North West SHA Expectations of QIPP Delivery

Introduction

Following the November Summit in Blackpool, NHS North West agreed to devise and share a set of clear expectations for planning and subsequent action across the five levels of action\(^1\). This document sets out these expectations for the planning and delivery of high quality health care and improved population health and well-being under the anticipated straightened financial circumstances. The challenges we will face will be unprecedented and will require optimal planning and delivery at all levels.

In terms of timescale for delivery, many of the early productivity and efficiency gains will be a consequence of actions that are taken now at Levels 1, 2, 4 and 5. Returns from decisions and planning at Level 3 may be likely to take longer but are essential and offer the scale and potential we need to meet the challenge we face.

The publication of the Operating Framework has now provided the context within which we need to act, including placing a requirement on PCTs and SHAs to reduce management costs by 30%, a need to have clear plans for community services and for future FT applicants. These requirements are integral to the delivery of QIPP, and add to the impetus to reduce cost whilst improving quality within the system.

The size of the financial gap

Part of the discussion at the Summit was a need for clarity on not only the expectations but also the size of the challenge being faced at the different levels. For example, if Level 5 (national) delivered an agreement on pay or progression restraint, how much of the gap has been filled? This is critical because, whilst actions and planning must be undertaken at all five levels, all savings will be delivered at an organisational level, that is, Level 1.

Nationally the efficiency challenge was originally estimated at £15 billion to £20 billion, and the North West’s weighted capitation share of this would be between £2.25 billion and £3 billion. Although the detailed assumptions underpinning this estimate are still be clarified, we are keen to make progress and set estimated shares of efficiency / productivity gain we expect to be determined at each level within the footprint group areas.

These gains will be achieved through a combination of activity at level 1, 2 and 3 and the following paragraphs represent our expectations of the actions of each level, how they will plan for them, assess progress and we will hold organisations to account. The most equitable basis for distributing this target is on a weighted capitation basis.

\(^1\) For ease, a copy of the summary of the five levels is provided as an appendix to this paper.
The indicative estimates for each area are as follows:

<table>
<thead>
<tr>
<th>Footprint</th>
<th>Estimated efficiency / productivity requirement (£'m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester</td>
<td>950</td>
</tr>
<tr>
<td>Lancashire</td>
<td>500</td>
</tr>
<tr>
<td>North Mersey</td>
<td>325</td>
</tr>
<tr>
<td>Halton, St Helens / Warrington / Knowsley</td>
<td>210</td>
</tr>
<tr>
<td>Wirral / Western Cheshire</td>
<td>200</td>
</tr>
<tr>
<td>Cumbria</td>
<td>165</td>
</tr>
<tr>
<td>Central and Eastern Cheshire</td>
<td>135</td>
</tr>
<tr>
<td></td>
<td>2,495</td>
</tr>
</tbody>
</table>

Wherever there is cross boundary flow we have tried to attribute in proportion e.g. Knowsley is allocated 50:50 between the two footprint groupings.

We already understand the scale and complexity of the challenge faced and detailed assessments must be undertaken and agreements reached. At the same time, NHS North West will also finalise the metrics to assess the progress of QIPP across the region (using the principle wherever possible of drawing on existing data sources and asking all NHS organisations including Foundation Trusts to support this work).

**Expectations at each level of action**

As outlined above the North West system has agreed five levels of action as follows:

**Level 1 – Individual organisations**

It is critical that individual organisations take action to minimise their cost bases and improve productivity and efficiency, whilst driving prevention and quality. Ultimately, all of the savings and improvements that need to be made will be realised at the level of individual organisations. Even where proposals require planning, decision-making and actions at a level with many participants – the outcomes will be delivered through individual organisations.

**Expectations**

At Level 1, the SHA expects not only to see robust financial plans in place but also a level of scrutiny and commitment by Boards on a regular basis. Evidence should be readily available to demonstrate that Boards are taking action in relation to:

- **Pay**, for example approaches to re-shaping of skill-mix, arrangements to utilise the full potential of pay progression rules within Agenda for Change;
- **Staff levels**, here the evidence in recent months has been of a continued growth in the total workforce that is not sustainable;
- **Agency costs**, where organisations should be taking the opportunity to reduce these in order to secure efficiencies or to support the redeployment of staff from elsewhere in the system;
- **Sickness absence rates** vary considerably across the region and within organisations whilst best practice approaches are not implemented;
- **Efficiency within organisational processes**. There is considerable evidence available to improve performance in areas such as length of stay, theatre utilisation, prescribing behaviours. There are also various tools that can be utilised to implement these changes, such as ‘Lean’;
• **Asset utilisation**, again this varies considerably across the region and best practice evidence is available to the NHS/public sector; and
• **Quality indicators** (eg. AQ, CQUIN, Patient Experience/Safety measures) to allow organisations to deliver efficiencies without detriment to service quality.

