One Plan

2011/12 – 2014/15

Surrey Health and Care System

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Contents

1. SIGNATURES OF ALL SYSTEM LEADERS

We the undersigned confirm our agreement to the plans set out in this document and its appendices and that we will work together to ensure their delivery.

CEOs

Name: _____ Organisation: _____

Signature: _____

Name: _____ Organisation: _____

Signature: _____

Chairs

Name: _____ Organisation: _____

Signature: _____

Name: _____ Organisation: _____

Signature: _____

Signatures of All System Leaders

Emerging GP Consortia Leads (as at present)

Name: _____ Organisation: _____

Signature: _____

Name: _____ Organisation: _____

Signature: _____

Director of Social Care

Name: _____ Organisation: _____

Signature: _____

Other locally determined clinical leads

Name: _____ Organisation: _____

Signature: _____

Signatures of All System Leaders

Other locally determined managerial/political leads

Name: _____ Organisation: _____

Signature: _____

Name: _____ Organisation: _____

Signature: _____

1. Health System Membership

Primary Care Trusts
NHS Surrey

GP Commissioning Consortia		
Dorking	East Elmbridge	EsyDoc
Farnham	Guildford and Waverley	Guildford Unaffiliated
Medlincs	Mid Surrey	North West Unaffiliated
SASSE	Surrey Heath	Thames Medical
Waverley Golden Valley	Waverley Unaffiliated	Woking Wide, Woking Central, West Byfleet

NHS Trusts
Epsom and St Helier University Hospitals NHS Trust
Surrey and Sussex Healthcare NHS Trust

Foundation Trusts
Ashford and ST Peter's Hospitals NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust

Local Authorities
Surrey County Council

Other Organisations
Central Surrey Health
Surrey Community Health

2. CONTEXT

2.1 National and local context

Nationally, the NHS has been protected from budget cuts, with a settlement that provides annual inflation uplift on existing budgets for the next three years (in line with national whole economy inflation assumptions). In the current climate that is a comparatively good settlement for the NHS.

The NHS in Surrey is focused on improving the quality of services for patients, delivering better value for taxpayers and returning the health system to financial balance. This requires a truly collaborative and connected approach from all partners to achieve far-reaching transformation in an environment of increasing demand and costs. This is why we have agreed the delivery of 'One Plan', which brings together all the different plans and initiatives, across the health and social care system. Living within the very different financial resource available is a key objective of the 'One Plan'.

We know, however, that there are a number of factors that make this financial equation very challenging including:

- Rising demand from an aging population , from increased "lifestyle" disease and from increasing technological capability (estimated at as much as 2% pa)
- The actual cost of NHS inflation (driven by technological advance) running ahead of general inflation
- VAT and National Insurance increases
- Pay bill increase resulting from increments and Excellence Awards
- Transfer of NHS resources to Local Government (announced in the CSR)
- Challenges to Local Government and other public sector partners resulting from real budget cuts which may require actions that in turn have consequences for the efficiency and effectiveness of NHS operations or indeed for demand for services.

Concurrently with the ongoing structural reforms of the NHS, real focus is being given to tackling the significant challenges posed by the factors listed above. Nationally, it has been recognised that the combination of these factors leads to a potential gap between resources required and resources available of £15-20 billion cumulative by 2014/15- if the NHS carries on as it does now.

2.2 The Current Provider/Commissioner landscape

Surrey's NHS includes five acute hospitals in Surrey (based at five trusts, three of which are Foundation), two major community providers (one social enterprise), a county-wide mental health trust, 12 GPCC (ten pathfinders) and with the volume of patients accessing London and other private providers, the landscape is busy. Surrey shares the same population demographic of increasing age as other counties but with mostly articulate and generally wealthy residents, demand for care is pushing activity, particularly acute activity, faster and faster. The geographic position of the county also gives significant exposure to London Trusts such as Epsom & St Helier, Kingston and St George's as well as a number of other specialist tertiary hospitals. A large proportion of tertiary activity is undertaken by London Trusts, where it attracts a significantly higher Market Forces Factor. Our proximity to London plus the effect of the historical underlying debt at Surrey & Sussex Healthcare continue to have a significant financial impact on NHS Surrey and constitute risk to achieving sustainability. A large proportion, therefore, of our acutes services are provided outside of Surrey and are commissioned on our behalf by other PCTs. For a number of years, including the predecessor PCTs prior to Surrey PCT being formed, Surrey has had difficulty living within its allocated resources. So there remain huge challenges to achieving financial balance.

Mental health and learning disability has a mixed provider landscape. At tiers two to three the majority of spend is in the voluntary and charitable sector providing IAPT services, community and supported employment services. At tiers 3 to 4 there is one main local foundation trust provider Surrey and Borders Partnership and 2 small boundary trust contracts. At tiers 4 to 5 there are limited specialist tertiary services in the main local NHS trust and so services are commissioned by NHS Surrey with more than 20 providers through contracts or on an individual spot purchase basis with providers in the independent and NHS sectors. The biggest shift in provision is in the learning disability care area where people who have been 'living in NHS provision' are being reprovided for in social care models with two significant programmes of change taking place divesting services from SABP to the independent sector.

Community services offer the back up to the post acute patient who requires ongoing support and treatment, but also offer the right model of care to support patients outside the hospital environment potentially avoiding admission. These new models of services need careful scrutiny and mapping to assure commissioners of value for money (VFM). This sort of scrutiny requires a new approach to service design and costing that has not been required for a number of years where the NHS has continually received growth monies. During times of growth it is all too easy to add items to pathways without the VFM test, but it now necessary to revisit and review pathways and services, in agreement with providers and partners, to achieve this level of understanding. The Local Transformation Boards (LTBs) will take the lead on this and set up a programme of review delivering Quality, Innovation, Productivity and Prevention (QIPP), but based on their more detailed knowledge of local services. This process should recognise both opportunity provided by

research and evidence but also local knowledge on discomfort about specific services. The GPCCs will be leaders in ensuring this work is completed, but must also recognise that they need support and information to ensure the best possible outcomes for patients within the resources available. With the wide involvement of all the stakeholders, this will create the best possible sustainable service change, which has to start with the interface between clinician and patient. The importance of the LTB should not be underestimated in the value they can bring to this strategic objective or the cohesion provided by them to the wider health economy.

2.3 The Future NHS landscape and transformation

The White paper Equity and Excellence: Liberating the NHS, the Health and Social Care Bill 2011 and other policy directives will result in a major structural change to the NHS landscape. Strategic Health Authorities and Primary Care Trusts will be abolished and replaced by new NHS bodies (organisations) responsible and accountable for the provision of health and social care. These include:

- PCT Clusters which will act as transition vehicles responsible for overseeing interim service delivery and the transition to the new NHS landscape
- National Commissioning Board responsible for commissioning primary care services, certain public healthcare services and overseeing GP Consortia performance
- GP Consortia, working with other health and care professionals and in partnership with local communities and local authorities, will commission NHS services for their patients, excluding those for which the National Commissioning Board is responsible
- Health and Wellbeing Boards with a duty to promote integrated working between health and social care commissioners, as well as promoting joint working with commissioners of services that impact on wider health determinants
- Public Health England will be created as a service that gives more power to local people over their health, whilst keeping a firm national grip on crucial population-wide issues
- Healthwatch responsible for providing evidence about local communities and their needs and aspirations.

In Surrey linked to these changes will be:

- Divestment of the provider arm (Surrey Community Health) through the “Transforming Community Services” programme
- Transfer of public health responsibilities and functions to the Local Authority.

2. Context

Under the Health & Social Care Bill, local authorities will use Health & Wellbeing Boards to carry out their lead role in integrating commissioning of health, social care and public health services to meet the needs of their populations. They will have a duty to produce and respond to their Joint Strategic Needs Assessments by developing Joint Health &Wellbeing Strategies to integrate health and social care planning with plans for other services which influence health, for example housing and education. They will be able to comment on GPCC commissioning intentions and take advantage of statutory flexibilities, including pooled budgets and lead commissioning.
We are awaiting clarity on the role of National commissioning Board and which specialties will be nationally commissioned and which will be locally commissioned by GPCCs is essential as they set their local business priorities. The GPCCs will need to have an infrastructure to communicate with the National Commissioning Board (NCB) and also to return information when requested, or answer queries or complaints. Alongside these tasks it will be necessary to set up a lead commissioner role for a number of contracts, because of size, influence or proximity, ensuring that they are ready to respond to the NCB requirements as part of local business processes. The relationship between the GPCC, County Health & Wellbeing Boards and the NCB will also be crucial in this new NHS Landscape.

Transformation, system reform and the journey to balance cannot, and will not, be achieved at the expense of patient safety and the quality of services. Raising quality and ensuring patient safety are paramount and are key to unlocking the transformation needed in Surrey. This One Plan broadly describes the issues surrounding Surrey's £360m theoretical gap between available resources and increasing costs over the next four years. Surrey's initial plan showed a significant gap which is being tackled through the 2011/12 contracting round.

The NHS has adopted a strategy for responding to this challenge that combines:

- A recognition that at present there remain inexplicable variations in quality of care and health, and of the use of health services, with many opportunities to significantly improve quality through raising the many to the levels of the best, not carrying on doing what we do now but looking for ways to do it better
- A recognition that in many instances, improving quality can also reduce costs, for example, reducing rates of infection
- A recognition that whilst the NHS often does a great job, it is better at responding to ill health when it becomes a serious problem than spotting problems earlier and heading them off at the pass before they get serious
- A recognition that with the assistance of new technologies, such as Telehealth and Telemedicine, it is now perfectly feasible to support care at home or in the community that was previously the sole domain of high tech hospitals
- A recognition that there are still many examples where the NHS is simply not maximising productivity in how it works (e.g. duplication of treatment or diagnostic processes, high levels of temporary staff usage, or not achieving potential day case rates) or value in how it buys things in (procurement)

- A recognition that some of the opportunities for health and social care to work together to streamline care are not being maximised
- A recognition that some of what the NHS provides to patients is of low clinical benefit and that it is inappropriate in times of economic restraint for such activity to be allowed to crowd out other activity that offers greater clinical benefits
- A recognition that the management costs within the PCTs and SHAs will be reduced

2.4 Transition and Reform in Surrey

Commissioning Development sits at the heart of the reforms that this new legislation brings and NHS Surrey is supporting local GP commissioning consortia (GPCC) through its Accountability Framework agreed at the March 2011 Board meeting. This Accountability Framework sets out the high level governance which then informs the accountability agreements between NHS Surrey and each GPCC and establishes the consortia as formal committees of the Board. The accountability agreements will translate responsibility into a number of key capability areas to support delivery of the One Plan. GPCC will operate under the practice based commissioning guidance of 2006. The goal is to use this financial year as a period of readiness, 2012/13 as a shadow year to bring consortia to full statutory status by April 2013.

As important is the focus on NHS Surrey becoming a new 'cluster' in the transition period and how we need to work more closely with Surrey County Council (SCC) to better join children's and mental health commissioning, while also managing the transition of public health to the local authority in due course. What must be clear in this major transition process is the delivery responsibilities for GP consortia, NHS Surrey as a cluster; those of South East Coast Strategic Health Authority and SCC. NHS Surrey's Transition Assurance Committee (TAC), with membership from SCC, has the responsibility of overseeing this complex process by providing assurance of the multiple and complementary transitions work streams to the Board of NHS Surrey. The Transition Programme has been established to enact the outcomes of the Bill, and manage the transitional impact on NHS Surrey and the wider Surrey health economy.

The National Transition Programme has been paused until 31st May 2011 to enable a "listening exercise" to commence. This will be undertaken by The NHS Future Forum, a group of clinicians, patient representatives, voluntary sector representatives and others from the health field, including frontline staff, who will drive the process of engagement with staff, patients and communities.

The Forum's first task will be to report on what they have heard on the following four themes:

- Choice and competition

- Accountability and patient involvement
- Education and training
- Advice and Leadership

Following its initial report, which will be submitted by the end of May, the NHS Future Forum will continue to listen and advise on other non-legislative aspects of the modernisation plans, implementation of the changes, and the design of any secondary legislation. Changes so far identified to the programme of work are that the following pieces of work, originally scheduled for April 2012, will now occur in July 2012:

- The abolition of Strategic Health Authorities;
- The assumption of its full statutory powers by the NHS Commissioning Board;
- The assumption of their full powers by the NHS Trust Development Authority, Health Education England and Public Health England;
- The first phase of taking on its new powers by Monitor, and
- The establishment of HealthWatch England and other changes to Arm's Length Bodies.

The creation of shadow bodies and the appointment of senior staff to these organisations will also be delayed to allow time for the engagement process to take place. The approval process for the statutory establishment of GP Commissioning Consortia in April 2012 could be potentially delayed as a consequence, but all other timelines regarding their formation remain unchanged.

2.4.1 Objectives of the Transition Programme in Surrey

The key objectives of the Surrey transition programme will include:

- Ensuring quality and safety of services for Surrey patients during transition
- Managing the transfer of statutory responsibility from NHS Surrey to other organisations specified in the Bill
- Managing the enactment of centralised policy within NHS Surrey
- Implementing statutory legal requirements set out in the Bill
- Managing the risks involved in transition

- Delivery of the benefits of the vision set out in the Bill
- Maintaining a fully functioning health economy in Surrey during transition
- Dissolving NHS Surrey as an NHS Trust

2.4.2 Impact - the benefits (impact) of the programme will include the following*:*

- A net reduction in commissioning running costs through:
  - Simplifying the architecture of the health and care system and streamlining business (commissioning) functions and processes, removing bureaucracy, inefficiency and duplication
  - Simplifying the organisation structures with a consequent reduction in management costs
  - Reductions in non staff transition costs (IT, accommodation, double running costs, estate)

- Facilitation of the achievement of QIPP plans through:
  - Establishment of new statutory arrangements to facilitate integrated and joint working and partnership arrangements across organisations.

- Improved patient outcomes as the new NHS Outcomes Framework focuses on the three domains of quality: effectiveness, safety and patient experience.

2.4.3 Scope of the transition and key tasks to be achieved

The Surrey Transition Programme requires the following tasks to be achieved:

- NH Surrey primary responsibility:
  - Establishment of a PCT Cluster
  - NHS Commissioning Board
  - Divestment of its provider arm through the Transformation of Community Services Programme
  - Establishment and development of GP Consortia

- In collaboration with the Local Authority
  - Transfer of Public Health functions to the Local Authority

  - Establishment of the Health and Wellbeing Board
- In collaboration with the Local Authority and the Local Involvement Network, the establishment of HealthWatch.

Achieving this will require collaborative working with all key stakeholders. To ensure this is achieved work streams have been identified with responsibility assigned specifically to a lead director and an operational lead. The work streams are as follows:

Key work streams	Enabling work streams
• PCT Cluster Development • NHS Commissioning Board • GP Consortia Development • Commissioning Support Unit Development • Public Health Transfer • Health and Wellbeing Board • HealthWatch • Transforming Community Services (a separate programme reporting into the Transition Programme	• People management • Finance • Estate • IM &T • Communication • Commissioning and Contracting • Governance and Legal

2.4.4 Governance

Assurance for delivery of the key tasks is provided by the establishment of a sound programme structure which includes:

- Reporting into the NHS Surrey Board on progress to date.
- Establishment of a Transition Assurance Committee, a sub-committee of the NHS Surrey Board, with responsibility for assuring delivery.
- Reporting on a regular basis to the Executive Management Team.
- Appointment of a designated director and programme team with overall responsibility for delivery
- Appointment of a lead director and operational lead for each of the work streams highlighted above.

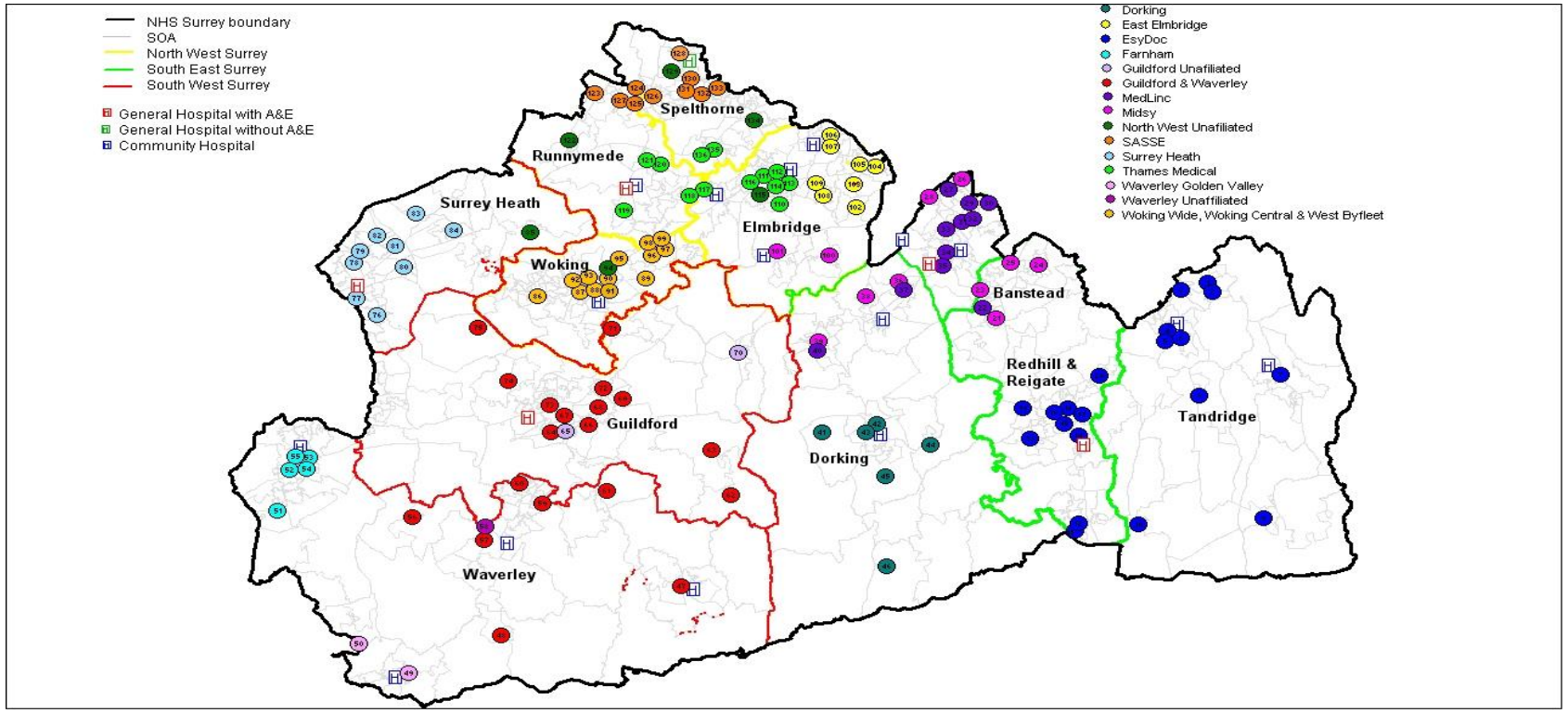
The key deliverables within the Surrey Transition Plan are included as Appendix 4.

2.4.5 People, Estate, IT and Contract Transition

Plans are in the process of being developed for the transition of staff, estate, IT and contracts. These will be aligned to, and integrated with, the timeframes in Appendix 4.

2.5 Transition into GP-led commissioning – Emerging General Practitioner Commissioning Consortia (GPCC) in Surrey

Map showing 12 emerging GPCC in Surrey



2. Context

Surrey has 136 practices (1,101 GPs) with total list size of 1,069,266 patients. The emerging GPCC currently replicate the Practice Based Commissioning cluster arrangements, however this is beginning to change as national guidance is made available. Surrey has 12 GPCC, 3 situated in the North West, 5 in the East and 4 in the South West, with registered populations ranging from 56,000 to 210,000. Ten of the 12 are pathfinders. It is anticipated that the remaining two will be successful in their applications later in 2011. Each of the 12 consortium have retained their former PBC leads, 9 out of the 12 commission some form of external support using their PBC incentive scheme and anticipate the £2 per head of registered population will continue to pay for this resource until commissioning support requirements become clearer

The PCT and GPCC leads have become more focused over the last 6 months to agree priorities to underpin new ways of working that best support the pace of change for each emerging consortium. To date the PCT has:

- A Transition Assurance Committee in place that will assure the Board of the strategic development of the entire transition programme, including GPCC
- Dedicated operational lead for the transition of GPCC across Surrey with an agreed development plan in place
- Interim GPCC support teams to work with individual consortium to deliver the one plan across Surrey
- Monthly GPCC leads meetings
- Draft GPCC Accountability Framework agreed by the Board on 11th March 2011. Work is in progress to deliver this framework through Individual Accountability Agreements between the PCT and each consortium by May 2011. The process will be that each consortium will complete the self assessment against the four levels of capabilities. The PCT will then complete a formal assessment through a panel of representative stakeholders. The draft accountability agreements will be presented to GPCC boards in April 2011 and final agreements to the PCT Board in May 2011.
- GPCC information task group to progress common data sets to support the development of GPCC and the delivery of the one plan at a local level.
- Draft GPCC budgets in place which reflect the total running costs for each consortium and will be included within the Accountability Agreement. Monitoring and support arrangements will vary dependant on the level of capabilities for each consortia. The PCT has committed to offer £2.35 to incentivise the delivery of QIPP in Unplanned Care (Acute), Long Term Conditions and Medicine Management for 2011/12. In addition the PCT will make available the £2 per head of registered population as stipulated within the Operating Framework.

