Nottingham & Nottinghamshire Clinical Commissioning Group

Financial Strategy: 2019/20 to 2023/24

PLEASE NOTE: Whilst this document is largely complete, this version remains a working draft which is still being developed and written. There may be some gaps (identified with placeholders) and further editing to be undertaken. It is being shared at this stage to seek further comment and input.

Executive Summary

The financial allocations for the Nottingham and Nottinghamshire CCGs for the five years to 2023/24 have been confirmed as part of the NHS Long Term Plan. This means that for the first time in a number of years we have the certainty over the CCGs' collective resources that we need to allow us to set out a comprehensive medium term Financial Strategy which meets our short-term and longer-term financial requirements. This medium term Financial Strategy is one which will also enable the new single CCG to deliver its commissioning strategy, and the local health and social care system to deliver both its emerging clinical strategy, and also the vision and objectives of the NHS Long Term Plan.

To achieve all of these objectives will be very challenging, and we will need to move at pace and scale in order to do so successfully, but the high level opportunities and priorities have been identified and agreed, and we are resolved to working with system partners to ensure that we meet both our own financial targets, and also those of the wider system, whilst at the same time ensuring that the standard and quality of care for patients, and the performance of our clinical services, not only does not deteriorate, but actually improves, over this five year period.

In order to do this there are five key objectives that this Financial Strategy seeks to achieve:

1. Over the next five years, we will ensure that investment in primary care and community services will grow faster than our allocation. There will be a financial benefit from this investment as demand for emergency care will be reduced – a planned return on investment of approximately 3:1. We will ensure these investments represent value for money, and that these services are productive and outcomes-focussed, working with partners to create the right financial environment to create a sustainable urgent care system. These investments must include additional funding in preventative services.
2. We will invest in mental health services to ensure that expenditure grows faster than the overall CCG allocation, to enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people.
3. We will ensure that the funding is available to increase the number of planned operations and cut long waits. A digital model of outpatient services will increase productivity and efficiency whilst improving the experience for patients.
4. We will realise the financial benefits of merging six CCGs together as one, and the efficiencies that can be made both directly through more streamlined structures which avoid duplication of efforts, but also the indirect benefits of the merger – commissioning at scale and being able to direct resources in a focussed way at the CCGs' priorities in order to deliver real transformational change. Merging our six CCGs' financial allocations into one also allows additional flexibility and resilience which reduces the financial risk compared to having six individual organisations each with its own control total and statutory requirement to make a surplus or break even each year.
5. We will work with provider colleagues, and our local authority partners, within the Nottingham and Nottinghamshire Integrated Care System (ICS) to ensure the health and care system is affordable and sustainable. Without joint working, we will not solve our collective problems, and merely move the financial challenge around different parts of the system. This is not our aim, and we will adopt a collaborative approach in the delivery of this strategy.

Through all of the above, we will seek to achieve the best possible value for every pound of allocation we spend as a CCG and as a system.

Medium Term Financial Plan

Based on our modelling, we will deliver an in-year surplus for each CCG, totalling £2.3m, as planned in 2019/20, but with non-recurrent mitigations of approximately £25m meaning that the exit underlying recurrent position will be a £22m deficit heading into 2020/21.

We will then deliver an in-year break-even for the new single CCG in each of the four years of the plan from 2020/21, and will start to deliver a recurrent underlying surplus from 2021/22.

Strategic Investments

Investments in the right services are key to delivering transformation to achieve the objectives of the Long Term Plan and the local clinical services strategy. Our planned investments are focussed in three key priority areas: (1) Mental Health, (2) Primary Care and (3) Community Services. These investments will support reductions in acute activity which will result in QIPP efficiency savings.

Quality, Innovation, Productivity and Prevention (QIPP)

Our MTFP model quantifies a cumulative QIPP requirement of £197m over the five years to 2023/24 in order to bridge the projected financial gap and hit the single CCG's control total in each year.

This is more heavily weighted towards the earlier years, with the requirement in 2020/21 being a 3.4% reduction on "do nothing" spend, reducing to 1.1-1.2% in 2022/23 and 2023/24. Whilst the plan for 2019/20 is £78.2m (4.7%), and we are currently working to deliver this in full, the current risk assessment is that only £55.5m (2.4%) of the target will be delivered recurrently, meaning that the balance (£22.7m) will need to be found in 2020/21 as part of a £58.9m QIPP requirement (3.4%). This will be very challenging, but the scale and ambition of the transformation planned over the next 2-3 years will ensure that the £99m of QIPP that we are planning to deliver in 2020/21 and 2021/22 can be achieved. This represents over half of the recurrent QIPP forecast over the five year period.

This is an important point to emphasise, both in this document, and also in the discussions that will follow both within the CCGs and with partner organisations. The QIPP requirement will be reduced in later years, but only if we deliver the transformation required in the early years of the strategy at the scale set out in this strategy. If we fail to deliver the transformation then the financial gap will not go away and will only be greater in future years. It is therefore vital that we drive the required changes at pace and in collaboration with partner organisations.

Collaboration with Integrated Care Providers (ICPs)

In order for the Financial Strategy to be successful and deliver as planned, we need the support and commitment of our local provider partners. We are under no illusions; the current local system is unaffordable in the short term, and there will be a need to reduce cost in the short term, where this is clinically appropriate. This will challenge our relationships but also there is a growing sense of shared responsibility for the system control total which is an essential prerequisite for the changes ahead.

Digitalisation, Analytics and IM&T

Digitalisation, Analytics Information Management and Technology will have a key role to play in the delivery of many of the wider service changes described in this strategy which will generate efficiency savings. We will ensure we identify and secure the required funding, through all routes open to us, in order to deliver the investments required to support the transformation of clinical services.

Governance and Reporting

The CCGs have implemented a Governance and Accountability Framework in 2019/20 which describes governance, roles and responsibilities for overall financial performance, financial reporting, financial controls and financial recovery (achievement of QIPP target). The working governance arrangements, effective from June 2019, include Finance and Turnaround Committees in Common and Audit and Governance Committees in Common.

There will be a need to report at different levels in the new system architecture that will be in place. We will no longer report as six CCGs as we will no longer be six statutory organisations. This will mean that there will no longer be a need to achieve financial balance for each individual organisation and can instead spread the financial risk across a larger single budget. However, instead we will need to report at ICP level. We will also look to develop a framework to align costs with PCNs so we can understand the resource consumption of different PCNs with different needs.

Each of the current CCGs have been given details of their financial allocation of resources for the next five years. The allocations process uses a statistical formula to make geographic distribution fair and objective, so that it more clearly reflects local healthcare need and helps to reduce health inequalities. Although the financial allocations would be combined for a single CCG the organisation will be able to make spending decisions in line with the needs of the local populations.

ICS Priorities and ICS Outcomes Framework

This Financial Strategy is aligned with the emerging system-level Outcomes Framework. The ICS Board recently confirmed that the ICS Outcomes Framework is being based on the triple aims (improved health and wellbeing, transformed quality of care, and sustainable finances), whilst increasing healthy life expectancy remains the overarching system outcome.

Strategic Alignment

There are a number of ICS-wide strategies currently under development which are expected to be completed in summer 2019 in order to inform the local response to the Long Term Plan.

1. Clinical Services
2. Mental Health
3. Primary Care
4. Workforce
5. Estates
6. IM&T

We will ensure that as the objectives and requirements of these strategies become clearer this Financial Strategy continues to be aligned with the plans contained within. As a general principle, we will aim to ensure sufficient funding is available to deliver the system outcomes and maximise the value of every pound we spend as a CCG and as a system.

ICS Financial Plan

It should be noted that a five year plan is currently being developed for the ICS over summer 2019. This CCG Financial Strategy is aligned to the principles and assumptions feeding into this wider plan. As the ICS plan develops and undergoes revision following review by Directors of Finance across the system we recognise that the CCG plan may need revisions to maintain alignment.

Next steps – delivering the strategy

This document is of course just a strategy; it is a articulation of our intentions, our priorities and our objectives, and a high level set of actions we will take in order to fulfil these and achieve the high level impacts that have been modelled in order to achieve financial affordability in each year. But now we need to ensure that it becomes more than just another strategy that is produced, archived and never delivered.

Over August and September we will ensure that the key messages and our intentions are shared with key primary care and secondary care partners. Without their support we will not deliver the vision, the transformation, or – most importantly for this particular strategy – the numbers. The CCG strategy is currently aligned with the principles of the ICS strategy, and we need to ensure this remains the case as the latter evolves and crystallises as our local response to the Long Term Plan.

Over October and November we will work up detailed delivery plans through our QIPP planning process, and wider financial planning process, ensuring close working between Finance and Commissioning colleagues within the CCG, but also more widely with system partners to ensure co-production, and early buy-in and agreement.

Over December and January we will ensure that we agree contracts for 2020/21 which align with our commissioning intentions and which are of an appropriate value and form to bring about the transformation we seek to deliver. We need to transform our system so that the right care is delivered in the right place at the right time, but we must not destabilise out partners in the process.

August - September 2019

Key financial message communicated to Primary Care and Secondary Care partners.

August - September 2019

Key commissioning intentions and actions communicated to provider partners

August - September 2019

Continue system engagement with jointly developed financial plan

August - September 2019

Commence QUIPP identification process

October - November 2019

Develop detailed delivery plans for efficiency

October - November 2019

Further enhance system financial planing process with detail

October - November 2019

Commissioning co production across the system for all plans

December 2019 to January 2020

Review contract reform opportunities

December 2019 to January 2020

Commence and complete contract negotiation

Content

1. Context and 2018/19 Position

The two Mid-Nottinghamshire CCGs (Mansfield & Ashfield CCG and Newark & Sherwood CCG) have made considerable progress in addressing their governance and leadership requirements and financial management concerns. They were rated as "Good" at the 2018/ 19 year-end annual assessment, which is an improvement from the previous year where both CCGs were rated "Requires Improvement".

It is recognised that there is a structural deficit in the Mid-Nottinghamshire system. In recent years there has been movement of the financial problem between providers and commissioners but overall a reduction in system costs is required. Building on the work of the Vanguard and Alliance programmes, the Integrated Care Provider Board, which includes the Mid-Nottinghamshire CCGs, is taking forward the transformation required.

Although the scale of the financial challenges within the CCGs meant that special measures remained in place during 2018/19, these have now been lifted.

The four Greater Nottingham CCGs (Nottingham City, Nottingham North & East, Nottingham West and Rushcliffe) have delivered their Control Totals for all years over the period 2013/14 to 2018/19 and cumulative surplus growing from £10.2 million in 2013/14 to £19.3 million in 2018/19. None of the Greater Nottingham CCGs are subject to financial management concerns.

All six CCGs worked with Deloitte in 2018/19 to establish a robust and consistent financial baseline which the newly appointed Executive team and Governing Body can take forward. The CCGs exited 2018/19 with a combined underlying deficit of £25.4m and a savings/QIPP challenge of £78.2m in 2019/20. This position has been presented to Governing Bodies, discussed and reviewed at Finance committee's and shared with regulators, system partners and auditors.

2. Medium Term Financial Plan - Key Metrics

Based on our current risk assessment, we will deliver an in-year surplus for each CCG, totalling £2.3m, as planned in 2019/20, but with non-recurrent mitigations of approximately £25m meaning that the exit underlying recurrent position will be a £22m deficit heading into 2020/21.

The MTFP, as set out below, will then deliver an in-year break-even for the new single CCG in each of the four years of the plan from 2020/21, and will start to deliver a recurrent underlying surplus from 2021/22.

