

REPORT TO JOINT BOARDS

Date of Meeting: 19th May 2011

Agenda No: 9.1

ATTACHMENT 04

Title of Document: The South West London Cluster Year One (2011/12) QIPP Plan	Purpose of Report: Approval
Report Author: Steve Davies Interim Director SWL QIPP Programme	Lead Director: Jill Robinson Director of Finance

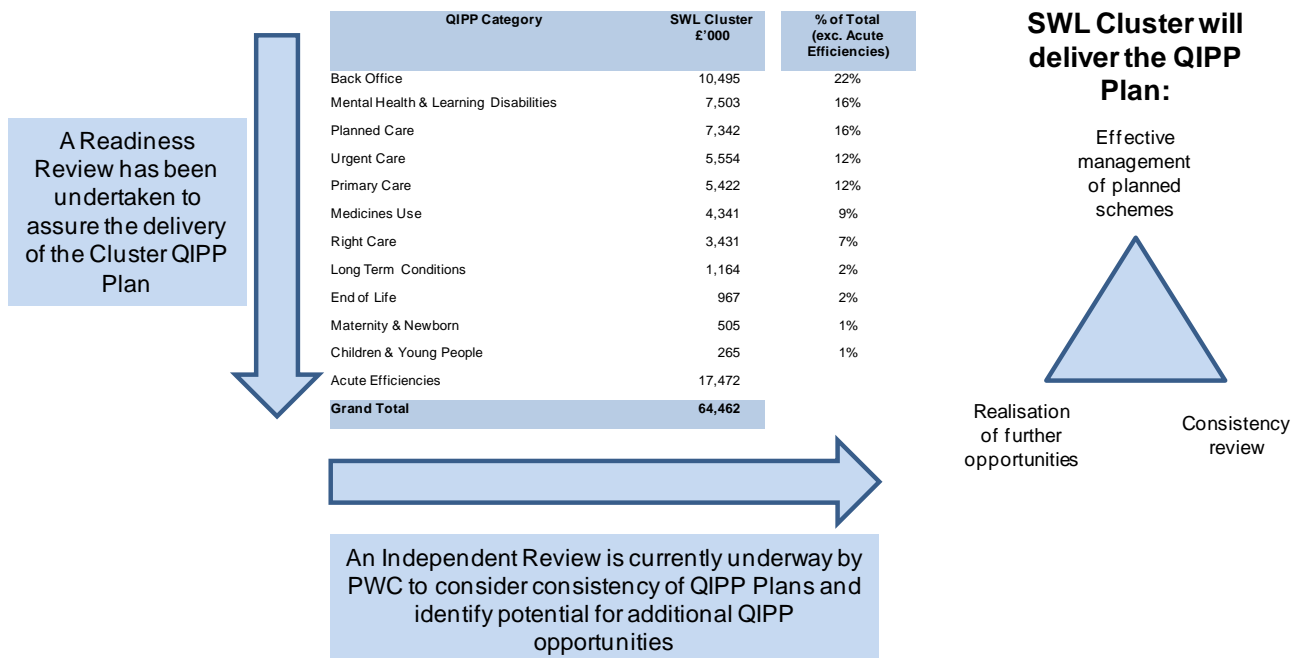
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Executive Summary:

The plan describes how implementation for 2011/12 delivery of the QIPP (Quality, Innovation, Productivity & Prevention) plan in NHS south west London will take place. It brings together Year 1 of QIPP with the Operating Plan for 2011/12.

Summary

- Draft QIPP Plan of **£66.2m** revised down by £1.7m to **£64.5m** following review of NHS Richmond proposals. Surplus requirements unchanged following finalisation of SLAs and refinement of budgets
- The implementation of these QIPP savings will close the financial gap in 2011/12 for SW London.



<p>Key sections for particular note (paragraph/page), areas of concern etc:</p> <p>Please carefully read this entire important document.</p>
<p>Recommendation(s):</p> <p>Following sign-off by NHS London, SWL Cluster joint-Board is asked to approve this plan which is already in implementation phase (commenced 1 April 2011)</p>
<p>Committees which have previously discussed/agreed the report:</p> <p>SWL Cluster Senior Management team.</p>
<p>PEC Comments where appropriate: None</p>
<p>Financial Implications: Financial implications are material and significant – failure to deliver plan may result in breach of break-even obligations. Refer to the report for detailed implications.</p>
<p>Implications for each Board: Refer to report for detailed Borough breakdowns for QIPP 2011/12</p>
<p>Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/Staffing): 11/12 Draft QIPP plan was considered by the previous JCPCT and by Borough Committees. The Joint Boards has also considered a draft of the plan in April. During April, each Borough Management Team has signed off the 11/12 borough budget of which the QIPP plan is an integral component. The SWL Finance Committee will consider the 11/12 aggregate budget in May. NHS London has also considered the SWL Finance Plan for 11/12.</p>
<p>Equality Impact Assessment: No impacts forecast</p>
<p>Information Privacy Issues: None</p>
<p>Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution): Stakeholders, partners and patient representatives have been involved in the development of QIPP plans at borough level to varying degrees. Going forward a South West London Communications and Engagement Strategy will be developed.</p>



South West London

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- **Operating Plan and QIPP Implementation Plan 2011/12**

The South West London Cluster Plan

DRAFT

21 March 2011

Vr 0.2

Section 1: Introduction and guide...

Introduction:

This document describes how implementation for 2011/12 delivery of the QIPP plan in NHS SW London will take place. It brings together QIPP with the Operating Plan for this year.

The document has developed considerably since the end of January 2011.

In the development of the plan through February and March, we have taken detailed steps to ensure the 'ownership' of the plan 'moves' from the early iterations to what might be possible to – what you will read now – a plan which takes the analysis of opportunities and translates this to the delivery of outcomes based on what is operationally possible.

As a result we have a plan which has been designed and written by SWL cluster leaders and staff. We are now confident this plan is a current and true reflection of the outcomes we must deliver in order to meet the challenges of 11/12.

Guide:

This document tells a story. It is divided into a small number of sections that take the reader through a narrative and arithmetic 'build' of the operational development of the SWL Cluster for 11/12.

The financial numbers and associated narrative were baseline and current as of Monday 21 March 2011. Users of this document should read the sections in sequence.

Section 1 can be read – in isolation – as a very brief summary.

Section 2 is fundamental as this describes the characteristics of the Financial 'journey'.

Section 3 describes the approach adopted in respect of risk management.

Section 4 focuses on the impact of the emerging Commissioning Consortia.

Section 5 requires further development of plans for estates but sets out our intentions to do this.

The remaining sections support the understanding and delivery of the implementation plan.

Section 1: Executive Summary...

- The NHS SWL Cluster spends £2.3 billion on Health Care services provided to the patients and public of SW London.
- Without action to improve the quality, innovation, productivity and prevention 'agenda' and if SWL carries on spending to historical pattern, the resulting 'gap' between funding and the cost of services could be as high as £125 m by 2014/15.
- In order to address this gap, on 1 April 2011, the SWL Cluster (SWLC) will mobilise a £64.5m QIPP Programme for 2011/12.
- This integrated plan brings together the QIPP plan with the 2011/12 Operating Plan.
- QIPP schemes for 2011/12 have been specified in some detail and pending finalisation of the transitional organisation, those leaders and teams responsible and/or accountable for delivery will be confirmed.
- All QIPP schemes for 2011/12 have been risk assessed. A detailed spreadsheet showing all schemes and risk ratings is included in the appendices for this document. Since December 2010, the PCT led QIPP schemes have been matured and their RAG rating has been greatly improved. In March 2011 70% of schemes are assessed as Green, 29% Amber and only 1% Red.
- QIPP schemes are defined both by their impact on the Divisions (Boroughs) of SWL Cluster and 13 QIPP categories.
- More work is being undertaken to ensure that the Divisional (Borough) impact of the 13 schemes that impact all of SWL Cluster is consistent across all Boroughs. The reader will note that there is an inconsistency in the savings targets across the (old) PCT structure used in this document. SWL Cluster expect to see savings levels consistent (relative to budgets of course) across all Boroughs.
- The QIPP programme will operate as a single entity supporting the Executive vision and ensuring SWL Cluster develops as a single integrated organisation for the period of transition.

Section 1: Executive Summary...

- The QIPP programme is supported by a management system which includes a central Programme Management Office (PMO) and comprehensive supporting project and programme management process. The PMO will provide delivery assurance through rigorous performance management and – for 6 months from 1 April – support will be provided by a small team of financial recovery and efficiency experts who will not only assure performance but – perhaps more importantly – transfer skills to develop the SWLC workforce.
- The importance of system leadership and management both prior to and during QIPP is recognised in this plan. The SWLC vision is to work collaboratively with all stakeholders to ensure the risks to provision are controlled and well managed.
- SWLC will not allow QIPP plans to jeopardise the financial health or sustainability of the patient service. SWLC recognise that this does not mean avoiding difficult discussions or issues but the current environment places even more emphasis on intelligent and considered analysis of the ‘cause and effect’ of this plan – including understanding and mitigating for unplanned consequences.
- Methodology and terms: The impact of SWL’s QIPP plans is measured relative to a 2010-11 baseline and against the required spend in a “do-nothing” scenario. In terms of impact on providers, gross savings represent income expected to be ‘lost’ by the current provider, while that portion of the cost of savings that is spent on re-provision of services will be ‘gained’ by an as-yet undetermined provider.
- Consideration has been given to what further improvement might be possible, beyond those already planned. Comparisons across the 5 SWL PCTs and to national benchmarks, as well as comparison with the SWL model of care and the results of workshops held in December and January, have all yielded ideas which are in development.
- A ‘readiness for implementation’ challenge process will take place within 2 weeks of the programme going live on 1 April 2011.
- The Estates Plan is a key ‘building’ block and ‘enabler’ for QIPP. At this point in the delivery and development of this plan, the Leadership of SWL Cluster recognise the need to create more robust implementation plans that integrate readily with this document. This work will commence in late March/April.

- **What is the scale of the financial challenge?**

In terms of revenue allocation and expenditure

- **Why does the financial gap emerge in 2011/12?**

- **How do we address the gap in 2011/12?**

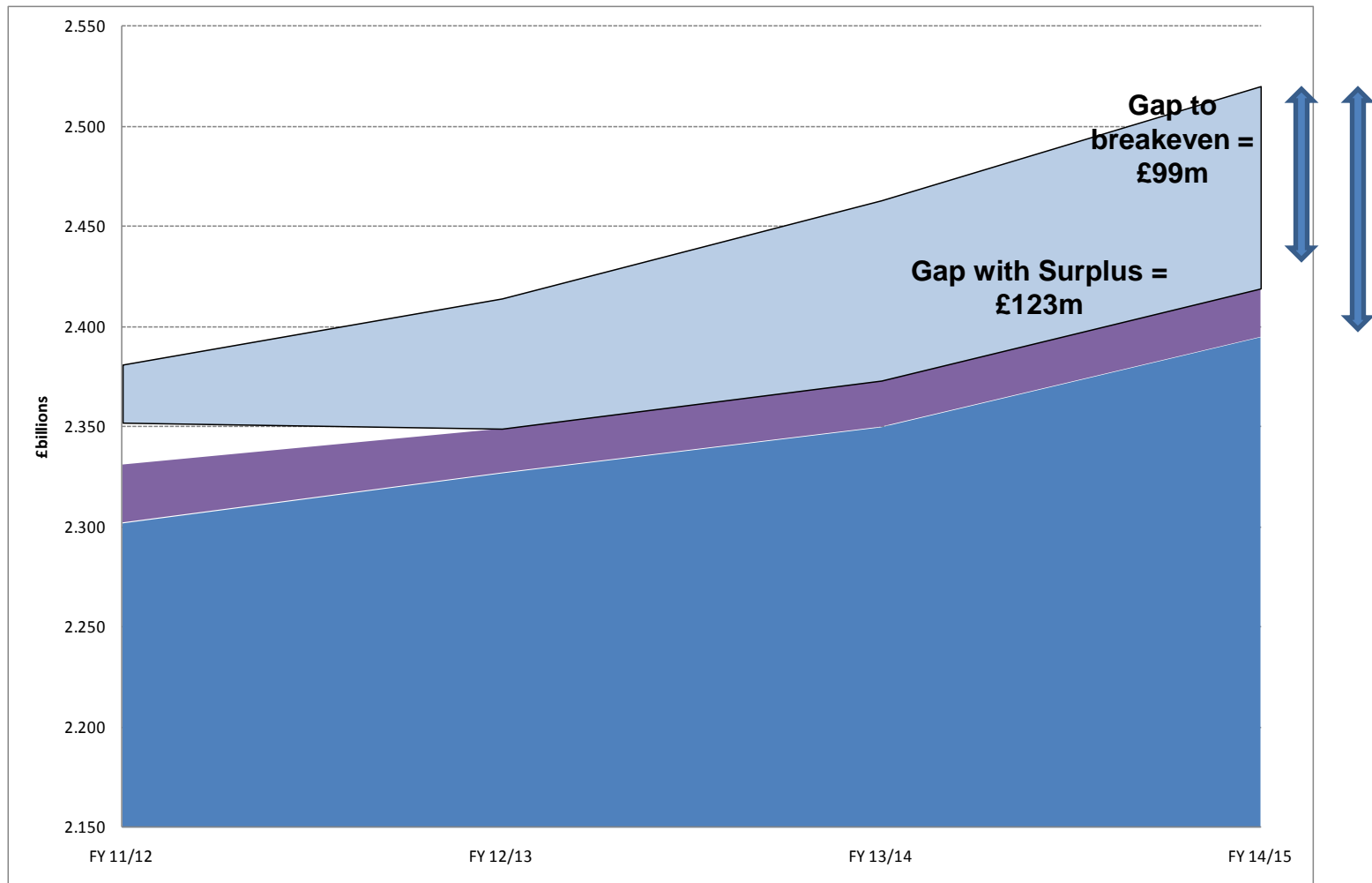
- **What is the impact on our providers in 2011/12?**

Appendices 7 and 8 describes further financial reference material

Section 2a: What is the scale of the financial challenge?

In terms of revenue allocation and expenditure for 2011/12...

Graph to show 2011/12 to 2014/15 revenue allocation and anticipated spend and the resulting gap in resources in available funding



Section 2a: Why does the financial gap emerge in 2011/12?

This is derived from NHSL assumptions for financial no change baseline...

The financial no change baseline for 2010/11 to 2014/15 is shown below. The table shows the surplus/(deficit) **after the delivery of 2% and 0.5% national requirements only, i.e. before the delivery of mandatory surplus** :

Financial no change baseline surplus/(deficit) £million	2010/11	2011/12	2012/13	2013/14	2014/15
Croydon	5	(7)	(16)	(21)	(22)
Kingston	3	(3)	(8)	(11)	(11)
Richmond	3	(5)	(7)	(7)	(4)
Sutton & Merton	0	(23)	(44)	(61)	(74)
Wandsworth	12	11	12	12	12
Surplus/(deficit)	23	(27)	(63)	(89)	(99)
National surplus (see note below)	N/A	29	22	23	24
Gap to achieve surplus	0	(56)	(85)	(111)	(123)

The summary shows that:

- **SW London has a combined cluster deficit of £27m in 2011/12.**
- **Sutton & Merton has the largest 2011/12 deficit of £23m.**
- **The cumulative position for SW London combined cluster is a deficit of £123m by end of 2014/15.**

Note - For 11/12 SWL has agreed with NHS London a surplus of 1.4%. For 12/13 onwards surplus of 1% assumed

This figure reflects the financial no-change baseline and is not the gap addressed by QIPP schemes which is shown overleaf.

Section 2: The challenge – Why does SWL cluster have to save money? - What are the financial constraints?...

The financial model uses PCTs' 2010/11 income and expenditure position as the baseline data.

Income and expenditure is projected forward annually based on local and NHS London assumptions.

Income and expenditure is matched on a recurrent basis. Non-recurrent expenditure is considered as part of QIPP plan initiatives.

PCT in-year financial positions are constrained by certain national requirements, which are applied in each year. These are:

- 2% non-committed investment reserve to be available in each PCT in each year
- 0.5% contingency in each PCT
- Challenge Trust Board contributions (2010/11 only)
- QIPP benefits are reinvested in the originating PCT
- In-year surpluses are available for carry forward

2010/11 baseline data sources:

Baseline positions have been validated with each PCT Director of Finance

Modelling growth assumptions:

- NHS London planning assumptions for recurrent funding growth, pay/non-pay inflation and tariff inflator /deflator.
- Tariff deflator of 1.5% applied across all providers (mental health, acute, community).
- Locally agreed growth assumptions for acute/non-acute activity (including demographic and non-demographic growth) and prescribing inflation:
 - Demographic growth based on GLA 2008 low forecast for each borough
 - Non-demographic activity growth established by individual PCTs
 - Benchmarked using NHS London data which resulted in some changes
- Primary care efficiencies are included within QIPP initiatives
- Delivery of management cost savings across the SWL cluster of £18 million.
- Top slice of £7.8 million PCT resources in 2011/12 to contribute to the pan London GP Consortia Development Pool & London wide commissioning support

Section 2: The challenge – Why does SWL cluster have to save money? – Some notes about the model used for analysis...

Providers for which impact of SWL QIPP initiatives has been modelled

- The likely impact of SWL PCT QIPP proposals on provider activity and income has been modelled only for 7 key providers in SWL:
 - Epsom And St Helier University Hospitals NHS Trust
 - Imperial College Hospital NHS Trust
 - Kingston Hospital NHS Trust
 - Croydon Health Services NHS Trust (formerly Mayday Healthcare NHS Trust)
 - West Middlesex University Hospital NHS Trust
 - St George's Healthcare NHS Trust
 - South West London And St George's Mental Health NHS Trust

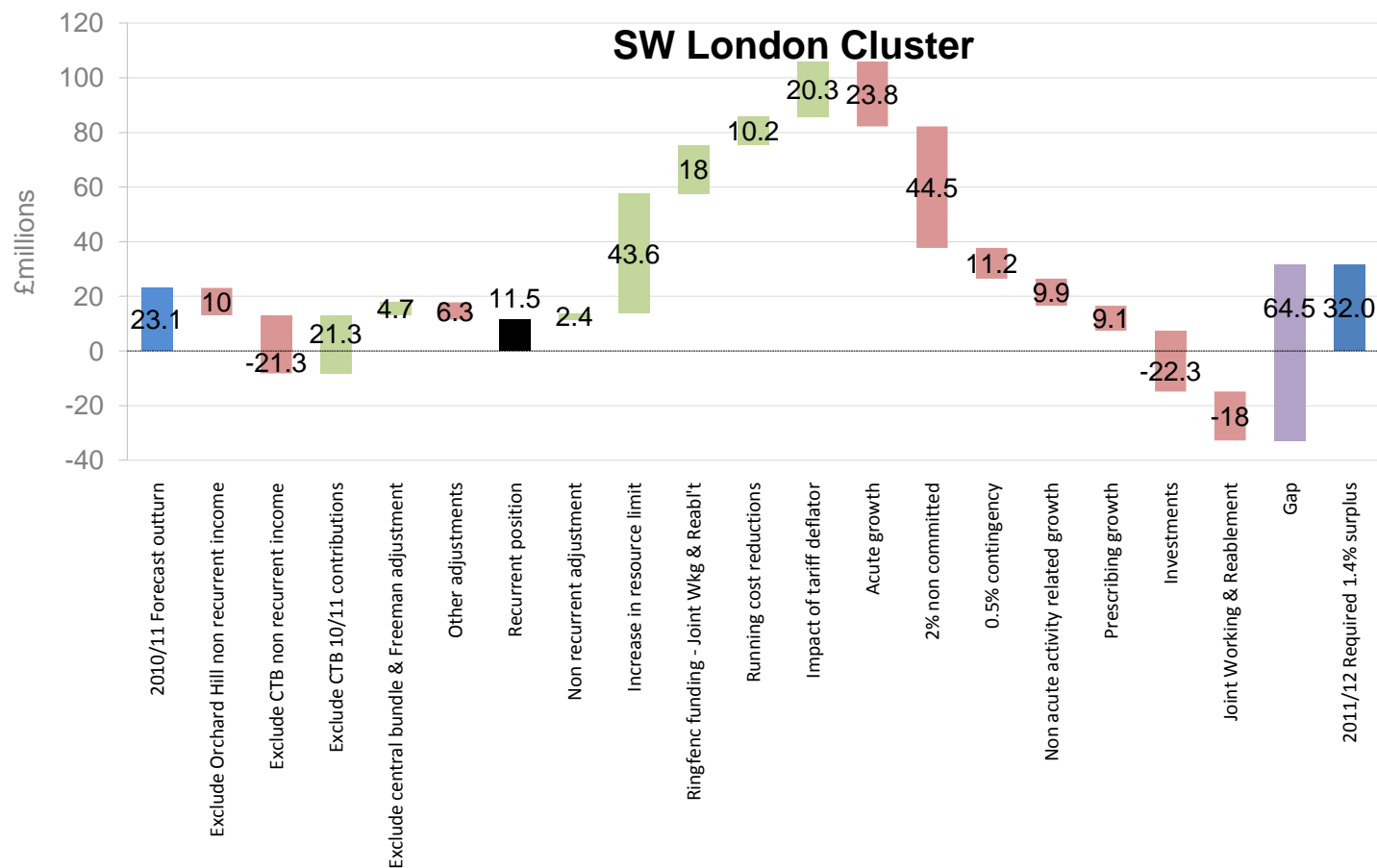
- The 'other current acute providers' include:
 - Chelsea and Westminster Hospital
 - Great Ormond Street Hospital For Children
 - Guy's And St Thomas'
 - King's College Hospital
 - Moorfields Eye Hospital
 - Royal Brompton and Harefield
 - Royal Free Hampstead
 - Surrey And Sussex Healthcare
 - The Royal Marsden
 - University College London Hospitals
 - Others

- Impact on providers of PCT and ACU led savings plans will be the combination of
 - 1) PCT-led QIPP plans
 - 2) KPIs and London commissioning intentions
 - 3) Sutton & Merton PCT's Better Healthcare Closer to Home programme (BHCH)

- (1) and (2) above have been integrated into all relevant slides throughout this document; (3) has not, because BHCH is a distinct and long-standing business-as-usual project

The analysis of this plan has taken account of the content of individual provider QIPP (some known as CIP) schemes. Plans exist to engage further in the detail of these plans and those of existing and emergent community providers. Maintaining the vision of a QIPP programme that integrates with provision and manages any local service risks is paramount. It is for this reason that SWL intends to implement a major provider engagement programme 'around' the implementation of this plan.

