Harrow CCG - 3 Year Strategic and Financial Recovery Plan (2014/15 – 2016/17)

Final Version: 7 November 2013

Executive Summary (page 1 of 4)

Harrow Clinical Commissioning Group

Context

- This '3 Year Strategic and Financial Recovery Plan (2014/15 – 2016/17)' is part of an ongoing process to establish an affordable and sustainable health economy that improves health and health services in the Borough of Harrow.
- A three year Recovery Plan (12/13 to 14/15) was submitted and agreed in November 2011. It was reviewed and updated in 12/13.
- Over the past 12 months, the CCG has engaged widely with patients and the public, worked hard to strengthen relationships with key partners, and implemented a range of service developments.
- Following Harrow's submission of a £10.4m deficit plan in 2013/14, the CCG was asked by NHS England to develop its financial recovery plan.
- In line with our vision and the financial challenge that we are facing, Harrow has undertaken a new round of comprehensive strategic and financial planning.
- Guiding principles of this process include that it is actively owned and developed by the CCG, and it is directed by patient and population health needs.

Future financial projection and QIPP requirement (2014/15 to 2018/19)

- Financial planning assumptions, based on the latest Monitor guidance as set out in the discussion document on "Preparation for Call to Action", as well as anticipated demographic and non-demographic growth, have been used to forecast the financial challenges facing Harrow CCG.
- To deliver break even in 14/15 would require a QIPP of £22.7m, which would represent a 10% QIPP; which is unrealistic.
- To achieve break even over the five year planning period would require a cumulative QIPP of £47.8m.
- Two QIPP scenarios have been modelled 4% per annum (which reduces the deficit from a £22.7m gap in 2014/15 to a £0.2m surplus by 2018/19) and 3% per annum (which results in a £11.9m deficit by 2018/19).
- An upside case has been modelled which assumes an additional 1% of growth funding per annum. The upside case with a 4% QIPP achieves in year balance during 2017/18 and a £12.6m surplus by 2018/19 and with a 3% QIPP in year balance by 2018/19.
- A downside case has also been modelled building in two factors: that the Integration Transfer Fund is not cost-neutral, and that prior year deficits need to be repaid. Without mitigations this results in a deficit of £80.8m by 2018/19 if a 4% QIPP was delivered each year and a deficit of £116.4m by 2018/19 if a 3% QIPP was delivered per annum.

Commissioning Strategy

The planning process has been driven by the health needs of Harrow's population:

- Health outcomes in Harrow are generally good compared to peers, but there are significant variations across the borough.
- Patient feedback has also repeatedly identified the need for greater coordination, collaboration and communication across all services.
- A small proportion of the population (5% c.12k people) use c.50% of resources. The top 20% use c.75%.
- Focusing on proactively supporting these patients to meet their ongoing physical, mental and social care needs would both improve their quality of care and reduce costs.

Plans are built of existing strategies:

- Our CCG vision acts as the foundation on which our other strategies are built.
- Our core strategies include the Joint Health and Wellbeing Strategy (HWBS) to improve health and wellbeing in Harrow by focusing on 7 core areas; Shaping a Healthier Future (SaHF), a programme to improve health services across North West London (NWL) by reshaping acute and out-of-hospital health and care services across the region; and 'Better Care, Closer to Home' ('Out of Hospital' strategy), which describes the transformation of out of hospital services necessary to enable the delivery of SaHF.
- These are supported by a number of 'service' and 'enabler' strategies and plans,

The CCG has considered the drivers that characterise the QIPP gap:

- Harrow's population has grown by 4.5% over the past 4 years;
- Over the past 3 years, acute activity has grown at between 2-5% per annum (despite alternative services being introduced to provide care out of hospital).
- Financial projections forecast an ongoing growth in acute activity pre-QIPP interventions.

Consequently, the CCG's QIPP strategy...

- Is to continue with the existing plans which look to transform how acute care is provided, and to go further, based the following principles:
  - Integration: proactive and integrated management of high risk / high need patients, (top 5 and top 20%) including their social, mental and physical care needs.
  - Prevention: primary prevention for lower risk patients, and secondary prevention to reduce the rate of increasing needs.
- The CCG will expand a patient-centred approach for vulnerable patients with multiple needs, rather than a disease-specific approach.
- Delivery of this Plan over three years will require the CCG and its partners, including the Local Authority and NHS England, to work in radically different ways.

Proposed three year QIPP Plan

Our QIPP plans will focus on:

Consistent provision of care, *including:*	**Aligning care settings to patient needs:**	**Integrating care (mental, physical & social):**
• Reduce unwarranted variation in outpatient, elective and direct access referrals from primary care • Improved access to primary care; hubs to support Out of Hospital strategy • Effective medicine management • Continuing care – patient review processes & dispute resolution • Recovery based approach to mental health	• Expand rapid response & intermediate care services • Expand Ambulatory Emergency Care • Paediatric pathways • MH Strategy – shifting settings of care • Implement new planned care pathways	• Build on and adapt Integrated Care Pilot • Pilot new models from WSIC • Integrated care for CYP; incl. safeguarding • Optimise use of Integration Transfer Fund • Integrated community nursing

In addition, we will continue to carefully review contract performance and service value for money.

A comprehensive QIPP programme organised around 10 workstream, each with CCG clinical leadership, provides the basis for delivery of the ambitious transformational changes. Moreover, the workstreams will link with the strategic NWL changes programmes, in particular Shaping a Healthier Future, Better Care Closer to Home and Whole Systems Integrated Care. The financial impact of the plans are summarised in the table:

Workstreams *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Integrated care	15,322	6,084	9,238	794	2,641	5,804
Planned Care	11,727	5,642	6,085	2,359	2,704	1,023
Unscheduled Care	6,467	1,897	4,569	2,512	1,477	580
Adult Mental Health	3,083	322	2,761	1,403	875	483
Medicines Management	2,612	155	2,457	866	870	721
Continuing Care	2,493	575	1,918	926	401	591
Community	801	0	801	291	285	225
Children's Services	512	73	440	72	183	185
Grand Total	**43,019**	**14,748**	**28,271**	**9,224**	**9,436**	**9,611**

Details of the workstreams and initiatives are provided in section 4 of this document.

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Delivery Plans

- Development and implementation of the initiatives identified in the 3 Year Plan is the responsibility of the respective named leads and workstreams.
- Each workstream is led by a clinical and managerial lead, and includes other GPs, partners and other stakeholders as required.
- The QIPP PMO will monitor progress against the plan on a monthly basis and supports remedial action where required.
- Harrow has also reflected on the challenges it has faced in fully delivering its QIPP Plans in previous years, and agreed how these will be addressed to increase deliverability in the future.
- Changes include:
    - A set weekly ‘Corporate Day’ when the entire clinical and managerial team work together on site
    - 13 – 14 new staff to support delivery of the strategy (using non-recurrent funding)
    - Strengthened project management processes
    - Named leads for each scheme
    - Being proactive in learning from other CCGs

Conclusion

- Harrow CCG will build on its existing strengths and achievements, as well as lessons learned in recent years, in order to implement the core strategies and supporting plans outlined in this 3 Year Strategic & Financial Recovery Plan.
- This will transform the delivery of local health services, achieve financial balance, and improve the quality of care and health status of the Harrow population.

1. Document Overview

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1b) Document Overview
Overview of the Strategic and Financial Planning process

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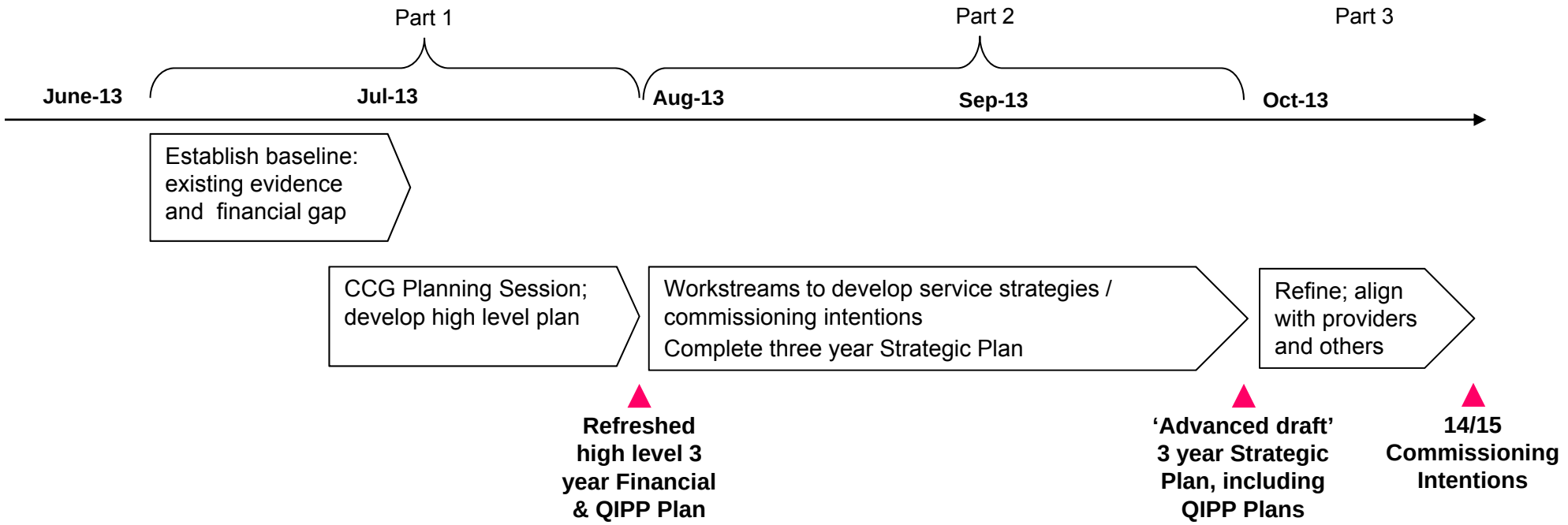
In line with the CCG vision, and in the context of the financial challenge that Harrow is facing, over the past 4 months, the CCG has undertaken a comprehensive strategic and financial planning process.

Guiding principles of the planning process:

1. Actively owned and developed by the CCG.
2. Directed by patient and population health needs.
3. Developed with patients, providers and other partners (e.g. Local Authority).

Leading to a plan to better align our available spend to meet population health needs.

Timescales



1c) Document Overview

Purpose of the document

- To describe Harrow CCG's 3 Year Strategic and Financial Recovery Plan (2014/15 – 2016/17), including how it is aligned to the CCG's vision and objectives, its population needs, and other core strategies.

Overview of each section

- Section 1: Provides an overview of the document and the process by which the plans have been created.
- Section 2: Describes the financial challenges and plan for the next 5 years.
- Section 3: Provides an overview of the population health needs, a summary of key existing strategies, and explanations of the nature of the QIPP gap, the QIPP strategy and a summary of the Commissioning Strategy.
- Section 4: Describes in some detail the QIPP plans for the next 3 years. It provides an overview of the workstream vision and key initiatives, together the planned financial impact.
- Section 5: Explains the delivery approach, structure, learning, key enablers and plans to improve delivery.
- Appendices provide further detail.
- Note: detailed QIPP financial plans, assumptions, and risk ratings are contained in a separate spreadsheet .

2. Future financial projection and QIPP requirement

a) Recent financial history and QIPP delivery

- A three year Recovery Plan incorporating a QIPP plan of £43m (covering 2012/13 to 2014/15) to establish a financially stable CCG was agreed in November 2011.
- This original Recovery Plan assumed that non recurrent support would be received in 2012/13 (£14.6m) and 2013/14 (£5m) to enable the CCG to deliver an in year break-even position (if it delivered the QIPP plan).
- Harrow achieved its financial and QIPP plan in 2012/13. However, this was in part due to £5m benefit from the in-year block acute contract that had been agreed with its main acute provider, NWLHT.
- In 13/14, a deficit plan of £10.4m has been agreed with NHSE, compared with the £5m projected in the initial recovery plan.

QIPP delivery

- Although Harrow delivered a QIPP saving of approximately 4.2% of its income in 11/12, the actual for 12/13 was 2.5% (PbR basis excluding NWLHT block impact) and the latest forecast for 13/14 is 3.0% (see table below).

	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m
Original Recovery Plan (11/12)				
Income (PCT)	348.7	358.5	366.7	375.2
QIPP (in-year)	19.0	14.1	14.2	14.9
QIPP (as % of income)	5.4%	3.9%	3.9%	4.0%
Actual / forecast QIPP delivery				
Income actual/plan (CCG)	348.7	358.5	229.0	
QIPP Plan (in-year)	19.0	14.1	9.6	
QIPP actual/forecast	14.7	14.5	6.8	
QIPP actual/forecast (PbR)		9.1		
QIPP actual as % of income	4.2%	2.5%	3.0%	

a) Recent financial history and QIPP delivery: QIPP current performance (M6)

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- The following two slides show the M6 FOT adverse variances, RAG rating and comments.
- The M6 QIPP FOT is a shortfall of £2.72m (main variances summarised below). This is a slight improvement on M5 which was £3.08m.

Main Variances from Plan	Savings in 13/14 plan £k	M6 Forecast Variances	Clinical Lead	Project Manager
Referral Management	1034	-399	Amol Kelshiker	Anna Donovan
Planned Care Pathways-Outpatients	478	-478	Amol Kelshiker	Anna Donovan
Rapid response and home care-ACS stretch	749	-749	Dilip Patel	Jason Antrobus
Integrated Care Programme	548	-115	Amol Kelshiker	Jason Antrobus
Continuing Healthcare	513	-513	Amol Kelshiker	Sarah Nyandoro

The main variances are:

- Referral management: Accurately assessing the effectiveness of the scheme has been very challenging as a result of the required data not being available from the CSU.
- Outpatients: The procurement approach has now been agreed but the delay in planned implementation has resulted in the realisation of planned savings being pushed back to 14/15.
- IC / STARRS / ACS: The proportion of planned saving being achieved by the existing provider is increasing – 88% forecast NEL admission avoidance; 91% forecast attendances avoided in the most recent period;
- Continuing Care Efficiency: There is a cost pressure in continuing care - a reduction in universal services has resulted in the CCG having to supplement the difference with increased care packages e.g. reduction in Community and District Nursing services where continuing care is picking up costs.

a) Recent financial history and QIPP delivery:
QIPP current performance (M6)

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Project Name	PMO deliverability RAG	Savings in 13/14 plan £k	M6 Forecast Variances	Comment
Programme Total		**9554**	**-2719**	
Referral Management	R	1034	-399	Additional data is required from the CSU before the effectiveness of schemes designed to reduce outpatient referrals to secondary care can be measured. The resolution of this matter is being apursued through the SLA process.
Prescribing within budget plan	R	343	154	
Planned Care Pathways	R	478	-478	Delays in the agreement of a procurement approach have pushed the majority, if not all, of the savings opportunity into 14/15.
Assessment Tariff	R	455	-455	This scheme is closed: the assessment tariff was not included in the 13/14 contract with NWLH.
Rapid response and home care-ACS stretch	R	749	-749	Risk share with NWLH that will deliver planned savings in the remainder of 13/14 and 14/5 confirmed. Current service level SUS validated performance is 88% FOT NEL admission avoidance and 91% FOT attendance avoidance. Any delay in decision making will result in a loss of savings in 14/15 due to the reduction of the provider ramp-up phase (present to 31 March 14).
Rapid response and Home Care-STARRS cohort strecth	R	5	-5	
Reduction in Non-Election admissions	R	1111	169	Overperforming against plan.
NHS 111	A	70	-36	
EOLC Rebasing	G	107	36	Overperformance of £36k delivered.
Integrated Care Programme	A	548	-115	Audit of care plans complete.
Productive MH Services / MH Strategy	G	213	0	Some financial risk from transfer of funding for psychiatric liaison.
Productive Mental Health Services	G	337	0	Forecast to achieve plan.
Redesign of Rosedale Bedded Unit	G	94	-94	Savings against this scheme will be accounted for under Continuing Care (HA5-3)
Continuing Healthcare-Adults&Children	A	513	-513	Scheme under review to assess impact of arbitration process.
Pathology Tender	G	264	0	Saving realised, scheme closed.
West London/BEH Contract Review	G	56	0	Forecast to achieve plan.
Acute Direct Access	R	200	-200	Risk of overperformance in diagnostics.
Non-eligible Continuing Care	R	556	-26	Scheme being reviewed.
Reconfiguration of CLDT	G	248	0	Forecast to achieve plan.
Community Paediatrics	R	125	-63	
Continuing Care-children		135	0	Forecast to achieve plan.
Cross Border Contracts	G	169	0	Saving realised, scheme closed.
Podiatry	G	54	46	Although there is no plan against this scheme it is possible that there will be a saving of approximately £40k.
ICO contract (specialist nursing)	G	54	46	Saving realised, scheme closed.
Continuing Care - Block	R	150	-11	Scheme being reviewed.
Specialist Palliative Care	G	150	-26	Saving realised, scheme closed.
A&E Demand management	R	632	0	Forecast to achieve plan.
Mental Health Repatriation	G	259	0	Full savings forecast
CAMHS Tier 4 cost per case risk	G	306	0	Saving realised, scheme closed.
Productive Community Health Services	G	141	0	Saving realised, scheme closed.

b) Working Draft Recovery Plan for Harrow – Response to NHSE Feedback (1 of 4)

Comment	Response
Base Case - Impact on CCG of Achieving Run Rate Balance	The CCG has modelled the impact of both a 3% and 4% QIPP achievement each year. Under the 4% scenario run-rate balance is achieved in 2018/19 as in the previous iteration of the plan. In the 3% scenario run rate balance is not achieved by 2018/19. Both scenarios have been based on a revised set of assumptions regarding tariff deflator, resource and acute expenditure growth.
Base Case - Impact on CCG of Achieving Business Rules	• 1% Surplus This is not achieved during the 5 year planning period. Under the 4% scenario break-even is achieved by year 5 2018/19. In the 3% scenario the business rules are not achieved by 2018/19. • 2% headroom The base case has assumed no contribution to the NWL strategy fund in 2014/15 and 2015/16, 1% in 2016/17 and 2% from 2017/18 onwards. • 0.5% Contingency This has been included for each year of the 5 year period.
Base Case - Impact on CCG of Repaying the deficits	The Harrow CCG Governing Body does not consider this a viable option given the likely detrimental impact on local service provision of repaying previous year deficits. This is borne out by the worst case scenario shown on slide 26 (downside scenario). Worst case scenario is of £81m cumulative deficit by 2018/19 (assuming 4% QIPP).

b) Working Draft Recovery Plan for Harrow – Response to NHSE Feedback (2 of 4)

Comment	Response
Financial Assumptions - Tariff Deflator	The base case has been remodelled to show latest assumptions around tariff deflator in 2014/15 and future years. This results in a benefit of £3.6m over the 5 year period
Financial Assumptions - Resource Growth	The base case has been remodelled to show 2% resource growth each year. This results in a negative impact of £3.5m over the 5 year period.
Financial Assumptions - Rationale for Demographic / Non-Demographic Growth	The non-demographic acute growth assumption has been revised from 3% to 2% in the latest iteration of the model to reflect better most recent experience of acute growth including impact of Specialist Commissioning transfer. This results in a benefit of £8.9m over the 5 year period.
Scenario Analysis - Upside	Upside and Downside cases have both been modelled. The upside model factors in an additional 1% allocation growth each year based on Harrow's DFT position. This results in the achievement of run rate balance by 2017/18 and a cumulative benefit of £12.4m over the 5 year period.
Scenario Analysis - Downside	The downside model factors in the impact of the Integration Transfer Fund if it is not cost neutral and the requirement to repay the deficit each year. This would result in a spiral of ever-increasing deficits resulting in a deficit of £80.8m by 2018/19 (4% QIPP) and £116.4m by 2018/19 (3% QIPP).

b) Working Draft Recovery Plan for Harrow – Response to NHSE Feedback (3 of 4)

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Comment	Response
QIPP - 4% Annual Target	The base case has been modelled on the assumption of the delivery of both a 3% and 4% QIPP each year from 2014/15. A range of between 3-4% is considered the likely range of achievement by the CCG over this period. The current 2014/15 QIPP plan as outlined in the recovery plan is £9.2m (4%). The acute element of the QIPP is 7% gross of Acute expenditure in 2014/15.
QIPP - Resourcing	In 2013/14 the CCG has been supported by Finnamore consultancy services and the BEHH PMO. Use of this budget is under review to ensure best use of this resource to support delivery of the challenging plan.
Integration Funding	The base case has assumed the neutrality of the transfer. However the downside case has modelled the impact of a 50% pressure in 2015/16 and 100% pressure by 2016/17. This results in a potential risk of £4.9m pressure in 2015/16 rising to £9.8m in 2016/17.
General - Alignment with SaHF Assumptions	The assumptions regarding QIPP, resource growth and acute activity included within this model are being used in the latest iteration of the SaHF model.
General - Section on Cash	Cash assumptions have not been modelled in detail as part of the model. However we are assuming that cash will be available to match planned expenditure (as in 2013/14).

c) Planning assumptions (expenditure & income): Update to the financial plan from previous draft submitted 1st October 2013

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- The financial plan has been updated to reflect:
  - the month 6 forecast out-turn (changed 13/14 baseline used in the model from opening annual budget to the month 6 reported forecast position);
  - the latest tariff deflator assumption per latest Monitor guidance for 2014/15;
  - the latest recurrent allocation growth funding assumption per NHSE feedback;
  - reduction in acute non-demographic growth from 3% to 2% per latest assessment of future growth levels.
- The overall impact of these four changes is an additional pressure of £2.7m in 2014/15 but a £3.8m improvement over the 5 year planning period.

NHS Harrow CCG Movement from previous plan Impact on surplus / (deficit)	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m	Year 4 2017/18 £m	Year 5 2018/19 £m	5 Year Total £m
1) Change in 13/14 Baseline	(4.3)	(0.3)	(0.2)	(0.1)	(0.3)	(5.2)
2) Change in tariff deflator assumption	0.7	0.7	0.7	0.8	0.8	3.6
3) Change in allocation growth funding	(0.7)	(0.7)	(0.7)	(0.7)	(0.8)	(3.5)
4) Acute Non-Demo Growth 3% to 2%	1.6	1.7	1.8	1.9	2.0	8.9
Total Impact on surplus / (deficit)	**(2.7)**	**1.3**	**1.6**	**1.9**	**1.8**	**3.8**

1) The main factor for the £4.3m additional pressure in 2014/15 is the assumption that the £2.8m in year recovery plan is most likely to be non recurrent in nature (as a recurrent solution has not yet been identified) and the £1.5m forecasted benefit from the reduction in continuing care retrospective claims provision is non recurrent. The model assumes the current £5.3m gap on specialist services is funded/mitigated throughout the period.
2) The tariff deflator used in the model has changed from -1.3% in 2014/15 to -1.6% for Acute services and -1.9% for Non Acute services. Additionally for 2015/16 to 2018/19 the deflator for all services has changed from -0.2% to -0.5%. This has the overall impact of improving the position by c£0.7m per annum, which totals £3.6m by 2018/19.
3) The recurrent allocation growth funding assumption has reduced from 2.3% per annum to 2.0% per annum over the period. This creates a pressure of c£0.7m per annum from the previous model, which totals £3.5m by 2018/19.
4) Acute non-demographic growth reduced to 2% which improves the position by c£1.8m per annum and £8.9m over the five year period.

