

Financial Recovery Plan

This paper is for:	Decision
Recommendation:	The Governing body is invited to review the proposals and to confirm their support.
For further information or for any enquiries relating to this report please contact:	
Adam Wickings, Chief Operating officer Reg Middleton, Chief Finance Officer	

	Date: 20 th December 2016
Reporting Officer: Reg Middleton	Agenda Item: 239/16
Lead Director: Reg Middleton	Version: 1
Report Summary:	
<p>The CCG Integrated Performance Report has signaled areas of the CCG commissioned services where activity and cost have exceeded planned levels. The key areas are in acute services (MTW, London and Independent Sector providers) and mental health placements. The CCG's contingency for the entire year has been consumed, and if the CCG is to achieve its planned financial position, it will be necessary to identify and secure additional cost reductions in the remainder of the year.</p> <p>This paper describes a number of recommendations to secure additional cost reductions in the remainder of the year. The Governing body is invited to review the proposals and to confirm their support.</p>	
FOI status: This paper is disclosable under the FOI Act	
Strategic objectives links:	Strategic Goal E: Deliver sustainable finances Strategic Goal F: Ensure robust governance Strategic Goal G: Organisational competence
Board Assurance Framework links:	Strategic Risk E: Loss of control over provider activity and system finances could result in the CCG being unable to invest in service development and ultimately breaching its statutory duties.

	<p>Strategic Risk F: Loss of control of corporate governance could result in the CCG acting ultra-vires and becoming subject to regulatory or legal action, with resultant harm to the CCG's reputation, influence and capability, as well as possible financial harm</p> <p>Strategic Risk G: The CCG's failure to deliver the requirements of NHS England (including the quarterly CCG Assurance Framework and the terms of the CCG's Authorisation) could result in the CCG losing its freedom to operate independently (or ultimately being de-authorised).</p>
Identified risks & risk management actions:	Failure for the CCG to achieve its planned financial position.
Resource implications:	As outlined in the paper
Legal implications	N/A
Equality and diversity assessment	<p>Has an equality analysis been undertaken?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No – equality analyses will be undertaken once the proposals have been agreed.</p>
Report history:	Second report to Governing Body on the Financial Recovery Plan.
Appendices	None
Next steps:	Subject to Governing Body support, many of the schemes will require significant work up by commissioners before implementation, including engagement with patients and local clinicians, and will have to be pursued with a high degree of clinical leadership.

Financial recovery plan – further measures

December 2016

1. Introduction

Achievement of the planned financial position of the CCG remains a very difficult challenge, with a considerable risk that it does not secure the position agreed with NHS England¹. This could have consequences for the CCG in the following ways:

1. Potential intervention from NHS England
2. Financial outlook in 2017/18 and beyond will become yet more challenging
3. Potential that access to Quality premium in 2016/17 (payable 2017/18) is denied
4. Reputational risk

At the Governing Body in September, a package of measures was approved that were designed to reduce cost, improve health outcomes and help support an improvement in urgent care waiting times in West Kent.

Progress has been made in implementing these measures, but it was recognised at the time that the cost reduction impact of these measures was unlikely to be sufficient, and that there was a level of inherent risk associated with the schemes agreed by the Governing Body. The financial impact is expected to be seen in the final quarter of 2016/17.

Since the September Governing Body, progress has been made with the identification of other cost reductions to support the CCG position, although many of these are of a non-recurrent nature. In addition, there has continued to be a steady and ultimately significant rise in costs in some sectors – notably the Acute sector (£412k - primarily Independent Sector and Tertiary providers); Mental Health (£226k); and continuing care (£177k) which has negated the financial benefit of the cost reductions that have been realised to date. The net result is that the CCG still needs to identify further cost reductions if it is to remain on track to achieve its planned financial position.

Based upon the level of financial pressure and risk faced by the CCG, it is assessed that the CCG needs to secure an additional £4m of cost reductions before the end of the year.

The following proposals provide a range of measures that have the potential to secure the necessary cost reductions for the CCG and should be seen as a clear escalation of the steps that the CCG need to undertake in order to control its finances. They include a combination of some measures that are short term in nature and extend to the close of this financial year and others that may be applied on a sustained basis. The financial outlook for the NHS is such that the CCG will need to continue to assess the basis upon which it can offer the fullest range of access to services in order that resources can be directed to those interventions that represent the greatest possible value in terms of health outcomes.