Section 2b: Addressing the financial gap between allocation and spend in 2011/12... Understanding the bridge



- ❑ PCTs are planning to deliver £32.0 million surplus (1.4% of RRL) in 2011/12
- ❑ Total QIPP programme of £64.5 million
- ❑ Ring-fenced Social Care & Re-ablement funding of £18 million with spending plans
- ❑ Activity growth of £23.8m in respect of acute and £9.9m for non acute included

Section 2b: Addressing the financial gap between allocation and spend in 2011/12...



South West London

Summary

- SW London has plans to deliver **£64.4m** of QIPP savings in 2011/12.
- The implementation of these QIPP savings will close the financial gap in 2011/12 for SW London.
- Current plans will eliminate the commissioner gap shown in the financial no change baseline.

QIPP Category	NHS Croydon	NHS Kingston	NHS Richmond	NHS Sutton & Merton	NHS Wandsworth	Grand Total	% of Total (exc. Acute Efficiencies)	Cum % of Total (exc. Acute Efficiencies)
Back Office	2,965	1,007	-	6,448	75	10,495	22%	22%
Mental Health & Learning Disabilities	1,872	1,240	1,797	945	1,648	7,503	16%	38%
Planned Care	3,415	380	1,791	894	862	7,342	16%	54%
Urgent Care	2,715	369	348	1,737	384	5,554	12%	66%
Primary Care	1,794	522	733	32	2,340	5,422	12%	77%
Medicines Use	1,946	324	825	595	651	4,341	9%	87%
Right Care	573	90	-	2,550	218	3,431	7%	94%
Long Term Conditions	194	214	-	756	-	1,164	2%	96%
End of Life	628	39	-	300	-	967	2%	98%
Maternity & Newborn	-	70	-	435	-	505	1%	99%
Children & Young People	25	138	-	102	-	265	1%	100%
Acute Efficiencies	1,977	2,414	3,500	8,674	907	17,472		
Grand Total	18,104	6,809	8,995	23,468	7,086	64,462		

Note: Currently, some PCTs do not have QIPP schemes identified for FY 11/12 in all categories as shown above. This will be addressed during FY 11/12 and beyond as the SWL Cluster implements information and 'best practice' sharing across the PCTs
 Further supporting information of the SW London Cluster workshops that informed this plan are in appendix 2
 Details of financial assumptions that have been used are in appendix 3.
 Appendix 5 lists SWL Cluster QIPP schemes.

Section 2b: Addressing the financial gap between allocation and spend in 2011/12... Overall Plans



South West London

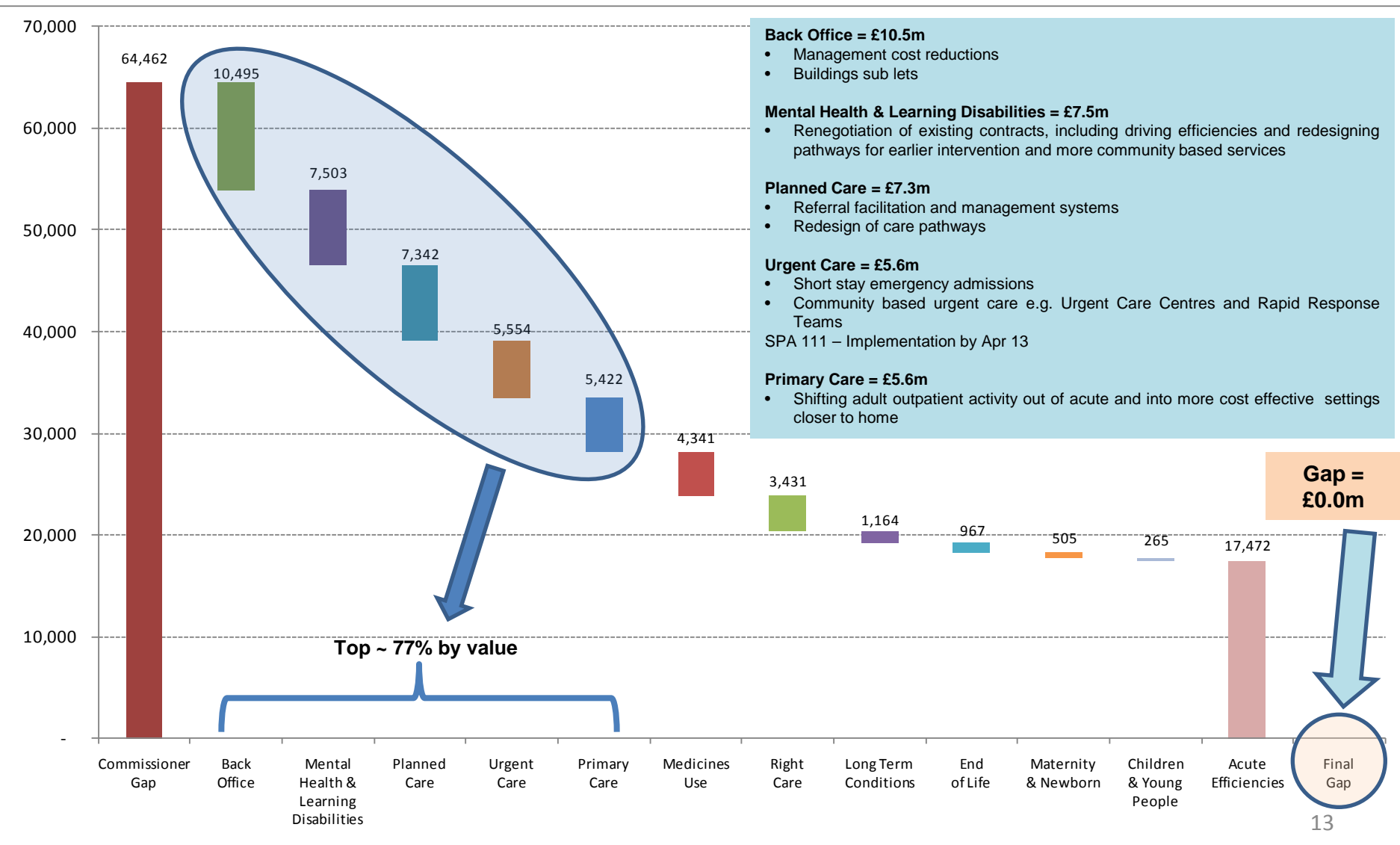
- Delivery of 10/11 control totals and additional surplus
- NHS Sutton & Merton delivery of first year turnaround as agreed
- Achievement of 2% QIPP savings for 10/11

	<u>2009/10</u>	<u>2010/11</u>						<u>2011/12</u>				
	Final Accounts £000s	Plan £000s	Actual £000s	% RRL	QIPP Plan £000s	QIPP £000s	QIPP as % of RRL %	RRL £000s	Surplus/ (deficit) £000s	%	QIPP £000s	QIPP as % of RRL %
Croydon	3,412	5,535	5,535	1.0	5,178	8,183	1.4	580,775	8,301	1.5	18,104	3.1
Kingston	103	2,623	2,623	1.0	8,428	8,428	3.0	278,473	3,953	1.5	6,809	2.4
Richmond	112	2,812	2,845	1.0	4,959	3,534	1.2	289,543	4,199	1.5	8,995	3.1
Sutton & Merton	(2,286)	0	266	0.0	28,021	22,988	3.9	597,417	3,240	0.5	23,468	3.9
Wandsworth	4,386	5,439	12,322	2.3	9,776	6,053	1.0	590,506	12,322	2.2	7,086	1.2
SWL Cluster	5,727	16,409	23,591	1.0	56,362	49,186	2.1	2,336,714	32,015	1.4	64,462	2.8

- 11/12 QIPP programme of @ 3% increases stretch by £17m over achieved QIPP in 2010/11
- Cluster surplus of £32m delivers a 1.4% surplus
- NHS SM to achieve 0.5% surplus
- 2% non-recurrent investment funds ring fenced at cluster level
- 0.5% contingency

Section 2b: Addressing the financial gap between allocation and spend in 2011/12...

QIPP savings initiatives by QIPP category (With the top ~ 77% by value highlighted excluding KPI's & CI's)



Section 2b: Addressing the gap between allocation and spend – our *analysis ‘points’ us towards operational priorities for QIPP...

Priority QIPP areas for SWL have been identified for both quality and productivity improvement

Areas with opportunity to improve quality and deliver significant savings

Back Office
Planned Care
Mental Health & Learning Disabilities
Primary Care
Urgent Care
Medicines Use
Right Care
Long Term Conditions
Acute Efficiencies

Key enablers to improve quality and delivery savings

Polysystems / local community networks
Primary Care

Areas that are a priority for quality improvement but not significant savings opportunities

End of Life
Maternity & Newborn
Children & Young People

SWL QIPP portfolio:

- PCT-led QIPP plans have been grouped into 15 bundles of similar initiatives, in turn mapped to 9 Clinical Working Group/other categories
- 80% of the QIPP savings will be achieved in the top 5 categories.
- Consideration has been given to what further improvement might be possible, beyond those already planned. Comparisons across the 5 SWL PCTs and to national benchmarks, as well as comparison with the SWL model of care and the results of workshops held in December and January collectively yielded many ideas, some of which have already been identified as SWL Cluster wide opportunities for implementation in FY 11/12 onwards.

Section 2b: Addressing the gap between allocation and spend in 2011/12 – our analysis ‘points’ us toward operational priorities for QIPP...

These are the biggest impact improvements currently planned

<p>Mental Health and Learning Disabilities Renegotiation of existing contracts, including driving efficiencies and redesigning pathways for earlier intervention and more community based services</p>	<p>Urgent Care Short stay emergency admissions Communitybased urgent care e.g. UCC's and Rapid Response Teams SPA 111 - Implementation by Apr 13</p>
<p>Primary Care Shifting adult outpatient activity out of acute into more cost effective setting closer to home</p>	<p>Maternity and Newborn Maternity day assessment unit</p>
<p>Long Term Conditions Pathway improvement including case management, self care support and targeted interventions including falls prevention</p>	<p>Right Care Atrial fibrillation Alcohol admissions Sexual Health</p>
<p>Planned Care Referral facilitation and management systems Redesign care pathways in selected areas, e.g. MSK..</p>	<p>Children and Young People Community Paeds Short breaks and palliative care</p>
<p>End of Life Care Implementing fully Care of Dying pathways, linked to long term conditions management</p>	<p>Acute Efficiencies Acute: Tightening schedules to increase quality and reduce cost (ACU Led following London Commissioning guidance. Review of non PbR payments and clinical challenges of invoices Community: Renegotiating with current provider and going out to tender, using market management to ensure value for money. Mainly CHS and continuing care Primary: Review of contracts and list cleansing</p>
<p>Medicines Use Reducing the prescribing projected cost growth by several percentage points</p>	<p>Specialist services Centralisation of specialist cardiovascular surgery</p>
<p>Other Acute Efficiencies</p>	<p>Back Office Management cost reductions Buildings sub lets</p>

Section 2c: Triangulation of PCT / Provider Plans... focus on the key issues

Basis of SWLC Acute Planning 2011/12

- 2010/11 M6 used as baseline
- 1.5% tariff deflator applied to all contracts
- Demographic & Non Demographic growth included – average between 2% to 3% (growth for cluster 2010/11 @ 2.2%)
- Additional non demographic reserves being held by each PCT, but excluded from SLA negotiations
- QIPP programmes allocated to individual contracts where activity is being reduced
- Reprovision of activity not allocated to individual contracts unless already tendered & agreed

Potential Risks

- Detailed work on tariff deflator based on actual case mix indicates overall deflator of 1.24% - exposure of £2.5m across SWL Cluster portfolio (all providers)
- Tariff deflator will impact differentially across PCTs, ranging from NHS C (0.02%) to NHS SM (0.98% = £1.2m)
- Impact of QIPP plans on financial stability of individual providers → both ESH and SGH have major financial challenges, especially with combination of QIPP proposed by NHS Surrey
- On going discussion to finalise 2010/11 outturn with SGH

Section 2d: The impact of delivering QIPP - How will the SWL cluster plan impact on providers...

These tables detail the proposed financial impacts of KPI/CI & QIPP schemes on providers for 2011/12

2011/12 total proposed impacts by provider	Croydon	Kingston	Richmond	Sutton & Merton	Wandsworth	TOTAL
	£m	£m	£m	£m	£m	£m
Epsom & St Helier	1.4	0.8	0.1	11.3	0.5	14.1
Imperial Healthcare	0.1	0.1	1.4	0.2	0.4	2.1
Kingston	0.0	4.6	2.3	0.9	0.5	8.2
Croydon Health Services	15.7	0.0	0.0	0.7	0.2	16.6
St Georges	0.8	0.7	0.3	6.0	7.1	14.9
West Middx	0.0	0.0	2.0	0.1	0.0	2.2
Sub total local acute	18.1	6.2	6.2	19.1	8.7	58.2
Other acute	2.1	0.4	1.4	4.3	4.8	13.0
Sub total acute	20.2	6.6	7.6	23.4	13.5	71.2
Other providers	6.9	4.0	2.3	3.9	6.8	23.9
Total proposed income reduction	27.1	10.6	9.9	27.3	20.3	95.1
KPI development adjustment	(4.6)	(2.5)	0.0	0.0	(4.4)	(11.5)
Reprovision costs	(4.4)	(1.3)	(0.9)	(3.8)	(8.8)	(19.2)
Total 11/12 QIPP net impact	18.1	6.8	9.0	23.5	7.1	64.4

The information above triangulates the agreed QIPP plan with initial starting discussions for 11/12 SLAs. Whilst the QIPP plan will deliver £64.5 million efficiencies, this will not necessarily be through the income adjustments shown above

Section 2d: The impact of delivering QIPP - How will the SWL cluster plan impact providers?...



South West London

This year's task - How will we do it?...

- More efficient working at hospitals through;
 - Reduced length of stay – e.g. hospital to home programme for all patients, integrated community rehabilitation and discharge services for respiratory medicine, stroke and cardiac conditions
 - Moving more care into community settings – e.g. re-provision of rheumatology services utilising specialised GP triage, moving diagnostics into community and enabling direct GP access/referrals
 - Reduce emergency admissions – e.g. proactive management and improved care pathways for angina, diabetes and epilepsy and increasing Rapid Response team hours
 - Reducing consultant to consultant referrals within hospitals
 - Tighter management of follow-up appointments and better clinical coding

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Section 2d: The impact of delivering QIPP - How will the SWL cluster plan impact providers?...

Impact on providers: SWL's QIPP plans will impact all providers, especially in-cluster acute providers:

- Plans will likely remove ~£92-100m+ from current providers in 2011/12; of this, ~£10-11m is available for re-capture (i.e., re-provisioning)
- SWL Cluster will monitor provider stability amidst this expected loss of income; in-cluster acute providers are each estimated to lose between 4.4% to 7.7% of income (before the effect of any re-capture, and excluding the impact of the 4% (this includes the per annum in-year 1.5% tariff efficiency requirement) and of other clusters' QIPP plans)

This section of the plan considers the – significant – commercial (financial) impacts of SWL Cluster QIPP targets on providers.

Engagement and collaboration with providers in respect of QIPP has commenced at the highest level (CEs, Chairs and medical/finance directors). However, as a part of the 'change plan' a more comprehensive programme of engagement and system collaboration will be required in order to mitigate the obvious commercial risks to providers – especially in the acute cluster.

NOTE: Impact on providers of PCT and ACU led savings plans will be the combination of (see appendix seven)

- 1) PCT-led QIPP plans
- 2) KPIs and London commissioning intentions
- 3) Sutton & Merton PCT's Better Healthcare Closer to Home programme (BHCH)

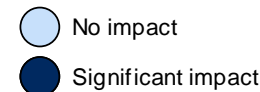
- (1) and (2) above have been integrated into all relevant slides throughout this document; (3) has not, because BHCH is a distinct and long-standing business-as-usual project

At this stage in the development of our plan we have focused our 'impact analysis' on acute provision (this is in line with the significance of risks in the area of the local health market). Over the coming weeks impact analysis will be broadened to include community provision – including the 'emergent' community provider that is Hounslow & Richmond Community Services. Further analysis will also include the impact of 'out-of-cluster' commissioning plans on 'in-cluster' providers – e.g. NHS Surrey commissioning plans.

- New national models of care mean more healthcare delivered outside of hospitals
- NHS trusts have been used in recent years to an income rise and now their income is set to fall by approx 8- 10 % as a result of:
 - QIPP initiatives (minus 5-8%)
 - Tariff deflator (minus 1.5%)
 - Efficiency savings (minus 2.5%)
 - Move to FT requiring increased liquidity (where a provider is not already an Foundation Trusts)
- In 2011 every Trust in SW London will have to become more productive.

Section 2d: The impact of delivering QIPP - How will the SWL cluster plan impact providers?...

SWL's QIPP strategy will impact all provider types



	Description	Acute	Mental health	CHS	Prim. Care	Implication
PCT-led service and contract changes	<ul style="list-style-type: none"> Reduction in income due to decommissioned services and service re-provision (although some of the re-provision may be done by the providers themselves) 	●	●	◐	◐	<ul style="list-style-type: none"> Providers need to be more productive and efficient, to reduce unit costs and contain activity levels (thereby countering demographic and non-demographic activity trends) Some services may need to be consolidated onto fewer sites Hospitals and mental health inpatient facilities will need to reduce capacity as less activity is provided in an acute and/or inpatient setting
Nationally-led tariff efficiency savings	<ul style="list-style-type: none"> Need to deliver ~4% year-on-year efficiency saving, becoming more efficient in providing the activity that remains with them 	●	●	●	○	<ul style="list-style-type: none"> Staff may need to work differently in the future, especially working more closely with colleagues in different care settings, providing more outreach services and support in the community Some acute or mental health providers may become financially and/or clinically unsustainable and may need to look at options such as merging with other organisations and/or putting in place network support arrangements with other providers
Consolidation for clinical quality	<ul style="list-style-type: none"> Consolidation of some services (e.g., specialised cardiovascular surgery) will mean the movement of some income between providers 	●	◐	◐	◐	<ul style="list-style-type: none"> Providers of out-of-hospital services will need to work together to provide out-of-hospital care more efficiently and in a much more integrated way, and reduce demand for activity through joint working

Section 2e: Assumptions around utilisation of 2% non recurrent funding...

The business cases for application of the 2% should demonstrate the true non-recurrent nature of the expenditure proposed. Any movement in resource to another organisation (whether or not the source of that funding is recurrent or non-recurrent) cannot be classified as non-recurrent in itself. It is the ultimate use of that resource which will define whether the commitment is truly non-recurrent in nature. When considering the non recurrent application, expenditure associated with over performance pressures, or other activity pressures, should not be treated as non recurrent unless it can be robustly demonstrated that the pressures are truly one off.

SW London cluster must sign off PCT expenditure that comes under the generic categories below:

- QIPP start up costs and Service Redesign
 - One off setup costs for pathway redesign or changing setting of care
 - Double running costs relating to pathway redesign or changing setting of care
 - Other one off costs related to QIPP start up or service redesign
- Revenue to capital transfers for capital expenditure that will be completed in 2011/12
- Workforce reconfiguration costs
- Non pay transition costs for developing the new system
- Other transition costs

Slide 60 details the expenditure across the generic categories above.

Any expenditure, which does not come under the categories in slide 63, will be signed off at the SHA Directors of Finance meetings through a business case template. Note that this does not need to be by PCT, but as an overall template for the region.

Section 2e: Assumptions around utilisation of 2% non recurrent funding

It is proposed to subdivide the overall reserve into the following investment pools:

£millions	Total value	Croydon	Kingston	Richmond	Sutton & Merton	Wandsworth
Borough local approval	13.4	3.3	1.6	1.7	3.6	3.2
Borough specific	13.4	3.3	1.6	1.7	3.6	3.2
Provider transition	8.9	2.2	1.1	1.1	2.4	2.1
Cluster allocated	8.9	2.2	1.1	1.1	2.4	2.1
TOTAL	44.5	11.0	5.3	5.6	11.9	10.7

	£million
IT transition	2.0
Consultancy	2.0
Estates	1.7
Turnaround	0.8
Interim staff	0.5
Excess travel	0.5
Pay overhang	0.3
Pay protection	0.3
Transition extra posts	0.3
HR contract termination	0.3
Finance year end	0.2
Total cluster allocated	8.9

Investment Pool	Type of expenditure	Recommending body
Borough local approval	QIPP schemes < £500k	Borough Management
Borough specific	QIPP schemes > £500k Provider Double running Revenue to Capital transfers	SWL Management Team
Provider transition	Workforce Reconfiguration Provider Double running	
Cluster allocated	Provider Reconfiguration Non Pay Transition	

Non pay transition includes redundancy or any other one off staff related costs for commissioners & providers

QIPP & reconfiguration includes costs associated with initial implementation and development of QIPP

Rev to cap transfers that will be completed in 11/12: Any recurrent resource used to fund capital expenditure in 11/12. Capital must be non recurrent & completed in 11/12

Current analysis suggests that SWL cluster will achieve £47.19 per weighted population in 2011/12 (excluding Public Health)

	10/11 PCT costs £'000	10/11 per weighted pop £	11/12 costs £'000	11/12 GP Dvpt Fund £'000	11/12 Transition Costs £'000	11/12 TOTAL £'000	11/12 costs £	11/12 GP Dvpt Fund £	11/12 Transition Costs £
Croydon	14,194	43.29	13,179	761	2,279	16,219	40.19	2.32	6.95
Kingston	6,735	46.66	5,558	382	978	6,918	38.51	2.65	6.78
Richmond	11,758	82.80	7,263	398	981	8,642	51.14	2.80	6.91
Sutton & Merton	29,610	84.96	19,437	787	2,828	23,052	55.77	2.26	8.11
Wandsworth	14,900	53.33	13,187	738	1,833	15,758	47.20	2.64	6.56
SWL cluster	77,197	62.15	58,625	3,066	8,900	70,589	47.19	2.47	7.16

- 11/12 costs will decrease as a result of further transition in year
- 11/12 includes cluster costs of £24.3 million
- Target reduction over 2 years is a further saving of £15m to £27m
- Key areas to address – Estates , IT, etc
- Clarification on what is included in £25-£35 per head (e.g. Primary Care Contracting shift to NCB – value for SWL cluster is £1.3m)
- Continual review of transition structures
- Transition costs are detailed on the previous slide

Section 2f: Assuring QIPP implementation through excellent performance and project management...

