NHS
Vale of York
Clinical Commissioning Group

Vale of York Medium Term Financial Strategy

A new approach to commissioning

FINAL v0.1

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NHS Vale of York Clinical Commissioning Group

EXECUTIVE SUMMARY

Executive Summary

Vale of York's current situation

- Vale of York (VoY) CCG commissions health services on behalf of a population of 350,000.
- The CCG has had an underlying financial deficit since its creation in 2013 and reported a deficit position of £6.3m at the end of 2015/16.
- The CCG is one of nine to have recently been put into Special Measures by NHS England and received Legal Directions on 1st September 2016.
- VoY responded with the development of a Financial Recovery Plan ('FRP'), submitted to NHSE on 6th October 2016, and including a plan to achieve an in-year deficit of no more than £7m (£13.3m cumulative)[1].
- A new Accountable Officer has also been appointed (in post from 3rd October) to oversee the rapid organisational change required and inject challenge.

Purpose of financial strategy

- The CCG recognises the need to articulate a strategic plan which addresses the underlying causes of financial deficit and identifies a path to sustainability.
- VoY spends less per head of population than any other CCG within the STP footprint yet receives the lowest allocated spend per head from NHSE (a function of how the allocation formulae recognises the health needs of the population).
- This means that the CCG needs to spend 11% less per person than the STP average in order to live within its means.
- The Medium Term Financial Strategy seeks to:
  - **outline a plan** for how the CCG can reach a balanced and sustainable financial position;
  - **align with existing system plans**, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan (which the CCG is a partner to);
  - **meet key statutory financial targets and business rules;**
  - **be consistent with the CCG's vision** and support the delivery of the CCG objectives;
  - recognise and **meet the scale of the challenge** in the Five Year Forward View;
  - **deliver operational and constitutional targets;**
- VoY has taken a fundamentally different approach to the development of its strategy based on a detailed understanding of its local population needs which has allowed it to pinpoint a number of areas it needs to focus on.

A new approach to commissioning

- The CCG believes that, in order to deliver real change, a radical new approach to system leadership, commissioning and delivery is now required.
- Up until now, the health and social care system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.

1) Improvement Plan in response to NHSE Legal Directions (issued 1 Sept 2016), 6 October 2016

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- This is evidenced by the fact that only 24 to 29% of the CCG's targeted QIPP cost savings have been achieved over the past two years.
- Moving forward, VoY needs to play its part in redesigning and delivering a new health and social care system which is better able to care for patients, whilst also delivering financial sustainability.
- VoY's strategy for doing this is embedded in the work of the STP and includes a vision for new models of accountable care in VoY, strategic commissioning across the system and new approaches to system governance and risk sharing.
- This builds on the ideas put forward in the Five Year Forward View and best-practice national and international examples of whole population management and outcomes-based commissioning.
- VoY has already made progress in a number of areas, for example in articulating a vision for a VoY Accountable Care System.

Financial opportunity

- The CCG has identified 6 areas of immediate financial opportunity to focus on: Elective Orthopaedics, Out of Hospital, Outpatients, Continuing Healthcare, Prescribing and High-cost Drugs.
- Combined, these 6 opportunities have the potential to release savings to the CCG in the order of £50m by 20/21.
- Following a Confirm and Challenge process led by NHS England the CCG has now identified specific interventions and schemes (including the 6 opportunity areas and others) with a total value of £47.7m.
- This would allow the CCG to reach in-year surplus by 20/21 although a cumulative financial deficit of approximately £51m would still remain, or at best, £38m with further QIPP not yet identified.
- The CCG has agreed delivery plans, next steps and work with stakeholders to progress each of the 6 major opportunities.
- Further work to firm up the size and potential for delivery of the additional pipeline opportunities is ongoing.

Next steps

- Moving forward, VoY recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals.
- Development of the financial strategy will require close collaboration with providers and other STP partners, as well as a strong and realistic understanding of the capabilities required to deliver the new vision articulated.

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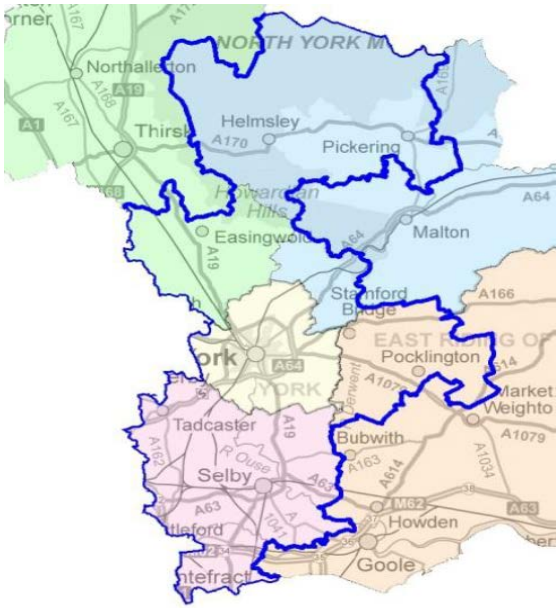
SECTION 1: INTRODUCTION

Vale of York Clinical Commissioning Group

1.1 Introduction

- Vale of York CCG is responsible for commissioning the following healthcare services on behalf of a population of 350,000:
  - Planned hospital care
  - Urgent and emergency care
  - Community health services
  - Mental health and learning disability services
  - Tackling inequality including children's health and wellbeing
- VoY's footprint covers an area of approximately 857 square miles that runs broadly north to south through North Yorkshire. It is mainly rural with a number of small market towns and the main urban centre of York .
- The Vale of York is a comparatively affluent area but with pockets of significant deprivation in the York, Selby and Sherburn-in-Elmet areas.
- Three local authority areas span VoY's commissioning population:
  - City of York Council
  - East Riding of Yorkshire Council
  - North Yorkshire County Council
- The CCG has 27 GP member practices.
- VoY's commissioning budget was £435.3m in 2016/17, with minimum growth from 2015/16 .
- Allocations, albeit indicative for future years, suggest the CCG can expect to receive minimum growth in allocations to 20/21.

- The main providers of VoY's services are:
  - York Teaching Hospital NHS Foundation Trust (acute and community services)
  - The Leeds Teaching Hospitals NHS Trust (acute services)
  - Leeds and York Partnership NHS Foundation Trust (specialist mental health and learning disability services)
  - Tees, Esk and Wear Valleys NHS Foundation Trust (mental health, learning disability and eating disorder services)
  - Hull and East Yorkshire Hospitals NHS Trust (acute services)



Vale of York Clinical Commissioning Group

1.2 Recent financial performance

- The CCG has had an underlying deficit since its creation in 2013.
- Consistent under delivery of QIPP (24% of QIPP achieved in 2014/15 and 29% achieved in 2015/16) means that the organisation has been reliant on non-recurrent mitigations.
- The CCG reported a deficit position of £6.3m at the end of 2015/16. This represented a significant deterioration of £10.25m from the planned 1% surplus of £3.95m. Consequently, the CCG was classed as an organisation in turnaround.
- The CCG has experienced a range of financial and operational challenges in recent years including:
  - Growth in demand, particularly acute services, over and above that which was planned for
  - Stretched workforce and gaps in clinical leadership
  - Historical financial difficulties have strained local partner relationships
  - Limited existing joint commissioning arrangements
  - Rising elderly and frail local population leading to increased pressure on services
  - Shortfalls in the programme management and governance of QIPP schemes leading to under performance

Financial Year	2013/14	2014/15	2015/16	2016/17 Forecast
Planned Surplus/ (Deficit)	£3.7m	£2.1m	£3.9m	(£13.3m)
Actual Surplus/ (Deficit)	£2.1m	£3.9m	(£6.3m)	(£28.1m)
Planned QIPP	£10.9m	£9.4m	£19.5m	£12.2m
Actual QIPP	£4.7m	£2.3m	£5.6m	£1.9m
% delivery	43%	24%	29%	15%
Of which recurrent	£4.7m	£2.3m	£5.6m	£1.7m

The CCG was placed in Special Measures in September 2016 and has subsequently responded with a Financial Recovery Plan

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1.3 Recent history

Special Measures

- The CCG is one of nine CCGs to have recently been put into Special Measures by NHS England and received Legal Directions from the NHSE Commissioning Board on 1 September 2016.
- The Legal Directions included the requirement for VoY to:
  - Produce an Improvement Plan that sets out how it shall ensure that the capacity, capability and governance of the CCG is made fit for purpose including agreeing with the NHSE Commissioning Board how it will strengthen its financial leadership;
  - Provide for the implementation of the recommendations of the CCG Capability and Capacity Review date 28 January 2016.

VoY response

- The CCG is determined to respond positively and at pace to the Legal Directions it has received.
- The CCG has developed a Financial Recovery Plan ('FRP') with an independent assessment of facts, figures and projections. This was submitted to NHSE on 6th October 2016 and includes a plan to achieve an in-year deficit of no more than £7m (£13.3m cumulative)[1].
- A new Accountable Officer has also been appointed (in post from 3rd October) to oversee the rapid organisational change required and inject challenge.
- The FRP also outlines plans to develop the capacity and capability of the CCG through strengthening of the senior team, a new management structure and revised governance processes. This has included the creation of four new executive posts.
- Development of a new commissioning approach and this Medium Term Financial Strategy, based on evidence, benchmarking and the principles of accountable care.

1) Improvement Plan in response to NHSE Legal Directions (issued 1 Sept 2016), 6 October 2016

Without further change beyond 16/17, the CCG's in-year deficit would reach £39m by 20/21, with a cumulative deficit of £176m

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1.4

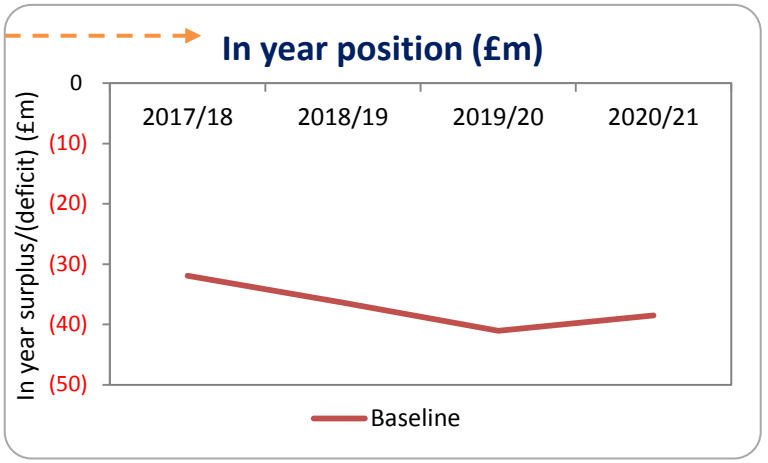
Forecast financial position: baseline

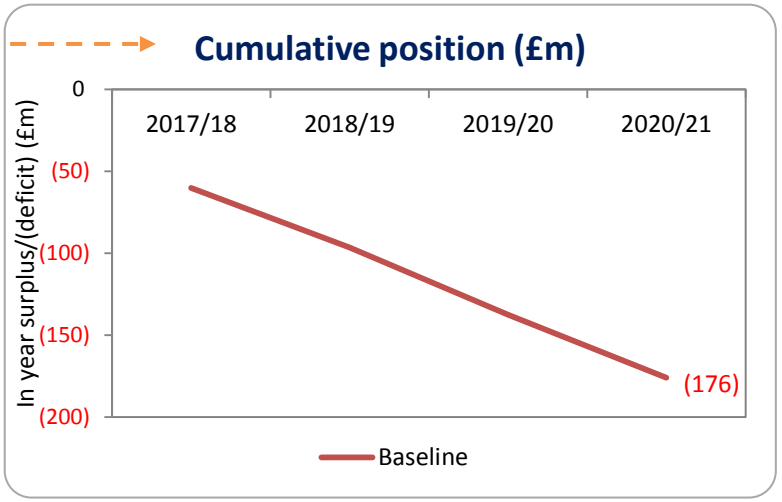
Baseline position

- These graphs illustrate the CCG's financial position to 20/21 based on no further QIPP delivery beyond 2016/17.
- Under this scenario, by 20/21:
  - The CCG's **in-year deficit** would be £39m
  - the **cumulative deficit** would be £176m
- These figures are in line with with modelling from the STP.

Implications for Legal Directions

- In this position the CCG would **fail to meet** the requirements of both its current legal directions and NHS planning guidance:
  - the CCG's legal directions require the CCG to achieve an in-year break even position in 2017/18;
  - the 2017 to 2019 NHS Planning Guidance states that deficit CCGs are *"expected to plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved".*





1.5 Plan for document

- In addition to the development of the FRP, the CCG recognises the need to develop a longer-term strategic plan which addresses the underlying causes of its financial deficit and identifies a path to financial sustainability.
- The Medium-term Financial Strategy seeks to:
  - Outline a plan for how the CCG can reach a position of a recurrent balanced, sustainable financial position;
  - Align with existing system plans, in particular, the Humber, Coast and Vale (HCV) Sustainability and Transformation Plan (STP), which VoY is a key partner to;
  - Meet key statutory financial targets and business rules;
  - Be consistent with the CCG's vision and support the delivery of the CCG objectives;
  - Recognise and meet the scale of the challenge in the Five Year Forward View;
  - Deliver operational and constitutional targets.

- This Medium-term financial Strategy is structured as follows:
  - **Section 2** describes the CCG's overall approach to change including its plan for a radical new approach to commissioning based on a population health management approach and accountable care, grounded in the vision of the STP.
  - **Section 3** presents the findings of population analytics and benchmarking which has been carried out to understand the underlying causes of VoY's financial deficit and pinpoint areas where it needs to focus in the future, given its local population needs.
  - **Section 4** presents a number of immediate cost saving plans which have been identified through the analysis completed in Section 3, including plans for their delivery and the combined financial opportunity they represent.
  - **Section 5** provides a summary of next steps that VoY will take to progress the strategy.
  - **Section 6 Appendices** provide some supporting additional information.

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SECTION 2: A NEW COMMISSIONING APPROACH

VoY CCG recognises that it will need to take a fundamentally different approach if it is to become financially sustainable

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2.1 New system approach to change

- The CCG believes that, in order to deliver on the cost saving opportunities that it has identified, a radical new approach to system commissioning and delivery is now required.
- Up until now, the health and social system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.
- This is evidenced by the fact that only 24% to 29% of the CCG's targeted QIPP cost savings have been achieved over the past two years.
- In order for the CCG to reach in-year balance by 20/21 the QIPP that must be delivered year on year equates to 2.4% of allocation. In order to eliminate the cumulative financial deficit by 20/21, a 3.3% year on year QIPP is required. This compares with an actual QIPP delivery of 1.5% in 2015/16 and 0.6% in 2014/15.
- Based on past performance, it is likely to be very challenging for Vale of York CCG to achieve an in-year balance in financial year by 20/21, let alone an elimination of its cumulative deficit by then.
- The implication is that a radically different approach to delivery of cost savings is required.

Financial Year	2014/15	2015/16
Programme and running cost allocation(1) (£m)	375,751	381,161
Planned Surplus/ (Deficit) (£m)	2.1	3.9
Actual Surplus/ (Deficit)	3.9	(6.3)
Planned QIPP	9.4	19.5
Actual QIPP	2.3	5.6
% delivery	24%	29%
Planned QIPP (% of allocation)	2.5%	5.1%
Actual QIPP (% of allocation	0.6%	1.5%

(1) Vale of York CCG 5 year plan 2014-2019
(http://www.valeofyorkccg.nhs.uk/data/uploads/publications/5-year-plan/nhs_vale_of_york_ccg__integrated_operational_plan_2014_to_2019-final-30th-june-with-signatories.pdf)

2.2 Sustainable Transformation Plan (STP) work

- The Humber, Coast and Vale (HCV) STP recognises that ensuring system sustainability must be the focus of all partners to the local health locality going forward.
- The HCV current in-year deficit for FY15/16 is £87m and this is projected to increase to an in-year figure of £420m under a "do nothing" scenario.
- The STP vision aims to tackle a number of challenges across the locality including i) poor acute provider performance; ii) provider sustainability; iii) care market sustainability; iv) the devolution agenda; v) increasing demand; and vi) an ageing primary care workforce.
- The STP identifies 6 key priorities as a route to achieving system sustainability:

1. **Greater focus on prevention -** including a focus on the broader determinants of health to drive wellbeing and prevention at scale through social investment
2. **A single acute provider model across the STP footprint** – including acute services working in a consolidated model, standardised clinical pathways, shared back office and a networked tertiary care model with links to Leeds and Sheffield
4. **Out of hospital accountable care** – including a standardised care model, a new approach to managing demand through population management approaches, transformed primary care, and increase in personal health and care budgets
5. **Mental health –** new care models and market stimulation, including better navigation of pathways, an improved approach to dementia and increased uptake of personal health and care budgets
6. **Strategic commissioning** – including common standards and planning assumptions, a smaller number of contracts, new approach to performance management of acute providers, and outcomes focused contracting approaches
7. **System-led governance** – including new rules of engagement between organisations, new approaches to payment and contracts and new statutory duties and obligations accounted for

- Further detail to the STP is provided in the Appendices.

