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Intensive Planning Support to Challenged LHEs

Report 3: Final report to National Partners including a gap analysis on the final plans, flagging any risks or issues remaining and highlighting priority areas for follow up work

South West London

Monitor, NHS England, NHS Trust Development Authority

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Version 1.1

Commercial in Confidence

Contents

Glossary of terms and abbreviations

Abbreviation	Definition
A&E	Accident and Emergency
BCF	Better Care Fund
BSBV	Better Services, Better Value
CAG	Clinical Advisory Group
CCG	Clinical Commissioning Group
CDG	Clinical Design Group
CIP	Cost Improvement Plan
ENT	Ear, Nose and Throat department
FMOC	Future Model of Care
FY	Financial Year
KPI	Key Performance Indicators
LHE	Local Healthcare Economy
LA	Local Authority
LQS	London Quality Standards
MD	Medical Director
NHS	National Health Service
PCTs	Primary Care Trusts
OD	Organisational Development
QIA	Quality Impact Assessment
SCB	Strategic Commissioning Board
SWL	South West London
TOR	Terms of Reference

1. **Overview of project's delivery**

There has been significant progress within the South West London LHE since our first report in April 2014. Historically, there had been a number of attempts to change services with no success, priorities for the LHE were local or institutional and there was no joint system wide programme. Implementation capacity and capability were the main concern for the LHE and while this challenge remains there is a new sense of urgency and purpose with providers and commissioners contributing to the process at senior levels.

Our first report identified four key risks to the delivery of robust, aligned and implementable plans for South West London:

- The lack of a shared view on the case for change
- Insufficient provider engagement and misalignment of commissioner and provider strategies
- Lack of a strong leadership coalition to drive through the change
- Absence of an implementation plan, with the governance and capability to support.

Although the LHE had invested considerable time and effort into the analysis and generation of solutions it lacked the ability to implement the necessary reforms. Therefore, as agreed by the local tripartite, our priority was not to dedicate significant resources to this analysis, instead, to focus on the following three areas of risk:

1. Facilitation of agreement by all commissioners and providers to the financial and clinical case for change across the system;
2. Support for LHE production of the strategy implementation approach and plan;
3. Support for LHE development of proposals for implementation leadership, governance and support.

Since our first report the LHE has made significant progress detailed in the table below;

Workstream	**Objective**	**MoS**	**Deliverables**	**Results**
WS1: Diagnosis and supply	A financially sustainable future for both commissioners and providers.	#5 #6	**Shared Case for Change** Restatement of the financial and clinical case for change, which has been accepted by all commissioners and providers in the LHE (final, formal ratification has been delayed until 10 July 2014).	Clarity of understanding about the scale of the challenge, the need for LHE-wide action, and system reform (moving on from prior debates about hospital reconfigurations).
WS2: Solutions development	A sustainable set of high quality services for patients in each health economy. Recommended future service configurations.	#4 #5 #6	**Governance, Leadership and Support** Facilitation of collaboration between leaders of provider organisations to develop new delivery models. Facilitation of collaboration between leaders of commissioning organisations through regular engagement with collaborative commissioning meetings,	Instigation of new collaborative working arrangements and improved relationships between chief executives of the main acute providers. This will continue beyond the intensive support period and focus on developing plans for a new local hospital model and 3-4 service areas where providers can collaborate, building on success in SWL pathology. Leaders have started to work more closely as a team and have agreed the key principles for collaborative working going forward. Formalisation of this agreement and instigation of

			events, and organisation of a set piece OD event for CCG chief officers. Review of programme governance and the current support requirements for the transformation programme.	an OD programme for chairs and CFOs is part of the implementation plan. The CCGs have agreed that one chief officer will lead the programme with support of the other five. A new governance model has been accepted by the Strategic Commissioning Board (SCB) which oversees the strategy work. This includes options for providers to be more closely involved in decision making (See Appendix 3). Proposals for setting up a joint committee when the legislation allows it in October 2014 have been discussed by CCGs; a discussion with NHS England (London) about the details is now needed. Recognition that a revamped central support function is required for the implementation of the strategy, including appointment of a transformation director. (Approx.30 NHS managers and external consultants provide PMO and analytical support until end of September 2014)
WS3: Plan Development	Outline implementation proposals.	#4 #5 #6	**Implementation approach and plan** Support to senior clinical leaders (CAG in SWL to challenge, evaluate and assess the impact of 60 initiatives produced by the CDGs but prior to the project undeveloped or financially assessed.	Creation of a burning platform amongst clinical leaders about the need for transformation. Initial assessment of impact of initiatives on the funding gap, and triggering the next phase of LHE detailed work on costs and benefits appraisal of each key initiative.
Ws4 Implementation plan	Critical friend input and facilitation of implementation plan development	#6	**Implementation plan** Facilitation of the production of a high level implementation approach and plan.	Construction of basic design for a transformational programme organised around 5 major workstreams to have the most impact on delivery of the strategy. (see Appendix 4) Identification of key priorities for the next 3-6 six months. Building understanding of investment required for strategy implementation and pooled resources required to fund transformation.

2. Financial bridge

Significant progress has been made with the LHE to understand and agree to a shared vision on the financial (and clinical) case for change. The table below provides a breakdown of the financial gap in

the South West London (SWL) Local Health Economy (LHE). These figures indicate what the gap will be by FY 2018/19; however the challenge begins immediately and will grow over the next five years and beyond. Estimates are likely to increase if no immediate action is taken. Intermediate savings are required year-by-year for the LHE to remain financially sustainable.

All the figures in the table below relate to the 2018/19 position.

Gap analysis	**… at a glance**
Commissioner gap as % of the total commissioner budget.	• 11 % savings (approximately £210m) to achieve a 1% surplus.
Provider gap as % of the total provider budget.	• Acute provider's savings of 22% of the cost base or an average of 4.8% p.a (approximately £361m) to achieve a 1% surplus.
Total gap by 2018/19 before provider efficiencies.	• £542m.*
Total gap as % of the total LHE budget.	• 19%.
Specialised commissioning.	• Specialised commissioning pressures are recognised across the LHE but not yet factored into the plans. The LHE is working with NHSE local area teams to understand the extent of this challenge. There is concern over the data and extent of gap.
Impact of the Better Care Fund investment in social care (cost pressures and any benefits realisation).	• Estimated as being in the region of £45m • BCF costs are included in these figures, but potential benefits are not. In this sense the funding gap is presented as a worst case in respect of BCF. The plans will need to be reassessed after 27/06 when CCGs resubmit their plans to NHSE.

