NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Date of Meeting: 26th January 2016

Agenda No: 7.4 **Attachment:** 12

Title of Document: South West London Collaborative Commissioning programme progress update to Governing Body	**Purpose of Report:** Progress update
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Executive Summary: These slides set out a progress update from SWLCC and cover: • The set up of the Strategic Planning Group • Agreement of the financial baseline • Out of Hospital level of ambition • Acute provider work • Clinical service model definition • Revised plan	
Key sections for particular note (paragraph/page), areas of concern etc: NA	
Recommendation(s): To review update	
Committees which have previously discussed/agreed the report: NA	
Financial Implications: NA	
Implications for CCG Governing Body: CCG Governing body to note progress update and role of Merton CCG in working collaboratively to respond to challenges outlined in the paper and deliver the five year strategy	

How has the Patient voice been considered in development of this paper: Progress update only. Patients and public engaged through our patient and public engagement steering group.
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing)
Equality Assessment: NA
Information Privacy Issues: NA
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) NA

South West London Collaborative Commissioning

SWLCC Update

Update January 2016

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

Next Steps

- Priorities for January to March 2015 are:
  - Form a Strategic Planning Group and associated governance
  - Agree financial baseline
  - Establish level of ambition for Out of Hospital activity shift
  - Move forward with acute provider productivity work
  - Define clinical service models
  - Agree a plan for consultation (should this be required)

The formation of a Strategic Planning Group

- South West London and Surrey Downs CCGS and local providers have agreed to form closer working arrangements and develop a single programme of work – the South West London and Surrey Downs Healthcare Partnership programme (SSHP).
- Since these discussions, guidance has been received from NHSE that indicates that commissioners, providers and local authorities will be asked to work together as a Strategic Planning Group ("SPG") to develop a place-based, multi-year plan and put in place effective leadership, governance, partnership arrangements and supporting working groups.
- The next two slides show the NHSE guidance in respect of a SPG.

Governance and partnership considerations for SPGs

NHS England

Partnership arrangements	SPGs should include the following partners: • **CCGs, Providers, Primary Care colleagues, Better Health for London, Specialised Commissioning**, Local Education Training Board (**LETB**) • Local authorities (**Health and Wellbeing Boards**) and Health and Overview Committees • **Members of the local community**: patients and the public, Healthwatch and Voluntary Sector organisations • Health prevention and Health promotion **(Public Health England)**
Governance	• Each CCG and each provider should belong to **one SPG** only • The **SPG should be locally agreed** and have clear clinical ownership and leadership • It is based on existing health economies that **reflect patient flows across Health and Wellbeing Board areas and local provider footprints** • It should not split across CCG or HWB boundaries wherever possible • It should have sufficient **scale** to deliver geography-wide clinical improvements • It should enable the **pooling of resources** to reduce the risk associated with large investments • It should not cut across existing locally agreed collaboration agreements
Finance	Each SPG should be able to demonstrate that they meet the **SPG Financial Success Criteria**: • Clear **economic evaluation** • **Financially sustainable** post implementation • LHE **reconfiguration** contributes towards achievement of national productivity requirement • Reconfiguration costs are affordable • Provides an outline of **capital assumptions** • Clarity of **project interdependencies** and sequencing • Demonstration of **strong leadership** and **capabilities** for delivery

Governance delivery arrangements for consideration

Strategic Planning Group Board
Commissioners, Providers, Local Authorities

	Transformation	Finance and Activity	Clinical
Focus	A group that shapes the plan, involving key stakeholders and partners during its development ***Deliverable: strategic plans***	A finance and technical group that drives financial affordability and transformation ***Deliverable: Financial modelling***	A clinical forum that guides design work to ensure the STP is clinically driven ***Deliverable: Clinical strategy***
Membership	Local authorities, providers, commissioners, primary care, specialised commissioning, commissioning support units, analytical services, finance teams, representatives of patients and the general public, Healthy London Partnerships, education, public health		

Governance principles

- Clearly **devolved accountabilities** and responsibilities for different partners within the governance structure.
- **open and transparent** throughout its design and implementation, with opportunity for challenge by key stakeholders such as patients, carers and the voluntary sector.
- **Patient safety and quality** should be at the heart of decision making and the SPG should have a clear understanding of gaps and how these this will be managed.

