Briefing note for Kent County Council HOSC

NHS Dartford Gravesham and Swanley CCG and NHS Swale CCG: Financial Recovery Report for 2017/18

Dartford, Gravesham and Swanley CCG challenges

Dartford, Gravesham and Swanley CCG was facing an over spend of £13.5m in 2017/18 in addition to the £7.3m deficit planned at the start of the year. The agreed deficit plan in part recognises the shortfall in allocation growth from Ebbsfleet and other local housing developments. In total the £20.8m potential variance from break-even represented 4% of the CCG's turnover.

The key driver behind the financial recovery programme was a change of approach, attitude and culture where it is unacceptable to over-spend coupled with a continuous programme of added value review and scrutiny to address the financial gap.

We also needed to change the culture and relationship with have with the CCG's providers so that we can control and manage the financial value of contracts. We aim to do this in part through the development of the Integrated Care System proposition with DVH, which will move us to a greater system approach with one control total and plan. The first stage of this process has focused on the establishment of the joint PMO with DVH and both the Trust and CCG have aligned staff to support this endeavour.

In addition, the CCG and Trust have commissioned GE Healthcare Finnamore to complete a longer term financial model looking at how the system can achieve financial balance and sustainability over a 3-5 year period, factoring growth and efficiency gains through joint working. However, this significant piece of programme work will require regulator support and facilitation both in terms of resource, nominal investment and agreement to manage the system as a system rather than as separate control total parts. However, the financial recovery plan for 2017/18 was not predicated on the delivery of the Integrated Care model.

The main reasons for the £13.5m challenge are as follows:

- QIPP shortfall (£4.0m) –The CCG has a £12.8m QIPP Programme in 2017/18. However, at month 5 the CCG was forecasting £8.8m delivery, which was a £4m shortfall.
- MSK pathway - a slippage £0.6m on the assumed benefits
- Contract Management projected over performance - the assumption was £6m over spend projection on acute contracts
- Re-admissions – the assumption is of a gain £1.0m from the readmissions clinical audit is not materialising.
- CHC – with more regular placement reviews a further £0.4m gain was assumed.

Swale CCG: the challenges

Swale CCG was facing a challenge of £9.7m in 2017/18. The agreed plan for the CCG was break-even. This financial challenge of £9.7m represents 6% of the CCG's turnover.

It should be noted that to achieve the agreed control balance, the CCG planned a QIPP programme of £5.8m, which contained several demand management and cost reduction projects, although £2.8m was "unidentified" at the start of the year.

As with DGS CCG the key drive behind the recovery programme, is a change of approach, attitude and culture where it is unacceptable to over-spend and there is a continuous programme of added value review and scrutiny to address the financial gap.

The development of the FRP was based on efficiencies the CCG have identified through benchmarked data, evidence of effectiveness from other CCGs and indeed successes of our own and moving these harder and faster, for example medicines management. However, these gains will get us so far. Longer term efficiencies and sustainably can only be achieved at a system level and further work is required to create the potential for system gain.

The main reasons for the £9.7m challenge are as follows:

- QIPP shortfall (£3m) –The CCG has a £5.8m QIPP Programme in 2017/18. However, at month 6 the CCG was forecasting £2.8m delivery, which is a £3m shortfall.
- Projected acute contract over-performance of £6m
- Running costs over spending projections of £500k
- Medicines management – initial projected lower delivery shortfall of £400k

The Recovery Plan

The recovery plan in both CCGs consisted of three elements:

1. **QIPP stretch targets** – this addresses the forecast under-performance in the current QIPP programme by supporting and challenging the project leads in the existing schemes to produce a higher financial return from the original agreed projections.
2. **Reduction in expenditure run rate** – this addresses the CCG's forecast commissioning and running costs with a focus on those areas that the CCG can control and affect by agreed management action.
3. **Commissioning spend reduction** – these address the remaining gap by looking at the full range of contractual levers in all sectors. By their very nature some of these actions only delivered savings in quarter 4.

The detail in each of these areas was generated using various tools available for benchmarking and self - assessment within the NHS commissioning environment:

- Clinical Variation – using Right Care data, the Atlas of Variation and STP opportunities to identify areas of clinical variation in planned care. The Commissioning structure had recently been re-aligned to focus on the FRP schemes; within this a lead had been assigned for each area of clinical variation. A GP clinical lead had also been appointed to champion this programme. The CCGs identified size of opportunity for each GP practice.

- Menu of Opportunities – national best practice examples across all commissioning areas. This was a long list of opportunities and the CCGs all self - scored where they were on taking ideas forward.

- VFM disinvestment - some overlap with Menu of Opportunities and COO list; Items under disinvestment will fall under the CCG value for money review and areas where activity is high should be picked up by the clinical variation.

Recovery Plan Governance and Delivery

The CCGs also changed their focus and governance structure so that financial recovery is an integral part of the CCGs decision making process. This ensures that staff resources are appropriately prioritised across QIPP and financial recovery projects. The Programme Delivery Steering Group, which supports the financial recovery is currently meeting weekly to embed the process. The process is overseen by a Programme Management Office (PMO) which is led by Company Secretary and Assistant AO.

The CCGs has also made changes to its meetings and the CCG now has meetings held at the same time for each CCG for Governing Body, Quality Finance and Performance and Audit Committee. This reduces the time in meetings for senior staff, including those with joint roles and gives strength in knowledge and experience from the lay members.

The Director of Commissioning and Performance post which has been vacant was filled in July 2017 and the new post holder brought additional drive and challenge to the financial recovery plan.

The CCG has also restructured its contracting and performance teams to provide more direct support to DGS and Swale CCGs and to integrate the teams into the commissioning and finance teams.

The financial results achieved in 2017/18

The financial performance results quoted are those submitted to each CCG Governing Board and NHSE, and prior to annual accounts audit.

DGS CCG against its original financial plan target of £7.3m deficit has achieved a deficit of £9.1m.

It should be noted however that the variation from target was driven by a national issue related to the supply and cost of generic drugs which accounted for £1.4m of the £1.8m gap. The remaining £400k was driven by increased activity in the acute sector.

Swale CCG against its original financial plan target of break-even has achieved a deficit of £3m

The key drivers of the deficit includes the generic drugs issue (noted above), increased activity within the acute contract and slippage in the QiPP programme.

Whilst both CCGs have not achieved their financial plan target, it should be noted that the results are substantial improved from the 2017/18 mid -year forecasts.

Conclusion

Looking forward, both CCGs have committed to the NHSE control limit in 2018/19 of break-even. Despite the gains made in the under lying run rate and the culture of both CCGs, the achievement of these control totals will be very challenging without the radical change to the systems cost base as presented within the Kent and Medway STP.

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