- Moving to forecast in the 13/14 baseline has reduced CCG funding by c£13m (additional specialist services and secondary dental care allocation adjustments). This combined with lower growth funding has reduced the 4% and 3% QIPP values from the previous plan, as shown in the table below:

Movement in QIPP Value (Latest Model vs Previous Model)		2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	14/15 to 18/19 £m
4% QIPP Target		(0.6)	(0.6)	(0.7)	(0.8)	(0.8)	**(3.5)**
3% QIPP Target		(0.5)	(0.5)	(0.5)	(0.6)	(0.6)	**(2.6)**

- Overall the lower QIPP value (£3.5m at 4%) reduces the net £3.8m benefit from all the other changes in the financial plan.

b) Planning assumptions (expenditure & income): Key assumptions – 2014/15 to 2018/19 – base case

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- On 15/8, NHSE have published “indicative target” allocation figures, showing Harrow as £6m (2%) under target. They also announced a fundamental review of allocation policy etc. The current base case plan assumes 2.0% growth in funding levels per annum over the period based on latest feedback from NHSE.
- Tariff and other uplift assumptions are summarised in the table below.

Incremental %s applied to the 2013/14 baseline	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent Allocation Growth (13/14 = 2.30%) - Base Case	2.00%	2.00%	2.00%	2.00%	2.00%
Acute Contracts - National Acute PbR Tariff deflator	(1.60%)	(0.50%)	(0.50%)	(0.50%)	(0.50%)
Other Acute - uplift / (deflator)	(1.60%)	(0.50%)	(0.50%)	(0.50%)	(0.50%)
Mental Health Services - uplift / (deflator)	(1.90%)	(0.50%)	(0.50%)	(0.50%)	(0.50%)
Continuing Care - uplift / (deflator)	0.00%	0.00%	0.00%	0.00%	0.00%
Community Services - uplift / (deflator)	(1.90%)	(0.50%)	(0.50%)	(0.50%)	(0.50%)
Prescribing Price Increases	2.50%	2.50%	2.50%	2.50%	2.50%
Primary Care - uplift / (deflator)	0.00%	0.00%	0.00%	0.00%	0.00%
Corporate & Estates - Pay Awards/Non Pay Inflation	1.00%	1.00%	1.00%	1.00%	1.00%

- Activity and other pressure growth assumptions:
  - Demographic Growth (1.0% per annum)
  - Non Demographic Growth (per annum):
    - Acute (2%)
    - Mental Health (1%)
    - Continuing Care (1%)
    - Community Services (1%)
    - Prescribing (2.5%)

b) Planning assumptions (expenditure & income): Key assumptions – 2014/15 to 2018/19 – base case

- Contingency is included at 0.5% (additional c£1.2m recurrent per annum).
- National requirement to maintain 2% non recurrent headroom. The plan assumes the following profile: 1% in 2016/17, and then 2% from 2017/18.
- 2013/14 forecast outturn (as reported at month 6) used as the starting point in the financial model adjusted for known non-recurrent items.
- Specialist Commissioning changes assumed to be neutral.
- Recurrent acute in-year risk reserve of 1.5%, average of c£2.3m per annum, built into the model. (3% built into 14/15 £4.4m).
- Introduction of PbR in Mental Health assumed to be neutral.
- A key uncertainty is the treatment of the repayment of 13/14 deficit - this has not been built into the base case (No RAB assumed in base case model).
- The transfer to social care as a result of the spending review has not been reflected (implicitly assumed to be financially neutral for the CCG).
- National target is to deliver a 1% surplus. However, to deliver break even in 14/15 would require a QIPP of £22.7m, which would represent a 10% QIPP; which is unrealistic. Two QIPP scenarios have been modelled 4% per annum and 3% per annum as summarised in the table below.

NHS Harrow CCG I&E Summary	Current Yr 2013/14 £m	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m	Year 4 2017/18 £m	Year 5 2018/19 £m
Total Resource Income	229.0	230.5	235.1	239.7	244.5	249.4
Total Net Expenditure	239.4	253.1	264.4	275.6	287.0	297.2
Financial Gap to Break Even	(10.4)	(22.7)	(29.3)	(35.9)	(42.5)	(47.8)
4% QIPP (Cumulative)		9.2	18.6	28.2	38.0	48.0
(Deficit) / Surplus Plan	(10.4)	(13.4)	(10.7)	(7.7)	(4.5)	0.2
3% QIPP (Cumulative)		6.9	14.0	21.2	28.5	36.0
(Deficit) / Surplus Plan	(10.4)	(15.7)	(15.4)	(14.7)	(14.0)	(11.9)

← 4% QIPP per annum delivers break-even by 2018/19.

← 3% QIPP per annum results in a deficit position of c£12m by 2018/19.

b) Planning assumptions (expenditure & income): Base case - 2014/15 to 2018/19: 4% QIPP

Harrow Clinical Commissioning Group

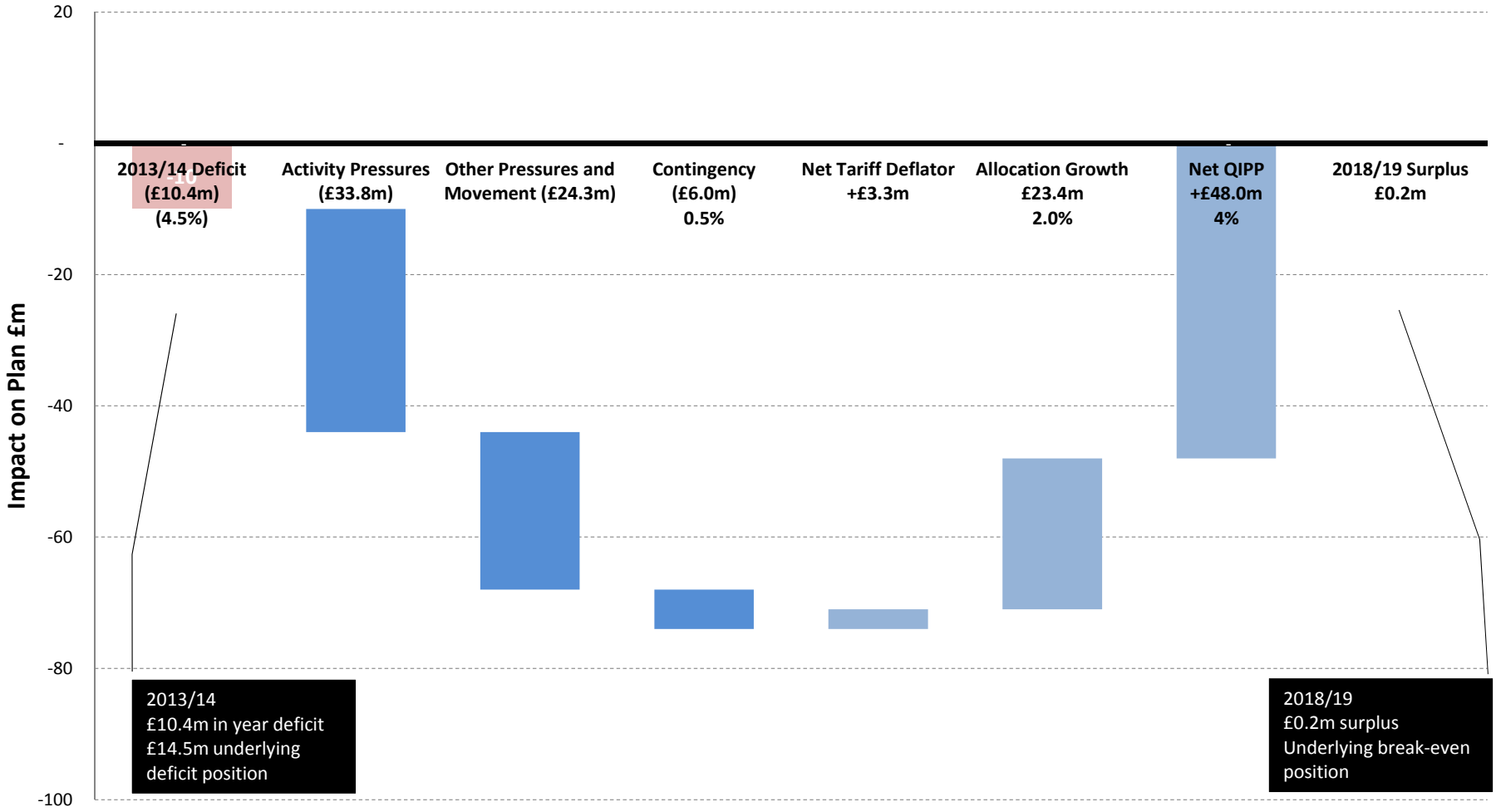
- The full set of planning assumptions, with a 4% cumulative QIPP, results in the following Income & Expenditure profile by budget area:

NHS Harrow CCG I&E Summary	Current Yr 2013/14 £m	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m	Year 4 2017/18 £m	Year 5 2018/19 £m
Total Resource Limit Funding	**229.0**	**230.5**	**235.1**	**239.7**	**244.5**	**249.4**
Acute Commissioning	155.0	162.8	170.4	176.7	181.7	187.8
Mental Health Commissioning	20.5	20.5	20.8	21.1	21.5	21.8
Continuing Care	15.6	15.9	16.2	16.6	16.9	17.2
Community Services	18.6	18.6	18.9	19.1	19.4	19.7
Prescribing	28.7	30.2	31.7	33.3	35.0	36.8
Primary Care	2.9	2.9	2.9	2.9	2.9	2.9
Corporate & Estates	2.4	1.8	1.8	1.8	1.8	1.8
Sub-Total Commissioning Budgets	**243.8**	**252.7**	**262.8**	**271.6**	**279.3**	**288.1**
Contingency (New In Year)	0.0	1.1	1.2	1.2	1.2	1.2
Cumulative Contingency	0.0	0.0	1.1	2.3	3.5	4.7
2% Non Recurrent Headroom	0.0	1.1	1.2	2.4	4.9	5.0
Other Reserves	(4.4)	(1.8)	(1.8)	(1.8)	(1.8)	(1.8)
Total Net Expenditure	**239.4**	**253.1**	**264.4**	**275.6**	**287.0**	**297.2**
Financial Gap (Funding vs Expend)	**(10.4)**	**(22.7)**	**(29.3)**	**(35.9)**	**(42.5)**	**(47.8)**
4% Cumulative QIPP		**9.2**	**18.6**	**28.2**	**38.0**	**48.0**
(Deficit) / Surplus Plan	**(10.4)**	**(13.4)**	**(10.7)**	**(7.7)**	**(4.5)**	**0.2**

- The (£4.4m) other reserves line in 2013/14 includes (£5.3m) specialist services funding gap, (£1.5m) retrospective continuing care provision released, (£2.8m) in-year recovery, £2.9m NWLHT 18 week RTT and winter pressures and £2.3m committed reserves including QIPP re-provision not yet allocated to budgets.
- The (£1.8m) other reserves line from 2014/15 onwards includes (£5.3m) specialist services funding gap and £3.5m committed reserves including QIPP re-provision not yet allocated to specific budget lines.

b) Planning assumptions (expenditure & income):
Base case - 2014/15 to 2018/19: 4% QIPP – Financial Bridge 2013/14 to 2018/19

Harrow Clinical Commissioning Group



- Other pressures and movements includes Acute in-year risk reserve £14m, non recurrent headroom movement of £5m and other £5m (includes non recurrent return of 2012/13 surplus in 2013/14 £2.3m and 13/14 non recurrent in year recovery £2.8m).
- A 4% cumulative QIPP improves the underlying position from a £14.5m deficit in 2013/14 to break-even.

b) Planning assumptions (expenditure & income): Base case - 2014/15 to 2018/19: 3% QIPP

Harrow Clinical Commissioning Group

- The full set of planning assumptions, with a 3% cumulative QIPP, results in the following Income & Expenditure profile by budget area:

NHS Harrow CCG I&E Summary	Current Yr 2013/14 £m	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m	Year 4 2017/18 £m	Year 5 2018/19 £m
Total Resource Limit Funding	**229.0**	**230.5**	**235.1**	**239.7**	**244.5**	**249.4**
Acute Commissioning	155.0	162.8	170.4	176.7	181.7	187.8
Mental Health Commissioning	20.5	20.5	20.8	21.1	21.5	21.8
Continuing Care	15.6	15.9	16.2	16.6	16.9	17.2
Community Services	18.6	18.6	18.9	19.1	19.4	19.7
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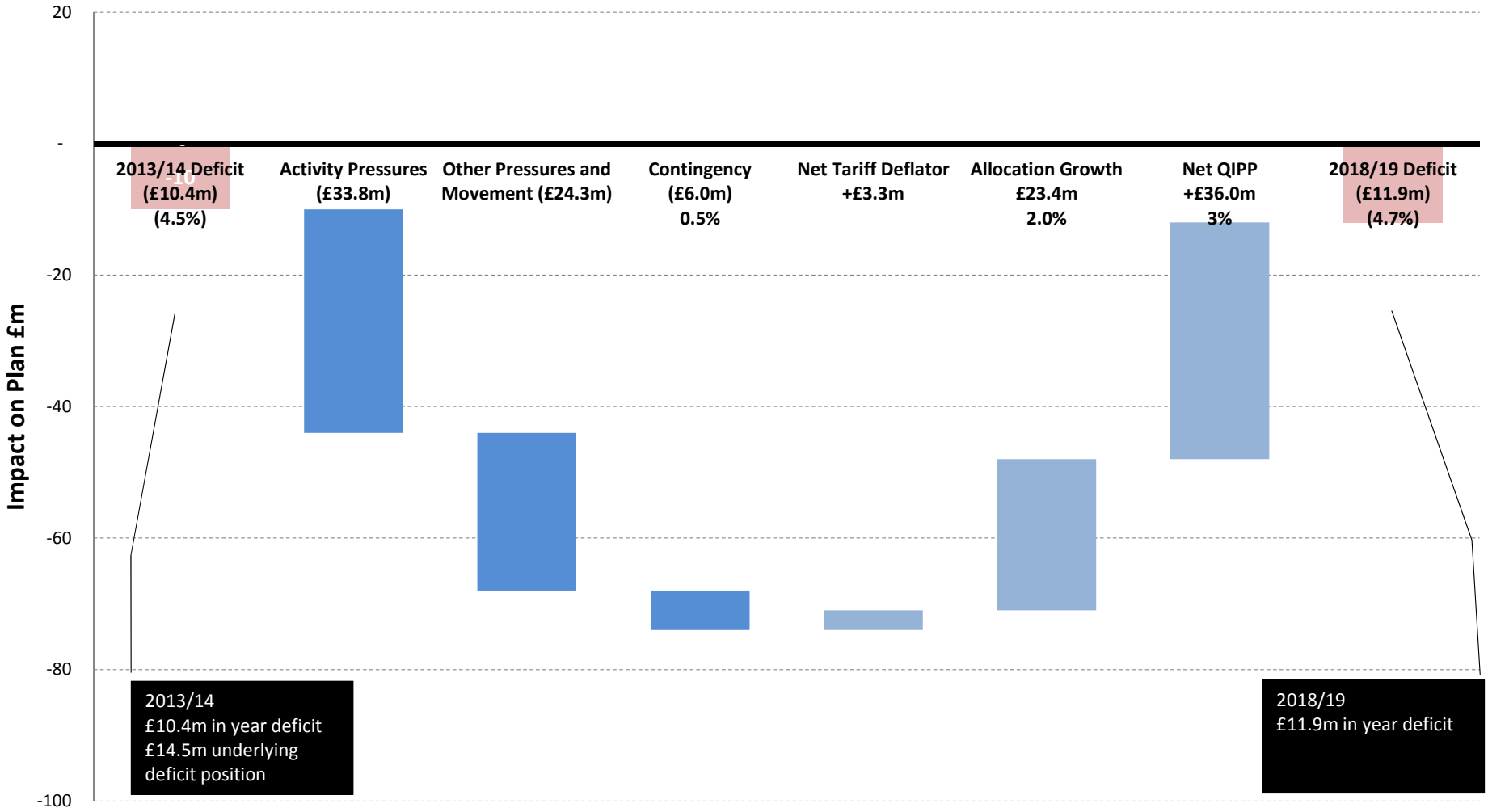
Primary Care	2.9	2.9	2.9	2.9	2.9	2.9
Corporate & Estates	2.4	1.8	1.8	1.8	1.8	1.8
Sub-Total Commissioning Budgets	**243.8**	**252.7**	**262.8**	**271.6**	**279.3**	**288.1**
Contingency (New In Year)	0.0	1.1	1.2	1.2	1.2	1.2
Cumulative Contingency	0.0	0.0	1.1	2.3	3.5	4.7
2% Non Recurrent Headroom	0.0	1.1	1.2	2.4	4.9	5.0
Other Reserves	(4.4)	(1.8)	(1.8)	(1.8)	(1.8)	(1.8)
Total Net Expenditure	**239.4**	**253.1**	**264.4**	**275.6**	**287.0**	**297.2**
Financial Gap (Funding vs Expend)	**(10.4)**	**(22.7)**	**(29.3)**	**(35.9)**	**(42.5)**	**(47.8)**
3% Cumulative QIPP		**6.9**	**14.0**	**21.2**	**28.5**	**36.0**
(Deficit) / Surplus Plan	**(10.4)**	**(15.7)**	**(15.4)**	**(14.7)**	**(14.0)**	**(11.9)**

- The (£4.4m) other reserves line in 2013/14 includes (£5.3m) specialist services funding gap, (£1.5m) retrospective continuing care provision released, (£2.8m) in-year recovery, £2.9m NWLHT 18 week RTT and winter pressures and £2.3m committed reserves including QIPP re-provision not yet allocated to budgets.
- The (£1.8m) other reserves line from 2014/15 onwards includes (£5.3m) specialist services funding gap and £3.5m committed reserves including QIPP re-provision not yet allocated to specific budget lines.

b) Planning assumptions (expenditure & income):
Base case - 2014/15 to 2018/19: 3% QIPP – Financial Bridge 2013/14 to 2018/19

Harrow Clinical Commissioning Group



- Other pressures and movements includes Acute in-year risk reserve £14m, non recurrent headroom movement of £5m and other £5m (includes non recurrent return of 2012/13 surplus in 2013/14 £2.3m and 13/14 non recurrent in year recovery £2.8m).
- A 3% cumulative QIPP results in a £11.9m in year deficit by 2018/19.

c) Scenario analysis:
Other potential upsides and downsides

Upsides:

- Achievement of the full 2013/14 QIPP Plan.
- Other measures taken to reduce the underlying deficit in 2013/14.
- Allocation growth is higher than base case assumptions (see slide 25).
- Lower than forecast level of underlying activity growth.

Downsides:

- Allocation growth is lower than base case assumptions.
- Benefit from tariff deflator at lower level in 2014/15.
- Increase in underlying deficit due to budget overspend in 13/14.
- Specialist financial gap is not mitigated in 13/14 and future years.
- Requirement to repay some (or all) of the prior year Deficit (see slide 26).
- Impact of spending review integration fund is not neutral (see slide 26).

c) Scenario analysis: Upside case

- The CCG has modelled an upside case with a change to the allocation growth assumption.

+1% allocation growth funding as Harrow CCG is below target c£2.2m in 2014/15 and £12.4m impact by 2018/19.

Upside Case - 4% QIPP (Cumulative)	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
a) Base case surplus/(deficit)	(13.4)	(10.7)	(7.7)	(4.5)	0.2
b) Additional 1% Allocation Funding Growth	2.2	4.6	7.1	9.7	12.4
c) Impact of b on base case	**(11.2)**	**(6.1)**	**(0.6)**	**5.2**	**12.6**

← 4% QIPP per annum in Upside case achieves in year balance during 2017/18 and a £12.6m surplus in 2018/19.

Upside Case - 3% QIPP (Cumulative)	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
a) Base case surplus/(deficit)	(15.7)	(15.4)	(14.7)	(14.0)	(11.9)
b) Additional 1% Allocation Funding Growth	2.2	4.6	7.1	9.7	12.4
c) Impact of b on base case	**(13.5)**	**(10.8)**	**(7.6)**	**(4.3)**	**0.5**

← 3% QIPP per annum in Upside case achieves a £0.5m surplus in 2018/19.

c) Scenario analysis: Downside case

Harrow Clinical Commissioning Group

The CCG has modelled a downside case building in two factors: that the Integration Transfer Fund is not cost-neutral, and that prior year deficits need to be repaid:

- Integration Transformation Fund (ITF) (*scenario b below*)

  This fund has been described as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This pooled budget will be drawn from the CCG's allocation, creating the risk that the CCG will have fewer resources to fund its existing services.

  Harrow's share of this fund is £9.8m, which will be fully phased in by 2015/16, as per table.

Harrow share	£'000
14/15 £200m	785
15/16 £400m	1,567
15/16 £1.9bn	7,454
Total	9,806

- Deficit repayment *(scenario c below)*

  It has not yet been established whether CCGs will be expected to repay deficits incurred.

The following tables demonstrate the cumulative impact that these two scenarios would have on Harrow's financial balance (worst case scenario).

Downside Case - 4% QIPP (Cumulative)	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
a) Base case surplus/(deficit)	(13.4)	(10.7)	(7.7)	(4.5)	0.2
b) Integration Transfer Fund is not cost-neutral	0.0	(4.9)	(9.8)	(9.8)	(9.8)
c) Deficit repayment from 14/15	(10.4)	(23.8)	(39.4)	(56.9)	(71.2)
d) Combined impact of b&c	**(23.8)**	**(39.4)**	**(56.9)**	**(71.2)**	**(80.8)**

←50% cost pressure for 15/16; 100% 16/17
←Previous year deficit repayment
←Cumulative impact

Downside Case - 3% QIPP (Cumulative)	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
a) Base case surplus/(deficit)	(15.7)	(15.4)	(14.7)	(14.0)	(11.9)
b) Integration Transfer Fund is not cost-neutral	0.0	(4.9)	(9.8)	(9.8)	(9.8)
c) Deficit repayment from 14/15	(10.4)	(26.1)	(46.4)	(70.9)	(94.7)
d) Combined impact of b&c	**(26.1)**	**(46.4)**	**(70.9)**	**(94.7)**	**(116.4)**

Mitigation of the downside case

- Integration Transformation Fund: the CCG has initiated planning with the Local Authority in order to manage the financial risk associated with this transfer – see next slide
- Deficit repayment: this scenario would lead to a spiralling increase in deficits year-on-year that could not be addressed.

c) Scenario analysis: Integration Transformation Fund

Harrow Clinical Commissioning Group

Requirements

- The ITF has been described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”.
- The June 2013 Spending Round set out the following:

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements.

- Whilst the ITF does not come into full effect until 2015/16 it is essential that CCGs and local authorities build momentum in 2014/15, using the additional £200m due to be transferred to local government from the NHS to support transformation.
- To access the ITF each locality will be asked to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met.

