

North Central London Cluster Commissioning Strategy and QIPP Plan 2011/12 – 2014/15

Updated Version

30th June 2011

Foreword

The next few years will be extremely challenging for the NHS as we implement the vision contained in the coalition government's White Paper, "Liberating the NHS" together with the Health and Social Care Bill 2011, and deal with the unprecedented financial challenges facing us over the next four years. They are also opportunities, with our GP commissioners and working in partnership with local authorities, health service providers, the voluntary sector, patients and our communities, to improve health, reduce inequalities and develop high quality, sustainable health services.

This plan describes the NHS North Central London (NHS NCL) cluster's strategic commissioning and Quality, Innovation, Productivity and Prevention (QIPP) plans for the next four years to support improvement in health and healthcare provision in NCL within the financial resources available. Within this, there will be a particular focus on the next two years as we aim to ensure that the healthcare system our General Practitioners inherit is both financially sustainable and clinically able to meet the needs of the local population.

The plan builds on our previous Commissioning Strategy Plan (CSP) published in January 2010 and retains the key themes of that plan of transferring care, where appropriate, from hospitals to community and primary care settings. Our discussions with General Practitioner (GP) commissioners as part of the planning process highlighted this as a key priority for them, along with improving services for Mental Health patients. Other priorities in the plan reflect work undertaken across London to improve patient outcomes in specialist services such as cancer and cardiovascular, local services such as maternity and areas where we have benchmarked our performance against others and identified improvement opportunities.

Our plan takes account of the approval of the Barnet, Enfield and Haringey (BEH) Clinical Strategy in January 2011 and assumes that the consultation on the reduction of Mental Health bed capacity with Camden and Islington NHS Foundation Trust leads to bed closures taking place. At this point, our plan does not include other major service or provider reconfigurations other than those agreed across London in specialist services. Throughout the course of our planning we have continued to discuss and review with providers the implications of our plan on them both in the short and longer terms. Potentially, these discussions may conclude that there is a need for further changes to the pattern of services within NCL.

We recognise that health service changes are very important to the public, patients, partners and other stakeholders. We have already engaged with various groups in developing our plan and, in keeping with our stated aim of being open and transparent, we will look to build further on this in the coming months, both in relation to the overall plan and individual initiatives and proposals within it.

We will make sure that as we implement the plan and develop it further, GP commissioners will increasingly take leadership roles and we expect to work with them and our other partners to deliver the changes we have set out in our plan.

Paula Kahn

Cluster Chair, NHS North Central London

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Cluster Chief Executive, NHS North Central London

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Introduction and Context

VISION, VALUES AND PRINCIPLES

In developing the strategy and QIPP Plan for NHS NCL, we have maintained a clear focus on improving health and addressing health inequalities:

- Our vision sets out what we want to achieve for our population;
- Our values are embedded in each of our organisations as fundamental ways of working;
- Three overarching principles underpin our models of care.

Together:

Our vision, values and core principles have guided our approach to developing our plans for the future and will remain central as we deliver their content.



Introduction and Context

NATIONAL CONTEXT

- The National Health Service (NHS) is undergoing unprecedented change driven by the government's savings target of £20 billion over 4 years together with the government's White Paper of July 2010 followed by the Health and Social Care Bill 2011. These set out the plans to transition the responsibility for healthcare commissioning away from Primary Care Trusts to GP consortia from 2013
- Some of the savings will come from reducing the existing NHS commissioning workforce bill, London having achieved a reduction in management costs of over 50% from April 2011, with existing commissioning bodies having formed larger clusters with single management teams
- A National Commissioning Board will shortly be established in shadow form that will allocate resources to and manage the performance of GP commissioning consortia
- The White Paper further stated that all Trusts would need to achieve Foundation Trust status and will be granted increased freedoms.

NHS NORTH CENTRAL LONDON POPULATION HEALTH

- The population of the five boroughs in NCL is approximately 1.27 million. Population is expected to grow to 1.31 million by 2014, an increase of approximately 3 per cent
- Across NCL and within each borough, there is significant variation in healthcare needs across the population impacted by age, gender, ethnicity and levels of deprivation
- Across NCL, there is a mix of areas of great wealth and high deprivation often very close together
- Diversity of cultures across NCL means a huge variety of health needs exist, to which different responses are required
- There is an increasing number of people with Long Term Conditions (LTCs) such as chronic obstructive pulmonary disease (COPD), Heart Failure and Diabetes
- There is an increasing number of people being diagnosed with cancer each year
- Our population often uses A&E services when they need unplanned care rather than visiting their GP or other local service
- There is a particularly high number of people in the south of the sector with severe and enduring mental health issues, with a higher than expected prevalence amongst the black and minority ethnic community. A growing prevalence of people with alcohol dependency and dementia has been highlighted.

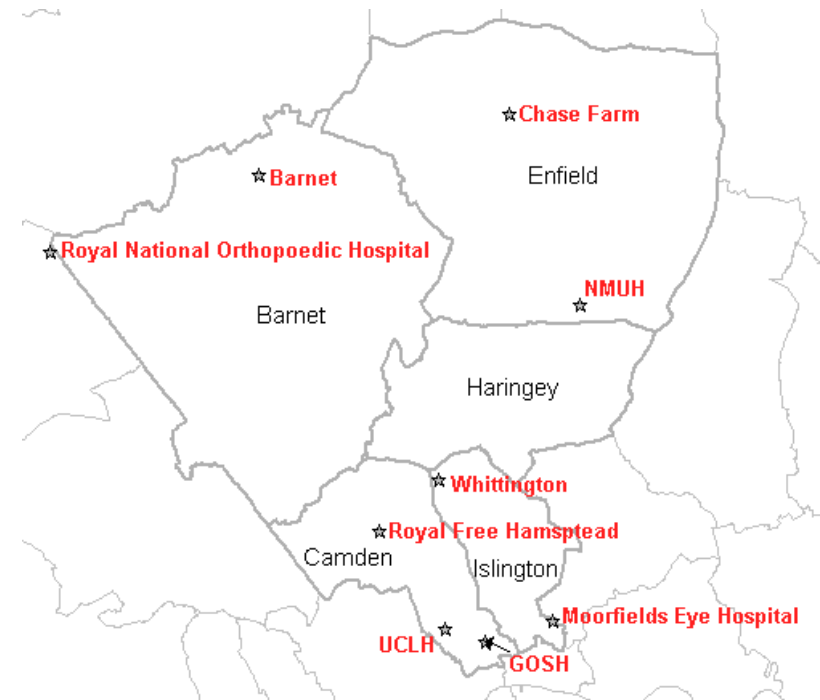
Introduction and Context

NORTH CENTRAL SECTOR – CURRENT PROVIDER LANDSCAPE

- In NCL there are five Primary Care Trusts (PCTs) – Barnet, Camden, Enfield, Haringey and Islington, serving a combined population of 1.27 million
- There are eight acute hospital providers delivering a wide range of secondary (general hospital) and tertiary (specialist hospital) care:
 - Barnet and Chase Farm Hospitals NHS Trust (BCF)
 - Great Ormond Street Hospital NHS Trust (GOSH)
 - Moorfields Eye Hospital NHS Foundation Trust (MEH)
 - North Middlesex University Hospital NHS Trust (NMUH)
 - Royal Free NHS Hospital Trust (RFH)
 - Royal National Orthopaedic Hospital NHS Trust (RNOH)
 - University College London Hospitals NHS Foundation Trust (UCLH)
 - The Whittington NHS Trust (WHITT)
- In the north of the patch, three PCTs and two Trusts are working on the implementation of the Barnet, Enfield and Haringey Clinical Strategy, with the objective of progressively moving an agreed proportion of Maternity and Paediatrics activity between hospitals and some outpatient and unplanned care activity to community providers in order to treat patients closer to home where possible
- There are three mental health organisations:
 - Barnet, Enfield and Haringey Mental Health Trust
 - Camden and Islington NHS Foundation trust
 - Tavistock and Portman NHS Foundation Trust
- There are four providers of community services:
 - Barnet, Enfield and Haringey Mental Health Trust in Enfield
 - Whittington Health in Islington and Haringey
 - Central and North West London Foundation Trust in Camden
 - Central London Community **Health** in Barnet

- There are financial and service quality challenges facing the local health economy over the next few years. These will have significant implications for future service provision and may call into question the sustainability of some existing provider organisations
- The whole health economy and its partners must assess the implications of both commissioner and provider-driven changes and together develop viable solutions that ensure NCL develops a sustainable provider landscape to serve the population in the longer term.

Acute trust locations in NCL



NCL's COMMISSIONING CHALLENGE

Case for Change

The cluster faces a cumulative commissioning deficit of £268.5 million by 2014/15.

There are additional financial risks to our healthcare providers that challenge their long-term sustainability. To date, only four of 11 Trusts have achieved Foundation Trust status.

There are health inequalities between communities within the five boroughs.

The quality of services varies across the sector.

Primary care is underdeveloped relative to other areas and very variable.

Our workforce needs to adapt in order to meet these challenges.

Engagement and prioritisation

Working with local stakeholders, including GPs and other clinicians, clinical networks, PCTs, local authorities, and local healthcare providers, we have generated a long-list of initiatives designed to address these issues.

We have developed these initiatives with the help of our key stakeholders, and have applied a robust prioritisation process to focus our resources on the work streams and initiatives that will drive the greatest improvements for NCL.

Given the pressing financial challenges NCL face, initiatives likely to yield savings in Years 1 and 2 have been prioritised for development.

We will continue to engage with GPs, Local Authorities and the wider public as we bring implementation of our plan.

Our work streams

Our priority clinical areas have been identified from national, regional or local priorities where there are recognised issues with financial or workforce sustainability, either in terms of the current level of investment of levels or future demand, and/or quality of outcomes and patient experience. Our programme of work can be grouped into either clinical priority work streams.

- Unscheduled care
- Mental health
- Cancer
- Cardiovascular disease (CVD)
- Care closer to home
- Maternity
- Paediatrics

...or cross-cutting QIPP themes:

- Acute productivity
- Medicines management
- Management costs
- Low Priority Treatments (LPTs), decommissioning and thresholds
- QIPP in Primary Care
- Staying Healthy

Whole health economy response

We are testing the impact of these initiatives with our local healthcare providers and are designing contracts, performance management processes and incentive schemes to ensure that all parties in the NHS in NCL respond jointly to the issues in the case for change.

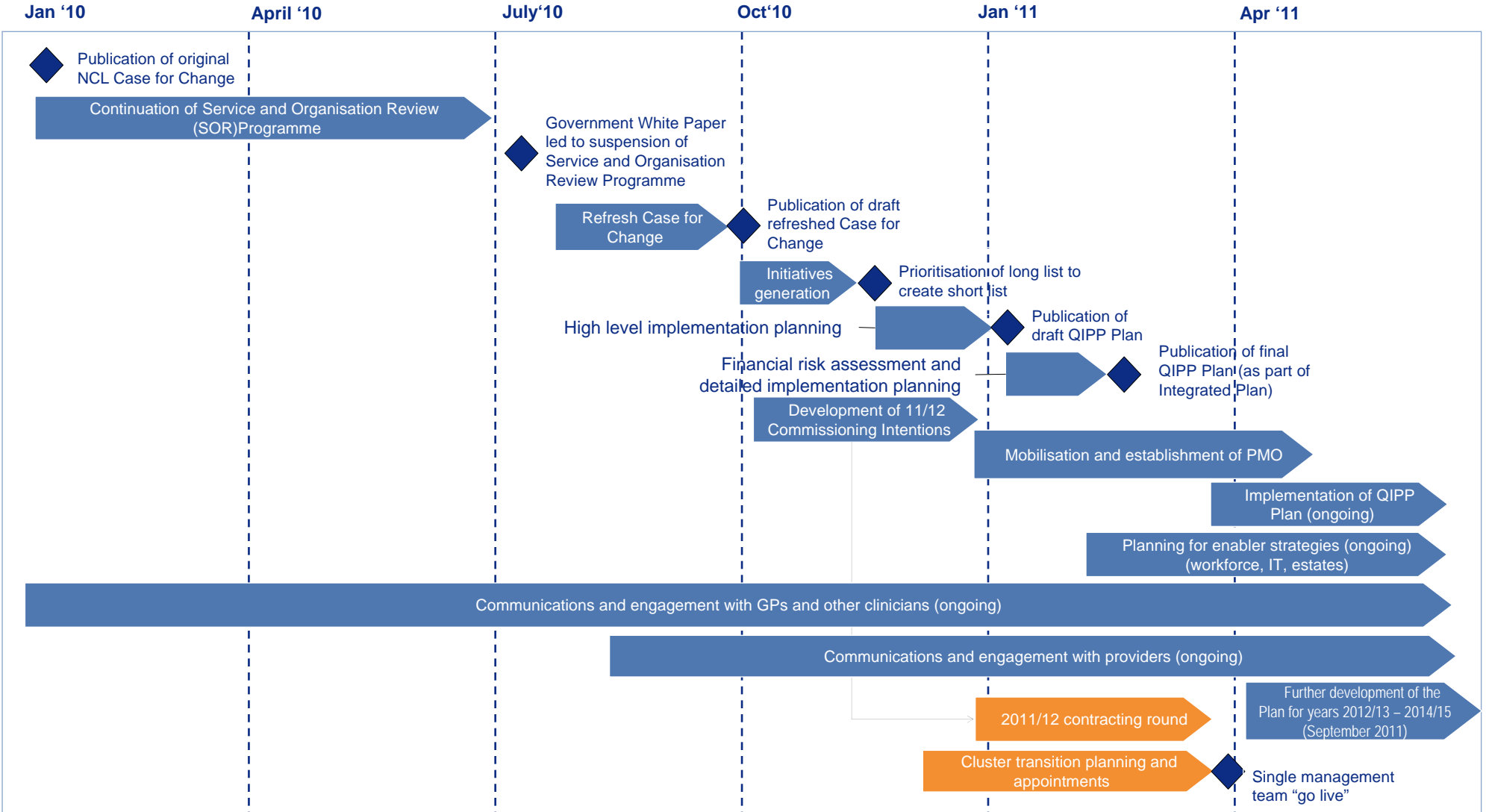
We are looking for opportunities to use local contractual arrangements to motivate mutually beneficial behaviours amongst both providers and commissioners

We are exploring innovative options for gain-sharing to ensure that all providers work together to ensure maximum quality for our patients and efficiency in the local health system. Our work with UCL Partners will be particularly important if we are to ensure that we innovate to get the best possible health outcomes for our population.

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Our Approach to Developing the NCL Commissioning Strategy and QIPP Plan



Key:

Core strategy development /QIPP programme activity

Adjacent activity impacting on QIPP programme

Milestone

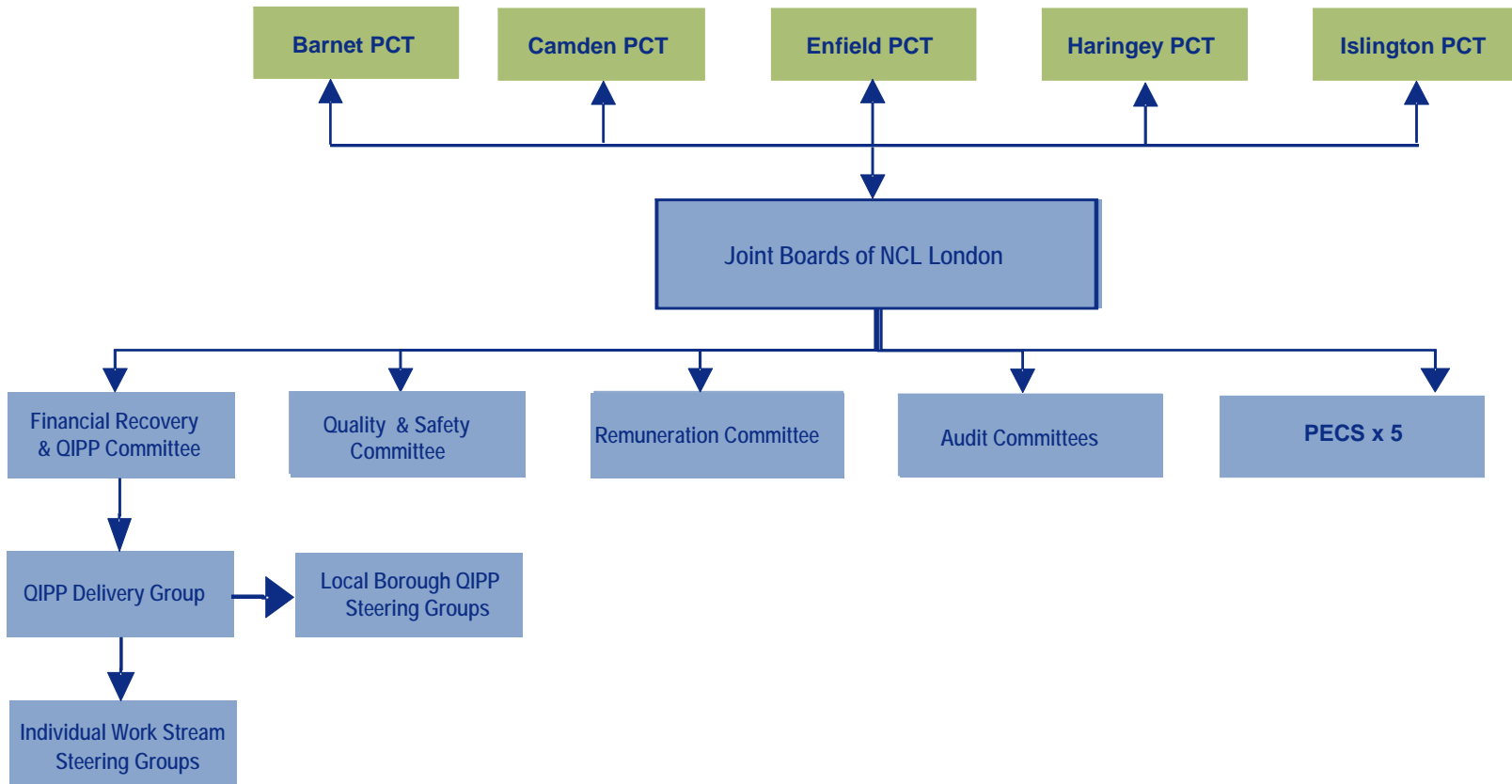


Our Approach to Developing the NCL Commissioning Strategy and QIPP Plan (cont.)

KEY ACTIVITIES	Service and Organisational Review (SOR)	Refresh Case for Change	Initiatives generation and prioritisation	Implementation planning	Mobilisation	Communications and engagement
Activity	<ul style="list-style-type: none"> ● Development and communication of detailed Case for Change ● Development and evaluation of options for the configuration and provision of health services in NCL 	<ul style="list-style-type: none"> ● Detailed review and update of existing underpinning evidence base ● Benchmarking of NCL against peer regions ● Remodelling of financial base case ● Engagement with key stakeholders ● Refresh and publication of draft refreshed Case for Change building on past work ● Development of finance and activity baseline model including sharing with providers 	<ul style="list-style-type: none"> ● Development of long list of potential QIPP initiatives designed to address issues in refreshed case for change ● Collaboration with PCTs to ensure all existing QIPP plans are captured in long list ● Development of PiDs ● Application of agreed prioritisation framework to agree short list ● Two clinically led challenge and review panels held ● Consultation and workshops with GP Commissioners ● Development and publication of 11/12 Commissioning Intentions 	<ul style="list-style-type: none"> ● Development of detailed delivery and implementation plan for each initiative ● Evaluation and communication of finance and activity impact of initiatives on acute providers at speciality level 	<ul style="list-style-type: none"> ● Identification of temporary Programme Management Office resource ● Development and agreement of Programme Management Strategy ● Programme governance structure reviewed ● Substantive delivery and PMO teams in place ● Individual project plans for 2011/12 projects risk assessed 	<ul style="list-style-type: none"> ● Develop overall Communications and Engagement Strategy ● Hold three GP engagement events ● Engagement events with Local Authorities, scrutiny committees, LiNKs and other stakeholders ● Engagement exercise around the BEH Clinical Strategy and Mental Health reconfigurations
Impact	<ul style="list-style-type: none"> ● Reduction in variation in health services ● Increase in quality of patient outcomes ● Improvement in productivity 	<ul style="list-style-type: none"> ● Clear commissioner understanding of the issues that the QIPP plan should be designed to address ● Increased understanding of the issues facing the NHS in NCL across a wide stakeholder population ● Alignment of strategic planning objectives with providers 	<ul style="list-style-type: none"> ● Priority areas identified by GPs for revised QIPP Plan ● Agreed priority work streams to enable best allocation of management resource 	<ul style="list-style-type: none"> ● Detailed plans available on the basis of which 11/12 contract negotiations can take place ● Clearer understanding of impact on provider sustainability 	<ul style="list-style-type: none"> ● Robust programme management strategy in place ● Appropriate assurance, review and sign off for QIPP Plan itself and the individual projects for delivery in 2011/12 	<ul style="list-style-type: none"> ● Shared understanding of the challenges facing the NCL sector ● GP acceptance of the issues and ownership of the emerging plans ● Building consensus on priorities and plans ● Proactively managing media coverage
Key Stakeholders	<ul style="list-style-type: none"> ● PCT Boards ● NCL Board ● All providers ● Clinical, patient and local authority groups ● Scrutiny committees 	<ul style="list-style-type: none"> ● Clinical, patient and local authority groups ● All providers ● BEH Clinical Strategy Implementation Group 	<ul style="list-style-type: none"> ● GP Commissioners ● PCTs ● QIPP Delivery Group ● NCL Delivery Board ● NCL Strategy Committee ● NCL Board 	<ul style="list-style-type: none"> ● All providers ● PCTs ● NHS London ● BEH Clinical Strategy Implementation Group 	<ul style="list-style-type: none"> ● QIPP Delivery Group ● NCL Delivery Board ● NCL Strategy Committee ● NCL Board ● BEH Clinical Strategy Implementation Group 	<ul style="list-style-type: none"> ● GP Commissioners ● PCT Commissioners ● Clinical community ● Local Authorities ● Scrutiny committees ● LiNKs ● Patients and public
Status	<ul style="list-style-type: none"> ● Suspended August 2010 on publication of the White Paper "Liberating the NHS" 	<ul style="list-style-type: none"> ● Completed October 2010 	<ul style="list-style-type: none"> ● Completed December 2010 	<ul style="list-style-type: none"> ● Completed March 2011 	<ul style="list-style-type: none"> ● Completed by 31st May 2011 	<ul style="list-style-type: none"> ● On-going

Our Approach (cont.)

GOVERNANCE STRUCTURE FOR QIPP PROGRAMME



Terms of Reference

•Work stream SROs and functional leads make up the **QIPP Delivery Group** which is chaired by the Cluster Chief Executive and responsible for ensuring the delivery of the QIPP programme to the agreed timescales, with specific focus on:

- Agreeing the overall programme plan, key responsibilities and internal milestones;
- Risk assessment and mitigation;
- Programme resourcing to deliver the programme;
- Leading development and quality assurance of QIPP initiatives and delivery plans;
- Effective communications with stakeholder groups.

The structure will change over time as GP Consortia Pathfinders become more established.

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Case for Change

SUMMARY OF KEY CHALLENGES



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Case for Change – Population Health Needs

POPULATION HEALTH NEEDS

- NCL's population is expected to rise by approximately 3% by 2014, with the highest growth (6%) in those aged between 45 and 74. This age group is more likely to manifest long term conditions that can be influenced by behaviour change and early diagnosis.
- Within NCL there are a disproportionately a high number of deprived wards, with 65% in the bottom two quintiles nationally and 34% in the bottom quintile. These are primarily concentrated in specific areas in the east of the sector, within the south of Camden, Islington and the east of Haringey and Enfield. This contrasts with a small number (2%) of wards in the least deprived quintile nationally.

