North Central London NHS
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| THE NHS IN NORTH CENTRAL LONDON | **BOROUGHS:** All<br>**WARDS:** ALL |
|---|---|

**REPORT TITLE: Quality, Innovation, Productivity and Prevention – Commissioning Plans for 2011/12**

**REPORT OF:**
Nick Losseff, Consultant Neurologist and Clinical Director, NHS North central London
Senior Responsible Officer QIPP, NHS North Central London.

| **FOR SUBMISSION TO:**<br>North Central London Joint Health Overview & Scrutiny Committee | **DATE: 21st January 2011** |
|---|---|

**SUMMARY OF REPORT:**

This report provides an update to Members regarding the NHS North Central London Quality, Innovation, Productivity and Prevention (QIPP) programme. It is an update to the QIPP Report dated 14 January.

When we submitted our papers to the Joint Health Overview & Scrutiny Committee, we had intended to then provide a copy of the draft QIPP plan to Committee Members when it was available in the week commencing 17 January.

Since that time, a new deadline for the QIPP plan has been agreed with NHS London, and so the North Central London QIPP Plan is not yet available to share with Members.

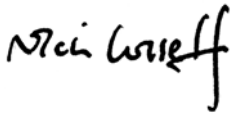
We would still like to update Members on our QIPP programme and therefore provide the QIPP Update Summary Report that will be presented to the NHS North Central London Board on Thursday, 20 January.

Dr Nick Losseff will discuss this Update Report with Members on 21 January.

CONTACT OFFICER:
Sylvia Kennedy
Director of Clinical Strategy, NHS North Central London
Telephone 0203 317 2794 Email sylvia.kennedy@islingtonpct.nhs.uk

**RECOMMENDATIONS:**
Members are asked to note the attached QIPP Update presented to the NHS NCL Board.

**SIGNED:**



Dr Nick Losseff
Clinical Director, NHS North Central London
DATE: 18 January 2011

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**AGENDA ITEM: 8.1**
**ATTACHMENT: H**

# North Central London Board
# 20 January 2011
# NCL Quality, Innovation, Productivity and Prevention Plan 2011/12 – 2014/15 Update

**Sylvia Kennedy**
**Director of Clinical Strategy**
**sylvia.kennedy@islingtonpct.nhs.uk**

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## 1. SUMMARY

Good progress has been made on the NHS North Central London Quality, Innovation, Productivity and Prevention (QIPP) plan 2011/12 – 2014/15. There has been close liaison with NHS London to ensure that the plan is fit for purpose and meets requirements. Work is in hand to finalise details and move to implementation planning. There will be an update at the NCL Board meeting on 20 January. Further information and analysis can be supplied if required.

## 2. ACTIONS REQUESTED

The NCL Board is asked to **RECEIVE** and **NOTE** this summary report.

# Vision, Values and Principles

In developing the strategy for North Central London, 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 Vision**

To improve the health of our population over the next five years compared with Londoners as a whole. In particular, we will improve health outcomes by addressing health inequalities within our population, focusing on our most deprived communities.

As healthcare commissioners our population will have access to more services closer to home and the highest quality hospital services.
.

North Central London uses three overarching principles to underpin our models of care. These are:

**OUR PRINCIPLES**

1. Centralising the most specialist service means better clinical outcomes and safer services for patients.
2. Localising routine medical services means better access closer to home and improved patient experience.
3. Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care.

The sector has developed values, which are embedded in each of our organisations as fundamental ways of working.

**Our Values**

QUALITY
Improving quality through the implementation of care pathways.

DIVERSITY AND INCLUSIVENESS
Ensuring our interventions are effective by targeting those in greatest need.

PARTNERSHIP WORKING
Working with all 16 NHS organisations. Strong local partnership with local authorities.

DELIVERING VALUE FOR MONEY
Driving up productivity through contract management and service change.

SUSTAINABILITY
Ensuring all our organisations are robust and sustainable for the long term.

Our vision, values and principles support us to meet our challenges in the Case for Change.