** The commissioner and provider numbers contain some overlap. The savings, based on CCG plans, show that £29m relates to provider efficiencies and therefore manifests as a gap for the providers as well. Hence the £29m overlap.*

The sustainable strategic solution for the SWL LHE is undoubtedly one that will require large scale system-wide transformation. The SWL Clinical Design Groups (CDGs) have identified over 60 initiatives. We modelled these initiatives to determine 'big ticket' items that are most likely to have the system impact required (reducing emergency admissions, outpatient attendances, A&E attendance, and average length of stay). The initiatives were modelled to ensure there was no overlap between the initiatives in each work stream. (e.g. Integrated Care and Primary Care).

Workstream	**Initial initiatives included**	**Potential benefit**
Integrated Care	• Establish multidisciplinary working • Interoperable IT systems/Technology enabled care solutions in place	**c£49m**
Urgent and Emergency Care	• Implement 7-day working across the UEC system • Implement Ambulatory Emergency Care model • Strengthen LAS, community pharmacy, 111 and OOH	**c£60m**
Primary Care	• Expanded primary care workforce • Primary care estates review and development • 7 day working and meeting of standards	**c£52m**
Children's and Maternity	• Agree model for children's integrated care in SWL • PAUs established in all acute sites • New maternity model	**c£9m**
Planned Specialist Care	• Phase 1: Urology Delivered in specialist centre • Phase 2: Specialty 2 moved to MSEC from April 2017	**c£8m**
POTENTIAL ANNUAL SAVINGS FROM KEY CDG INITIATIVES BY 2018/19 = c£178		

Note: The potential impact of the initiatives on meeting the financial challenge is shown in a diagram in appendix 1. CCG and provider financials are included in appendix 2.

Further work is required (and underway) to cost these initiatives, although initial estimates are in the region of £40m, making the net benefit figure around £140m (against an identified commissioner gap of £210m by 2018/19). We believe the LHE can go further to close the gap by being bolder around a number of the initiatives in the plan. But there is a limit to how far they can go and therefore a residual financial gap is probable. It seems likely that the LHE will need support from NHS England to find a resolution to the two difficult issues of Croydon's accumulated financial deficit (which currently stands at £18.2m) and the distance from target at which SWL CCGs are funded (which based on the current pace of change would leave SWL CCGs £33m below target allocation by 2018/19). We do not believe that any CCG governing body will agree voluntarily to transfer funds to another CCG either to deal with the Croydon issue or to compensate for variable funding levels (at least not in the near future). They are, however, prepared to pool resources to fund a transformation investment fund along the lines of that set up in North West London.

On the provider gap, the current plans show the £361m gap being closed by 2018/19 with each trust coming into surplus. This would require providers to make savings of over 22% of the cost base or an average of 4.8% p.a. which is highly ambitious. Historic CIP performance (locally and nationally) suggests that it is more realistic to expect providers to make savings of c2% from traditional CIPs initiatives. This means that transformation will be required by providers to enable services to be provided at lower cost.

Providers, supported by our work in the LHE, have started to work together on ideas for a new local hospital model, securing local access to key services as part of a comprehensive system of care and achieving the London Quality Standards in excellent physical accommodation. There is recognition that key to change will be taking fixed costs out of the system and truly transforming the approaches adopted across the LHE. In the short term, there are opportunities for further collaboration at a service line level building on successful developments such as SWL Pathology.

3. Key areas for focus and issues remaining

The LHE recognises that it has much to do over the next few months in order to build confidence that the strategy can be implemented. The short-term actions summarised below have been agreed:

Priority areas of focus for July

- LHE to formally sign up to the case for change on 10th July LHE event
- Review PwC's proposals for transformational leadership and support to deliver the programme.
- Scope and agree Transformation Director role specification
- CFOs and directors of commissioning workshop on 04/07 to progress CDG initiative costing
- SWL LHE to explore options to solve or fund the Croydon underlying / historical deficit.

Key areas of focus and issues remaining from July to September 2014

Refining the strategy and plan

- Complete provider alignment process once all provider plans have been finalised
- TDA to adopt a system wide plan review approach to support deliverable long term provider plans
- Update SWL plans in light of revised CCG BCF plans
- Agree alignment with emerging specialised commissioning plans.
- Publish CCG commissioning intentions for 2015/16 fully aligned with SWL strategy requirements
- Completion of NHS England plan assurance process
- Detailed Costing of plan, assessment of impacts and prioritisation to meet CCG financial resources
- Continue initiative development process through CDGs and CAG to close remaining financial gap
- Implement new communications and engagement strategy.

Contracting

- Decide the SWL contracting model: what we will commission at scale and what will be local
- Agree collective commissioning intentions letter for providers in relation to financial year 2015/16
- Agree our primary care co-commissioning approach with NHS England and Local Authorities.

Leadership, governance and collaboration

- Agree new governance structure for next phase and define the TOR for each governance group. This structure will be based on the emerging governance model adopted by the SCB.

- Further develop our leadership proposals and appoint to key roles
- Finalise formal Collaborative Commissioning Agreement for approval by CCG Governing Bodies and NHS England as co-commissioner
- Continued LA engagement through the SWL forum ,(meetings already taken place in April and June), the new governance structure
- Develop a SWL LHE OD programme to work on leadership (clinical and managerial), collaboration, governance, and behaviours to support successful implementation.

4. Risk assessment for delivery and next steps

We have assessed the LHE's delivery capability as significantly improved from the starting position in April. But there are a number of key risks that need to be guarded against.