- **Plan delivery:** Executing the QIPP plans effectively means that SWL cluster is putting in place the right set of enablers, aligned with the most appropriate implementation model for each of the initiatives (some decisions already made at the January workshop).
- SWL has secured the support of an expert implementation team and is quickly building an appropriately resourced and influential Programme Management Office (based on what has worked for NHS Sutton & Merton) to oversee delivery.
- This section details these and further developments that will ensure 'best in class' performance management of this plan.
- Supporting information is to be found in appendix one.

DRAFT

Section 2f: Assuring QIPP implementation through excellent performance and project management...



South West London

The detailed implementation plan for 2011/12 QIPP initiatives is in the latter stages of being finalised. A detailed milestone plan for all schemes in all boroughs is shown in the following two slides. This has been prepared by individual borough leads together with support from the Cluster PMO and it shows trajectories for in year delivery for all initiatives over 200k. This is part of the 'readiness review' currently in progress with all boroughs. This task is being undertaken in order to be clear and confident that boroughs are ready to commence delivery of the 2011/12 QIPP programme by the 1st April 2011. The programme for QIPP is ambitious and so this task is intended to develop even greater clarity about the outcomes within the plan, the project controls, management and governance framework and reporting that will optimise QIPP delivery in the SW London Cluster.

The QIPP PMO team in mid March is 'auditing' implementation readiness and is working with Boroughs to support achieving 'best in class' standards for leading and managing the delivery of 2011/12 QIPP. The review is being carried out in a constructive way designed to identify and share cluster wide the good practice available; to identify those who need help and to increase our chances of delivery. This also aims to move the SW London cluster to a position where there are a set of consistently applied implementation standards across the patch.

At the same time an investment review for the next 5 years has also started with all Borough Managing Directors and GP consortia.

Section 2f: Assuring QIPP implementation through excellent performance and project management...



South West London

SWL Cluster QIPP Schemes - Key Milestones (For all QIPP Schemes over £200k)

QIPP Category	CPCT	KPCT	RTPCT	SMPCT	WPCT	Scheme	RAG Rating	Net Savings	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Back Office				X		Management Cost reductions	G	4,700.0	£'s	Budget adjustment										
	X					Back Office (As per Operating Plan)	G	2,965.0	£'s	Contract adjustment										
				X		HCAS Payment	G	822.0	£'s	Budget adjustment										
				X		CSL	G	676.0	£'s	Budget adjustment										
		X				Primary care improvement grants	G	459.6	£'s	Contract adjustment										
				X		HQ Sub Let	G	250.0	£'s	Budget adjustment										
	X				Non Pbr	G	235.0	£'s	Contract adjustment											
Total								10,107.6												

QIPP Category	CPCT	KPCT	RTPCT	SMPCT	WPCT	Scheme	RAG Rating	Net Savings	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	
Mental Health & Learning Disabilities	X					Mental Health Efficiency	G	1,682.0	£'s	Contract adjustment											
				X		Mental health savings	G	945.0	£'s	Reprovision											
		X				Mental health under commitment to block	G	915.1	£'s	Contract adjustment											
			X			Mental Health Pathway Redesign	A	800.0	£'s			Phased equally								£'s	
					X	Mental Health Contract (2% reduction)	G	788.0	£'s	Contract Adjustment											
			X			Contract Rebasing	A	500.0	£'s	Contract adjustment											
			X			Data Validation	G	497.2	£'s			Ramp up	↑ £'s			↑ £'s			↑ £'s		
		X			X	Forensics	A	459.7	£'s				Phased equally								£'s
					Mental health south bank house closure	G	325.2	£'s	Contract adjustment												
				X	DAAT : Drugs And Alcohol 1 - SWLGH	G	200.2								£'s		Phased equally		£'s		
Total								7,112.3													

QIPP Category	CPCT	KPCT	RTPCT	SMPCT	WPCT	Scheme	RAG Rating	Net Savings	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	
Planned Care	X					MCATS (Musculoskeletal) - FYE + Extension	G	999.0	£'s	Contract adjustment											
	X					Decommissioning - combined	A	538.0	£'s			Ramp up	↑ £'s					↑ £'s			
			X			Quality Gateway	A	502.3							£'s		Phased equally		£'s		
			X			Continuing Care VFM	G	499.3	£'s			Ramp up	↑ £'s			↑ £'s			↑ £'s		
			X			Continuing Care VFM (Mental Health & Learning Disability)	G	499.3	£'s			Ramp up	↑ £'s			↑ £'s			↑ £'s		
				X		Early Discharge Service	A	435.3	£'s			Ramp up	↑ £'s			↑ £'s			↑ £'s		
	X					Waste Avoidance (OP Attendance Efficiency)	G	409.0	£'s	Contract adjustment											
	X					Gynaecology Outpatients - FYE + Extension	G	363.0	£'s	Contract adjustment											
	X					Gynaecology - Hysteroscopy Daycases	G	316.0	£'s				Phased equally								£'s
				X		Anticoagulation	A	206.0	£'s				Phased equally								£'s
			X			Clinical Assessment Service	A	205.4	£'s				Phased equally								£'s
				X		Alternative Therapies - Decommissioning	G	200.0	£'s	Decommissioning											
				X		Hips and Knees reducing attendances	G	200.0	£'s			Ramp up	↑ £'s			↑ £'s			↑ £'s		
Total								5,372.5													

Section 2f: Assuring QIPP implementation through excellent performance and project management...



South West London

SWL Cluster QIPP Schemes - Key Milestones (For all QIPP Schemes over £200k)

QIPP Category	CPCT	KPCT	RTPCT	SMPCT	WPCT	Scheme	RAG Rating	Net Savings	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	
Primary care					X	GP List Cleansing	G	2,090.2			£'s			£'s			£'s		Specific months		
	X					Primary Care Efficiency	G	650.0	£'s	Contract adjustment											
	X					Primary Care Growth Saving	G	644.0	£'s	Contract adjustment											
		X				Primary care FP69	G	522.3	£'s			£'s	Specific months								
	X					PMS Review	A	500.0	£'s	Contract adjustment											
			X			GP Overheads/PMS	G	364.9	£'s				Phased equally								£'s
			X			GP Led Health Centre	A	303.7	£'s						£'s			Ramp up			↑ £'s
					X	Dental practice UDA adjustment	G	250.0	£'s	Contract Adjustment											
		X			Primary Care efficiencies	G	214.8	£'s				Phased equally								£'s	
Total								5,539.8													

QIPP Category	CPCT	KPCT	RTPCT	SMPCT	WPCT	Scheme	RAG Rating	Net Savings	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	
Urgent Care	X					Polysystem Urgent Care Programme: A&E	G	2,250.0	£'s	Contract Adjustment											
				X		Negotiation of Short Stay Tariff	G	800.0	£'s			Phased equally									£'s
	X					COPD Community Service Redesign	G	441.0	£'s			Ramp up	↑ £'s		↑ £'s			↑ £'s			
					X	Community Urgent Care Commissioning	G	384.4	£'s				Phased equally								£'s
		X				Urgent Care	G	369.4	£'s	Contract Adjustment											
			X			Rapid Response Service	A	348.0	£'s			Ramp up	↑ £'s		↑ £'s			↑ £'s			
				X		Reducing Short Stay admissions - (Increase in ambulatory care)	A	347.0	£'s				Phased equally								£'s
				X		Clinical support for nursing homes BHCH	A	250.0	£'s				Phased equally								£'s
			X		Reducing A&E attendances	G	220.0	£'s				Phased equally								£'s	
Total								5,409.8													
Grand Total								33,542.1													

The QIPP schemes described above constitute more than 70% of the total QIPP schemes for the South West London Cluster.

Section 2f: Assuring QIPP implementation through excellent performance and project management...



South West London

SWL Cluster QIPP Governance arrangements

The implementation plan includes SW London governance arrangements to ensure implementation of the QIPP schemes through a PMO structure, adherence to contracts led by the Acute Commissioning Unit and financial management in each of the Boroughs led by the Director of Finance.

Additionally there is emphasis on supporting clinical commissioners in the development of their new role as Commissioners.

The cluster QIPP director in collaboration with PCT colleagues and GPs, identified areas for stretch of QIPP schemes. This includes where schemes could be extended locally and cluster wide to meet best practice. This work will be taken forward in 2011/12 across the SW London Cluster.

This step also describes engagement in the QIPP plan development and sets out a strong communications and engagement plan in SW London to ensure ownership from a large number of key stakeholders.

SMPCT methodology has been accepted as best practice for cluster implementation due to proven track record of success in 2010/2011

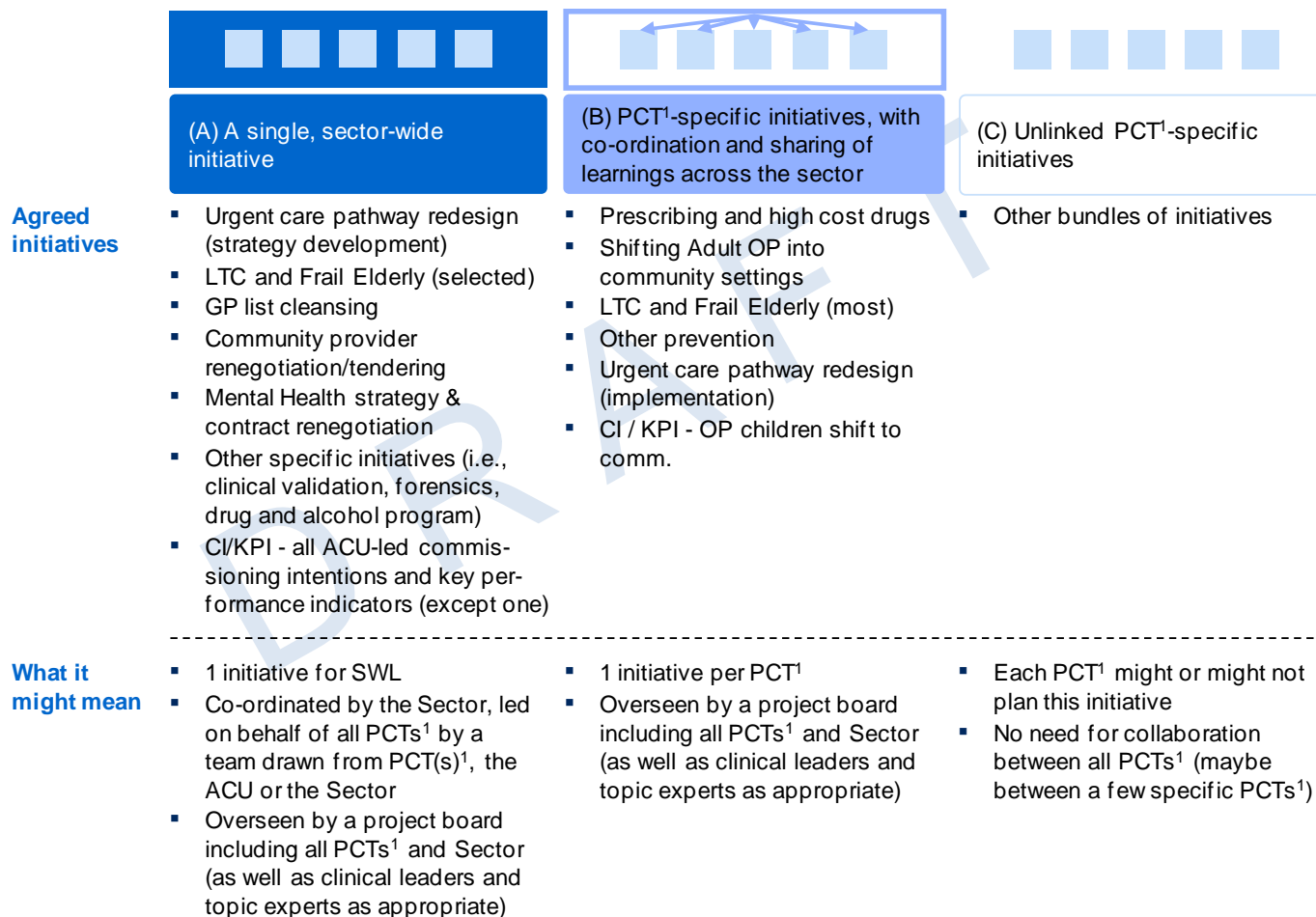
The responsibilities for implementation of 11/12 QIPP will sit with the Cluster Director of Finance:

- PMO will have responsibility for monitoring and reporting on the progress of in-year QIPP Initiatives;
- PMO will maintain close links with borough staff, GP Commissioners and Providers;
- PMO will maintain a close working relationship with the QIPP Planning element of the Strategy, Performance and Planning Directorate to facilitate transfer from planning phase to in-year delivery.

Acute Contract Management and Monitoring will be led by the ACU working with Borough MDs as appropriate.

Section 2f: Assuring QIPP implementation through excellent performance and project management...

SWL Cluster have agreed best approach implementation practice for each of the main planned improvements



¹ Or other future commissioning body, or group of such bodies

Each meeting should have a clear purpose with supporting reports and analysis

Meetings	Frequency	Objectives
Cluster PMO update team meeting	<ul style="list-style-type: none"> ▪ Weekly 	<ul style="list-style-type: none"> ▪ Exception review of projects via ‘Flash Reports’ ▪ Go / No Go gate for new projects
Cluster-coordination meeting	<ul style="list-style-type: none"> ▪ Monthly 	<ul style="list-style-type: none"> ▪ Review, challenge, and approve Sector best-practices for Sector-coordinated initiatives
QIPP Steering Committee meetings	<ul style="list-style-type: none"> ▪ Monthly 	<ul style="list-style-type: none"> ▪ Review QIPP project Finance, Delivery & Risk at SWL Sector level ▪ Approve Sector ‘Best Practice’ findings for Sector-coordinated initiatives ▪ Make Go / No Go and other required decisions ▪ Review communications strategy every third month
NHS SWL leadership updates	<ul style="list-style-type: none"> ▪ Monthly 	<ul style="list-style-type: none"> ▪ Review QIPP programme progress and key risks

Section 2f: Assuring QIPP implementation through excellent performance and project management...QIPP schemes have been 'de-risked'

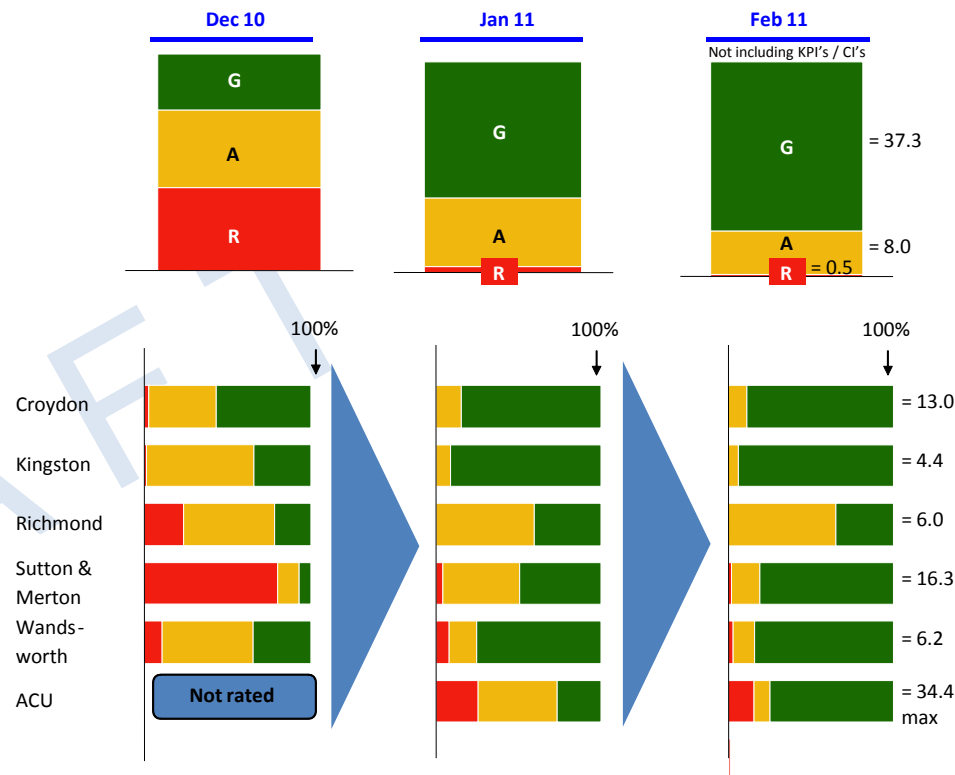
Delivery and Implementation

- The implementation plan includes SW London governance arrangements to ensure implementation of the QIPP schemes through a PMO structure, adherence to contracts led by the Acute Commissioning Unit and financial management in each of the Boroughs led by the Director of Finance.
- Additionally there is emphasis on supporting clinical commissioners in the development of their new role as Commissioners.
- The cluster QIPP director in collaboration with PCT colleagues and GPs, identified areas for stretch of QIPP schemes. This includes where schemes could be extended locally and cluster wide to meet best practice. This work will be taken forward in 2011/12 across the SW London Cluster.
- Risk Assessment methodology has been designed by the interim Turnaround team who are experienced in such matters. It follows the same methodology which has been employed to date across NHS Sutton & Merton (NHSSM). It bases its assessment on a number of factors which have been consistently applied across Cluster plans. It has been used to good effect across NHSSM for 12 months.
- Savings to be delivered by a combination of PCT QIPP Leads and the Cluster Programme Management Office (PMO)

ACU Delivery

Delivery to be assured via:

- Robust management – Contact round negotiations methodology & review of current contact monitoring and performance methodology

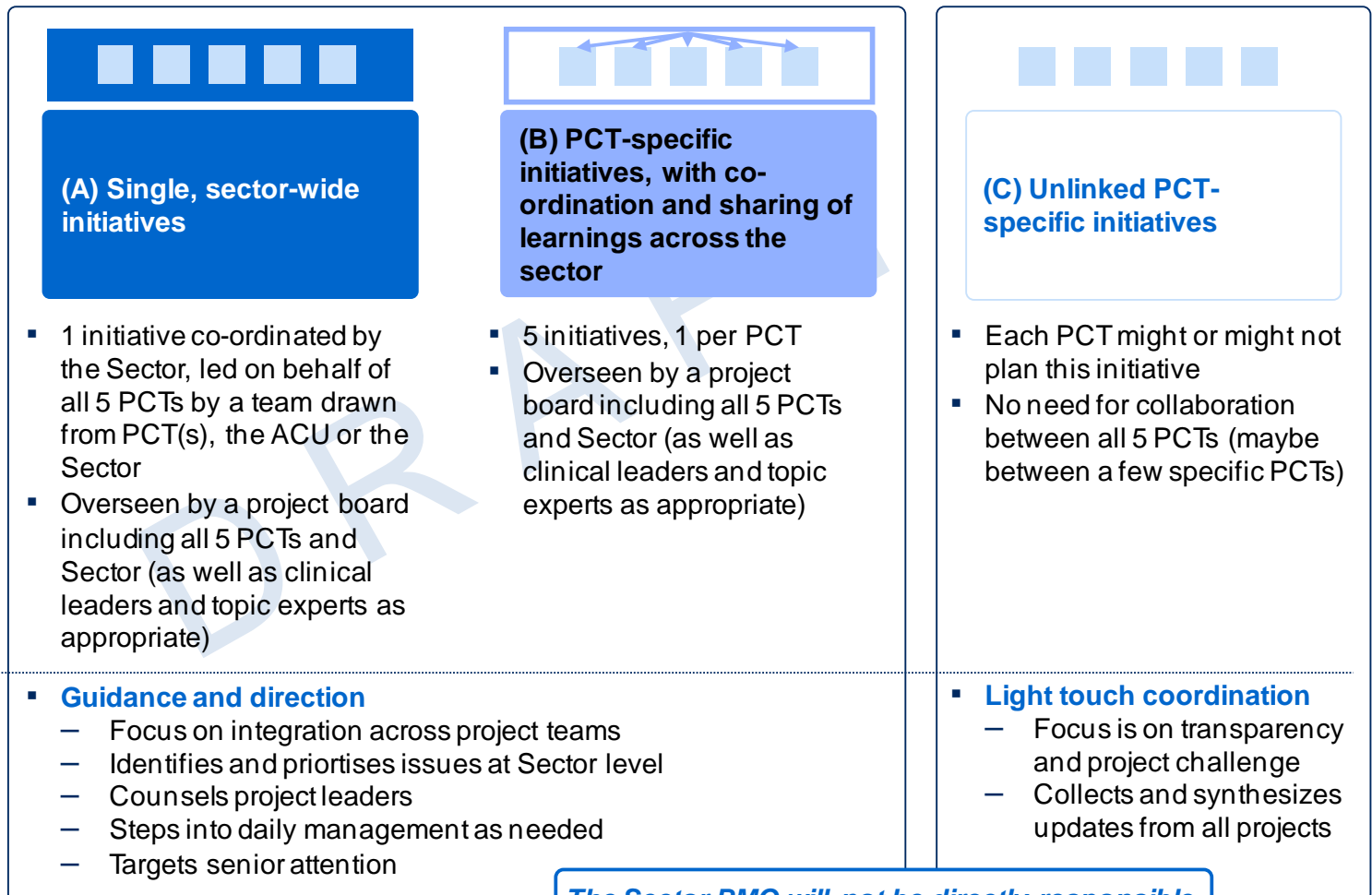


RAG Rating of Schemes

- Since Dec 10, the PCT led QIPP Schemes have been matured and their RAG rating has been monitored. As of now (Feb 11) 70% of the schemes are assessed as 'Green', 29% as 'Amber' and just 1% as 'Red'
- Appendix 6 provides some examples of programmes under development.