- Working with the SHA to agree resources to support education, training and learning networks that best support the transition of commissioning arrangements from PCT to emerging GPCC.

Progress is being made in developing communications, relationships and trust between the PCT and the emerging GPCC. Our vision is that the interim commissioning support arrangements, together with emerging national guidance will enhance the smooth transfer of commissioning arrangements to GPCC. The PCT is working closely with the LMC, SHA and DH to lead the transfer of primary care regulated contract functions for Surrey over to the National Commissioning Board in shadow form in October 2011. The progress to date includes:

- Dedicated project management resources in place to support the delivery of the transitional arrangements
- Project plan in place, aligned to SEC plans. The first priority is to undertake a baseline assessment of all statutory functions of primary care contracting. First phase completed and now focusing on alignment of staff that would potentially transfer to the NCB.
- Attendance and active contribution to the SEC primary care leads meetings
- Delivery of the Primary Care contracting QIPP plan with target savings of £8.6m over the next 4 years

2.6 Approach to Health and Wellbeing Board locally and agreed roles and responsibilities

Under the Health & Social Care Bill, local authorities will use Health & Wellbeing Boards to carry out their lead role in integrating commissioning of health, social care and public health services to meet the needs of their populations. They will have a duty to produce and respond to their Joint Strategic Needs Assessments by developing Joint Health &Wellbeing Strategies to integrate health and social care planning with plans for other services which influence health, for example housing and education. They will be able to comment on GPCC commissioning intentions and take advantage of statutory flexibilities, including pooled budgets and lead commissioning.

Surrey County Council is one of about 25 local authorities which have already been granted 'early implementer status' by the Department of Health for their Health & Wellbeing Boards. The Council has appointed a Programme Lead, seconded from the role of Director of Planning at NHS West Sussex for one year, as its Health & Social Care Bill Lead. Three development workshops for the Surrey Health & Wellbeing Board, led by King's Fund facilitators, took place on February 17th, March 10th and April 6th 2011. Invited stakeholders included members of NHS Surrey and county council senior teams, GPs representing the GP consortia and representatives from borough and district councils, the voluntary sector, patients and the public as well as elected council members. The first workshop

focused on the Joint Strategic Needs Assessment and Surrey's commissioning priorities; the second focused on how to achieve integrated working and planning in Surrey; the third on how the Surrey Health & Wellbeing Board will work. The workshops enabled agreement on the principles and processes by which the Board's Terms of Reference will be developed. The first meeting of the Shadow Board will be in May 2011. The Shadow Board will meet regularly during 2011/12 to develop its work programme with the aim of establishing the Full Board by April 2012. Details of the Board's supporting structures will need to be agreed jointly to ensure the Board has the right infrastructure to carry out all its functions effectively.

To facilitate integration of public health functions into Surrey County Council, and in preparation for the full transfer of public health functions to the local authority, senior members of the NHS Surrey Public Health Team have been aligned to Surrey County Council Directorates. Pending publication of national human resources guidance, the intention is to transfer public health team members to Surrey County Council by April 2012 to fit in with plans to reduce the number of staff based in PCT premises in Leatherhead.

One of the functions on the Health and Wellbeing Board will be to set the Health and Wellbeing strategic direction for Surrey based upon priorities identified from the joint strategic needs assessment. This will inform the commissioning of services and programmes for the needs of the Surrey population, including the wider determinants of health.

2. Context

On 30 November 2010 DH England published the White Paper: *Healthy Lives, Healthy People: Our strategy for public health in England*, and the Review of Regulation of Public Health Professionals. The Public Health White Paper outlines the considerable public health challenges facing us. It supports Professor Sir Michael Marmot's recommended 'life course' approach to improving health and addressing health inequalities, which focuses on health and wellbeing throughout life to ensure that everyone is supported to make healthier choices. It also emphasises the importance of addressing the wider determinants of health such as employment, educational achievement, environmental, social and cultural factors, as well as housing. It highlights the need to improve wellbeing – mental and physical - as well as treating sickness, and highlights the lead role that local government has in addressing this agenda through prevention measures. Furthermore, the White Paper emphasises the importance of tackling inequalities in health.

The White Paper takes a 'life course' approach to health improvement outlined in Prof. Sir Michael Marmot's report. Addressing health and wellbeing throughout life with a particular focus on children through 'starting well' and 'developing well'. This focus on the importance of children and young peoples' development is going to be central to the new delivery system for health and wellbeing in Surrey. Examples of how this will work are below:-

- **Starting well** – focusing on maternal and child health and breaking the Intergenerational cycle of ill-health and inequalities. There will be a particular focus on children who are at risk of poor outcomes. In Surrey work has started between NHS Surrey and Surrey County Council mapping current provision/initiatives and gaps against current best practice. This piece of work will inform future commissioning of services and programmes.

  The Government recently published details of a new health visitor workforce of 4,200 to improve child health; in essence this is about nationally increasing the number of people working as health visitors. In Surrey this equates to 64.2 WTE (not headcount) by 2015. The White Paper highlights the role of Health and Wellbeing Boards (HWBs) in ensuring that they join up with existing services and plans for early years. NHS Surrey has applied to become an early implementer and work is being conducted with partners to ensure this is achieved through promotion of our return to practice schemes or flexible training packages for new health visitors. There is an expectation that this commitment will revitalise the health visiting service to deliver a new model of support to families, building on the Healthy Child Programme. There are initiatives such as providing more support through nurses and health visitors to encourage and support new mothers to breastfeed. (Maternity & Newborn/Children's QIPP)

2. Context

- **Developing well** – focus on child and adolescent wellbeing, including mental wellbeing and self esteem. Schools have an important part to play in delivering better health outcomes for children and young people in promoting physical activity (incentivising children to walk to school), providing high quality personal, social and health education, improving self-esteem and mental wellbeing through a range of existing and new programmes. In line with the 'starting well' work NHS Surrey and Surrey County Council have mapped current provision and gaps against current best practice. This piece of work will inform future commissioning of services and programmes. An example of this is the contribution Public Health has made to the health part of the quality standards the youth service has developed as part of the services for young people redesign. (Mental Health, Children's and Staying Healthy QIPP)

- **Growing up well –** focuses on risk-taking and experimental behaviour such as high levels of binge drinking, smoking, STIs (poor sexual health) and illicit drug use. Adolescence/young adulthood is an important development stage characterised by physical, neurological and emotional development. In line with the 'starting well' work NHS Surrey and Surrey County Council have mapped current provision and gaps against current best practice. This piece of work will inform future commissioning of services and programmes. (Mental Health, Children's and Staying Healthy QIPP)

- **Living well** – encompasses all factors which contribute to health and wellbeing, including housing, planning, the natural environment, access to active transit etc. The White Paper lists a range of new and existing schemes to support people to make healthier choices in relation to eating, physical activity, environmental sustainability and use of alcohol. It highlights many ways that councils can influence health through their housing, planning, environmental, licensing, community development and regulatory functions. (Staying Healthy QIPP)

- **Working well** – promoting good physical and mental health at work. The White Paper focuses on the importance of work in promoting health and wellbeing and the intention of the Government to support people with long term health conditions to get back into the world of work. (Staying Healthy and Long Term Conditions QIPP)

- **Ageing well** – supporting older people to remain active, healthy and independent within their own homes. The White Paper summarises a wide range of universal benefits and more targeted support that enable older people to maintain their health, wellbeing and capacity. A crucial component is the *Vision for Social Care* published on 16 November 2010. There is a focus on mental health and wellbeing throughout life, with a particular emphasis on mental wellbeing of children and adolescents. (Mental Health [Dementia], Unplanned Care and Long Term Conditions QIPP)

2. Context

The health and wellbeing strategy will inform the prevention side of the QIPP and will feature in most of the 17 QIPP programmes over the 4 years of delivery. For example, the promotion of normalising birth and the breastfeeding peer support programme in the Maternity and Newborn QIPP.

Examples of health improvement/prevention in QIPP programmes in 2011/12:

QIPP programmes	Prevention element
Children	• Implementation of Smokefree Tobacco Education Toolkit in all Secondary Schools • Identifying Teenage Pregnancy hotspots and targeting schools and youth services in the area to ensure they are signposting to relevant health services and looking at building at risk groups self esteem
Long term conditions	• Better primary care/ community management of patients with LTC to reduce acute episodes and improve long term outcomes for patients as seen through:- 1. Telecare/Telemedicine 2. Combined predictive modelling 3. Virtual wards 4. Community Matrons 5. Care planning
Maternity and Newborn	• Promotion of Healthy Start through Children Centres • Delivery of breastfeeding peer support
Medicines management	• Raising awareness of the cost of unused prescribed medicines
Mental Health	• IAPT

2.7 How health and social care are working together to meet their respective and joint challenge (Joint Commissioning)

Adult Social Care (ASC) and NHS Surrey are involved in a number of joint initiatives designed to ensure delivery of coherent, cost effective services integrated across health and social care boundaries. Key areas include a Joint Working Group to identify areas of (short and longer term) addressable spend where the NHS and ASC both hold contracts with the same suppliers. Areas identified include; home based care, 3rd sector, carers and the development of a joint longer term strategy. Initially modelling indicates NHS savings of around £258k per annum (domiciliary care) if the NHS paid the same rates as Surrey County Council (SCC). SCC Framework expires in March 2012 and longer term options could include pooling of children's and Mental Health, NHS and SCC spend for Joint Commissioning. Benefits to this approach would include spend leverage, joint (single) contract management, one point of contact for providers. Progress to date includes:

Children and Young People

- Discussions between NHS Surrey, Surrey County Council, and more recently GP Commissioning Consortia leads, to progress joint commissioning of children's services to improve outcomes and value for money, are progressing well. A joint proposal paper to establish a Joint Commissioning Steering Board was approved by SCC Cabinet in February and was tabled for approval at the NHS Surrey Board in March.
- NHS Surrey, SCC and GPCC leads met on the 18th February 2011 to set out the planned approach, including timeline, to move this work programme forward. It was decided to base the development of joint commissioning of services around the needs of 8 cohorts of children and young people. To date the review of the first 4 cohorts which are Safeguarding, Looked After Children, Children with Complex Needs and CAMHS are near completed; the finance schedule which pulls together NHS expenditure on all the 8 cohorts is also nearly complete. The reviews on the final 4 cohorts will be completed shortly.

Mental Health

- Surrey has a strong joint working basis on mental health and learning disability. There is a new Dementia joint commissioning strategy that has been consulted on, that describes a 4 year plan on how the agencies will be improving dementia services jointly in terms of quality and efficiency to be in a better position to cope with the growth of the future.
- CAMHS is jointly commissioned with a pooled budget and has also benefited from the completion of a new joint commissioning strategy in 2010/11 focussing on how the emphasis needs to shift to universal, early intervention, prevention and family orientated approaches in order to have a positive impact on future generations mental health and wellbeing.

- With the successful transfer of £62.2 million of Learning Disability social care from NHS Surrey to Surrey County Council there continues to be joint work in improving the services for people with a learning disability in the county from a primary care level through to specialist health care and both agencies are involved in the development of QIPP and PVR for learning disability.

- With the transition to GPCC a Joint Commissioning Unit for MH/LD hosted by SCC has been proposed. This unit would provide added capacity, less duplication of effort and efficiencies in service commissioning. This has been started by the move to a Joint DOLS/MCA arrangement beginning in April 2011.

2.7.1 Partnership Grant (Re-ablement) 2011/12

NHS Surrey and Surrey County Council (SCC) are leading the planned approach for spend against the DH investment for Partnership Grant in 2011/12. Based on local need, it has been agreed that the priority for this funding is to develop a whole system, integrated re-ablement and recovery service centred on promoting, recovering and maintaining levels of independence and self care wherever possible. The principle adopted in the plan is to develop permanent service arrangements on the basis that the measures are likely to prove advantageous from an 'invest to save' point of view. Each element of this funding has been linked to delivery of the One Plan (QIPP) Programmes; Acute Care, Long Term Conditions, End of Life Care, Mental Health (dementia) and Digital Vision. As such, delivery will be monitored through the One Plan governance structure, led by the NHS Surrey Acute Care and LTC Lead and the Surrey County Council Associate Director of Adult Social Care.

This integrated system will:

- contain service and support elements which actively promote independence
- Managers understand their budgets (pay & non-pay); provide opportunities for re-ablement to support those in the community with long term health conditions to remain independent for as long as possible.
- Develop key competencies and skills with Health and Social care staff to deliver such services.

Projects include:

- A range of preventative services designed to prevent or delay admission to hospital
- Services which provide the opportunity to maximise recovery and re-ablement for those discharged from hospital and in the community

- Services which enhance the management of people with long term health conditions within the community with a view to reducing or delaying hospital admissions, as well as supporting their carers.
- Initiative that shifts the culture of the organisation towards delivering improved outcomes.

2.7.2 Alignment of SCC to NHS Structures, Resource Hubs and Localities

Staff from Personal Care and Support are aligned to each of the Local Transformation Boards. Managers from ASC (adult social care). Commissioning and Personal Care and support are also aligned to each of the locality areas and managers from ASC commissioning are beginning to be involved with their PCT locality counterparts. The Associate Director and Managers from ASC Commissioning are meeting with GPs and are in the process of looking at ASC reporting structures for GPCC Boards. Staff from ASC and Personal care and Support are involved in the development of a range of local initiatives (i.e. North West Future Models of Care for EOLC/LTCs and South West Annual Stroke Review Project).

2.8 Estates

The Health and Social Care Bill outlines a broad framework but some uncertainty remains around the future ownership of estate, existing leasehold, PFI opportunities and pressures despite its strategic importance. NHS Surrey is developing an estates plan in line with the expected guidance and with members of the health system whilst maintaining continuity in current provision as a Corporate Landlord, Capital Investment, maintenance and contributing to the QIPP agenda. Guidance on the future ownership of assets will inform occupation and the necessary legal and corporate governance structures that will need to be discussed, agreed and put in place. In the interim NHS Surrey continues to develop a level of detail on the current picture that will support any future decisions.

2.9 How we will deliver in Surrey

Nationally the financial and transformation issues above have been brought together under the banner of QIPP, Quality Innovation Productivity and Prevention, and all local organisations in the NHS have been developing plans for how to realise these opportunities locally. Nationally this has come under the banner of the Integrated Strategic Operating Plan (ISOP). Many expert assessments of the QIPP challenge have suggested that, in principle, the opportunities for improvement and the value associated with them can indeed more than bridge the potential financial gap. They require, however, an enormous effort to manage substantial change across a multiple of fronts, simultaneously. They also require recognition that the same evidence shows that as much as 75% of the opportunities can only be achieved if all organisations in a local “health and care system” work together as opposed to in isolation. This constitutes an

unprecedented leadership challenge for the service but also requires action at every level, from the individual, to the organisation, to the local health and care system, to the Department of Health.

The Surrey Transformation Board has agreed there is no transformation without improved outcomes and that high quality care must reduce costs associated with the care of both individual patients and the health economy. The system leaders have agreed to make change happen through the five local transformation boards which are focused around each major acute hospital. They are focusing on a whole system approach to the QIPP priority work streams.

This document sets out in summary form the QIPP plans for the Surrey health and care system. It should be read in conjunction with the numerical activity and finance detail included in the long term sustainability model templates included in the Finance Section of this plan. The 'One Plan' is how the NHS in Surrey will ensure a coordinated approach to the improvements in services and care to deliver £360 million in Surrey over the next four years. The ambition of the 'One plan' is safe, effective care and financial balance. The strategic approach is to ensure that Surrey's resources over the next four years are targeted at improving the overall health of the whole population and reducing the demand on health services.

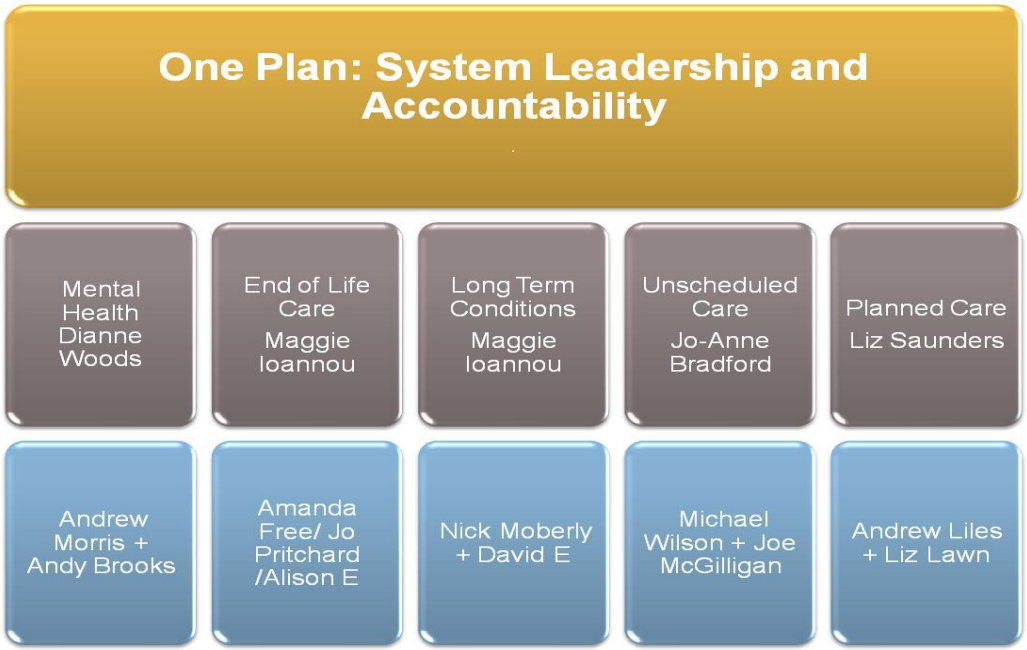
The 'One Plan' delivery cycle includes several key piece of work described in other aligned documents. The Joint Strategic Needs Assessment (JSNA) identifies the population health need in Surrey. The data and evidence from the JSNA support the recommendations for clinical services within the Clinical Strategy. These recommendations are set within available resources (both money and staff) which in turn feed Commissioning Intentions and the QIPP plans. The QIPP plan becomes the annual operating plan for 2011/12 and sets out what has to be done to deliver the savings for next financial year and the following three years.

Of the 17 national QIPP programmes, five have been identified locally as having the greatest impact on achieving the identified savings. These are unscheduled care (acute), planned care, mental health (including the major dementia programme supported via 2010/11 South East Coast Transformation Fund), end of life care and long term conditions. Each of these has three 'big ticket' initiatives that will need to make 60-70% of the savings required to deliver robust healthcare outcomes and achieve better value. Chief executive and GP consortia leads have been identified (see QIPP Leadership table below) for the five priority programmes to specifically support change in the following way:-

- Provide clinical lead and executive level support for one of the 5 QIPP priority programmes.
- Ensure a 'voice' at clinical lead and chief executive level, bringing detailed knowledge of the work steam to all executive meetings.

2. Context

- Meet regularly with the programme lead, advising on and developing the work stream as appropriate and providing senior level support in overcoming any risks or issues that have been identified.
- Chair County networks/boards as appropriate and to 'head up' SHA and county assurance events.
- Champion the work stream at all opportunities.



The One Plan describes:-

- Our local assessment of the size of the QIPP challenge , for commissioners and providers;
- What the key strategic challenges are in terms of health of the population, the shape of provision and quality of care that we agree should underpin our plans;
- What this means for the local health system in terms of how we must respond;
- The interaction with the challenges and opportunities being pursued by Social Care locally;
- The initiatives that make up the plan, what they will deliver in terms of improved quality and value, how and by when;
- What that means for changing patterns of commissioner spend; provider income; activity levels; key components of capacity (such as beds); workforce requirements;
- For each initiative (and work stream within that) what each party needs of the other to achieve success;
- The benefits overall that are intended for patients and how we will ensure those are realised;

- How the implementation is being managed across our health and care system locally, including how to maximise engagement in the plans and most importantly how the new GP Commissioning leadership will be taking up the reins in key aspects of delivery;
- How we intend to achieve assurance of safety through a period of extensive change;
- The issues that arise that we must ensure are properly resolved in our formal contractual agreements before end March 2011.