The formation of a Strategic Planning Group

- The SPG and South West London & Surrey Downs Healthcare Partnership have a shared purpose: **to deliver a clinically and financially sustainable future NHS in SWL** both at a system level and an individual organisation level (recognising that future structures may be difference from those in place at the current time)
- This being the case, it is proposed that the recently formed Partnership be subsumed into the SPG, with the governance arrangements proposed for the Partnership being adapted for the SPG.
- We are working together to define what is managed through:
  - SPG (ie providers, commissioners, LA etc together)
  - Collaboration of providers or commissioners
  - Individual organisation

SPG Self Assessment

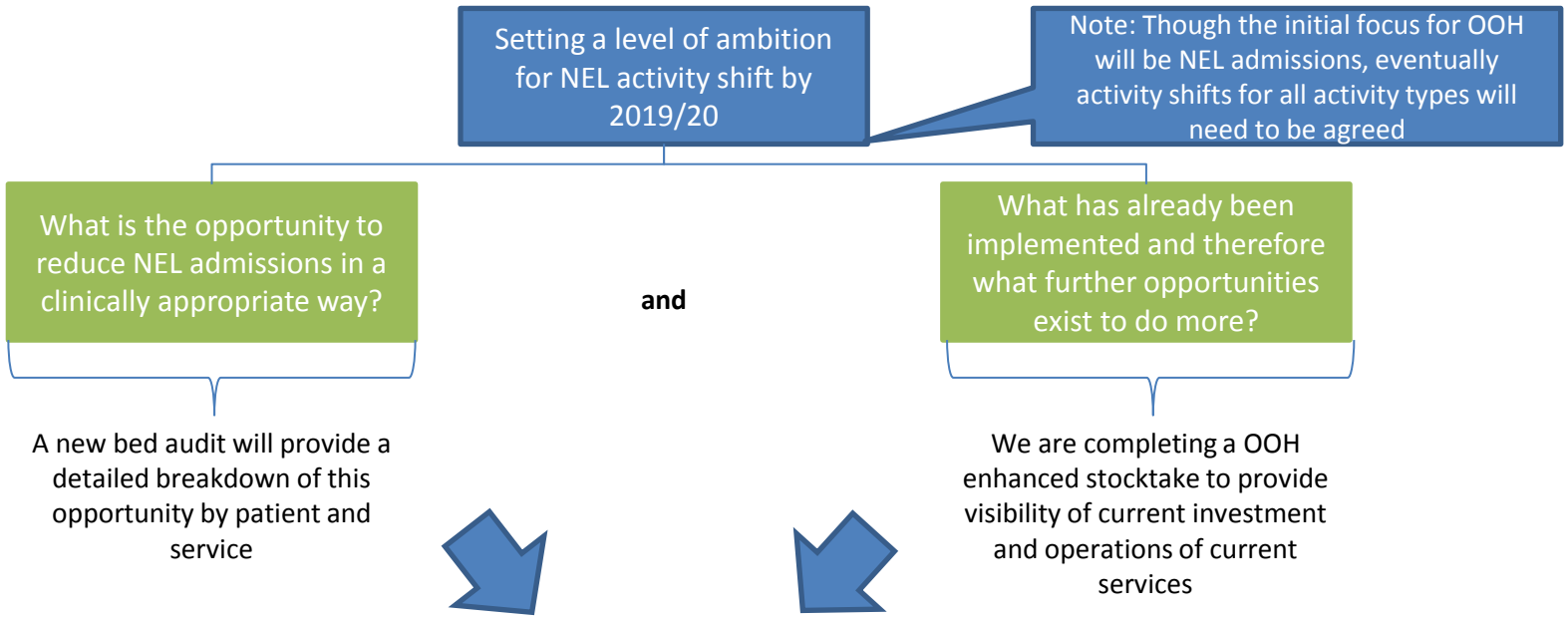
- Self assessment of governance conducted for NHSE
- Recognition of:
  - History of collaboration and framework to build on
  - Need to improve working between CCGs and providers
  - Work required to improve integration of OOH providers, Local Authorities, Health Education England, Public Health, Patients and Public and Specialised Commissioning
  - Programme leadership and support needed to drive the programme forward (Programme Director, PMO, CSU)

Progress to establish new governance arrangements

Organisation	Sign off date	Status
Croydon CCG	1 December 2015	Approved
Kingston CCG	8 December 2015	Approved, with comments in respect of: • Public Health input • Accountability • Pace needed • Surrey Downs as commissioner from Kingston
Merton CCG	17 December 2015	Approved
Richmond CCG	19 January 2015	Not yet met at time of writing
Sutton CCG	6 January 2015	Not yet met at time of writing
Wandsworth CCG	9 December 2015	Approved
Surrey Downs CCG	18 December 2015	Awaiting feedback
Epsom & St Helier NHS Trust	27 November 2015	Approved with comments in respect of: • Clarity on CCG representation on Board • Request for HESL on Clinical Board
Kingston NHS Foundation Trust	25 November 2015	Approved with comments in respect of: • Whether clinicians speaking in own right, representing working group or organisation
St Georges University Hospitals NHS Foundation Trust	3 December 2015	Approved
Croydon Health Services NHS Trust		Approved with comments in respect of: • Clarity on CCG representation on Board • Role of Tripartite • Recognition of NHSE as commissioner • Role of SPG • Pace needed
South West London & St Georges NHS Trust	21 December	Approved
South West London & Maudsley NHS Foundation Trust	15 December	Approved