Section 2f: Assuring QIPP implementation through excellent performance and project management...a cluster PMO is being set up

The Cluster PMO will play different roles for initiatives based on QIPP implementation categories (1/2)



The Sector PMO will not be directly responsible to implement and deliver any QIPP initiatives

Section 2f: Assuring QIPP implementation through excellent performance and project management – KPIs...

Quality Performance Measures provide tangible evidence of how we have improved clinical outcomes and patient experience of the services we commission.

Historically we have performed well against the key performance measures. Our aim is to not only sustain but to further improve our performance against the Quality Performance Measures. Delivery of initiatives' summarised in the SWL QIPP Plan is essential in this regard.

We have reviewed current performance and identified areas at risk of under achievement. We have identified leads, for all Quality Performance Measures by mapping where their delivery best sits – Cluster or Borough level. For those measures where there is a risk of underperformance these leads are developing action plans to secure achievement in 2011/2012.

Summarised below are the key performance issues for 2011/2012:

Health Care Associated Infections (HCAI)

- During 2010/2011 all acute trusts reported incidents of MRSA and CDI.
- MRSA reported incidents breached or came close to the trajectory set.
- CE lead meetings were held with acute hospitals with the purpose establishing assurance policies and procedures are in place.
- Actions arising from these meetings will be monitored to ensure that the risk of HCAI is mitigated.

RTT Waits

- A key priority in the SWL QIPP plan is the shift of outpatient activity from a hospital setting to a variety of community based settings.
- The roll out of polysystems/LCNs, which includes outpatient shifts, will continue across SWL in 2011/2012.
- Examples of shifts in the QIPP plan include dermatology and ophthalmology in Wandsworth; Better Healthcare Closer to Home in Sutton and Merton and ambulatory pediatrics services developed by Croydon.
- By delivering increased activity in the community, capacity can be freed up in the acute hospital to ensure that all RTT standards are met.
- Matching standards will be set for outpatient activity provided in the community preventing deferential waiting times across settings of care.
- There will also be an expansion of current schemes, such as the Clinical Assessment Service across SWL cluster.

Mixed Sex Accommodation (MSA) Breaches

- Commissioner visits were made in 2011 to each of the 4 non-FT trusts in SWL to assure guidance for MSA was being applied correctly and that action was being taken to eliminate all MSA were at all possible by 1st April 2011.
- Following these visits 1 trust was found to have no significant issues. The other three trusts were requested to complete actions plans detailing how breaches in MSA were being addressed.
- The SWL Cluster will continue to monitor these action plans during 2011/2012 to ensure that MSA breaches are kept to a minimum. We will also work with non-acute and mental health providers to ensure that they also comply with the MSA guidance were at all appropriate.

Cont...

Section 2f: Assuring QIPP implementation through excellent performance and project management – KPIs...

Cont...

A&E Quality Indicators

In SWL we have been piloting a range of A&E Indicators enabling accurate reporting against the new performance measures from 2011/2012 onwards. We acknowledge that all our A&E Departments have been experiencing an annual growth in attendances that has presented challenges to in meeting the new performance measures. To address the growth in attendances and to support the achievement of the performance measures in 2011/2012 we are adopting a range of measures such as –

- Primary Care Led Urgent Care Centres co-located with A&E Departments as proposed at St George's
- Meet and greet services where the nurse redirects appropriate patients from A&E back to primary care
- Rapid Response Service run by Hounslow and Community Healthcare to reduce A&E admissions
- LTC care pathways redesign such as COPD in Croydon to prevent patients attending A&E and being admitted.

QIPP initiatives will reduce unnecessary attendances to A&E giving providers the headroom to focus on achieving the quality indicators.

Emergency Readmissions

Reduction of readmissions within 30 days is a key priority within the SLW QIPP. Schemes include –

- Elderly assessment in Sutton and Merton to proactively manage patients in a community setting.
- Improved care pathways and proactive management of patients with LTC in order to reduce emergency readmissions
- Roll-out of admission avoidance schemes such as the Rapid Response Team in Richmond and the Virtual Ward in Wandsworth to manage patients in their home or community setting.

Acute Commissioning Unit – performance underpinned by contractual agreements...

The implementation of London Commissioning Intentions and the development of additional/strengthened contract KPI's have been established by SWL ACU.

To demonstrate and assure strategic alignment with PCTs and Clinical Commissioning Groups and to optimise productivity and value for money benefit these schemes have been:

1. Externally assessed and benchmarked London and national top quartile indicators.
2. Aligned with local QIPP and pathway redesign initiatives to remove duplication of activity count.
3. Costed against revised national tariffs for 2011/12 and detailed PbR guidance (where schemes are specialty and not
4. HRG based the generic 1.5% average deflator has been applied)

Final agreement on implementation of 30 day re-admission KPI local application of re-enablement funding and adjustments to 'emergency threshold' subject to final DH contract documentation.

Other strategic impact assessments have been undertaken to shape contract negotiations and to finalise assumptions on benefits of CI's and KPIs. These include:

1. Impact on providers of other health community QIPP plans (NB NWL & Surrey)
2. Alignment with cluster (and borough) PMO and other delivery mechanisms
3. Coherence with emerging Clinical Working Group recommendations and sign off of 2010/11 negotiating frameworks

- ❑ **St Georges Healthcare achieved 75% delivery of 18 weeks in 10/11:**
 1. New Programme Director at SGH has shown that across the Trust the 18 week PTL shows the same patient numbers on the waiting list as 12 months ago, i.e. zero increase in numbers waiting;
 2. SWLACU has agreed transitional relief with SGH for first quarter of 11/12. This will be invested in additional Independent Sector lists to ensure the delivery of 18 week max target.
- ❑ **Other SWL providers are delivering 18 week max waits in 10/11:**
 3. A continuation of existing performance monitoring arrangements should ensure delivery of 18 week max target for 11/12.
- ❑ **Impact of QIPP programme in 11/12:**
 4. Cluster PMO has undertaken an initial review of the extent to which individual schemes have an impact on statutory targets, including 18 week max wait. Activity will be monitored through the PMO to ensure a commensurate reduction in order to ensure max waits delivered and performance to activity and financial plans.

Section 2f: Assuring QIPP implementation through excellent performance and project management – detail of KPIs...

	Headline Measure	QIPP Initiative/ACU Intervention	PCT Trajectory	LEAD
QUALITY (Safety, Effectiveness & Patient Experience)	HCAI Measure (MRSA & CDI)	Contractual Obligation Non-elective admission avoidance reduction in ne admissions and therefore rate of HCAI	Yes – target figures set nationally	ACU
	Patient Experience Survey (national inpatient survey)	Contractual Obligation	No	ACU
	RTT Waits Admitted 95 th Centile – 23 weeks Non-admitted Centile – 18.2 weeks Incomplete 95 th Centile – 28 weeks	Contractual Obligation Planned Care – Outpatients and other services delivered in alternative settings of care e Referral Management – reduce high referral rates	No	ACU/Borough
	Mixed Sex Accommodation Breaches	Contractual Obligation	No	ACU/Borough (community)
	A&E Quality Indicators Unplanned re-attendance rate (re-attendance with 7 days) >5% Total time spent in A&E – 95 TH centile > 4 hours Left Department without being seen rate >5% Time to initial assessment – 95 th centile Time to treatment in department - median	Contractual Obligation Primary Care UCC schemes Alternative care pathways LAS Admission Avoidance Schemes LTC risk assessment & case management Reablement schemes	No	ACU/Borough

Section 2f: Assuring QIPP implementation through excellent performance and project management – detail of KPIs...

	Headline Measure	QIPP Initiative/ACU Intervention	PCT Trajectory	LEAD
QUALITY (Safety, Effectiveness & Patient Experience)	Cancer Waits 9 indicators	Contractual obligation Referral Management (2WW) Poly system development	No	ACU/Borough
	Emergency Readmissions with 30 days	Contractual obligation Admission Avoidance schemes Reablement schemes LTC risk assessment & case management – Croydon Diabetes Network; elderly assessment	No	ACU/Borough
	VTE Risk Assessment	Contractual obligation	No	ACU
	% Deaths at home (inc care homes)	End of Life Care Admission avoidance and re-ablement monies Implementation of the Gold Standards Framework	Yes	Boroughs
	Stroke Proportion of people who have had a stroke who spend at least 90% of their time in hospital on stroke unit. Proportion of people who experience a TIA are assessed and treated within 24 hours	Contractual Obligation	No	ACU
	Carers Breaks Agree and make available to local people policies, plans and budgets to support carers	Join carers strategy agreed with LAs	No	Borough

Section 2f: Assuring QIPP implementation through excellent performance and project management – detail of KPIs...

	Headline Measure	QIPP Initiative/ACU Intervention	PCT Trajectory	LEAD
QUALITY (Safety, Effectiveness & Patient Experience)	Access to NHS Dentistry	Re-negotiation of UDAs and piloting the new national contract for Dentistry	Yes – trajectories already in place and being	SWL Cluster
	PROMS Scores	Contractual Obligation	No	ACU
	Maternity 12 weeks	Existing commitment. PCTs improvement plans in place to hit 90% in 11/12. Contractual obligation	No	ACU/Borough
	Mental health Measures Early intervention teams CR/HT teams CPA IAPT	Remodeling of inpatient/community services Redesign of primary mental health pathway Developing IAPT services	Yes for IAPT – no for the rest	Borough
	Low Value Procedures	Contractual obligation SWL Policy established for several years	No	ACU
	Smoking Quitters	Existing commitment. PCTs improvement plans in place	Yes	Borough
	Breastfeeding at 6 weeks	Existing commitment. PCTs improvement plans in place	Yes	Borough
	Breast Screening	Focus on implementing age extension and improvement at the Duchess of Kent Unit	No	ACU/Borough
	Bowel Screening	PCT plans in place for achievement in place	Yes	Borough
	Cervical Screening	Existing commitment. PCTs improvement plans in place	Yes	Borough
	Diabetic Retinal Screening	Existing commitment. PCTs improvement plans in place	No	Borough
	Coverage of NHS Health Checks	PCTs have delivery plans in place to meet 18% coverage target by end of 11/12	Yes	Borough
	People with Long Term Conditions feeling independent and in control of their condition	The service design work around the shifting of care programme for LTC will help meet this measure	Yes	Borough
	Emergency Admissions for Long Term conditions	Admission avoidance and re-ablement monies. Admission Avoidance Schemes LTC risk assessment & case management	No	ACU

3a: A commissioning risk. NHS Sutton and Merton

3b: Overall Risks & Opportunities

DRAFT

- In 2011/12 NHS Sutton & Merton is entering the second year of a 2 year turnaround programme, with a QIPP plan of £23.5m
- Year 1 (10/11) of the £22m Better Value/Turnaround programme was supported substantially by suspending non-core investments and through the sale of assets
- Year 2 (11/12) returns the PCT to a position of underlying financial balance, building on the successes of the year 1 programme
- Much of the year 2 plan is focussed on driving down acute spend, which requires even greater operational focus
- To lead this process, NHS SM will continue to be supported by a dedicated turnaround director with the support of the sector PMO
- CTB funding in 2010/11 requires turnaround director, and requires demonstrable progress against plans before further investment funds can be accessed
- Established QIPP projects will continue to be delivered under the management of the borough teams, new projects will be supported by dedicated QIPP team

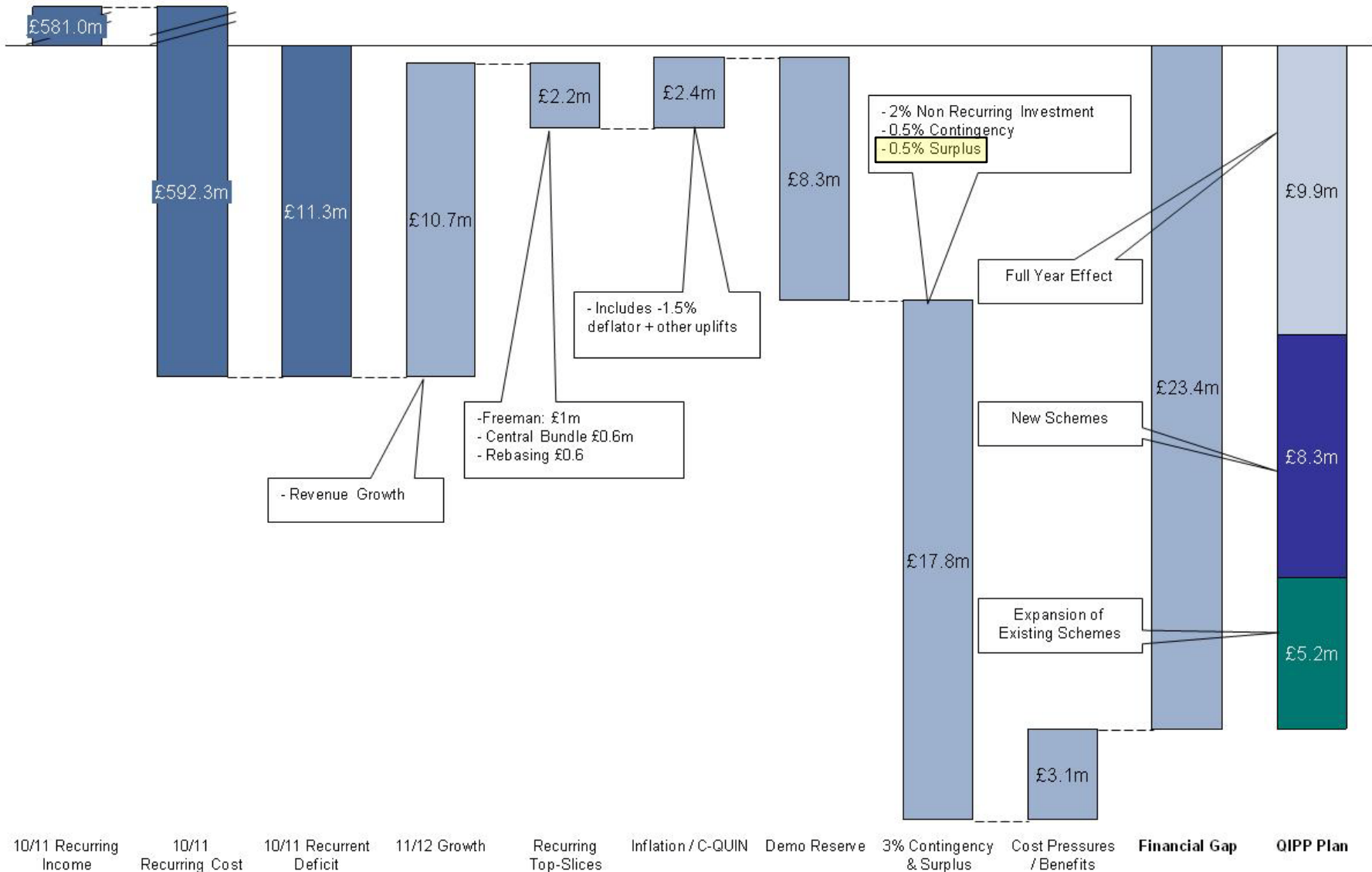
Section 3a: SWL A commissioning risk NHS Sutton & Merton Programme...

	Risk	Mitigation
1	Lack of support from clinical commissioners to the relevant aspects of the programme.	<ul style="list-style-type: none"> • Joint sign off of the PCT commissioning intentions and QIPP plan. • Responsibility for aspects of the plan taken on by clinical commissioners. • Seminar to review the QIPP plan with clinical commissioners. • Continued attendance of clinical commissioner reps at the better value board.
2	Lack of buy in from acute clinicians and management to support the required service developments.	<ul style="list-style-type: none"> • Continuation of the demand management board with ESH. • Establishment of a fortnightly operational meeting with SGH.
3	Loss of organisational memory due to the transition process.	<ul style="list-style-type: none"> • All QIPP schemes will have a detailed delivery plan held centrally by the PMO • Expectation that a number of key existing ADs and managers will be retained in the new structures
4	Lack of resources to deliver the programme as a result of the reduction in headcount.	<ul style="list-style-type: none"> • Matrix working across the two boroughs to make best use of resources. • Dedicated QIPP function incorporated into the borough structures. • Development of some schemes across SWL at sector level.
5	Failure of specific QIPP plans.	<ul style="list-style-type: none"> • Sector PMO established to monitor delivery of QIPP programme. • Development of further QIPP schemes underway to allow for shortfalls on existing schemes.
6	Unforeseen cost pressures in other areas such as bariatric surgery and forensic mental health	<ul style="list-style-type: none"> • The development of specific plans to protect against over spends in areas that are likely to give rise to cost pressures. This includes the development of a system of acute challenges based on the existing model but expanded to include clinical support and a focus on clinical coding.

Section 3a: SWL A commissioning risk NHS Sutton & Merton underlying deficit for 2011/12...



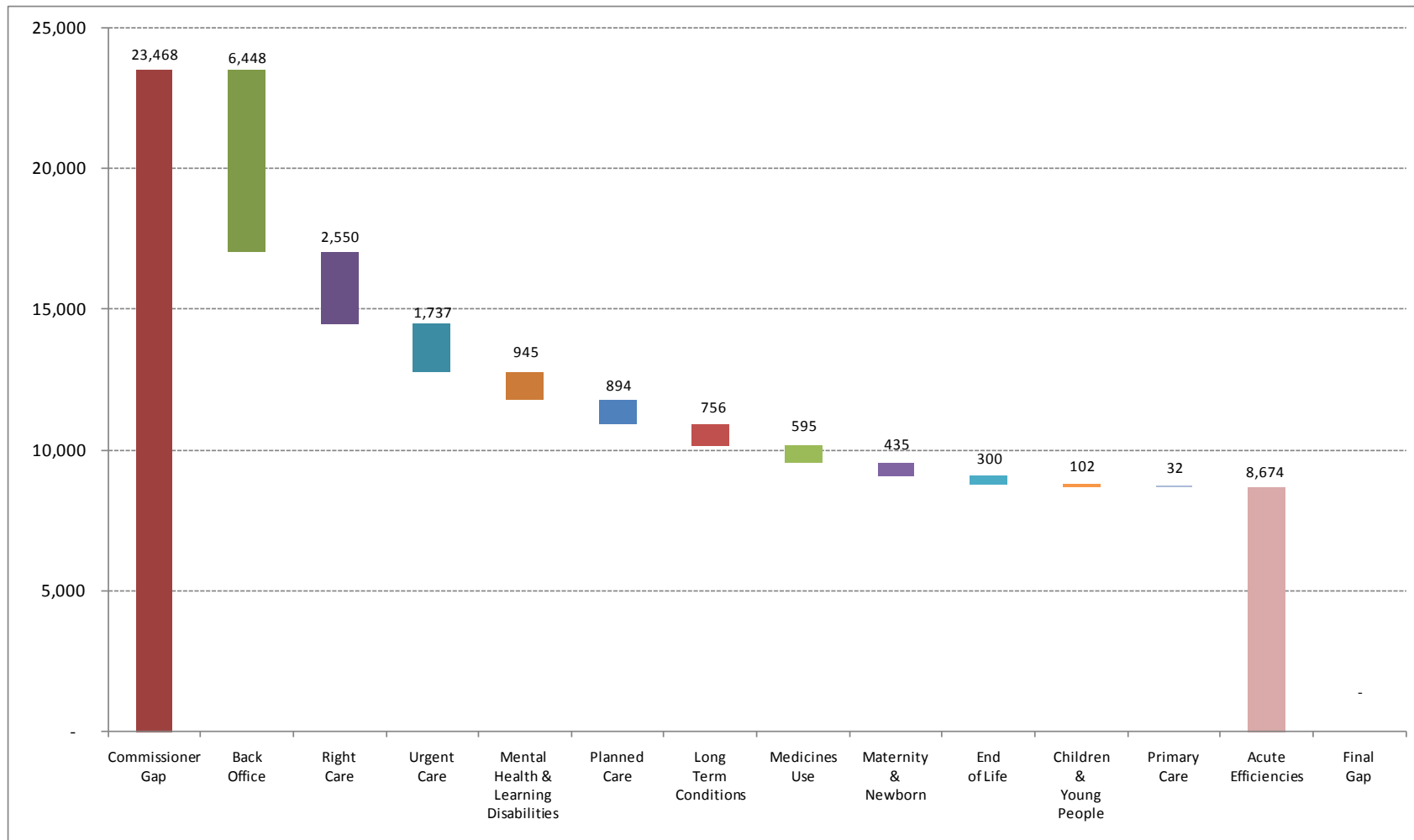
South West London



Section 3a: SWL A commissioning risk NHS Sutton & Merton QIPP plan, Closing the Gap...



South West London



Section 3a: SWL A commissioning risk

Key NHS Sutton & Merton QIPP projects by work stream...



