Delivery Group meeting
7 March 2011

Title:	February QIPP Report		
Agenda item:	7a		7a
Action requested:	For information.		
Timing	None.		
Executive Summary:	This paper provides a summary of the feedback on the January integrated plan submission and the key points of the submission sent to DH on 24 February. This includes progress to date of the QIPP programme including finance, KPIs and milestones.		
Summary of recommendations	The Delivery Group is asked to note the contents of this paper.		
Fit with NHSL strategy:			
Reference to related / other documents:			
Date paper completed:	24 February 2011		
Other forums that have considered this paper:	None.		

Author name and title:		**Performance Directorate**		**Director name and title and date they signed off this paper:**		**Sara Coles Director of Performance Performance Directorate 28 February 2011**	
Date paper seen by and by which PLG	**N/A**	**Equality Impact Assessment completed?**	**N**	**Risk assessment undertaken?**	**N**	**Legal advice received?**	**N**

NHS London February QIPP Submission

1 Introduction

1.1 Feedback on the January Integrated Plan submission was received from the Department of Health (DH) on 22nd February 2011. No specific feedback was received from the DH on the January QIPP dashboard and report card submission The February QIPP submission was given to the DH on 24th February 2011. This report provides an overview on the feedback received for the January Integrated Plan submission and a high level summary of the February submission, including a summary of overall programme progress, breakdowns on workstream finances and changes to the reporting process.

1.2 Due to the frequency of reporting and the date of the March Delivery Group there was no written report provided to the Delivery Group on the January QIPP submission.

2 Feedback on QIPP in the January Integrated Plan submission

2.1 Written feedback from DH was received on 22nd February, the focus of the QIPP feedback was again on the delivery of the SHA's four year plan and the continuing concerns around this.

2.2 The key messages from the feedback were:

- The DH recognises the significant work that is being carried out on the QIPP plans.
- The DH reiterated its significant concerns around the SHA's ability to produce a four year QIPP plan by the March deadline.
- Further work is required on the regional workstreams for future years as the pace of development has slowed in recent months.
- The DH continues to share the SH[illegible]e level of system engagement in QIPP and the impa[illegible]y of savings.

2.3 Further reference to this feedback is also covered in the paper on the progress of the delivery of the integrated plan.

3 February summary of progress

3.1 Workstreams

For headlines and risks – see appendix 1.

3.2 Financials

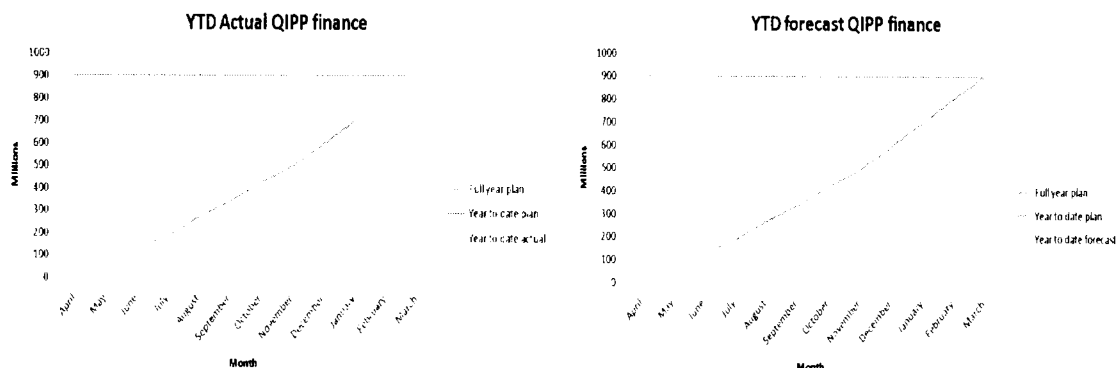
Overall the programme is reporting a negative variance of £78m against plan. The biggest variance continues to be attributed to Clinical Overheads (-£22m / -25.9%). The end of year financial forecast for the programme is currently -£113m (-12.6%); this is a 1.5% improvement on the January position, however the forecast does not take into account that several programmes e.g. Decommissioning, are weighted towards to the end of the financial year with sectors expecting to deliver significant savings by the financial year end. Most opportunities with the exception of Non-Clinical Overheads, Safe Care and Primary Care continue to report a negative variance in month.