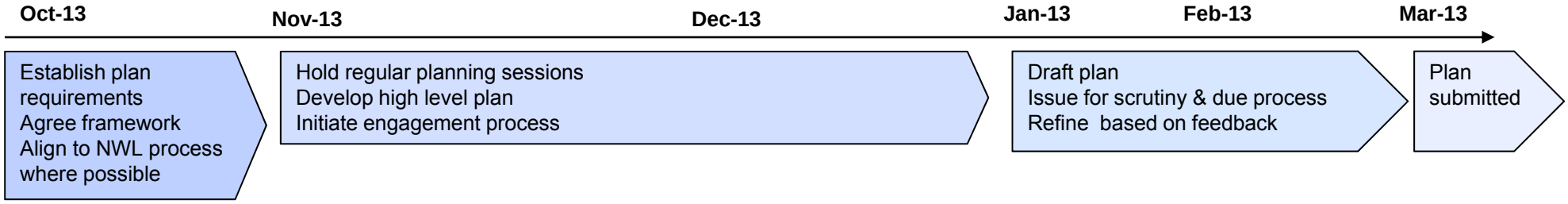
Conditions

- The ITF will be a **pooled budget** which will can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:
  1. plans to be jointly agreed
  2. protection for social care services (not spending)
  3. 7-day working in health and social care
  4. better data sharing between health and social care
  5. joint approach to assessments and care planning
  6. an accountable professional for integrated services
  7. risk-sharing principles and contingency plans
  8. agreement on the consequential impact of changes in the acute sector

Key risks

- Developing a joint plan within the required 13/14 timeframe
- Differing views of integration across health and social care
- Health and social care organisational financial pressures reducing integration commitments in light of Section 256, 28a and 117 expenditure

Timeline for developing the plan



d) Conclusion

- The pressures being experienced against the 2013/14 plan results in an additional pressure of £4.3m in 2014/15 and £5.2m over the 5 year planning period compared to the previous model using opening budgets as the 2013/14 baseline.
- The increase in the tariff deflator and reduction in funding growth assumptions effectively cancel each other out over the planning period.
- The reduction in estimated acute non-demographic growth from 3% to 2% reduces spend by £1.6m in 2014/15 and £8.9m over the five years.
- To deliver break even in 14/15 would require a QIPP of £22.7m, which would represent a 10% QIPP; which is unrealistic.
- To achieve break even over the five year planning period would require a cumulative QIPP of £47.8m.
- Two QIPP scenarios have been modelled 4% per annum (which reduces the deficit from a £22.7m gap in 2014/15 to a £0.2m surplus by 2018/19) and 3% per annum (which results in a £11.9m deficit by 2018/19). Both the 4% and 3% QIPP values have reduced from the previous model, £3.5m and £2.6m respectively over the five year period. The 4% and 3% values have reduced because the level of funding and associated commissioned services has reduced due to the increased specialist services and secondary dental care adjustments and the impact of lower funding growth.
- An upside case has been modelled which assumes an additional 1% of growth funding per annum. The upside case with a 4% QIPP achieves in year balance during 2017/18 and a £12.6m surplus by 2018/19 and with a 3% QIPP in year balance by 2018/19.
- A downside case has also been modelled building in two factors: that the Integration Transfer Fund is not cost-neutral, and that prior year deficits need to be repaid. Without mitigations this results in a deficit of £80.8m by 2018/19 if a 4% QIPP was delivered each year and a deficit of £116.4m by 2018/19 if a 3% QIPP was delivered per annum.

3. Commissioning Strategy

Contents:

a. Health needs summary
b. Existing strategies
c. Characterise the QIPP gap
d. QIPP strategy
e. Commissioning Strategy summary

3a) Health needs summary: Overview

Health needs summary overview

- JSNA analysis shows that health outcomes in Harrow are generally good compared to peers, but there are significant variations across the borough.
- Patient feedback has repeatedly identified the need for greater coordination, collaboration and communication across all services
- Public Health England's data is consistent with the JSNA, confirming that Harrow's health outcomes are generally good compared to peers.
- However, Harrow's overall spend per weighted head of population is above both national average and at the high end of the ONS Cluster.
- A small proportion of the population (5% c.12k people) use c.50% of resources. The top 20% use c.75%. Advances in medicine will benefit longevity, but may increase cost pressures.
- ***Consequently, Harrow CCG intends to maintain and improve the good health outcomes.***
- ***And, to focus on proactively supporting patients with the greatest needs to meet their ongoing physical, mental and social care needs by integrating services to provide higher quality care more cost effectively.***

- *The following pages provide further details and analysis...*

3a) Health needs summary:
Findings from the Part 1 planning baseline assessment

Harrow Clinical Commissioning Group

Health outcomes in Harrow are generally good compared to peers, but there are significant variations across the borough.
A small proportion of the population (5% c.12k people) use c.50% of resources.
Patient feedback has repeatedly identified the need for greater coordination, collaboration and communication across all services.

JSNA review:

- Demographics
- Life expectancy & mortality
- Lifestyle factors
- Long terms conditions
- Mental health
- Infectious diseases
- Maternity & births
- Children
- Learning disabilities
- Older people
- End of life
- Service areas

Patient perspectives

Needs based on usage / risk

Key points:

1. Generally good health outcomes.
2. But, some significant variation across the Borough.
3. Higher proportion of older people and growing.
4. Child health is generally good; also lower rates for 'children in need' - giving every child the best start in life is crucial to reducing health inequalities across the life course.
5. High rates of obesity and high risk drinkers; low levels of physical activity and low levels of smoking quitters are significant lifestyle issues.
6. High incidence of diabetes but generally well managed;
   Low rates of cancer but opportunities to improve early detection;
   Incidence of circulatory and respiratory disease (COPD) are lower than average but are the main causes of life expectancy gap across the Borough;
7. Many people with long-term conditions also have mental health problems; opportunity to manage mental and physical health in a more integrated manner.
8. Stakeholder engagement, across many services, identified the need for greater coordination, collaboration and communication.
9. c. 5% of the population (12,000 people) use approx 50% of health and social care resources; c. 20% use approx 75%.
10. These patients have ongoing care needs from multiple agencies.

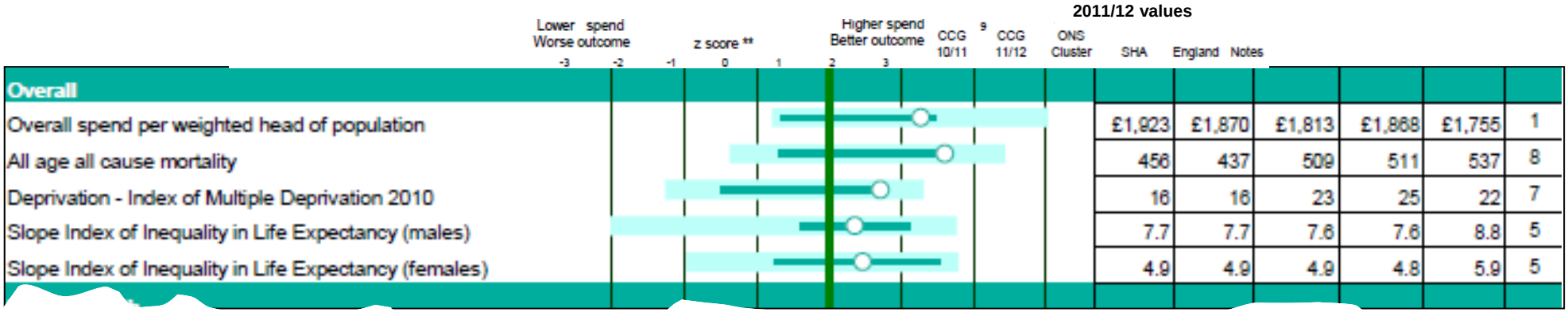
Details of the JSNA review are contained in Appendix A.

3a) Health needs summary:
Public Health analysis of spend and outcome

Harrow Clinical Commissioning Group

Public Health England's data is consistent with the JSNA, confirming that Harrow's health outcomes are generally good compared to peers. However, Harrow's overall spend per weighted head of population is above both national average and the high end of the ONS Cluster.

Public Health England - spend and outcome relative to other CCGs in England (excerpt only)



	2011/12 values					
	SHA	England				Notes
Overall						
Overall spend per weighted head of population	£1,923	£1,870	£1,813	£1,868	£1,755	1
All age all cause mortality	456	437	509	511	537	8
Deprivation - Index of Multiple Deprivation 2010	16	16	23	25	22	7
Slope Index of Inequality in Life Expectancy (males)	7.7	7.7	7.6	7.6	8.8	5
Slope Index of Inequality in Life Expectancy (females)	4.9	4.9	4.9	4.8	5.9	5

Key:

- CCG value
- SHA range
- ONS Cluster range

Source: http://www.yhpho.org.uk/quad/Default.aspx

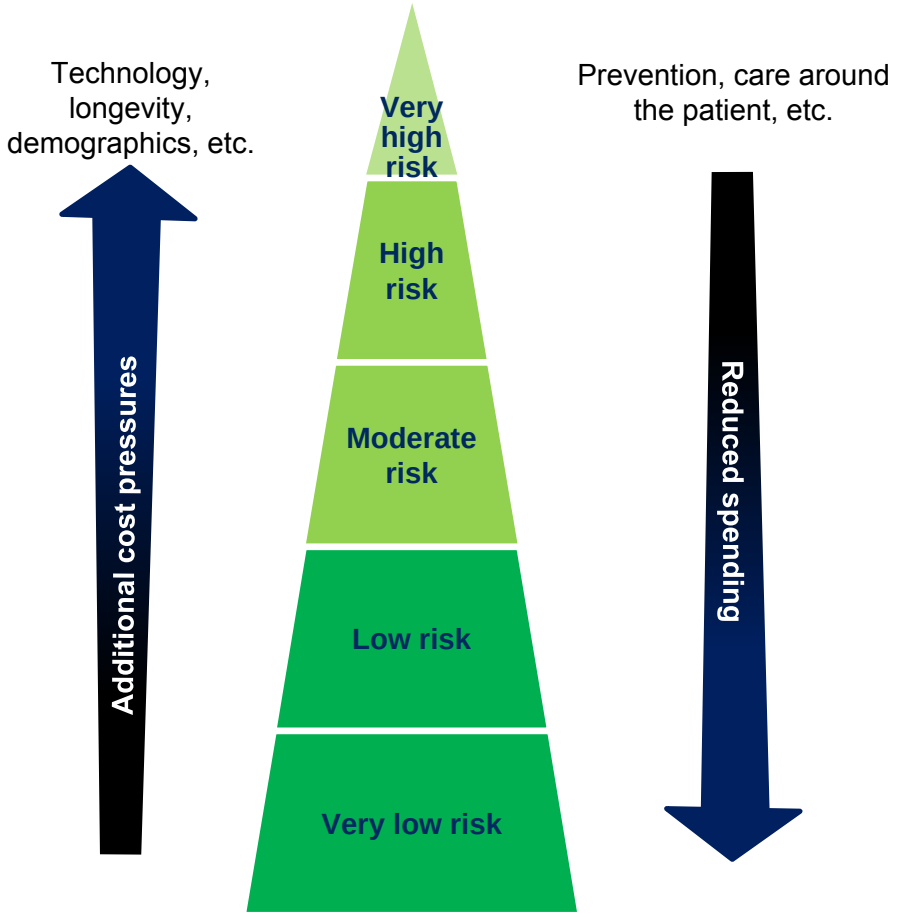
3a) Health needs summary: Population needs triangle

Harrow Clinical Commissioning Group

A small proportion of the population (5% c.12k people) use c.50% of resources. The top 20% use c.75%. Advances in medicine will benefit longevity, but may increase cost pressures.

Consequently, focusing on proactively supporting patients to meet their ongoing physical, mental and social care needs offers the opportunity to integrate services and provide higher quality care more cost effectively.

% Pop'n	Population	% Spend	13/14 Spend (£m)
0 – 0.5%	1,000	50%	127
0.5 – 5%	11,000		
5% - 20%	35,000	24%	60
20 - 50%	70,000	23%	59
50 - 100%	112,000		
Total	231k	2.5% on 'Other'	252.5 £6.3m on 'Other'



SOURCE: NWL Whole Systems Integrated Care programme; local team analysis

3b) Existing Strategies: Overview

Harrow Clinical Commissioning Group

Existing Strategies overview

- Harrow CCG's vision acts as the foundation on which others strategies are built:

  'To work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets available.'

- The vision is further described by a set of promises.
- Harrow CCG and London Borough of Harrow have developed their Joint Health and Wellbeing Strategy (HWBS) to improve health and wellbeing in Harrow by focusing on 7 core areas: Long term conditions; Cancer; Worklessness; Poverty; Mental health and well-being; Supporting parents and the community to protect children and maximise their life chances; and Dementia.
- Shaping a Healthier Future (SaHF) is a programme to improve health services across North West London (NWL) by reshaping acute and out-of-hospital health and care services across the region.
- The SaHF proposals include the merger of Ealing Hospital NHS Trust and North West London Hospitals NHS Trust; they will take 3 – 5 years to implement.
- Harrow CCG's strategy 'Better Care, Closer to Home' (Out of Hospital strategy) describes the transformation out of hospital services required to enable the delivery of SaHF.
- Harrow's vision, promises and objectives will be delivered through the core strategies.
- These are supported by a number of 'service' and 'enabler' strategies and plans.

- *The following pages provide further details and analysis...*

3b) Existing Strategies:
Harrow CCG's vision and promise to the residents of Harrow

Harrow Clinical Commissioning Group

Harrow CCG's vision acts as the foundation on which others strategies are built:

'To work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets available.'

The vision is further described by a set of promises...

Our promise to Harrow:

- We appreciate that planning and designing the health services for the people of Harrow is an **important and responsible role**, and that we have been entrusted with a large amount of public money to commission these health services.
- We promise to put **high quality and safe care at the centre of our decision-making.**
- We believe that patients want to receive **health care which is right the first time**, in hospital when this is appropriate, but closer to their home when possible.
- We want to ensure our patients have **timely and equitable access** to primary, community and secondary care services.
- We will **listen to our patients** and what they tell us about the health care they receive.
- Our aim is for all of the Harrow population to aspire to **the same healthy life expectancy across Harrow**.
- We appreciate, however, that this is a time of financial austerity, and that this means we must ensure we **spend money in the most efficient way.** We also know we will have to make difficult decisions. We won't shy away from these difficult decisions, but will make our plans after consultation with our partners in health and in the Local Authority, and with participation from our patients.
- We will work in **partnership with the London Borough of Harrow**, including our joint participation at the Health and Wellbeing Board (HWB) together with HealthWatch and other representatives, to shape the health priorities of Harrow over the next five years.
- To help us deliver our promise we will:
  - Work in partnership with you and our health and social care partners;
  - Demonstrate the principles of good governance; and
  - Make informed and transparent decisions that can be upheld with respect to probity.

3b) Existing Strategies:
Joint Health and Wellbeing Strategy for Harrow 2013-2016 (HWBS)

Harrow Clinical Commissioning Group

Harrow CCG and London Borough of Harrow have developed their Joint Health and Wellbeing Strategy (HWBS) to improve health and wellbeing in Harrow by focusing on 7 core areas...

The Joint Health and Wellbeing Strategy for Harrow 2013-2016

- Harrow's Joint Health and Wellbeing Strategy (HWBS) was published in 2012, setting out the strategic direction for partners to work together to improve health and wellbeing, reduce health inequalities and promote independence. The success of this work will be guided and measured by the Harrow Health and Wellbeing Board (HWB).
- The setting of priorities within the HWBS was based on the evidence presented in the Joint Strategic Needs Assessment and the best available evidence.
- The HWB has agreed that the priorities for Harrow should reflect three important criteria:
    - They affect the wellbeing and quality of life of the people of Harrow
    - They will lead to a reduction in the health inequalities gap
    - They will have long term impact

Seven local priority areas have been agreed:

1. Long term conditions: the HWB initially agreed to focus on cardiovascular disease (heart disease stroke and hypertension), respiratory disease and diabetes.
2. Cancer
3. Worklessness
4. Poverty
5. Mental health and well-being
6. Supporting parents and the community to protect children and maximise their life chances
7. Dementia

Annual implementation plans will identify what we want to achieve within the year and how we will achieve it.

The Harrow Health and Wellbeing Board is responsible for the delivery of these implementation plans.

3b) Existing Strategies: Shaping a Healthier Future (SaHF)

SaHF is a programme to improve health services across North West London (NWL) by reshaping acute and out-of-hospital health and care services across the region.

The SaHF proposals include the merger of Ealing Hospital NHS Trust and North West London Hospitals NHS Trust, and will take 3 – 5 years to implement, coordinated with the implementation of the CCG's Out of Hospital Strategy (see following slide).

Shaping a Healthier Future (SaHF)

- SaHF is a programme to improve NHS services for the two million people who live in North West London and will save hundreds of lives each year. The SaHF programme has developed a vision for how health services will be developed and improved in NW London.
- In February 2013 the Joint Committee of Primary Care Trusts (JCPCT) agreed with all the recommendations put forward by the 'Shaping a healthier future' programme following public consultation, including:
    - To agree and adopt the North West London acute and out of hospital standards, the North West London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals.
    - To agree and adopt the model of acute care based on 5 major hospitals delivering the London hospital standards.
    - To agree that the five major hospitals should be: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea and Westminster Hospital and St Mary's Hospital.
    - To agree that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week.
    - To agree that Ealing Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, 7 days a week.
    - To recommend that implementation of resolutions should be coordinated with the implementation of the CCG out of hospital strategies.
    - The JCPCT recommends that Ealing CCG and all other relevant commissioners should work with local stakeholders, including Ealing Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Ealing Hospital site consistent with decisions made by this JCPCT.
- The 'Shaping a healthier future' proposals will take 3-5 years to implement, ensuring that improvements in out-of-hospital care are in place before major changes to hospital services are implemented.

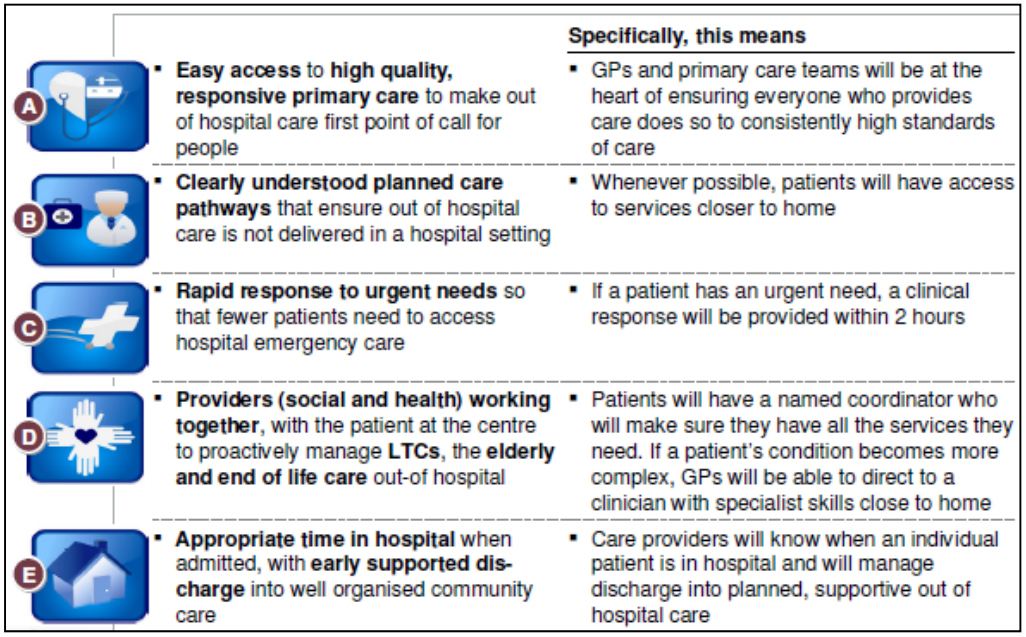
3b) Existing Strategies:
Out of Hospital Strategy: Better Care, Closer to Home (August 2012)

Harrow Clinical Commissioning Group

Harrow CCG's strategy 'Better Care, Closer to Home' (Out of Hospital strategy) describes the transformation of out of hospital services necessary to enable the delivery of SaHF.

Better Care Closer to Home - *Our strategy for co-ordinated, high quality out of hospital care*

- In 2012/13 NHS Harrow consulted on its Out of Hospital Strategy, which sets out the intention to commission services which reduce reliance on hospital based care through strengthening the range and focus of services delivered in primary and community settings.
- The 'Out of Hospital Strategy', contains the following five strategic goals:



	Specifically, this means
A **Easy access** to **high quality, responsive primary care** to make out of hospital care first point of call for people	GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care
B **Clearly understood planned care pathways** that ensure out of hospital care is not delivered in a hospital setting	Whenever possible, patients will have access to services closer to home
C **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care	If a patient has an urgent need, a clinical response will be provided within 2 hours
D **Providers (social and health) working together**, with the patient at the centre to proactively manage **LTCs**, the **elderly and end of life care** out-of hospital	Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
E **Appropriate time in hospital** when admitted, with **early supported dis-charge** into well organised community care	Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care

- Successful delivery of the Out of Hospital Strategy is required to enable the delivery of SaHF.
- The eight CCGs in NWL have agreed a Memorandum of Understanding (MOU) setting out how they will work together in a collective way to successfully implement the Shaping a healthier future strategy whilst recognising each CCG's individual sovereignty and the need for decision making to be made at a local level.

3b) Existing Strategies: Summary

Harrow Clinical Commissioning Group

Harrow's vision, promises and objectives will be delivered through the core strategies.
These are supported by a number of 'service' and 'enabler' strategies and plans; including this '3 Year Strategic and Financial Recovery Plan'.

Vision & promises

Corporate Objectives:

1. Improve the health and wellbeing of the local residents of Harrow, in line with commissioning plans
2. Engage patients and the public in decision-making
3. Manage resources effectively
4. Implement our Out of Hospital Strategy
5. Develop robust and collaborative commissioning arrangements
6. Improve performance against priority targets
7. Ensure people have a positive experience of care
8. Improve the quality and safety of the treatment and care provided to patients

Core Strategies:

- Health & Wellbeing Strategy (HWBS)
- Shaping a Healthier Future (SaHF)
- Better Care Closer to Home (Out of Hospital)

Service strategies & plans:

- Primary Care Strategy
- Health & Wellbeing Action Plan (2013/14)
- The Harrow Children and Young People's Plan 2011-2014
- Dementia Strategy
- Carers' Strategy
- Mental Health Strategy

Enabling strategies & plans:

- 3 Year Strategic and Financial Recovery Plan
- Quality and Safety work plan
- Equality, Diversity & Human Rights Strategy and Action plan
- Communication & Engagement Strategy
- Organisational Development plan (planned)
- Informatics / IT Strategy (planned)
- Public Health CCG work plan

3c) Characterising the QIPP gap: Overview

Characterising the QIPP gap - overview

The QIPP challenge can be characterised from a number of interlinked perspectives...

- Harrow's population has grown by 4.5% over the past 4 years.
- From an activity perspective, over the past 3 years, acute activity has grown at between 2-5% per annum; despite alternative services being introduced to provide care out of hospital. This is broadly in line with financial planning assumptions which have been used in this plan. The QIPP Plan has been developed to focus on how these activity trends can be addressed in order to achieve financial balance.
- Financial planning assumptions (activity growth, cost increases/decreases, etc.) have been described in detail in section 2. From a budget / service area perspective, the implications over the next 3 years (to 2016/17) are:
    - The most significant forecast growth is in the acute contracts c.£21.7m (c. 4.5% pa).
    - Prescribing forecasts (+2.5% growth and +2.5% increase in prices) represents £4.6m increase.
    - And, moving from a position of deficit to surplus (including non recurrent headroom and contingency) presents a further c. £8.4m challenge.
    - Overall, taking account of resource growth, the CCG has a QIPP requirement of £35.9m over the next 3 years (excl. repayment of deficits).
    - A QIPP target of 4% p.a. of income represents a requirement for c. £28.2m p.a.
- From an QIPP delivery perspective, the profile of QIPP initiatives over past 3 years shows the changing nature of planned benefits – with increasing need to deliver savings through changing care settings, consistency of provision and proactive management of patients through integrated care.
- And, the planned benefits from these 'transformational schemes' have taken longer than planned to deliver.