**How will progress be assessed?**

The SHA will be examining actual performance in relation to the above issues as well as the extent of Board analysis and action. We will select a number of metrics of Level 1 performance that are readily available and publish monthly tables of organisations to allow Boards to benchmark their progress.

We are aware that FT Boards will be required by Monitor to maintain a clear focus on these issues for regulatory returns and we will endeavour to dovetail Monitor/PCT contractual requirements and any additional QIPP metrics, should we agree that any are required. Organisations will be required to deliver contractual obligations, meet financial and service targets and publish their outcomes in annual reports including quality accounts.

**Level 2 – Key bilateral relationships within health economies**

Level 2 deals primarily with the critical nature of the interdependent relationships within each local health economy and their contribution to the relative success of each of the partner organisations in meeting the QIPP challenge. It is also at level 2 that care pathways for patients are determined and delivered, including the key contributions of primary care and social care.

**Expectations**

We expect to see evidence of monthly meetings between the Chair and Chief Executive of the PCT with relevant local Trusts and the relevant local authority(ies). These meetings should assess: the relative risks associated with the financial challenge being faced by each partner; the performance of suppliers of services against contract; and the plans to meet / manage activity schedules. The SHA expects to receive exception reports from these sessions where it is believed that a local health economy may be at risk or where risk management actions have not been agreed.

We would expect NHS Trusts, FTs and PCTs to share their financial and performance data on a completely open book basis to allow accurate assessment of risk of failure. This would include the important shared assessment of primary, community, social and acute services financial and service performance.

The SHA expects that partners will undertake work to implement clinically and cost effective care pathways. Work is in hand at national and regional level using the Clinical Pathway Groups and Clinical Leaders Networks to define these pathways and we will expect PCTs, GPs (primary health care teams)Community Health and Social Services and Trusts to utilise them.

We also expect that work at Level 2 will include substantial involvement of Local Authorities in respect of their key contributions as joint commissioners and the development of more effective joint commissioning to drive up efficiency (in both adult and children’s care) and shared plans to provide an effective joint public health system aimed at improving health, promoting well being and helping to manage demand more effectively in collaboration with practice based commissioners.

It will also be at level 2 that the plans of individual organisations come together and the SHA expects to see coherence between partners and between short and medium term commitments. This will require partners to hold open and transparent discussion of aspirations and conduct a rigorous process of option appraisal.
How will progress be assessed?

Actions at Level 2 will manifest themselves in agreed contracts for 2010/11 and agreed management of outstanding issues in the 2009/10 contracts. We will expect to see contracts for activity next year that reflect the requirement to reduce quantifiably overall levels of acute activity and to meet any new demand for services through productivity gain. (this would be equally true for contracts with community and primary care suppliers).

All contracts will need to be in line with the 2010/11 Operating Framework guidance and NHS North West guidance on regional financial planning. In particular, the SHA will make clear the national/regional elements of CQUIN and the penalty arrangements for PCTs failing to manage expected demand for non-elective care. Any penalties levied will be held by the SHA, with the potential for them to be redeployed in support of strategic change initiatives that accelerate the region’s ability to deliver the QIPP agenda.

With regards to plans, PCT Commissioning Strategic Plans are required by the SHA for the purpose of WCC evaluation and assessment in the week commencing 25 January 2010. These should be consistent with actions the FT IBPs as agreed between key partners in the local health economies. In the case of NHS Trusts who are yet to apply for FT status who are required to agree plans with the SHA for becoming Foundation Trusts in the next CSR period by March 2010, the SHA will expect to see that PCT CSPs are also fully consistent with these plans.

In addition, PCTs are required in the Operating Framework to set out plans for the commissioning and organisational delivery of community services by March 2010. The DH is to set out a series of tests which the Plans will be subjected to prior to approval by the SHA. We expect these tests to identify that all key parties have been involved in the discussions locally and that options for vertical integration (acute – community – primary; NHS – local government; mental – community) have been fully explored. Ultimately, we expect plans for community services to be totally consistent with actions at Level 2 to deliver QIPP and plans without evidence of transparent local dialogue or sufficient emphasis on efficiency / productivity / quality gain will not be acceptable. It is important that careful consideration is given to the appropriate integration model for individual services. The wide range of services in PCT community services makes it unlikely that a simple clustering of organisations will be sufficient to make maximum improvement in clinical pathways.