# Case for Change – Population Health Needs

## POPULATION HEALTH NEEDS

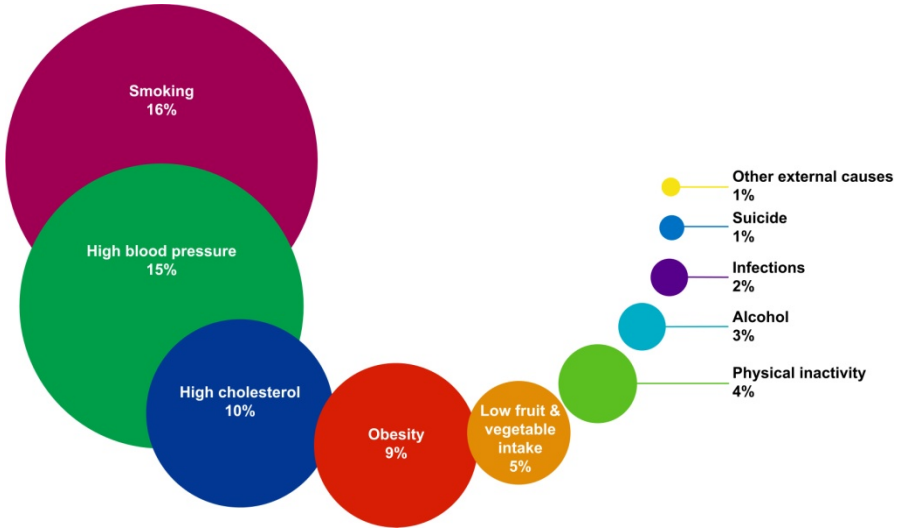
- North Central London's population is expected to rise by 3.2% by 2014, with the highest growth (6%) in those aged between 45 and 74. This age group is more likely to manifest long term conditions that can be influenced by behaviour change and early diagnosis.
- Within NCL there are a disproportionately 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 modifiable behaviour. These are highlighted in the accompanying figure.

### 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.




Key modifiable behavioural factors contributing to death in NCL

## SERVING OUR POPULATION

The five PCTs have identified seven 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:

- Long term conditions
- Maternity
- Paediatric
- Cancer
- Cardiovascular
- Unscheduled care
- Mental Health

The case for change for each of these clinical areas is described in detail in the following section.

# Case for Change – Clinical Priorities

## CLINICAL PRIORITIES

In addition to the generic raising of standards the clinician led work on the seven priority areas includes specific quality improvements for all areas. Some of the quality areas to be addressed under these areas are described in the table below.

It is recognised that in many cases delivery of high quality care away from an acute setting is dependent on the quality of the estate. This is not uniformly of the required standard and is being addressed as a priority.

| PRIORITY AREAS | SUMMARY ISSUE | PERFORMANCE CHALLENGES |
|---|---|---|
| Long Term Conditions | There is fragmented provision and lack of early detection, resulting in variable admission rates. | There is an increasing number of people with Long Term Conditions (LTCs) such as Heart Failure, Asthma, Diabetes and COPD within NCL who use more NHS resource than any other group of patients.<br>Most care can take place in the community; however, the majority of LTC care takes place in hospital settings. Patients and clinical staff tell us that this is usually inconvenient and often the wrong place altogether.<br>There is still insufficient focus on methods designed to prevent unnecessary hospital admissions, such as Staying Health programmes, or on care management plans to avoid readmission to hospital.<br>Primary care provision is, in places, unfit for future purpose and is driving quality and access issues. |
| Maternity | Raising standards to comply with 'Maternity Matters', ensuing patient choice and the correct level of antenatal appointments. | The Sector is not yet meeting women's expectations and needs in terms of offering choice of care provider, antenatal care setting and birthing options.<br>Provision of safe and sustainable services in the future depends on the resolution of medical and midwifery workforce issues, the most significant of which relate to the recruitment, retention and age of our midwives, the ability to provide the required level of consultant presence on labour wards and ensuring adequate junior staff cover without over-reliance on locum staff.<br>Approximately 30% of women in NCL are still not assessed by a midwife before their 12th week of pregnancy which can restrict their screening options and can compromise their antenatal care leading to a poorer outcome for them and their baby.<br>Birth rate predictions vary making future capacity planning difficult, particularly as NCL's resident women can elect to have their babies outside of NCL and vice versa.<br>Earlier assessment, greater clarity around risks and pathways that reflect women's needs, together with more choice of care setting for antenatal care would all help deliver a more patient-centric service that avoids unnecessary appointments, medical intervention and to support more efficient use of resources and capacity. |

