PAN DORSET QUALITY INNOVATION PRODUCTIVITY AND PREVENTION (PDQ)

REPORT TO BOARDS OF NHS ORGANISATIONS IN BOURNEMOUTH, DORSET AND POOLE

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1. INTRODUCTION

1.1 For the next three to five years the NHS will face a period of severe financial constraint; however NHS organisations in Bournemouth, Dorset and Poole are determined to:

- continue improving the **health of the local population,** as assessed through the emerging NHS Outcomes Framework;
- deliver **financial stability**, allowing for the planned development of services to meet the needs of the local population in the most effective, efficient and cost-effective way.

1.2 As no significant funding growth is expected, financial pressures for all NHS organisations will inevitably increase. These are fuelled by demographic trends, changes in the patterns of disease, patient and national expectations for service developments and the introduction of new technologies. There will also be significant pressures from the absolute reductions in Social Services and other public sector budgets.

1.3 Given the NHS across Dorset has a budget of around £1.2bn, the challenge is to meet the demands for service and improving outcomes, whilst staying within that budget.

1.4 The estimated gap in Dorset between the historic rate of NHS funding growth and the forecast expenditure for the next three year period (2011/12 to 2013/14) amounts to about £200 million. Given no significant new money this equates to an estimated improvement in productivity of around 5 to 6 per cent per year. This is probably double the rate the NHS has achieved historically.

1.5 NHS organisations in Bournemouth, Dorset and Poole have agreed to work together in a Pan Dorset QIPP (PDQ) Programme to plan in a co-ordinated and transparent way the:

- **quality and productivity** improvements required to meet the expected funding gap from 2011/12 onwards;
- **re-profiled spend --** in a flat cash environment any requirement for new investment must be handled via a transparent and consistent prioritisation process that ensures maximum benefit for patients and the public, as well as for taxpayers.

1.6 The purpose of this paper is to secure the support of Boards to the PDQ objectives and guiding principles and to agree that responsibility for implementing solutions will be shared by NHS and partner organisations, holding each other to account.

Principle 1
All NHS organisations locally recognise and accept responsibility for the requirement to deliver financial improvements and avoidance of growth. This applies to all sectors and parts of the NHS system in Dorset, amounting to a total provisionally estimated £200 million during 2011/12 to 2013/14. We will do this by improving quality, innovation, productivity and prevention, in a way that maximises population health outcomes.

2. CONTEXT AND STRATEGIC VISION

2.1 "QIPP and reform" plans are required for each health economy, as set out in the recent White Paper. As soon as appropriate these need to be led by GP consortia and Local Authority Health & Wellbeing Boards. The plans need to show how clinical outcomes and financial stability will be achieved.

2.2 Each NHS organisation in Bournemouth, Dorset and Poole has its own strategic or service development plan. The PDQ aims to develop a shared strategic vision and an agreed programme of top priority service changes in order to meet the challenge.

2.3 To change this pattern requires a significant change in the way health care resources are allocated, as well as changes in the model of care. Future investments in local health services should aim to maximise the impact on population health outcomes, as well as transforming the current model of care so that intervention and support occurs earlier in disease pathways.

Table 1: Changing the Focus

Principle 2
All NHS organisations locally recognise the need for future health care investment to be made in ways that maximize the impact on population health outcomes. If we do nothing to alter the current pattern of expenditure the current model of care will become unaffordable. Changing the current pattern of care will require all organisations to ensure interventions are provided earlier in disease pathways, including disease prevention.

