Brent	**Community Wellbeing Scrutiny Committee** 24th October 2019
	Report from Brent Clinical Commissioning Group
North West London NHS Financial Recovery Plan	

Wards Affected:	All Wards
Key or Non-Key Decision:	1). To note the financial position of NWL Collaboration of CCGs and of Brent CCG and the financial recovery programmes in place to improve the position and make the NWL health economy more sustainable.
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
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1. Background

1.1. The NWL CCGs were set a financial target in 2018/19 (known in the NHS as a "control total") of a deficit no greater than £9.4m. The control total was set as a deficit to recognise the long-standing financial problems in Harrow CCG. In fact the CCGs ended the year with a deficit of £56.7m, a variance to control total of £47.4m. An estimated £10.2m of the deficit related to GP at Hand.

1.2. The deficit needs to be seen against total expenditure of £3.5bn, so the deficit represents 1.6% of expenditure.

1.3. For the year we are currently in, 2019-20, the CCGs were given a control total of £21.5m deficit, but regulators accepted that the CCGs were unlikely to

achieve this and set us a target of a deficit no worse than £50.9m. Included in this position were savings of £98.9m through the CCGs QIPP (quality, innovation, partnership and prevention) programme.

1.4. The CCG planned savings for 2019-20 represents £100m out of £3.5bn or 2.8%. There are some national policies which call for greater savings in specific areas. For example the CCGs have to demonstrate a 20% reduction in running costs compared with 2017-18.

1.5. In September, four months into the financial year, we recognised that we were in danger of going significantly off plan, and identified a potential additional expenditure of £61.6m, on top of the deficit already in our plans.

1.6. At the same time, on the provider side, London North West NHS Trust recognised risks to its financial plan of £20m, making the total risk to the system £82m.

1.7. Of this potential additional £61.6m variance from plan, £54.6m related additional acute costs. The table shows the breakdown against Points Of Delivery (POD). In addition CCGs are also facing Continuing Healthcare pressures, equating to £7m.

1.8. Combined, this equates to a financial challenge which would result in a further deficit of £61.6m above plan.

POD			VARIANCE	
	YTD M4	FOT	Risk Share	Total
	£m	£m	£m	£m
A&E	-£1.67	-£5.70		-£5.70
NEL	-£10.70	-£34.60		-£34.60
Critical Care	£1.30	£1.40		£1.40
OP FA	-£2.50	-£7.00		-£7.00
OP FU	-£2.70	-£7.30		-£7.30
OP Procedures	-£1.00	-£2.90		-£2.90
OP Sub-Total	-£6.20	-£17.20		-£17.20
DC & EI	-£5.30	-£13.20		-£13.20
Direct Access	-£1.40	-£3.00		-£3.00
Maternity	-£0.40	-£2.10		-£2.10
All other	£8.72	-£11.50	£31.20	£19.70
Total	**-£15.65**	**-£85.90**	**£31.20**	**-£54.60**

2. In response to these pressures we developed a plan to bring our finances back to plan.

2.1. Brent CCG is currently projecting a forecast outturn of an £8.1 million deficit, which is in line with the financial plan that we submitted to NHS England. Whilst a financial deficit is clearly not desirable, it is acknowledged that it will

take time to recover our position, and our financial recovery plan is aimed at addressing that.

2.2. It is important to note that no matter what financial challenges we face, as a clinically-led organisation, **the safety of our patients and the quality of our services will always come first.** The draft plan we published involves looking at a 20% saving driven by reforming the way we work, and enforcing existing policies. This figure does not relate to service changes or patient care. We will continue to work closely with patients, local residents, NHS staff, our local authority partners, Healthwatch and the voluntary sector as our plans for the next five years take shape.

2.3. We continue to abide by NHS constitutional standards, that is, we are committed to achieving waiting list targets, cancer and mental health waiting times and A&E waiting time targets as set out in our operating plan submission. In addition we continue to meet the mental health investment standard, that is, additional investment in mental health standards in line with the CCGs overall increase in allocation each year.

3. Why are we in deficit?

3.1. Since 2015, expected growth in our population has been outstripped by increased demand for hospital care. The North West London population has grown by 5%, while acute activity has increased by 18%. In particular, unplanned care has risen by 25%, accounting for over half our increased spending.