2.9.1 The QIPP Challenge

If demand, activity, costs and therefore spend were to increase in line with trends from recent years, a gap will open up between available resources and that of level of spend. It is this gap between existing levels of funding and what may occur in terms of gaps in finances to meet the service demand, quality expectations and adoption of new technologies (technically, the "counterfactual") which is the QIPP challenge. It is not a theoretical notion as trends in these key measures have been stubbornly consistent across the whole NHS over many years.

Nationally, for the NHS this gap has been sized at £15-20 billion by 2014/15. In the South East Coast Region that gap is expected to be £1.58 billion. The modelling work undertaken by NHS Surrey, which is summarised in Appendix 1, suggests a gap for the Surrey of £360 million. The shared view of all parties to our One Plan, informed as appropriate by both national and regional modelling, is that the QIPP challenge locally is as set out in Appendix 1 by locality, providers and GP commissioners. The purpose of the QIPP plan is to deliver better services and better health outcomes for the population we serve, including accommodating rising demands within a fixed resource envelope. It is essential therefore to document at the outset the main strategic challenges that our health & care system agree need to be tackled as part of this plan. These are summarised below:

2.9.2 Key challenges to sustainable provision that must be addressed

Surrey has real challenges in reducing its use of hospital services for more minor problems, it has to support older people to stay as well as possible and reduce admissions for infections that can be managed outside of hospital and also needs to manage End of Life care to best effect for patients allowing them to die at their location of choice and to minimise treatment to aid comfort and dignity. Addressing these patient initiated events with support and information will benefit commissioner's ability to target resource.

Elective Surgery access for Surrey patients requires a more detailed understanding of how access is afforded and needs to prove that it is in line with agreed thresholds and therefore can be seen to be at the right place, right time and value for money. This will require close working of clinicians in both primary and secondary care to achieve a right size for Surrey. Growth in specific specialities requires investigation for redesign to ensure more sustainable productivity.

2.10 Key Successes to date that we can build on

A successful QIPP plan requires commissioners and referring clinicians to achieve reductions in the level and intensity of demand. This means that providers need to be able to redesign services in a way that will deliver higher quality at lower cost, releasing a proportion of that economic benefit back to the local system and, in many cases, reducing capacity to avoid the universally recognised factor of "supply-induced demand". It will require integration of services as experienced by patients and carers. It will only happen through concerted local action. We have reviewed our recent successes and challenges to date in order to have a shared view on the lessons learned that can then be taken forward.

2.10.1 Planned Care - Dental

Since the new dental contract was introduced in 2006 there has been an increase in the number of patients referred to hospitals for tooth extraction. The hospitals were also concerned at how they would achieve their 18 week target without further clinical staff appointments. A triage project was started in May 2008 to divert simple tooth extractions away from the hospital sector. Alternative specialist led provision was set up in primary care at about 10 dental surgeries across Surrey. A price much lower than hospital tariff was negotiated. The total number of referrals has risen in the last five years from about 3,500 to 6,000 but the level of referrals sent through triage and on to be treated in the hospital sector has dropped by about 5%. An agreement was made with the hospitals that NHS Surrey would only pay for referrals that had been through the referral triage service.

The project initially identified savings of about £500,000 but this was not achieved. This is because:-

- There has been a significant increase in overall activity
- Dental access has significantly increased mainly due to additional funding coming from the centre (alongside a target to provide additional primary care access in this period and people who have not seen a dentist for some years present with higher than average levels of need
- Resources are within block contract values and savings in one speciality are counterbalanced by over-activity in other areas.

If the extra patients were seen in the acute sector this would have significantly increased costs for the PCT for treating this cohort of patients who needed relatively simple treatments. Therefore this project should be seen as a cost containment exercise and demand management rather than a savings programme. This project was successful in mitigating some element of the growth in acute sector activity which has supported the delivery of the 18 week target. Patients are seen quickly closer to home and still access care from specialists.

2.10.2 Planned Care – Low Priority Procedures

Our list of low priority procedures list has grown through the inclusion of more procedures and tighter thresholds. Decisions about the inclusions and tighter thresholds have been driven through engagement with clinical commissioning advisory groups. These groups have been set up with multi-disciplinary memberships and include groups for Orthopaedics/Pain, Dermatology, Urology, Ear Nose and Throat, Ophthalmology, Oral Health Advisory Committee and Surrey Area Prescribing Committee.

Ensuring compliance has been the key challenge. NHS Surrey has undertaken clinical auditing of notes for specific specialties. This showed that there was not full compliance with the thresholds. NHS Surrey then introduced prior approval of key procedures with thresholds (as part of the fast, steady, stop approach). This has been implemented successfully in the independent sector (high compliance with thresholds and process). A way forward is to gain greater involvement with GPCC and transformation boards to identify more local economy wide solutions to prior approval/ensuring compliance with thresholds.

2.10.3 Planned Care - Safer Care

There has been engagement with lead nurses across SEC and Surrey undertaking work that has already had an impact on improving patient safety and reduction of harm from Pressure Ulcers, falls and HCAI. These initiatives are High Impact Actions, Energising for Excellence, Safer Smarter Nursing.

2.10.4 Planned Care – Primary Care

The Tier 2, or interface, service reviews last year has lead to a wider understanding by all concerned of the necessary attention to detail to ensure that such services not only add ease of location to the patients but need to be compliant with national quality standards and offer value for money. Clarity on patient diagnostic groups, procedures and potential HRG identification is a fundamental part of re-provision of services and the only way in which changes to secondary care commissioning can be made. Using existing baselines of activity is essential to ensure that unintended new growth is not created by a new offer of service.

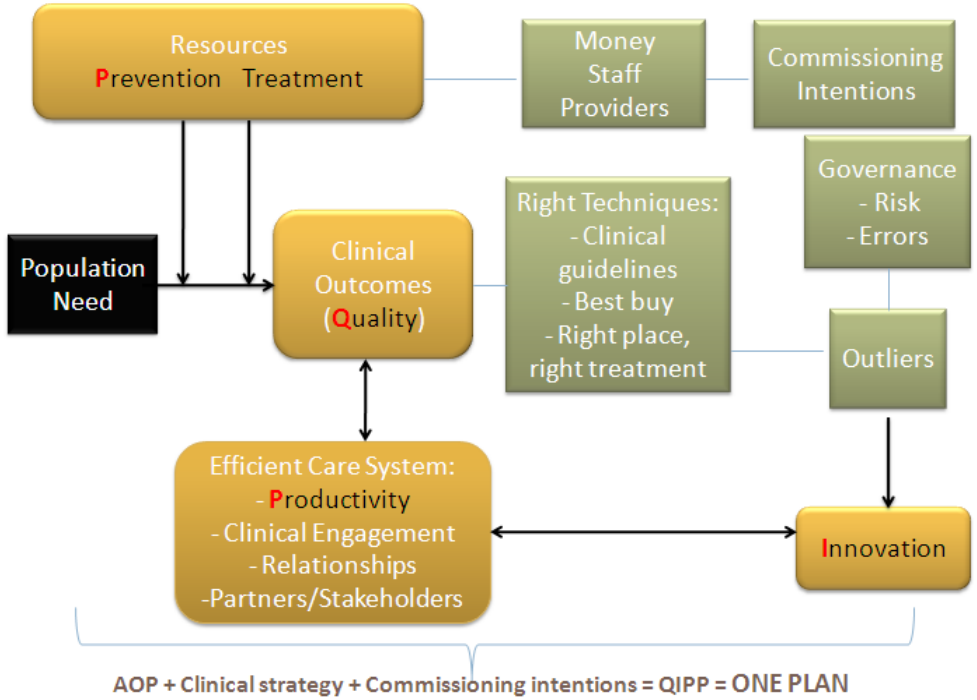
3. OVERVIEW OF THE PLAN

3.1 The Overall approach to plan delivery

As stated above, the QIPP plans for our system are interconnected in a fundamental way, hence The One Plan. We have therefore developed a shared approach to bringing this plan together.

- The Surrey wide Transformation Board has agreed 5 key QIPP Workstreams in line with national and regional recommendations. A combined GP and Provider CEO leadership has been agreed (17th December 2011). Each of the QIPP County Leads will set-up a structure to receive the direction, leadership and support necessary to make whole system changes across the County.
- Financial challenges have been broken and presented to the Surrey Transformation Board down by Local Transformation Board, Locality Cluster and Consortia.
- The Director of QIPP has had follow up discussions with each of the GP Leads and Provider CEO's to explore what the PCT can provide to support the QIPP agenda in each Workstream across the County.

- As already stated the 'One Plan' delivery cycle includes several key piece of work described in other aligned documents. The Joint Strategic Needs Assessment (JSNA) identifies the population health need in Surrey. The data and evidence from the JSNA support the recommendations for the Clinical Strategy. clinical services within are set within available These recommendations and staff) which in turn resources (both money Intentions and the QIPP feed Commissioning plans.



3.2 Values and principles that will guide us in delivering One Plan

All the organisations in our local system have agreed a core set of principles to underpin how we work together in taking this plan forward. These have been confirmed by our Boards and represent an agreed basis on which we can hold each other to account. These principles are set out below as related to each of the elements of the One Plan:-

Key Area	Principles: We will	Systems Actions/Decision Required	Decision Making Group
Manage Resources Appropriate % spend on **Prevention** Treatment & Care	• Spend at least 1.5% of service budgets across care sectors to deliver effective preventative actions to reduce demand	Agree a list of routine preventative services to be delivered routinely as demand management actions	Health & Wellbeing Board
	• Encourage private funding for care where desired and to buy the right care at the right time		Health & Wellbeing Board
	• Require all providers to help deliver preventative activities as set out and agreed in the Surrey Health & Wellbeing strategy	Preventative activities included in all provider service plans	Health & Wellbeing Board
	• Require primary care providers to deliver preventative activities as part of normal business where practicable	Agree a list of routine preventative services to be delivered in primary care routinely	Health & Wellbeing Board
Managing Money Workforce	• Give Clinical leaders an expressed permission to make radical improvements across care systems	Identify the clinical senate permitted to propose and implement system change decisions	Local Transformation Boards

3. Overview of the Plan

Key Area	Principles: We will	Systems Actions/Decision Required	Decision Making Group
	• Promote leadership behaviours and the courage to do what is right for the system, particularly when it is contrary to what individual parts of the system desire	A list of desirable behaviours written down and agreed by system leaders	Local Transformation Boards
	• Spend not more than 6-months as systems leaders to reach decisions on desirable changes to current services	The forum where all proposed plans can be monitored against the 6-month deadline agreed	Local Transformation Boards
	• Make the desired changes to the size and shape of current services in one part of the system when we have agreed to provide care in a new way elsewhere		Local Transformation Boards
	• Acting together to develop and support our workforce and help them follow the new ways of working		Local Transformation Boards
Comprehensive Commissioning Intentions	• Ensure that these lead to service contracts that describe the outcomes required (clinical quality and patient experience) and not just the number of patients to be treated		Local Transformation Boards
	• These bring all incentives in line with each other to support improvements to the whole system, and changing the old 'rules' where they are really getting in the way of achieving best value		Local Transformation Boards

Key Area	Principles: We will	Systems Actions/Decision Required	Decision Making Group
	• Withhold payments for avoidable errors and only release this funding to providers when verifiable corrective actions to avoid such errors are in place		Monthly Contract & Quality Meetings
	• Use CQUIN payments to promote transformational actions and pay these only when outcomes are evident		Monthly Contract & Quality Meetings
	• Pay for the right care in the right place only once and local providers will need to work with each other to agree who is best to commission as service contractors		Local Transformation Boards
	• Jointly commission services where economies of scale are possible starting with Mental Health, Learning Disabilities, 3rd Sector Provision and Children's Services		Health & Wellbeing Board
	• Fully commission in primary care and community services what these services can deliver safely and not duplicate the commissioning of such services in other parts of the system		NHS Board
Right Techniques: - Clinical guidelines - Best buy - Right place, right treatment at the right price and not necessarily at full price	• Design common pathways for routine services across providers and cost these for local payment schedules		Local Transformation Boards
	• Continue with Fast, Steady, Stop and make it simpler to implement		NHS Board
	• Work to explicit clinical guidelines based on evidence-informed recommendations from Clinical Networks and Public Health		Local Transformation Boards

3. Overview of the Plan

Key Area	Principles: We will	Systems Actions/Decision Required	Decision Making Group
	• Pay what is affordable for services rather than system rule prices as long as the services are effective and we can agree a price that will ensure service providers stay in financial balance		NHS Board
Manage Outliers	• Encourage peers to challenge variations in outcomes and help support remedial actions		Local Transformation Boards
	• Document learning proactively and share across the system		Local Transformation Boards
Innovation	• Permit service managers to make improvement to services without prolonged administrative sign-off		Local Transformation Boards
	• Ensure that system-wide innovations do not fragment current care and services		Local Transformation Boards
	• Ask that service innovation proposals pass three key tests: • Is this big enough to matter? • Is this real innovation that will deliver QIPP goals? • Can we implement the proposal now and faster than any other agreed proposals yet to be implemented?		Local Transformation Boards
Efficient Care System: - Productivity - Clinical Engagement - Relationships - De-duplication - Connected & Anticipatory	• Pool budgets with other relevant organisations to improve all elements of care and not just some elements of care in a pathway		Local Transformation Boards

3. Overview of the Plan

Key Area	Principles: We will	Systems Actions/Decision Required	Decision Making Group
	• Backing ideas which contribute to best value and promoting the best ideas so they can be put in place as consistently and quickly as possible across the whole system.		Local Transformation Boards
	• Sharing knowledge of how what we do compares with others, sharing information and giving feedback on how new approaches to providing care are working, and being open to learning from others.		Local Transformation Boards
	• Avoid behaviours and actions which simply pass the problem, funding risks, and patients from one institution to another without aiming to resolve the issue once and for all in the system		Local Transformation Boards
	• Avoid making unilateral decisions within organisations that create a new supply pipeline for services which increases overall system spend because of duplication		Local Transformation Boards
Clinical Outcomes (Quality)	• Promote equitable access to services		Health & Wellbeing Board
	• Focus on overall wellbeing and not just treating diseases		Health & Wellbeing Board
	• Improve the experience of the service of overall to patients, carers, families and the community		Health & Wellbeing Board

3.3 Principles from the 2011/12 Commissioning Intentions.

NHS Surrey will adopt robust turnaround principles to all aspects of its work, most specifically its commissioning, and will ensure that this applies consistently throughout the whole £1.65 billion budget. This will mean that all investment decisions must be underpinned by strong business cases before approval and strong programme management during implementation. Additionally, NHS Surrey will be looking to introduce:-

- Contractual consistency across all Providers, whether Primary, Secondary (including Secondary services provided by non-Acute Providers) and Tertiary
- Locality budgets
- Programme budgets, with capped expenditure
- Effective demand management
- Effective medicines management
- An extended list of Low Priority Procedures. If there is no clinical need for the treatment or little or no clinical evidence behind an intervention, the intervention will not be funded. This will aid NHS Surrey in safeguarding key services and aspects of the budget to continue to offer clinically essential services
- For routine surgery, patients will be treated in turn unless there are special circumstances
- Increased numbers of non-PbR pathways and tariffs
- Zero payment for zero LOS
- From 1st December 2010 to November 2011 there will be no new referrals for IVF. If treatment has already started, this will continue. As IVF is not usually offered beyond 39 years, if women are approaching this age and meet the clinical criteria, treatment will go ahead. This decision will be reviewed in November 2011
- A review of weight management policies
- A review of community hospitals, walk-in centres and minor injury units. In the November 2010 Board meeting it was agreed that NHS Surrey would explore a “lead” community hospital model, concentrating budgets and services in four hospitals removing service variation across the county and offering improved services. We do not have a definitive plan at this stage but are considering enhanced services at four community hospitals in Woking, Caterham Dene, Farnham and Haslemere. These community hospitals could offer:-
    - 24/7 consultant led in-patient care
    - Urgent treatment centres
    - Point of care testing
    - Rapid assessment and diagnostics

  - Integration with social care
  - Ambulance destination for non life threatening conditions (category B and C calls)
- Tight application of the thirty day re-admission rules
- Roll-out of the 49 ambulatory care pathways
- NHS Surrey will no longer pay for consultant to consultant referrals unless they are clinically urgent. All other referrals will be returned to primary care. Approval can be sought prospectively or retrospectively
- Local Enhanced Services will be reviewed
- Smokers to continue to be referred into a smoking cessation course prior to being added to the waiting list for elective surgery

3.4 Contracts

NHS Surrey has now reached agreement in principle with the majority of its local NHS Trust for 2011/12, including community and mental health providers. Heads of Agreement are in the process of being signed and the target is to complete having full contract documentation in place by the early May where NHS Surrey is the host PCT, The Royal Surrey County Hospital and Ashford & St Peter's Hospitals. For non hosted contracts this is the responsibility of other PCTs i.e. Hampshire in case of Frimley Park Hospital.

The principle behind agreeing contracts for 2011/12 for local acute contracts has been to run contracts on a full PbR basis with a robust monthly quality and performance management process in place, this also applies to Mental Health and Community contracts although within a block arrangement. In addition principles underlying One Plan initiatives have been embedded in contracts, as both activity and finance reductions in the core contract or as service improvement plans, where locally agreed. Similarly changes arising from GPCC Commissioning Plans have either been removed from contracts or included in Schedule 7 as Service Development Improvement Plans. These changes may turn into contract variations in year as services are re-designed and new pathways agreed. Local CQUIN targets for hosted contracts incentivise Trust to work on One Plan programmes with indicators for Ambulatory Care, Staying Healthy, Stroke and Dementia.

The major risk for NHS Surrey has been the continued growth, year on year, in contract performance and to mitigate this risk a variety of risk management strategies have been agreed with local acute Trusts. For Royal Surrey and Ashford & St Peter's a cap and collar arrangement is in place whereby activity above and below the base contract value within plus or minus £2m is either not paid for or refunded. Outside this tolerance full PbR rules will apply. For Frimley Park a slightly different arrangement is in place where a contract

ceiling has been agreed to a maximum of £1.5m above the baseline contract. For Surrey and Sussex Healthcare and Epsom & St Helier Trust no risk sharing has been agreed as it is felt that full PbR with no cap or collar will work most effectively.

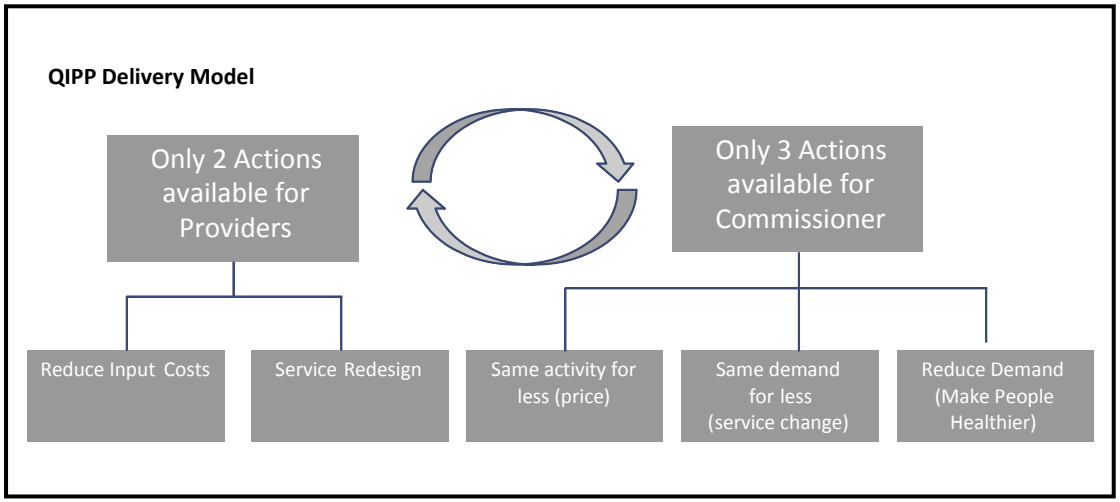
Given that full PbR will apply it is incumbent on the PCT to continue with a robust monthly reconciliation process for its hosted contracts and to ensure for non hosted contracts that host PCT's follow this process on our behalf. Particular emphasis needs to be given to this relationship with the Sussex cluster Commissioning Support Unit who manage the hosted agreement with Surrey and Sussex Healthcare. Work is ongoing to reach agreement with out of Surrey providers in particular London Trusts. Agreement has been reached with a number and for the remainder proposals are being reviewed and updates sent as London Trusts conclude discussions with host PCTs. For these contracts the PCT will work with QIPP initiatives and key performance indicators agreed by hosted PCTs, with Surrey as associates to contracts where ever possible.

