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Croydon
Clinical Commissioning Group

Croydon CCG Operating Plan Overview
2017/18 and 2018/19

March 2017 v9.0

Working with GPs, Croydon Council, Croydon Hospital Services, South London and Maudsley Mental Health Trust and other providers, within the South West London NHS, to delivery improved and sustainable patient care for all the people of Croydon

Longer, healthier lives for all the people in Croydon

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Our strategic vision and goals

Following a wide-reaching engagement process with a variety of stakeholders, we have reconfirmed our vision and developed organisational values. In addition we have revised our objectives for 2017/18. The strategic direction of travel is summarised below:

Vision

Longer healthier lives for all the people in Croydon

Through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners, we will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services

Objectives

1.1 To commission high quality health care services that are accessible, provide good treatment and achieve good patient outcomes

2.1 To reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital for physical and mental health

3.1 To achieve sustainable financial balance by 2017/18 and NHS business rules of 1% surplus by 2018/19

4.1 To support local people and stakeholders to have a greater influence on services we commission and support individuals to manage their care

5.1 To have all Croydon GP practices actively involved in commissioning services and develop a responsive and learning commissioning organisation

Values

Patient focused | ***Outcome focused*** | ***Professional*** | ***Ambitious***

This vision and strategy is a product of understanding the needs of our population and the service challenges that we face. Croydon's population is growing by 1% per year, with particular increases in younger people and with older people living longer. Given this, our priority areas that we aim to deliver on are:

1. Reducing potential years of life lost through amenable disease;
2. Ensuring patients are treated in the right place;
3. Children and young people reach their full potential;
4. Early detection and intervention; and,
5. Positive patient experience.

The principles upon which we will deliver these priorities and indeed all areas we commission are that:

- Prevention is better than cure;
- When someone does become ill, self management is the best option;
- When a person does need treatment they are seen in the right place at the right time; and,
- There is shared decision making between the patient and the health professional.

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Introduction – health in Croydon

Strong delivery of better healthcare

- Wider access to mental healthcare
- Top quartile (UK) cancer care
- Improved support to children and young people
- Reduced waiting times for outpatients

Facing exceptional healthcare challenges

- Rapid population growth
- Proportionally more young people & older people
- Obesity & associated long-term conditions
- Achieving financial sustainability

Continuous improvement in services

- Reduced variation in service provision
- Faster access to consultants for critical illnesses
- Development of improved care pathways
- Development of Outcomes Based Commissioning

Transforming healthcare in Croydon

- Working across the healthcare economy to deliver the Sustainability and Transformation Plan (STP) for South West London/Croydon
- Leading the introduction of new models of care

Better access to services

- 7-day, 365 day Urgent Care GP Hubs across Croydon (April 2017)
- Extended primary care access – April 2017
- Expanded Out-of-Hospital services

Improved outcomes for patients

- Tighter integration of health and social services across GPs, Council, CHS and other providers
- Services provided closer to patient's homes
- Greater support for living healthier lives

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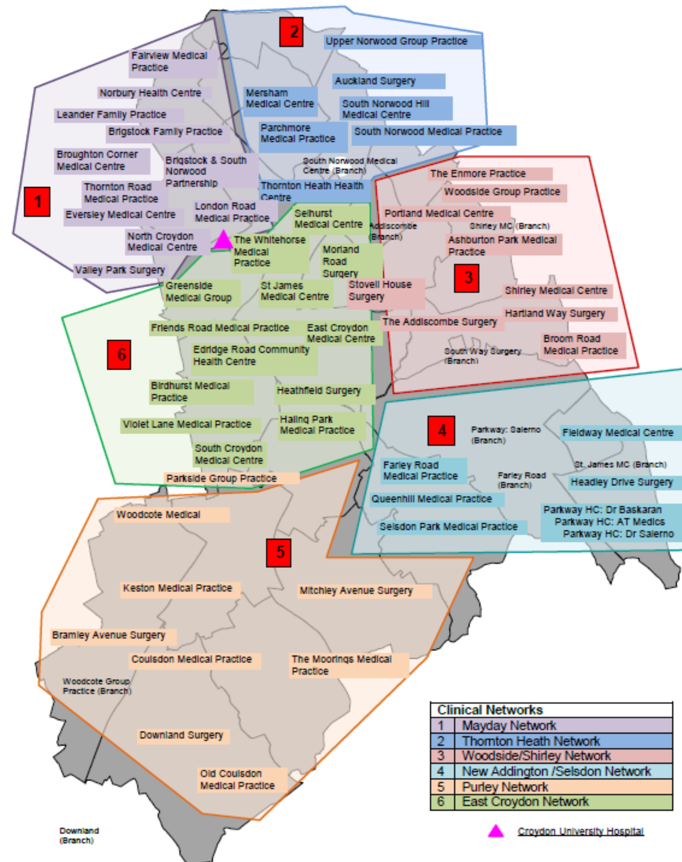
Serving the people of Croydon

Providing health care to a growing population of 400,000+ people



- 57 GP Practices
- Extending patient access to 3 GP Hubs, 1 Urgent Care Centre (incl. 24x7, 24-hour) and Minor Injuries and Ailments centre
- Croydon University Hospital and access to other London acute hospitals

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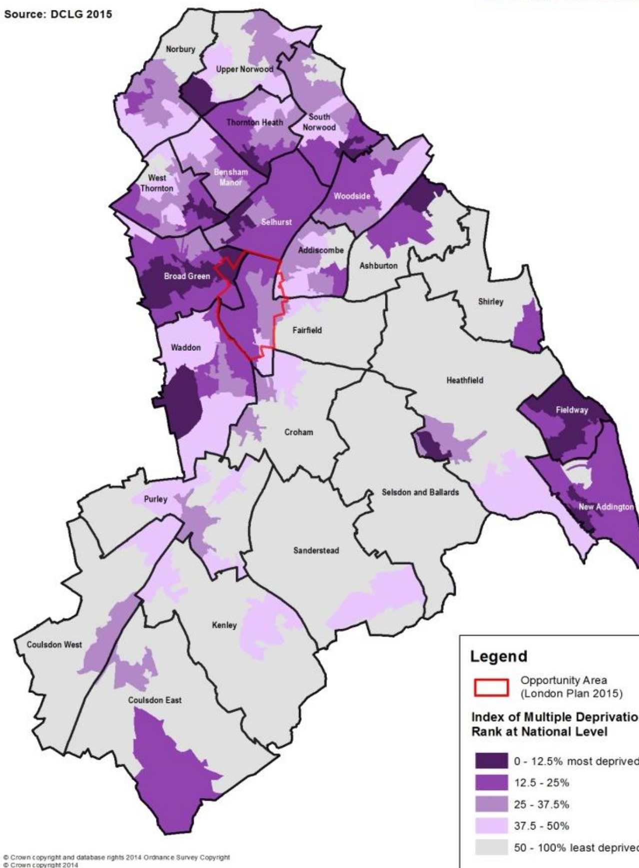
Level of challenge facing Croydon



List Size Growth

Year	2015	2016
Total Croydon population (ONS 2015 /GLA 2016)	381,046	383,764
YoY Growth	0.8%	0.7%
Decade Growth 2005-2015	12%	
Decade Growth 2006-2016		12%
GP list size (HSCIC October 2016)	398,092	404,633
Ratio to population	104%	105%

The GP list size appears to growing faster than the overall population – it is suspected that the population data is not reflecting recent population movements

High Levels of Deprivation in some areas

CCCG - Responding to the needs of Croydon

Key Highlights of Annual Operating Plan - Financial

- The CCG continues to face a very high level of financial challenge
  - Forecast deficits 2017/18 (£6.9m) and 2018/19 (£nil). This includes a challenging QIPP programme 2017/18 (£29.1m) and 2018/19 (£18.4m)
- Three key transformational programmes underpin the move to a sustainable position
  - Out of Hospital: proactive and preventative strategy for transformed care in the home/community
  - Planned Care: supporting the shift of care to primary and community care
  - Outcome-based-commissioning: improved service integration for over 65s across all service providers
- Transformational savings for 2017/18 are c£15m gross with c£7.3m associated reinvestment costs to deliver the transformational change

CCCG - Responding to the needs of Croydon

Key Highlights of Annual Operating Plan - Services

Maintaining effective commissioning to optimise and improve service provision

- Primary Care: implementation of extended access in line with GP Forward View and GP standards; review of GP contracts
- Mental Health: improved access through community provision, earlier intervention, better support to children & young people and driving parity of esteem within available resources
- Urgent Care: new model providing better access: 3 new GP Hubs (8 to 8) incl. minor injuries & aliments & a new Urgent Care Centre (24x7 – opening April 2017)
- Transformation of Out of Hospital and Planned Care
- STP: working with CHS and other providers to implement the SW London STP and achieve a sustainable health economy with improved health outcomes

Strategic Context and Local Context

The Croydon Operating Plan is set within the framework of national priorities, the SWL STP (Sustainability and Transformation Plan) and local priorities.

