Deloitte.

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NHS Briefing
Joined up QIPP

Introduction

Our work with NHS Trusts, Clinical Commissioning Groups (CCGs) and across whole health and care systems consistently identifies financial sustainability as a key priority. The NHS to date has failed to achieve the scale of savings required to delivery sustainability.

The recent wealth of policy initiatives regarding long term strategic planning and the establishment of the Better Care Fund provide a catalyst for health and social care organisations to work differently together to re-engage and realise Quality, Innovation, Production and Prevention (QIPP) Programmes. QIPP plans are typically based on initiatives reducing activity, shifting settings of care through alternative care pathways and managing demand within the health care system. For these initiatives to deliver they require all parties to pull in the same direction. Health and care organisations who are slow to collaborate to deliver QIPP are likely to experience unpredictable activity patterns which will lead to adverse financial and quality performance on critical national targets.

One year since their inception many CCGs continue to face significant financial challenges with one in eight CCGs expected to overspend their budgets in their first year. Most CCGs have encountered a challenging first year, establishing themselves as new and different clinically led organisations whilst managing an ever-tightening budget.

Over the next 10 years the substantial increase in demand relative to flat funding will increase the economic pressure on many local health economies. 'The NHS belongs to the people: a call to action' says the NHS could face a funding gap of £30 billion by 2020-21, driven by cost pressures namely:

- overall population growth and changes in age mix which suggest there will be approximately 9% more people by 2021/22, 19% of whom will be 65 years or older; and

- an increasing proportion of people with multiple long term conditions, including Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD) and diabetes, which is expected to rise from 3.7% to 5.1%.

These factors are contributing to many commissioners and providers forecasting current and future deficits, even after ambitious efficiency targets have been set.

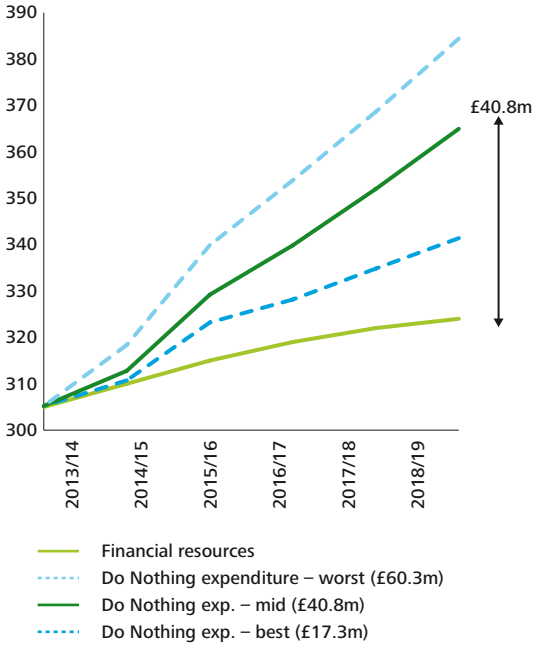
Our recent work with NHS England on the 'Any town' tool recognises the scale of the quality and financial challenge ahead for local health systems and provides a support toolkit for commissioners to map how a range of best practice and evidence based transformative interventions could improve local health services and contribute to closing the financial gap.

The 'Any town' tool uses detailed data including population size and disease prevalence to predict what a typical health systems quality and financial baseline may look like in 2018/19.

The toolkit includes modelling specifically to reflect typical urban, suburban and rural health systems. For example, for a typical urban health system the modelling performed identified that if no action was taken the system would face a potential financial gap of £40.8m in 2018/19. Deficits of this scale would impact both commissioners and providers.

Financial gap pre-interventions

Figures projected, in £m



The call to action

If the £30bn gap is be reduced health and care organisations need to act differently. A much more strategic and longer term approach across health and social care in hospital and in the community is needed with a focus on co-ordinating a fragmented system.

Monitor and NHS England have sought to support this shift, by moving the planning process to a longer term five year strategic plan, with greater focus on alignment between provider plans and those of local and national commissioners. This reflects the transformative changes that may be required in some local health economies. It identifies the 5 year plans as the platform to engage and base vital discussions between provider and commissioner on the nature of the changes that are needed to secure sustainability across health systems. Though the extent of change required varies between health economies, to deliver the changes and savings required, strong relationships between all partners in the system will be essential.

The stark financial outlook must be the catalyst for providers and commissioners to move away from incremental annual plans and instead develop longer term plans in partnership that respond to the key challenges faced by the NHS.

QIPP

Quality Innovation Productivity and Prevention programmes are still the main mechanism with which CCGs try to balance their books and manage the gap between flat income and increasing activity.

