ITEM 6

North Yorkshire County Council

Scrutiny of Health Committee

9 November 2012

NHS North Yorkshire and York – Turnaround Initiatives

Purpose of Report

1. The purpose of this report is to highlight to the Scrutiny of Health Committee the progress that is being made to deliver a £10m turnaround package of savings in NHS North Yorkshire and York's budget situation during this year.

Introduction

2. Members will recall that NHS North Yorkshire and York (NHS NY&Y) projected budget situation at the end of this financial year is a £19m deficit. In order to ensure this figure is not exceeded the PCT Board at its meeting on 25 September 2012 approved a package of turnaround measures listed in APPENDIX 1 which would deliver in year savings of £10m.

3. At the Board meeting on 23 October 2012 the Chairman/Accountable Officer from each Shadow Clinical Commissioning Group gave a progress report against each item. The report considered by the Board is attached as APPENDIX 2.

4. Bob Wiggins, Turnaround Director, on behalf of NHS NY&Y will be attending the Committee to give an update of progress against each item, how any impact on patients is being managed and to respond to Members' questions.

Recommendation

5. That Members note the measures being introduced by NHS NY&Y to save £10m in this year and explore the impact that these measures will have on patients and offer comment to the Turnaround Director.

Bryon Hunter
Scrutiny Team Leader
County Hall, NORTHALLERTON
31 October 2012

Background Documents: None

NHS NORTH YORKSHIRE & YORK

Proposed turnaround initiatives.

		Potential Savings 12/13 £m
1	A review of elective activity	2.8
2	A review of outpatient follow up appointments in line with best practice	3.1
3	A review of Minor Injuries Units opening hours with a view to some closures	0.4
4	A review of community hospital beds with a view to some short term closures	0.4
5	A review of high cost treatments and drugs	0.6
6	Potential cessation of enhanced primary care service payments	0.6
7	A review of Mental Health and continuing health care placements	1.5
8	Ceasing expansion of health visitor implementation	0.2
9	Redesigning patient transport services.	0.4
Total potential savings built into financial forecasts		**10.0**

24th September 2012

Item Number: 8

NHS NORTH YORKSHIRE AND YORK CLUSTER **CLUSTER BOARD MEETING**	NHS North Yorkshire and York

Meeting Date: 23 October 2012

Report's Sponsoring Director:	**Report Authors**
Christopher Long Chief Executive	CCG leaders

1. Title of Paper: Quality, Innovation, Productivity and Prevention (QIPP) Programme Going Further and Faster

2. Strategic Objectives supported by this paper:

Supports all strategic objectives

3. Executive Summary

The Clinical Commissioning Groups within NHS North Yorkshire and York recognise the financial challenge within their locality and the wider health economy. To support delivering the financial control total, the CCGs have developed actions to accelerate QIPP delivery as both corrective actions for the challenge in 2012-13 and as foundations for the CCGs' 4-year financial plan.

The attached reports (from the four CCGs) set out the latest position on the additional actions proposed this financial year as requested at the Board meeting last month..

4. Risks relating to proposals in this paper

Financial
Quality

5. Summary of any finance / resource implications

The attached papers set out savings which are planned to deliver an additional £5m in the current financial year (in excess of current QIPP forecasts). In addition, further savings on central schemes and prescribing are planned to deliver a further £2.5m.

The paper at the Board meeting last month highlighted the need for at least £10m additional schemes and the £2.5m shortfall on this amount is still under discussion . It is hoped that a

verbal update on this gap will be available at the Board meeting.

These plans are built into the financial projections set out in the performance dashboard elsewhere on the agenda.

6. Any statutory / regulatory / legal / NHS Constitution implications

The PCT has statutory responsibility to break even. As NHS North Yorkshire and York has an agreed deficit control total of £19m, the focus is on delivery of this position or better at year end.

7. Equality Impact Assessment

An Equality Impact Assessment will be done on the specific projects subject to agreement by the CCG governing bodies and the NHS North Yorkshire and York Board.

