NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Date of Meeting: 20th May 2016

Agenda No: 7.3 **Attachment: 09**

Title of Document: QIPP Programme and Governance 2016/17	**Purpose of Report:** To inform the Governing Body of the QIPP programme and governance process for 2016/17
Report Author: Chris Moreton	**Lead Director:** Andrew Hyslop
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Executive Summary: Merton CCG's (MCCG's) primary responsibility is to ensure the delivery of high quality, clinically safe, efficient and effective services. The governance arrangements for the 2016/17 QIPP programme described within the paper have been designed to ensure that QIPP delivery has a positive impact on quality of care and the patient experience. The attached paper describes a process that will ensure the rigorous monitoring and reporting of QIPP schemes' performance. The paper also provides analysis on 2016/17 and 2017/18 QIPP delivery. It explains that £5.3m (risk assessed) of a £7.3m target for 2016/17 is on track for delivery leaving a £2m gap still to find. The paper also discusses the value of 2017/18 QIPP. £2.0m of a 2017/18 QIPP will be found from schemes started in 2016/17. The remainder (£7.9m) will come from the CCG's transformation activities and the Financial Recovery Plan (FRP).	
Key sections for particular note (paragraph/page), areas of concern etc: Scale of QIPP in 2017/18. Value of unidentified QIPP in 2016/17. QIPP Governance arrangements.	
Recommendation(s): The Governing Body is requested to review, comment upon and approve the recommendations in the paper.	
Committees which have previously discussed/agreed the report: EMT, Finance Committee	
Financial Implications: The 2016/17 QIPP is a key tool in the CCG's financial planning strategy for the year.	

Implications for CCG Governing Body: None other than those reported in the paper.
How has the Patient voice been considered in development of this paper: The impact on the patient experience is considered as part of the project initiation document, is approved by the QIPP governance process and monitored on an ongoing basis.
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) Please see paper for details.
Equality Assessment: N/A
Information Privacy Issues:
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution)

1. Purpose

1.1. MCCG's primary responsibility is to ensure the delivery of high quality, clinically safe, efficient and effective services. This report describes the governance framework for MCCG's planning and assurance of QIPP Delivery.

1.2. MCCG must ensure that the delivery and shape of change in the healthcare system is achieved so that innovative, high quality care can be delivered within the resources available.

1.3. The Merton QIPP Programme Management Office monitors progress and provides support to the management (SRO) and clinical (CRO) leads and project managers that are responsible for the delivery of individual projects.

1.4. The QIPP SRO for MCCG is the CFO. The CFO personally assures the Chief Officer on the detailed delivery of the QIPP.

2. Approach

2.1. The CCG has identified the need to strengthen both the PMO process and project management resources if it is to deliver an ambitious QIPP programme in 2016/17. This direction is also in keeping with the Internal Audit opinion highlighted in their January 2015 QIPP programme report.

2.2. The QIPP is a continuous process. All QIPP schemes will be "bottom up" in approach and owned by a project manager and subject to rigorous scrutiny by the QIPP Delivery Group.