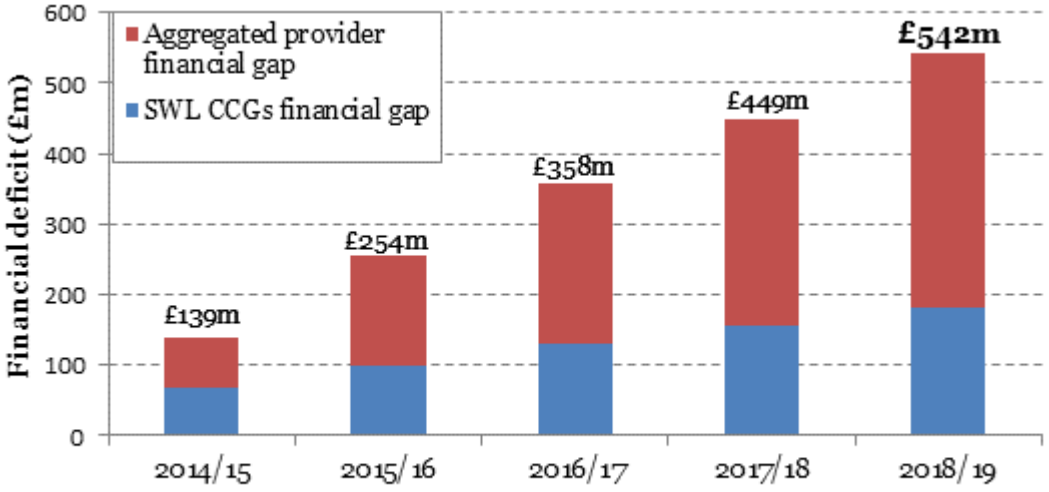
Risks	Mitigation
The LHE will lose momentum which will lead to failure to implement the plans	• SWL LHE continues to build a culture where there is a shared sense of purpose, clarity about values and behaviours and how they work • Adhere to the governing principles of how the SWL LHE leadership intends to work together and translate each of those principles into a programme of actions and behaviours , supported by an effective OD initiative • Sign off by providers and commissioners of the case for change at July event.
Collaborative working model fails to stand up to implementation challenges	• Agree the governance structure for and define the terms of reference for each governance group including clarity of roles, responsibilities and accountabilities • Continued provider collaboration including how providers are included in the governance model • Appointment of a strong transformation director who can direct the work and support the leadership to do what it needs to do.
Programme lacks skill and expertise to support implementation	• Appointment of a support team that has a different combination of skills sets with greater emphasis on large scale transformation to support the whole health economy (commissioners and providers)
The remaining financial gap will not be closed	• LHE fully cost (cost and benefits) the five key solutions going forward to determine the financial impact and benefit, and what else may need to be done to close the residual gap.
Initial clinical engagement is not sustained during next phase of work	• Implementation of a governance model that ensures the Clinical leadership and implementation groups have appropriate representation to undertake their specified tasks.

5. Lessons learned

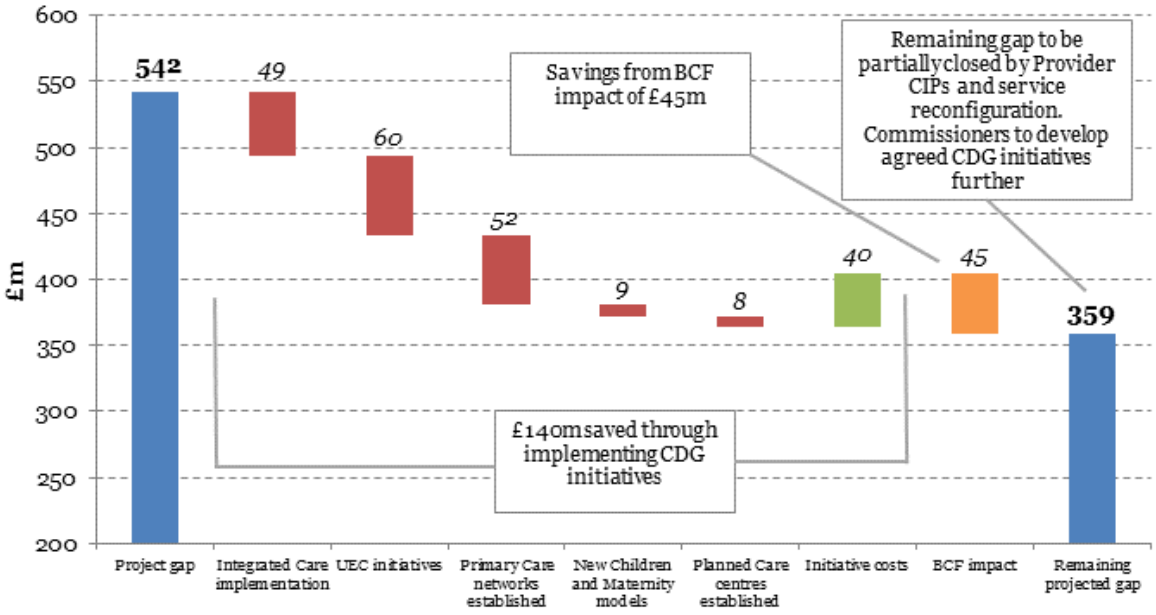
- Informal and small group interventions were the most effective in making progress, although large groups were important in surfacing emotive views on the position of the LHE and get issues out into the open
- Viewing conflict as constructive and a reason to keep on talking; demonstrating willingness to engage in the process of searching for a solution that meets the needs of many
- Greater focus on relationships, trust and understanding of each other's perspectives
- Maintaining focus on the size and scale: a draft implementation 'route map' for the next 5 years plotting key decision points and milestones demonstrated the scale of on-going leadership challenge and focused and improved the performance of the leadership group
- Recognising things that can be done prior to reconfiguration (e.g. LTC work, EOLC, planned care centre) and can be important quick wins
- Building on the work that has already been done, not losing information collected to date on the programme to eliminate fatigue and repetition
- Weekly meetings of the local tripartite resulted in stronger relationships with NHSE, TDA and Monitor working as a collective to advise the LHE on developing the required whole system approach, to navigate roadblocks such as when to compete and when to collaborate.

Appendix 1:

The nature of the do nothing" financial challenge is shown in the diagram below.



The potential impact of the CDG initiatives and BCF on meeting the financial challenge is shown is the diagram below



Appendix 2: CCG and provider financial plans to 2018/19

Combined CCG Combined CCG planned financials to 2018/19/19

	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£m's	£m's	£m's	£m's	£m's	£m's
Total						
Recurrent Income	**1,650.3**	**1,719.1**	**1,771.8**	**1,823.4**	**1,873.1**	**8,837.6**
Acute	972.2	1,008.0	1,047.7	1,081.0	1,115.4	5,224.3
Non-Acute & Primary Care	636.4	715.8	749.1	784.8	819.0	3,705.2
Mental Health	196.7	200.2	208.1	214.9	221.2	1,041.2
Community	151.5	139.2	146.4	153.2	158.5	748.9
Continuing Care	88.9	86.3	92.3	100.4	109.2	477.1
Better Care Fund transfer	-	85.8	85.8	85.8	85.8	343.3
Primary Care	199.3	204.3	216.5	230.4	244.2	1,094.6
Other Programme	59.7	51.2	64.8	75.6	85.1	336.5
Running Costs	34.5	33.9	34.5	34.6	35.2	172.8
Contingency	8.3	8.5	8.6	9.0	9.3	43.7
Total Costs (Pre-QIPP)	**1,711.1**	**1,817.5**	**1,904.7**	**1,985.1**	**2,064.2**	**9,482.4**
In-year run rate QIPP challenge	**77.3**	**115.6**	**150.6**	**179.9**	**209.8**	**733.2**
In-year run rate QIPP challenge as % of post-QIPP expenditure	**5%**	**7%**	**8%**	**10%**	**11%**	**8%**
Surplus/(Deficit) In-Year Movement	**(19.3)**	**(14.2)**	**(10.4)**	**(5.5)**	**(0.3)**	**(49.7)**

Source: CCG submissions 4th April 2014.