This is illustrated on the Croydon Operating 'Plan on a Page' overleaf.

Croydon CCG faces significant financial and transformational challenge. We are working closely with our partner in CHS to address this. The new joint CCG/CHS Transforming Care Board terms of reference and governance are being reviewed to meet this challenge.

Croydon CCG "Plan on a Page"

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- Extended Access
- Primary Care specifications

- Roll out of Sutton Vanguard & dovetail with local initiatives

- Intermediate Care
- Locality Teams
- LTCs (incl. diabetes)
- Prevention

- PAU & IP model
- Ambulatory model, incl. LTCs
- Obesity & CAMHS

- Maternity Pioneer
- Better Birth recommendations

- Community Mental Health
- Dementia Prevention & early diagnosis
- Psych liaison
- Dementia Friendly communities
- Dementia Support Well

- EoLC
- AEC
- Consultant Directed / Supervised Care
- Psych Decision Unit

Transforming primary care

Care homes

Sub-regional groups – delivery

Children & Young People

Maternity

Mental Health, Psychological & Dementia services

- Prostate (1c FU)
- Bowel Screening
- Holistic Cancer Care Reviews
- Performance, including 62 day waits

UEC

Transformation portfolio and Delivery of OBC:
- Delivery of financial and activity shifts in STP associated with out of hospital care
- Delivery of 'must dos' for primary care, UEC and OBC

National and local priorities:
- Delivery of 'must dos' for cancer, mental health, elective and LDs
- Delivery of quality improvement schemes in STP for CYP and dementia
- Assumed that costs and benefits captured in CCG allocations

Cancer

- Outpatients and elective pathways review

OP and Elective pathways

Learning disabilities

- Transforming Care Partnership
- Primary care

Croydon CCG

Finance:
- Delivery of financial recovery plan and QIPP challenge
- Support to OBC and Out-of-Hospital contracting

Acute configuration

Acute delivery model:
- Delivery of acute configuration elements of STP
- Liaison with NHSE Spec comm team

Productivity:
- Delivery of financial savings in STP associated with collaborative productivity

De-commissioning effective commissioning initiative 'choose wisely'

Local Digital Roadmap delivery & ETTF

Clinical networking

Model of care – acute pathways

Specialised services (NHSE led)

Individual provider productivity (CIP)

Collaborative opportunities for providers

Individual commissioner productivity (QIPP)

Communications and engagement
incl. consultation

Enablers

Workforce strategy development

Estates strategy development & ETTF

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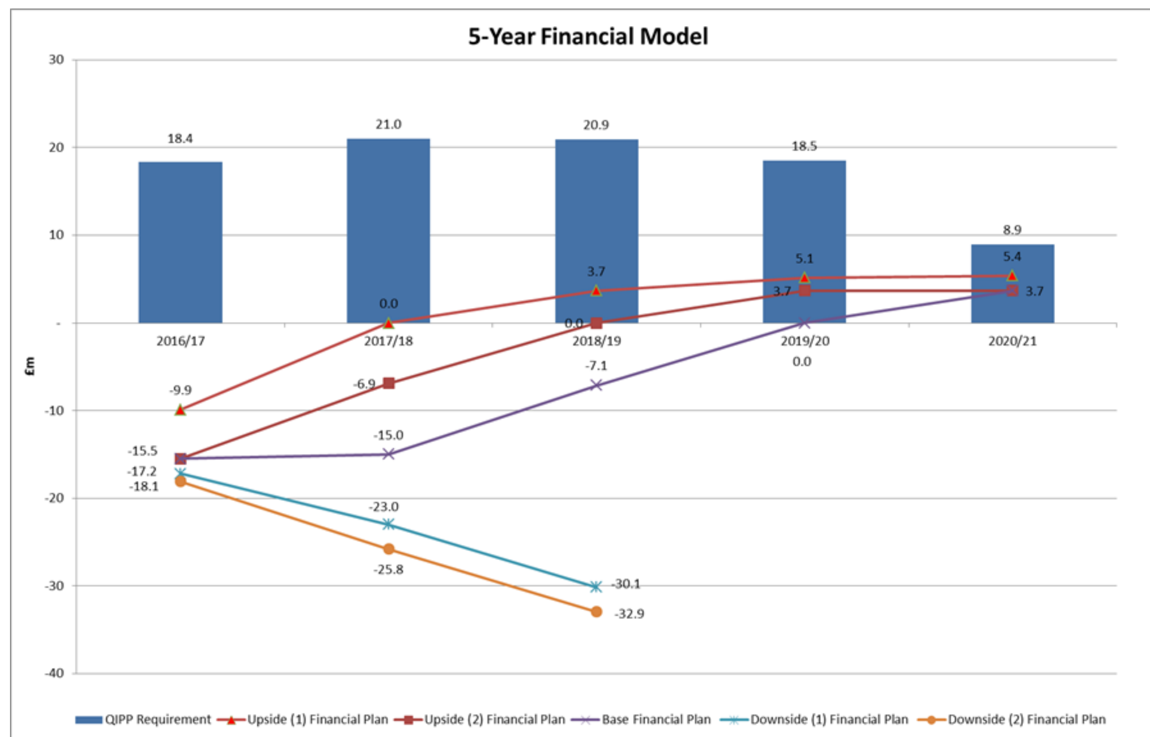
Achieving Financial Balance

- Delivery of financial balance by 2018/19
- Delivery of net £29.1m savings in 2017/18 and £14.8m savings in 2018/19 in cooperation with its providers. £8.1m of savings for 2017/18 has yet to be identified (£21m plan)
- Includes £9.2m overall investment in better healthcare for Croydon.
- Delivery of the STP transformational goals in activity shift to community, Out-of-Hospital and primary care.



Note: 2017/18, 2018/19 plan dependent on achievement of the 2016/17 forecast run rate

Planned QIPP Schemes 2017/18 and 2018/19

(Quality, Innovation, Productivity and Prevention plans)

Area	Focus	Savings 2017/18 (£k)	Savings 2018/19 (£k)
Planned Care	Elective - "Choosing Wisely" project (formerly ECIs)	7,938	4,980
	Prevention & Public Health - Together for Health / Health Help Now app to better signpost to patients the most appropriate care resource		
	Long Term Conditions & Other – improving self-care and preventative services	2,401	
Emergency Care	Proactively working to reduce demand through wider primary care and community services	3,395	3,900
A&E, Urgent Care	Reducing non-elective admissions through better support to patients in the community, improving end of life care	1,538	900
NETA	Non-Elective Threshold Adjustment (30% reduction on cost)	-1,604	-1,170
Decommissioning	CReSS, IVF, Prescribing, Voluntary Sector – Non Statutory	841	490
Mental Health	Demand Management & Radical Redesign	4,315	500
Prescribing	Reducing waste, using bio-similars and improved procurement	2,293	1,800
Continuing Health Care	Improving care plans and new systems for tighter financial management	2,107	2,000
Learning Disabilities	Improved care plans and commissioner responsibilities to support patients in the community	1,163	0
Contingency /Unidentified		-3,387	5,000
	Totals	**21,000**	**18,400**

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Significant Transformational Change Needed:

"shifting" activity from an acute setting to a primary care and community setting

	CCG 16/17 Forecast Outturn	Underlying Trend and Demographic Growth	Transformational Change	17/18 Annual Plan	Underlying Trend and Demographic Growth	Transformational Change	18/19 Annual Plan
Total GP Referrals (General and Acute)	87,997	3641	-12774	79,021.0	3264	-7691	74,594.0
Total Other Referrals (General and Acute)	47,513	1952	-6847	42,366.0	1750	-4123	39,993.0
Consultant Led First Outpatient Attendances	127,203	5298	-19621	113,987.0	4708	-11814	106,881.0
Consultant Led Follow-Up Outpatient Attendance	352,231	12285	-49325	285,414.0	10874	-29699	266,589.0
Total Elective Admissions	36,472	1105	-3128	35,821.0	1046	-2369	34,498.0
Total Non-Elective Admissions	38,972	1631	-2629	36,582.0	1588	-1695	36,475.0
Total A&E Attendances excluding Planned Follow	131,869	3548	-12162	184,476.0	4593	-12162	176,907.0

106,500 reduction in Acute Activity in 2017/18

69,500 reduction in Acute Activity in 2018/19

Note: figures shown are draft figures and may change for the final CCG submission to NHS England in March 2017

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The Out of Hospital Transformation Programme

Focuses for next 2 years across Croydon on increased preventative and proactive care through better delivery of integrated care across health, social care, mental health and voluntary sector services.