8. Any related work with stakeholders or communications plan

Each CCG will need to consult their stakeholders on the changes.

9. Recommendations / Action Required

The Board is asked to note these papers and to support the work being led by the CCGs.

10. Assurance

The Board will be provided with a regular financial and transformational change updates.

For further information please contact:

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Harrogate and Rural District
Clinical Commissioning Group

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP)
RECOVERY PROGRAMME

1. Introduction

NHS Harrogate and Rural District CCG (HaRD CCG) fully recognises and accepts the challenging financial position within the locality and more widely across North Yorkshire and York health economy. The CCG is committed to improve the financial position and work to reduce activity and spend to recover the financial position and deliver within its budget. HaRD CCG has developed a number of extended QIPP schemes that will underpin the current QIPP schemes. This is in order to support delivery of the CCG current savings target figure of £2.9m but to also to act as an enabler, to support in year financial recovery.

The CCG has identified a number of potential turnaround measures. These will be developed and considered further. The agreed areas are detailed below.

2. Detailed Areas of Focus

2.1 Elective Activity

2.1.1 Referral Management and Clinical Thresholds

The CCG has developed and implemented a number of initiatives relating to referral management during 2012/13, and these will continue to be monitored and reviewed at practice level to ensure full and continued compliance.

Other actions to support this include:

- Orthopaedic gateway on Choose and Book for all Orthopaedics referrals to ensure adherence to current clinical thresholds
- A second audit of compliance with hip and knee thresholds to be completed and shared with practices and providers.
- Prospective peer review of referrals in practices, supported by data from CCG to target areas of unexplained variation.
- QOF GP practice learning sets to perform peer review of sampled practice referrals to share good practice and reduce referral variation
- All referral thresholds and the referrals guidelines to be re-circulated to practices
- Contract activity breakdown by practice – enabling practices to monitor individual performance against contract, supported by the CCG contracting team

2.1.2 Shared Decision Making

Patient Decision Aids (PDAs) are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them. Research shows that shared decision making are really effective in helping patients make informed choices about their healthcare and increase patients' awareness of the expected risks, benefits and likely outcomes. The CCG identified this area

in its plan for 2013, but will bring forward the introduction of these aids. There are currently nine available, with a further twenty six being published before end of March 2013.

2.2 Outpatient Follow-up Appointments

Follow up activity is an area of high expenditure in the CCG at £9.6m planned for 2012/13. Evidence shows that some follow ups add no clinical value and some could be managed in primary care. This area is already targeted for 2013/14, the CCG will move to commission performance levels at secondary care providers at the highest benchmarked standards. For the last quarter of 2012-13, to support in year financial recovery, the CCG will commission activity at a maximum follow up ratio of 1:1.

Such a significant shift in such a short-time may not be sustainable into the early part 2013-14. Thus, the CCG intends to commission follow ups at 1:1.5 for the whole of 2013-14, working towards a minimum 1:1 ratio from 2014-15 onwards. To support this change the CCG will:

- Agree with secondary care clinician's specific procedures, specialties and patient types where routine follow-up will not be required and where patients can be discharged back to management in primary care. This work is being led by GPs from the CCG with colleagues in the Harrogate District Foundation Trust (HDFT)
- Provide GP clinical review to all high-volume outpatient specialities to assist in safely and appropriately discharging patients back to primary care.
- Develop cost effective alternatives to face to face consultation services for the major specialities by providing GPs with non-face-to-face support to assist in patient management without follow-up.

2.3 Access to Diagnostics

There is significant variation in the use of direct access imaging between practices.
The CCG intends to only support direct access referrals for MRI scans as part of a referral protocol for referral to neuro-surgery as this is an established protocol.
All other requests for direct access imaging will be agreed with a Consultant Radiologist prior to referral.
The CCG will work with the Practices and colleagues in Radiology to monitor impact in order to ensure the most efficient and cost effective pathways are in place and that tests are requested appropriately in line with best practice and guidance.