3.5 One Plan interdependent changes

One Plan will involve a wide range of interdependent change initiatives by commissioners and providers. Patients, Carers, Advocates, Families and the Community at large will need to understand these changes. A proactive approach to managing expectations will be required. We will act as One Team across Surrey to deliver these initiatives. This ambition does not inhibit locally championed initiatives or difference of approach by emerging GP Consortia. What the One Plan Approach allows us to do is to work to a set of principles and focus on the 'Big Ticket' items that matter and will transform the whole system.

It is important to recognise that whilst the details of local initiatives can be complex and highly bespoke, in reality, at a summary level there are only five ways in which commissioners and providers can improve value (reduce costs) whilst maintaining or improving quality of services provided. This simplified framework helps us check that each QIPP Programme Plan has exhausted all the opportunities for improvement. The decision tree to help allocate activities to the five options is appended at the end of this paper (Appendix 2). The framework is depicted below and includes 3 key strategies for commissioners

1. Reduce demand by working hard to keep people healthy (prevention)
2. Find ways of delivering the same level of services at a lower cost
3. Maintain affordable level of services to meet as much need as possible through re-design



Our commissioning intention this year is to award service contracts within available resources. In section 4.4 details of contractual levers required to deliver our major initiatives are provided. This is important because of the financial contracts agreed between commissioners and providers, we will have the opportunity to work together to transform the system and slow down the historical increase in demand year-on-year as well as prepare for the inevitable increased demand arising from the factors already highlighted.

3.6 The Big Ticket Items

We have reviewed the following in order to determine our local priorities:-

- Opportunities identified by South East Coast NHS QIPP Workstreams
- NHS Assurance Check and Validation of Proposals from LTBs, Providers, and GPCCs
- Public Health Evidence Reviews

The 'big ticket' items are transformational projects that will deliver improved care quality as the mechanism for improving patient outcomes and achieving a sustainable system. Over recent months, work has been undertaken to identify where the greatest opportunities lie to improve both quality and value by doing things differently. These shared opportunities have informed local planning in

3. Overview of the Plan

Surrey and following recent assurance events and joint planning with clinicians, GP Commissioners, and Providers, the following big ticket items have been identified for 2011/12. We aim to achieve financial balance this year while delivering good quality services, based on the activities highlighted below:-

- **Mental health:** reduce high cost out of area treatment and placements; redesign substance misuse service; and a major Surrey dementia programme.
- **Unscheduled (Acute) Care**: new community hospital model pilot spans both unscheduled and planned care and includes redesign of ambulatory care pathways; children's unplanned care pathway development; implement NHS Pathways with expectation to reduce A&E admissions by 10%.
- **Planned Care:** acute contracting efficiencies to reduce consultant to consultant referrals and implement 30 day readmissions challenges; local pricing to achieve consistency of pricing across providers for patients with low clinical complexity and shift activity from consultant-led acute outpatient services; Low priority procedures refine in line with regional thresholds and continue prior approval of surgery through "Fast, Steady, Stop" programme.
- **Long Term Conditions:** targeted and proactive management of people at increased risk, enhancing their ability to self care, provision of individual care plans, development of a LTC whole system model, embedding virtual wards, improved access to Telehealth and Telecare technology to reduce unplanned admission and ensure planned admissions are shorter and clinically more effective, COPD pathway redesign ; implement NICE Quality Standards and best practice tariff for stroke patients to decrease length of stay and unscheduled readmissions; achieve atrial fibrillation best practice to reduce risk of stroke and prevalence of disability requiring long term care.
- **End of Life Care:** improve the quality of care (at home, care home, hospital) by implementing Gold standard framework and reduce inappropriate hospital admissions by extending current pilot areas to offer patient choice about treatment and place of death and implementing do not attempt resuscitation protocol.

3.7 Future care delivery system

The essential characteristics of our future Care Delivery System

- Connectedness: Social Care Integration, Joint Commissioning, Instant Care, Rapid Support Teams, End-to-End Care Navigation
- Anticipatory: Predictive Modelling and Risk Stratification, Active Management of current 'missed opportunities'
- Intelligent System: seeks the right information, shares it easily, and create actionable insights for all parts of the system to work together
- Fair & Equitable: ensures that unequal needs receive unequal share of available resources
- Trusted & Respected: planned with local people and create the best experience for service users
- Locally Relevant: based on ability to benefit and not just demand
- Managed Risk: agreed risk sharing protocol to cover low volume high cost events Action JO/MI

3.8 The expected consequences of actions taken in 2011/12

The high level outcomes expected to be delivered by this plan are set out in this section and further granularity can be seen in Section 4. By implementing the Big Ticket items we expect to see the following changes to activity by Trust set out below:

KEY	Increased Activity	0 - 5%	6 – 15%	16%+	Decreased Activity	0 -5%	6 – 15%	16%+	Stable Level of Activity	
		↑	↑↑	↑↑↑		↓	↓↓	↓↓↓		⇄

Primary Care	
GP Consultations	↑
Dental UDAs	↓
Items Prescribed	↑

Mental Health	
Bed Days	↓
Attendances	↑
Contacts	↑↑

Community Based	
Bed Days	↓
Attendances	↑
Contacts	↑↑

Social Care	
Residential Care	↓
Home Care Packages	↑↑

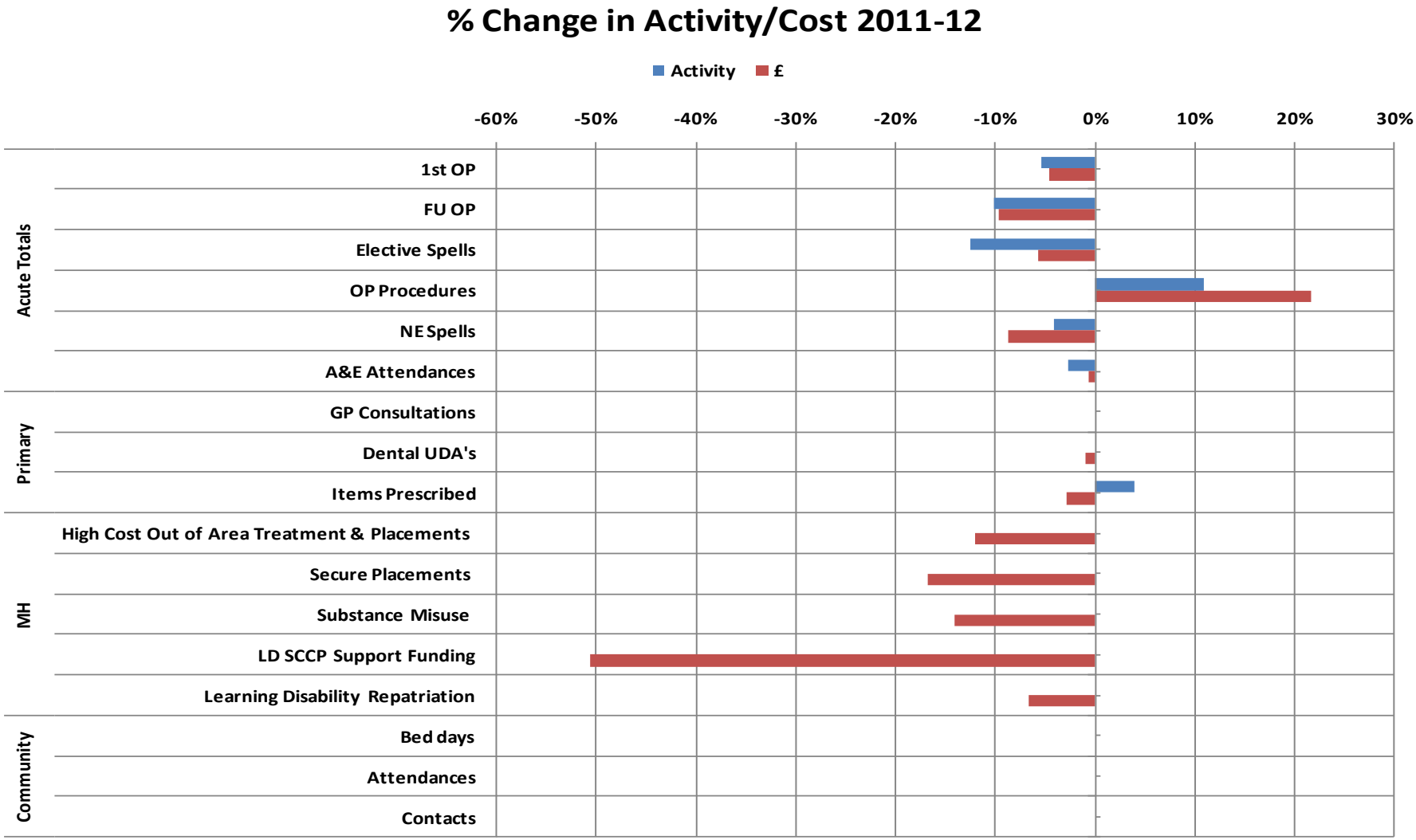
Ambulance Service	
Journeys to A&E	↓
Non A&E Journeys	↓
Patients treated at scene	↑
Calls resolved via telephone advice	↑

Acute Hospital	
First Outpatients	↓
Follow-Up OP	↓↓
Elective (Ord & DC) Spells	↓↓
OP Procedures	↑
Non-Elective Spells	↓
A&E Attendances	↓

End of Life / Palliative Care	
Beds	↓
Home-based Care	↑↑

NHS Funded Care	
Nursing care placements	↓
Continuing Care Placements	↓

3.8.1 Proposed Changes in commissioner spend



3.8.2 % Change in Activity/Cost 2011-12

		Activity	£
Acute Totals	1st OP	-5%	-5%
	FU OP	-10%	-10%
	Elective Spells	-13%	-6%
	OP Procedures	11%	22%
	NE Spells	-4%	-9%
	A&E Attendances	-3%	-1%
Primary	GP Consultations	0%	0%
	Dental UDA's	0%	-1%
	Items Prescribed	4%	-3%
MH	High Cost Out of Area Treatment & Placements		-12%
	Secure Placements		-17%
	Substance Misuse		-14%
	LD SCCP Support Funding		-51%
	Learning Disability Repatriation		-7%
Community	Bed days		
	Attendances		
	Contacts		

3.8.3 Activity Shifts QIPP 2011/2012 ACUTE		Emer/Non Elec	A&E attendances	Local Price	Outpatients and Procedures		Total required for QIPP Stream £'000
Ambulatory care and Emergency Zero LOS (SWL)	"0" and "1+" LOS All adults, top 6 acutes, top 40 ambulatory care conditions, April 2009 - March 2010, emergency and non elective	-20,267		11,354	8,000		6,192
Paediatric Ward Attendances at Local Price							
Cap emergency admissions	Surrey acutes only excl ESHUT, all emergency m8 2010/2011 to FOT	-1,000					1,151
Zero LOS at Local Prices	Surrey acutes only excl ESHUT, all "0" LOS m8 2010/2011 to FOT	-4,013		4,013			2,853
NHS Pathway Effect (999)	A&E attendances by ambulance excl deaths and admissions. Low, standard only m8 2010/2011 to FOT. Top 5 acutes		-3,207				284
Home CPAP	repatriation no activity shift						97
Unidentified schemes							36,830
Total per March Tracker QIPP		**-25,280**	**-3,207**	**15,367**	**8,000**		**47,407**

	Forecast Spend		Savings for 2011/12 Acute Care		2011/12 Plan Spend	
	2010/11 FOT		£47.42m			
	Activity	£	Activity	£	Activity	£
1st OP	**300,744**	**£56,080,345**			**300,744**	**£56,080,345**
FU OP	**692,721**	**£68,259,925**			**692,721**	**£68,259,925**
Elective Spells	**124,638**	**£187,993,938**			**124,638**	**£187,993,938**

3. Overview of the Plan

OP Procedures	126,681	£21,178,910			126,681	£21,178,910
NE Spells	79,511	£173,181,947	-25,280	-£10,196,000	54,231	£162,985,947
Locally Priced Activity			23,367		23,367	£0
A&E Attendances	429,609	£42,933,202	-3,207	-£284,000	426,402	£42,649,202

Project	Consultant to Consultant referrals	30day Readmission	DC->OP procedures	Planned Treatments not carried out (WA14Z) at local price	OP New:FUP	IVF Suspension	LPP prior Approval	NW Bus Cases	Integration of Sexual Health Services	TOTAL
Planned Care QIPP Cost and Activity changes	C2C at mo8 to FOT 2010/2011, excluding oncology, obstetrics etc. For top 5 providers and adj for SWL St G's and Kingston. Total adjusted for in year challenges	After Elective Care 100%: All providers readmission rates after elective episode 2009/2010 After Emergency Care 40%: All providers readmission rates after emergency episode 2009/2010	All Day cases with equivalent OP procedure code for Nov 2009 - Oct 2010. All providers.	no activity shift	Implementation of new F/Fup rules calculated by SWL. Reduction of Follow Ups	IVF activity - non PbR	Agreed LPP and threshold adj applied. Based on 2009/2010 admission activity for defined procedures.	Worked up business cases from NW GPCCs	Activity remains the same, local tariff negotiated	TOTAL £'000
Savings/ Costs	Acute Adjustments									
1st OP	-£1,417							-£957	-£167	-£2,541
FU OP	-£2,352				-£3,242			-£833	-£203	-£6,630
Elective Spells			-£8,986	-£46		-£937	-£640			-£10,609
OP Procedures			£4,824					-£234		£4,590
NE Spells										£0
A&E Attendances		£0								£0
	Community Adjustments									

1st OP								£734		£734
FU OP								£517		£517
OP Procedures								£352		£352
TOTAL	-£3,769	£0	-£4,162	-£46	-£3,242	-£937	-£640	-£422	-£370	-£13,588
Activity	Acute Adjustments									
1st OP	-9,952							-6,165	0	-16,117
FU OP	-28,512				-32,134			-9,597	0	-70,243
Elective Spells			-15,233	0		-195	-253			-15,681
OP Procedures			15,233					-1,412		13,821
NE Spells										0
A&E Attendances		-8,632								-8,632
	Community Adjustments									
1st OP								6,207		6,207
FU OP								7,499		7,499
OP Procedures								1,412		1,412

3.9 Changes that patients will notice and how these will enhance their experience of local services

In many cases patients will see no major changes to their local services as interventions are about changing the price paid per service item to providers rather than service changes. However some changes will be seen, as set out below globally and then by programme area:

- Many services will make more sense to people because they will be integrated and will be offered at the first point of entry into systems pathway
- Care will be increasingly delivered closer to home and using new technologies
- Some interventions will not be routinely available because they will not be funded normally based on cost-effectiveness or therapeutic effectiveness criteria

- There will be more opportunities for dialogue at the clinical frontline with patients, carers and their advocates about service offering and planned re-design
- Staff will be trained in using new and better techniques and are likely to assume roles different to traditional roles that are more familiar to patients and the public

Safer Care
Changes in service provision will not compromise patient safety. Patients should not experience any harm, in particular in relation to the following:-

- Development of a grade 3 or 4 pressure ulcer
- A fall whist an in-patient that results in moderate or severe harm
- A catheter associated urinary tract infection.

Mental Health
Introduction of psychological therapies at a primary care level will increase the number of people able to access services and improve the outcomes for people with common mental health problems preventing people from needing to go to secondary care services unless appropriate and facilitating a retention/return to employment. Increase in information on mental health awareness/promotion through First Steps and Mental Health First Aid training will improve peoples understanding of what they can do to help themselves and if they need services what services are available and how to access them.

Dementia
Currently pathways are complex and often unknown to the patient or carer. There will be more information available on what services are available to people and the services will be integrated between health and social care simplifying and making quicker access to evidence based services. People will receive earlier identification and diagnosis and will have their outcomes improved keeping them independent and at home for longer.

Planned Care
During 11/12 the majority of the planned care QIPP savings are delivered through acute contracting efficiencies which will not lead the patient to experience any material change in service. Low Priority Procedures will result in fewer unnecessary interventions of evidence of low clinical effectiveness. However, tough choices around services that can be provided within the current budget may need to be made, such as the suspension of IVF treatment. To protect services as far as possible, NHS Surrey has identified low complexity

outpatient activity for specific specialities that could be performed at reduced costs through utilising a mixed professional input and may be provided outside of the acute setting. If a community based provision model is pursued, patients could experience care closer to home. Enhanced Recovery (CQINN) will lead to reduced length of stay due to faster recovery and better post operative outcomes.

3.10 Planning & Implementation beyond 2011/12

Indicative savings across the 4-year planning period by programme area is detailed below.

QIPP Initiatives Surrey County

	Programme	2011/12	2012/13	2013/14	2014/15	Total
1	Acute Care	13.10	1.78	3.48	12.79	**31.15**
2	Back Office	5.42	1.93	1.93	3.49	**12.77**
3	Children	0.50	0.00	0.00	0.94	**1.44**
4	Contracting Efficiencies CSU	0.00	0.00	0.00	0.00	**0.00**
5	Contracting Efficiencies Primary Care	3.30	2.64	0.99	1.64	**8.57**
6	End of Life Care	0.00	0.00	1.20	2.33	**3.53**
7	Estates Optimisation	0.33	0.33	0.33	0.37	**1.36**
8	Long Term Conditions	3.10	37.99	29.91	22.74	**93.74**
9	Maternity & Newborn	2.01	1.10	3.20	3.13	**9.44**
10	Medicines Management	14.01	3.00	3.00	7.53	**27.54**
11	Mental Health	11.42	1.96	0.00	5.03	**18.41**
12	Planned Care	9.66	8.00	9.30	7.59	**34.55**
13	Rationalisation of Pathology	1.31	4.97	2.47	3.91	**12.66**
14	Staying Healthy	1.94	0.42	0.47	0.48	**3.31**
15	Safer care	2.50	0.00	0.00	0.94	**3.44**
16	Workforce Productivity	0.91	1.29	1.06	0.27	**3.53**
17	Digital Vision	0.49	1.59	1.66	1.82	**5.56**
Total		**70.00**	**67.00**	**59.00**	**75.00**	**271.00**

QIPP Initiatives Surrey County					
QIPP Initiatives Surrey County	**70.00**	**67.00**	**59.00**	**75.00**	**271.00**
Provider Savings	**27.00**	**26.00**	**24.00**	**30.00**	**107.00**
Total QIPP Programme	**97.00**	**93.00**	**83.00**	**105.00**	**378.00**

Reconciliation of Savings for Surrey Health Economy

	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	Total £m
Surrey QIPP Savings	**74.00**	**93.00**	**83.00**	**105.00**	**355.00**
In Year Additional Savings	23.00	0.00	0.00	0.00	**23.00**
Total QIPP Programme	**97.00**	**93.00**	**83.00**	**105.00**	**378.00**

3.11 Finance Summary 2011/12

Financial Framework

		Deductions						Add Back		
	Gross	GPCC	QIPP	London Contract KPIs	Readmissions	CQUIN	Sub total	Readmissions	CQUIN	Baseline Proposal
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
General & Acute - Local	620.9	-9.3	-17.4	-6.1	-19.4	-4.2	564.5	19.4	4.2	588.1
General & Acute - Other	250.0		-1.3	-1.7	-0.7	-1.7	244.5	0.7	1.7	247.0
Mental Health	133.2		-1.1			-0.6	131.5		0.6	132.1
Community Services	231.4	-0.2	-1.4			-0.9	228.9		0.9	229.8
Primary Care	198.2		-3.3				194.9			194.9
Prescribing	193.6		-14.0				179.6			179.6

3. Overview of the Plan

Corporate	33.4		-3.4			30.0			30.0
Funding Issues	19.9					19.9			19.9
Reinvestment		9.1		7.8	20.1	37.0	-20.1		16.9
Contingency	20.5					20.5			20.5
Total	1,701.1	-0.4	-41.9	0.0	0.0	-7.4	1,651.3	0.0	7.4	1,658.8

Resource Limit	1,659.7
Planned Surplus	-1.0

NHS SURREY QIPP & GPCC PLANS							
			Gross Plan		**Reinvestment**		**Total**
			2011-12		**2011-12**		**2011-12**
			£000's		**£000's**		**£000's**
QIPP	***Transformational***						
	Ambulatory Care		-4,791				-4,791
	Paeds ward attendances		-4,003				-4,003
	NHS pathways 999		-287				-287
	Cardiac PPCI		-138				-138
	Patient Safety Ulcers and falls		-1,061				-1,061
	Heart Failure		-302				-302
	Stroke TIA etc		-200				-200
QIPP	***Transactional***						

	C2C at 25%		-3,620				-3,620
	Prior approval		-268				-268
	IVF suspension		-626				-626
	Pathology 10%		-1,314				-1,314
	Alcohol		-68				-68
	Smoking		-1,396				-1,396
	Weight Management		-473				-473
	Other		-135				-135
	Medicines Management						
	- Primary Care Prescribing		-10,391				-10,391
	- Non Primary Care Drugs budgets		-3,619				-3,619
	Mental Health		-1,360				-1,360
	Back Office		-4,423				-4,423
	Primary Care		-3,302				-3,302
	Voluntary Services		-111				-111
Total QIPP			**-41,888**		**0**		**-41,888**
SWL KPI's			-7,825		7,825		0
GPCC							
	Changes re PIMs services GPwSI in NWest		-2,204		1,782		-422
	Surrey Heath transfer no new services yet estab FYE		-2,483		2,483		0
	SASH TB unscheduled care/scheduled care/hand surgery		-4,812		4,812		0

Total QIPP, SWL KPI's and GPCC changes			**-59,212**		**16,902**		**-42,310**

3.12 Quality Metrics (CQUIN)

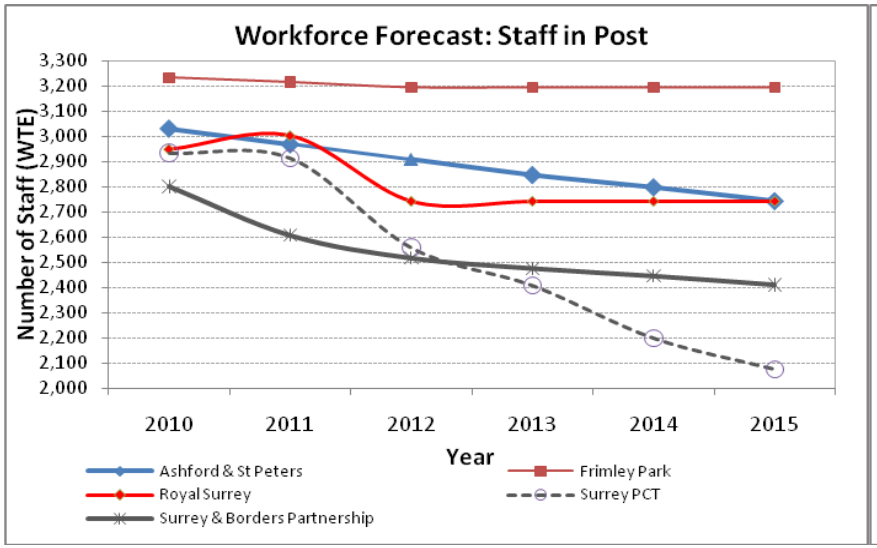
Quality indicators that will help drive the quality that will be monitored and tied to financial consequences in the contract and which programme they relate too.