3.2. Our funding allocations have increased. We have seen a 3.4% budget uplift for this year. Some additional capital investment has been made available for Hillingdon Hospital and St Mary's Hospital in order to address the urgent and longstanding site maintenance issues.

3.3. However, while our funding allocations have increased, the rise in demand for health services has outstripped the increases in funding. Lack of standardisation and efficiency in commissioning of clinical and non-clinical services has increased costs and led to variations in the quality and costs of care. Estates and staffing costs have also played a part in the size of our deficit.

3.4. Until recently, our financial performance was broadly similar to the NHS in London as a whole. However, our position has worsened over the last year.

4. Brent's Financial Allocation from NHS England

4.1. NHS England published 5 year allocations for CCGs in January 2019 covering the period from 2019/20 to 2023/24. These allocations are part of the deployment of NHS England's five-year revenue funding settlement, averaging 3.4% a year in real terms and reaching £20.5bn extra a year by 2023/24.

Overall CCG allocations are being set on the basis of NHS England's five-year real terms revenue funding profile, which has now been set by Government as 3.6%, 3.1%, 3.0%, 3.0% and 4.1%.

Individual CCG allocations are based on historic funding levels uplifted by differential growth rates depending on their relative distance from target allocation, which is based on a national funding formulary.

4.2. Changes to Target Allocations

Target allocations are based on a revised target formula following changes recommended by the long standing independent advisory committee, the Advisory Committee on Resource Allocation (ACRA).

4.3. Pace of Change

Pace of change prevents movements in target allocations leading to volatility in terms of final allocations. Key principles are:

- Additional growth is applied to those areas most below target, with an aim that no area is more than 5% below target. This is achieved is 2019/20 and every year thereafter.
- Areas close to target receive equal funding growth per capita. This applies to all CCGs between -2.5% and +5% from target in 2019/20, and CCGs between 0% and +5% from target in all later years.
- Areas more than 5% above target receive a lower level of funding growth, tapering down to floor growth for those more than 10% above.
- 0.1% of CCG programme and primary care allocations are distributed on a place-based basis. This continues the approach adopted in the last allocations round and is intended to take a more holistic view of allocations for a place (including CCG, primary care and specialised funding).

Further information on the published allocations can be found on the link below.
https://www.england.nhs.uk/wp-content/uploads/2019/01/note-on-ccg-allocations-2019-20-2023-24.pdf

The table below shows the published allocations for 19/20 for both the core CCG and primary care allocations.

Within London we have the most over-target CCG (West) and the most under-target CCG (Brent). This means that Brent CCG gets higher growth than over-target CCGs (4.15% compared to 1.93% in West).

Overall NWL CCGs are 0.70% over-target allocation (£23m). Part of the reason for Brent moving below target is due to changes in the calculations of the target allocations for 2019/20 giving higher weighting to deprivation.

	2019/20 RRL								
	Total	**Brent**	**Central**	**Ealing**	**H&F**	**Harrow**	**Hillingdon**	**Hounslow**	**West**
Core and Primary									
Allocation	3,315,300	503,844	317,094	579,539	308,884	348,722	432,025	412,141	413,051
Target Allocation	3,292,228	525,654	298,535	591,754	320,338	352,076	436,933	418,095	348,844
Difference	**23,073**	**(21,810)**	**18,559**	**(12,214)**	**(11,454)**	**(3,354)**	**(4,908)**	**(5,954)**	**64,208**
Difference %	0.70%	-4.15%	6.22%	-2.06%	-3.58%	-0.95%	-1.12%	-1.42%	18.41%

5. Our Financial Recovery Plans: four strands

5.1. Strand one: same service, lower cost

There are changes we can make which will offer the same services for a lower cost to the NHS through a change in supplier. These will not impact patient care, and although details will be publically available, we do not see any rationale for a public engagement process.

Example: We expect to see savings from the new London-wide procurement of the home oxygen service.

5.2. Strand two: Changes to referral behaviour

Strand two of our financial recovery work involves looking at ways we can influence GP behaviours by comparing referral patterns and identifying best practice. By looking at the underlying causes of the different referral patterns we can identify best practice, share learning, and make sure we are always referring patients in the most appropriate way, so they get the right care for their need.