In our experience QIPP schemes tend to involve commissioner and GP-led initiatives focused on reducing activity and managing demand within the healthcare system. Examples of QIPP schemes include:

- **Referral management interventions** that address unwarranted variation in referral patterns and reduce hospital outpatient attendances. This includes referral management strategies of peer review and audit, incorporating consultant feedback and clear referral criteria as well as more structural referral management centres which increasingly incorporate triage and intermediate services to reduce the need for hospital referrals. Successful referral management interventions brings GPs and secondary care together to review care pathways to develop effective and appropriate referrals or support in primary and community services.

Examples of consultants working alongside GPs to design system changes, are, in our experience, currently rare.

- **Emergency admission reduction schemes** focusing on improving community healthcare and diverting patients away from A&E. Examples include:
  - The introduction of emergency ambulatory care pathways to reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions such as COPD, cardiac failure and diabetes to manage patients in an alternative to A&E such as an 'acute medical clinic' with full access to diagnostics, medical advice and care with the intention that they will be appropriately discharged into the community as soon as possible. Ambulatory Emergency Care is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed;
  - Divert and redirection systems including patient education, GP registration, booking of GP appointments, and redirection hubs including single point of access; and
  - The development of integrated teams to help patients manage their long term conditions at home to deliver reductions in unplanned admissions through better management of multi morbid long term conditions.
- **Redesigning care pathways** to deliver more efficient and effective care across a patient's journey through the entire health system. This may involve moving certain procedures into the community at a lower cost than in an acute setting, or delivering an integrated service across providers for specific conditions or services for example stroke or musculoskeletal (MSK) conditions. A number of CCGs nationally including Bedfordshire and Sussex are closely examining the benefits of an integrated MSK service incorporating Elective Orthopaedics, Rheumatology, Chronic Pain and Community MSK. Similarly Cambridgeshire and Peterborough CCG are commissioning a service to provide integrated older people's services.

What these examples show is that QIPP requires change across a health system that cannot be achieved by the CCG acting alone. We have seen examples where commissioners have imposed QIPP schemes without the providers involvement up front and it doesn't work.

The challenges of change are less when commissioners and providers co-design the solution up front. These schemes are of mutual benefit and it is in the interest of all parties to reduce the activity in the system through such QIPP-style initiatives. Successful schemes can benefit NHS Trusts which are struggling to meet their Referral to Treatment and 4 hour A&E waiting time targets with consequent knock on effects for patient flow throughout the hospital and quality of care.

However QIPP has had mixed success since it was launched in 2010. Whilst there are good examples of QIPP delivery, particularly around cost cutting, there is less evidence that it has delivered the deeper change of shifting healthcare to the community that was originally intended.

In our experience, very few CCGs have to date implemented sustainable QIPP driven by fundamental service transformation. One of key reasons for QIPP failure is the fragmented delivery across organisations of projects which require CCGs and Trusts to cooperate to positively influence activity levels.

For example, the best referral management solutions involve secondary care consultants working alongside GPs to provide advice and guidance on which patients should be referred, increasing everybody's skill levels and learning and understanding, and ensuring that the right patients end up in hospital and others can be managed in different ways.

Such examples, however, are currently rare in our experience.

It is increasingly acknowledged that the only way to create sustainable local health economies in England is for commissioners and providers to work together to develop sustainable solutions to the financial challenges currently facing the NHS.

There is a wealth of policy moving in this direction:

- "Everyone Counts: Planning for Patients 2014/15 to 2018/19" sets out a bold framework within which commissioners will need to work with providers and partners in local government to develop strong, robust and ambitious **five year plans** to secure the continuity of sustainable high quality care for all.

What hasn't worked is individual plans from Trusts and CCGs making overly bold savings predictions without a joined up vision or strategy.

- The **Better Care Fund,** formerly known as the Integration Transformation Fund, was announced by NHS England in June 2013 with the aim of "transforming" integrated health and social care. A single, pooled budget of £3.8 billion was taken from clinical commissioning group (CCG) and local government funding to support health and social care services to work more closely together.

- The identification of **11 challenged health economies** and support package is an initiative jointly led by NHS England, Monitor and the NHS Trust Development Authority (TDA). The 11 economies have all been identified on the basis of the scale of clinical and financial sustainability challenge for both commissioners and providers within a defined locality.

Put together, these policy changes should provide the catalyst for the reconfiguration and integration of the health and social care system so that it can deliver high quality care within the resources available in future. The NHS is at a tipping point and these initiatives provide a refreshed impetus for all parties to work together to provide financial sustainability.