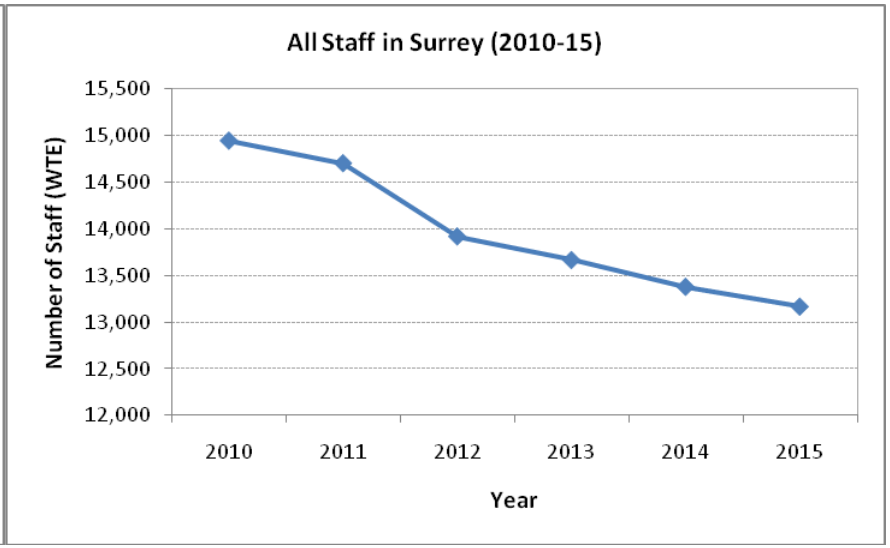
Goal Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	QIPP Programme
1	VTE Risk Assessment.	0.15	Safe Care
2	Composite indicator on responsiveness to personal needs.	0.15	Safe Care
3a	EQ Pneumonia, Orthopaedic, Heart Failure pathway improvements.	0.225	Safe Care & Acute Care
3a	EQ AMI pathway improvements in the agreed MINAP areas.	0.075	Safe Care & Planned Care
3b	EQ Acute Pneumonia and Heart Failure outcome improvements.	0.05	Safe Care & Acute Care
3c	Acute pathway maintenance and development.	0.15	Safe Care & Acute Care

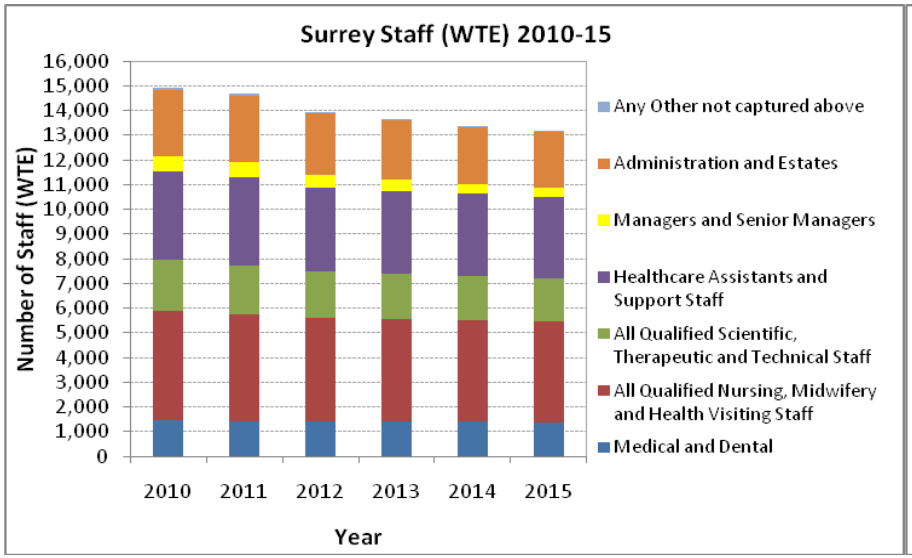
Goal Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	QIPP Programme
4	Composite indicator on Stroke Assessment, Stroke Discharge and Thrombolysis.	0.1	Long Term Conditions
5	Ambulatory Care.	0.3	Acute Care
6	Targeted screening for alcohol misuse within A&E Departments, successful smoking quitters, and Baby Friendly progress.	0.17	Staying Healthy & Maternity
7	Specialist Mental Health Teams to facilitate earlier discharge.	0.13	Mental Health
	Totals:	**100.00%**	

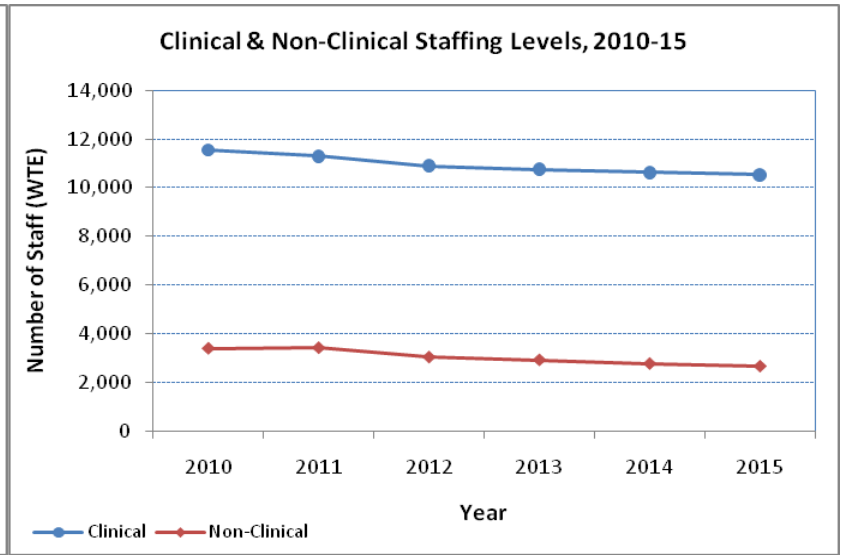
3.13 Workforce Implications

The following tables summarise the workforce implications of QIPP over the next 4 years and indicate the level of workforce by category (admin/clinical).

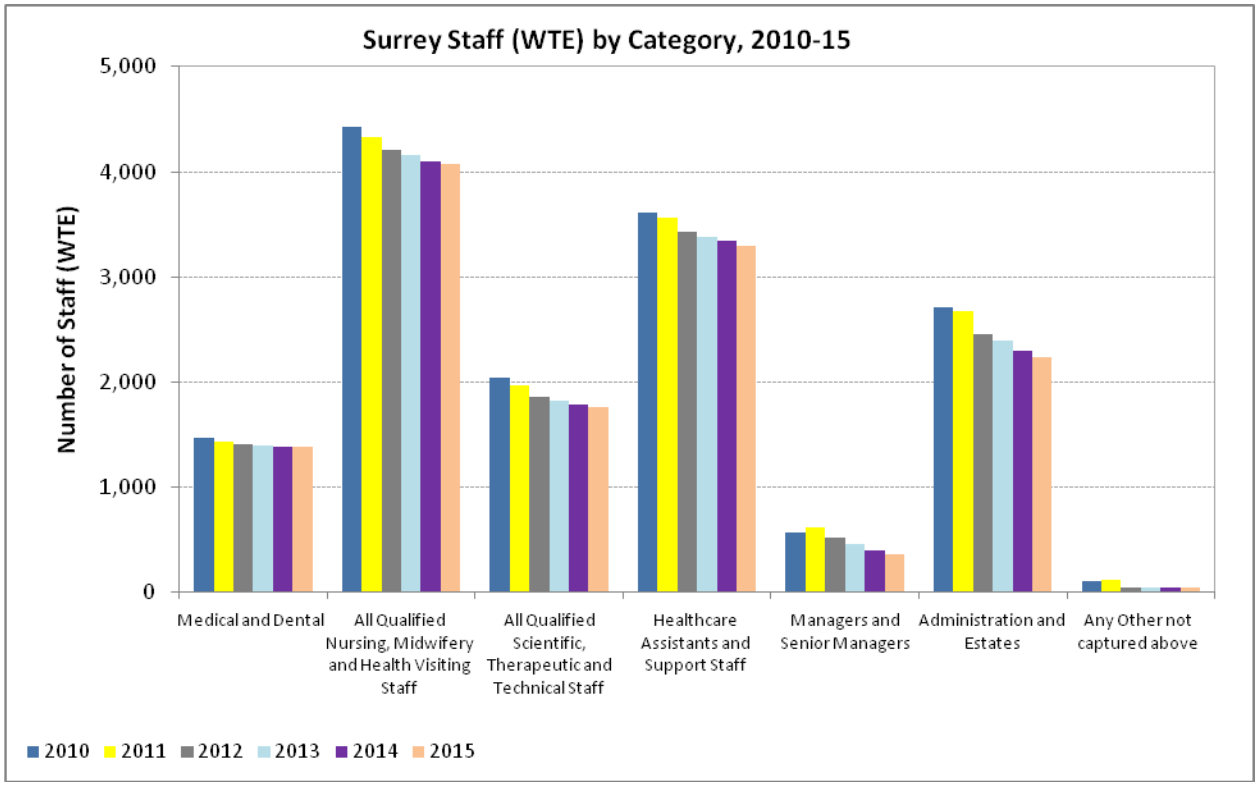

Workforce Forecast: Staff in Post
Number of Staff (WTE)
3,300
3,200
3,100
3,000
2,900
2,800
2,700
2,600
2,500
2,400
2,300
2,200
2,100
2,000
2010
2011
2012
2013
2014
2015
Year
Ashford & St Peters
Frimley Park
Royal Surrey
Surrey PCT
Surrey & Borders Partnership


All Staff in Surrey (2010-15)
Number of Staff (WTE)
15,500
15,000
14,500
14,000
13,500
13,000
12,500
12,000
2010
2011
2012
2013
2014
2015
Year


Surrey Staff (WTE) 2010-15
Number of Staff (WTE)
16,000
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2010
2011
2012
2013
2014
2015
Year
Any Other not captured above
Administration and Estates
Managers and Senior Managers
Healthcare Assistants and Support Staff
All Qualified Scientific, Therapeutic and Technical Staff
All Qualified Nursing, Midwifery and Health Visiting Staff
Medical and Dental


Clinical & Non-Clinical Staffing Levels, 2010-15
Number of Staff (WTE)
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2010
2011
2012
2013
2014
2015
Year
Clinical
Non-Clinical

3. Overview of the Plan



4. ONE PLAN IN DETAIL

4.1 How we will deliver the 17 QIPP Programmes within One Plan

One Plan is being delivered in 2011/12 through a number of change initiatives with particular emphasis on the 'Big Ticket' items highlighted in Section 3.5. In some cases, individual organisations are acting alone to deliver these initiatives; some are local joint initiatives across a Local Transformation Board Area; some are being implemented through a system-wide partnership arrangement. A number of the planned activities require local innovation and some require adoption of good practice developed elsewhere.

In each case we are clear on what constitutes success, what the essential milestones are, and how these are to be managed and measured.

The table below summarises all of our main initiatives, the main actions required to deliver these and which organisation is taking the lead. Individuals leading the programme area and executive sponsors are in Appendix 3.

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Unscheduled (Acute) Care	NHS Ambulatory care Pathways have been prioritised by activity/cost analysis and defining % avoidable Children Unplanned Care – Pathway development: cap admissions Introduce short stay Tariff NHS Pathways– 2011/2012 Detailed project plan in place – go live March 24th		NHSP – extensive population of DoS. System testing w/c 31 Jan 2011. Exploring technical links to primary care and community services. Exploring solutions for urgent care transport to support NHSP. Ambulatory care – pathways identified for the next 24 months, meetings established with all acute	Increased zero LOS with agreed new tariff Decreased 1-3 day LOS as more ambulatory care delivered Reduction in variance in clinical quality &outcomes	JoAnne Bradford	£6.88 – 9.37m 4.5m £380K

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	2011. Potential to reduce A&E admissions by 10%. once operational		trusts to drive forward new pathways, tariff discussions arranged. James Wilkinson working with Surrey to support pathway re design. Additional resource identified to support role out. Pathways shared through urgent care network. Short stay audit arranged for RSCH to identify inappropriate admissions Meet and greet services being rolled out within A+E departments to re-direct patients to the community as appropriate Support to new GP hubs to develop urgent care models.	Safer Smarter Nursing metrics Patient feedback Actual number of bed days saved Levels of weekend discharge Benefits realisation work for NHS P and 3DN SECAMB metrics for non conveyance and alternative pathways Patient reported satisfaction (NHS Pathways) NHS pathways reports on urgent care usage (A+E and alternatives)		

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Planned Care	Acute Contracting Efficiencies from 1st December 2010: To reduce in the number of consultant to consultant referrals and hence reduce expenditure. In line with the revised operating framework, to implement a system to challenge providers for any emergency re-admissions with 30 day of a previous inpatient stay. Local Pricing to determine and implement local pricing, which ensures consistency of pricing across providers, for new and existing services targeted against a patient cohort of low clinical complexity. Patients will potentially be shifted to these services from current consultant led acute OP services. Low Priority Procedures		Agreement with Frimley Park Hospital over contractual caps for Non GP / GDP referrals Agreement of contractual caps with acute providers for 2011/12. First round of audits completed 1st Oct 2010 New contracts for 2011/12 to include caps on non GP/GDP referrals. Agreement to the principle of	Improved service descriptors with stated health outcomes Greater choice for patients to care closer to home Identification of the patient cohort with low clinical complexity that can be treated outside of an acute setting: Appropriate use of clinical pathways – Ensuring patients are seen according to clinical need. Communications plan with primary care will embed ownership at the first step of the pathway leading to improved patient satisfaction through better management of expectations	Liz Saunders	£4.35m £2.65m

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	(LPP) to consider clinical evidence and experience, activity information, resources, costs and provision across the SEC and SC SHAs in order to develop a list of LPPs which should not be routinely funded. The list also contains a number of surgical procedures with thresholds that from December 10 require prior approval.		Local Pricing Top down model costs and savings Service Spec complete Bottom Up financial modelling Engage with PBC around implementation Implementation of service specs	Care closer to home - Minimising the need for patients to re-attend secondary care		£1.23m

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Long Term Conditions	Development of a LTC Whole System Model, which incorporates risk stratification, care planning, extensive use of Telecare and Telehealth virtual wards and health coaching. COPD - Development of a personalised, efficient, integrated model of care for people with long term conditions through : Development of efficient and integrated community services through pathway redesign, Optimisation of partnerships with local authorities, Optimisation of primary care to improve personalisation Stroke - Optimising the acute stroke pathway by: Implementing the best practice tariff for stroke, Implement the NICE Quality Standards for Stroke June 2010,	Respiratory programme (national COPD strategy.) Management of COPD in the community pathway" Management of Asthma in the community pathway Review of patients with COPD Improved home oxygen service and procurement. Clinical review of patients with Asthma. 24/7 clinical service for patients with respiratory illness Development of COPD champion Partnership with Neurological Commissioning Support (NCS)		Number of (re) admissions for patients with COPD Number of bed days/LOS utilised by patients with respiratory illness. Number of calls to SECAMB related to COPD and Asthma. Number of people with COPD and Asthma receiving a personalised care plan/ self–management plan. Percentage of people with respiratory illness who have been involved in a care planning discussion (personalisation) Number of patients with 3+ admissions per year Number of people on	**JoAnne Bradford**	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	Decreasing length of stay and unscheduled readmissions to hospital Atrial Fibrillation - To improve the identification, diagnosis, risk stratification and optimal management of patients with AF to reduce the risk of stroke. To reduce the prevalence of disability in adults requiring long term care and support. To increase the number of people on QOF AF1 registers.	End-to-end, personalised care planning process across Primary, Community and Secondary Care Re-organising the urgent care floor Implementing the directory of ambulatory emergency care Optimising pathways Enhancing quality Productive ward programme Implementation of high impact actions for nursing Improved utilisation of urgent care centres implementation of the high risk TIA pathway TIA direct SECAMB referral pilot project GRASP-AF Audit –		home oxygen registers Service performance is measured in relation to the annual number of successful 'four-week quits' reported, relates directly to Vital Signs (VSB05) and National Indicators (NI 123). AF prevalence in low-prevalence practices – target of 1.2% (calibrate with age ranges): QOF AF1 Register Increased numbers of patients attending Anticoagulation Services with diagnosis of Atrial Fibrillation (60% patients presenting with stroke with atrial fibrillation discharged on warfarin or with a plan for anticoagulation		

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		Review of high risk AF Patients in 51 practices 30 practices targeted for AF detection initiatives (flu clinic pulse palpation; on-screen reminders) Acute trusts & Community Hospitals – raise profile of pulse palpation Palpitations Care Pathway pilot – to improve access to longer-term ECG monitoring Purchase of 7-day ECG event monitors for acute trusts to		indicated in discharge summary		

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Cancer: Single Urology Centre	Cancer: Single Specialist Urology Centre	Implementation Plan and Timescale to deliver specialist urological cancer surgery in line with the Urology IOG and National Cancer Peer Review requirements	SWSHCN managing an externally-led review of Specialist Urology configuration across Surrey, W Sussex and Hampshire Development of a Urology Implementation Framework at the SWSH Cancer Policy Board Monitoring, support and performance management to deliver the outcomes from the external Specialist Urology review	External Review: 21 March 2011	SWSH Policy Board approved Specialist Urology Implementation Plan Progress against Key Milestones as outlined in the Implementation Plan	