# Case for Change – Clinical Priorities

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CLINICAL PRIORITIES (cont.)

| PRIORITY AREAS | SUMMARY ISSUE | CURRENT PERFORMANCE CHALLENGES |
|---|---|---|
| Paediatrics | The need to achieve a critical mass for surgery and that appropriate urgent services are available. | 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. This would be convenient for them and less costly to the local health economy, allowing emergency services to focus on those patients who need the expertise most.<br>Children attending A&E in NCL are often assessed by junior staff who are not paediatric specialists. This results in higher levels of admissions which should be avoided.<br>Some healthcare providers in NCL only undertake very small numbers of inpatient paediatric surgery and are therefore not meeting the standards expected for best practice.<br>Child Health in North Central London is typically worse than the rest of the England. |
| Cancer | Growing numbers of cases. Poor screening uptake. The need to improve survival rates for Breast and Colo-rectal cancer. | There is a dramatic increase in number of patients diagnosed with cancer. In North Central London an additional 275 diagnosed patients each year. We need to do more on prevention and early detection.<br>We want to drive up the quality and reduce variability of the patient experience and health outcomes.<br>There are inequalities in cancer care, both in terms of prevention measures and access to treatment. Inequalities relate to socio-economic deprivation particularly with regard to risk factors for cancer, especially smoking, but also in terms of gender, ethnicity, religion, disability and age.<br>North Central London, compared to England, has achieved a consistently lower uptake and coverage of screening for breast, lung and colorectal cancer. There are wide variations between Primary Care trusts and services in terms of uptake.<br>Four of the five PCTs in NCL have a higher level of cancers being diagnosed at a later stage when compared to London as a whole. Addressing system delays and improving system efficiency and configuration will also enable cancer to be diagnosed at an earlier stage. In particular survival rates for Breast and Colo-rectal cancer are low and need to be improved.<br>The CSL recommendation that specialist services should serve optimal populations not just the minimum defined, if accepted this would lead to the reconfiguration of a number of specialist cancer services within the sector. |

# Case for Change – Clinical Priorities

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CLINICAL PRIORITIES

| PRIORITY AREAS | SUMMARY ISSUE | CURRENT PERFORMANCE CHALLENGES |
|---|---|---|
| Cardiovascular | Access to early diagnostics, making best use of innovation and ensuring necessary surgical volumes to maintain specialist skill set. | Health outcomes for people undergoing certain complex hospital procedures could all be improved if performed in hospitals that undertake sufficient numbers of these specialist procedures and by consultants with the greatest specialist skill. This is currently not the case.<br>Waits for transfers between hospitals are too long for unplanned cardiac surgery patients.<br>Not all patients that experience severe, sudden chest pain currently get early access to angiography (diagnostic test) and angioplasty (a widening of the blood vessels in the heart) and evidence suggests many patients would benefit from this.<br>We believe the early adoption of innovative, new techniques, together with a better planned approach to implementation, would improve patient outcomes, patient experience and length of stay for certain procedures.<br>The impact of the European Working Time Directive has reduced the availability of junior medical staff and new non-medical staff roles are needed to provide sufficient numbers of appropriately qualified staff. |
| Mental Health | Inpatient facilities are not all fit for purpose and spread across 9 sites. Applying best practice would shift more work into a community setting. | Across North Central London fewer people have access to specialised mental health care than elsewhere in London. 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.<br>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 when ever possible should continue with hospital and residential treatment being focused on those who benefit most from this approach.<br>As well as improving the quality and accessibility of mental health services, there needs to be a focus on improving the mental well-being of the population as a whole.<br>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. |

# Case for Change – Clinical Priorities

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CLINICAL PRIORITIES(cont.)