There is some risk that the WCC, QIPP, FT, TCS, Children’s plans and contracting processes create major pressures on local planning capacity. The SHA and PCTs have set up a small Task and Finish Group led by Jane Cummings and Kirsten Major to identify overlaps between these processes and to streamline planning activity. This work will be completed and presented to the SHA/PCT meeting on 15 January 2010 although work is already underway to streamline the plans required by the end of January.

Level 2 arrangements will not require a separate plan, but the discussions and agreements made at this level must be manifest in the plans required by the Operating Framework and described above. The SHA will monitor these plans at the outset to ensure they commit to delivering the financial and service improvements required to deliver QIPP, and will assess delivery in-year through the normal processes of performance management.

The SHA will expect all actions at Level 2 to be consistent with the overarching plans at level 3 and the underpinning commitments manifest in each organisations individual plans at level 1.

Level 3 – Sub-regional footprints

The main areas that require distinctive Level 3 planning and working include: configuration of acute services; sub-regional labour market management; exposing and tackling the variability of care
pathways; shared PCT and LA system wide commissioning arrangements; and providing a system wide view to augment and support the SHA in its scrutiny of PCT and NHS Trust plans at Level 2.

**Expectations**

Each Level 3 footprint group will be expected to articulate and then oversee the actions it anticipates at this higher “system” level (this includes Cumbria and Central & Eastern Cheshire where Level 2 and 3 are the same). This is because QIPP delivery requires additional activity at Level 3 in order to create the productivity and efficiency gains we require, and that increasingly it will be actions taken at this level that produce a large part of the medium to long term gains.

The SHA expects that each footprint will demonstrate not only an understanding of what needs to be achieved but to set out and embark on the potential solutions. To that end, every footprint should develop plans setting out their actions that would respond to the following:

- What actions would be needed at level 3 to enable at least a 10% reduction in demand on acute services by end March 2011 including any implications for managing and redeploying the workforce
- What actions at level 3 could support a 15% reduction in acute and in-patient mental health sector capacity across the system whilst continuing to deliver high quality, safe, prevention oriented and effective services to patients if this were to be implemented? How would this be staged to ensure completion by end March 2013?
- What actions at level 3 would support a reduction in expenditure of 10% in all sectors (including primary care, community services, acute and mental health sectors), whilst maintaining service quality and access for patients? How would this be staged to ensure completion by end March 2013?
- What actions on the commissioning side at level 3 would secure a 30% reduction in management costs by 2014 including a 15% reduction in 2010/11?

The responses would identify what actions each of the partners to the footprint take before the next financial year, during 2010/11 to make progress on the above efficiency and productivity gains. Clearly the specifics will be limited at this stage but the estimated order of productivity and efficiency attributable to each action needs to be defined alongside who the group is holding responsibility for delivery. All plans will need to demonstrate how services will continue to be resilient to a range of risks.

In meeting these challenges, partners to Level 3 plans should be able to draw on the Level 2 assumptions at each health economy. Groups may also wish to use their collective benchmarking opportunity to scrutinise and address the variation in clinical quality and treatment thresholds and the poor performance on Better Care, Better Value indicators when compared with the rest of England. Level 3 planning and action is more complex as a consequence of the lack of formal governance structures in our current arrangements. Therefore the SHA expects to see footprint groups establish an appropriate system of organisation at this level, and to devote some resource to underpin their collective work. It should be clear how the Chairs, Non-Executive Directors and Clinical leaders of organisations are being involved in scrutiny and agreements as well as relevant Local Government links at this level. As part of this work, groups will be expected to demonstrate that they have secured effective clinical and staff engagement (including trade unions) in their work.

In developing new models of care for level 3 it is essential that consideration is now given to the optimal, evidence based provision of services for a range of issues such as Urgent Care and Trauma, Cancer, ICU, CVD and Stroke and Mental Health. Whilst discussion will need to focus on each pathway it is essential that the proposals are reviewed in their entirety to ensure coherent and efficient clinical adjacencies and critical mass is taken into account in decision making.
The SHA will provide O/D input to assist Level 3 arrangements and will work closely with lead CEOs / Chairs by convening an ongoing Forum of Footprint Leaders to share best practices and approaches. It is also likely that the SHA and footprint groups will need to work together to secure necessary external analytical support.

**How will progress be assessed?**

Level 3 groups will be expected to produce regular separate reports by the week commencing 25 January 2010 (although in the case of Cumbria and Central and Eastern Cheshire, they will not be required to produce a separate plan to their CSP). Whilst these will not be a major bureaucratic exercise, the footprint groups will need to describe the scale of the financial benefits that they envisage being delivered by each element of their plan using the scenario work to model and set out quantifiable options for general capacity reductions and productivity gains and the levels of cash released.