Out of Hospital – setting a level of ambition

To set an evidence based plan for an out of hospital shift, we need to have visibility of the size of the opportunity:



Over time an increasingly detailed plan can be built by identifying the degree to which:

1. The health economy is investing in the right services but could invest further to shift activity more
2. The health economy needs to invest in new clinical models to better target the opportunity identified
3. The health economy has invested sufficiently in the right areas but operational delivery needs to improve

Acute Provider Collaborative progress

- The acute providers are continuing to develop their scenarios for a clinically and financially sustainable NHS in SW London, which they will feed into joint commissioner and provider service design groups in the new year.
- This includes work on:
  - Reducing length of stay
  - Reducing non elective admissions
  - Clinical networking
  - Estates strategy
- They also recognise the need to improve productivity to address the financial gap and are working on:

Key opportunities in the Carter review

Agency costs - shared staff bank Up to £43m savings by replacing agency staff with bank staff	**Shared approach to procurement:** Aligning procurement in 2015-16 and 16-17 Developing procurement cluster	**Single payroll** Exploring moving to a single payroll for SWL

Enablers for shared working

Shared approach to workforce: honorary contracts Removing barriers to shared working, and inefficiencies	**Shared approach to workforce: statutory / mandatory training** Reducing inefficiencies through a standardised approach to training	**Patient flows and transfers** Making better use of SWL capacity to repatriate activity back into SWL where it is being lost through inefficient use of capacity

Financial diagnostic

- The aim of the programme is to deliver a clinically and financially sustainable NHS in SW London
- To address the issue of financial sustainability, it is necessary to first understand the financial baseline and 'do nothing' scenarios
- Work is currently underway by commissioners and providers to establish and agree a financial baseline across SWL – the scope of this work is set out overleaf
- This is undergoing an external validation to ensure that there is an agreed and triangulated position between commissioners and providers upon which to base plans

Scope of the financial diagnostic

Establish current year financial and activity baseline for all hospitals and CCGs

- Output should be at summary programme level and by organisation (by significant site) for providers
- Bridge from 14/15 financial outturn to 15/16 financial plan
- Bridge from 15/16 plan to 15/16 forecast financial outturn and normalised (recurrent) 15/16 financial outturn
- Establish current year provider income assumptions by site and compare to CCG expenditure assumptions per site, identifying and reconciling / normalising variance
- Clarify provider activity data source (SUS, SLAM etc.)
- Include mental health and community providers
- Include NHS specialised commissioning and primary care

Establish 'do nothing' financial summary for all hospitals and CCGs

- Bridge from normalised 15/16 outturn to 20/21 normalised outturn using base case, downside and upside growth and price / efficiency assumptions
- Providers to include assumptions of HRG4 plus on projected income
- Triangulate provider income assumptions by site to CCG expenditure assumptions by site and reconcile
- Manage the collection of data from providers and aggregate the data to produce the system-wide position
- Include backlog maintenance (essential investments in infrastructure) split by funding source, excluding investments for additional capacity due to growth
- Provider submissions reviewed to ensure that they are internally consistent and are supported by relevant source documents
- Provider CIPs / CCG QIPPs in current plans to be excluded from base case from 16/17 unless agreed and to be reflected in bridge as an opportunity
- That opportunity to be based on realistic and evidence-backed provider plans
- Scope to include social care (adults and children), e.g. increased demand for continuing health care placements and costs
- Programme to link with NHS England re specialised commissioning and primary care for base case financial gap
- All organisations to agree this via appropriate board / governing body

Transparency by organisation of key assumptions for baseline

- GDP deflator
- DfT movement and pace of change
- Demographic growth – acute averaged by PoD, non-acute, prescribing, other
- Non-demographic growth
- Efficiency and productivity assumptions
- Included revenue impact of revised loan and debt funding mechanisms applied from 1 April 2015 including temporary borrowing limits, loans, revenue PDC and capital PDC
- Provider scaling adjustments
- Significant case mix changes