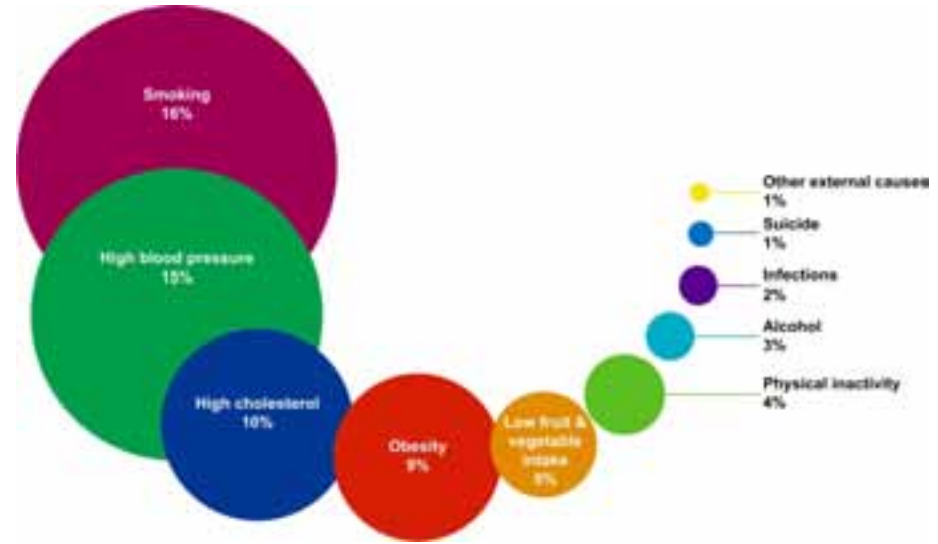
Life Expectancy

- Life expectancy for men varies between 75.1 years in Islington to 79 years in Barnet, with Islington and Haringey significantly below the national and London average.
- Life expectancy for women varies from 81 years in Islington to 84 years in Barnet with Islington significantly below the London average and Barnet significantly above.
- The variation in life expectancy between the richest and poorest wards is in excess of 10 years.
- Our review of deaths in NCL between 2006-8 found a high proportion that were linked to preventable conditions. These are highlighted in the diagram opposite.
- Premature mortality rates for major causes of death in the sector are shown in the table opposite. These highlight the issues in the south of the sector.

Mental Health

- The prevalence rates of serious mental illness on practice registers in NCL are above the England average in all 5 PCTs, with Islington the highest nationally at 14.4 per 1000 registered patients compared to a national average of 7.5 and London average of 9.3. Camden's rate of 13.8 is again one of the highest nationally.

The approach to improving population health needs to focus on encouraging local communities to modify lifestyle choices .



Key modifiable behavioural factors contributing to death in NCL

MORTALITY RATES	BARNET	CAMDEN	ENFIELD	HARINGEY	ISLINGTON
CARDIOVASCULAR	+	-	=	-	-
CANCER	+	=	+	=	-
COPD	+	-	+	=	-

Key :
 Above the National average – Green +
 Similar to the National average – Amber =
 Worse than the National average – Red -

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Case for Change – Clinical Priorities

SERVING OUR POPULATION

This section outlines the Case for Change for each of the clinical areas described in detail .

Our local PCTs have identified six discrete clinical areas that represent the largest categories of commissioning expenditure, the largest patient populations with likely future growth in demand, and those services facing a range of quality and workforce issues. These are:

- Care Closer to Home (including Long Term Conditions and selected elective pathways)
- Unscheduled care
- Mental Health
- Maternity
- Cancer
- Cardiovascular.

The table below sets out the known and evidenced issues with the NCL’s provision in our priority clinical areas. The QIPP initiatives described later in the plan are designed to directly address these issues amongst others.

CLINICAL AREA	CURRENT PATIENT OUTCOME	CURRENT PATIENT SATISFACTION	OTHER ISSUES IMPACTING ON CURRENT PERFORMANCE
Care Closer to Home	<ul style="list-style-type: none"> ● Inequality of outcomes ● Lack of focus on early detection and on avoidance of acute exacerbations ● Lack of focus on pulmonary rehabilitation leading to readmissions ● Fragmented provision of service particularly in primary care 	<ul style="list-style-type: none"> ● Patients would prefer more treatment in the community, rather than hospital based ● Mixed satisfaction with primary care services 	<ul style="list-style-type: none"> ● Increasing number of people with LTCs and high resource users ● Greater focus needed on risk stratification and admission avoidance ● Inconsistent quality of primary care, unfit for future purpose
Unscheduled Care	<ul style="list-style-type: none"> ● Patients attending A&E who could be better treated elsewhere ● High readmission rates, especially for end of life care ● Limited access to diagnostics to make decisions at point of need ● Delayed discharge due to poor planning or lack of community support 	<ul style="list-style-type: none"> ● Longer than necessary lengths of stay ● Mixed satisfaction levels with out of hours services 	<ul style="list-style-type: none"> ● Over use of A&E services and many access points into services ● Under provision of A&E front end primary care triage functions leading to higher than necessary rates of A&E activity and admissions

Case for Change – Clinical Priorities (cont.)

CLINICAL AREA	CURRENT PATIENT OUTCOME	CURRENT PATIENT SATISFACTION	OTHER ISSUES IMPACTING ON CURRENT PERFORMANCE
Mental Health	<ul style="list-style-type: none"> ● The nature and quality of existing inpatient provision: currently inpatient care is spread across nine sites with low volumes of activity at each ● Service planning does not reflect the relationship between physical and mental health for certain patient groups, e.g. patients with long term conditions 	<ul style="list-style-type: none"> ● Achieve greater emphasis on prevention and treatment in a community setting 	<ul style="list-style-type: none"> ● Less access to specialised mental health (MH) services than elsewhere in London ● High Mental Health need in the south of the sector ● Requires greater focus on mental wellbeing of population as a whole ● Priority areas for improvement are; alcohol dependency, dementia and BME needs
Maternity	<ul style="list-style-type: none"> ● Lack of clarity around low and high risk pathways ● Improving shared care arrangements ● Meeting 'Maternity Matters' standards ● Midwife assessment by 12th week low ● High intervention rates ● High c-section rate 	<ul style="list-style-type: none"> ● Need to develop more patient centric services, avoiding unnecessary appointments ● Women still not aware of available choices ● Care Quality Commission (CQC) 2010 results show women have a poorer experience of maternity care in NCL than on average in England ● Need to ensure care is provided closer to home in a non-medicalised environment 	<ul style="list-style-type: none"> ● Workforce issues, specifically age of midwives, consultant presence on wards and junior doctor cover ● Birth rate predictions make planning difficult ● Insufficient middle grade and consultant staff
Cancer	<ul style="list-style-type: none"> ● Breast and colorectal survival rates are lower than the average ● Need to embed multi-disciplinary teams across all cancer sites ● More progress is required to meet palliative care standards ● Late diagnosis of cancer in 4 of 5 PCTs 	<ul style="list-style-type: none"> ● Londoners' are reported to have a poorer experience of cancer than the rest of England ● National cancer patient experience survey 2010 included all 158 acute trusts nationally; of the 34 trusts who were ranked in the bottom 20% for the survey, 18 were in London and 6 were in the cancer commissioning network 	<ul style="list-style-type: none"> ● Increasing incidence rates, particularly in deprived communities ● Poor uptake rates for screening ● Inequalities in cancer care ● Significant improvements to be made, across the patient pathway from seeing GPs, diagnosis, treatment options, inpatient and outpatient care
Cardiovascular	<ul style="list-style-type: none"> ● Levels of throughput not high enough to maintain surgical skill set ● Not all appropriate patients are getting angiography and angioplasty ● London mortality rates higher than other parts of UK 	<ul style="list-style-type: none"> ● Patients want improved continuity of care with better communication and less clinical jargon ● The need to reduce inter-hospital transfer delays and high lengths of stay 	<ul style="list-style-type: none"> ● Need faster adoption of innovation and new techniques to improve outcomes and satisfaction ● EWTD impact on the availability of junior doctors

Case for Change – Clinical Priorities (cont.)

CLINICAL AREA	CURRENT PATIENT OUTCOME	CURRENT PATIENT SATISFACTION	OTHER ISSUES IMPACTING ON CURRENT PERFORMANCE
Paediatrics	<ul style="list-style-type: none">• Some providers undertaking low volumes of inpatient paediatric surgery• Variation in quality and provision of tertiary paediatrics services• Lack of dedicated paediatric medical staff	<ul style="list-style-type: none">• Families prefer to use services closer to home but opt for A&E in a large proportion of cases	<ul style="list-style-type: none">• High volume of A&E attendances presenting with emergency and non-emergency conditions• Rate of admissions driven up by large number of junior staff assessing children in A&E

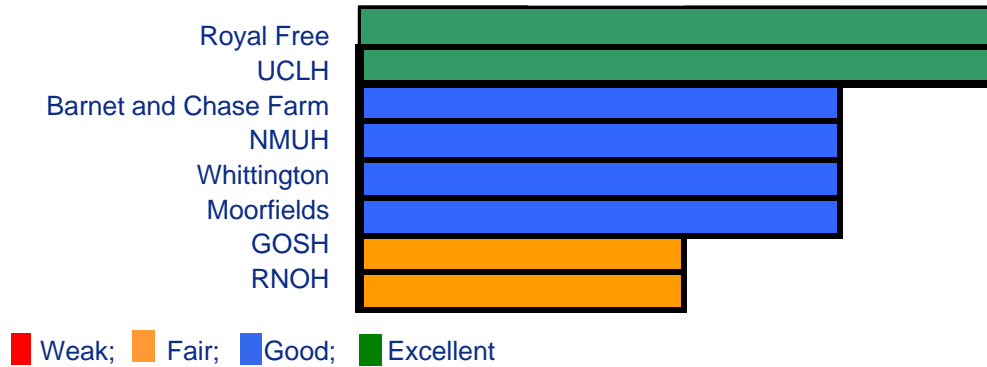
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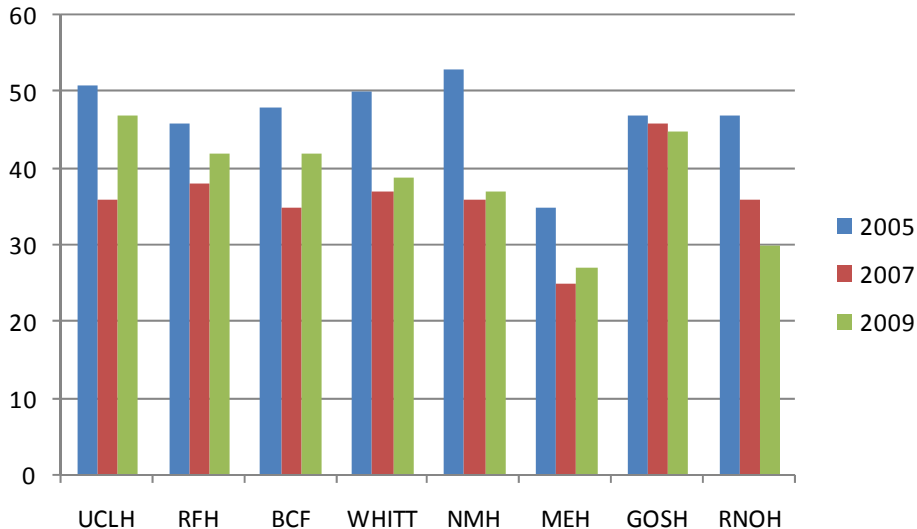
Case for Change - Improving Quality, Safety and Patient Experience

QUALITY IN ACUTE CARE

NCL Acute Providers – Quality of Services (2009 Annual Health Check)



% staff witnessing potentially harmful errors, near misses or accidents in the last month 2005-2009



QUALITY STANDARDS IN NCL

The CQCs Annual Health Check review of NCL's providers has shown that while six out of the eight sector acute trusts were classified as good or excellent, the overall levels of quality are inconsistent.

PATIENT SAFETY

The annual staff surveys in recent years have shown that for six out of eight Trusts, staff reported a small increase in potentially harmful errors, near misses or accidents between 2007 and 2009. We can use this measure as a proxy for patient safety and may therefore indicate an issue that our QIPP Plan should seek to address, or could recent encouragement of staff to highlight such issues.

Case for Change - Improving Quality, Safety and Patient Experience (cont.)

	Barnet and Chase Farm	North Middlesex	Royal Free	UCLH	Whittington	RNOH	Moorfields
Getting an appointment	😊	😊	😊	😊	😊	😊	😊
Waiting in the Outpatient Dept	😞	😊	😊	😊	😊	😊	😞
Outpatient environment	😞	😞	😊	😊	😊	😊	😊
Seeing a doctor during appt	😞	😊	😊	😊	😊	😊	😊
Seeing other professional	😊	😞	😊	😊	😞	😊	😞
What happened during appt	😊	😞	😊	😊	😞	😊	😞
Tests and treatment	😞	😊	😊	😊	😊	😊	😊
Medications prescribed	😊	😊	😊	😊	😊	😊	😊
Information given by staff	😊	😊	😊	😊	😊	😊	😊
Overall views about experiences	😞	😞	😊	😊	😞	😊	😊

OUTPATIENT SURVEY RESULTS 2009

Three of our providers scored worse than average on the patients overall experiences of outpatients.

Specific areas of weakness in NCL appear to be related to 'other professionals' and experiences during an appointment.

	Barnet and Chase Farm	North Middlesex	Royal Free	UCLH	Whittington	RNOH
Emergency, A&E	😊	😊	😊	😊	😊	n/a
Waiting lists/planned admissions	😊	😊	😊	😊	😊	😊
Waiting to get a bed on a ward	😊	😊	😊	😊	😊	😊
The hospital and ward	😊	😞	😊	😊	😊	😊
Doctors	😊	😊	😊	😊	😊	😊
Nurses	😊	😞	😞	😊	😊	😊
Care and Treatment	😊	😊	😊	😊	😊	😊
Operations and procedures	😊	😊	😊	😊	😊	😊
Leaving Hospital	😊	😊	😊	😊	😊	😊
Overall views about experiences	😊	😊	😊	😊	😊	😊

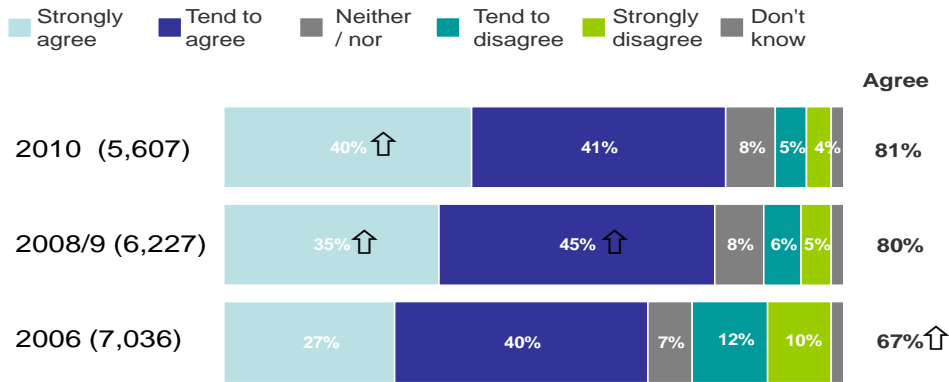
INPATIENT SURVEY RESULTS 2009

UCLH was rated better than average for inpatient services, all other services were rated average for overall view.

Case for Change - Improving Quality, Safety and Patient Experience (cont.)

During Summer 2010, NHS London commissioned IPSOS MORI to conduct survey of Londoners views on their local NHS services. The chart below summarises the views of NCL resident views. Camden was one of the highest scoring PCTs (86%) and Haringey one of the lowest with 71%.

Q1. To what extent do you agree or disagree with the following statement: My local NHS provides me with a good service.



Base: All respondents – base in brackets. Fieldwork dates: 28 June – 3 September 2010, 24 October – 7 December 2008 & 6 April – 17 May 2009, 22 September – 27 November 2006

Q14. Which one of the following (NHS services in your local area) would you say needs most improvement?

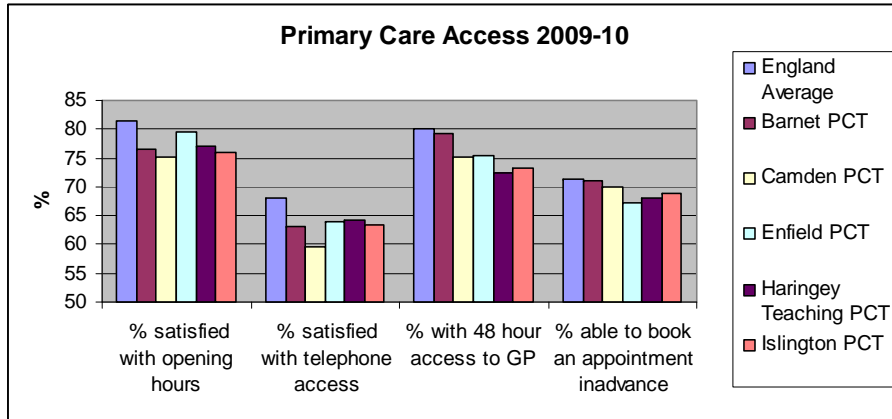


Base: All respondents (5,607). Fieldwork dates: 28 June – 3 September 2010, 24 October – 07 December 2008 (London – Dec 08), 6 April – 17 May 2009 (London – May 09)

Ipsos MORI

Case for Change - Improving Quality, Safety and Patient Experience (contd.)

QUALITY IN PRIMARY CARE



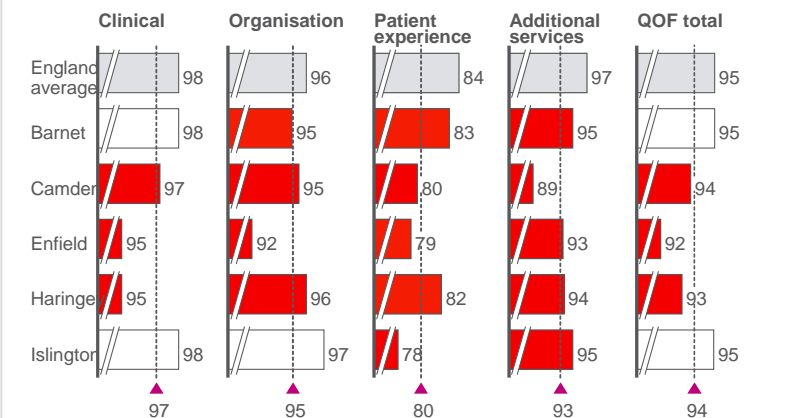
Access to Primary Care

- Surveys carried out during 2009/10 showed that patient views of access to primary care in NCL were consistently lower than across the rest of England. An accurate assessment of demand is therefore required and systems put in place to ensure matching supply e.g. reducing non-patient facing time.
- Opening hours and telephone access were a particular cause for complaint so there is a need to review coverage of extended hours services, and UCC and ensure these are linked to GP services plus also linkage to community pharmacy schemes e.g. opening of 100h pharmacies and improved access through repeat dispensing and pharmacy medicines use reviews (MURs).
- The Quality and Outcome Framework (QOF) scores for 2008/09 reflect a similar position.

Quality in Primary Care

- Information taken from the Primary Care Commissioning (PCC) Quality & Productivity Calculator for 2009/10 shows the average % of patients very satisfied with the quality at their GP practices in the sector as only 43% so this is a significant driver for change.
- Quality of primary care premises across the sector is also very variable contributing to the patient satisfaction figures & the need to sustainably consolidate services into the highest quality estate.
- QOF scores are low but improving with a case for change in terms of performance management of GP practices and the priority to work with NHSL to adopt the pan London approach to quality improvement in general practice.
- Access to NHS Dentistry is a key Operating Framework priority & vital sign as measured by the number of patients seen in 24 months & most recent data (December 2010) shows a case for change in Enfield, Haringey & Islington that are performing below the London average of 0.5% above set trajectory.
- Similarly performance for patients satisfied with dentistry received and patients satisfied with the dental care received is below the London average across the 5 sector PCTs. This is a need for robust performance management of dental practices with timely introduction of the pending new Dental QOF.

QOF survey, share of total available points, %



Source: QOF, 2008/09

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Case for Change – Provider Landscape (cont.)

ACUTE

- An assessment by those Trusts not currently FTs identified the following key areas as potential risks to progression, with common themes around affordability and cost improvement programmes.

	NCL affordability/structure	CIP Delivery	Performance Risk	Redevelopment issues	Liquidity	Loss of Income	Critical mass
RNOH		x	x	x			
Whittington	x	x	x				
Royal Free	x	x				x	
BandCF	x	x			x		
N Mid	x				x		x
GOSH	x	x		x			

- The financial challenge within the health economy will impact on provider revenue streams, with the largest proportion of the QIPP savings falling on the acute providers. The total value of these reductions will be approximately £242 million cumulatively over 4 years, in addition to the tariff reductions.

- The Service and Organisation Review Programme (2009-10) demonstrated over capacity in the acute sector, including workforce.
- The Foundation Trust (FT) regulatory regime with its focus on turnover and growth creates a challenging environment in terms of aligning incentives to deliver QIPP savings

Our review of the acute market in 2010 showed that for the majority of high volume specialities there was a good level of exercised choice with comparably low levels of market concentration across the sector. In some specialities, however, patient choice is offset against low volumes of some complex procedures being delivered at some hospitals.

Creating secure and sustainable FT organisations within this environment will be challenging and require changes to the way we commission health care services.

Innovative developments already taking place include :

- UCL partners working with the proposed Integrated Care Organisation of the Whittington, Islington and Haringey to develop a pathway based approach to provision in some areas.
- The Royal Free working with South Barnet and Camden GPs on developing integrated pathways to manage long term conditions.
- The implementation of the BEH strategy, which will deliver care closer to home as well as higher quality obstetric services and reduced infection rates and lower cancellation rates through the separation of elective and non-elective activity at Chase Farm.

Case for Change – Provider Landscape (cont.)

ACUTE (cont.)

Trust-wide productivity opportunities identified as part of the Better Care Better Value productivity metrics (Q4 2009/10).

TRUST	REDUCING DID NOT ATTENDS (DNAs)	REDUCING ELECTIVE PRE-OPERATIVE STAY	REDUCING FOLLOWUP APPOINTMENTS	REDUCING NON ELECTIVE PRE-OPERATIVE STAY	READMISSION RATES WITHIN 14 DAYS	TOTAL
RNOH	£123,000	£340,000	£1,873,000	£253,000	£0	£2,589,000
Whittington	£2,321,000	£56,000	£5,546,000	£3,988,000	£401,000	£12,312,000
Royal Free	£1,859,000	£476,000	£6,811,000	£6,009,000	£283,000	£15,420,000
BandCF	£1,593,000	£114,000	£3,405,000	£6,577,000	£920,000	£12,609,000
N Mid	£1,812,000	£46,000	£3,163,000	£2,896,000	£1,087,000	£9,004,000
GOSH	£120,000	£1,433,000	£5,167,000	£2,308,000	£297,000	£9,325,000
TOTAL	£7,828,000	£2,467,000	£25,965,000	£22,031,000	£2,968,000	£61,259,000

The Better Care Better Value indicators suggest that over £60 million of savings could be made by providers if top quartile productivity were achieved across the board. The acute productivity metrics designed into acute contracts for 2011/12 directly address many of these measures.

Case for Change – Provider Landscape (cont.)

MENTAL HEALTH PROVIDERS

- Camden and Islington and the Tavistock and Portman have already achieved Foundation Trust status, although as smaller organisations may have concerns around their longer term viability.
- Barnet Enfield and Haringey Mental Health Trust is working to become a viable FT.
- The move towards Payments by Results (PbR) in Mental Health and the requirements for greater efficiencies will create challenges.
- NHS NCL is working with Local Authority commissioners to assess likely future patient volumes and financial flows into each organisation.
- Across NCL fewer people have access to specialised mental health care than elsewhere in London. Analysis shows that there appear to be obstacles to accessing these services when needed and, equally, difficulty in discharging back into the community as quickly as should happen.
- There is a particularly high number of people in the south of the sector, Camden, Islington and parts of Haringey, with mental health needs. There is clinical consensus that the move towards treating in the community whenever possible should continue, with hospital and residential treatment being focused on those who benefit most from this approach.
- As well as improving the quality and accessibility of mental health services, there needs to be a focus on improving the mental wellbeing of the population as a whole.
- The areas recognised by clinicians and others as in greatest need of attention are: alcohol dependency, dementia and meeting the specific needs of people from BME communities.
- Mental Health providers face the dual challenge of responding to funding reductions in both health and social care budgets.