Unwarranted variation in GP referral patterns has already been reduced through practice visits and action plans, which we now have in place with 132 practices across North West London. CCGs have agreed with in-sector providers a standardised approach for consultant-to-consultant referrals, and for follow-up appointments with outpatients. We are working on agreed pathways for same day care, and working with community trusts to agree in common a set of ‘out of hospital standards’ to safely reduce avoidable and unnecessary admissions, and speed up patient discharge.

CCGs will continue the practice visits where we discuss activity trends against peer comparisons. Feedback from most practices is that this has proved useful and raised awareness of alternative primary and community care pathways that can provide a more convenient and better value care alternative for the patient.

Example: There may be disproportionately high referral rates into acute or specialist services from a particular GP practice because they do not have the right information about alternative community services that are available.

5.3. Strand three: enforce existing policies

NHS England has national policies on prescribing medicines which are available over the counter (and in some cases are cheaper over the counter than with a prescription). Compliance with these policies varies across North West London and we are working to understand the reasons for this variation and ensure the policy is fully implemented by all our providers. NWL has previously agreed an approach to consultant to consultant referrals but has not fully implemented it.

Example: Consultant-to-consultant referrals are very high in parts of North West London. It is agreed national best practice that in cases where a patient is referred to a consultant and the consultant believes the patient needs to see a specialist in an unrelated area, the patient be referred back to the GP first.

5.4. Strand four: updating eligibility criteria

Although we will prioritise savings from administration and by reforming how we commission care, we will look at all aspects of our spend. This may involve updating the eligibility criteria for some of our Planned Procedures with a Threshold (PPwT) and for our patient transport services to ensure the standardised guidance fully reflects the most up to date evidence, best clinical practice, and value for money.

Example 1: We are in the process of standardising the eligibility criteria for patient transport across North West London, to make sure access is consistent and fair regardless of where a patient lives, and looking at the reasons for variation between contract costs. We evaluate the eligibility criteria on an ongoing basis in partnership with patients as this work develops. We will continue to engage with patients on this work through the patient transport group and other patient groups, through special events, and through written or online feedback submissions, among other channels.

Example 2: We are reviewing our Planned Procedures with a Threshold policies, with a view to updating the eligibility criteria for certain procedures. The current areas of focus are the eligibility thresholds for bariatric surgery, and Smoking Cessation and Pre-operation Weight Management Programme.

This is the area which is likely to be the focus for patient engagement and consultation if necessary.

5.5. Stages of implementation

The implementation of this plan has now begun, with some reforms relatively simple to achieve (such as those which are administrative in nature and do not impact patient care) and others may require wider public engagement and planning before they are taken forward.

There are four strands of work and only the fourth category will require an Equalities Impact Assessment (EQiA) or patient engagement. North West London CCGs will share this information with the JHOSC and other stakeholders as early in the process as possible.

5.6. Impact of winter

As we develop our financial recovery plans we will take into account the impact of winter on demand, activity performance across North West London. This includes increased emphasis on the urgent care pathway, so that the spike of costs anticipated for winter is minimised.

5.7. Impact on hospitals and provider trusts

Since our recovery plan is aimed at getting the NHS system back to plan, the remedial work on referrals and waiting lists should help hospitals removing the need to put on additional capacity. We continue to work closely together as a single system.

5.8. What does success look like?

We aim to return to our original plan, which was a £51m deficit. No matter how much or little money we have, it is always right and fair that we use the money we do have as efficiently as possible, and put resources where they will do the most good for patient care.

5.9. Next and Subsequent Years

Our financial planning for next year has already begun. We are anticipating that financial recovery will be a three year programme of getting us back to balance. Our plans for next and subsequent years will be guided by our NHS Long Term Plan submission, which is already available in draft on our website: https://www.healthiernorthwestlondon.nhs.uk/about/patientsandthepublic/longtermplan/draftltp

6. How These Changes Will Affect Brent Patients

6.1. The section below provides further detail on how specific recovery schemes are likely to affect Brent patients, as requested by the Community Wellbeing Scrutiny Committee.