| PRIORITY AREAS | SUMMARY ISSUE | CURRENT PERFORMANCE CHALLENGES |
|---|---|---|
| Unscheduled Care | Many access points to services and in some cases limited access to diagnostics for decision making at point of need. | NCL patients favour use of A&E over other access points when they urgently need care or advice. This leads to a strain on resources, as highly trained staff are diverted from treating emergencies and can result in overspend on A&E services and can lead to patients waiting to be seen in A&E for longer than necessary.<br><br>Currently there is often limited access to diagnostics and availability of staff to make clinical decisions at the point of need. This slows the journey of diagnosis and treatment for the patient which in turn can lead to poorer outcomes or longer than average length of stay for emergency patients.<br><br>Discharges are currently often delayed due to poor discharge planning, lack of community or home support and delay in clinical decision making. |

# 2011/12 Baseline Run Rate

Work has been undertaken to establish the baseline run rate for each PCT. This adds back – in totality – the activity subsumed in the in-year deals agreed in 2010/11 even though some of this growth was mitigated by in-year action.

Barnet, Enfield and Haringey all enter 2011/12 with a deficit.

| | |
|---|---|
| **Barnet** | **20,927** |
| **Enfield** | **25,641** |
| **Haringey** | **29,441** |

The net position for NCL is 59,151.

## Key assumptions

The key assumptions before application of QIPP plans include that there is no Challenged Trust Board (CTB) top slice in 2011/12 and that Camden and Islington's 2010/11 surpluses are not returned and there is no pay back of debt by Barnet, Enfield and Haringey. 2% is withheld for the non-recurrent reserve, 0.5% of RRC contingency, and a 1% surplus. Acute growth is 6% for Barnet, Enfield and Haringey, 3% for Camden and Islington reflecting past trends. £5m has been set aside for provider incentives. £2.5m non-recurrently to boost input capacity in 2011/12 given the financial challenge in the sector. No provision has been made for Barnet, Enfield and Haringey transition work.

## QIPP Savings (as at 17 January 2011)

| Annual QIPP Savings Profile | 11/12 | 12/13 | 13/14 | 14/15 |
|---|---|---|---|---|
| Primary Care | 2982 | 2982 | 2982 | 2982 |
| Prescribing | 5638 | 12,138 | 18,638 | 23,638 |
| Acute | 74,418 | 87,263 | 95,175 | 101,963 |
| Mental Health/CC | 12,000 | 12,000 | 12,000 | 12,000 |
| Community/Other | 17,523 | 17,522 | 17,522 | 17,522 |
| Corporate | 10,100 | 15,100 | 23,100 | 23,100 |
| | 122,461 | 147,005 | 169,417 | 181,205 |

### Gap

Based on these plans, balance is not achieved during the plan period. This is not acceptable.

## Risks & Opportunities

The principal opportunities relate to

I. More work on QIPP Plans especially Care Closer to Home and Urgent Care

II. Demand Management

III. Additional ‘wins’ from acute contract negotiation

IV. Acute underlying growth less than then forecast

The principal risks relate to

I. Slippage on savings schemes

II. Larger contingency requirement

# Key Priorities

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| INITIATIVES | CLINICAL OUTCOMES | PATIENT EXPERIENCE | ACCESS | SAFETY |
|---|---|---|---|---|
| 1.0 Medicines Management | ● Improved Formulary compliance<br>● Right prescribing | ● Higher quality primary care | ● Right care right place | ● Right prescribing – reduced inappropriate prescribing |
| 2.0 QIPP in Primary Care | ● Reduced variation | ● High quality care closer to home | ● Right care right place | ● Effective first point of access |
| 3.0 Maternity | ● Reduction in C-sections<br>● Right care for high risk pregnancy<br>● Right intrapartum care | ● More choice of place for birth<br>● Antenatal and post natal care closed to home | ● Improved access through community based care<br>● Access to risk stratified care pathway | ● Doing the right things to address high risk pregnancy |
| 4.0 LPT, Decommissioning and Thresholds | ● Reduction in clinically ineffective procedures (right care) | ● Clarity of service provision available | | ● Reduction in risks to patients from ineffective procedures |
| 5.0 Cancer | ● Earlier Diagnosis, Prevention and screen<br>● Improved survival rates | ● Effective co-ordinated care pathways<br>● Reduced readmission rates | ● Increasing take up of access to screening | ● Treatment provided earlier |
| 6.0 Care Closer to Home | ● Increased use of local community medical centres and services | ● Able to more easily navigate the health system | ● Right care right place | ● Improved clarity of care point location<br>● Improved quality |
| 7.0 Unscheduled Care | ● Reduction in short stay admissions<br>● Reduce duplication of diagnostics | ● Reduced travel & shorter waits<br>● Reduced likely hood of admission<br>● Right treatment first time<br>● Care delivered in a more appropriate setting | ● Access care closer to home | ● Reduced number of access points in the system<br>● Skilled and competent workforce in right setting |
| 8.0 Mental Health | ● Earlier intervention in SMI | ● Reduced out of area treatments – minimising social exclusion<br>● Proactive identification of patients with dementia, drug and alcohol issues | ● Appropriate in-patient capacity | ● Improved liaison between acute and community based care to improve case management |