- *The following pages provide further details and analysis...*

3c) Characterise the QIPP gap: Trends in activity: population

Harrow's population has grown by c.4.5% between 2010/11 and 2013/14.

Population trends

Harrow CCG's registered list size has grown by 4.8% between 2010/11 and 2013/14 (or 11,263 patients). The normalised weighted list size has grown over this period by 4.5%. There appears to have been a particular increase in the population between 12/13 and 13/14.

1. Harrow CCG GP - registered list size

Financial year	List size	Normalised weighted list
2010/11	236,761	214,349
2011/12	240,280	219,510
2012/13	238,245	218,769
2013/14	248,024	223,964

Source: Exeter

The normalised weighted list has been weighted by a number of factors, including: age-sex, additional needs, list turnover, Staff MFF, practice rurality, residential home/Nursing homes index – see Connecting for Health site for further details: http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/downloads/newgpcontractpay/ngms-contents/appaglobalsum

3c) Characterise the QIPP gap:
Trends in activity: Non-elective admissions

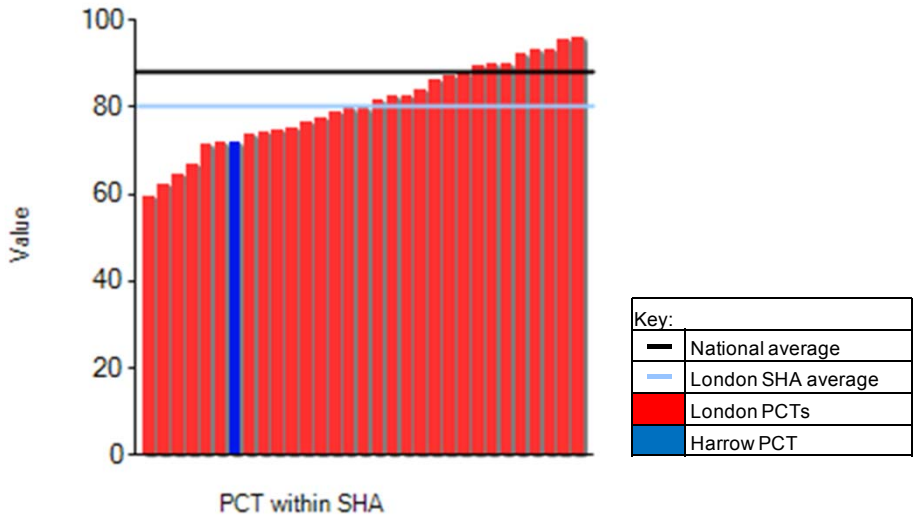
Harrow Clinical Commissioning Group

Non elective admissions in Harrow have risen by 8.5% over the past three years (c. 3% per annum).

Harrow CCG had a below average rate of emergency admissions in 11/12 compared both nationally and within London (see Figure 1).

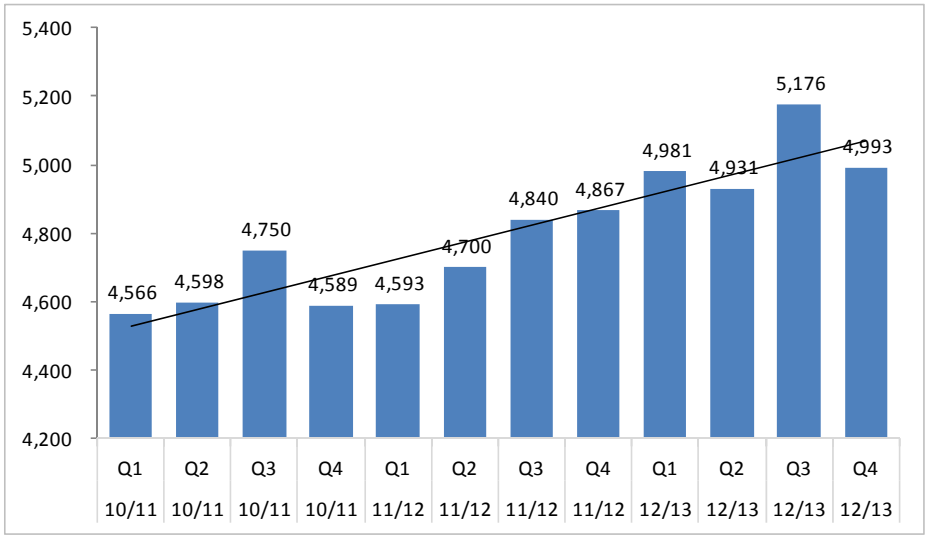
Despite initiatives such as STARRS, between 2010/11 and 2012/13 NEL activity rose by c.3% p.a. (see Figure 2).

1. Emergency admissions per 1,000 population - benchmarking *(Oct 2011 – Sept 2012)*



Source: NHS Comparators

2. NEL admissions by quarter *(Apr 2011 – June 2013)*



Source: SUS (Non elective First Finished Consultant episodes for general and acute specialties only)

3c) Characterise the QIPP gap: Trends in activity: A&E attendances

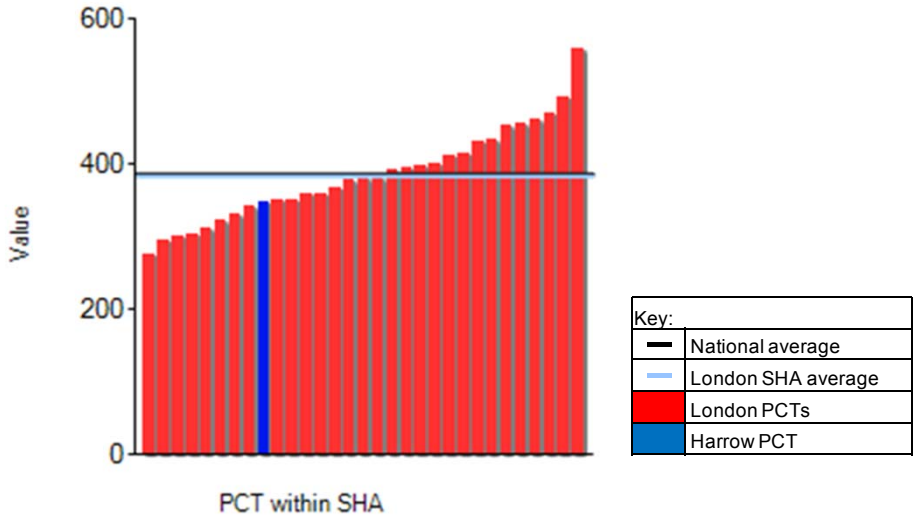
Harrow Clinical Commissioning Group

A&E attendances in Harrow have risen by c.8% over the past two years.

Harrow CCG had a below average rate of A&E attendances in 11/12 compared both nationally and within London (see Figure 1).

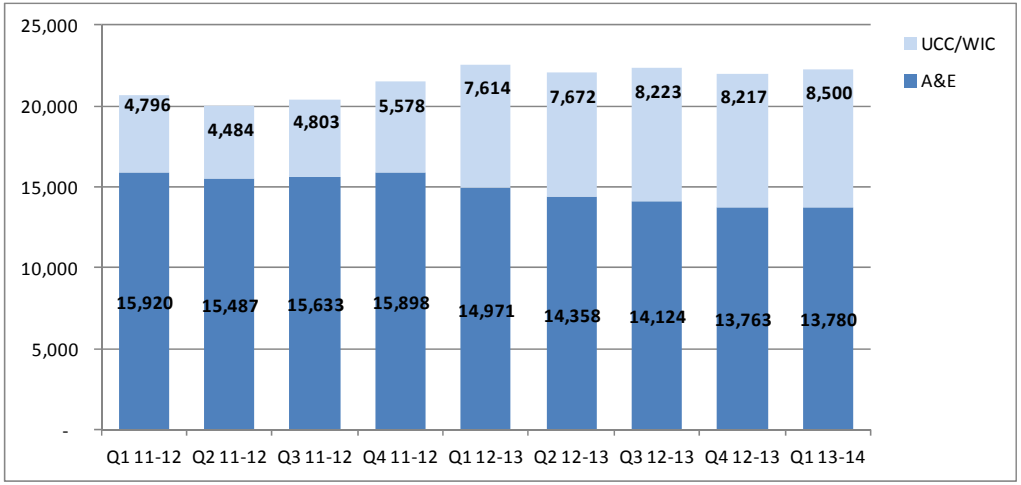
Over the course of 2011/12 and 2012/13 total A&E activity (A&E + UCC) rose by c.8% (based on a quarterly trend line). However, a greater proportion of activity is now being delivered by the UCC/WIC.

1. A&E attendances per 1,000 population - benchmarking *(Oct 2011 – Sept 2012)*



Source: NHS Comparators

2. A&E attendances (all types) by quarter *(Apr 2011 – July 2013)*



Source: BEHH SUS database

Notes:

- Prior to 2011/12, UCC/WIC activity data was not submitted.

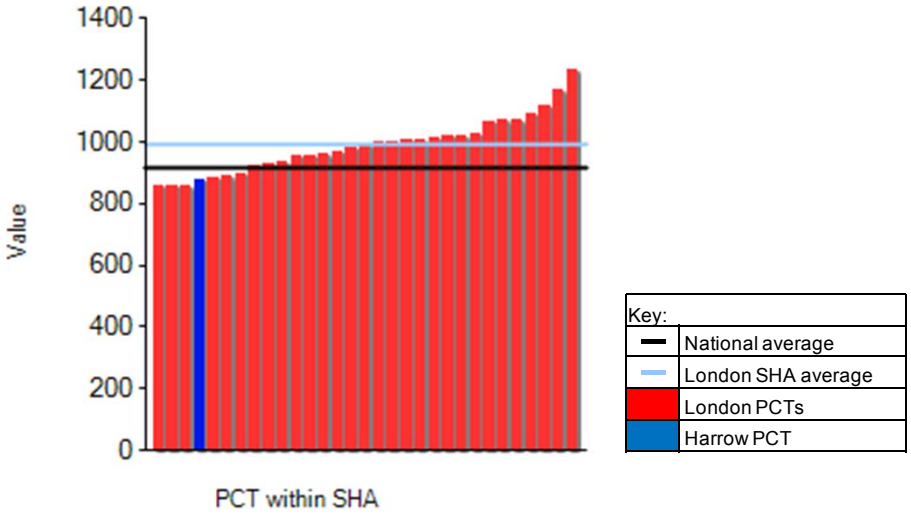
3c) Characterise the QIPP gap: Trends in activity: OP attendances

Harrow Clinical Commissioning Group

OP attendances in Harrow have risen by 3% over the past three years.

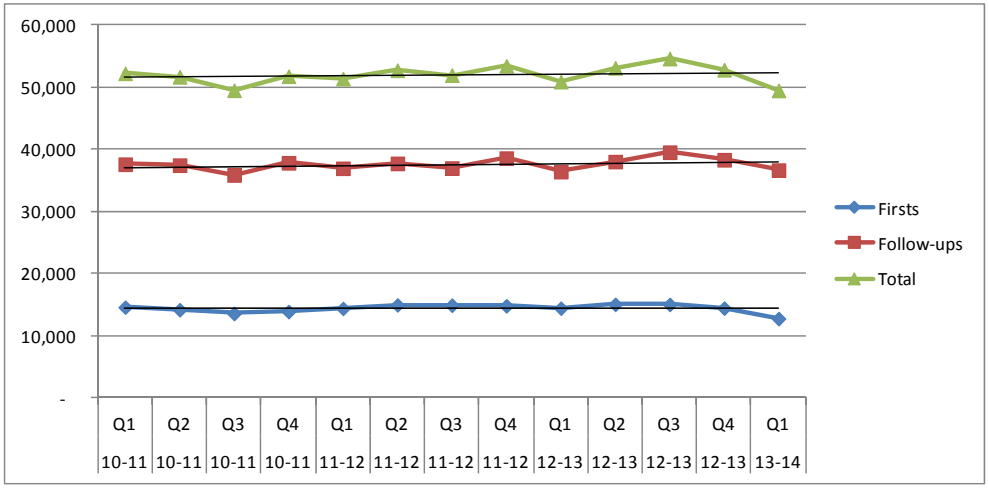
While Harrow CCG had a below average rate of OP attendances in 11/12 compared both nationally and within London (see Figure 1), there has been a 3% increase in activity over the past three years.

1. Total OP attendances per 1,000 population - benchmarking *(Oct 2011 – Sept 2012)*



Source: NHS Comparators

2. OP attendances (all) by quarter *(Apr 2010 – June 2013)*



Source: SUS

Notes:

- First OP attendances are lower than benchmark against peers, but the Follow-up to First ratio is above national and London rates.

3c) Characterise the QIPP gap:
Trends in activity: Elective admissions

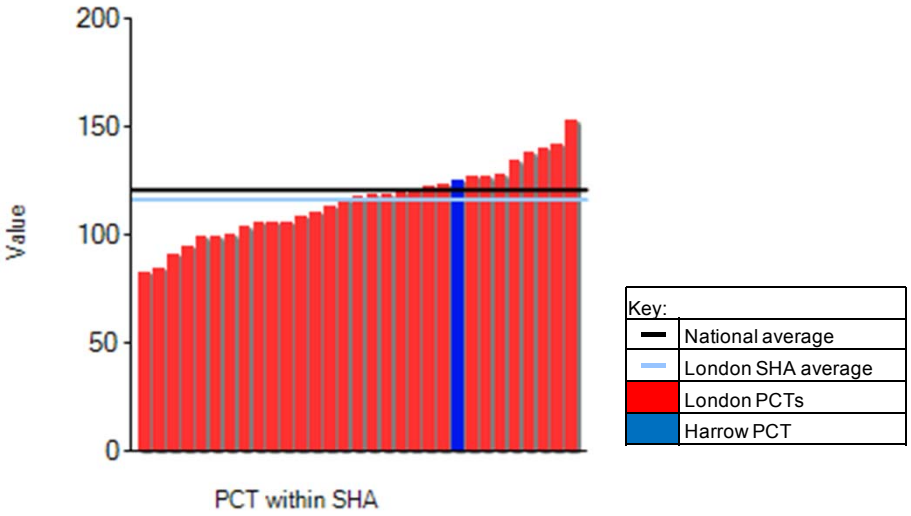
Harrow Clinical Commissioning Group

Elective admissions in Harrow have risen c.5% per annum over the past three years.

Harrow CCG had an above average rate of elective admissions in 11/12 compared both nationally and within London (see Figure 1).

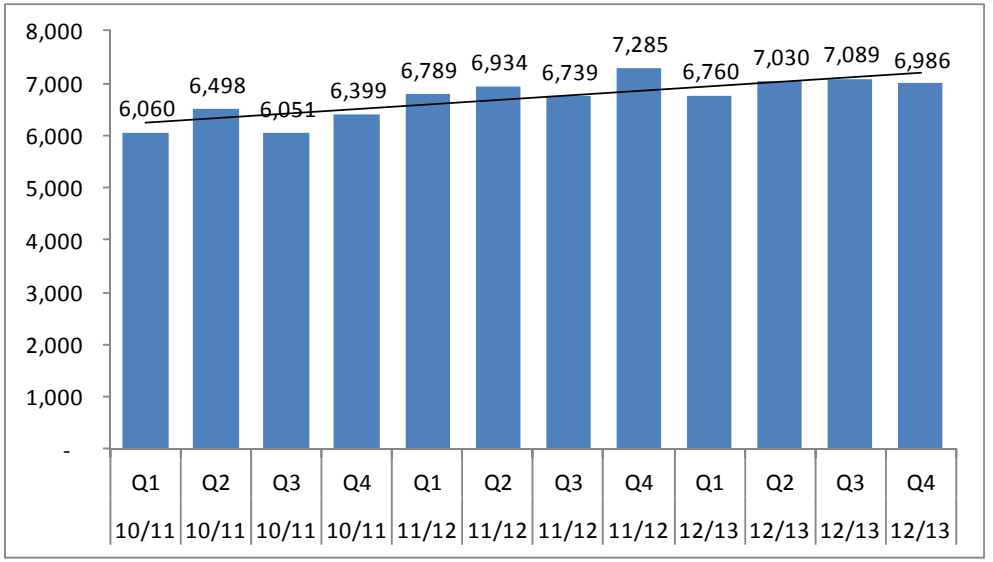
Based on the trend line in Figure 2, elective admissions have increased by 15% over the course of three years, c. 5% per annum.

1. Elective (IP + DC) admissions per 1,000 population - benchmarking *(Oct 2011 – Sept 2012)*



Source: NHS Comparators

2. Elective admissions (all) by quarter *(April 2010 – March 2013)*



Source: SUS

3c) Characterising the QIPP gap: Summary of the Financial Challenge by Budget Category and Spend

Harrow Clinical Commissioning Group

Over the next 3 years, based on the planning assumptions, the most significant forecast growth is in the acute contracts c.£21.7m (c.4.5% pa).
Prescribing forecasts (+2.5% growth and +2.5% increase in prices) represents £4.6m increase.
And, moving from a position of deficit to surplus (including non recurrent headroom and contingency) presents a further c. £8.4m challenge.
Overall, taking account of resource growth, the CCG has a funding gap of £35.9m; QIPP at 4% pa will provide £28.2m.

NHS Harrow CCG I&E Summary	Current Yr 2013/14 £m	Year 1 2014/15 £m	Year 2 2015/16 £m	Year 3 2016/17 £m	Year 4 2017/18 £m	Year 5 2018/19 £m
Total Resource Limit Funding	**229.0**	**230.5**	**235.1**	**239.7**	**244.5**	**249.4**
Acute Commissioning	155.0	162	0.4	176.7	181.7	187.8
Mental Health Commissioning	20.5	20.5	20.8	21.1	21.5	21.8
Continuing Care	15.6	15.9	16.2	16.6	16.9	17.2
Community Services	18.6	18.	3.9	19.1	19.4	19.7
Prescribing	28.7	30.	1.7	33.3	35.0	36.8
Primary Care	2.9	2.9	2.9	2.9	2.9	2.9
Corporate & Estates	2.4	1.8	1.8	1.8	1.8	1.8
Sub-Total Commissioning Budgets	**243.8**	**252.7**	**262.8**	**271.6**	**279.3**	**288.1**
Contingency (New In Year)	0.0	1.1	1.2	1.2	1.2	1.2
Cumulative Contingency	0.0	0.0	1.1	2.3	3.5	4.7
2% Non Recurrent Headroom	0.0	1.1	1.2	2.4	4.9	5.0
Other Reserves	(4.4)	(1.8)	(1.8)	(1.8)	(1.8)	(1.8)
Total Net Expenditure	**239.4**	**253.1**	**264.4**	**275.6**	**287.0**	**297.2**
Financial Gap (Funding vs Expend)	**(10.4)**	**(22.7)**	**(29.3)**	**(35.9)**	**(42.5)**	**(47.8)**
4% Cumulative QIPP		**9.2**	**18.6**	**28.2**	**38.0**	**48.0**
(Deficit) / Surplus Plan	**(10.4)**	**(13.4)**	**(10.7)**	**(7.7)**	**(4.5)**	**0.2**

+£21.7m c.xx%

+£4.6m c.15%

+£8.4m

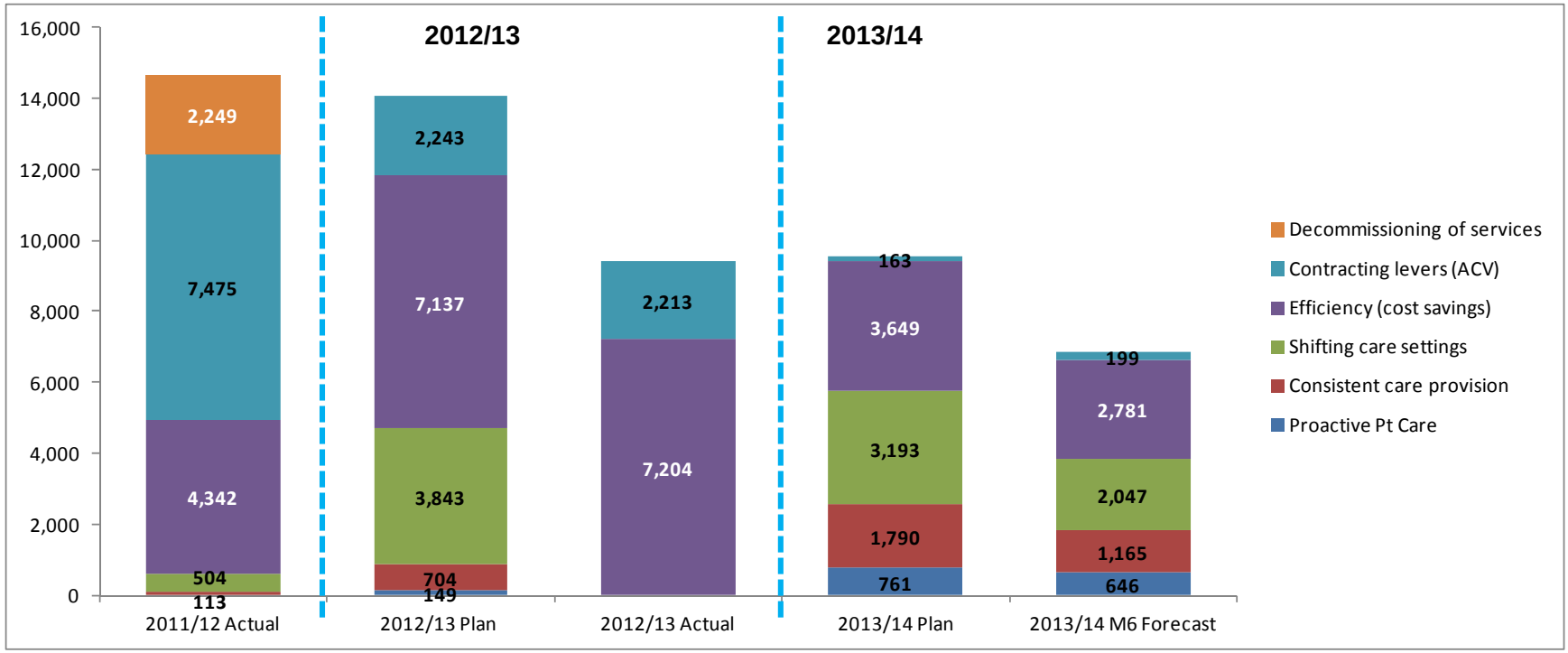
Note: other budgets +£1.5m c.6%

3c) Characterising the QIPP gap:
Nature of the QIPP delivered over the past 3 years (from 11/12 to 13/14)

Harrow Clinical Commissioning Group

The profile of QIPP initiatives planned and delivered over past 3 years shows the changing nature of planned benefits – including an increasing need to deliver savings through changing care settings, consistency of provision and proactive management of patients through integrated care.
In addition, planned benefits from these 'transformational schemes' have taken longer than planned to deliver.

Profile of Harrow's planned, actual & forecast QIPP savings (£k) by type of change *(2011/12 – 13/14)*



- Harrow's QIPP schemes have been categorised by type of change, including decommissioning, contracting, efficiency, shifting care setting (e.g. STARRS/Rapid Response), consistent provision (e.g. Referral Management) and proactive patient care.
- In section 5 'Delivery Plans' the CCG has considered the lessons learned and planned changes to delivering QIPP.

Source: Various financial reports, QIPP Plans

3d) QIPP strategy:

Harrow Clinical Commissioning Group

Considering the health needs of our population, the financial challenge and our existing strategies and plans, our QIPP strategy is...