Metric	2019/20	2020/21	2021/22	2022/23	2023/24
Total RL (£m)	£1,586.7	£1,650.9	£1,719.8	£1,786.5	£1,852.7
Planned In Year Total Surplus / (Deficit) £m	£2.3	£0.0	£0.0	£0.0	£0.0
Planned Recurrent Surplus / (Deficit) %	(0.3%)	(0.5%)	0.2%	0.4%	0.7%
FOT Exit Recurrent Surplus / (Deficit) £m	(£22.3)	(£0.3)	£11.5	£15.8	£21.9
FOT Exit Recurrent Surplus / (Deficit) %	(1.4%)	0.0%	0.7%	0.9%	1.2%
FOT Cum Surplus / (Deficit) c/f (£m)	£9.5	£11.8	£11.8	£11.8	£11.8
FOT Cum Surplus / (Deficit) % (excl. PCCC)	0.7%	0.8%	0.8%	0.7%	0.7%
QIPP Target (£m)	£78.2	£58.9	£40.3	£22.0	£20.2
QIPP Target %	4.7%	3.4%	2.3%	1.2%	1.1%
Provider efficiencies in contracts (1.1%)	n/a	£9.2	£9.6	£10.0	£10.5
QIPP + Provider Efficiencies (£m)	£78.2	£68.1	£49.9	£32.1	£30.7
QIPP + Provider Efficiencies %	4.7%	4.0%	2.8%	1.8%	1.6%

3. Medium Term Financial Plan – Statement of Comprehensive Net Expenditure

We have completely refreshed our MTFP model up to 2023/24, including adopting a bottom-up approach to quantifying the impact of QIPP efficiencies on different service areas, and incorporating the output of a detailed demand projection modelling exercise to inform the "do nothing" activity projections – assumptions also used in the ICS financial planning and strategy approach.

The output of this MTFP model is set out in the table below.

£m	2019/20	2020/21	2021/22	2022/23	2023/24
	FOT	FOT	FOT	FOT	Plan
Core Allocation	1,417.8	1,478.3	1,539.1	1,599.4	1,658.8
Primary Care Delegated Allocation	146.4	152.8	160.9	167.4	174.1
Running Cost Allocation	22.4	19.8	19.8	19.8	19.8
Total Allocation	**1,586.7**	**1,650.9**	**1,719.8**	**1,786.5**	**1,852.7**
Acute	774.8	789.7	809.8	830.1	853.0
Mental Health	160.1	167.7	175.4	184.1	191.8
Community	131.3	140.9	149.4	157.7	164.1
Continuing Care	112.4	117.8	124.1	131.0	138.4
Prescribing	145.8	148.8	152.4	156.8	162.1
Other Primary Care	32.2	36.6	40.5	44.4	47.8
Other Programme	60.3	79.6	91.8	99.5	96.2
Primary Care Co-Commissioning	147.1	152.0	160.1	166.5	173.2
Running Costs	20.3	17.7	16.4	16.5	16.7
Total Costs, excl. contingency	**1,584.3**	**1,650.9**	**1,719.8**	**1,786.5**	**1,843.4**
Contingency	-	-	-	-	9.3
Total Costs	1,584.3	1,650.9	1,719.8	1,786.5	1,852.7
In Year Total Surplus / (Deficit)	**2.3**	**0.0**	**0.0**	**0.0**	**0.0**

This financial plan is underpinned by a set of assumptions about demographic and non-demographic growth, cost inflation, QIPP efficiencies, provider efficiencies, investments and cost pressures, as set out in Appendix A. The assumptions around demographic and non-demographic growth represent the output of a detailed exercise by the CCGs' Information and Performance team to model the expected activity growth for the next five years based on historic trends, demographic projections and disease prevalence projections. The assumptions around cost/tariff inflation and provider efficiencies have been updated in line with those included in Appendix B in the NHS Long Term Plan Implementation Framework issued on 27 June 2019.

Appendix B contains further detail about the allocation assumptions used in the plan.

4. Strategic Investments

Investments in the right services are key to delivering transformation to achieve the objectives of the Long Term Plan and the local clinical services strategy.

Our planned investments are focussed in three key priority areas: (1) Mental Health, (2) Primary Care and (3) Community Services, as set out below:

£m	2020/21	2021/22	2022/23	2023/24	4 Year Total
	FOT	FOT	FOT	Plan	
Mental Health	5.6	6.0	3.8	2.7	18.1
Community	6.9	5.6	2.7	2.1	17.3
Primary Care	3.4	2.8	2.7	2.1	11.0
Total investment	**15.9**	**14.4**	**9.2**	**6.9**	**46.4**

These investments will support reductions in acute activity which will result in QIPP efficiency savings.

These areas of expenditure will attract "do nothing" growth inflation in addition to these targeted investments, but will also be subject to QIPP, where appropriate, as set out below, and provider efficiencies of at least 1.1%. However, the new money that we are planning to invest in these areas means that net growth in each of these three areas will not just be in line with the overall core allocation uplift, but in excess of this, as set out in the three sections that follow.

Mental Health

We will invest in mental health services to ensure that they grow faster than the overall CCG allocation, to enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people. This will ensure we improve our IAPT performance. We will also look to invest in closer-to-home alternatives to out-of-area placements.

£m	2020/21	2021/22	2022/23	2023/24
	FOT	FOT	FOT	Plan
Allocation uplift	**4.3%**	**4.1%**	**3.9%**	**3.7%**
Mental Health PY	160.1	167.7	175.4	183.2
Investment required	6.8	6.9	6.9	6.8
Mental Health CY	167.7	175.4	184.1	191.8
Investment planned	7.6	7.7	8.6	7.8
Additional investment	0.8	0.8	1.8	0.9

Primary Care & Community

Over the next five years, we will ensure that investment in primary care and community services will grow faster than our allocation. We will benefit financially from this investment as demand for emergency care will be reduced – a return on investment of approximately 3:1.

Primary Care

£m	2020/21	2021/22	2022/23	2023/24
	FOT	FOT	FOT	Plan
Allocation uplift	**4.3%**	**4.1%**	**3.9%**	**3.7%**
Primary Care Co-Commissioning PY	147.1	152.0	160.1	166.5
Other Primary Care PY	32.2	36.6	40.5	44.4
Total Primary Care PY	179.2	188.6	200.6	210.9
Investment required	7.6	7.8	7.9	7.8
Primary Care Co-Commissioning CY	152.0	160.1	166.5	173.2
Other Primary Care CY	36.6	40.5	44.4	47.8
Total Primary Care CY	188.6	200.6	210.9	221.1
Investment planned	**9.4**	**11.9**	**10.4**	**10.1**
Additional investment	1.7	4.2	2.5	2.3

Community Services

£m	2020/21	2021/22	2022/23	2023/24
	FOT	FOT	FOT	Plan
Allocation uplift	**4.3%**	**4.1%**	**3.9%**	**3.7%**
Community Services PY	131.3	140.9	149.4	157.7
Investment required	5.6	5.8	5.9	5.9
Community Services CY	140.9	149.4	157.7	164.1
Investment planned	9.6	8.5	8.3	6.3
Additional investment	4.0	2.7	2.5	0.5

5. Quality, Innovation Productivity and Prevention (QIPP)

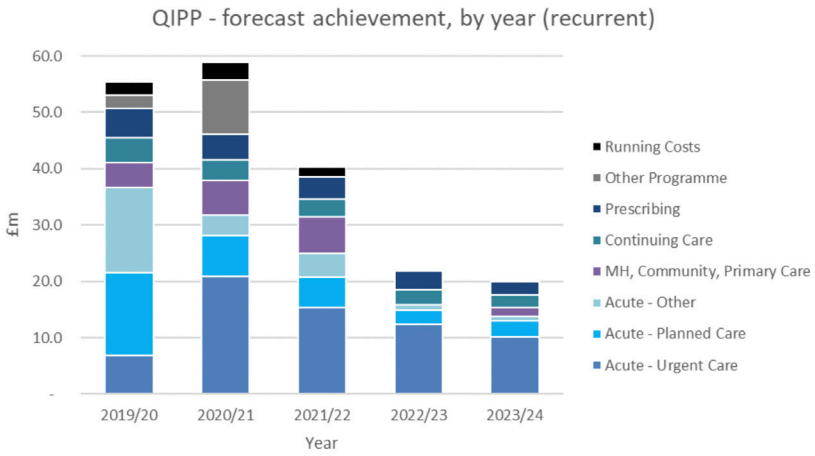
Our MTFP model quantifies a cumulative QIPP requirement of £197m over the five years to 2023/24 in order to bridge the projected financial gap and hit the single CCG's control total in each year.

This is more heavily weighted towards the earlier years, with the requirement in 2020/21 being a 3.4% reduction on "do nothing" spend, reducing to 1.1-1.2% in 2022/23 and 2023/24, as shown in the table below. Whilst the plan for 2019/20 is £78.2m (4.7%), and we are currently working to deliver this in full, the current risk assessment is that only £55.5m (2.4%) of the target will be delivered recurrently, meaning that the balance (£22.7m) will need to be found in 2020/21 as part of a £58.9m QIPP requirement (3.4%). This will be very challenging, but the scale and ambition of the transformation planned over the next 2-3 years will ensure that the £99m of QIPP that we are planning to deliver in 2020/21 and 2021/22 can be achieved. This represents over half of the recurrent QIPP forecast over the five year period.

This is an important point to emphasise, both in this document, and also in the discussions that will follow both within the CCGs and with partner organisations. The QIPP requirement will be reduced in later years, but only if we deliver the transformation required in the early years of the strategy at the scale set out in this strategy. If we fail to deliver the transformation then the financial gap will not go away and will only be greater in future years. It is therefore vital that we drive the required changes at pace and in collaboration with partner organisations.

£m	2019/20 Plan	2019/20 FOT	2020/21 FOT	2021/22 FOT	2022/23 FOT	2023/24 FOT	5 Year Total
Total QIPP	78.2	55.5	58.9	40.3	22.0	20.2	196.9
As % of "Do Nothing" expenditure	4.7%	3.4%	3.4%	2.3%	1.2%	1.1%	

The graph below summarises the forecast recurrent delivery by year, by service area. Note that the 2019/20 figures represent a risk-adjusted forecast based on current estimates.



The model also assumes, in addition to the QIPP set out here, that the CCG's providers will achieve productivity efficiencies of 1.1% a year, in line with assumptions set out in the Long Term Plan.

The QIPP assumptions broadly align with ten draft "high impact levers of change" identified by the Nottingham and Nottinghamshire ICS Programme Team to inform the system Five Year Plan. These have not yet been quantified and the quantitative assumptions used in this Financial Strategy are CCG assumptions, not ICS assumptions. The draft levers of change are set out in Appendix D.

The QIPP assumptions also align with the delivery plans for key service areas which are set out in the Commissioning Strategy. No direct cost savings are expected from the Learning Disability and Autism delivery plans, and the impact of the Cancer delivery plans are very difficult to quantify and therefore no savings associated with this service area are included here.

5.1 Acute Expenditure

Of the total QIPP requirement, approximately two-thirds (£123m) is allocated against the acute sector:

£m	2019/20 FOT	2020/21 FOT	2021/22 FOT	2022/23 FOT	2023/24 Plan	5 Year Total
Acute – Urgent Care	6.9	20.9	15.4	12.4	10.2	65.8
Acute – Planned Care	14.6	7.3	5.3	2.5	2.7	32.4
Acute – Other	15.1	3.6	4.2	1.1	0.8	24.9
Acute – TOTAL	**36.6**	**31.8**	**24.9**	**15.9**	**13.8**	**123.1**

5.1.1 Urgent Care (£66m)

Key impacts:

- **Reduction in ambulance conveyances (£3.2m)**
- **Reduction in A&E attendances (£4.3m)**
- **Reduction in emergency admissions (£29.2m)**
- **Reduction in emergency length of stay (£29.2m)**

Years 1-3 will see a focus on Urgent and Proactive Care, with investment in in primary and community care, both as part of Primary Care Networks and more widely, to improve capacity and to ensure that a greater proportion of people with long term conditions stay well and have access to out-of-hospital services when they need them. This will include targeted support for elderly people living in care homes and those within in the last 12 months of life, to avoid acute hospitalisation for these groups of people through providing alternative care in the community.

Over the five year period we will continue to develop and refine the ICS Population Health Management approach, with proactive identification of "at risk" patient groups and individuals to ensure an earlier targeted intervention can be put in place in order to prevent ill health and reduce demand for medical emergency activity at the acute hospitals.

In years 4 and 5 we also expect to start seeing the benefits of the emerging strategies for primary prevention and personalisation – with people adopting healthier lifestyles, leading to reduced prevalence of long term conditions and reduced demand for emergency acute activity associated with these conditions. We will ensure investment is available to help our patients stop smoking, to reduce obesity, and to lower alcohol consumption.