# Key Priorities

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| INITIATIVES | CLINICAL OUTCOMES | PATIENT EXPERIENCE | ACCESS | SAFETY |
|---|---|---|---|---|
| 9.0 Cardio-Vascular | ● Reduce variation within NCL sector | ● Improve support services and continuity of care throughout pathway | ● Right care right place | ● Right care right place |
| 10.0Tertiary Paediatrics | ● Scoping to understand and agree what can be achieved to reduce variation and improve quality | ● Scoping to understand and agree what can be achieved to improve patient experience | ● Scoping to understand and agree what can be achieved to get access right | ● Scoping to understand and agree how safety of services can be increased |
| 11.0 Acute Productivity | ● Levelling up to the best practice in NHS | ● No Impact | | ● Performance management through effective metrics |
| | | | | |

# Delivery Impact – Key Enablers

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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 and IT programmes that will support either individual or groups of schemes.

## ESTATE RATIONALISATION

- Both Camden & Islington Mental HealthFoundation Trust and Barnet, Enfield& Haringey Mental Health Trust are undergoing a rationalisation of their estate as they change their clinical models to support additional services in the community and a reduced bed base.
- 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 providers 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.

## 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.

# Care closer to home in North Central London

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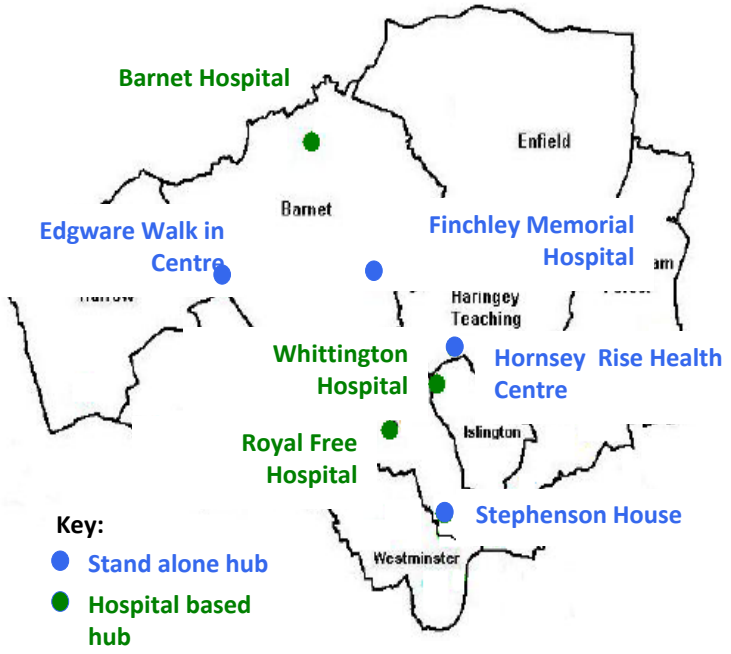
## CARE CLOSER TO HOME IN NCL

- It will be necessary to ensure a critical mass of activity in local services – long term viability is yet to be assessed.
- Our emerging plans are therefore based around seven fixed point centres in NCL, supplemented by plans to improve access to core primary care services in GP surgeries and investment in community and domiciliary care.
- Should further analysis indicate that these centres would not have sufficient capacity to absorb the proposed activity, additional hubs will be explored based on existing capacity.

- The following slides show early thinking about how NCL's QIPP initiatives could decrease reliance on acute hospitals and shift activity into more appropriate and cost effective settings.