South West London

Back office

- Reductions in headcount are expected to yield savings in running costs of £4.7m
- Following the agreement for the down sizing of CSL, NHS SM's contribution will decrease by £0.7m

Right care

- Reductions in outpatient referrals through GP peer review within and between practices, additional review of junior GPs and telephone/e-mail advice and support to GPs to save £1.3m
- Introduction of stop before the op into the referral pathway to reduce the costs of surgery and to generate a one off in year saving by delaying patients going for surgery to save £0.75m
- Introduction of patient decision aids to ensure that all treatment options are discussed with patients before proceeding to surgery, such as using osteopathy to treat lower back pain in place of spinal surgery to save £0.5m

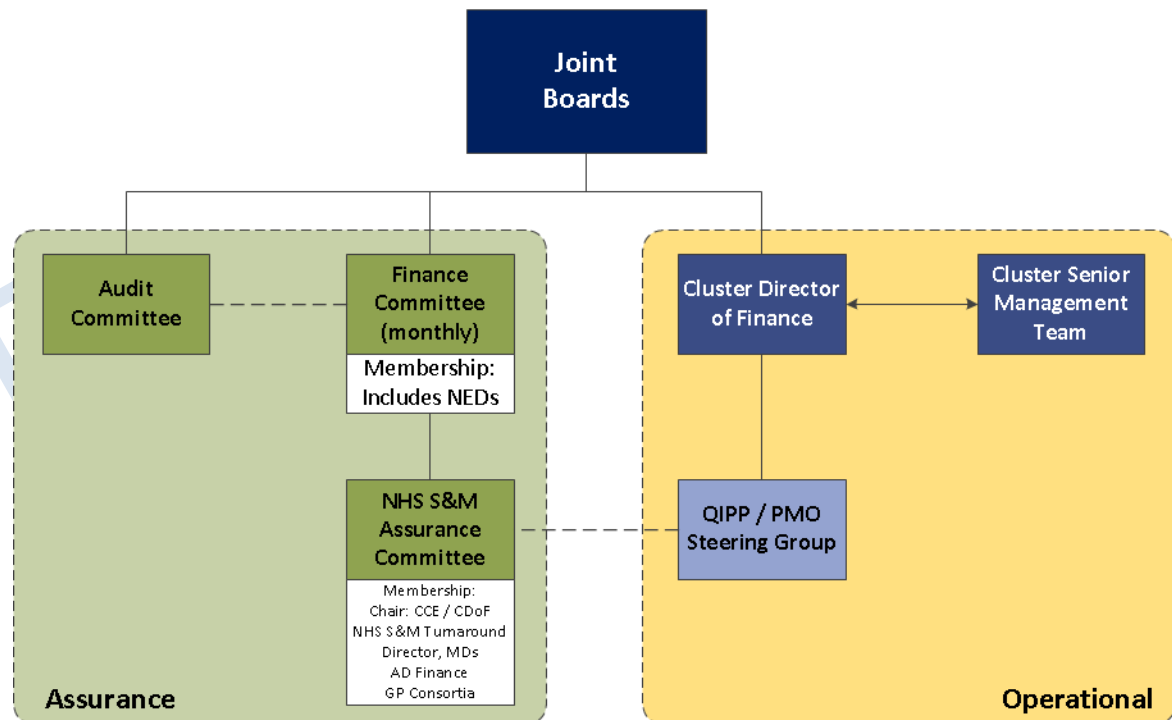
Other acute efficiencies

- On top of the savings from contract levers detailed in urgent care further acute efficiencies will be extracted using contract levers including specifying settings of care, outpatient KPIs, multiple first outpatient appointments and ante natal contacts saving £5.8m
- In addition, from 1st April 2011 NHS SM will no longer pay the high cost area supplements to the two acute trusts that it hosts saving £0.8m

Section 3a: SWL A commissioning risk NHS Sutton & Merton Programme Governance...

- The NHS SM QIPP team will form part of the shared services function which will operate across both boroughs reporting to the borough MDs
- The QIPP team will not operate as a PMO function, but will be responsible for taking new QIPP initiatives from conception to mobilisation. Once operational, responsibility passes to the commissioning team
- The QIPP team will draw on additional commissioning and clinical expertise as required, and will support emerging clinical commissioners
- The QIPP team will be responsible for liaising with the acute trusts and other stakeholders to ensure that there is joined up working where required

Governance & CTB Funding



Section 3a: SWL A commissioning risk: Assuring QIPP implementation – ‘special’ treatment in respect of NHS Sutton & Merton...



South West London

Whilst NHS Sutton and Merton (NHSSM) has made huge strides in addressing its underlying financial position during 2010/11, their Better Value (now QIPP) programme has always been a 2-year recovery.

NHSSM will be a part of the implementation performance management and governance processes described in this section.

It will also receive ‘special’ treatment in terms of:

- The support of a dedicated interim Turnaround Director (Simon Currie – who has been interim Commissioning Director NHSSM for 7 months)
- Specific scrutiny as a stand alone item on the agenda of all performance assurance meetings (weekly and monthly).
- Continuance of the Better Value management controls and governance which have – to date – successfully delivered year one recovery (2010/11)

Sutton & Merton’s approach to 2010/11 financial recovery will also inform the cluster implementation plan.

The overall Cluster Turnaround Director (Steve Davies – who has been interim Turnaround Director for NHSSM for 10 months) will ensure that NHSSM best practice is transferred from NHSSM Better value programme to the benefit of the cluster Turnaround plan.

Furthermore the additional professional, interim Turnaround Support requirement (2 x Programme Managers) will be ‘satisfied’ by using the two interim experts who have supported NHSSM plans for 9 months.

Section 3a: SWL A commissioning risk: Assuring QIPP implementation – ‘special’ treatment in respect of NHS Sutton & Merton...

Accountability & responsibility matrix FY11/12 QIPP plans (Agreed with NHSSM Better Value Programme Board - pending agreement with NHSSM’s PEC/Commissioning Board)

Principles of the transition process from Better Value to QIPP

- Minimum bureaucracy and only essential central control and performance management.
- Accountability and responsibility to be understood and accepted before 1 April 2011.
- Year one management of programme by prevailing delegated and non-delegated accountability.
- Year one accountability at cluster and Borough MD level.
- Need clear escalation rules to ensure Programmes / Projects stay on Plan

Note - There is no national or delegated accountability or responsibility being placed on emerging federations or consortia of GPs for QIPP 2011/12 – we rely on good collaboration and teamwork between providers, local consortia, PBCs and MDs. The latter of which are ultimate recipients of non-delegated responsibility for QIPP delivery.

Plans are underway to begin the transition from PCT to GP consortia with shadowing in 2011/12 followed by handover in 2012/13

	Accountable	Responsible
Overall NHSSM FinancialBalance	X2 BoroughMDs	X2 BoroughMDs Collaboration and teamwork with Consortia& Federation
GP Commissioning FinancialBalance	X2 BoroughMDs Collaboration and teamwork with Consortia& Federation	ProgrammeLeads
Borough QIPP Plans (ProgrammeLevel)	ProgrammeLeads	ProjectLeads
Borough QIPP Plans (ProjectLevel)	ProjectLeads	ProjectTeams
	Accountable	Responsible
Overall turnaround reportingto the Board	Consortia& Federation	X2 BoroughMDs Collaboration and teamwork with Consortia& Federation
Design & Delivery of turnaround Reports andReportMaterials	ProgrammeLeads	ProjectLeads

This page demonstrates that the NHSSM has a clear and communicated understanding of where the accountability and responsibility resides for QIPP delivery

Section 3b: Overall Risks & Opportunities



South West London

	Risks	Opportunities
Cluster wide	<ul style="list-style-type: none"> • Management capacity • Acute over-performance against SLAs • Non acute over-performance • Inability to fully deliver QIPP initiatives • Inability to rigorously implement contract KPIs • Increased re-provision costs for QIPP initiatives • Assumptions in respect of SGH for growth/KPIs and business case activity • Slippage of investment provisions and contingencies 	<ul style="list-style-type: none"> • Further stretch for QIPP initiatives • Cluster wide application of QIPP initiatives
Borough specific:		
Croydon	<ul style="list-style-type: none"> • Dependency on delivery of QIPP programme to support 11/12 plan. 	
Kingston	<ul style="list-style-type: none"> • Dependency on delivery of QIPP programme to reinstate reserves may reduce surplus if QIPP does not deliver 	<ul style="list-style-type: none"> • Expansion of Clinical Assessment Service
Richmond	<ul style="list-style-type: none"> • Inability to realise required QIPP KPI efficiencies at key non SWL providers • Activity over-performance beyond 10/11 outturn at non SWL providers • Planning information of insufficient quality from local providers to support QIPP initiatives 	<ul style="list-style-type: none"> • Establishment of Clinical Assessment Service – additional efficiencies may be possible
Sutton	<ul style="list-style-type: none"> • Cost overhang for PCT resulting from externalisation of community provider to RMH 	
Merton	<ul style="list-style-type: none"> • Delivery of surplus given significant value of QIPP savings required for final year of turnaround • GP focus addressing consortium priorities may not coincide with PCT priorities 	
Wandsworth	<ul style="list-style-type: none"> • Time limited fixed term investment schemes may not complete within planned timetable and additional costs may be incurred 	

Section 4: Further strategic changes - developing clinical GP commissioning consortia...

Three consortia in South West London have been accepted onto the Pathfinder Programme in Tranches 1 and 2. These consortia are the Kingston Consortium, the Sutton Consortium (Tranche 1) and Croydon Healthcare Consortium (Tranche 2)

Each of these consortia is currently participating in the KPMG led Development Programme and has identified their key areas of work as:

Kingston:

Mental health – altering currencies for CDAT, IAPT and transferring that to the management of mental illness

Prescribing and Medicines Management – work to manage primary care prescribing PLUS managing the secondary care expensive drugs process in a far more robust manner

Working with the SW London Acute Commissioning Unit to manage commissioning better and to give it a clinical focus

Transforming Community services - working with Your Healthcare to ensure services are sensitive to the user

Sutton

Urgent Care Redesign

Long Term Conditions Management in the community

Croydon Healthcare Consortium:

Enhanced recovery

Children

Dysfunctional Families (joint pathfinder project with the local authority agreed)

Mental Health

Urgent Care

The details of the remaining consortia in SWL are:

- **Merton:** The Federation includes practices in Merton and in Sutton. The Federation has not yet decided on its key areas of work but they are likely to include community services. The Federation has strong acute links with both St Georges and Epsom and St Helier. The Federation was accepted onto the Pathfinder Programme as part of Tranche 3 in Mar 11
- **Richmond:** The arrangement will be one of a single borough consortium with two locality groups working together in a federated model but meeting separately and with their own leadership arrangements. The consortium was accepted onto the Pathfinder Programme as part of Tranche 3 in Mar 11
- **Wandsworth:** There will be one consortia in Wandsworth which will encompass all practices in the borough. The consortium was accepted onto the Pathfinder Programme as part of Tranche 3 in Mar 11
- **Croydon:** Commissioning4Croydon submitted their application for Pathfinder status in Jan 2011 but were unsuccessful. They re-submitted their application for Pathfinder status on **25 Feb 11**
- The two Croydon consortia will operate within the boundary of the borough of Croydon.

Section 4: Further strategic changes - developing clinical commissioning consortia...

GP Consortia Pathfinders Application Status



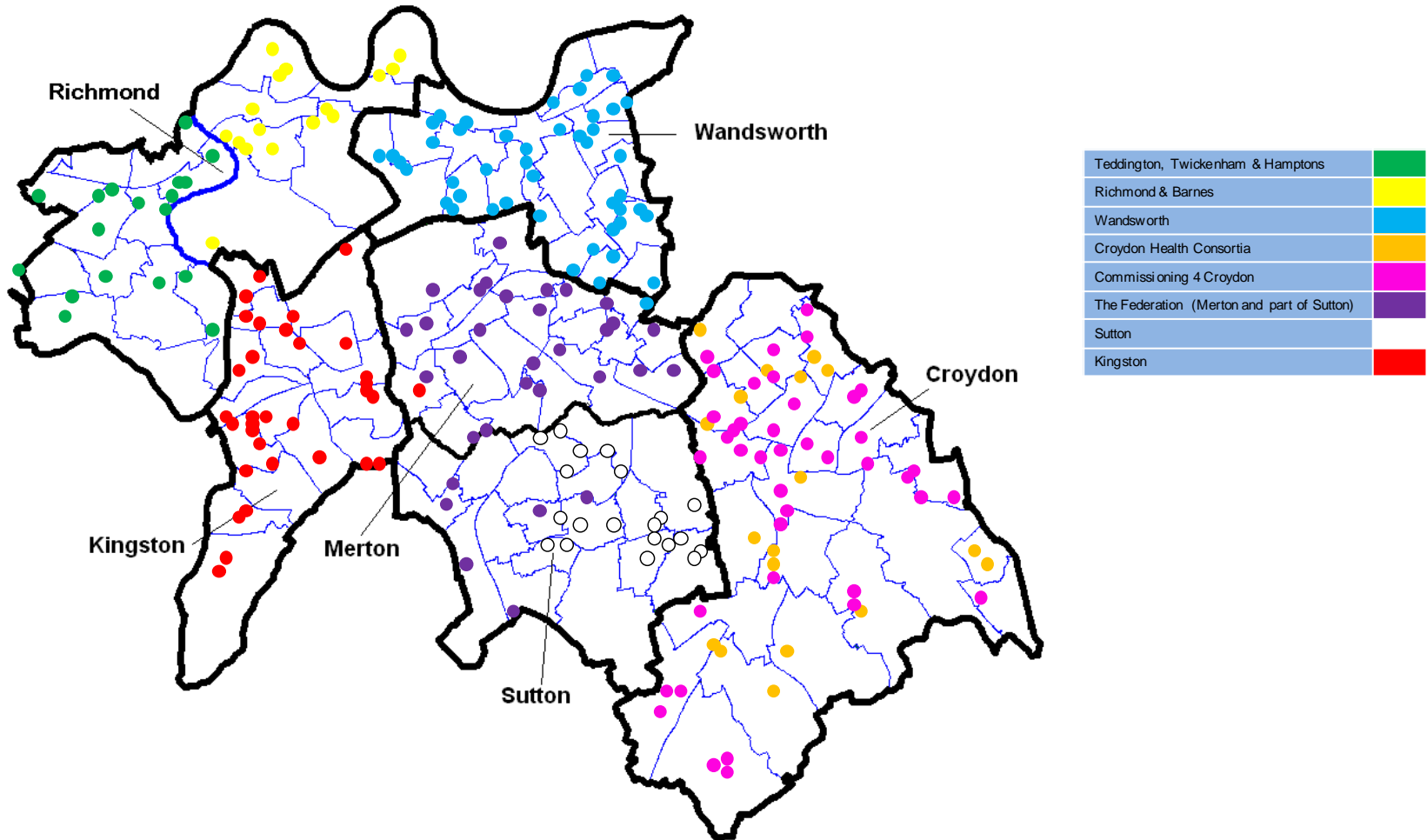
Splits between Croydon Healthcare Consortium and Commissioning 4 Croydon and between Sutton and the Federation are illustrative.

Section 4: Further strategic changes - developing clinical commissioning consortia...

SWL Pathfinder Submission Status

	2010		2011			
	November	December	January	February	March	April
Commissioning 4 Croydon			Re-submitted application to enter Design, Planning and Preparation stage			
Croydon Healthcare Consortia		Application Submitted		Application approved to enter Design, Planning and Preparation stage		
Kingston	Application Submitted		Application approved to enter Design, Planning and Preparation stage			
The Federation (Merton and part of Sutton)						Application approved to enter Design, Planning and Preparation stage
Richmond						Application approved to enter Design, Planning and Preparation stage
Sutton	Application Submitted		Application approved to enter Design, Planning and Preparation stage			
Wandsworth						Application approved to enter Design, Planning and Preparation stage

Section 4: Further strategic changes - developing Commissioning Consortia...



Section 5: Developing an approach to strategic management of estates...

A strategic asset management team has been established and work is beginning to integrate PCT strategies across SW London. Across south west London the NHS has a wide range of sites and facilities. While many are extremely good, others are poorly located, need considerable work to meet modern standards or are simply not suited to current or future needs. Some sites are under-utilised. Meanwhile access to capital to develop improved or new facilities remains very challenging and work across sectors and London to increase the availability of capital through the disposal of unsuitable assets is essential.

At the current time all proposals will need to take account of the limitation on capital and revenue resources to ensure the delivery of out of hospital care.

Work to date is proposed in:

- Understanding the demographic profile across the sector and implementing QIPP initiatives to ensure current PCT estate strategies are fit for purpose, making the best use of the current estate.
- Developing an agreed and affordable capital investment strategy that meets the local operational needs of PCTs and the sector, including development opportunities arising from Local Authority and Private sector regeneration.
- Included in the overall consideration of the estate is the need for the PCT estate strategy and the ambulance estates strategy to extract maximum QIPP benefit from their joint consideration.

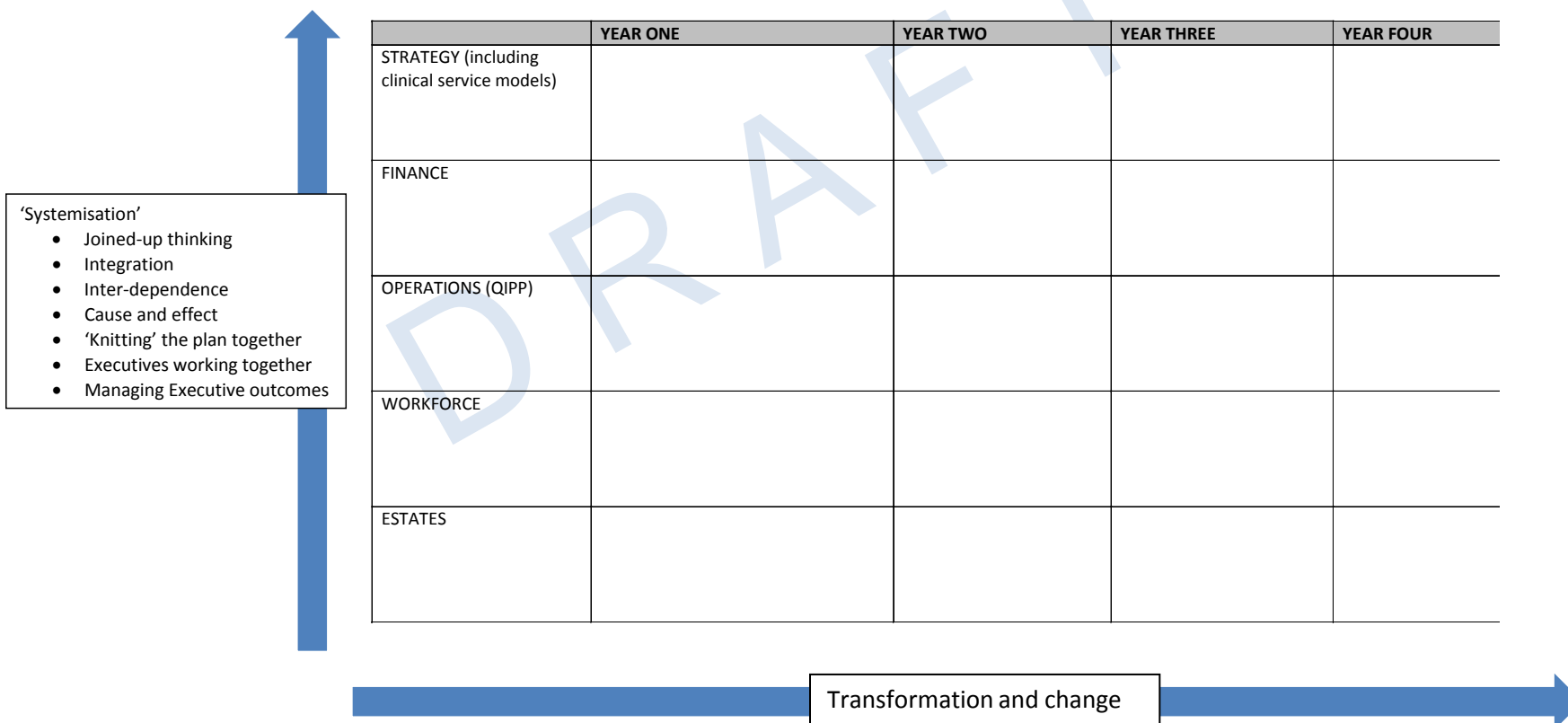
Further systems and processes are being developed to ensure that any available strategic capital in the future can be allocated in a fair and transparent manner using agreed criteria.

Section 6: Still to do before mobilisation and 'go-live' 1 April 2011 – 'systemisation' of the plan...

- During March 2011, members of the Turnaround team are supporting Borough teams to ensure that SWLC has in place 'best in class' Project and Performance processes to drive the implementation of this plan.
- Detailed operational implementation plans will be reviewed by the expert support team we have in place and a risk rating of each plan produced for review by the Cluster Chief Executive and Finance Director.
- The few remaining RED and AMBER plans will receive more intensive support from the Turnaround team.
- Where plans do not meet the required standard, they will be asked to attend a challenge meeting led by the Chief Executive.
- The challenge session will invite the Borough Managing Director and their QIPP and Finance leads to attend SWLC HQ and seek further direction and support to get the plan to a satisfactory level of risk mitigation and control.
- In line with the CE's vision of 'one, supportive organisation' these sessions will be rigorous but supportive and constructive. At this stage SWLC will be focusing its QIPP management efforts on the creating of a single, motivated and focused team. Overtly punitive or aggressive performance management is not conducive to creating this environment.

Section 6: Still to do before mobilisation and ‘go-live’ 1 April 2011 – ‘systemisation’ of the plan...

By its nature (discreet projects in discreet departments delivering common programmes across the cluster) the SWL Cluster QIPP & Strategy plan leads us to consider methods to better plot and manage the implementation of the 4-year plan to ensure system thinking and teamwork. The matrix below will be completed prior to 1st April. The matrix will plot the inter-related and inter-dependant outcomes that need system co-ordination to ensure outcomes are delivered. This will ensure that SWL Cluster can better understand and lead the discreet departmental outcomes, described in this matrix or ‘swim lane’ chart whilst constantly maintaining a system ‘overview’ of these outcomes.



Section 6: Still to do as a part of ongoing plan development, mobilisation and go-live...

