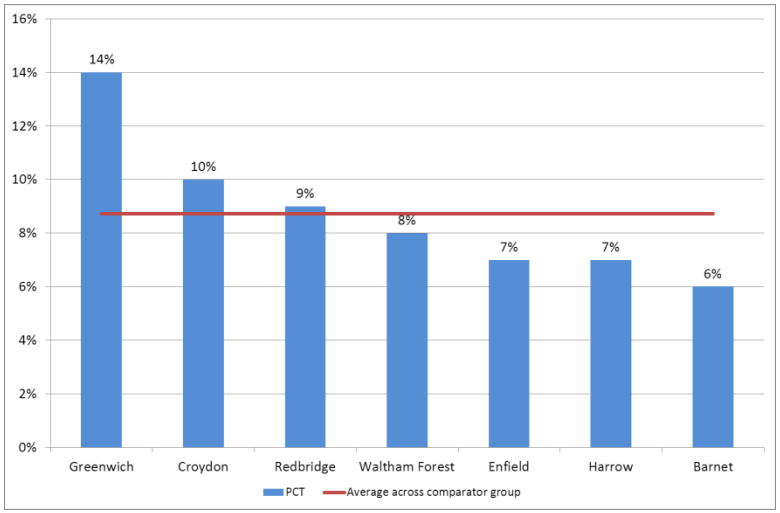


Budget and financial gap (%): PCT compared to CCG

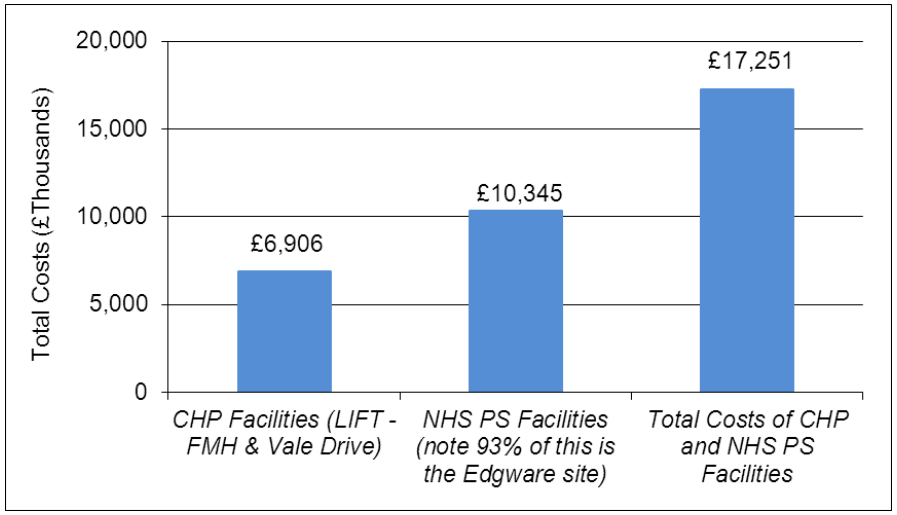
We know and understand the size of the challenge:

- We have compared spend on community and mental health services with our ONS comparator CCGs (PCT data from 2011/12). We have compared spend on estate with other North Central London CCGs (due to available data). We have compared our acute spend with other London CCGs. At a high level this shows:
  - We invest 3% less than average in mental health services;
  - We invest about the average in community services, however when embedded estates costs are taken into account this falls to significantly less than average;
  - We invest up to 10% more of our budget in acute services than the best performers; and
  - We invest 2% more than average on estate.
- Action is needed to significantly re-profile spend across these four areas, by reducing acute and estates costs.

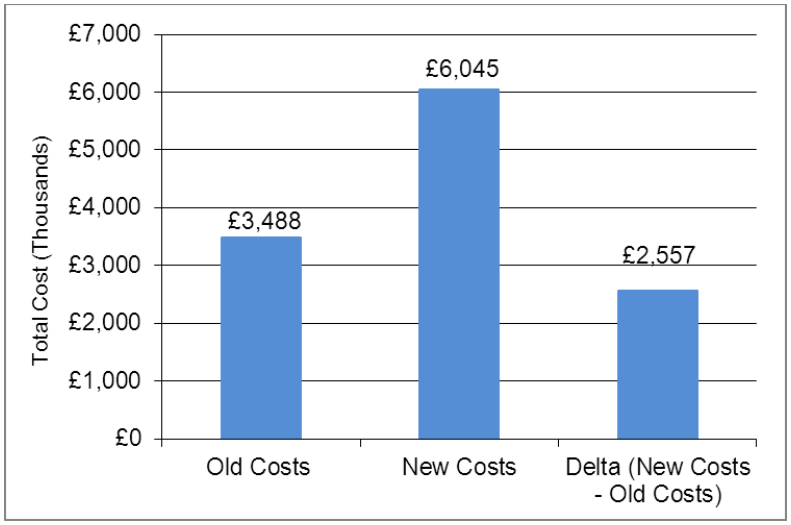
II. Executive Summary - Headlines



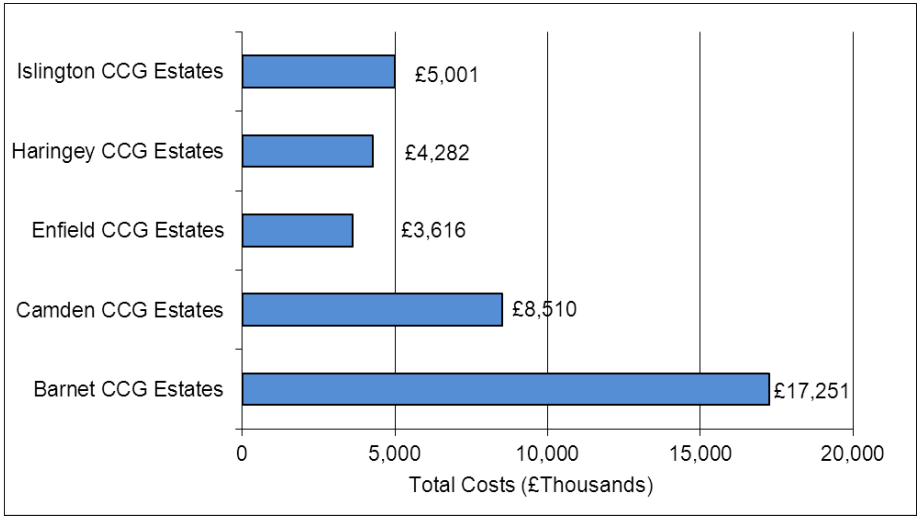
% of Barnet's expenditure on mental health against ONS comparator PCTs in 2011/12



Barnet total estates costs (2013/14)



Finchley Memorial Hospital old versus new total costs



North Central London CCGs total estates costs (2013/14)

*Not all comparator PCTs had comparable data available

II. Executive Summary - Headlines

We have considered a range of trajectories to achieve financial balance:

- An independent review of our financial position commissioned in March 2013 identified no one rapid solution, but rather that sustained effort is required across a range of system changes.
- To achieve in year breakeven in 3 years time will require the delivery of £42m of QIPP.
- Our model indicates in year breakeven in 3 years, in year business rules in 4 years and legacy deficit cleared in 5 years, although this assumes that the 2% headroom is utilised to repay the deficit.
- Without the 2% headroom benefit, these figures deteriorate to breakeven in 4 years, in year business rules in 5 years and legacy deficit cleared in 7 years

We have taken steps to achieve this trajectory:

- We have taken proactive steps over the last months to establish a robust, CCG owned QIPP plan for 13/14.
- As a result of these steps, QIPP opportunities have been identified of £18.9m for delivery in 13/14, risk assessed to deliver £17.05m
- We are developing further opportunities for 14/15. These will be worked up over the next 6 months.
- We are putting in place the right capability and capacity to drive the change programme underpinned by a best practice PMO.

We will know the financial impact of changes and the associated risks

- As programmes develop for FY15 and beyond, quality and risk will continue to be central to the approval process.
- The changes will require closer partnerships with providers sharing incentives to deliver change.
- In order to achieve its Recovery Plan, the CCG will need support from NHSE to increase capacity and capability. Change of the quantum required to deal with the deficit inherited by the CCG is outside of the scope envisaged within the resources available utilising the running costs allowance.
- If additional resources are not available to the CCG, the pace of delivery of change will be at risk, resulting in a prolonged and increased deficit position.

We will know the likely impact of the proposed changes on providers in the borough

- We are putting in place a robust quality KPI monitoring process. Therefore, we do not anticipate that provider operational standards or patient experience will suffer.
- Every QIPP scheme is subject to a Quality Impact Assessment and Equality Impact Assessment;
- Provider clinicians and GPs are being engaged through our plan development process and will continue to be engaged going forward, on implementation.
- Scheme level KPIs are being developed to help us track the impact of the QIPP on activity and finances.
- We will monitor the impact of our programme through the PMO to ensure we keep a real time view on performance both from an activity level and also in terms of savings made.

II. Executive Summary - Headlines

Clinical Commissioning Programmes

The PCT`s work was largely driven by the productivity elements of QIPP and we are determined to ensure we deliver quality and innovation which will in turn drive productivity. We are moving to a Clinical Commissioning Programme (CCP) delivery model which covers comprehensively the range of services we commission. These are clinically and managerially led with each CCP supported by a GP Board member as clinical strategic lead, a senior manager and project management team. The two directors of commissioning (Integration and Clinical) will support the six CCPs.

Each CCP will, working with partners, providers, the local authority, patients and the public, review the needs assessments, current service delivery and outcomes in order to decide which services within each portfolio need to be reviewed and in what priority. These will form the projects to be delivered in year by the project teams. This will encompass the delivery of QIPP and be supported by the project management office (PMO).

Our proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for. CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages.

Our integrated plan and ‘plan on a page’ set out the strategic priorities for the CCG. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;
- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.
- This will require new ways of working; to provide robust foundation for a rebalanced system, we are restructuring the work of the CCG, and our team, into Clinical Commissioning Programmes (CCPs), which reflect the objectives set out in our plan on a page, which follows.

We will work in partnership with local people to strive to: Improve the health and wellbeing of the population of Barnet , find solutions to challenges and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

Context

Health Inequalities in Cancer, CVD, Stroke and Respiratory conditions There were 294 early deaths from cancer, 158 from CVD and Stroke and 153 deaths related to winter in Barnet. in 2011/12	Barnet has the second largest cohort of Children in London with a 6.8% increase in the next 5 years.	Elderly population set to rise by 21% over next 10 years. Over 90 population to increase by 55% (1600)	Economic pressures and historic debt in the local health economy (7 years of over investment in Acute NHS Services)	The London Borough with the largest number of nursing home beds (999.)	Projected 26% increase in people with Dementia by 2020 (4743)	Challenged Local NHS Providers

Objectives	Clinical Commissioning Programmes	Initiatives	Outcomes To meet National Outcome Indicator Targets, and NHS Constitution standards, local, Health and Wellbeing and QIPP Outcome Measures – For example
Improve Inequalities in Health	Health and Well Being	Prevention CQUIN. Commissioning for every health contact to be a public health contact. Supporting Public Health colleagues to develop and implement ' preparing for a healthy life programme Lead with the London Borough of Barnet on the "Care when needed" programme.	Improve Potential Years of Life Lost (PYLL) from causes considered amenable to health care for adults and children and young people by 3.2% (59 deaths) Reduce the Under 75 mortality rate for Cardiovascular disease
Prepare Children and Young People for a Healthy Life	Children, Young People and Maternity	Maternity Care Pathways and Tariff Acute Paediatric Care Pathways Strategic Commissioning of CAMHS Barnet Children and Young Person's Plan Joint Procurement of Speech and Language Therapy	90% of pregnant women in Barnet to access NICE compliant maternity care by 12 weeks Gestation by March 2014. Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5% by 2015. Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet
Provide the Right Care at the Right Time, in the Right Place	Elective Care	Care Closer to Home – ENT, Ophthalmology, Orthopaedics, MSK, Pain Management, Gastroenterology Glaucoma screening. Urology, Cancer, Acute Medicines Management, Vascular, Neurology, and Diabetes.	90% of Admitted patients will have started treatment within 18 weeks from referral Increased percentage of patients using community health services All patients who have cancelled operations on or after the day of admission for non clinical reasons will be offered another date within 28 days, or provided at the time and hospital of the patients choice.
	Emergency and Urgent Care	NHS 111; Urgent Care Centre; Ambulatory Care; GP Out of Hours Cardiology, Respiratory, General acute medicine Trauma	Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Reduce emergency admissions for acute conditions that should not usually require hospital admission. The OOH Service meets all the national OOHs Quality Standards
Develop an Integrated Care System across health and social care	Mental Health and Learning Disabilities	Improving Access to Psychological Therapies RAID, Primary Care Mental Health Team Development Alcohol Standards, Complex and Secure Care pathways London Model of Care – Long Term Conditions	Year on year increase based on the 2009/10 baseline of people with a learning disability and those with a mental illness who have received an annual health check. Increase the number of patients receiving psychological therapies to 10% of those assessed as having depression or anxiety disorders.
	Frail Older People	Primary Care Risk Stratification, Care Navigators, Multidisciplinary Team and Case Management. Rapid Response and Enablement Plus, Palliative Care Services, Telehealth and Telecare, Admission Avoidance, Fracture Liaison Services, Enhanced Falls Service, Stroke Care Pathway, Dementia Care pathway.	Increase the percentage of people aged 65+ who are still at home 91 days after discharge into rehabilitation services to 87% in 2013 with a stretch target to reach 90% by 2015. Increase in the number of people who are receiving end of life care that are supported to die outside of hospital.

Enablers

Quality, Safety and Patient Experience	Primary Care Strategy	Medicines Management	Barnet, Enfield and Haringey Clinical Strategy	Demand Management , and Productivity	Health Promotion and Well Being

II. Executive Summary - Headlines

Management Structures

The CCG will draw, on broad terms, from three resources:

- The governing body provide oversight, challenge, and support. Specifically GP board members provide clinical leadership of programmes and, within localities, of their member practices. The Finance, Quality and QIPP committee provide specific oversight of the recovery plan. This is about 20% of the management allowance.
- The CCG commissioning team provide the intelligence and project management arrangements for finance, quality and commissioning, supported by corporate functions such as communications and engagement. This can be described as the service redesign elements of the commissioning cycle. This is about 20% of the management allowance
- The North and East London Commissioning Support Unit provide the procurement, contracting and review elements of the commissioning cycle, PMO review and advice, and a range of back office functions. The CSU have a Barnet presence at Director and senior level and this team contributes to planning and project management. The CSU is about 60% of the management allowance and is key to this recovery plan. The CCG and CSU have regular performance reviews. There is good support for contracting and the borough office has recently been strengthened. The remainder of the CSU remains developmental.

The CCG has appointed to the full governing body. The CCG has appointed permanently to the Chief Officer, Director of Integrated Commissioning and the Director of Quality. All deputy director level posts are filled with permanent and experienced staff who transfer their skill sets, from predominantly primary care commissioning to acute and community on an integrated basis. The CCG has been in extended and detailed discussion with the Local Authority and has formally agreed a joint commissioning structure and system which will provide the infrastructure to deliver the Integrated Commissioning Agenda. This in now out to one months formal consultation within the local authority, and will then be implemented.

The CCG has not recruited a permanent Chief Financial Officer (CFO) and is currently headhunting. The Interim CFO has the confidence of the board and the London Office and will continue until a permanent appointment is made. An experienced deputy interim CFO who has been both CFO and Director of Commissioning in previous roles, is supporting the shift in acute costs. The CSU, with CCG support, appointed Owen Richards, an experienced secondary care commissioner to the Borough Director role and Owen has agreed to support the vacant Director of Clinical Commissioning role. The CCG has appointed an experienced director as Transformation Director who will manage the PMO and a number of the most significant acute QIPP projects.

The revised support structures are attached at Appendix V and demonstrate considerably increased delivery capacity. We recognise Barnet is not as accessible as other London bases and this appears, alongside the level of financial challenge, to restrict recruitment.

The CCG will look for additional support particularly in people able to deliver projects on the ground and to accelerate progress with reducing acute costs and estate costs. We are clear on the challenges, benchmarking and analysis has been done and the focus is now on delivery.

II. Executive Summary - Headlines

The actions required to deliver the CCG's recovery plan are set out in the table below:

Action	Detailed action to be taken by the Governing Body	Delivery RAG	By when	Measure	Priority RAG
Agree and sign contract with main providers	- Sign off contracts for FY14 that support immediate action to align proportionate spend on acute services with other CCGs. - Finalise financial value for QIPP plan		May 2013	Signed contract in place	
Launch Clinical Commissioning Programmes	- Agree clinical leadership and supporting team; - Agree and communicate CCP work programme.		May / June 2013	Full team working to CCP	
Phase 1 PMO	-Strengthen PMO resource -Short term resource to set up PMO -Appoint Director of Transformation -Secure visibility on & reinforce existing QIPP schemes -Engage CSU support in QIPP scheme development -Appoint resource to develop formal PMO regime		May 2013	Evidenced to FPQ board on 16 May	
Phase 2 PMO	-Strategic PMO development complete to include: -Project life cycle & gateway review process -PMO controls -Reporting, governance & support structure -Training & go live -Embed new day to day working PMO practices within the CCG		May - July 2013	New PMO embedded	
New FY14 Opportunities	-For identified areas, ensure that each has a designated clinical lead and managerial support - Review outline QIPP plans; develop into robust, deliverable plans		Immediate	New plans have QIPP workbooks	
New FY15 Opportunities	- Building on work carried out to date. Carry out appropriate detailed analytics and develop business cases for approval.		August/ September 2013	New plans scoped for review	
Confirm CCG allowed a deficit budget and use of headroom and repayment of deficit with NHSE	-Agree and confirm with documentary evidence to backup position with NHSE.		May 2013		

III. Context – Strategic vision

The CCG's strategic vision

Local clinicians working with local people for a healthier future

We will work in partnership with local people to strive to improve the health and well-being of the population of Barnet, find solutions to challenges, and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

What will success look like?