Croydon CCG

Croydon	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**401.5**	**415.5**	**434.2**	**448.5**	**463.4**	**478.6**	**2,240.2**
02. Acute	254.4	255.8	256.7	256.9	259.1	262.7	1,291.2
03. Mental Health	51.8	55.6	55.0	57.1	58.7	59.0	285.5
04. Community	30.4	34.8	29.7	29.7	29.8	29.9	153.9
05. Continuing Care	21.1	21.9	22.7	22.2	23.3	24.5	114.7
06. Primary Care	46.8	51.1	48.6	51.1	53.6	56.3	260.8
07. Other Programme	14.5	3.6	25.6	32.0	34.0	36.1	131.3
08. Total Programme Costs	**419.0**	**422.8**	**438.4**	**448.9**	**458.6**	**468.6**	**2,237.3**
09. Running Costs	7.6	7.6	7.6	7.6	7.6	7.6	38.2
10. Contingency	-	2.0	2.1	2.1	2.2	2.4	10.8
11. Total Costs	**426.6**	**432.5**	**448.2**	**458.7**	**468.4**	**478.6**	**2,286.4**
12. Surplus/(Deficit) In-Year Movement	**(25.1)**	**(17.0)**	**(14.0)**	**(10.1)**	**(5.1)**	**0.0**	**(46.2)**
Savings (QIPP) included above		***11.0***	***20.5***	***31.2***	***39.5***	***46.2***	***148.4***
Further savings required to achieve 1%		***21.2***	***18.3***	***14.6***	***9.7***	***4.8***	***68.6***
Total savings required		***32.2***	***38.8***	***45.8***	***49.2***	***51.0***	***217.0***
% of allocation		***7.7%***	***8.9%***	***10.2%***	***10.6%***	***10.6%***	***9.7%***

Kingston CCG

Kingston	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**193.9**	**201.7**	**209.6**	**215.6**	**221.6**	**227.5**	**1,076.0**
02. Acute	108.5	108.6	110.7	112.2	115.1	117.4	564.0
03. Mental Health	20.0	19.8	20.2	20.4	20.7	21.2	102.4
04. Community	24.0	23.0	20.3	20.5	20.8	21.3	105.9
05. Continuing Care	13.0	13.4	14.1	15.2	16.4	17.7	76.7
06. Primary Care	22.5	23.2	24.1	25.1	26.3	27.5	126.2
07. Other Programme	3.1	8.0	14.9	16.8	16.9	16.9	73.5
08. Total Programme Costs	**191.0**	**196.0**	**204.2**	**210.3**	**216.2**	**222.0**	**1,048.7**
09. Running Costs	4.6	4.7	4.3	4.3	4.3	4.3	21.8
10. Contingency	-	1.0	1.0	1.0	1.1	1.1	5.2
11. Total Costs	**195.6**	**201.7**	**209.5**	**215.6**	**221.5**	**227.4**	**1,075.7**
12. Surplus/(Deficit) In-Year Movement	**(1.6)**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**	**0.3**
Assumed savings (QIPP) included above		***4.6***	***8.9***	***13.1***	***15.8***	***18.9***	***61.3***
Further savings required to achieve 1%		***2.0***	***2.0***	***2.1***	***2.2***	***2.2***	***10.5***
Total savings required		***6.6***	***10.9***	***15.2***	***18.0***	***21.1***	***71.8***
% of allocation		***3.3%***	***5.2%***	***7.0%***	***8.1%***	***9.3%***	***6.7%***

Merton CCG

Merton	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**203.6**	**214.2**	**226.5**	**236.6**	**246.1**	**254.1**	**1,177.5**
02. Acute	126.6	126.0	125.0	125.5	124.9	124.0	625.4
03. Mental Health	19.9	20.6	20.8	21.3	21.7	22.1	106.6
04. Community	16.7	19.8	31.5	32.4	32.9	33.5	150.1
05. Continuing Care	7.7	8.0	8.1	8.2	8.4	8.5	41.3
06. Primary Care	25.9	26.7	27.5	28.3	29.2	30.1	141.8
07. Other Programme	3.0	6.9	7.8	14.9	23.1	29.8	82.5
08. Total Programme Costs	**199.7**	**208.0**	**220.7**	**230.7**	**240.1**	**248.1**	**1,147.6**
09. Running Costs	4.7	5.0	4.5	4.6	4.6	4.7	23.4
10. Contingency	-	1.1	1.1	1.2	1.3	1.3	6.0
11. Total Costs	**204.5**	**214.1**	**226.4**	**236.5**	**246.0**	**254.0**	**1,177.0**
12. Surplus/(Deficit) In-Year Movement	**(0.8)**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.5**
Assumed savings (QIPP) included above		***6.6***	***12.4***	***18.0***	***23.6***	***29.1***	***89.7***
Further savings required to achieve 1%		***2.1***	***2.1***	***2.3***	***2.4***	***2.5***	***11.3***
Total savings required		***8.7***	***14.5***	***20.3***	***26.0***	***31.6***	***101.0***
% of allocation		***4.0%***	***6.4%***	***8.6%***	***10.5%***	***12.4%***	***8.6%***

Richmond CCG

Richmond	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**207.5**	**213.6**	**220.8**	**226.0**	**231.2**	**236.3**	**1,127.9**
02. Acute	112.1	112.8	115.3	117.7	120.1	122.6	588.4
03. Mental Health	25.6	25.2	25.5	25.9	26.4	26.9	130.0
04. Community	24.4	23.7	20.8	21.1	21.5	21.9	109.1
05. Continuing Care	12.8	13.6	14.7	15.8	16.8	18.0	78.9
06. Primary Care	22.6	23.6	24.5	25.6	26.7	27.9	128.3
07. Other Programme	5.3	9.7	15.5	15.3	14.9	14.3	69.7
08. Total Programme Costs	**202.7**	**208.7**	**216.3**	**221.4**	**226.5**	**231.6**	**1,104.4**
09. Running Costs	4.7	4.7	4.3	4.3	4.3	4.4	22.0
10. Contingency	1.0	1.0	1.0	1.1	1.1	1.1	5.5
11. Total Costs	**208.5**	**214.4**	**221.6**	**226.8**	**232.0**	**237.1**	**1,131.9**
12. Surplus/(Deficit) In-Year Movement	**(0.9)**	**(0.8)**	**(0.8)**	**(0.8)**	**(0.8)**	**(0.8)**	**(4.0)**
Assumed savings (QIPP) included above		***3.9***	***8.4***	***11.7***	***14.9***	***18.1***	***57.0***
Further savings required to achieve 1%		***2.9***	***3.0***	***3.1***	***3.1***	***3.2***	***15.3***
Total savings required		***6.8***	***11.4***	***14.8***	***18.0***	***21.3***	***72.3***
% of allocation		***3.2%***	***5.2%***	***6.5%***	***7.8%***	***9.0%***	***6.4%***