2.3. Each project is regularly reviewed to assure that progress of the project is adhering to plan.

2.4. Each project is reviewed to identify key issues and problems at an early stage.

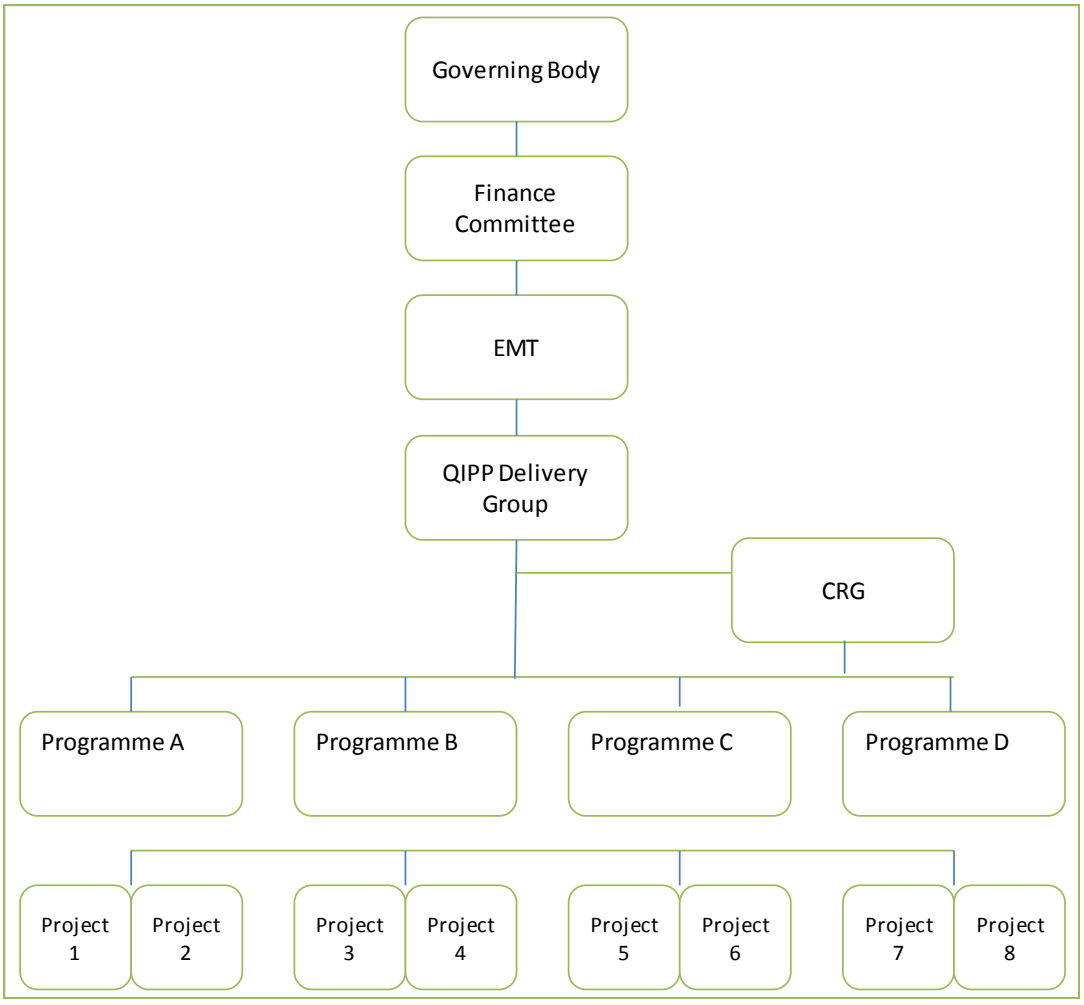
2.5. Savings and investments are risk assessed and suitable adjustments to net savings achievable are made in accordance with the risk assessment.

2.6. In year QIPP projects are monitored on a weekly basis. Plans for projects for the following year are reviewed and developed at monthly development meetings. This ensures that there is a continuous pipeline of QIPP projects for both the current and following year.

3. Governance Model

3.1. The QIPP Governance Framework Structure is intended to show how the QIPP Delivery Group interrelates with the PMO, the Finance Committee and the Governing Body. (See figure 1).

Figure 1



Projects are assigned to strategic programmes that reflect MCCG's overall direction of travel.

4. CCG Clinical Engagement

4.1. Each project requires the active engagement and leadership of clinical staff and the early engagement of clinical colleagues from secondary care services.

4.2. Consistent clinical and stakeholder engagement is necessary to ensure that schemes do not compromise:

4.2.1. The safety of patients.

4.2.2. The delivery of services that meet required quality standards.

4.2.3. The effective use of resources.

4.3. Programme leads will obtain clinical input in the following ways;

4.3.1. *Informal input* – clinical input is provided during the work up and development of the costing model used to drive QIPP as well as the design of the clinical pathway itself.

4.3.2. *Semi-formal input* – there is a bimonthly meeting of all practice clinical leads where the CCG presents its entire work programme.

4.3.3. *Formal input* – attendance at the clinical reference group (CRG) which more formally receives papers for consideration on QIPP. Decisions are made in principle as to the content of schemes and options appraisal.