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Cancer: Single Specialist Gynae centre	Delivery of specialist gene-oncology surgery as per the relevant Gynae IOG and recommendations by the National Cancer Peer Review	Recruitment of an additional Consultant Gynae Surgeon at the RSCH (to provide surgical capacity)	March 2011	Consultant Gynae Surgeon to be appointed (this has now happened – 0.7wte appointed in February 2011) Monitoring and SWSHCN support to ensure delivery of IOG compliance following recruitment – via SWSHCN Policy Board, Clinical Advisory Board and the Gynae NSSG	PCT RSCH – re. recruitment SWSHCN – delivery of IOG compliance and performance monitoring	
Cancer: Haematology / Oncology repatriation	Development of a framework to facilitate / deliver Outreach Chemotherapy across the SWSHCN region, for patient benefits (care closer to home)	Single framework for authorisation by SWSHCN Policy Board Identification of a Pilot Site and arrangements Finance support to develop tariff modelling Patient Involvement / Participation support from PCT regarding user engagement	Q2, 2011	SWSHCN Policy Board approved framework Commencement of Pilot Site Winning Principals plan for dissemination across SWSHCN Implementation Plan	SWSHCN Policy Board	

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
End of Life Care	Extending Beacon model of care beyond areas currently participating in the pilot project Implement DNAR training Care home training	The Beacon model of care project (currently subject to pilot) Care Home training & education Marie Curie service to support patient choice and educate staff working in care homes DNACPR training & education	Establish baseline for current activity and financial expenditure Verify future model of care based on learning from Beacon pilot to support patient choice and deliver value for money Develop service specification to describe "Sustainable" EOLC model Procurement of education for DNACPR Procurement of Care Home education	% of patients offered choice of place of care & place of death % of patients achieving preferred place of care at end of life at home Reduction in the number of emergency admissions for EOLC patients Uptake of EOLC training by health and social care professionals	Maggie Ioannou	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
MH High Cost Out of Area Treatment & Placements (incl secure)	Reducing the number and length of stay of these and medium and low secure placements for people with mental health	Milestone 1: Steering Group Formed Milestone 2: Project Plan , Milestones and KPI's Agreed and Baselined Milestone 3: Financial Analysis Milestone 4: Contracts signed Milestone 5: Transfer of Resource & Contracts Milestone 6: Sub/Devolved Commissioning Protocol Agreed Milestone 7: Quarterly Pathway & Data Set Review	29/11/10 31/1/11 28/2/11 28/2/11 4/4/11 25/4/11 27/6/11	ALOS of people using LMS & OOA services Numbers of people using LMS & OOA services Unit cost (against median) LMS & OOA services	Diane Woods	£3.2m
Substance Misuse	Redesign service in line with new drug strategy and reduced envelope	Milestone 1: Steering Group Formed Milestone 2: Proposals Signed off Milestone 3: Included and signed off in 2011/12 Contract Milestone 4:	17/1/11 28/3/11	Vital signs targets achieved each month	Diane Woods	**£650k**

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		Implementation Plan Agreed Milestone 5: Quarterly Review of Implementation	28/2/11 25/4/11 27/6/11 26/9/11 26/12/11 26/3/12			
LD SCCP Funding	Completion of programme will allow withdrawal of transition funding	Milestone 1: Timelines of Closures Signed Off Milestone 2: Monitoring Arrangements in Place Milestone 3. Payments Adjusted as Closures Occur	28/2/11 24/1/11 18/7/11	Number of Surrey voids Number of homes Number of beds	Diane Woods	
Learning Disability Repatriation Pathway	Local LD pathways to be improved and developed, preventing OOA and enabling 11 clients to be repatriated.	Milestone 1: Project Group Formed Milestone 2: Individual Assessments Completed Milestone 3: New Placements Identified	28/2/11 24/1/11 21/3/11	ALOS of people using OOA services Numbers of people using OOA services Unit cost (against median) OOA services	A McCalllum	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		Milestone 4: Transition Plan Signed Off with consultation Milestone 5: New placement established contract agreed	8/8/11 26/9/11			
Dementia	Remodelled integrated pathway improving early identification and admission avoidance	Milestone 1: Steering Group Formed Milestone 2: Strategy Signed off Milestone 3: Predictive modelling completed Milestone 4: Service Mapping and Gap Analysis completed Milestone 5: Financial Planning Completed Milestone 6: D'LIGs Established Milestone 7: Business Case for TF Release Milestone 8: Local Implementation Plans Agreed Milestone 9: 2012/13	29/11/10 10/1/11 21/2/11 14/3/11 28/3/11 28/3/11 4/4/11	EQP KPIs. Service redesign and workforce remodelling Improving the interface between sectors of care and working across whole systems Current KPIs and metrics: a) Acute service and mental health in-patient data - Length of stay - Diagnosis - Number of admissions b) Mental health and community services community data - Diagnosis	Diane Woods	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		Local Resource and Activity Plans Agreed Milestone 10: 2012/13 Activity Plan Agreed in Contracts	23/5/11 28/11/11 27/2/12	- Specialty c) Mental Health National Minimum Data Set data d) QOF mental health data e) Annual programme budget data for organic mental health f) social care data Reduction in length of stay and reduced admissions within mental health services, acute services and care homes Decrease in attendance at A & E Finance will be modelled and linked with developments in progress in relation to mental health payment by results.		

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Physical Health/Mental Health	Improved pathways with reduced demand, improved outcomes and integrated pathways in primary, secondary care and acute hospital settings	Milestone 1: Steering Group Formed Milestone 2: IAPT Gap Analysis completed Milestone 3: IAPT Quarterly Review Milestone 4: Business Case Completed Milestone 5: Quarterly MH Liaison Development Reports	29/11/10 21/3/11 27/6/11 26/9/11 26/12/11 26/3/12 26/12/11 27/6/11 26/9/11 26/12/11 26/3/12	KPI's for Physical Health awaiting identification through national workstream	Diane Woods	
Adult Mental Health Pathways	Review of effectiveness of redesigned pathways	Milestone 1: Steering Group Formed Milestone 2: KPI's and Benchmarking Data Agreed Milestone 3: Quarterly Data Review Milestone 4: Strategy Completion Milestone 5. Commissioning Intentions Formed	29/11/10 28/3/11 27/6/11 26/9/11 26/12/11 26/3/12 28/11/11 26/12/11	Number occupied bed days ALOS Delayed discharges SUI Rates % occupancy over month Readmission rates EI number of caseload CRHT Gate kept	Diane Woods	

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Mental Health PbR	The centre has given a challenging timeframe for delivery of mental health PbR which will in turn have an impact on the future financial transactions of the QIPP plan.	Milestone 1: Steering Group Formed Milestone 2: Project Plan and Milestones Agreed Milestone 3: Information Workstream Established Milestone 4: Tariff and Contract Workstream Established Milestone 5: Care Package and Outcomes Workstream Established Milestone 6: All Eligible Clients Allocated to Care Cluster Milestone 7: Local Tariff Formula Established	29/11/10 31/1/11 4/4/11 1/8/11 4/4/11 26/12/11 26/3/12	All Staff trained in cluster tool and allocation by 31/3/ 2011 Allocation to clusters begin April 2011/12 All eligible service users will be allocated to a cluster by 31/12/2011 Reference costs to be collected on a cluster basis in 2010/11 Local tariff developed – Dec 2011	Diane Woods	

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Staying Healthy	Stop smoking Alcohol Weight Management	Stop before the Op – Smoking Pre-operative patients to be put through 8 week stop smoking course before surgery is undertaken Alcohol Health Worker in ASPH & RSCH A&E to deliver routine Identification and Brief Advice (IBAs) through CQUIN. Provision of 6 month weight management programme for all patient referrals prior to bariatric surgery	Q1 – Alcohol CQUIN negotiated and smoking and specialist obesity referral rates included in acute contracts. Q2 – Alcohol, smoking and specialist obesity programmes implemented and running. Q3 – Activity and savings monitored. Q4 – Evaluate programmes and make recommendations for 2012/13.	Number of patient's completing the 8 week stop smoking service prior to surgery. Reduced A&E attendances/hospital admissions due to alcohol. Number of patient's completing the 6 month specialist obesity programme prior to bariatric surgery	Lisa McNally	£1,397,320 £ 67,500 £473,148

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Primary Care	**Minor improvement grants :** • Review of the minor improvement grants budget to release savings where appropriate • Budget will be aligned to CQC requirements and contingency allowance **List size reduction:** • The PCT have commissioned the PCSS to carry out an annual reconciliation between the patient database and the GP clinical system. • This will ensure that all amendments, registrations and	Delivery of Tier 2: Phase 2 service reviews to ensure value for money in services Review focusing enhanced service resources to support AOP and QIPP priorities Phased decommissioning of PBC Incentive Scheme Price reduction or decommissioning of IUCD LES Full implementation of Personal Medical Services Contract Delivery of the decrease QOF Exception Reporting levels in Primary Care Review of Primary Care Contracting policies Delivery of Dento-alveolar Referral		Completed questionnaires returned from 9 Tier 2 service providers by 19th September 2010 Panel reviews of all Tier 2: Phase 2 services complete by 10th October 2010 Services redesigned with new contract by 10th January 20100 Services decommissioned by 31st January 2011 Savings target confirmed by 31st January 2011. To commence new QOF assessment process in2010/11 To assess the 15 highest exception reporting practices (using 2008/09 data) in 2010/11	Karen Parsons	**£700,000** **£646,000**

	removals of patients have been captured correctly **PBC:** • The PCT currently invest £3.2m from Enhanced Services to support the development of PBC through an incentive scheme • Phased in reduction against the overall running costs over 3 years from enhanced services budget	Service (DARS) Delivery of renegotiation and reduction of persistently under performing dental contracts More effective audit and management of claims for non-domestic rates, maternity, paternity and service contract templates Services efficiencies through more effective clinical and performance reviews Continuous development of practice based demand management systems		and develop an action plan to reduce the exception reporting levels.		**£789,000**

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Workforce Productivity	Reduction in absence to 3.5% by April 2011 and 3% by April 2013 (SEC target) Reduction in agency (SEC target for SEC £38m and based on agency bill estimate Surrey target £8m, by April 2013) Roll out of Productive series (national definition awaited) (SEC target – see contract annex)	Reductions in sickness absence levels – 3.5% 2011 and 3% 2014 Reduction in agency costs – SEC target to be broken down by provider and SEC project taking lead Roll out of NHSI productive series – different targets for each programme. Likely to introduce an outputs measure during 2011 Other KPIs which are not included as projects here but are part of normal business and will contribute to workforce productivity (not measurable in terms o f outputs and risk of inclusion in other QIPP workstream productivity measures:- Appraisal/PDP		Reduction in sickness absence related costs; both in terms of loss of contribution/where cover is required additional cost of cover Reduction in agency costs and substitution of lower bank costs, plus reduction overall in temporary staffing costs Increase in activity linked to productivity measures freeing up more time/possible reductions in staff numbers required	Vanessa Burchall-Scott	£8m

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		Stat and Mand Training Staff survey response rate and satisfaction rate Health and wellbeing Equality and diversity Workforce plan, including education commissioning plan NHS Constitution				
Initiative	**Description**	**What are the key actions required**	**Deadline(s)**	**KPI(s)**	**Lead Person/Organisation**	**Total Savings from Initiative (£000s)**
Children and Young People	Significant variation in the emergency admission rates across Surrey Acute's – agree &implement an appropriate maximum admission rate and develop agreed pathways for high admission HRG's. Savings can be made through pathway development however, a appropriate cap on admissions payments		2011/12: new SALT service spec embedded in contract Clinical engagement events 11/10-03/11 Develop local action plans 2010/11	Number of A&E attendances Number of emergency admissions Reduction in spend on zero LOS Referral to tertiary providers Waiting times Parent Satisfaction	Sally Miller	•

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	would offer immediate savings High numbers of children admitted for a zero length of stay – develop and introduce a short stay tariff for children (possibly linked to adult short stay tariff). Introduction of this tariff would ensure that payment is made in accordance with the level of care required.		Develop Integrated Care Pathways 2010/11 Integrated commissioning 04/10 – 03/13 Development of zero LOS tariff – February 2011 Negotiation of tariff implementation – March 2011 Clinical pathway workshops – February / March 2011	with Services for Disabled Children VSC33 Number of Tier 4 admissions		

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Safer Care	HCAI - No avoidable MRSA bacteraemia March 2011 Safer Smarter Care Programme (SEC programme aligned with National Safety Express)	HCAI Improvement Programme Safer Smarter Nursing Programme Energising for Excellence Programme CQUIN TCS NPSA New Safer Smarter Care Programme	InfHCAI bacteraemia and Cdiff targets to be met by all providers and Surrey PCT. Monitored through the contract and Surrey Infection & Prevention Control Committee Savings for providers to be revalidated for 2010/11 contract setting. Scoping of feasibility of not paying for excess bed days Feb 2011 Within	Improved patient experience and impact on quality of life Reduction in avoidable harm, focusing on key areas pressure ulcers, falls, catheter associated UTIs, improvements in the number of adult in-patients who have had a VTE assessment on admission Improved efficiency-through reduction in length of stay and treatment costs.	Maggie Ioannou	•

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
			contracting schedule 3 2011/2012: Collection of new baseline data Jan-June 2011 Setting of trajectories and data collection Q3&4 Workshops for safer smarter care – Feb, March, June 2011			

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Maternity	• Normalising Birth Promotion of normal birth capping trusts at 23% c-section rates • Non birth episodes Fetal Fibronection Screening- Implement SEC led project via contract variation Scope to check all non-birth delivery codes • Neonatal Community Outreach Teams Reducing unnecessary admissions to neonatal units, improved care on postnatal wards	Work with contract managers to ensure capping of c-sections and FFN is included in the acute contracts Map c-sections by acute trust and community midwifery teams and target those you have greater number of c-sections in their catchment areas for normalising birth messages Work with knowledge management and contracting to look at what is being coded Work with the Neonatal Network to explore current community outreach provision and how it can be improved	Complete scoping (28/02/11) Align maternity pathways with national best practice and local needs (June 11) Agree spec, procure, launch antenatal education service (Sept 11); Launch CS reduction education programme (May 11) Implement fetal fibronectin screening (April 11)	90% of women booking by 12 weeks and 6 days 2% increase in breastfeeding initiation and continuation rates Reduction in c-section rates Neonatal unit occupancy rates IUTs and EUTs out of network pathway Admission rates and length of stay on neonatal units Corrected gestational age at discharge 100% of families offered to take part in user feedback 80% reduction in women with symptoms of preterm labour	Akeem Ali	£22,371.72 £226,961.62

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Pathology	New Local Prices for Direct Access Pathology Consolidating core services currently provided by each of the three Pathology organisations in Surrey to 1-2 central sites across the network and rationalisation around hot labs.		Phase 1 (2 year roll out) would see pathology sites centralised to 1-2 centres across Surrey for cold work with 'hot' laboratories established on two of the acute sites. P1 Trust savings: Net 4m-6m Phase 2 (2 year roll out) moves to a single site for cold work for the whole of Surrey plus four 'hot' labs servicing the four acute units. P2 potential Trust savings: up to 4m NHS Surrey has reviewed direct	Turnaround times for routine and urgent tests across all disciplines Turnaround times for transportation of specimens from GPs and between sites National Quality Assessments including CPA, MHRA compliance, HTA licensed, EQAS performance HR metrics including sickness, staff turnover, appraisal rates, mandatory training	John Omany	£4-6m

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
			access pathology costs and will be reducing spend by 10% across the board. D.A. PCT savings: 1.4m			
Initiative	**Description**	**What are the key actions required**	**Deadline(s)**	**KPI(s)**	**Lead Person/Organisation**	**Total Savings from Initiative (£000s)**
Digital Vision	Summary Care Record – Primary Care uploads	• Secure Funding from Transformation Fund • Identify project manager & other key resources	• April 2011 • May 2011	• Patients who have not opted out have a planned SCR creation by Aug 2012 • Patients with LTC or EOLC plan have an enriched SCR creation planned by Aug 2012 • Clinicians will change their clinical decision in 20% of those cases SCR viewed cases as a result of viewing the SCR	• Christine Ratcliffe	
	Electronic Prescribing Service Release 2 in	• Secure Funding	• April 2011	• 70% reduction in patient visits to practice to pick up	• Christine Ratcliffe/Rut Patel for NHSS	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	primary care			prescription in live sites • Patients able to exercise their first choice of pharmacy in 90% of cases • Turnaround of prescriptions reduced from 48 hours to 24 for repeat prescriptions		
Digital Vision	Map of Medicine used in one GPCC consortia (Medlincs)	• Staff resource agreed by GPCC	• June 11	• Increase in usage of the Map from current 4 in May 2010 to over 100pm by December June 2011 • Stroke & CHD local pathways will be signed off and published by May 2011 • Tier 2 services (following review) will be signed off and published as and when	• Christine Ratcliffe NHSS/Nicky Kirby (Medlincs)	
	SW Telecoms Tender	• Transition to new solution • Inter site voice traffic	• June 11 • Aug 11	• New system in place by end July 2011	• Mike Gilderdale NHSS	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
		• Integration of mobiles	• Dec 11	• Financial benefit being realised from end April 2011		
	GPCC Portal access to HCS PBC data	• Access available	• June 11	• Need KPIs	• Sailesh Chauhan NHSS	

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Medicines Management	**Improving prescribing efficiency** across a large range of care pathways, including alternative methods of procurement and decommissioning **Improving medication safety** to reduce the potential for harm and free-up resources **Promotion of innovation and quality** through effective use of prescribing information and contract management	Improving prescribing efficiency across a large range of care pathways, including alternative methods of procurement and decommissioning Improving medication safety to reduce the potential for harm and free-up resources Promotion of innovation and quality through effective use of prescribing information, contract management, and refinements of systems and processes	£4.3 million of efficiency savings for 2011-12 identified to date Project plans for all identified schemes to be in place by18th February Further scoping to be completed by 11th February 2011, including full-year impact of 2010-11 activities that will produce benefits in 2011-12 Data to support prescribing efficiency opportunities at	Cost per ASTRO-PU Better Care Better Value (Statins, PPIs, ACE/ARBs) Antibacterial items per STAR-PU % higher risk antibacterials of total items % oral diclofenac of total NSAID items Cost reduction/benchmarking for other prescribing efficiency schemes	Kevin Solomons	£4.3m

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
			GP Consortia level to be obtained by 11th February Identification of potential savings in relation to LTC care pathways and reduced acute admissions associated with improved medicines management (reduction in medication errors, adverse effects and improved medicines adherence) by March 2011 Discussions with GP Consortia to agree local priorities February/March 2011			

4. One Plan in Detail

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
Estates Optimisation/ Back office	Estates - Disposal of Almond Villa, St David's HC and Bond Street Surgery Back Office – Removal of £2m as price adjustment – SCH/East R2R Estates -Review occupancy terms and income generation at Cobham Hospital (pharmacy and dental sublets), Wayside and Bourne Hall. Identify possible use of vacant space at Farnham Hospital. Roll out occupancy review across the remainder of the portfolio, by appointing a database, space manager. (advertising post) Back Office – finalise definition and roll out of 'running costs' Estates - Reduce Backlog	Internal asset management and corporate landlord function – establishing internal processes within the limitations of the White Paper. Damage limitation across legacy arrangements. Mitigating risk across portfolio. Improving landlord role. Improving administration of landlord role Improving tenant role Third party primary care expansion schemes Advice throughout organisation on property matters. Utilisation projects underway Capital investment underway for backlog and compliance Disposals underway			Michael Munt	£2m

Initiative	Description	What are the key actions required	Deadline(s)	KPI(s)	Lead Person/Organisation	Total Savings from Initiative (£000s)
	maintenance.	Opportunities for engineering disposals under way. A revised operating plan for 2010/11 moved the management costs target from a 30% reduction on 2008/09 levels to 33.3% over the next 4 years. For NHS Surrey this represents a total saving of £11.782m, as detailed in the table below; The PCT will outline proposals for a revised organisational structure to deliver the required management cost savings at the end of September. Work has been undertaken to benchmark back office functions across commissioner and providers to identify areas and functions to be explored to deliver additional savings.				

4.2 How we will deliver this plan together

Currently the 3 'big ticket' initiatives for the QIPP programmes have been centrally developed at NHS Surrey by the QIPP Programme Leads. They are a mixture of transactional and transformational initiatives that over time need to become truly transformational to ensure that the NHS in Surrey can provide safe, effective and good quality services within its financial envelope. It is also essential that these plans move from being centrally developed to incorporating local plans to be developed and implemented by GPCC and Local Transformation Boards (LTBs). To ensure we do this in a coordinated and effective way we will be asking QIPP Programme Leads and Locality GPCC Support Leads (Resource Hubs) to work with the GPCC and LTBs to further develop their local plans in line with the QIPP requirements. Over time this will ensure we move from central 'big tickets' initiatives for QIPP to local transformational QIPP plans led by GPCC and LTBs. It is also essential that we hold LTBs accountable for delivering the QIPP programmes and savings at a local level.
The plan requires the close collaboration of all clinicians in Surrey to be able to deliver the changes required to come into financial balance. It requires the application of thresholds in both primary and secondary care to ensure that everyone is applying criteria in the same manner and ensuring equity for patients. It requires openness and transparency, and mutual respect within the LTB to ensure that the plans are delivered and risks mitigated, while ensuring the continuation of quality in services. Sharing risk and decision making required to mitigate risks will require all participants to engage and share responsibility.