Case for Change – Provider Landscape (cont.)

PRIMARY CARE PROVIDERS

Primary care providers cover GP practices, community pharmacists, optometry and dental practices. The key issues to be faced in NCL for this group are:

- Variation in access driving low levels in patient satisfaction with practices creating the case for an improved understanding of appointment utilisation, reducing DNAs, reducing non patient facing time and considering alternative approaches e.g. telephone consultations where appropriate to better match supply with demand for appointments.
- Variation in quality and performance of GP practices creating the case for NCL to work with NHSL to adopt the pan London approach quality improvement in general practice.
- Spend often reflecting historical allocations and patterns of expenditure rather than identified patient need creating the case for reducing variability (higher and lower) in rates and reimbursements per patient to GP practices for core services.
- Poor infrastructure in some parts of NHS North Central London which is not fit for purpose in the longer term creating the case for reviewing the NCL estates utilisation strategy with a view to consolidating services into the highest quality estate.
- Some duplication of services across primary and community services creating the case to undertake a thorough review of enhanced service provision and payments.
- Services often not integrated along care pathways creating the case for a review of referral management processes in the sector.
- GP lists overinflated in some cases creating the case for thorough and regular processes for list cleaning/validation.

The GP Landscape in North Central London

	GP Headcount	GP practice staff	Number of GP Practices	Registered patients (,000)
Barnet	219	435	72	361
Camden	169	260	39	238
Enfield	188	369	63	301
Haringey	163	370	55	277
Islington	148	211	38	212
North Central London	887	1645	267	1389

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Case for Change – Workforce Sustainability

OUR WORKFORCE

The NHS in NCL currently employs 33,346 Whole Time Equivalents (WTEs). The following figure shows the breakdown across the three organisations.

Approximately 70% of commissioner's investment is spent on provider workforce .

STAFF GROUP	WTE
Admin and Estates	6,853
Managers and Senior Managers	1,416
Scientific, Therapeutic and Technical	5,292
Healthcare Assistants and other Support	5,358
Medical and Dental	4,287
Qualified Nursing, Midwifery and Health Visiting	10, 124
Other	16
Total	33,346

In addition there are 857 GPs.

EDUCATION AND TRAINING

The multi professional education and training budget (MPET) is currently £1.2 billion for London. NCL has approximately 2,000 medical trainees funded through this source who are integral to service provision.

OUR WORKFORCE CHALLENGE

Over the next 5 years the employer landscape and workforce will change significantly, the key drivers of this will be:

- Innovative ways of working, including transforming community services
- The consolidation of selected clinical and support services across employers
- The impact of the financial constraint
- The development of GP led commissioning.
- The expansion of FTs
- Pathway changes, including care closer to home, will change clinical working practices
- A reducing MPET budget, impacting on the 2000 trainees in the sector, who are integral to service provision, together with modernisation of the training programmes reducing trainee availability for service commitments
- An aging workforce in key staff groups
- European Working Time Directive compliance
- Workforce shortages in key staff groups e.g. paediatricians, midwives
- London's productivity is believed to be 30 per cent less than the National average.

Case for Change – Workforce Sustainability (cont.)

OUR WORKFORCE CHALLENGE (cont.)

- Variation in acute hospital workforce ratio of clinical staff to beds varies from 1:4.5 to 1:6.5.
- 9 per cent of primary care practices in NCL are single-handed GPs, compared to 7 per cent across London

DEVELOPING A FIT-FOR- PURPOSE WORKFORCE

- Workforce will be a key enabler for the required changes and to develop a sustainable fit for purpose workforce will require ongoing change as services reconfigure.
- Workforce will be a catalyst to service change as how we train and recruit clinical staff changes.
- Improved workforce productivity will be required, with the biggest opportunities in NCL in reducing clinical variation in all settings . As part of this process we will ensure that the NHS does not lose valuable experience and skill sets and make best use of the new training programmes and opportunities.

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Case for Change – Financial Challenge

KEY BASE CASE ASSUMPTIONS (BEFORE QIPP)

RRL

11/12 As notified in Operating Framework, adjusted for recurrent non recurrent RRL

2012/13	2013/14	2014/15
2.27%	2.62%	2.65%

Surplus requirement

Deficit budget overall in the sector in 2011/12 and breakeven overall in 2012/13

Achieve run rate balance or better in Barnet, Enfield and Haringey during 2012/13

Non recurrent spend

2% non recurrent spend

No access to these funds assumed other than agreed £20.5m in 2011/12 to accelerate acute productivity.

Contingency

0.5% of RRL

Acute growth

Annual % includes demographic, activity growth and impact of coding changes

PCT	Annual %
Barnet	6.30%
Enfield	6.00%
Haringey	6.30%
Camden	3.00%
Islington	3.00%

Activity growth %	Coding changes %
2.17%	3.18%
2.17%	3.69%
2.17%	3.41%
2.17%	0.28%
2.17%	0.11%

Demographic growth

PCT	2011/12	2012/13	2013/14	2014/15
Barnet	0.48%	1.14%	1.11%	1.08%
Enfield	0.22%	0.12%	0.11%	0.11%
Haringey	0.75%	0.72%	0.71%	0.70%
Camden	0.73%	0.50%	0.49%	0.49%
Islington	1.21%	0.58%	0.56%	0.55%

Although for planning purposes we are assuming a total overall growth of 5.1% for each of the 4 years, we have a planned QIPP from 2012/13 onwards aimed at reducing the growth due to pricing increases / coding changes.

Inflation

PCT	2011/12	2012/13	2013/14	2013/14
Pay	1.0%	1.0%	2.9%	2.9%
Non pay	2.9%	2.9%	2.9%	2.9%
Acute tariff deflation / specialist commissioning / community	-1.5%	-1.5%	-1.5%	-1.5%
GP Inflation	0.0%	0.0%	0.0%	0.0%
Mental Health	0.0%	0.0%	0.0%	0.0%
Prescribing inflation	4.0%	4.0%	4.0%	4.0%

Learning Disabilities

Transfer out of £29169k in 2011/12; social care cost increase of £17,181k - resource and costs transfer to London Boroughs therefore net zero impact on NCL

PCT	2011/12	2012/13
Barnet	-10,604	3,927
Enfield	-4,624	3,518
Haringey	-3,507	3,000
Camden	-3,626	3,455
Islington	-6,808	3,281
TOTAL	-29,169	17,181

Sources:

- RRL / LD – PCT notified 11/12 RRL allocations
- Non recurrent spend / contingency – NHS London planning requirements
- Surplus – local variation agreed with NHS London
- Pay / Non pay / Tariff deflator – NHS London planning guidance
- Acute growth – historic trend
- Demographic growth – GLA lower population estimates (2008 round)
- GP inflation / MH / Prescribing inflation – local assumption

Case for Change – Financial Challenge

THE UNDERLYING FINANCIAL POSITION

- All three challenged PCTs have, during 2010/11, undergone assessment through the Challenged Trust Board (CTB) to access support from other London PCTs to cover historical and in-year deficits. There was a positive outcome from the assessment and, as a result, the sector starts 2011/12 debt free
- After stripping out non-recurrent income support from the 2010/11, the sector enters 2011/12 with an underlying run rate deficit of £63.9m, and, in the three challenged PCTs an underlying run rate deficit of £81.3m.

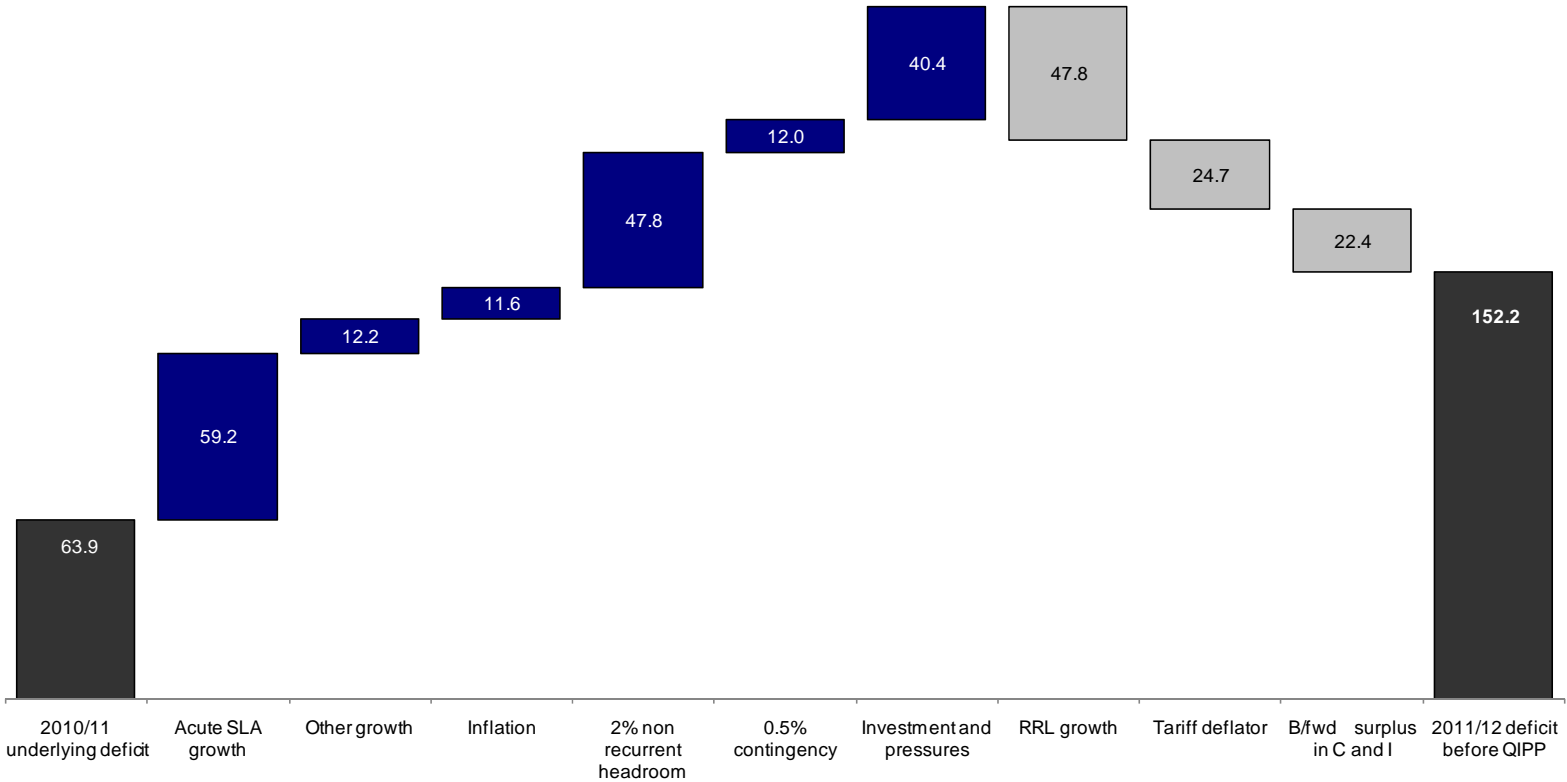
£'000	Underlying closing run rate 2010/11
Barnet	-25,927
Enfield	-25,641
Haringey	-29,692
SUBTOTAL	-81,260
Camden	16,253
Islington	1,105
Total NCL	-63,902

Case for Change – Financial Challenge

THE FINANCIAL GAP BEFORE QIPP

NCL 2010/11 underlying position to 2011/12 deficit before QIPP £m

The forecast position for NCL is a run rate deficit of £63.9m going into 2011/12. The impact of activity growth, inflation, planning requirements and local cost pressures sees this rise to a gap of £247.1m. Growth in resource, the tariff deflator (-1.5%) and brought forward surpluses in Camden and Islington offset partially to leave a QIPP target of £152.2m to reach break even.



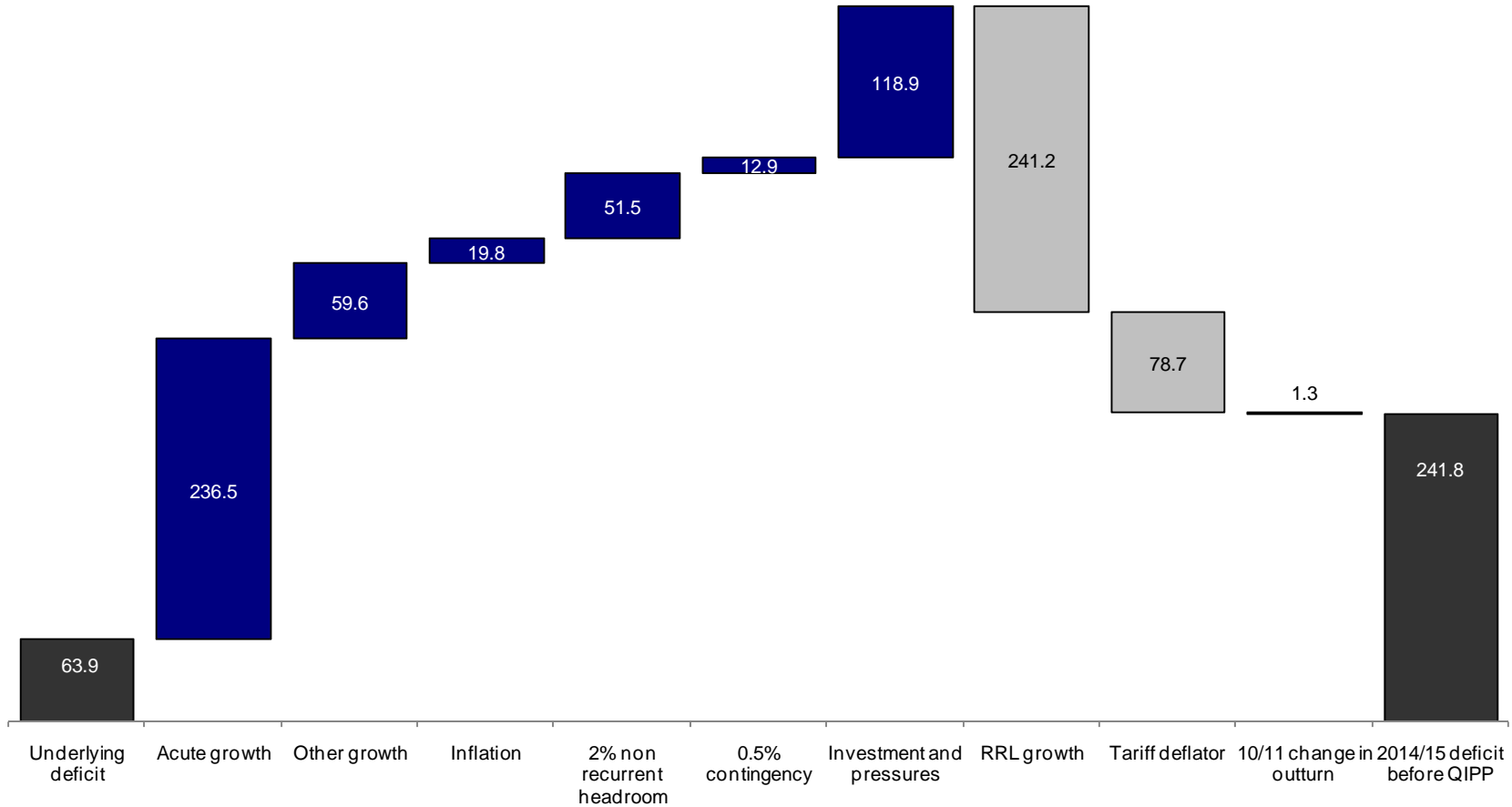
Case for Change – Financial Challenge

THE FINANCIAL GAP BEFORE QIPP

NCL 2010/11 underlying position to 2014/15 cumulative deficit before QIPP

£m

The forecast position for NCL is a run rate deficit of £63.9m going into 2011/12. The impact of activity growth, inflation and other planning assumptions increases the deficit to £241.8m by 2014/15 under the 'do nothing' scenario. The cumulative QIPP target of £268.5m will bring NCL into surplus in 2012/13 as a cluster and by PCT in 2013/14. Delivery of this programme will result in an overall NCL surplus of £26.7m by 2014/15.



Case for Change – Financial Challenge

SUMMARY OF FINANCIAL CHALLENGES FACING NCL COMMISSIONERS

- NCL PCTs are the most financially challenged commissioners in London. Two of the five PCTs, Barnet and Enfield, declared significant deficits in 2009/10. A third, Haringey, slipped significantly into deficit in 2010/11
- Although the sector achieved balance in 2010/11 this was only achieved through support from the Challenged Trust Board of £123.3m, of which £80.3m related to historical deficits. The underlying deficit totals £63.9m, of which the 3 north PCTs total £81.3m. This is therefore a major challenge
- NHS Islington and NHS Camden are financially robust, though Islington's 2010/11 outturn of £10.3m was supported by £9.2million of brought forward surpluses. However, the post QIPP 2011/12 forecast for both is above the required 1% surplus
- The main acute providers in the sector are not currently in financial difficulties, although the Royal National Orthopaedic Hospital, for which NCL is lead commissioner, posted a deficit in 2010/11. However, due to the delay in the implementation of the BEH Clinical Strategy, both Barnet and Chase Farm and North Middlesex have very challenging QIPP programmes as a result of the high overhead costs associated with the PFI at North Middlesex and the delays in releasing capacity at Chase Farm.
- Further pressures on the health system arise from the significant reductions in Council funding with a range of reductions between 8-11%. Pooled and social services budgets are being reduced.

Case for Change – Financial Challenge

DRIVERS OF FINANCIAL CHALLENGE IN NCL

The causes of NCL's financial issues are broad and numerous. Key themes are:

Acute Contracts

2010/11 contracts were set with levels of growth inconsistent with previous trends (collective total increase of 0.7% in value across Barnet, Enfield and Haringey) compared to prior years at around 6%. There was poor reconciliation between individual PCT savings schemes and acute contracts resulting in PCTs expecting savings on acute spend which were not locked into contracts (Barnet, Enfield and Haringey). Some contracts were underdeveloped. There was a loss of organisational history in establishing 10/11 acute baselines (Haringey). The Acute Commissioning Unit was undersized in the original business case. The contracting position for 2011/12 was significantly improved.

Acute Growth

Relatively high growth in acute spend occurred in Barnet, Enfield and Haringey over the last four years. Budgets were exceeded in all PCTs. Some of this is unexplained, some as a result of under commissioning (Haringey & Enfield), or failure to deliver saving plans & CIPs (Barnet, Enfield and Haringey). Demand management QIPP projects, in particular, were not achieved as high level plans proved over-optimistic and were not implemented. Price inflation is noted in some providers

Informatics

The Acute Commissioning Unit was set up in 2009 to receive full informatics support from Commissioning Support for London (CSL). CSL's delivery timetable slipped. Considerable effort was put into making the products effective which proved futile and a decision made in autumn 2010 to invest in an alternative solution. This original delay resulted in significant deterioration in information to support contract monitoring to the Acute Commissioning Unit, PCTs and GPs. The information base is now comprehensive and rigorous review will enable challenge of all providers.

Primary Care Involvement

Historically there were mixed demand management measures and some concerns about the capacity of primary and community care to deliver on the service redesign and productivity measures required. All emerging GP consortia will require support to enable them to deliver in a challenging financial environment, but this is a great opportunity

Delivery of Savings

All PCTs have a mixed history of delivery against savings plans. Many of the plans set for 2010/11 were not fully implemented. Implementation planning was poor. Savings plans were developed in year including a range of non-recurring measures. In the development of this plan, PCT Directors of Finance (DoF) have led a rigorous financial risk assessment process to provide assurance to all stakeholders of the robustness of this plan. NCL has also invested in programme management arrangements to support implementation

Balance of Savings Plans

There has been an over-reliance on savings from squeezing efficiencies from contracts and on non-recurrent measures and tactical moves. The NCL QIPP plan therefore features a greater focus on pathway redesign initiatives focused on Long Term Conditions, elective pathways, unscheduled care, demand/referral management, decommissioning and acute productivity requirements that reflect robust performance benchmarking

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Key Priorities

The QIPP Plan submitted to the Cluster Board and NHS London in March 2011 largely focused in detail on 2011/12 and had a cumulative stretch of £230m still to be identified. At the time the Cluster indicated our intention to complete the planning for years 2012/13 – 2014/15 by the end of September 2011.

Since the March submission further intelligence gathering has been commissioned, or intelligence from external sources has become available, to support the further development of the Plan, this includes;

- PWC review of the Plan to identify additional opportunities
- A review by the public health team of our Plan and other health economy plans to identify further opportunities
- Benchmarking data from the NHS Benchmarking Network
- High level programme budgeting review of spend on all programmes at PCT level
- Cluster Quality and Safety review of service provision
- NHS London commissioned work reviewing emergency medical and surgical services within London
- NHS London commissioned work on requirements to provide safe and financially effective services
- Directory of Ambulatory Emergency Care for Adults

In a number of instances further work is required to understand the implications of this intelligence on the further development of the Plan. It is therefore only reflected in a very limited way in the descriptions of our priorities outlined in the pages that follow and not at all in the financial benefits section of the Plan.

