NHS
Thurrock
Clinical Commissioning Group

Agenda item: 5b

THURROCK BOARD MEETING

26/03/14

Title of Report:	**Thurrock CCG QIPP and Commissioning report**
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Presented by:	Raymond Arhin and Rahul Chaudhari
Committees previous consutled:	QIPP Committee
Executive Summary:	The paper aims to appraise the Board of monthly (Feb 14) progress and development of Thurrock's QIPP initiatives; and Commissioning updates on NELFT and BTUH contracts
Recommendation to the Board:	Board members are asked to note the actions and progress being made by the various QIPP work-streams
Financial Implications:	The QIPP plan forms part of the CCG's financial plan
Fit with CCG strategy/objectives:	Forms part of the CCG's 2013-14 Integrated Operational Plan
Risks identified:	Failure to deliver the full effect of the QIPP plans and the resultant pressure on the CCG's fiancial plan. Failure to adequately monitoir the provider contracts will adversely offect CCG's commissioning vision
Resource Implications:	QIPP committee and various provider contract monitoring committees

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Introduction

This paper aims

- to appraise the Board of progress and development of Thurrock's QIPP initiatives encompassing Medicines Management, Planned, Unplanned Care, Mental health and Paediatrics work programmes.
- To inform the board of the draft proposals for 14/15 QIPP schemes

CCG QIPP meetings (minutes of the meetings are attached)

Since the last board meeting the QIPP committee met once and the members were presented with the current performance on the 13/14 QIPP projects and year end forecast delivery. The committe also reviewed the draft business cases for 14/15 QIPP schemes and will be formally signing the business cases at the next core meeting

Unplanned Care

Operational delivery against unplanned care QIPP initiatives continues to be strong including:

- RRAS experiencing continued growth in activity in December and January; with 174 and 192 patient contacts seen by month respectively. Conversion from contact to assessment also improved within this time period from December: 69% *(174)* to January: 71% *(192);*
- Primary Care MDT reviews saw a slight fall in the number of meetings and patients discussed within December *(falling to 86 patients)* though post-holiday season picked up to 129 patient reviews *(56 new / 81 follow-up);*
- Telehealth: currently 39 *(of 54 units)* are in active use; with NELFT looking to increase utilisation through risk stratification of patients in their Integrated Community Geriatrician service.

The CCG has been working in partnership with Basildon and Brentwood CCG *(acute commissioning lead)* to agree and finalise unplanned care commissioning arrangements with Basildon hospital for 2014/15. The revised contracting arrangement with BTUH *(based on Block-contract modelling)* should facilitate renewed interest in improving care-pathway redesign for non-elective activity. The following initiatives are currently being reviewed by BTUH and the CCG commissioners for part-year implementation in 2014/15:

- **Ambulatory Emergency Care**

Ambulatory Emergency Care *(AEC)* is a service which provides same-day emergency care to patients; this means that patients are assessed, diagnosed, treated and are able to go home the same day without being admitted overnight. The national directory of AEC

pathways was first published in 2007 and now comprises of 49 evidence-based pathways e.g. cellulitis.

BTUH are currently in the process of formalising implementation dates for their revised AEC model within the main acute hospital; though anticipate full delivery of their revised plan prior to the new intake of Junior Doctors in August 2014. Within the initial draft of this document, BTUH have proposed a hybrid of the traditional AEC care-pathway specific approach; moving toward a model more responsive to patients identified as having an 'ambulatory' condition irrespective of their respective required care-pathway.

NELFT, as part of their 2013/14 Q4 AEC CQUIN are in the process of completing a template devised by the CCG to map against the full list of the national 49 care-pathways those that can be delivered safely and efficiently and managed within a community environment *(current and prospective).* We anticipate the AEC matrix, currently being formalised by NELFT, will be a vehicle for further discussions with BTUH on system-wide delivery incorporating:

- Clinical policy challenge to ensure follow-up AEC treatments are managed *(where appropriate)* within the community e.g. DVT;
- Identification of care-pathways requiring joint development / cross-pollination of workforce *(as seen within the Integrated Community Geriatrician model locally);* and thereby creating an on-going work plan and commitment between the key provider stakeholders;
- Aid development of the local NHS 111 disposition-based directory of service;
- Expansion of RRAS / SPOR *(Community Assessment Unit)* service portfolio;
- Inform contracting arrangements for the Thurrock Walk-in Centre.
- **Frail Elderly**