# Implementation

## COMMISSIONING INITIATIVES

There are some examples of the Commissioning  Initiatives we have already developed that demonstrate our approach:

- 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 Workstream – which is aiming to identify approaches to incentives and risk and gain sharing that can be applied in a variety of different circumstances.

# Implementation

## PROGRAMME STRUCTURE AND RESOURCES

- The last quarter of 2010/11 represents a period of change for NCL Sector as we prepare for the implementation of a new transitional commissioning structure from April 2011. 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.

- The intention is to maintain a programme management approach to implement governance arrangements. These will be reviewed to align with the sector committee structure from April 2011.

- The existing approach whereby each priority area within the plan has an SRO and a management lead / support resource will be maintained. A dedicated Service Transformation and Financial Recovery will exist to provide dedicated project management support. Specific posts within the finance and information functions have been allocated to the programme and there will also be a dedicated Programme Management Office to ensure robust monitoring of progress. The Medical Director roles (primary and secondary care) will provider clinical leadership and advice at a sector level and a small 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 will be undertaken by either a sector or borough director where appropriate. Individual project boards will be established to support delivery. An Unscheduled Care Board has just been established and a Care Closer to Home Board is in the process of being launched.

- February and March 2011 represents a key mobilisation period for the QIPP Plan. It is recognised that implementing structural change during that period represents a significant risk. A full risk assessment and mitigation planning exercise will be undertaking to ensure that everything possible is done to manage this risk effectively.

# Implementation

## PROGRAMME OF WORK

- There are 12 priority workstreams within the QIPP Plan and 4 enabling workstreams. Each workstream has a number of individual initiatives sitting within it.

| WORKSTEAMS | NO . OF INITIATIVES |
|---|---|
| 1.0 Medicines Management | 9 |
| 2.0 QIPP in Maternity Care | 5 |
| 3.0 Maternity | 5 |
| 4.0 Decommissioning and Thresholds | 9 |
| 5.0 Cancer | 10 |
| 6.0 Care Closer to Home | 17 |
| 7.0 Unscheduled Care | 5 |
| 8.0 Mental Health | 6 |
| 9.0 Cardiovascular | |
| 10.0 Acute Productivity | 19 |
| 11.0 Tertiary Paediatrics | |
| 12.0 Staying Healthy | |

A Project Initiation Document was completed for each initiative by the end of November 2010 and since than these have been developed further into delivery plans, each with an associated project implementation plan. Examples of Programme Plans are shown below.

For some individual initiatives further work is required to improve the robustness of the project plans. By the end of February every initiative will have a fully worked up project implementation plan (with the exception of Acute Productivity where delivery is via contract metrics) and the key milestones from these will have been incorporated into an overall QIPP programme plan. The overall Programme Plan will also include plans for each of the enabling workstreams and for overarching workstreams such as communications and engagement and provider viability.

# Risk Management

## SUMMARY

The QIPP PMO has identified twelve potential risks to the delivery of the QIPP Plan. They consist of five key issues that fall into the high consequence/high probability area and seven key issues that fall into the medium consequence/medium probability area.