This updated version of the March 2011 Plan does reflect a review of the scope, initiatives and financial values of the individual work streams recently undertaken by the SROs and programme /project leads

Key Priorities

1.0 CARE CLOSER TO HOME

Case for Change

- Too many preventable admissions/readmissions are leading to inefficient use of resources
- Aim to provide right care in the right place at the right time not yet being realised
- Over-reliance on secondary care, particularly by patients with LTCs
- Need to Improved patient experience and outcomes together with clinical productivity
- Need to ensure a care pathway approach to commissioning that redefines care settings and transfers of care

Scope

- Proactive model of care for LTCs
- Improve provision of out of hospital care
- Improving care in nursing and care homes
- Improvement of pathways and re-provision of selected elective services in a community setting
- Admission avoidance and early discharge schemes
- Improving end of life care pathway
- Integrated working with the local authority and social care

Initiatives / Projects

Local PCTs have developed a wide range of pathway redesign initiatives covering three areas:

Admission Avoidance

- Implementation of virtual wards and early intervention programmes and case management
- Schemes to reduce preventable admissions from Care Homes
- Rapid response palliative care service
- Integration of intermediate care and enablement pathway
- Some provision of both step-up and step-down community beds
- Acute Provider led initiatives in A&E to assess and redirect older patients from potential admission into community e.g TREAT

Planned Care (largely focused on shifting a proportion of existing outpatient activity into the community where clinically and financially beneficial)

- Renal
- Cardiology
- Anti-coagulation
- Dermatology
- Urology
- ENT services
- Ophthalmology
- Gynaecology
- Specialist colorectal
- Oral surgery /dental

LTCs management schemes

Key Priorities

1.0 CARE CLOSER TO HOME (cont.)

Best practice	<ul style="list-style-type: none"> ● Use of Telehealth and Post Acute Care Enablement (PACE) schemes ● Risk stratification and case management approach ● Development and systematic and consistent implementation of evidence based pathways ● Development and sophisticated use of referral management processes to avoid unnecessary admissions
Mode of delivery	<ul style="list-style-type: none"> ● Pathway redesign to redeliver appropriate activity in community settings ● Build support and commitment to adherence to pathways with consortia, providers, social care and the public ● Use of contractual levers and performance management processes ● Development of protocols and agreement on right sizing of secondary care to combat the “Roemer effect” ● Development of incentives and risk/gain sharing schemes ● Pathway approach to commissioning based on specified outcomes
System Levers and Incentives	<ul style="list-style-type: none"> ● Contracting ● Detailed service specification ● Procurement ● Incentive Schemes ● Performance Management
Key Enablers	<ul style="list-style-type: none"> ● Engagement of consortia, providers and the public ● Development of primary care and community services to ensure capacity and capability to support services being transferred out of acute setting ● Systematic workforce modernisation to ensure fitness for purpose ● Telehealth system implementation ● Establishment of Integrated Care Organisation (ICO) to provide whole pathway services ● Robust data sharing between organisations to support care delivery ● Measurement of impact of service changes across health and social care

Key Priorities

1.0 CARE CLOSER TO HOME (cont.)	
Identified savings	<ul style="list-style-type: none"> ● 2011/12 = £4.9m ● 2014/15 = £6.4m
Interdependencies	<ul style="list-style-type: none"> ● Sustainable decommissioning of capacity in acute sector ● Delivery of Primary care QIPP schemes including contracting ● Managing the future of the provider landscape ● Availability of community diagnostics ● Development and implementation of sophisticated alternative tariffs that support and reward direction of travel
Risks	<ul style="list-style-type: none"> ● Failure to close capacity in acute setting leading to increased activity due to admissions of the “next sickest patient” ● Impact of commissioner change and consortia development derailing initiatives ● Workforce availability and competence not sufficient to implement new initiatives quickly enough ● Under developed use of data undermines commissioners’ ability to drive meaningful change ● Collective impact on provider sustainability has negative effect on provider landscape
Progress to Date	<ul style="list-style-type: none"> ● Engagement with clinicians on care pathway redesign ● Delivery plans for initiatives developed ● Detailed finance and activity modeling completed and benefits identified ● Development of ICO covering two PCTs with support from UCLP to maximise impact and cross sector learning ● Inclusion of most developed plans in 2011/12 contract negotiations
Next Steps	<ul style="list-style-type: none"> ● Implement effective performance management processes to assure the Board of implementation progress ● Further engagement with GP consortia and wider clinicians to develop and deliver initiatives ● Engagement with acute sector to prepare for change ● Development of plans to rapidly and systematically roll out projects across the Sector

* All savings noted in the *Key Priorities* section have been risk assessed based on the robustness of the associated delivery and implementation plans

Key Priorities

2.0 UNSCHEDULED CARE

Case for Change	<ul style="list-style-type: none"> ● Multiple access points for unscheduled care needs results in duplication of services and confusion for patients ● High levels of A&E attendances for non-urgent conditions resulting in ineffective use of resources and patients travelling unnecessarily ● Ensure Providers are clinically & financially stable ● Address funding gap as demand for unscheduled healthcare rises ● Inconsistent access to primary care services driving over-reliance on A&E Walk In Centres (WIC) and Urgent Care Centres (UCC) and high levels of spend ● Address diverse range of health requirements ● Improve quality and reduce variation in service access and provision
Scope	<ul style="list-style-type: none"> ● Streamlining of access points to 24/7 unscheduled care across all 5 PCT areas ● Remove duplication of services in the system ● Reduce cost of providing unscheduled care in A&E ● Co-location of urgent care services with A&E ● Working with London Ambulance Service (LAS) on the implementation of their QIPP service development plans to reduce number of patients conveyed to A&Es to 60% of all calls by 2015 ● Implement Directory of Services and undertake strategic options appraisal with modeling for 111 Single Point of Access (SPA)
Initiatives / Projects	<ul style="list-style-type: none"> ● Co-location of Urgent Care Centre (UCC) at NMUH service commenced May 2011 ● Establishment of Pilot for Primary Care urgent care front end at Chase Farm ● Primary care front door to A&E at The Whittington UCC service commenced April 2011 ● Scoping the potential for an UCC at UCLH ● Redirection of patients out of hospital to Primary Care services in Barnet and (Chase Farm and Barnet) ● Directory of Services Project for SPA 111 ● Commissioning of Out of Hours (OOH) ● Contribution to LAS QIPP service development plans to include <ul style="list-style-type: none"> ○ Increasing conveyance to UCCs in partnership with Primary Care ○ Increasing the number of calls passed to NHS Direct (NHSD) for resolution ○ Increasing the number of motorcycle and pedal bike based paramedics and technicians ○ Expanding the use of Community First Responders ○ Implementing further technology and digital projects such as CommandPoint and the electronic patient record
Best practice	<ul style="list-style-type: none"> ● Single point of access for all Unscheduled Care services ● Jointly agreed models between Primary, Community and Secondary care providers ● Evidence based outcome focussed services

Key Priorities

2.0 UNSCHEDULED CARE (cont.)

Mode of delivery

- Collaborative service redesign with acute providers
- Collaborative service redesign with GPs to incorporate appointments for patients who are redirected from another service
- Collaborative working with community providers and Care Closer to Home Programme to deliver admission avoidance and risk stratification pathways and services
- Commissioning options appraisals for services to ensure best value
- In year contract variation required for BCF and RFH
- LAS transformation programme
- Incorporation into contracts of service requirements and activity/finance impacts of unscheduled care initiatives
- Inclusion of requirements for Directory of Services into contracts for 12/13
- Monitoring Quality and Performance through centralised tracking system

System Levers and Incentives

- Ability to reduce number of existing points of access to concentrate activity to most appropriate locations
- Robust service specifications incorporated into contracts to enable robust performance management against plans
- Ability to negotiate pricing
- Trends in patient behaviour and choice indicate preferences for certain points of access

Key Enablers

- GP leadership and involvement in provision
- GP Commissioners as Pathfinders identifying Unscheduled Care as a priority
- Robust outcome based service specifications
- Clinical ownership and leadership
- Estate and other infrastructure fit for purpose
- Appropriate workforce development plans in place to deliver service as specified
- Strong collaborative links with Acute Providers

Identified savings

- 2011/12=£1.9m
- 2014/15 = £9.7m

Key Priorities

2.0 UNSCHEDULED CARE (cont.)

Interdependencies	<ul style="list-style-type: none"> ● Primary Care QIPP (contracting) – engagement of GPs to help keep patients out of hospital where clinically appropriate ● Provider landscape and aspirations of current acute primary and community providers ● Social care service provision and sign up ● Alignment with OOH services ● GP engagement ● Links with Care Closer to Home work stream to ensure a seamless approach to patient journey and care ● Links with BEH Clinical Strategy implementation ● Effective communication and engagement plans
Risks	<ul style="list-style-type: none"> ● Increased access points across economy – thereby increasing activity unnecessarily and driving up spend ● Inconsistency of model and service specification offering across the sector perpetuating inequality of access ● Variation in quality and access to primary care provision preventing availability of a real alternative to A&E ● Patient behaviour does not change in line with service changes ● Misalignment of priorities between health and social care perpetuates fragmentation of provision ● Lack of robust modeling of new service model resulting in estimated financial benefits that are unrealistic or unrealised ● Introduction of revised A&E tariff invalidates original savings estimates ● Volume of patients being redirected is not as great as predicted therefore decreasing the benefits realised ● Primary Care capacity unable to manage the additional workload ● Lack of GP engagement resulting in patchy changes ● BCF and RFH require in year contract variations ● Range of projects that cumulatively do not address the whole system challenge
Progress to Date	<ul style="list-style-type: none"> ● Agreement of core principles of approach to unscheduled care across NCL (see Appendix 5 for full details) ● NCL wide specification for UCC's developed for local adoption and embedded within 2 acute contracts for 11/12 ● Delivery of stage 1 of the Directory of Services as a critical enabler to SPA/111 and improved pathways across unplanned care ● Written specification for the model (BEH) ● Local consultation held in Islington ● Piloting Primary Care front end at Royal Free and ● Whittington and North Middlesex Primary Care stream schemes incorporated into 2011/12 contracts ● Established principles for the monitoring and evaluation for Whittington and ● Sharing good practice and benefits from RFH UC service (LAS pathway, PACE and TREAT) ● Clinical model has significant clinical buy in ● Governance and reporting arrangements reviewed and refreshed post transition

Key Priorities

2.0 UNSCHEDULED CARE (cont.)

Next Steps

- Formalise the commissioning of Urgent Care (UC) services at RFH, Chase Farm and Barnet
- Carry out preparatory work for SPA options appraisal and timing for roll out
- Develop and sign off strategic approach for 24/7 Unscheduled Care
- Develop further implementation and communication/consultation plans where needed
- Escalate areas where changes are not progressing and ensure there are plans to mitigate the risks
- Identify further schemes for both in year and 2011/12 commissioning intentions
- Review modeling of 24/7 Unscheduled care and activity trends as part of the development of strategic options appraisal, including the DoS and SPA 111 and potential alignment with OOH
- Review and analysis of A&E data sets

Key Priorities

3.0 MENTAL HEALTH

Case for Change

- To promote a personalised recovery model which supports mental health policy and NICE guidance
- To improve service capability to provide the right care in the right place at the right time in the least restrictive setting possible and in a way that is most acceptable from the service user's perspective
- To improve the consistency and coherence of service provision regardless of the service user's borough of residence
- To reduce the variance in service quality, cost and outcomes in different boroughs and different providers
- To reduce over-reliance on specialist inpatient services and provide care closer to home through enhancing community capacity and capability
- To ensure that people with mental health problems also have their physical health care needs met

Scope

- Improved clinical pathways that support service users and their carers, both people in crisis as well as people with long term mental health problems
- Admission avoidance and early discharge schemes with improved care outside hospital settings
- Secondary and specialist inpatient mental health beds across North Central London sites: Barnet, Camden, Enfield, Haringey and Islington
- Secure mental health inpatient beds provided within North Central London and as Out of Area Treatments (OATs)
- Specialist mental health interventions and liaison services within acute providers including alcohol, dementia and perinatal care pathways
- Community mental health services
- Psychological interventions

Initiatives / Projects

- We are working with providers to develop coherent pathways:
- into and out of acute services for people in crisis
 - to provide secure care locally, to divert people from secure care where possible and to enhance linkages across the acute pathway into and out of local secure services
 - into and out of services for people with long-term mental health conditions
 - linking community services to acute liaison services within acute providers to reduce alcohol harm
 - linking community services to liaison services within acute providers to improve care for people with dementia
 - to improve access for primary care teams who support people with mental health problems in primary care
 - to improve the physical healthcare of people with mental health problems

Key Priorities

3.0 MENTAL HEALTH

Best Practice	<ul style="list-style-type: none"> ● Use of single point of access and Directory of Services for all services and particularly crisis services ● Jointly agreed model across primary, community and secondary care providers ● Collaborative service redesign ● Incorporation of service detail, service requirements, KPIs and appropriate risk share arrangements into contracts ● Application of evidence of clinical effectiveness and good outcomes for service users, consistency with national policy and benchmarking with practice London-wide
System Levers and Incentives	QIPP programme clinical leadership including primary care leadership <ul style="list-style-type: none"> ● Opportunity to work across boroughs and London Health Programmes to strengthen mental health commissioning capacity ● Performance management of mental health contracts and effective use of outcome measures ● Shift towards Payment by Results in mental health, creating local discussion on activity and investment levels ● London Health Programmes acute models of care models with clinical evidence and consultation already achieved
Mode of delivery	<ul style="list-style-type: none"> ● Development of agreed clinical thresholds and monitoring against agreed care pathways ● Enhanced risk sharing agreements for secure services and Out of Area Treatments ● Performance monitoring against agreed outcomes ● Incorporate mental health appropriately into LTC work. ● Development of service model e.g. liaison services.
Key Enablers	<ul style="list-style-type: none"> ● Stakeholder support through robust engagement and consultation processes ● Identified GP leads and full engagement with primary care and consortia ● Clinical sign up and engagement with system change across all aspects of clinical pathways, mental health and acute ● QIPP initiatives incorporated into contract terms, risk shares and outcome monitoring ● Provider capacity to bring local people back from specialist services into local services ● Strong collaborative relationships with providers
Identified savings	<ul style="list-style-type: none"> ● 2011/12 = £6.2m ● 2014/15 = £6.2m

Key Priorities

3.0 MENTAL HEALTH (cont.)

Interdependencies

- Adherence to care pathways in clinical practice and respect for protocols and threshold levels put in place
- Coherent contractual framework which supports commissioning strategy and provider delivery
- Capacity and capability of enhanced community services to support acute care pathway
- Provision of single points of access, effective and confident management of community-based crisis services and provision for long-term case management through the Care Programme Approach
- Early detection for admission avoidance initiatives to function, and good clinical planning to speed up discharge arrangements
- Good clinical leadership to promote smooth transition across community-based and secondary acute and mental health services
- Decommissioning of capacity to support the above in accordance with agreed thresholds

Risks

- Introduction of mental health contract currencies under PbR may destabilise financial planning
- Contracting framework for secure services and Out of Area Treatments will need to revisit risk share agreements within financial and service planning
- Commissioner approaches may impact on BEHMHT longer-term efficiency planning and on its FT application
- Skills and capacity for complex partnership governance, integrated system redesign and negotiating solutions based on recovery model
- Care pathways may be only fully or partly implemented leading to fragmented approach for service users and potentially inefficient use of capacity
- Workforce available lacks capacity and needs reskilling fully to implement pathways and recovery model leading to delays and potential inefficiencies, which could impact on outcomes for service users

Progress to Date

- QIPP programme well established with communications and governance arrangements in place and project managers allocated
- 2011/12 lessons learnt from QIPP implementation to date are being applied to future planning
- Enabler are being put in places across QIPP commissioning finance and contracting teams at cluster and borough level to support implementation of PbR and contract currencies in mental health
- Resources are being targeted on areas of highest risk such as secure services and Out of Area Treatments
- Clinical evidence base, needs assessments and commissioning toolkits already prepared by London Health Programme give support to proposed secure services and acute liaison developments

Key Priorities

3.0 MENTAL HEALTH (cont.)

Next Step

- Further develop implementation, stakeholder and communication plans where required
- Focus on good decision making across commissioners and providers to mitigate risks and maximise opportunities
- Develop preparations and local negotiations for mental health PbR
- Utilise best practice, best clinical evidence models and accepted toolkits
- Maintain strategic relationships with key providers to achieve fit between QIPP and provider landscape strategic planning

Key Priorities

4.0 MEDICINES MANAGEMENT

Case for Change

- Big differences in the quality of service being delivered by the NHS
 - Unexplained variation in primary care prescribing both within and across PCTs
 - Variation in efficiencies of prescribing spend/patient
- Cost of health care is rising more quickly than the amount of money available for our residents
 - Variation in costs charged by local providers against London and national benchmarking prices
 - Need for assurance that the commissioning and prescribing of medicine across the health economy is line with national guidance and/ or good practice (i.e. NICE, DH)

Scope

- Primary care medicines management: Concentrates on the changing of clinical behaviour of GPs by reducing wasteful prescribing, encouraging the use of the most cost-effective medicines and reducing variations in prescribing behaviour
- Secondary care medicines management: Using contractual levers to reduce opportunities for inflated drug prices, surcharging, and using drugs outside of agreed indications. More explicit commissioning of high cost drugs. Development of regular challenges to Trusts from SLAM data
- Development of cluster clinical and governance leadership including development of a medicines management network
- Developing incentives including possible shared saving schemes with providers

Initiatives / Projects

- Secondary care initiatives
 - Review and agree commissioning arrangements for PbR excluded drugs including prices for all Providers
 - Review of on costs on PbR excluded drugs and Renal drug (erythropoietin) tariff costs at Royal Free Hospital
 - Developing and agreeing shared savings schemes with providers to promote use of most cost-effective biosimilar drug choices
- Commissioning good practice (aligning incentives in Primary care) – PCT specific
 - NHS Enfield – Medicines Management (MM) scheme focused on 32 individual prescribing initiatives
 - NHS Barnet - MM scheme focused on 28 individual prescribing initiatives
 - NHS Islington - MM scheme focused on 23 individual prescribing initiatives
 - NHS Camden – MM scheme focused on 20 individual prescribing initiatives
 - NHS Haringey - MM scheme focused on 32 individual prescribing initiatives

Key Priorities

4.0 MEDICINES MANAGEMENT (cont.)

Best practice	<ul style="list-style-type: none"> ● Cluster wide approach – sharing of resource between PCTs and cluster ● Benchmarking good practice across and between clusters and PCTs, developing novel Key Performance Indicators (KPIS) ● Clinically led change management ● Incentive scheme approach
Mode of delivery	<ul style="list-style-type: none"> ● Contractual mechanisms and levers within acute contracts including the inclusion of drug specification ● Monitoring, professional and practical support by PCT pharmacists ● Cluster wide GP/clinical leadership and championing ● Cluster wide consistency in programme management
System Levers and Incentives	<ul style="list-style-type: none"> ● Contractual terms ● Performance management against contracts and raising challenges where appropriate. Post Payment verification (PPV) audits ● Financial Incentive schemes and Quality and Outcome indicators (QOF) for GPs ● Consortium peer review and support ● Clinical sign up and engagement in both primary and secondary care initiatives, especially where cost effective drug choices are recommended ● Risk/gain sharing schemes
Key Enablers	<ul style="list-style-type: none"> ● Interim realignment of resources to ensure appropriate distribution to support delivery of initiatives (pending formal restructure) ● Timely, accurate data and information, from practice to national level. In secondary care, much more data and information requested routinely. Providers to meet contractual minimum data set requirements. ● Engagement of clinicians to support the initiatives as prescribing responsibility rests with them ● Development of GP Consortia ● Trust efficiency saving responsibilities ● More benchmarking data in secondary care available ● Inclusion of drug specification in the acute contracts ● Development and management a robust database to manage the high cost drug funding requests

Key Priorities

4.0 MEDICINES MANAGEMENT (cont.)

Identified savings

- 2011/12= £9.3m
- 2014/15 = £28.4m

Interdependencies

- Contracting rounds and negotiation
- Acute and primary care trust data provision
- Primary Care QIPP initiatives and Trust CIP plans
- Restructure of commissioning function
- Finances, in particular inflationary uplift
- NICE recommendations
- Cancer drug (shadow tariff) local prices negotiations

Risks

- Currently not delivering on primary care medicine plans in all PCTs
- Relevant data sets analyzed in a timely manner
- Evaluation of changes implemented and their impact
- Clinical engagement
- Resource and Skills; numbers in medicines management workforce
- IT support and level of information provided by trusts
- Delay in Contract negotiations and agreement

Progress to Date

- Delivery plans written, incentive schemes developed and new QOF indicators rolled out to GPs
- Support materials developed or developing
- Implementation in primary care underway
- Metrics developed
- Drug specification for the management of PbR excluded drugs in acute trusts developed and agreed as part of the acute contract
- Agreement for Information team to support the development of Drug database for monitoring use of PbR excluded drugs

Key Priorities

4.0 MEDICINES MANAGEMENT (cont.)

Next Step

- Implement project plans

Key Priorities – DRAFT

5.0 QIPP IN PRIMARY CARE

Case for Change	<ul style="list-style-type: none"> ● Inconsistent and irregular processes for maintaining patient lists resulting in inaccurate financial allocations to GP practices ● Adherence to historical patterns of funding allocation for enhanced level services without clearly defined outcomes or assurance of value for money ● Variation in quality and performance in primary care services due to inconsistent approaches to performance management across the cluster ● High level of use of acute services where primary care services are more appropriate and cost effective
Scope	<ul style="list-style-type: none"> ● Primary Care Dentistry ● General Medical Services ● Community Pharmacy ● Community Optometry
Initiatives / Projects	<ul style="list-style-type: none"> ● Reducing list inflation in General Practice through a rolling programme of list validation agreed across the cluster aiming to remove patients who practices can not prove are still active patients. Using locally agreed list validation policies, carry out patient removals and continued maintenance of accurate lists ● Primary Care Enhanced Services review in General Practice to ensure they deliver clinical quality and value for money. Using a validated public health evaluation tool review all LES across the cluster to determine whether they offer value for money, improve patient outcomes, do not duplicate other incentives and address a health need contribute to reducing health inequalities. Evaluation of each LES will lead to it being i) decommissioned, ii) modified to make it more effective, iii) recommended to be used and developed into a business case to determine whether the LES should be rolled out across the rest of the cluster ● Primary Care Enhanced Services review in dentistry, pharmacy and optometry to ensure delivers clinical quality and value for money. This will be following the completion of the General Practice Review. ● General Practitioner performance management based on engagement with NHSL to adopt the pan London approach to quality improvement in general practice plus engagement with other clusters to ensure consistency in approach across London. Plans developed to implement the outcome standards and creating an approach to improvement that aligns to the London model with recognition that year 1 is a baseline year. Using existing performance management tools until the pan-London tool is available for full implementation ● Dental Performance Management, further utilizing the NHSL Dental dashboard to identify dental practices with above average dental recall rates at 6 and 9 months to drive access to London average & ensure VFM on investment into commissioned UDAs. Years 2 and 3 will involve review of the efficiency/productivity of sector community dental services and scoping of process to equalize UDA prices across all sector dental practices with implementation in Year 4 by which time the new dental contract may have been launched.

Key Priorities

5.0 QIPP IN PRIMARY CARE (cont.)

Initiatives / Project (cont.)

- Referral /demand management - reducing referrals where General Practitioners can care for the patients within their own practice with the appropriate support, driven through GP consortia when they are established.
- PMS Review – Undertake a stock take of PMS practices and collect baseline information to assess clinical quality, outcomes and value for money, and to ensure that they are addressing health equality requirements.

Best practice

- Incorporation of National contract developments e.g. General Practice QoF, Dental QOF and Pan London approach to quality improvement to identify, monitor and remedy poor performance
- Innovative models of ensuring clinical effectiveness and VFM on enhanced service investment and commissioning across general practice, dentistry and community pharmacy

Mode of delivery

- Development of robust, up to date balanced scorecards and performance dashboards to benchmark performance across the Cluster
- GP Referral management - consortia led delivery. This is through the identification of best practice for changing referral patterns, implementation of processes to support clinicians, including practice based information on referral rates, development & implementation
- Disinvestment in low value enhanced services and refocus of enhanced service outcomes to addressing health inequalities and reductions in acute activity where applicable
- Implementation of a rolling programme of list validation across the cluster using each boroughs agreed list validation policies. Implementation of a Pan-London list cleaning policy when this is developed.
- Develop productivity measures in primary care to improve quality and create capacity

Key Priorities

5.0 QIPP IN PRIMARY CARE (cont.)

System Levers and Incentives

- Clinical leadership of the overall QIPP in Primary Care programme
- Performance management of contracts – use of national and local contractual levers and productivity information upon which investment and disinvestment decisions can be made
- Creating capacity, capability and prioritisation criteria in the NCL cluster team to support practices to improve and work with underperforming practices
- Clinical engagement with GP Commissioning Consortia and Local Representative Committees (LMC/LDC/LPC/LOC) to ensure performance standards are built into future models of peer review and performance
- Further strengthen governance systems and processes for taking forward Primary Care QIPP, particularly within each project
- Commissioning for outcomes with enhanced services and performance review

Key Enablers

- QIPP in Primary Care clinical lead - Camden is Primary Care lead consortium
- Engagement of clinicians through consultation with Cluster LMC representatives & GP representatives for overarching QIPP programme
- Engagement with borough Heads of Finances to ensure agreement to financial contribution from each PCT
- Engagement with Borough Directors and borough finance teams to validate current levels of commissioning, performance and savings potential
- Agreement for robust performance monitoring processes with consistent approach to use of national and local contract levers
- Developing the ability to accurately manage the savings achieved
- Availability of timely information to support referral management

Identified savings

- 2011/12 = £2.1m
- 2014/15 = £2.3 m

Key Priorities

5.0 QIPP IN PRIMARY CARE (cont.)

Interdependencies

- Care closer to home initiatives maybe commissioned at borough level & overlap with GP enhanced services also commissioned
- Unscheduled care dependency on primary care delivering the capacity to manage the access and responsiveness for unscheduled care
- BEH Clinical Strategy dependency on primary care delivering the capacity to manage the access and responsiveness of care moving from the acute sector to primary care
- Unscheduled care - Joint agreed models of care between primary care, community and secondary care
- Individual PCT referral management centres where reductions in acute activity may be double counted with outcomes associated with commissioned LESs
- Interdependencies in implementation of similar processes to achieve objectives of GP referral management, decommissioning, low priority treatments, changes in treatment thresholds

Risks

- Achieving adequate primary care leadership & engagement
- LMC and Consortia agreement in achieving the savings
- Ability of primary care providers to address the required level of change and recognize the necessary contribution of primary care to financial recovery targets
- Ability to provide referral information, including achievements in cost reduction, in adequate detail on a regular basis at GP and secondary care level
- Potential delays due to the Pan London Performance Framework
- Insufficient staff to visit all practices about performance
- Risk of delaying the progress of GP referral management while the consortia are developing

Progress to Date

- Primary Care QIPP Delivery Group established
- Comprehensive delivery plan and gantt chart developed for each project
- Project managers and project teams set up for delivery of the projects
- Local Medical Committee (LMC) engagement and involvement in Primary Care QIPP
- Local Enhanced Service review processes established
- List validation rolling programme established and commenced in Camden

Key Priorities

5.0 QIPP IN PRIMARY CARE (cont.)

Next Steps

- Identification of further savings plans for primary care QIPP to achieve savings for 2011/12
- Developing of primary Care 4 year QIPP plan
- Delivery of existing QIPP plans for 2011/12

Key Priorities

6.0 MATERNITY

Case for Change

- No agreed definition of what constitutes low and high risk care for women. The pathway is not clear for women or health professionals which leads to some duplication and unnecessary appointments. Often, the women who need the most care, do not receive the support they need.
- Complex flows of women into and out of services. Women 'shop around' for the best maternity care which duplicates service provision and makes capacity planning across the provider landscape highly challenging as trusts cannot assume they are only serving their local population. Many women who choose to have care provided by an NCL trust, do not live within the trust's catchment area or the sector boundary.
- Significant numbers of women still do not receive a health and social needs assessment by the 12th completed week of pregnancy. Earlier access to services has been proven to improve outcomes for mother and baby. A continued emphasis on improving early booking rates in some trusts and robust performance management is required.
- Wide health and social inequalities in NCL.
- Variation in quality of service across NCL. Care pathways based on risk stratification. Benchmarking and patient experience monitoring needs to be standardised.
- Lack of continuity of care during the antenatal and postnatal periods.
- Inadequate junior staff and consultant cover on labour wards (not all units in line with 'Safer Childbirth' recommendations).
- Number and age profile of midwives in particular mean difficulties with recruitment and retention of staff. Vacancy rates are high in comparison to national average.