(1) Humber, Coast and Vale STP Finance Template (submitted October 2016)

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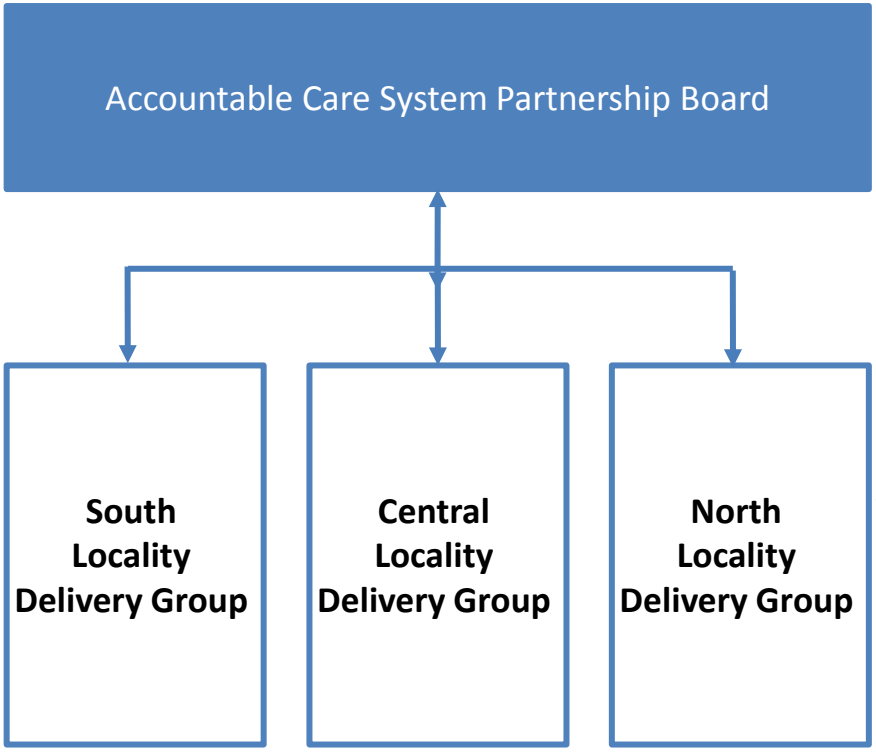
2.3 System-led change

- VoY recognises that simply expanding the current model will not deliver financial sustainability.
- Moving forward, VoY needs to play its part in helping to redesign and deliver a new health and social care system which is better able to care for patients, whilst also delivering system financial sustainability.
- VoY's strategy for doing this is now embedded in the work of the emerging accountable care system, it's Local Place Based Plan and collaborative work within the STP – these includes a vision for new models of accountable care in VoY, strategic commissioning across multiple commissioner organisations and new approaches to system governance and risk sharing.
- This builds on the ideas put forward in the Five Year Forward View and best-practice examples taken both nationally and internationally on whole population management.
- Such an approach needs to based on joint working with provider and commissioner partners in the VoY and across three localities to support a whole system change that will reduce cost, manage demand and deliver better results for patients by:
  - Realigning resources within the system through an outcomes-based approach, which focuses on measuring and rewarding outcomes (end results) rather than inputs;
  - Allowing system efficiencies to be realised – duplication and over supply is eliminated while "cost shift" from one service line or organisation to another is avoided
- ;
  - Incentivising and implementing a whole system approach to prevention at individual, community and place levels across VoY and the HCV;
  - Focusing on the priorities for each locality which transform services and models of care and best deliver the improvements in outcomes – finance, health and well-being and care & quality;
  - Enabling the achievement of a scaled reduction in demand, enabled by a new relationship between residents and public services whereby individuals are empowered to take control of their own health and wellbeing;
  - Reducing dependence on oversubscribed and expensive specialist resources such as emergency services, non-elective admissions, general practitioners and care homes;
  - Supporting the right care and the right workforce to be delivered in the most efficient cost settings which deliver best outcomes for patients, including having GPs coordinate more joined-up care closer to home, and improving VoY's community response to help people leave hospital sooner;
  - Employing new contracting models and payment structures, including a phased move away from PbR, to enable an increased alignment of resources to outcomes;
  - Having an effective governance and leadership structure to develop and deliver these plans, which overcome challenges the CCG has faced in the past on collaborating effectively as a health economy;

2.4 Accountable care framework for VoY

- The CCG and partners are now actively mobilising the Vale of York accountable care system (ACS) based around a three locality delivery model. The intention is that joint programmes of transformation will be developed based on the specific local needs and priorities of these locality populations that will best address the current gaps in funding, health and social care in outcomes for the VoY population.
- This emerging accountable care system will support closer integration between all aspects of care (primary, community, mental health and social) through a focus on realigning resources in such a way that maximises outcomes (end results) for residents and patients.
- The CCG and partners have come together in an emerging accountable care system, as presented below:



Accountable Care System Partnership Board (with organisational form to be determined) is accountable for delivering agreed outcomes which best address the gaps in outcomes for the VoY locality. The Board includes representatives from providers and commissioners across the health and social care system.

Locality level commissioners and providers offering an integrated set of services determined by local priorities. This will be supported by common standards of governance, a shared asset based approach to delivery and joint decision-making. Delivery of services is based around community focused locality teams, building on existing work delivering integrated care hubs and other examples of local authority and Public Health services and new ways of working which are proving to have a positive outcome on population health improvement.

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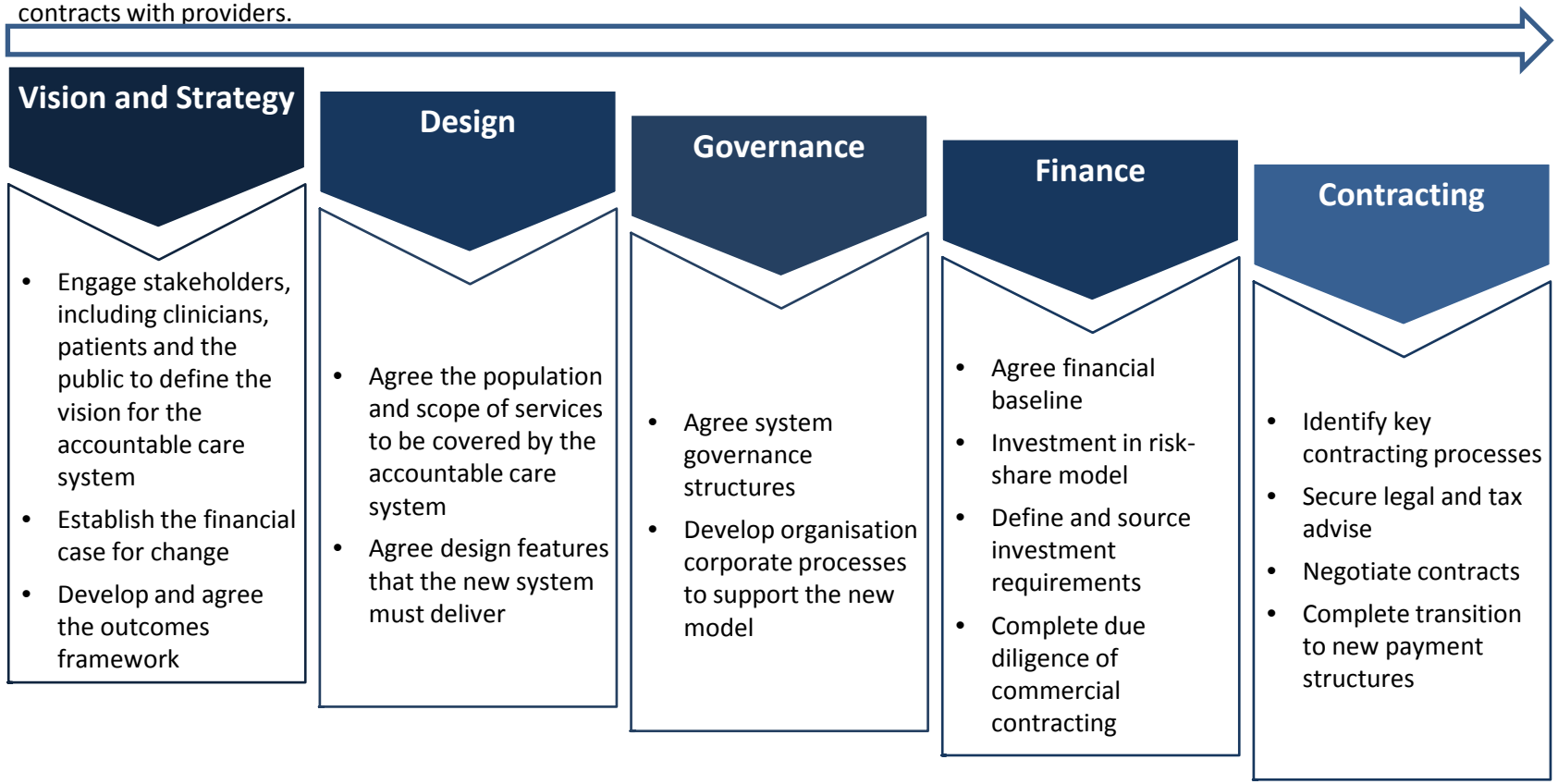
2.5 Steps to deliver an accountable care system

- The CCG recognises that development of an accountable care system for the population of the VoY will require an iterative and phased approach to mobilising alongside all health and care partners. This process has started and the ACS Partnership Board and three Locality Delivery Groups will have all met at least once by March 2017.
- A high-level five phase approach to the phases of work required is provided below. This describes the process from agreeing a strategy to defining the accountable care framework (and the outcomes that it will need to deliver), through to being able to negotiate and issue new contracts with providers.



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2.6 Characteristics of successful Accountable Care systems

- A review of the experiences of other health and social care systems in delivering accountable care models indicates that successful systems demonstrate a number of common characteristics and capabilities.
- VoY recognises that it will need to work with others within the system do a full self-assessment against these characteristics and then develop a plan for filling any identified capability of resourcing gaps – a review of how ACSs are developing across the STP will support this assessment.

1

- Clearly defined outcomes for the accountable care model which are aligned to the VoY Local Place Based Plan objectives (and STP)
- Focus on priorities for each locality
- Key outcomes and KPIs are shared and agreed with all impacted stakeholders
- The process for monitoring, evaluating and responding to outcomes is established

2

- Clear governance arrangements which reflect appropriate stakeholder representation
- Incentives in place to support the system to continually develop and improve outcomes
- Proposed structures are appropriate and proportionate to effective delivery and shared decision-making

5

- Key capabilities to implement the plan have been defined and mapped against the current capabilities of the organisations involved e.g. Programme Leadership, PMO, enablers, clinical expertise
- A plan to fill "gaps" identified through the capabilities assessment has been agreed with appropriate resources set-aside

3

- Options for contracting structures have been considered and a preferred approach selected – e.g. outcome based models, capitated budgets
- Proposal incorporates approach to risk management including controls to manage safety, reputational, demand and financial risks
- Clear proposals for managing performance are incorporated

4

- Comprehensive delivery plan in place including resource requirements, detailed timeline, key governance check-points, activities and interim outcomes
- Impacts of accountable care system on workforce, estates, IT and other enablers are clearly demonstrated and built into the delivery plan.
- Investment set-up costs and resource requirements have been allocated.

2.7 National policy context

- As VoY develops its thinking, it is determined to take advantage of new national thinking on accountable care models.
- This includes drawing on guidance from NHS England and the findings from the accountable care vanguard programmes.
- NHSE has stated that it expects 50 to 60% of the population will be served by a whole population model by 2020/21. It has made available a number of supporting tools and guidance to support local care economies to move towards new models of care which VoY seeks to draw on – examples include guidance on how to implement Multi-speciality Community Provider (MCP) models.
- The emerging core components of a successful MCP model align closely with VoY's vision for its own accountable care system and include a population health and care model focused on proactive and preventative care; empowerment of patients and local people to support each other and themselves; and multi-disciplinary care professionals working together to deliver health and care services for their population.
- Further clarity on the role of the GP contract within an MCP model is an area that is being looked at by a number of the vanguards and by NHS England directly. Emerging thinking indicates that general practice *must* be at the heart of the MCP model and that no MCP can be commissioned without the inclusion of primary medical services. There may be a number of different transition paths for GPs becoming part of an MCP.
- A further area where guidance is expected is the capabilities that health and social care providers who form an MCP will be expected to demonstrate. Capabilities that MCPs may be asked to demonstrate include:
  - capability to work within existing resources and deliver value for money;
  - be a well-managed and transparent organisation;
  - have full and clearly defined decisions rights;
  - use its budget flexibly in a way which enables it to innovate;
  - work collaboratively with other organisations to deliver integrated care;
  - fully harness the opportunities of digital technology;
  - empower and organise staff to work in different ways;
  - mobilise patients and their families, carers, communities and the voluntary sector;
  - give its patients choice and control and protect NHS values;
  - respect the trust placed in it by VoY's community and the tax payer; and
  - be a good employer for all staff.

2.8 Summary of VoY's new approach to commissioning

- VoY CCG recognises that it will need to take a new approach if it is to become financially sustainable. Up until now, the health and social system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.

- VoY's strategy for delivering change is grounded in the work of the Humber, Coast and Vale STP and includes a vision for commissioning based around the development of an accountable care system for the population of VoY.

- Characteristics of the new system of care will include:
  - Realigning resources within the system through an outcomes-based approach to commissioning;
  - Supporting the right care and the right workforce to be delivered in the most efficient cost settings ;
  - Incentivising and implementing a whole system approach to prevention;
  - Employing new contracting models and payment structures, including a phased move away from PbR, to deliver the right incentives and behaviours;

- Successfully implementing an Accountable Care Model will require the VoY system to demonstrate a series of capabilities and work closely with its local and STP partners to deliver on this significant programme of change.

- Section 3 will now present the findings of population analytics and benchmarking which has been carried out in order to pinpoint opportunities for VoY to focus on in the future, given its local population needs. Section 4 will then present plans for delivery of a number of immediate cost saving opportunities, including the financial opportunity they represent.

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SECTION 3: POPULATION ANALYTICS AND BENCHMARKING

We have used an innovative approach to understanding how we currently spend our population allocation based on population need

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3.1 VoY's approach

Report sections		Key activities
3	***Population analytics and benchmarking***	• Reviewed weighted population allocation to understand areas where VoY does and does not "live within its means" • Conducted benchmarking with other STP commissioners to understand areas of VoY over- and under-spend • Reviewed VoY population characteristics to identify underlying cause of the deficit • Reviewed Right Care analysis to identify potential areas of saving • Reviewed other literature/best practice to identify additional opportunity ideas
4	***Financial opportunity***	• Identified specific financial opportunities based on population analytics/benchmarking analysis undertaken • Quantified opportunities based on evidence available • Phased savings over four year period to 20/21 • Calculated residual financial "gap" for VoY CCG under different scenarios • Reviewed delivery plans and enablers for each opportunity identified • Agreed approach to working with stakeholders and immediate next steps

VoY CCG's spend per head of population is the lowest in the Humber, Coast and Vale, however VoY also receives the lowest allocated spend per head from NHSE

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3.2 CCG spend per head

In 15/16, Vale of York CCG's **spend per head of population** was the lowest in the Humber, Coast and Vale STP footprint; at the start of 16/17, Vale of York CCG's plans also showed the **lowest forecast spend per head** (as shown in the table below).