3 Years:

- In collaboration with our partner CCGs we will have delivered the Barnet, Enfield and Haringey Clinical strategy and the development of the Royal Free/ Barnet and Chase Farm acquisition and clinical systems
- Quality and innovation will be recognised as the key priorities in our organisation
- We will be leading the development of integrated care systems across our providers

5 Years:

- People living in Barnet will understand and experience a health and social care system which will:
  - Encourage healthier lives and independent lives
  - Support people taking responsibility for their own lives and health
  - Provide seamless care when needed

III. Context – Clinical Commissioning Programmes

Health and wellbeing

There are four themes for health and social care commissioning identified in Keeping Well, Keeping Independent, (the Barnet Health & Well-being Strategy 2012 – 2015), Barnet Joint Strategic Needs Assessment and the 2012-13 Barnet Public Health Report.

- Preparation for a healthy life - Enabling the delivery of effective pre-natal advice and maternity care and early-years development;
- Wellbeing in the community - Creating circumstances that better enable people to be healthier and have greater life opportunities;
- How we live - Enabling and encouraging healthier lifestyles;
- Care when needed - Providing appropriate care and support to facilitate good outcomes and improve the patient experience.

These four health and wellbeing themes and the health programmes are an integral part of our Strategic and Operational Plans. Critical within this, is targeting people at highest risk both systematically (through specific health improvement programmes) and opportunistically ('making every contact count').

Our Health programmes are focussed upon:

- Reducing smoking prevalence through tobacco control and increasing smoking cessation
- Promoting healthier eating and increasing physical activity in people's everyday lives to reduce overweight and obesity and to reduce the risk of other conditions, including cardiovascular disease, dementia, poor mobility
- Encouraging and enabling people to be more independent, including those with physical, mental and learning disabilities, through various social development schemes and in the way that health and social care is provided
- Ensuring the recognition and proper management of concomitant mental health problems in people who have physical health problems
- Encouraging and enabling people to use alcohol in a sensible and healthy way if their lifestyle / religion permits its use
- Encouraging and enabling better sexual health
- Encouraging and enabling the earlier detection and thus early management of disease through screening and earlier presentation of suspicious symptoms.

These themes and health programmes form the basis of our strategic direction and the priorities in our plan, particularly improving health outcomes for children, frail older people and people with mental health needs.

III. Context – Clinical Commissioning Programmes

Children, Young People and Maternity

All children and young people in Barnet should achieve the best possible outcomes, to enable them to become successful adults, especially our most vulnerable children. They should be supported by high quality; integrated and inclusive services that identify additional support needs early; are accessible, responsive and affordable for the individual child and their family.

Strategic Needs / Issues to address

- Barnet has the second largest cohort of Children in London (87,641 0-19s in 2011) with a 6.8% increase in the next 5 years.
- About 17.6 % of children in year 6 (611 pupils) are classified as obese.
- A lower percentage than average pupils spend less than 3 hours per week on school sport.
- 10% of expectant mothers smoke during pregnancy.
- Ensuring that acute hospital activity for children and young people is in line with best practice.

Target Outcomes

- All women in Barnet to access NICE compliant maternity care by 12 weeks.
- Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5% (Public Health Lead) .
- Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet. (National Commissioning Board and Public health Lead).
- Reduce the rate of obesity in reception year school children from 11% to be better than the London average. Reduce the rate of obesity in year 6 children from 17.5% baseline towards the England best of 10.7% (Public Health Lead).
- Reduce the number of children and young people misusing alcohol and drugs by 91% by 2014/15.(Public Health Lead).
- Work with the local authority to improve the management of children with complex needs including the development of transition pathways (London Borough of Barnet Lead).
- Reduce acute activity by 50% in outpatients, and 30% in A&E.

Clinical Commissioning Programme Objectives

Working with the London Borough of Barnet and NHS England the programmes priorities are:

1. Effective Implementation of the Maternity Pathways Tariffs by April 2013
2. The implementation of the Barnet, Enfield and Haringey Clinical Strategy that will transfer the provision of maternity services at Chase Farm and support increasing numbers of women to use expanded services at Barnet and North Middlesex University Hospital, likely to be from November 2013.
3. Ensure appropriate use of paediatric tertiary services at Great Ormond Street Hospital and ensure that children and families are supported within secondary and primary care when appropriate.
4. Achieve more effective and efficient provision of paediatric speech and language therapy services through a joint procurement with the London Borough of Barnet.
5. Continue to roll out the Family Nurse Partnership and enrol 100 families to the programme
6. Develop a section 75 agreement with the local authority for the joint commissioning of Child and Adolescent Mental Health Services .

III. Context – Clinical Commissioning Programmes

Elective Care

Ensure that good quality care is provided in the right place at the right time by the right person first time round.

Strategic Needs / Issues to address

Acute activity has traditionally been high in Barnet across a range of secondary care specialities. It is vital that this is addressed in order to ensure that funding is focused on those that need it most.

The latest national and peer group benchmarking has identified key areas where we can focus to reduce the higher than average elective admissions rates, for dermatology, urinary tract and male productive systems, vascular disease and children. Similarly there are high levels of outpatient attendances, particularly, in cardiology (including consultant to consultant referrals), nephrology, ophthalmology, rheumatology and urology.

Approach

We have used a Referral Management Service for the last two years, which has introduced support for GPs in directing referrals to the right setting. This is currently being strengthened with clinical support and development of clear referral protocols. Our approach will be to work in collaboration with acute clinicians, redesign services to make them more efficient, reducing the steps in the patient pathway and thereby reducing costs for both he provider and commissioner.

Recent workshops involving a range of clinicians identified across primary and secondary care identified the following key features to delivery of this:

- Integrated protocolised work ups
- Single point of access
- Consultant/Senior clinician at front end, essential to ensuring that patients are directed to the most appropriate service, first time
- Services to be one stop primarily with follow up only for the most complex

Clinical Commissioning Programme Objectives

GP Development - Managing and controlling demand

1. Ensure that GPs are fully aware of all local services, that primary care local protocols are followed prior to referral. Skills and learning needs of GPs are identified and addressed to enable GPs to do this. These will be identified and supported through the LPR programme.
2. Rationalise existing services making it easier and more straight forward for GPs to understand where they need to refer to.
3. Ensure that GP practices utilise the referral management system ensuring that referrals are complete, clear in their purpose, with all relevant information , including diagnostics attached and that these are directed to the right place first time.
4. Redesign services to ensure optimise use of resources and reduce steps in patient pathway where appropriate.
5. Work with acute trust to ensure that once patients have been referred appropriately, that they are not kept in the “system” for longer than is necessary and that discharge protocols are followed and that GPs/acute consultants agree and understand these. This will also ensure that capacity is created in the acute system to deal with red flags and more complex patients in a more timely way.

Self Care

1. Move care closer to home where possible, providing services in settings and locations closer to people’s homes for easier access.
2. Use LPR to identify self care/prevention initiatives to support self care.

III. Context – Clinical Commissioning Programmes

Emergency and Urgent Care

Ensure that good quality care is provided in the right place at the right time by the right person first time round.

Strategic Needs / Issues to address

- Develop a whole system urgent care model for an integrated urgent care system 24/7 across Barnet and neighbouring boroughs
- Improve patient flow through A&E and emergency pathways to reduce the number of unplanned hospital admissions
- Link with the integrated care programme to provide alternatives to admission.
- Effective discharge planning through integrated pathways that support step down arrangements and rapid care in the community where required
- Increase the number of ambulatory care sensitive pathways that will reduce the need for emergency admission and the discharge of patients from A&E for management within planned services
- Reduce duplication of services across the whole urgent and emergency care pathway
- LAS to convey suitable patients to UCCs, and improve handover arrangements with A&E departments
- Enable GPs to access clinical support from secondary care specialists to support a reduction in A&E attendances
- Reduce 0 length of stay through improved ambulatory pathways and step down arrangements

Clinical Commissioning Programme Objectives

1. Implement the Barnet, Enfield and Haringey (BEH) Clinical strategy, which includes implementation of the Barnet UCC.
2. Use of 111 as a single point of entry to ensure the first point of contact is to the most appropriate service.
3. Reduction in adult and childhood admissions for ambulatory care conditions..
4. Review of walk in services to understand impact on health, and to identify if there is duplication across existing unplanned services
5. The promotion of self-care options with people looking after themselves at home, accessing resources such as the minor ailments scheme
6. Implementation of the London LAS UCC Exclusion criteria with local A&E departments
7. Monitoring of urgent care services through the BEH urgent Care Network and development of an urgent care dashboard

- **Target Outcomes**
- Barnet UCC implemented, GP fronted, 12 hours per day, 365 days a year – new service specification and KPIs
- 40% of all A&E attendances are seen within the UCC and managed at Band 5 PBR tariff
- 98% of all patients that are seen within the A&E are treated within the 4 hour target
- Monitor OOH and 111 Service to ensure they are meeting all the national OOHs Quality Standards and local key performance indicators
- Reduce 0 length of stay for inpatient non-elective admissions to a performance improvement within the 20th percentile in line with the best performing CCGs
- LAS to meet Cat A&B calls within agreed contractual times

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III. Context – Clinical Commissioning Programmes

Mental Health and Learning Disabilities

To develop and commission high quality and safe services that are person-centred and promote people's recovery and independence, enabling them to live rewarding and fulfilling lives. To ensure that all mental health and learning disabilities commissioned services take into account the physical health conditions as part of the holistic assessment and treatment process.

Strategic Needs / Issues to address

- Approximately 40,000 people in Barnet experience common mental health problems.
- Life expectancy amongst people with learning disabilities and people who experience mental ill health is lower that the general population and is also associated with higher levels of obesity and respiratory disease including COPD.
- An estimated 25% of people with long term health conditions such as diabetes, COPD etc. also experience Common Mental Illness which affects their recovery.
- There is a higher level of social exclusion and unemployment amongst this population group. Over 40% of incapacity claims in Barnet are related to mental ill health.

Clinical Commissioning Programme Objectives

1. To develop a mental health commissioning plan by end May 2013;
2. Increase the availability of NICE compliant evidence based talking therapies and re-commission the Barnet IAPT & Wellbeing Service;
3. Support the developments of 'RAID' style liaison arrangements between acute and mental health providers to achieve a redesigned effective pathway for patients with mental health conditions in acute hospitals settings;
4. Review and develop care pathways for co-morbid conditions including autism, ADHD, substance misuse and personality disorder;
5. Collaborate with Enfield and Haringey CCGs to develop and implement rehabilitation and recovery care pathways and systems to reduce need for Out of Area Treatments and other high cost placement;
6. To improve access to health care including annual health checks and health screening programmes for people with learning disabilities.
7. Building on the DH Concordat, to work with the Council to secure further opportunities for community based options that reduces the need for inpatient and out of area treatment options for people with learning disabilities.
8. Council to lead on the recommissioning of prevention services for people with learning disabilities, autism and mental health conditions.

Target Outcomes

- Year on year increase of people with a learning disability and mental illnesses to have received an annual health check.
- Increase by 9% the number of people with long term mental health problems and people with a learning disability in regular paid employment for 2012/13, increasing to 10% for 2013/14 and 11% by 2014/15.
- Increase the number of patients (of those assessed as having depression or anxiety disorders) receiving psychological therapies to 10%.

III. Context – Clinical Commissioning Programmes

Integrated Care

To continue to develop proactive, planned care approaches including effective multidisciplinary working between providers in an integrated way. Through locality based integrated health and social care teams, commissioning will support the redesign of care pathways that promote improved management of patients with complex care needs , those who experience episodes of crisis and those with long term conditions to enable them to remain in their home . This approach will reduce the need for non-elective, unscheduled hospital and residential care admissions .

Strategic Needs / Issues to address

- Elderly population set to rise by 21% over next 10 years.
- 38% of older adults living alone.
- Older people are three times more likely to be admitted to hospital following attendance at an A&E department. Once there, they're more likely to stay and suffer life-threatening infections, falls and confusion.
- Older people are more likely to suffer from chronic and long-term conditions, mental health issues, falls and fractures.
- Hip fractures prompt entry to a care home in up to 10% of cases.
- The number of dementia sufferers is expected to increase. With early diagnosis, treatment and support they can continue to live good lives.
- There is an increased risk of social disconnectedness and isolation in an estimated 18,300 older adults in living alone, making up 38% of the elderly population in the borough. Over two thirds of these single pensioner households will be aged 75 or over.

Clinical Commissioning Programme Objectives

1. Increased use of health and social care preventative programmes supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health leading to a reduction in unplanned and emergency admissions to hospital and delay admission to residential care .
2. Redesign services to ensure that they accessible and responsive to those who need them including out of hours support and rapid access.
3. Introduce locality based integrated health and social care teams to support patients remaining at home through appropriate interventions avoiding hospital admission where possible .
4. Proactive risk assessment to identify those with emerging complex health issues and those long term condition and ensure care is actively managed.
5. Supporting people to remain connected to their family ,carers and community and influencing well-being.

Target Outcomes

- The balance of spend on older people in both the NHS and Social Care has been realigned to provide a greater focus on prevention.
- Percentage of frail elderly people who are admitted to hospital three or more times in a 12 month period to be reduced from the 2010 baseline.
- Number of emergency admissions related to hip fracture in the over 65s to reduced by 10% from the 2009/10 baseline of 457.3 by 2015.
- The percentage of people aged over 65 who are still at home 91 days after discharge into rehabilitation services, to be increased to 87% in 2013 with a stretch target to reach 90% by 2015.
- All people who have continuing healthcare needs to have a personal health budget by 1st April 2014.
- An increase of 20% from 2012 to 2015 in the number of carers who self report that they are supported to sustain their caring role.
- Increase in the number of people (receiving end of life care) that are supported to die outside of hospital.

III. Context – Financial position (1)

- Barnet CCG has inherited an underlying deficit of c.£ 34m based on its operation as a PCT adjusted for non recurrent items and services where the responsibility for commissioning has been transferred to NHS England.
- This underlying CCG deficit is increased for FY13, pre QIPP, to c.£46m as a result of the required FY14 planning assumptions. Based on its inherited deficit the CCG has forecast a deficit of £20.9m for FY14. This assumes it will be able to deliver £17.0m of QIPP and that it will be able to use its 2% 'headroom allocation' (c.£8m).
- The CCG deficit is a result of a number of factors. In particular:
  - The loss of non-recurrent cluster support – c.£17m in 2013:
  - The loss of revenue allocation in the transition from PCT to CCG. c£9m of specialist revenue allocation has been lost, incorrectly, in the transition from PCT to CCG as allocations were made in late 2012 based on incorrect assumptions, see slide 20
  - Additional estates costs over and above existing community hospital costs for the new Finchley Memorial Hospital, of £2.2m
  - In 13/14 an additional impact of £1.9m following transfer of PCT estate
  - The CCG has a reasonable track record on delivery of QIPP targets, achieving between £20m-£30m per year over the past four years although delivery in 2012/13 was £14.5m against a target of £23m
  - Barnet is seeing population growth that is higher in percentage and real terms than other boroughs in North Central London. See page 22.
  - Potential under funding:
    - £10m to £20m if Barnet CCG received per capita 13/14 funding increases in line with the national, ONS Group or London average, see page 21
- A bridge from the PCT Forecast Out Turn (FOT) of £3.7m to the £20.9m forecast FY14 deficit is shown on page 23

III. Context – Financial position (2)

Loss of revenue allocation & increased costs

- £9m of specialist revenue allocation has been lost, incorrectly, in the transition from PCT to CCG, this relates to services that have moved to NHS England and public health from 1/4/13. The NHS England public health revenue deductions were the result of a complex process undertaken during 2012 utilising a combination of 12/13 plans, September year to date actuals and a number of supplementary templates submitted to NHS England by NHS North Central London. It has proved difficult to achieve a cost neutral position.

- Consequently, although £161.7m of revenue has passed across to NHS England, at this stage only £158m of the associated costs have been identified. The balance or shortfall of £3.7m currently rests with the CCG which in simple terms means that the CCG has £3.7m less to deliver the services that it is actually responsible for in 13/14.

- A similar situation exists with the public health deduction where although revenue has been reduced by a total of £12.5m, only £11.2m of costs have been identified. The shortfall of £1.3m has also been left with the CCG.

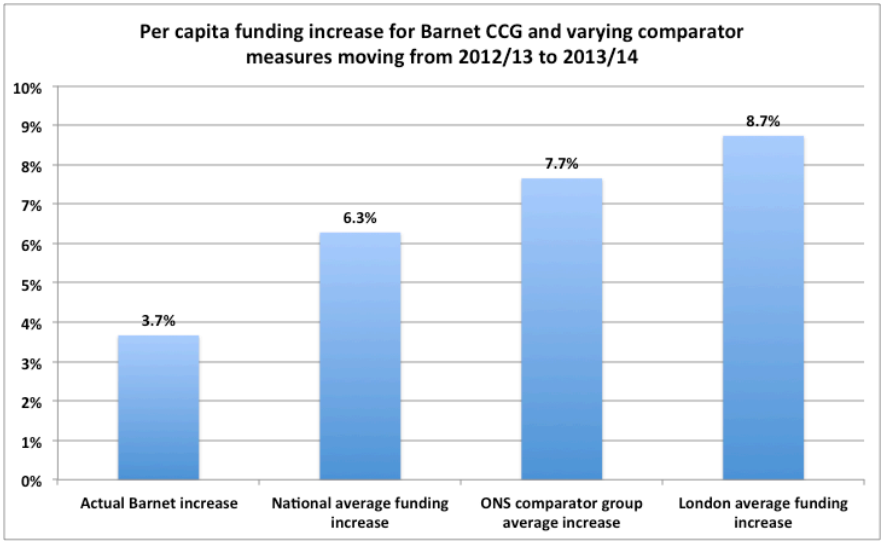
- In respect of the running cost allowance, during the submission phase last year there appears to have been a degree of confusion over the definition of the running costs that were deducted from the CCG baseline. The figure deducted was based upon the wider PCT/SHA definition of running costs rather than the narrower CCG definition, so for example the revenue to cover the costs of medicines management has not been passed to the CCG. This has translated into a shortfall in funding for the CCG of £3.5m.