Includes the development of:

- Integrated Community Networks: providing health, social care and voluntary sectors multi-disciplinary teams aligned to each of the 6 networks in Croydon
- Living Independently for Everyone (LIFE): providing a community-based single point of contact for access to all reablement, intermediate care services and improved access to preventative care
- Together for Health Programme: providing enhanced prevention, self-management and shared decision making within the community setting

Key benefits:

- Improved proactive identification of vulnerable people
- Streamlined access and advice through a single point of assessment
- Expanded 7 day access to LIFE services
- Expanded Rapid Response intervention and support
- A single shared care record for vulnerable/at risk people accessible via CMC

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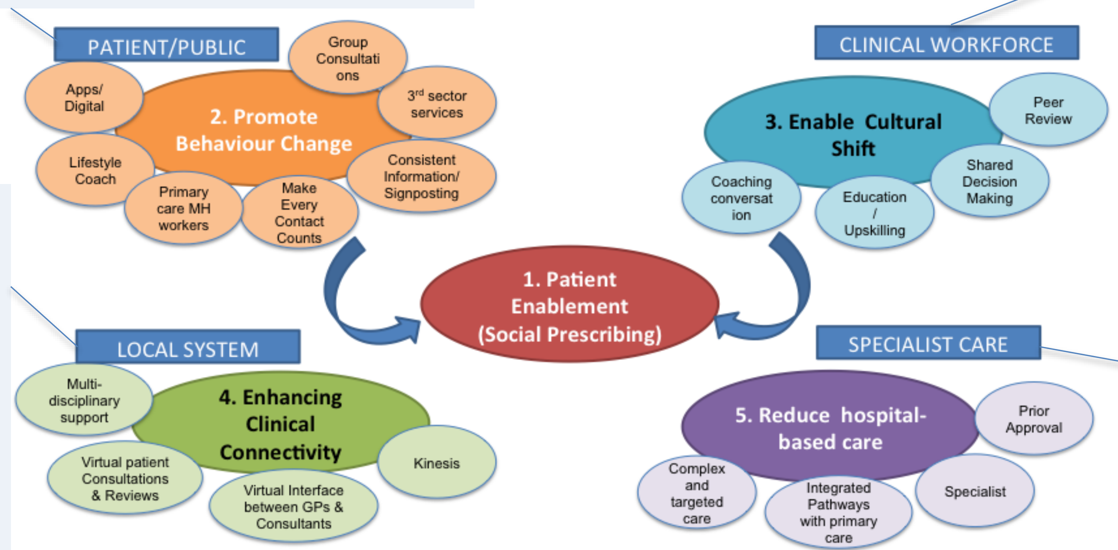
Croydon Planned Care Transformation Programme

Promote Behaviour change which includes supporting patients and public take ownership of their health and lifestyle through initiatives such as Health help now, make every contact count and altogether better

Enable Cultural Shift across the clinical workforce through peer review initiatives, shared decision making guide and GP and consultant joint educational workshops

Enhancing clinical connectivity to support a multidisciplinary approach which provides a range of skills in the community, examples of which include the MSK primary care pilot, advice and guidance telephone lines



Reducing hospital-based care thus creating appropriate capacity for secondary care to provide care for complex needs and develop integrated pathways with primary care

Patient Benefits

- Improved patient pathways to enable them to receive the right care at the right time in the right place
- Better patient access to care
- Additional care in the community to avoid hospital attendance unless necessary
- More joined up services
- Giving patients the tools, education and support to manage their health conditions where clinically appropriate
- Improved experience of service users and carers

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Outcomes Based Commissioning for Over 65s

A Whole System Approach

Vision - For all partners (statutory, voluntary and community) to come together to provide high quality, safe, seamless care to the older people of Croydon that supports them to stay well and independent. Our users will have a co-ordinated, personalised experience that meets their needs.

Patients/Users age 65 or older at the date of attendance / discharge and registered with a Croydon GP

In-scope services include:

- Acute / Hospital Care
- Community and Out of Hospital Care
- Older Peoples Mental Health
- Adult Social Care

A capitated budget for over 65 population (£212M in year one) - will incentivise the Alliance to invest proactively in maintaining and managing the health of the population

A Commissioner / Provider Alliance model - responsible for delivering transformed health and social care services over the contract term (10 years). An initial 1 year transition period with an option to extend by a further 9 years.

The Alliance is:
Age UK Croydon
Croydon CCG
Croydon Council Adult Social Care
Croydon GPs Group (this is all the GP practices in the borough)
Croydon Health Services NHS Trust
South London & Maudsley NHS Foundation Trust
Alliance to move to an Accountable Care model over time.

Patient Benefits

- Proactive and preventative care
- Implementation of Integrated Care Networks
- Realisation of Living Independently For Everyone (LIFE)
- Personal Independence Co-ordinators (PICs) led by Age UK Croydon

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Improving Our Performance

A continuing record of performance improvement for Croydon

Performance Indicator	Target	2016/17					2017/18					2018/19					Comment
		Q1	Q2	Q3	Q4	Full Year	Q1	Q2	Q3	Q4	Full Year	Q1	Q2	Q3	Q4	Full Year	
A&E 4-hour Wait	95%																Increased demand mitigated by new local urgent care services
18-week RTT	92%																Historically good CCG performance impacted by Kings/St Georges issues
Diagnostic Test Wait	1.0%																Improved performance due to provider investment
Cancer 2-week wait	93.0%																Continuation of current good performance
Cancer 62-day wait	85.0%																Improved performance due to provider investment
Dementia Diagnosis >65	66.7%																Continuation of current good performance
IAPT Roll-out	15%																Continuing Year on Year performance improvement
CYP – Eating Disorders	95.0%	New measure for 17/18															Reflects CCG investment in MH 2015/16 and 2016/13

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Improving Our Quality

Working across the NHS to deliver improvements in the quality of services

In alignment with the STP, the key levers for improving quality are:

- **CQUINS**: acute providers are incentivised to deliver transformation and improvement
- **Quality Premiums**: the CCG is incentivised to deliver transformation and improvement with a focus on primary care

CQUINS 2017/18, 2018/19

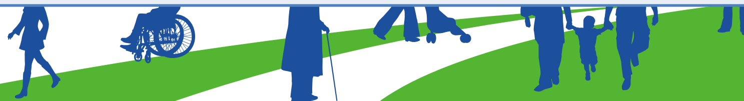
- CQUINS are being set at a national and at STP / Croydon level to a value of 2.5% of the CHS contract
- 1.5% is aligned to National standards (as below), O.5% to successful implementation of locally-agreed transformation schemes and 0.5% to meeting financial control targets

Quality Premiums 2017/18, 2018/19

- The CCG can select one local Quality premium in addition to the National schemes – to be determined

The National CQUINS & Quality Premiums are shown below

CQUINs				Quality Premiums
1. Improving Staff Health & Wellbeing	2. Reducing the impacts of serious infections	3. Improving physical healthcare to prevent premature mortality of people with serious mental illness (PSMI)	4. Improving services for people with mental health needs who present at A&E	1. Early Cancer Diagnosis 2. Access and experience
5. Transitions out of Children & Young People's mental health services	6. Offering advice and guidance	7. e-Referrals	8. Supporting proactive and safe discharge	3. Continuing Healthcare 4. Mental Health
9. Preventing ill health by risky behaviours – alcohol and tobacco	10. Improvement the assessment of wounds	11 Personalisation of care and support planning	12. Ambulance conveyance 13. NHS 111 referrals	5. Bloodstream Infections 6. Local QP (Mental Health)



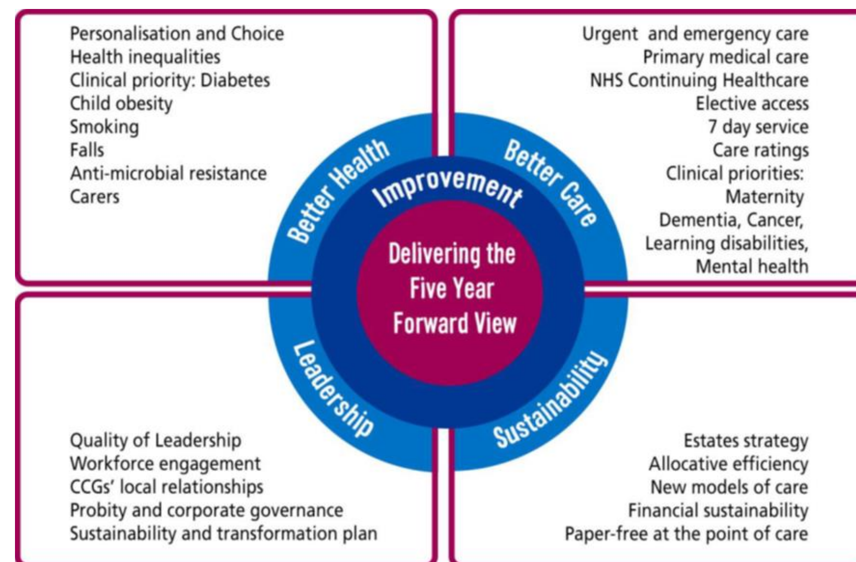
Improvement & Assessment Framework

The National CCG assessment framework, improving public accountability

The Improvement and Assessment Framework came in to effect from April 2016. To improve CCGs' accountability to the public, performance against the indicators within the four domains of Better Health, Better Care, Leadership and Sustainability are published on www.nhs.uk, along with overall ratings, in an 'Ofsted-style' scale.