Sutton CCG

Sutton	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**202.8**	**212.2**	**223.2**	**231.9**	**239.8**	**246.8**	**1,154.0**
02. Acute	129.4	129.4	131.1	134.1	136.0	137.7	668.4
03. Mental Health	22.0	21.2	22.1	23.4	24.8	25.9	117.5
04. Community	16.6	17.3	16.3	18.5	20.8	22.6	95.5
05. Continuing Care	6.4	7.6	18.1	18.8	19.5	20.2	84.1
06. Primary Care	24.3	24.9	26.2	27.5	28.9	30.3	137.8
07. Other Programme	4.0	6.3	4.1	4.2	4.4	4.6	23.6
08. Total Programme Costs	**202.8**	**206.7**	**217.9**	**226.6**	**234.4**	**241.3**	**1,126.9**
09. Running Costs	4.5	4.4	4.1	4.1	4.1	4.2	20.9
10. Contingency	-	1.1	1.1	1.2	1.2	1.2	5.8
11. Total Costs	**207.3**	**212.2**	**223.1**	**231.9**	**239.8**	**246.7**	**1,153.6**
12. Surplus/(Deficit) In-Year Movement	**(4.4)**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.4**
Assumed savings (QIPP) included above		***4.9***	***10.9***	***16.1***	***21.3***	***26.5***	***79.7***
Further savings required to achieve 1%		***2.1***	***2.1***	***2.2***	***2.3***	***2.4***	***11.1***
Total savings required		***7.0***	***13.0***	***18.3***	***23.6***	***28.9***	***90.8***
% of allocation		***3.3%***	***5.8%***	***7.9%***	***9.8%***	***11.7%***	***7.9%***

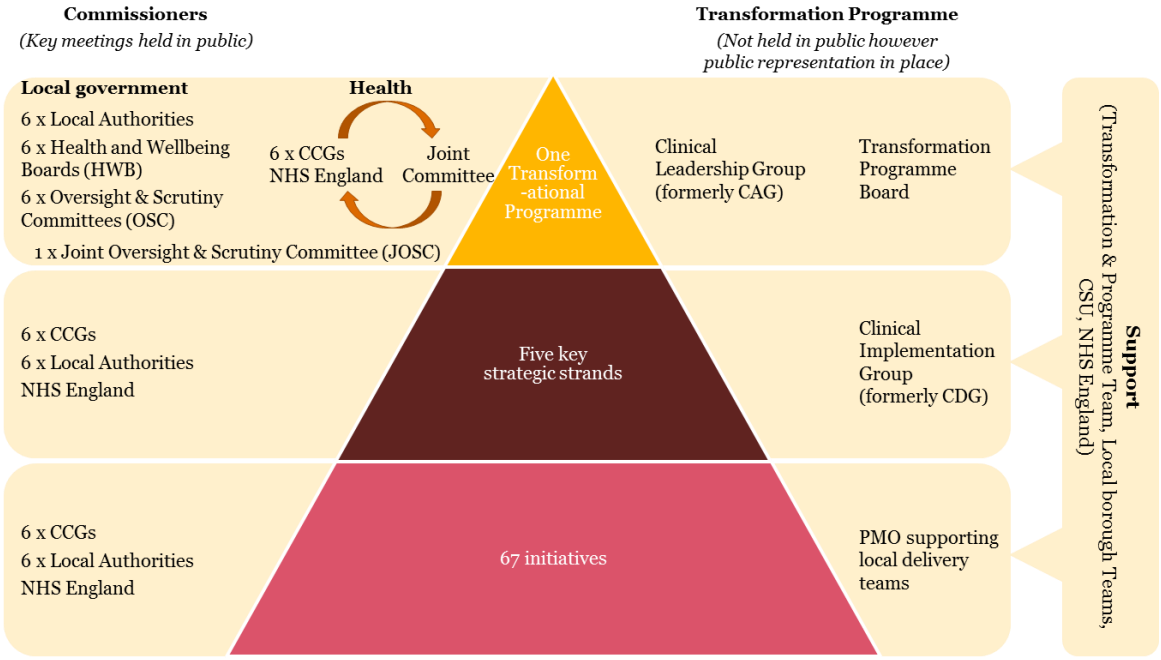
Wandsworth CCG

Wandsworth	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	5 Yr Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
01. Recurrent Income	**399.3**	**393.1**	**404.8**	**411.8**	**418.6**	**425.5**	**2,053.8**
02. Acute	212.8	212.3	213.4	217.9	219.7	221.7	1,085.1
03. Mental Health	50.0	50.5	49.0	48.7	48.8	50.0	246.9
04. Community	30.3	30.4	41.5	42.3	43.5	44.7	202.4
05. Continuing Care	18.0	20.5	21.3	22.8	24.4	26.2	115.2
06. Primary Care	43.5	46.2	44.6	45.3	46.9	47.6	230.5
07. Other Programme	24.9	25.3	25.5	25.2	25.7	25.7	127.3
08. Total Programme Costs	**379.6**	**385.2**	**395.3**	**402.1**	**409.0**	**415.8**	**2,007.4**
09. Running Costs	8.3	7.5	6.7	6.8	6.8	6.8	34.6
10. Contingency	1.5	2.0	2.0	2.1	2.1	2.1	10.2
11. Total Costs	**389.3**	**394.7**	**404.0**	**411.0**	**417.8**	**424.7**	**2,052.2**
12. Surplus/(Deficit) In-Year Movement	**10.0**	**(1.6)**	**0.7**	**0.8**	**0.8**	**0.8**	**1.6**
Assumed savings (QIPP) included above		***10.7***	***21.8***	***30.5***	***38.1***	***46.8***	***147.9***
Further savings required to achieve 1%		***5.5***	***3.3***	***3.3***	***3.4***	***3.4***	***18.9***
Total savings required		***16.2***	***25.1***	***33.8***	***41.5***	***50.2***	***166.8***
% of allocation		***4.1%***	***6.2%***	***8.2%***	***9.9%***	***11.8%***	***8.1%***