6.2. Elective hospital services and bringing some elective hospital services back to local North West London providers

This programme will focus on "repatriating" elective procedures begin referred by General Practitioners and Trusts to providers outside North West London back into the North West London sector. The project aims to change referral patterns where NWL GPs consider using NW London providers and only refer outside of the sector if there is no capacity or if the patient requires intervention provided by specialist centres out of area. North West London NHS has an agreement with local NHS Trusts that specific quantities of activity will be delivered in each trust. Any activity above a set threshold is paid at 70% of the Payment by Results Tariff. This means that if more activity is referred to North West London providers, then approximately 30% of the tariff will be saved on each procedure. This is not true of providers external to North West London or to private sector providers.

The total amount of activity that we could bring back into the sector amounts to around 15% of all secondary care activity.

For Brent patients, they should see no change in the healthcare that they receive, except that they are more likely to be referred to a local provider rather than a provider external to the North West London health economy such as Royal Free Hospitals NHS Trust, for example. This is likely to be a benefit to patients in not having to travel longer distances across the city.

It should be noted that patients and GPs will always retain the right under the NHS Constitution to be referred to a provider of their choice and that GP retain the right to make decisions for the wellbeing of their patients.

6.3. Outpatient services and changes to outpatient appointments

NWL CCGs have reached agreement with providers that all activity in Quarters 3 and 4 of 2019/20 will be at contracted (planned) levels of activity, unless this puts waiting list commitments at risk. It was agreed that there will be no rise in 52 week waiters.

Additionally, our providers have agreed to adhere an existing consultant to consultant referral policy. The key principle behind this is that referrals relating to the original complaint can be referred on directly to another consultant. However, if an entirely different complaint comes to the attention of the consultant (unrelated to the original referral) this should be referred back to the patient's GP first.

We have an outpatient transformation programme in North West London which has developed standardised referral guidelines. Consultants are currently triaging GP referrals against these guidelines when the referrals arrive at the hospital. Any referrals which do not adhere to the guidelines will be sent back to the referring GP with advice. In this way, unnecessary outpatient appointments can be avoided and patients may receive their care from their local GP practice.

6.4. Reducing spending on over the counter medicine prescriptions

Using the NHS London published guidance, we are working with secondary and primary care to reduce the volume of over the counter medication (for example paracetamol or ibuprofen) prescribed to patients. We have in place a communication plan for clinicians, patients and the wider public to support roll out. We will work with secondary care colleagues to support the programme and ensure that advice to patients is consistent across primary and secondary care.

Patients who are considered to be particularly vulnerable and are in receipt of free prescriptions may still receive these over the counter medications on prescription, at the discretion of their GP.

6.5. Standardising assessments for patient transport

This programme involves the renegotiation of the price on the LNWHT patient transport contract and a consistent application of current eligibility criteria. Discussions are currently underway with LNWHT with regard to the first element of the programme. Patient care will not be affected and those patients who require patient transport will still be able to receive it.

6.6. Home Oxygen and Enteral Feeds

This programme is made up of 3 elements. The first is the benefit of a pricing change following national procurement for home oxygen. The next is a clinical review of patients on home oxygen, prioritising those patients who have not been reviewed in the last 12 months and/or those patients where the data shows they are using less oxygen than prescribed. This review process will ensure that patients are not receiving a higher dosage of oxygen than they need, and that oxygen is not being wasted where it is no longer required. It will not change the criteria for patients to receive oxygen.

The enteral feeds procurement provides commissioners with a saving by reducing the costs of consumables and securing a better deal with the NHS's external providers. It does not alter the care pathway and patients will not experience any change.

6.7. Unscheduled Care

A&E attendances and unplanned emergency admissions to hospital continue to rise in an unsustainable way. These are one of the biggest drivers of the deficit to the NWL financial system. There are a number of workstreams to

address this. These schemes are divided up into “front door demand”, which is about reducing the number of patients turning up at the front door of A&E/ Urgent Care Centres, and “short stay flow”, which is about getting senior level clinician input at the start of patients’ journeys into the A&E department so that they can be turned around more quickly. This in turn means that they are less likely to be admitted to an inpatient bed.