'Do nothing' scenarios

- Three scenarios including base case, best case and worst case with flex (high and low) on activity growth, tariff efficiency requirement, and financial allocations

Definition of Clinical Service Models

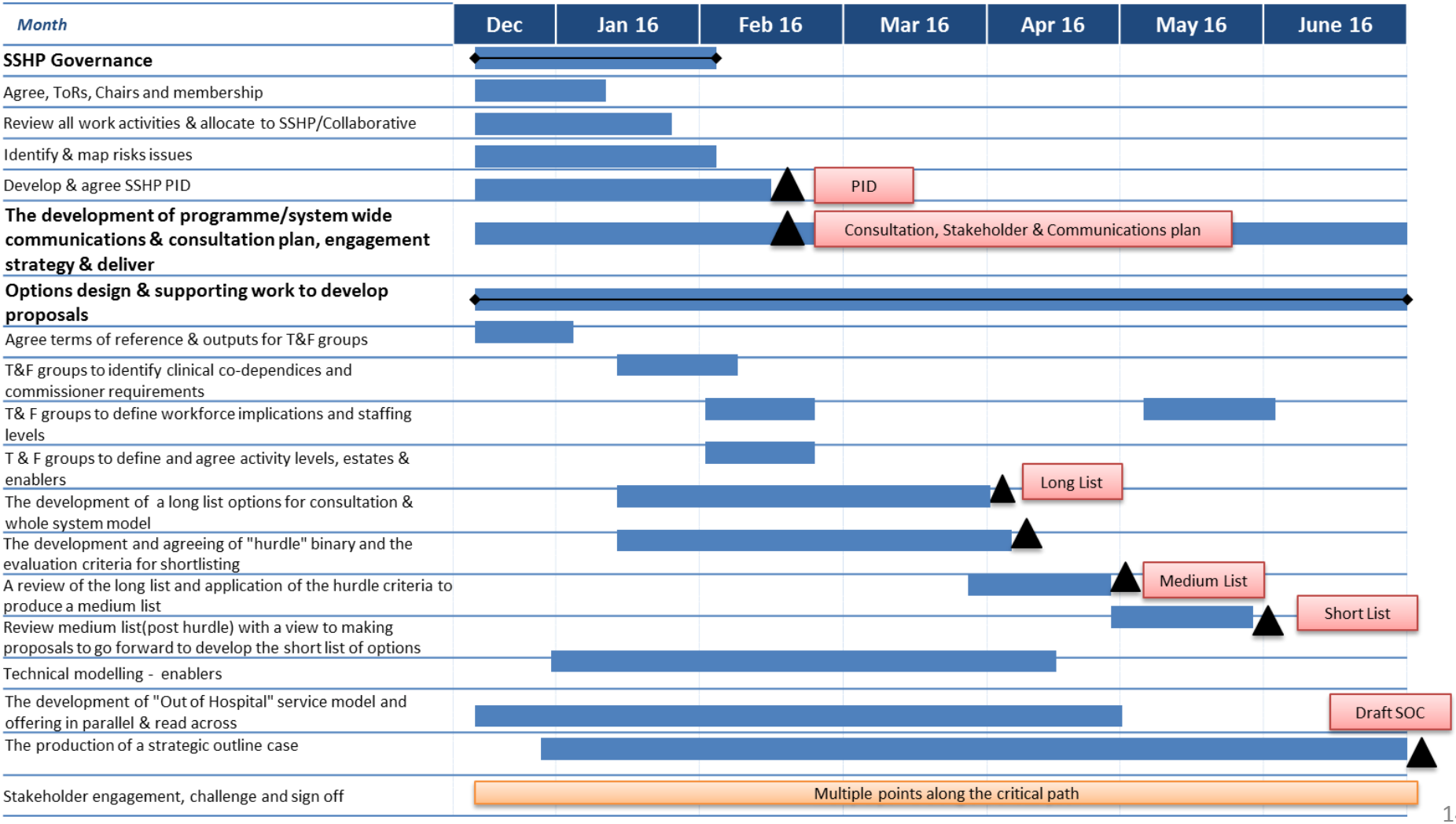
Service specific groups (UEC, Paediatrics, Maternity, Planned Care) will be meeting in three workshops from January to March to:

1. **Define acute models of care to enable a (non-site specific) list of all possible whole system models by**
   - Setting out the different acute service delivery models that are compliant with commissioning standards - e.g.:
     - models for urgent and emergency care, such as “emergency centre with specialist services”, “emergency centre”, “urgent and emergency services delivered at a site with no A&E – e.g. local hospital”;
     - models for elective care; and
     - any other models, such as stand-alone models.
   - Describing clinical dependencies that are “key variables” for each model – i.e. the most key services that determine the nature of an acute site, such as whether it has surgery, maternity, A&E etc.