A good example of such plans is provided by the local Better Care Fund plans which have arisen from collaboration across the whole system of health, care and support, engaging fully with all NHS, local authority and third sector partners – especially with acute and community health partners. These plans focus on improving the relationships between acute and community care, for example, by implementing discharge to assess schemes where patients can be discharged more quickly from the acute sector to the community sector.

The role of Providers and Commissioners

CCGs are developing and implementing plans to reduce or avoid acute activity. At the same time, NHS Trusts need to continue to reduce the resource implications of activity in order to operate within deflating national tariffs.

Many existing plans exist on paper, but are not live initiatives with ownership across the organisations that need to be involved. In order for real integration, real QIPP and whole system redesign to go beyond theoretical plans, a constructive relationships needs to exist between providers and commissioners.

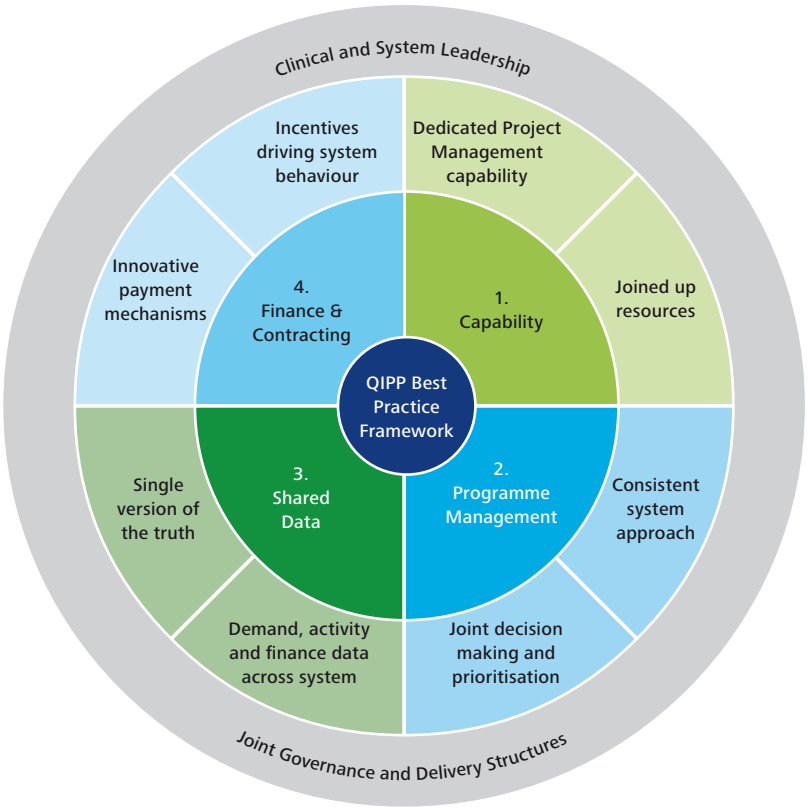
CCGs and NHS Trusts need to create a joined up strategy. What hasn't worked in the past, and won't work in the future, is a set of individual plans from Trusts and CCGs that make overly bold savings predictions and lack any vision or strategic thought as to what the future will look like. In too many places at present, commissioner and provider strategic plans are not aligned. In the most extreme cases providers may be looking to grow whereas commissioners are planning for activity within their own envelope to decrease.

CCGs have a key role to play as the system brokers building better trust, support and challenge based on the equal responsibility of all partners to deliver a joint vision. Whilst CCGs may be the right vehicle to bring about the shift of work from hospitals to the community, a lot of work is required to provide the credibility required to inspire and execute across the wider system.

Providers on the other hand need to be more proactive. A Foundation Trust Network survey (April 2014) identified that only 2 per cent of providers feel fully involved in their local plans. Concerns have been expressed by Trusts that many Better Care Fund plans are making heroic demand reduction assumptions that providers can't prudently accept or reflect in their own plans. Many Trusts still see the Better Care Fund as a problem and not an opportunity. This was mirrored by the recent Cabinet Office review which has expressed some concerns regarding the lack of detail contained within Better Care Fund plans on how savings would be delivered.

We have developed this briefing to assist and encourage NHS Trusts to work collaboratively with their local commissioners. Organisations need to collaboratively develop joined up QIPP schemes that will drive the sustainability of the whole health and care system.

Best Practice Framework



Key success factors to the successful delivery of joined up QIPP include:

1. Clinical and System Leadership

Strong system leadership will be essential to deliver the complex change programmes that underpin QIPP. Leadership from both commissioners and providers is required to build collaboration across organisations to deliver value and achieve outcomes built on shared risks and benefits. System leadership should establish a compelling vision of financial sustainability which is shared by all partners in the system.

