Item Number: 11

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP **GOVERNING BODY MEETING**	NHS Vale of York Clinical Commissioning Group

Meeting Date: 5 June 2014

Title : Quality, Innovation, Prevention and Productivity (QIPP) Update

Responsible Chief Officer:	**Report Author:**
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Strategic Priority

To support development and implementation of QIPP schemes across the CCG.

Purpose of the Report

To provide an update on progress associated with QIPP schemes to date.

Recommendations

The Governing Body is asked to note the progress on QIPP.

Impact on Patients and Carers

See detail on individual schemes as appropriate

Impact on Resources (Financial and HR)

See detail on individual schemes as appropriate.

Risk Implications

That identified QIPP schemes do not deliver the anticipated savings within the timescales identified.

Equalities Implications:

That individual schemes have unintended negative consequences on individual patient groups. To be mitigated through equalities impact assessment of individual schemes.

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NHS
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Clinical Commissioning Group

GOVERNING BODY MEETING: 5 JUNE 2014

Update on QIPP Schemes – April and May 2014

1. Purpose of the Report

To provide an update on current activity and implementation of 2014-15 QIPP schemes.

2. Background

For the last few months, the Innovation and Improvement team have been working up a number of projects as part of the overall Clinical Commissioning Group QIPP workplan for 2014-15 and beyond. A number of schemes have already been presented to both the Governing Body and to the April meeting of the Quality and Finance Committee. A summary sheet of all current schemes, and schemes still to be considered, is shown in Appendix 1 (NHS Vale of York Clinical Commissioning Group – QIPP Overview, 2014-15).

3. Project and Programme Architecture

3.1 To improve and standardise quality of reporting against QIPP initiatives, a standard "flash report" has been implemented since April 2014. These reports will be considered at future meetings of the Programme Delivery steering group (first meeting 29 May) where QIPP delivery will be overseen and monitored. The reports will be a key programme document to ensure how schemes are being implemented and how financial efficiencies are being delivered against agreed trajectories.

3.2 Since the last meeting, a considerable amount of work has been undertaken on standardising the project planning tools from Initial Viability Assessment, Equality Impact Assessment, and Financial Planning to Full Business Case documentation. The CCG has recently commissioned Covalent as a standard project and risk tool to be used across the CCG and these key documents are now being uploaded to Covalent. It is expected that phase one of Covalent, which focuses on the project management documentation, will be in place by the end of May/early June.

4. Project Updates

The projects currently being implemented are outlined briefly below. A full set of flash reports detailing activity and progress over the last two weeks is available to members on request. Key highlights are outlined below.

4.1 Urgent Care Programme

4.1a Emergency Care Practitioners (ECPs)

This project builds on the pilot scheme funded from winter pressure budgets to develop and roll out a number of ECPs across key localities in vale of York. The project aims to see and treat at scene wherever possible, avoiding unnecessary transportation of patients to Emergency Departments. To date approximately 37% / 550 patients have successfully been treated by the ECPs. Current activity involves developing the service specification with Yorkshire Ambulance Service (YAS), developing a risk sharing agreement with YAS for the future sustainability of the scheme, and developing a number of treatment pathways. This scheme aims to deliver savings across the full year, with projected efficiencies of £1.4m this year. Key risks remain the availability of ECPs to deliver the service and work is ongoing with YAS to address this.

4.1b Dressings Project

This project aims to reduce spending on dressings by approximately 15% through standardising ordering and catalogues – current spend is around £83k per year. A wound care formulary group is now meeting to standardise the approach and an implementation plan is expected to be in place for early June. Planned savings are expected to be around £125k part year effect, with the project starting to realise savings from June/July onwards.

4.1c Gluten Free Foods Prescribing

This is one of several smaller scale prescribing projects aimed at reviewing and standardising the prescribing list for a range of products. The project aims to review the allocation criteria for prescriptions for products which currently cost the CCG over £620k each year. A paper was presented at the Senior Management Team meeting on 27 May to agree next steps with further work on formulary, pathways and communications plan to follow in August.

5. Planned Care

5.1 Referral Support Service (RSS)

A key enabler to the planned care workstream, the RSS continues to be rolled out with consolidation work to support greater uptake of the service by individual practices. A year end report on RSS activity is an agenda item for the Governing Body at the June meeting. Current work has focused on ensuring sustainability of the assessor roles and options for funding the GP reviewers. Other work over the last month has considered the use of electronic referrals for all outpatient referrals and a proposal has been shared with the Local Medical Committee for consideration. Planned savings of £250k full year effect are planned based on an 8% reduction on outpatient appointments from experience of the service in other parts of the country. Additional efficiencies may be realised once alternative services are implemented and other delivery models explored. The impact of the RSS on April outpatient attendances will be reported in July when data is available.