Scope

- The four initiatives/projects outlined in the section below support delivery of the NCL maternity improvement programme. In redesigning maternity provision, care in NCL will be safe, efficient and women-centred, with a focus on improved productivity and efficiency.
- Vision for maternity services in NCL:
 - The maternity network will drive up standards across all trusts and will focus on delivery of safe, high quality services in an appropriate environment.
 - More women will access services earlier and women will book for maternity care with the network rather than an individual provider. This will ensure that women's care setting is appropriate to their level of clinical and social risk factors.
 - The maternity care pathway (focusing initially on the antenatal and postnatal periods) will be defined and standardised in NCL for women and health professionals. All roles and responsibilities will be clear. Women will therefore receive care according to their needs. GPs will have greater input into maternity care.

Key Priorities

6.0 MATERNITY (cont.)

Scope (cont.)

- Vision for maternity services in NCL (cont.):
 - Care protocols for certain conditions and interventions, e.g. Induction of Labour and maternal request for c section, will be developed and standardised to improve quality across NCL.
 - Patient experience will improve through benchmarking and review at NCL Maternity Network Board and relevant sub groups.
 - Any significant gaps in service provision will be identified and addressed through a networked approach.
 - There will be a new payment system(s) for maternity services to ensure best value for money (payment for a pathway rather than for individual contacts).

Initiatives / Projects

- Development of a standardised maternity 'spine pathway' for all women and 'offshoot' pathways for higher risk women. This will clarify roles and responsibilities for health professionals and for women. This will lead to improved quality and safety.
- Improving early access to maternity services .This initiative will focus on improving NCL's performance against the Department of health's maternity early access vital sign. Although performance overall has improved over the last two years, NCL PCTs still have lower rates of early booking compared with London and national averages despite a sector wide focus on this issue. This initiative will also focus on the development of a network approach to booking women for care in NCL. This will reduce the number of duplicate appointments for women who shop around or transfer care.
- Intrapartum (deliveries) and inpatient activity not related to deliveries (for example, reducing antenatal admissions, reducing c - sections and increasing the number of deliveries outside of obstetric setting).
- Improving quality, standards and patient experience in maternity services. This initiative brings together a number of work streams which will be clinically led. Improving quality and safety and ensuring efficiency will be the primary focus of the maternity and newborn network. Outputs of this initiative will include a standardised approach to audit in NCL, standardised patient experience monitoring and review, standardised maternity dashboards and serious incident reporting and benchmarking/peer review to encourage innovation and change and to also support performance management.
- Introduction of cluster wide procurement for delivery packs and other equipment

Key Priorities

6.0 MATERNITY (cont.)

Best practice

- Implementing recognised best practice in NCL- levelling up.
- Linking with UCL partners' work on maternity through the NCL Maternity Network..
- Piloting new models of care to assess suitability for adoption NCL-wide.
- Learning from other trusts and PCTs who have reduced c section rates and increased normality.
- Liaison with the neonatal network (perinatal network) through the maternity network board.
- Contributing to the Department of Health's development of a new maternity tariff for 12/13 contracting (payment for a pathway of care as opposed to individual contacts).

Mode of delivery

- Pathway re-design for low and high risk women (whole pathway approach across the sector).
- Contractual terms and conditions- using the contract to deliver better value for money.
- Updated Service Specification to reflect new pathways and model of care.
- Monitoring and benchmarking through NCL Maternity Network.
- All initiatives and work streams will be governed through the NCL Maternity and Newborn Network Board. In line with the White Paper, this network is provider-focused.

System Levers and Incentives

- Involvement of managers and clinicians from all providers and GPs in NCL Maternity Network established with remit to redesign services.
- Contracting and performance management to current service specification in 11/12 and beyond.
- Patient experience and choice (regular monitoring and benchmarking through maternity network sub group).
- National standards and guidance on best practice- NCL will strive to provide the best service by working together.
- Clinical Negligence Scheme for Trusts (CNST) for maternity services provides an incentive for trusts to develop detailed protocols of care. The network clinical leads will standardise these across NCL.
- New maternity payment system to be developed during 11/12 which will incentivise trusts to provide care in more efficient ways
- Introduction of sector wide procurement of delivery packs and other equipment which will contribute cost savings for providers and commissioners through a gain share agreement

Key Priorities

6.0 MATERNITY (cont.)

Key Enablers	<ul style="list-style-type: none"> • The Maternity Network Board and clinical leads (all CEOs of acute trusts have signed up to working together strategically). • Public, provider and commissioner engagement through network and Maternity Service Liaison Committee. • Workforce strategy and development of new ways of working, piloted through the Maternity Network. • Public facing information which is clear and explains the work of the network and the pathways that are produced.
Identified savings	<ul style="list-style-type: none"> • To be confirmed
Interdependencies	<ul style="list-style-type: none"> • National work on tariff for maternity services. • Financial modeling and establishment of agreed baseline position. • Recruitment of dedicated clinical leadership. • Primary and community care capacity and quality. • London wide approaches to improving maternity services.
Risks	<ul style="list-style-type: none"> • Access to appropriate, detailed data sets as record of activity and pricing varies between providers therefore commissioners do not have an accurate activity baseline. Estimating savings continues to be a challenge. • Workforce issues will negatively impact on NCL's ability to redesign the model of care. • Availability of community facilities suitable for providing maternity care closer to home. • GPs may not agree maternity shared care arrangements across NCL. • Need to develop new payment system for maternity based on a pathway of care. This will require significant finance input and resource. There is a risk that trusts will not agree to the new payment approach. • Contract negotiation in year and from 12/13 may not deliver the required outcomes.

Key Priorities

6.0 MATERNITY (cont.)

Progress to Date

- Clear programme objectives established and work streams identified.
- NCL Maternity Network, which will drive the maternity QIPP programme, has now been established . The first network sub groups have also been established.
- Clinical Leads (both midwife and obstetrician) have been recruited.
- Excellent engagement from maternity service providers and clinicians in NCL.
- Maternity services specification has been included in all contracts. This will be amended in 11/12 as a result of QIPP initiatives.

Next Steps

- Formulation of full project /work plans for all initiatives in conjunction with clinical leads. Define roles and responsibilities fully for all clinical leads. Allocate programmes of work.
- Development of pathways and protocols for agreement at the Maternity Network Board
- Focus on reduction of c section rates in NCL.
- Agree membership for NCL Maternity Network sub groups/working groups to progress the work.

Key Priorities

7.0 PROCEDURES OF LIMITED CLINICAL & COST EFFECTIVENESS	
Case for Change	<ul style="list-style-type: none"> ● Variation in clinical thresholds across a range of services ● Pressing need to ensure limited financial resources are focused on the most effective care
Scope	<ul style="list-style-type: none"> ● Streaming back office approaches to managing exceptional treatment requests ● Determining appropriate and consistent clinical thresholds ● Decommissioning activity of limited clinical value
Initiatives / Projects	<ul style="list-style-type: none"> ● Extension of existing low priority treatment policy (originally implemented in 2010/11) ● Determining revised clinical thresholds for bariatric surgery ● Decommissioning of acute terminations ● Decommissioning of acute vasectomies ● Reducing unnecessary cataract activity ● Not routinely funding Cyberknife treatment ● Recommissioning Chronic Fatigue Syndrome services using a single pathway
Best practice	<ul style="list-style-type: none"> ● Supports consistency of approach across the NCL cluster in a number of services – strengthening our business as usual approach to contracting
Mode of delivery	<ul style="list-style-type: none"> ● Development of agreed clinical thresholds to reduce volumes of activity ● Prior approval for treatment authorisation to ensure only the right patients are treated ● Guidance for clinicians to empower them to help enforce thresholds and LPT policies ● Performance monitoring against agreed outcomes ● Monitoring of activity to ensure reduction and take early action in cases of overperformance

Key Priorities

7.0 PROCEDURES OF LIMITED CLINICAL & COST EFFECTIVENESS (cont.)	
System Levers and Incentives	<ul style="list-style-type: none"> ● Market ● Contracting framework
Key Enablers	<ul style="list-style-type: none"> ● Clinical leadership to support and lead change in practice ● Public agreement to support following of protocols
Identified savings	<ul style="list-style-type: none"> ● 2011/12 = £12.8m ● 2014/15 = £13.5m
Interdependencies	<ul style="list-style-type: none"> ● Alignment of senior management views and sign up to proposals ● Recruitment to cluster treatment funding process support team
Risks	<ul style="list-style-type: none"> ● Political /public reaction overturns commissioning decisions ● Lack of consensus between PCTs makes sector-wide approach to implementation a challenge ● Lack of support from key stakeholders e.g. GPs lead to protocols not being respected ● Cluster team is not able to manage volume of prior approval requests ● Community providers do not have adequate capacity to accommodate decommissioned activity from acute sector
Progress to Date	<ul style="list-style-type: none"> ● Clear worked up proposals with specified outputs and outcomes for initiatives to be kicked off in 2011/12 ● Exceptional Treatment Request policy agreed in principle by commissioners
Next Steps	<ul style="list-style-type: none"> ● Implementation of proposals that have been agreed ● Further development of some proposals to enable value to be determined and decision making on whether to proceed to take place ● Set up of NCL cluster-wide treatment funding panel

Key Priorities

8.0 CANCER

Case for Change

- Late diagnosis
- Increased rates of cancer
- Lower than, or on par with, England and London survival rates for breast and colorectal patients
- Inequitable access to treatment
- Variation in quality of care
- Low uptake of screening services
- Inequalities within the sector in relation to both incidence and outcomes
- Not achieved full compliance with Improving Outcomes Guidance (IOG) standards in all organisations for all tumor sites

Scope

- Specialist services – London model of care
- Commissioning and contracting frameworks and tariff
- Market Review of Chemotherapy provision
- Service redesign and new pathway development
- Development of National Cancer Screening Programmes
- Cancer follow up
- Cancer inpatient (elective and non-elective) efficiency - length of stay reduction

Initiatives / Projects

- Optimisation of routine follow up for breast, colorectal and prostate patients
- Development of brain, lung, colorectal, breast and prostate commissioning pathways
- Implementation of bowel screening age extension in line with NHS Operating Framework requirements
- Development and implementation of 23 hour breast cancer surgery (excluding immediate reconstruction and reconstruction)
- Development and implementation of an enhanced recovery programme for colorectal cancer
- Market review of Chemotherapy services to develop commissioning recommendations for 2012-2013 which will improve clinical quality, patient experience and reduce commissioner spend
- Introduction of Acute Oncology Services (AOS) in NCL Providers, including a recurring admission patient alert flagging system in A&E departments to help prevent non-elective admissions and reduce non-elective length of stay

Key Priorities

8.0 CANCER (cont.)

Initiatives / Projects (cont.)

- Raising public awareness of signs and symptoms linked to earlier diagnosis: 2011-2012 Colorectal Improvement Programme, Practice Profiles, Risk Assessment Tool for Lung & Colorectal Cancer
- Implementation of HPV triage and test of cure to our local population – national investment in cervical screening programme to generate reduction in colposcopy activity in the medium and long term.
- Reconfiguration of cytology screening services to meet minimum volumes of 35,000 per year and review of colposcopy services

Best practice

- Development of whole pathway commissioning with provider network responsible for delivering improvement in outcomes and experience of care
- Integrated service delivery across whole pathway of care

Mode of delivery

- Service redesign
- Designation of formal Integrated Cancer Systems (ICS) through the London Cancer Implementation Team
- Decommissioning of determined unwarranted outpatient activity
- Development of detailed service specification for cancer
- Roll out of technology
- ICS and Provider collaboration
- Procurement

System Levers and Incentives

- Contracting and performance monitoring framework
- Specifying and commissioning services on a whole pathway basis
- Integrated Cancer System (ICS)
- Alternative pricing approaches for pathways

Key Priorities

8.0 CANCER (cont.)	
Key Enablers	<ul style="list-style-type: none"> • Effective ICS • Capacity in the system – e.g. Facilities • Patient sign – up • Positive press reportage • Workforce redesign • Effective clinical governance systems and processes • Effective data sets • GP and provider support
Identified savings	<ul style="list-style-type: none"> • 2011/12 = 0 • 2014/15= £6.9m
Interdependencies	<ul style="list-style-type: none"> • London model of care programme • Configuration of provider landscape
Risks	<ul style="list-style-type: none"> • Lack of communication to stakeholders about the benefits of the QIPP programme for patients leading to less positive public perception • Funding of networks beyond 2011/12 • Complexity of delivering whole systems change
Progress to Date	<ul style="list-style-type: none"> • Well defined plans with key objectives • Development of long term cancer commissioning strategy • Provider Network and Cancer Network commissioning team established • Service specification, QIPP schemes and metrics included in 2011/12 contract offers
Next Steps	<ul style="list-style-type: none"> • Progress to implementation of scoped projects

Key Priorities

9.0 CARDIO-VASCULAR DISEASE

Case for Change

- Need to improve patient outcomes and patient experience
- Need to reduce treatment delays
- Need to improve timely access to key cardiac interventions
- Slow uptake of evidence based innovative procedures
- Workforce constraints relating to the availability of junior doctors

Scope

- Redesign and implement revised pathways to move appropriate services closer to home
- Using evidence-based practice to reduce variation and inequitable access to cardiac and stroke services
- Admissions avoidance
- Reduction of length of stay
- Centralisation of specialist services
- Detection and treatment of stroke risk factors

Initiatives / Projects

- Creation of a single specialist vascular centre for NCL
- Heart Failure diagnosis – cost effective use of tests, which leads to more appropriate use of heart failure specialist services
- Re- admission avoidance for people with heart failure
- Implementation of service redesign for patients in need of complex arrhythmia procedures to produce a more equitable service provision
- Non- ST elevation acute coronary syndrome pathway redesign, reducing length of stay and double admissions during the same non-elective episode
- Cardiac surgery – reducing the average length of stay for non elective surgery through the use of an electronic referral system
- Work towards a door to needle time of 30 minutes for thrombolysis of stroke patients
- Improve diagnosis of atrial fibrillation and anti-coagulation following a stroke
- Unbundle London Stroke tariff to fund Early Supported Discharge (ESD) services
- Creation of a Hyper Acute Stroke Unit (HASU) ESD coordination role to provide cost-effective stroke discharge services across NCL
- Deliver 6 month post-discharge reviews of all stroke patients
- Embed stroke rehabilitation standards and data collection into community contracts

Key Priorities

9.0 CARDIO-VASCULAR DISEASE (cont.)

Best practice	<ul style="list-style-type: none"> ● Early adoption of new technologies ● Changing the provider landscape to create more targeted access to specialist and tertiary services ● Earlier diagnosis and triage of Heart Failure and Non-ST elevation acute coronary syndromes (NSTEMI) patients, with quicker access to specialist services and reduced length of stay for NSTEMI patients ● Providing fast track diagnostic services supporting primary care ● Providing ESD services cost-effectively from hyper-acute and acute stroke units ● Developing post-acute stroke services
Mode of delivery	<ul style="list-style-type: none"> ● Care Pathway redesign ● Service specifications ● Contract and performance monitoring and contractual terms and conditions ● Provider designation (if required for vascular services) ● Creation of new roles and workforce redesign
System Levers and Incentives	<ul style="list-style-type: none"> ● Contracts ● Specifying pathways across tertiary, acute and primary care
Key Enablers	<ul style="list-style-type: none"> ● New technologies ● Workforce redesign ● Effective patient data transfer between primary and secondary care ● Existence of Cardiac and Stroke Network to manage implementation ● National funding
Identified savings	<ul style="list-style-type: none"> ● 2011/12 = £0.2m ● 2014/15 = £0.8m

Key Priorities

9.0 CARDIO-VASCULAR DISEASE (cont.)

Interdependencies	<ul style="list-style-type: none">● Contracting and business as usual initiatives● IT and informatics● London cardiovascular model of care
Risks	<ul style="list-style-type: none">● Capacity to deliver scope of programme● Resistance to the centralisation of vascular services● Ability to provide ongoing funding following pilot phases● Longer term sustainability of outcomes, if no mechanism for ongoing monitoring in place
Progress to Date	<ul style="list-style-type: none">● NCL localisation of London wide redesign work● Service specifications for cardiac services included in contract documentation for 2011/12● Service specifications for vascular services prepared and shared with providers● A collaborative approach with providers to achieving the changes to vascular services● Robust scoping of project deliverables● Pilots being undertaken
Next Steps	<ul style="list-style-type: none">● Full implementation of proposals in 2011/12 for agreed initiatives● Scope additional measures to control hypertension and cholesterol

Key Priorities

10.0 PAEDIATRICS	
Case for Change	<ul style="list-style-type: none"> ● High volumes of children and young people attend A&E, presenting with a range of emergency and non-emergency conditions ● Families would most often prefer to go somewhere other than A&E if services were open and close to home ● Children attending A&E in NCL are often assessed by junior staff who are not paediatric specialists resulting in higher levels of admissions which should be avoided ● Some healthcare providers in NCL only undertake very small numbers of inpatient paediatric surgery and are therefore not meeting the standards expected by the Royal Colleges, or by recognised best practice ● Variation in quality and provision of tertiary pediatric services ● Fewer larger centres to focus on complex needs ● Creation of North London Tertiary Provider network to bring deliver capacity small specialties
Scope	<ul style="list-style-type: none"> ● Acute paediatric inpatient services (medical and surgical) ● Paediatric outpatient and community services ● Proposed service model for London for tertiary services
Initiatives / Projects	<ul style="list-style-type: none"> ● To be confirmed for tertiary services following consultation on the proposals for London ● NCL Paediatric Network to identify appropriate future service configuration for NCL and agree pace of change
Best practice	<ul style="list-style-type: none"> ● TBC
Mode of delivery	<ul style="list-style-type: none"> ● London Tertiary Paediatric Network ● NCL local Paediatric Network

Key Priorities

10.0 PAEDIATRICS (cont.)	
System Levers and Incentives	<ul style="list-style-type: none"> London wide proposals for tertiary service with clear implications for services and providers in NCL
Key Enablers	<ul style="list-style-type: none"> Clinical leadership and engagement
Identified savings	<ul style="list-style-type: none"> To be confirmed
Interdependencies	<ul style="list-style-type: none"> Further London wide redesign proposals Impact of the London health economy response to the tertiary services proposals NCL Unscheduled Care QIPP work stream Local authority children's services
Risks	<ul style="list-style-type: none"> Future disposition of tertiary services disadvantages local providers who are not designated as specialist centers Financial and clinical implications for providers' acute paediatric proposed model of care Public and stakeholder reactions to any proposed changes Alignment of health and social care plans
Progress to Date	<ul style="list-style-type: none"> London tertiary proposals out to consultation Discussions underway within the Paediatric Network regarding future models of care
Next Steps	<ul style="list-style-type: none"> Proposals for tertiary services finalised following consultation Detailed plan developed for acute paediatrics network

Key Priorities

11.0 ACUTE PRODUCTIVITY

Case for Change	<ul style="list-style-type: none"> • More efficient operation of acute providers • Addressing the financial gap inherent in NCL cluster
Scope	<ul style="list-style-type: none"> • Acute contract metrics relating to elective and emergency inpatients, outpatients, A&E attendances and Diagnostics
Initiatives / Projects	<p>Specific metrics built into contract relating to:</p> <ul style="list-style-type: none"> • A&E conversion rate • A&E attendance when left without seen a clinician • A&E minor ailments resulting in admission • Admissions via A&E with a zero length of stay • C2C Paid as Follow up • Day case coding to out patient (OP) procedure • Excess bed days • Non Emergency Re-admission 30 days • Non Emergency Re-admission 30 days to another provider • OP attendances whilst an inpatient • Pre Operative excess bed days. • Procedures requiring prior approval
Best practice	<ul style="list-style-type: none"> • Standardising and enforcing contract changes consistently to implement metrics and promote more efficient ways of working
Mode of delivery	<ul style="list-style-type: none"> • Incentives and penalties written into contract • Robust monitoring and enforcement of contract terms
System Levers and Incentives	<ul style="list-style-type: none"> • Contractual Terms

Key Priorities

11.0 ACUTE PRODUCTIVITY (cont.)

Key Enablers	<ul style="list-style-type: none"> • Changes in primary care and pathway redesign to support best practice in the acute sector • A strong evidence base to support the change in the terms of the contract, and continuing access to comparative benchmarking • High quality staff to deliver and negotiate contract changes in a consistent way that create the necessary detailed and enforceable contract terms • A workforce with the necessary skills and capacity to monitor and enforce contract terms fully during the year
Identified savings	<ul style="list-style-type: none"> • 2011/12 = £46.7m • 2014/15 = £73.0m
Interdependencies	<ul style="list-style-type: none"> • 2012/13 acute contract negotiations • FT pipeline • Trust CIP Plans
Risks	<ul style="list-style-type: none"> • Unable to agree terms in all provider contracts • Necessary capacity and skill set of staff to monitor and enforce contract metrics is not available • Knock on effect creates additional unplanned activity in other settings
Progress to Date	<ul style="list-style-type: none"> • Metrics negotiated into all acute contracts for 2011/12
Next Steps	<ul style="list-style-type: none"> • Refining the quality of the metrics • Developing benchmarking for mental health and community services