Within our acute hospitals, we will continue to support models that facilitate Same Day Emergency Care, to increase the proportion of acute admissions discharged on the day of attendance to at least a third, as set out in the Long Term Plan, avoiding the need for an overnight stay for these patients. We will ensure that acute frailty units are developed so that such patients can be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving unit.

We will also work with acute and community provider colleagues to improve discharge processes and ensure the right step-down capacity is in place. This will reduce acute length of stay and also the number of days required in community hospital beds, allowing patients to return home earlier.

Through implementation of the nationally mandated Integrated Urgent Care (IUC) pathway we will seek to simplify the local urgent care offer for patients, and through doing this avoid unnecessary attendances at local A&E departments. We will ensure that alternatives to A&E, such as GP-led Urgent Treatment Centres, are available and accessible, to treat patients with minor injuries and illnesses. We will also ensure that patients are directed to these alternative options, where appropriate, through a Clinical Assessment Service (CAS) which will provide a 'consult and complete' model for patients calling 111, reducing onward referrals to other services including ambulances and A&E. It will also facilitate health and social care professionals to navigate the system.

5.1.2 Planned Care (£32m)

Key impacts:

- **Reduction in outpatient first attendances (£3.7m)**
- **Reduction in follow-up attendances (£6.1m)**
- **Change in model for follow-up attendances (£6.1m)**
- **Reduction in procedures of limited clinical effectiveness (£8.3m)**
- **Transformation of the local elective care pathway (£8.2m)**

We will continue over the next few years to work with acute and primary care partners to transform the outpatient pathway over the next 3-4 years, aiming to complete a 33% reduction in face-to-face outpatient activity. There has already been a lot of good local work in recent years, especially around developing out-of-hospital alternatives to outpatients in order to deliver care closer to home. The next phase at both NUH and SFH is to focus on reducing unnecessary follow-ups, where this is clinically appropriate, both saving time for patients and releasing consultant time to ensure they are adding value with the patient contacts they undertake.

Following the completion of a county-wide policy for Procedures of Limited Clinical Effectiveness, and the implementation of Bluetec, we expect further reductions in certain planned care procedures in years 1 and 2 – although in overall terms, we are planning for an increase in planned care procedures.

Finally, we will work with our local providers to transform services, ensuring both that pathways are efficient and also ensure there is sufficient capacity so that patients can access high quality local care with reduced waiting times.

Specifically, we will:

- **Implement MSKN pathway across whole ICS**
- **Commence work to realise opportunities identified by RightCare in MSKN Procedures**
- **Implement community gynaecology across whole ICS**
- **Identify and develop referral guidelines in an agreed number of specialties**
- **Implement 1 diabetic pathway across ICS**
- **Implement standardised advice and guidance specifications**
- **Implement virtual clinics in specialties not undergoing whole pathway redesign**
- **Implement neurology virtual clinics for chronic headaches**
- **Commence work in Urology and ENT pathway redesign**

5.1.3 Other Acute (£25m)

There are a number of contractual efficiencies in year 1, but the main focus going forward will be (1) continued work to ensure value-for-money is being achieved in the prescribing of High Cost Drugs (£4.8m). We are also working with provider colleagues to review non-PbR acute services and investments to ensure these represent the best value-for-money, and to ensure that patients are being treated in the right place for their needs (£18.7). Finally, we anticipate that any consolidation and reconfiguration of maternity services resulting from the Clinical Services Strategy will yield some savings, which we have conservatively included as £1.4m.

5.2 Non-Acute Expenditure

£m	2019/20	2020/21	2021/22	2022/23	2023/24	5 Year Total
	FOT	FOT	FOT	FOT	Plan	
Mental Health	1.5	3.3	3.5	-	-	8.4
Community	2.8	2.8	3.0	-	1.7	10.2
Continuing Care	4.4	3.6	3.2	2.7	2.1	16.0
Prescribing	5.2	4.6	3.9	3.2	2.5	19.4
Other Programme	2.4	9.6	11.1	1.5	1.6	**12.0**
TOTAL Non-Acute	16.5	24.0	13.6	5.9	6.2	**66.0**

5.2.1 Mental Health (£8m)

We will continue in Mental Health services overall. However we know there is a financial opportunity through the reduction in out-of-area placements. We will work with our local Mental Health provider colleagues to ensure that there is appropriate capacity in Nottinghamshire so that patients do no need to be sent elsewhere in the country. This is better for patients and also more cost-effective.

5.2.2 Community (£9m)

Again, we are planning for a net investment in community services. However we know there are efficiency opportunities. A number of these have been contractualised in 2019/20, and we are currently working with providers to reconfigure and right-size our community bed stock over 2019/20 and 2020/21, in order to move to a more home-based model of step-down care after an acute hospital admission.

5.2.3 Continuing Care (£15m)

Through the coming together of the six CCGs there is an opportunity to spread good practice and improve processes and control around CHC and FNC expenditure over the next 1-2 years. Once the function is running effectively across the wider footprint, the opportunity for further efficiencies will be reduced in years 3-5. However we still expect business-as-usual efficiencies and these have been modelled into the plan.

5.2.4 Prescribing (£20m)

We have had good success in recent years in generating efficiencies in our expenditure on drugs. We expect this to continue, although we recognise that a lot of the easy wins have already been delivered, and therefore we have modelled a lower degree of efficiency in later years.

5.2.5 Other Programme (£17m)

In order to ensure that we are securing value-for-money for every pound we spend going forward as a single CCG, we are currently conducting a range of Service Benefit Reviews, a value-for-money review of Better Care Fund investments and a full budgetary review of all other budget lines. It is likely to be 2020/21 when the benefit of these reviews is realised.

	2019/20	2020/21	2021/22	2022/23	2023/24	5 Year Total
	FOT	FOT	FOT	FOT	Plan	
Running Costs	2.4	3.1	1.8	0.3	0.2	7.7

Through administrative efficiencies achieved through the merger of the six CCGs, we have plans to realise the 20% savings which will allow us to meet our new running cost target in 2020/21. There will be a part-year saving in 2019/20, with the remainder in 2020/21.

We will also generate estates savings through consolidating administrative functions across fewer sites. In addition to this, through work led by the ICS, we will continue to actively pursue options to reduce the void costs which are currently charged to the CCGs, by ensuring that LIFT and NHS Property Services properties are fully utilised, and avoiding NHSPS service charges by transferring ownership to local providers, where it is possible and appropriate to do so.

6. Collaboration with Integrated Care Providers (ICPs)

In order for the Financial Strategy to be successful and deliver as planned, we need the support and commitment of our local provider partners. We are under no illusions; the current local system is unaffordable in the short term, and there will be a need to reduce capacity in the short term, where this is clinically appropriate.

We are already working closely with Sherwood Forest Hospitals FT and Nottinghamshire Healthcare FT in the Mid Nottinghamshire footprint, through the Integrated Care Provider governance structure, which reports into the ICP Board.

In the south of the County, governance structures are emerging at both an ICP level – Nottingham City and South Nottinghamshire, but also an overarching Transformation Steering Group has been established to manage the interface of these ICPs with Nottingham University Hospitals, which is the main acute provider for patients in both Nottingham City CCG, and also the three South Nottinghamshire CCGs. Structures and relationships are less mature than in Mid Nottinghamshire, but there is a real drive and determination currently to work together to drive the transformation needed.

In 2019/20 we have already moved to aligned incentive contracts with both our main acute providers, and we will build on this going forward, adopting a payment model which moves away from payment-for-results, and instead aligns much more closely with our providers' cost base. This brings risks to the delivery of QIPP efficiencies, as it means there will be a need to identify actual cost in the system which is not adding value and services which we need to jointly agree should be stopped or downsized. This is a far more challenging exercise than just planning to reduce activity and leaving providers to find mitigations to the financial problems this causes them. However it makes the delivery of the schemes agreed and the realisation of the benefits identified more likely due to joint ownership of the problem and the solution. It also offers the opportunity for commissioners to benefit from system solutions where the greatest benefit is seen at the acute hospital, e.g. by helping to reduce length of stay or improving the efficiency of the outpatient delivery model.

As an Integrated Care System, we have established an aligned planning and triangulation process with our local providers and an ICS Financial Framework is currently in development – see Section 10 and Appendix C for more details.

7. Digitalisation, Analytics and IM&T

Digitalisation, Analytics Information Management and Technology will have a key role to play in the delivery of many of the wider service changes described above which will generate efficiency savings.

To inform the best value-for-money investments, we will continue to develop and refine population health management solutions to understand the areas of greatest health need and design our primary care and community services to meet these. These solutions will become increasingly sophisticated in identifying those groups of people who are at risk of adverse health outcomes and predict which individuals are most likely to benefit from different health and care interventions, as well as shining a light on health inequalities. We will be able to routinely identify missed elements of pathways of care for individuals and ensure that those gaps are filled.

Interoperability of provider information systems will aid more timely transfer of information between providers so that all the health and care professionals have access to the same shared records of the patients they are caring for. This will improve emergency response, in many cases identifying alternative care solutions to avoid emergency hospital admissions, and also improve flow both within the hospital and more widely, e.g. as part of the discharge pathway, to reduce length of stay and the number of emergency acute beds needed.

Digital technology will also provide convenient ways for patients to access advice and care as part of the elective pathway, replacing the traditional outpatient model with a more efficient, cost-effective digital model, reducing travel time and the need for physical estate, including through telephone and video consultations. Patients will be able to access virtual services alongside face-to-face services via a computer or smart phone.

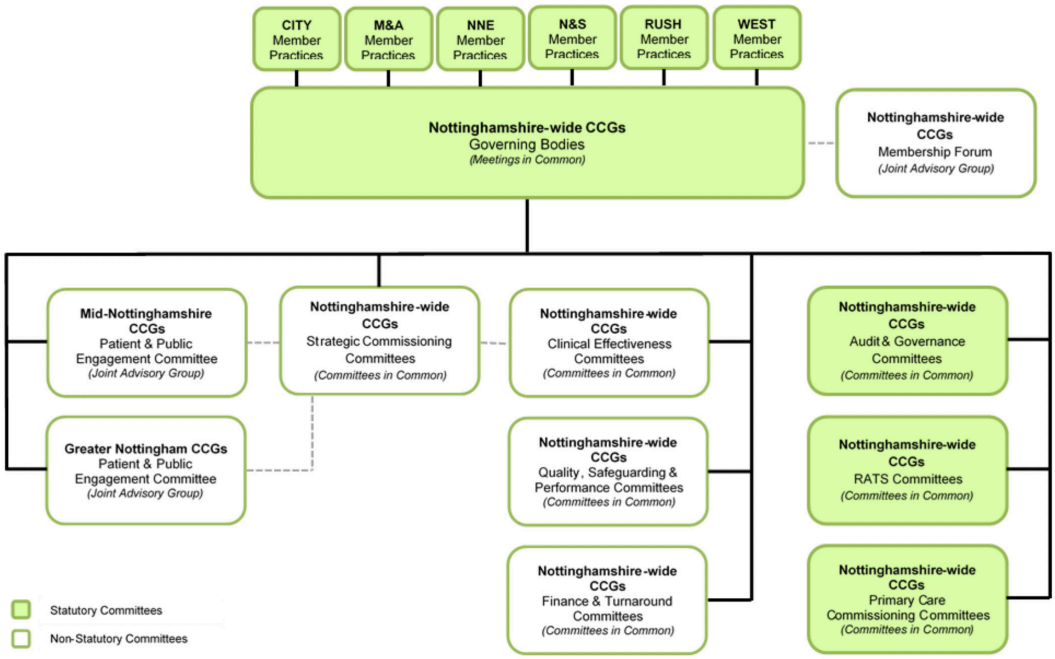
Working for our people will also be important to supporting an effective, productive, agile workforce working over a larger geographical footprint. We will need to ensure that the right technology solutions are in place to support this 21st century way of working, including reliable laptops and other mobile devices, cloud-based data storage solutions, video and VOIP telephony solutions, and the infrastructure to support all of these.

Although CCGs cannot hold capital, we will explore and maximise all opportunities to secure investment through initiatives such as Health System Led Investment (HSLI). Through the Integrated Care System infrastructure, we will work with providers to develop a 5 year ICS capital strategy which acknowledges the reduction in available capital nationally but which prioritises the key capital developments needed to support the planned transformation, including IM&T capital.