Combined provider planned financials to 2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
	£m	£m	£m	£m	£m
Croydon Health Services					
Operating Revenue	243.2	247.8	255.6	258.9	262.5
Non-operating revenue	-	-	-	-	-
Total costs	(261.1)	(260.5)	(262.4)	(261.9)	(262.0)
Normalised Surplus/(Deficit) In-Year Movement	**(17.9)**	**(12.7)**	**(6.8)**	**(3.0)**	**0.5**
Total cumulative CIP savings required	*16.2*	*34.1*	*47.8*	*61.3*	*74.7*
% of allocation	*6.2%*	*6.8%*	*5.3%*	*5.2%*	*5.2%*
Epsom & St Helier University Hospitals					
Operating Revenue	365.2	367.2	371.4	371.2	370.8
Non-operating revenue	-	-	-	-	-
Total costs	(365.2)	(365.3)	(367.8)	(368.0)	(367.9)
Normalised Surplus/(Deficit) In-Year Movement	**0.0**	**1.9**	**3.6**	**3.2**	**2.9**
Total cumulative CIP savings required	*15.4*	*35.4*	*51.8*	*67.4*	*83.1*
% of allocation	*4.2%*	*5.4%*	*4.4%*	*4.3%*	*4.3%*
Kingston Hospital Foundation Trust					
Operating Revenue	189.1	188.8	190.1	191.4	192.6
Non-operating revenue	26.1	27.0	28.0	29.1	30.1
Total costs	(213.0)	(214.3)	(216.2)	(218.6)	(220.8)
Normalised Surplus/(Deficit) In-Year Movement	**2.2**	**1.5**	**1.9**	**1.9**	**1.9**
Total cumulative CIP savings required	*9.7*	*19.9*	*29.5*	*38.4*	*47.2*
% of allocation	*4.6%*	*4.8%*	*4.4%*	*4.1%*	*4.0%*
St George's Healthcare					
Operating Revenue	692.1	710.3	732.9	741.2	751.5
Non-operating revenue	-	6.5	-	-	-
Total costs	(686.5)	(704.7)	(718.9)	(731.2)	(741.6)
Normalised Surplus/(Deficit) In-Year Movement	**5.6**	**12.1**	**14.0**	**9.9**	**10.0**
Total cumulative CIP savings required	*30.3*	*64.4*	*98.0*	*125.9*	*154.8*
% of allocation	*4.5%*	*4.9%*	*4.8%*	*3.9%*	*4.0%*
Total SWL					
Operating Revenue	1,489.6	1,514.1	1,550.0	1,562.7	1,577.4
Non-operating revenue	26.1	33.5	28.0	29.1	30.1
Total costs	(1,525.8)	(1,544.8)	(1,565.3)	(1,579.7)	(1,592.2)
Normalised Surplus/(Deficit) In-Year Movement	**(10.1)**	**2.8**	**12.7**	**12.1**	**15.3**
Total cumulative CIP savings required	*71.6*	*153.8*	*227.1*	*293.1*	*359.8*
% of allocation	*4.9%*	*5.6%*	*4.9%*	*4.4%*	*4.4%*

Appendix 3: Emerging Governance Model for the Transformational Programme



This diagram shows how the overall transformational programme has been built up from the five key strategic strands, which in turn are comprised of the 60+ initiatives across South West London. Each level of the overall programme requires its appropriate level of governance. How this governance will work in practice will be determined by the final approach adopted. The Chief Officers have expressed a preference for collaborative commissioning with providers. However, the final approach could be commissioner-led.

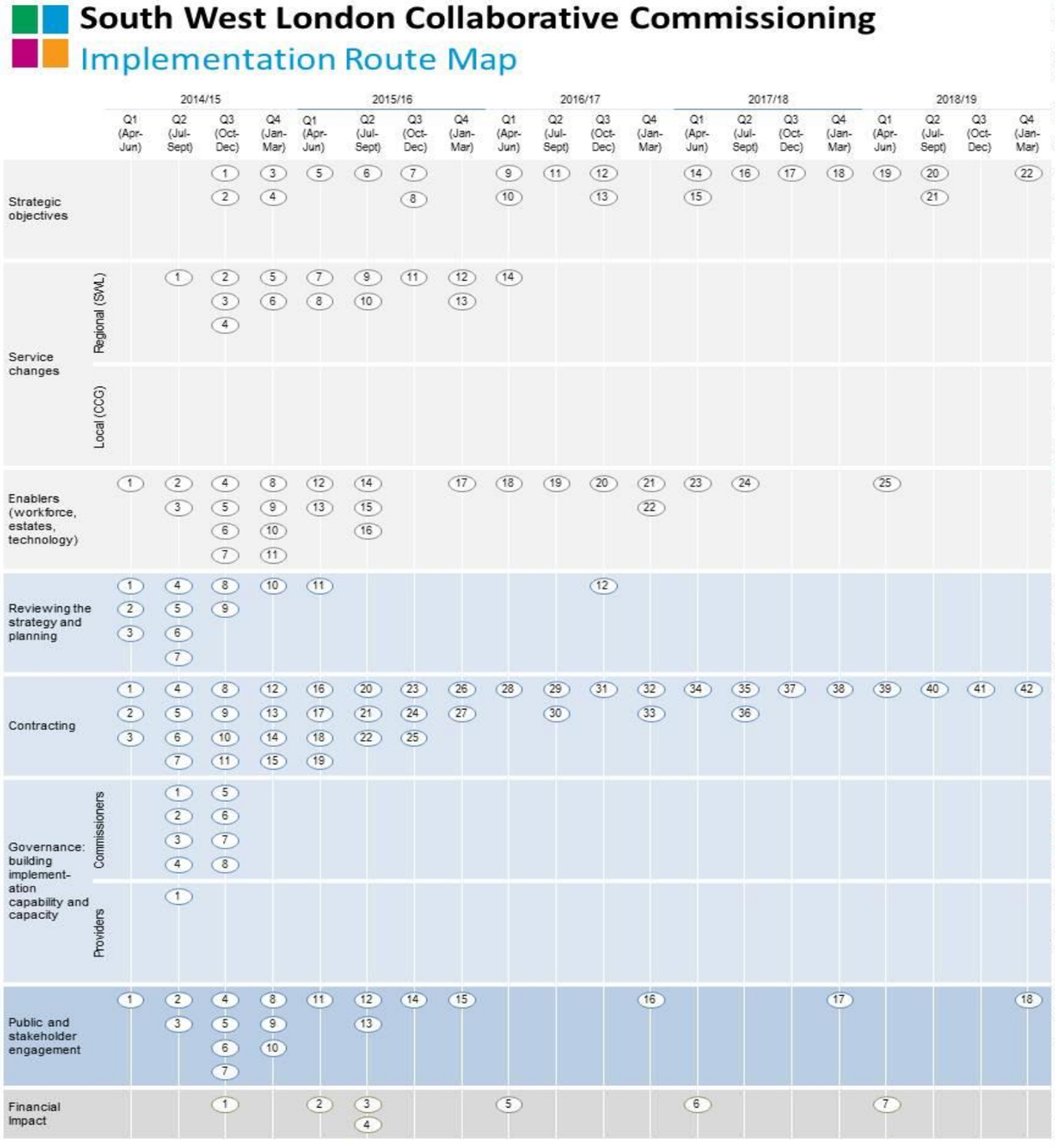
Below is a brief description of some proposed key changes to existing governance groups. These changes are yet to be fully agreed and are subject to change.