System leaders need to drive the principles of partnership and mutual trust. Transparency will be key to building this trust, understanding and confidence.

Clinical leaders have an important role in promoting leadership and decision making that is distributed throughout all levels of the systems. Ultimately, clinical networks need to link primary, secondary and tertiary care with social services and other care providers.

2. Dedicated Capability

QIPP success requires dedicated capacity and capability. All partners need to ensure that sufficient resources are available to deliver the agreed work programmes and to deliver the actions required in a timely manner.

Joint project management of plans is currently rare, but is increasingly required as savings move from tactical initiatives to strategic, transformational change. In particular it requires an approach which is business case and benefits led drawing on business analysis skillsets. This requires analysis and problem solving expertise which supports the effective identification of business problems, assessment of proposed solutions and understanding of the needs of stakeholders. In our experience, most organisations have limited in-house capacity in this area and need to consider how to together support key strategic projects.

3. Shared data to drive a shared vision

Data and information, particularly activity and financial data, needs to be shared safely and securely across the health and care system to ensure a common understanding of the challenges being addressed.

Commissioners and providers need to develop a clear understanding of demand, activity and capacity across the system – the development and validation of a "single version of the truth" for the whole system. The measurement of baselines, setting and measuring the delivery of clear targets and assessing the intended and unintended consequences of interventions is essential.

4. A contracting mechanism that promotes provider collaboration

It is important that a contracting and payment mechanism is in place that creates shared incentives for effective management of demand and moves the conversation away from who should be paying the bill to how organisations work together to change the system. Nationally across health economies a range of alternative payment and incentive methods are being considered including outcome based, block, activity based, capitated budgets, the development of longer term agreements and benefit sharing arrangements.

Contracting, if used effectively, is an important tool to support the delivery of system priorities and can encourage providers and commissioners to work together to find a lower cost way of working and to reduce transaction costs.

In order to agree mutually beneficial contracts that focus on the best outcomes for the local population, clear contracting processes must be in place between commissioners and providers. These should be open and transparent involving all parties early in the process and should include clear and jointly produced activity plans.

5. Governance

There is a need to develop joint governance and operational models to support the delivery of the shared QIPP objectives of the partner organisations. This should include:

- Joint Implementation plans;
- Joint Programme Boards and/or Joint Integration and Change Boards; and
- Joint delivery groups e.g. care pathway and design groups which GPs, commissioners, consultants, social care and allied health care professionals as well as nurses and managers to review and improve care delivery from 'end to end' ensuring that it is both high quality and cost effective.

6. Consistent Programme Management

Rigorous programme management is essential to make sure that there are robust implementation plans, a delivery team is in place and that the change is effectively governed to enable decisions, risks and issues to be managed appropriately. In our experience individual organisations often have dedicated programme management resources is in place. However these rarely link up across a system.

A consistent and where possible joined up programme management approach across all partners supports the structured sharing of QIPP management resource and encourages joint decision making and shared learning. It plays a critical role in identifying the key shared priorities and managing their interdependencies. The PMO should be responsible for advising the Joint Programme Board on the composition of the portfolio and its progress against plans and any conflicting priorities, risks and issues.

Key Questions

All NHS Trusts will need to ask themselves whether their plans fully align with their local commissioners five year strategic plans and the Better Care Fund plans. The key questions that you should consider are:

1. Clinical and System Leadership

- Is there shared and collective responsibility to deliver QIPP?
- Does your local health economy have a shared vision to achieve financial sustainability?

2. Governance:

- Do you have a single governance body in place to track progress of system wide QIPP initiatives and assess risk and implement mitigation?
- Can this body hold its members to account for delivery of each organisation's contribution to the achievement of the agreed priorities?

3. Capability:

- Do you have dedicated resource to support the delivery of QIPP?
- Do you have the appropriate expertise to implement major system change?
- Do you have joint project management capacity?

4. Shared Data:

- Do you understand your local commissioners' QIPP assumptions? And do you understand how local commissioners' QIPP assumptions translate to your own Trust's obligations?
- Does your own Trust's five year strategic plan align financially with the five year plans of local commissioners?
- Are all system partners actively involved in the development of local Better Care Fund plans?
- Are the Better Care Fund Plans consistent across the system? For example do the demand management assumptions align with the plans of the systems own providers?

5. Finance and Contracting:

- Does your contracting process and form incentivise the right behaviour?
- Do you have a mechanism in place to share the financial benefits of the delivery of QIPP?
- Are risks appropriately shared across the health system and matched to rewards?

6. Programme Management:

- Are there potentially duplicative Programme Management Office arrangements in place across individual health and care organisations?
- Could these be effectively co-ordinated?

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