The following table summarises the proposals outlined below. They are estimated to have the potential to achieve £3.6m during the remainder of 2016/17, assuming all are supported by the Governing Body. Some of the proposals require further work to be undertaken with an appropriate

¹ The NHS England requirement is not just for financial balance but for achievement of a surplus.

level of clinical leadership and to be supported by patient engagement and equality impact assessment work. These measures have the potential to contribute to financial sustainability in West Kent in 2017/18 but are unlikely to impact in 2016/17 to a significant degree.

	2016/17 PYE £000	2017/18 £000
Immediate implementation		
Compliance with criteria	375	375
Reduction in non-urgent surgery	3,200	0
Male and Female sterilisation	30	120
Grand total	3,605	495

2. Actions to be implemented in 2016/17

The following actions are proposed with immediate effect

Compliance with Referral and Treatment Criteria

Rationale for change

The CCG has in place a range of criteria that are agreed across Kent and Medway and are designed to avoid expenditure on treatments that are deemed to be of limited clinical value or to be more expensive than other available options of equivalent clinical efficacy.

The scope of these service restrictions include:

- Complementary and alternative therapies
- Cosmetic Surgery
- Non health essential treatments
- Procedures of limited clinical value

The CCG has previously undertaken audits to test compliance with these criteria at Maidstone & Tunbridge Wells NHS Trust. However, many of the criteria apply to the kind of activity undertaken by private sector providers under Any Qualified Provider (AQP) contracts, and it is intended that the CCG conducts an audit of retrospective compliance with the criteria at Independent Sector providers. In the event of non-compliance with the RATC, the CCG would apply deductions from contract performance in 2016/17.

In addition it is proposed, to undertake a prospective exercise into compliance with the RATC criteria by conducting an audit of waiting lists wherever evidence suggests there may be non-compliance. Again, the CCG will advise providers that any instance of non-compliance will not result in providers being reimbursed for activity undertaken.

Impact

It is difficult to assess the potential financial impact of such an exercise ahead of undertaking the audits. As an indication, the value of activity undertaken by Independent Sector providers on activity where RATC criteria apply is estimated at just over £5m in a full year. Assuming a fairly high ratio of compliance/non-compliance of 90%/10%, a nominal sum of £500,000 has been identified in 2016/17 (to avoid double counting, assume £375,000). Dependent upon the findings and the impact of

resulting contractual penalties, it is possible that the impact in 2017/18 may be larger, but for the purpose of this report, this is not assumed to be the case.

Male and female sterilisation

The CCG is proposing to stop all male and female sterilisation (and reversals). For males this comprises of both conventional and no-scalpel vasectomy and for females this relates to blocking or sealing of fallopian tubes.

Rationale for change

The vasectomy and female sterilisation services are considered to be one of many forms of contraception and are deemed to have no or limited clinical value. Other forms of contraception are available which are recognised as being more appropriate.

Impact

As there are numerous methods of contraception available locally (both free and paid for) and with the clinical rationale deeming sterilisation to have no or limited clinical value the CCG believes this to be an appropriate restriction that would have minimal impact on both male and female patients.

The financial impact of this proposal will be limited in 2016/17, but with a larger impact in a full financial year (£30,000).

Suspension of non-urgent surgery until April 2017

Proposal

It is not intended to suspend non-urgent GP referrals, but member practices will be asked to be especially vigilant in their referral practice and take full advantage of available pathways to help reduce pressure on acute services in the winter period, reduce the level of clinical variation between member practices and practitioners, and to reduce costs for the CCG. It is also proposed to have further supportive discussions with practices that have particularly atypical referral practice where opportunities for reduced consequent expenditure could be explored.

It is proposed that secondary care providers should be asked to reduce non-urgent elective care until the end of the financial year. This will inevitably mean delays in treatment for some patients.