Following receipt of these plans in week commencing 25 January, NHS North West will be in a position to provide feedback to footprints as well as handing over the more detailed modelling described above. This will allow further refinement of footprint plans and the contributions to be locked into the regional QIPP plan which has to be submitted formally to the DH in week commencing 22 February.

Following feedback from DH, a further version of the plan will be expected by 31 March 2010, and we will aim to hold the next Summit in early March in order to ensure we have coherence between all the plans and consistency with contracts and actions underway on delivering efficiency and productivity in 2010/11.

The SHA will monitor progress against these plans through the footprint leaders forum and report back collectively to the series of regional summits we are planning to hold every 6 months.

**Level 4 – Region-wide contributions**

Level 4 work is also critical to the achievement of QIPP. By working together on issues of mutual benefit and support we have the capacity to reduce cost, to optimise our available talent and expertise, to negotiate collectively, engage the North West public through regional media, create synergy with regional partners, and to advocate more strongly for helpful policy and resources.

Level 4 working is commonly but not exclusively the responsibility of the SHA but other key regional networks such as the FT Network and the PCT Alliance also have opportunity and responsibility to act at this level. It is through the SHA and these networks that innovative solutions can be identified and spread (see appendix 1 for a list of suggestions arising from previous forums on QIPP which the SHA will explore)

**Expectation**

The SHA expects that work on a region wide basis will most productively cover a variety of initiatives (which were subject to previous discussion and agreement at our first Summit). These include -

- **Establishing AQuA** as a ‘by the NHS, for the NHS’ quality observatory and improvement organisation. AQuA has the ability to serve all PCTs and trusts, identify and support quality improvement in all parts of the care pathways, bring international expertise and inward resource, use systematic methodology and training to secure quality improvement for less resource
- **Developing a productivity benchmarking tool** in order to help organisations benchmark and improve performance
• Exploring the use of threshold management systems such as Interqual that help Trusts and PCTs to assess and manage demand for acute care

• Exploiting Connecting for Health and IT potential through utilising existing contractual opportunity and negotiating new opportunities to take out costs and improve service quality (eg telehealth, reduced paper based bureaucracy, faster access to records, web 2.0 applications etc)

• Measuring the QIPP gap and making it sensitive to local systems, thereby enabling systems to set their own productivity and quality improvement targets

• Regular clinical and performance benchmarking across the system and sharing best practice (including using the SHA’s Innovation funding to create speedy diffusion and adoption of ideas, technologies and practices; and to secure inwards investment)

• Holding the system to account for delivery of the expectations and being clear and non-bureaucratic in the execution of progress reporting. Also by ensuring appropriate actions are being taken at the right level and arbitrating when not.

• Working to coordinate other region wide actions where non NHS and non SHA run initiatives collaborate to create synergy with the NHS QIPP programme. For example, support the work of the Joint Improvement Partnership and the Transformation of health and well being.

• Conducting regional and leading local campaigns to engage the North West public managing their resource use

• Organising the summits as a means of setting out the landscape, reporting on regional and sub regional performance, sharing best practice and holding ourselves collectively accountable for behaviours and strategic change

• Advocacy at a national level for supportive policy and effective pay negotiations

How will we assess progress?

The SHA will set out a clear programme of actions related to the above including a timetable for delivery and, wherever relevant, a costed plan for return on investments. This will be available by the next Summit and be subject to the scrutiny of the participants.

Level 5 – National contributions

At this stage, the national contribution to QIPP has been articulated in the 2010-2015 Good to Great policy framework and the 2010/11 Operating Framework.

A further work programme of support to QIPP delivery is being discussed and agreed by the NHS Management Board and is likely to be made clear to the NHS in the early part of 2010.