We will also continue to fund our GP Information Technology team and our Data Management team to support local clinical innovation in technology, ensure that systems are tailored to local clinical requirements, deploy the right analytics to identify further opportunities to improve care, and ensure that we are compliant with all information governance and data protection legislation.

8. Governance

The CCG has implemented a Governance and Accountability Framework in 2019/20 which describes governance, roles and responsibilities for all the CCG's responsibilities, including overall financial performance, financial reporting, financial controls and financial recovery (achievement of QIPP target). The working governance arrangements, effective from June 2019, are set out below:



Chief Finance Officer

The CCG Chief Finance Officer (CFO) is accountable for the delivery of the CCG financial performance in line with targets set by NHS England. The role is also responsible for development of the Financial Recovery Plan (FRP) and QIPP programmes, leading implementation of the performance framework through the PMO, providing assurance to CCG Committees and Governing Bodies, and working effectively with ICS and ICP system partners.

There are three key committees which are particularly relevant to supporting the CFO to discharge his/her duties: (a) Finance and Turnaround Committees in Common, (b) Audit and Governance Committees in Common, (c) Strategic Commissioning Committees in Common.

(a) Finance and Turnaround Committees in Common

This Committee exists to:

i) scrutinise arrangements for ensuring the delivery of the CCG's statutory financial duties, including the achievement of the CCG's Financial Recovery Plan and QIPP targets.

ii) review the monthly financial performance and identify key issues and risks requiring discussion or decision by the Governing Body.

iii) scrutinise arrangements for ensuring the delivery of the CCG's statutory financial duties, including the achievement of the CCG's Financial Recovery Plan and QIPP targets. The Committee will review the monthly financial performance and identify key issues and risks requiring discussion or decision by the Governing Body.

(b) Audit and Governance Committees in Common

This Committee exists to:

i) Provide the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with the laws, regulations and directions governing the CCG in as far as they relate to finance.

ii) Approve the CCG's Annual Report and Accounts.

iii) Scrutinise every instance of non-compliance with the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies and monitoring compliance with the CCG's Conflicts of Interest Policy and Gifts, Hospitality and Sponsorship Policy.

iv) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the organisation's objectives. This will include scrutinising compliance with legislative and regulatory requirements relating to information governance.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.

(c) Strategic Commissioning Committee

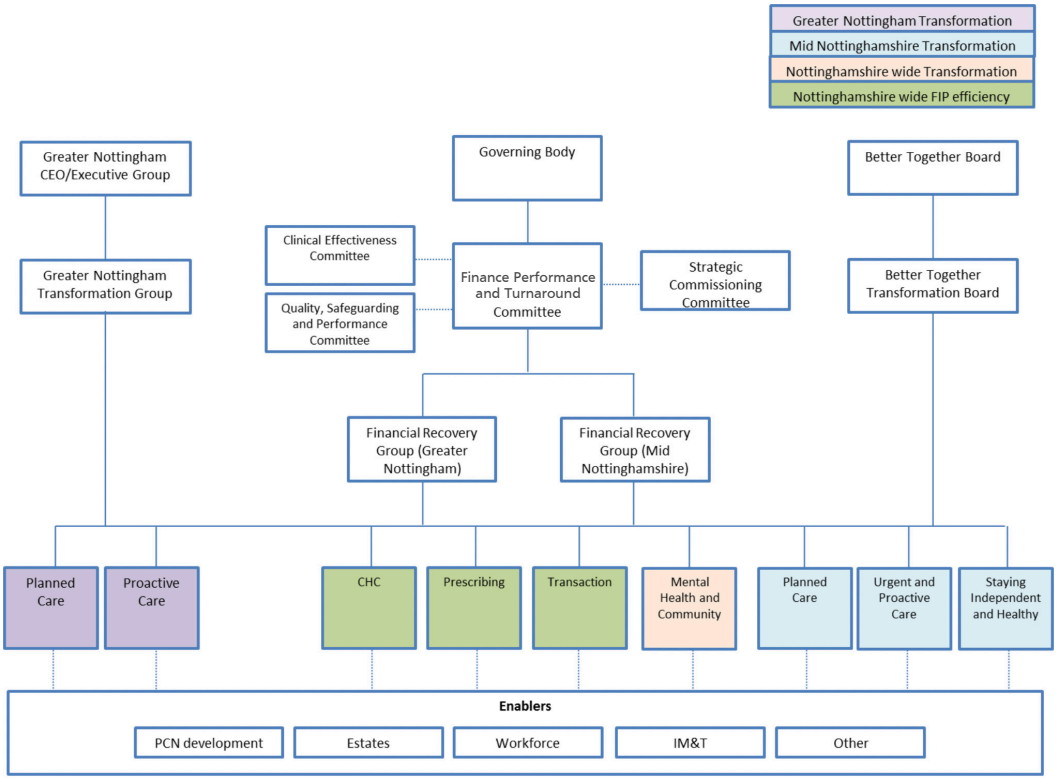
This Committee exists to:

i) evaluate, scrutinise and quality assure the clinical and cost effectiveness of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services. This will include assessment of any associated equality and quality impacts arising from proposals and feedback from patient and public engagement/consultation activities where necessary.

ii) ensure that the CCG's responsibilities are appropriately discharged, including oversight of annual procurement plans.

Financial Recovery

There is additional governance around the Financial Recovery process, which is both internal to the CCG but also includes shared governance structures with provider organisations and other system partners. The proposed governance structure is set out in the diagram below. Work is currently underway to understand the best way to link the emerging Integrated Care Providers (ICPs) into this governance structure.



A key part of the Financial Recovery governance process is **Clinical Effectiveness Committees in Common,** which has accountability for ensuring clinical oversight to the Financial Recovery Programme, including maintaining clinical standards and safety at all times throughout the Financial Recovery Programme.

Financial Recovery Group

The Finance and Turnaround Committees will be supported in 2019/20 by a Financial Recovery Group in Greater Nottingham and Mid Nottinghamshire which will provide detailed assurance in relation to achievement of the Financial Recovery Plan and QIPP targets. The group will also act as a gateway for the review of business cases and Project Initiation Documents (PIDs), before approval at Strategic Commissioning Committee, and Governing Body, if required.

Programme Management Office

A single Financial Recovery PMO has been established to assure and support delivery of the CCG QIPP targets including:

- Ensuring high quality QIPP plans are in place with leadership and skilled resource for delivery
- Assesses delivery through the QIPP performance assurance framework
- Develop a pipeline of new QIPP opportunities to inform in year delivery and next year's plan
- Promotes a culture of financial recovery and turnaround
- Provides internal and external assurance.

The QIPP performance assurance framework has been established to provide both the PMO and Senior Responsible Officers (SROs) a tool to drive delivery. This is based on a monthly cycle of reporting and formal assurance reviews between the CFO and SROs. This provides detailed scrutiny of delivery, risks, issues, mitigations and recovery plans which in turn informs an assured risk assessed year end forecast by the PMO.

Where there is continued under-performance the PMO will provide more intensive support as necessary to ensure delivery of recovery plans. Delivery teams are encouraged to escalate issues to the PMO for same day resolution in line with turnaround culture. Where the PMO is unable to resolve issues these may be escalated for resolution (e.g. to system Executive to Executive forums).

Senior Responsible Owners

The CCG Executive Sponsor (or SRO) is accountable for the development and delivery of specific QIPP programmes and achievement of the benefits (quality and financial) from QIPP and joint transformation programmes. Executive Sponsor (SROs) are supported by a Programme Director and experienced Programme Manger to provide day to day oversight of delivery.

System Transformation

The Greater Nottingham Transformation Steering Group and Mid Nottinghamshire Transformation Board are collaborative system partnerships to plan and deliver transformation jointly with health and social care partners at ICS and ICP level. The Governing Body remains accountable for QIPP targets where these are delivered through system partnerships.

9. Financial Reporting

There will be a need to report at different levels in the new system architecture that will be in place. We will no longer report as six CCGs as we will no longer be six statutory organisations. This will mean that there will no longer be a need to achieve financial balance for each individual organisation and can instead spread the financial risk across a larger single budget.

However, instead we will need to report at ICP level: (1) Mid-Nottinghamshire (Mansfield, Ashfield, Newark & Sherwood), (2) South Nottinghamshire (Rushcliffe, Nottingham West, Nottingham North & East) and (3) Nottingham City. There is currently work under to understand the costs that sit in each ICP as we look to move away from a Payment-by-Results system to one where we match resource with need, fund services and make decisions on investments and disinvestments as agreed by an ICP Board. Financial decisions will need to be more transparent and high quality financial information will need to be available to inform these decisions. One option in future years would be to devolve a capitated budget to each of the three ICPs. We will liaise with NHS England and Improvement and will ensure compliance with any ISAP processes required ahead of any delegation of budgets. This process will align with the development of the Integrated Care System and the function of strategic commissioner.

We will also look to develop a framework to align costs with PCNs so we can understand the resource consumption of different PCNs with different needs. This will require careful consideration to ensure that services are designed such that they maximise value-for-money of investment in services.

Each of the current CCGs have been given details of their financial allocation of resources for the next five years. The allocations process uses a statistical formula to make geographic distribution fair and objective, so that it more clearly reflects local healthcare need and helps to reduce health inequalities. Although the financial allocations would be combined for a single CCG the organisation will be able to make spending decisions in line with the needs of the local populations.

10. Contracts, Incentivisation and Outcomes

We will consider new approaches to payment and contractual mechanisms to ensure they are outcomes-focussed and aligned with our strategic objectives through appropriate financial incentivisation and penalties in order to share risk and reward.

This builds on the aligned incentive contract approach used in the 2019/20 planning round for both the Sherwood Forest Hospitals Foundation Trust contract and the Nottingham University Hospitals Trust contract.

The ICS programme team is facilitating work with system finance leaders to develop a financial framework for the ICS to ensure that payments and contracts evolve to best support the transformation work needed to realise the ICS vision and objectives. Through this framework we will ensure that system risk is managed, even if it is not possible to mitigate this risk at this stage, such is the size of the underlying provider financial deficit. This risk and its implications are included in the financial risk assessment below.

This framework covers five domains:

- Understanding the cost of health and social care services
- System reporting to enable value based decisions
- Payment mechanisms and risk management approach to align incentives
- Financial recovery actions to support achievement of financial balance
- Cash and capital regime to support better use of capital investment

See Appendix C for more details on the content of the Financial Framework

11. Risk Assessment

There are a number of key strategic risks to the delivery of this Financial Strategy, which are set out in the table below. Whilst these are significant, we have identified mitigations that we will ensure are in place in order to meet our financial target requirements.

Risk	Consequence(s)	Impact	Likeli-hood	Score	Mitigations
Underdelivery against QIPP target in years 1 and 2	i. Failure to meet financial control total in years 1-2 ii. Larger level of savings required in years 3-5	5	5	25	i. Continue to improve risk ratings of existing schemes. ii. Development of further QIPP schemes. iii. Financial mitigations (non-recurrent).
Additional cost pressures caused by actual activity growth higher than planned	i. Failure to meet financial control total ii. Larger level of efficiencies required than in original plan	4	5	20	i. Agree contracts with providers which are cost-based, with payment not directly linked to activity ii. An appropriate level of reserves and contingency held back each year to mitigate in-year pressures iii. Robust demand modelling to ensure planning assumptions are sound
System financial pressures and delays to transformation leading to deterioration in provider positions	i. CCG is set a larger surplus control total by the ICS, thus increasing the efficiency target ii. Providers seek to maximise income instead of controlling costs	4	5	20	i. Agreement and implementation of ICP recovery plans with system partners. ii. Aligned incentive contracts with providers to incentivise the right behaviours.
Transformation does not deliver the financial benefits planned	i. Failure to deliver CCG efficiency targets ii. Failure to deliver system efficiency targets iii. Failure to meet CCG control total	5	3	15	i. Instilling a culture where Financial Recovery and Transformation are closely linked, with the latter focussed on delivery of the former. ii. Robust financial review of business cases and transformation plans. iii. Realistic planning and robust and transparent delivery tracking and reporting.
Pressures on other services mean that the CCG is unable to meet planned investment targets for mental health, primary care and community services	i. Reputational damage to the CCG ii. Adverse impact on the capacity and quality of mental health and primary care and community services iii. Resulting impact on acute services as demand is not managed in an out-of-hospital setting	3	4	12	i. Ensure that investment in out-of-hospital services leads to reduced demand on acute services and therefore allows a shift in expenditure. ii. Management of expectations – whilst we would like to. iii. An appropriate level of reserves and contingency held back each year to mitigate in-year pressures so that investments do not need to be delayed or cancelled.