Within the range of indicators, six Clinical Priority Areas have been designated, nationally as:

- Cancer
- Dementia
- Diabetes
- Learning Disabilities
- Mental Health
- Maternity



An improvement against the CCG's baseline assessment will be delivered through action plans monitored through the Focused Performance Group.

Appendices: Programmes and key work streams

Work streams	Includes
Out-of-Hospital Transformation	Integrated community networks, proactive and preventative care, Living Independently for Everyone (LIFE) programme for care homes, intermediate care
Transforming Primary Care	Implementation of the 17 standards of primary care, the GP forward view, and the 10 high impact actions
Transforming Planned Care	MSK / T&O (musculoskeletal, trauma and orthopaedics), genealogical, ENT (ear nose and throat), ophthalmology, dermatology
Together for Health	To improve patient outcomes and through actively promoting and encouraging prevention, self-care, self-management and shared decision making
UEC	AEC, 111 Integrated Urgent Care, MH Urgent Care Pathway, E-o-L Care
Cancer	Prostate, Bowel Screening, Holistic Cancer Care Review, Cancer Waits
Mental Health	Community, Acute and Crisis Care, Perinatal, Psychological Therapies, Diagnose Well, Support Well, Live Well. Support Well - Carers
Children & Young People	Inpatient Paediatrics, PAU and Ambulatory Model Childhood Obesity, CAHMS
Learning Disabilities	Transforming Care and improving care in primary care
Maternity	Pioneer programme – improving choice and personalisation for women accessing maternity services, Better Births Recommendations
Decommissioning	CCG proposals and engagement for decommissioning services
Enablers including OBC	IT, Workforce, Estates, New Models of Care, Contracting vehicles including OBC

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CCG Transformational Delivery Area: Croydon
Project: Out of Hospital

Project sponsor: Stephen Warren
Project lead: Paul Young

Objectives:

Through an ambitious Programme of innovation and by working together with the diverse communities of Croydon and with CPA, Croydon CCG will use resources wisely to transform healthcare to help people look after themselves, and when people do need care, they will be able to access high quality services

Key Milestones

1. Locally based teams with Primary Care at the centre of highly coordinated MDTs by 1st April 2017 including specific focus on patients with complex needs
2. Model for managing long-term conditions and frailty by implementing health and social care stratification tool by 30th April 2017
3. Completion of the Integrated Care Networks, with shared responsibility and risk across the system and involvement in proactive care by 4th December 2017
4. Increase access to Out of Hospital (OoH) services by developing Enhanced Health in Care Homes (EHCH) framework on integrated MDT care planning standards for care homes by 30th June 2017
5. Ensuring co-ordinated care and best practice for those patients reaching their last year of life by developing 4 EOL care campaigns by 31st March 2018

Benefits & KPIs:

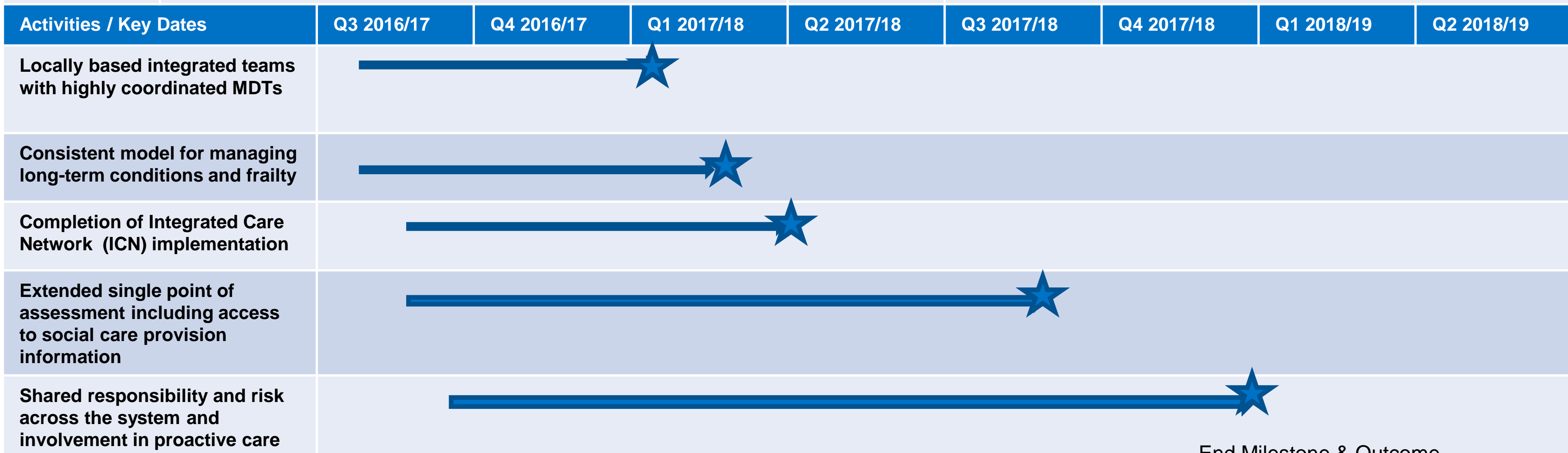
- Integrated networks and care coordination with improved access to support with improved primary care delivery.
- Developing 'My Life Plan' supporting person-led preventative care planning in the community
- Improved integration of pathways and agreed tariff costs e.g. AgeUK, Marie Currie, St Christopher's
- Expanded delivery of integrated care provision with full involvement from MH and voluntary sector
- Review and redesign of priority LTC areas of focus highlighted through benchmarking reviews.
- Implementation of initiatives to foster greater partnership between patients and professionals, to maximise health care conditions
- Extended single point of assessment including access to social care provision of information

Financial impact:

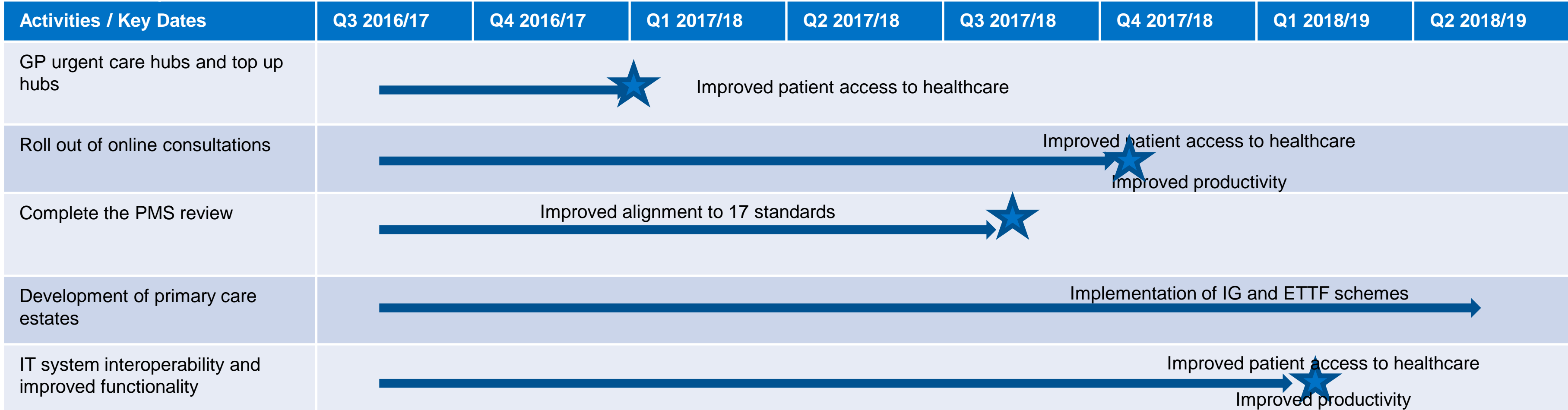
4% QIPP savings of projected activity in 17/18. 10% cost reduction in 17/18 for TACS and EOL through a reduction in deaths in hospitals from care homes and homes.