Within our contractual arrangement with MTW, the Trust is able to seek authorisation from the CCG to sub-contract planned care work to third parties. The Trust currently outsources a significant level of activity to the independent sector. As part of the general approach to drive down planned care activity and cost in the remainder of the year, it is proposed that the CCG should not authorise the Trust to sub-contract this work, which will mean that supply side considerations will serve to slow down activity levels. We propose in this context to undertake detailed work with the Trust on prioritisation so as to ensure that patients with long waits or urgent clinical need should not be affected.

Rationale for change

Without further action, the CCG is likely to incur more costs on planned care than it set out in its plans for the year. The approach outlined above is designed to reduce costs back toward budgeted levels but still allows for patients who have an urgent need for surgery to receive their treatment. It recognises that restricting planned care in this way does take a degree of pressure off MTW who are

experiencing considerable difficulty in terms of managing urgent care activities at present, and this is expected to continue throughout the period of January–March.

With respect to MTW, reducing the level of outsourcing in the final quarter of the financial year would result in a lower cost to the CCG of some £2.1m.

Activity and cost at all of the Independent Sector providers are running in excess of plan. If activity and cost can be brought back to planned levels over the whole year, this would have the effect of improving the CCG forecast position by some £1.1m.

Impact

These measures will result in some patients waiting longer than expected, but will not affect those who have an urgent need for treatment. It is projected that these measures could be introduced without detrimentally affecting the CCG's RTT performance, but this will be continuously monitored. The impact of this will be assessed by commissioners in collaboration with our principal provider - MTW.

3. Proposals that will require further work and clinical leadership

Further detailed analysis is now commencing as well as liaison with other CCGs that have introduced similar measures. The endorsement in principle is sought from the Governing Body so that plans might be worked up and engagement commenced with stakeholders.

Cataract criteria

Proposal

Restrict access to cataract surgery for people with mild vision difficulties.

Rationale for change

All requests for the surgical removal of cataract(s) will only be supported by the CCG where the patient's best corrected visual acuity, as assessed by high contrast testing (Snellen) is;

- Binocular visual acuity of 6/9 or worse for drivers;
- Or binocular visual acuity of 6/12 or worse for non-drivers;
- Or monocular visual acuity of 6/18 or worse irrespective of the visual acuity of the other eye;
- Or the patient's expressed wish or requirement is to continue driving but the patient does not meet the Driving and Licensing Authority (DVLA) minimum sight requirements;

Or there is a significant impact on the patient's quality of life. For example patients with cataract can experience other serious symptoms such as double vision or disabling glare from lights even though visual acuity is relatively unaffected.

The following categories of patient or ophthalmic conditions are exempt from application of the access criteria and may be referred for possible cataract surgery;

- Patients with anisometropia presenting with suspect cataract(s).

- Patients with diabetes in whom the removal of cataract is considered necessary to facilitate effective digital retinopathy
- Patients of 18 years of age or less at the date of referral;

Impact

It is expected that the majority of suspect cataract(s) will be detected initially following sight testing or eye examination, under either NHS or private contract, undertaken by a community optometrist.

Some patients with suspect cataract (s) may present initially direct to their GP. In such cases, the GP should require that their patient is referred for a sight test or eye examination, including the measurement of visual acuity, to be undertaken by a community optometrist.

Criteria for surgery

Proposal

In September the Governing Body agreed to the development of a new pathway for hip and knee replacements, which offer patients access to counselling on lifestyle choices, for example smoking and fitness.

CCG to agree the principle of extending this approach to a wider range of surgical procedures.

Rationale for change

There is clinical evidence that smokers and obese patients have a poorer outcome and/or increased risk during surgery.

For this reason, the CCG has implemented a new pathway for hip and knee replacements, which supports the direction of patients towards lifestyle services where this is appropriate. This proposal takes this a stage further, and extends the concept to other treatments, which might result in more patients not undergoing surgery, or delaying surgery.

The proposal is to introduce this as a short term financial remedy for the remainder of 2016/17, and to undertake a review thereafter.

Impact

For some patients this proposal introduces a delay in having routine surgery while they quit smoking and/or lose weight. The consequence of this is that the surgical risks to the patient are reduced resulting in a better outcome for the patient.

In-Vitro Fertilisation (IVF) and Assisted Conception (excluding those in existing treatment)

Proposal

CCG will fund 1 full cycle of IVF with or without ICSI. The full IVF cycle will consist of one fresh and one frozen embryo/ blastocyst transfer. These fertility treatments (also known as assisted conception) are for local patients, namely Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)

Policy is intended to reflect the current evidence base described by NICE.