2.4 Use of Community Hospitals

The position of the CCG clinicians and that of the wider Governing Body is that the risk to the reputation and integrity of the developing CCG would be significant, if any short term cuts to services within the Ripon Community Hospital were undertaken. The CCG is not prepared to undertake that risk.

The CCG is committed to Ripon 2020, a joint vision of integrated services with a focus on well being for all of Harrogate and Rural District.

As part of the developing Harrogate and Rural District Urgent Care Strategy, the CCG will be reviewing access and provision of all services including minor injuries facilities. The CCG wants to ensure a responsive affordable and sustainable solution that fits with NHS 111.

The CCG is working closely with colleagues in HDFT to review activity and bed utilisation at Ripon to ensure that these beds are used in a most clinically appropriate way. This also fits as part of the development of the integrated care teams within Ripon that will be rolled out

across the wider CCG area in partnership with colleagues at North Yorkshire County Council.

2.4 Primary care prescribing

The CCG are working with colleagues in the Medicines Management team to reduce the overspending position on the CCG prescribing position. These schemes are in development but will link to the work already taking place through the Quality and Outcomes QIPP prescribing initiatives. There will also be a focus on secondary care prescribing impact on primary care.

3. Financial Summary

Summary	Saving	Timeframe
Demand Management	£99,000	November - March
Follow up ratio 1:1	£918,000	Quarter 4
Adherence with clinical thresholds (including hip and knee	£189,000	November onwards
Reduction in open access diagnostics	£66,000	November –March with review
Prescribing savings	£150,000	November onwards
Total	£1,422,000	

The CCG is working closely with HDFT who have given a firm commitment to work with the CCG to deliver a reduction in the forecast overtrading position on the contract. As well as agreeing the work on follow ups and open access diagnostics, this includes reviewing pathway charges and auditing elective activity for threshold compliance.

4. Risks

The CCG is currently delivering 80% of its current QIPP programme. The additional areas of focus identified build on the current plans. The main area of over activity and spend on the contract are in the areas of emergency activity. Short term measures have little impact on these admissions and this remains the greatest area of risk to delivery. Managing growth in this area will be addressed by the longer term development of the integrated care teams and greater community resources. These are currently being delivered, the rollout time is into 2013 and the further development is part of the longer term strategy of the CCG.
The CCG is committed to delivery and will work to deliver this, but acknowledge there is risk to delivery due to the continued growth in demand from the local population.

Amanda Bloor
Chief Officer Designate
NHS Harrogate and Rural District CCG

October 2012

NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CLINICAL COMMISSIONING GROUP

QIPP AND TURNAROUND PLAN

1. Introduction

The 2012/13 financial plan for NHS NYY was set with a budget deficit of £19m of which **£2.6m has been attributed by the PCT to HRW CCG**. This means that the delegated budget for the CCG and therefore the amount of money being spent on healthcare in 2012/13 is approx £2.6m more than the funding available for this area. Built into this financial plan are QIPP (Quality, Innovation, Productivity and Prevention) savings of £3.2 million, which if not delivered will increase the year-end deficit.

The NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) **recognise the financial challenge** within its locality and the wider health economy of North Yorkshire and York. To support delivering our statutory financial duties the CCG has developed actions to accelerate QIPP delivery as both corrective actions for the financial challenge in 2012-13 and as one of the foundations for the CCGs 4-year financial plan.

The actions describe the CCG implementation of the relevant elements of NHS North Yorkshire and York (NHS NYY) **financial recovery actions**, as detailed at the NHS NYY Board meeting of September 2012.

2. Financial Dashboard (5 month) and Contractual Performance

As at the end of August 2012 the CCG is forecasting a £5.1million overtrade against delegated budgets of £168 million. This includes £2.6million share of the PCT Cluster deficit. Of the £2.5 million in year trading deficit £1.5 million relates to the South Tees Hospitals NHS Foundation Trust contract. £0.8million of the £2.5 million relates to the County Durham and Darlington Hospitals NHS Foundation Trust and £0.7million for Newcastle Hospitals Foundation Trust relates to the overtrade on core activity (non SCG).