We are still in the process of exploring additional areas to potentially extend the pipeline of QIPP initiatives:

	Potential areas to explore further	Illustrative examples
Quality	<ul style="list-style-type: none"> ▪ Comparing the current QIPP plans versus previous plans indicated several areas where the sector can develop additional initiatives to drive H4SWL objectives ▪ Examples include ensuring consistent urgent care centres in the community or plans to introduce elective streaming and develop elective surgery centres in specialties such as urology, ophthalmology and oral surgery 	<ul style="list-style-type: none"> ▪ Achieving gold standard in end of life care ▪ Further development and implementation of SWL's mental health strategy
Productivity	<ul style="list-style-type: none"> ▪ SWL can tap further sources of productivity initiatives <ul style="list-style-type: none"> – Additional “menu of opportunities” at sector level based on intra-SWL and national benchmarking – Ideas generated at sector workshop 	<ul style="list-style-type: none"> ▪ Croydon PCT's menu of additional opportunities
Enablers	<ul style="list-style-type: none"> ▪ To support the implementation of initiatives, the sector should also ensure that the right sets of enablers are in place to carry out the programs <ul style="list-style-type: none"> – Role modelling by senior sector leadership and clinical leadership groups – Developing required skills (leadership and managerial, experience from built-in test beds, workforce pipeline) – Compelling and well-structured communication with clear clinical rationale – Robust re-enforcing mechanisms (i.e., transformation architecture, incentives, information flow, supporting systems, protocols) 	<ul style="list-style-type: none"> ▪ Strong senior management communication on the importance of QIPP ▪ Assessment of skills gap versus QIPP programme requirements

Section 6: Still to do as a part of ongoing plan development, mobilisation and go-live...

- Developing the post-2011/12 go live engagement and communications plan (known as The Change Plan).
- Strategic development plan has commenced and is developing in line with the details described in this plan.
- Project resourcing – tentatively and pending final phase of ‘people’ re-organisation – responsibility and accountabilities at management level are nearing completion.
- To ensure robust risk management of provider economic impacts (both intended and unintended) much deeper analysis will take place for the provider (all providers including out-of-cluster) impacts of QIPP. This includes a deeper understanding of each providers own efficiency and productivity plans to avoid duplication and unintended consequence.
- Broader and deeper engagement will be developed with bordering commissioners – especially NHS Surrey.
- Mobilisation campaign pending with staff and all resources involved in development and delivery of this plan.
- Implementation of challenge process referred to earlier in this plan.
- Both the Workforce and the Estates Plan are central ‘building’ blocks and ‘enablers’ for QIPP & Strategy. The Leadership of SWL Cluster recognise the need to create more robust implementation plans that integrate readily with this document. This work will commence in late March/April.

Appendix One: Implementation & PMO 2011/12...

Appendix Two: The details of the SWL Cluster workshops that informed this plan...

Appendix Three: Financial assumptions...

Appendix Four: NHS Sutton and Merton programme overview...

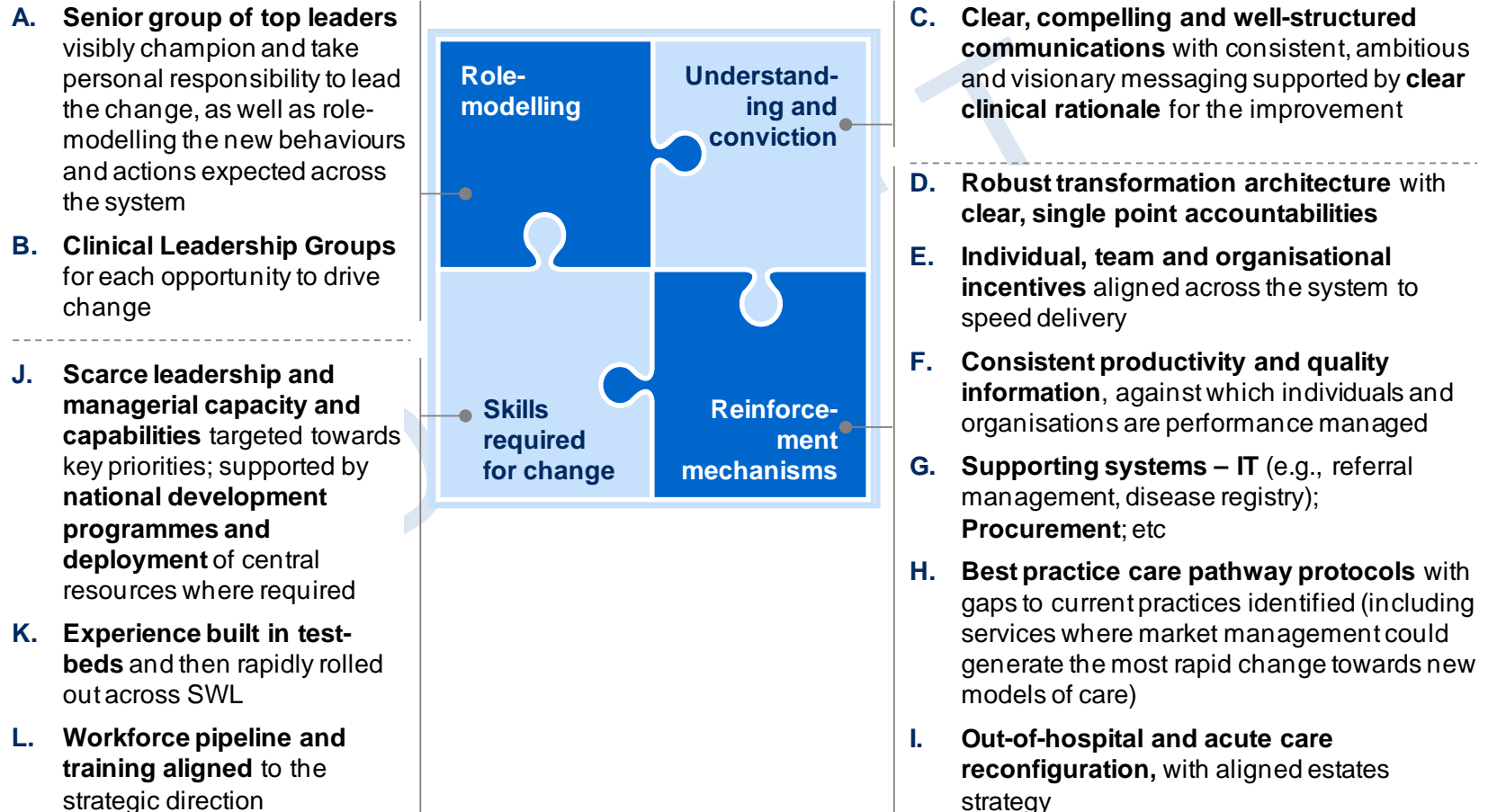
Appendix Five: SWL Cluster QIPP Schemes...

Appendix Six: Examples of programmes under development...

Appendix Seven: Financial assumptions...

Appendix Eight: What are the financial constraints...

The SWL Cluster implementation plan 2011/12 is designed based upon 12 key principles



Appendix One – Implementation & PMO 2011/12 a cluster PMO has been established...

Cluster PMO six main objectives

- 1 Support leadership in multi-project management**
 - Help define the project teams that are required immediately given priorities and deliverables
 - Explicitly agree with project teams the nature of support from leadership and PMO
 - Address “white spaces” not covered by specific projects
- 2 Ensure integration and consistency across project teams**
 - Establish a common problem solving approach/ language and integrating forums that resolve cross-project team issues
 - Share insights into projects to manage interdependencies and resolve interface problems
- 3 Develop and execute proactive communication strategies**
 - Use unique positioning to provide an integrated perspective and articulation of the QIPP messages across internal and external communications
 - Advise on appropriate communication approach at strand and project level
- 4 Ensure accountability through transparency**
 - Ensure single-point accountability for each aspect of the QIPP programme
 - Provide fact-based information on milestones and benefits achieved by project teams
 - Set up a credible baseline for each metric that is acceptable to the line and top management
 - Ensure constructive senior management intervention
- 5 Challenge and selectively support project teams**
 - Challenge and selectively support project teams with problem solving and content
 - Maintain focus on content and challenge, not just process management
 - Establish a network of experts and sponsors that can be accessed by the project teams for experience/best practices
- 6 Role modelling values and new behaviours**
 - Modelling NHS SWL values and behaviours to the rest of the organisation
 - Initiative ownership and execution consistent with the new NHS operating model, i.e., local healthcare

QIPP Governance and PMO arrangements

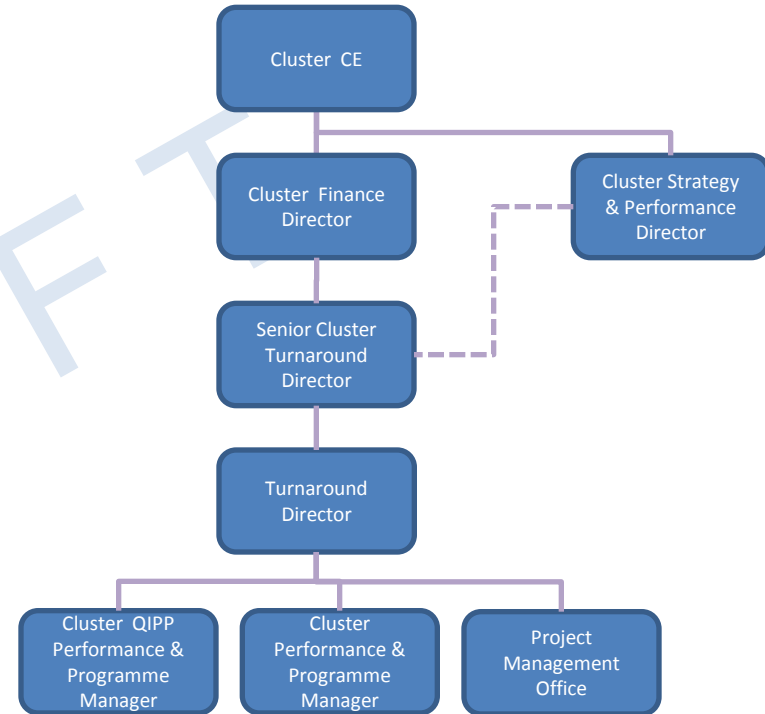
The responsibilities for implementation of QIPP have been split into elements – in-year delivery and design and planning:

- In-year delivery (11/12) will sit with the Sector Director of Finance:
- PMO will have responsibility for monitoring and reporting on the progress of in-year QIPP Initiatives;
- PMO will maintain close links with borough staff, GP Commissioners and Providers;
- PMO will maintain a close working relationship with the QIPP Planning element of the Strategy, Performance and Planning Directorate to facilitate transfer from planning phase to in-year delivery.

Design and Planning will be overseen and guided by the Strategy and QIPP Programme Board and supported by the Clinical Strategy Group and the Clinical Cabinet (GPs representatives from consortia).

- The Programme Board will also receive 'exception' reports from the Director of Finance based on QIPP initiatives.
- The Programme Board will provide updates and when appropriate recommendations to the SWL Joint Boards.
- Acute Contract Management and Monitoring will be led by the ACU working with Borough MDs as appropriate.

SWL Cluster reporting structure



Roles & Responsibilities cont:

Senior Turnaround Director

- Lead on sector wide leadership of Turnaround Programme
- Programme 'kick-start' - Lead and performance manage cluster Turnaround programme
- Rigorous performance management at Borough level (MDs), manage overall programme performance
- Accelerate implementation plan and de-risk programmes in 'pipeline.
- Lead the change plan (including senior stakeholder relationships)
- Coach/mentor cluster leadership and skills transfer to cluster Turnaround leadership

Turnaround Director

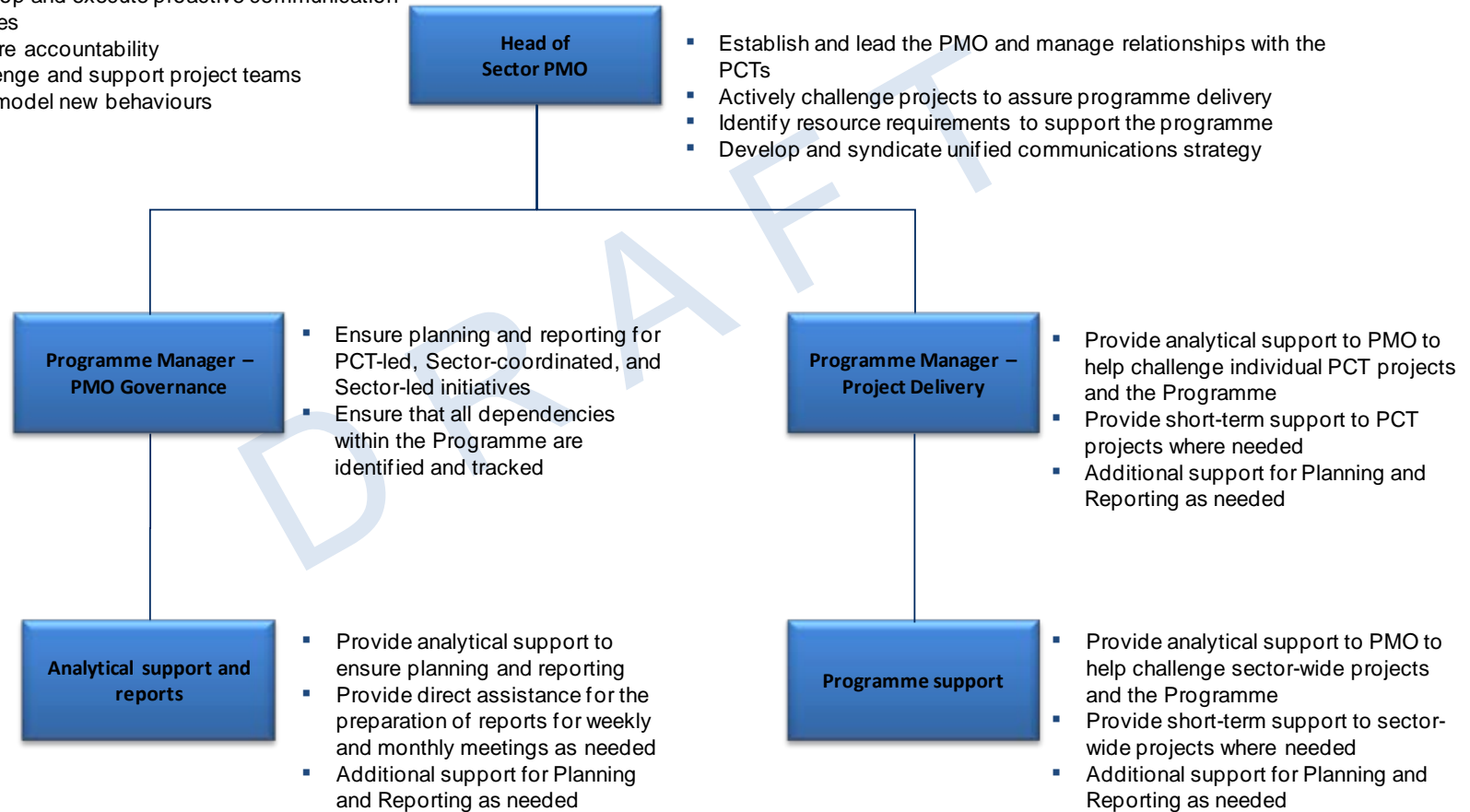
- Lead the NHSSM 2011/12 QIPP plan and develop the substantive sector PMO may also have SRO role for sector wide programmes
- Specific Turnaround Director role for NHSSM's 2011/12 QIPP Programme, rigorous performance management at NHSSM
- Programme Manage a discreet number of specific (individual) cluster Turnaround (QIPP) programmes

Performance & Programme Managers

- Ensure performance across sector QIPP Plan (including NHSSM), develop skills and competence to fully 'embed' turnaround method, systems and delivery
- Accelerate implementation plan and de-risk programmes in 'pipeline'
- Develop the change plan (including senior stakeholder relationships)
- Coach/mentor mid management including skills transfer
- Manage/challenge programme performance at project level
- Project/programme management of specific and cluster wide projects/programmes

PMO objectives:

- Support leadership in multi-project management
- Ensure integration and constancy
- Develop and execute proactive communication strategies
- Ensure accountability
- Challenge and support project teams
- Role model new behaviours



Implementation model by bundle: LTC, Polysystems/ local community networks and Mental Health

Bundle	Implementation model			Details (including rationale)
	A	B	C	
LTC, Frail/Elderly	✓ Tele-health; Met Office scheme	✓ All other		<ul style="list-style-type: none"> Tele-health is a new area and it doesn't make sense to figure it out five times across the sector Met office scheme already running at S&M PCT could relatively easily be scaled up to cover the whole sector The strategic thinking on LTC and frail elderly management has already been done as part of the Clinical Working Group work – now it is time for locally-tailored implementation
Mental health strategy and contract renegotiation	✓			<ul style="list-style-type: none"> Development of mental health strategy ideally suited for sector-wide single action Some implementation decisions (i.e., team / org design at local level) still need to be made locally Specific initiatives also suggested for Forensics

1 Group also noted for the sector to review what plans are in place for shifting OP paediatric to community (which was discussed in another group)
 2 A specific initiative on Drugs and Alcohol also cited for possible sector-wide implementation; this is better grouped under "Other Prevention"

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Planned Care and End of Life

Bundle	Implementation model			Details (including rationale)
	A	B	C	
End of life	✓			<ul style="list-style-type: none"> Models vary widely across the sector QIPP aspiration was to implement the gold standard Would benefit from in-depth work to ensure delivery, which would make sense to do once for the whole sector
OP demand management and decommissioning			✓	<ul style="list-style-type: none"> Decommissioning is a routine activity, local action to identify and execute Some best practice sharing could be useful for, e.g., GP referrals demand managements
Other pathway redesign		✓		<ul style="list-style-type: none"> The group decided that some initiatives could be (B) or (C), depending on how much localised implementation is allowed in (B) The large size of the initiatives warrants formal coordination and best practice sharing
Other prevention	AF ✓	All other ✓		<ul style="list-style-type: none"> Atrial fibrillation screening scheme already running in S&MPCT could easily be scaled up across the whole sector at minimal cost The other prevention schemes, effective strategy already exists, and now is the time for locally tailored implementation
Shifting adult OP to the community		✓		<ul style="list-style-type: none"> With RSH sexual health re-categorised, all initiatives within this bundle were voted to be done at the (B) level

1 Not part of the original bundles discussed

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Prescribing and High-Cost Drugs

Bundle	Implementation model			Details (including rationale)
	A	B	C	
Primary care prescribing and high cost drugs		✓		<ul style="list-style-type: none"> Strong local medicines management teams in each PCT with a history of success Opportunities to share best practice and pursue innovative opportunities such as E.g., reviews of home oxygen, specials and other procurement (e.g. vacuum pumps)

1 Not part of the original bundles discussed

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Urgent Care

Bundle	Implementation model			Details (including rationale)
	A	B	C	
Urgent care pathway redesign – strategy	✓			<ul style="list-style-type: none"> Important for a given provider to hear a single message from all their commissioners Basis for this strategy already exists in the form of the Healthcare for London work
Urgent care pathway redesign – implementation		✓		<ul style="list-style-type: none"> Current provider landscape and service user pathway vary significantly within and between PCTs – so doesn't make sense to attempt a consistent sector wide implementation of the strategy

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Contracting (1/2)

Bundle	Implementation model			Details (including rationale)
	A	B	C	
Community provider renegotiation/ tendering		✓		<ul style="list-style-type: none"> Originally assessed during the workshop as a potential sector-wide actio, given the assessment and contract renegotiation aspects However, workshop participants also highlighted the need to consider local aspects of implementation (i.e., would a hub and spoke model work for community health services?) Classifying in B seems appropriate over-all, given that each PCT has a different CHS¹
GP list cleaning	✓			<ul style="list-style-type: none"> This is currently being undertaken by all PCTs except Richmond and S&M – who acknowledged there was a potential opportunity in this area Kingston and Wandsworth are doing a large-scale list cleaning exercise as it hasn't been carried out for a while For future "mop-ups", for example for overseas and multi-occupancy dwellings, this should be a single-sector process
Non-ACU led acute provider renegotiation	✓			<ul style="list-style-type: none"> Only one initiative in this bundle – Richmond's Clinical Efficiencies Improvement in Acute Care (this was the basis of the discussion) This Richmond initiative is a BUPA service that involves clinicians challenging acute provider adherence to contract – a process that may make sense to do sector-wide

¹ Group also noted for the sector to review what plans are in place for shifting OP paediatric to community (which was discussed in another group)

² A specific initiative on Drugs and Alcohol also cited for possible sector-wide implementation; this is better grouped under "Other Prevention"

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Contracting (2/2)

Bundle	Implementation model			Details (including rationale)
	A	B	C	
Primary care provider renege/tendering		✓		<ul style="list-style-type: none"> ▪ PMS reviews are being carried out differentially across the sector and have met with resistance. ▪ Some PCTs are using them as an opportunity to drive quality improvements ▪ Future reviews could be coordinated by the sector to ensure equity across the sector and reduce resistances

1 Not part of the original bundles discussed

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Implementation model by bundle: Other

Bundle	Implementation model			Details (including rationale)
	A	B	C	
Shifting Paediatric OP to the community		✓		<ul style="list-style-type: none"> No initiatives in 2011/12 - acknowledged that more work is needed on this to deliver against commissioning intention of shifting 40% to the community
Dentistry (UDA renegotiation) ¹		✓		<ul style="list-style-type: none"> Opportunity identified by Wandsworth PCT to undertake UDA reviews across the sector as the contract is up for renewal
Maternity ¹			✓	<ul style="list-style-type: none"> Only one initiative exists

¹ Not part of the original bundles discussed

Breakout output: Additional initiatives to consider

JANUARY 12, 2011 WORKSHOP

	Ideas	Details (including rationale)
Quality	<ul style="list-style-type: none"> IAPT / increasing community provision of psychological therapy 	<ul style="list-style-type: none"> Leverage on existing IAPT programs/frameworks Unlikely to have savings in 2011/12, but possible for succeeding periods
	<ul style="list-style-type: none"> End of life care – getting to gold standard on EOL 	<ul style="list-style-type: none"> Increased local provision Requires GP alignment on advance care planning Potentially cost neutral (i.e., might be double counting some benefits in programs for urgent care or other services)
	<ul style="list-style-type: none"> Management of long-term conditions 	<ul style="list-style-type: none"> Potential program for all PCTs Financial impact might also overlap with other programs

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout output: Additional initiatives to consider

JANUARY 12, 2011 WORKSHOP

	Ideas	Details (including rationale)
Productivity	<ul style="list-style-type: none"> GP list cleansing 	<ul style="list-style-type: none"> Roll out to S&M & Richmond (thought savings may be limited)
	<ul style="list-style-type: none"> Review of home oxygen, specials and other devices (e.g., vacuum pumps) 	<ul style="list-style-type: none"> Currently only being looked at in 1-2 PCTs – opportunities to role out approach sector-wide
	<ul style="list-style-type: none"> Ensuring acute compliance with primary care formulary on discharge and ensuring that there is no cost shifting (i.e. patients are discharged with drugs as per the HRG tariff) 	<ul style="list-style-type: none"> Croydon has this initiative, but it is not an explicit scheme in other PCTs Potential to make significant savings
	<ul style="list-style-type: none"> Review of equipment and devices which are excluded from PBR in acute but paid for by PCTs (for example, prosthetics, pacemakers and stents) 	<ul style="list-style-type: none"> Ensure paying lowest price and have pre-approved list and cost across sector No PCT is currently doing this
	<ul style="list-style-type: none"> Dentistry UDA review 	<ul style="list-style-type: none"> Only Wandsworth doing this now
	<ul style="list-style-type: none"> Check HCD prices are the same across sector 	<ul style="list-style-type: none"> Different providers charge different prices; no PCT doing this now
Quality	<ul style="list-style-type: none"> Using PMS review to embed improved quality in primary care (like CQUIN) – combine with QOF 	<ul style="list-style-type: none"> Part of S&M plan – can other PCTs also do this?
	<ul style="list-style-type: none"> For example, ensuring LTC patient registers and care plan development 	

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout output: Additional initiatives to consider

JANUARY 12, 2011 WORKSHOP

	Ideas	Details (including rationale)
Productivity	<ul style="list-style-type: none"> Wandsworth’s Dental UDA Wandsworth’s Hysteroscopy in gynaecology clinic Wandsworth’s RSH sexual health 	<ul style="list-style-type: none"> Other PCTs could replicate
	<ul style="list-style-type: none"> Croydon’s specialty referral management 	<ul style="list-style-type: none"> A ‘thick guide’ for specialty referrals that could be shared across the sector
	<ul style="list-style-type: none"> COPD ENT 	<ul style="list-style-type: none"> Coordinating Met Office for COPD and telehealth for COPD Moving ENTs into local surgery
	<ul style="list-style-type: none"> Sutton & Merton’s “one stop shop” for hips and knees 	<ul style="list-style-type: none"> Uses Oxford ratings much earlier in the pathway
Quality	<ul style="list-style-type: none"> ... 	<ul style="list-style-type: none"> ...
Enablers	<ul style="list-style-type: none"> ... 	<ul style="list-style-type: none"> ...