Summary timescale

<table>
<thead>
<tr>
<th>Date</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td>Actions and scrutiny led by Boards within individual organisations.</td>
</tr>
<tr>
<td>8 January</td>
<td>SHA to send progress report to the DH using national template</td>
</tr>
<tr>
<td>15 January</td>
<td>Completion and dissemination of output from SHA / PCT group on rationalising of planning requirements.</td>
</tr>
<tr>
<td>Date</td>
<td>Output</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25 January</td>
<td>Operating Framework Plans to be submitted to the SHA</td>
</tr>
<tr>
<td>29 January</td>
<td>PCT CSPs consistent with initial Level 3 Plan and Level 2 arrangements submitted to SHA.</td>
</tr>
<tr>
<td>29 January</td>
<td>Initial submission of Level 3 Plans to SHA.</td>
</tr>
<tr>
<td>29 January</td>
<td>SHA to give initial feedback to the DH on PCT Operating Framework Plans</td>
</tr>
<tr>
<td>8 February</td>
<td>Feedback from NHS North West and handover to system of detailed QIPP financial models</td>
</tr>
<tr>
<td>19 February</td>
<td>SHA to provide feedback to PCTs on the Operating Framework Plans</td>
</tr>
<tr>
<td>22 February</td>
<td>North West regional QIPP plan to DH</td>
</tr>
<tr>
<td>End February</td>
<td>SHA published metrics across organisations to allow benchmarking of progress across organisations.</td>
</tr>
<tr>
<td>Early March</td>
<td>Summit for North West system.</td>
</tr>
<tr>
<td>12 March</td>
<td>Final Operating Framework Plans submission to the DH</td>
</tr>
<tr>
<td>31 March</td>
<td>Further version of regional QIPP plan to DH.</td>
</tr>
<tr>
<td>31 March</td>
<td>Detailed plans from PCTs for commissioning and organisational delivery of community services as per Operating Framework to be submitted to SHA.</td>
</tr>
<tr>
<td>31 March</td>
<td>Detailed alternative plans for Trusts who will not become FTs by December 2010, including arrangements to reach FT status during the next CSR period, to be submitted to SHA.</td>
</tr>
<tr>
<td>End March</td>
<td>Contracts in place fully compliant with new Operating Framework arrangements.</td>
</tr>
</tbody>
</table>
**Working Arrangements**

In addition to the formal reporting arrangements described above, the SHA will establish the Footprint Forum where 2 members (including the Chair) representing both a PCT and a provider will meet to provide updates on progress as well as to share approaches and best practice across the region. These will be scheduled to meet on a monthly basis.

Actions at other levels will be picked up through the routine CEO, Chair, and Clinical Engagement networks/ events.

**Conclusion**

This document sets out our expectations of the North West health system in its requirement to improve productivity and quality at pace and scale. Organising coherently and clearly now is vital if we are to succeed. Ensuring that each level of action is operating and only doing what it can only do is at the heart of achieving effective organisation. Creating clear expectation and setting ambitious goals for our system provides the motivation. With all of this in place and knowing the quality of our leaders and staff, we have not only the ability but also the assurance that this system can and will deliver QIPP.

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Mike Farrar  
Chief Executive

Sir David Henshaw  
Chairman
Appendix 1

Key QIPP Innovations for Further Exploration

- Threshold management for access to ambulance service; primary care and acute care (Level 1,2);
- Targeted cost reductions in administrative costs of secretarial support (level 1)
- Earlier access to specialist assessment in order to increase likelihood of earlier effective diagnosis (level 1,2)
- Better priority setting/ management of tertiary services development (level 4)
- Roll out of tele-health innovations - eg remote cardiac monitoring (level 3,4)
- NHS/LA shared back office on sub regional and regional basis (level 3,4)
- Strategic use of outsourcing to for profit and not for profit suppliers (level 3,4)
- Skill mix and AFC grading assessments (level 1)
- Integrated Care Organisations with acute/community (level 2)
- Aggressive estate rationalisation strategy locally and across the region (level 1,4) and encompassing local Government (level 2)
- NPFFit – more room for local manoeuvre within the programme (level 1,4)
- Remove paper based recording from community services (level 1,2)
- Constraints on ACCEA awards in light of affordability by setting higher bar (level 1)
- Relevant community services combine with mental health trusts (level 2)
- Wholesale adoption of Lean methodology to speed its implementation and reduce support costs on how to get it in place (level 1)
- SHA to be more directive when system can’t or won’t agree especially where level 3 savings are being thwarted (level 4)
- Cost of locums could be managed down through national action (level 5)
- Regional pay negotiation in terms of restraint v security (level 1,3,4)
- Staff offering a reduction of 1 hour’s pay in return for a second hour of protected time for them to undertake some physical activity – evidence suggests massive impact on sickness absence (level 1)
- Reduce expenditure on management consultants by 50% or get better deal (level 1,2,3,4)
- Enable consultants and specialist staff to work with them to manage demand for secondary care (level 2)
- Impose the North West Care Pathway Group recommendations through contracts (level 2,4)
- Create one infrastructure at reduced overall cost to support Specialised Commissioning, and Clinical Networks (level 3,4)
- Implement 7 day working throughout the year especially for managing discharge (level 1)
- Embrace self care concepts at all levels of acuity of care (level 1)

The SHA will continue to canvas, collect, cost and convey ideas of innovative QIPP work through its clinical, management and Non executive Networks. (We will be using websites and news communications to set out more detailed case studies and exemplars).