3. QIPP Performance

Currently the CCG has 10 QIPP Schemes and have **performed well year to date** on QIPP. This has been delivered through **strong clinical engagement in both secondary and primary care.** The planned savings YTD are £1.07 million and the actual delivery is £1million which is -6% under target. 5 schemes are not delivering the full QIPP value. These are:

- reducing GP first attendances
- reducing ophthalmology attendances
- improved community systems based on levels of care
- non North Yorkshire and York Community Hospitals
- A&E QOF

We are working closely with health system partners to bring these back on track by year end to ensure we deliver in full. We have also throughout the month held a number of **Member Practice Locality Meetings** to deliver QIPP performance improvements. We are also holding individual peer review meetings throughout November to review clinical variations.

Despite strong delivery on QIPP the CCG is still experiencing significant pressures on in year contracts which if not corrected would result in the CCG being in significant deficit than planned and being required to repay a higher level the following year.

4. Key Turnaround Initiatives and Actions

Below is a summary of the initiatives we are taking to recover an in year balanced position and hold the historic debt of £2.6 million.

No.	Initiative	Description	Saving to be achieved (000s)	Timeframe
1	South Tees NHS Foundation Trust	Agree with South Tees treatment and application of non-elective threshold.	£1,500	October 2012
2	County Durham and Darlington	Review the non-elective threshold and agree adjustments to the baseline to implement in 2012/13.	£296	November 2012
3	Turnaround Initiatives	**A) Referral Management and clinical Thresholds** i) Orthopaedic Shared Decision Making and clinical thresholds ii) Pain management and shared prescribing guidelines **B) Outpatients Follow Up** Commission 1:1 outpatients follow up ratio for selected specialities **C) Other quantified schemes:** i) Direct Access Diagnostics. Agree direct referral protocols. ii) DVT Pathways Implementing community based pathway. **Turnaround Total**	 £155 £10 £300 £18 £10 **£493**	December 2012 – March 2013
Total Savings			**£2,289**	
Current shortfall **Un-quantified schemes to be confirmed:**			**-£211**	
4	Newcastle Hospital NHS	Complete an activity deep drive on contract	**TBC**	November 2012

	Foundation Trust	performance to identify mitigating actions		

5	Turnaround Initiatives	i) Ambulatory Care ii) Review opening hours and use of reablement monies for Whitby Walk in Centre	**TBC**	December 2012 – March 2013

The CCG, since becoming a shadow governing body has focussed on building a **strong and credible reputation**. It is important to us to maintain members and providers confidence through this financially challenging period. Currently all are supportive of the initiatives developed and will continue to support. This relationship has been **seen by progress made on contract terms in 2012/13** and the ongoing engagement on TCS and with lucentis tariffs. We are keen to ensure all new plans being developed continue to maintain this level of provider and clinical engagement. We will quantify the remaining schemes throughout the coming month with our members and providers.

5. Conclusion

The HRW CCG is committed to supporting the PCT Cluster financial position in 2012/13 and to taking the **necessary actions to provide a sustainable financial** framework for the CCG in its first years of operation. This is described in more detail within the **CCGs 4-year financial plan**; this includes recognition that the CCG inherits its share of the current PCT Cluster deficit. The plans outlined above set out the actions we are currently taking to minimise the year end deficit position and this brought forward deficit.

6. Recommendations and Next Steps

This paper will be taken to the Shadow Governing Body on 25th October following the PCT Cluster Board on the 23rd October for **final approval and action**.

Debbie Newton
Chief Operating Officer/Finance Officer

NHS Hambleton, Richmondshire and
Whitby Clinical Commissioning Group

Dr Vicky Pleydell
Clinical Chief Officer Designate

NHS Hambleton, Richmondshire and
Whitby Clinical Commissioning Group

NHS SCARBOROUGH AND RYEDALE CLINICAL COMMISSIONING GROUP

QUALITY, INNOVATION, PRODUCTIVITY, AND PREVENTION (QIPP) PROGRAMME

GOING FURTHER AND FASTER

1. Introduction

The NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG) recognise the financial challenge within its locality and the wider health economy of North Yorkshire and York. To support delivering statutory financial duties the CCG has developed actions to accelerate QIPP delivery as both corrective actions for the financial challenge in 2012-13 and as one of the foundations for the CCG's 4-year financial plan.