Figure 1 – QIPP year to date and workstream totals

		Total					
	QIPP Opportunities £000	**Original savings as per May 2010**	**Forecast Outturn**	**Variance**	**Plan savings to date**	**Actual savings to date**	**Variance**
	Reducing Drug Spend and Prescription	23,943	27,267	3,325	22,420	20,407	(2,012)
	Workforce Productivity	109,943	122,527	12,585	98,196	93,827	(4,368)
	Clinical Overheads	101,704	76,475	(25,228)	85,044	63,024	(22,020)
	Non-Clinical Overheads	185,026	222,343	37,317	161,855	171,737	9,882
	Safe care	-	890	890	127	549	422
TOTAL	Decommissioning Ineffective Procedures	95,388	72,583	(22,805)	71,353	57,003	(14,350)
	Staying Healthy	4,745	3,510	(1,235)	3,917	2,498	(1,419)
	Primary care	231,381	189,216	(42,165)	143,904	150,546	6,642
	Schemes not yet identified or unclassified	148,164	72,055	(76,109)	109,544	58,349	(51,195)
	Total	**900,293**	**786,867**	**(113,425)**	**696,360**	**617,941**	**(78,418)**
	Management Cost Reduction	47,117	39,835	(7,282)	39,723	33,655	(6,068)

Below is the graphical representation of the financial variances submitted in the report to the DH – see appendix 2 for the individual workstreams.

Figure 2 – Year to Date Financials - Overall programme



3.3 Milestones

Eight of the eleven workstreams are rated green for achievement of milestones, the same number as last month, with two workstreams rated red, and one rated amber.

Workstream	Rating	Comment
Non-Clinical Overheads Decommissioning Ineffective Procedures	Amber	The non-delivery of DH milestones, this has been discussed with the DH
Implementing GP-led Networks of Care centred on Polyclinics	Red	Slippage on the opening of some polyclinics which now have dates in the next financial year

3.4 KPI development

Alignment of KPIs continues. Four workstreams are rated green for KPIs, four are rated amber and Clinical Overheads rated red, this is unchanged from last month. Two primary care workstreams are not reporting as these are in development and are expected to come on-line in the next financial year.

3.5 Overall RAG status

The RAG status of each workstream is aligned to National RAG rating criteria.

Figure 2 – overall RAG status for each workstream

Workstream – current position	Milestones	Finance	KPIs
Reducing drug spend and prescription variability	G	A	G
Workforce	G	G	A
Clinical Overheads	G	R	R
Non-clinical Overheads	R	G	G
Safe Care	G	G	G
Decommissioning Ineffective Procedures	R	R	A
Staying Healthy	G	R	A
Management Cost Reduction	G	A	G
Implementing GP-led networks of care centred on polyclinics	A	G	A
Outcomes Framework for General Practice	G		
Single Point of Access for Urgent Care	G		

4 Next steps

4.1 SHA reviews of sector QIPP / Operating one year plans and the QIPP four year plans is ongoing, these are being led by the strategy and commissioning directorate with support from the finance, performance and the Chief Nurse's directorate.

4.2 Bespoke timelines have been agreed for resubmission of one year plans. Plans will be reviewed again for QIPP content, the outcome of these reviews will be fed into the integrated plan to be submitted to the DH in March.

Sector	**Date for plan resubmission**	**Sector**	**Date for plan resubmission**
NWL	23rd February 2011	**ELCA**	1st March 2011
NCL	7th March 2011	**SWL**	1st March 2011
ONEL	25th February 2011	**SEL**	28th February 2011

4.3 The NHS London QIPP PMO is working with the NHS London communications directorate to develop a strategy to support delivery in 2011/12 including mitigation of risks identified in the SHA's corporate risk assessment framework (CRAF).

Appendix 1

QIPP workstreams – Headlines and Key Risks

Opportunity	Progress	Key Issues and delivery Risks
Reducing drug spend and prescription variability	• Medicines management dashboard and savings reporting system is being finalised with the view to start regularly recording savings from the next quarter • Analysis of KPIs identifies that the net ingredient cost per ASTRO-PU for London has risen for the latest month, following the trend of last year. London continues to perform well with a lower net ingredient cost than the national average, and the cost per item has decreased from last month. • An Oral Nutrition Supplement flyer has been drafted to support the dissemination of the work of the ONS project team. This is a two-page overview of the findings of the project which is intended for circulation to a senior commissioners audience to share best practice in identifying savings in management of malnutrition. • Total savings figure for Foundation Trusts,Q1/Q2 2010/11, as recorded via the London Procurement Programme is £3.5m.	▪ There is a risk that current restructurings due to the rapid changing landscape will challenge the implementation of this programme, as it may mean that there are changes in the borough level teams resulting in lost momentum on the savings programmes. ▪ Currently there is a lack of savings being recorded via trust FIMS reports which we are trying to resolve by making trusts aware of the actual savings as recorded by the London Procurement Programme. ▪ There is a risk that the savings delivered to FTs by LPP will not be added to the FIMs figures and as a result our workstream savings will not be correctly recorded.
Workforce productivity	▪ Discussions are ongoing with Performance Directorate regarding the London Healthcare Benchmarking Tool and how it can be developed to manage in year delivery of QIPP. ▪ The first draft of the Operating Plans was submitted to the DH on the 28th January. Workforce Planning and Information have supplied detailed feedback on the template. Final DH submissions to be made by the 28th March. ▪ A series of workforce reports has been developed and posted online at www.london.nhs.uk/workforcereports to assist trusts in managing and understanding workforce productivity.	▪ There is a risk that the sector workforce transformation plans will not be delivered to time as the plans are dependent on the sector service plans being developed. As a consequence, work to transform the workforce to meet future service needs will be delayed which will have the impact of delaying the implementation of service visions.