Income and activity shift for 2017/18:

- Income: Expected savings for 17/18 is £1.52M (TACS – transforming adult community services) & £.349M EOL (end of life)
- Planned Activity 17/18 is 14,643 (TACS),



CCG Transformational Delivery Area: Transforming Primary Care			Project sponsor: Stephen Warren Project lead: Pat Radley
Objectives:	To develop primary care at scale to provide a consistent quality service to residents of Croydon Implementation of the 17 standards of primary care, the GP forward view, and the 10 high impact actions		
Key Milestones	Establishment of the GP urgent care hubs and top up hubs Roll out of online consultations Development of Croydon GP collaborative to support delivery of primary care at scale Develop new roles in primary care such as care navigators, and medical assistants Complete the PMS review Development of a sustainable primary care workforce, through recruitment and training Development of primary care estates IT system interoperability and improved functionality		
Benefits & KPIs:	Benefits • Delivery of Primary Care at Scale • Transfer of care into the community • Proactive, coordinated, and accessible care • Increased capacity in primary care • Use of technology to increase patient self care • Reduction in variation through revised PMS contract • Improved sustainability of primary care		KPIs • PMS KPIs • Practice Headcount • Access delivered • Access type (online, skype, telephone) • Premises availability • Patient satisfaction • System interoperability
Financial impact:	Investment enabling the out of hospital agenda	**Income and activity shift for 2017/18**:	• Income – assumptions included under Transformation work streams • Activity - ditto

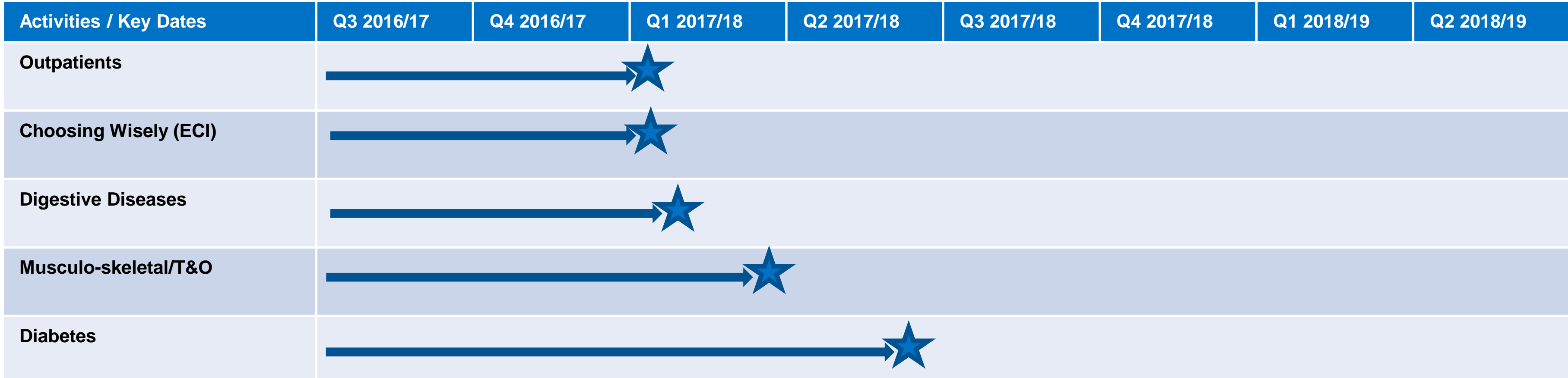


CCG Transformational Delivery Area: Transforming Planned Care	Project sponsor: Stephen Warren Project lead: Aarti Joshi

Objectives:	To work collaboratively with partners and stakeholders to transform both Outpatient and Elective care services to achieve effective and innovative models of care across local primary and community systems whilst ensure that they are clinically effective, accessible and use resources available appropriately and wisely.
Key Milestones	1. Identify, understand, agree activity flows across all providers for outpatient and elective care by December 2016.. 2. Identify and agree speciality areas of priority to drive transformational programme by December 2016. 3. Review current pathways and service models by end of January 2017. 4. Undertake options appraisal of impact on current commissioning arrangements across intermediate, community and acute services by end of January 2017. 5. Develop business case and plan to deliver and implement transformation programme by Mid February 2017. 6. Develop clear implementation plans for new proposed pathways and models of care by Mid February 2017. 7. Review and revision of ECI clinical thresholds to be completed by end of February 2017. 8. Prior approval and effective contract management processes in place by end of March 2017.

Benefits & KPIs:	• Additional capacity and resources within primary and community care setting • Enhanced workforce in Primary care. • Reduced referral variation across the borough. • Increased support and promotion of Prevention, Self Care/management and shared decision making. • Improved demand management mechanisms across the system facilitating better access to care and deliver of RTT.	• KPIs • Activity targets for outpatients and elective care. • 18 week RTT • Peer review/clinical triage impact. • Demand management targets • Prevention, Self Care/Management and Shared Decision targets.

Financial impact:	QIPP savings to the value of approximately £18m to be delivered via the transformation of outpatients and elective care over two years.	**Income and activity shift for 2017/18**:	• Income – a proportion of the efficiency target will be reinvested into primary and community care. • Activity - seeking a reduction of over 70,000 episodes of care in 17/18 and over 40,000 in 18/19



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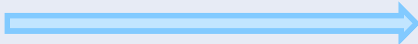
CCG Transformational Delivery Area: **Together for Health** Project: **Prevention**	Project sponsor: **Stephen Warren** Project lead: **Michael Sutton**

Objectives:	Outcome: to improve patient outcomes and experience as well as creating conditions for a more financially sustainable local healthcare system, through actively promoting and encouraging prevention, self-care, self-management and shared decision making (PSSSD) among the population to increase independence and responsibility around health.	
Key Milestones	Completion of pilot projects and delivery of evaluations in Q4 of 2016-17. Dissemination and implementation of findings in 2017-18	
Benefits & KPIs:	Long-term Outcome Measures. For example, • Increased Healthy Life Expectancy at birth, • Reduced Inequalities in life expectancy between areas of deprivation, • Lower levels of Social isolation • Reduced Smoking prevalence (18 y/o plus) • Lower incidence of Excess weight in 4-5 and 10-11 year olds • Lower incidence of Excess weight in adults • Reduced Binge drinking (% adults), Greater % active adults • Increased Number of patients who feel supported to manage their long term condition • Improved Health related quality of life for people with LTCs etc.	KPIs. For example: • Number of NHS health checks completed • Number of referrals into IAPT / % recovery rate • Number of Making Every Contact Count / Assets Based Community Development (MECC-ABCD) activities delivered • Proportion of 4 and 12 week smoking quits from priority population • Number of referrals into Tier 2 child weight management service from primary care • Number of referrals into weight management services from primary care • Number of people at increased risk of harm from alcohol who are screened/ offered brief advice in primary care • Number of referrals into Behaviour Change Services for physical activity from primary care / % participants who are more active as a result of the intervention • Increase in self-care knowledge amongst Croydon residents • Number of people attending prevention, self-care, self-management and Shared Decision Making events/activities to access information and advice • Flu vaccination uptake in 65 and over age group (with focus on those with LTCs)

Financial impact:	Financials being developed. Programme currently benefits from approx. £70K one-time Quality Premium funding in 2016-17 for a number of pilot projects.	Income and activity shift for 2017/18: tbd	• Income - None • Activity – supporting other delivery programmes

Activities / Key Dates	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
1. Delivery of an Education and Training Programme 2. Delivery of a Communication and Engagement Programme 3. Embed TFH in Targeted Areas: MSK, Diabetes, Respiratory 4. Deliver ABCD MECC community based projects 5. Pilot Projects: Brief Interventions training in a single pathway Shared Decision Making support in practice 6. Pilot Project: Group consultations 7. Develop Partnership work 8. Deliver Health Help Now app								

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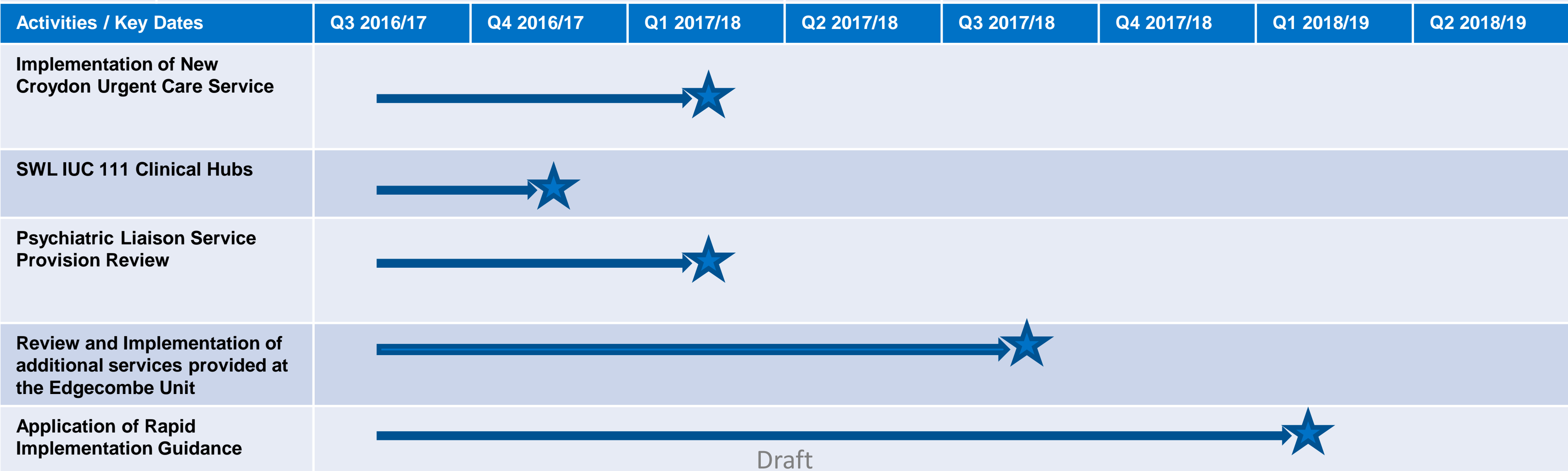
CCG Transformational Delivery Area: UEC **Project:** Urgent Care Procurement, SW London IUC, Psychiatric Liaison Nurse, Edgecombe Unit, Rapid Implementation Guidance	**Project sponsor:** Stephen Warren **Project lead:** Chris Wintle