Key Priorities

12.0 STAYING HEALTHY

Case for Change	<ul style="list-style-type: none"> ● Reduce premature mortality and all age all cause mortality in addition to improving the prevention, diagnosis and treatment of long term conditions ● Understanding the role that preventable risk factors play in the morbidity and mortality of the NCL ● Smoking is the single largest cause of deaths in NCL, including lung cancer and COPD as well as being a key risk factor for CVD, particularly Coronary Heart Disease (CHD)
Scope	<ul style="list-style-type: none"> ● NCL population especially those people with LTCs ● Local authority input and partnership working with NHS partners
Initiatives / Projects	<ul style="list-style-type: none"> ● CVD, Cancer and Mental Health include; ● NHS Health Checks, vascular risk underpinned by weight management, healthy eating and tobacco control programmes ● Cancer screening continues to be a priority area for continued delivery with strategic links to interventions ● Smoking cessation, impacting on reduced COPD prevalence. ● Increasing childhood immunisation rates ● Joint Alcohol Harm Reduction Strategies set out work plans to reduce alcohol related A&E attendances ● IAPT aims to tackle common mental health disorders such as anxiety and depression ● Local projects focused on reducing teenage pregnancy rates
Best practice	<ul style="list-style-type: none"> ● NHS Health Checks through multi dimensional community based models of delivery and targeted work within Primary Care ● Developing service models as a result of insight from social marketing and engaging local communities ● Utilising health intelligence data to further understand the underlying determinants of health and associated impact upon long term conditions
Mode of delivery	<ul style="list-style-type: none"> ● Effective partnership working with multi disciplinary teams to ensure sustained focus and maintain scale and traction required for long term change ● GP Consortia ● The local authority led Health and Wellbeing Boards and future public health workforce ● One size and model will not fit all and local areas will need to continue to understand the needs of their population

Key Priorities

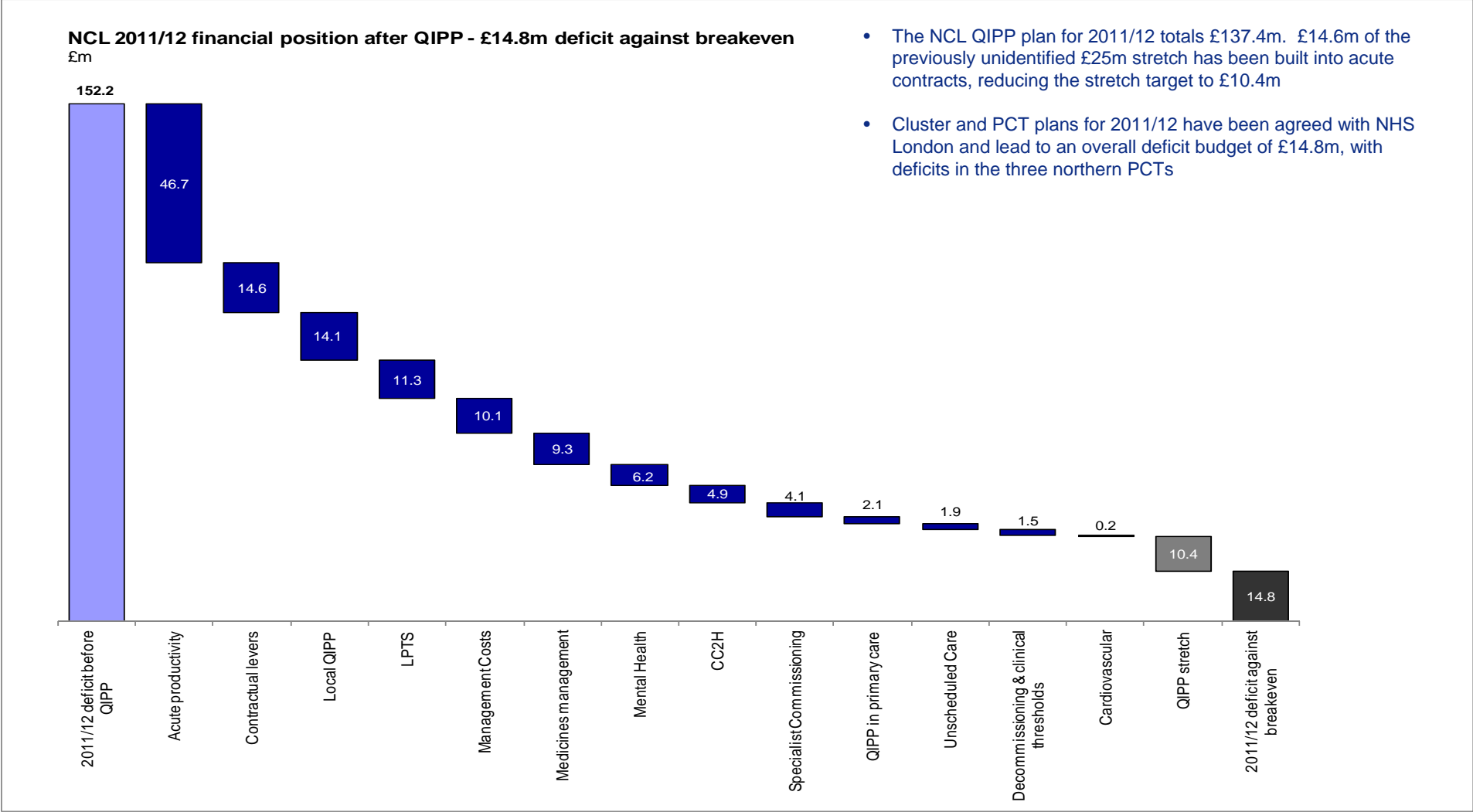
12.0 STAYING HEALTHY (cont.)	
System Levers and Incentives	<ul style="list-style-type: none"> ● Incentives such as LES, DES, Low Income Scheme (LIS) to promote the uptake of services and prevention activities ● New NHS and Public Health Outcome Frameworks ● Wider role of the GP
Key Enablers	<ul style="list-style-type: none"> ● Healthy Lives and Healthy People; ● Public Health White Paper ● NHS and Public Health Outcome
Identified savings	<ul style="list-style-type: none"> ● To be confirmed
Interdependencies	<ul style="list-style-type: none"> ● NHS and Public Health outcome frameworks
Risks (KF added this)	<ul style="list-style-type: none"> ● Transfer of public health to local authorities ● Uncertainty and concern about the capacity of local teams to deliver all the proposed public health functions ● Prioritisation of staying healthy in the future commissioning arrangements
Progress to Date	<ul style="list-style-type: none"> ● Initiatives identified for implementation
Next Steps	<ul style="list-style-type: none"> ● Local planning of how the new commissioning functions and public health landscape need to work together to jointly deliver required outcomes ● Agree robust delivery and implementation plans with Public Health teams across the sector

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Delivery Impact – Impact on Commissioners

QIPP PLANS

The following chart shows the impact of QIPP plans by work stream

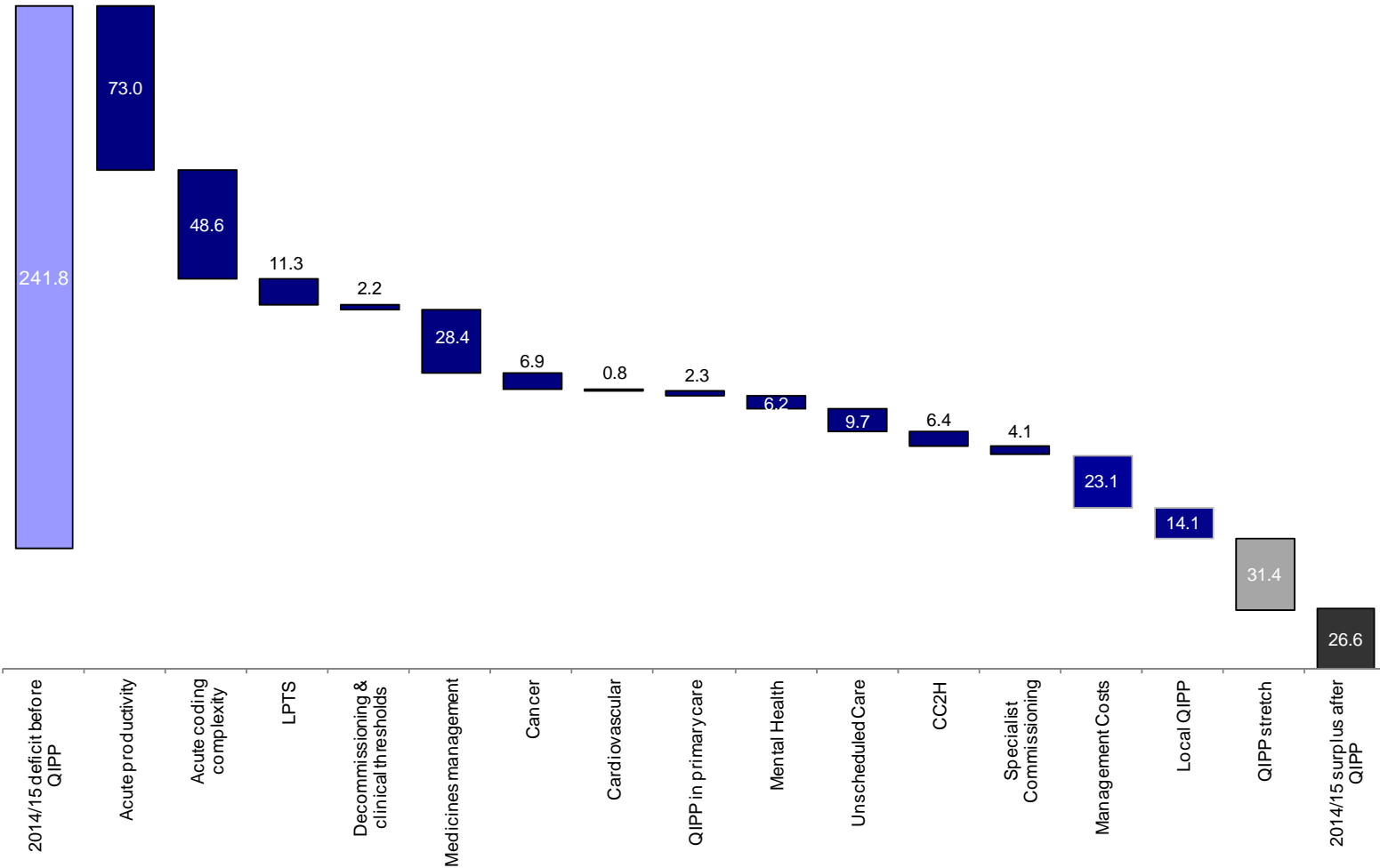


Delivery Impact – Impact on Commissioners (cont.)

QIPP PLANS

NCL 2014/15 financial position after QIPP - £26.7m surplus
£m

Note: the financial savings in 2012/13-2014/15 are being finalised and may therefore be subject to change e.g. addition of maternity savings



Delivery Impact – Impact on Commissioners (cont.)

PCT FINANCIAL POSITIONS

By 2012/13 NCL cluster will achieve an in year surplus of £18.4m and during 2013/14 all PCTs will have achieved run rate balance and returned to surplus

£m	Underlying 2010/11	Forecast 2011/12	Forecast 2012/13	Forecast 2013/14	Forecast 2014/15
Barnet	-25.9	-17.2	-7.9	0.2	0.4
Enfield	-25.6	-18.8	-7.4	0.5	0.3
Haringey	-29.7	-20.3	-8.4	0.3	0.0
Subtotal outer PCTs	-81.2	-56.3	-23.7	0.9	0.7
Camden	16.3	22.8	23.0	12.6	14.3
Islington	1.1	18.7	19.1	8.5	11.6
Total NCL surplus / -deficit	-63.9	-14.8	18.4	22.0	26.7
Cumulative surplus / -deficit		-14.8	3.6	25.6	52.3

Delivery Impact – Impact on Commissioners (cont.)

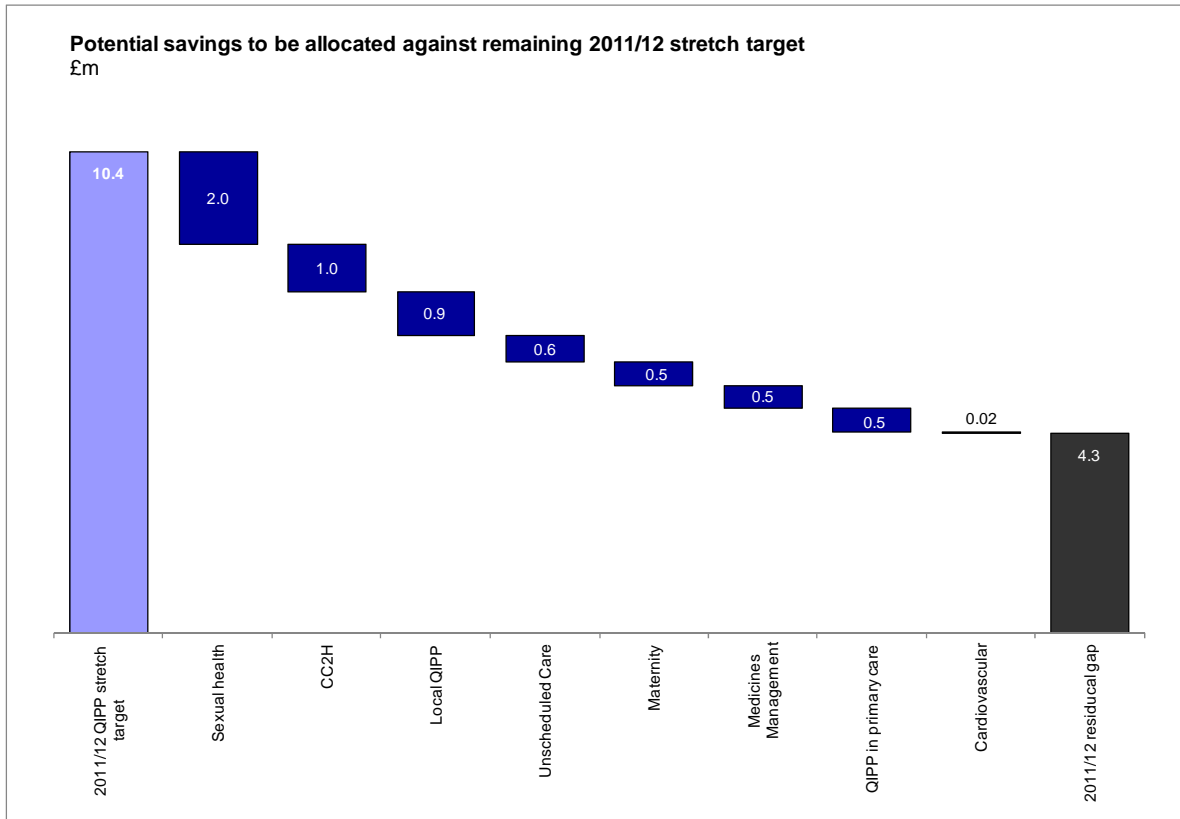
PCT FINANCIAL POSITIONS

Additional in-year QIPP

£m	Forecast 2011/12	Forecast 2012/13	Forecast 2013/14	Forecast 2014/15
Barnet	36.2	19.1	14.5	9.1
Enfield	28.5	11.0	8.9	8.1
Haringey	29.4	14.9	11.8	8.1
Subtotal outer PCTs	94.1	44.9	35.3	25.2
Camden	21.0	7.2	5.1	2.7
Islington	22.3	5.7	3.4	1.6
Total NCL QIPP	137.4	57.8	43.7	29.6
Cumulative QIPP	137.4	195.2	238.9	268.5

Delivery Impact – Impact on Commissioners (cont.)

CLOSING THE GAP IN 2011/12



- £14.6m of the previous QIPP stretch target of £25m has been built into acute contracts for 2011/12, reducing the gap to £10.4m. There is a continued focus on identifying additional opportunities to close the gap.
- An initial review of all work streams has been completed to ascertain which may be extended to contribute further savings to generate in year opportunities – the risk adjusted results of this exercise is shown in the chart opposite.
- GP leadership of demand management is key to mitigating the risk of hospital overspends.
- Further non recurrent opportunities of approximately £6.5m have also been identified, although the focus remains on generating recurrent savings to offset recurrent expenditure pressures
- In addition, robust contract management with challenges to billed activity will be in place to manage the risk of overperformance on acute contracts.
- The following ideas continue to be explored to further mitigate risk:
 - Cross-fertilisation of schemes between the five PCTs
 - Stretching PCT community services schemes
 - Extending Care Closer to Home schemes across the sector
 - Reviewing referral management plans with the aim of achieving top quartile performance within a shorter lead time
 - Revisiting existing PCT procurements for Care Closer to Home schemes to ascertain whether similar schemes from other PCTs can be implemented through the same tender exercise to accelerate delivery.

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Delivery Impact – Impact on Patients

WORK STREAM	CLINICAL OUTCOMES	PATIENT EXPERIENCE	ACCESS	SAFETY
1.0 Care Closer to Home	<ul style="list-style-type: none"> ● Fewer crises situations requiring emergency intervention leading to improved quality of life and better outcomes 	<ul style="list-style-type: none"> ● Able to more easily navigate the health system ● Care provided in more local care settings 	<ul style="list-style-type: none"> ● Right person right care right place right time 	<ul style="list-style-type: none"> ● Improved clarity of care point location ● Improved quality
2.0 Unscheduled Care	<ul style="list-style-type: none"> ● Reduction in short stay admissions ● Reduce duplication of diagnostics 	<ul style="list-style-type: none"> ● Reduced travel and shorter waits ● Reduced likelihood of admission ● Right treatment first time ● Care delivered in a more appropriate setting 	<ul style="list-style-type: none"> ● Access care closer to home 	<ul style="list-style-type: none"> ● Reduced number of access points in the system ● Skilled and competent workforce in right setting
3.0 Mental Health	<ul style="list-style-type: none"> ● Earlier intervention in SMI 	<ul style="list-style-type: none"> ● Reduced out of area treatments – minimising social exclusion ● Proactive identification of patients with dementia, drug and alcohol issues – less hospital based care 	<ul style="list-style-type: none"> ● Appropriate in-patient capacity 	<ul style="list-style-type: none"> ● Improved liaison between acute and community based care to improve case management
4.0 Medicines Management	<ul style="list-style-type: none"> ● Improved formulary compliance ● Right prescribing 	<ul style="list-style-type: none"> ● N/A 	<ul style="list-style-type: none"> ● Potentially limits choice of drugs 	<ul style="list-style-type: none"> ● Right prescribing – reduced inappropriate prescribing

Delivery Impact – Impact on Patients (cont.)

WORK STREAM	CLINICAL OUTCOMES	PATIENT EXPERIENCE	ACCESS	SAFETY
5.0 QIPP in Primary Care	<ul style="list-style-type: none"> ● Improved performance against the 20 QOF clinical domains ● Above average performance against clinical outcomes for all DES ● More accurate & targeted screening for the right patients at the right time ● 0-5yr old increase in early clinical diagnoses & prevention for dental conditions ● Increased number of community pharmacy Medicines Usage Reviews increasing medicines compliance 	<ul style="list-style-type: none"> ● Increase in % patient satisfaction for GPs up to sector average ● Increase in % patients satisfied with dental treatment received up to London average ● Increase in % patients satisfied with time they have to wait for a dental appointment up to London average ● Increase in % return of community pharmacy patient satisfaction surveys 	<ul style="list-style-type: none"> ● Increase in the number of available GP appointments with an associated reduction in A&E attendance ● Increase in dental vital sign performance ● Commissioning capacity of Units of Dental Activity (UDAs) to be aligned to sector targets so increasing patient access ● Increased access for new dental patients ● Increase in number of 100h pharmacies across the sector increasing access to medicines, clinical advice & Minor Ailment services 	<ul style="list-style-type: none"> ● Tight monitoring of national contractual patient safety issues within each contractual framework GMS/ GDS/ Community Pharmacy contracts
6.0 Maternity	<ul style="list-style-type: none"> ● Reduction in C-sections and increase in birth outside obstetric setting ● Right care for high risk pregnancy ● Clearer pathway for low risk pregnancy ● Increase in women booking before 12th week of pregnancy to ensure better access to screening choices 	<ul style="list-style-type: none"> ● More choice of place for birth ● Antenatal and post natal care closer to home ● Women and partners feel well supported during established labour through the provision of 1:1 midwife care ● Women have a named midwife who coordinates their care 	<ul style="list-style-type: none"> ● Improved access through community based care ● Access to risk stratified care pathway ● Better access to screening 	<ul style="list-style-type: none"> ● Doing the right things to address high risk pregnancy ● Ensuring that units are working to Safer Childbirth Levels ● CNST ● Standardised care protocols across NCL

Delivery Impact – Impact on Patients (cont.)

WORK STREAM	CLINICAL OUTCOMES	PATIENT EXPERIENCE	ACCESS	SAFETY
7.0 Procedures of Limited Clinical & Cost Effectiveness	<ul style="list-style-type: none"> ● Reduction in clinically ineffective procedures (right care) 	<ul style="list-style-type: none"> ● Clarity of service provision available ● Treatment delayed due to authorisation process 	<ul style="list-style-type: none"> ● Restricted treatments for patients with certain conditions 	<ul style="list-style-type: none"> ● Reduction in risks to patients from ineffective procedures
8.0 Cancer	<ul style="list-style-type: none"> ● Earlier detection, diagnosis, prevention and screening ● Improved survival rates ● Improved clinical outcomes 	<ul style="list-style-type: none"> ● Effective co-ordinated care pathways ● Reduced readmission rates ● Shorter lengths of stay 	<ul style="list-style-type: none"> ● Increasing take up of access to screening ● Earlier access to diagnostics and screening 	<ul style="list-style-type: none"> ● Care provided in line with outcome focused pathways, leading to less variation ● Compliance with recognised standards
9.0 Cardiovascular	<ul style="list-style-type: none"> ● Improved clinical outcomes ● Reduce variation within NCL sector ● Improved use of new techniques ● Earlier detection 	<ul style="list-style-type: none"> ● Improve support services and continuity of care throughout pathway 	<ul style="list-style-type: none"> ● Patients access the right treatment centre the first time 	<ul style="list-style-type: none"> ● Care provided in line with outcome focused pathways, leading to less variation
10.0 Paediatrics	<ul style="list-style-type: none"> ● Reduce variation and improve quality in acute services ● Improved outcomes for patients requiring tertiary care ● Consolidation of services onto two sites will improve critical mass, help clinicians maintain skills and improve safety 	<ul style="list-style-type: none"> ● Understanding and agreement on what can be achieved to improve patient experience ● Reduction in average length of stay and readmission rates 	<ul style="list-style-type: none"> ● Understanding and agreement on what can be achieved to get access right for acute services 	<ul style="list-style-type: none"> ● Consistency of tertiary service delivery standards

Delivery Impact – Impact on Patients (cont.)

WORK STREAM	CLINICAL OUTCOMES	PATIENT EXPERIENCE	ACCESS	SAFETY
11.0 Acute Productivity	<ul style="list-style-type: none"> ● Levelling up to the best practice in NHS 	<ul style="list-style-type: none"> ● Care delivery streamlined ● Reduction in admissions ● Reduction in Length of Stay 		
12.0 Staying Healthy	<ul style="list-style-type: none"> ● Improved outcomes as measures in place to encourage healthier lifestyles for local population ● Improved uptake of prevention services and earlier detection 	<ul style="list-style-type: none"> ● Improved as more positive interactions with local NHS 		

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Delivery Impact – Impact on Providers

- It is estimated that the overall financial impact of the NCL QIPP plan on our five main providers will be approximately £69.4m in 2011/12 assuming the initiatives proposed for year 1 are implemented in full and benefits realised as planned
- Over 4 years, this would equate to a cumulative saving of approximately £147m from our five main providers
- The majority of this saving (£46.7m in 2011/12, £73.0m over the 4 years) is expected to come from Acute Productivity initiatives such as reducing the number of follow up appointments delivered in hospitals, and reducing the rate of consultant-to-consultant referrals through tighter contract management.
- It is recognised that a revenue reduction of this magnitude has very significant implications for all our providers and presents considerable risks to their achievement of Foundation Trust status. We therefore had detailed contract negotiations for 2011/12 with our main providers which resulted in the agreement of cap and collar deals with three of our main providers, supported by £17.5m of non recurrent funds, to stabilise risk in the sector and accelerate the delivery of the productivity savings.
- NCL hosts three specialist providers, for whom our sector represents a much smaller proportion of their overall revenue. Due to the lower overall commissioning spend and the reduced purchasing power of our sector with respect to these providers, our savings targets for these organisations are materially lower than for our main five providers. Nonetheless, our plan is to implement our care closer to home, low priority treatments, decommissioning and thresholds and acute productivity initiatives through all acute contracts.