The actions describe the CCG implementation of the relevant elements of NHS North Yorkshire and York (NHS NYY) financial recovery actions, as detailed at the NHS NYY Board meeting of September 2012.

2. Referral Management and Clinical Thresholds

The King's Fund research into referral management (King's Fund 2010) suggests the most cost effective and clinically effective referral management strategies are those:

- built around peer review and audit
- supported by consultant feedback
- with clear referral criteria and evidence-based guidelines.

The analysis suggests that the greater the degree of intervention, the greater the likelihood that the referral management approach will not represent value for money. Thus, if this analysis is to be accepted, the use of large-scale stand-alone referral management services may not provide an effective solution.

The approach developed by the CCG involves the following actions:

- Implement a referral template on primary care information systems to be used for all referrals, providing the required core information for providers.
- All referrals into secondary care to be reviewed and agreed by a second GP.
- Use the existing CCG learning sets to perform peer review of sampled practice referrals in high-volume
- CCG board leads to engage with high-volume speciality hospital consultants to agree referral thresholds
- All referral thresholds to be re-circulated
- The Audit of compliance with hip and knee thresholds to be completed and shared with practices and repeated with a second audit by the year-end.
- Referring, where appropriate, smoking patients to the smoking cessation service before referring for non-urgent treatment.

The learning sets will conduct retrospective and prospective referral review, with the aim of sharing good practice and reducing overall referral variation.

3. Outpatient Follow-up Appointments

As this is considered to represent a high-cost service area much of which could be managed in primary care, this is a target area for the CCG to move to performance levels at the highest benchmarked standards.

For the last quarter of 2012-13, to support in –year financial recovery, the CCG will commission activity at a level of 1:1 first to follow-up overall.

Such a dramatic shift in such a short-time may not be sustainable into 2013-14. Thus, the CCG intends to commission at 1:1.5 for the whole of 2013-14, before moving to 1:1 as an ongoing ratio from 2014-15. To support this shift the CCG will:

- Provide GP clinical support to all high-volume outpatient specialities to assist in safely and appropriately discharging patients back to primary care.
- Develop 'expert consulting' services for the major specialities providing GPs with non-face-to-face support to assist in patient management without follow-up.
- Agree specific procedures and patient types where routine follow-up will not be required and where patients can be discharged back to management in primary care.

4. Primary care prescribing

In 2010 primary care delivered significant efficiency gains through prescribing initiative labelled the '30-day Plan'. To support financial recovery in 2012-13 a similar scheme is developed, targeting prescribing changes that will release significant resource. The estimated full-year effect of the current plan is an additional full-year saving of £400,000. Practices will each be given their own prescribing data and targets for specific drug switches, identifying the forecast efficiency gains.

The plan will take effect from early November 2012 and will form an on-going element of the 4-year QIPP programme.

5. Urgent Care Access

The CCG is engaged in a detailed review of attendances at Accident and Emergency (A&E) departments, as part of the delivery of the Quality and Productivity indicators with the Quality and Outcomes Framework (QOF). To further increase urgent care efficiency, the CCG is actively engaged in redesigning the urgent care pathways into the localities Minor Injury Unit (MIU), and GP Walk-in centre, in addition to further integrating the current GP Out of Hours service with other access routes into urgent care. The direct financial gains are likely to be small in 2012-13, but will form part of the longer-term efficiency programme.

In support of the urgent financial pressures in 2012-13 the CCG will work with York Teaching Hospitals Foundation Trust (YFT) to reduce the opening hours of the Malton Hospital MIU to become a 5 day service, whilst involving the population of Ryedale in consultation on the future configuration of the unit.