- To continue our existing plans which look to transform how acute care is provided, including *Shaping a Healthier Future / Better Care Closer to Home,* are fundamental to delivering higher quality care more effectively, and provide a foundation for the plans.
- In addition, to go further, based on the following principles:
  - **Integration**: proactive and integrated management of high risk / high need patients, (top 5 and top 20%) including their social, mental and physical care needs.
  - **Prevention**: primary prevention for lower risk patients, and secondary prevention to reduce the rate of increasing needs.
- **We will expand a patient-centred approach for vulnerable patients with multiple needs, rather than a disease-specific approach.**
- An integrated, patient-centred approach will improve the quality of care. Even so, the evidence of financial savings to be realised from an integrated care approach is currently limited in the UK (although there are numerous successful international studies). Therefore we will carefully monitor and adapt our integrated care plans to ensure that ambitious outcomes are being achieved.
- ***Delivery of this Plan over three years will require the CCG and its partners, including the Local Authority (LA) and NHS-E, to work in radically different ways.***

Consequently, our QIPP plans will focus on:

Consistent provision of care, *including:*	**Aligning care settings to patient needs:**	**Integrating care (mental, physical & social):**
• Reduce unwarranted variation in outpatient, elective and direct access referrals from primary care • Improved access to primary care; hubs to support Out of Hospital strategy • Effective medicine management • Continuing care – patient review processes & dispute resolution • Recovery based approach to mental health	• Expand rapid response & intermediate care services • Expand Ambulatory Emergency Care • Paediatric pathways • MH Strategy – shifting settings of care • Implement new planned care pathways	• Build on and adapt Integrated Care Pilot • Pilot new models from WSIC • Integrated care for CYP; incl. safeguarding • Optimise use of Integration Transfer Fund • Integrated community nursing

In addition, we will continue to carefully review contract performance and service value for money.

3e) Commissioning Strategy summary: Agreed with Governing Body (end July 2013)

Harrow Clinical Commissioning Group

Context

- NHS Harrow CCG's vision is to work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets available.
- Harrow has embarked on a three month process to develop its Strategic Plan, including updated Financial and QIPP Plans. This process has focused on developing a clear understanding of the population's health needs, building on the JSNA.

Situation

- Health outcomes in Harrow are better than peer group averages, but there are significant variations across the Borough.
- Patient analysis shows that 5% of the population (12k people) use c. 50% of health and social care resources, while c. 20% use approximately 75%.
- Patient feedback has repeatedly identified the need for greater coordination, collaboration and communication across all services.
- In 2013/14, the CCG is operating with a planned deficit.
- In keeping with the whole of the NHS, growth in funding will not match forecast increases in demand.
- Over a 3 year period through to 2016/17, the combined impact of the starting deficit position and the forecast gap between funding and predicted demand, creates a significant financial challenge which needs to be addressed.

Our strategic plans

- Our existing plans which look to transform how acute care is provided, including *Shaping a Healthier Future / Better Care Closer to Home,* are fundamental to delivering higher quality care more effectively, and provide a foundation for the plans.
- In addition, we will go further, based on the following principles:
  - **Integration**: proactive and integrated management of high risk / high need patients, (top 5 and top 20%) including their social, mental and physical care needs.
  - **Prevention**: primary prevention for lower risk patients, and secondary prevention to reduce the rate of increasing needs.
- **We will expand a patient-centred approach for vulnerable patients with multiple needs, rather than a disease-specific approach.**
- An integrated, patient-centred approach will improve the quality of care. Even so, the evidence of financial savings to be realised from an integrated care approach is currently limited in the UK (although there are numerous successful international studies),
- ***Delivery of this Plan over three years will require the CCG and its partners, including the Local Authority (LA) and NHS-E, to work in radically different ways.***
- The CCG seeks support from its Primary Care, Specialist Services and Social Care commissioning partners, and Public Health, to develop and implement the initiatives required.

4. Proposed three year QIPP Plan (2014/15 -2016/17)

Contents:

a. Overview of the QIPP Plan – key priorities by workstream
b. For each workstream –
   (i) vision,
   (ii) initiatives covered (plus simple summary of the scheme),
   (iii) financial benefit (3 year gross, re-provision, net ; net by year).
c. Summary financial QIPP plan

4a) Proposed three year QIPP Plan (2014/15 – 2016/17)
Overview

Based on the QIPP strategy described in the previous section, a detailed programme comprised of 10 workstreams defines the key initiatives to bring about the necessary transformation.

While financial planning assumptions have been modelled through to 2018/19, Harrow's QIPP Plan has been set out over three years, 2014/15 – 2016/17.

The QIPP Plan is comprised of 10 workstreams:

1. Unscheduled care
2. Planned care
3. Primary care
4. Integrated care
5. Adult mental health and LD
6. Medicines management
7. Continuing care
8. Children's services and maternity
9. Community services

Each workstream is a combination of existing initiatives which are either already implemented, being expanded or in the process of implementation, as well as new initiatives that in the process of being defined.

The Commissioning Intentions for 2014/15 have been defined alongside the QIPP plans and are aligned and consistent.

4a) Proposed three year QIPP Plan (2014/15 – 2016/17)
Overview – commissioning priorities by workstream

Commissioning priorities

Commissioning priorities by workstream are summarised in the table below – more detail about each workstream is available in the remainder of this section.

Children's Services & Maternity	• Joint workstreams with LA: CYP Mental Health & Well-being; Early Intervention Services; and Integrated Pathway for Complex Children • Paediatric pathways for patients at all 'levels' of the population needs 'triangle': Community paediatric pathway for episodic care & Year of Care tariffs for children with manageable long-term conditions • Safeguarding • Maternity – quality and safety
Integrated Care	• Pilot new models of Whole Systems Integrated Care (WSIC) • Build on learning and achievements of the Integrated Care Pilot • Carers Strategy • Optimised use of the Integration Transformation Fund pooled budget
Unscheduled Care	• Achieve best practice standards in acute emergency care and management of acute flow/discharges • Expand Rapid Response and Intermediate Care services • Expand of Ambulatory Emergency Care • Develop an integrated primary care led unscheduled care model, aligned with Whole Systems work
Planned Care	• Implement up to 11 new planned care pathways • Reduce variation in outpatient and acute direct access referrals from primary care • Implement integrated End of Life pathway and service • Develop Respiratory pathway, including procurement of a local Pulmonary Rehabilitation service
Primary Care	• GP practice team education • Enhanced locally provided services • Improved access to primary care • Develop GP networks and hubs to support Out of Hospital Strategy and Integrated Care

4a) Proposed three year QIPP Plan (2014/15 – 2016/17)
Overview – commissioning priorities by workstream

Commissioning priorities

Medicines Mgmt	• Medicines safety and effective decision making • Primary Care Prescribing and Medicines Optimisation • Effective commissioning for medicines optimisation • Community Pharmacy
Community Services	• Co-design Integrated Nursing model between primary and community nursing • Collaborate with Voluntary & Community Sector
Adult Mental Health, Learning Disabilities & Challenging Behaviours	• Embed recovery-based approach, and achieve parity of esteem for Mental Health • Mental Health Strategy, including Shifting Settings of Care • Dementia Strategy • Integrated care pathways • Embed Winterbourne recommendations
Continuing Care	• Embed Dispute Resolution process • Review of Hadley House and nursing/care home commissioning • Establish duty of care • Strengthen patient review processes

4a) Proposed three year QIPP Plan (2014/15 – 2016/17)
Overview – of the QIPP planning process

Harrow Clinical Commissioning Group

The QIPP Plan represents, for each workstream, the current view of the CCG's key initiatives.
The plan will continue to be developed and refined.

- The Strategic & Financial Recovery planning process was led by a Strategic Plan Working Group, which included clinical, managerial and lay members.
- The strategic direction, set by this Group and agreed by the Governing Body, has been used as the basis for the CCG's Workstream Groups to develop service specific strategies and financial plans. This work builds on the existing strategies and QIPP plans.
- Detailed activity modelling and benchmarking data has been prepared to support the planning process.
- The QIPP Plan represents, for each workstream, the current view of the CCG's key initiatives and the associated gross, re-provision and net financial impact, as well as the associated risk assessment.
- These have been developed in collaboration with the Clinical and Managerial Lead for each workstream.
- The planning numbers will continue to be refined; for example, greater definition of future models of care will strengthen the robustness of reprovision figures. Planning figures for 2014/15 are more robust than for future years.
- Note on the Integrated Care workstream:
    - Integrated Care is a high priority both locally and nationally. Nevertheless, the proven potential scale of impact is unclear. Analysis to model the potential is being progressed within NWL and nationally.
    - The anticipated scale of the opportunity associated with the Integrated Care workstream is particularly important for the QIPP Plan. The figures provided in the plan have been developed through a review of the available evidence, a dedicated workshop held with the existing multi-disciplinary ICP leads to scope out what potential models could look like, and a follow-up meeting to agree Harrow specific assumptions.
    - *The planning assumptions used will need to be refined as (i) better local and national evidence is understood and (ii) as we see the results of changes that are implemented.*

4b) Workstream - Unscheduled Care:
Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- The current unscheduled care pathway is under pressure due to a number of factors which had led to our local acute provider repeatedly failing to achieve national A&E standards, compromising patient safety and experience.
- Patients find it difficult to access available services and/or choose to access UCC/A&E settings instead of self care / community services. This has driven up the cost of financing this population and will result in an unsustainable financial environment if trends continue.
- The overall pathway experienced by patients is fragmented in areas causing delays, and information about treatment frequently does not follow in a timely fashion.

By doing what:

Primary Care:

- Integrated primary care led unscheduled care model
- Patient level education – choose well and knowledge of pathways (white card system)

Admission Avoidance (Rapid Response):

- Maintain NHS 111
- Expand STARRS service
- Embed A&E demand management, incl. UCC
- Improve care for key groups, including Mental Health and Paediatrics

Acute pathways:

- Effective acute contract management
- Embed good practice from A&E Recovery Plan and Centre for Healthcare Improvement and Research
- Expand Ambulatory Emergency Care pathways – from 20 to 40 conditions
- Implement MCAP (or other tool to assess appropriateness of patient care setting)

Intermediate Care:

- Rapid step up and step down physical community rehabilitation and EMI community rehabilitation services (assumed to be cost-neutral for now but may release savings)

WSIC

- Aligning services to WSIC to support

Improved services i.e. 7 day working, data sharing, increased joint pathways

To:

- An end to end primary care led unscheduled care service where the patient is at the centre of the care plan.
- Our population will be well informed to use the most appropriate services at the appropriate time.
- The service will be easily accessible to patients to support the management of long term conditions and episodic care in the community with reduced reliance on acute services.
- Integrated health & social care pathways will make the most appropriate use of all suitable resources.

We intend for services:

- To be safe, high quality & timely
- To be more responsive
- To be simple to navigate
- To be cost effective & clinical value for money
- To have early senior clinical input
- Where appropriate, to be open on a 24/7 basis
- To share treatment information in a safe and timely way

4b) Workstream – Unscheduled Care: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Integrated primary care led unscheduled care model	Establish a hub and spoke model: hospital front end service with satellite clinics in the community to deliver services closer to primary care	Anticipated financial benefits to be identified as part of the scoping process	Scoping/ development
NHS 111	Provide a single point of access via telephone triage service to direct patients to the right place at the right time. Strengthen Directory of Services.	This service is an enabler to support other unscheduled care schemes. No independent savings are identified	Live
Rapid Response & Home Care (STARRS) 14/15 stretch	Expand the Intermediate Care team providing a Rapid Response service to avoid A&E attendances and non-elective admissions. Expand by an additional 1,615 admissions avoided & 837 A&E attendances avoided.	Expanding the existing service to avoid an additional 1,615 NEL admissions & 837 A&E attendances in 14/15	Planned
Rapid Response (STARRS) - growth	Expand the Intermediate Care team providing a Rapid Response service to avoid A&E attendances and non-elective admissions. Expand to meet a percentage of the additional avoidable activity that current financial modelling assumes will take over the next 3 years.	Assumes that STARRS will expand further in 15/16 to avoid an additional 524 NEL admissions 290 A&E attendances. This will cover the growth for 15/16 and 16/17	Planned
Urgent Care Centre / A&E Demand Mgmt	Reduce demand for A&E services through a number of demand management and rapid response services.	-UCC will take an additional 8,470 spells phased over 2 years -3869 spells will be redirected to primary/self care -3650 spells not paid for due to reducing double payment in A&E -AECU activity accounted for in separate scheme	Live
Paediatrics Unscheduled Care Review	Understand the key drivers behind paediatric unscheduled care activity and develop an action plan to support patients being treated at the right place, at the right time.	Anticipated financial benefits to be identified as part of the scoping process. These will be linked with the Children's Services workstream initiatives, including Year of Care and asthma pathways.	Scoping/ development

c) Workstream – Unscheduled Care: QIPP initiatives summary cont.

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Improve A&E Flow	Improve the timeliness of care delivery in A&E through a number of improvements (delivered through CQUINs, contract management and shared improvement plans), including early senior medical review in A&E within 1 hour of attendance, timely turnaround of diagnostics, and staffing levels in line with national standards. Also impact of implementation of Liaison Psychiatry Service.	-50% of all NEL admissions with a LoS < 4 hours could be avoided through improved through contractual processes. -Reduction of 20% in highest volume adult and paeds HRG activity for short stay admissions. Reduction of 253 adult and 255 paeds short stay admissions. -Reduction of 83 A&E mental health related attendances (6%) through increased patient management	In progress
Improve Acute Flow	Reduce inpatient Length of Stay delivered by embedding the A&E Recovery Plans to improve acute flow and bed capacity, and to improve discharge performance, and other aspects of contract management (e.g. CQUIN for 7 day consultant ward rounds, and all patients to receive an EDD and Consultant review within 12 hours of admission.	75% of NEL excess bed days (XBD) costs at NWLHT are avoided over 3 years targeting cardiology, gastroenterology, general medicine and trauma & orthopaedics	In progress
Expand Ambulatory Emergency Care	Expand the Northwick Park-based service to treat and discharge acute emergency patients with nationally defined Ambulatory Emergency Care conditions (who would otherwise have been subject to an overnight stay).	Developing up to 20 clinical pathways and implementing contractual processes within the NWLHT contract. Benefit is achieved through the difference between current costs admission and the national best practice tariffs for Ambulatory Emergency Care	In progress

c) Workstream - Unscheduled Care: Summary of financial impact

Harrow Clinical Commissioning Group

The three year net plan for the Unscheduled Care workstream is £4,569k.
The plan assumes reprovision of £1,897k.

Scope

- The total Acute budget in 2013/14 is £155m.
- According to the 12/13 SLAM, NEL activity (emergency admissions, NEL excess bed days and A&E attendances) were c. £50m, or c.30% of the overall Acute budget. Note that c.16% of this NEL activity relates to Children and Young People.
- Planning assumptions forecast that the pre-QIPP Acute budget will be £176.7m by 2016/17.

Workstream summary - financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Unscheduled Care	6,467	1,897	4,569	2,512	1,477	580
Rapid Response & Home Care (STARRS) - >1,700	2,530	1,404	1,126	704	422	0
Improve A&E Flow	1,085	0	1,085	358	358	369
Improve Acute Flow	902	263	639	214	214	211
Rapid response and home care - ACS stretch	584	0	584	584	0	0
Expand Ambulatory Emergency Care	574	0	574	574	0	0
Rapid Response (STARRS) - growth	668	230	438	0	438	0
NHS 111	92	0	92	45	46	0
Urgent Care Centre / A&E Demand Management	33	0	33	33	0	0

All figures in the table have been risk-rated.

4b) Workstream - Planned Care:
Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- Fragmented services leading to poor patient experience
- Largely hospital based rather than local services
- No 'end to end' pathways of care
- Few opportunities for GPs to enhance skills
- Poor buy in from local GPs
- Lack of patient engagement in service redesign
- Poorly monitored and managed contracts with providers
- Conflict in relationship with local providers
- Limited self management programmes

By doing what:

Planned Care Pathways:

- Implement new planned care pathways in the following specialties: Ophthalmology; Gynaecology; MSK; Cardiology; Dermatology; Diabetes; Urology; Thoracic/Respiratory; Pain Service; Paediatrics Medicine/Care of the Elderly

Referrals:

- Referral Management
- Acute Direct Access

Long Term Conditions:

- Update End of Life Care (EOLC) pathway, including the roll-out of Coordinate My Care (CMC)
- Expert patient programme
- Respiratory Pathway, including implementation of a local Pulmonary Rehab service
- Cancer: in line with London-wide plans - improving early detection, delivering care closer to home, and consolidating specialist care.

To:

- End to end seamless pathways of care across all specialties
- Implementation of year of care models for long term conditions
- Community focused services provided closer to home by the most appropriate clinician/service
- Upskilling of GPs to provide a wider range of enhanced services
- Transparent assurance for patients and the CCG of safe, high quality, timely and accessible services
- Fully integrated health and social care services for patients with Long Term Conditions or on an End of Life
- Fully developed expert patient programme to enable patients to self manage effectively
- Public involvement in identifying opportunities for and implementing , service redesign and monitoring

4b) Workstream – Planned Care: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Planned Care pathways	Shift activity from specialist acute into standardised primary and community services in order to deliver effective care at a lower cost by either developing new lower cost pathways collaboratively with providers and/or procuring new services. New planned care pathways will be implemented in the following specialties: Ophthalmology; Gynaecology; MSK; Cardiology; Dermatology; Diabetes; Urology; Thoracic/Respiratory; Pain Service; Paediatrics Medicine/Care of the Elderly.	New planned care pathways will be commissioned at 75% of current cost.	In progress
Referral Management	Improve the quality and appropriateness of referrals to secondary care through increasing awareness of community based pathways and increasing the use of enhanced knowledge and skills within the primary care team.	Reducing variation expects to realise a c.7% reduction in outpatient referrals to 14/15.	Live
Acute Direct Access	Improve the quality and appropriateness of diagnostic tests ordered by GPs (including pathology, radiology, and physiotherapy), and to optimise the benefit of physiotherapy services through delivery within a consolidated MSK pathway.	Increased control of direct access referrals could reduce referrals by 4% per annum (this varies by specialty).	Planned
End of Life Care pathway, including the CMC roll-out	Commission an integrated pathway for specialist end of life care to ensure that providers work seamlessly across organisational boundaries so that patients receive a streamlined high quality service, and are managed via a single caseload. Roll-out the Coordinate my Care (CMC) system across Harrow to support coordinated care.	There is a net saving of £2,100 per patient managed using CMC (source: Royal Marsden); 0.06% of patients who should be managed by the EoLC Pathway/CMC; have assumed only these patients die over the next 3 years (no new patients); and risk rated	In progress
Respiratory pathway, including implementation of Pulmonary Rehab service	Commission a Pulmonary Rehab service in order to repatriate existing provision to Harrow, and to consider extension of services to all chronic respiratory patients where appropriate. 'PR can be defined as an interdisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise each patient's physical and social performance and autonomy. Programmes comprise individualised exercise programmes and education'.	C. 450 patients per year quality for PR; 180 receive it (out of borough). Saving of £1,059 per patient repatriated. New service will cost £450 per patient. For every four additional patient who receive PR, 1 admission would be avoided.	Planned
Elective Procedures	CCG to achieve the elective and day case rates for the five best CCGs in the following specialties: Cancer, Endocrine, Neuro, Circulation, Respiratory, Musculo Skeletal, and Genito Urinary. Specific initiatives to achieve this include implementation of the CCG's Cancer plan.	That CCG achieves the elective and day case rates for the five best CCGs across selected specialties (based on the NHS England Commissioning for Value insight pack)	Scoping/ development

4b) Workstream - Planned Care: Summary of financial impact

Harrow Clinical Commissioning Group

The three year net plan for the Planned Care workstream is £6,085k.
The plan assumes reprovision of £5,642k.

Scope

- The total Acute budget in 2013/14 is £155m.
- According to the 12/13 SLAM, Elective activity (Maternity, maternity-related excess bed days, Elective & OP attendances) were c. £84m, or c.49% of the total Acute budget. Note that c.9% of this elective activity relates to Children and Young People.
- Planning assumptions forecast that the pre-QIPP Acute budget be £176.7m by 2016/17.
- Other Planned Care related budgets include c.£4.5m for Acute Direct Access.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Planned Care	11,727	5,642	6,085	2,359	2,704	1,023
Outpatients at lower cost - stretch	7,428	5,571	1,857	929	929	0
Referral management	1,537	0	1,537	777	760	0
Elective & day case admission variation	1,514	0	1,514	0	757	757
EOLC pathway, including CMC roll-out	781	0	781	258	258	266
Acute Direct Access	229	0	229	229	0	0
Respiratory pathway, including Pulmonary Rehab	238	71	167	167	0	0

All figures in the table have been risk-rated.

All figures in the table have been risk-rated.

4b) Workstream - Primary Care & Health Promotion: Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- Perceived poor GP access by patients in spite of Urgent Care Centres, Opted in GP out of hours services, WIC and extended hours
- Inconsistent quality of care and outcomes across all practices
- Estates infrastructure inadequate to support full implementation of SaHF and enhanced primary care
- Lack of integration of community and practice nursing leading to inefficiency and variation in access to high quality care across Harrow
- Limited range of community based services provided due to lack of capacity , training and resources within practices
- Pharmacists, optometrists and dentists not engaged in promoting and supporting delivery of high quality integrated community care
- Peer group structure needs further development to support delivery of locally focused services and collaboration between practices
- Lack of integration and collaboration with social care leading to fragmented pathways and sub optimal care
- Lack of meaningful public participation in shaping high quality primary care

By doing what:

Primary Care Transformation workstreams:

- Primary care access: improve access to care based on health need, including out of hours
- Consistent standard of quality in Primary Care
- GP Networks: develop networks of practices and other local health professionals to provide services and share resources
- Education: develop an appropriately skilled workplace to maximise the role of general practice
- Estates: ensure that premises are fit for purpose to support SaHF and provide core and extended primary care
- Informatics: invest in IT which supports care planning and integration
- Integration/proactive management (*see Integrated Care)*
- Proactive management of long-term conditions, including Ambulatory Care Sensitive conditions (*see Integrated Care section)*

Other Primary Care/Public Health initiatives:

- Redesign COPD/Respiratory pathway, including Pulmonary Rehab service & remote monitoring
- Implement Harrow Cancer Plan
- Prevention work related to obesity, physical activity, alcohol use, etc. (Public Health)

To:

- Working with the NHSE who lead on GP contracts, achieve improved GP access through local collaboration including out of hours
- Patient education programme on the appropriate use of services including alternatives such as pharmacists and helplines
- Measured improvement in the consistency quality and outcomes of primary care
- Provision of a comprehensive training and education programme for GPs, nurses and other clinicians to support development of existing and new skills
- Provision of a range of services in the community to support end to end pathways of care and SaHF
- GP networks developed to facilitate sharing of resources and skills across a local area
- Fully integrated community and practice nursing providing accessible, comprehensive high quality services across Harrow
- Network 'teams' include local pharmacists, dentists and optometrists supporting delivery of care
- Social care services fully integrated with primary care
- Patients involved in all stages of service development and redesign to improve quality of and access to local primary care services
- Estates strategy developed and implemented supports delivery of SaHF and enhanced GP services

c) Workstream - Primary Care & Health Promotion: Summary of financial impact

There are currently no specific savings associated with the Primary Care workstream .