Opportunity	Progress	Key Issues and delivery Risks
Non clinical overheads	• Second workshop for pan-London procurement pilot has been held to support participants identify opportunities for improving efficiency and effectiveness for their organisations and London as a whole. • Planning has been completed for the first trust based back office workshop which is to be run by the national workstream. • Resources have yet to be identified to support training to enable capacity and capability of Service Line Reporting.	• There is a risk that providers fail to sustain overall productivity gains for this opportunity and that this impacts on achievement of FT trajectories and the overall productivity gains outlined in the affordability analysis. Collaborative design of pan-London Back Office programme roll-out will consider applications to HR and IT. • There is a risk that the OD issues associated with moving to shared services which are likely to yield the greatest productivity gains (e.g. outsourcing, off-shoring and Total Shared Agenda) will require large scale change which will delay or fail to maximise savings identification. The result is that affordability is compromised and as a consequence equality of access to and quality of patient care suffers.
Safety Express	• The third Safety Thermometer recording has been completed by the improvement teams. This is a tool designed to measure progress in implementing improvements • The first Learning Session for all improvement teams in the system (100 people) took place on 10th February, with a focus on reducing harm by improving clinical leadership and safety culture. • Funding from the national programme is being used to hold development sessions, for each of the 10 improvement teams – these will be in March. • A London Safety Express Campaign newsletter has been produced and circulated.	• The aims of this workstream are reductions in the four most prevalent avoidable harms. These reductions may not be achieved if NHS reconfigurations prove to be a distraction. Also, as the campaign is a two year programme (Nov 2010 to Nov 2012) the later phases of the campaign will need to be established in a new body. This could result in discontinuity, presenting a risk to the success of the campaign. If the aims are not met the consequence is patients continuing to experience avoidable harm, and failure to achieve planned savings due to reduced admissions and reduced length of stay

Opportunity	Progress	Key Issues and delivery Risks
Clinical overheads	• Economic and commercial modelling is now complete. • The final service review report including clinical expert panel recommendations is due for approval at Pathology Modernisation Board 24th March. • Clinical and other stakeholder meetings are progressing. • Savings identified are attributed to the entire clinical overhead work stream not only to the pathology subset of this workstream.	• The Modernisation Board needs to manage the conflict / interface between a market driven approach to pathology services at individual trust / PCT level and the opportunity for rationalising services across a wider area and so maximising the use of available capacity. • NHS London needs to consider, in consultation with trust Chief Executives, how to take the implementation of the service reconfiguration recommendations forward. • Engagement of non-pathology clinicians is an issue. More work is being done to engage this group of clinicians as part of the ongoing communication work within the SHA.
Decommissioning ineffective procedures	• The adverse financial variance is unchanged on month 9. • Progress on decommissioning is being discussed with sector CEOs at quarter 3 performance reviews being held in February. • The main focus is now on assuring sector decommissioning and demand management plans for 2011/12.	• No new risks have been identified for decommissioning this month, with sectors now concentrating efforts on 2011/12.

Opportunity	Progress	Key Issues and delivery Risks
Staying healthy	**Smoking** ▪ Last tobacco control conference held in month, the project is now being handed over to the sectors. ▪ Discussions being held over whether the stop smoking CQUIN is to be included on the London acute CQUIN pick list. **Breast Screening** ▪ London Screening Improvement Team is no longer at risk from LSCG consultation on management cost savings and restructuring. **Sexual Health** ▪ Draft good practice document developed and disseminated for PCT input. ▪ Initial discussions have started on the development of a London wide LARC train the trainers programme ▪ Abortion and Emergency Contraception Quick Guide developed ▪ Initial discussions to develop London wide PGD for pharmacy supply of emergency hormonal contraception.	**Smoking** ▪ With the disbanding of the London tobacco team there is a risk that proper handover arrangements are not fulfilled, and therefore priorities may be sidelined. **Breast Screening** ▪ No new risks identified. **Sexual Health** ▪ The risk is unchanged since last month – Potential disinvestment in London sexual health Programme and NHSL management cuts resulting in redundancy of Senior public Health Programme manager will impact on the support available to localities to improve sexual health.
Management cost reduction	▪ Work continues through out the system in relation to the Management cost Reduction programme. Consultations have been completed or are near completion, with at risk staff identified and appropriate support given. ▪ Sectors are maintaining that they will meet their management cost reduction savings by year end, although the financial forecast does not reflect this.	▪ The risk remains unchanged i.e. The risk associated with this workstream is dependent on the robustness of the consultation processes underway and the subsequent cost of redundancies made in March 2011.