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout output: Additional initiatives to consider

JANUARY 12, 2011 WORKSHOP

Initiatives to improve quality

	Ideas	Details (including rationale)
Productivity and Quality	<ul style="list-style-type: none"> Ensure more appropriate use of NHS Children's urgent care services to improve user experience and avoid waste 	<ul style="list-style-type: none"> For example: <ul style="list-style-type: none"> Raise parents' confidence in primary care Educate children on how to use the NHS
	<ul style="list-style-type: none"> Do more IVs in the community 	<ul style="list-style-type: none"> Avoids admissions
	<ul style="list-style-type: none"> Redesign the chest pain pathway 	<ul style="list-style-type: none"> Bexley have a good model Quicker access to scans
	<ul style="list-style-type: none"> Stop IVF 	<ul style="list-style-type: none"> S&M PCT have already done so
	<ul style="list-style-type: none"> Review the Maternity tariff 	<ul style="list-style-type: none"> S&M PCT have already done so
	<ul style="list-style-type: none"> Accelerate Pathology consolidation (Carter) 	<ul style="list-style-type: none"> Group leading this for the Sector has lost momentum – could start and effort to drive it forward Use the consolidation as a chance to improve quality and efficiency, e.g., pickup-to-test time elapsed, near-patient testing, test result reliability
Enablers	<ul style="list-style-type: none"> Idea sharing website 	<ul style="list-style-type: none"> Could be a very simple blog-style site, listing who is doing what, good practice examples, results of benchmarking, etc

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout group output: Urgent care: A&E conversion/0 LOS/ Re-admission

JANUARY 12, 2011 WORKSHOP

Key question	Breakout response	Key next steps/owner
<p>1 Which of these metrics should be prioritized, especially between A&E conversion and 0 LOS?</p> <p>2 What are the right thresholds / parameters for each of these (A&E conversion, 0 LOS, and re-admission)?</p>	<ul style="list-style-type: none"> 0-1 LOS over A&E conversion – due to differences in front-ends and risk of “gaming” the statistics Acknowledged that different providers and PCTs will focus on different areas of reduction as they are in different places 	<ul style="list-style-type: none"> Develop a bucket of metrics to reduce 0-1 day admissions Ensure alignment with MAU/CDU/AAU tariffs
<p>3 What will change in the pathway in order to enforce these KPIs: A&E conversion, 0 LOS, and re-admission (e.g., how to apply re-ablement funds)?</p>	<ul style="list-style-type: none"> Use re-enablement funds to introduce more intermediate services – particularly rapid access clinics (e.g. COPD and chest pain) Need to introduce ongoing audit (technical and clinical) to ensure compliance 	<ul style="list-style-type: none"> ACU to ensure ongoing audit processes in places Individual PCT leads to take forward discussions on re-enablement funds
<p>4 How should we treat readmissions?</p>	<ul style="list-style-type: none"> Audit based on identifying <ul style="list-style-type: none"> Poor discharge Failure of care outside of hospital Legitimate readmissions 	<ul style="list-style-type: none"> ACU to net-off re-enablement funds from the savings ACU to introduce audit based on criteria described

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout group output: Consultant to consultant and first to follow-up (1/2)

JANUARY 12, 2011 WORKSHOP

Key question	Breakout response	Key next steps/owner
<p>1 Consultant to consultant: Can we actually enforce this?</p> <ul style="list-style-type: none"> What will need to change in contracting/ monitoring or in the pathway in order to make this happen? What actions are required of PCTs/CCGs to support the patients (i.e., retention in primary care)? 	<ul style="list-style-type: none"> Yes, but requires several actions Target top quartile for threshold Include specific clauses in the contract with acute providers <ul style="list-style-type: none"> Reach out to NWL for examples of C2C wording in their contracts (i.e., clauses covering threshold, first charged as follow-up, and onward referrals in 10/11 contracts) Include clause to not pay when data is not complete or not useful for monitoring analysis (i.e., use of generic referrer codes) Include clause specifying minimum information to be shared with GP when discharging patients for further consultation Align on C2C protocol for the sector; leverage similar existing documents (i.e., example cited by Wandsworth GP during plenary) 	<ul style="list-style-type: none"> NA ACU ACU Single GP consortia or PCT to lead, with support from ACU

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout group output: Consultant to consultant and first to follow-up (2/2)

JANUARY 12, 2011 WORKSHOP

Key question	Breakout response	Key next steps/owner
<p>2 First to follow-up: How do we get alignment across PCTs on consistent thresholds by provider?</p> <ul style="list-style-type: none"> What actions are required of the ACU? 	<ul style="list-style-type: none"> Target top quartile performance by specialty for across the sector (note: needs follow-up to confirm that no side deals will be developed) Review and challenge provider-proposed exclusions to avoid complications in monitoring during contract period Review impact on obstetrics (i.e., use maternity calculator) and ophthalmology (i.e., glaucoma in community) Set-up regular monitoring process including spreadsheet to track first to follow-up movement by period 	<ul style="list-style-type: none"> ACU ACU ACU
<ul style="list-style-type: none"> What actions are required of PCTs/CCGs to support the patients? 	<ul style="list-style-type: none"> Consider identifying “packages of care” at local tariffs to optimize OP activity Progress community-based services for OP, while ensuring continuity of care 	<ul style="list-style-type: none"> PCT/ GP consortia PCT/ GP consortia

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout group output: PoLCE (1/2)

JANUARY 12, 2011 WORKSHOP

Key question	Breakout response	Key next steps/owner
<p>1 What PoLCE list should be adopted and how should the sector agree on the list?</p>	<ul style="list-style-type: none"> ▪ List is in place and agreed, so stick to it ▪ Don't worry too much about making it perfectly consistent across the sector (allow for PCT "tweaking") ▪ Build-in longer list (London list) into contracts to keep options open 	<ul style="list-style-type: none"> ▪ ACU to accelerate the analysis of the longer London list by drafting-in more resource
<p>2 What needs to change in order to enforce the PoLCE list?</p>	<ul style="list-style-type: none"> ▪ Focus on retrospective audit as the mechanism for enforcement – the value of which has been demonstrated by Wandsworth PCT with quarterly audits at St George's ▪ Publicise the list annually and more visibly to all primary and secondary care clinicians ▪ Also publicise provider activity and GP referral rates – to highlight outliers ▪ Standardise forms across the sector for a few priority (high cost and/or volume) procedures – and introduce more consistent use of relevant metrics as part of that, e.g., Oxford hip and knee score, visual impairment score ▪ Referral management systems in Richmond and Kingston have yielded 3% - 10% rejection rates – but GPs in other PCTs have refused to have one. The option of having a sector-wide system, or 5 x PCT-specific systems, may be worth revisiting 	<ul style="list-style-type: none"> ▪ WPCT audit approach should be shared across the sector ▪ ACU to publicise the list and provider activity and GP referral rates ▪ SWLECI group to review forms for high-priority procedures

Appendix Two – The details of the SWL Cluster workshops that informed this plan...

Breakout group output: PoLCE (2/2)

JANUARY 12, 2011 WORKSHOP

Key question	Breakout response	Key next steps/owner
3 Who should be leading the effort?	<ul style="list-style-type: none">▪ SWLECI group (which exists) with some senior Sector leadership▪ ACU▪ Senior clinician	<ul style="list-style-type: none">▪ Identify one senior person (ideally a clinician) to lead on this across the sector▪ That person should work with the SWLECI group and ACU as appropriate

DRAFT

Appendix Three – Assumptions used by SWL for do-nothing scenario...



South West London

Year-on-year growth in spend

		09/10	10/11	11/12	12/13	13/14	14/15
Prescribing inflation	▪ Croydon	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
	▪ Kingston	5.0%	8.0%	8.0%	8.0%	8.0%	8.0%
	▪ Richmond	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
	▪ S&M	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
	▪ Wandsworth	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Demographic growth	▪ Croydon	1.5%	1.5%	1.5%	1.5%	1.5%	1.4%
	▪ Kingston	0.6%	0.6%	0.6%	0.6%	0.5%	0.5%
	▪ Richmond	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
	▪ S&M	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
	▪ Wandsworth	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
Acute – non-demographic growth	▪ Croydon	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
	▪ Kingston	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
	▪ Richmond	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%
	▪ S&M	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
	▪ Wandsworth	2.4%	1.3%	2.4%	2.4%	2.4%	2.4%
Nonacute – non-demographic growth	▪ Croydon	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	▪ Kingston	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	▪ Richmond	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	▪ S&M	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	▪ Wandsworth	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Acute Tariff deflator	▪ Croydon	2.3%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Kingston	2.3%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Richmond	2.3%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ S&M	2.3%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Wandsworth	2.3%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
Nonacute Tariff deflator	▪ Croydon	2.9%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Kingston	2.9%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Richmond	2.9%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ S&M	2.9%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
	▪ Wandsworth	2.9%	0.0%	(1.5%)	(1.5%)	(1.5%)	(1.5%)
Primary care inflation	▪ Croydon	0.0%	0.0%	2.9%	2.9%	2.9%	2.9%
	▪ Kingston	0.0%	0.0%	2.9%	2.9%	2.9%	2.9%
	▪ Richmond	0.0%	0.0%	2.9%	2.9%	2.9%	2.9%
	▪ S&M	0.0%	0.0%	2.9%	2.9%	2.9%	2.9%
	▪ Wandsworth	0.0%	0.0%	2.9%	2.9%	2.9%	2.9%

Appendix Three – How assumptions for SWL do-nothing scenario have been applied...



South West London

How assumptions for SWL do-nothing scenario have been applied

Spend area	Year-on-year growth assumptions (previous page)				Tariff	
	Prescribing	Demographic	Acute non-demographic	Non acute non-demographic	deflator	Inflation
Acute		✓	✓		✓	
Non-acute		✓		✓	✓ ¹	
Mental Health		✓		✓	✓ ¹	
Community		✓		✓	✓ ¹	
Primary care		✓		✓		✓
Prescribing	✓					

¹ The inclusion of the tariff deflator in respect of non tariff areas is to be reviewed alongside QIPP initiative impact assumptions

Appendix Three – Assumptions made about activity impact of KPIs and LCIs...

Average ratio of Daycase to OP procedure tariff of 100:19 assumed, based on SUS and SLAM data

KPI/LCI	Assumed activity impact			
	Point of delivery		Service line	
	From	To	From	To
PoLCE	ELDC, ELIP, OP FU	N/A	General surgery, Other surgery, T&O	N/A
DC - OP Procedures	ELDC	OP FU	General medicine, general surgery	General medicine, general surgery
Consultant - Consultant	OP First	N/A	All	N/A
NFuP ratio	OP FU	N/A	All	N/A
Re-admission Rate	NEIP	N/A	All	N/A
Zero LoS	NEIP	N/A	General medicine, Other medicine, Other, Maternity, Cardiac	N/A
Planned Procedures Not Carried Out	ELDC, ELIP, OP	N/A	All	N/A
C Sections	NEIP	NEIP	Maternity	Maternity

Expenditure Across Generic Categories (ref slide 63)

QIPP start up costs and service redesign costs: This includes costs associated with the initial implementation and development of QIPP. It should not include any ongoing, recurrent costs. This should also include costs that are directly related to initial costs of any service redesign being implemented locally. This may include any double running costs that occur as the service is developed.

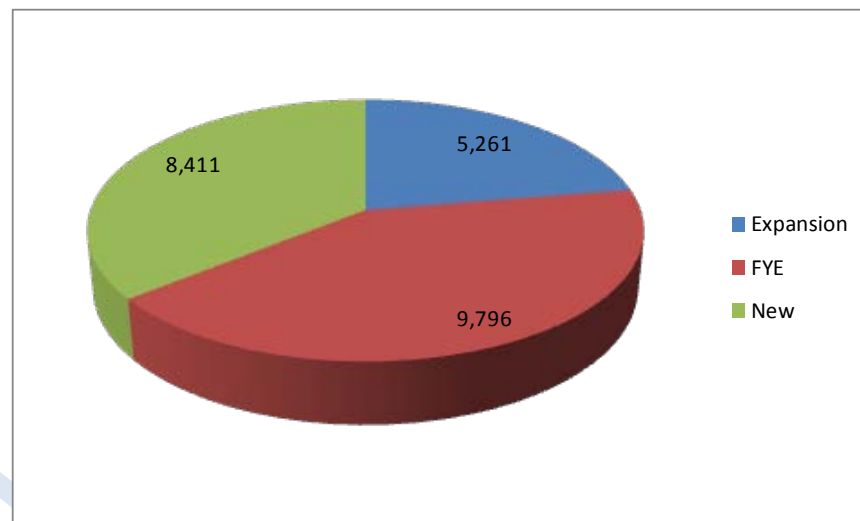
Revenue to capital transfers for capital expenditure that will be completed in 2011/12: Any recurrent resource used to fund capital expenditure in 2011/12. The capital expenditure must be non-recurrent to the extent that the capital expenditure will be completed in 2011/12.

Workforce reconfiguration costs: This includes any costs associated with the redundancies, or any other one off staff related costs.

Non pay transition costs for developing the new system: This may include any non-pay costs associated the development of consortia and work being done with pathfinders. It may also cover one off project costs, or start up costs.

Other transition costs: This will include any other transition related costs, such as lease write offs, legal costs, contract settlements and costs of integration

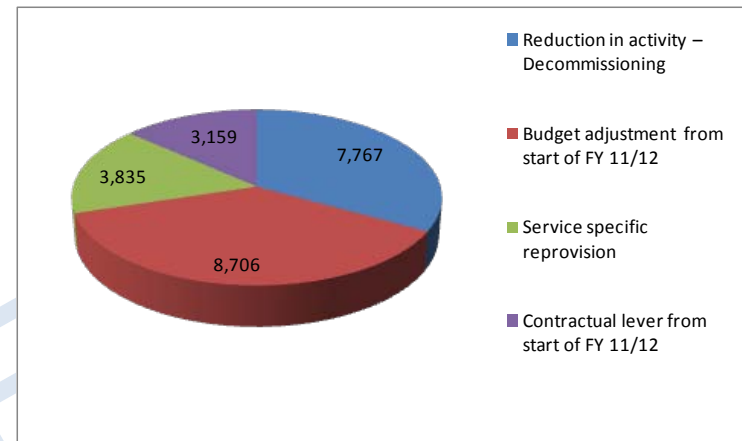
- **FYE = FY10/11 QIPP schemes carried forward into FY 11/12 which will require limited additional support to deliver**
- **Expansion = FY10/11 QIPP schemes carried forward into FY 11/12 with enhancements to deliver additional savings which will require moderate levels of additional support**
- **New = New QIPP schemes for FY 11/12 which will require dedicated resources to mobilise and deliver**



QIPP Category	Expansion	FYE	New	Grand Total
BACK OFFICE	4,700	-	1,748	6,448
RIGHT CARE		1,300	1,250	2,550
URGENT CARE		1,467	270	1,737
MENTAL HEALTH & LEARNIG DISABILITIES		-	945	945
PLANNED CARE		159	735	894
LONG TERM CONDITIONS	561	-	196	756
MEDICINES USE		495	100	595
MATERNITY & NEWBORN			435	435
END OF LIFE		300		300
CHILDREN & YOUNG PEOPLE		102		102
PRIMARY CARE		-	32	32
COMMUNITY SUPPORT		-		-
ACUTE EFFICIENCIES		5,974	2,700	8,674
Grand Total	5,261	9,796	8,411	23,468

Appendix Four - Programme overview NHS SM – scheme drivers...

- Budget adjustments and contractual levers will require limited in year resources once agreed as part of the planning process which provides solid foundation for full year delivery.
- Additional schemes in year require reduction in activity levels, only some of which is supported by alternative service provision in different settings of care.



QIPP Category	Reduction in activity – Decommissioning	Budget adjustment from start of FY 11/12	Service specific reprovision	Contractual lever from start of FY 11/12	Grand Total
BACK OFFICE	6,448				6,448
RIGHT CARE	-		2,550		2,550
URGENT CARE	800		320	617	1,737
MENTAL HEALTH & LEARNIG DISABILITIES	-			945	945
PLANNED CARE			200	694	894
LONG TERM CONDITIONS	-		270	486	756
MEDICINES USE			495	100	595
MATERNITY & NEWBORN	435				435
END OF LIFE	-			300	300
CHILDREN & YOUNG PEOPLE	84			18	102
PRIMARY CARE	-	32			32
COMMUNITY SUPPORT	-				-
ACUTE EFFICIENCIES		8,674			8,674
Grand Total	7,767	8,706	3,835	3,159	23,468

Appendix Five - SWL Cluster QIPP Schemes...



South West London

NHS Croydon

QIPP Category	Scheme	RAG Rating	Net Savings
Back Office	Back Office (As per Operating Plan)	G	2,965,000
Children & Young People	BCG Immunisations	G	-
Children & Young People	Children's Planned Care	G	25,000
End of Life	End of Life	G	628,000
Long Term Conditions	Continuing Care (3m and 12m Reviews)	G	120,000
Long Term Conditions	Long Term Conditions	G	74,000
Medicines Use	Medicines Management Support	G	228,000
Medicines Use	Prescribing Efficiency	G	1,143,000
Medicines Use	Reduction of Wastage in Medicine Use	G	226,000
Medicines Use	Refocus of Care Home Pharmacy Services	G	90,000
Medicines Use	Specials: Drugs and Dressings	G	259,000
Mental Health & Learning Disabilities	Intensive Assessment Service for Older Adults with MH	G	89,000
Mental Health & Learning Disabilities	Mental Health Efficiency	G	1,682,000
Mental Health & Learning Disabilities	Primary Mental Health Care Pathways	A	101,000
Other Acute Efficiencies	Provider Efficiency 1	G	1,700,000
Other Acute Efficiencies	Provider Efficiency 2	G	200,000
Other Acute Efficiencies	Provider Efficiency 3	G	77,000
Planned Care	CORS - FYE	G	131,000
Planned Care	Decommissioning - combined	A	538,000
Planned Care	ENT - FYE + Extension	G	97,000
Planned Care	Gynaecology - Hysteroscopy Daycases	G	316,000
Planned Care	Gynaecology Outpatients - FYE + Extension	G	363,000
Planned Care	In-Health: Direct Access	G	182,000
Planned Care	Waste Avoidance (OP Attendance Efficiency)	G	409,000
Planned Care	Integrated Discharge Service	A	173,000
Planned Care	Intermediate Dermatology Service	G	7,000

Appendix Five - SWL Cluster QIPP Schemes...



South West London

NHS Croydon - cont.