6. Financial Summary

The actions identified above are supported by detailed financial modelling of the likely impact. The overall financial summary of targeted actions is provided below:

Summary of Financial Recovery Schemes	Cost (£)	Timeframe
Primary Care Demand Management	-£162,576	Nov - Mar
Commission Top Decile Follow Ups	-£321,553	Q4
Implementing Clinical Thresholds	-£313,987	Q4
Primary Care Prescribing	-£125,000	Nov - Mar
MIU Opening Hours	-£100,000	Nov - Mar
TOTAL	**-£1,023,116**	

The CCG will coordinate actions with the other NHS NYY CCGs and will consider whether the current list of actions provide sufficient efficiency gains to achieve the required financial objectives

7. Conclusion

SRCCG is committed to supporting the PCT's financial position in 2012-13 and to taking the necessary actions to provide a sustainable financial framework for the CCG in its first years of operation. This is described in more detail within the CCG's 4-year financial plan. This includes recognition that if the CCG inherits its share of the current PCT deficit, and any other further in-year deficit incurred between now and the end of the financial year, significant efficiency gains will be required to bring the CCG into recurrent balance. To that end the CCG is not forecasting achievement of recurrent financial balance until the financial year of 2014-15 at the earliest.

Simon Cox
Chief Officer Designate
NHS Scarborough and Ryedale clinical Commissioning Group

Dr Phil Garnett
Clinical Chair
NHS Scarborough and Ryedale clinical Commissioning Group

VALE OF YORK CLINICAL COMMISSIONING GROUP

QUALITY, INNOVATION, PRODUCTIVITY, AND PREVENTION (QIPP) PROGRAMME

1. Introduction

The Vale of York Clinical Commissioning Group recognises the financial challenge within its locality and the wider health economy of North Yorkshire and York. The CCG is committed to improve the financial position and to work to reduce activity and spend. To support delivering statutory financial duties the CCG has developed a number of specific actions to build on existing QIPP schemes. These will further extend QIPP delivery as both corrective actions for the financial challenge in 2012/13 and as one of the foundations for the CCG's 4 year financial plan.

The CCG has identified a number of potential turnaround measures which are detailed below. These actions support the CCG's implementation of the relevant elements of the NHS North Yorkshire and York financial recovery actions, as presented at the NHS North Yorkshire and York Board meeting held in September 2012.

2. Referral Management and Clinical Thresholds

The King's Fund research into referral management (King's Fund 2010) suggests the most cost effective and clinically effective referral management strategies are those that are:

- Built around peer review and audit
- Supported by consultant feedback
- Based on clear referral criteria and evidence-based guidelines.

The analysis suggests that the greater the degree of intervention, the greater the likelihood that the referral management approach will not represent value for money. Thus, if this analysis is to be accepted, the use of large-scale stand-alone referral management services may not provide an effective solution.

The CCG has developed and implemented a number of initiatives relating to referral management during 2012/13, and these will continue to be monitored and reviewed at practice level. This work will be further supported by the following actions:

- All referrals into secondary care made by a Locum or Registrar in general practice to be signed off by a second GP.
- Implement referral review with a GP and Consultant reviewing all referrals in 4 specialties initially, Gynaecology, ENT, Pain, General Surgery. This will be further extended to include Rheumatology and Gastroenterology.
- This review to include compliance with thresholds and in particular procedures of limited clinical value.
- All referral thresholds to be re-circulated
- All referrals for MSK to be reviewed through the MSK service. With the exception of red flag to ensure compliance with hip and knee thresholds.

- Contract activity breakdown by practice which will enable practices to monitor individual performance against contract, supported by the CCG contracting team

The learning from the referral review work will be shared with GPs through the development work with practices and the GP Forum, with the aim of reducing variation.

3. Elective Activity

Patient Decision Aids (PDAs) are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them. Research shows that shared decision making is really effective in helping patients make informed choices about their healthcare and increase patients' awareness of the expected risks, benefits and likely outcomes.

There are currently nine PDAs available, with a further twenty six expected to be published before the end of March 2013. In considering those aids currently available relating specifically to routine elective procedures, as a priority, the Vale of York CCG will work with both NHS and private providers to implement shared decision making through the use of patient decision aids for hips, knees and cataracts.