5. Roles and Responsibilities

5.1. The Finance Committee

The Finance Committee will consider routine reports, prepared by the PMO, on the delivery of the QIPP Programme by project, in addition to reviewing wider business cases. The Finance Committee will then report to the Governing Body on progress.

QIPP Delivery Group

The role of the group will be to:

5.1.1. Meet weekly.

5.1.2. Hold the wider programmes to account for the delivery of the annually agreed QIPP projects.

5.1.3. Monitor progress made by each of the programmes on the planning and delivery of projects.

5.1.4. Resolve difficulties experienced by the programmes in delivering projects.

5.1.5. Make recommendations to the EMT and Governing Body of actions required to ensure project delivery.

5.1.6. Approve significant changes to projects' costs and benefits at the request of project leads.

5.1.7. Escalate progress of project delivery for each programme to the EMT and Finance Committee.

5.1.8. Signing-off PIDs for each project.

5.1.9. Identifying mitigating actions for risks to the delivery of projects.

5.1.10. Working with partners to ensure the delivery of project milestones.

5.1.11. Produce remedial plans to rectify slippage in implementation or underperformance against project benefits.

5.1.12. Develop plans for additional projects.

5.1.13. Intentions to vary schemes from what has been signed off at Governing Body must be reported to the Governing Body at the next available meeting.

5.2. **PMO**

The PMO is responsible for:

5.2.1. The collection, analysis and reporting of information on the delivery and outcomes of QIPP projects and programmes.

5.2.2. Reporting to the QIPP Delivery Group where clinical/quality benefits to patients or financial efficiencies are unlikely to be fully realised and to suggest timely corrective action and mitigations.

5.2.3. Ensuring that appropriate risk management and key stakeholder engagement processes are undertaken on 2016/17 QIPP projects.

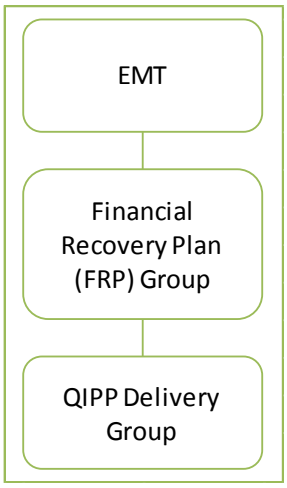
6. Accountability

6.1. Accountability for the QIPP process is shown in figure 2 below. The DoC will assume responsibility for programme delivery whereas the CFO will assume responsibility for governance and reporting.

6.2. The CFO and the DCFO will attend the QIPP Delivery Group on a routine basis. Project Managers are invited to the QIPP Delivery Group and are held to account for the delivery of their project using a weekly flash report.

6.3. The QIPP Delivery Group will report to the Financial Recovery Plan Group which in turn will report to the EMT.

Figure 2

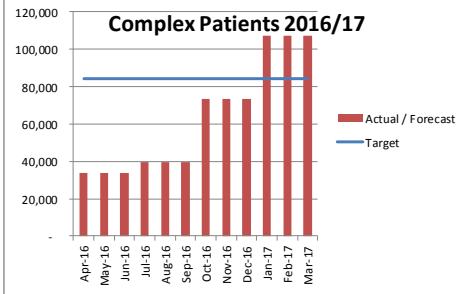


7. Reporting

7.1. The details of each project will be recorded on a “page to view” flash position. (see figure 3 below). The flash report contains the following up to date information;

Figure 3

Lead Commissioner		Murrae Tolson			RAG Programme		Amber					Financial Summary	16/17/YTD	16/17 FY	16/17 FY adj	17/18 FY
QIPP Name		Case Finding 50+			RAG Savings		Amber					Target	84,500	1,014,000	1,014,000	0
Month		Apr-16			Risk factor		100%					Actual/Forecast	33,800	1,014,000	1,014,000	1,286,400
												Over / (Under)	(50,700)	0	-	1,286,400
												QIA Assessment complete?	In progress			
	Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17	17/18	
Target	Savings	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	1,014,000		
Target	Investments	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Target	Net Savings	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	84,500	1,014,000	-	
Actual / Forecast	Savings	33,800	33,800	33,800	67,600	67,600	67,600	101,400	101,400	101,400	135,200	135,200	135,200	1,014,000	1,622,400	
Actual/Forecast	Investments				- 28,000	- 28,000	- 28,000	- 28,000	- 28,000	- 28,000	- 28,000	- 28,000	- 28,000	- 252,000	- 336,000	
Actual/Forecast	Net Savings	33,800	33,800	33,800	39,600	39,600	39,600	73,400	73,400	73,400	107,200	107,200	107,200	762,000	1,286,400	