In addition to this longer term risk assessment, the CCGs have a corporate risk register, as part of the Board Assurance Framework, to manage the ongoing Finance risks and mitigating controls and actions. This has been updated in July 2019, with the following six risks added to the register:

Risk Reference	Risk Narrative	Current Risk Score
RR090	Failure to delivery identified 'cash releasing' QIPP savings schemes, that reduce our cost baseline, may result in non-delivery of the CCGs' financial statutory duties for 2019/20.	Overall Score 15: Red (I5 x L3)
RR091	Delivery of identified QIPP savings schemes utilising nonrecurrent monies presents a risk that the CCGs' 2019/20 underlying position may not improve.	Overall Score 12: Amber/Red (I4 x L3)
RR092	Failure to identify substantial and robust QIPP schemes to meet the CCGs' financial gap may impact the CCGs' ability to meet its financial statutory duties for 2019/20.	Overall Score 15: Red (I5 x L3)
RR 093	Increasing levels of uncoded activity (U codes) at NUH presents a risk that the CCGs are unable to accurately validate activity data. This, in turn, presents a risk that the CCGs are unable to assure themselves of the quality of activity data and level of activity being delivered by the provider. Furthermore, there is a financial risk as the average cost applied to the uncoded activity may be below actual costs.	Overall Score 9: Amber (I3 x L3)
RR095	Increasing number of 'pass through payments' (including high cost drugs) relating to NUH presents an additional cost pressure to the CCGs as activity is outside the agreed 'block' contract value.	Overall Score 9: Amber (I3 x L3)
RR 096	With the delegation of transformation funds, alongside a lack of clarity regarding system architecture accountability, there is a risk that the CCGs' may be liable for recurrent costs resulting from non-recurrent investment. This, in turn, may result in future cost pressures and impact the CCGs' future financial position.	Overall Score 16: Red (I4 x L4)

The full Finance risk register as at July 2019 is presented in Appendix E.

12. ICS Priorities

A facilitated development session took place with ICS Board members and key leaders from across the system on 24 April 2019. The purpose of the workshop was to reaffirm the vision, ambitions and outcomes of the ICS and identify and agree strategic priorities to deliver these. A short session just for ICS Board members followed, focused on the principles of working together to build collective leadership for system transformation.

Workshop attendees agreed the revised vision for the Nottingham and Nottinghamshire ICS contained within the ICS Narrative agreed at the February 2019 ICS Board, and reaffirmed support for the ambitions and outcomes set out in the emerging System-Level Outcomes Framework.

Workshop attendees also supported the five emerging system priorities for the Nottingham and Nottinghamshire ICS – all of which received strong support from the early respondents to the public engagement on the Long Term Plan and the local system plan, as well as the emerging system enablers. These are set out below:

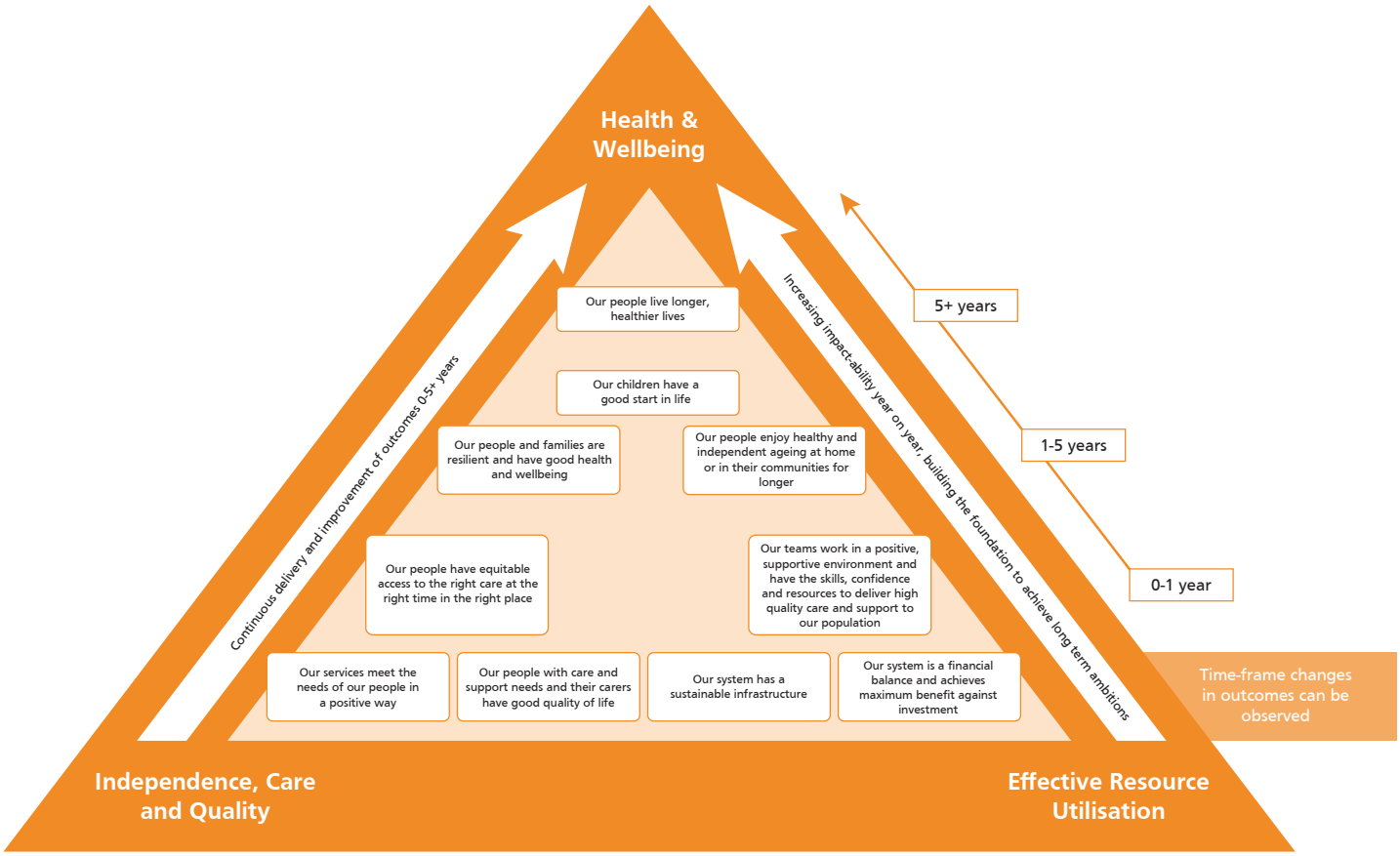
In the construction of this Financial Strategy for a single Nottingham and Nottinghamshire CCG we have sought to ensure alignment with these priorities, with a QIPP focus on urgent and emergency care, investments in primary care, community care and mental health, and a overarching objective to achieve value, resilience and sustainability not just for the CCG as a single organisation, but the wider system as well.

13. ICS Outcomes Framework

This Financial Strategy is also aligned with the emerging system-level Outcomes Framework. The ICS Board recently confirmed that the ICS Outcomes Framework is being based on the triple aims (improved health and wellbeing, transformed quality of care, and sustainable finances), whilst increasing healthy life expectancy remains the overarching system outcome.

The purpose of the Framework is to provide a clear view of our success as an ICS in improving the health, wellbeing and independence of our citizens and transforming the way the health and care system operates. The Framework sets out short, medium and long term outcomes based on ten ambitions. These remain in draft but are currently as follows:

No.	Outcome Ambition
1	Our people live longer, healthier lives
2	Our children have a good start in life
3	Our people and families are resilient and have good health and wellbeing
4	Our people enjoy healthy and independent ageing for longer, at home or in their community
5	Our people have equitable access to the right care at the right time in the right place
6	Our people have a positive experience of care and better care outcomes.
7	Our people with care and support needs and their carers have good quality of life.
8	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population.
9	Our system is in financial balance and achieves maximum benefit against investment
10	Our system has a sustainable infrastructure



Delivery of the CCG's Financial Strategy will contribute directly to achieving ambitions (9) and (10).

We will also need to ensure the funding is available to facilitate ambitions (1) – (8) as well, and the strategy has set out the additional expenditure that we will invest in Primary and Community Care and Mental Health services in order to facilitate development of services to achieved these outcomes. However we will also expect to see a financial benefit from these investment as demand for emergency care will be reduced – a planned return on investment of approximately 3:1. We will ensure these investments represent value-for money, and that these new and expanded services are productive and outcomes-focussed.

14. Strategic Alignment

There are a number of ICS-wide strategies currently under development are which are expected to be completed in summer 2019 in order to inform the local response to the Long Term Plan. These strategies will align with the Long Term Plan as this progresses through the remainder of the year. The key strategies referred to in this document are listed below:

1. Clinical Services
2. Mental Health
3. Primary Care
4. Workforce
5. Estates
6. IM&T

We will ensure that as the objectives and requirements of these strategies become clearer this Financial Strategy continues to be aligned with the plans contained within. As a general principle, we will aim to ensure sufficient funding is available to deliver the system outcomes and maximise the value of every pound we spend as a CCG and as a system. However, given the constrained starting financial position, we will have some important and difficult decisions to make about what we stop spending money on in order to fund the new models of care. This may challenge relationships with provider colleagues, especially in the acute sector, so it is essential that objectives are clear, tangible and agreed by all senior leaders in the system.

There are some key themes to all of these strategies – investment in prevention and proactive care; reduction in avoidable emergency activity; improving mental health outcomes performance; ensuring that our system operates in a productive and efficient manner.

The financial plan set out in section 3 of this strategy is underpinned by these themes and as such demonstrates a strong alignment to the wider strategies being developed within the ICS.

14.1 Clinical Services

A draft ICS Clinical Services Strategy was presented to the ICS Board on 13 June 2019. This draft strategy set out six design principles:

1. Care and support will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access
2. Prevention and early intervention will maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
3. Mental health and well-being will be considered alongside physical health and wellbeing
4. The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs
5. The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication.
6. They will be designed in partnership with local people and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified

14.2 Primary Care

A draft Primary Care Strategy, covering the period 2019/20-2023/24, was presented to the ICS Board on 13 June 2019. The strategy sets out a vision for primary care which is built on the foundations of Primary Care Networks which will enhance integrated care and which will deliver a person-centred (holistic) approach to continuous and proactive lifetime care, rather than the traditional disease focused approach. The vision will deliver:

(a) Effective Resource Utilisation - fully integrated, primary and community based healthcare, successfully incorporating new models of care and multidisciplinary teams with wide ranging clinical and social care skills and capabilities

(b) Independence, Care and Quality - care organised around individuals and populations – as opposed to organisations - delivering the right type of care based on people's needs

(c) Proactive and Community-Based Health & Wellbeing - providing models of health and care that are more proactive and preventative, ensuring more people are looked after at home, and closer to home, thereby reducing the rising demand for hospital-based care.

The strategy sets out five key objectives:

(1) We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

(2) The NHS will reduce pressure on emergency hospital services

(3) People will get more control over their own health and more personalised care when they need it

(4) Digitally-enabled primary and outpatient care will go mainstream across the NHS

(5) Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

The publication of the NHS Long Term Plan and Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan have provided added impetus to progress the work to formally establish Primary Care Networks across the ICS area.