However, Vale of York CCG has the **lowest allocation** per head in the STP footprint due to the relatively low calculated health needs of the population.

This means that, although the CCG's forecast spend per head was 9% lower than the STP average, this still leads to the **highest percentage forecast overspend** compared to funding allocation for FY17.

	NHS East Riding of Yorkshire CCG	NHS Hull CCG	NHS North East Lincolnshire CCG	NHS North Lincolnshire CCG	NHS Scarborough and Ryedale CCG	NHS Vale of York CCG	Vale of York % below STP average
Spend per head (£k, FY16)(1)	1.22	1.29	1.29	1.25	1.30	**1.13**	8%
Forecast spend per head (£k, FY17)(1)	1.26	1.31	1.31	1.26	1.34	**1.13**	9%
***Allocation per head (£k, FY17) (2)**	1.24	1.31	1.31	1.26	1.33	**1.11**	10%
FY17 % overspend forecast	1%	0%	0%	0%	1%	**2%**	

*Allocations are calculated based on the weighted population, with future years forecast using ONS population growth estimates. Understanding the basis behind the funding allocation, and comparing this with actual spend, can help to identify areas where spend may need to be reduced for the CCG to live within its means.

(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) NHS England Allocations CCG Core Services

There is reduction of 11% made to the allocation to VoY owing to population need, level of health inequality and remoteness

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3.3 Explaining the population weighted allocation in more detail

- The relative youth, health and affluence of the VoY population means that there is a reduction of **11%** made to the unweighted allocation for VoY:
  1. This is largely driven by acute need **(-10%)** since, compared to the STP average, Vale of York has a lower proportion of population aged 50+
  2. There is also a **1%** reduction for unmet need and health inequalities as the population has a relatively low mortality ratio for under 75s
  3. There is no adjustment for the remoteness criteria
- The CCG is therefore only allocated 89p per person for every £1 per person allocated across the country. In contrast, the other CCGs in the STP footprint are allocated £1.02-£1.07 per person for every £1 per person allocated across the country

NHS Funding Formula

- Further explanation behind the calculation of allocations and the key drivers for the VoY population weighting are discussed in the **Appendix**.
- The funding allocation received by CCGs firstly depends on the number of people registered to GPs within that CCG. The registered population is then weighted based on:
  1. **Healthcare service need due to age, gender and other factors**
  2. **Unmet need and health inequalities, based on standardised mortality ratio for those under 75 years of age**
  3. **Unavoidable costs of remoteness**

Key steps in the population weighting formula (15/16 population)[1]

	Unweighted 2015 registrations	**1. Population weighted for healthcare service need**	**2. Population weighted for unmet need and health inequalities**	**3. Population weighted for cost of remoteness**	Overall % uplift as a result of weighting	"Allocation units" per person
NHS East Riding of Yorkshire CCG	301,429	313,027 (+4%)	306,262 (-2%)	306,122 (-0%)	**2%**	1.02
NHS Hull CCG	291,334	291,741 (+0%)	305,964 (+5%)	305,823 (-0%)	**5%**	1.05
NHS North East Lincolnshire CCG	168,957	174,887 (+4%)	177,690 (+2%)	177,608 (-0%)	**5%**	1.05
NHS North Lincolnshire CCG	171,625	174,057 (+1%)	175,258 (+1%)	175,178 (-0%)	**2%**	1.02
NHS Scarborough and Ryedale CCG	118,999	127,351 (+7%)	125,586 (-1%)	127,734 (+2%)	**7%**	1.07
NHS Vale of York CCG	**352,219**	**317,732 (-10%)**	**313,992 (-1%)**	**313,847 (-0%)**	**-11%**	**0.89**

(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet J)

VoY's target allocation per head for FY17 is below all other commissioners within the STP

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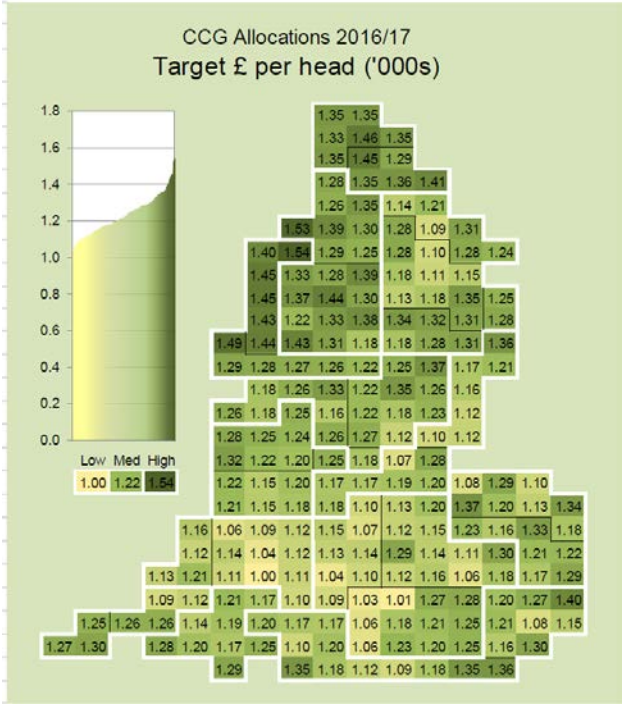
3.4 FY17 target allocations

- Target allocations are calculated based on the weighted population
- Future years are forecast using ONS population growth estimates
- Vale of York CCG has the **lowest target allocation per head in the STP footprint** for FY17, due to relatively low calculated health needs. VoY needs to target spend 11% less per person than the STP average in order to live within its means
- "Actual" allocations are then calculated based on a combination of the target allocation and the previous year allocation
- **All CCGs in the STP footprint have an actual allocation higher than their target**, so allocations will grow more slowly in this STP than the national rate



	Target allocation per head (£k, FY17)[1]	Actual allocation per head (£k, FY17)
NHS East Riding of Yorkshire CCG	1.24	1.24
NHS Hull CCG	1.28	1.31
NHS North East Lincolnshire CCG	1.28	1.31
NHS North Lincolnshire CCG	1.25	1.26
NHS Scarborough and Ryedale CCG	1.31	1.33
NHS Vale of York CCG	**1.09**	**1.11**
Vale of York % below STP average	**11%**	**10%**

(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY receives a lower allocation weighting for population age distribution compared to others in the STP

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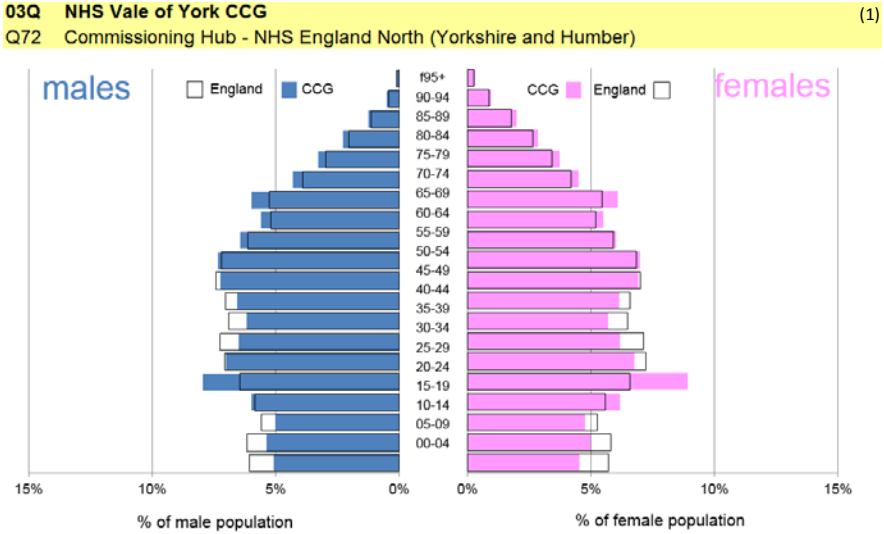
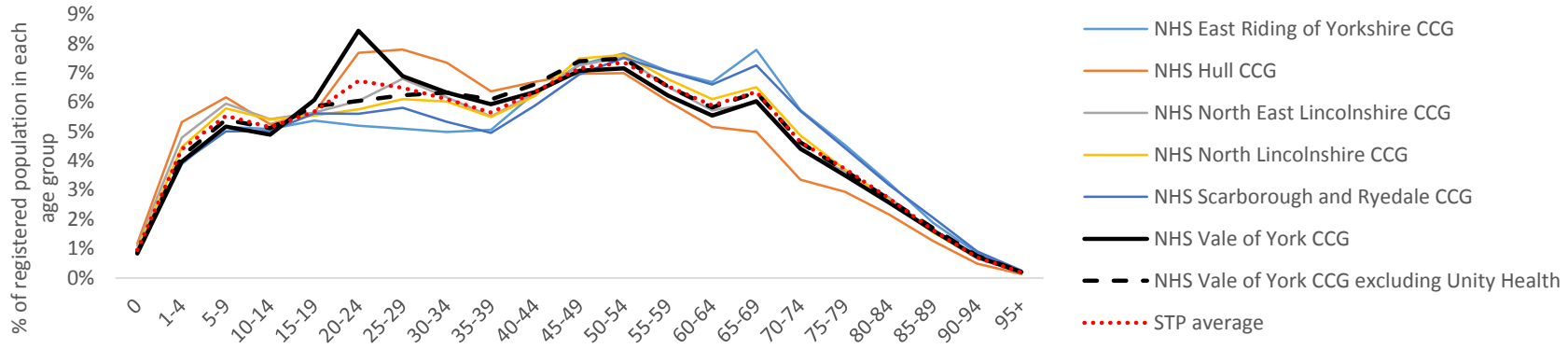
3.5 Population need

- The biggest factor in the population weighting is age distribution, as the elderly tend to have the greatest healthcare needs
- **Compared to the national average** (as shown on the right), Vale of York CCG has a higher proportion of population aged 50+
- However, compared to the STP average (shown below), Vale of York has a lower proportion of population aged 50+, although a higher proportion aged 90+
- This drives a lower weighting for Vale of York CCG **compared to the STP average**, as there are relatively fewer elderly patients. This is discussed further on the following slide
- The higher proportions in the 15-19 and 20-24 age groups is largely due to university students in York (as shown in the age distributions graph below with Unity Health excluded)



Age distributions by CCG(1)



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet A)

VoY has a relatively high acute spend for its level of patient need

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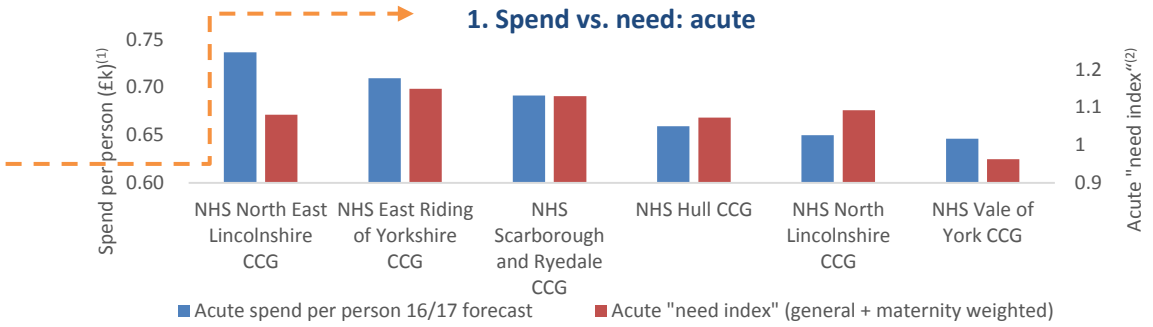
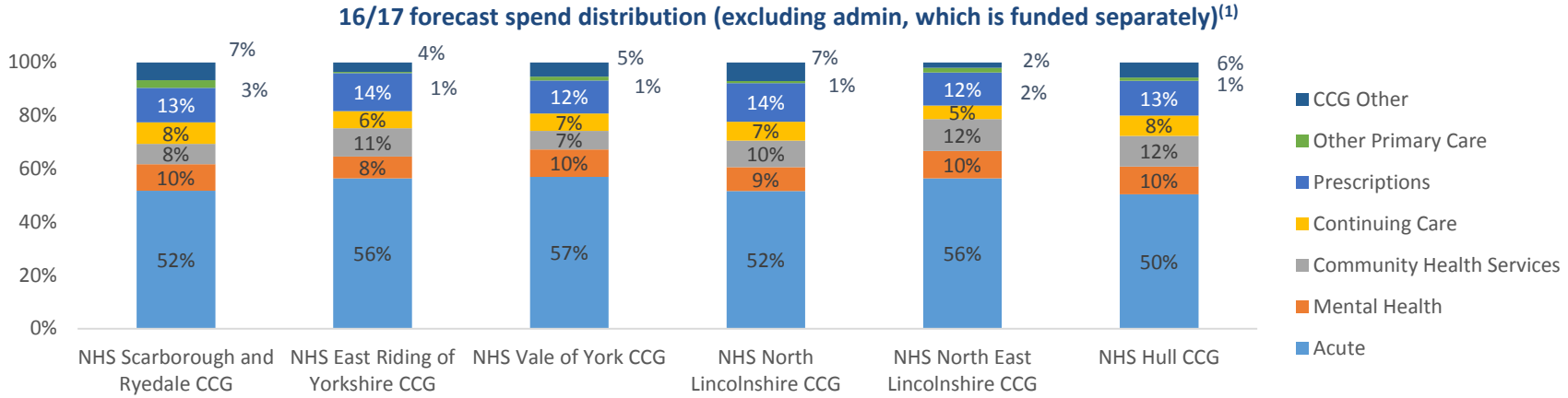
3.6 Acute spend

- A comparison of forecast spend versus need (as calculated through the population weightings) is useful for identifying areas of potential "overspend" within Vale of York
- Within the STP footprint, Vale of York CCG has a **relatively high acute spend** for the level of patient need
- Based on forecasts from the start of 16/17 (shown below), Vale of York CCG also has the **highest proportion of acute spend amongst the STP commissioners**
- Further detail is provided in the **Appendix**





(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets C and E)

Variability in primary care referral behaviour indicates there may be an opportunity to reduce acute spend

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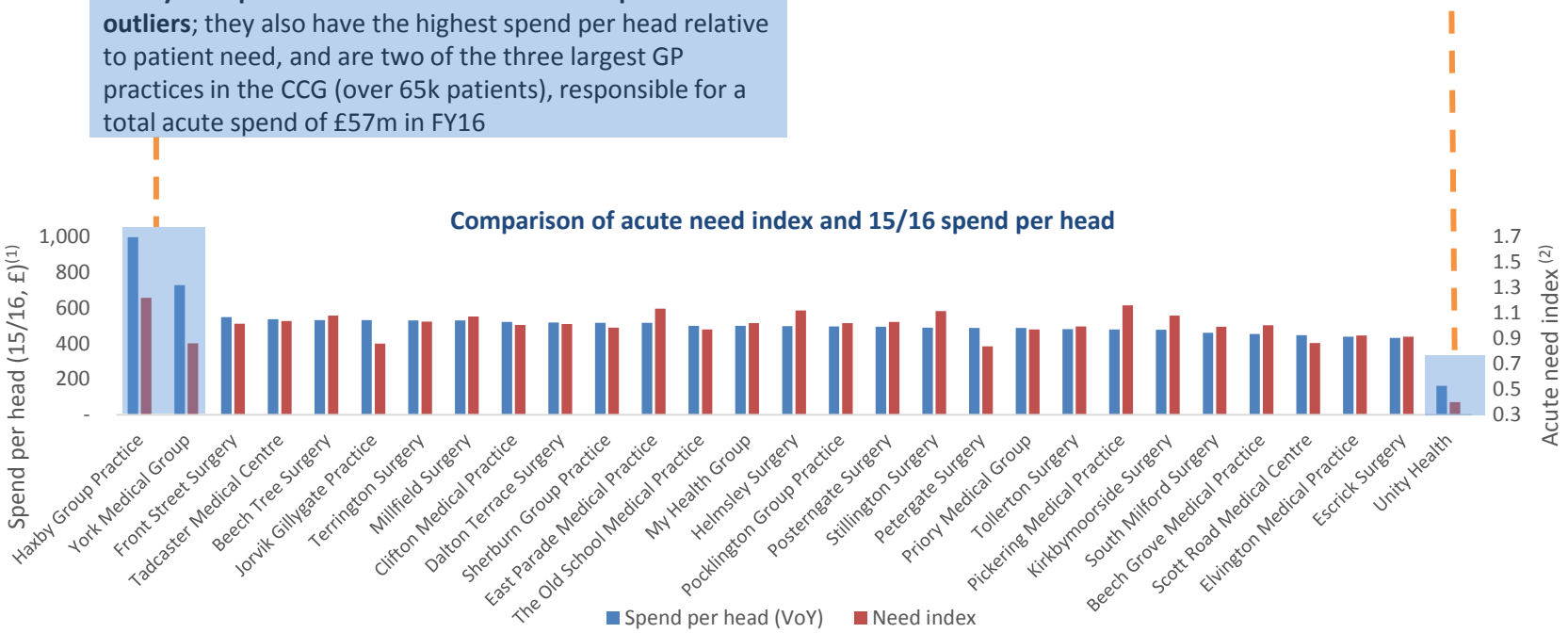
3.7 Primary care referrals