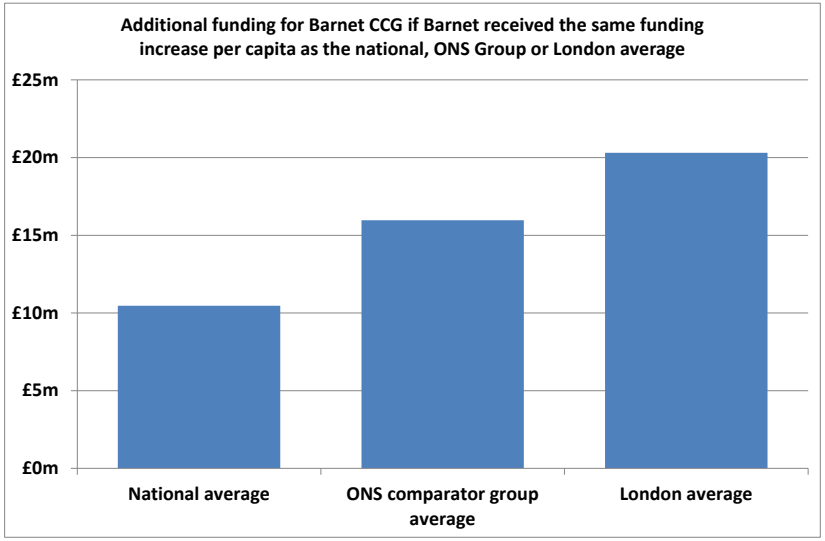
- In addition to the above & the CCG will now incur costs for un-tenanted space and the non-booked sessions in sessional space to the tune of £3.8m, of which £2.2m relates to FMH alone.

	£m pa
NHS E - Specialised services	3.71
NHS E - Public Health	0.00
Public Health - Local Authority	1.82
Public Health - England	-0.52
Running costs allowance - error	3.52
FMH - void/sessional cost pressure	2.20
Other - void/sessional cost pressure	1.60
Total	12.33

III. Context – Reduction in capitation funding

- The graphs below show the unfavourable Barnet position in terms of per capita increase in allocation when compared with National, ONS comparator group, and London average funding increase.





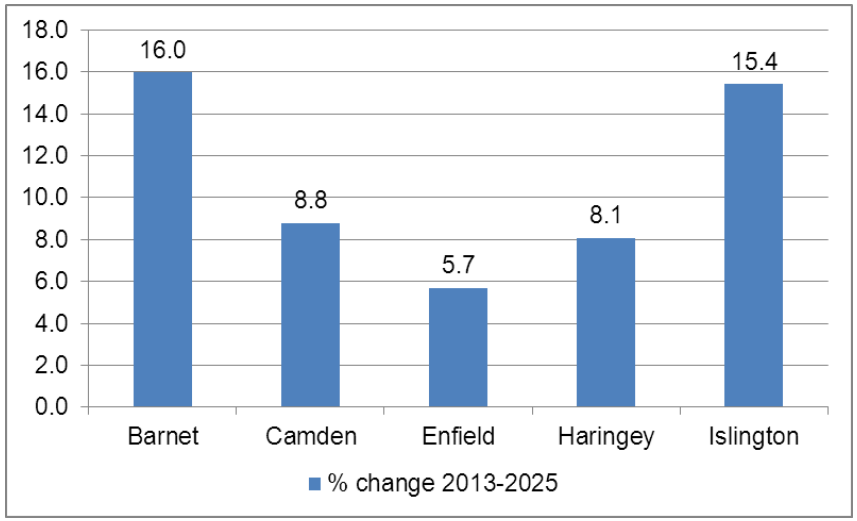
III. Context – Population growth

ONS projections are based on patterns of births and deaths, and migration into and out of an area. They take no account of changes in the number of dwellings in an area. The Greater London Authority does, however, produce projections which take account of planned changes in the quantity of housing stock within an area. For London Borough of Barnet, this has been calculated as 375,197 in 2013, a difference of 4509. By 2020, the GLA projection is 414,000, compared to the ONS projection of 411,000. By 2025, the ONS and GLA projections are very close at 435,500 and 435,100 respectively.

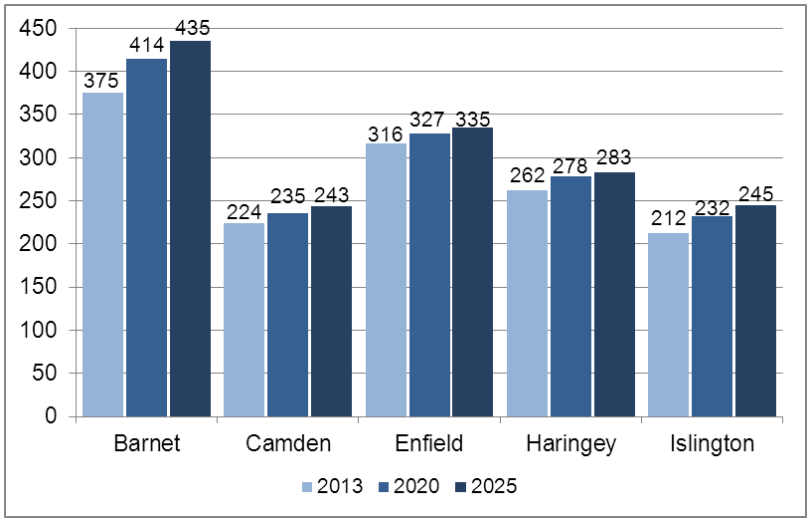
Within the Council's Local Development Framework, the Housing Strategy contains a projection of 28000 new homes being constructed by 2026 to meet housing need, alongside another 3000 units being brought back into use. Key areas for development by 2018 include:

- Colindale (including Grahame Park) - 5887
- West Hendon - 630
- Stonegrove/Spur Road – 155
- Mill Hill East – 1264
- Dollis Valley 250
- Brent Cross Cricklewood – 1138
- North London Business Park – 250

Further work is required to try and assess the impact of the development of these sites.

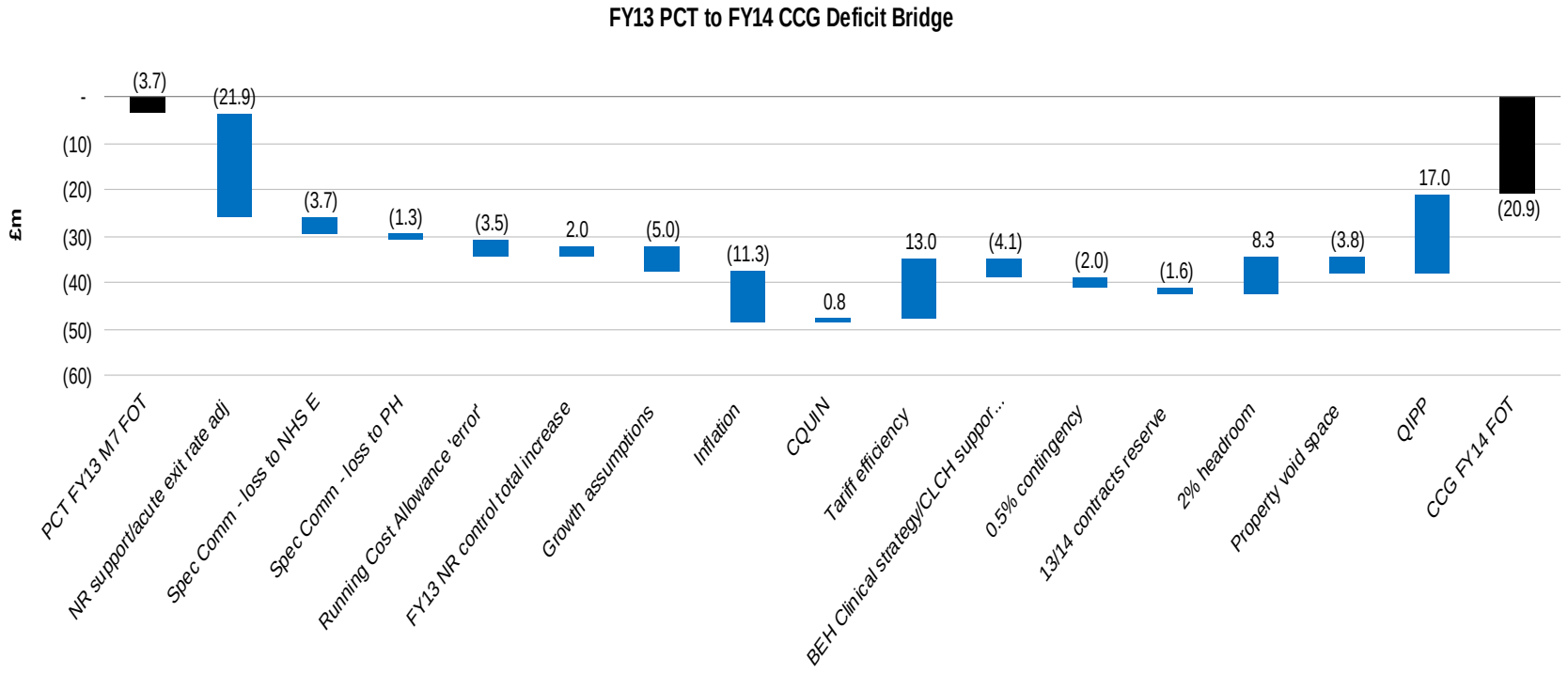


% increase, 2013-2025. GLA population projections



Population increase (000s), 2013-2025. GLA population projections

III. Context – PCT to CCG deficit bridge



FY14 Budget

The bridge from 12/13 to FY14 details the move from the PCT FY13 out turn to the CCG FY14 budgeted deficit of £20.9m.

This position deteriorates to a deficit of £29.2m if the benefit of the 2% non-recurrent is excluded.

The next slide illustrates the future years position with a reducing QIPP target but continued use of the 2% non-recurring headroom benefit.

III. Context – Financial position (5)

FY14 & beyond

The table opposite shows the FY14 budgeted deficit of £20.9m (after QIPP savings of £17m) and the forecast budget for FY15 and future years.

The FY15 & future years forecast has been prepared on the basis of the FY14 run rate and therefore assumes:

- delivery of the previous years budget including QIPP;
- the 2% headroom is available to offset against deficits;
- the CCG QIPP target is reduced by 10% p.a. to reflect lower level opportunities available over time
- benefit of £2m NR increase in FY13 control total excluded from FY15 calculations onwards
- the following annual increases in RRL & cost pressures

	Demo growth	Non demo growth	Inflation	Tariff Efficiency
Revenue Resource Limit				
Baseline Allocation	2.30%			
Spend				
Acute and Integrated Care	2.35%	1.65%	2.70%	-4.00%
Acute Other	2.35%	1.65%	2.70%	-4.00%
Mental Health	2.35%		2.70%	-4.00%
Continuing Care	2.35%		2.70%	
Community	2.35%		2.70%	-4.00%
Specialist Commissioning	2.35%	1.65%	2.70%	-4.00%
Prescribing	2.35%		2.70%	
Primary Care	2.35%			
Other Commissioning	2.35%		2.70%	-4.00%
Public Health	2.35%		2.70%	
Corporate	0.00%		0.00%	0.00%

FY14 - FY18 Forecast

	FY14 £m	FY15 £m	FY16 £m	FY17 £m	FY18 £m
RRL Income	416.0	423.6	433.4	443.4	453.6
Expenditure					
Acute	258.2	249.1	241.1	234.0	227.8
Non Acute	149.5	153.4	157.3	161.3	165.5
Primary Care/other	9.6	9.9	10.1	10.4	10.7
Operating costs	16.9	16.9	16.9	16.9	16.9
Reserves/contingency	2.7	2.8	2.8	2.9	2.9
Total expenditure	436.9	432.1	428.3	425.6	423.8
Net surplus/(deficit)	-20.9	-8.6	4.9	17.6	29.6
QIPP savings	17.1	15.7	14.5	13.3	12.3
QIPP as a % of total costs	3.9%	3.6%	3.4%	3.1%	2.9%

III. Context – Financial position (6)

Worst case scenario

The CCG's projections have assumed that the 2% headroom allocation requirement will be relaxed to allow the CCG to reduce its in year deficit and therefore return to an in year operating surplus in 2015/16.

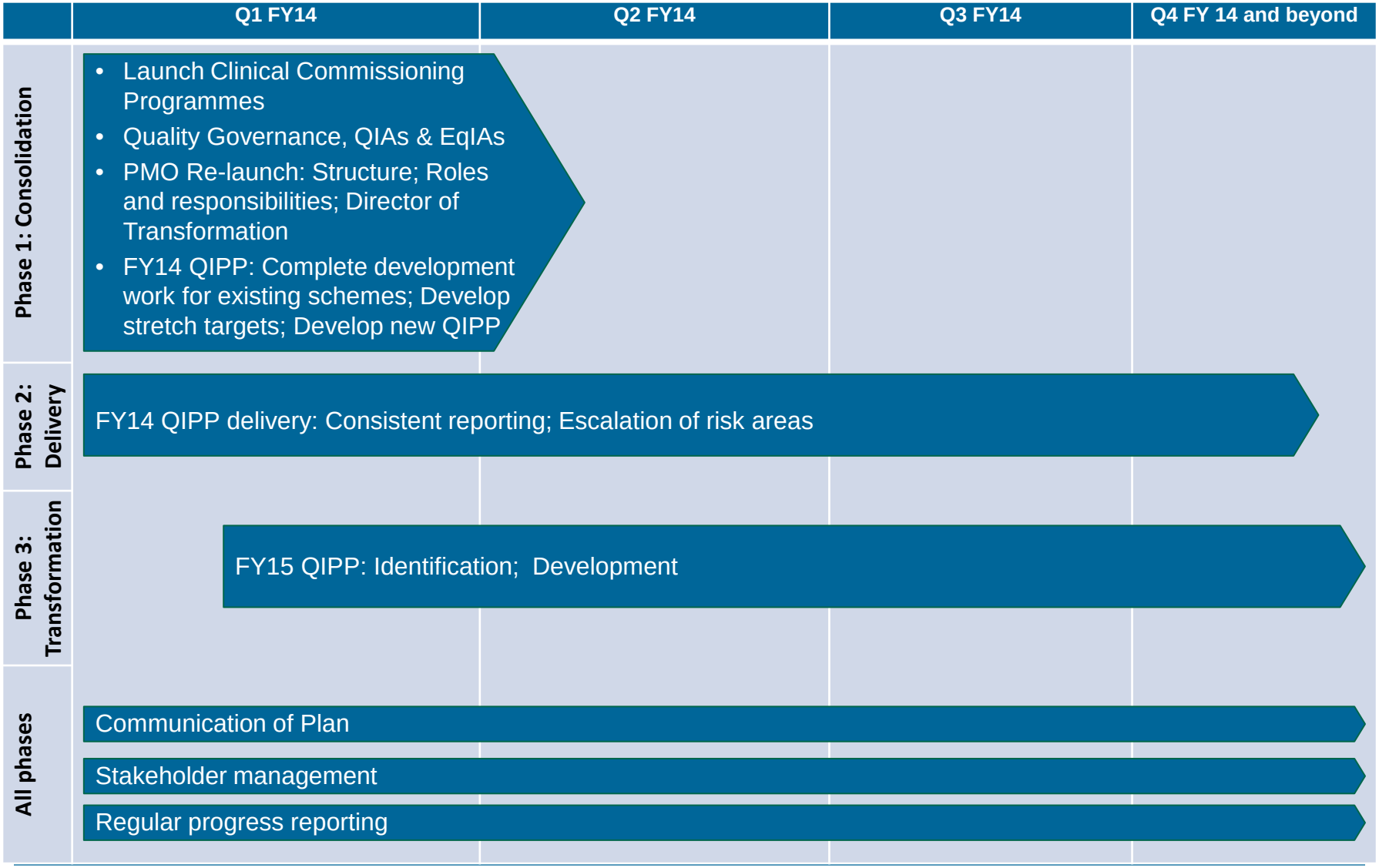
Should the 2% not be made available and the CCG be required to deliver 'normal business rules' the impact would be catastrophic and require an undeliverable QIPP target as modelled below. This would effectively render the CCG unviable:

		FY13/14 £'m	FY14/15 £'m	FY15/16 £'m	FY16/17 £'m	FY17/18 £'m
	In year (deficit)/surplus (including 2% headroom)	(29.3)	(17.0)	(3.7)	8.8	20.5
	Repayment of deficit	0.0	(29.3)	(46.3)	(50.0)	(41.3)
	(Deficit)	(29.3)	(46.3)	(50.0)	(41.3)	(20.8)
	Planned QIPP to deliver forecast	17.0	15.6	14.4	13.2	12.2
1% in FY13/14, 2% in FY14/15	Additional QIPP required to deliver surplus of 1% / 2%	33.3	54.3	58.0	49.3	28.8
	Total QIPP requirement for 'Business Rules'	50.3	69.9	72.4	62.5	41.0
	Memo: Total QIPP to deliver breakeven	46.3	61.9	64.4	54.5	33.0

The CCG does not believe it would be practical or possible to deliver cost reductions of this magnitude without the immediate cessation of services without replacement. Such actions would have a detrimental effect on the health provision and outcomes for the local population.

IV. Approach

Overview timeline



IV. Approach

Development of the Recovery plan

The following slides set out the approach taken by the CCG in the development of its recovery plan.

The Recovery Plan builds upon the work already being carried out by the CCG as commissioners including :

•QIPP development;

•Pathway redesign;

•Provider discussions and contract negotiations; and

•External advice (e.g. PwC, CSU)

The Recovery plan has also drawn upon the recent baseline and QIPP review carried out by PwC.

Timetable for recovery

The CCG has prepared a model based on its FY13 exit rate, (see page 14) to determine when it may reasonably expect to deliver an operating surplus but also clear legacy deficits.