14.3 Workforce

The long term people and culture vision for the Nottingham and Nottinghamshire ICS is that by 2029, we will have in place:

1. A sustainable, affordable workforce with the right skills, knowledge and capacity working in partnership to deliver new models of care designed around the needs of our citizens
2. Teams with the confidence and capability to work in partnership with others and lead and deliver service improvement and change
3. Teams with positive attitudes and behaviours to deliver and sustain transformed services, improve outcomes and outstanding patient and service user experience
4. Citizens and communities as partners in care and support, building resilient, supportive neighbourhoods
5. Teams with the skills and knowledge to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches
6. Teams that are capable of and comfortable with taking forward digitalised care and working with new technologies and artificial intelligence
7. Teams that are diverse and inclusive of and drawn from the populations they serve

As noted in the CCG People Strategy, as a system leader the single CCG will need to support through our approach to commissioning and our partnership working, the delivery of a transformed workforce with richer and diverse skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.

We will need to understand with providers the future workforce requirements and the additional cost of expanding the workforce to meet increased demand in a new way, support the new models of care proposed and deliver the transformation required. As we move away from a Payment-by-Results approach to purchasing services, understanding the cost implications of transformational changes to services and pathways will become all the more important for the commissioner function. Workforce and financial planning will be aligned through the strategic planning function of the ICS. The working assumption is that these additional costs will be largely in line with (a) the demand growth set out in Appendix A, and (b) the transformational initiatives set out in section 5, which move the system towards a more preventative, proactive approach to care, delivered to a greater extent in an out-of-hospital setting. This reflects the assumptions that underpin the MTPF above. Through investing more in primary care, community care and mental health services, at a rate in excess of our allocational uplift, we will enable the providers operating in these settings to invest in new workforce and to upskill existing workforce so that the required size, shape and skill-mix of workforce is in place to deliver preventative, proactive and productive services to meet the needs of our population.

We will also need to ensure that there is an appropriately sized budget within the CCG's running costs for training, professional development and organisational development in order to support the people and culture vision.

14.4 Estates

An ICS Estates Strategy was completed in July 2018 and is being refreshed over summer 2019. The key capital investments included in this strategy which are relevant to the CCGs are:

The ambition of the ICS, which will be reflected in the 2019 strategy refresh, is to ensure that the Nottingham and Nottinghamshire estate will be used as effectively as possible in order to maximise the resources available to support front-line provision and investment in preventative services. In order to achieve this, ICS partners will need to rationalise estate and dispose of properties releasing revenue funds and reducing the backlog risk. This will require the ICS to maximise the utilisation of high-quality long-term estate, such as LIFT and PFI, and dispose of the high-cost poor quality estate.

The ICS Clinical Services Strategy will act as a driver to this programme ensuring that clinical and non-clinical can be aligned where appropriate, streamlining services, improving outcomes and increasing productivity. This has led to 20 sites being deemed as fixed points whether in full or in part. 16 of these sites are LIFT or PFI buildings. There are a number of LIFT buildings and NHS Property Services buildings in Nottingham and Nottinghamshire. Several of our GP practices operate out of these buildings, and the CCGs are financial liable for paying the costs of any empty space.

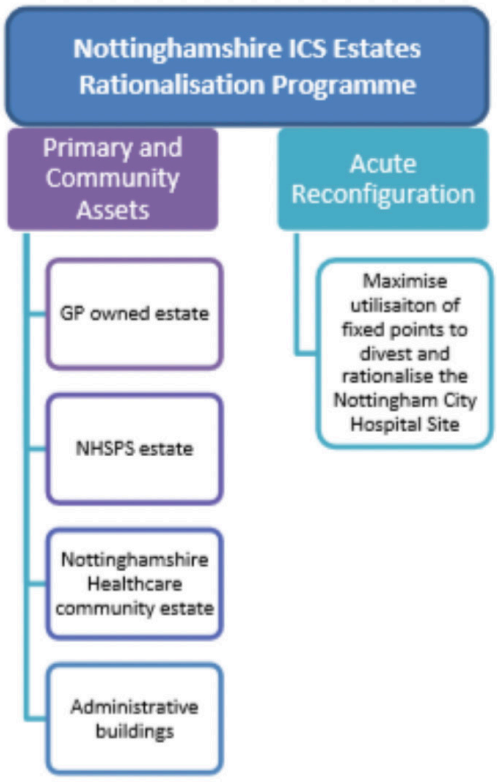
The strategy to drive the efficient use of the estate will be based around maximising the utilisation of these fixed points and streamlining clinical services within the fixed points – e.g. enabling the navigation of the urgent care system. In turn, the ICS will look to consider services within the wider estate to understand best-fit within the fixed points and therefore what sites can be considered for disposal. In doing so there are 2 strands of work being considered, looking at different service requirements and implementation timescales.

Primary and Community Assets

The ICS is developing a 2-year plan for Primary and Community Assets by end of July 2019. Working alongside the Clinical Services Strategy, this plan will describe how the community fixed point assets (mainly LIFT) can be maximised producing a list of properties and implementation plan for disposal of assets.

The starting point for this will be ensuring a robust understanding of our estate including costs, occupancy and service provision. Given the size and number of properties this will be developed at a Primary Care Network level. PCNs are considered to be planning footprint for community and primary services and therefore should be used to consider best utilisation of the estate.

Admin buildings are an exception to this and can be provided on a wider footprint. Nottinghamshire plans to merge its CCGs by April 2020. This provides an opportunity to consolidate administrative teams but we will also look wider than this at how all our administrative teams might work more closely together.



Whilst the system approach will require the health and social care estate to be used differently in order to facilitate the new models of care, the direct capital investment and management of this capital is not in our direct control as a commissioner. It will be the responsibility of our providers to ensure that estate is fit for purpose in order to deliver the services commissioned.

Therefore, none of the CCG's 5 year recovery plan is directly predicated on the amount of capital funding, but it will depend on providers to invest this limited capital funding in the right areas which align with the commissioning strategy and the financial strategy. Through the Integrated Care System infrastructure, we will work with providers to develop a 5 year ICS capital strategy which acknowledges the reduction in available capital nationally but which prioritises the key capital developments needed to support the planned transformation.

14.5 Digitalisation, Analytics Information Management and Technology

A Digitalisation, Analytics and IM&T Strategy is currently in development. This will build on the Local Digital Roadmap and the achievements of the Connected Nottinghamshire programme.

The strategy will support the ICS priorities and set out steps to ensure that these functions have a plan to provide the required functionality to deliver the clinical transformation described in the sections above. These will largely be the items described in section 7 of this Financial Strategy.

15. ICS Financial Plan

It should be noted that a five year plan is currently being developed for the ICS over summer 2019. This CCG Financial Strategy is aligned to the principles and assumptions feeding into this wider plan. The ICS Plan will involve four steps:

1. Baseline spend (year 0)	■ Understand current shape of health and care spend – cost buckets ■ Long-Term Plan and local priorities used to determine buckets and shape of spend ■ Flexible format: can be cut by ICS, ICP, PCN or organisation ■ Limiting factor will be available data
2. Calculate "do nothing" gap	■ Forecast forwards to give 'do nothing' over 5 year period (18/19 base year) ■ Baseline spend adjusted for pay & prices uplift, activity growth (demographic and non-demographic) and LTP investment commitments ■ Realistic 'do nothing' to reflect scale of the challenge but not a 'downside'
3. Develop high level financial sustainability model	■ High level model (finance and outcomes) developed to present a scenario of how the shape of spend needs to change to deliver sustainable services within available resources • Model will identify 10 high level levers to change shape of spend (see Appendix D)
4. ICS/ICP Financial Plans	■ ICPs develop implementation plans (in line with strategic direction and supported by high level sustainability model) ■ Financial Plan (along with activity and workforce) is an output of do nothing projection + implementation plans

In 2018/19 the financial position of the system (NHS and Social Care) deteriorated, with an in-year deficit of £91.8 million (pre-PSF); this is £24.4 million worse than the notified control total. Key challenges were growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The original STP plan (2016) identified a five-year finance and efficiency gap of £628m (£473m NHS and £155m local authority social care)

NHS figures have been updated and the indicative do nothing five year gap is £428m. This represents a realistic "do nothing" position, not a downside scenario. The system starting point is an underlying deficit of £150m brought forward from 2018/19. It should be noted that the ICS has higher levels of fixed costs in comparison to other systems due to PFI costs.

The final financial model will include Local Authority figures, but these are currently not included in the £428m gap.

The £197m QIPP target included in this CCG Financial Strategy represents 46% of the ICS gap, although it should be noted that the ICS position has not yet been updated for the NHS Long Term Plan Implementation Framework.

As the ICS plan develops and undergoes revision following review by Directors of Finance across the system we recognise that the CCG plan may need revisions to maintain alignment. We will ensure this alignment through close working with ICS financial planning colleagues.

Appendix A – Assumptions informing the MTFP

The financial plan is underpinned by a set of assumptions about demographic and non-demographic growth, cost inflation, QIPP efficiencies, provider efficiencies, investments and cost pressures.

The assumptions around cost/tariff inflation have been updated in line with those included in Appendix B in the NHS Long Term Plan Implementation Framework issued on 27 June 2019.

Tariff	2020/21	2021/22	2022/23	2023/24
Acute - Ambulance	2.5%	2.5%	2.1%	2.1%
Acute –All other PODs	2.7%	2.7%	2.3%	2.3%
Mental Health	2.4%	2.4%	2.0%	2.0%
Community	2.4%	2.4%	2.0%	2.0%
Continuing Care	5.0%	5.0%	5.0%	5.0%
Prescribing	0.5%	0.5%	0.5%	0.5%
Other Primary Care	3.0%	3.0%	3.0%	3.0%
Other Programme	0.0%	0.0%	1.0%	1.0%
Running Costs	2.9%	2.8%	2.1%	2.1%

The assumptions around demographic and non-demographic growth represent the output of a detailed exercise by the CCGs' Information and Performance team to model the expected activity growth for the next five years based on historic trends, demographic projections and disease prevalence projections.

Activity Growth	2020/21	2021/22	2022/23	2023/24
Ambulance	3.1%	3.1%	3.1%	3.1%
A&E	2.2%	2.2%	2.3%	2.3%
Emergency Zero Day LoS	4.9%	4.9%	4.9%	4.9%
Emergency 1+ Day LoS	2.3%	2.3%	2.3%	2.3%
Outpatient Firsts	7.9%	4.9%	5.0%	5.0%
Outpatient Follow-Ups	3.8%	3.6%	3.6%	3.7%
Outpatient Procedures	3.9%	3.9%	3.9%	3.9%
Day case Procedures	3.2%	3.2%	3.2%	3.2%
Elective Inpatient Procedures	2.7%	2.7%	2.7%	2.7%
High Cost Drugs & Devices	4.5%	4.5%	4.5%	4.5%
Maternity	0.5%	0.5%	0.5%	0.5%
Independent Sector	3.1%	3.1%	3.1%	3.1%
Other Acute	3.1%	3.1%	3.1%	3.1%
Mental Health	1.9%	1.9%	1.9%	1.9%
Community	2.9%	2.9%	2.9%	2.9%
Continuing Care	3.1%	3.1%	2.7%	2.3%
Prescribing	4.5%	4.5%	4.5%	4.5%
Other Primary Care	1.2%	1.2%	1.2%	1.2%
Other Programme	0.0%	0.0%	0.0%	0.0%

The assumptions around QIPP represent a quantification of the transformational clinical service change described in Section 5. These input percentages generate the absolute numbers set out in Section 5.

QIPP Efficiencies (Ccg)	2020/21	2021/22	2022/23	2023/24
Ambulance	3.0%	1.5%	1.0%	2.0%
A&E	3.0%	2.0%	2.0%	2.0%
Emergency Zero Day LoS	1.0%	1.0%	1.0%	2.0%
Emergency 1+ Day LoS	3.5%	2.0%	2.0%	2.0%
Outpatient Firsts	2.0%	2.0%	2.0%	1.0%
Outpatient Follow-Ups	5.0%	5.0%	2.0%	1.0%
Outpatient Procedures	1.0%	0.0%	0.0%	1.0%
Day case Procedures	1.0%	0.0%	0.0%	1.0%
Elective Inpatient Procedures	1.0%	0.0%	0.0%	1.0%
High Cost Drugs & Devices	3.0%	2.5%	2.5%	2.5%
Maternity	0.0%	0.0%	0.0%	0.0%
Independent Sector	3.0%	2.0%	0.0%	0.0%
Other Acute	2.5%	2.5%	0.0%	0.0%
Community	2.0%	2.0%	0.0%	1.0%
Continuing Care	3.0%	2.5%	2.0%	1.5%
Prescribing	3.0%	2.5%	2.0%	1.5%
Running Costs	15.0%	10.0%	1.5%	1.0%

QIPP Efficiencies (System)	2020/21	2021/22	2022/23	2023/24
Emergency 1+ Day LoS	3.0%	3.0%	2.0%	1.0%
Outpatient Follow-Ups	2.5%	2.5%	2.0%	1.0%
Maternity	0.0%	2.0%	2.0%	1.0%
Mental Health	2.0%	2.0%	0.0%	0.0%

We have also assumed a level of provider efficiencies and productivity in our expenditure plan. These assumptions have been updated in line with those included in Appendix B in the NHS Long Term Plan Implementation Framework issued on 27 June 2019.