Delivery Impact – Impact on Providers (cont.)

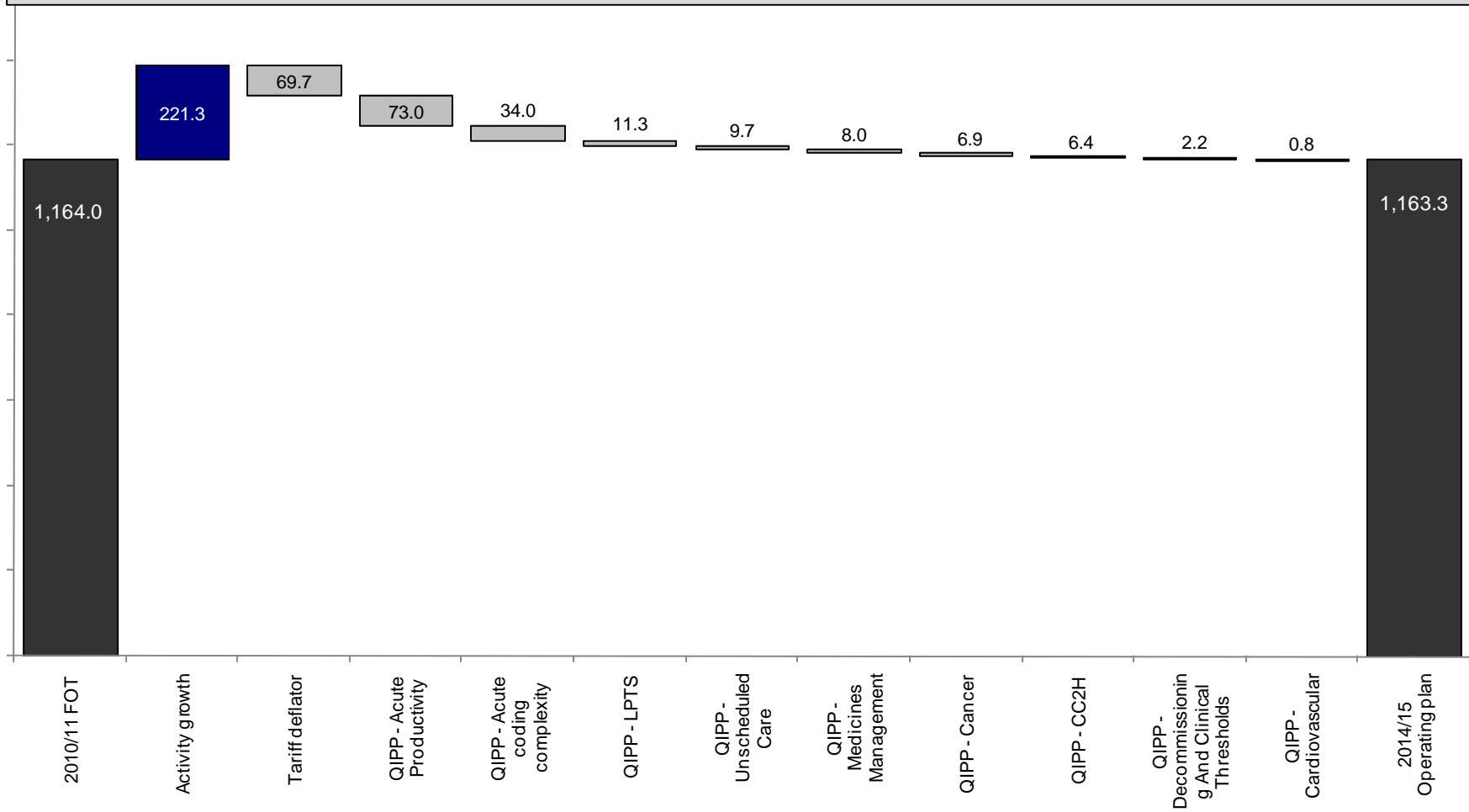
- In the first year of the NCL QIPP Plan, there is a significant emphasis on driving productivity and efficiency improvements within the acute sector through more challenging acute contract metrics.
- A large proportion of the planned acute savings will also come from medicines management schemes to improve value for money on drugs spend.
- Primary Care and Community Services are key enablers of reduced hospital spend.
- It is recognised that, in further developing the plan, a greater emphasis needs to be placed on influencing GP behaviour and further pathway redesign to manage demand in primary care.

Delivery Impact – Impact on Providers (cont.)

NCL Sector Acute Providers: 2010/11 forecast outturn to 2014/15 operating plan

£m

The 2010/11 forecast outturn for NCL providers is £1164.0m. The impact of activity growth and the tariff deflator lead to a projected spend of £1315.6m by 2014/15 under the 'do nothing' scenario. The NCL QIPP programme aims to reduce acute spend by £152.3m, the analysis by workstream is shown below. This is a key factor in achieving a surplus for NCL by 2012/13 and run rate balance in each PCT by 2013/14.



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Delivery Impact – Key Enablers

In order to deliver these initiatives there are a number of cross cutting programmes of work that we will need to deliver. We have already described the work on changing incentives. This slide gives an overview of the estates, IT and workforce programmes that will support either individual or groups of schemes.

ESTATE RATIONALISATION

- Both Camden and Islington Mental Health Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust are undergoing a rationalization of their estate as they change their clinical models to support additional services in the community and a reduced bed base. In addition, the changes to the Cluster and PCT structures effective from April 2011 will result in a rationalisation of commissioners requirements as we centralise the core cluster team and pursue opportunities for local presence teams to co-locate with local authority colleagues.

- These changes will impact on PCTs and some acute providers and we are working together across NCL to ensure that we maximise the utilisation of our assets.

- Individual hospital sites will also be the subject of rationalisation as different institutions take out clinic and bed capacity. Commissioners are working with provider to ensure that any potential opportunities are maximised.

- To support this we have conducted a stocktake of our estate and will use this as a baseline going forward

IT INFRASTRUCTURE

- To support a number of cross health-economy schemes, the effective electronic transfer of information is a key enabler. We will work with GP commissioners to ensure that all communications are transferred electronically.

- We are also working within specific programmes to ensure that we have the most appropriate IT systems. For example, within the Care Closer to Home programme, we will invest in Telehealth/medicine technology where appropriate. Our PCTs have also invested in case-finding software to support virtual ward and other similar schemes.

Delivery Impact – Key Enablers

WORKFORCE

We have described how the workforce will need to transform elsewhere in this document. What is becoming clearer, as this plan has developed, is that there will be a need, during programme implementation, to make the right decisions around service redesign and the resulting workforce implications.

- For example, within the Unscheduled Care programme, we do not simply want to substitute one point of access (A&E) with another. Rather, we wish to redesign services so that our staff work differently in the future. At the Royal Free and the North Middlesex we have begun to do this.

WORKFORCE IMPLICATIONS FROM THE COMMISSIONING STRATEGY / QIPP PLAN

The workforce in NHS NCL is facing significant change over the next four years. The key implications are outlined below:

Service Delivery

The consequence of pathway development is a significant change to service provision with the associated impact on the existing workforce. Often this will be a change in skill or change to service delivery requiring workforce development. Such changes will need to be managed effectively to ensure efficient implementation of revised pathways.

As an example, the consolidation of maternity services at Barnet and North Middlesex Hospitals through the BEH Clinical Strategy will make better use of scarce midwifery resources.

Changes to system and reconfiguration of services

As providers respond to challenges in the strategic plan, it will be imperative for employers to work together to manage the transition and to mitigate the potential loss of skill and expertise, and to manage the cost of implementing change across the health system in NCL.

Improving Productivity

As we seek to improve acute and primary care productivity and improve the quality of healthcare, the workforce will face significant change to how they work and to the environment in which they work. There is the opportunity to reduce the variation in productivity across the settings of care. NHS NCL will use workforce benchmarking data to understand where the differentials in productivity exist and work with providers to address them.

Improving Quality

There is evidence to support that employment practice is a key indicator for standards of patient care. Whilst the NHS regulatory framework will monitor compliance with statutory employment duties NHS NCL will wish to monitor key workforce measures to provide assurance of employment practice and patient outcome.

Workforce Planning

Commissioning and de-commissioning decisions will have an impact on the workforce. A workforce planning system that involves the commissioners' long term service planning assumptions and the provider response will ensure that the workforce of the future is commissioned effectively through education providers.

Providers and education commissioners need to work closely with service commissioners to ensure that appropriate workforce is commissioned through education to meet the needs of longer term service planning.

NHS NCL will have key role in understanding the workforce demands of commissioning intentions in order to inform education planning and commissioning.

System Change

As the health system develops over the next two years NHS NCL will support the development of GP consortia and the development of commissioning support for utilising the significant leadership development support from 'Leading for Health' (NHS London).

NHS NCL will work in support of NHS London (NHSL) as it responds to the changes to the education commissioning system to ensure that there is alignment between service and education commissioning.

Engagement

NHS NCL has an active HR lead network where currently commissioners and providers meet to discuss key workforce issues, consider the monthly workforce benchmarking report and inform workforce implementation. This network will need to consider its role in ensuring staff engagement with commissioning strategy.

Delivery Impact – Key Enablers

WORKFORCE (contd.)

HOW PREPARED IS NCL TO MEET THE WORKFORCE CHALLENGES AND WHAT ARE THE NEXT STEPS?

There are a number of building blocks that have been put into place in NHS NCL to ensure that the workforce implications of commissioning strategy can be identified to support implementation.

The PCTs in NCL, together with other Clusters, has been engaged in a large scale organisational change. As a result there is London transition framework, agreed in partnership that provides a good basis for employers to work together on delivering large scale workforce change.

In 2010 we developed a monthly workforce report that provides workforce productivity benchmarking data to employers in NCL. In 2011/12 it is intended to use workforce productivity and quality indicator data as a part of the contracting process and to inform assurance and productivity improvements.

In addition the London Healthcare Benchmarking tool launched in 2010 provides invaluable productivity benchmarking data across all service providers in England.

In 2010 NCL introduced a HR network to facilitate employer collaboration, develop workforce thinking and to share learning. As provider networks develop in NCL it will be important to ensure that employers continue collaborate on the workforce issues to facilitate the management of the workforce implications of planned changes, to maximise the opportunity for change and minimise time and cost of implementation.

2010 was the first year of a revised pan London workforce planning process that brings together commissioning strategy and provider intentions. This process is to be developed in 2011 to provide more robust information to inform education commissioning.

The challenge for NCL will be to build the relationship between the provider/employer and the commissioner in order to identify the workforce impact of the commissioning strategy and to plan and implement workforce for change in order to deliver service change, and high quality efficient healthcare to the population of NCL.

As part of the next phase of work on the commissioning Strategy/QIPP /Plan the Cluster's Workforce Transformation Strategy will be reviewed and refreshed to reflect our current plans and a detailed plan for 2011/12 will be developed in collaboration with work stream leads.

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Delivery Impact – Future Settings of Care (cont.)

WHOLE SYSTEM IMPACT ANALYSIS – ACTIVITY FLOWS INTO NON-ACUTE SETTINGS (CARE CLOSER TO HOME)

The tables below describe the potential flow of activity, by pathway, out of a traditional hospital setting into community and primary care that will result from our proposed initiatives. The table lists all the proposals from PCTs, which were subject to a prioritisation process in early February 2011

PATHWAY GROUPING	PRIMARY CARE SERVICES	COMMUNITY CARE PATHWAY
LTCs (Including Diabetes, COPD and Heart Disease)	<ul style="list-style-type: none"> ● Repatriation of stable patients ● Outpatient monitoring and follow up ● Diagnostic tests ● Pulmonary and Cardiac rehab ● Psychological therapies 	<ul style="list-style-type: none"> ● Acute exacerbation management ● Supported discharge ● Community based intermediate level care ● Specialist community nursing ● Telehealth/Telecare
Admission/Readmission Avoidance and Early Discharge (including End of Life care and support)	<ul style="list-style-type: none"> ● Support for virtual wards ● Use of PARR and combined model to identify people vulnerable to admission ● Palliative Care Register ● Gold Standard Framework 	<ul style="list-style-type: none"> ● Joint working with social services to develop initiatives ● Rapid response services ● Development of Re-ablement services ● Implementation of virtual wards ● Work on PACE and TREAT with acute providers ● Medication reviews ● Community Nursing and End of Life Care working with Care Home staff ● Training with Care Home and Social Care staff ● Development of protocols with LAS ● Palliative care community team working with GPs and community services to enhance End of Life Care ● Advanced Care Planning
Planned Care (Including: Gynaecology, Dermatology, Musculoskeletal (MSK), Anticoagulation, Ophthalmology, Dental, Urology, Cardiology, Colorectal)	<ul style="list-style-type: none"> ● Use of pathways and protocols to avoid unnecessary referrals to secondary care ● Redesigned Out-patient clinics ● Diagnostics tests ● Increased range of treatments e.g. joint injections 	<ul style="list-style-type: none"> ● Advanced physiotherapy

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Implementation

APPROACH TO IMPLEMENTATION

- A clear need has been recognised for a robust and comprehensive approach to programme management in order to ensure the programmes and work streams are delivered on time and produce the highest quality outputs and outcomes. A Programme Management Office (PMO) has therefore been established to manage the governance, monitoring and managing the QIPP programme throughout the mobilisation and implementation phases. Given the breadth of the initiatives that make up the QIPP Plan a variety of approaches are relevant in terms of implementation, including:
 - Contract mechanisms e.g. commissioning intentions, activity and finance baselines taking account of QIPP initiatives, pricing agreements, KPIs with penalties and contract terms
 - Whole pathway commissioning based on output specifications and financial envelopes with providers responsible for delivery
 - Collaborative service re-design
 - Provider designation for specific clinical services
 - Market procurements
 - Incentivising behavioural change e.g. Commissioning for Quality and Innovation (CQUINS), GP and other provider incentive schemes
- Recognising the changing commissioner landscape, the implications of a significantly reduced commissioning workforce from April 2011 and the fact that service integration will be key to improving service quality within a very financial challenged environment we have been both developing and testing less interventional approaches to commissioning that encourage provider collaboration and ownership of solutions and improving our approach to contracting.

COMMISSIONING INITIATIVES

Some examples of service specific Commissioning Initiatives demonstrate our approach:

- BEH Clinical Strategy – working with providers in the north of the sector to develop a plan to improve the pattern of services for changes to women and children's services, urgent care, and planned or elective care
- Cancer Services – building a framework for whole pathway commissioning using brain and lung cancer as the pilots for testing the implications for commissioners and providers
- Vascular Services – inviting providers to identify the single centre for NCL based on a service specification
- Whittington Health (ICO) – for certain services asking the ICO to take responsibility for delivering change across a pathway with payment based on a block contract in the short term and potentially a capitation budget in the longer term
- QIPP Incentives work stream – which is aiming to identify approaches to incentives and risk and gain sharing that can be applied in a variety of different circumstances.

Implementation (cont.)

CONTRACT MANAGEMENT

The Cluster investment in a central contract management team will ensure robust management of the agreed 11/12 contracts. As well as acute provider contracts, this will include the mental health and community contracts as responsibility for these transferred to the Cluster contracts team from April 2011.

Contract management Strategy

The overall financial position of the cluster makes it imperative that robust contracts are delivered aligned to PCT available resources, thus enabling the cluster to deliver a financially balanced Operating Plan for 2011/12 and to ensure that we are well positioned financially for 2012/13. To that end, strategic contracting positions have been agreed with 3 NHS providers enabling commissioners and providers to better understand their underlying financial and operational performance.

The Cluster team will continue to work closely with borough based commissioners to ensure there is full alignment with borough based QIPP and demand management programmes. In addition, the Cluster will continue to seek additional savings in support of the QIPP stretch.

The Cluster will work pro-actively with nominated clinical commissioners. The Cluster contract team will support clinicians to lead the management of the contracts through timely and accurate information. This is specifically important in relation to MHT and Community Contracts.

The NHS NCL contract management strategy aims to achieve this by triangulating finance and activity information, data on quality and performance with the technical aspects of the contract and national guidance. This strategy will also use the Trusts' strategic ambitions as key levers, and will be supported by the appropriate use of contract levers. In addition the contract management process will also enable tracking delivery of individual PCTs' Commissioning Intentions.

A robust process of claims management aligning it much more closely with those that GPs have already put in place is also being implemented

For each contract we shall agree a programme of work that will set out the areas that commissioners and providers will work together on in order to deliver greater transparency on quality, safety, productivity and pricing.

Principles:

- That all stakeholders in the contract work in partnership;
- That drivers on both sides are recognised since it is necessary that both parties to the contract can derive some benefit from the delivery of the agreed contract value;
- That the overarching financial position of the NCL cluster is recognised by all parties and it is understood that contract values are there to be delivered as part of the NHS NCL 2011/12 Operating Plan;
- That national guidance shall apply to all sides;
- Agreement on in year run rates so there is clear visibility on out turn and start point for 2012/13;
- That clear metrics will be used to monitor and manage performance.

Implementation (cont.)

CONTRACT MANAGEMENT (CONT.)

Approach to 2012/13 contracts

- We will invest in those services where the provider has capacity to undertake additional activity at lower than tariff and disinvest in those services where the Trust is currently forced to use locums and agency staff to meet demand, ensuring changes to activity happen by working with Clinical Consortia to influence referral patterns.
- Where there have been increases in case-mix in year, we will require the review of the non PbR prices at the Trust to reduce tariffs to reflect the income gains for the trust in respect of case-mix.
- Ensure that where there are demonstrable reductions in activity, capacity has been reduced;
- Continue to promote choice;
- Ensure alignment of productivity metrics over the 4 years with aspirant FT providers integrated business plans and Commissioners' expectations of performance
- Work with commissioners and providers to ensure that agreed strategic positions are deliverable.

Approach with respect to KPIs and Cluster projects

- We will continue to target the impact of borough based QIPP schemes on all contracts and will agree capacity reductions in line with activity shifts;
- Continue to negotiate productivity improvements into all contracts;
- A key piece of work will be the costing of pathways in support of MH tariff developments.

Development of Acute Contract Metrics Work-Stream

The development of contract metrics will continue to be the primary area of focus in delivering acute productivity savings.

We will work with providers in the summer and autumn to agree the metrics that will form part of the 2012/13 contracts. These will be based on a robust assessment of metrics using nationally recognised providers. We will also ensure that commissioners and providers understand the relationship of metrics with clinical practice.

As a minimum we shall expect all providers to be in top quartile. For those providers that have financial pressures we shall be expecting them to deliver top decile performance.

These principles have been translated into performance metrics for:

- Day case / Outpatient procedures
- Readmissions
- New-FU ratios
- Consultant to Consultant
- A&E conversion rates
- Excess Bed Days
- Outpatient Attendances during admissions
- 18 Weeks
- Pre-operative excess bed days
- Non PBR Pricing

We shall bring forward proposals to discuss with community and MH providers productivity metrics.

Prioritisation to manage the financial risk

Planned 2011/12 acute contract QIPP savings are £46.7m; current analysis indicates that the overall acute productivity improvement in 2011/12 can be further increased by 55%. Taking 2011/12 as a recurrent baseline and modelling a 55% improvement over and above the baseline in increments of 20%, 20% and 15%, further savings of £9.3m, £9.3m and £7.0m can be achieved recurrently in each of 2012/13, and 2014/15 respectively. These figures will be tested using the newly refined metrics and as part of benchmarking against peer group upper quartile and upper decile performance

Implementation (cont.)

PROGRAMME STRUCTURE AND RESOURCES

- The importance of the delivery of the QIPP Plan has been recognised at the highest level in the new structure by the creation of the post of QIPP Director and the decision that the Cluster Chief Executive will chair the QIPP Delivery Group
- The intention is to maintain a programme management approach to implementation; the governance arrangements align with the cluster committee structure.
- Each priority area within the plan has an Senior Responsible Officer (SRO) and a management lead/support resource.
- A dedicated Service Transformation and Financial Recovery Unit provides dedicated project management support
- Specific posts within the finance and information functions are allocated to the programme and there is also be a dedicated Programme Management Office to ensure robust monitoring of progress
- The Medical Director roles (primary and secondary care) provides clinical leadership and advice at a cluster level and resource has been allocated to remunerate clinicians for participation in specific initiatives
- The expectation is that over and above this primary care engagement will be organised through the emerging GP Consortia
- For the most significant QIPP priorities the SRO roles are undertaken by either a cluster or borough director where appropriate. Dedicated senior project/programme management roles (8d) are included in the structure within the Service Transformation unit to lead these work streams. Individual project boards have been established to support delivery where required.
- PricewaterhouseCoopers were commissioned to review:-
 - Effectiveness of the Programme Management Office(PMO)
 - Governance structure
 - Robustness of project plans
 - Finance and activity assumptions supporting the plans
 - Reporting arrangements
 - Potential for further development of the plan

This has further improved the processes around QIPP strengthened the Programme Management Office and provided assurance around delivery of the plan

Implementation (cont.)

PROGRAMME OF WORK

There are 14 priority workstreams within the QIPP Plan. Each work stream has a number of individual initiatives sitting within it.

WORKSTREAMS	NO . OF INITIATIVES
1.0 Cancer	6
2.0 Mental health	8
3.0 Care closer to home	21
4.0 Procedures of Limited Clinical & Cost Effectiveness	2
5.0 Decommissioning	6
6.0 Medicines management	9
7.0 Unscheduled care	9
8.0 Primary care	4
9.0 Cardiovascular disease	6
10.0 Maternity	4
11.0 Local QIPPs	116
12.0 Specialist commissioning, acute productivity, running costs	24

QIPP Project Plan

Ref. Q005d
 QIPP work stream: Medicines Management
 Initiative title: Use of Biosimilar Drugs
 Senior Responsible Officer: Stephen Delich

Ref	Task	Start date	Due date	Accountable	Dependencies	Jan-11					Feb-11					Mar-11					Apr-11					May-11				
						3	10	17	24	31	7	14	21	28	7	14	21	28	4	11	18	25	2	9	16	23	30			
[Phase 1] Planning																														
1a	Identify current spends in the 4 target areas for the 5 Trusts	04/01/2011	16/01/2011	Project manager																										
1b	Establish projected (assumed) savings as a result of UCH pilot	17/01/2011	21/01/2011	Project manager																										
1d	Assess Trust willingness to engage in savings plan	31/01/2011	25/02/2011	Project manager																										
1e	Identify project lead within secondary care and ascertain engagement	28/02/2011	31/03/2011	Project manager																										
1f	Create PID	04/01/2011	14/01/2011	Project Manager																										
1g	PID reviewed and signed off		28/01/2011	SRO	1f																									
1h	Create QIPP Delivery Plan document and Gantt	14/02/2011	25/02/2011	Project Manager	1g																									
1i	Signoff QIPP Delivery Plan and Gantt		01/03/2011	NHS London Board	1h																									
1j	Create Communication plan	Not applicable																												
1k	Agree and obtain funding for project resources (pharmacist, data analyst)	10/01/2011	11/03/2011	SRO																										
1l	Project resources allocated to this project	14/03/2011	14/03/2011	SRO	1k																									
1m	Organise allocation of IT resource to create Medicine database	10/01/2011	11/03/2011	SRO																										
1n	IT resource in place	14/03/2011	14/03/2011	SRO	1m																									
[Phase 2] Design																														
2a	Present Project to SRO	01/01/2011	07/01/2011	Project Manager																										
2b	Perform baseline assessment	01/01/2011	07/01/2011	Project Manager																										
2d	Build Medicine database	14/03/2011	25/03/2011	IT resource	1n																									
2e	Medicine database in place	28/03/2011	28/03/2011	IT resource	2d																									
2h	Draft Monitoring mechanism	07/03/2011	25/03/2011	Project Manager																										
2i	Monitoring mechanism in place	28/03/2011	28/03/2011	SW??	2e, 2h																									
[Phase 3] Implementation																														
3a	UCH to implement all 4 target areas	03/01/2011	01/04/2011	UCH																										
1b	Establish current actual savings as a result of UCH pilot	04/04/2011	15/04/2011	Project manager																										
1c	Update QIPP plan if necessary based on realised savings from pilot	24/01/2011	27/01/2011	Project manager	1b																									
1d	Decision point: review savings with Medicine management Board	tba	tba	Business manager	1b, 1c																									
1c	Update QIPP plan if necessary depending on outcome of review with Board			Project manager	1d																									
[Phase 4] Project Close and Benefits Evaluation																														
4b	Draft evaluation report	tba	tba	Project manager																										
4c	Publicise evaluation report	tba	tba	Project Manager	4b																									
4d	Handover project documents to PMO	tba	tba	Project manager	4c																									

Examples of Project Plan

A Project Initiation Document (PID) is completed for each initiative, these are then developed further into detailed delivery plans, each with an associated project implementation plan showing clear milestones and dependencies (with the exception of Acute Productivity where delivery is via contract metrics) and the key milestones from these will be incorporated into an overall QIPP programme plan.