The changes implemented by this workstream will be enablers to realising savings in other schemes, including Integrated Care and Unscheduled Care.

- **There are currently no specific savings associated with the Primary Care workstream – the initiatives being led by this workstream will be enablers to realising savings in other schemes, particularly Integrated Care.**

- There is a clear distinction between the Primary Care Transformation workstream and the CCG's budget lines identified as 'Primary Care'.
- These 'Primary Care' budget items come to £2.6m in 2013/14, and include the Locally Enhanced Services (LES) (£1.6m), the Walk-In Centres, and NHS 111.

4b) Workstream - Integrated Care (top 20%): Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- Reactive
- Uncoordinated – no name clinical contacts and no named coordinator
- Inconsistent
- Disease-centred
- Patients may feel out of control
- Duplicated care effort
- No shared patient record
- Siloed care plans
- Lack of transparency and professional accountability
- Lack of governance framework to support Integrated Care
- Lack of contacts and communication across multi-disciplinary team
- Lack of effective mechanism for solving system issues
- Lack of shared learning for professionals
- Mistakes are duplicated

By doing what:

- Enhanced Integrated Care Pilot: building on the strengths and learning from the current model to have an even greater impact on patients within the top 20% of the triangle.
  - May include expansion of the Care Homes Case Management and Hospital at Home, including Falls Prevention
- Whole Systems Integrated Care: working with the NWL Strategy & Transformation team to identify a targeted population cohort, to co-design a new approach to managing their care, piloting this within a single locality, and then rolling out as appropriate.
- *Supported by Integrated Nursing initiative*
- Carers' Strategy
- Integration Transformation Fund - jointly implement locally agreed integration schemes with the Local Authority in line with national guidance and local strategic priorities.

To:

- Proactive/anticipatory
- Coordinated – named clinical contact and named coordinator
- Patient-centred
- Patients feel empowered and supported
- Integrated health and social care teams
- Shared patient record, including care plans
- Recovery-based where possible
- Transparency and professional accountability
- Clear professional roles and responsibilities
- Clear governance framework to support Integrated Care
- Established local networks with clear contacts across multi-disciplinary team
- Robust mechanism for identifying and addressing common issues encountered
- Shared learning for professionals
- Mistakes are avoided

4b) Workstream – Integrated Care: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Enhanced ICP	Build on the strengths and learning from the current model to have an even greater impact on patients within the top 20% of the triangle. The following objectives have been identified as part of enhancing Integrated Care: focus on vulnerable patients; improve continuity of care; provide holistic patient 'diagnosis' (mental, physical and social) – leading to holistic & purposeful support; patient at the heart of decision making; improve real time advice and guidance for complex cases; and build consistent, whole system capability to manage/support people with complex needs.	Enhancing ICP will be aligned with the Whole Systems Integrated Care programme, and together they will avoid the acute activity as per the 'Integration of primary, acute, social and community care' assumptions.	In progress
Integration of primary, acute, social and community care	Improve the coordination and delivery of care for patients with complex conditions, e.g. those with long-term conditions, the elderly and the socially vulnerable.	Existing evidence was reviewed in order to understand the potential impact of Integrated Care on acute activity. A reasonable mid-point has been used as the basis of Harrow's planning assumptions: • 25% reduction in A&E attendances • 20% reduction in NEL admissions • 10% reduction in Elective adms • 20% reduction 20% Outpatients Reprovision costs were estimated as follows: assuming an average additional cost of proactive IC = £170	Scoping/ development
Carers' Strategy	Embed delivery of the Carers Aware Practice initiative, and will underpin delivery of the Out of Hospital and Integration agenda. Work in partnership with the London Borough of Harrow to increase identification and support of Young Carers as part of an integrated pathway of care. Work with Harrow Council to develop a local Carers Hub where Carers across Harrow would receive information, advice and support for their needs. This scheme is an enabler of savings in other initiatives.	A whole systems study tracked a sample of people over 75 years old who entered the health and social care system and found that for 20% of those needing care – often costly hospital care – this was due to the breakdown of a single carer on whom the older person was mainly dependent.	In progress

4b) Workstream - Integrated Care: Summary of financial impact

The three year net plan for the Integrated Care workstream is £9,238k.
The plan assumes reprovision of £6,084k.

Scope

- There is no specific budget line associated with 'Integrated Care'; rather, it impacts across all budget areas, particularly Acute and Community Services.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Integrated care	15,322	6,084	9,238	794	2,641	5,804
Integration of primary, acute, social and community care	15,322	6,084	9,238	794	2,641	5,804

All figures in the table have been risk-rated.

4b) Workstream - Adult Mental Health Transformation: Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- Existing Modernisation work program underpinned by NWL Mental Health strategy, including review and redesign of rehabilitation services
- Newly established process to facilitate access to and review of CCG packages of care to ensure high quality cost effective outcomes
- Strong engagement with key local provider
- Well-established repatriation programme to ensure care is delivered closer to home with high quality best value outcomes
- Psychiatric liaison service based in A&E of key acute provider
- Established IAPT service (10% by 13/14)

Challenges:

- Challenges from Carers and Users re existing service model (experienced as overly medicalised)
- Inconsistent Recovery focussed approach to care outcomes
- Lack of Whole System approach care planning
- Lack of integrated primary care and specialist MH pathways and communication challenges
- Under resourced, fragmented Dementia care pathway
- Local Mental Health service in Accelerated Service Improvement Programme (ASIP)

By doing what:

Shifting Settings of Care:

- Enhanced Primary Mental Health Care
- Review of Acute inpatient service
- Liaison Psychiatry Service (LPS) redesign
- Mental Health inclusion in the developing CCG Integrated Care programme

Service redesign:

- Redesign of Roxbourne Complex & Annex
- Implement new Personality Disorder (PD) pathway
- Review spend and pathways of shared care protocols for Mental Health prescribing

Service development:

- Increase IAPT service capacity
- Integrated Dementia Strategy

Internal review processes:

- Implementation of Mental Health panel
- Mental Health repatriation

To:

- Recovery-focused approach to care, i.e. maintaining a belief that people's mental health conditions have the ability to improve
- High quality, appropriate management of care by all services and providers for MH users
- Integration between health and social care to deliver high quality care outcomes
- Delivery of NWL MH Strategy
- Reduction in reliance of specialist MH care – cost reduction
- Commission needs led high quality placements to deliver recovery focussed health outcomes.
- Integrated locally agreed care pathways to deliver high quality care outcomes
- Services developed in conjunction with Carers and Users
- Expanded IAPT service (15% by 14/15)

c) Workstream - Adult Learning Disabilities & Challenging Behaviours: Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

Recently established:

- Health only LD Panel to facilitate access to and review of CCG packages of care to ensure high quality cost effective outcomes
- Joint assessment process between health and social care for all Assessment & Treatment in-patient beds
- Newly established Winterbourne View Task and Finish group to deliver Concordat requirements
- Refocusing of care outcomes to recovery model
- Establishment of appropriate assessment services-ADHD/ASD
- Reconfiguration of LD Community Team to target and meet specialist needs of LD client

General characteristics:

- Inconsistent quality and access to universal services (e.g. Specialist dental services)
- Fragmented LD care pathway between health and social care
- Requirement to define care pathway for access to challenging behaviour and support for management of hyperkinetic conditions
- Lack of integrated long term resource planning between health and social care and assessment of implications on local services

By doing what:

Learning Disabilities:

- Embed new service delivery, universal access up skilling and training to include Primary Care
- Winterbourne Review: delivery of concordat recommendations by April 2014 to define future services
- Undertaking LD SAF and implementation of recommendations
- Joint planning between social care, health, and wide range of key stakeholders
- Embed LD panel process and ensure appropriate contracts in place to ensure high quality care outcomes delivered at best value.

Challenging Behaviours:

- Autism: implementation of national requirements by delivery of integrated care pathway
- Embed ADHD and Autism assessment pathways whilst developing integrated pathways of care.

To:

- Service provision focused on early intervention ,maximisation of potential recovery-focused approach to care.
- Universal access services delivering high quality ,appropriate response and management of care by all services and providers.
- All providers demonstrably achieving quality standards and response.
- Standardised GP practice education to support caring for LD patients.
- Integrated locally agreed care pathways to deliver high quality care outcomes between all key stakeholders.
- Optimisation of resources and joint commissioning in relevant areas.
- Appropriate range of high quality placements to deliver recovery focussed health outcomes within the borough wherever possible.
- Services developed in conjunction with Carers and Users.
- Local policy development to meet the borough need linked to resource and capacity analysis.

c) Workstream – Adult Mental Health & Learning Disabilities: QIPP initiatives summary

Initiative name	Initiative summary	Logic of benefit	Status
Liaison Psychiatry Service (PLS) Funding Re-allocation	It is the intention in 2014/15 that the Liaison Psychiatry Service in mainstream acute ward settings (not A&E) will be fully funded through the PbR Tariff. During 2013/14, CCGs have provided a contribution, through CQUIN, towards the Psychiatric Liaison Service to smooth transition for acute providers in line with PbR. In line with prevailing national PbR guidance this commissioning contribution will be discontinued in 2014/15.	Based on the savings realised by Brent CCG from a similar re-allocation.	In progress
Redesign of Roxbourne Complex & Annex	Redesign of the 40-bed inpatient rehabilitation unit, which has been operating as a long stay unit. The specification will be updated to ensure it functions as a rehabilitation unit with a maximum length of stay. This will also reduce the need for external rehab placements.	Estimated based on the savings realised through the redesign of CNWL Rosedale.	Planned
Mental Health - growth	Prevent a proportion of the Mental Health demographic and non-demographic growth modelled in the Harrow financial plan.	Assumes that a proportion of the cost pressures in Mental Health will be avoided. This will require support from the Local Authority, and therefore has been risk-rated to 20%.	Planned
Implementation of Mental Health panel	Implementation of a robust MH Panel to carry out high quality assessments and enable patients to be moved into more appropriate lower cost settings.	Saving assumptions are based on experience from the PEP programme.	In progress
Enhanced Primary Mental Health Care	Support the transfer of identified patients from specialist mental health services into primary care through development of an enhanced Primary Care Mental Health Team which will include Community Psychiatric Nurses (CPNs), rapid access to consultant psychiatric advice to support primary care, and the enhancement of GP capacity and competence through mental health training. The service will improve the step-down pathway and provide specialist support to reduce admissions and re-admissions to secondary care.	Projected savings based on the NWL Mental Health strategy assumptions (i. shift 100% of clusters 1 and 2; 50% of cluster 3 and 4; and 25% of clusters 5, 6 and 11; reprovision costs estimated at 33% while the new primary care-based models are designed.	Scoping/ development
Repatriation of Learning Disability clients (formerly PEP)	Repatriation of Learning Disability clients from out of borough placements.	Saving assumptions are based on experience from the PEP programme.	In progress

c) Workstream – Adult Mental Health & Learning Disabilities: QIPP initiatives summary cont.

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Shifting settings of care – Acute Inpatient Service	Identify clinically appropriate care shifts from acute to community settings and alignment of resources accordingly.	To be confirmed	Scoping/ development
Implementation of new Personality Disorder pathway	Implement Personality Disorder care pathway to maximise care outcomes, develop locally skilled workforce and reduce specialist associated care requirements.	To be confirmed	Scoping/ development
Care planning for high risk Mental Health patients / Urgent Assessment Pathway / impact of LPS service	There are a number of initiatives for 14/15 and beyond that will reduce the incidence of patients with Mental Health issues presenting at A&E and/or being admitted to a general acute bed. Implementation of phased Urgent Assessment care pathway, which will be aligned with the Personality Disorder care pathway.	Savings are accounted for within the Unscheduled Care workstream 'Improve A&E flow'.	In progress
Review spend and pathways of shared care protocols for Mental Health prescribing	See Medicines Management workstream – note that this is a joint project across workstreams/service areas.		
Implement Dementia Strategy	See Continuing Care workstream – note that this is a joint project across workstreams/service areas.		
West London Mental Health Trust/Barnet, Enfield and Haringey Trust	Continued review of activity and alignment of local services to maximise resources and care outcomes.	Completion of work started in previous years	In progress

c) Workstreams - Adult Mental Health, LD & Challenging Behaviours
Summary of financial impact

Harrow Clinical Commissioning Group

The three year net plan for the Adult Mental Health, Learning Disabilities and Challenging Behaviours workstreams is £2,761k.
The plan assumes reprovision of £322k.

Scope

- The total Mental Health budget in 2013/14 is £20.5m (note that £1,784k of this total budget is related to Children's Services).
- Planning assumptions forecast that the pre-QIPP Mental Health budget will be £21.1m by 2016/17.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Adult Mental Health	3,083	322	2,761	1,403	875	483
Enhanced Primary Mental Health Care	975	322	653	216	216	222
Implementation of Mental Health panel	600	0	600	300	200	100
Redesign of Roxbourne Complex & Annex	600	0	600	300	300	0
Repatriation of Learning Disability clients (formerly PEP)	450	0	450	250	100	100
Mental Health growth	180	0	180	59	59	61
Liaison Psychiatry Service Funding Re-allocation	165	0	165	165	0	0
Shared Care prescribing protocols	83	0	83	83	0	0
Mental Health West London / BEH contract review	30	0	30	30	0	0

All figures in the table have been risk-rated.

- The Adult Mental Health workstream will lead/collaborate on a number of initiatives impacting on the Continuing Care budget: review of Section 28a patients, review of Section 117 patients, and implementation of the Dementia Strategy.
- The workstream is also working with the Unscheduled Care workstream to strengthen response to urgent mental health issues and to reduce acute activity.

4b) Workstream - Medicines Management: Vision / operating model for future of the service

Harrow Clinical Commissioning Group

From:

- Safe and evidence-based
- Some inefficient repeat prescribing systems in some Primary Care practices
- Medicine wastage
- Financially stretched because of successful achievement of more 'obvious' saving areas ("quick wins" have been addressed historically)
- Limited involvement of LPC and community pharmacies in Prescribing agenda.
- Long history of engagement with primary and secondary care
- Lack of robust process to manage entry of new appliances and devices into Primary Care (e.g. stoma products, incontinence items).
- Earlier engagement of stakeholders in prescribing issues e.g. ICO, CSU, Clinical Networks
- Good ownership of prescribing decisions by clinicians
- Good outcomes for diabetes and cardiac patients suggests Primary Care clinicians use new drugs effectively and appropriately by adhering to local and National guidance
- Lack of communication impacting on prescribing

By doing what:

Medicines Safety and Effective Decision Making

- Provide advice on medicines management to the CCG board through the MMC.
- Develop relationships through the local DTCs and NWL Medicines Management Network.
- Implementing the NWL integrated Formulary that takes into account cost-effectiveness, quality, safety, patient acceptability, medicines optimisation and implementation of NICE guidance.
- Improving interface transfer of prescribing with secondary care, community and mental trusts, by agreeing robust shared care protocols for selected medicines.

Primary Care Prescribing and Medicines Optimisation

- QIPP Dashboard & targeted savings indicators link to the LES.
- Management of prescribed non-medicinal products/appliances.
- Virtual support for prescribing decision making using Scriptswitch.
- Operational support for practice from prescribing advisers.
- Campaign to reduce wastage of medicines.

Effective commissioning for medicines optimisation

- Efficient, robust and safe repeat prescribing systems within GP practices.
- Efficient, robust and safe repeat dispensing systems with community pharmacies.
- Quality Medication Reviews in GP Practices and for patients requiring care at home
- Medication optimisation services for elderly patients cared for at home and in care homes.
- Evaluating performance of PbR-excluded drug prescribing and strengthen contract management of acute prescribing.

Community Pharmacy

- Commissioning medicines 'not dispensed schemes' from community pharmacies.
- `Quality, targeted Medicines Usage Reviews and New Medicines Services within community pharmacies

To:

Medicines Safety and Effective Decision Making

- Effective networks of all partner organisations/stakeholders established, to ensure effective joint decision making to deliver innovative, safe and cost-effective prescribing and use of medicines (and non-medicinal products) across health care services.
- Medicines governance mechanisms will be in place to assure safe, effective and affordable medicines usage, to reduce variation in prescribing, reduce waste and limit medicines related hospital admissions.

Primary Care Prescribing and Medicines Optimisation

- Formulary choices of prescribed medicines will be evidence based; cost-effective and be an efficient use of NHS resources.
- Prescribing decisions will be owned by clinicians, involving the patient to improve medication adherence and concordance.

Effective commissioning for medicines optimisation

- Services will be commissioned from providers who demonstrate that medicines prescribed for patients meet patients' needs, are safe, evidence–based and cost-effective.
- Patients transferring between care settings will have appropriate advice and information about their medicines to enable on-going safe and effective use.
- Medication review services will be commissioned to optimise medicines use, through maximising adherence and reducing waste.

Community Pharmacy

- Community pharmacists will be integrated with the CCG to maximise the opportunities to achieve QIPP and medicines optimisation priorities.

4b) Workstream – Medicines Management: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Medicines Management	In 14/15, a number of initiatives will reduce growth in Prescribing budget: • QIPP Dashboard & targeted savings indicators • Virtual support for prescribing decision making using Scriptswitch • Campaign to reduce wastage of medicines • Medication optimisation services for elderly patients cared for at home and in care homes • Commissioning medicines 'not dispensed schemes' from community pharmacies. • `Quality, targeted Medicines Usage Reviews and New Medicines Services within community pharmacies.	The savings in14/15 will be realised through a number of initiatives that aim to reduce waste and optimise medicines usage. Note that the cost of hospital admissions as a result of incorrect medicine usage could be nearly £200m a year; NHS primary and community care prescription medicines waste costs £300m a year; and The Royal Pharmaceutical Society estimates that up to 50% of patients do not take their medications correctly. In 15/16 and 16/17 we will limit growth in the Prescribing budget to 2.5% per year (rather than 5% per year as in the Harrow financial plan).	Scoping/ development
Non PbR acute prescribing	Evaluate performance of PbR-excluded drug prescribing and strengthen contract management of acute prescribing.	10% of the annual plan for 13/14, which was £3,107,981 (across all providers).	Planned
Shared care protocols	Improve interface transfer of prescribing with secondary care, community and mental trusts, by agreeing robust shared care protocols for selected medicines.	Brent has agreed at £110k saving in 14/15 - specific amount to be agreed for Harrow.	In progress

4b) Workstream - Medicines Management: Summary of financial impact and key planning assumptions

The three year net plan for the Medicines Management workstream is £2,457k.
The plan assumes reprovision of £155k.

Scope

- The total Prescribing budget in 2013/14 is £28.7m.
- Planning assumptions forecast that the pre-QIPP Prescribing budget will be £33.3m by 2016/17, due to price changes and growth.
- The acute contracts include an additional £3.1m for non-PbR drugs.
- Cost pressures in Prescribing will include:
    - New drugs - already NICE approved drugs, incl. Rivaroxaban, Dabigatran, etc.
    - New drugs - forecast to be NICE approved drugs
    - Increased drug tariffs
    - Out of Hospital – shifting settings of care
- The anticipated balance between actual cost pressures and saving opportunities will provide the QIPP plan for Prescribing over the next three years.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Medicines Management	2,612	155	2,457	866	870	721
Medicines Management	2,312	155	2,157	716	720	721
PbR Excluded Drugs Review	300	0	300	150	150	0

All figures in the table have been risk-rated.

4b) Workstream - Continuing Care: Vision / operating model for future of the service

Harrow Clinical Commissioning Group

From:

- Misinterpretation of the National Framework for Continuing Healthcare
- Challenges in agreeing operational policies and joint working approaches
- Reactive planning and commissioning of care
- Embedding standards and quality checks of care package
- Completion of all retrospective claims
- Lack of agreed Dispute Resolution process with the Local Authority

By doing what:

- Analysis and agreement of interpretation of Continuing Healthcare eligibility requirements across the Outer NWL region
- Review of Section 28a patients (*in collaboration with Mental Health workstream)*
- Review of Section 117 patients (*in collaboration with Mental Health workstream)*
- Timely reviews of LD CC patients *(in collaboration with Learning Disability workstream)*
- Implementation of the Dementia Strategy (leading to reduction of inpatient Continuing Care beds) (*in collaboration with Mental Health workstream)*
- Agree Dispute Resolution process with Local Authority
- Carry out a review of Hadley Hall
- Support the roll-out of Personal Budgets in order to best meet patient needs
- *The CCG's long-term goal is to work to guidance in all areas*

To:

- Standardisation of the Continuing Healthcare assessment tools across the sector - agreement on local practice, specification of outcomes and procurement processes for care packages to ensure that Continuing Healthcare decisions are based on the objective assessment of the patient's clinical need, safety and best interests.
- Timely joint assessments to determine the appropriate support and care packages for individuals and reviews of local provision to ensure this is in line with identified need.
- Strategic planning to ensure that local Continuing Healthcare processes and practices comply with Department of Health Guidance, including Personal Health Budgets.
- Improved planning and commissioning through developed formal processes and pathways – a multi-agency decision-making processes that clarify health and social care needs and responsibilities.
- Key performance indicators to manage quality, safety, and performance of services for individuals who qualify for NHS Continuing healthcare, drawing on best practice to drive the improvement of services.
- Management of provider markets to ensure innovation, quality and value for money.
- Agreed Dispute Resolution process.

4b) Workstream – Continuing Care: QIPP initiatives summary

Initiative name	Initiative summary	Logic of benefit	Status
Non Eligible Continuing Care	A number of patients whose care is currently funded by the CCG do not meet the criteria for Continuing Health Care, and therefore the cost of their care will be transferred to the Local Authority.	Based on the number of cases in dispute with the Local Authority and the likelihood of agreement.	Live
Shared Lives	'Shared Lives' is funding that was provided for adult fostering patients, but that the CCG should no longer be paying for.	The current spend on Shared Lives patients is £73k.	Scoping/ development
Shifting Continuing Care settings	Implement an equitable level of service provision across all patients, depending on their needs. This may include shifting the setting of care in which some patients are treated.	To be confirmed	Scoping/ development
Section 117	Section 117 imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the Mental Health Act. While these aftercare costs are currently split 50-50 between the CCG and Local Authority, the CCG would like to move towards a funding model based on assessed need, as it in place in other boroughs.	Still to be established – note there are currently 10 LD patients on the Section 117 list (estimated annual cost of £453k), and 21 MH patients, with an estimated annual costs of £397k.	Scoping/ development
Review of Section 28A patient funding status	'Section 28a' patients are those who were previously known as Old Long Stay (OLS) patients, for whom it has been custom and practice for Health to cover all costs of their care (regardless of assessed need). Harrow will work with partners to (a) confirm a valid list of 'Section 28a/Old Long Stay patients', and (b) agree how best to manage their care given that the Department of Health no longer adjusts PCT/CCG allocations to cover these costs.	Assumes that 90% of current 'Section 28a' patients don't genuinely have health needs (based on Brent's experience), and that the Local Authority will be willing to pick up 50% of these costs.	Scoping/ development
Implement Dementia Strategy (leading to reduction of EMI costs) *(note: joint workstream with Mental Health)*	Deliver the joint Dementia Strategy and reconfigure existing dementia services to deliver an effective care pathway which supports: • Improved early diagnosis of dementia in primary care. • Genuinely integrated easy to access service. • Review and realignment of Elderly Mentally Ill (EMI) inpatient bedded services to maximise local resources and care outcomes. • Support from specialist services to manage those diagnosed with dementia in a community setting.	The national lead for Dementia thinks that 2/3 of all Dementia patients in CC beds may not need to be there, if adequate support was available in the community. Harrow will assume that 1/3 can be managed from home, and that reprovision costs will be 50%.	In progress

4b) Workstream – Continuing Care: QIPP initiatives summary cont.