3. IDENTIFYING THE PRODUCTIVITY SAVINGS

3.1 The PDQ approach requires a shared understanding of where cost pressures, investment priorities, prevention and productivity opportunities arise across all organisations. How the target of £200m over the next three years can be achieved should be thought of under four headings:

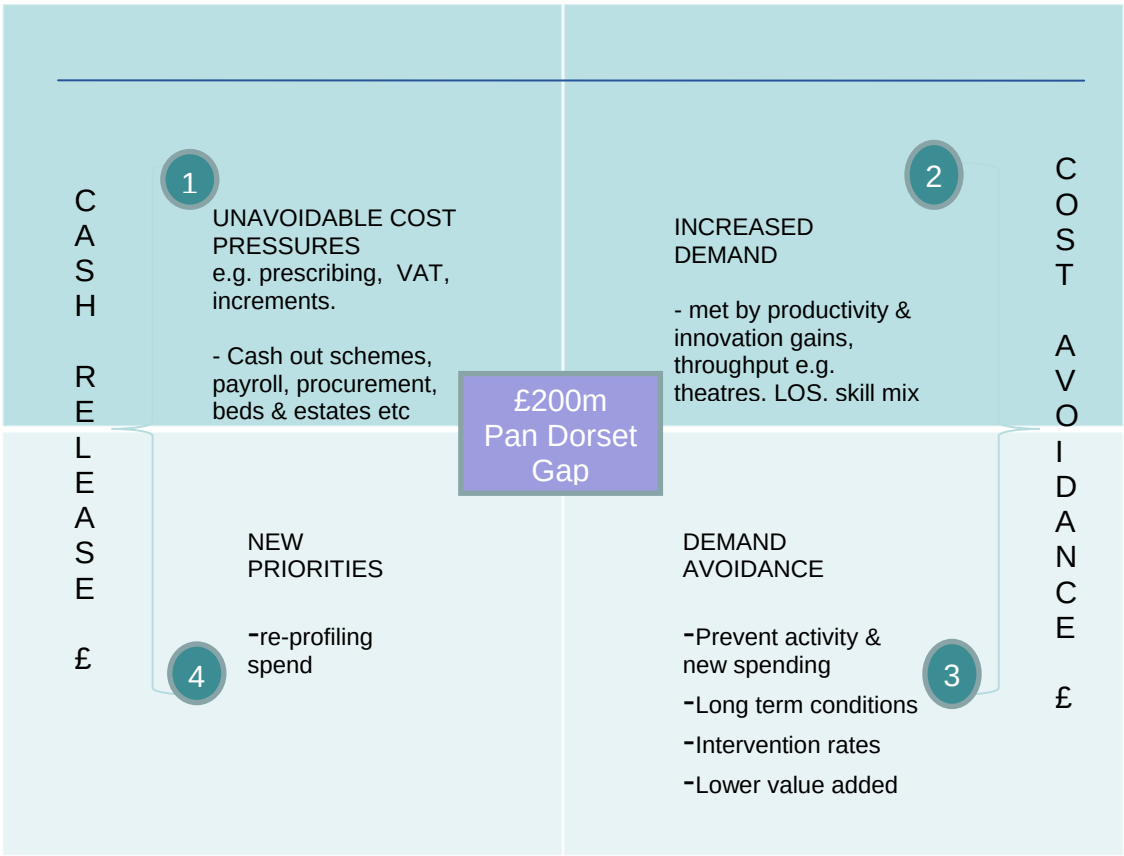
1) **Unavoidable cost pressures**: to be financed by cash releasing savings and real cash out of the system;

2) **Increased demand**: to be offset by increasing productivity, innovation and managing expectations of the public and patients;

3) **Demand avoidance**; although in the past this has been funded via NHS growth; as there will be no growth the focus must change to ensure that the historic increases in activity are managed back down or reversed, in ways that target areas where there is less value added, such as emergency admissions.

4) **New priorities**; that improve population health outcomes: these should be funded by re-profiling current investments, and where they require new funding this will increase the amount of “cash out” schemes.

Table 2: QIPP Productivity Pot



3.2 The diagram above represent the four areas, with the left hand boxes requiring cash releasing and budgeted savings, and the right hand boxes productivity and avoidance. Work is underway with the Directors of Finance in Dorset to assign the expected £200m gap against these categories.

3.3 To meet the requirements of the Department of Health and of NHS South West, an initial Pan Dorset QIPP Plan was submitted to NHS South West on 23 July 2010. The plan was based upon best practice initiatives and benchmarking to identify and scope the size of opportunities. The financial summary is shown in Table 3.