- There is wide variation in the spend per person on acute care by GP practice, indicating a potential opportunity to reduce acute referrals through a stronger primary care offering /behaviour change
- The chart presented compares acute spend per head with patient need, by GP practice:
  - **Haxby Group Practice** and **York Medical Group** are two **outliers**; they also have the highest spend per head relative to patient need, and are two of the three largest GP practices in the CCG (over 65k patients), responsible for a total acute spend of £57m in FY16
  - There may be multiple reasons for the variations however it could indicate an unnecessary level of referral to acute care when enhanced community or primary care might better serve the patients' needs
  - The University campus health centre has a high spend per head compared to need. This may result from a neighbouring elderly population to the campus



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet C)
(2) SUS data 2015/16

VoY spends less on community health services compared to others within the STP

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3.8 Community spend

- The chart on the previous slide also indicates that VoY has the **lowest proportion of community health services** spend in the STP
- The table below illustrates the 16/17 forecast spend per head for each of the STP CCGs, across different areas of spend. VoY CCG spends 36% less per head on community health services than the STP average.
- This indicates that there is **potential for the CCG to increase spend on community services,** which may support patients to receive care closer to home and reduce the need to spend on acute services

16/17 forecast spend per head (£, April 2016 forecasts)[1]

	NHS East Riding of Yorkshire CCG	NHS Hull CCG	NHS North East Lincolnshire CCG	NHS North Lincolnshire CCG	NHS Scarborough and Ryedale CCG	**NHS Vale of York CCG**	**% below STP average**
Acute	710	659	737	650	691	**646**	**5%**
Mental Health	103	136	135	112	134	**118**	**3%**
Community Health Services	133	151	156	126	101	**78**	**36%**
Continuing Care	81	100	67	90	109	**74**	**13%**
Prescriptions	179	170	161	182	172	**141**	**15%**

(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY spends relatively more on older people (75+) than others within the STP, in both planned and unplanned care

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3.9

Inpatient activity and spend profile (FY16)(1)

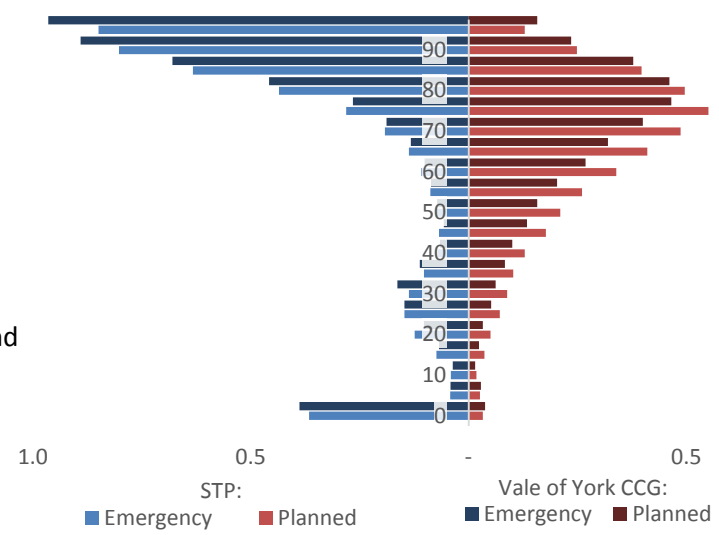
Planned inpatient care (elective and day case)

- Vale of York CCG had fewer spells per person in the population than the STP average across all age bands except 0-9 and 95+
- The spend per person was lower than the STP average for ages 5-69, but higher than the average for ages 70+

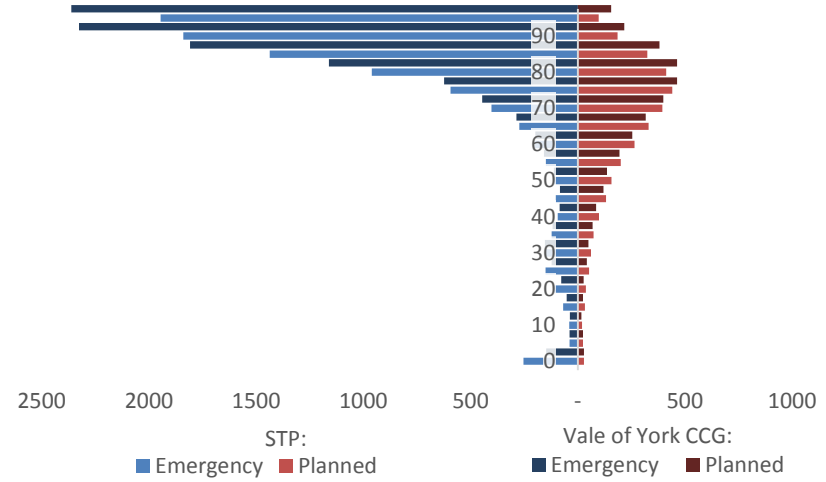
Emergency inpatient care (non-elective)

- The population aged 80+ had 9% more spells per person but 25% higher spend per person in the population
- The population aged 40-79 had fewer spells per person but a higher spend

Spells per person by age band



Spend per person by age band (£)



- On average, the FY16 spend per person on inpatient spells was **2% lower** at Vale of York CCG than across the STP:

	STP average	Vale of York CCG	% difference
Spend per head (planned)	£149	£140	-6%
Spend per head (emergency)	£223	£225	+1%
Spend per head (total)	**£372**	**£365**	**-2%**

(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

In planned care, there are particular opportunities in orthopaedics

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3.10 Elective orthopaedics

- Vale of York CCG's average spend per person in the population on planned care was 15% higher than the STP average for trauma and orthopaedics (T&O). The difference is most marked for older patients
- Findings from the population analytics and benchmarking indicates that VoY spends relatively more on older people (75+) than others within the STP in both planned and unplanned care. It is likely that high spend on T&O is a key driver of this overspend
- RightCare benchmarking shows that the CCG has the **4th highest primary hip replacement rates** in the country and high rates of knee replacement compared to similar CCGs

What is the potential saving?

- By bringing spending in line to the STP average, VoY could save £4.2m on planned T&O. This figure is also backed up by RightCare benchmarking findings

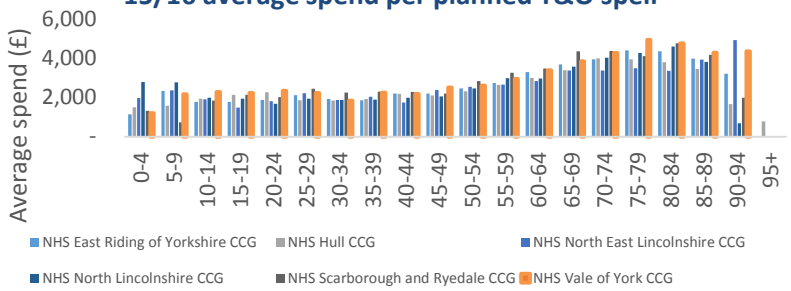
Key assumptions:

- Reduce elective orthopaedics spend to the average of the 10 similar CCGs identified by RightCare benchmarking
- Includes £0.2m savings in 17/18 identified from arthroscopies
- Includes £0.4m savings in 17/18 identified from a review of knee replacement coding & tariff following change in NICE guidance

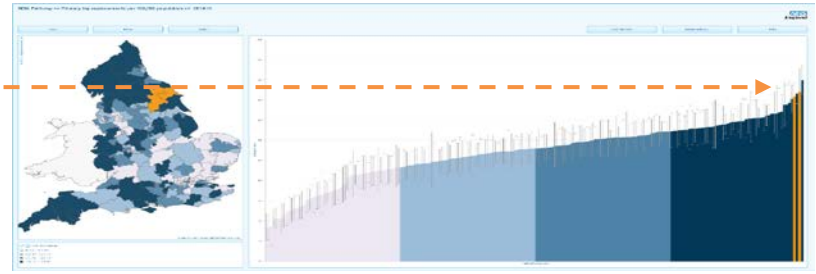
15/16 spend per head across the STP and at Vale of York CCG(1)

	STP average	Vale of York CCG	% difference
Spend per head (planned T&O)	£44	**£51**	**+15%**

15/16 average spend per planned T&O spell(1)



Primary hip replacement rates



(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

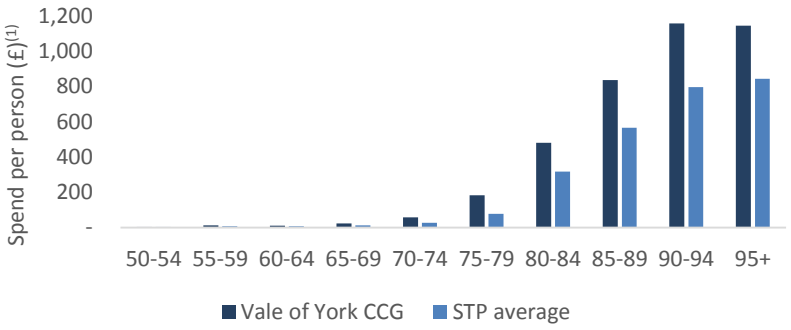
3.11 Geriatric and respiratory medicine

- In 15/16, the CCG's non-elective inpatient spend per person in the population was greater than the STP average in all four of the largest treatment specialties (Geriatric Medicine, Respiratory Medicine, Trauma & Orthopaedics, Cardiology), which account for over half of the CCG's non-elective inpatient spend; this was largely due to spend on patients aged 50+
- There are particular opportunities to reduce in spend Geriatric Medicine and Respiratory Medicine, as shown to the right:
  - In Respiratory Medicine, the Vale of York population aged 50+ had twice as many spells per person than the STP average (weighted for age distribution). The spend in VoY per person was double the STP average overall
  - In Geriatric Medicine, the Vale of York population aged 50+ had both more spells per person and a higher spend per spell (weighted for age distribution). The spend in VoY was 64% higher than the STP average overall

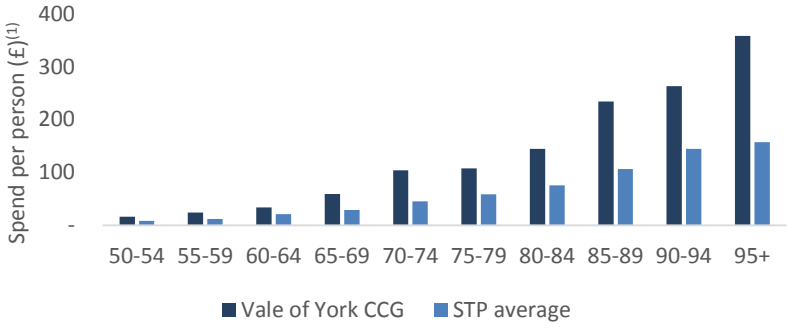
Average non-elective spend per person in the population aged 50+ (£)

	STP average	Vale of York CCG	% difference
Geriatric Medicine	£78	£128	+64%
Respiratory Medicine	£35	£70	**+101%**
Trauma & Orthopaedics	£34	£43	+28%
Cardiology	£29	£43	+49%
Total other	£213	£159	-25%
Total	**£389**	**£443**	**+14%**

Spend per person in the population on non-elective Geriatric Medicine



Spend per person in the population on non-elective Respiratory Medicine



(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY spends more on Joint Funded Care than most other CCGs within the STP

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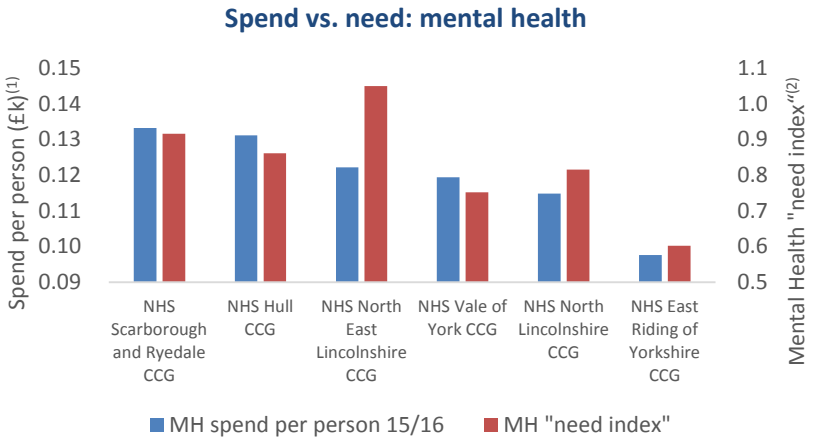
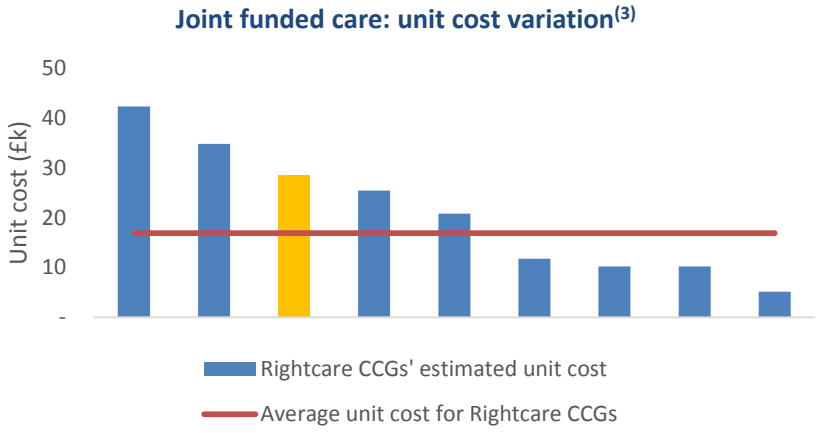
3.12 Continuing Healthcare

- STP benchmarking on mental health suggests that the CCG is not an outlier, and in 15/16 the CCG's spend on mental health services was relatively near to the STP average
- However, in May – August 2016, the CCG conducted a review into Continuing Healthcare (CHC) and Funded Nursing Care (FNC) budgets
- This covered low volume, high cost packages of care, specifically those within CHC, FNC and Mental Health
- The review included benchmarking of Vale of York expenditure and activity against available data sources for Yorkshire and the Humber CCGs and RightCare comparator CCGs
- Although Vale of York ranks at an average position across CHC and FNC it total, there are potentially areas of savings, if the CCG were to move closer to the lower end of the comparators
- The area for which Vale of York CCG is an outlier primarily relates to Joint Funded Care. The CCG is both an outlier in terms of activity and unit cost
- Against the RightCare average the CCG spends £800 per patient per annum more on Fully Funded CHC packages and £11,600 more on Jointly Funded packages. The variation to the best performing CCG in the benchmark is significantly greater
- This suggests that spend on fully funded and jointly funded CHC packages should be a key area of focus for the CCG