Clinicians from LNWHUT and Brent and Harrow CCGs are currently participating in a “6As audit”. Emergency admission to hospital is a major event in people’s lives. It should never happen because it is easy to admit or to access services that could be available as an out-patient or to administer treatment that may be available closer to home or to get a specialist opinion. All of these are spurious reasons for an emergency admission. To transform emergency healthcare we need to understand why we put patients through this process when alternatives exist and operate effectively across the country but haven’t been widely implemented.

Emergency admission implies a patient is sick and requires a high level of intervention. As such, all proposed emergency admissions should prompt a clinical conversation between senior doctors, ideally consultants.

The 6 As audit is about establishing whether patients are currently going to the optimal place, or whether improvements could be made to better utilise community care pathways. The audit involves asking whether the following alternatives could have been used:

- Advice - suggest a clinical management plan that allows the patient to be managed in primary care
- Access to out-patient services - suggest an outpatient referral for specialist assessment
- Ambulatory Emergency Care - clinically stable patients appropriate for same day discharge
- Acute Frailty Unit - to provide comprehensive geriatric assessment for frail older patients
- Acute Assessment Units - to diagnose and stabilise patients likely to need admission
- Admission to specialty ward directly - for agreed clinical pathways and specialised clinical presentations

Once the conclusions of the audit are received, we will aim to optimise our referral pathways so that patients are seen in the most appropriate service and location.

6.8. High Intensity Users

This programme is about pro-active case finding of high intensity users (5 or more A&E attendances or admissions within the last 12 months) and to ensure that members of the frequent attenders forum are fully informed. The forum aims to identify other services and resources that may help the patient address their needs e.g. housing, drug and alcohol treatment programmes,

psychological interventions etc. As part of this process, the patient's GP is consistently informed of their registered patient's interactions with the ambulance/ hospital/ urgent care services. A care plan is formulated and stored on the Co-ordinate My Care system, which means that it is then accessible to hospital clinicians who need to access it as part of any future re-attendance. The aim of the programme is to reduce future unnecessary re-attendances. It will improve patient care in Brent as patients will receive pro-active care that is better tailored to their needs, rather than turning up in an A&E department, which may not be best suited to the type of expertise that the patient needs.

6.9. LAS Demand

This scheme is about supporting the London Ambulance Service (LAS) to book into extended access hub appointments based in GP practices, where this would be the most appropriate course of action for the patient's needs.

Where appropriate, the 999 service will also be able to book into the access hub appointments.

To support the LNWUHT system Brent, Harrow, and Ealing CCGs have been selected for rollout in phase 1 of GP in-hours and Extended Access booking from LAS Clinical Hub (known as CHUB). Clinical engagement is underway for opening these slots to the CHUB.

6.10. LAS Walk-In Demand

The Brent category of the LAS has some of the highest rates of conveyance to A&E of all categories. This may be due to higher than average vacancy rates in the service, and a less experienced cohort of incoming paramedics that may be more risk averse in their assessment of patients. This should improve over time as staff become more experienced, but a programme of shadowing is taking place so that LAS staff understand what is available in the community and can refer patients to community pathways where a conveyance to A&E is not deemed to be required.

6.11. Same Day Emergency Care (SDEC)

SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.

Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

When a patient comes to hospital, an SDEC service (which may operate under the name of ambulatory emergency care unit) means patients with some medical concerns can be assessed, diagnosed, treated and safely discharged home the same day, rather than being admitted.

SDEC services treat a wide range of common conditions including headaches, deep vein thrombosis, pulmonary embolus, pneumonia, cellulitis, and diabetes. The types of conditions that can be managed through SDEC will vary depending on the hospital and needs of the local population.

We aim to expand the usage of SDEC as part of our financial recovery programme, which will reduce overnight non-elective admissions (1-2 days length of stay) and A&E attendances by increasing activity through the SDEC pathways and optimising the ambulatory emergency care units. Shorter lengths of stay attract a lower tariff for the CCGs and therefore reduce costs.