Provider Efficiencies & Productivity	2020/21	2021/22	2022/23	2023/24
Acute	1.1%	1.1%	1.1%	1.1%
Mental Health	1.1%	1.1%	1.1%	1.1%
Community	1.1%	1.1%	1.1%	1.1%
Other Primary Care	1.1%	1.1%	1.1%	1.1%

Appendix B – CCG Allocations

CCG	Allocation					% Change in Allocation			
	19/20	19/21	19/22	19/23	19/24	20/21	20/22	20/23	20/24
Core Allocation									
Mansfield & Ashfield	284.2	296.2	308.5	320.7	332.8	4.2%	4.2%	4.0%	3.8%
Newark & Sherwood	185.9	193.9	202.2	210.5	218.7	4.3%	4.3%	4.1%	3.9%
Nottingham City	467.1	487.1	506.8	526.4	545.8	4.3%	4.0%	3.9%	3.7%
Nottingham North & East	199.4	208.3	217.4	226.5	235.4	4.5%	4.4%	4.2%	4.0%
Nottingham West	126.3	131.3	136.4	141.2	145.9	4.0%	3.8%	3.6%	3.3%
Rushcliffe	155.0	161.4	167.9	174.1	180.1	4.1%	4.0%	3.7%	3.4%
Total Core	**1,417.8**	**1,478.3**	**1,539.1**	**1,599.4**	**4.3%**	**£58.9**	**4.1%**	**3.9%**	**3.7%**
Delegated Primary Care Commissioning									
Mansfield & Ashfield	27.5	28.7	30.1	31.3	32.5	4.1%	5.1%	3.8%	3.8%
Newark & Sherwood	18.6	19.3	20.3	21.1	22.0	4.2%	5.2%	3.9%	3.9%
Nottingham City	50.7	53.2	56.1	58.5	61.1	4.8%	5.6%	4.3%	4.3%
Nottingham North & East	20.2	21.0	22.1	22.9	23.8	4.1%	5.2%	3.9%	3.9%
Nottingham West	13.0	13.5	14.1	14.7	15.2	3.8%	4.9%	3.7%	3.7%
Rushcliffe	16.5	17.2	18.1	18.8	19.6	4.3%	5.3%	4.0%	4.0%
Total Delegated PCC	**146.4**	**152.8**	**160.9**	**167.4**	**174.1**	**4.3%**	**5.3%**	**4.0%**	**4.0%**
Running Costs									
Mansfield & Ashfield	4.1	3.6	3.6	3.6	3.6	(11.8%)	0.0%	0.0%	0.0%
Newark & Sherwood	2.8	2.5	2.5	2.5	2.5	(11.8%)	0.0%	0.0%	0.0%
Nottingham City	7.4	6.5	6.5	6.5	6.5	(11.8%)	0.0%	0.0%	0.0%
Nottingham North & East	3.4	3.0	3.0	3.0	3.0	(11.2%)	0.0%	0.0%	0.0%
Nottingham West	2.0	1.8	1.8	1.8	1.8	(-11.8%)	0.0%	0.0%	0.0%
Rushcliffe	2.7	2.4	2.4	2.4	2.4	(-11.7%)	0.0%	0.0%	0.0%
Total Running Costs	**22.4**	**19.8**	**19.8**	**19.8**	**19.8**	**(-11.7%)**	**0.0%**	**0.0%**	**0.0%**
Total Allocation	**1,586.7**	**1,650.9**	**1,719.8**	**1,786.5**	**1,852.7**	**4.0%**	**4.2%**	**3.9%**	**3.7%**

Appendix C – Proposed ICS Financial Framework

Domain	Current Position	Future position (proposed)
1. Understanding the cost of health and social care services	■ Costing used to support decision making at an at organisation level ■ Nationally acclaimed PLICS programme at NUH ■ Improving PLICS in mental health and community (local and national) ■ System PLICS pilot underway – Diabetes ■ Transformational savings plans (QIPP) primarily calculated at PbR and translated into cost	■ Patient level costs across full system ■ Inclusion of social care and public health ■ Full and transparent understanding of system cost across full pathways, recognising interdependencies between organisations ■ Costing approach to support population health management (PHM) approach – e.g. understanding of costs of care within agreed population segments ■ Ability to understand cost at different levels: organisation, PCN, ICP and ICS ■ All savings plans (short and long-term) to be based on true marginal costs
2. System planning and reporting to enable value-based decisions	■ Consolidated I&E plans at a high level. ■ Aggregated bottom line monthly in-year I&E reporting ■ Monthly triangulation exercise ■ Agreed approach to ICP splits (financial sustainability group 24/4) ■ Lack of City Council participation ■ Savings plans recognise organisational impact only ■ Some integration between activity and finance reporting but little on workforce and performance measures	■ True consolidated I&E reporting at organisation, PCN, ICP and ICS level. ■ Recognise costs and variances of key cost drivers (e.g. workforce by sector) to enable appropriate decisions. ■ Cash/capital reporting at system level – recognising current differences in commissioner and provider framework. ■ Savings plans and reporting based on system cost impact. ■ True integrated reports recognising the interdependencies of activity, cost, workforce and performance. ■ Long-term plans to be developed, focussed on best value within total available resources.
3. Payment mechanisms and risk management approach to align incentives	■ Movement away from PbR as principal acute mechanism in 2019/20. ■ Contract risk mechanisms are bi-lateral only. ■ National direction to expand the use of blended payments. ■ PSF used as an incentive to meet system control total in provider organisations ■ Risk management funds controlled at an organisational level ■ CQUIN values diminishing. No local incentives for outcomes	■ Payment mechanisms to reflect efficient cost of service provision ■ Incentivise overall ICS strategy – e.g. recognise integration between services and 'shift left' ■ Consider the impact of the national drive to wider blended payments and the impact on organisational and system plans ■ Consideration to be given to how risk is managed to achieve financial balance at all levels, e.g. System level risk reserves, Control total offsets, Governance and decision making ■ Open and transparent mechanisms to understand how system cost pressures affect individual organisations to inform changes in payment mechanisms and risk sharing.

Appendix C – Proposed ICS Financial Framework

Domain	Current Position	Future position (proposed)
4. Financial recovery actions to support achievement of financial balance	■ Short-term actions to meet in-year control total. ■ Need for non-recurrent mitigations leading to significant underlying deficit ■ Decisions tend to be based on organisational recovery although contractual changes have looked to align focus. ■ Impact of financial recovery on wider system often not recognised or funded – e.g. increased demand in primary care, community care, social care.	■ Realistic multi-year do-nothing plan to enable the development of a financial sustainability programme. ■ Multi-year transformational savings plan including development of headroom for investment in priority areas – e.g. prevention. ■ Savings plans to be developed on cost basis at the outset recognising the impact on workforce, quality and performance across all sectors. ■ Development of system model to enable savings decisions to be based on value not just cost release.
5. Cash and capital regime to support better use of capital investment	■ Little sight of organisational cash positions or their implications at an ICS level. ■ Organisational capital committed through organisational boards with no reference to system decision making. ■ Transformational capital led by organisational 'bids' rather than system priorities. ■ 'Improving' estates strategy means that ICS capital funds cannot be accessed until 'Good' status has been reached. ■ Significant capital funding gap through traditional routes	■ Comprehensive monthly system reporting including balance sheet, cash and capital. ■ Clear system governance in relation to capital expenditure including organisational plans. ■ Development of estates strategy as a live document with full alignment to long term plan and clinical services strategy. ■ Build pipeline of capital schemes to ensure quick response to capital funding releases. ■ Develop system capital funding strategy to enable access to capital in the absence of central funding.

Appendix D – ICS 10 High Impact Levers of Change

Lever	Description	£Ms
1	**Keep people safe and well in their own homes** and communities and reduce the need for emergency attendances at hospital (Non elective admissions and type 1 ED attendances)	TBC
2	**Reduce pressure on acute medical beds** by ensuring they are utilised only by those who need care in acute setting (Non-elective OBDs)	TBC
3	**Reduce inappropriate attendances at A&E departments** through public education and providing alternatives (Minor A%E attendances)	TBC
4	Deliver care closer to home for **Mental Health out of areas patients (OAPs)**	TBC
5	Service Benefit Reviews - including a review of the **core offer**	TBC
6	Deliver increased value across the system - **Optimise medicine spend**	TBC
7	Deliver increased value across the system - **Redesign outpatient services to reduce face-to-face contacts by 30%**	TBC
8	Deliver increased value across the system - **Business as usual efficiencies (BAU)** in providers and commissioners	TBC
9	Deliver increased value across the system - Estates and Back Office	TBC
10	Estimated full-year recurrent delivery of 2019/20 ICP Transformational Plans (QIPP and CIP/FEP)	TBC

Appendix E – Corporate Risk Register for Greater Nottingham and Mid-Nottinghamshire CCGs (July 2019) – Finance