3.4 This plan has not been agreed with providers, Local Authorities and potential GP Consortium leaders. It does though capture the assessment of PCT staff, using benchmarking and best practice collated by the SHA and McKinsey. As such it provides a starting point for discussions about how the level of savings could be met. Far greater detail is available on request.

3.5 This plan showed that the Bournemouth, Dorset and Poole health community has potential plans to achieve net savings of £197m, with the mix of cash savings and avoidance still to be specified, as well as impact per organisation. This will be worked through initially via DOFs, and then as part of the contracting and planning process.

Table 3: Initial system wide saving potentials, as at 23/07/10

	Cumulative Net Savings		
	2011/12	**2012/13**	**2013/14**
	£'000	**£'000**	**£'000**
Shifting settings of care and optimising urgent care	6,189	11,456	17,852
Optimising elective care pathways	11,457	41,072	65,079
Adopting best practice care pathways for long term conditions	4,644	8,896	14,190
Improving prescribing	1,698	2,774	4,001
Improving primary & community care	5,655	9,955	15,690
Improving mental health	-10	-350	8,759
Improving learning disabilities	1,800	2,690	4,070
Improving non clinical productivity	6,300	17,220	27,220
Schemes not covered by other prescriptions (mainly FYE CRES)	22,517	31,517	40,517
TOTAL	**60,250**	**125,230**	**197,378**

3.6 The allocation of these savings, and the underpinning plans need to be developed, with alternatives being found where proposed plans cannot be progressed. This is the work expected for September-November, which will be captured in a second QIPP Board paper. These will in turn influence the budget and contract setting for 2011/12 onwards. However this detailed work cannot begin until the Boards agree the overall direction and issues within this paper.

Principle 3
All local NHS organisations are responsible for their part of implementing the pan-Dorset QIPP plans when agreed. While responsibility for delivering healthcare services within budget rests with the boards of individual organisations, there is recognition that implementing the plans requires collaboration between organisations, and across organisational boundaries.

4. HEALTH SYSTEM REFORM: PRIORITIES FOR THE PDQ

4.1 The four priorities are:

- agreeing re-profiling of spend towards maximising population health outcomes. (See Table 1)
- reversing the growth in non-elective activity, mainly by optimising long-term condition management;
- keeping a tight control on elective costs;
- prioritisation and re-allocation of any re-profiled spending.

Table 4: Opportunities to Maximise Population Health Outcomes

Improving the management of **stroke** risk factors including atrial fibrillation (AF) has the potential to reduce the number of strokes dramatically in Dorset. The National Stroke Strategy focus on access to acute stroke beds is important but improving outcomes for those admitted with stroke, will not reduce the numbers presenting. An estimated £80 million is spent each year on diagnosis and treatment of **cancer** patients in Dorset – yet the estimated NHS spend on programmes to reduce the incidence and prevalence of cancer is about £4 million – and this includes the three national cancer screening programmes for breast, bowel and cervical cancer A systematic offer of health checks for **cardiovascular** risk factors to the population could improve the identification and management of risk factors for many chronic diseases such as smoking, lack of physical activity and diet. They are currently offered to less than 1 per cent of eligible patients in Dorset.

4.2 The historic pattern of growth locally shows that the first priority for the PDQ should be to constrain and reduce demand, particularly **non-elective admissions to secondary care**. Some of this will be growth avoidance, and some releasing actual costs, especially in beds, diagnostics, and duplication and delay in services.

4.3 The PDQ plans submitted to the SHA on 23 July contain a number of initiatives under the urgent care and LTC heading that are aimed at admission avoidance. Priority should be given to identifying how these schemes can be funded, such as through planned reduction in secondary care capacity linked to transfer of resources to preventative work.

4.4 The important point to agree is that there should be an avoidance of creating new capacity, unless it is matched by greater capacity reduction elsewhere.

This is because this new capacity tends to fill by creating new demand, while the existing capacity and costs remain in place. Clearly this is not a viable option, and all invest to save schemes will need to demonstrate how they will avoid this.