Commentary

Functionally merge health and social care provider teams to enable delivery of a single pathway for patients with complex health and social care needs through health and social care response individualised to patients.
Create primary care capacity to enable medical management of complex patients as part of the integrated health and social care teams.
Improve information sharing for direct patient care purposes in order to reduce administrative time related to management of patients with complex care needs.
Improve the 7 day response for people with complex health and social care needs.

The draft PID forecasts 525 prevented NEL admissions which (using 2015/16 tariff). This is valued at £1,014k gross QIPP . The PID forecasts £326k costs for GP service and project management.
Phasing of savings are currently estimated as ;
10% Q1
20% Q2
30% Q3
40% Q4

Key actions

Due Date	By Who	Description
30-Apr-16	Carrie Chill	Service specification for GP service for complex patients
30-Apr-16	A Bunka	Identify contracting options for GP service
TBC	A Bunka	Mobilise GP service
24-Apr-16	M Tolson	Monthly change management workshops commmence

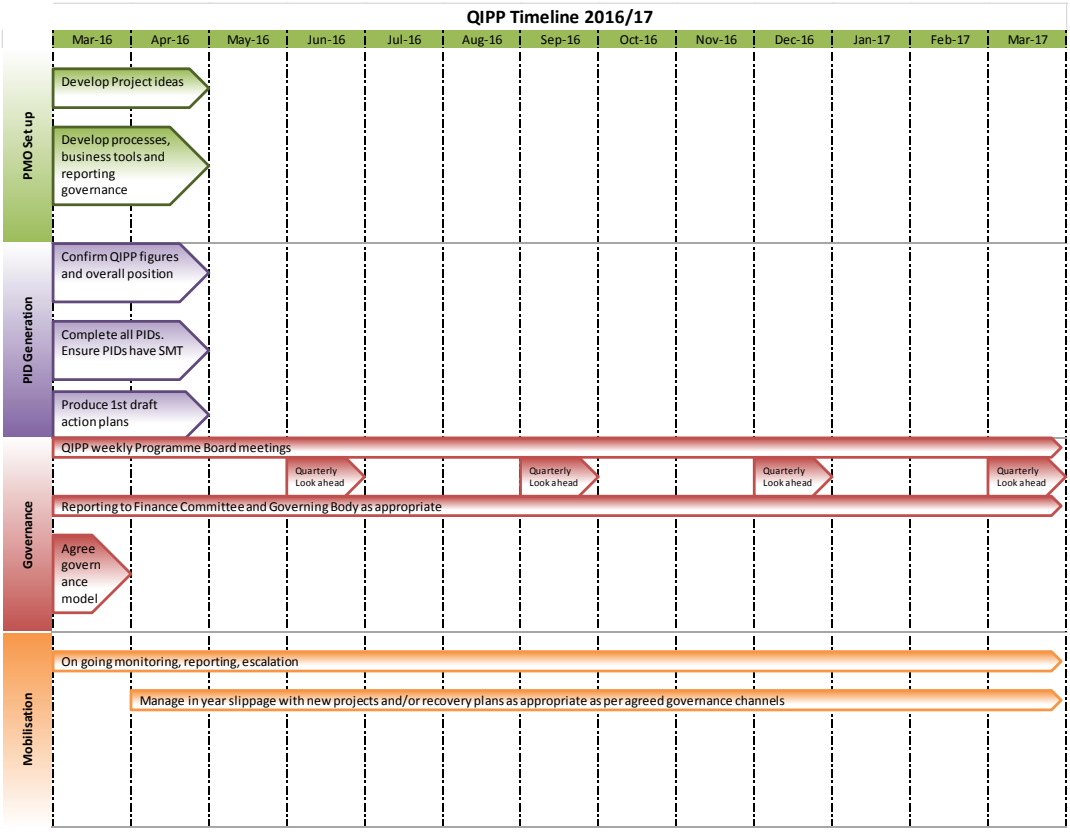
Risk analysis

Description of risk	RAG Status
Insufficient capacity in primary care, community health and social care services to fully support a single patient pathway meaning that many of the patients on the new pathway are more likely to become an emergency admission in the following days.	Red
	Red
Hospital based systems do not embrace new model - particularly in terms of the Interface Geriatrician model	Amber
Reputational impact if an adverse clinical outcome occurs in new pathway	Amber
Unable to recruit appropriate professionals with skill mix required	Amber
New model fails to make savings / is more expensive. (Activity takes place in the community but there is not a corresponding shift of activity in secondary care)	Amber

8. QIPP Programme Governance (see figure 4)

8.1. Every project must have a detailed project plan (PID) outlining milestones, risks finance and KPIs. Plans should be drawn up with input from Project Managers, CCG and Clinical Leads and the PMO. All plans will be signed off by the CFO, DoC, and the project managers who will take full ownership of these plans.

Figure 4



9. Escalation

9.1. All QIPP Delivery Group meetings will afford the opportunity for leads to flag up any issues for escalation. These issues will be recorded through risk registers, milestone delivery reports and detailed meeting minutes and actions. Issues requiring escalation will then be handled by the PMO and escalated through the governance structure.