Risk Ref	Oversight Committee (as per June 2019 Governance Structure)	Directorate (as per April 2019 joint CCG structure)	Relevance to Statutory CCG	Risk Source / Previous Risk Ref (e.g. GN or MNs)	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Next Review due
	(Relevant committee in the CCGs' governance structure responsible for monitoring risks relating to their delegated duties)		(Risk relevant to all six statutory CCGs or specific CCGs, as noted).	(Previous risk register ref if applicable)	(Date risk originally identified)	(These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)				Impact	Likelihood	Score	(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).	Impact	Likelihood	Score	(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		
RR015	Finance and Turnaround Committee	Finance and Turnaround	Nottingham City CCG	GN032		There is a risk that different processes followed across the City and County CCGs when screening Individual Funding Requests (IFRs) may result in inconsistent and/or inequitable decisions being made, in particular, due to differences in the level of clinician engagement. The introduction of Blueteq may also increase the volume of IFRs which could present a risk in terms of staff capacity to support the process and potential increased costs. (Reworded May 2019)	Finance	Lucy Dodge	Mark Brayford / Ross Wallingham	3	3	9	• Service Restriction Policy in place across GN and MNs CCGs. • Establishment of multi-disciplinary Panels to review IFRs (to determine if set criteria are met) • Blueteq online 'gateway' system for IFRs 'live' (for direct input by GPs or Secondary Care Doctors)	Action: To monitor the impact of Blueteq in terms of volume of IFRs received. Action: To continue to bring together processes (from City and County) as part of staff consultation (in preparation for merger to a single CCG organisation).	3	2	6	**June 2019:** The IFR process is currently being led by the IFR Team based in Birch House on behalf of all 6 CCGs. There is admin and managerial support from the GN Contract Team, as appropriate, and any City specific IFR requests are being handled by City clinicians and City Public Health, this ensures that there is a consistent approach to dealing with the process of IFRs. This is an interim measure until the team becomes a single function for all six CCGs, at this point it is likely that review panels will be in common for County and City.	25/06/19	23/09/19
RR016	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	GN036		There is a risk that the GN CCGs' may not meet the required Mental Health Investment Standard for 2019/20, which may result in reputational damage to the CCG, as well as adversely impact the level of mental health care/support received by members of the CCGs' population. There is an increased risk in relation to mental health services given the significant focus in the NHS Long Term Plan. (Reworded March 2019)	Finance	Andrew Morton	Becky Mitchell / Lucy Anderson	3	4	12	• Regulatory reporting requirements (e.g. monthly reports to Regional NHS England Area and quarterly to National NHS England)	Action: To meet with Finance and Contracting colleagues to agree approach to ensure Investment Standard is met (from a finance and activity perspective). Action: To introduce internal 'risk based' reporting regarding achievement of Investment Standard. Consideration will be given as to where this would be appropriate to report to within the CCGs governance structure. Action: To take forward any actions identified from the KPMG audit.	3	3	9	**June 19:** It was confirmed that KPMG is currently reviewing the CCGs' Mental Health Investment Figures. They will be reviewing 2017/18 figures (previous year) to confirm the CCGs' baseline position.	19/06/19	17/09/19
RR019	Finance and Turnaround Committee	Commissioning	GN CCGs	GN047	Jul-19	There is a risk that the CCGs' contract management processes (e.g. monitoring and reporting) may not be suitably robust to ensure activity is being delivered in line with agreed plans for 2019/20. This may result in contract values exceed the agreed financial envelopes, thus impacting the CCGs' ability to meet its' financial control total. (Reworded July 2019).	Contracting and Performance	Lucy Dodge	TBC	3	4	12	• Provider Contract Monitoring Meetings and/or Contract Executive Boards (e.g. contract management framework) (including Quality and Performance Meetings and Quality Scrutiny Panels for larger providers) • Contract monitoring / management 'dashboards' and/or performance information. • Robust contract documentation (e.g. NHS Standard Contract) • Establishment of an aligned contract management framework (PENDING)	Action: To continue to ensure robust contract management processes are in place and being followed. Action: To implement actions from the 360 Assurance Contract Management Internal Audit. Action: To embed contract reporting arrangements to the Finance and Turnaround Committee.	3	4	12	Awaiting update.	04/07/19	02/10/19
RR020	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	GN053		RISK TO BE ARCHIVED JULY F&T. Non-delivery of financial plan for 2019/20 due to: • Deterioration in underlying position of the CCGs; • Unidentified or undeliverable 2019/20 QIPP schemes; • Delays in system-wide transformation. (Reworded May 2019)	Finance	Stuart Poynor	Mick Cowley / Andrew Morton	4	4	16	Risk proposed to be archived at July F&T Committee meeting.	Risk proposed to be archived at July F&T Committee meeting.	4	4	16	**June 2019:** Risk reviewed by Operational Directors of Finance (MN and GN) and Corporate Governance and Assurance Manager. Risk narrative, mitigating actions and score to be reviewed for July 2019 meeting.	19/06/19	19/07/19
RR044	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	GN108		RISK TO BE ARCHIVED JULY F&T. Failure to deliver the Financial Recovery Plan (FRP) and recurrent saving schemes, due to unidentified QIPP, non-delivery of anticipated savings and/or workforce capacity within the PMO, may adversely impact our ability to address the CCGs' 2019/20 underlying financial position. (Re-worded May 2019)	Finance	Stuart Poynor	Mick Cowley / Andrew Morton	5	4	20	Risk proposed to be archived at July F&T Committee meeting.	Risk proposed to be archived at July F&T Committee meeting.	5	3	15	**June 2019:** Risk reviewed by Operational Directors of Finance (MN and GN) and Corporate Governance and Assurance Manager. Risk narrative, mitigating actions and score to be reviewed for July 2019 meeting.	19/06/19	19/07/19
RR058	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	MN Risk No. SR3	Jul-17	RISK TO BE ARCHIVED JULY F&T. There is a risk that the CCGs contract management and reporting processes are not effectively or efficiently identifying activity variances or appropriately managing providers to the contracted activity plans in 2019/20. The consequence is that the actual contract values will exceed the agreed financial envelopes and the CCG's financial control total.	Contracting and Performance	Lucy Dodge	TBC	4	3	12	Risk proposed to be archived at July F&T Committee meeting as duplicate with risk RR 019.	Risk proposed to be archived at July F&T Committee meeting as duplicate with risk RR 019.	4	3	12	**July 2019:** Risk proposed to be archived at the July 2019 meeting as duplicate with risk RR 019. RR 019 reworded to encompass theme of both risks.	08/07/2019	06/10/19
RR059	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	MN Risk No. SR4	Sep-14	RISK TO BE ARCHIVED JULY F&T. There is a risk that over performance against budgeted expenditure across key areas will continue, which would lead to the CCG not achieving their respective planned surplus targets with the associated risk of the CCG not remaining within their cash limits.	Finance	Stuart Poynor	Mick Cowley / Andrew Morton	5	4	20	Risk proposed to be archived at July F&T Committee meeting.	Risk proposed to be archived at July F&T Committee meeting.	5	4	20	Risk proposed to be archived at July F&T Committee meeting.	08/07/2019	06/10/19

Risk Ref	Oversight Committee (Governance Structure)	Directorate (as per April 2019 joint CCG structure)	Relevance to Statutory CCG	Risk Source / Previous Risk Ref (e.g. GN or MNs)	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Next Review due
	(Relevant committee in the CCGs' governance structure responsible for monitoring risks relating to their delegated duties)		(Risk relevant to all six statutory CCGs or specific CCGs, as noted).	(Previous risk register ref if applicable)	(Date risk originally identified)	(These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)				Impact	Likelihood	Score	(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).	Impact	Likelihood	Score	(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		
RR062	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	MN Risk No. SR6	Apr-19	RISK TO BE ARCHIVED JULY F&T. There is a risk that the CCG will under deliver its QIPP requirement which is impacted by the provider's resistance to moving capacity out of the system.	Finance	Stuart Poynor	Jonathan Nycroft	4	5	20	Risk proposed to be archived at July F&T Committee meeting.	Risk proposed to be archived at July F&T Committee meeting.	4	5	20	Risk proposed to be archived at July F&T Committee meeting.	08/07/2019	06/10/19
RR080	Finance and Turnaround Committee	Finance and Turnaround	GN CCGs	GN 113	May-19	RISK TO BE ARCHIVED JULY F&T. Failure to deliver the Financial Recovery Plan (FRP) and QIPP saving schemes for 2019/20, specifically the need to reduce in-year secondary care activity, presents a risk that the 2020/21 contract value for NUH will significantly exceed the CCGs' affordability. This, in turn, presents a risk regarding the CCGs' 2020/21 financial position.	Finance	Stuart Poynor	Jonathan Nycroft	5	4	20	Risk proposed to be archived at July F&T Committee meeting.	Risk proposed to be archived at July F&T Committee meeting.	5	3	15	Risk proposed to be archived at July F&T Committee meeting.	08/07/2019	07/08/19
RR090	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	Failure to delivery identified 'cash releasing' QIPP savings schemes, that reduce our cost baseline, may result in non-delivery of the CCGs' financial statutory duties for 2019/20.	Finance	Stuart Poynor	Jonathan Nycroft / Jack Hudkin / Head of PMO	5	4	20	• Established Joint Finance and Turnaround Committee (across the GN and MN CCGs) with clear membership and reporting structure • Financial Recovery governance structure, which reports to the Finance and Turnaround Committee (PENDING) • Appointment of a Chief Finance Officer including Turnaround Director (across the six MN and GN CCGs) • Nominated SRO leads for individual QIPP schemes. Associated QIPP reporting and scrutiny processes. • Provider Contract Monitoring Meetings and/or Contract Executive Boards • Finance Report provided to the Finance and Turnaround Committee (monthly) and to Governing Bodies (monthly). • Financial Recovery Plan Update Reports to the Finance and Turnaround Committee (monthly)	Action: To establish a robust challenge and confirm governance structure to support the delivery of identified QIPP schemes. This includes the need to: • Implement a single CCG Financial Recovery and Accountability Framework; • Strengthen FRG governance arrangements (which includes establishment of clinical leadership); • Confirm Executive SROs, Programme Directors, Programme Managers and delivery teams (and establish Programme Delivery Boards); • Develop engagement strategy to raise awareness and promote a culture of QIPP delivery and turnaround • Establish and support joint system Transformation Groups; and • Promote a turnaround culture within the CCG and wider system. Action: To implement a comprehensive 5 point plan in response to the CCGs' significant financial challenges, specifically points: 1. Improve confidence in delivery of existing QIPP schemes; and 2. Develop and mobilise further QIPP opportunities.	5	3	15	New risk identified.	15/07/2019	14/08/19
RR091	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	Delivery of identified QIPP savings schemes utilising non-recurrent monies presents a risk that the CCGs' 2019/20 underlying position may not improve.	Finance	Stuart Poynor	Mick Cowley / Andrew Morton	4	4	16	• Established Joint Finance and Turnaround Committee (across the GN and MN CCGs) with clear membership and reporting structure • Financial Recovery governance structure, which reports to the Finance and Turnaround Committee (PENDING) • Appointment of a Chief Finance Officer including Turnaround Director (across the six MN and GN CCGs) • Nominated SRO leads for individual QIPP schemes. Associated QIPP reporting and scrutiny processes. • Provider Contract Monitoring Meetings and/or Contract Executive Boards • Finance Report provided to the Finance and Turnaround Committee (monthly) and to Governing Bodies (monthly). • Financial Recovery Plan Update Reports to the Finance and Turnaround Committee (monthly).	Action: To implement a comprehensive 5 point plan in response to the CCGs' significant financial challenges. This includes, specifically: 1. Implement financial measures to increase control of spend; 2. Develop and mobilise ICP financial recovery plans; and 5. Develop additional financial efficiency opportunities	4	3	12	New risk identified.	08/07/2019	07/08/19
RR092	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	Failure to identify substantial and robust QIPP schemes to meet the CCGs' financial gap may impact the CCGs' ability to meet its' financial statutory duties for 2019/20.	Finance	Stuart Poynor	Jonathan Nycroft / Jack Hudkin / Head of PMO	5	4	20	• Cross-partner forums to identify potential savings opportunities (at both ICS and ICP level) • '3 way' Executive to Executive meetings with Chief Finance Officers (across MNs patch) • CCG PMO presence/attendance in relevant ICP forums/groups (in all 3 ICPs)	Action: To implement a comprehensive 5 point plan in response to the CCGs' significant financial challenges. This includes, specifically: 3. Implement financial measures to increase control of spend; 4. Develop and mobilise ICP financial recovery plans; and 5. Develop additional financial efficiency opportunities	5	3	15	New risk identified.	08/07/2019	07/08/19
RR093	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	Increasing levels of uncoded activity (U codes) at NUH presents a risk that the CCGs are unable to accurately validate activity data. This, in turn, presents a risk that the CCGs are unable to assure themselves of the quality of activity data and level of activity being delivered by the provider. Furthermore, there is a financial risks as the average cost applied to the uncoded activity may be below actual costs.	Finance	Stuart Poynor	Andy Hall	3	4	12	• Contract Management Framework (including Contract Executive Board meetings) with NUH • Information Breach Notice (potential to re-open) • CCG data quality / validation checks (monthly)	Action: To consider reopening IBN if U code performance does not improve.	3	3	9	New risk identified.	08/07/2019	07/08/19
RR095	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	Increasing number of 'pass through payments' (including high cost drugs) relating to NUH presents an additional cost pressure to the CCGs as activity is outside the agreed 'block' contract value.	Finance	Stuart Poynor	Andrew Morton	3	3	9	• Contract Management Framework (including Contract Executive Board meetings) with NUH	SMART actions in development.	3	3	9	New risk identified.	08/07/2019	07/08/19
RR096	Finance and Turnaround Committee	Finance and Turnaround	All 6 CCGs	N/A	Jul-19	With the delegation of transformation funds, alongside a lack of clarity regarding system architecture accountability, there is a risk that the CCGs' may be liable for recurrent costs resulting from non-current investment. This, in turn, may result in future cost pressures and impact the CCGs' future financial position. (Draft risk)	Finance	Stuart Poynor	Mick Cowley / Andrew Morton	4	4	16	Controls being identified.	SMART actions in development.	4	4	16	New risk identified.	11/07/2019	10/08/19

RISK MATRIX

Impact	1-Rare	2-Unlikely	3-Possible	4-Likely	5-Almost Certain
5 - Very High	A/G	A/G	R	R	R
4 - High	A	A	A/G	R	R
3 - Medium	A/G	A	A	A/G	A/G
2 - Low	G	A/G	A/G	A	A
1 - Very low	G	G	G	G	G

Likelihood