The overall Programme Plan includes plans for each of the enabling work streams and for overarching work streams such as communications and engagement and provider viability. The PMO works with the work stream teams to mobilise their plans, the PMO then monitors and reports the progress and realisation of benefits against plans.

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Communications and Engagement

OVERVIEW

Our communication and engagement plan aims to :

- Support the review and development of the NCL case for change
- Engage and involve target groups in the emerging initiatives under QIPP
- Recognise the long term challenges facing the health economies across NCL.

Our objectives are to:

- Promote awareness of the case for change and provide the opportunity to identify potential initiatives
- Add to/update the evidence base supporting the case for change where relevant
- Develop among GPs in particular an understanding, acceptance and ownership of this emerging case for change
- Generate ideas and approaches to tackle the issues set out in the case for change
- Build strong relationships to support effective future working.

Target Audience	Sub-groups of the Target Audience
GPs	<ul style="list-style-type: none"> ● Commissioning GPs (Individuals, PBC Groups, PECs) ● All GPs
NHS Organisations (Trusts & PCTs)	<ul style="list-style-type: none"> ● Boards and Executive Teams ● Consultants ● Other Clinical Staff ● Non-clinical Staff
Political Partners	<ul style="list-style-type: none"> ● MPs and GLA members ● Local Authority Executives ● Local Authority Scrutiny Committees (OSCs and JOSCS - joint)
General Public	<ul style="list-style-type: none"> ● Patients ● Patient Groups, including LINKs ● Voluntary and community groups ● Wider, non-service users
External	<ul style="list-style-type: none"> ● NHS London & Department of Health ● Independent assessment ● Local media

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Communications and Engagement

NHS North Central London (NCL) is implementing a comprehensive communications and engagement strategy and plan across Barnet, Camden, Enfield, Islington and Haringey to support our QIPP Plan and ensure that key stakeholders are involved in commissioning and organising health services.

Our overall aim for communications and engagement is to provide a solid infrastructure that enthuses and enables clinicians to own and lead the QIPP initiatives, and also ensure the right people and groups are involved in planning services that affect them.

Our communications and engagement functions are coordinated together, with activities and resources focussed on different QIPP workstreams at different times, depending on the priority and implementation timeframe of the project. Our approach is flexible enough to adapt to the changing NHS landscape.

ACHIEVING OUR VISION THROUGH QIPP

NHS NCL's strategic vision to improve the health outcomes in our communities over the next years is central to our communications messages and engagement activities. We know that achieving our vision is only possible through working in partnership with GPs (as commissioners and healthcare providers), local authorities and other key local partners such as NHS community and hospital services, UCL Partners, Local Involvement Networks (LINKs). We also know that working closely with our colleagues in the voluntary and community sector is the best way to reach seldom heard groups and work towards reducing the health inequalities that exist across our population.

TARGETED ACTIVITIES FOR QIPP DEVELOPMENT

We involved clinicians (primary and secondary), health scrutiny councillors and local authority leads, health and social care commissioners, and LINKs throughout the development of our current QIPP plan. Key activities included:

- publishing our commissioning intentions for 2011/12 in each borough and notifying providers
- publishing the NHS NCL case for change (known as 'Now and into the future') in November 2010 and inviting feedback
- holding clinical leadership forums in July and October 2010, and again in June 2011, where clinicians - especially GPs - agreed NCL's commissioning priorities, submitted ideas for further quality and efficiency improvements and volunteered their expertise in particular areas to support implementation of QIPP initiatives and integrated care pathway design
- hosting a stakeholder event in March 2011, where councillors, clinicians, commissioners, providers, and LINKs representatives learned more about our objectives for QIPP and provided input into the final version submitted to NHS London, and valuable feedback for implementing some of the key initiatives
- regular meetings with LINKs Chairs and Host Organisations across NCL to update them on the commissioning priorities, and QIPP development
- regular updates to Joint Health Overview & Scrutiny Committee on QIPP targets, and progress updates on individual workstreams and projects.

Communications and Engagement (cont.)

KEY PROJECTS TO DATE

Across the Cluster, three significant projects in the past year have included patient, public and clinical engagement. They are:

- **Camden and Islington NHS Foundation Trust's** public consultation from January to April 2011, sought feedback on the Trust's proposal to reduce the number of sites providing mental health services from four to two, and on whether Queens Mary's House or St. Pancras Hospital should be retained. The result was a decision to: [to insert]
- **Barnet, Enfield, Haringey Clinical Strategy** - The Secretary of State for Health has asked the Independent Reconfiguration Panel for advice regarding the assurance of the Board of NHS London that the four tests have been met and the report and recommendations by Enfield Council. This advice is due back to the Secretary of State by 8 July 2011. We await the outcome of this advice.
- There is a three-year **Mental Health Strategy for Barnet, Enfield and Haringey (BEH)** and BEH Mental Health Trust's "Changing for good" programme. Together, they involve the development of mental health services across the three boroughs, with the aim of improving services based on the recovery model. A public consultation on Children & Adolescent s Mental Health Services across BEH was undertaken from April to July 2011.

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Communications and engagement planning

PLANNING FOR THE IMMEDIATE FUTURE

We are now delivering the communications and engagement activities that support the 2011/12 QIPP initiatives. These include building on the feedback gathered through the previous clinical leadership and other stakeholder events, specific public consultations, and ongoing dialogue with LINKs and the Health Overview & Scrutiny Committees.

The NHS NCL QIPP SROs work closely with the communications and engagement team to ensure the right people and groups are involved in key stages in each project and project milestones are openly communicated, thereby reducing the risk of challenge to proposals being implemented.

INTO THE FUTURE

Our focus looking forward is to take what we have already heard and to support clinicians to lead the ongoing QIPP work.

Our GP Pathfinders will be the key drivers for delivering this next wave of engagement work, and will own the borough QIPP projects. NHS NCL will support these GP leaders and clinical experts to host engagement activities them own the engagement projects

Engagement activities throughout Summer and into Autumn 2011 will include targeted workshops for each of the priority QIPP workstreams.

The workshops will trigger a range of virtual stakeholder working groups, who will continue to gather feedback and share information via online surveys and blogs, clinical seminars, teleconferences and e-updates .

By October, all QIPP projects will have a range of stakeholder feedback to consolidate and validate with the original working group. The aim is to then share the proposals with a wider audience, and consult where appropriate.

Our statutory stakeholders – LINKs, health scrutiny and GP commissioners – will be involved at key decision-making points throughout the project, if they haven't been already involved through the targeted working groups.

A communications and engagement plan will be prepared for each QIPP area. An overview of the key stakeholders, and the communications and engagement activities to involve them, is provided in the following table.

It should be noted that due to the reduced capacity within the NHS NCL communications and engagement team, priority will be given to those initiatives requiring greatest support. Similarly, engagement activities will be focussed on stakeholders who have high interest in and high influence on a QIPP initiative or project.

Key stakeholder	Aims and activities
GP Commissioners and all other GPs	Regular (weekly) GP e-news to all GPs Generate new ideas, and generate consensus around these if they are to be developed Regular updates and 'sense-checking' of emerging proposals with GP Cabinet Engagement officer assigned to supporting Pathfinders to plan and deliver borough engagement plans
Other clinicians and service providers	Clinical leadership forum Agreeing clinical leadership networks and reference groups for specific QIPP initiatives, and facilitated via Medical Director and GP leaders
Local authority partners and health scrutiny, and MPs	Monthly briefings on change and development of the case for change Ongoing relationship and updating Joint Overview and Scrutiny Committee. Personal briefings to all MPs by Borough Directors and NCL Chair and Chief Executive Representatives of local authorities on NCL cluster board Continually update on QIPP work and invite feedback at key project milestones through NHS Alerts and NCL stakeholder newsletter Partnership working through emerging HWB boards
Local Involvement Networks (LINKs) and service users	Monthly meetings with all LINKs chairs and Hosts Representatives of LINKs on NCL cluster board and LINKs or patient rep on key sub committees On-request briefings for individual LINKs on specific, borough-based QIPP initiatives Test proposals from the perspective of the public and patients, pre-consultation and consultation
Provider organisations	Share the risk and responsibility for mitigation with partners within the system Recognise providers' contribution to meeting QIPP challenges Utilise clinical experts in QIPP working groups (note: volunteers from previous activities) Continually update on QIPP work and invite feedback at key project milestones through NHS Alerts and NCL stakeholder newsletter
Voluntary and community sector	Continually update on QIPP work and invite feedback at key project milestones through NHS Alerts and NCL stakeholder newsletter
General public	Updates on QIPP workstreams via NCL website Promote initiatives that represent successful improvement to patient care, service quality(QIPP and other) through media and online Consult on proposals for substantial service change.

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Risk Management

SUMMARY

Nine potential risks have been identified relating to the delivery of the QIPP Plan. These are Stakeholder Engagement, Strategic Development, Finance, Primary and Community Care Strategies, Resourcing, and Demand Management.

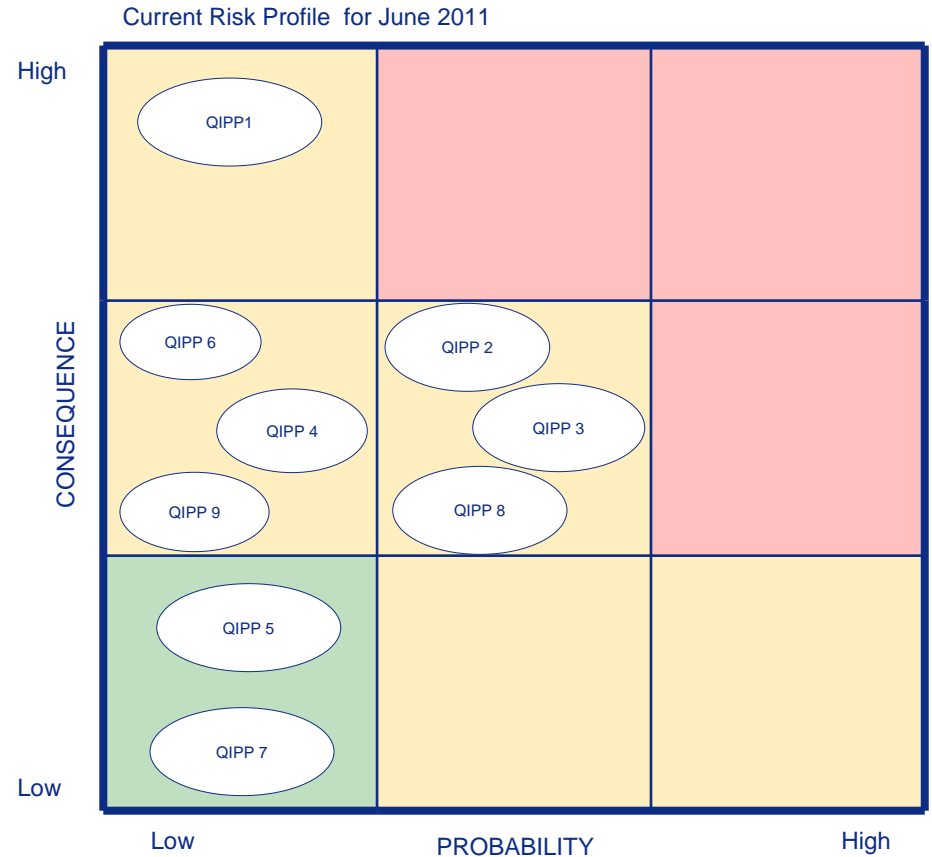
There are currently no risks that fall into the high consequence/high probability area and three key issues that fall into the medium consequence/medium probability area. (see Risk Profile on next page).

The four greatest risks to the successful delivery of the QIPP programme

- are:
- Engagement: The level of engagement in the development of the strategy from key local stakeholders e.g. GP commissioners
 - Engagement: The lack of engagement in the development of the strategy is such that the final result is not owned by clinical leaders, resulting in significant opposition and consequential delay or rear guard action
 - Strategic Development: The strategy is not sufficiently innovative, nor representative of the required "whole system approach" and reflects a compromise between provider organisational interests
 - Resources/Demand Management: Acute activity increases at a higher rate than planned for reducing the level of resources available for other investments.

RISK CHALLENGE PROFILE

The Risk Challenge profile provides a summary of all the risks currently identified.



Impact is a measure of the potential consequences on the delivery of outlined objectives of the QIPP Plan if the risk occurs. Probability describes the likelihood of the risk occurring.

Risk Management (cont.)

RISK MANAGEMENT GOVERNANCE OVERVIEW

- The QIPP Director is responsible for reporting to the Audit Committee, which is a sub-Committee of the NHS NCL Cluster Board with a remit to provide assurance to the Board that appropriate governance structures and risk management processes are in place.
- The risks are also reviewed by the NHS NCL Senior Leadership Team on a monthly basis.
- Each risk has an assigned Director 'owner' who is responsible for identifying and implementing mitigating actions to reduce the level of risk.
- As the QIPP Programme moves from the planning to delivery phase, the PMO is working with each work stream programme/project manager to develop a risk register for individual projects within their work stream.

Risk Management – Risk Reporting

Risk Name	Description of Risk	Mitigation Strategies	RAG Status	Risk Owner/s
QIPP 1	<p>Engagement</p> <ul style="list-style-type: none"> Level of engagement in the development of the strategy is such that the final result is not owned by GP commissioners 	<ul style="list-style-type: none"> A Communications and Engagement plan has been developed to underpin the planning process designed to include PCT and GP Commissioners in all stages of the process Increased involvement of GP Consortia leaders in development and delivery of plans through the GP Commissioning Forum and Consortia Boards (once established), involvement of 2 leaders in the QIPP Delivery Group and direct GP involvement of individuals in key work streams e.g.. QIPP in Primary Care Full Stakeholder event held on 3rd March where the need for increased stakeholder engagement was discussed. 	A	QIPP Director, and Director of Communications
QIPP 2	<p>Engagement</p> <ul style="list-style-type: none"> Level of engagement in the development of the strategy is such that the final result is not owned by clinical leaders, resulting in significant opposition and consequential delay or rear guard action 	<ul style="list-style-type: none"> Increasing the direct involvement of GPs in key work streams The QIPP Clinical Lead agreed with two GP Leads their involvement in the QIPP Delivery Group The QIPP Clinical Lead liaising with secondary care clinicians regarding the involvement in priority areas. Process to further develop the 2012/13 – 2014/15 years of the plan will aim to fully involve clinicians 		Cluster Medical Director

Risk Management – Risk Reporting

Risk Name	Description of Risk	Mitigation Strategies	RAG Status	Risk Owner/s
QIPP 3	<p>Strategic Development</p> <ul style="list-style-type: none"> – Strategy is not sufficiently innovative, nor representative of the required "whole system approach" and reflects a compromise between provider organisational interests, tying in NCL to more of the same and not significantly addressing the projected financial deficit, through QIPP initiatives only. – This would undermine the reputation of both the strategic development process and the Cluster 	<ul style="list-style-type: none"> • UCLP innovation projects have been assessed for possible additional inclusion • Benchmarking and review of sources of best practice, opportunities reflected in work streams where appropriate • Bilateral and collective discussions with trusts as part of plan development, agreeing approaches to implementation and alignment of trust and commissioner strategies as part of the FT application process • Case for Change and QIPP Plan presentation included in two contracting sessions for all Trusts. Included in individual Trust contract negotiation timetable. 	A	QIPP Director
QIPP 4	<p>Primary and Community Care Strategies</p> <ul style="list-style-type: none"> – The primary and community care strategies needed to deliver changes in secondary care are not sufficiently aligned nor robust and as a consequence, the acute strategy is isolated or becomes seen as aspirational 	<ul style="list-style-type: none"> • Delivery Board agreed on 17th Dec that responsibility for development of delivery plans for Unscheduled Care, Care Closer to Home and Mental Health initiatives would be devolved to PCT leads , to ensure alignment with local non-acute plans. • The process for further developing the plan will have an element that is borough based and there will be borough representation in cluster led activities to ensure alignment 	A	QIPP Director

Risk Management – Risk Reporting (cont.)

Risk Name	Description of Risk	Mitigation Strategies	RAG Status	Risk Owner/s
QIPP 5	<p>Strategic Development</p> <ul style="list-style-type: none"> – Strategy is too innovative and reflects inadequate timescales for implementation thus losing credibility with GPs and other key stakeholders 	<ul style="list-style-type: none"> ● Process for strategy development ensures robustness of resulting plans with full account taken of required enablers through a number of challenge and assurance sessions at key stages in the process. ● Planning process being designed to ensure delivery of future years planning and specific detail for 2012/13 in time for next year's contracting round 	G	QIPP Director
QIPP 6	<p>Finance</p> <ul style="list-style-type: none"> – Cluster QIPP programme for 2012/13 not developed in time to determine priorities for 2012/13 contracting round resulting in investment in services that may potentially be decommissioned, and not producing adequate savings in Year 2 	<ul style="list-style-type: none"> ● All 2012/13 QIPP schemes reflected in Cluster Commissioning Intentions ● All fully worked up schemes included in contract offers to Trusts ● QIPP Plan will reflect risk rating based on deliverability and accurate timescales for benefits realisation. 	A	QIPP Director
QIPP 7	<p>Resourcing</p>	<ul style="list-style-type: none"> ● Post April structures have been augmented to more fully reflect requirements to deliver the QIPP Plan. 	G	QIPP Director

Risk Management – Risk Reporting (cont.)

Risk Name	Description of Risk	Mitigation Strategies	RAG Status	Risk Owner/s
QIPP 8	<p>Resources/Demand Management</p> <ul style="list-style-type: none"> Acute activity increases at a higher rate than planned for reducing the level of resources available for other investments 	<ul style="list-style-type: none"> Contract arrangements for 2011/12 with a number of trusts mitigate the over performance risk, work will be undertaken with trusts in year aimed at mitigating risk for future years. QIPP in Primary Care work stream to develop initiatives designed to change GP referral behaviour and stem demand for acute services. 	A	Director of Contracts and QIPP Director
QIPP 9	<p>Demand Management</p> <ul style="list-style-type: none"> Limited change in public/patient behaviours continues to drive increase in acute activity and limited uptake for redesigned services 	<ul style="list-style-type: none"> Patient and public communications events via Joint LINKs Full stakeholder engagement event scheduled for 03/02/11 and further events over the summer Publicity and campaigns aimed at service users and patients and readily available patient information. 	A	Director of Communications and Engagement

Glossary of Terms

Acronym	Description	Acronym	Description
AAA	Abdominal Aortic Aneurysm	ENT	Ear Nose Throat
A&E	Accident and Emergency	ESD	Early Supported Discharge
BCF	Barnet and Chase Farm Hospitals NHS Trust	EWTD	European Working Time Directive
BEH	Barnet Enfield Haringey	FOT	Forecast Outturn
BME	Black and minority ethnic	FT	Foundation Trust
BNP	B-type natriuretic peptide	FUP	Follow up
CAMHS	Child and Adolescent Mental Health Services	GDS	General Dental Services Contract
Candl	Camden and Islington NHS Foundation Trust	GMS	General Medical Services Contract
CC	Critical Care	GOSH	Great Ormond Street Hospital NHS Trust
CHD	Coronary Heart Disease	GP	General Practitioner
CIP	Cost improvement plan	HCAI	Healthcare Associated Infection
CLCH	Central London Community Healthcare	HASU	Hyper Acute Stroke Unit
CMHT	Community Mental Health Team	HR	Human Resources
CNWL	Central and North West London NHS Foundation Trust	IAPT	Improving Access to Psychological Therapies
COPD	Chronic obstructive pulmonary disease	ICO	Integrated Care Organisation
CQC	Care Quality Commission	IOG	Improving Outcomes Guidance
CQUINS	Commissioning for Quality and Innovation (payment framework)	IPSOS MORI	Survey research organisation
CSL	Commissioning Support for London	IT	Information Technology
CSP	Commissioning Strategy Plan	JOSC	Joint Overview and Scrutiny Committee
CTB	Challenged Trust Board	JSNA	Joint Strategic Needs Assessment
CVD	Cardiovascular disease	KPI	Key Performance Indicator
CVS	Councils for Voluntary Services	LA	Local Authority
C2C	Consultant to Consultant	LAS	London Ambulance Service
DES	Directed Enhanced Service	LDC	Local Dental Committee
DH	Department of Health	LES	Locally Enhanced Service
DOF	Director of Finance	LINKs	Local Involvement Networks
EI/Non EI	Elective/Non Elective	LIS	Low Income Scheme

Glossary of Terms (cont.)

Acronym	Description	Acronym	Description
LMC	Local Medical Committee	PCC	Primary Care Commissioning
LOS	Length of Stay	PCT	Primary Care Trust
LPC	Local Pharmaceutical Committee	PoD	Point of delivery
LTC	Long Term Condition	PoICE	Procedures of Limited Clinical Effectiveness
LPT	Low Priority Treatment	PID	Project Initiation Documents
MEH	Moorfields Eye Hospital NHS Foundation Trust	PMO	Programme Management Office
MH	Mental Health	PMS	Primary Medical Services Contract
MDT	Multidisciplinary Team	QIPP	Quality Innovation Productivity Prevention
MFF	Market Forces Factor	QOF	Quality and Outcome Framework
MM	Medicines Management	RFH	Royal Free NHS Hospital Trust
MP	Member of Parliament	RNOH	Royal National Orthopaedic Hospital NHS Trust
MPET	Multi professional education and training	RRL	Recurring Resource Limit
MSK	Musculoskeletal	SLA	Service Level Agreement
NCL	North Central London	SLAM	Type of reporting system
NHS	National Health Service	SMI	Severe Mental Illness
NHSD	NHS Direct	SOR	Service and Organisation Review
NHSL	NHS London (Strategic Health Authority)	SPA	Single Point of Access
NICE	National Institute for Health and Clinical Excellence	SRO	Senior Responsible Officer
NMUH	North Middlesex University Hospital NHS Trust	UCC	Urgent Care Centre
NSTEACS	Non-ST elevation acute coronary syndromes	UCLH	University College London Hospitals NHS Foundation Trust
OAT	Out of Area Treatment	UCLP	University College London Partners
OOH	Out of hours	UDA	Units of Dental Activity
OP	Outpatient	VFM	Value for money
PACE	Post Acute Care Enablement	WIC	Walk In Centre
PARR	Patients At Risk of Re-hospitalisation	WHITT	The Whittington NHS Trust
PBC	Practiced Based Commissioning	WTE	Whole Time Equivalent
PbR	Payment by Results		