(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet D)
(3) Review of Financial Procedures and Forecasting of Continuing Healthcare and Funded Nursing Care Budgets and Benchmarking (presented to Quality and Finance Committee August 2016)

VoY has traditionally performed well on prescribing although there are pockets of comparatively high spend

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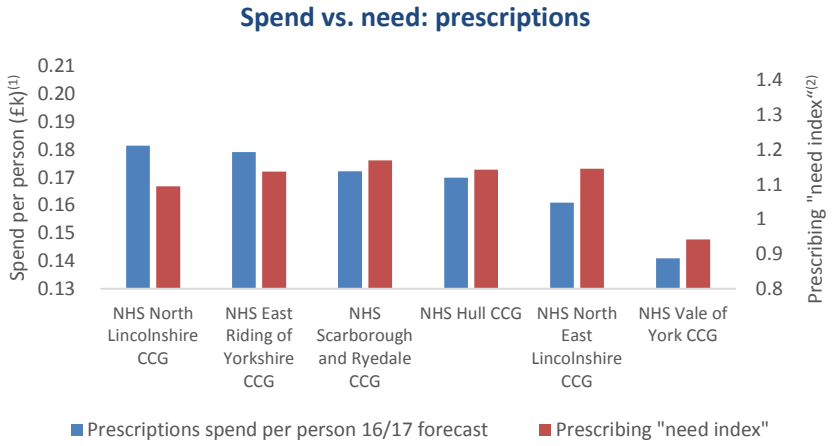
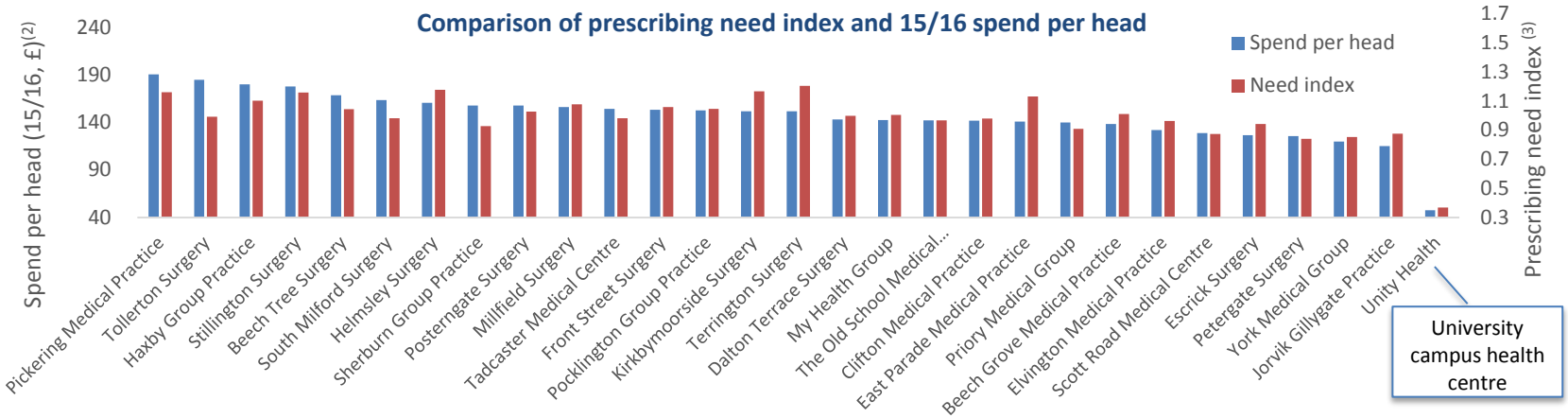
3.13

Prescribing

What is the evidence?

- Within the STP, Vale of York CCG has a relatively low prescribing spend compared to other commissioners and for its level of patient need, as illustrated in the chart opposite.
- However, there are pockets of comparatively high levels of prescribing spend within the CCG (e.g. Tollerton Surgery), where there could be opportunities for further efficiencies
- While there may be a number of reasons for the variation between GP practices (shown below), it could indicate an unnecessary level of prescribing in some instances
- If all practice alliances (Unaligned practices as an alliance) reduced to the CCG average spend per weighted head of population this would save £2.5m; £5.5m potential saving if all reduced to the lowest alliance





(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet D)
(3) 2015-16 Prescribing Data

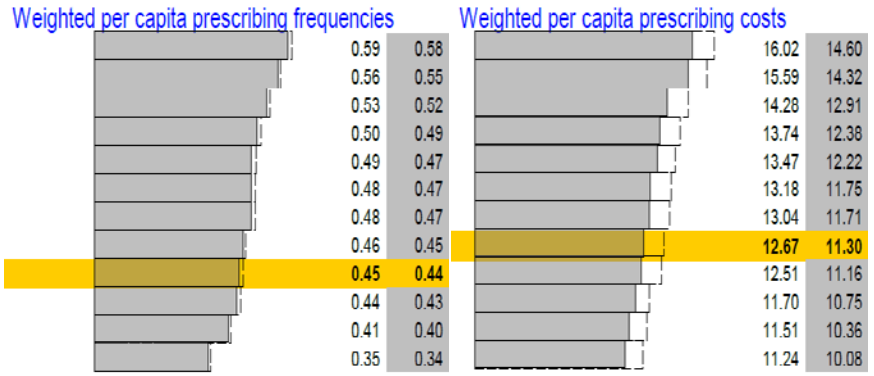
By matching the performance of its top 5 performing comparators, the CCG could target additional prescribing savings

NHS Vale of York Clinical Commissioning Group

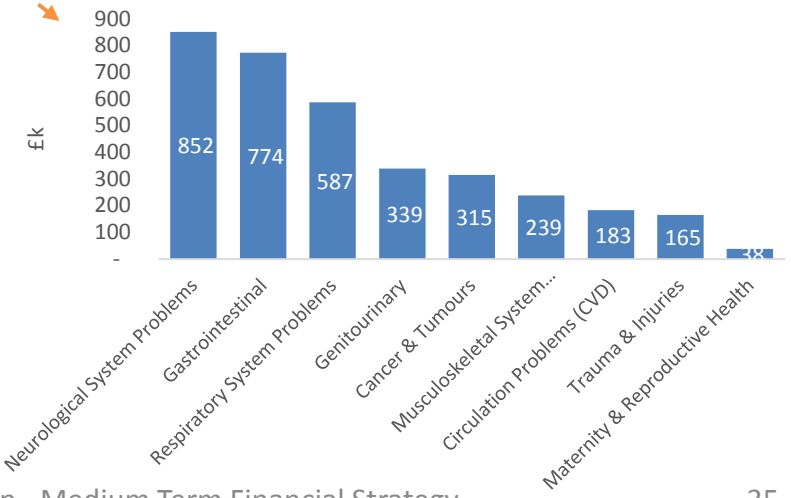
3.14 Prescribing

- Analysis performed by the Regional Drug and Therapeutics Committee on RightCare comparators (completed in July 2016) finds that VoY performs **4th and 5th out of 12 comparators** on weighted per capita prescribing frequencies and costs, respectively
- RightCare analysis also indicates that the CCG could target £3.5m of savings in prescribing costs (i.e. 7% of prescribing spend), compared to the top 5 comparison CCGs. The key disease areas for these opportunities are:
  - Neurological system problems
  - Gastrointestinal
  - Respiratory system problems
- This target opportunity does not take into account the high levels of growth in prescribing costs expected by NHS England (average growth of 4.6% per year for 17/18 to 20/21), which would increase the target savings to £4.2m by 20/21
- The CCG believes this target can be stretched further, given the historically strong achievement of prescribing savings in the past, which makes prescribing a **key area of focus for the CCG** where there is a high level of confidence that savings can be made

Prescribing frequencies and costs, analysed through Regional Drug and Therapeutics Committee, RightCare comparators (July 2016)



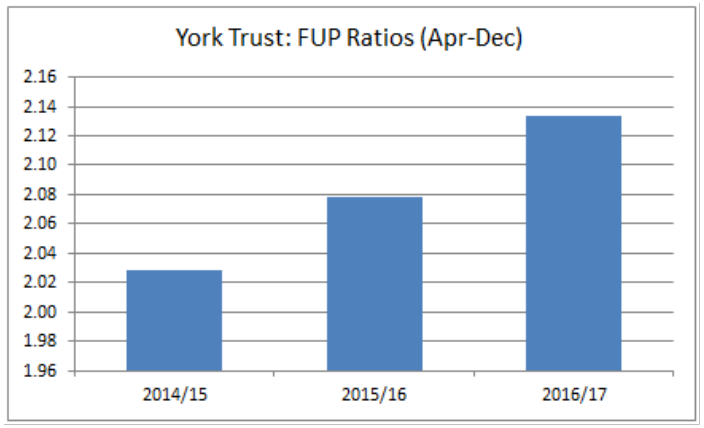
Opportunity based on top 5 comparators (£k)[1]



(1) RightCare 'Where to look' packs – January 2016

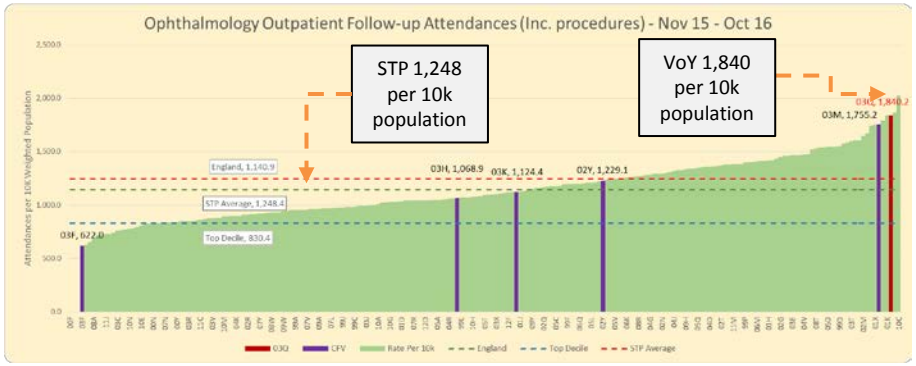
3.15 Outpatient appointments

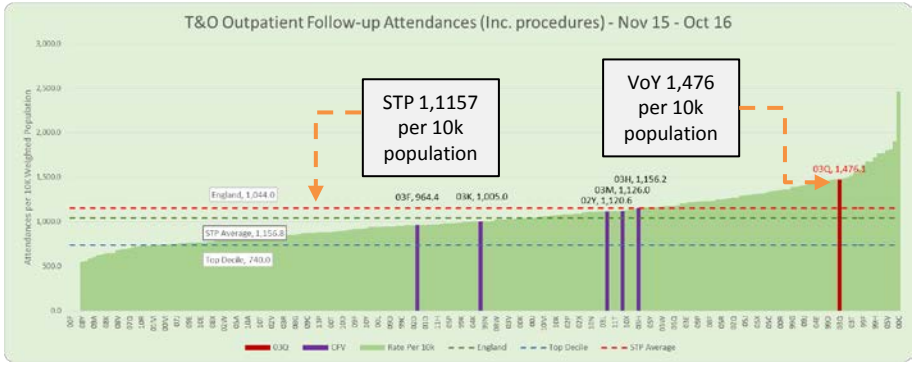
- VoY believes that there may be opportunities to achieve additional cost savings through a reduction in the number of commissioned outpatient appointments, in particular with regards to follow-up appointments.
- This is encouraged in the NHS 17/19 NHS Planning guidance that proposes new payment mechanisms to reduce the number of unnecessary follow-up outpatient appointments. Guidance stipulates that a percentage of follow-up costs will be bundled into first attendances
- In 2014/15 YTHFT developed and implemented the Conditions Registers to ensure only those patients that require an acute based appointment are followed-up bringing the first to follow-up ratio down to 1:2.02. Since then there has been a gradual increase in the ratio.



(1) HES data extract

- The opportunity is reinforced by national benchmarking data (1) around outpatient follow-ups and procedures within the two largest specialty areas for the VoY.





- The use of outpatient procedures may be beneficial in terms of avoiding day cases. However, the CCG is still likely to be an outlier that requires further exploration.

3.16 Summary of population analytics and benchmarking

- Although the CCG spends less per head on its population than any of the other STP commissioners (8% below the STP average), it is allocated the least. This is largely due to its lower calculated population need resulting from its relative youth, health and affluence
- The CCG needs to spend 11% less per person than the STP average in the future in order to live within its means
- Population analytics and benchmarking indicates that the CCG should target the following areas:
    - A reduction in spend on acute care, where the CCG has a relatively high spend, given its level of patient need
    - Savings in planned orthopaedics care where the CCG spend is 15% higher per head than comparators
    - A re-focus on community care investment, given its comparatively low spend, particularly targeted at reducing non-elective spend on older patients
    - Reductions in spend on joint funded care, where the CCG is a comparatively high spender
    - Further opportunities for efficiency savings in prescribing
    - Reducing the number of follow-up outpatient appointments
- Section 4 will now identify specific plans for the realisation of these opportunities in more detail, including agreed plans for delivery and a quantification of the financial opportunity that the plans represent

NHS Vale of York Clinical Commissioning Group

SECTION 4: FINANCIAL OPPORTUNITY

NHS Vale of York Clinical Commissioning Group

4.1 6 key opportunities

- The CCG identified 6 key areas of financial opportunity based on the population analytics and health benchmarking findings
- These opportunities have been subject to an NHS England Confirm and Challenge session with the relevant, executive director, clinical, operational and finance and contracting leads signing up to schemes that deliver the same overall amount, phased differently. Although the overall opportunity still exists, it is the confirm and challenge numbers that have been used in constructing the CCG's financial plan

Section reference	Opportunity	Initial Assessment					Confirm and Challenge Assessment				
		Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)
(4.2)	***1) Elective orthopaedics***	4.2	1.3	1.0	1.0	1.0	3.0	0.8	2.3	0.0	0.0
(4.3)	***2) Out of hospital care***	21.3	0.0	9.1	7.2	5.0	15.0	3.6	4.5	4.3	2.5
(4.4)	***3) Contracting for outpatients***	5.0	3.0	2.0	0.0	0.0	2.0	1.0	1.0	0.0	0.0
(4.5)	***4) Continuing healthcare and funded nursing care***	9.3	3.1	2.5	2.5	1.2	9.6	1.8	2.5	2.5	2.8
(4.6)	***5) Prescribing***	6.2	1.7	1.5	1.5	1.5	6.2	1.6	1.6	1.5	1.5
(4.7)	***6) High cost drugs***	2.0	0.2	0.6	0.2	1.0	2.1	0.3	0.6	0.2	1.0
	Other	0.0	0.0	0.0	0.0	0.0	9.8	6.8	1.8	1.0	0.2
	Total	**50.0**	**9.4**	**16.7**	**12.4**	**9.6**	**47.7**	**15.9**	**14.3**	**9.5**	**8.0**

- This chapter also includes VoY's agreed approaches to delivering the opportunities identified, driven by the CCG's overarching new approach to commissioning, described in Section 2 based around the following key headings:
  - What is the potential saving?
  - Key assumptions
  - How can this be delivered?
  - What are the agreed next steps?
  - How will the CCG work with stakeholders?

By bringing spending in line to the STP average, VoY could save £4.2m on elective orthopaedics

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4.2 Opportunity 1: Elective orthopaedics

What is the potential saving?

- By bringing spending in line to the STP average, VoY could save £4.2m on planned T&O. This figure is also backed up by RightCare benchmarking findings

Key assumptions:

- Reduce elective orthopaedics spend to the average of the 10 similar CCGs identified by RightCare benchmarking
- Includes £0.2m savings in 17/18 identified from arthroscopies
- Includes £0.4m savings in 17/18 identified from a review of knee replacement coding & tariff following change in NICE guidance

How can this be delivered?

- New approaches to contracting are required including use of outcomes-focused commissioning, new population management based approaches
- Potential consolidation of suppliers including working differently with private providers (65% of planned trauma and orthopaedics in VoY is currently delivered through private providers)
- Greater focus on patient self-management of musculoskeletal conditions
- Enhanced orthopaedic knowledge base in primary care and greater support GPs to better manage patients' expectations
- Use of clinical thresholds where carefully managed and evidence tested

What are the agreed next steps?