Objectives:	- Deliver a functionally integrated 24/7 Urgent Care service for Croydon. Providing public access to the right treatment, in the right place, first time. This service will include NHS 111, GP Out of Hours, Urgent Care Centres, community services, ambulance services, social care and emergency departments. - Collaborate to deliver high quality, clinical assessment, advice and treatment with all services having access to patient records.		
Key Milestones	1. Signing of Croydon Urgent Care Contract and Implementation of New Service 2. Go-Live of SWL IUC 111 Clinical Hubs 3. Psychiatric Liaison Nurse service provision review 4. Review and Implementation of additional services provided at the Edgecombe Unit e.g. Pneumonia 5. Application of 'Rapid Implementation Guidance' to Accident & Emergency Delivery Board Plan (Streaming, Flow, Discharge, Ambulance Response and 111)		
Benefits & KPIs:	**Benefits** • Providing a seamless service and high quality care for our patients **(1-5)** • Increase opening and access points plus improve the care given. **(1,2,5)** • Reduce the confusion to patients plus improve patient care and access **(1,2)** • Reduce unnecessary admissions **(4,5)**	**KPIs** • Reduction in ED Attendances **(1,2)** • Increased performance against 4 hour target **(1-5)** • Reduction in NEL Admissions **(4,5)** • Assessments within 1 hour (Emergency) or 14 hours (Urgent) **(3)** • Length of stay of NEL Admissions **(3,4,5)** • Hospital Bed Provision **(3,4,5)**	
Financial impact:	£1,538,000 £948,000 Urgent Care QIPP £590,000 Urgent Care Contract	**Income and activity shift for 2017/18:**	• Income • Activity Shift of 7,714 ED spells into the new Urgent Care service.



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CCG Transformational Delivery Area: Cancer	**Project sponsor:** Stephen Warren **Project lead:** Angharad Rudkin

Objectives:	• Continue to support the work of Cancer Strategy Development and Implementation Group • Continue participation in National Peer Review Programme (NCPR) • Ensure that all commissioning follows NICE guidelines and reflecting management of anti-cancer treatments • Ensure all breast cancer services commissioned using best practice timed pathway with follow-up in line with NCSI including the management of those with a family history of breast cancer • Ensure all prostate cancer services commissioned using best practice pathway with follow-up in line with NCSI • Ensure all colorectal services commissioned using best practice timed pathway with follow-up in line with NCSI • Deliver the Cancer Commissioning Intentions 2017-18 - Endoscopy, imaging pathology, lung cancer, related fertility issues, prostate cancer, breast cancer, colorectal cancer • Support the continued delivery of the prostate LIS • Maintain relationship and support with MacMillan GP and the CRUK co-ordinator • Meet national performance targets for cancer • Support earlier diagnosis and treatment of cancers
Key Milestones	• This is a continuation programme from 2016/17

Benefits & KPIs:	Benefits • Reduce wait times • Improved clinical outcomes • Earlier Diagnosis • Greater patient satisfaction	KPIs • NHS Constitution targets: Cancer waits (2 week wait, etc.) • Cancer staging data • Cancer Survival rates • Patient experience

Financial impact:	Significant changes are not expected to financial position	**Income and activity shift for 2017/18**:	• Income - limited change from current trajectory • Activity – limited change from current trajectory

Activities / Key Dates	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
Breast Cancer Screening programme	→	→	→	→	→	→	→	→
Prostate Cancer Screening Programme	→	→	→	→	→	→	→	→
Colorectal Cancer Screening Programme	→	→	→	→	→	→	→	→
Enabling Programmes	→	→	→	→	→	→	→	→

CCG Transformational Delivery Area: Mental Health **Project:** Community, Acute and Crisis Care, Perinatal, Psychological Therapies, Diagnose Well, Support Well, Live Well. Support Well - Carers	**Project sponsor:** Stephen Warren **Project lead:** Jennifer Francis

Objectives:

- Decrease Occupied Bed Days (OBDs) through reduced Length of Stay (LOS) and improved discharge planning
- Timely access to evidence based person-centred care which is focused on recovery and integrated with primary and social care and voluntary care sector
- Reduction in premature mortality of people living with severe mental illness
- Physical health needs being identified and met as part of the mental health treatment provision to enable early detection
- Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder within available resources and so that at least 25% of people with common MH conditions access services each year
- Eliminate OOA placements for acute overspill patients trajectory to zero by end of 16/17 and maintain through 2017/18 and onwards.
- All acute hospitals have all age mental health liaison teams in place, with 50% meeting Core 24 standards (A&E and inpatient wards) by 2020/21
- Working with Public Health to reduce the number of people taking their own lives (national target of 10% reduction)
- Increased access to specialist perinatal mental health services in the community
- Timely Diagnosis for Dementia and developing dementia friendly community in Croydon

Key Milestones

- Scope new models of care and pathways for community, acute and crisis services; activity and workforce baseline and gap analysis against pathway
- Work with primary care to better meet the needs of people with SMI in primary care; physical care assessments and intervention;
- A framework for post diagnostic Dementia support will developed and implemented

Benefits & KPIs:

Benefits

- Effective community and primary care based services
- Effective community crisis and liaison services to ensure people only receive inpatient care when required
- People receive care closer to home and no inappropriate OAT
- Integration of MH with primary care social care and other local services
- Better care for families and patients suffering from dementia
- Improved health outcomes for patients with dementia
- Hospital admission avoidance

KPIs

- % people receiving treatment in 2 weeks (EIP)
- Specialist EIP provision in line with NICE recommendations
- People with a SMI receiving a full annual physical health check
- Increasing the number of people accessing individual placement and support
- Crisis care milestones
- OAT milestones and number of non specialist acute MH OATs
- Number of women receiving specialist perinatal care in a community team
- CCG spend on specialist perinatal community services

Financial impact:

Savings to be generated by re-procurement of IAPT to provide a more efficient service.

Income and activity shift for 2017/18:

- Activity – reduction in 4,000 OBDs from Acute Inpatient beds

Activities / Key Dates	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
Implement Work on reducing Delayed Transfers of Care								
Re-procure IAPT service to meet national targets								
Develop Enhanced Primary Care Service to support Discharge of patients into Primary Care								

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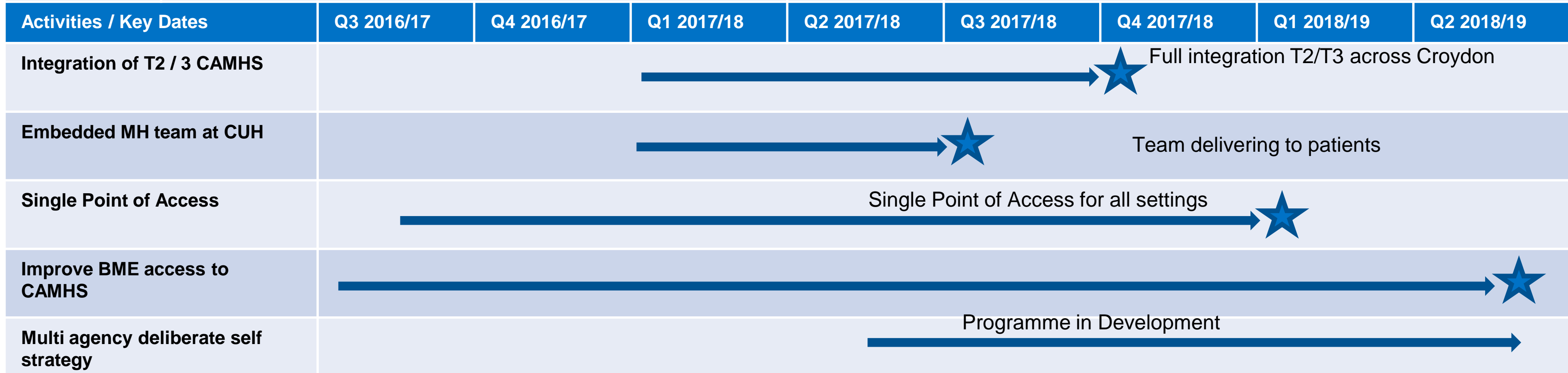
CCG Transformational Delivery Area: Children & Young People **Project:** Mental Health - CAHMS	**Project sponsor:** Stephen Warren **Project lead:** Sam Taylor/Clare Brutton/Lyndsey Hogg