9.2. Issues that require additional resources or an alternative approach to the deployment of resources will be referred to the DoC by the CFO.

10. Risk Management

10.1. Risks, issues, milestones & benefits will be monitored, tracked and reported by the process of weekly QIPP Delivery Group review meetings attended by the DoC, CFO, Head of PMO, and project managers. These meetings afford the opportunity for close scrutiny of milestones, benefits and risks following which minutes, action logs and updated milestone and risk tracker reports will be produced. The DoC and the CFO assure the risk process.

10.2. All risks will be mitigated either through action logs, milestones and accountability measures to understand if all risks are maintained. In order to monitor and manage risks, the PMO will update a QIPP programme risk log on a weekly basis.

10.3. The PMO will assess the changes to the programme risk logs and update a master risk register on a weekly basis and report on a monthly basis.

11. Progress to date

11.1. In accordance with the governance arrangements designed around QIPP management, the 2016/17 QIPP programme is split in to several programmes. Within each programme, a number of projects support each programme's delivery. A project manager has been assigned to each project within the QIPP.

12. Financial position

12.1. A summary of the progress to date on 2016/17 QIPP is as follows;

Project	Q1	Q2	Q3	Q4	Total	17/18
Coding and Counting	-	-	-	637,500	**637,500**	637,500
Continuing Healthcare	-	-	160,500	220,687	**381,187**	431,875
Corporate Efficiency	-	-	179,506	179,506	**359,012**	718,023
Case Finding 50+	101,400	202,800	304,200	405,600	**1,014,000**	1,622,400
QMH Referrals	5,195	59,718	93,935	102,103	**260,952**	260,952
0-16s respiratory	12,185	12,185	12,185	12,185	**48,738**	73,108
Practice Variation/Demand mgt	140,655	140,655	140,655	140,655	**562,622**	562,622
Referral Management Centre	-	-	-	169,190	**169,190**	676,760
MSK Connect Pathway	70,200	70,200	70,200	70,200	**280,800**	605,700
Prescribing	108,675	108,675	108,675	108,675	**434,700**	434,700
Foetal medicine	-	-	-	1,100,000	**1,100,000**	1,100,000
	438,310	**594,233**	**1,069,856**	**3,146,301**	**5,248,700**	**7,123,639**

12.2. Known QIPP plans total £5,711k at this stage in the financial year. However, each project's financial delivery has been risk assessed to take in to account potential uncertainties. Applying individual risk scores to each project reduces the pre risk assessed QIPP from £5,711k to £5,249k. This reduction equates to an average of around 8%.