Governance group	*Role of the group*
Joint Committee	• Align on and commission key shared programmes of work which require sharing commissioning resources.
Transformation Programme Board	• Review and make strategic decisions on the implementation of the one transformation programme in order to execute the 5 year strategy. • Provide direction to the Clinical Implementation Group (CIGs).
Clinical Leadership Group (formerly CAG)	• Provide expert clinical and public health advice and support the Transformation Programme. • Ensure the CIGs have appropriate representation to undertake their specified tasks. • Provide oversight of the implementation of clinical design work, providing assurance and managing interdependencies across the individual CIGs. • Align work between the CIGs and ensure that the models of care implemented by each group are compatible. • Act as a conduit for the management and escalation of clinical risks across the programme. • Provide assurance and sign-off of the outputs of the eight CIGs.
Clinical Implementation Group (formerly CDG)	• Oversee the implementation of the agreed pathway-based content and interventions for the five year strategic plan within agreed timeframes and to national and London Quality

	Standards. • Actively support engagement with stakeholders and other clinicians. • Escalate identified clinical risks to the Clinical Leadership Group (CLG) • Provide regular reports to the CLG.

The PPESG (Public and Patient Engagement Steering Group) which is a newly established group will continue in its current form and oversee the implementation of the programme's communications and engagement strategy.

Appendix 4 Implementation Route Map



STRATEGIC OBJECTIVES

1. Establish children's network
2. Establish multidisciplinary working for integrated care
3. Achieve 98 hour obstetrician presence across SWL
4. Increased access to psychological services
5. Establish viability across sites of meeting Children's LQS
6. Implement BCF Plans
7. Implement 7-day working across the urgent and emergency care system
8. Implement shared models of integrated care e.g. virtual wards /RRT
9. Providers to implement an Ambulatory Emergency Care model across SWL
10. Phase 1: Urology Delivered in specialist centre
11. Establish new midwife model
12. Fully implement crisis concordat
13. Increased proportion of BME with mental health needs accessing services
14. Full roll out of revised community contracting models
15. Phase 2: Specialty 2 moved to MSEC from April 2017
16. SAMLU established
17. Review and evaluate the Ambulatory Emergency Care model
18. Reduction in capacity for mental health in secondary care
19. Achieve 40% midwife / 60% obstetrician led birth ratios
20. Phase 3-5: Specialties 3-5 moved to MSEC from April 2018
21. Achieve all Maternity LQS
22. Achieve all LQS

SERVICE CHANGES

Regional (SWL)

1. P. Core Estate ongoing with NHSE from Q1
2. Agreeing SWL model for children's integrated care
3. Developing model for OOH AN and PN care
4. Reviewing Keogh recommendations for the introduction of two levels of emergency departments and apply to SWL
5. Identifying desired models for key MH services, i.e. Crisis management / community psychiatry
6. Exploring AEC models, considered how far to extend AEC in terms of clinical threshold and identified champions
7. Agreeing NICU plan
8. Determining system-reconfiguration options
9. Developing a single point of entry across mental health services
10. Developing healthy living networks with community pharmacists (MH)
11. Developing primary care mental health
12. Rolling out practice networks (primary care)
13. Developing a plan for how to strengthen LAS, community pharmacy, 111 and out of hours services (CDT to develop)
14. Establishing PAUs in all sites

Local (CCG)

1. [nothing planned]

ENABLERS (WORKFORCE, ESTATES, TECHNOLOGY)

1. IT as an enabler across all providers re access to clinical data
2. Baseline children's community services
3. Implement and evaluate pilot sites to support development of practice networks (primary care)
4. Community workforce planning for integrated care
5. Establish baseline activity for key MH services in community and secondary care against local and national benchmarks
6. Primary care workforce planning
7. Consultation on SWLS+Gs mental health estate
8. Establish multidisciplinary working (skill-mix stratification)
9. Agree process for provider response to UEC clinical, financial and workforce challenges including LQS peer review to determine workforce baselines
10. Review UC services and developed shared principles
11. Enablers strategy agreed for 5 years
12. Increased investment to meet 1:30 and 1:900 ratios (greater focus that upfront investment will be required)
13. Investment in home treatment teams to expand MH provision
14. Expanded community workforce (integrated care)
15. Primary care estates review and development
16. IG issues to support integrated working resolved
17. Expanded primary care workforce
18. Development of primary care estate
19. Interoperable IT systems / Technology-enabled care solutions in place for integrated care
20. Have an appropriately skilled emergency and urgent care workforce in place
21. Complete procurement of consultants
22. Meet LQS across all emergency departments in SWL
23. Additional estates capacity in the community for maternity care
24. Implement innovative technology-enabled solutions and apps, including IT systems for UEC
25. Review UEC workforce plans

REVIEWING THE STRATEGY AND PLANNING

1. Assurance process initiated
2. Provider plans signed off
3. Specialised commissioning - agree process for alignment of plans
4. 5-year strategic plans assured and signed off by NHS England
5. Plan articulated at SW London level & at 6 Borough levels
6. Costing of 5-Year Strategy
7. Draft an implementation plan
8. NHSE sign-off on implementation plan
9. Deliver detail of financial impact of QIPP schemes for next five years with saving profile for the first two years
10. Review III/OOH/VCC/A&E progress
11. Strategy refreshed ahead of national election
12. Deliver detail of financial impact of QIPP schemes with saving profile for through to 2018/19