Objectives:	• Delivery of Child and Adolescent Mental Health services (CAMHS) Local Transformation Plan • Greater integration of Tier 2 / 3 CAMHS services, which will give clinical assurance at Tier 2. • Improved access into CAMHS for CYP in crisis via an embedded MH team at CUH – ensuring that CYP are assessed and have a follow up plan within 4hours • Improve the shared care protocol to ensure that physical and mental health needs of CYP with complex / LD needs are met • Continue to improve access into CAMHS via the Single Point of Access – improve access in to T3 (currently 1.8% against a national average of 3.6%) • Improve BME access to CAMHS Tier 2 Tier 3 services via on line counselling and support platforms • Multi agency deliberate self strategy – to reduce ED attendance by developing more appropriate treatment pathways
Key Milestones	• Refresh service specification ensure alignment between statutory and voluntary sector. • Further pathway redesign for: Neuro Development, YOT, LAC and CSE. • Review and action planning for CAMHS national benchmarking data set • Quarterly benchmarking of key performance indicators between the 4 SLaM borough • (No new procurement is envisaged for 17/18)

Benefits & KPIs:	• Better after care and support for young people who experience MH problems • Increased access to evidence based treatment leading to improved outcomes • Improved access to evidence-based, community eating disorder services • Specialised commissioning that targets most pressing need (based on baseline review) • Reduction in waiting times • Appropriate placements to support improved outcomes for CYP in crisis • Increment in number of CAMHS workforce • Equality of access for those who are most vulnerable	KPIs • Continue to reduce DNA rates through flexible CAPA modelling of appointments, coupled with moving services into primary care – in line with PPI with both CYP and GPs. Monitoring against contract on the delivery of face to face • Improvements to ensure CYP complete treatment plans

Financial impact:	Significant changes are not expected to financial position	**Income and activity shift for 2017/18**:	• Income - limited change from current trajectory • Activity – limited change from current trajectory



CCG Transformational Delivery Area: Children & Young People
Project: Children's Health / Paediatrics / Asthma

Project sponsor: Stephen Warren
Project leads: Amanda Tuke/Sam Taylor (Asthma PM: Jane McAllister)

Objectives:

- To agree a vision for children's health services in Croydon and to make sure the impact that services have on children's health outcomes can be evidenced
- To improve patient experience and service quality through pathway redesign across acute and community services
- To evidence strengthened working of community and acute paediatric services across pathways
- To improve outcomes for children with asthma with a reduction in unplanned hospital attendances and admissions
- To make sure that the needs of children with SEND are identified and statutory responsibilities for these children are delivered to improve their health outcomes
- To reduce waiting times for ASD joint diagnostic assessments to within guidelines while maintaining good practice waiting times
- To deliver efficiency savings in the annual costs of the children's medical service

Key Milestones

- Review services and agree an overall shared vision for children's health services by Jun 2017.
- Agree cost-neutral acute and community paediatrics pathway redesign and service development priorities to strengthen integration by Sep 2017.
- Agree cost-neutral pathway redesign needed to enable improvements to Autism Spectrum Disorder (ASD) diagnostic pathway by Sep 2017.
- Asthma service audits completed to evidence service impact by Mar 2018 and asthma pathway development workshop(s) undertaken by Mar 2018.

Benefits & KPIs:

Benefits

- Improvements in children's health including improved health outcomes for children with SEN and Disability
- Improvements in patient experience and reduced waiting times for statutory and other priority pathways
- Reduction in risk of significant harm to health for children with long term conditions including asthma

KPIs

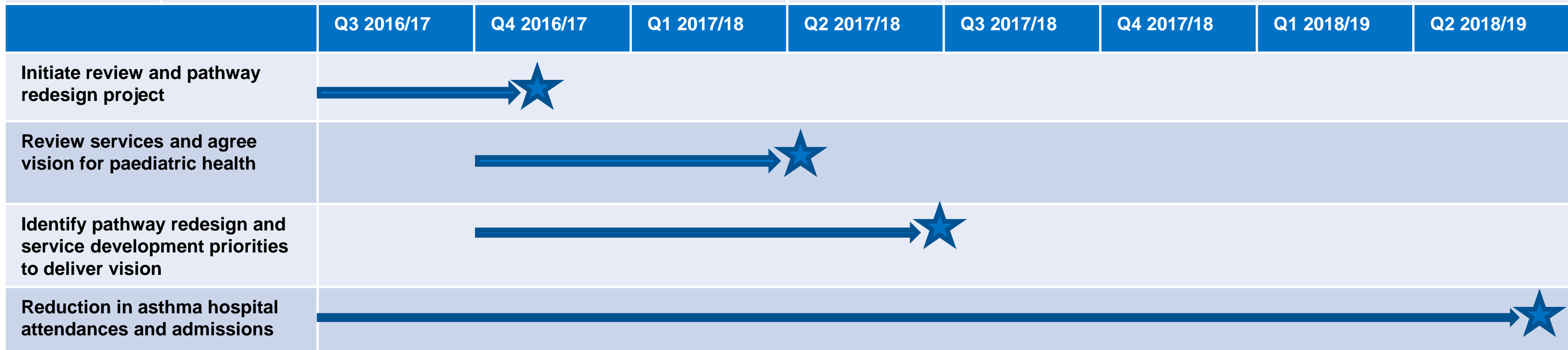
- Waiting times for ASD diagnosis
- Waiting time for health assessments for looked after children
- Delivery of assessments for Education, Health and Care plans within 6 week statutory requirements.
- Asthma - targets achieved for reductions in hospital activity

Financial impact:

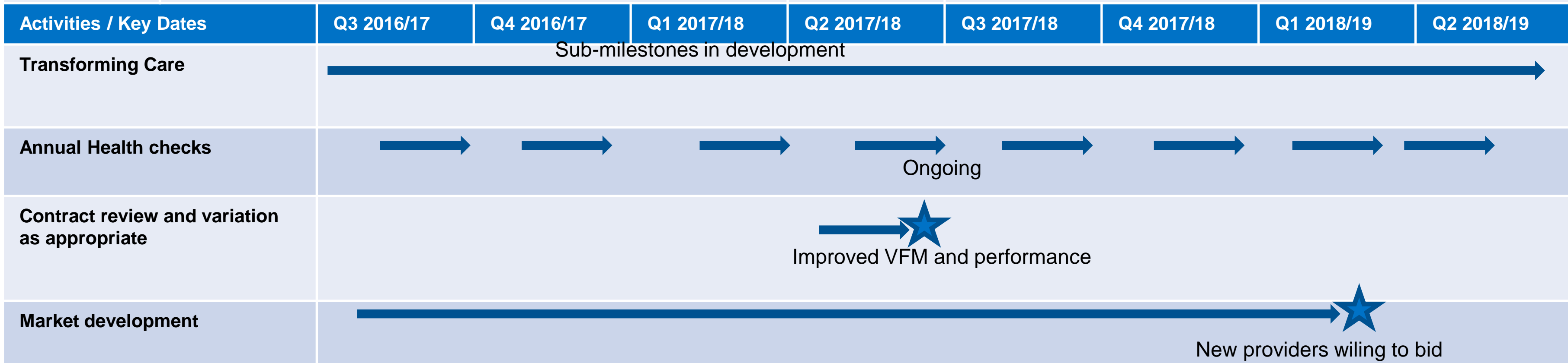
- At the outset of pathway redesign, net saving for £100,000 from realigning community paediatric clinics and staffing.
- Further savings to be identified through review process.
- QIPP targets achieved for asthma

Income and activity shift for 2017/18:

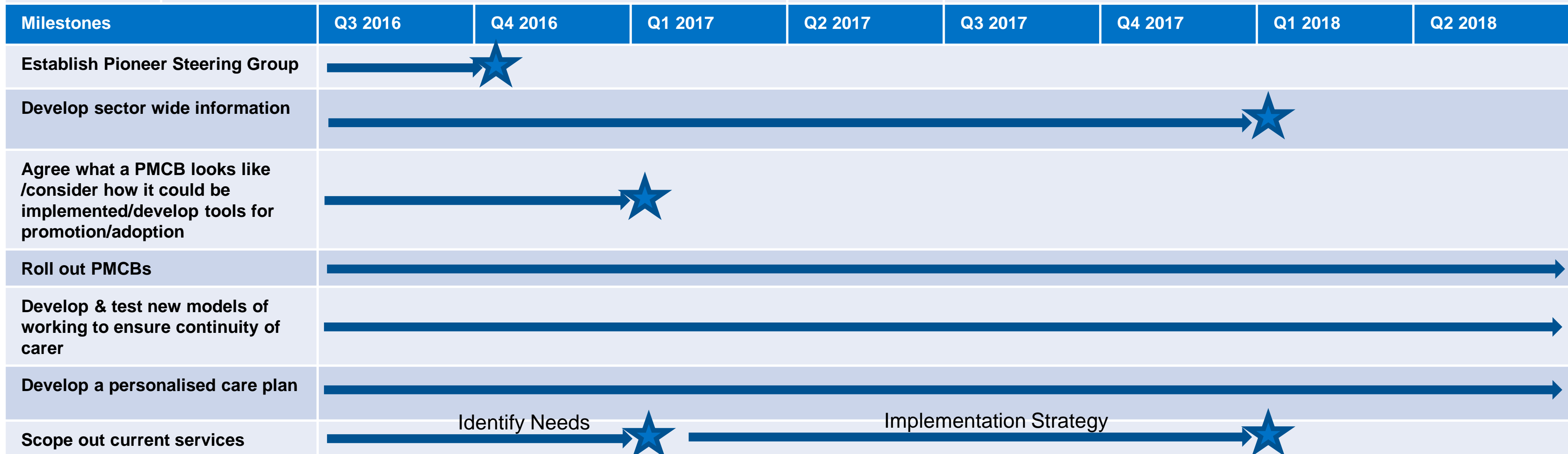
- Reduced activity in children's community medical services.
- Asthma - investment continues at current level (mainstreamed) and a reduction of 10% in unplanned hospital activity