  The Frail Elderly work-stream encompasses a number of initiatives being explored and developed in partnership with key commissioning stakeholders including:

o **Adaptation of the Frail Elderly Ward model at BTUH**

  The proposed reconfiguration of the Frail Elderly ward at BTUH is currently being finalised by the Trust for review by the Unplanned Care working group. The frail elderly ward mirrors the principles of AEC, ensuring non-elective admissions occur where medically required and are not informed purely on the perceived 'frailty' of the patient's condition.

It is envisaged this model will initially be more resource intensive as investigations, diagnostics and assessments are carried out within a short-time frame by a multi-disciplinary team encompassing: Consultant Geriatricians, specialist nurses, therapists and social care professionals.

- **Comprehensive Discharge**
  The Unplanned Care working group has commenced with a pilot which aims to identify an appropriate structure for delivering an acute comprehensive discharge plan for all frail elderly patients *(>75yrs)* as part of their non-elective admission.

  This proposal would see the discharge plan encompassing an on-going care management plan to aid GP-led monitoring of their frail elderly patients; following a non-elective attendance / admission.

  It is envisaged this initiative will inform Primary Care MDT lists within 2014/15 *(as we await confirmation of changes to the Section 251: Information Governance restrictions)* and help the development of primary care remote monitoring of patients and their onward care.

- **SystmOne Integration with Care Homes**
  TPP have recently offered CCGs to implement a S1 module for care homes. This would allow for full-read and write access to a patient's integrated S1 record from within the care home setting; which at present will include 90% of GP records, all Community Services and all NHS 111 and GP OOHs records.

  Currently S1 are offering this system free to all elderly care homes and fortunately does not indicate there is a necessity for N3 connection *(normally a large associated cost to implementation).*

  This is an exciting opportunity for the CCG, as this would afford General Practice or Community Services to structure patient care within the Care Homes, in addition to potentially being utilised as a remote monitoring tool for agreed vital clinical signs *(utilising and expanding upon the principles of Telehealth).*

  As part of this initiative NELFT have been asked to compile a matrix of all Thurrock-based Care Homes; mapping against each all active or planned Community Service initiatives e.g. Community Geriatrician reviews. It is

proposed this matrix would help inform the identification as to which Homes we promote as being appropriate for S1 implementation.

These proposed initiatives have been endorsed by the Core QIPP commissioning group and will feature with two separate business cases.

Paediatrics


CSU CYP Report BB Thurrock February 2C

Prescribing

The Medicines Management Team is currently working with a number of practices in order to provide practice-based support around all areas of prescribing, including diabetes, respiratory and nutritional prescribing. The Medicines Management Team is also finalising QIPP plans for 2014/15 in order to optimise savings from existing QIPP initiatives such as ScriptSwitch, as well as new transformational opportunities around diabetes and respiratory pathways. Close collaboration is currently underway with BTUH to develop and implement local asthma, COPD and diabetes guidelines which will promote high quality and cost-effective prescribing in both primary and secondary care. The new Home Enteral Feed (HEF) arrangements for tube fed patients will also ensure significant cost-savings for 2014/15, as well as marked improvements in patient care.

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Thurrock CCG 2013-14 QIPP performance based on Feb data

Key risks- Section 251 around information governance continues to remain a risk in terms of data reporting.