2. **Resolve the key clinical questions required to develop the future models of care for evaluation and any implications for activity flows.**
   - To include:
     - activity flows (e.g. % of patients seen in UCC vs. A&E);
     - a minimum staffing model;
     - any other key clinical questions required to develop each model for evaluation (e.g. estates or clinical quality implications).

3. **Identify the principal challenges associated with implementing the future acute model of care, and with interfaces with out-of-hospital care, and how these should be addressed**

DRAFT plan to consultation



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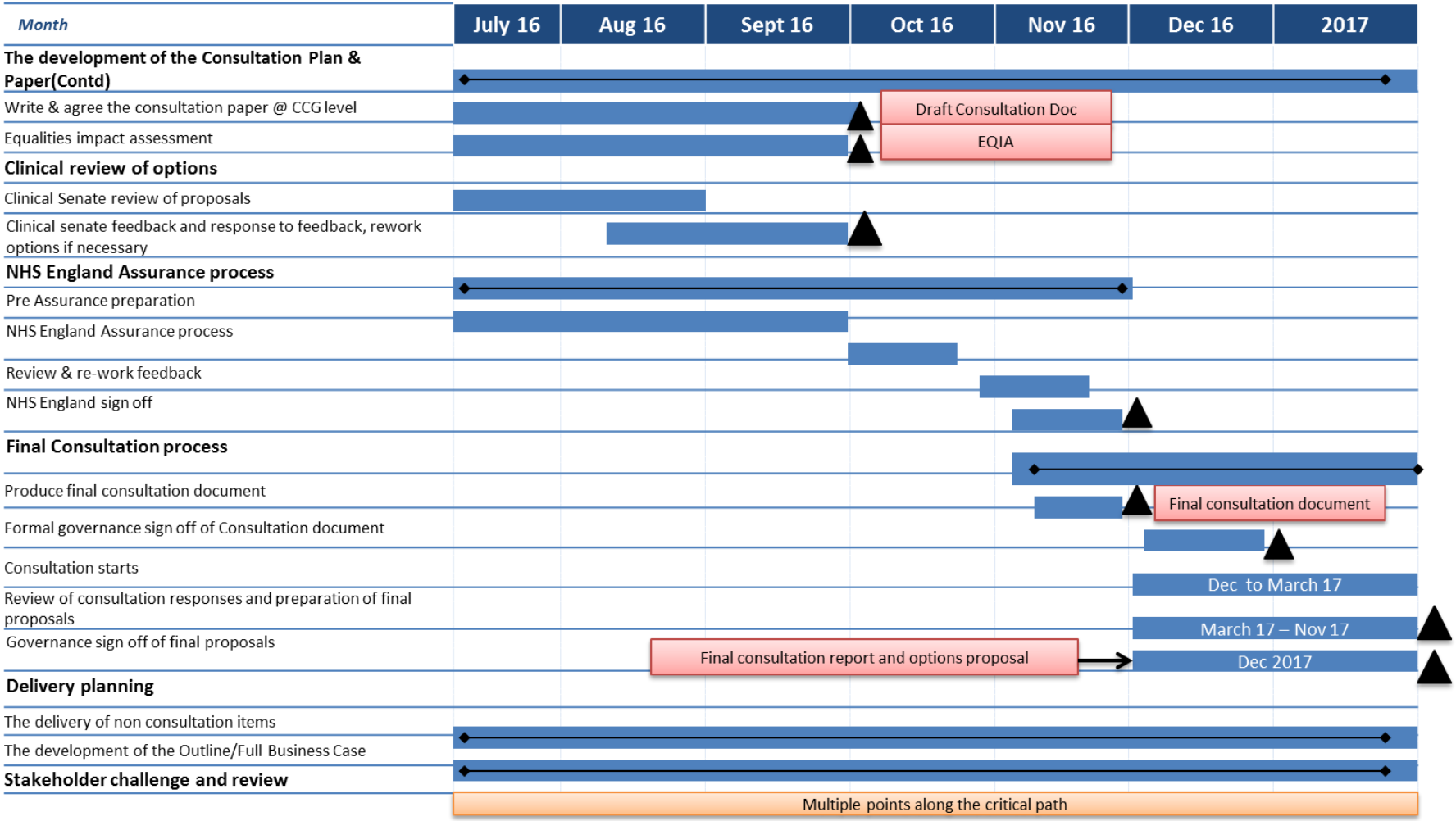

Questions?