CONTRACTING

1. Draft BCF Plans finalised and submitted to NHSE
2. Draft constituent CCG strategic and operational plans submitted to NHSE (April)
3. Determine contract value with detail of forecast spend on current contracts for 13/14 and anticipated contract value for forward years
4. Deliver JSNA
5. Review community contracting options
6. CCG Governing Boards sign-off "Collaborative Commissioning Agreement"
7. Decision on what contracting models to use across services (SWL & local map)
8. Commissioning intentions released
9. Implementation of BCF plans
10. Outline Phase 1 (Urology) Business case developed by providers by late Autumn 2014 for consideration in CCG CIs/contracting round
11. Develop arrangements for co-commissioning in primary care
12. Finalise commissioning plans (by end of March)
13. Full Phase 1 (Urology) Business case to be developed by end Feb 2015 & approved by commissioners end March 2015
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16. Coordinate commissioning approach of SWL community model for Children's care
17. Pilot community contracting models implemented (new piloting/phased approach)
18. Determine contract value with detail of forecast spend on current contracts for 15/16 and anticipated contract value for forward years
19. Croydon: Outcomes based commissioning approach new people 15/16
20. Deliver JSNA
21. BCF outcomes evaluation and response
22. Implementation of Phase 1 (Urology) including agreement of performance metrics contracts
23. Commissioning intentions released
24. Single community service contract for SWL (from BCF proposals) Model SLA
25. Outline Phase 2-5 (MSEC) Business case developed by providers by late Autumn 2015 for consideration in CCG CIs/contracting round
26. Finalise commissioning plans (by end of March)
27. Roll out of primary care co-commissioning
28. Determine contract value with detail of forecast spend on current contracts for 16/17 and anticipated contract value for forward years
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GOVERNANCE: BUILDING IMPLEMENTATION CAPABILITY AND CAPACITY

Commissioners

1. Review support functions for collaborative commissioning
2. Determine procurement requirements
3. Commissioning capability and capacity to commission at scale
4. Resource to deliver - 3 big ones currently have same resource on all workstreams but have biggest impact and one SWLCC team
5. Governance: identify and appoint implementation team and leadership
6. Evaluate how CAG/CDGs are functioning
7. Joint committee of CCGs
8. Procure external consultancy support including specialist IT & workforce support

Providers

1. Agree role of providers in governance including types of future contracting

PUBLIC AND STAKEHOLDER ENGAGEMENT

1. Determine key messages for each year/quarter
2. Public engagement on CDG initiatives that are being developed
3. Develop communication strategy
4. Further organisational development between CCG/LAs and provider organisations for integrated care
5. Providers explore how they will get to Maternity LQS
6. Consult providers on BCF and other plans
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8. Public communications and consultation on final 5-Year Strategy
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13. Determine whether service specific consultation or one major reconfiguration proposal are required
14. Consultation on new initiatives
15. Planning governance /allocations announced
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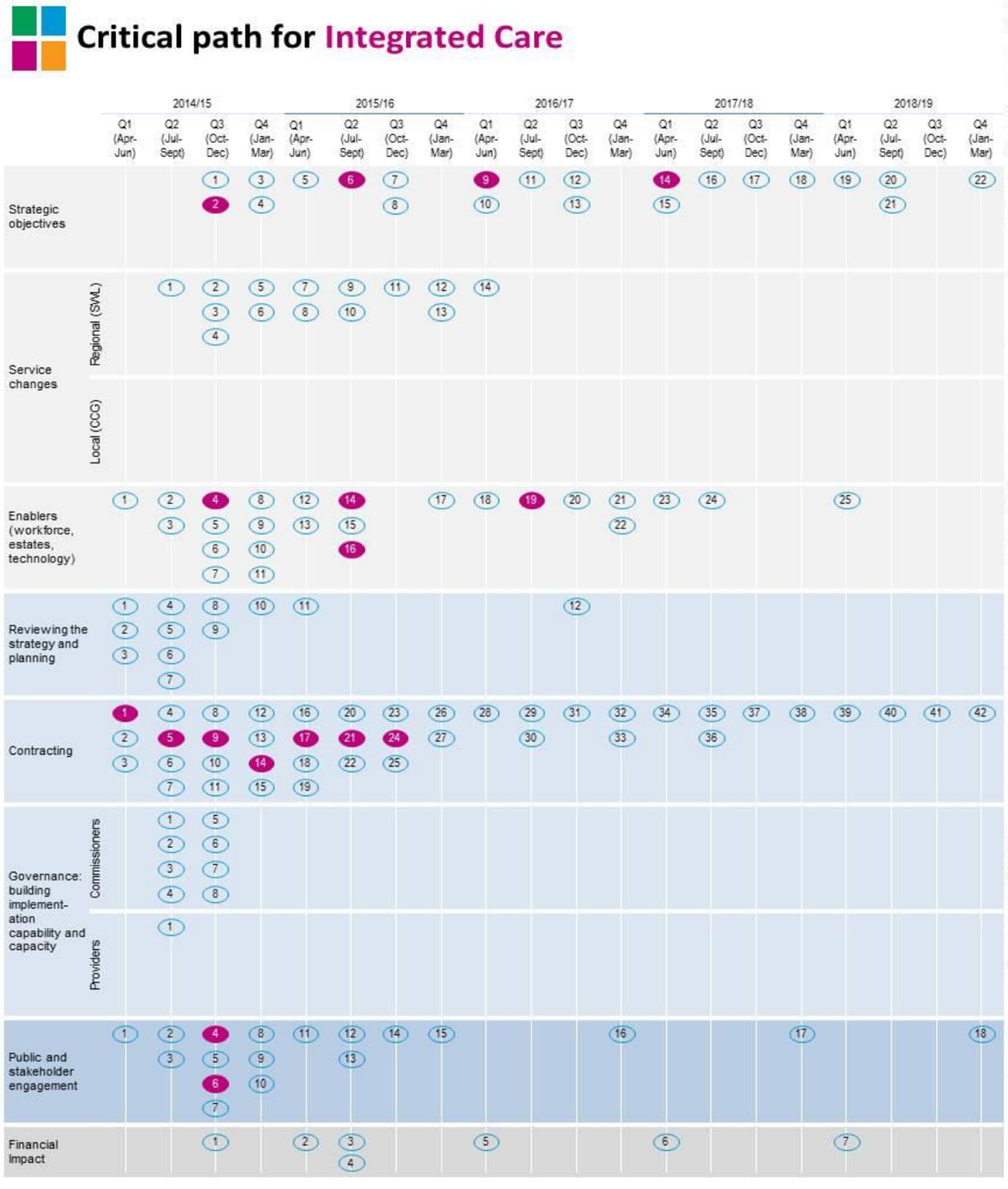
PUBLIC AND STAKEHOLDER ENGAGEMENT

1. Set expected outcome targets
2. Tariff changes impact on mental health & other services
3. Refresh financial challenge plans
4. Comp. spending review
5. Refresh financial challenge plans
6. Refresh financial challenge plans
7. Refresh financial challenge plans

Example of critical path for a work stream



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