Criteria:

- CCG will not fund IVF treatment when the woman has had three or more previous IVF cycles, whether these have been funded privately or by the NHS
- Referral for IVF is offered to women aged up to and including 41 years old. Women should be referred so that they can commence a treatment cycle before their 42nd birthday.
- Referring clinicians should be aware of the work up time required by the providing trusts, and ensure that referrals for older women are made in time for them to commence a treatment cycle before their 42nd birthday.
- The woman must have a body mass index (BMI) of between 19 and 30 at the time commencement of treatment.
- Patients must be non-smokers in order to access any fertility treatment and continue to be non-smokers throughout treatment

Rationale for change

The CCG feel that this decision supports transparency and equity of approach to the population and reduces the perception that for some people we are funding whilst for others not supporting funding at all.

Impact

The CCG also considers that withdrawing support for funding for those in the system is unfair without notification of this change in decision or approach.

Over the counter medicines

The CCG is proposing to issue guidelines and support to GPs prescribing over the counter / minor ailment medicines for conditions other than those where the clinical need can only be met by a prescription.

The CCG has embarked upon a process of pre-engagement to test patient and public views of this issue. The proposal is to issue guidelines to support the reduction in prescriptions and spend in all areas of primary care.

Rationale for change

These changes apply only to situations and minor conditions where NHS Choices recommends selfcare. For some conditions this will be related to the severity of the condition (e.g. mild acne is included but severe acne requires prescription only medicines) and/or to the duration of the condition (for example, a cough that has persisted for more than three weeks requires a GP appointment

Over the counter medicines refers to the types of medicines that can be bought over the counter either from a community pharmacy or, in many cases, a general retailer like a supermarket. Some of these medicines can only be sold under the supervision of a pharmacist, others are deemed safe

enough to be widely available from general retailers. Examples of some of the medicines included are:

- Painkillers
- Cough and cold remedies
- Antihistamines and other treatments for hay fever
- Antacids for heartburn and indigestion
- Diarrhoea – adults and older children
- Constipation
- Haemorrhoids
- Creams for vaginal and vulval infections or thrush
- Nicotine Replacement Therapy for smoking cessation
- Malaria prevention
- Threadworm
- Creams for fungal infections such as athlete's foot

Impact

The CCG will still prescribe any medicines that are available by prescription only, such as antibiotics, statins, blood pressure treatments etc. Where a treatment is needed which can only be prescribed, then the patient's regular doctor will still be able to prescribe this.

Pain treatments

To stop offering hip injections and spinal cord stimulation. Spinal cord stimulation is an NHS England commissioned service that will no longer be funded by the CCG. Where patients meet the criteria specified by NHS England, they will still be eligible for spinal cord stimulation at the designated centres.

Rationale for change

The CCG's approach to the current financial challenges is to prioritise the limited funding it has so that the local population has access to the healthcare that is most needed. This assessment of need is made across the whole population of the CCG and, wherever possible, on the basis of best evidence on what is clinically proven to work.

As a result of this, the CCG has identified procedures that are either limited clinical value or that do not cater for the wider needs of the population and therefore it has been proposed to implement these changes in order for the local health economy and services to be sustainable.

Impact

The proposed changes would mean that these forms of pain relief would no longer be funded by the CCG however there will still be numerous alternative pain relief methods available that are funded and can be prescribed.

Lucentis/Avastin

Proposal

To commence all new patients entering the Wet AMD pathway with (Bevacizumab) Avastin. This drug, although not licensed as first line treatment for this condition, is widely used within the private sector and across Europe and America.

Rationale for change

There have been a number of head to head studies comparing Avastin and Ranibizumab (Lucentis) for wet AMD, including the well documented CATT and IVAN trials. The results of these studies demonstrated that there was no significant difference in outcome of visual acuity from either drug. The studies further proved that despite the lack of a licence Avastin is a safe and effective drug for the treatment of wet AMD.

Impact

Circa 230 new patients join the AMD pathway each year. The change outlined above would bring an efficiency saving of £773,000 based on the current cost of Avastin against Lucentis.