- Continued development of the new MSK pathway including patient direction to self-management tools, more referral to lifestyle interventions and evidence-based decision making prior to surgical intervention
- Development of an MSK web hub which will act as a source of information for GPs and patients and provide information on treatment options, sign-posting, and help to manage patient expectations
- Development of commissioning statements relating to BMI and smoking thresholds for hip and knee arthroplasty and hip and knee arthroscopy. Processes to be put in place to monitor implementation of thresholds via CCG's Referral Management Centre
- Implementing the CCG's *"our NHS, let's take care of it campaign"* – first phase will aim to raise awareness of waste medicine and costs to the local economy

4.2 Opportunity 1: Elective orthopaedics

- Provide support to GPs to improve their knowledge and skills through online video demonstration of joint examination, post-graduate training events and support for GPs wishing to gain more expertise in managing MSK conditions. Also ensure closer working with physiotherapists and extended scope practitioners in GP practices
- Further conversations with providers and system stakeholders to develop new approaches for contracting and payment based on whole population management strategies

How will the CCG work with stakeholders?

- Engagement with primary care to support GPs in using new MSK care pathways and engagement with the public to promote usage of the MSK web hub
- Engagement with providers and other partners in the STP to explore new models for commissioning and contracting
- MSK Programme Delivery Board consists of the commissioner, primary care and three local providers

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4.3 Opportunity 2: Out of hospital care

What is the potential saving?

- The STP analysis has estimated a potential £21.3m cost saving for Vale of York CCG, over 4 years to 20/21, by reducing need for acute care and avoiding emergency hospital admissions
- This potential saving has subsequently been supported by the further work undertaken by BDO Consulting to determine a more localised, patient level opportunity assessment for the CCG's Out of Hospital programme which estimated £20.5m.

Key assumptions:

- The STP out of hospital intervention consists of a number of targeted programmes. Each programme is assumed to reduce emergency admissions and/or A&E attendances by a percentage agreed across the STP
- Reprovision investment into primary or community services is between 10% and 50% of the cost savings, depending on the programme
- Provider fixed costs need to be recognised in the assessment of the net savings deliverable

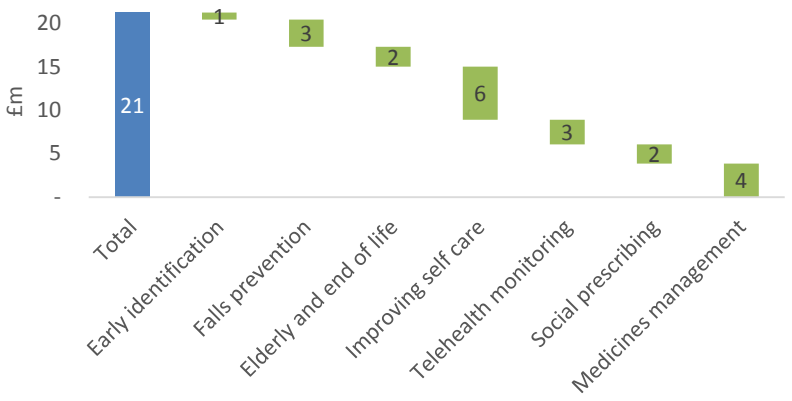
How can this be delivered – The STP vision?

- The STP vision supports integrated care pathways with primary, community and acute services working in coordination to enable patients to be treated closer to home where appropriate

(1) Modelling for the Humber, Coast and Vale STP Finance Template (submitted October 2016)

- Seven of the twelve STP-wide interventions are targeted at reducing emergency admissions and A&E attendances across the whole population, including the elderly, COPD and long term conditions:
  - Early identification
  - Falls prevention
  - Elderly and end of life
  - Improving self care
  - Telehealth monitoring
  - Social prescribing
  - Medicines management
- The total potential saving is divided between the seven STP-wide interventions shown in the graph below

STP estimated potential savings from integrated care(1)



4.4 Opportunity 2: Out of hospital care

- These interventions will prevent or reduce emergency acute activity through new models of care as part of a move towards Accountable Care services
- This will include reconfiguration of community services to deliver care closer to home in line with the CCG's vision

How can this be delivered? – Independent benchmarking and identification of high-cost patient cohorts

- In late 2016, NHS Vale of York CCG commissioned BDO Consulting to complete an independent review of patient level activity which based on a clinical review and the VoY Out of Hospital programme could potentially be deflected away from an acute setting
- Four separate cohorts were identified:
  - Acute conditions that should not usually require hospital admissions = £2m
  - Ambulatory Emergency Care deflections = £7.5m
  - Long term condition as the patients primary diagnosis = £9m
  - Two or more long term conditions (included in the 13 diagnosis codes) = £2m
- This equates to a combined total of 11,854 admissions

What are the agreed next steps?

- Work with the Humber, Coast and Vale STP to make detailed and fully costed plans for these STP-wide interventions
- Production of locality information packs that allow the identification of the opportunity at a practice and disease specific level to inform the development of targeted interventions
- Collaborate with the local community and acute providers on potential early adoption of some of these schemes
- Strong focus on geriatric and respiratory medicine given the comparatively high areas of spend in these specialities for York

How will the CCG work with stakeholders?

- Continued engagement with local authorities and community care providers both in the Vale of York area and the STP footprint
- Engagement with primary care to support GPs in changing behaviours around referral patterns

4.5 Opportunity 3: Reduced follow-up outpatient appointments

What is the potential saving?

- Potential saving of £7.1m over 4 years to 20/21
- Key assumptions:
  - Target a 1:1 new to follow-up ratio for outpatients through only providing follow-up appointments where there is clinical need
  - Reinvest 30% of savings into primary and community care

How can this be delivered?

- Increased care closer to home and reduced requirements for patients to attend hospital appointments unless it is clinically necessary
- Further streamlining of elective care pathways and outpatient redesign
- Contracting differently for outpatients including a move towards 1:1 first to follow up ratio
- The CCG continually carries out detailed and robust assessments of acute activity as part of its business as usual processes. This will be supplemented by an independent review of contract performance in 2016/17

What are the agreed next steps?

- Improved patient guidance and information
- Consider local variations to NHS planning guidance on payment reform including more far reaching reforms to complement local redesign

How will the CCG work with stakeholders?

- Engagement with primary care to encourage GPs to provide follow-up care
- Closer working with acute clinicians to explain the need for change and demonstrate the benefits
- Collaboration with STP partners on new approaches to contracting/payment

4.6

Opportunity 4: Continuing Healthcare

What is the potential saving?

- £9.6m over 4 years to 20/21
- Key assumptions:
  - £3.1m cost saving if performing at average unit cost in Fully Funded and Joint Funded care
  - £9.3m cost saving if performing at best unit cost in all areas (excluding CCGs with zero spend)
  - The CCG has modelled a move to the average (i.e. £3.1m cost saving) in 17/18 and to the best performing CCG (i.e. £9.3m cost saving) by the end of 20/21

How can this be delivered?

- Review of approaches to commissioning continuing health care including population management approaches and outcomes based contracts
- Stronger reporting and forecasting and increased scrutiny of benchmarks
- New approach to negotiation with providers
- Consider the utilisation of out of area placements in localities where the cost of care is lower than Vale of York
- Ensure adequate and timely case reviews are undertaken and are sufficiently resourced
- Negotiate the relative contribution of Health to Joint Funded Packages of Care

What are the agreed next steps?

- Further internal working between CCG finance and contracting teams to agree strategy and approach to future contracting
- Review and learning from successful joint commissioning approaches applied elsewhere

How will the CCG work with stakeholders?

- Work with community services providers to strengthen services and reduce the need for expensive nursing care packages
- New approaches to agreeing defining value and agreeing outcomes with providers

4.7 Opportunity 5: Prescribing

What is the potential saving?

- £6.2m cost saving over 4 years to 20/21 (£1.5m per year)
- Key assumptions:
  - Target saving of 3% per year, based on historic prescribing QIPP achievement
  - If the Medicines Management Team resource remains as it is then there is a highly probable risk that the targeted prescribing QIPP for 17/18 will not be delivered. As it stands the team have identified the capacity to deliver c£900k.

How can this be delivered?

- The prescribing QIPP programme has been split into four key areas with multiple individual schemes within each:
  - **De-Prescribing:** Targeted reductions in dose or cessation of medication that may be causing harm, of little benefit or potentially inappropriate. This will include Medication Reviews , specials interventions and Therapeutic Area Reviews.
  - **Rebates:** The CCG will make use of manufacturers' drug rebate schemes in line with the CCG's rebate scheme policy to continue to ensure a high standard or corporate behaviour, clinically appropriate prescribing whilst maximising savings on products supplied.
  - **Reducing Medicines Waste:** Including the reduction of repeat prescribing. This will be achieved through targeted and formal medicines optimisation training to all primary care staff.
  - **Quality Intervention:** Continue to improve high quality prescribing through cost effective medicines choices including the use of Optimise Rx, Specials and the Antibiotic Quality Premium.

What are the agreed next steps?

- A detailed programme of work has already been identified that delivers around £900k of the potential opportunity in 17/18.
- Further review and consideration of the medicines management team and potential approval of additional investment to deliver larger savings.
- Methodology to be agreed to quantify and monitor delivery of savings associated with the Reducing Medicines waste area.

How will the CCG work with stakeholders?

- Continued work with primary care to change behaviours and reduce prescribing frequency
- Work with pharmacists on waste campaigns
- Work with NHSE to ensure, where necessary ,appropriate contract arrangements and levers are used with pharmacists.

High cost drugs represent a potential saving of £2m over 4 years for VoY

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4.8

Opportunity 6: High cost drugs

What is the evidence?

- Reduction in high cost drugs due to increased competition/opening up of biosimilar alternative medicines:
  - Etanercept price reduction
  - Biosimilars for Rituximab (2017), Adalimumab (2018), Ranibizumab and Aflibercept (2020)

What is the potential saving?

- £2.1m potential saving over 4 years to 20/21
- Key assumptions:
  - Assumes 40% initial reduction in prices, 20% in following year with 50-50 gainshare between provider and commissioner

How can this be delivered?

- Commissioners and providers share the cost reduction benefit
- Acute providers take responsibility for managing the transition away from higher cost drugs and risks associated with this – including medicines management and changing consultant prescribing behaviour

What are the agreed next steps?

- Ensure contracts with acute providers in place with 50-50 gainshare agreement included
- Regular discussions with acute provider pharmacy leads to refined saving assumptions as biosimilar products come to market and ensure that patients are switched are the earliest suitable opportunity

Combined, delivery of the 6 opportunities in full imply that the CCG could reach in-year surplus by 19/20, but with a cumulative financial deficit of £51m still at 20/21

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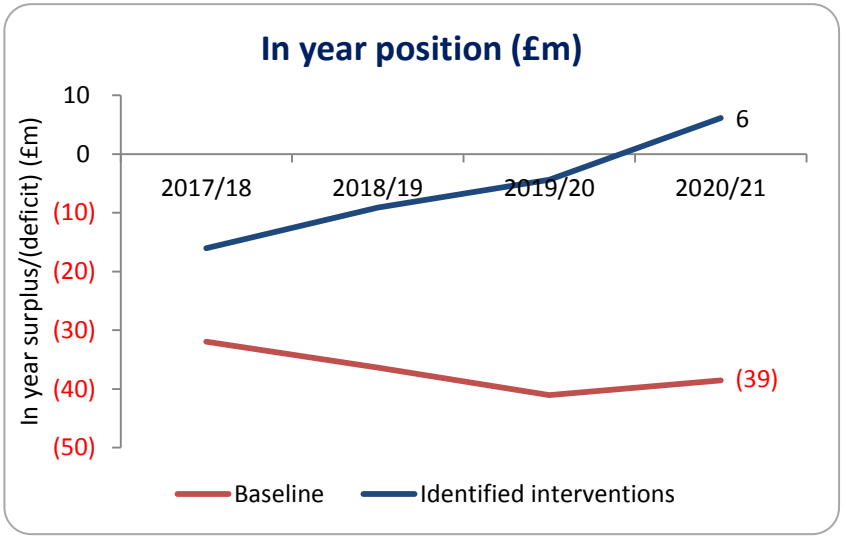
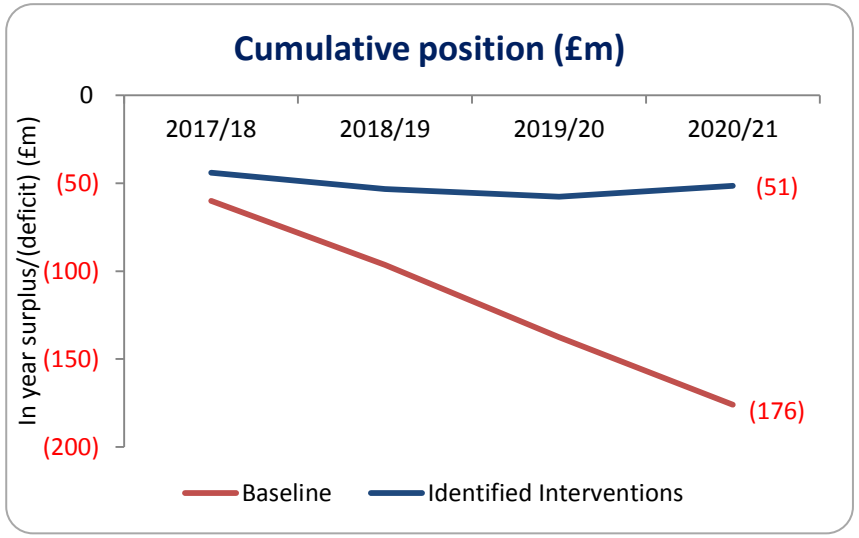
4.9

20/21 financial position with full delivery of 6 key opportunities

- The graphs below the CCG's in year and cumulative position:
  - Without making any QIPP savings, the in-year deficit would be £39m by 20/21, with a cumulative deficit of £176m ("do-nothing" scenario)
  - If the specific interventions and schemes identified through the Confirm and Challenge process were achieved in full, the CCG would reach in-year surplus by 19/20 but would still have a cumulative deficit of £51m at 20/21





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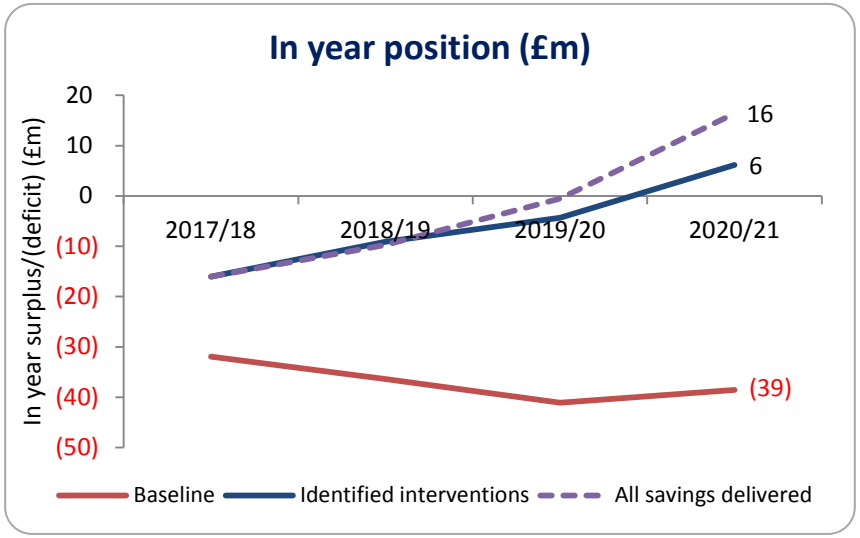
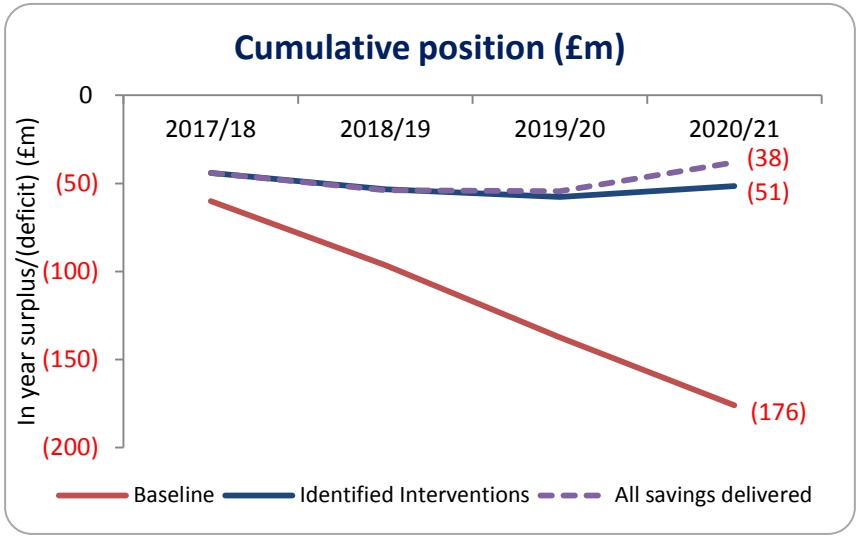
4.10 Additional opportunities