5.2 Diabetes pathway redesign

Work has been ongoing with the diabetes team at York Hospital for some months to redesign the diabetes service. The focus is on development of a community team to work alongside and support primary care in the delivery of level 1 diabetes care. It has taken some time to develop the financial model for both the community team and for primary care support and costings have now been shared with the Acute Trust. Agreement on costings is now awaited, which may result in some delays to the original May deadline for sharing the model with primary care teams. The plan remains for the new service to be cost neutral, based on moving activity from secondary care into the community with Acute Trust estimates on possible savings to outpatient appointments and unplanned admissions remaining conservative. Savings on similar models of care in other areas however have demonstrated higher levels of reduced admissions. Efficiencies of £288k are planned based on standardising the consumables associated with diabetes. Details of the planned proposal and financial envelope for primary care to deliver level 1 care are currently being finalised and will be shared in the next month with practices.

5.3 Neurology – development of integrated care plans.

Review of pathways of care for epilepsy, motor neurone disease, Parkinson's Disease and multiple sclerosis. A stakeholder event with over 80 attendees was held a few weeks ago, and outcomes are currently being reviewed in relation to quick wins and areas to consider in the redesign. The project is on target to start implementation of the revised pathways in July 2014, with a focus on delivery within a community setting wherever possible, and reduced attendances in secondary care. Efficiencies of £183k in year have been forecasted to come into effect in month 9, with a full year effect of £731k in 2015/16. With the revised pathways initially focussing on reducing unplanned admissions for neurological conditions, additional opportunities exist to further reduce first outpatient referrals once the revised community pathways are in place – estimates of 20% reductions are achievable. If delivered, this would offer additional savings on this programme.

The Neurological Commissioning Support Unit have been providing a specialist nurse to support the work in Vale of York, and it has been agreed that they will continue to fund this post for a further 6 months to enable additional developments to be delivered. Secondary care consultants have also recently agreed to work with the RSS on referral guidelines for the 4 conditions identified, providing further opportunity to refine the pathways across community, primary and secondary care.

6. Community pathways/integrated Care Pilots

6.1 Selby District Integrated Care Pilot

Work continues to develop the integrated care pilot based within Selby Community Hospital, led by the Acute Trust in York. Workshops have been held with key stakeholders and identification of the initial cohort of patients who will be supported by the integration pilot is underway. An information sharing protocol between health and social care is currently being developed,

with task and finish groups established to take this forward over the month of May. The initial proposal of a minimum investment of 2:1 on set up costs has been identified and numbers of patients required to support this return is now being modelled. The start date for new processes and support of patients is identified as August 2014 with savings starting to be made by month 6, escalating to a planned cumulative year effect of £1.6m. Outcomes include 50% reduction in selby Community Hospital spells, with workforce deployed in the community, and a 10% reduction in A&E attendances for patients 2 65+ identified by the pilot with corresponding reduction in two day plus non elective admissions.

6.2 Priory Medical Group: Integrated Care Pilot

The Priory Medical Group pilot follows a similar scheme to the initiative outlined above, but with a more major focus on GPs to lead advanced care planning and care co-ordination. The pilot is working closely with colleagues in the Acute Trust to ensure seamless services, and with support from a newly appointed care co-ordinator, the project aims to visit and review any Priory Medical Group patients admitted to secondary care to facilitate discharge planning at the earliest opportunity. The pilot is initially focussing on 500 care home residents who Priory Medical currently support. However, plans are currently being established to identify how the project can be scaled up to support larger groups of vulnerable patients to optimise the outcomes from care planning and co-ordination.

As with the Selby integrated care pilot, all Better Care Fund (BCF) schemes are currently producing two weekly flash reports which are considered by the multiagency Joint Delivery Group to ensure that the BCF delivers against local and national trajectories. A part year saving of £375k is planned, with much larger full year effect savings once the project is scaled up.

The pilot is also working to a minimum return on investment of 2:1.

Work is ongoing with the University of York to establish the evaluation criteria for both pilots and to collect baseline data.

7. Summary

With the establishment of the new Programme Delivery Steering Group where day to day delivery of QIPP across the CCG will be monitored, future reports to this committee will focus on exception reporting and slippage on key schemes and programme areas of work.

8. Recommendations

The Governing Body is asked to note the progress to date on the 2014-15 QIPP schemes identified above.