Once the new ways of working are established, a coherent "plain English" plan and overview can be shared with patients and the public. This way we can involve the public in the decisions that will need to be enacted to deliver this plan. Some aspects of the plan will be unwelcome but a shared understanding of the Surrey situation to create a sustainable stability through the One Plan will support its delivery. Progress against the One Plan will be available on our website.

4.3 Engagement with commissioners, providers, clinicians, management, patients' and service users

The NHS in Surrey faces uncharted communications territory as it tackles the challenges brought by the global economic crisis, increasing demand on health services and the rising cost of delivering modern high quality healthcare. In addition to our ongoing responsibilities under the NHS Act sections 242 and 244, in July 2010 the Department of Health set out four key tests for service change, which are designed to build confidence within the service, with patients and communities. With national efficiency savings of £20 billion to be found over four years and the serious and current financial pressures in Surrey, we have started having the difficult conversations with our stakeholders – patients, carers, public and others - now.

Other Surrey public sector partners are doing the same. For example, Surrey Police have reduced the number of police officers and support staff by 140 and consolidated a number of police stations to reduce costs. They continue to face "severe financial pressures." Surrey County Council has also spoken of its need to make £150 million efficiency savings over the next five years.

In order to meet the challenges of talking to over a million people, we have developed a strategic approach: "Transforming the conversation" which was approved by the Surrey Transformation Board in May 2010. The Transformation Board is made up of NHS Surrey, Surrey County Council, Surrey NHS providers, GP commissioning leads, and Surrey LINks.

This sets out:

- The landscape within which we operate and communicate and the challenges this presents. This includes a detailed stakeholder analysis
- How we will tackle the communications challenge with a framework setting out the opportunities for conversations at local level, via channels such as Local Executive Committees (LECs) and local transformation boards, and activity done best Surrey-wide
- Implementation and resource implications
- How we will evaluation our impact – are we influencing public opinion and behaviours in order to deliver transformational changes to health and social care?

Transforming the conversation builds on our digital strategy to harness the power of online media. This is a cost effective way to reach future heavy users of the health and social care services - currently our working and commuting population. This includes use of Twitter! http://twitter.com/NHSSurrey and facebook and is an integral part of our current consultations.

As described in our overall communications strategy, NHS Surrey has adopted the best practice principle of co-design to bring together commissioners, clinicians, patients, members of the public, carers, 3rd sector organisations and statutory partners in all strategic planning of services. NHS Surrey has received praise for the use of this method of engagement from both Surrey LINks and Surrey Health Scrutiny Committee.

We have identified the common themes throughout our co-design events which we continue to use in our service planning:

- More prevention of ill-health and help people to help themselves
- When people are ill they should receive the very best quality healthcare with services designed around their needs
- This must be based on the best possible clinical evidence on what treatments are effective and which are not

- We must not forget that the needs of carers must also be taken into account when we are planning services
- Although individual services may be providing good care there are still gaps that cause problems when patients care moved from one provider of services to another.

NHS Surrey will continue to use our established co-design process in the implementation of the areas set out in this document. Specific areas of activity already underway are:

- Fading Memories affect everyone – start talking about your mental health. Joint consultation with Surrey County Council on a strategy for mental health services for older people
- Unplanned care – development of model of care working in North West Surrey led by the GP commissioners
- Neuro-rehabilitation – reviewing existing pathway against national clinical best practice
- Patient Transport Services – joint work on this major procurement with Surrey County Council
- Working with the voluntary, user and carer and faith sector as providers of services
- Waste medicines campaign
- Tender process for a local GP practice
- IAPT: Work in partnership with the Department of Health to extend access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions
- At GPCC level patient representatives and League of Friends are actively involved in the development of models of care. Surrey wide co-design event scheduled for 23/2/11 to agree process of engagement and balance of local v Surrey wide.

Engagement with clinicians

Through the Clinical Commissioning Advisory Groups (orthopaedics, dermatology, gynaecology, ENT, ophthalmology and urology), the planned care workstream has ensured robust clinical engagement around developing thresholds for the low priority procedure list refreshes. The groups have also supported the identification of the cohort of patients who are of low clinical complexity for the development of the Local Pricing service descriptors. Wider stakeholder engagement with the trusts, GPs, pharmacist, LMC, LOC, LDC and LINKs have ensured comment is received on the appropriate elements of the service descriptors and LPP. Trusts have responded to the ‘Fast Steady Stop’ approach and Prior Approval process agreed at our November Board with alternative proposals and schemes are being worked up. Joint development of the GPCC/ LTB plans and the central plans now needs to start to ensure robust costings and that the actions are put in place to ensure implementation to ensure savings.

4.4 How we are assuring the safety and quality of the services provided in our local health and care system through a period of unprecedented change and where there are heightened risks of the interaction between those changes producing unintended negative consequences

Strategic Planning is underway to ensure clinical leadership and delivery of the Patient Quality and Safety measures within the Safe Care QIPP. Lead Nurses from Surrey providers attended the first national/SEC event held on 10th February 2011 along with managers from some Surrey nursing homes. The first Surrey Collaborative meeting was held on 2nd March. This event planned the future work plan, which includes sharing of good practice, action plans from organisations to improve on areas of potential harm, working across networks. The public engagement strategy linked to the safe care QIPP has not been agreed by SEC at this stage but will be addressed through the established meetings.

In order to ensure that this plan is fully realised, we have agreed that the following issues need to be fully resolved as part of the contractual agreement(s) that we conclude by the end of April 2011. This is not necessarily the full list, as further issues may emerge as further guidance regarding the National Operating Framework emerges, or as work progresses. This the current list based on what we know today.

Issue	Details
Activity levels/referral & treatment thresholds	Embedded in contracts, as both activity and finance reductions in the core contract or as service improvement plans, where locally agreed
Price	The principle behind agreeing contracts for 2011/12 for local acute contracts has been to run contracts on a full PbR basis
Quality standards	Agreed and within Schedule 7 as Service Development Improvement Plans
CQUINs	Agreed and within Schedule 7 as Service Development Improvement Plans
Data/reporting requirements	Embedded in the core contract
Re-enablement/emergency readmissions within 30 days	Embedded in contracts, as both activity and finance reductions in the core contract

4.5 What we have agreed are the key risks to delivery of the plan and how we are managing those

The rich provider landscape in Surrey poses ongoing risk for commissioning and transformation. The complexity of the Surrey health economy exacerbates the potential for conflict of interest as the new commissioning and provider landscape is shaped. One of the strategic issues is resolving the conflict of interest position with GP as commissioners and providers.

Estates, Back Office, Digital Vision and Workforce Productivity are enablers which form part of each clinical workstream to release QIPP benefits. Uncertainty exists about future estate ownership and liability until detailed guidance is received from the Department of Health. There is a lack of visibility of the future delivery of IM&T services including business intelligence, IT services, information governance and provision of innovation projects across health economies.

Gaps in the 'One Plan' remain which include fully costed GP consortia commissioning intentions, linking provider cost improvement plans and costed additional or alternative schemes with QIPP savings plans. These are being worked through urgently and will improve the level of confidence in 'One Plan' delivery.

Safety and quality of patient care remains the utmost priority. Further recent media reports from the Health Service Ombudsman have highlighted past and current shortcomings. The Surrey Transformation Board has agreed that CQUINs must address these real issues and welcomed the embedding of the 10 Point Dignity challenges in each and every contract. NHS Surrey intends to continue work with LINks as it becomes HealthWatch to ensure these standards are not simply monitored but are rigorously adhered to. In addition a Quality & Safety Report is submitted to the Quality & Performance Committee and then to the Board to assure progress/deterioration.

4. One Plan in Detail

A detailed breakdown of the main risks are presented below:-

Risk identified (description)	Work stream	Mitigating control (actions)	Owner
Risk that PBC Demand Management LES savings will not be realised in year. Independent contractors means that there are no contractual obligations for the GPs to comply.	Contracting & Procurement - Primary Care	Continual working with clusters on Demand Management Plans	Karen Parsons
Risk that NHS Surrey does not have the organisational capacity to support PBC Demand Management LES	Contracting & Procurement - Primary Care	Prioritise resources	Karen Parsons
All funding for digital vision plans have been deferred until financial year 2011/2012	Digital Vision	Defer plans until next financial year	Mike Dicker
Risk that OD work will impact on ability to deliver county wide digital vision plans in future years	Digital Vision	Retention of trained staff to support AOP recovery and Knowledge PMO office	Mike Dicker
Risk that cancellation of QIPP digital vision steering group will prevent further development of digital vision plans and monitor delivery	Digital Vision	Maintain the digital vision QIP board to meet in January 2011	Mike Dicker
Risk that CSU business case will not be finalised	Contracting and Procurement - CSU	Continue working as cluster lead to develop Business Intelligence aspects for business case approval	Mike Dicker

Risk that NHS Surrey and acute trusts will be unable to agree to cap c-sections at 23%. (We are not lead commissioners for Kingston and Epsom and SW London are asking them to reduce c-sections by 2%).	Maternity and Newborn	Support contract managers with evidence why acute trusts that aren't capped are no different to those that have been and that 23% is achievable. Communicate with maternity commissioners before contract meetings going forward.	Kelly Morris
Risk that there will be a delay in contract being signed and set up for Fetal Fibronectin	Maternity and Newborn	Continue to progress with contract negotiations and gain agreement	Kelly Morris
Risk that the project will not be implemented in 2011/12 because CQUIN may not be agreed internally	Staying Healthy/ Alcohol CQINN	Escalate to OPDB. Implement the programme outside of the CQUIN measure. DH are raising alcohol in A&E as a key performance measure this year.	Gail Hughes
Risk that 10/11 SHA savings assumption's are incorrect and/or does not benefit the Surrey population	Staying Healthy	Evaluating data from health checks and from this we can confirm if the savings have been made.	Lisa McNally
Risk that Commissioners fail to reduce demand on buildings as in work streams 1 & 2.	Estates Optimisation	Escalated to executives - exec leads required in PCT and all provider trusts to reduce demand.	J Andrews
Risk that there is no funding to collect asset management data	Estates Optimisation	Funding from transformation fund application and recruitment of consultants underway. Temporary staffing solution sought to manage database of occupancy throughout programme.	J Andrews

Risk that NHS Surrey staff reductions limit the capacity to apply corporate landlord and asset management work streams 4, 5, 6,7,8,9 in engineering disposals from property portfolio.	Estates Optimisation	Following PMO discussion, agreement reached to prepare bid for additional staffing resources for executive decision. Being reviewed by Dir and Dep Dir Finance before being sent to the executive.	Jamie Andrews
Risk that asset management and occupancy monitoring functions may be lost following the Provider split (TCSS)	Estates Optimisation	Transfer of this function to NHS Surrey	Jamie Andrews
Risk that QIPP target is too optimistic in terms of scale and programme.	Estates Optimisation	Closely monitoring asset database and reality checks with the governance and process requirements associated with the reduction in commissioned services, service closures disposal of property.	Jamie Andrews
Risk that factors outside NHS Surrey control e.g. property related and planning laws, cause delays and disputes and impact delivery	Estates Optimisation	Advice sought on legal and professional requirements. Procurement of project managers to support capacity.	Jamie Andrews
Risk that Providers will not implement savings initiatives detailed in CEO's letter of 18th November to providers	Planned Care	i) 2010/11 data acute challenges raised from month 9. ii) C2C and 30 day readmission being negotiated as part of the SLA.	Carol Bewley
Risk that Proof of Concept is not sufficiently compelling to warrant High Risk Surgical Patient Pathway roll-out	Planned Care	Extend proof of concept to allow for further testing	Jackie Huddleston
Local Pricing is stalled at implementation phase	Planned Care	Local Pricing is being presented to GPCCs as an enabler to their local QIPP plans	Liz Saunders

Risk that project will be delayed or stopped due to major NHS and local authority reconfigurations and reduced funding	Children & Young People, Maternity and Newborn	Plan to defer projects as necessary; work closely with providers and SCC to ensure continuity where possible	S Miller
Risk that project is delayed or stopped due to the lack of commissioning capacity	Children & Young People, Maternity and Newborn	Prioritise order of commissioning with providers	S Miller
Risk that midwife-led facilities are not developed due to a lack of capital investment available to ASPH	Maternity and Newborn	Plan to defer projects as necessary	Kelly Morris
Risk that re-invested savings from reduced hospital admissions, appointments, length of stay and normalising birth are insufficient to fund improvements	Maternity and Newborn	Promote resulting efficiencies and better patient experiences	Kelly Morris
Risk of achieving patient satisfaction and health outcomes due to difficulties in ensuring choice, continuity of service and optimal midwife: mother ratios while carrying high vacancy levels	Maternity and Newborn	SEC monitor workforce 6 monthly	Kelly Morris
Risk that Providers supply: demand ratio is compromised due to rising birth rates	Maternity and Newborn	SEC monitor birth rate 6 monthly	Kelly Morris
Risk of non-sustainable service for Surrey Early Support beyond March 2011 when Aiming High for Disabled Children funding ends	Children & Young People	Continue to explore avenues for continued funding in SCC; risks identified in paper to SCC	S Miller
Risk to NHS Surrey and SCC reputations if Surrey Early Support Service ends	Children & Young People	Inform families of the situation early Early engagement with both SCC and PCT Communications teams	S Miller
Risk of poor health outcomes in patients due to no direct payments to families when young people with disabilities transfer to adult services	Children & Young People	Prepare for direct payments for health services	S Miller

Risk of using expensive care packages from providers outside of Surrey due to lack of organisational capacity and capability to provide complex care packages at home	Children and Young People	Development of joint commissioning for children with complex healthcare needs with SCC and implementation of a commissioning framework for children with complex needs in line with national model.	Sally Miller
Risk that NHS Surrey does not have the organisation capacity to deliver projects specifically for SALT, You're Welcome and Urgent Care	Children & Young People, Maternity and Newborn	Undertake resource management review to ensure capacity internally	S Miller
Risk that NHS Surrey Medicines Management team do not have the capacity to deliver such a wide range of projects	Medicines Management	Through structural review, prioritisation and clear objectives for all team members.	Kevin Solomons
Risk of not delivering cost-saving efficiencies due to lack of clinical engagement	Medicines Management	Use of APC to gain consensus and focus around the quality agenda and contractual levers. Encourage GPCC uptake of proposed MM QIPP plans.	Kevin Solomons
Risk of not delivering savings target due to insufficient contract levers	NHS Surrey	Work with clinical leads (PCT, GP and acutes) to establish appropriate clinical support	Kevin Solomons
Risk that failure to deliver SCR due to SCR funding deferment will impact on service development or redevelopment of EOLC, LTCs, Medicines Management, Acute Unplanned Care.	NHS Surrey	3 year implementation plan Explore funding from Transformation Funds. Explore using substantive posts and resources from external organisations e.g. Connecting for Health, SHA.	Mike Dicker

Failure to deliver EPS2 will affect productivity and efficiency gains associated with the transactional costs of prescribing in Primary Care	Digital Vision	3 year implementation plan Application made for Funding from Primary Care IM&T Budget	Mike Dicker
Risk to delivering services specification on time and delivering QIPP savings due to lack of organisation capacity to assign project resource to undertake detailed analysis and develop service specification	EOLC	SHA bid includes funding to support this activity	Lindsey Coeur Belle
Risk in delivering robust gap analysis necessary to identify projects to deliver the QIPP plan due to difficulties in collecting non-acute activity	EOLC	Chief Executives of both community provider organisations supporting development of the plan	Lindsey Coeur Belle
Risk of producing multiple business cases and service specifications as Local Transformation Boards may wish to adopt differing delivery models.	EOLC	• GP lead and Surrey Transformation Board leads part of project team. • Stakeholder Engagement Strategy to address this	Lindsey Coeur Belle
Risk that NHS Surrey does not have the resources to deliver estates optimisation programme	Estates Optimisation	Develop a single estate function with SCH estates team to make the most of what we have. Regular Review of Resources required	Jamie Andrews
Risk that Trusts do not engage will mean the programme will not deliver consistently	Estates Optimisation	Running Cost Reductions are mandatory Keep under review. Escalate via County QIPP structures	Jamie Andrews
Risk that decisions on asset ownership is delayed.	Estates Optimisation	Developed a paper to describe clear terms and conditions of ownership and occupancy to reduce the impact of delays	Jamie Andrews

Risk of loss of service continuity during changes could be compromised if affected staff become unsettled and leave	Estates Optimisation	Staff engagement and communication	M Munt
Risk that there will be resistance to new ways of working, e.g. unwillingness to change to new structures	Estates Optimisation	Education and training.	J Andrews
Risk that future arrangements for estates management do not have the organisational capacity to work with multiple stakeholders	Estates Optimisation	Ongoing review of market place and national initiatives for future estates management	Jamie Andrews
Risk of uncertainty about back office and running costs of GP commissioning consortia.	Back office	Savings targets to be revisited after running cost definition is clear	Malachy McNally
Risk that abolition of PCTs will make it difficult to enter into new long term contractual arrangements for back office	Back office	Savings will be delivered as part of the move to GP consortia	Michael Munt
Risk that the organisational change costs are unaffordable, therefore impacting on timely WTE reduction	Back office	Use Transformational Funding in 2011/12	Malachy McNally
Risk that GP Consortia set up increase transaction costs	Back office	Keep GP Consortia Management Arrangements under review	Malachy McNally
Risk of delay in implementing new structure with failure to deliver in year cost savings	Back office	Early determination of new structure based on initial assessment of running cost impact	Michael Munt
Risk of inability to agree contract with SCH for 2011/12	Estates Optimisation	Contract requirements already flagged	M McNally

Risk of identifying true financial savings as multi-faceted including outpatient and inpatient costs at all acute providers and tertiary, rental contracts and equipment purchases	Acute Care	Working closely with finance and information colleagues to identify savings wherever possible. Repatriation savings have been focused on, but also tertiary outpatient attendances will be examined. Acute admission data, for this patient cohort, cannot be identified	Joanne Bradford
Risk that Primary Care continue to refer patients to tertiary centres after local services are in place	Acute Care	Communication with primary care, including letter from medical director. Monitor referrals to tertiary providers.	Joanne Bradford
Risk that SECAmb is unable to provide appropriate clinical support to crews	Acute Care	SECAmb introducing interim solution prior to implementation of clinical support desk. SHA performance manage SECamb.	Joanne Bradford
Local Pricing project has stalled at implementation phase	Planned Care	Handover project lead role (as part of reorg) Identify a project sponsor	Liz Saunders
Risk that too many Tier 2 services are set up across Surrey (to manage the cohort of low clinical complexity patients) which are highly complex and resource intensive versus the potential savings benefit.	Planned Care	Review implementation options and make recommendation to EMT to offset risks (perhaps revisit lead provider, single speciality)	Liz Saunders
Risk that SCC will delay the decision to joint fund the transport contract and savings will not be delivered	Planned Care	MoU in place to hold SCC to account Joint chair on procurement board Close project in May 11 if no outline spec	Andy Rouse

Risk of savings not being delivered due to PTS over performing thus negating efficiency target for new contract	Planned Care	Sign up of trusts to new proposals in place Close scrutiny of trust operational practise Trusts to be recharged for aborts and eligibility abuse	Andy Rouse
Risk that savings will not be delivered due to mismatch in the Sexual Health Finance and activity data and therefore inability to confidently set a financial envelope	Planned Care	Benchmarking against statistical neighbours	Kelly Morris
Risk that savings will not be delivered if NHS Surrey Board decides to split the Sexual Health service and not commission a County wide service	Planned Care	Recommend to the Board that the service will be more efficient and cost effective if provided County wide	Kelly Morris
Risk that savings will not be made due to Providers not being able to offer economies of scale on IVF so price increases may be requested.	Planned Care	Robust contract negotiation and potential rationalisation of providers explaining current economic restraints and ensuring 1.5% local price reduction has been applied.	Amelia Whitaker
Risk of increased costs and waiting times due to backlog of IVF patients to be treated at 1st December 2011.	Planned Care	Robust contract negotiation and potential rationalisation of providers explaining current economic restraints and ensuring 1.5% local price reduction has been applied for 2011/12. Ensuring we are keeping abreast of the levels of patients waiting and ensure early discussions with providers.	Amelia Whitaker