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Woodland Hall re-charge	There are 7 non-Harrow patients currently staying in Woodland Hall. Harrow has been charging them the basic CCG block rate, but will now start charging them the same cost per case price that the CCG pays for non-Woodland Hall beds.	The full year effect of charging full price for 3 Brent patients in the Harrow block bed base is £180k; this has been extrapolated across other 4.	In progress
Continuing Care – efficiency of placements	Will review CC and non CC packages to ensure the CCG is commissioning all care packages in line with national benchmarked costs.	To be confirmed	In progress
Continuing Care - children	Planned savings from 13/14 will be re-phased into 14/15, as the required nurse assessors are now in place. Savings due to residential schools are also planned.	To be confirmed	In progress

Note that London Continuing Care benchmarking data is available in Appendix C.

4b) Workstream - Continuing Care: Summary of financial impact

Harrow Clinical Commissioning Group

The three year net plan for the Continuing Care workstream is £1,918k.
The plan assumes reprovision of £575k.

Scope

- The Continuing Care budget in 2013/14 is £15.6m.
- Planning assumptions forecast that the pre-QIPP Continuing Care budget will be £16.6m by 2016/17.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Continuing Care	2,493	575	1,918	926	401	591
Implement Dementia Strategy (leading to reduction of IP CC beds)	1,150	575	575	58	86	431
Woodland Hall recharge	399	0	399	399	0	0
Section 117	319	0	319	0	159	159
Review of Section 28A patient funding status	311	0	311	155	155	0
Non Eligible Continuing Care	278	0	278	278	0	0
Shared Lives	37	0	37	37	0	0

All figures in the table have been risk-rated.

4b) Workstream - Children's Services and Maternity: Vision / operating model for future of the service

Harrow Clinical Commissioning Group

From:

Complex & continuing:

- Invoice driven; expensive placement
- Based on historic split of finance
- High proportion of 52 week placements
- Lack of assurance around quality
- Insufficient support to parents to maintain children at home
- Perceived gaps in service and lack of oversight

Mental Health

- Fragmented, gaps – perceived and real; misunderstanding of shared vision and role
- Over emphasis on medical model
- Involvement of education, social care & health
- Strong T3 service and prevention of T4 admissions

Early intervention

- Maternity: early identification of vulnerable; lack of integration to maximise maternal health
- Risk of the reconfiguration of Health Visiting and School Nursing
- Inconsistent approach to supporting and identifying unborn children and mothers
- Lack of integration with Local Authority
- Lack of involvement in terms of Children's Centres; lack of network involvement with GPs

General

- Lack of third sector or alternative provision awareness and lack of CAF

By doing what:

Partnership working:

- 3 workstreams with Local Authority
- New MH Integrated service specification and agreed pathway

Paediatrics pathways:

- Planned Care episodic + year of care for complex
- Part B procurement

Long-Term Condition management:

- Audit of complex and LTC children – cost and quality analysis
- Clarification on what complex falls into CCG and what is specialist commissioning

Principle: in general to maximise:

- Identification and targeting
- Low cost and high impact

To:

Complex & continuing:

- Joint process with LA:
  - Assessing needs, reviewing quality and services/needs
  - Justification of placement length
  - Needs led services
- Working with LA to support parents and extended local service offer
- Respite fostering for complex children
- Seamless integrated pathway by maximising the service specifications
- Unscheduled: Primary Care Transformation
- Planned:
  - Episodic low cost right pathway
  - Skilling up Primary Care to reduce referrals
- LTCs:
  - Maximise best practice tariff use – DM & Epilepsy
  - Community nurse for training, one to one relationship for DM, Epilepsy
- MH:
  - Jointly responsible pathway of care and early identification to increase resilience
  - Clarify roles
- T3 + T4: to improve and continue

4b) Workstream – Children's Services and Maternity: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Integrated Pathway for Complex Children	Work with the LA and Education Services to develop an integrated plan for children with complex needs, to support them to stay in family settings where possible. We will work with LB Harrow Education and Social Care services to develop a single assessment pathway for children with complex needs. The pathway will include the process by which statements of Special Educational Need (SEN) are completed.	That 20% of the health costs associated with 20% of the Harrow children with a statement of Special Educational Need (SEN) can be avoided through the integrated pathway.	Planned
CYP - Year of Care	To provide better integrated care for children with complex physical and developmental conditions. 'Year of Care' tariffs will be developed to support the care of children with complex physical and developmental conditions. A 'Year of Care' scheme aims to move away from "payment by results" and introduce a block contract based on a year's care for a population. The approach is suited to areas with high concentrations of patients with long term conditions such as respiratory disease or diabetes, where it is best to encourage providers to keep patients as well as possible at home.	Currently a conservative estimate while the specific patient cohort and baseline costs are established. Current estimated savings are based on the admissions that would be avoided if all Harrow peer groups achieved the best rate of CYP admissions for asthma, epilepsy and diabetes.	Planned
CYP - Asthma	The GP Respiratory lead will work with the Respiratory Paediatrician and Community Paediatrics team to develop a step-up and step-down pathway to educate and support families with children who present at A&E and/or are admitted to hospital with respiratory symptoms.	That 50% of the admissions and readmissions for asthma or wheezing in children under 5 can be avoided (will aim to reduce by 33%).	Scoping/ development
Children's Continuing Care	See Continuing Care section		

4b) Workstream - Children's Services and Maternity: Summary of financial impact

Harrow Clinical Commissioning Group

The three year net plan for the Children's Services workstream is £440k.
The plan assumes reprovision of £73k.

Scope

- Children's services are not categorised separately within the Harrow budget, but are estimated (conservatively) to be approximately £22.6m, or just under 10% of total spend.

The logic of potential financial savings in Children's Services includes:

- Prevention of anticipated cost pressures through early intervention and integration.
- Reduction of acute activity through improved Long Term Condition management, including Year of Care tariffs for complex patients

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Children's Services	512	73	440	72	183	185
Integrated Pathway for Complex Children	291	73	218	72	72	74
CYP - Asthma	126	0	126	0	63	63
CYP - Year of Care	95	0	95	0	47	47

All figures in the table have been risk-rated.

4b) Workstream - Community Services, including Nursing: Vision / operating model for future of service

Harrow Clinical Commissioning Group

From:

- Unreliable service, staff feeling very stretched
- A reactive rather than preventative service
- Poor communication between district nursing service and practices
- Also poor communication between hospital discharge co-ordinators and district nurses
- Low morale, low retention and difficult to recruit staff
- No major focus on patients with long term condition or on case-co-ordination

By doing what:

- Undertaking two main streams of work with regards to community nursing:
  - A core improvement work stream
  - A transformational provision work stream
- Community Paediatrics: aligned to the Planned Care redesign programme
- Other Specialist Nursing
- Other work in Community, including investment to support Out of Hospital Strategy and Integrated Care

To:

- A service which is integrated with primary care and provide seamless patient care regardless of whether patients are housebound
- Sharing responsibility for patient outcomes, taking a preventative approach to patient care
- A service which is attractive to nurses to join and stay in
- A service which is able to support complex patients in the community safely and effectively

Note: the full 3-5 year vision for the Integrated Nursing service to be agreed in first phase of work

4b) Workstream – Community Services: QIPP initiatives summary

Harrow Clinical Commissioning Group

Initiative name	Initiative summary	Logic of benefit	Status
Productive Community Services	While no specific efficiencies will be sought in the Ealing ICO budget, no growth is anticipated in this budget.	The value of avoiding budget growth at Ealing ICO, i.e. c. £100k per year	Planned
Community budgets - growth	The intention is to avoid any growth in the remaining Community budgets.	The value of avoiding budget growth within the other Community budget, i.e. c. £122k per year	Planned
Community Paediatrics	An integrated paediatric service will be commissioned through a Part B procurement process with a single point of referral and enhanced GP interface in line with the planned care redesign principles. Will provide a sustainable high quality paediatric pathway for Harrow children which effectively integrates community and acute services to avoid duplication and ensure that providers work seamlessly across organisational boundaries for the benefit of patients. The scope of the redesign will include community and acute outpatient appointments and ward attenders.	The scheme is aligned to the Planned Care redesign programme. The overall pathway will be commissioned at 75% of current cost (see Planned Care pathways). Paediatric outpatients is currently provided by acute NWLH (under a block contract) and Harrow Health. NHS Harrow will seek to streamline the pathway and reduce the overall cost. By aligning these clinics to a streamlined paediatric pathway it is anticipated that a 10% saving can be realised against the value of the block contract.	Planned
Integrated Nursing	Develop an integrated nursing service, incorporating practice and community nursing services. The service will support delivery of care for patients with long-term conditions and will avoid hospital admission. We will co-design the new integrated nursing model in partnership with existing providers.	This is a significant CCG initiative that is ultimately anticipated to avoid acute activity and realise efficiencies across Community services. The exact financial impact is yet to be established.	Planned

4b) Workstream - Community Services, including Nursing: Summary of financial impact

The three year net plan for the Community Services workstream is £801k.
The plan assumes reprovision of £0k, but it is likely that some reprovision in other schemes will be spent on community services.

Scope

- While the total Community budget in 2013/14 is £18.6m, only c.£9m of this relates to SLA agreements with key providers (e.g. Ealing ICO).
- The remainder includes other community-based services including Clinical Assessment Services (CAS) (£1.7m), the ICP pilot (£1.1m), the STARRS service (£2.6m) and UCC services (£2.2m).
- Planning assumptions forecast that pre-QIPP Community spending will be £19.1m by 2016/17.

Workstream summary – financial impact

Initiatives *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Community	801	0	801	291	285	225
Community budget growth	367	0	367	122	122	122
Productive Community Health Services	309	0	309	103	103	103
Community Paediatrics	125	0	125	66	59	0

All figures in the table have been risk-rated.

- It is likely that the impact of this savings plan on Community providers will be offset by the reprovision investment that is planned to support Integrated Care.

4b) Workstream – Other

In addition to the workstream-based QIPP savings that Harrow has developed, the CCG is also exploring other opportunities to reduce costs and realise savings.

In addition to the workstream-based QIPP savings that Harrow has developed, the CCG is also exploring other opportunities to reduce costs and realise savings. These opportunities include:

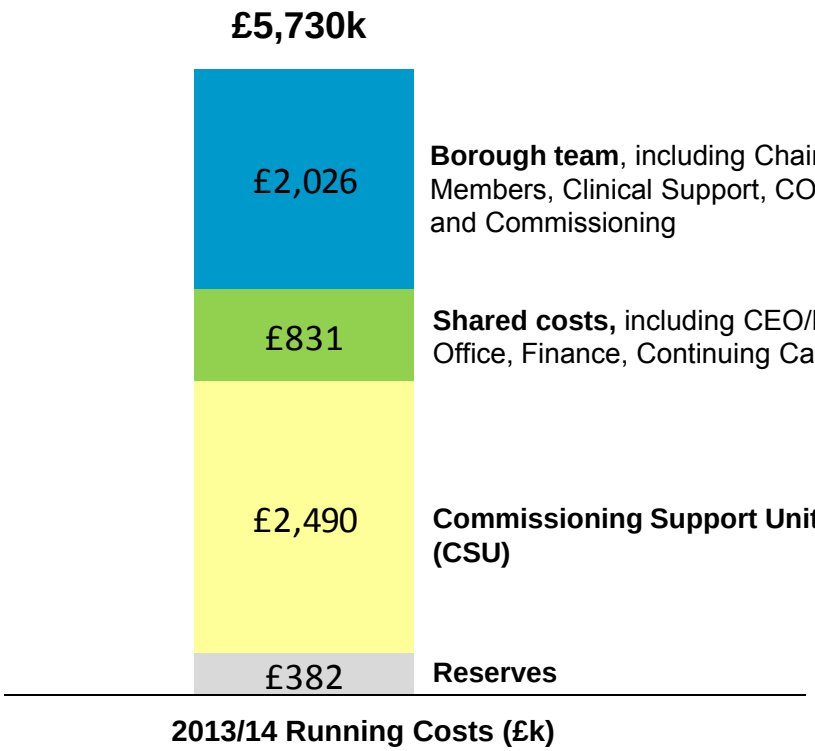
- Review opportunities to reduce CCG running costs (see following slide)
- Work with CSU to review the acute contracts
- Review all individual budget lines to ensure they are delivering value for money in line with the CCG's commissioning strategy.

4b) Workstream – Other: Running Costs

Harrow Clinical Commissioning Group

Planning assumptions are based on no growth in running costs, but also that 65% of these costs are not directly controllable by Harrow CCG.

Harrow CCG running costs (13/14 budget)



- Small team (14 WTE)
- Supported by non recurrent roles for transformation

- Not directly controllable – can only change if agreed across BEHH and North West London

4b) Workstream – Summary financial QIPP Plan

Harrow Clinical Commissioning Group

The combined financial impact of the QIPP workstreams is summarised in the table below...

Workstreams *(all figures £k)*	**Total Gross Opp (3 Yr to 16/17)**	**Total Reprovision (3 Yr to 16/17)**	**Total Net (3 Yr to 16/17)**	**In-Year Net (14/15)**	**In-Year Net (15/16)**	**In-Year Net (16/17)**
Integrated care	15,322	6,084	9,238	794	2,641	5,804
Planned Care	11,727	5,642	6,085	2,359	2,704	1,023
Unscheduled Care	6,467	1,897	4,569	2,512	1,477	580
Adult Mental Health	3,083	322	2,761	1,403	875	483
Medicines Management	2,612	155	2,457	866	870	721
Continuing Care	2,493	575	1,918	926	401	591
Community	801	0	801	291	285	225
Children's Services	512	73	440	72	183	185
Grand Total	**43,019**	**14,748**	**28,271**	**9,224**	**9,436**	**9,611**

- *See appendix B for a detailed table of initiatives for all workstreams.*

5. Delivery Plans

Contents:

a. Approach
b. Risks
c. Project Plan for the 14/15 Business Cycle

5a) Implementation approach: Workstream structure

Harrow Clinical Commissioning Group

Development and implementation of the strategic and financial recovery plan is the responsibility of each workstream.
Each workstream is led by a clinical and managerial lead, and includes other GPs, partners and other stakeholders as required.
The QIPP PMO monitors progress against the plan on a monthly basis and supports remedial action where required.

Harrow CCG workstream structure:

Workstream	Clinical Lead	Management Lead
Primary Care Transformation	Amol Kelshiker	Anna Donovan
Integrated Care	Amol Kelshiker	Javina Sehgal
Community Services	Kaushik Karia	Rebecca Wellburn
Children's Services	Genevieve Small	Rebecca Wellburn
Adult Mental Health	Dilip Patel	Sue Whiting
Adult Learning Disabilities & Challenging Behaviour	Lawrence Gould	Sue Whiting
Medicines Management	Lawrence Gould	Mandeep Butt
Continuing Care	Amol Kelshiker	Sarah Nyandoro
Unscheduled Care	Amol Kelshiker	Jason Antrobus
Planned Care	Kaushik Karia	Rebecca Wellburn

- The QIPP Project Management Office (PMO) operates across Brent, Ealing, Hillingdon and Harrow. The PMO reports on implementation and delivery on a monthly basis, highlights key risks and issues, and supports the development of remedial plans where required.

5a) Implementation approach: Increasing deliverability (1 of 2)

Harrow Clinical Commissioning Group

The CCG will build on its existing strengths and will continue to address improvement opportunities in order to successfully implement its plans

The CCG will build on its existing strengths and achievements in order to implement the planned initiatives:

Strengths and achievements

- Regular engagement with patients, carers, and the public
- Strong relationships with primary care and well-established GP peer groups/networks
- Active CCG Board support for NWL's Shaping a Healthier future programme and the Out of Hospital strategy
- Delivery of QIPP savings over the past 3 years of c. £31m
- Have worked hard in recent years at building relationships and working collaboratively with key partners, including providers
- Have worked with the LA to agree mechanisms to jointly resolve issues
- Robust and interoperable Electronic Health Record infrastructure in primary care (EMIS Web and Vision)
- High uptake rates of Integrated Care Pilot (ICP) care planning
- New services and schemes implemented, including services to support ADHD patients, and to strengthen support for Carers in primary care
- Dementia Strategy launched jointly with partners – identified by NHS England for support to complete an economic evaluation of the work

Delivery challenges

The CCG has also reflected on the challenges it has faced in fully delivering its QIPP Plans in previous years, including:

- Clinical and managerial capacity
- Governance and accountability
- IT and Information, both a lack of patient record sharing between providers, and a lack of patient-level data to support CCG monitoring and evaluation of initiatives
- Learning and innovation

The following page sets out how Harrow will strengthen these areas in order to support delivery of our plans...

5a) Implementation approach: Increasing deliverability (2 of 2)

Harrow has also reflected on the challenges it has faced in fully delivering its QIPP Plans in previous years, and agreed how these will be addressed to increase deliverability in the future.

Clinical and managerial capacity

- Tuesdays are now set as a 'Corporate Day', during which all Clinical Directors work full-time at the CCG's offices. This enables key meetings to be scheduled more easily, and for clinical and managerial leads to have protected time to work together.
- Objective setting processes for all staff will be strengthened to ensure alignment with delivery of the CCG's commissioning strategy.
- Harrow is currently recruiting 13 – 14 new staff to support the delivery of its strategy, using external non recurrent sources of funding.
- The existing Borough team structure has been recently strengthened including a new Prescribing Lead and new Commissioning Managers in Mental Health, Planned Care and Unscheduled Care.
- Project management processes will be strengthened through support from the PMO.

Governance and accountability:

- Named leads have been identified for each scheme and workstream; this creates clear ownership for delivery and focuses limited resources.
- An Away Day is scheduled to identify even further opportunities to optimise the effectiveness of team working.

IT and Information

- EMIS Web access is being established from the CCG's offices.
- Harrow's 14/15 Commissioning Intentions set out the need for providers to support electronic data exchange, timely discharge summary reporting, real-time read/write access to electronic health records, real-time data entry, N3 access, and the use of Coordinate my Care across all palliative care providers.

Learning and innovation:

- Harrow will be more proactive in learning from other CCGs, including visiting other health economies to observe innovative and/or best practice services

As the CCG continues to evolve and learn in its role, it will continuously review opportunities to develop and strengthen our ways of working.

This learning will be reflected in Harrow's Organisational Development plan, which will be defined by December 2013.

5a) Implementation approach: Enablers

Harrow Clinical Commissioning Group

As part of our deliverability review, we've identified the key enablers to support implementation of our 3 Year Plan.

Part of increasing deliverability of our plans includes a recognition of the enablers required. These include:

- **IT:** as described previously, patient record sharing between providers is key to supporting our Out of Hospital goals, including integrated care.
- **Information**: robust and timely Information, both patient-level and aggregate, is fundamental to effective commissioning, both planning and monitoring.
- **Education and skill mix:** our developing Primary Care Strategy recognises the need for the continuous development of all clinical staff, and the effective use of skill mix across health settings, including primary and community services.
- **Patient engagement**: Harrow will build on its tradition of patient engagement to ensure that service developments are guided by local priorities and that these developments benefit from the insights of patients, users and carers.
- **Collaboration with the Council**: our work is increasingly reliant on close collaboration with Harrow Council across many service areas, including Mental Health, Continuing Care, Unscheduled Care, Children's Services, and Learning Disabilities. Effective working relationships will ensure that the Integration Transformation Fund is targeted as effectively as possible to support the national and local Integrated Care agenda.
- **Estates**: the Out of Hospital strategy relies on appropriate use of NHS estates to support cost-effective delivery of services closer to home.
- **Project management skills and capacity**: the CCG has a complex agenda of change. Both sufficient project management resources and robust project management processes are required to ensure focused implementation, risk mitigation, and delivery of benefits.
- **Commissioning support**: Harrow CCG relies on robust commissioning support in order to be an effective clinical commissioning organisation.

5b) Programme Risks

Harrow Clinical Commissioning Group

As suggested by the deliverability review and identified enablers, there are a number of risks to successful delivery of this three year Plan. Actions to address these have been set out, and they will continue to be reviewed.

Risk	Mitigation/Action	Current Rating (likelihood X impact)
Delays across many workstreams due to ineffective relationships with the Local Authority	• Build more effective working relationships with Local Authority	3 * 4 = **12**
Lack of managerial capacity/capability to implement at required pace of change	• Use external non recurrent sources of funding to supplement permanent team • Strengthen project management processes	3 * 4 = **12**
Lack of clinical capacity/capability to implement at required pace of change	• Strengthen accountability, including through objective setting processes • Develop more robust decision-making processes through the establishment of a Corporate Day and other organisational developments; • Strengthen objective setting • Strengthen project management processes	3 * 4 = **12**
The significant scale of the transformation required, particularly with regards to Integrated Care	• Use external non recurrent sources of funding to supplement permanent team • Collaborate with other BEHH CCGs and across NWL where possible	3 * 4 = **12**
Lack of support from the CSU in terms of contract negotiation and management, including responses to variances	• Tighten management of CSU • Increase alignment and awareness of CCG priorities within the CSU	4 * 4 = **16**
Unplanned increases in acute activity	• Do a deep dive into unscheduled care activity to practice levels to target outliers • Ensure the Plan is agreed with providers and there is a shared responsibility	3 * 4 = **12**
Lack of collaboration with providers, including GP practices , NWLH, Ealing ICO and CNWL	• Review plans at Peer Groups and GP Forum • Ensure plan is aligned with key providers, including NWLH, and jointly owned with them	3 * 4 = **12**
Lack of collaboration and alignment with NHS England, Public Health, and other partners	• Meet with key partners in October to align plans	2 * 3 = **6**
Social Care budget pressures increase pressures on Health (incl. Continuing Care)	• Ensure the Integration Fund is used for jointly agreed priorities	4 * 4 = **16**

5c) Project plan for the 14/15 business cycle: 2014/15 timeline (1 of 3)

Harrow Clinical Commissioning Group

Key dates for the remainder of the 14/15 commissioning business cycle include publication of the 14/15 Commissioning Intentions and agreeing contracts. Other key dates include the submission of joint plans with Harrow Council for the Integration Transformation Fund.

In addition to the key dates in the 2014/15 business cycle outlined over the following slides, other key dates for the CCG include:

- January 2014: submit a five year version of the CCG's Plan
- March 2014: submit joint plans with Harrow Council for use of the Integration Transformation Fund (for 2014/15 and 2015/16)

Key dates for the 2014/15 business cycle

September 2013	
Draft Contracting Round Plan for 2014/15 Contracting Round Developed and shared with CCGs (Excel)	CSU
CCGs develop commissioning intentions for 2014/15 with support from the CSU	CCG/CSU
Identify Negotiation Teams for each Contract	CCG/CSU
Agree the Negotiation Meeting timetable, venues and required membership (and circulation) with CCGs and Providers. Consider extending existing governance meetings to avoid duplication. Agreement to be reached with each CCG.	CSU
Convene and CWHH/BEHH Contracting Round Planning Session: • Confirm MH and Community Programme Boards to oversee contracting process • Agreement to constitute an Acute Programme Board • Agreement to establish a steering committee to co-ordinate the activities and outputs of the Progrmme Boards • Agreement to establish seperate CWHH and BEHH steering groups to oversee the contracting round for the constituent CCGs • Agree local mediation process and contract sign-off process with CCGS	CCG/CSU
Set up SharePoint as central repository for contract round information	CSU
Notification Letters with high level Commissioning Intentions, Decommissioning and Service Change Notices compiled and served to Providers. (To include requirement to align provider CIPs with CCG QIPP plans)	CCG/CSU
Contract Round and Negotiation Process to be defined with providers	CSU
Review effectiveness of 2013/14 metrics and propose new 2014/15 metrics	CSU
Review 2013/14 Quality Schedule and develop draft 2014/15 QS Proposal	CSU
Review 2013/14 CQUINs	CSU/CCG
Review 2013/14 Information Schedule and develop draft 2014/15 Information Schedule	CSU

5c) Project plan for the 14/15 business cycle: 2014/15 timeline (2 of 3)

Key dates for the remainder of the 14/15 commissioning business cycle include publication of the 14/15 Commissioning Intentions, and initiating contract negotiations.