4.5 An important principle of health system reform locally is to recognise that acute hospital boundaries may become more porous in order to support people earlier in disease pathways and closer to home. Tariffs could be developed that incentivise and reward quality of care earlier in disease pathways, and for avoiding admission to hospital except when strictly necessary.

4.6 A second priority within the PDQ plans is planned work to **optimise elective care pathways,** including reducing standardised admission ratios to the level forecast by local population need and national benchmarking. This accounts for one-third of the identified savings opportunities locally. However it is expected much of this is around growth avoidance, given the high levels of growth in previous years. Positive work is already occurring such as in lower cardiac intervention rates in the east of the County.

4.7 The PDQ plans must reassure all stakeholders that any reduction in income and capacity will be managed in a way that does not leave providers with fixed costs and overheads that make them unsustainable for the remaining services they provide. Developing new business models, such as health maintenance and prevention work, or lower turnover but better margins, should all be part of the options considered.

4.8 The third priority for the PDQ is to agree and establish a **prioritisation process** that sets out some rules around how the anticipated savings will flow so that the productivity savings are re-invested in a way that maximises population health gains and outcomes.

4.9 The fourth priority is to **accelerate 5-6 significant projects in 2010/11** that would not otherwise happen at the scale and pace required to make a significant contribution to cost and clinical outcomes. These would be projects that either aren't in current CRES or commissioner plans, or aren't for delivery in this financial year.

4.10 In year 1 of the PDQ plans (2011/12) there is unlikely to be funding for new developments requiring significant new investment. This is because until system reform begins to happen at pace, there is a real risk of escalating cost pressures. This is because investing in new services and capacity, even if they are intended to avoid growth in other areas, has a tendency to induce new demand. Therefore any new investments need to match taking capacity out elsewhere in the system.

4.11 Therefore the need is to identify projects that are about reducing demand and improving outcomes, from existing resources being deployed in innovative ways. This may be new settings or ways of working, or other new approaches.

4.12 The suggested criteria to select these projects are thus:

- Extra clinical leadership and project support needed to deliver in year
- Delivers significant cost improvement, ideally in cash releasing terms
- Will improve patient outcomes, as measured via the draft National Clinical Outcomes framework
- Has a strong degree of clinical support, especially amongst those affected by any change
- Will not happen within the confines of existing CIP/CRES plans

4.13 A clinical conference on the 9th September, and work with clinical leaders will identify the projects that may have the greatest benefits. Work would then start in late 2010, so they have a full effect in 2011/12. Some initial areas that are being considered are:

COPD admission avoidance	Heart failure
Re-admission avoidance	Dementia care (inc acute settings)
End of life care	Long term condition management ie diabetes avoidance & management
Stroke pathways, from prevention to acute care	Single point of contact for emergency care

4.14 This list is not exhaustive, and work to develop the clinical consensus as to where the opportunity and will is greatest will be undertaken in September and form the basis of the 2nd QIPP board paper.

4.15 The approach to funding all new developments or investments will be to identify services or interventions of lower value that could be reduced or stopped in order to fund the newly proposed development. A scoring tool exists to support the development of ranked lists of investments within clinical pathways or programmes, based on the Portsmouth scorecard. This work should be led by clinicians, supported by public health and managers.

4.16 The incentive for all organisations in Dorset is to work flat out on reducing demand and avoiding admissions, in order that a bank of productivity savings is built up for re-investment in agreed and prioritised new schemes. Priority will be given to investments that are based on robust evidence and will maximise population health outcomes.

Principle 4
All NHS organisations locally recognise that the health care system needs to change in order for it to become sustainable and affordable. The PDQ will support providers to develop new models of care that enable more people to be supported in the safest, most cost effective setting, and deliver interventions earlier in disease pathways where possible. Income streams may have to change to facilitate system reform, but this will be managed in a way that leaves the health provision system with a viable future.