Typically a Recovery Plan would outline a 3 year timeframe to deliver a turnaround however given the size of the deficit this is not possible.

A 5 year plan has therefore been outlined to achieve in year surplus & clearance of legacy deficits to achieve business rules based on the use of 2% 'planned headroom' to repay deficits

Phased approach to the Recovery plan.

The recovery plan that has been developed has 3 distinct phases, which will overlap:

Phase 1 – Consolidation

- Clinical Commissioning Programmes are being launched
- Quality Governance processes are being embedded
- The CCG is actively strengthening its programme management resource and supporting processes, including Quality and Governance to enhance its delivery of the Recovery Plan.
- A Director of Transformation and a resource to set up the PMO are being recruited.

Phase 2 – FY 14 delivery

- The delivery of FY14 QIPP will be progressed with pace, whilst developing opportunities to stretch and enhance the existing programmes . The CCG will continue to progress the development of plans for FY15 and future years.

Phase 3 - Transformation – FY15 and beyond

- The detailed planning of QIPP opportunities for FY15 and beyond, following business case approval, and the development of FY15 contracting strategies.
- The nature of plans for FY15 and beyond will involve detailed analytics to allow business case preparation and detailed planning is likely to require partnership working with providers, joint commissioners and neighbouring CCGs. The Recovery Plan therefore details areas for additional investigation for FY15 where further detailed evaluation and planning is ongoing.

IV. Approach – Phase 1: CCPs

Leadership for Clinical Commissioning Programmes (CCPs)

- Each CCP will be led by the relevant GP board member(s) alongside the Director of Integrated Care, or the Director of Clinical Commissioning (for elective and non elective services), supported by the relevant Senior Manager, with the Deputy Chief Financial Officer providing financial support.
- The Directorate of Quality and Governance will provide a supporting role in relation to quality across all CCPs.
- Senior Managers will take responsibility for 1) elective care, 2) urgent, unscheduled and emergency care, 3) integrated care – frail elderly and long term conditions (X2) 5) mental health and learning disabilities, and 6) children's services. The development of primary care will sit within the integrated care Clinical Commissioning Programme. Each senior manager will have at least two project managers. There will be an individual administrator giving admin support to each team.
- The GP lead, Director and Senior Manager will agree the work programme for each CCP and together will be responsible for delivery. For joint commissioning the programme will also be agreed with London Borough of Barnet.
- The principal role of the GP is both Clinical Leadership and Corporate (Board) ownership.

Organisation of CCPs

- Each CCP leadership team will decide on the approach to implementation. This will include any overarching group leading the CCP, which partners should be included, any task and finish groups, and the priorities for the CCP.
- Provider input will be essential and will be sought at Clinical Director/Specialist Lead level.
- A pathway / specialty will be allocated to a CCP based on where/how the majority of care takes place i.e. in the community, in hospital through elective care, or in hospital through emergency care. Specialities which should mainly be in the community will be in integrated care; those which are highly acute are more likely to be in elective or non elective.
- Pathways / specialities will be covered within one CCP to prevent duplication. GP leads will agree the allocation with the Chair providing guidance.
- In general the first months of the commissioning cycle will focus on considering overall service provision and identifying priorities improvement/redesign. The remaining cycle will detail the required changes and embed these in to contracts. In 13/14 the priority will be to embed existing projects to ensure 13/14 delivery.
- Each CCP will informed by outcomes, quality measures (hard and soft), activity finance and other benchmarks, and alignment with current and emerging best practice, innovation and guidance. There is an expectation of complete transformation and different approaches to population healthcare. The CCP leadership teams will need to listen to practices, patients, the public, providers, partners and agree priorities across these groups. Each CCP is likely to have about 12 projects at any one time.

IV. Approach - Phase 1: Quality

Quality Governance

Barnet CCG holds quality at the heart of commissioning and we strive to improve the quality of the services we commission through effective clinical leadership, and listening to our patients, public, partners and stakeholders. We work together for mutual benefit, ensuring that patients are central to our decision making process.

It is our aim to achieve continuous quality improvement, to assure ourselves that the services we commission are of good quality and reflect national priorities, and to assure the achievement of safe standards.

The CCG will promote and assure quality improvement through its local mechanisms which include:

- Quality Impact Assessments of all developments;
- Ongoing dialogue with stakeholders
- Local peer review
- Complaints information, equality data, national survey and patient experience data
- Patient Survey
- Balanced scorecard
- Performance monitoring framework

A focus on quality through structure

In developing and delivering its Recovery Plan, the CCG recognises there is a clear risk to the quality and safety of service provision. The CCG is clearly sighted on these risks and will take assurance from its Quality Governance Framework and the arrangements that it will continue to develop to monitor risk.

Clinically led quality assessment

With the scale of the challenge the CCG is facing, robust clinical risk assessment of all QIPP schemes is an essential component of the CCG's assurance processes. Enhanced PMO arrangements will facilitate the monitoring of identified and agreed KPIs to provide sensitive early warning systems, which in turn will lead to responsive and timely action if required. Quality Impact Assessments of all schemes will be complete by the end of May. The PMO will be responsible for reporting the performance to support the management of this.

IV. Approach – Phase 1: Quality

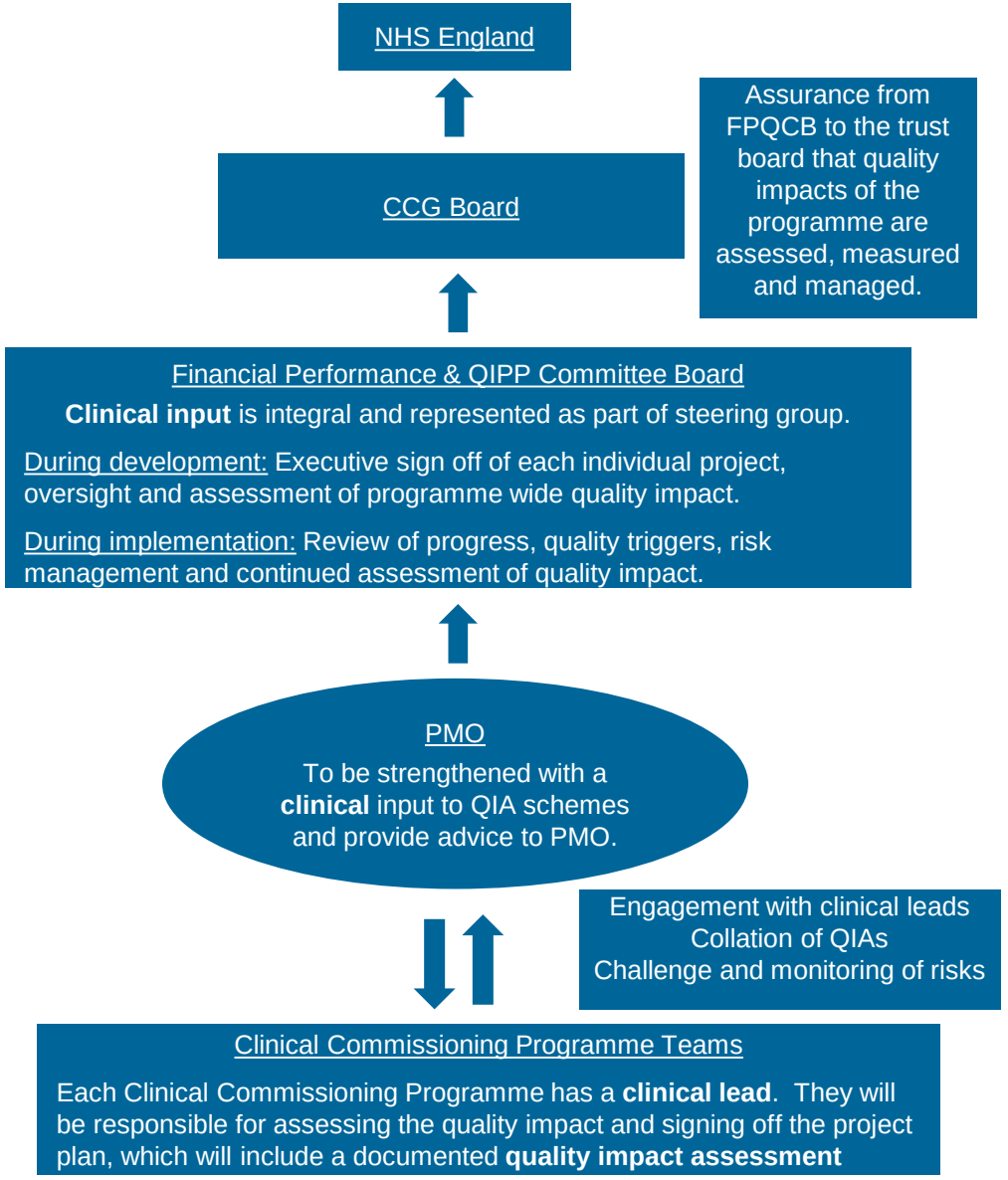
Quality Governance of the QIPP programme

The CCG is developing a more structured and integrated approach to its governance arrangements to ensure the CCG is best placed to deliver its challenging QIPP programme.

The structure and process outlined opposite will promote the sharing of information and the importance of risk identification and management.

In this model the escalation of blockers and the communication of project status will be much more straightforward. This will result in a more efficient and effective delivery of the overall savings programme.

Clinical engagement will be a significant part of this process and the CCG recognises the requirement for strong clinical ownership to drive the successful delivery of the identified QIPP schemes.



IV. Approach – Phase 1: Quality

Quality Governance of commissioning arrangements

- The Director of Quality and Governance chairs the quality contract monitoring meetings in place with our main local acute and community providers, Royal Free Hospital Trust, Royal National Orthopaedic Trust and Central London Community Healthcare Trust and is responsible for clinical review and sign off of all serious incidents.
- The Director of Quality and Governance and the clinical lead for Quality on the Governing Body are the strategic leads for quality within the CCG and champion Quality with all GP members.
- In addition the clinical lead for quality on the Governing Body has agreed to use the role to champion quality in primary care as well as commissioned services, at regional and national levels;
- The CCG will look to further refine the role not only of the clinical lead but also the role of all GP members in relation to monitoring.
- The CCG has had quality standards for patient safety, patient experience and clinical effectiveness in contracts for the past two years. Standards for contracts will be revised to build on current best practice and to further develop these standards into new areas such as safe staffing, integrated care, care and compassion, and collaborative working.

In light of the recommendations from recent events such as Mid Staffs and Winterbourne, the CCG has developed robust action plans which ensure that each of the recommendations is addressed in full. Safeguarding adults and children is of high priority to the CCG and we have ensured that we have the appropriate internal resources in place to manage, monitor, and maintain quality in these areas.

In particular:

- The CCG has put a structure in place to actively engage with GPs and their patients on a continuous basis. This builds on structures that the CCG has had in place previously.
- Each GP has an opportunity to gather feedback within each consultation; a patient feedback system is under development to allow the information gathered by GP's in consultation to be fed-back in a systematic way into the quality and risk system of the CCG. The CCG has a schedule of planned communication and engagement events as well as a patient participation system which allows patients and GPs to come together on a regular basis and discuss experience and concerns with care.
- The CCG's Clinical Quality and Risk Committee is chaired by a GP Board Member supported by the Clinical Director for Quality and Governance. Together they have overall responsibility for and oversight of clinical quality issues; the Quality committee as a sub committee of the board, also has a role to report areas of serious risk or concern to the Audit Committee, and both bodies report directly to the CCG Board.

IV. Approach – Phase 1: PMO

Re-establishing the PMO

The PwC draft report, dated 3 April 2013, makes 56 recommendations around the QIPP programme and the PMO within Barnet CCG, which can be summarised into seven clear areas of action:

1. Gain **visibility** over the entire programme of work, including the **gaps in resources**, and address them to ensure that projects are sufficiently resourced to achieve success
2. Complete the **project documentation** for existing projects to allow implementation to begin
3. Articulate and embed **a project lifecycle and gateway process** which supports projects from ideas generation, through start-up, initiation, delivery and close
4. Design and embed a **suite of PMO controls**, including a streamlined and **standardised reporting process**
5. Design and embed an **efficient governance structure**, including clear terms of reference for all roles, groups and meetings that sets out the responsibilities and accountabilities for each individual
6. Identify and address **communication and training** requirements to truly embed the new processes, tools and ways of working
7. Put patient **quality and safety is at the heart of programme delivery**.

A high level action plan to achieve the above focussing on the delivery of 11 key milestones within 40 working days has been developed & resource to implement is being identified. This will support the initial stages of the CCPs. The CSU are unable to resource the action plan however they will be fully integrated into the PMO framework once formally in place.

The key recommendations and steps taken by the CCG are detailed on the following pages.

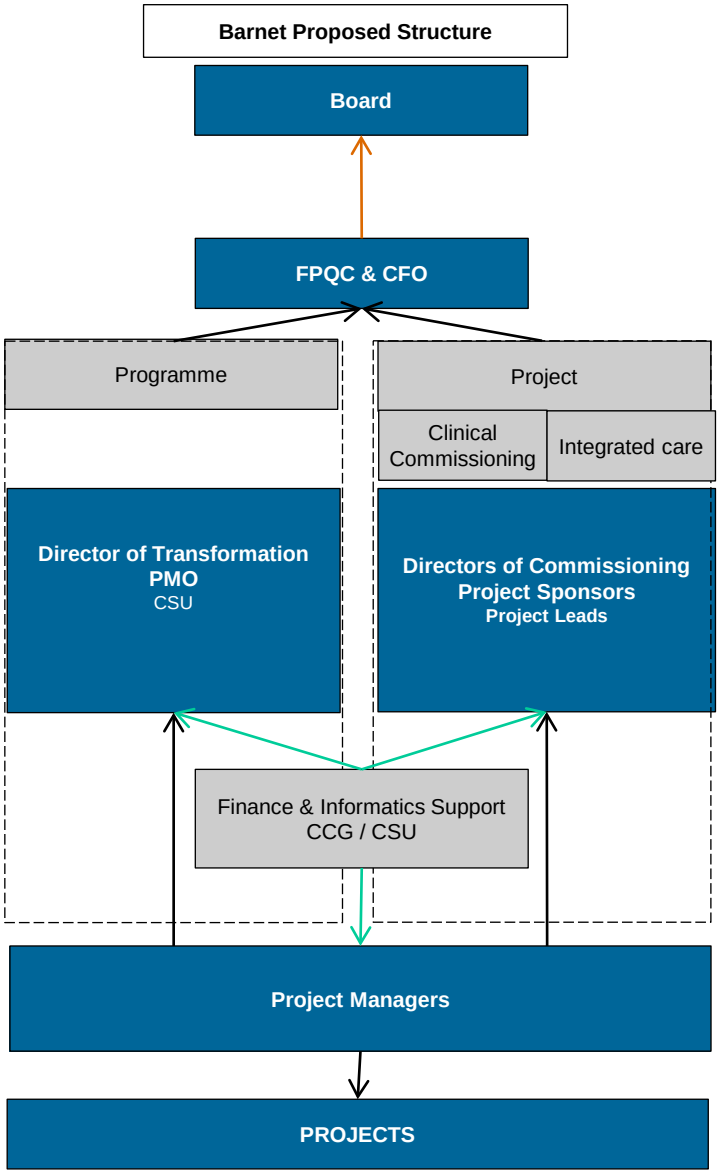
IV. Approach – Phase 1: PMO

PMO structure and delivery

In order to ensure a sustainable future, the CCG has had to improve the way it goes about both developing and delivering savings. We have recognised the need to develop the right capability and capacity required to drive the change programme, underpinned by a new best practice Programme Management Office (PMO) approach to project delivery. Key roles of the PMO:

- The approach in developing QIPP plans and monitoring and driving implementation is much more proactive and wide ranging than previous years and aims to maximise efficiencies and ensure deliverability.
- The PMO is responsible for managing the change programme and driving forward the delivery of the identified plans with rigour and pace.
- At the plan development stage of each project, the PMO will provide the robust check, challenge and reporting processes required to ensure the ambitions of the CCG in successfully delivering its savings and efficiency targets are achieved.
- The PMO is in the process of agreeing how it is supported by the CSU, both at an analytical and plan development stage and to support monitoring of plan implementation.
- Plan development is lead by the CCG's two Directors of Commissioning at a strategic level with GP clinical leads at plan level.

The diagram opposite outlines the tailored structure adopted within the CCG and shows the channels of reporting and approval. The roles and responsibilities at each level of this structure are described overleaf.

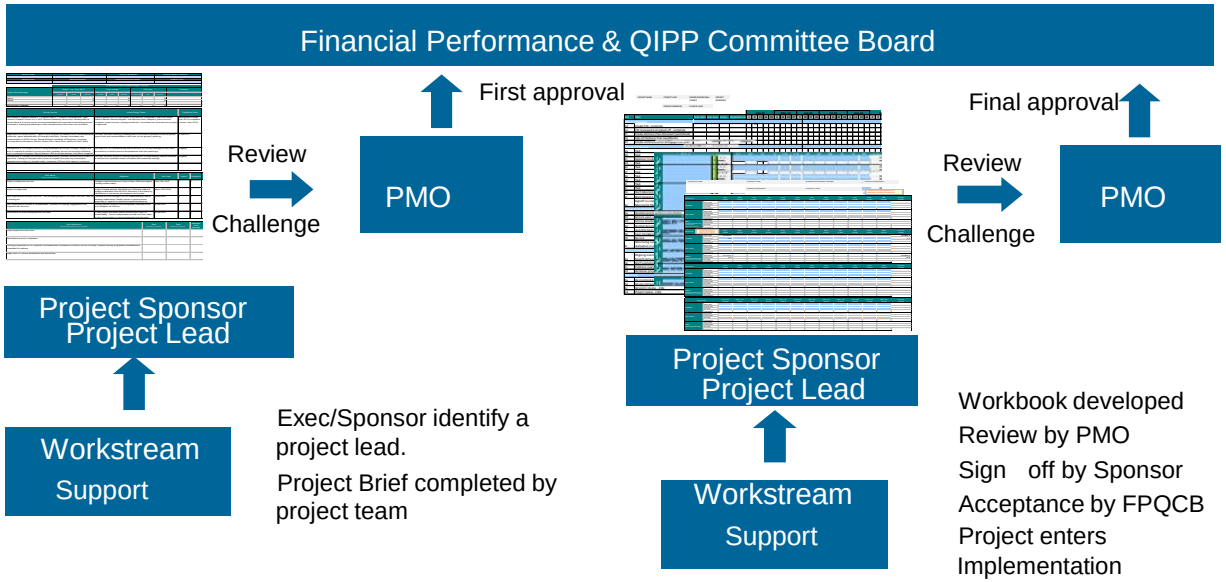


IV. Approach – Phase 1: PMO

QIPP plan development

The development of QIPP plans is underpinned by an agreed systematic process. This process assures the CCG Board that plans are transparent and have a framework for identifying and monitoring key deliverables / benefits through accountable leads. In addition plans contain clarity on what is agreed in terms of managing quality issues, change management, impact and risks to patient services.