12.3. Our budget planning assumption assumes adjusted QIPP delivery of £7,258k. Our risk assessed QIPP gap is therefore, £2,009k.

12.4. The QIPP Delivery Group have concluded that unidentified QIPP should have a risk assessed rating of 70% ie a 30% reduction on the pre risk assessed total. This is a higher reduction percentage than the identified schemes on account of the fact that schemes have not been identified for this part of the control total. The table below sets out the overall position.

	Gross savings pre risk adjusted	Risk factor	Gross savings post risk adjusted
Identified QIPP	5,711,371	92%	5,248,700
Unidentified QIPP	2,870,417	70%	2,009,292
Planning assumption	**8,581,788**		**7,257,992**

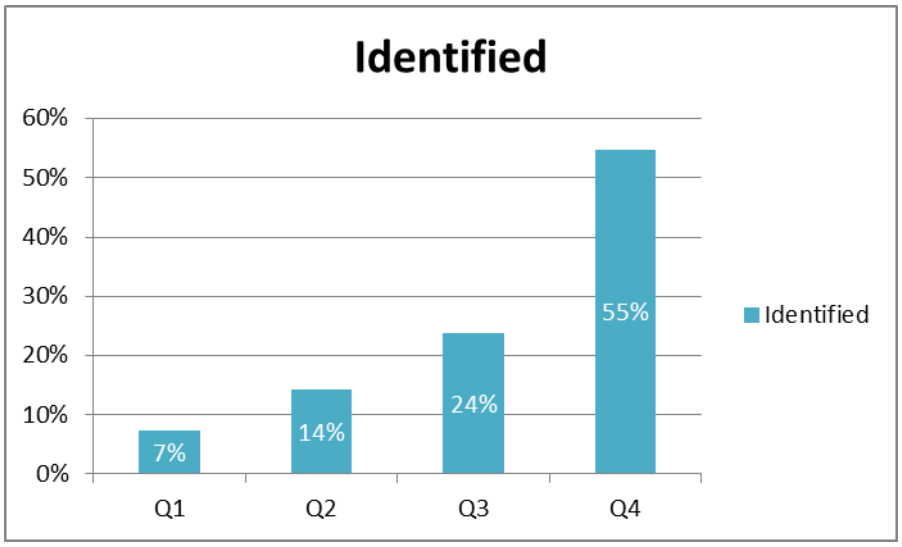
As can be seen from the table, unidentified QIPP needs to be £2,870k to achieve the overall QIPP target. It should also be noted that these figures exclude relevant direct costs. These will be added once they have been quantified.

13. Profiling of 2016/17 schemes

13.1. Detailed analysis of the projects forming part of 2016/17 QIPP, reveals that the savings profile is back end loaded towards the end of the financial year. The gross savings profile for identified schemes (adjusted for risk) is as follows;

Project	Q1	Q2	Q3	Q4	Total
Coding and Counting	-	-	-	637,500	**637,500**
Continuing Healthcare	-	-	160,500	220,687	**381,187**
Corporate Efficiency	-	-	179,506	179,506	**359,012**
Case Finding 50+	101,400	202,800	304,200	405,600	**1,014,000**
QMH Referrals	5,195	59,718	93,935	102,103	**260,952**
0-16s respiratory	12,185	12,185	12,185	12,185	**48,738**
Practice Variation/Demand mgt	140,655	140,655	140,655	140,655	**562,622**
Referral Management Centre	-	-	-	169,190	**169,190**
MSK Connect Pathway	70,200	70,200	70,200	70,200	**280,800**
Prescribing	108,675	108,675	108,675	108,675	**434,700**
Foetal medicine	-	-	-	1,100,000	**1,100,000**
	438,310	**594,233**	**1,069,856**	**3,146,301**	**5,248,700**

13.2. Savings by quarter expressed as a percentage of total savings are as follows;



13.3. The table above shows that £3.1m of a total of £5.2m post risk adjusted gross QIPP will be delivered in Q4. There are several particular reasons for this;

13.3.1. Coding and counting – Savings require in depth analysis of in year data. The current assessment assumes that the data gathering exercise will be undertaken with six months' data. Savings will be delivered once the analysis has been completed and the resulting changes to coding made and agreed.