Risk that savings will not be achieved due to lack of engagement with acute trusts regarding prior approval thus leaving the PCT unable to validate assumptions (Savings for prior approval are forecast on utilising Hertfordshire model and error rates).	Planned Care	Pilot shows high compliance with thresholds. Exploring alternatives to prior approval. Model activity trends/reductions in relation to change in thresholds.	Michael Baker
Risk of failure to secure pump-priming funding for AAA which is a national must do.	Planned Care	Development of robust bid and linking to review of vascular services. Working with providers on business cases and with the national programme team and the SHA.	Chloe Todd
Risk of failure to find sites/locations for the screening centres for AAA and therefore struggling to implement the programme which is a national must do.	Planned Care	Working with providers on business cases and with the national programme team and the SHA. Providers working closely with GPs and Surrey Community Health on likely sites.	Chloe Todd
Absence of orthopaedics comparator outcome information for Surrey providers, so unable to compare on quality measures for EOC project	Planned Care	Research alternative measures to those used by the current EOC. Approach CCAG to set up outcome measuring system	Lesley Rice
Lack of DH guidance on estate rationalisations	Estates Optimisation	Projects should progress at risk where benefits will be realised and assume approval	Jamie Andrews
Risk that savings are not delivered due to Providers not reducing their occupied space and disposing of assets.	Estates Optimisation	Providers have savings targets monitored my NHSS	Michael Munt
Delay in GPCC MOM training	Digital Vision	Encourage GPCC lead to nominate staff and funding	Mike Dicker

Risk of not achieving 11/12 target savings if short stay tariff is not agreed with acute providers	Children and Young People	Escalate to executives, contracting, Head of Finance for advice re implementation of short stay tariff within rules of competition	S Miller
Risk of not achieving the 4 week quit vital sign target	Staying Health/ Smoking cessation	1. Service expansion e.g. More clinics and telephone support 2. Increased service promotion to encourage patient access 3. Increased engagement with healthcare and community partners	Lisa McNally
Risk that workforce plans are developed in isolation to service and financial plans	Workforce Productivity	Raise the profile of the issue by involving Executive Management Team in Workforce requirements at One Plan meeting and separate meetings.	Colin Sherlock
Risk that the workforce reductions will compromise clinical safety	Workforce Productivity	Dir of Nursing and Quality is involved in joint work to assure clinical safety in the workforce across Surrey.	Colin Sherlock
Risk of a change in tariff for the maternity pathway which could lead to overspend	Maternity and Newborn	Actively encouraging FPH to be a pilot site to ensure more insight into future planning.	Kelly Morris
Risk that budget has been set on 10/11 allocation and not on outturn. Current position is ~£3m risk carried over.	Medicines Management	Encourage GPCC to deliver over and above £14m target.	Kevin Solomons
Risk that there will be a delay in implementing the specialist obesity service thus not achieving in year savings projections	Staying Healthy	David Selwood to ensure contracts are in place by April-11	Lisa McNally

Risk that we may not meet the demand for the service	Staying Healthy	Current process for application for funding to continue coming through the PCT	Lisa McNally
Risk that there is no capacity to ensure delivery of the Pathology Services work stream	Pathology Services	EMT to ensure access/support to people with in-depth knowledge of the area.	John Omany
Risk of loss of contract management and dental finance resource required to implement work stream	Contracting & Procurement - Primary Care	Discussions with line management to ensure adequate resource to deliver work stream	Karen Parsons
• Non engagement of local clinicians in work	MH Programme: LD Repatriation	Joint engagement with SABP clinicians in review and design of pathways	Diane Woods
Perverse incentives not being managed across health contracts and across health and social care budgets	MH Programme: LD Repatriation	Prioritise clients that are 100% health so no cost shift to local authority	Diane Woods
Lack of capacity in commissioning due to organisational changes and staff leave	MH Programme	Cover for maternity leave to be identified and agreed. Use of full team roles allocated to programme	Diane Woods
Failed negotiation with provider	MH Programme	Joint meetings and timetable of contract negotiation meetings	Diane Woods
Reduced performance on the Vital Sign: Numbers of drug users in effective treatment.	MH Programme: Substance Misuse	Specification and contract to include the expected outcomes and targets	Diane Woods
Lack of capacity and capability available throughout the system to lead and manage large scale change at the required pace	MH Programme: Dementia	Engagement with Senior Representatives of PCTs, Acute Trusts and Mental Health Trusts to provide leadership	Diane Woods

Disincentives and barriers to integrated working across the whole system. Inconsistent and disjointed planning across health systems	MH Programme: Dementia	Whole system programme approach with Joint Strategy and working across sectors of care and programme areas will facilitate working across multiple and complex systems	Diane Woods
Double counting of savings across programmes	MH Programme: Dementia	Cross-programme approach to identify interdependencies and financial linkages	Diane Woods
Information collection won't be supported fully by RIO	MH Programme: PbR	SABP liaising with information system provider	Diane Woods
Reference cost data not available by cluster	MH Programme: PbR	Liaison with SHA on measures available	Diane Woods
Training not completed and staff engagement limited	MH Programme: PbR	CQUIN applied for 2010/11 to incentivise for PbR	Diane Woods
Untested model and so finances and activity may not match leading to cost pressure on PCT or provider	MH Programme: PbR	Principle agreements reached between main provider	Diane Woods
Acute Trusts do not accept responsibility for commissioning liaison in the wards	MH Programme: Physical Health	Policy document obtained as evidence	Diane Woods
Evidence base for IAPT does not materialise on LTC's and MUS	MH Programme: Physical Health	Working with SHA and national IAPT teams to source this	Diane Woods
IAPT implementation encounters difficulties in achieving activity targets	MH Programme: Physical Health	Close monitoring of activity through contract meetings	Diane Woods

Business case for growth of IAPT not supported	MH Programme: Physical Health	Work with SHA's and GP consortia's and identification of any further national funds that become available for IAPT as mentioned in OF 2011/12 and CSR	Diane Woods

Appendix 1 :- size of the challenge (GPCC, LTB, Locality, QIPP Programme)

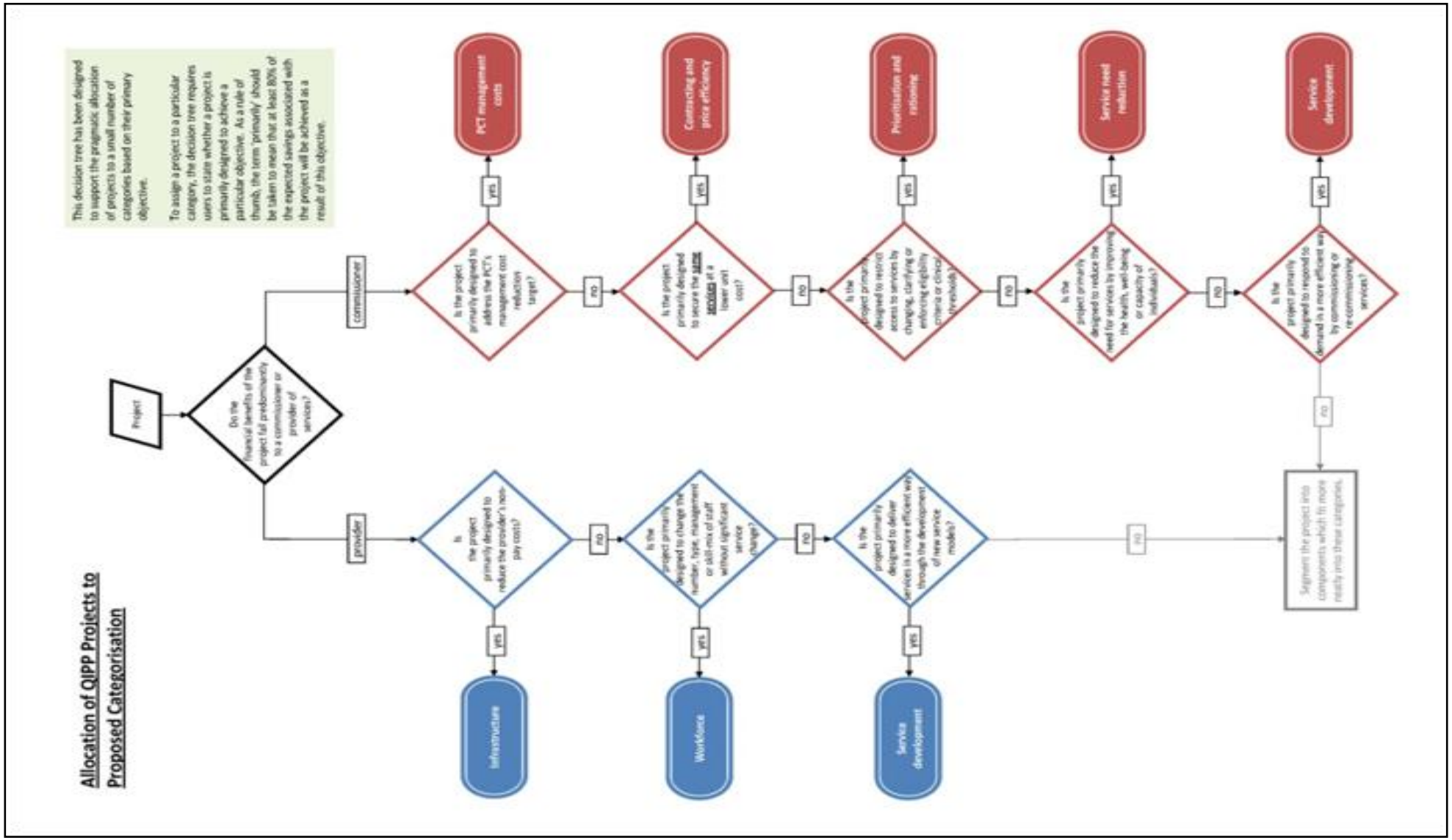
	2011/12	2012/13	2013/14	Total
Ind NW Cluster	4.82m	2.26m	2.28	9.36m
SASSE Cluster	13.91m	6.42m	6.49m	26.82m
Thames Medical	12.75m	5.89m	5.96m	24.61m
West Byfleet	3.88m	1.69m	1.71m	7.28m
Woking Central	5.74m	2.50m	2.53m	10.77m
Woking	5.65m	2.48m	2.51m	10.63m
Dorking	3.92m	2.50m	2.53m	8.95m
Easydoc	20.87m	10.16m	10.28m	41.31m
Medlinc	10.35m	5.09m	5.15m	20.60m

East Elm	3.13m	3.01m	3.05m	9.15m
Mid Surrey	12.73m	6.58m	6.65m	25.96m
Farnham	6.17m	2.88m	2.92m	11.97m
Guildford	13.84m	6.27m	6.35m	26.46m
Surrey Heath	12.50m	5.53m	5.60m	23.63m
Waverley	13.47m	6.31m	6.39m	26.18m

Appendix 1 :- size of the challenge (GPCC, LTB, Locality, QIPP Programme)

	2011/12	2012/13	2013/14
RSCH LTB	27.3m	12.5m	12.7m
SASH LTB	24.8m	12.6m	12.8m
ASP LTB	46.7m	21.2m	21.4m
ESH LTB	23m	11.6m	11.8m
FPH LTB	18.7m	8.4m	8.5m
Kingston	3.1m	3m	3m

Appendix 2 :- QIPP Model Categorisation Decision Tree



Appendix 3 – QIPP Teams

QIPP Work stream	Surrey County QIPP Lead	Operational Lead
Acute Care	Maggie Ioannou	Jo-Anne Bradford
Long Term Conditions	Maggie Ioannou	Jo-Anne Bradford
End of Life Care	Maggie Ioannou	Lindsey Coeur Belle
Planned Care	Akeem Ali	Liz Saunders
Mental Health	Diane Woods	Sue Gurney
Maternity and newborn	Akeem Ali	Kelly Morris
Staying healthy	Akeem Ali	Lisa McNally
Back Office/Supply Chain	Michael Munt	Malachy McNally
Contracting & Procurement CSU	Mike Dicker	Christine Ratcliffe
Contracting & Procurement Primary Care	Karen Parsons	Shelley Eugene
Digital Vision	Mike Dicker	Christine Ratcliffe

Appendix 4:-

Estates Optimisation	Michael Munt	Jamie Andrews
Medicines Management	Kevin Solomons	Jay Voralia
Safe Care	Maggie Ioannou	Pam Knott
Rationalisation of Pathology Services	John Omany	Avril Imison
Workforce	Vanessa Birchall-Scott	Angie Beard
Children and Young People	Maggie Ioannou	Sally Miller

Appendix 4 - Surrey Transition Timeframes

The timelines for achievement of the transition are governed by legislation that has been nationally defined. Regional implementation is being led by the South East Coast Strategic Health Authority who has prepared a Commissioning Development Plan with set timelines. Key deliverables to be achieved are highlighted in the tables below.

Financial Year 2011/12: Learning and planning for roll-out

Key Work Stream	Key Milestone	Deadline Date
Transformation of Community Services	Separate programme of work with its own governance and accountability framework. Reports into the Transition Assurance Committee	31/12/11
PCT Cluster	PCT Cluster established	30/06/11
GP Consortia	Consortia part of Learning Network and on Deanery Led Development Programme	30/06/11
	Scheme of Delegation in place	31/07/11
	Consortia Accountability Agreements signed off	30/09/11
	Consortia development through GP Pipeline Process completed	31/03/12
NHS CB	Primary Care regulated contracting functions transferred to NCB	31/03/12
Transfer of PCT public health functions to the Local Authority	Shadow alignment of Public Health within SCC	04/2011
Health and Wellbeing	Series of workshops to develop plans for the Health and Wellbeing Board with	30/04/11

Appendix 4:-

Key Work Stream	Key Milestone	Deadline Date
Board	partners from Health; Districts and Boroughs; GPs; Voluntary sector etc.	
	First Health & Wellbeing Board Established	31/05/11
	Development of Health & Wellbeing Board	31/03/12
HealthWatch	Shadow HealthWatch established - informed by better understanding of LINKs and the Health Bill	30/04/11
	Tender process complete	30/09/11

Financial Year 2012/13: Full dry run

- All entities will be operating in shadow form in preparation for implementation of the new system in 2013/14
- GP consortia authorisation will commence
- SHA abolished and PCT Clusters will be accountable to the NHS Commissioning Board, including some of the functions currently undertaken by the SHA.

Financial Year 2013/14: First full year of the new system

- From April 2013 PCTs will be abolished and consortia and health and wellbeing boards assume new statutory responsibilities.

In addition to this, the Department of Health has prepared a guidance document for PCT Cluster implementation which provides timeframes for the transition of PCT business functions. The timeframes are set out in the table below.

Appendix 4:-

Financial Year 2011/12: Learning and planning for roll-out

Function	Cluster	PCT	Consortia
Delivery of Integrated Plan	06/11: oversee and manage 2011/12 PCT level plans Oversee FT pipeline input from PCTs	Local implementation of 2011/12 plans under cluster guidance Develop 2012/13 plans under cluster guidance	Increased ownership of implementation of 2011/12 plans in line with state of development Increased role in creation of 2012/13 plans in line with state of development
Direct Commissioning	06/11: oversee and manage 2011/12 contracts and delivery of Operating Framework requirements Negotiate 2012/13 contracts	Agree 2011/12 contracts 06/11: Manage 2011/12 delivery Agree and deliver primary care contracts Annual accounts Input to FT pipeline sign off with commissioning intentions	Involvement in negotiation of 2011/12 contracts Manage agreed elements of 2011/12 contracts in line with state of development
Management and implementation of medium-term QIPP Plans	06/11: Ownership and leadership of cluster wide QIPP plans Manage and update medium term QIPP plans	Handover QIPP plans to cluster Leadership of service change elements as required by cluster leadership	Engagement with, and ownership of local QIPP plans
Oversight of PCT closedown	Leadership of appropriate consolidation of capacity and capability across cluster	Work with cluster on transfer of appropriate people and skills to developing arrangements	Agree with clusters which individuals to be assigned to consortia to help their development
Enabling development of GP Commissioning Consortia and wider reform	06/11: support of pathfinder development Work with Provider Development Authority linking commissioning and QIPP Plans to FT pipeline issues	Handover consortium development process to cluster Support consortium development as required by	Local development work

Appendix 4:-

Function	Cluster	PCT	Consortia
		cluster	
Development of Commissioning Support Unit (Office)	06/11: ensure continual availability of commissioning capacity Work with SHA commissioning support development team, consortia and other clusters to develop and begin implementation of organisational models for commissioning support Work with clinical networks to identify and put in place its role in developing commissioning landscape	Support cluster in making people and systems available in support of commissioning	Engage with initial commissioning support offer engage in process for designing future commissioning support options
Governance	Ensure all statutory duties of PCTs are appropriately covered Ensure cluster executive arrangements are consistent with agreed governance and delegation arrangements	Put in place Board arrangements Put in place Schemes of Delegation	Understand and engage with local governance and scheme of delegation arrangements
Maintain talent and support people through change	06/11: lead process of supporting PCT staff in securing future through transition	Support cluster in managing people transition Abide by relevant employment legislation and good practice	Agree with clusters which individuals to be assigned to consortia to help their development
Maintain relations with Local Government and key Partners	Oversee continuity of effective local joint working and engagement processes with patients, communities and marginalised groups Oversee development of Local Health and Wellbeing Boards	Maintain effective joint working and engagement processes with patients, communities and marginalised groups Plan transfer of public health	Engagement with joint working and commissioning arrangements

Appendix 4:-

Function	Cluster	PCT	Consortia
	Work with local public health and local authorities on development and use of Joint Strategic Needs Assessment Ensure resilience of emergency planning structures Work with DH to create local elements of new public health service Work with DH and local partners in effective development of HealthWatch	functions to national Public Health service and local authorities	

Financial Year 2012/13: Full dry run

Function	Cluster	PCT	Consortia
Delivery of Integrated Plan	Develop and delivery of 2012/13 integrated plans Input to FT pipeline sign off with commissioning intentions	Local implementation of 2012/13 plans under cluster guidance	Increased ownership of implementation of 2012/13 plans in line with state of development Leading role in creation of 2013/14 plans
Direct Commissioning	Oversee and manage 2012/13 contracts and delivery of Operating Framework/mandate requirements Support GPCCs in negotiation of 2013/14 contract Negotiate and prepare oversight arrangements for services to be directly commissioned by NHS Commissioning Board	Manage 2012/13 delivery as required by cluster Annual accounts Input to FT pipeline sign off with commissioning intentions	Involvement in negotiation and management of 2012/13 contracts in line with state of development Leadership of negotiation of 2013/14 contracts in line with state of development.

Appendix 4:-

Function	Cluster	PCT	Consortia
Management and implementation of medium-term QIPP Plans	Management and updating of medium term QIPP plans Handover of QIPP process to GP consortia for 2014 onwards	Leadership of service change elements as required by cluster leadership	Leadership of service change elements within QIPP plans as required by cluster leadership Development of QIPP approach beyond 2013
Oversight of PCT closedown	Work with NHS Commissioning Board and GPCCs to ensure to ensure smooth transfer of all residual PCT functions to new structure	Work with cluster on transfer of appropriate people and skills to developing arrangements	Once **authorised** increasingly employ staff directly including under TUPE arrangements
Enabling development of GP Commissioning Consortia and wider reform	Support consortium development and, as required by NHS CB, support assessment process and management of residual issues in consortia formation Work with Provider Development Authority linking commissioning and QIPP plans to FT pipeline issues	Support consortium development as required by cluster	Formal application and assessment
Development of Commissioning Support Unit (Office)	Ensure continual availability of commissioning capability Work with NHS CB to put in place new organisational options for commissioning support	Support cluster in making people and systems available to support commissioning	Make choices/place contracts for commissioning support
Governance	Prepare handover of statutory responsibilities to NHS CB and GPCCs		Take on additional responsibility as they become statutory bodies with increasing budgetary responsibility devolved from outgoing PCTs

Appendix 4:-

Function	Cluster	PCT	Consortia
Maintain talent and support people through change	Complete process of supporting PCT staff in securing future through transition	Support cluster in managing people transition Abide by relevant employment legislation and good practice	Once **authorised** increasingly employ staff directly including under TUPE arrangements
Maintain relations with Local Government and key Partners	Oversee continuity of effective local joint working and engagement processes with patients, communities and marginalised groups Work with developing Local Health and Wellbeing Boards Work with local public health and local authorities on development and use of Joint Strategic Needs Assessment Ensure resilience of emergency planning structures Work with DH to create local elements of new public health service Work with DH and local partners in effective development of HealthWatch	Maintain effective joint working and engagement processes with patients, communities and marginalised groups and ensure effective handover to GP consortia and Local Health and Wellbeing Boards Support of Local Health and Wellbeing Boards Transfer of public health functions to national Public Health service and local authorities Plan transfer of public health functions to national Public Health service and local authorities	Strategic partnership with local government, LHWBs and other key partners