Each scheme has an identified project team, which includes an accountable sponsor, clinical lead and project lead.



The first stage of the QIPP development plan is to complete a Project Initiation Document (PID) which brings together the information needed to define the project, why the work is needed, likely outcomes and any resources required.

The PID is submitted to the PMO and approval sought for the development of business case to the Finance Performance and QIPP Committee (FPQC).

The second stage is the submission of a fully worked up business case outlining why the project is going ahead. It will include what it is expected to deliver, benefits / savings / costs of delivery and any impact and risks to services . This business case is again submitted to the PMO for a sense check and agreement sought if appropriate by the FRQC.

Stage three includes the development of the project workbook which sets out how the project with be implemented to completion, identifies the key milestones, monitors the project, flagging any issues and risks raised/monitored and how they will be mitigated against.

The project teams meet frequently with the PMO to discuss progress and delivery of plans against targets. This process helps to raise issues, find solutions, support, challenge and hold the team accountable for delivery of the project , escalating issues as necessary. Following these meetings, the PMO is best placed to track and report progress of each project and flag issues to the FPQC.

IV. Approach – Phase 1: PMO

Risk management

For all QIPP schemes approved by the Finance, Performance and QIPP Committee, a workbook is completed to monitor the project through implementation and delivery of benefits. This includes a project specific risk register, which is centralised onto the PMO risk register. Risks common to more than one project are highlighted to enable a linked approach by project managers when mitigating. Current themes are listed below.

Risk	Mitigation
Lack of project management resource	Increase project management capacity. Consider interim options
Availability of clinicians may impact on project timescales	Involve clinicians from outset and ensure they understand commitment required
Lack of GP engagement – unaware of new service and do not refer patients, slow to adopt new systems.	Work with communications team to promote services. Work through CCG GP members to develop relationships with GP community and share good practice.
New service increases demand	Ensure robust primary care pathways and thresholds for referring into service. Use contract monitoring process to review and manage.
Lack of skills in primary care to enable shift of services from acute setting	Development of primary care through primary care strategy Use of learning through peer review GP education sessions.
Plans developed in isolation from other neighbouring CCGs and local boroughs	Liaise with all service commissioners and providers in early stages
Patient confidentiality may mean that interactions between non NHS services will limit multi-disciplinary approach	Patients to be given option to consent information sharing
New pathway may destabilise providers	Ensure early engagement with providers and include in contract planning sessions and negotiations.
Inability to track progress due to poor quality of data available and ability to accurately interrogate systems	Work with informatics team to design KPIs using most reliable data to monitor monthly. Test data quarterly.

IV. Approach – Phase 2: Delivery

Roles and responsibilities

The table opposite outlines the roles, purpose and responsibilities in delivery of this recovery plan

As a CCG we have highlighted the importance of clear role designation in order to ensure clear working practices and defined governance channels.

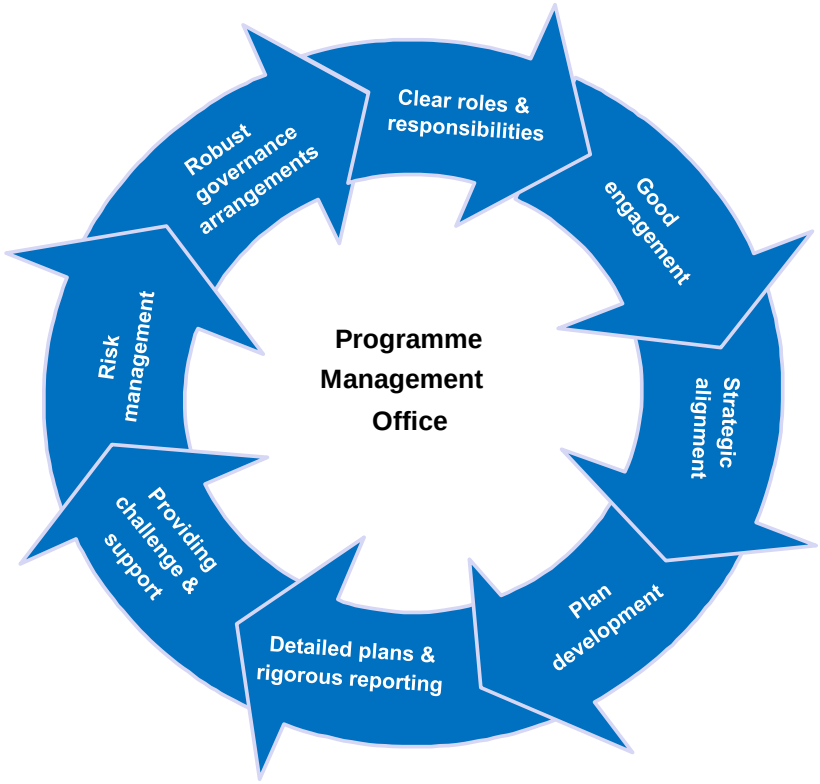
The identified positions and accountability will make sure each QIPP scheme is well worked up and delivered according to the agreed timeline and quantum identified in each plan.

	Role	Purpose	Responsibility and accountability
Monitoring	**Finance, Performance & QIPP Committee and Chief Financial Officer**	• Executive decisions and approvals to manage programme.	• Responsible for ensuring all CCG staff are fully aware of the scale and challenge of the turnaround programme • Management of communication with internal and external stakeholders • Regular review of resources required to deliver programme
Programme Management	**Director of Transformation**	• Leadership and coordination of the overall turnaround process	• Coordination, challenge and assurance of turnaround work streams and overall financials • Turnaround and project management advice, training & support to project sponsors • Ensuring turnaround focus incorporated into day to day operations across the CCG
	PMO	• Management and coordination of the turnaround programme	• Upkeep of central project management schedules • Maintenance of project records • Resolution or escalation of issues as appropriate to the QIPP Director & Steering group • Turnaround and project management advice, training & support to project leaders and resources • Preparation of weekly and monthly progress reports
Delivery	**Project Sponsor (Dir. of Clinical Commissioning / Dir. of Integration**	• Provides executive leadership of project groups and associated benefits	• Responsible for and accountable to the executive team for delivery of turnaround work stream benefits
	Clinical Leads	• Clinical quality assessment	• Ensure clinical quality is maintained throughout the delivery of each of the savings projects. • Accountable to the Project Sponsor
	Project Lead	• Delivery of turnaround work streams and associated benefits	• Project management of turnaround work stream • Coordination of turnaround work streams with business as usual operations • Accountable to the Project Sponsor for delivery of turnaround work stream benefits

IV. Approach – Phase 2: Delivery

FY14 QIPP delivery

- The PMO will need to provide support to the QIPP programme and monitor and report on the financial and overall progress of the cost improvement schemes.
- Regular reporting will take place following a detailed review led by finance in conjunction with the programme managers. The PMO will risk adjusts the forecast level of savings and report this to the FPQCB.
- The CCG is in the process of implementing an effective set of tools, including templates for the planning and monitoring of QIPPs.
- The organisation's understanding of the PMO's role, and developing the right team for the role going forwards are critical. The CCG has recognised the need to change its PMO in line with the recent PwC report.
- The CCG are now ensuring there are sufficient core PMO staff , and that the PMO's core role, to monitor, challenge and measure progress, is understood within the organisation.
- The CCG have recognised the need to improve its monitoring of the QIPP impact on quality.



IV. Approach – Phase 2: Delivery

Approach to finding additional QIPP

- In collaboration with CSU and external organisation, developing systems to ensure robust programme management and clear visibility of project progress in place at all levels.
- Developing cycle of benchmarking and peer review, with CSU to identify new areas of opportunity looking at various websites including Audit Commission PBR National Benchmarking, NHS Comparators, NHS Better Care better Value Indicators.
- Developing series of ideas gathering workshops with GP community using locality meeting forum.
- Setting up sessions with patient and public groups to gather user input on proposed service improvement areas.
- Working with Local Authority and Public Health to develop an integrated care programme informed by the JSNA and HWBB Strategy.
- Working with provider Trusts to look at areas for shared delivery of services with cost efficiencies to both sides.
- Periodic sharing of good practice within CCG POD and with comparable CCGs and pan-London
- New opportunities identified will be scoped following same robust programme management system as previous slide.

IV. Approach – Phase 3: Transformation

FY15 QIPP approach

- Scoping and first stage proposal documents for areas identified by PwC benchmarking (appendix ll) from Q2. This will determine size of opportunity and enable prioritisation and resource allocation.
- Programme presentation to CCG Board for approval early Q3.
- Final scoping and development of business cases and quality impact assessments for approved schemes, presented to Finance, Performance and QIPP Committee for sign off December/January.
- Implementation Q4 to enable full impact from FY15 Q1. In parallel agree methodology with CSU informatics and finance to monitor projects and ensure benefits tracking.
- In collaboration with CSU and external organisation, developing systems to ensure robust programme management and clear visibility of project progress in place at all levels.
- Developing cycle of benchmarking and peer review, with CSU to identify new areas of opportunity looking at various websites including Audit Commission PBR National Benchmarking, NHS Comparators, NHS Better Care better Value Indicators. Also sharing good practice within CCG POD and with comparable CCGs and pan-London.
- Working with Local Authority to develop an integrated care programme and with provider Trusts to look at areas for shared delivery of services (see previous slide outlining engagement with other stakeholders)

IV. Approach – Stakeholder Management

In the table below, the CCG has recognised the wide range of stakeholders who may be impacted by the implementation of the recovery plan. The table outlines the potential agenda of each stakeholder group, and the intended approach to communication. The PMO will be responsible for keeping the stakeholder matrix up to date and for making sure the communication requirements for each group are delivered.

Stakeholder	Key Priorities	Approach
Patients	• Engagement in commissioning	Continue implementing the communication and engagement strategy. Hold regular public meetings
GP's	• Engage GPs in commissioning and decision-making • Capitalise on clinical interests of GP's, encouraging participation as clinical leaders in the commissioning process	Locality meetings GP intranet / bulletin Use of Practice Development GPs and practice visits to keep practices appraised of CCG developments.
Local Authority	• Develop integrated working structure to facilitate integrated care	Work closely with the LA and Health and well being board
Acute Providers	Keep them informed of our commissioning issues. Ensure the delivery of Safe , quality services Develop a win- win working partnership	Hold regular provider events to engage them in the work of the CCG and to establish a partnership approach to local service delivery. Hold regular Clinical Quality and Risk meetings with provider Trusts.
NHS England	• To ensure we deliver the best possible health outcomes for Barnet patients by prioritising them in the decisions we make • commissioning quality services • Deliver a balanced health economy within budget	Hold regular meetings and submit the appropriate reports demonstrating our achievements.
CCG Staff	• Develop staff to ensure they are competent leaders within the commissioning process	Hold regular staff training / development events, directors will hold weekly staff meetings to ensure that staff are fully sited on the commissioning work being conducted throughout the CCG. Develop a staff news letter

V. Recovery plan

In addition to the actions identified within phases I and II, the CCG has developed a recovery plan which will focus on 'big ticket' QIPP opportunities that are required to deal with the deficit.

The table opposite summarises the anticipated impact of the CCG position; 3 years to in-year break even, 4 years to in-year business rules, and 5 years to clear legacy deficits.

As noted earlier in this report the CCG has forecast based on its existing 'run rate' and has made assumptions around demographic growth & associated cost pressures. The forecast also assumes that the 2% headroom requirement will be available to the CCG to reduce its in year deficit.

QIPP schemes with a target delivery of £17m (risk assessed from £18.9m) have been identified for FY 14. Individual QIPP schemes and targets have not yet been identified for FY15 and subsequent years.

The following pages summarise the existing QIPP plans for FY14 and the opportunity areas which will need to be explored to identify large additional savings for FY15 and beyond which will be key to the CCG's recovery.

These opportunity areas are based on initial benchmarking and experience of other CCG operations and will be investigated further to develop business cases for Board approval. The FY15 opportunities will be developed for implementation at the earliest opportunity. However, given the commissioning cycle, the majority of opportunities are unlikely to deliver savings in FY14.

In year & legacy deficit calculation

	13/14 £m	14/15 £m	15/16 £m	16/17 £m	17/18 £m
opening balance b/f		-20.9	-29.5	-24.6	-6.9
In year year surplus/(deficit)	-20.9	-8.6	4.9	17.6	29.6
Trading surplus/(deficit) c/f	-20.9	-29.5	-24.6	-6.9	22.6
2% headroom requirement	-8.3	-8.5	-8.7	-8.9	-9.1
1%/2% surplus requirement	-4.2	-8.5	-8.7	-8.9	-9.1
Surplus/(deficit) post Business rules	-33.4	-46.5	-41.9	-24.7	4.5

The transformational nature of many of the FY15 plans will involve changes in stakeholder behaviour – including acute and community providers, GP's, neighbouring CCG's and partner Local Authority organisations. The Barnet, Enfield and Haringey Clinical Strategy and the acquisition of Barnet and Chase Farm will be significant drivers for change.

These changes in stakeholder behaviour will require support and facilitation and the CCG recognises that, in many instances, this may prove challenging. The CCG will require additional resource capacity and capability in order to properly develop and implement its FY15 plans.

A number of these plans may also require initial investment in order to effect the changes required e.g. by dual running of pathways and pump priming (costs of set up) . Given the CCG's financial position it is therefore apparent that , in the absence of external support, the CCG may either be unable to progress with its transformation at pace or may result in an increased deficit position in the short term.

V. Recovery plan – CCG QIPP plans 13/14

The CCG's latest QIPP dashboard (23/04/13) shows plans of £18.9m are monitored within the PMO. A copy of the dashboard is included at Appendix 2. The net QIPP scheme savings (net after investment of £4.1m) identified for FY14 as at 23/04/13 are summarised below and described on the following pages:

	Clinical Lead	Existing Schemes	Comments		Pages
		Budget FY14 (£'000)		**Contracting**	
Children and Maternity	Dr Clare Stephens & Howard Ford	2.3m	Many of these schemes aim t achieve savings through procurement processes, tariff reductions and through a shift of activity out of the acute setting.		
Elective Care	Dr Lyndon Wagman, Dr Ahmer Farooqi and Teresa Callum	6.6m	Most of these schemes aim to achieve savings through moving services from a secondary setting into the community at lower tariffs.		
Emergency and Urgent Care	Dr Barry Subel and Beverley Wilding	1.5m	These schemes aim to achieve savings through a reduction in on sale costs and tariffs charged by the acute providers.		
Mental Health	Dr Charlotte Benjamin and Dr Ahmer Farooqi and Temmy Fasegha	0.6m	Most of this saving relates to a reduction in contract.		
Integrated Care	Dr Jonathan Lubin, Dr Deborah Frost and Karen Spooner	0.9m	These schemes aim to achieve savings through redesign of care pathways and initiatives to reduce acute admissions, and reduction of the Continuing Healthcare budget		
Other (Support Programmes)		6.9m	A majority of these savings are to come by way of contract negotiations and estates management.		
TOTAL		**18.9m**			

V. Recovery plan - Existing projects FY14

Children, Young People and Maternity (Total: £2,842k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
CAMHS Tier 3 Accepted referrals to the Generic Tier 3 service have been falling as a result of a new referral management process. Commissioners have used the CAPA model to understand demand, capacity and productivity. This indicates capacity for a significant reduction in the baseline budget.	To re-negotiate the contract for 2013/14 with a £500k reduction in the baseline contract value. Leads to reduced cost of children's mental health provision.	Demand and capacity modelling agreed with BEH MHT Trust. Contractual terms for a £500k reduction in contract value agreed and included in Heads of Terms. Contract due to be signed by 30 April 2013.	£500k	£500k
Maternity – national tariff In respect of maternity, contractual terms are being negotiated with the two largest providers, Royal Free and Barnet and Chase Farm. There is a need to agree the estimated activity and case split with the providers. There is also a recognition that PbR and loss of income should be shared between commissioner and provider.	Savings are to be achieved through a mandatory tariff change imposed by the department of health and through contract specification. 50% of the savings will be achieved in the first year. <u>Outcome of Scheme:</u> Implementation of the Maternity Pathways Tariffs by April 2013.	The nationally mandated tariff is embedded within the national contract for acute services. Contracts with the main providers of maternity services have been agreed for 2013/14.	£1.5m	£3.2m