6.12. Front Door Frailty

The aim of this programme is to implement **proactive frailty services** which will avoid admissions by providing a holistic response for frail older people in the community and during time of crisis. Frailty practitioners will screen patients who are 75 or over and for those who have a high score, a consultant geriatrician at the front end of A&E will provide a comprehensive geriatric assessment. This means that we are usually able to turn the patient around more quickly so that they get the care they need and may never need an admission to an inpatient bed. This is safer for the patient, as they are likely to stay more mobile at home and not pick up hospital acquired infections.

6.13. Admission conversion rates

This programme is about the rates of which A&E attendances 'convert' into unplanned admissions to hospital beds. We are using benchmarking data to compare our local hospitals to national averages and London averages so that hospitals who are above the average try to bring their conversion rates down to the average. This means that more patients will benefit from being able to stay out of hospital and reduce their risk of hospital acquired infections. It is a financial benefit to the system because it means that we are not funding unnecessary numbers of hospital beds or opening new beds. It also allows those patients who are most seriously ill to access a bed when they need it.

6.14. Demand Management

We have a comprehensive review programme of primary care variation. Across Brent, the amount of secondary care activity and prescribing spend that are attributed to individual GP practices varies significantly, and this does not always correlate with deprivation levels of the demographics of the GP practice. We intend to reduce this unwarranted variation in practice and to enable GP practices to learn from each other to ensure that best practice care pathways are being followed.

The programme includes:

- Reviewing A&E and UCC attendances, and contacting patients within 2 days of discharge where attendance was inappropriate;
- Practices promoting self-care management and continue to improve patient access. 40 practices currently offering E-consultations with a further going live imminently;
- Ensuring visible display of GP Access Hub, NHS 111 and Online Services Posters;
- Conducting internal and external peer reviews with CCG and PCN/network leads;
- Locum, GP trainees and associates referrals to be triaged by the lead clinician/GP partner
- Educational sessions for all GPs and clinical staff. Inter-practice referrals optimising skill mix at PCN level
- Kilburn Locality has a low outpatient referral activity - learning shared with other PCNs (advice and guidance at Imperial and MDT programme)

7. Governance and Reporting

The Financial Recovery Programme is overseen by a North West London Financial Recovery Board. Because the majority of North West London's deficit is centred upon the system surrounding LNWHT, there is a separate recovery board involving LNWHT, Brent, Ealing and Harrow CCGs. This is chaired by Lesley Watts, the leader of the NWL Health and Care Partnership and the Chief Executive Officer of Chelsea & Westminster Hospital NHS Trust.

Updates are also presented to the CCG's Finance, QIPP and Performance Committee, which is a subcommittee of Brent's Governing Body.

Appendix 1: NWL Financial Recovery Schemes

Scheme		Opportunity Identified
Additional CCG savings	Fully identified, over 70% now implemented, budgets removed at line level therefore high confidence of delivery	£16m
Reserves	All fed into forecast outturn. No risk.	£16m
CHC – eliminating overspend	Project team and support in place, schemes agreed with management team, implementation underway. Savings from: catching up with the review backlog, invoice scrutiny, use of decision support tool	£7.9m
Localising Services	Savings based on 15% of out of sector referrals being treated in NWL. Supports local hospitals, takes advantage of NWL marginal rate.	£1.5m
Elective	Agreed that providers will plan activity back down to contract level, unless this puts waiting list commitments at risk (no rise in list compared to March 18 and no +52 week waiters).	£4.6
RTT reserve	Not all of the waiting list reserve may be required.	£2.9
Emergency pathway	Four elements have been developed: - Improved frailty model on front door - Same day emergency care - Diabetes care - 111 and LAS dispatch	£4.6
Outpatients	System has agreed to policy on C2Cs and re-establish thresholds for new to follow ups. All Trusts to cap cost at contract level.	6.0
Management Costs	CCGs have agreed the shape of single operating model that will save £1m in this year	1.0
Patient Transport	Standardisation of contracts	1.4

Procurement	Project to procure enteral feeds is well advanced, saving £1m. Awaiting details on the Home Oxygen opportunity	1.5
Estates	Further rationalisation of the primary care estate. Projects identified to deliver the savings, risk is around ability to exit buildings in time to release sufficient cash in-year	1.1
Over the Counter Medicines	CCGs have agreed to implement the national policy in full.	8.0
TOTAL		**72.5** (Subject to Slippage)