- The CCG is developing a further pipeline of schemes and opportunities which do not yet have savings quantified.
- These pipeline savings schemes are reflected in the plan as unidentified savings in 19/20 and 20/21
- If these unidentified savings were developed into specific interventions and schemes and were delivered in full then the CCG would reach in-year financial balance by 19/20 but would still have a cumulative deficit of £38m at 20/21





If the CCG were to implement the 6 opportunity areas in full, its in-year surplus would be c£45 per head by 20/21 (compared to allocation)

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4.11 3 scenario summary

- The tables below summarise the in-year and cumulative position under the three scenarios discussed:

In year position (£m)

	17/18	18/19	19/20	20/21
"Do nothing"	(32.0)	(36.4)	(41.1)	(38.5)
Identified Interventions	(16.1)	(9.1)	(4.4)	6.2
All interventions (including pipeline savings schemes)	(16.1)	(9.8)	(0.5)	16.4

Cumulative position (£m)

	17/18	18/19	19/20	20/21
"Do nothing"	(60.0)	(96.4)	(137.5)	(176.0)
Identified Interventions	(44.1)	(53.3)	(57.6)	(51.5)
All interventions (including pipeline savings schemes)	(44.1)	(53.9)	(54.5)	(38.1)

- Over 80% of the total savings opportunities have been reviewed through the Confirm and Challenge process and developed into identified interventions and schemes
- Achieving all savings including pipeline schemes would bring the CCG's spend in line with the funding allocation by 20/21, with an in year surplus of c.£45 per head by 20/21

	FY18	FY19	FY20	FY21
Estimated spend per head with identified interventions (£k)	1.31	1.30	1.32	1.33
Estimated spend per head with all interventions (£k)	1.31	1.30	1.31	1.30
Allocation per head (including core, admin and primary medical allocations) (£k)	1.26	1.28	1.30	1.34
% overspend/(underspend) forecast	**4%**	**2%**	**(0)%**	**(3)%**

4.12

Summary of financial opportunity

- VoY has identified 6 potential opportunities for cost reduction based on findings from the health analytics and benchmarking work: elective orthopaedics; out of hospital care; contracting for outpatients; continuing healthcare and funded nursing care; prescribing; and high cost drugs
- The biggest opportunity is out of hospital care, which has the potential to achieve £21.3million cumulative savings by 20/21, if delivered in full
- If the potential savings of all identified interventions were achieved in full, the CCG could reach in-year surplus by 20/21 but would still have a cumulative deficit of £51m at 20/21
- The CCG has identified a number of additional “pipeline savings schemes” but these are at planning stage only and their numbers have not been rigorously benchmarked or tested
- VoY is clear on the next steps for taking forward each of the six major opportunities identified and is carrying out further work to progress plans on the pipeline schemes

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SECTION 5: NEXT STEPS

Moving forward, VoY recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals

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5.1 Next steps

- VoY's current situation means that it must now focus on articulating a strategy for reaching long-term financial sustainability whilst also ensuring that it delivers on short-term goals.
- As outlined in the Financial Recovery Plan, short-term priorities for the VoY include:
  - focussing on organisation stabilisation
  - delivering on key financial and operational targets articulated in the plan
  - adhering to constitutional standards
  - delivering on QIPP plans
  - meeting other requirements of the NHSE Directions, including organisational capability building and governance reforms
- In order to drive forward the medium-term financial strategy, VoY will work quickly with system partners to drive STP plans to delivery. This includes:
  - agreeing approaches to strategic commissioning across the STP, including at what spatial level commissioning will take place for different services
  - agreeing a delivery model for the single provider model across the STP footprint
  - agreeing models of system governance which will inform how the STP invests and delivers programmes of work going forward
  - agreeing system wide strategies for tackling named STP priorities including mental health and out of hospital care
- VoY will also focus on its own local population as it further develops plans for the VoY Accountable Care System. As outlined in Section 2, next steps include:
  - engaging providers, clinicians and primary care in the case for change;
  - engaging the public in the reality of the financial decisions that need to be made and how they can help and be a part of that;
  - engaging local authority and social care partners in a system financial solution that integrates services and budgets;
  - confirming the population to be covered by the VoY Accountable Care System and its scope of services;
  - agreeing the financial case for accountable care, including investment requirements;
  - learning more about the application of accountable care models applied elsewhere in the UK and abroad, and considering which aspects of their design are most relevant for the VoY;
  - considering different options of governance and organisational structure to best support the accountable care model;
  - confirming what the other enablers of a move to an accountable care model might be, including specific requirements from stakeholders;

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SECTION 6: APPENDICES

Commissioner allocations are calculated based on four key components

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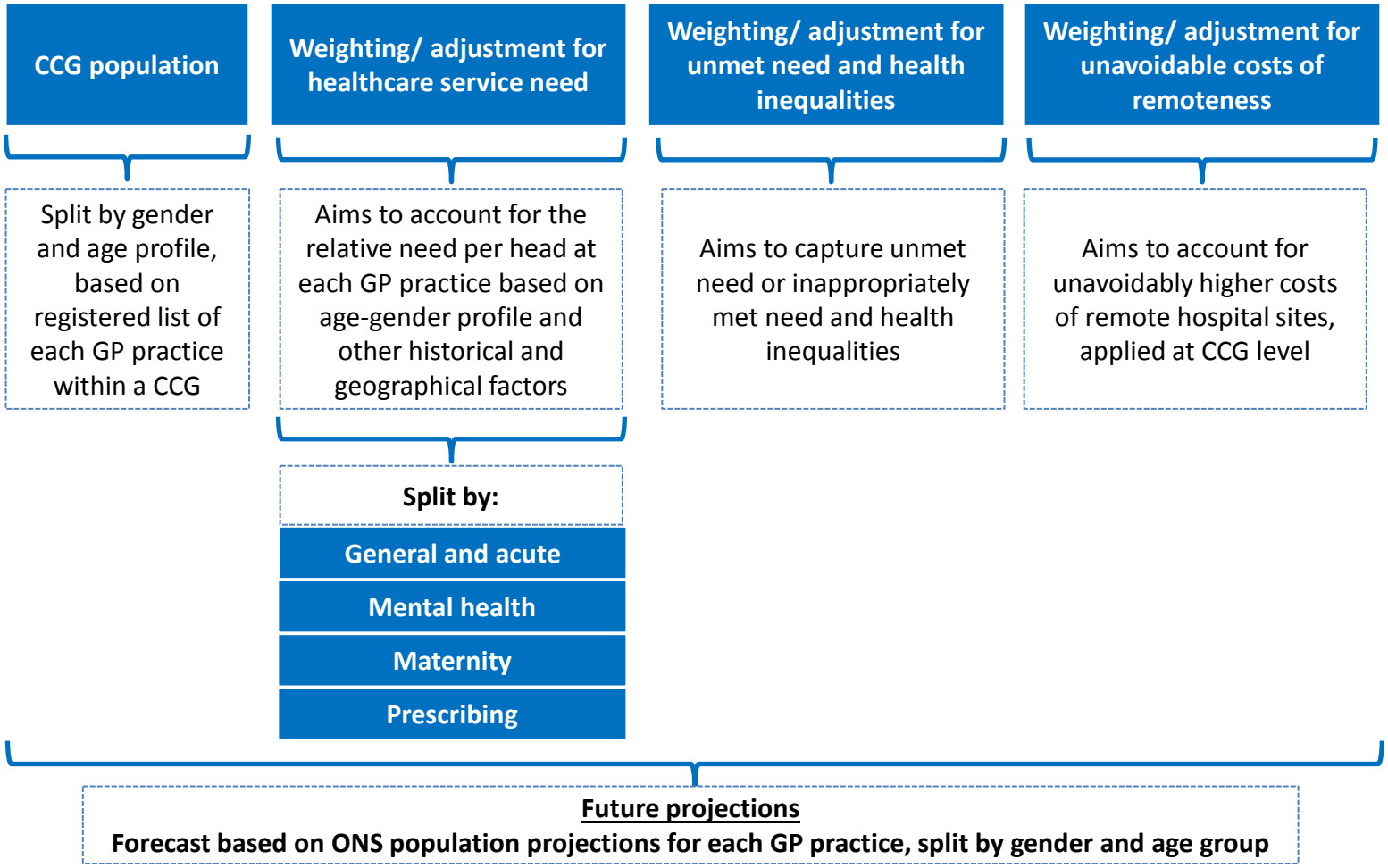
6.1

Weighted population formula overview(1)

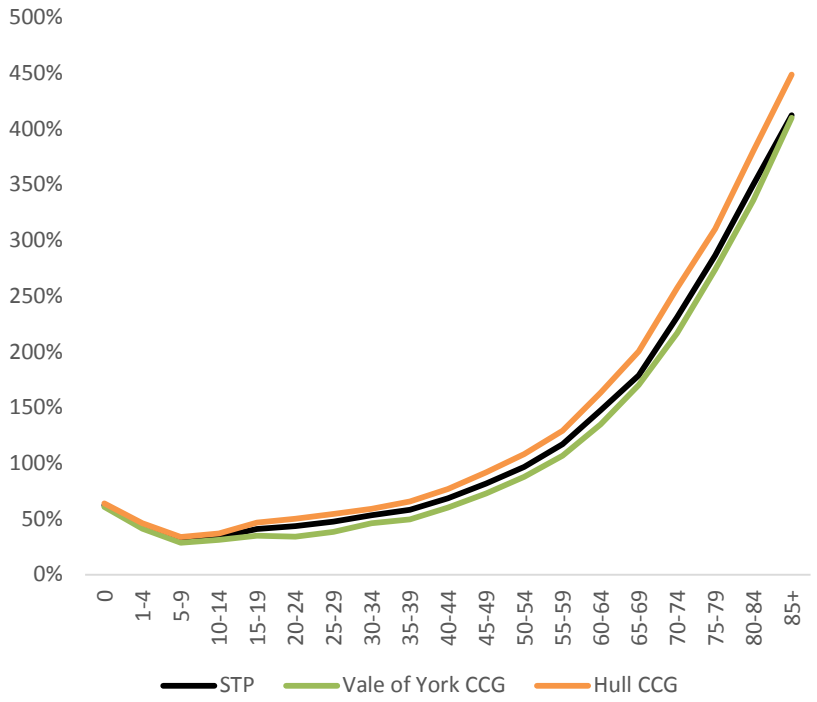


(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

6.2 Acute need weighting

- The graph on the right shows the impact of the acute need weighting by age group across the STP, and specifically for Vale of York CCG and Hull CCG.
- As a result of increased health needs, the more elderly patients have an increased acute need weighting: the weighting means that for every £1 allocated to an "average" person in England, £3 would be allocated to a person with a 300% weighting.
- Weighted populations are normalised to the national total at every stage, so these weightings should be seen as relative rather than absolute.
- Based on the age distributions of registered patients within the STP, the acute need weighting brings the allocation lower for Vale of York CCG compared to the STP average, as the proportion of elderly patients is lower.
- The age distributions also show that Hull CCG has a relatively young population. However, the acute weighting also includes statistical modelling of need estimated from past healthcare use and cost (using FY12-FY14 data).
- The impact of this "past need" factor increases the weighting for Hull CCG but decreases the weighting for Vale of York CCG, which has had a relatively healthier population in the past.
- The highest age group in the weightings is 85+, so they may not fully account for the very elderly (aged 90+) population who have greater health costs than those aged 85-89. As noted in the previous slide, the proportion of Vale of York CCG's population aged 90+ is higher than the STP average.

Acute need weighting impact by age group(1)



- In 15/16, 16% of the CCG's spend on inpatient care was for patients aged 85+; however, the population weightings indicate that only 11% of the CCG's acute care allocation is for patients aged 85.

(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets A and C)

VoY receives a lower allocation weighting for inequality compared to others in the STP

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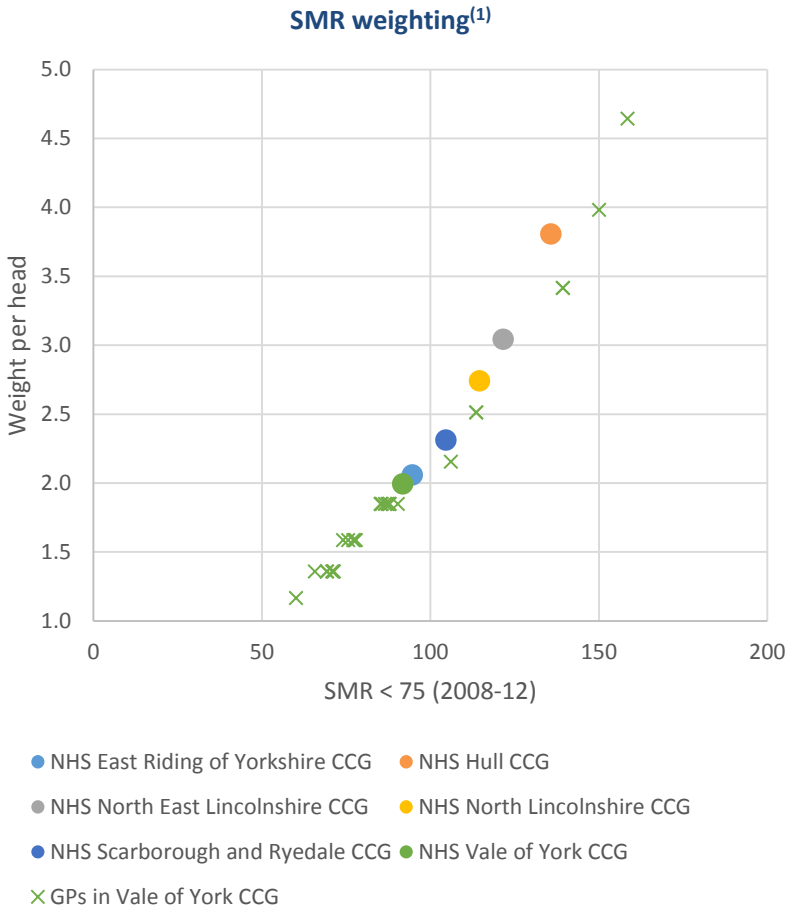
6.3 Health inequalities

- The weighting for unmet need and health inequalities is based on the Standardised Mortality Ratio (SMR) for those under 75 years of age (SMR<75).
- Vale of York CCG has a lower SMR<75 than the other CCGs in the STP footprint, leading to a lower weighting and a reduced allocation.
- However, 4 of the 29 GP practices within Vale of York CCG have a higher SMR<75 value than the average for any CCG in the STP footprint, indicating pockets of higher deprivation within the Vale of York population.
- These are indicated in the chart on the right:



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet G)

Vale of York CCG has a relatively high acute spend for the level of patient need

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6.4

- Within the STP footprint, Vale of York CCG has a **relatively high acute spend** for the level of patient need.
- Spend on mental health services is relatively near to the STP average.
- Vale of York CCG has a **relatively low prescribing spend** for the level of patient need.