5. "BUSINESS RULES" REQUIRING BOARD AGREEMENT

5.1 Accelerating progress in delivering plans that improve outcomes and costs requires new ways of working, which Board's need to endorse. These are the specific actions, and rules upon which a new way of working can start to have a significant impact. They are agreeing:

- Adhere to the timelines set out in section 6, so there are deadlines that Boards hold their management teams to account for meeting.
- Three to five year indicative provider contract values, with 2 year contract values for 2011/12 and 2012/13, with mutually agreed transition plans if that requires significant financial and operational change
- The principle of GP ownership of plans and incentive schemes to reward behaviour that improves clinical outcomes and cost control, as indicated within the White Paper
- The principle of moving to a new business model for providers, incentivising prevention and Long Term Condition management, above activity growth
- Sharing of internal performance management of cost improvement programmes and cost control, via Programme Management Office reporting, to enable reporting that is aggregated across Dorset.
- Savings are based upon cost release, not tariff variances.
- Agreement to participate fully in a single Dorset-wide process for prioritising all investment bids, funded from re-profiling current spend. All NHS organisations to nominate two representatives to assist with the scoring process which will use clear and consistent criteria to evaluate the impact on clinical outcomes and cost effectiveness. Funding will only be available after delivery of cash releasing savings beyond those required to meet unavoidable cost pressures.
- The current financial pressures require additional effort in 10/11 to deliver the run rate of lower activity and costs, so that 11/12 onwards the system is moving back to a sustainable level. Therefore action is required this financial year, above that is happening already. Agreement to supporting the selection and delivery of 5-6 major projects (as per 4.9 to 4.13) is required.

- Accepting different starting positions and solutions means the 3 year trajectories will vary as to how much is required in year one, by organisation, and the balance between productivity and cash out. The exact balance is to be agreed via the pan-Dorset Directors of Finance by the 22nd September, in order to influence the 11/12 contract setting.

Principle 5 The above set of business rules represents a new way of undertaking the planning and contracting of services with the Dorset health economy, and is supported by the Boards so as to deliver the basis for a transformed health system able to meet the challenges facing it.

6. TIMELINES

6.1 An outline pan Dorset QIPP Project Plan and timetable is being prepared and is summarised here:

6 Sept 2010	Dorset Chairs and CEOs;
9 Sept	Clinical leads conference;
Sept/Oct Board cycle	Common Board paper on PDQ approach, agreed by all the NHS Boards in Dorset
22 Sept	Pan-Dorset DoFs agree financial assumptions
23 Sept	SHA challenge session on pan-Dorset QIPP plans
Oct	Finalise draft CIP-QIPP plans for 2011/12 including the 5-6 major projects to start in late 2010; Secure support of GP consortia and Local Authorities as well as providers affected;
Nov/Dec:	Agree a common QIPP plan, via paper to all Boards
Jan/March 2011	Single NHS public consultation in Dorset on QIPP and Annual Plans; preceded by an engagement strategy involving key stakeholders. Agree common reporting format to track initiatives, as well as each organisation's own cost and quality improvement plans, via PMOs
April +	QIPP initiatives inform budget setting, contract agreements, clinical service redesign; with regular monitoring in place.

7. OPTIONS

7.1 Each NHS Board in Dorset needs to consider the options available, before committing considerable time and effort to progressing the Pan-Dorset QIPP approach, as set out here.

7.2 The default option would be to continue to work as now, finding internal savings to meet the pressures and developments each individual Board considers best allows it to meet its own duties. Collaboration would only occur where it is directly and quickly in the benefit of parties involved. The sustainability of individual organisations is the responsibility solely of that Board.

7.3 The alternative option is to commit to a pan-Dorset approach, which recognises the need to compete and collaborate, but fundamentally sees the success of the health system is based upon improving clinical outcomes and financial stability. The first practical steps to this are set out in section 5 and are endorsed by the Board.

8. RECOMMENDATION

8.1 The Boards of NHS organisations in Bournemouth, Dorset and Poole are asked to approve this report, and the recommended option of taking the Pan-Dorset QIPP approach to identifying and meeting the estimated £200m gap in Dorset.

8.2 Boards are specifically asked to endorse and support the implementation of the five principles as set out in the report, including the timeline.