V. Recovery plan - Existing projects FY14

Children, Young People and Maternity (Total: £2,842k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Children's SALT Procurement SaLT currently commissioned via 4 LA contracts and 1 CCG contract with same provider, and spot purchasing from smaller providers. There are significant gaps in the current provision, particularly for 12-18 year olds. There are unclear pathways for families and an inconsistent service offer to schools.	Savings are to be achieved through a procurement process to streamline the current SALT services. Outcome of scheme: A new SaLT service to be in place, managed under a single specification and contract by the CCG.	• Current service de-commissioned. • Needs assessment and service model agreed. • Joint service specification agreed. • Procurement commenced. Milestones: • 21/05/13 – Tender period closes. • 12/06/13 – Bidders present • 04/07/13 – Contract award • 01/09/13 – Service commences.	£184k	£364k
Children's elective & non elective Issue: Gaps in community service provision need to be reviewed.	• Implement triage referral management (TRM) service for paediatric referrals. • Develop validated management protocols and care pathways for GPs. • Support paediatric activity reduction and monitor demand at BCFH. Savings are to be achieved through: • Tariff reduction for community clinics. • Activity shift, acute into community clinic. • Reduction of follow up referrals to secondary care. Outcome: Improve management of children with complex needs including development of transition pathways. GP's with specialism would pick up a greater share of this work.	• GP training programme arranged. • Ongoing audit to inform service development and education. • Draft care pathways developed. • Service specification emailed to provider for feedback. Milestones: • Service specification and contract variation signed by provider. • Pathways to be signed off by all stake holder organisations. • Mainstream PIC project at Barnet. • Move triage to RMS. • Extend project to Royal Free Hospital.	£158k	£158k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Referral management (£2m) and PolCE (£197k) Barnet is a high referrer of patients into the acute setting. A referral management system (RMS) and learning through peer review (LPR) scheme already exist in Barnet. These need to be built upon and strengthened. Some referrals are of low clinical value and outside the Procedures of Limited Clinical Effectiveness policy.	Savings are to be achieved through lower acute referrals and activity being diverted to the primary care settings, through: • Ensuring gaps in knowledge or skills of the GP population are identified and addressed through LPR Programme. • Enhancement of the RMS service with greater clinical involvement. GPs are to be trained to provide triage services to ensure referrals are sent to the right service. • Practice development visits to raise awareness of local pathways. Outcomes from the schemes: • Referrals are controlled, managed and are appropriate. • GP practices utilise the referral management system as part of the demand management programme. • Patients are referred in line with care pathways. • Patients are seen more in the community setting. • A decrease in the number of incorrect or inappropriate referrals.	Progress to date: Learning through Peer Review, an educational programme for GPs moves into its second year. First meetings have already taken place. Practice Development GPs have been recruited and trained and the schedule of visits begin in May. Each practice will be visited 2,3 or 4 times, depending on how much support is needed. GPs are now triaging all referrals in eight agreed specialities, with all specialities being covered by August 2013. Key Milestones: • Introduction of GP triage at RMS (Jan 13) • Commence Practice Development Visits (Apr 13) • Increase the percentage of prospective referral review through LPR (Jul 13)	£2.356m and £197k	£2.356m and £197k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Urology Urological problems create a significant burden of work for primary care. The number of referrals to secondary care has been rising every year. With advances in diagnostics, urology becomes increasingly medicalised, offering an opportunity to reduce costs and allow treatment closer to home. An ongoing increase in the volume of referrals to local urological departments has resulted in a funding pressure. Patients can currently be seen by highly skilled urologist consultants for relatively minor conditions.	To expand the existing community service beyond continence, and relocate hormone therapy into primary care. The current specification sets out a proposed community urology service as a contract variation with CLCH. Savings are to be achieved through a shift of activity from secondary to the community. <u>Outcome:</u> • Appropriate referral process. • Improved clinical outcomes and patient experience by providing evidence-based care and ensuring patients access the most appropriate care, first time in a community setting. • Reduction in waiting times for patients. • Transfer of activity from acute to community at reduced costs.	• Ongoing engagement with CLCH • Contract funding discussion finalised with CLCH and BCF for roll out 2013/14 • Draft specification being finalised • CLCH undertaking preparatory work for roll out • GP supporting RMS for urology. <u>Milestones:</u> • Agree specification (Apr 13) • Pre-clinic assessment protocols and pathways agreed (Apr 13) • Contracts signed (Apr 13) • Staff recruited (Apr 13) • Infrastructure and equipment changes implemented (Apr 13) • Service starts (May 13) • Increase to full provision	£300k	£300k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Expand Community MSK Service Pathway A community service in place but there are further opportunities to shift additional out patient/day case activity into the service	Expansion of the current MSK community based service to include a podiatric surgery pathway. <u>Outcome:</u> Current podiatric surgery (agreed HRGs) undertaken as a day case procedure at 70% of PBR tariff within ECH	CLCH already provide the service to inner boroughs and will expand into Barnet. Appropriate HRG activity has been identified. Activity and savings identified as part of the QIPP plan 13/14 for both BCF/RFH. New pathway would be delivered via the MSK service. Scheme being scoped. <u>Milestones:</u> Pathway confirmed with CLCH/service spec BCF/RFH to confirm QIPP Plan TUPE issues resolved Contract Variation in place Advise general practice re new pathway RMS to divert all activity to MSK service	£58k	£115k
Micro-suction The current micro-suction model is not fit for purpose and doesn't offer value for money. There is a also a disparity in service provision as patients in the borough don't all have equal access. It currently costs £180 under the PBR tariff.	To streamline the patient pathway, provide care closer to home and reduce the cost of the service. Savings achieved by moving the provision of micro suction from acute to community through either local practices or alternative providers. <u>Outcome:</u> • Reduced baseline cost of service • Reducted number of patients having micro suction within ENT clinics . • 95% of patients seen in community clinic without secondary referral.	• Advice on procurement obtained from CSU and currently awaiting CCG decision. • PID has been approved. <u>Milestones:</u> • Agree service model • Develop service specification • Complete procurement • Provider to implement new service model • Release QIPP savings The timing of milestones is yet to be confirmed.	£58k	£381k

V. Recovery plan - Existing projects FY14

Elective care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Primary Care Medicines Management Prescription costs in the borough are slightly lower than the national average with a high levels of prescriptions of branded lipid lowering drugs , newer diabetes drugs; sip feeds and milk substitutes.	Medicines optimisation as an ongoing initiative. Additional schemes include appointing community dieticians to undertake targeted care homes work. Savings achieved through encouraging GPs to prescribe more cost-effective medicine alternatives, a move away from 'specials' and a reduction in wastage of medicines. <u>Outcome:</u> •Lower spend and wastage. •Cost of specials to be £200k less in 2013/14 compared to 2012/13. •Patent loss drugs to generate £1.1m of savings in 13/14 compared to 12/13 •Spend on corticosteroid inhalers to be £75k less in 13/14 compared to 12/13. •30-35% of decrease on in year drug spend on Omacor, Rosuvastatin and Ezetimibe comparing Q1 12/13 with Aug-Oct 2013	This is an ongoing initiative <u>Key Milestones:</u> •Review of branded to generic forecast savings and monthly monitoring (Apr 13 onwards) •Meet all 67 practices and agree savings areas (Apr -Sep 13). •Set practice drug budgets, monthly monitoring and feedback mechanisms (Jun - Oct 13). •Recruit paediatric dietician (Jul 13) •Development of primary care services such as FMH older people review service and LBB homes pilot homes project.	£2.2m	£2.2m

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Acute Medicines Management Issue: Prescription costs in the borough are higher than the national average in the acute setting. There is a high on cost of drugs from acute providers especially the Royal Free Hospital. Additional Pharmacist support at the CSU is required to undertake this work-proposal being debated in the 5CCGs.	This is an ongoing cost management initiative to reduce prescription costs in the acute setting, through; •pursuing bio-similar switches; • NICE audits; • Encouraging use of home care companies. •Challenging accuracy of high cost SLAM data Outcome: Lower prescription spend in acute setting	The plans are being worked up and for savings above 250k. Key Milestones: CSU bid for additional pharmacy support approved or declined 31st May 2013 Accurate information from the main acute providers (UCLH, Free and B/C) by 30th June 2013 Challenge data from the Royal Free audit re ant-tnfs and lucentus results in savings for Barnet CCG by 31st July 2013 BCF Business Case approved for improved home care service by 31st May 2013 CCU Med man team able to check high cost slam data re accuracy by 31st July 2013.	£250k	£250k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Gastro and GI Surgery Potential savings have been identified as part of a benchmarking exercise. The project is currently at scoping stage.	Using good clinical practice and guidance to redesign gastroenterology diagnostics, acute management and chronic conditions management. Quality and patient experience are maintained and improved through establishing standards and effective service models. Productivity may be improved by working with colleagues in primary and secondary care to: • Reduce morbidity, hospital admissions and unnecessary secondary care appointments for patients with long term conditions. • Provide a one stop clinic model for patients with acute conditions.	Reviewed literature and guidance from NICE and the British Society of Gastroenterology; Reviewed out patient and procedure activity data for previous 2 years; Identified key stakeholders and made contact with lead Consultants at Royal Free and Barnet and Chase Farm. <u>Milestones:</u> Confirm the primary care view of current gastro services and care pathway; Review the activity information for both out patient and procedures; Meet with Secondary Care Consultant leads and other stakeholders; Develop a Project Initiation document and present to Barnet CCG PMO group and then Barnet CCG Finance and QIPP meeting.	£110k	£110k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Ophthalmology Issues: A Community Ophthalmology service was commissioned in July 2011 for a pilot period of one year to test out the feasibility of providing such a service in a community setting. It became apparent that given the mobilisation period and time required to run a formal procurement, a year would not be long enough to properly test a new service. Therefore an extension of 18 months to the original pilot period of one year is being applied for. This extension will then be signed off on the understanding that we would go out to full procurement with a view to appointing a new provider at the end of the pilot extension in December 2013.	The scheme involves the provision of non-complex ophthalmology treatment in the community, including stable glaucoma. Objectives of the project are to: • Provide services closer to home • Bridge the gap between primary and secondary • Improve access and reduce waiting times. • Ensure referrals are appropriate • Develop common pathways of care Savings are to be achieved through lower acute activity and a shift to primary care. Outcomes of the scheme are: • Care closer to home – reduction of patients referred to secondary care • Cost benefits – services provided more economically • Better use of resources both in secondary and primary care • More responsive service to patients	Progress to date: Ophthalmology is in the middle of the procurement cycle. It is anticipated that a new provider will be appointed in August/September 13, with a start date of December 13/January 14. Milestones: • PQQ scoring by 9 May 2013 • ITT scoring by 26 June 2013 • Panel Presentation 5 July 2013	£120k	£314k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Pain Management Barnet does not have a community Pain Service. Benchmarking reviews indicate that establishing a community pain service would provide better outcomes for patients and savings through reduced acute activity.	The scheme involves the introduction of a community pain management service. This is to be done via a joint approach with Enfield CCG. Savings are to be achieved through a local tariff at 70% of PBR. <u>Outcome:</u> • Provide effective triage of pain management presentations. • Provide a multidisciplinary service that is appropriate to patients needs. • A single pain pathway for both Barnet and Enfield boroughs. • Greater self management through the Pain Management Programme.	Approval in principle from BCF to the local variation, meeting with RFH consultants being arranged Savings have been mapped into the QIPP plans for 13/14 contract negotiations Request to fund the primary care CBT programme to support the pathway – would require reinvestment . <u>Milestones:</u> BCF identify locations within primary care to provide the service Sign-off service specification with BCF Meet with RFH consultants to discuss pathway changes/opportuntiies	£60k	£60k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Diabetes Issues: In 2011 the Joint Strategic Needs Assessment (JSNA) identified that Barnet will continue to have a higher prevalence than both London and England. Barnet PCT has a higher than average follow-up ratio of Diabetes medicine outpatient appointments	To shift the care of stable patients with diabetes from secondary care into primary care in line with Healthcare for London Diabetes model Savings are anticipated through a reduction in follow-up appointments and investment within the community DSN team, and greater management of stable patients by their own GP	Progress to date: All practices with follow-up patients have been written to , feedback that at least 40% of the follow-ups could be managed in primary care. 40% of follow-up activity mapped and built into QIPP contract negotiatiions Milestones: Trust agreement to QIPP activity/cost to form part of 13/14 contracts Reinvestment additional DSN within community team Letter to GP practices to advise discharge plans Discharge of patients back to community/primary care from beg 3rd Qtr 13/14	£29k	£29k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
ENT Issues: Ear Nose and Throat has been identified by the West practice based commissioning cluster as an area that would benefit from service redesign and also one that could provide a more efficient use of resources if were provided in a community setting. Data from a pilot indicated that a community service would be able to see approximately 50% of ENT referrals. It was agreed that initially a pilot service would be set up to test some of the assumptions. The pilot period ended on the 31st March 2012 but it was agreed to extend this by 9 months to gather additional information and further develop the specification.	The ENT service will improve quality of care for patients by providing a high quality community based integrated service for ENT that is based on best practice and is clinically effective. Savings are to be achieved by shifting activity from secondary care into the community and through tariff savings on commissioning the community ENT service. A one stop shop approach should also reduce consultant to consultant referrals with only one charge for the CCG. Outcomes from the scheme include: • Reduction in secondary care referrals • More appropriate referrals • Reduced waiting times • Reduction in the number of follow up appointments • Better informed GP community in the management of simple ENT conditions	Progress to date: A joint procurement process with Enfield CCG was undertaken that resulted in the appointment of UCLH as the provider of community ENT services in Barnet and Enfield The new service started on 1st Feb and after a short ramp up phase, now covers the whole of Barnet ENT referrals. Primary care pathways have been developed between acute and primary care clinicians which will support the RMS triage process. Clinics are based at Edgware Hospital and will be available at Finchley Memorial Hospital from May 13. A potential third site may be identified later in the year near the north of the borough. Milestones: • Service Starts 1st Feb 2013 • Expanded to cover all of Barnet 1st April 2013.	£137k	£157

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Dermatology •There is a high referral rate for OP appointments (79% above national benchmark) •For 2011/12, the CCG is 2nd in country for total dermatology elective activity (197% above national benchmark). •There is under utilisation of community provider. Instead the activity is taking place in the acute setting. •There is high level of activity at acute providers for relatively minor procedures. •There are high referrals from the community provider into the acute providers. Bench marking was excluded from this Service redesign project because it was inaccurate. The reason for this was that we are a head in this area in comparison to other areas because of the way our services are configured locally. (given that we already have a community dermatology service in place) hence this is not available.	The aim of this project is to move activity away from acute providers and into community or to keep it in primary care wherever possible, ensure that our community dermatology service is equipped to see more complex patients that would otherwise be seen as day cases keeping them out of acute hospital. The pathway is to be adjusted so that the acute providers are only used for specialist treatments. Savings are to be achieved through activity shift at lower community tariffs. <u>Outcome:</u> •Patients to be treated in appropriate setting. •Reduced GP referrals •Reduce referrals to acute by 50% in year. •Enforce switch from DC to OPPROC of 80% at all acute providers. •Increase patient choice by delivering care from a greater number of locations in the borough. •100% of non-cancer referrals to go through specialist dermatologist triage.	•Full PID in place supported by a comprehensive workbook ready for implementation. • GP triage resources under review within the RMS • Dermatology pathways approved and ready for implementation as part of RMS. •Clinical audit of provider activity underway. <u>Milestones:</u> •Design service specification and confirm pathway with all key stakeholders (Apr 13). •Confirm new pathway, roll out to all necessary parties. •Make any contractual changes required to facilitate new services. •Implement regular monitoring processes to confirm adherence to referral pathway and outcomes	£328k	£328k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Cardiology Issue: Benchmarking has identified that the CCG has higher than average cardiology GPs and consultant to consultant referrals. The Royal Free Hospital (RFH) provide a community cardiology service for patients in the South with the north being provided via Primary Heart Care (now decommissioned). This decommissioning has left a gap in service delivery and creates inequalities in the delivery of Cardiology services in Barnet.	The target is for RFH to provide all services via a contract variation. Savings are to be achieved through a contract variation with RFH and a shift of activity from acute to community services, as well as reduced referrals. Outcome of scheme: • Expansion of the existing community cardiology services provided by the RFH to patients in the west and the north localities to fill the gap left by the Primary Heart Care Service. • A reduction of referrals to acute providers and a decrease in inappropriate referrals. • Care closer to home with improved patient experience. • To reduce Royal Free cardiology follow-up ratios and bring it back in line with national benchmarking average .	Progress to date: The implementation of the scheme has already began. The community service has been rolled out across all of Barnet in the week commencing 15 April 2013. A new community clinic is due to open in Finchley Memorial Hospital in the week commencing 22 April 2013. Milestones: • Local Tariff Negotiated and agreed • Business case approved • Revised Service Specification Drafted • Contract with Royal Free signed All of the above by end of Feb 13 • Project Phase 1 - Activity Ramp Up Start (Qtr 1) (April 13). • Project Evaluation (31 Jan 14)	£63k	£73k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Evidence based pathology Issue: Current practice is resulting in the ordering of duplicate, redundant, and otherwise unnecessary diagnostic tests from providers.	Outcome: To develop evidence based standard templates for commonly requested screens. These will include thresholds for retesting as well as the cost of each test listed. This will ensure all test requests are clinically appropriate. It will also provide GPs with information around the cost of all tests, which will influence the volume and sequencing of requests. Additionally, the full use of an electronic system means that processing of specimens at the lab will be increase the speed at which requests and results are processed, avoid "lost" specimen, and, more critically, mean that information is passed directly between clinical systems, improving clinical governance processes.	Progress to date: • A series of templates have been developed in partnership with the B&C clinical lead for pathology, Enfield CCG and Hertfordshire CCG GPs. These have now been loaded onto the TQuest system. •Roll-Out of TQUEST to North and West Barnet localities undertaken by BCF, 95% coverage in these localities; •Early implementers for South locality ID'd; •Lessons Captured from N + W Roll-Out •Logistics for S Roll-Out Captured Milestones: •Confirmation of Resourcing of South locality roll-out to be provided •PID due for submission to PMO 13/05/2013 •Roll-Out to Early Implementers; •Roll-Out to rest of South Locality; •End User Training & Awareness Events to take place.	£180k	£180k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Patient Navigator Issue: • Lack of robustness around the level of reduction we could expect to see in follow up appointments in each speciality. (which is likely to differ from specialty to specialty) • Difficulty in quantifying savings and potential costs. (see above) • Reluctance in acute trusts to take this forward without clarity in the above.	Outcome: In partnership with Enfield CCG we have agreed to tackle this specialty by specialty with a consultant and lead GP working through two virtual clinics to agree when it is appropriate to discharge back to primary care without additional follow up. We believe this will • Enable GPs to challenge the consultants in terms of the level of support general practice can provide. • Providing real examples for discussion with GPs, to get their buy in as to what can be discharged back to them. • Provide robust evidence around new to follow up rates that can be built into contracts for next year when the scheme is embedded. • Improve relationships between GPs and acute colleagues, working together.	Progress to date: Four initial specialities identified with a lead consultant and GP for each. Milestones: To have assessed the viability of this scheme in the initial four specialties by end of May.	£165k	£530k