13.3.2. Continuing health care – the service has been recommissioned with a new provider (CLCH) from July 2016. The savings impact has been phased to take effect from October 2016 to allow the new provider time to complete the necessary transformational changes.

13.3.3. Corporate efficiency – the savings profile assumes that cost reduction will take effect from October 2016.

13.3.4. Case Finding 50+ - savings have been phased 10% Q1, 20% Q2, 30% Q3, and 40% Q4. This allows for a ramping up of the impact of the locality teams, rapid response teams and the holistic assessment rapid investigation service. Within this timeframe the new provider is also expecting to rebuild the service, recruit up to establishment levels to deliver the intended outcomes.

13.3.5. QMH - Savings have been calculated with reference to the 2015/16 phased baseline. The 2016/17 profile is therefore greater for those quarters with higher spend in 2015/16.

13.3.6. Referral Management Centre – the savings profile assumes that savings start to be realised from January 2017.This is three months after the pilot go live date of October 2016.

13.3.7. Foetal medicine – the timing of the savings depends largely on when the agreement with NHS England is reached. Agreement in principle has already been obtained. Further meetings are being arranged to agree the quantum of the payment.

14. Programme risk mitigation

14.1. Identified risks in the programme will be mitigated through the robust monitoring and reporting of QIPP. These arrangements are the subject of the QIPP Governance report. In addition risk factors have been applied to projects to reflect the risk around the CCG's capacity to deliver savings in year.

14.2. Some projects also have the potential to "insure" savings. For complex patients, there is the potential to ring fence BCF funding to the value of the QIPP. For demand management, the CCG are reviewing the ability to insure QIPP savings via the negotiation of the PMS contract.

15. Process for closing the "unidentified" gap

15.1. The CCG has identified a number of processes for identifying further QIPP schemes in year. These schemes will form part of a phase 2 QIPP plan that will be developed in the coming weeks.

15.2. The CCG will review the QIPP schemes of other commissioners particularly those in the South West London region. Particular examples include Wandsworth CCG's pathology scheme and Kingston CCG's Mental Health Scheme.

15.3. The CCG is in the process of commissioning a company to develop analysis for a Financial Recovery Plan (FRP). It is expected that this work will identify further areas where the CCG can exploit savings in year with a knock on effect in 2017/18. The successful company will also bring knowledge of schemes that have worked well in other CCGs and in other health economies.

15.4. In addition to these plans, the CCG will develop a set of proposals centred around reducing expenditure on other budget lines. This piece of work would require a Quality Impact Assessment.

15.5. The timing of these strands of work will be critical to ensure that the projects have an impact in the current financial year. EMT will receive timely updates on progress throughout the year. The results of this work will be tabled at the May Finance Committee meeting.

16. 2017/18 Forward View

16.1. The CCG budget plan indicates that the QIPP target for 2017/18 is £9,939k. This is calculated as follows;

	Baseline	%	QIPP £
Commissioned Services/Running Costs Allocation	241,321	4.0%	9,653
Primary Care Allocation	28,595	1.0%	286
Total Allocation	**269,916**	**3.7%**	**9,939**

16.2. Some of the 2017/18 requirement will be met by the recurrent element of 2016/17 QIPP. The 2016/17 QIPP schemes have been assessed as having an impact on the 2017/18 QIPP plan as follows;

	QIPP £
2017/18 impact of 2016/17 QIPP schemes	1,875
Balance to deliver	8,064
	9,939

16.3. The value of 2017/18 QIPP not covered by the 2016/17 schemes is therefore currently valued at £8,064k. It is expected that this sum will be found from the transformation process that the CCG is currently undertaking. As the transformation process develops it will begin to populate ideas and new schemes that will have a financial effect in 2017/18.

17. Recommendations

17.1. The Governing Body is requested to;

17.1.1. review, comment and agree the QIPP Governance Structure for 2016/17.

17.1.2. agree the content and frequency of reporting of the QIPP programme.

17.1.3. review comment and approve the QIPP plan for 2016/17.

Chris Moreton
I/Deputy Chief Finance Officer