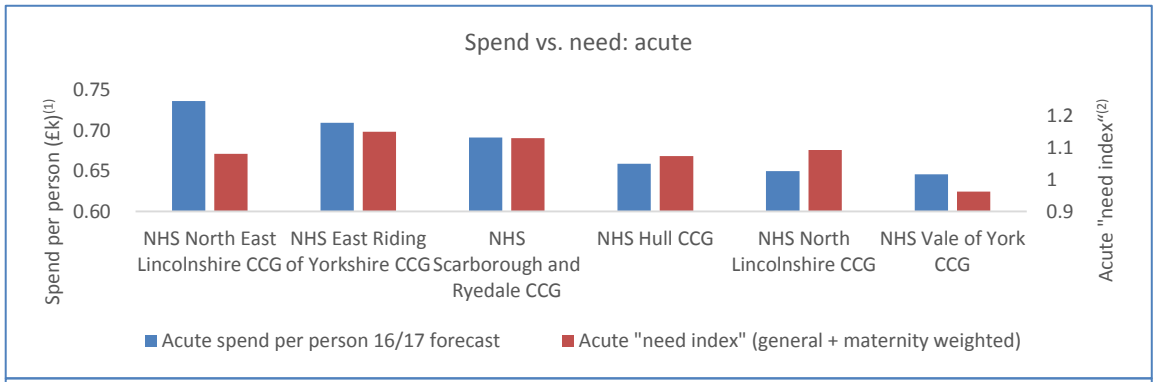
Spend to need ratios (higher numbers indicate a higher spend for the level of patient need):

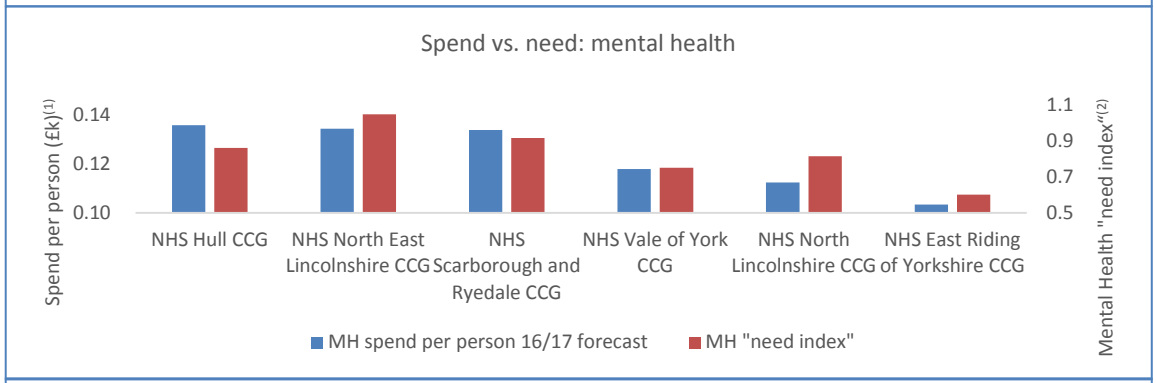
	STP average	Vale of York CCG	% diff.
Acute (inc. maternity)	633	671	+6%
Mental health	151	157	+3%
Prescribing	152	150	-1%

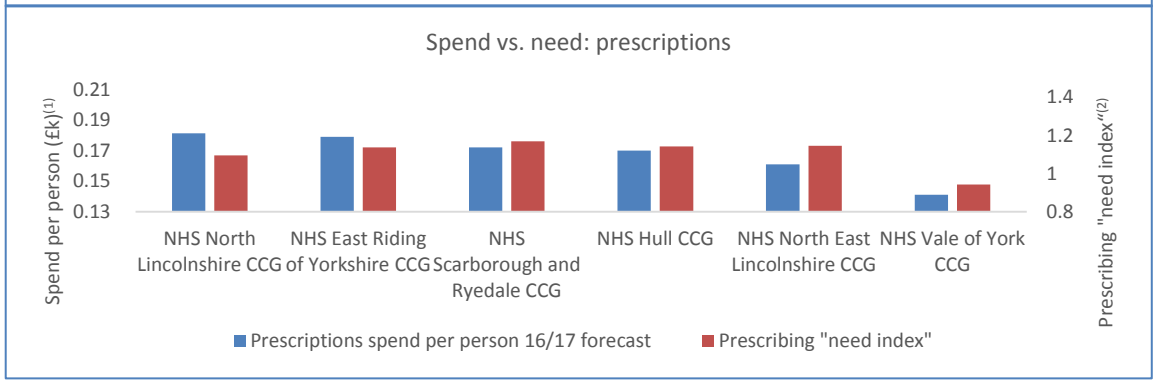
(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets C-F)

Spend versus need







The VoY non-elective spend per person in the population was greater than the STP average for ages 50+ in the four largest specialities

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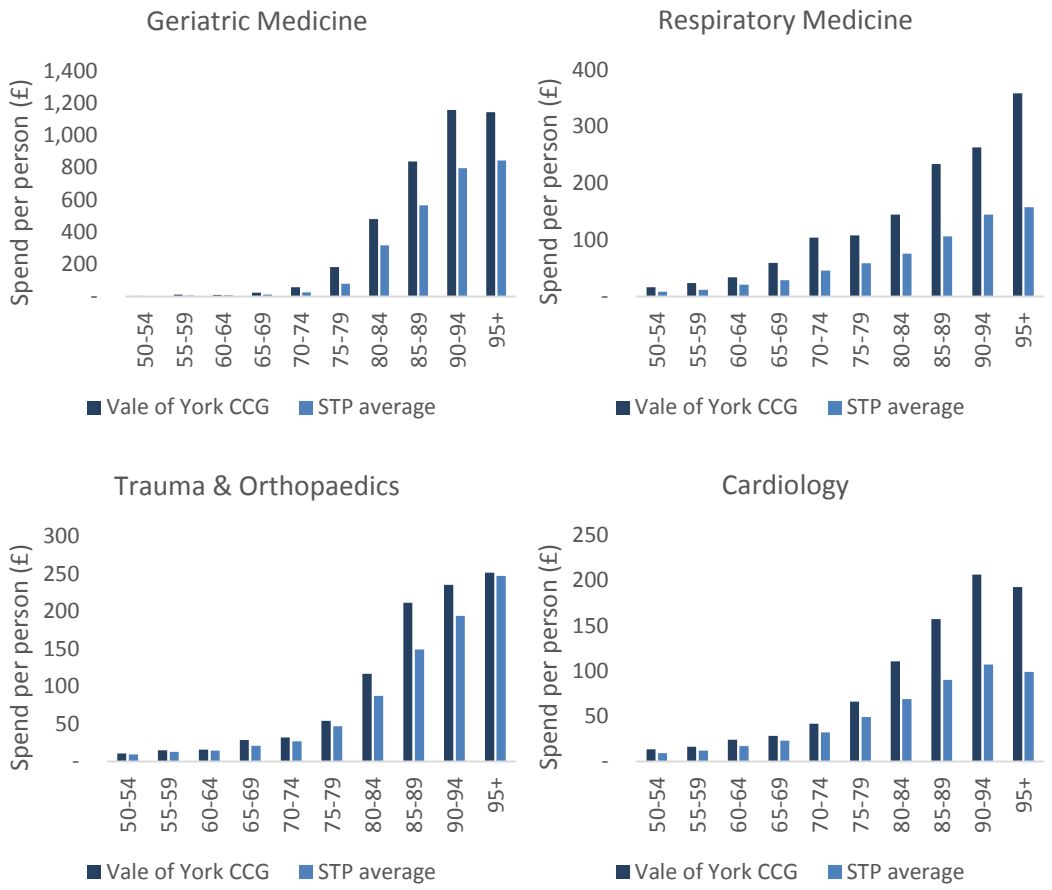
6.5

- Over 50% of Vale of York CCG's non-elective inpatient spend was in the largest 4 specialties: Geriatric Medicine (22%), Respiratory Medicine (14%), Trauma & Orthopaedics (9%), Cardiology (8%).
- The spend per person in the population was **greater than the STP average** for ages 50+ in all four of these specialties.
- The spend in respiratory medicine was **£5m higher than the STP average**, when weighted for age distribution, due to **twice as many spells per person** and a similar average spend per spell.
- The spend in geriatric medicine was **£6m higher than the STP average**, when weighted for age distribution, due to both more spells per person and a higher spend per spell.

Average spend per person in the population aged 50+ (£)

	STP average	Vale of York CCG	% difference
Geriatric Medicine	£78	£128	+64%
Respiratory Medicine	**£35**	**£70**	**+101%**
Trauma & Orthopaedics	£34	£43	+28%
Cardiology	£29	£43	+49%
Total other	£213	£159	-25%
Total	**£389**	**£443**	**+14%**

Non-elective spend profile



*Reducing the CCG's spend per head to the STP average for Geriatric Medicine and Respiratory Medicine for ages 50+ would bring the CCG's total non-elective spend per head to **13% lower** than the STP average, meeting the requirement of the allocations.*

Spend per head compared with need index varies by GP practice

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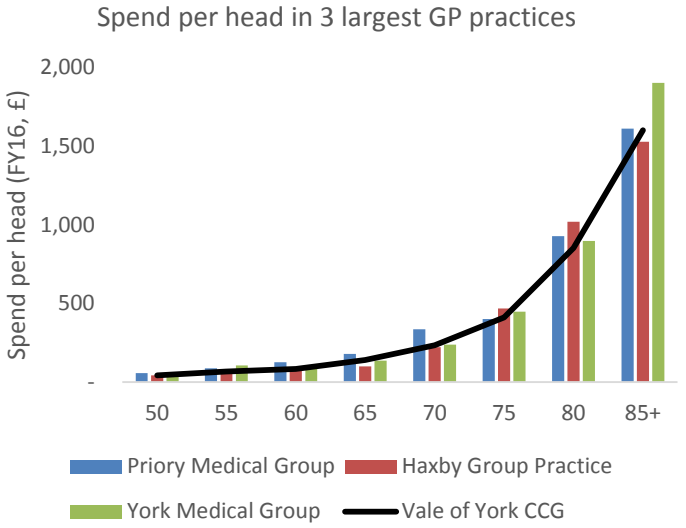
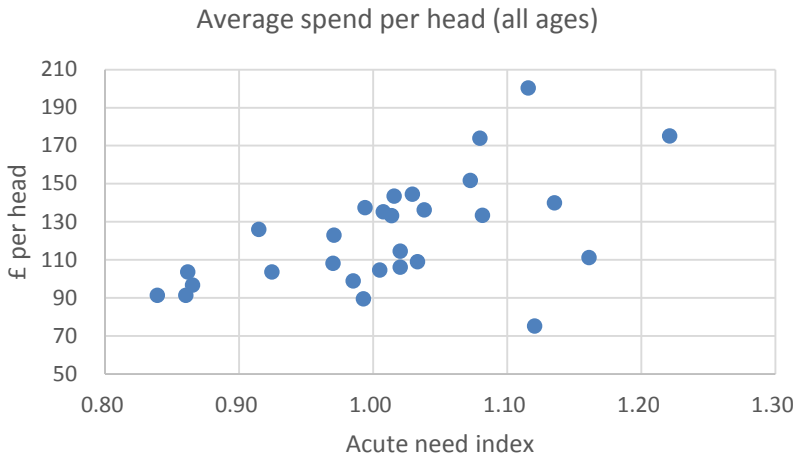
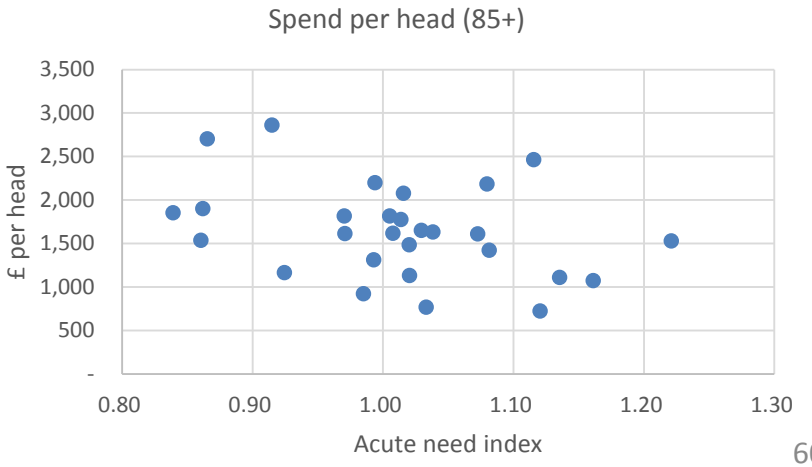
6.6 Non-elective spend profile by GP

- The graph on the right shows the non-elective spend for ages 50+ in the largest 4 specialties (Geriatric Medicine, Respiratory Medicine, Trauma & Orthopaedics, Cardiology), for the 3 largest GP practices in the CCG.
- For ages 85+, the average spend per head is highest at York Medical Group, which has the lowest need index, and lowest at Haxby Group Practice, which has the highest need index.
- Average spend per head appears to increase with acute need index (shown below). However, spend per head for ages 85+ appears to **decrease with acute need index**.
- The acute need weighting allocates 4-5 times as much funding to people aged 85+ than to people aged under 50, but the FY16 inpatient spend per head was **10 times larger**. This indicates that the high non-elective spend on elderly patients is not in line with the funding allocations.







Note: Unity Health, with acute need index of 0.4, is not shown on these graphs.

6.7 STP: Locality plan on a page

Locality Objectives

1. Sustainable local services and viable small hospitals services, through the Ambition for Health Programme on the East Coast and an Accountable Care model for the Vale of York
2. Ensure that Scarborough Hospital and other major services are of a high quality, are financially sustainable and that we all have access to the right care, in the right place, at the right time
3. Return to financial balance by reducing demand and an activity shift. Promoting self help and prevention and providing services as close to home as clinically possible to offer a greater range of services outside of acute settings, reduce unplanned attendances and admissions and support a timely return home from acute episodes
4. Effective and appropriate planned care via the referral support service, new approaches to outpatients and clinical advice, and community-based pathways re-design informed by RightCare analysis
5. Mobilise the community resource and assets, enabling the voluntary and community sector to offer flexible support and ensure patients aware of the right place to access the right support for their needs

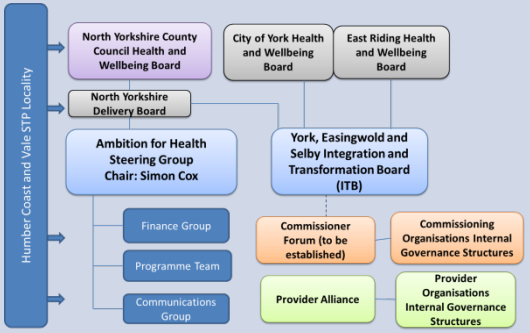
The Case for Change

The local community has an ageing population who are high users of health services, with the over 85's representing approximately 5% of the population, and accounting for approximately 20% of non-elective emergency admissions. The health needs of this cohort of patients have to be supported in a different way to achieve improved outcomes and address rural isolation alongside operational and financial sustainability.

In addition to forecast growth, the health and social care services are experiencing financial and operational pressures, partly as a result of an increase in demand and acuity of patients but also increasing workforce pressures in healthcare and domiciliary care.

Governance Arrangements

Management and clinical leads for the supporting work streams will be confirmed at the locality launch in October 2016.



Key Delivery Risks

- Vale of York Legal directions and supporting Financial Recovery and Improvement Plan
- Scarborough & Ryedale CCG Finance Recovery Plan
- System financial position
- Workforce availability
- Care market stabilisation
- Critical Care

Key Projects

- Ambition for Health programme
- Accountable Care development –
- Out of Hospital Strategy – including mental health
- Small sustainable hospital pioneer and ECIP
- Crisis Care review
- Prevention Strategy and Smoking Cessation
- Digital Roadmap and universal capabilities
- IAPT improvement plan
- Outpatients reform – Expert consultation
- Primary Care Strategy (GP 5YFV)

Targeted Clinical and Care Outcomes

- Constitutional Target delivery
- Improvements in population health measures, including: smoking cessation, reduction in obesity, alcohol related admissions, cancer survival (to address premature mortality from cancer)
- Acute activity maintained at sustainable level