As further decision aids become available for other routine elective procedures these will also be implemented.

4. Outpatient Follow-up Appointments

As this is considered to represent a high-cost service area, this is a target area for the CCG to move to performance levels to the highest benchmarked standards.

For the last quarter of 2012/13, to support in year financial recovery, the CCG will commission activity at best practice levels.

The CCG has agreed an improvement trajectory in the 2012/13 contract and intends to commission at 1:1.5 for the whole of 2013/14. To support this improvement the CCG will:

- Provide GP clinical support to high-volume outpatient specialities to assist in safely and appropriately discharging patients back to primary care. Where appropriate, to implement an open system as opposed to a booked system for follow up.
- Develop 'expert consulting' services for the major specialities providing GPs with non-face-to-face support to assist in patient management without follow-up.
- Agree specific procedures and patient types where routine follow-up will not be required and where patients can be discharged back to management in primary care.

5. Primary Care Prescribing

In 2010 primary care delivered significant efficiency gains through the '30 day' prescribing initiative. To support financial recovery in 2012/13 a similar scheme has been developed, targeting prescribing changes that will release significant resource. This will involve practices being supported by the Medicines Management Team and being provided with their own prescribing data and targets for specific drug switches, identifying the forecast efficiency gains.

The plan will take effect from early November 2012 and will form an on-going element of the 4 year QIPP programme.

6. Urgent Care Access

The CCG has worked jointly with York Teaching Hospitals Foundation Trust to develop an integrated urgent care centre. The walk in centre was transferred to York Hospital and integrated into A&E from 1 April 2012. Practices are engaged in a detailed review of attendances at Accident and Emergency (A&E) departments, as part of the delivery of the Quality and Productivity indicators with the Quality and Outcomes Framework (QOF). To further increase urgent care efficiency, the CCG is actively engaged in redesigning the urgent care pathways into the localities Minor Injury Units (MIU). The direct financial gains are likely to be small in 2012/13, but will form part of the longer-term efficiency programme.

7. Direct Access MRI and CT

There is significant variation in the use of direct access imaging between practices. The CCG will work with radiology colleagues at York Teaching Hospitals Foundation to Trust to reduce direct access referrals for MRI and CT. This will include a review of direct referrals and advice to GPs provided by a radiologist.

The CCG will work with the practices and colleagues in Radiology to monitor the impact of these actions in order to ensure the most efficient and cost effective pathways are in place and that tests are requested appropriately in line with best practice.

8. Financial Summary

The actions identified above are supported by detailed financial modelling of the likely impact. The overall financial summary of targeted actions is provided below:

Summary of Schemes	**Savings (£) £'000s**	**Timescale**
Referral Review and Clinical Thresholds	428	1 Dec - Mar
Shared Decision Making	561	1 Dec - Mar
Commission Top Decile Follow Ups	773	Q4
Primary Care Prescribing	200	1 Nov - Mar
MIU Opening Hours	100	1 Dec - Mar

Direct Access CT/MRI	12	Q4
TOTAL	2,074	

The CCG will coordinate actions with the other NHS North mYorkshire and York CCGs and will consider whether the current list of actions provide sufficient efficiency gains to achieve the required financial objective.

9. Conclusion

The Vale of York CCG is committed to supporting the PCT's financial position in 2012/13 and to taking the necessary actions to provide a sustainable financial framework for the CCG in its first years of operation. This is described in more detail within the CCG's 4-year financial plan. This includes recognition that if the CCG inherits its share of the current PCT deficit, and any other further in-year deficit incurred between now and the end of the financial year, significant efficiency gains will be required to bring the CCG into recurrent balance. To that end the CCG is not forecasting achievement of recurrent financial balance until the financial year of 2014/15 at the earliest.

Rachel Potts

Interim Chief Operating Officer
Vale of York clinical Commissioning Group

Dr Mark Hayes

Chief Clinical Officer Designate
Vale of York Clinical Commissioning Group

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