V. Recovery plan - Existing projects FY14

Emergency and urgent care (Total: £1,500k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Urgent Care Centre Implementation of a UCC at Barnet Hospital is a requirement of the BEH clinical strategy. Patients with primary care/minor injuries will be seen within the UCC at a Band 5 tariff that will include near patient testing diagnostics	The UCC model is already operating as a pilot at Barnet Hospital – GP led, 9-9 7 days a week. Savings are to be achieved through a redirection of activity through the urgent care centre for primary care/minor injury cases. These patients would be paid for at a Band 5 Tariff <u>Outcome:</u> The target is for c40% of lower band patients to be seen in the urgent care centre.	The contract with Barnet and Chase Farm is currently under negotiation with a target to finalise by the end of April 2013. • BH UCC Service specification is complete, with BCF to finalise • Participate in interviews for long term GP provider of UCC • Contract monitoring arrangements agreed	£300k	£300k
High cost drugs and pathology Excluded drugs should be charged at the acquisition cost. Where price reductions are achieved in year through local and London wide negotiations these reduced costs should be passed onto the commissioner. As part of recent discussions with NICE a national price reduction has been agreed for LUCENTIS. There are other drugs used at RFH where the charge is significantly above acquisition cost.	The scheme relates to contracting negotiations in place to reduce the on-cost for drugs to the CCG. <u>Outcome:</u> A renegotiation of costs with providers as part of the 2013/14 contract round, releasing resources to address the CCGs financial position	Included as part of Contract offer to RFH sent April 18th Final figure to be agreed by RFH but agreement in principle has been obtained <u>Milestones:</u> Head of Terms signed May 2013 Contract signed June 2013	£1.2m	£1.2m

V. Recovery plan - Existing projects FY14

Mental Health and Learning Disabilities (Total: £625k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Mental health contract - growth reduction The CCG is developing a mental health commissioning strategy to inform mental health commissioning going forward and improve efficiency and Value for Money. The 2013/14Contract with BEH mental health trust (BEH MHT) is being renegotiated.	Savings have been achieved by not passing on growth funding (£660k) to BEH MHT in the current contract negotiation. This will drive improvements in the Value for Money and efficiency of the contract.	Contract negotiations are currently under way.	£625k	£625k
Alcohol related illness Barnet has the highest prevalence estimates of binge and dependant drinkers in NCL (ONS, 2011). It saw an increase of **9%** in alcohol-specific and alcohol-related admissions to hospital in 11/12. Alcohol related disorder accounts for three of ten local community issues of concern Safer Neighbourhood Team (SNT) ward data.	Develop provision of evidenced-based brief interventions in Acute and Primary Care settings, and develop the existing hospital liaison service for alcohol users. Savings are predominantly to be achieved through reducing alcohol related acute admissions. Outcome of the schemes are to: • Reduce alcohol related admissions and re-admissions to hospital. • Reduce of alcohol-related bed days. • Reduce ambulance repeat call-outs. • Reduce alcohol related offending/re-offending.	• New Alcohol Treatment care pathway agreed. Single Point of Contact (phone number) costed. Recruitment awaiting funding assurance Training in development Key Milestones: • Recruitment for alcohol liaison workers • Training for GP surgeries formulated and scheduled for delivery . • Hospital training scheduled for delivery • Single Point of Contact established and advertised • Initial cohort of most frequent hospital attendees identified and in placed in supported assertive services.	£1k	TBA

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Dementia Issues: •Barnet has a fast aging population. •At present no specific memory service. •GP's refer patients to Old Age Psychiatry where they are assessed and a diagnosis is made. Referral data shows an increase in referrals. •Treatment is given and monitored by a nurse led memory treatment clinic. There are long waits for treatment and the memory assessment service is close to capacity. The project will support the development of a dementia hub in Barnet. The hub will integrate a network of key services and support provision for people with dementia and their carers. It will include the memory assessment service, a new dementia adviser service, and dementia café; along with the existing service provided by Barnet Alzheimers society. This is a joint project with the local authority.	The aim of the memory service is to deliver early diagnosis and intervention for people with mild to moderate dementia, which is estimated to be approximately 87.5% of people with dementia The scheme is to establish a multi-disciplinary memory assessment clinic. Patients ate to be referred to the memory clinic and placed on a dementia pathway. Savings are to achieved through: a reduction in activity and a shift of activity away from acute setting. Outcome: •Capacity to provide high quality early diagnosis and intervention for suspected Dementia sufferers. •Increase in early diagnosis from 57% to 69% over 5 years. •Early diagnosis to reduce institutionalisation, care home placements and acute emergency admissions.	Progress to date: •Wide Stakeholder consultation •Regular meetings BEHMHT •BEHMHT have submitted the business case and costings •Specification drafted •GP consultation commenced •Dementia café procurement completed (LBB) •S256 bid submitted for dementia advisor support •Project manager recruited Key Milestones: •Develop final specification (April 2013) •Agree delivery and location options (May 2013) •Determine contracting route (May 2013) •Review options for follow up in primary care (May 2013) •Procurement or agree contract with MH trust (May 2013) •Roll out and initial monitoring of KPIs (Jul-Dec 13)	£186k	**£379k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Comprehensive Falls System Issues: •Barnet has a substantial population of elderly people with a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. •Falls services is fragmented, with no clear pathway. •Falls usually result in the need for long term care, and impact the whole system (making it one of the key priorities for any health and social care economy).	The objective of the scheme is to reduce the number of falls, and falls related admissions by bringing together a multi-disciplinary, multi-agency team. A redesign of the falls pathway is to include multi-disciplinary input. The scheme will also address gaps in service and ensure compliance with best practice. The scheme will also build a system for early identification of patients and strengthen the prevention and self care pathway, and being more innovative in the use of community services. Savings achieved through a reduction in falls thus reducing acute activity, and falls related admissions to care homes. This is a joint project with the local authority. Outcome: Reduce number of falls and falls related admissions.	Progress to date • Wide stakeholder engagement • Steering group established • A series of workshops with stakeholders • Design and impact assessment of new falls system completed • S256 bid submitted for a falls co-ordinator • Additional resource (short-term) to support next steps identified Key Milestones: • Design service specification and confirm pathway with all key stakeholders (April 13). • Make any contractual changes required to facilitate new services (May 13). • Hold training sessions for falls champions (May 13). • Implement contractual obligations and CQINS to ensure this becomes a key deliverable and to ensure compliance from organisations (June 13). • Roll out by phase (June onwards)	£82k	**£109k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Stroke prevention and Intermediary care Issues: • Atrial fibrillation (AF) accounts for 14% of all strokes. Optimum management could reduce risk by 10% in population . • Traditional stroke care pathway includes acute and rehabilitation care in the hospital setting. • There is limited capacity of stroke-specific community rehabilitation services in Barnet. • There is not a comprehensive auditable system for stroke reviews in Barnet.	The stroke related schemes aim to increase provision of intermediate care and target a reduction of risk through early intervention and regular reviews, to maximise functionality and prevent a secondary stroke. Savings are to be achieved through reduced stroke activity and shift of activity away from acute setting. Outcome: An increase in the provision of specialist intermediate care/rehab for stroke patients including early supported discharge reducing acute activity. A formal review process resulting in better outcomes for patients. An increase in the recorded prevalence of AF and the proportion of patients with AF on anticoagulation across the sector. To be achieved through: •Integrating the GRASP AF- tool into each GP practice. •Opportunistic screening initiatives at GP practices. •Provide all practices with knowledge of, and access to, appropriate local anticoagulation pathways.	• Wide stakeholder engagement • Bid for S256 funding to LBB to part fund stroke reviews • Agreed mix of staff required for new ESD/Intermediate care team • Review of best practice in delivering stroke reviews • Project manager recruited Key Milestones: Stroke Intermediate care: • Advertise & train new staff (May/June 13) • Roll out of new service & KPIs (July 13) Stroke Prevention: • Training of GPs to use GRASP tool and agree contract with GPs (May/June 13). • Roll out and initial monitoring of KPIs (Jul-Nov 13). Stroke reviews • Agree delivery options and procurement route June/July 2013 • Develop specification and job roles June/July 2013 • negotiation Contract variation August 2013 • Service initiation 1 October 2013	£56k	**£74k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Older peoples Integrated Care (Admissions Avoidance – Phase 2) The frail elderly group within Barnet represent significant financial cost to both health and social care budgets. •Barnet's elderly population is expected to increase by 20% over the next decade, placing increasingly severe pressure on both health and social care services. 60% of unplanned admissions costs in FY1 1/12 were for those aged 65 and over, costing £39.7m. •The current care pathway delivered to people with long term conditions within Barnet is not sustainable in the face of the projected future level of need	This project forms part of the Health and Social Care Integration Programme and aims to implement proposals to improve elements of the existing Frail and Elderly service in Barnet. These interventions are aimed at improving the outcomes of service users within this care group. They are designed to create access to better; more integrated care within the community and lead to a reduction of elderly admissions to hospital and residential care (reduce the need for care packages) Outcome: •Prevent unnecessary A&E attendances and unplanned hospital admissions •Optimise individual patient's health status •Optimise individual patient's social care support •Prevent or delay elderly admissions to residential care •Empower patients to self-care and manage their condition •Improve the patient's experience	• Wide stakeholder engagement including establishment of a provider network • Integration board set up and memorandum of understanding signed • Review of best practice in delivering integrated care • Successful procurement of risk stratification tool • Framework for working model agreed including MDT structure • Project manager recruited Key Milestones: Risk stratification: • Training for GPs on risk stratification tool (May 13) • Roll out new service and KPIs (June 13) Care navigators: • Recruitments underway for care navigators and case managers (May/June 13). • Roll out and initial monitoring of KPIs (July 13). Multi-disciplinary MDT • Weekly MDT in place for complex patients (July 2013) • Establish frailty clinic at FMH (Q3 2013-14)	£120k	£528k

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Continuing Care Issue: There Is a need to manage the ongoing costs of continuing care (CC). The CCG have determined a £500k savings target against budget for the CC department. This will need to be delivered through focused operational management.	The QIPP target relates to an ongoing operational savings target for the continuing care department. The team intend to deliver the savings target against budget through tight operational management of costs, particularly focusing on high cost packages of care to ensure that the quality of care is maintained at more efficient prices. The budget will be compared to financial outturn on a monthly basis to identify areas of cost pressure. Specific action plans will then be formulated to address these cost pressures. To manage CC costs there are regular reviews into the eligibility and support needs of patients. Part of this function is to be carried out by community matrons and review nurses.	Progress to date: This is an ongoing process and therefore spend is measured against budget on a monthly basis.	£500k	£500k

V. Recovery plan - Existing projects FY14

Supporting Programmes: Estates Management (Total: £1,102k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
The CCG has a potential liability of c.£3.8m in association with the estate that transfers from Barnet PCT to NHS Property Services Ltd (NHS PS), Community Health Partnerships Ltd (CHP) or Central London Community Healthcare NHS Trust (CLCH). Financial liabilities essentially take two similar, but distinct, forms. •responsibility for the payment of rents on areas within CHP and NHS PS properties which are untenanted (vacant/void); and •responsibility for the payment of rent on areas within CHP and NHS PS properties which can be booked on a sessional basis.	The CCG has identified 9 work streams to mitigate the potential liability: •Manage the Sessional/Bookable Space •Relocate Services in Buildings Transferring to CLCH •Understand & Challenge Accommodation Charges •Project Manage NHS Property Services •Work with NHS Property Services on Disposals •Challenge the CCG's Accommodation Charges •Actively Manage the Whole Estate •Make Representation over Rental Income •Fitness for Purpose of Estate	<u>Progress to date:</u> The CCG has undertaken a detailed review of the Barnet estate with details of who occupies what space and full breakdowns of costs for all areas. From this the CCG has prepared a mitigation plan outlining work plans and business cases for each of the identified work streams and will be seeking formal FPQ committee approval for this strategy on 16 May <u>Major Milestones:</u> •31st May – Sessional Booking & Invoicing procedures in place to secure incomes (interim) •30th August – Strategic Estates Plan in place with longer-term restructuring planning to be undertaken with NHS PS	£1,102k	£2,100k

V. Recovery plan – FY15 and onwards

Further areas identified for investigation to deliver QIPP savings for FY15 and beyond are shown below and described on the following pages:

	New Opportunities FY15 and onwards	Benchmarked Potential Opportunity
		£'000
Health and Wellbeing		
Children and Maternity	• Maternity national tariff (Full year 3impact from FY14) • Paediatric assessment units	£1,800k
Elective Care	• Cardiology • Outpatients • Excess bed days	2014/15 £12,545k 2015/16 £5,979k Total £18,524k
Emergency and Urgent Care	• Ambulatory emergency care • Excess bed days • Care homes • Ambulance service • Decommissioning of specific services • Integrated assessment services • Clinical navigator	2014/15 £5,814k 2015/16 £4,375k Total £10,819k
Mental Health	• The RAID model	Only excess bed days identified as an opportunity within the original business case. Further work required to confirm savings
Integrated care	• Integrated Care programme for the frail elderly and people with long term conditions to reduce costs associated with secondary care admissions and residential care	This is required to deliver the savings above
Other	• Estates rationalisation (Full year impact from FY14)	2014/15 £2,100k
TOTAL		**2014/15 £20,159k** **2015/16 £12,454k** **Total £32,613k** **Three year total £49,663k**

V. Recovery plan - Projects for FY15

Children, Young People and Maternity

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Maternity – national tariff Issue: In respect of maternity, contractual terms are being negotiated with the two largest providers, Royal Free and Barnet and Chase Farm. There is a need to agree the estimated activity and case split with the providers. There is also a recognition that PbR and loss of income should be shared between commissioner and provider.	Second year of savings are to be achieved through a mandatory tariff change imposed by the Department of Health and through contract specification. Outcome of Scheme: Implementation of the Maternity Pathways Tariffs by April 2013.	The nationally mandated tariff is embedded within the national contract for acute services. Contracts with the main providers of maternity services have been agreed for 2013/14	£3.2m

V. Recovery plan - Projects for FY15

Children, Young People and Maternity

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Children's services- Non Elective The volume of outpatient appointments has been addressed through a triaging service. Inpatient non elective admissions are above the national average and will be addresses through the development of a paediatric assessment model and a range of community based services.	A review as taken place as part of the BEH clinical strategy, on the paediatric pathway. It has recommended the implementation of Paediatric Assessment Units (PAU) at both Chase Farm and Barnet hospitals. The primary benefits of this service are the quality of care received on a defined and appropriate pathway in the right setting. It is expected that assessment tariffs will be applied to the PAU pathway. There a number of community paediatrics projects which have commenced which include: • Triage of GP referrals by paediatric consultant • Community Ambulatory Care Service • Telephone advice for primary care, schools and local authorities • Rapid access	The current work includes determination of the staffing requirements and the clinical pathways for the PAU. The implementation date for the BEH strategy is November 2013. A paper which sets out the direction of travel for Barnet paediatric pathways is being drafted and stakeholders engaged in the proposed models. The triage service has commenced and forms part of the FY14 QIPP plans. The ambulatory care service is being introduced and should as it scales up, receive patients from urgent care, primary care and the community. Upon agreement of the direction of travel and formal project plan, activity benefits realisation will be developed.	Reduction in tariff for PAU Reduction in tariff (70%) Community Ambulatory Care Service.

V. Recovery plan - Projects for FY15

Elective Care QIPP 2014/15 and 2015/16

The table outlines where there is scope to reduce costs, identified through a national and peer group benchmarking exercise. These have been risk adjusted by 20%.

We intend to deliver these through a collaborative approach with our two main acute provider trusts and have already begun this work with them and agreed a shared approach.

The drivers behind this are the needs to reduce the commissioning spend of Barnet CCG, as well as the requirement to significantly reduce acute activity as part of the BEH clinical strategy.

The proposed merger of Barnet and Chase Farm and the Royal Free Hospitals will also support collaborative working and shared protocols as well as reduced activity.

In Patient Elective Admissions	Potential Savings	Risk Adjustment at 20%	Total Risk Adjusted Savings	Risk adjusted savings 14/15	Risk adjusted savings 15/16
Childhood and neonates	£668.00	£133.60	£534.40		£534.40
Female Reproductive System and assisted reproduction	£688.00	£137.60	£550.40	£550.40	
Mouth Head Neck and Ears	£1,219.00	£243.80	£975.20		£975.20
Vascular System	£1,188.00	£237.60	£950.40	£950.40	
Skin Breast and Burns	£1,646.00	£329.20	£1,316.80	£1,316.80	
Total Elective	**£5,409.00**	**£1,081.80**	**£4,327.20**	**£2,817.60**	**£1,509.60**
Outpatient Attendances					
Cardiology	£4,432.00	£886.40	£3,545.60	£3,545.60	
Clinical Haematology	£437.00	£87.40	£349.60		£349.60
Clinical Ocology	£912.00	£182.40	£729.60		£729.60
Dermatology	£860.00	£172.00	£688.00	£688.00	
ENT	£753.00	£150.60	£602.40	£1,201.40	
Gastroenterology	£1,502.00	£300.40	£1,201.60	£1,201.60	
Medical Oncology	£742.00	£148.40	£593.60		£593.60
Midwife Episode and obstetrics*	£1,600.00	£160.00	£1,440.00	£1,440.00	
Nephrology	£1,324.00	£264.80	£1,059.20		£1,059.20
Ophthalmology	£1,389.00	£277.80	£1,111.20		£1,111.20
Paediatrics	£690.00	£138.00	£552.00	£552.00	
Respiratory Medicine	£783.00	£156.60	£626.40		£626.40
Rheumatology	£1,374.00	£274.80	£1,099.20	£1,099.20	
Total Out patient attendances	**£16,798.00**	**£3,199.60**	**£13,598.40**	**£9,727.80**	**£4,469.60**
Total Potential QIPP Elective and Outpatient Attendances			**£17,925.60**	**£12,545.40**	**£5,979.20**

* Savings quoted for maternity and obstetrics reflect impact of new national tariff and are risk adjusted at 10% as opposed to 20%

The work with Barnet and Chase Farm and the Royal Free has already begun through a series of workshops looking at service redesign and identifying key features of success. Agreement following this was that these would be

- Robust primary protocols in place, rigorously enforced
- Single point of access
- Most senior clinician at the front end, ensuring that triage was effective
- One stop shop services where possible.