QIPP Category	Scheme	RAG Rating	Net Savings
Planned Care	LARC Clinic	G	53,000
Planned Care	MCATS (Musculoskeletal) - FYE + Extension	G	999,000
Planned Care	Sexual Health Service Redesign	G	147,000
Primary Care	PMS Review	A	500,000
Primary care	Primary Care Efficiency	G	650,000
Primary care	Primary Care Growth Saving	G	644,000
Right Care	Anti-Coagulation Extension	G	67,000
Right Care	Cardiac Rehab	G	143,000
Right Care	DVT	G	132,000
Right Care	GP Support for Care Homes	G	70,000
Right Care	TB Directly Observed Therapy (DOT)	G	161,000
Urgent Care	COPD Community Service Redesign	G	441,000
Urgent Care	Polysystem Urgent Care Programme: A&E	G	2,250,000
Urgent Care	Telehealth	G	24,000
Totals			18,104,000

Appendix Five - SWL Cluster QIPP Schemes...

NHS Kingston

QIPP Category	Scheme	RAG Rating	Net Savings
Back Office	Estates	G	100,000
Back Office	Non PbR	G	235,000
Back Office	OoH Procurement	A	59,100
Back Office	PMS review (primary care)	G	104,450
Back Office	Primary care improvement grants	G	459,580
Back Office	Productive community services	G	49,250
Children & Young People	Children services	G	137,900
End of Life	End of Life care	G	39,400
Long Term Conditions	CRIS	G	114,082
Long Term Conditions	Elderly Assessment	G	50,170
Long Term Conditions	Falls Management intense rehab	G	50,170
Maternity & Newborn	Maternity Day Assessment Unit	G	69,935
Medicines Use	Medicine management high cost drugs	R	
Medicines Use	Medicines	G	324,000
Mental Health & Learning Disabilities	Improving access to pshycological therapies (IAPT)	G	
Mental Health & Learning Disabilities	Mental health south bank house closure	G	325,163
Mental Health & Learning Disabilities	Mental health under commitment to block	G	915,065
Other Acute Efficiencies	Pathology Services	R	
Planned Care	Glaucoma management	G	66,774
Planned Care	OPD Redesign Dermatology	G	23,580
Planned Care	OPD Redesign Gynae	A	13,646
Planned Care	OPD Redesign MSK	A	
Planned Care	OPD Redesign Neurology	A	42,477
Planned Care	OPD Redesign Rheumatology	A	57,825
Planned Care	OPD Redesign Urology	G	108,367
Planned Care	Primary care dentistry	A	66,893
Primary Care	Primary care FP69	G	522,250

Appendix Five - SWL Cluster QIPP Schemes...



South West London

NHS Kingston - cont.

Right Care	Portfolio of public health interventions	G	
Right Care	Sexual Health MCN	A	20,068
Right Care	Substance Misuse	G	70,238
Right Care	Substance misuse transformation of services	G	
Urgent Care	Urgent Care	G	369,375
Totals			4,394,758

DRAFT

Appendix Five - SWL Cluster QIPP Schemes...



South West London

NHS Richmond

QIPP Category	Scheme	RAG Rating	Net Savings
Medicines Use	Prescribing	A	825,000
Mental Health & Learning Disabilities	Contract Rebasing	A	500,000
Mental Health & Learning Disabilities	Data Validation	G	497,228
Mental Health & Learning Disabilities	Mental Health Pathway Redesign	A	800,000
Planned Care	Clinical Assessment Service	A	205,369
Planned Care	Continuing Care VFM	G	499,300
Planned Care	Continuing Care VfM (Mental Health & Learning Disability)	G	499,300
Planned Care	Early Discharge Service	A	435,279
Planned Care	Quality Gateway	A	152,250
Primary Care	GP Led Health Centre	A	153,705
Primary Care	GP Overheads/PMS	G	364,910
Primary Care	Primary Care efficiencies	G	214,776
Urgent Care	Rapid Response Service	A	348,030
Totals			5,495,146

Appendix Five - SWL Cluster QIPP Schemes...

NHS Sutton & Merton

QIPP Category	Scheme	RAG Rating	Net Savings
Back Office	CSL	G	676,000
Back Office	HQ Sub Let	G	250,000
Back Office	Management Cost reductions	G	4,700,000
Back Office	Reduction in Community service payments	G	-
Back Office	HCAS Payment	G	822,000
Children & Young People	Community Paediatrics	G	84,000
Children & Young People	Short breaks and palliative care	G	18,000
End of Life	Change of setting for paliative phase	G	300,000
Long Term Conditions	Atrial fibrillation	A	65,000
Long term Conditions	Identifying dementia patients through shared data	A	100,000
Long Term Conditions	Met office COPD alert	G	205,000
Long Term Conditions	Reduction in emergency admissions - (LTC Phase 1 & 2)	G	355,000
Long term Conditions	Specialist neuro rehab care pathway	G	31,000
Maternity & Newborn	Assisted conception	G	435,000
Medicines Use	Home oxygen service	G	100,000
Medicines Use	Prescribing savings	G	88,000
Medicines Use	Prescribing workstreams	G	407,000
Mental Health & Learning Disabilities	Mental health savings	G	945,000
Planned Care	Alternative Therapies - Decomissioning	G	200,000
Planned Care	Anticoagulation	A	206,000
Planned Care	Gynaecology reduction in referrals	G	28,000
Planned Care	Hips and Knees reducing attendances	G	200,000
Planned Care	Musculoskeletal - Transfer of Acute Activity	A	50,000
Planned Care	Opthamology reduction in referrals	G	90,000
Planned Care	Reprovision of dental	G	79,000
Planned Care	Urology - Transfer of Acute Activity	G	41,000

Appendix Five - SWL Cluster QIPP Schemes...

NHS Sutton & Merton cont.

QIPP Category	Scheme	RAG Rating	Net Savings
Primary Care	List Cleanse	G	32,000
Right Care	Patient decision Aid	A	500,000
Right Care	Referral management	A	1,300,000
Right Care	Smoking Cessation	A	750,000
Urgent Care	Clinical support for nursing homes BHCH	R	250,000
Urgent Care	DVT	R	20,000
Urgent Care	Negotiaition of Short Stay Tariff	G	800,000
Urgent Care	Reducing A&E attendances	G	220,000
Urgent Care	Reducing Short Stay admissions - (Increase in ambulatory care)	A	347,000
Urgent Care	Reduction of #NOF	G	100,000
Totals			14,794,000

Appendix Five - SWL Cluster QIPP Schemes...

NHS Wandsworth

QIPP Category	Scheme	RAG Rating	Net Savings
Back Office	Choose and Book	G	25,028
Back Office	Contingency Returns	G	50,000
Medicines Use	Estimated Drug Savings 2011/12	G	405,000
Medicines Use	High Cost Drugs / Devices	G	246,250
Mental Health & Learning Disabilities	DAAT : Drugs And Alcohol 1 - SWLGH	G	200,220
Mental Health & Learning Disabilities	Forensics	A	459,667
Mental Health & Learning Disabilities	Learning Disabilities HCP	G	50,055
Mental Health & Learning Disabilities	Mental Health and LD HCP	G	150,165
Mental Health & Learning Disabilities	Mental Health Contract (2% reduction)	G	788,000
Planned Care	Continuing Care (on existing patients)	A	166,850
Planned Care	Dawes House/Ronald Gibson House	G	150,165
Planned Care	GP Referrals	R	179,317
Planned Care	Minor Oral Surgery	G	
Planned Care	Polysystems - avoid (40%)	A	
Planned Care	Polysystems - reprovisioning	A	
Planned Care	Private Osteopaths	G	47,052
Planned Care	RSH Sexual Health	G	162,400
Planned Care	Sir Jules Thorn Court	A	156,287
Primary Care	Dental practice UDA adjustment	G	250,000
Primary Care	GP List Cleansing	G	2,090,200
Right Care	Alcohol Reduced Admissions	R	
Right Care	Falls Management	G	152,250
Right Care	Smoking Cessation - Cease Smoke Free Homes	G	13,852
Right Care	Smoking Cessation - Reduce Tobacco Control Spend	G	13,852
Right Care	Talk In Therapy	G	38,042
Urgent Care	Community Urgent Care Commissioning	G	384,422
Totals			6,179,074

Appendix Six - Examples of programmes under development...

BOROUGH LED / SECTOR WIDE Sutton & Merton
PROJECT TITLE Referral Management
PROJECT MANAGER Gabby Walters
PROJECT SPONSOR Simon Currie
QIPP CATEGORY Planned Care
FINANCE MANAGER Karen McKinley

DESCRIPTION OF PROJECT

(1) What the scheme is and how it will be implemented:

The NHS Better Value indicators suggest that if first outpatient referral rates in Sutton and Merton reached national to quartile levels, the PCT would save £2.026m per year. Given that more outpatient activity is generally recognised to be related to increased listing for elective treatment, a reduction in outpatient firsts may well also link to a reduction in other hospital activity.

To support PBC groups in implementing the findings in The King's Fund report, aiming to reduce the historically high first outpatient rate for NHS Sutton and Merton to national to quartile performance.

Initial work to concentrate upon specialties with highest referral numbers, and will comprise:

Routine use of benchmarking information to spot outliers and problem areas as well as good practice to be shared; Agreed actions and monitoring where large volumes generated by other referrers; Clinical peer review system; Bespoke training in areas where referral practice appears problematic; Agreed and widely shared guidelines with clarity on how implementation will be monitored; Enhanced support/advice from acute clinicians; Revisions of PBC performance framework to drive delivery

(2) Support, resource and procurement requirements to deliver this project:

Initially, the project will require analysis and benchmarking using our existing information, ensuring this is built into robust performance and delivery systems with PBC groups over 2011/12. Commissioning leads will need to define the routine information required to support delivery of the project, and agree this spec with the health informatics team.

Following discussion at the PEC/Commissioning Board, it has been agreed that this project should include analysis of the appropriateness of all referrals (that is, consultant to consultant and other, as well as GP initiated).

The success of the programme will require prioritisation by and support of PBC groups. Given that the achievement of this year's Operating Plan is an essential core requirement for the groups, their input to this programme - including, for example, GP support for the proposed peer review process and input to the drafting and agreement of referral guidelines is a core requirement to be delivered within the existing PBC and management cost allowances, but the PCT will offer as much support as possible to ensure the success of the project.

Benefit Description and Units	Gross BENEFIT / Target Units (eg. clients/consultations)				Category	INVESTMENT / DEVELOPMENT COST (£000s)			
	Full/Part Year 2011/12	Full Year 2012/13	Full Year 2013/14	Full Year 2014/15		Full/Part Year 2011/12	Full Year 2012/13	Full Year 2013/14	Full Year 2014/15
first outpatient referral rates reaching national to quartile levels,	1584.0	1584.0	1584.0	1584.0	Initially, project to be delivered within existing resources (including PBC resources). During 2011/12, there may be some investment required eg to facilitate workshops, set up education programmes Charges for telephone consultations	0.0	0.0	0.0	0.0
Gross BENEFIT Totals:	1584.0	1584.0	1584.0	1584.0	Investment / Development Costs Totals:	275.0	275.0	275.0	275.0
NET BENEFIT (£000s)	Full/Part Year 2011/12 1309.0	Full Year 2012/13 1309.0	Full Year 2013/14 1309.0	Full Year 2014/15 1309.0					

Appendix Six - Examples of programmes under development...

PROJECT TITLE	Expert Patients Programme/ Chronic Disease Self Management Programmes
PROJECT MANAGER	Annette Bunka
PROJECT SPONSOR	Simon Currie
CLINICAL SPONSOR	
PROJECT SPONSOR DIRECTORATE	Commissioning
CSP GOAL	Long Term Conditions
FINANCE MANAGER	Karen McKinley

<p>(1) What the project is and how it will be implemented:</p> <p>The Expert Patients Programme (EPP) is a toolkit of basic techniques that can support people living with a long term health condition to improve their quality of life by helping them to manage their condition better on a daily basis, increase their confidence and make them less dependent on health and social care. There are alternative courses/programmes for chronic disease self management developed and delivered by a range of providers, and can be adapted to suit a range of participants and long term conditions. This programme seeks to address priority health need 5 in NHS Sutton and Merton's current Strategic Plan, Diabetes – self care. Within the Strategic Plan, improvement in patient education in diabetes has been identified as an area for action. Long term conditions account for a high proportion of consultations in primary and secondary care.</p> <p>The DH estimate that the NHS could see significant savings from improving and focussing on self-care, a 40% reduction in GP visits, decreases in hospital admissions up to 50%, and A&E visits reduced by 50%. (Department of Health, Support people with long term conditions to self care: a guide to developing local strategies and good practice, 2006)</p> <p>The proposal is to commission:</p> <ul style="list-style-type: none"> • The delivery of 3 EPP or chronic disease self management programme courses within the boroughs of Sutton and Merton. Approximately 15 participants in each programme. • Support participants to become expert patients, empower them to take a more active role in their health and well-being in order to improve their quality of life • Train participants to become volunteer tutors <p>Outcomes: Reduction in hospital attendances and admissions for complications; Reduction in GP visits; Improved clinician/patient relationships; Qualified volunteer tutors to continue supporting courses and patients.</p>
<p>(2) Support, resource and procurement requirements to deliver this project:</p> <p>Procurement requirements: The project will need to be commissioned from a provider who has experience of delivering the EPP course(s), or similar chronic disease self management programmes. This could be from within the NHS, a local partner or specialist provider. The provider can support: work with the NHS to customise support contract and courses, provide tutors to deliver sessions/courses and organise reunion events, support with marketing, promotion and recruitment to courses and supply and prepare up to date course materials, stationary and equipment. A specification for this has already been drawn up.</p> <p>NHS Support and Resources</p> <p>In our experience, it can be difficult to recruit participants to such courses. To ensure the project is successful, it is vital to:</p> <ul style="list-style-type: none"> • Have a dedicated resource from within the NHS to support and embed EPP into local services and providers. • Minimum of 8 to 12 weeks of dedicated time is required for course promotion and recruitment prior to courses starting. • A dedicated person with a good knowledge of local groups, organisations and communities to promote and recruit via meetings and targeted outreach sessions and is able to liaise with GP consortia/PBC groups, practice managers and other health professionals to raise awareness of the courses, encourage referrals and set up referral pathways. • Administration support required to process application and referral forms, send confirmation letters to participants, speak with participants, community representatives, practice managers and GPs, take enquiries and liaise with project lead and course provider. • Support/engage GPs, specialist nurses and practice managers to identify patients on their registers most at risk, to invite suitable patient to attend the course in person and by letter.

Gross BENEFIT / Target Units (eg. clients/consultations)					INVESTMENT / DEVELOPMENT COST (£000s)						
Benefit Description and Units	A	B	C=AxB	D	E	Category	H	I	J=HxL	K	L
	No. of Units/ Activity	Cost / Tariff (£000)	Full Year Gross Benefit	Full/Part Year 2010/11	Full Year 2011/12		No. of Units/ Activity	Rate (£000/ Unit)	Full Year Cost	Full/Part Year 2011/12	Full Year 2012/13
Hospital Admissions for Diabetes - links to Overall LTC project £32,162 saving proposed for diabetes			0.0	0.0	0.0	Cost of programme	3.0	6.000	18.0	18.0	0.0
Gross BENEFIT Totals:			0.0	0.0	0.0	Investment / Development Costs Totals:			18.0	18.0	0.0

Appendix Six - Examples of programmes under development...

BOROUGH LED / SECTOR WIDE	Sutton & Merton
PROJECT TITLE	Stop Smoking Programmes - for Planned Surgery
PROJECT MANAGER	Sue Tree
PROJECT SPONSOR	Director of Public Health
PROJECT SPONSOR DIRECTORATE	Public Health
QIPP CATEGORY	Right Care
FINANCE MANAGER	Karen Mckinley

(1) What the scheme is and how it will be implemented:

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health. (Department of Health, NHS Stop Smoking Services, 2009). Reducing smoking is therefore a key priority in improving the health of the local population of Sutton and Merton. Specifically there is a strong clinical case for stopping smoking prior to surgery. Smoking is associated with local wound complications, pulmonary and cardiac complications, an increased need for postoperative intensive care and longer periods of hospitalisation. Smokers can have a need for increased anaesthetic dosage (Department of Health, Stop smoking interventions in secondary care, 2009). 'Stop before the Op' a paper from the London Health Observatory, 2006 demonstrates the potential cost savings for the NHS and evidences that the optimum time to stop smoking before surgery is 8 weeks.

The aim of this QIPP project is for stop smoking advice to be an integral part of the 18 week elective surgery pathways with referral of smokers to the local NHS Stop Smoking Service. Prior to referral to the Acute Trust the GP will establish the patient's smoking status. Identified smokers will be offered a referral to the local NHS Stop Smoking Service to attend the 6 week treatment programme. Once the smoker has completed the treatment programme then the GP will complete the referral the Acute Trust and encourage the patient not to relapse.

The Sutton and Merton Stop Smoking Service consists of a core specialist service and a network of community stop smoking advisors. The aim of the service is to provide evidence-based, effective treatment for smokers who are motivated and ready to quit. The service delivers a six-week programme using a combination of behavioural support and stop smoking medication i.e. Nicotine Replacement Therapy (NRT), bupropion (Zyban) or varenicline (Champix) which increases the chances of stopping smoking by a factor of four. Clients are given the choice of a group programme or one to one support. The Stop Smoking Service currently delivers circa 3000 stop smoking programmes per annum.

Using figures from the London Health Observatory smoking profiles 2010 for smoking prevalence in Sutton and Merton (19%), the expected number of smokers offered referral to the Stop Smoking Service is 9000. The expected take up rate is 20% using the PCT vascular toolkit version 5, and the service quit rate is 43%. The estimated extra activity generated by this QIPP project is therefore 1800 programmes per annum/36 new clients per week.

(2) Support, resource and procurement requirements to deliver this project:

1. Adequate capacity to increase service output by 60%

HR and Management Team authorisation to increase the Stop Smoking Service establishment by 1.5 FTE band 6 specialist advisers and .5 FTE band 3 administration.

Level 2 training programme to increase numbers of community advisers in established venues

2. The project outcome is dependent on stop smoking advice being given systematically within the elective pathways

3. The project is included within the 2010-11 Acute Trust contracts either via CQUINs or KPIs as leverage

4. The Acute Trusts have consistent and accurate coding of smokers, non smokers and ex smokers

5. Processes are in place within the Stop Smoking Service to manage volume calls, appointments, payments data collection and patient tracking

6. Use of PCT clinics and facilities to hold clinics with reception and security cover.

Gross BENEFIT / Target Units (eg. clients/consultations)					INVESTMENT / DEVELOPMENT COST (£000s)				
Benefit Description and Units	No. of Units / Activity	Cost / Tariff (£000)	Full Year Gross Benefit	Full/Part Year 2011/12	Category	No. of Units / Activity	Rate (£000 / Unit)	Full Year Cost	Full/Part Year 2011/12
Successful completion of Smoking Cessation Course	1800	0.17	313.2	312.0	Additional staffing, non pay & materials costs	1800	0.21	378.0	378.0
One off saving within the financial year resulting from the delay of elective surgery by (6 + 8) = 14 weeks	490	1.6	784.0	780.0				0.0	0.0

Appendix Seven - Financial allocation – funding and fixed contributions...

NHS London Planning Assumptions					
	10/11	11/12	12/13	13/14	14/15
Funding levels	5.10%	2.00%	2.27%	2.62%	2.65%
Inflation					
Pay	2.25%	1.00%	1.00%	2.90%	2.90%
Non pay	3.10%	2.90%	2.90%	2.90%	2.90%
Tariff inflator/deflator	0.00%	(1.50)%	(1.50)%	(1.50)%	(1.50)%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
Surplus (see note below)	1.00%	1.00%	1.00%	1.00%	1.00%
Non recurrent investment reserve	2.00%	2.00%	2.00%	2.00%	2.00%
CTB contribution	0.75%	0.00%	0.00%	0.00%	0.00%

Note

For 11/12, 1% surplus will be delivered across SWL cluster. For future years 1% surplus will be delivered by each PCT

Appendix Seven - SWL Cluster, financial allocation – Social Care & Re-ablement...

2011/12	Social Care ¹ £'000	Reablement ² £'000	TOTAL £'000
Croydon	3,714	935	4,649
Kingston	1,512	413	1,925
Richmond	1,753	406	2,159
Sutton & Merton	4,028	997	5,025
Wandsworth	3,454	800	4,254
SWL	14,461	3,551	18,012

Notes

¹ PCTs are required to transfer this funding via an agreement under Section 256 of the NHS Act 2006 to local authorities for spending on social care services to benefit health and to improve overall health and social care outcomes.

PCTs and Local Authorities must agree plans for how funding will be used.

² PCTs are required to show how this funding will be used to support people back into their own homes after a spell in hospital, i.e. re-ablement.

Appendix Eight - What are the financial constraints...

What are the financial constraints

- The financial model uses PCTs' 2010/11 income and expenditure position as the baseline data
- Income and expenditure is projected forward annually based on local and NHS London assumptions
- Income and expenditure is matched on a recurrent basis. Non-recurrent expenditure is considered as part of QIPP plan initiatives
- PCT in-year financial positions are constrained by certain National requirements, which are applied in each year. These are:
 - 2% non-committed investment reserve to be available in each PCT in each year
 - 0.5% contingency in each PCT
 - Challenge Trust Board contributions (2010/11 only)
 - QIPP benefits are reinvested in the originating PCT
 - In-year surpluses are available for carry forward

2010/11 baseline data sources:

- Baseline positions have been validated with each PCT Director of Finance

Modelling growth assumptions:

- NHS London planning assumptions for recurrent funding growth, pay/non-pay inflation and tariff inflator /deflator.
- Tariff deflator of 1.5% applied across all providers (mental health, acute, community).
- Locally agreed growth assumptions for acute/non-acute activity (including demographic and non-demographic growth) and prescribing inflation:
 - Demographic growth based on GLA 2008 low forecast for each borough
 - Non-demographic activity growth established by individual PCTs
 - Benchmarked using NHS London data which resulted in some changes
- Primary care efficiencies are included within QIPP initiatives
- Delivery of management cost savings across the SWL sector of £18 million.
- Top slice of £7.8 million PCT resources in 2011/12 to contribute to the pan London Development Pool & London wide Commissioning support.