CCG Transformational Delivery Area: Learning Disability /Transforming Care		Project sponsor: Stephen Warren Project lead: Suzanne Culling	
Objectives:	To deliver the objectives listed in the SWL Transforming Care Plan including : - Discharge remaining individuals in Transforming care cohort to appropriate community placements - Plan ahead for the next cohort stepping down from NHS England provision - Use risk register to reduce reliance on out of area in –patient units - Commission community services that prevent hospital admission - Commission range of housing based community support - Market development including review of current provider contracts for quality and value - Forward plan re likely demand for complex care support - Ensure people with LD have full access to mainstream and specialised support locally - Reduce health inequalities and ensure there is access to Annual health checks in primary care - Improve the number of GP health checks		
Key Milestones	• Transforming care Partnership : use the 3 work streams to inform the delivery of objectives by March 2020 : ○ adult care pathway ○ 0-25 care pathway ○ Provider development • Commissioned pathways - review specialist contracts with CHS and SLAM • Increase awareness of and uptake of access of AHC July 2017		
Benefits & KPIs:	Benefits • Improved quality of life for people with LD • Improved access to wider healthcare services • Greater parity of access for people with LD to primary and secondary care	KPIs; • Reduction in in patient usage for people with learning disabilities • increase local performance target from 49% to 75% which is the national target for access to annual health checks of 75%	
Financial impact:	In development	**Income and activity shift for 2017/18**:	• Income – in development • Activity – in development



STP Theme: Maternity **Project:** Choice and Personalisation Pioneer			**Project sponsor:** Paula Swann **Project lead:** Maggie Lam, Sam Taylor, Caroline Boardman
Objectives:	• To deepen as well as widen the choices available to women across CCG boundaries, including exploring attracting new providers into the area • To increase the availability of home births and midwife-led care • To improve continuity of care and carer throughout the maternity pathway • To deliver more personalised and woman-centred care • To increase early access to maternity services • To trial Personal Maternity Care Budgets		
Key milestones and activities:	• Establish a Pioneer Steering Group to shape and lead the work of the Pioneer with associated Task and Finish Groups (completed) • Develop sector wide information to inform women of all the choices that are available to them • Develop a decision aid to enable healthcare professionals and women to hold meaningful discussions on the choices available and reach agreement • Consider the introduction of a single point of access for women across SW London • Develop and test new models of working to ensure continuity of carer for women across the maternity pathway • Develop a personalised care plan based on a woman's needs and preferences • Agree what a Personal Maternity Care Budget might look like; consider how it could be implemented; develop tools for how PCMBs can be promoted/adopted • Identify current and/or new commissioned services which could be the basis for testing the market, with the potential for introduction of new providers		
Benefits & KPIs:	• Improved patient experience with women reporting an increase in the choices offered to them across the maternity pathway • Improved outcome measures – less intervention, lower caesarean section rates, lower rate of episiotomy • An increase in the number of home births and midwife led births • Reduced health inequalities • Reduced staff turnover • Women report feeling empowered to make decisions about their care		
Financial impact:	No expected financial savings. Initiatives are largely around delivering quality improvements	**Income and activity shift for 2017/18:**	N/A



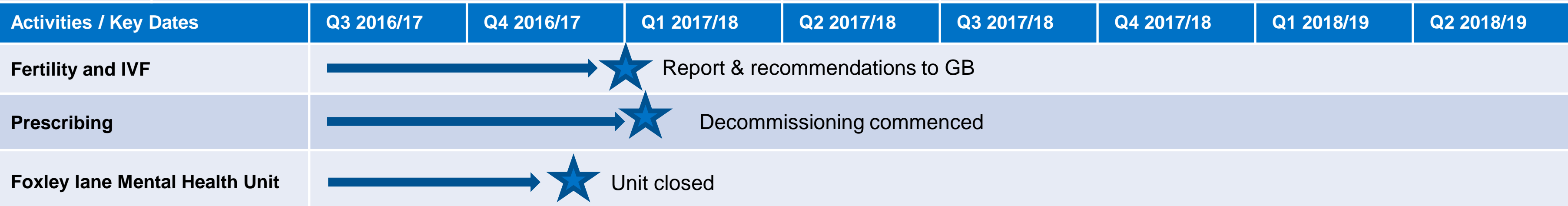
Croydon Clinical Commissioning Group

CCG Transformational Delivery Area: **Planned Care, Mental Health and Prescribing** Project: **Service Decommissioning**	Project sponsor: **Stephen Warren** Project lead: **Aarti Joshi, Jennifer Francis, Janice Steele**

Objectives:	To restructure the provision of a range of services, emphasising community-based services and self-care, with provision for clinically appropriate exceptions. The list includes the following services: • Fertility and IVF services • Primary care prescribing of i) Gluten free foods ii) travel immunisations, iii) Vitamin D iv) over the counter medicines • Secondary care prescribing of i) Liothryonine ii) Lidocaine patches • Foxley Lane Mental Health Unit
Key Milestones	• Fertility and IVF - i) Public consultation complete - 01/03/17 ii) Post consultation report and recommendations to GB 14/03/17 • Prescribing - i) Public engagement complete 06/01/17 ii) Post engagement report and recommendations to GB 19/01/17 iii) Decommissioning commenced 01/04/17 • Foxley Lane – i) Public engagement completed 06/01/17 ii) Post engagement report and recommendations to GB 17/01/17 iii) Unit closed 15/02/17

Benefits & KPIs:	Benefits are primarily concerning Value For Money that contribute to returning the CCG and wider health economy to financial sustainability.	KPIs • Process KPI – ongoing monitoring of public engagement in each project • If projects move beyond public engagements to implementation, financial savings will be monitored. Clinical exceptions will also be observed to facilitate patient safety and appropriate use of services • Should fertility and IVF service moves to decommissioning the cohort of patients who have already commenced treatment will be closely followed to enable provision of a full service across the whole pathway

Financial impact:	The full year savings effect on the assumption that services are decommissioned – Fertility and IVF services - £416,000 Prescribing - £511,000 Foxley Lane Mental Health Unit - £576,000	**Income and activity shift for 2017/18**:	• Income – No negative income impact on the CCG



CCG Transformational Delivery Area: Enablers including OBC **PROJECT IT, Workforce, Estates, New Models of Care, Contracting vehicles incl. OBC**		**Project sponsor: CCG Directors** **Project leads: Simon Lee, Simon Keen, Martin Ellis, David Boothroyd**	
Objectives:	• To deliver the enabling foundations for the delivery of the CCG Annual Operating Plan 2017/18, 2018/19 across IT, Workforce, Estates, New Models of Care and contracting vehicles including OBC		
Key Milestones	• IT: delivery of pan SWL STP IT enabling projects (care record integration, practice wireless, pc video consultations, Kanesis) by end 2017/18 • Workforce: completion of a further review of workforce planning to support the new models of care in Q1 2017/18 • Estates: delivery of ETTF schemes for East Croydon and New Addington by end 2018/19 and support the premises Improvement Grant process • New Models of Care: to be developed as part of the Out-of-Hospital programme • Contracting vehicles including OBC: Signing of the OBC contract in April 2017		
Benefits & KPIs (OBC focus):	Benefits • that are more joined up and allow people to live more independently, stay at home for longer and are better suited to the needs of the people that use them • that incentivise proactive health and wellness management across the population, improve outcomes and user/patient experience • that are not activity driven – as not all activity is necessary or effective • that put the users/patients at the centre of their care, supported to manage their lives/conditions and actively involved in decisions about their care • that use health and social care resources more effectively	KPIs OBC has five high-level domains reflecting the patient linked outcomes which clearly demonstrate achievement or otherwise of the desired outcomes 1) I want to stay healthy and active for as long as possible; 2) I want access to the best quality care available in order to live as I choose and as independent a life as possible; 3) I want to be helped by a team/person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me; 4) I want to be supported as an individual with services specific to me; and 5) I want good clinical outcomes.	
Financial impact:	These are enabling programmes. The financial impacts are shown in the delivery plans above	**Income and activity shift for 2017/18:**	• Income: see delivery plans in previous slides • Activity: see delivery plans in previous slides