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Cardiology Issue: Benchmarking has identified that the CCG has higher than average cardiology GPs and consultant to consultant referrals. Although there is to be a shift of activity from the acute providers to a community service in FY13, approximately 50% of patients still require referral into the acute trust. BCFHT currently charge, in addition to the outpatient tariff, a Consultant to Consultant referral charge for each diagnostic test, with over one hour's time lapse.	The following options could be used to address the issue of charging for individual diagnostics at Consultant to Consultant rates: 1. Negotiate an integrated assessment process from the Trust which includes all investigations at a lower cost than the existing arrangements [cost from Paul] 2. Use an alternative provider to provide the cardiology service, to include diagnostics at a lower cost. The community hospitals could be used as the setting to deliver the service. 3. The Referral Management System could be used to approve the additional diagnostic tests, however this would not be a streamlined solution.	Milestones: • Obtain comparative rates for diagnostic tests and determine the potential savings. • Research and propose a list of viable options for re-providing or renegotiating the service. • Complete an options appraisal process and present paper to the Board. • Complete Business Case for service change and dependant upon the outcome: - Draft revised Service Specification - Agree with the acute the tariff for an integrated service and serve notice and implement or - Tender and award new service contract to an alternative provider.	

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings

Outpatients
Issues:
There is a high volume/cost of for OP appointments in a number of specialties, the key areas are:
• Cardiology
• Nephrology
• Rheumatology
• Ophthalmology
• Respiratory medicine
• Gastroenterology
 	
The gross opportunity to make savings is:
£6,250k to national average
£9,353k to Upper 20th centile
	• In order to understand the issues and the activity which have impacted on the benchmark data is to be reviewed:
	  • First Outpatient appointment
	  • Follow up
	  • Consultant to consultant referral
	• Clinical conversations will then take place to agree the appropriate settings and treatments:
	  • Is the follow up required at all?
	  • Can it be provided in a primary or community care setting rather than the acute?
	• Determine what will be required to be commissioned in an alternative setting and how it could be delivered.
	• Where community services such as MSK are in place, in receipt of the drilled down benchmarking data, a review of the current service will take place, if required.
		Milestones:
		• Design service specification and confirm pathway with all key stakeholders for each area.
		• Confirm new pathway, roll out to all necessary parties.
		• Make any contractual changes required to facilitate new services.
		• Implement regular monitoring processes to confirm adherence to referral pathway and outcomes
			OP new
			OP follow up
			C2C referrals

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Excess bed days The excess bed day costs for elective inpatient stays in Barnet CCG is £892,000 which ranks Barnet CCG 70th nationally.	In order to understand the specialties and HRGs which have impacted upon the excess bed day costs, the CCG Trust data requires detailed analysis to determine the reasons for the excess bed days Discussions will then be held with the acute trusts, specialty leads and community services, if required to agree an action plan put in place processes to reduce length of stay e.g. • Reduce pre-operative bed day admissions • Effectively utilise EDD to manage patients through the elective pathway • Co-ordination of discharge processes	Milestones: • Review data set • Highlight areas for further review and investigation • Agree action plan on a specialty basis • Monitor implementation of plan and maintain exception reporting process	In patient elective admissions

V. Recovery plan - Projects for FY15

Emergency and Urgent Care QIPP 2014/15 and 2015/16

The table outlines where there is scope to reduce non-elective costs, identified through a national and peer group benchmarking exercise. These costs have been risk adjusted.

We intend to deliver these through a collaborative approach with our two main acute provider trusts and have already begun initial work with them by agreeing a shared approach to service redesign:

- Single point of access
- Most senior clinician at the front of service, ensuring effective triage
- One Stop shop where appropriate
- Robust primary protocols in place, rigorously enforced

The drivers behind this are the need to reduce the commissioning spend of Barnet CCG, as well as the requirement to significantly reduce acute activity as part of the BEH clinical strategy.

In Patient non-elective Admissions	Potential Savings	Risk Adjustment at 20%	Risk Adjustment at 10%	Total Risk Adjusted Savings	Risk adjusted savings 14/15	Risk adjusted savings 15/16
Female Reproductive System and assisted reproduction	430	86		344	172	172
Obstetrics *	1600		160	1440	1440	
Respiratory	2660	532		2128	1064	1064
Total non-Elective	4690	938	160	3912	2676	1236
Length of Stay						
length of stay - proportion of all inpatient non-elective 0 days	3,308	661.6		2646.4	1323.2	1323.2
Total admissions 0 day in-patient admissions from A&E	2,787	557.4		2229.6	1114.8	1114.8
	6095	1219		4876	2438	2438
Total Potential QIPP Non-Elective inpatient admissions				8788	5114	3674

*New National Tariff - Maternity**

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Ambulatory Emergency Care (AEC) The benchmarking data shows Barnet CCG as an outlier for the proportion of inpatients who have a zero length of stay. The gross opportunity to make savings is: £3.3m to national average £7.8m to Upper 20th centile In addition, the CCG spends £29m on 0-2 day length of stay for patients > 65 years old.	Further develop to an 'industrial scale', the emergency ambulatory approaches for the 49 AEC clinical conditions. The scheme will increase the number of appropriate discharges from emergency departments; and secondly, where this is not possible, to increase the number of emergency admissions that have a zero day length-of-stay. Utilisation of the Best Practice tariff for a range of conditions is to be considered and appropriate tariffs commissioned. However, an opportunity exists to consider how these can be further improved to: a) provide alternative non-bed based pathways to deflect such activity; and b) extend / expand the number of areas / HRGs currently being considered.	Develop a business case to address the progress to date and the potential opportunities to develop further AEC pathways. An example of the key milestones is shown in the appendix.	Non elective inpatient admissions 0-2 days > 65 years
Excess bed days The non- elective excess bed day costs for Barnet CCG are £2,802,000	A review is required to understand the reasons for incurring excess bed day costs. Part of the investigation into costs will examine how patients move into the community setting from acute, the delays in transfers of care, including gaps in services, social care delays and equipment requirements.	Carry out audits of the reasons for delay in the discharge of those patients that are medically fit for discharge. Review data, ascertain the gaps in service or other capacity issues in community, primary or local authority.	Non- elective inpatient admission costs

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Other Urgent Care initiatives to be considered: **Development of Integrated Assessment Services**	The establishment of a combined primary and acute led service at the front of A&E to provide a rapid assessment of all walking patients prior to them presenting at A&E. The service has the potential to result in reduced A&E attendances and short stay admissions by diverting any inappropriate attendances to alternative services. Utilising GPs to support junior doctors as part of the A&E team could increase the level of early discharges from A&E.		Non elective attendances and admissions
Excess bed days	Due to the nature of PbR reporting, proactive discharge management is required . Working with the acute trusts, an audit can be carried out determine the reasons for being an inpatient and gaps in services in primary and community care can be identified and addressed. Daily reports from the acute trusts detailing all patients with over 20 days length of stay and discharge status can be utilised by the discharge teams to proactively manage these patients home. This cohort of patients normally accounts for 75%-80%+ of the excess bed day costs. In year savings may be possible from addressing this issue	• .Agree the areas which need improvement and agree a plan of action. • Commence daily reporting for the agreed cohort of patients and align the discharge teams to focus on these patients. • Monitor weekly and report monthly on progress.	

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Ambulance Service The cost of the ambulance service contract is c £10m. Currently there is no visibility of contract, but it appears to be based on last year's activity and there is a lack of influence over the commissioning criteria.	In order to reduce the number of ambulance conveyances to the acute trust, there are a variety of services which could be discussed and can be commissioned from LAS. Some options are: • Hear and treat • See, treat and refer • See, treat and convey	• Understand the current contract with LAS • Review the conveyancing rates and develop a case for locally agreed service specifications • Detail the commissioning contract including performance metrics	Non elective attendances Non elective admissions
Decommission services Given the CCG's budgetary constraints, services are to be reviewed to determine the viability of the service. Community provision and other supply side services will be reviewed.	Approximately £4m is spent on Walk In Centres. These centres will be reviewed to determine the level of duplication or substitution of services, particularly with Primary Care. If the outcome of the review is case to decommission a walk in centre, formal consultation will.be required.	• Carry out a review of the activity in the walk in centres to determine the nature and primary care practice of the patients • Work with primary care to agree the reasons for attendance at the walk in centres rather than general practice • Model the changes to patient behaviour a walk in centre is closed • Carry out Equality Impact assessment and write business case for change • Commence consultation process	Community costs

V. Recovery plan - Projects for FY15

Mental Health and Learning Disabilities

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
The RAID Model BCFH have busy Accident & Emergency Departments with more than 110,000 presentations per year and 40,000 admissions. Roughly 1,400 (1.3%) of these present with explicit mental health problems such as depression or self-harm. There is a trend across the country for more patients to present to A & E with mental health problems as open access mental health centres close due to financial pressures and changes in commissioning. Mental health patients can present significant problems for A & E staff because: · Staff lacking appropriate experience, skills and training · Health system processes are focussed on physical health patients	RAID is a Rapid Assessment Interface and Discharge psychiatry liaison service. An effective liaison psychiatry service offers the prospect of saving money as well as improving health. RAID is a service which offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The analysis of cost savings of RAID focuses on the ability of the service to promote quicker discharge from hospital and fewer re-admissions, resulting in reduced numbers of in-patient bed-days. Most of these savings come from reduced bed use among elderly patients. The service also offers some potential savings in addition to reductions in bed use, such as fewer discharges of elderly patients to institutional care rather than their own homes. The study also stated that there are possible benefits in admissions avoidance with over 40% of all referrals to the RAID service during the study period came from A&E and it is possible that interventions by the service at this point may have prevented some in-patient admissions.	• Provider to Provider discussions between BEHMHT and BCFH have been taking place and BEHMHT has developed an initial business case for mental health liaison in Barnet General and Chase Farm hospitals. • Set up stakeholder meeting with all partners impacted by the proposed service (May/June) • Determine the impact, both costs and savings by partner and propose a way forward • Obtain agreement to fund and pilot the RAID model	Reduction in length of stay Admissions avoidance - reduction in non elective admissions **(cont)**

V. Recovery plan - Projects for FY15

Mental Health and Learning Disabilities

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
The RAID Model	There may also have been a 'RAID-influence' effect, associated with the training of A&E staff by the RAID team. However, no information has been collected on such diversion at this point of entry into the hospital. Based on LSE savings identified for City hospital Birmingham, the RAID model could potentially deliver savings to the health economy in the range of £3.4 - £9.5m for BCF hospital patients. Most of these savings would come from reduced bed days from the elderly. The report also suggests a costs benefit ratio of more than 4:1.		

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones 13-14 or 14-15	FY15 Potential Savings
Integrated Care •Elderly population is set to increase significantly over the next 10 years •Older people are more likely to be admitted to hospital following an A&E attendance •Older people are more likely to suffer from chronic and long-term conditions, mental health issues, fractures and falls •There is a high frail and elderly population utilising urgent care within Barnet. The CCG spent £29m on non elective admissions of patients over 65 years old, £22.6m of which was for patients over 75 years old.	The aim is to integrate Health and Social Care in a Care Outside of Hospital model to deliver the frail and elderly pathway and better manage long term conditions. The model will focus on: •Admissions avoidance •Proactive care of 'at risk' populations •Crisis intervention. The health and social care model is currently being rolled out within Barnet with some services operational and others planned for 13-14. The services will require ramping up, converting to 24/7 where necessary and to become fully integrated health and social care teams with a single point of access. <u>Outcome:</u> •Rapid response to prevent admission •Case management of most 'at risk' •Optimal LTC case management •Reduction in A&E attendance, admissions and nursing/residential home spend	Programme includes: •Rapid response service in place (to be extended) (Q1 13-14) •Risk stratification tool implemented in practices (Q1 13-14) •Care navigators and case managers in place to identify and manage patients 'at risk' (Q2 13-14) •Weekly MDT in place for complex patients (Q2 13-14) •Establish a multi-disciplinary frailty clinic at FMH (Q3 13-14) •Development of Integrated locality team incorporating health and social care (13-14) •Comprehensive falls service (Q2 13-14) •Stroke prevention and intermediate care (Q2-3 13-14) •Dementia hub planned (Q2-3 13-14) •Establish robust older peoples assessment at Barnet A&E (13-14) •Review current community palliative care pathway including link to enablement (13-14)	Non elective in-patient attendances Non elective inpatient admissions

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Integrated Care (continued)	•Improved quality of life and independence •Provision for care closer to home	•Establish Advance Care Planning across all care agencies, including primary care (13-14) •Care Homes pilot scheme underway building on 'My Home Life' (started May 2013) •Develop single point of access to integrated locality teams (14-15) •Review discharge arrangements from secondary care into community and link to integrated pathways (14-15) •Strengthen self-management programmes and primary care management of LTC and ambulatory care pathways (14-15)	

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Community Hospitals	A review of the form and function of community hospitals to ensure that value for money and efficiencies are being achieved in relation to integrated care model. To include: •A review , with the acute trusts, of utilisation of the community hospital as a step down facility for those patients that are medically stable but have a long length of stay •A review of how any additional capacity can be used to enhance the care outside of hospital strategy. •A review of the functions and opportunities related to the on-site GP surgery/OOH/pharmacy and diagnostics in relation to the integrated care model	To be scoped and options appraisal carried out.	Non elective excess bed days A&E attendances Non elective admissions

V. Recovery plan - Projects for FY15

Supporting Work Programmes

Contract Negotiation and Management

CCG Lead: Steve Hobbs (Chief Financial Officer) **Clinical Lead: Dr Subel, Dr Frost and Dr Wagman**

The CCG contract negotiations for FY13/14 with its main providers, supported by the CSU, commenced with an offer of c.£196.8m, some £16.7m lower than the FY12/13 forecast out-turn.

Of this contract reduction £6.7m is related to productivity metrics for:

- A&E Conversion ratio;
- Daycase to Outpatient ratio;
- Consultant to Consultant referral rate; and
- First to Follow Up ratio.

Activity with the acute providers is seen by the CCG as the primary opportunity for QIPP. Whilst part of the QIPP opportunity results from providing alternative provision, and therefore reducing activity , a large part of the opportunity presents itself through improving the negotiation of provider contracts (of which the acute providers are the largest element) and effectively managing the contracts, and agreed metrics, following agreement. In particular it is looking to Support Trusts to achieve better procurement to deliver commissioner and provider savings including non-tariff drugs whilst:

- Using contract levers to drive quality improvement including incentives/penalties whilst maintaining focus on provider performance to ensure achievement of national & local KPIs.
- Further developing & implementing effective QIPP, CQUIN & productivity metric programs to drive service improvement through the use of appropriate ratios to manage patient pathways, including outpatient contacts
- Developing challenges to support fair reimbursement to providers for high quality patient pathways, including avoiding inappropriate acute admission.
- Monitoring delivery of the productivity and QIPP challenges through the PMO

In negotiating acute provider contracts the CCG is the contract lead for the Royal Free, CLCH and RNOH Contracts with other CCGs leading with its remaining providers.

The ‘cluster’ negotiation of contracts is a challenge for the CCG given its financial position which drives a need for greater opportunities to be delivered from its contracting arrangements. As a result the CCG is seeking to drive robust collaborative contracting arrangements agreed with local CCGs and supported by the CSU.

V. Recovery plan - Projects for FY15

Supporting Work Programmes

Contract Negotiation and Management

CCG Lead: Steve Hobbs (Chief Financial Officer) **Clinical Lead: Dr Subel, Dr Frost and Dr Wagman**

Future contracting strategy:

Building on the FY14 contracting round, and focussing on best practice, future contract strategy will seek to:

- Develop an overall 3 year contracting strategy approach underpinned by our commissioning plans and start to signal the scale of contract value change envisaged .
- Work with our providers to agree an agreed contract change phasing approach based around the scale of income/cost change that can be feasibly delivered in year.
- Focus providers on moving to upper quartile performance targets e.g. for out-patient follow up
- Include upper ceiling caps into known areas of potential high activity cost variance eg consultant to consultant referral, 0-1 admissions, direct access to diagnostic areas, critical care episode costs.
- In areas where we are planning major pathway change –e.g. the development of emergency ambulatory care pathways that avoid in – patient admission , we will seek to move away from current PbR tariffs and agree a new local tariff structure that 'shares' the savings profile and hence incentivises the provider to provide the new type of pathways.
- Align Barnet with our partner CCGs on both contractual changes and performance metrics to provide a stronger consolidated position.

This strategy will continue to:

- Involve GP leads in setting contract performance parameters (e.g. service quality , efficiency , shared activity management approaches).
- Require clear provider KPIs aligned to our commissioning and financial plans. In particular non -cute contracts will contain SMART objective driven KPIs to manage productivity/ efficiency , service quality, patient experience and outcomes.

In respect of Block/non-PbR contracts we, working with the CSU, will:

- Undertake a programme of joint work with providers to understand the activity and cost profile and outcomes associated with the portfolio of services commissioned to review the effective value of particular services as part of our priority based funding exercise.
- In conjunction with providers , ensure regular benchmarking of non PbR services.
- Pursue a targeted programme of deep dive review on areas of expenditure / services where provider costs appear to be high.