**The five greatest risks to the successful delivery of the QIPP programme**

**are:**

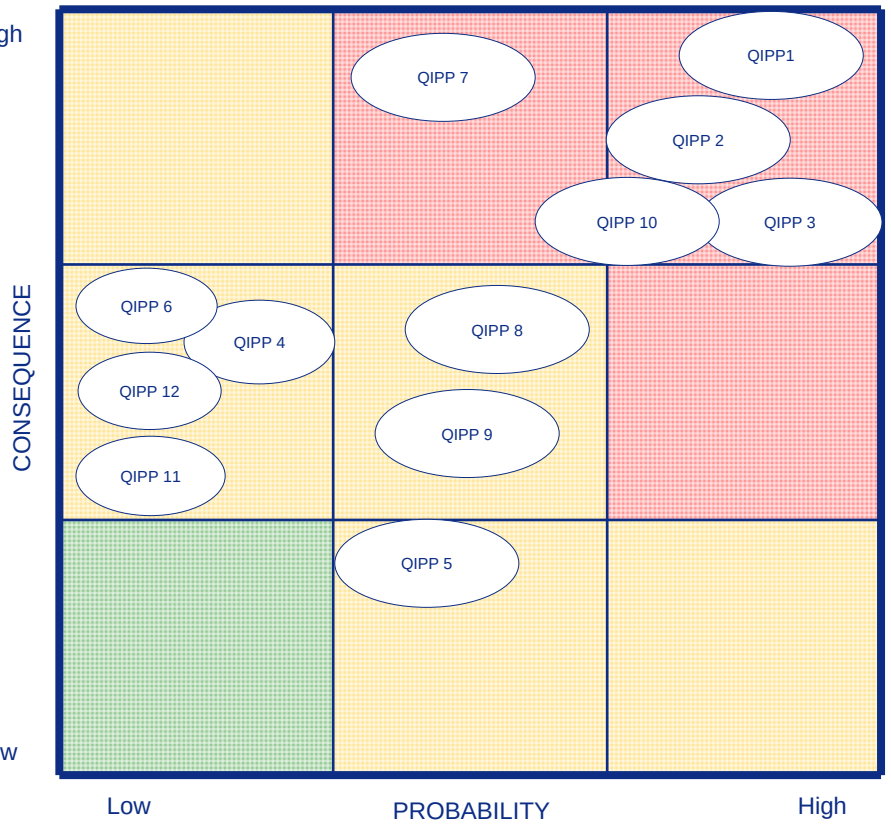
- The level of engagement in the development of the strategy from key local stakeholders e.g. GP commissioners
- The lack of engagement in the development of the strategy is such that the final result is not owned by clinical leaders, resulting in significant opposition and consequential delay or rear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

**These risks have been considered by the Risk and Assurance Committee as recently as January 2011 and are being address through specific groups and workstreams.**

## RISK CHALLENGE PROFILE

The Risk Challenge profile provides a summary of the risks currently identified as Stakeholder Engagement, Strategic Development, Finance, Primary and Community Care Strategies, Resourcing, Transition, Changes to the 2011/12 Tariff, Demand Management and forming Key Relationships.

Current Risk Profile for January 2011




Impact is a measure of the overall opportunity to create a negative impact on the delivery of outlined objectives of the QIPP Plan.
Likelihood describes the chance with which we expect the risk to occur.

Our prioritised focus lies with the risks that are described as High Impact and High Likelihood.

# Risk Management – Risk Reporting

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| Risk Name | Description of Risk | Mitigation Strategies | RAG Status | Risk Owner/s |
|---|---|---|---|---|
| **Issue QIPP 1** | **Engagement**<br>– Level of engagement in the development of the strategy is such that the final result is not owned by key local stakeholders (e.g. GP commissioners) and/or fails to comply with DH guidance | • The QIPP Clinical Lead to continue to chase follow up with GPs via the GP Commissioners Forum in January.<br>• Full Stakeholder event taking place on 3rd February where the need for increased stakeholder engagement is required.<br>• A Communications & Engagement plan has been developed to underpin the planning process designed to include PCT and GP Commissioners in all stages of the process. | R | Director of Clinical Strategy, and Director of Communications |
| QIPP 2 | **Engagement**<br>– 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 | • The QIPP Clinical Lead to continue to chase follow up with GPs via the GP Commissioners Forum in January.<br>• The QIPP Clinical Lead to continue to chase GP Leads for involvement in the QIPP Delivery Group. | R | Director of Clinical Strategy |
| QIPP 3 | **Strategic Development**<br>– 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 Sector | • UCLP innovation projects to be assessed for possible additional inclusion.<br>• All initiatives in the QIPP will be road tested with providers during development, with full account taken of required enablers, starting with bilateral meetings with providers in early November, to ensure need for "whole systems" approach recognised.<br>• Bilateral meetings with providers have taken place with follow up meetings taking place in early January | R | Director of Clinical Strategy |

RAG (Red, Amber, Green) – Red (High Impact & High Likelihood); Green (Low Impact & Low Likelihood)