Opportunity	Progress	Key Issues and delivery Risks
Implementing GP-led networks of care centred on polyclinics	▪ The delivery of polyclinics/polysystem hubs due to open in 2010/11 is on track with a few exceptions. Currently 30 polyclinics are open with a further 3 to open by year-end. 6 polyclinics that were due to open by the end of 10/11 have slipped to 11/12. Sectors have provided reasons for slippage and revised timescales, the SHA is working with sectors to understand reasons for slippage and recovery actions to ensure new timescales will be met. ▪ Development of a KPI dashboard to measure the financial and clinical impact of networks of care continues. An additional workstream focusing on evaluating cost-effectiveness and productivity will also be undertaken.	▪ The agreed KPIs have resulted in an additional requirement for new data collections to be established, this will delay the overall reporting against KPIs. NHSL are working with sectors to establish data flows to ensure robust reporting against the KPIs. ▪ Significant support from finance and K&I are required to ensure the robust monitoring of the impact of networks of care against expected financial and clinical benefits. The overall scope and work programme is being finalised and the resources required to deliver the work will be clearly articulated.
Outcomes Framework for General Practice	▪ The outstanding amendments to the Outcome Standards and Technical Guidance have been agreed by the Programme Board. The Primary Care PLG will sign off the final standards and guidance at the meeting on 16 Feb. ▪ The successful agency for the Public and Patient Engagement work, The Futures Company, were notified on 31st Jan and two patient engagement sessions will take place this month to develop the patient friendly expression of the standards. ▪ An engagement and implementation planning event took place on Friday 11 Feb with Sector Directors, clinicians and LMC Chairs.	▪ Delivering the technical solution – The Futures Company has been recruited to develop this work. The main output of this will be a translation of the outcome standards into patient friendly language. This will be published on the Greater London Authority (GLA) data store under the Information Revolution workstream. ▪ Delivering a bottom-up framework – We continue to work with the London-wide LMCs, Clinical Leaders and Sectors on developing, testing and implementing the outcome standards. ▪ Maintaining alignment with national developments – We continue to support DH as they develop plans to transition primary care into the new structures and have shared our outcome standards and guidance with DH colleagues.

Opportunity	Progress	Key Issues and delivery Risks
Single Point of Access for Urgent Care	• The NHS London programme team as part of their ongoing programme of stakeholder engagement hosted two 'Break the System' days here at NHS London on 18 and 19 of January. The purpose of the events was to demonstrate the NHS Pathways clinical assessment tool, using simulated clinical scenarios. • The Programme team were also keen to respond positively to DH letter to all SHAs dated 16 December 2010 requesting expressions of interest to be submitted for further NHS 111 pilots. With a focussed, localised communication and marketing strategy and some technology interventions this type of phased rollout of NHS 111 pilots within London could be achieved in a clinically safe and appropriate way. NHS London submitted an expression of interest on 27 January to become a NHS 111 pilot. • The DH letter of 16 December 2010 also announced that a deadline for universal coverage of the NHS 111 Service had been set for April 2013. The final version of the Single Point of Access preparing for the rollout of 111 in London business case was presented at the NHS London Delivery Group meeting on 31 January 2011 and approved. The Delivery Group signed up to delivering a (CMS) Directory of Services across London by 31 March 2012.	• National implementation timetable and expectation: There is a risk that in the context of the Management Cost Savings and the extent of NHS Transition, national implementation of 111 may not progress at the pace and scale required to meet the DH 111 national coverage target of April 2013. • Financial and workforce planning at sector level to implement 111: There is a risk that resources for this programme have not been sufficiently identified in sector 2011/12 operating plans and four year QIPP plans. The consequence could be that there will be insufficient financial/ benefits analysis and workforce planning at a local level to support the investment to commit resources for delivery of a major transformation change in the commissioning and provision of unscheduled and urgent care. • Insufficient depth and breadth of services populated onto the (CMS) Directory of Services to support NHS 111 Service pilots in London: There is a risk that the Pan-London Directory of Service will not be populated adequately to provide patients with the necessary dispositions to refer them to the most appropriate and cost effective services first time. • The telephony challenges of operating a 111 pilot within a bespoke geographical part of the 0207 / 0208 STD codes was initially viewed as a significant risk to a phased approach to the rollout of the NHS 111 Service in London.

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Appendix 2

Finance – individual workstreams