Green >= 95% of plan Amber/Green >= 80% of plan Amber/Red >= 50% of plan Red <= 50% of plan	Workstream	13/14 Planned Savings	Current Month				YTD Performance				Forecast Outturn	Schemes included and YTD data months
			Planned Savings	Actual Savings	Variance	% Savings Achieved	Planned Savings	Actual Savings	Variance	% Savings Achieved		
Savings	Planned Care	(1,240,903)	(95,232)	(155,668)	(60,436)	163%	(907,121)	(929,360)	(22,239)	102%	(907,742)	Practice Level Referral Management M1 to M9 Consultant to Consultant BTUH M1 to M11 Fortis RMC M1 to M11 SRP M1-M6 Accupuncture M1 to M9 Nuffield MRI M1 to M8 Paediatrics Best Practice Tariff M1-M11
	Unplanned Care	(1,475,108)	(120,523)	(66,910)	53,613	56%	(1,161,958)	(707,938)	454,019	61%	(898,113)	EEAST-Impact of Reduced Unplanned Care+ Decommission Admissions Avoidance Car M1 to M11 Primary Care MDT Reviews M1 to M9 GP in A&E M1 to M9 Telehealth M1 to M9
	Mental Health	(468,390)	(48,361)	(36,123)	12,238	75%	(376,279)	(335,621)	40,658	89%	(377,869)	Dementia Challenging Behaviour M1 to M11 MCCH M1 to M11 (commenced in M5) Out of Area M1-M5 Crisis Redesign (Inc RAID) M1 to M10 (commencing M5)
	Medicines Management	(946,000)	(78,833)	(30,658)	48,175	39%	(709,500)	(483,346)	226,154	68%	(644,462)	Dietetics/ Oral Nutritional Supplements M1 to M9 Scriptswitch M1 to M9 Respiratory M1 to M9 Diabetes/ Insulins M1 to M9 Specials M1 to M9 Care Homes/Mental Health M1 to M9 Stoma M1 to M9 Lipid Lowering M1 to M9 Woundcare M1 to M9assumed to be achieved to plan pending validation of the apparent extra saving achieved Misc savings M1-M9
	Paediatric Services	(306,768)	(25,564)	(25,564)	0	100%	(281,204)	(281,204)	0	100%	(306,768)	CAMHS NCA M1 to M11
	Contract Reductions	(1,405,382)	(117,115)	(117,115)	0	100%	(1,288,267)	(1,288,267)	0	100%	(1,405,382)	Price Deflator (NELFT & SEPT) Non Acute 1.3% M1 to M11 Price Deflator Acute 1.1% M1 to M11
	Total	**(5,842,551)**	**(485,628)**	**(432,039)**	**53,589**	89%	**(4,724,329)**	**(4,025,737)**	**698,592**	85%	**(4,540,337)**	
			(495,172)	**(340,579)**	**154,594**	Previously	**(4,557,357)**	**(3,638,624)**	918732.709	**Forecast Planned**	**(4,540,337)**	
										Planned Savings	**(6,332,551)**	
										Variance	**(1,792,214)**	

TABLE 2

THURROCK CCG - 2013/14 CCG QIPP Workstream Savings Summary (Non-Validated Figures)

	Workstream	13/14 Planned Savings	Current Month				YTD Performance				Schemes included and data months
			Planned Savings	Actual Savings	Variance	% Savings Achieved	Planned Savings	Actual Savings	Variance	% Savings Achieved	
Savings	Planned Care	(65,000)	(5,629)	0	0	0	(46,577)	0	0	0	Consultant to Consultant non BTUH M1 to M9 Dermatology M1 to M9
	Unplanned Care	(400,000)	(32,000)	0	0	0	(299,200)	0	0	0	DIST Service M1-M9-notional
	Mental Health	(25,000)	(5,000)	0	0	0	(10,000)	0	0	0	Dementia Care Line
	Total	**(490,000)**	**(42,629)**	**0**	**0**	**0%**	**(355,777)**	**0**	0	0	

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Contract Negotiations and QIPP 2014/15.

Memorandum of understanding for both the BTUH and NELFT contracts had been agreed by 28th Feb 2014 dead line. Contracts are expected to be formally signed by 31st march 2014.

The current QIPP requirement for 14/15 has been revised in light of further information and is now £6.007 m, schemes identified to date total £5.17. Proposed schemes agreed by the QIPP committee have been shared with providers and factored into the activity and finance model. Table below gives a summary of the identified QIPP schemes for 14/15.
Officers are currently working on developing plans to cover the current shortfall of £0.834m and additional schemes to cover the slippage.

Work stream	**Savings**
Planned care	£1.61m
Unplanned care	£0.62m
Paediatrics	£0.33m
Mental health	£0.55m
Medicines management	£1.15m
Community services	£0.29
Other schemes	£0.62m
Total	**£5.17m**