# Risk Management – Risk Reporting (cont.)

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| Risk Name | Description of Risk | Mitigation Strategies | RAG Status | Risk Owner/s |
|---|---|---|---|---|
| QIPP 4 | **Primary and Community Care Strategies**<br>– 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 | • 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 , with expectation of alignment with local non-acute plans due 6th January. | A | Director of Clinical Strategy |
| QIPP 5 | **Strategic Development**<br>– Strategy is too innovative and reflects inadequate timescales for implementation thus losing credibility with GPs and other key stakeholders | • Process developed for strategy development ensures robustness of resulting plans with full account taken of required enablers;<br>• Follow up bilaterals with Trusts in early January.<br>• QIPP Clinical Lead pursuing GP Commissioning Forum and GP Lead for clinical engagement.<br>• Full Stakeholder event taking place on 3rd February | A | Director of Clinical Strategy |
| QIPP 6 | **Finance**<br>Sector QIPP not being developed in time to determine priorities for 2011-2012 contracting round resulting in investment in services that may potentially be decommissioned, and not producing adequate savings in Year 1 | • Feed QIPP activity impact assumptions to finance team for input into contract baselines and metrics by 10th January.<br>• Make maximum use of ability to vary contracts in year - ongoing. The Director of Contracting is involved in the QIPP review process and changes will be clearly reflected in the final Commissioning Intentions. | A | Director of Clinical Strategy |

# Risk Management – Risk Reporting (cont.)

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|---|---|---|---|---|
| QIPP 7 | **Resourcing**<br>– Staff capacity and capability required to deliver the strategic initiatives is not in place. Specifically, no SRO or identified project management resource to lead two major work streams (unscheduled care and care closer to home) to replace non-permanent staff who left in December. | • Via Delivery Board in December the QIPP Delivery Group asked PCTs to contribute to resource requirements. In particular Unscheduled Care, Care Closer to Home, Mental Health and QIPP in Primary Care in terms of leadership and project/content management. PCTs have responded to the NCLs request and a summary of what is available has been developed. The programme director along with the programme manager have established how best to utilise resources and put in place arrangements to facilitate the smooth transition of staff as required. | R | Director of Clinical Strategy |
| QIPP 8 | **Transition Planning**<br>– Transition planning and execution together with short term financial issues distracts attention and resource from delivery of QIPP initiatives | • Camden PCT are supporting the transition to PMO arrangements to mobilise project teams. A detailed understanding of what transition will involve, risk assessment and mitigation plan have been developed. | A | TBC |
| QIPP 9 | **Changes in 2011/12 Tariff**<br>– National tariff increases at a rate higher than planned for leading to lower level of technical efficiency savings, reducing the level of resources available for other investments | • QIPP finance and activity model developed assuming 1% tariff deflator for 11/12<br>• C&P team to report to Delivery Board and Business Group on likely effects of tariff pronouncement when known (date TBC)<br>• Negotiate local pricing into acute contracts to reduce reliance on tariff pricing - contracts to be signed by 28th Feb | A | Director of Contracts & Performance |

# Risk Management – Risk Reporting (cont.)

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| Risk Name | Description of Risk | Mitigation Strategies | RAG Status | Risk Owner/s |
|---|---|---|---|---|
| QIPP 10 | **Resources/Demand Management**<br>– Acute activity increases at a higher rate than planned for reducing the level of resources available for other investments | • (Supply side) Account teams to negotiate metrics into acute contracts for 11/12 designed to control/cap activity in over-performing areas - contracts to be signed by 28th Feb<br>• (Demand side) QIPP in Primary Care work stream to develop initiatives designed to change GP referral behaviour and stem demand for acute services - delivery plans due 4th Jan | R | Director of Contracts & Performance |
| QIPP 11 | **Demand Management**<br>– Limited change in public patient behaviours continues to drive increase in acute activity and limited uptake for redesigned services | • Patient and public communications events via Joint LINks (date TBC)<br>• Further GP engagement event scheduled for 20/01/11<br>• Full stakeholder engagement event scheduled for 03/02/11.<br>• Publicity and campaigns aimed at service users and patients and readily available patient information. | A | Director of Communications & Engagement |
| QIPP 12 | **Relationships**<br>– Poor relationships/culture/behaviour within healthcare system and with other partners and/or limited response from the market days development and implementation of new models of care | • Establishment of Aligning Incentives work stream to explore opportunities to use contract levers and different procurement methods across acute and non-acute sectors to motivate collaborative behaviours - initial meeting with providers held 15th Nov<br>• RT wrote to provider Chief Executives on 21st Dec inviting their contributions on incentive alignment | A | Director of Clinical Strategy |