Task Name	Lead
October 2013	
OD Input required for the development of negotiation teams, to clarify roles and responsibilities including tactical negotiation training	CSU/CCG
CCGs to draft QIPP plans for 2014/15	CCG
QIPP plans to be modelled at HRG level using M5 data	CSU
QIPP Plans to be aligned with Provider CIP plans to identify impact and areas of mutual benefit	CSU
1st Cut Contract Baselines developed using M5 data	CSU
Agree CCG Strategic Aims for each provider	CSU/CCG
CI workshop to ensure common understanding between CCG/CSU, to develop contracting intentions and provider notices	CCG/CSU
Develop proposed 2014/15 CQUINs	
Negotiation strategies to be developed for each provider reflecting CCG key priorities	CSU/CCG
November 2013	
Detailed Commissioning Intention Notification Letters including impact on strategic programme (s) and priorties to be sent to providers	CSU/CCG
Engage with providers to agree the Information Schedule in principle	CSU
Engage with providers to agree the Quality Schedule in principle	CSU
Engage with providers to agree the CQUIN schemes/initiatives in principle	CSU

5c) Project plan for the 14/15 business cycle: 2014/15 timeline (3 of 3)

Harrow Clinical Commissioning Group

Key dates for the remainder of the 14/15 commissioning business cycle include publication of the 14/15 Commissioning Intentions, and initiating contract negotiations.

Task Name	Lead
December 2013	
2nd Cut Contract Baselines developed using M6 Frozen SUS	CSU
CCG Allocations Announced - Triangulation of budgets and financial envelopes	CCG/CSU
Investment Fund Agreed betweenCCGs and LAs at respective HWBs	CCG
Changes to Tariff Announced - Commence Build of 2014/15 Model	CSU
Detailed QIPP Plans to be shared and discussed with providers	CSU
January 2014	
3rd Cut Baselines developed costed at new prices at POD and HRG level(Includes, QIPP and metrics)	CSU
First offers to be issued to providers agreed with CCGs	CSU/CCG
First cut offers issued to providers	CSU
Finalise Quality Metrics and Information Schedule incorporating 2014/15 Guidance with CCGs and agreed with Providers	CSU
CQUINs agreed with providers	CSU
QIPP Plans for inclusion in contract agreed with Providers	CSU
Weekly negotiation meetings with Providers commence - activity, finance and metrics	CSU/CCG
DQIPs and SDIPs agreed with providers	CSU/CCG
February 2014	
Weekly negotiation meetings with Providers continue	CSU/CCG
2nd cut offers agreed and issued to providers	CSU/CCG
March 2014	
Local mediation (lock-down) sessions	CSU/CCG
Activity and finance schedules agreed	CSU/CCG
Heads of Agreement signed	CSU/CCG
Final contract documentation completed	CSU
Contracts signed by Providers and Commissioners	CCG

Appendix A –
Population Health Needs

Population Needs
JSNA 2012-2016: Life expectancy

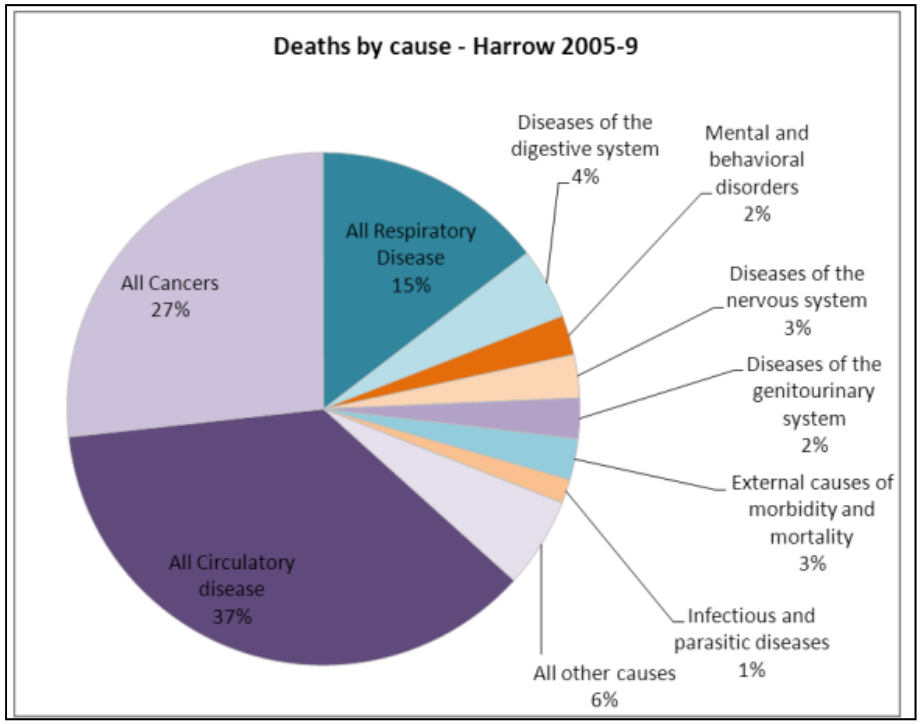
Life expectancy	Years
Female	84.6
Male	81.2

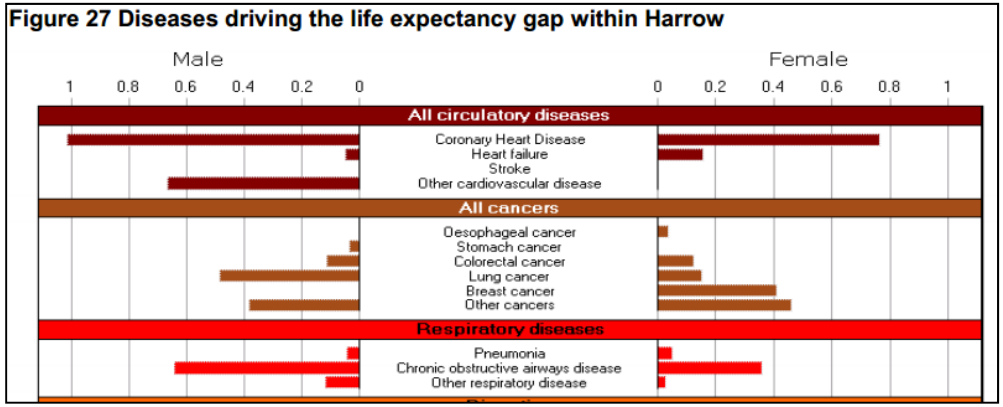
- Overall life expectancy in Harrow is better than that of England as a whole
- But, there are significant inequalities across the Borough.

Mortality causes	# of deaths
Total per year	1,875
Circulator disease (37%)	694
All cancers (27%)	506
Respiratory disease (15%)	281

- Three causes drive almost 80% of all deaths.
- Looking at the causes of death in the most affluent and the most deprived wards in Harrow, indicates the diseases that are causing the gap in life expectancy.
- Biggest impact on life expectancy by focusing on circulatory disease - increase by over a year in males and over 9 months in females.
- Other significant gains from lung cancer in men, breast cancer in women and COPD in both sexes.

- *Data on the next pages shows causes of 'premature' deaths (i.e. before age 75) – average 726 per annum...*



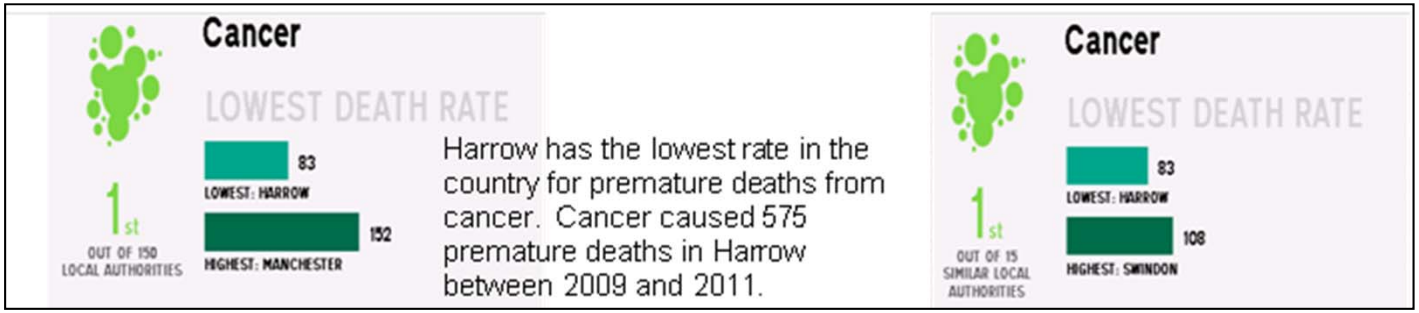


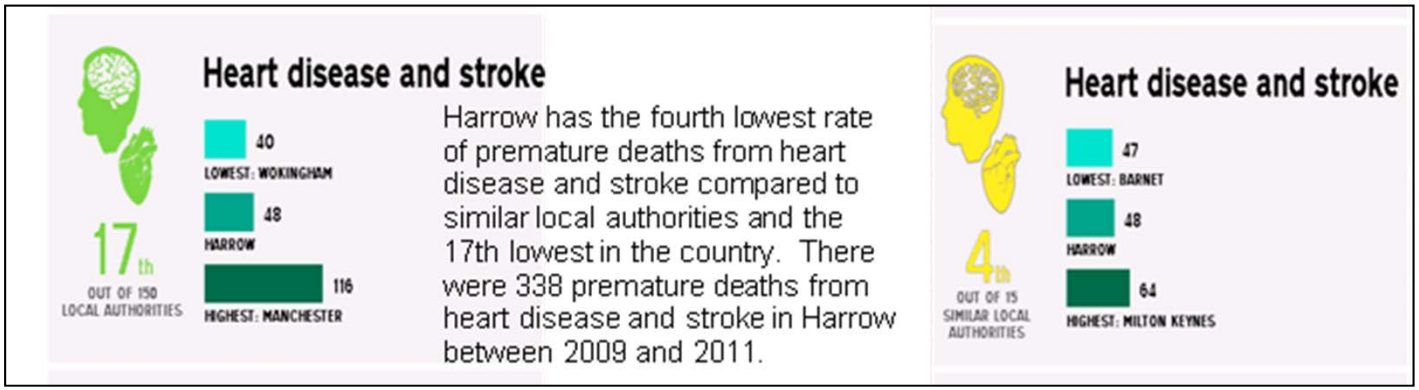
Source: Harrow Joint Strategic Needs Assessment (June 2012); data from London Health Observatory

Population Needs
Latest data on causes of premature death *(before age 75)*

Harrow Clinical Commissioning Group

Data for period 2009-11 – total of 1452 premature deaths (average 726 per annum).



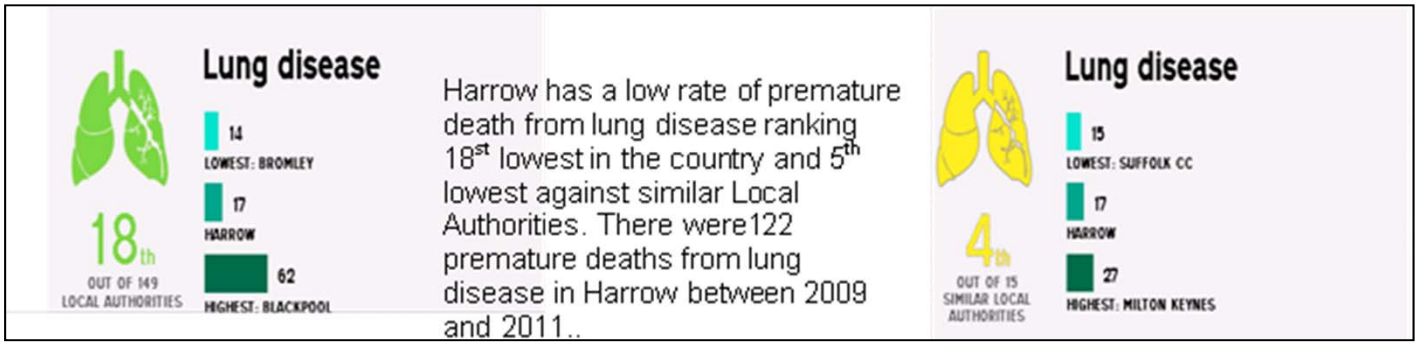


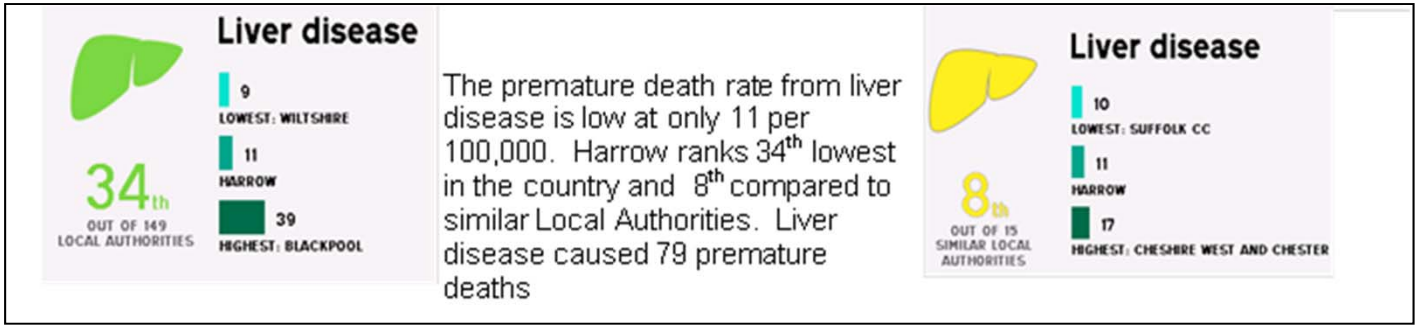
Source: "Longer Lives" data published by Public Health England (May 2013)

Population Needs
Latest data on causes of premature death *(before age 75)*

Harrow Clinical Commissioning Group

Data for period 2009-11 – total of 1452 premature deaths (average 726 per annum).





Source: "Longer Lives" data published by Public Health England (May 2013)

Population Needs
JSNA 2012-2016: Health issues – long term conditions

Harrow Clinical Commissioning Group

Key stats - Diabetes	
# of adults registered as being diabetics (7.1% of adults aged 17+)	13,163
Estimated diabetes prevalence based on APHO Diabetes Prevalence Model (16+)	16,597
Note: London prevalence is 5.25% and England prevalence is 5.4% (diagnosed patients)	

Key stats - Cancer	
# of new cancer cases in Harrow per year (average)	854
# of people were living with cancer Note: breast, prostate and colon cancers accounted for 50%	6,534
% of all new cancer cases in the 70+ age group	50%
% of all persons living with cancer who are aged over 60 years	65%

Diabetes

- Diabetes is more common in Harrow than in England as a whole due mainly to the higher prevalence in South Asian communities.
- Generally well managed, although there have been small increases in diabetic coma and amputations in recent years, the rates for all diabetes complications are still amongst the lowest in England.
- Prevalence of type 2 diabetes may be at least twice as high amongst people of Asian and Afro-Caribbean as European origin
- Up to 58% of type 2 cases are preventable.
- At practice level, blood sugar control achievement varies from 30% to 60%.

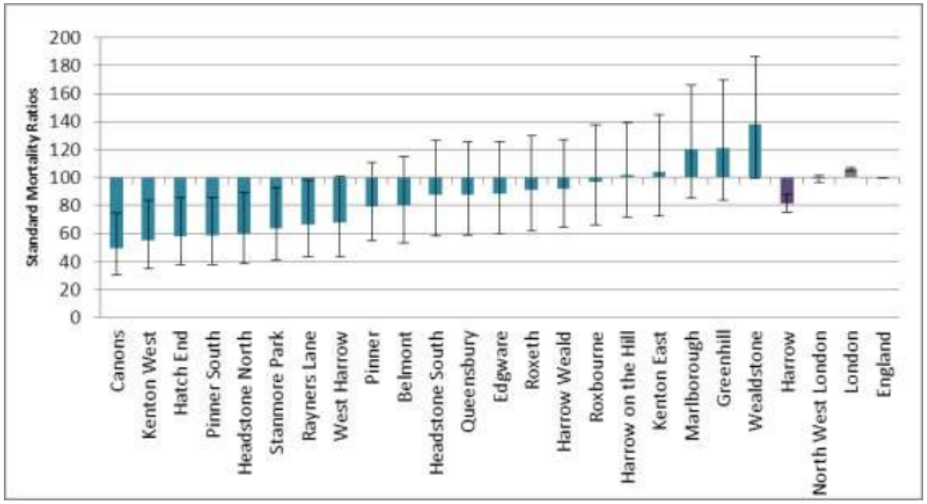
Cancer

- Rates of cancer are lower than those of England as a whole and are decreasing.
- However, the impact of past smoking rates, particularly in women means that female lung cancer rates are increasing.
- Cancer screening rates are lower than the England average and currently the cervical and bowel cancer programmes do not meet national targets.
- The breast screening programme achieved the 70% target for the first time in 2010-11.

- *Primary prevention targeted toward high risk groups and early identification and intervention are key to proactively managing long terms conditions.*

Source: Harrow Joint Strategic Needs Assessment (June 2012)

Figure 120: Standard mortality ratio for circulatory disease, Harrow wards, 2005-09, (under 75).



Circulatory Disease

- Cardiovascular disease (CVD) encompasses heart disease, stroke, hypertension and other conditions.
- Although it is the main cause of death in Harrow, both the rate of new cases and rate of death are lower than for England and London and are decreasing.
- Prevalence: CHD c.3% (c.7000); Stroke 1.3% (c. 3000); Hypertension registered 13% (c.30k), expected 23% (c.53k).
- Smoking , diet, physical activity and alcohol consumption are **modifiable risk factors** which are linked to each other and to the risk of diabetes, hypertension(high blood pressure) and high blood cholesterol.
- **It is the main cause of the gap in life expectancy in both men and women in Harrow.**

Key stats – Respiratory Disease	
# of people registered with COPD	1,927
# of people it is estimated that have COPD	7,121
Implied # of people who remain undiagnosed	5,194
# of people estimated to be suitable for Pulmonary Rehabilitation	467

Respiratory Disease

- **'Social inequality causes a higher proportion of deaths in respiratory disease than in any other disease area**'.
- Of the wards that had a higher rate of admissions for respiratory disease, four are in the top six most deprived wards in Harrow.
- Prevalence of COPD is higher in males, those who smoke and increases with age.
- There has been a steady increase in the number of women diagnosed with COPD which is expected to increase in the next decade.
- Early diagnosis of COPD is essential to effectively manage and treat the disease and reduce further deterioration by encouraging smoking cessation.
- It is estimated that there are a l**arge number of people who remain undiagnosed.**

Source: Harrow Joint Strategic Needs Assessment (June 2012)

Population Needs
JSNA 2012-2016: Health issues – mental health

Harrow Clinical Commissioning Group

Key stats – Mental Health	
# of adults common mental health (incl .anxiety & depression)	440
# of adults neurotic mental health	356
Admission to hospital under Mental Health Act	339
'10% of children with clinically recognised mental disorder'	[c.4200]
'1 in 4 older people have depressive symptoms'	[c.8,100]
'A third of people who acre for dementia sufferers suffer from depression'	[c.780]

- Many people with long-term conditions also have mental health problems and this raises total health care costs by at least 45% for each person with long-term condition and co-morbid mental health problems.
- [Updated MH profiles were produced by PHO and circulated .]
- One in four older people have depressive symptoms that require intervention, and the risk of depression increases with age.
- In addition, carers are at risk of depression and a third of people who care for someone with dementia suffer from depression.
- 10% of children and young people have a clinically recognised mental disorder; 6% have a conduct disorder, 4% have an emotional disorder.

Key stats – Dementia	
# people with dementia over the age of 65	2,377
% of people with dementia are likely to need at least daily supervision or care in order to lead a safe and dignified life.	Over 80%

- The prevalence of dementia increases sharply with old age. It is estimated that only c.1% of people aged 65 to 69 in Harrow have dementia, but this rises to c.30% of people aged over 90.
- Diagnosing the underlying cause of dementia is important, because the different types of dementia vary in the range of symptoms suffered and the rate of progression of symptoms.
- This number is projected to rise by over 50% by 2030 to an estimated 3,726.

- *The identified numbers of patients with 'common' and 'neurotic' mental health conditions seem to represent only a small proportion of the total older people and younger people's mental health needs?*

Source: Harrow Joint Strategic Needs Assessment (June 2012)

JSNA 2012-2016: Health issues – infectious diseases

Overall 'infectious disease' management appears to be in control; however, there are some specific issues which need to be tackled.

Infectious diseases include:

- Respiratory-spread e.g. Tuberculosis, Influenza, Vaccine preventable childhood infections
- Food borne e.g. Salmonella
- Sexually transmitted and blood borne e.g. HIV, hepatitis B, gonorrhoea.
- Imported infectious disease, e.g. malaria
- Environmental airborne , e.g. Legionnaires disease;
- Healthcare associated infections, e.g. MRSA

Commentary...

Immunisations

- Immunisation coverage for vaccine preventable diseases has been falling in recent years and significant outbreaks are again beginning.
- Childhood vaccinations are offered predominantly by GPs.
- Over 95% of Harrow children receive the immunisations due by their 1st birthday.
- Harrow is failing to meet the recommended national target of uptake for immunisations due by the time children reach their 5th birthday.

MRSA

- In 2011, 65 cases of MRSA across the whole of Harrow; 5 were attributed to community services, 60 were attributed to the North West London Trust.

Clostridium difficile

- In 2011, 114 cases, a 28% increase on 2010. 60 of these cases were thought to have occurred in the community, an 11% increase.

Sexual Health

- HIV: 318 HIV+ people in Harrow; >50% from Black African ethnic group. Cost of treatment c.£2.4m. In 2010, late diagnosis was an issue in Harrow [PH has action plan – will need cooperation by primary care].
- Sexually Transmitted Infections: Harrow has amongst the lowest diagnosed rates of STIs in North West London and is significantly below the London average.
- Teenage Pregnancy : Harrow currently has very low rates of teenage pregnancy and is significantly below the London and National averages.

TB

- Harrow's rate (c.60 / 100k) is considerably higher than the England (c.18) and London (c.44) averages.
- Significant variation by ethnic group; Black African incidence c.250 /100k .

Source: Harrow Joint Strategic Needs Assessment (June 2012)

JSNA 2012-2016: Health issues – maternity

Key stats - Maternity	
# of births per year (2009) *Note: Growth of 5% from 2006*	3,242
% of Harrow births at NWLHT (60%)	1,945

- Almost half of all births were in the Asian group (who are 26% of the overall population).
- Around 1 in 4 births in Harrow are by caesarean section – similar to London and England averages.
- In 2008, the infant mortality rate in Harrow at 3 infant deaths per 1,000 live births was 4th highest in London . In 2009, there was an further rise to 7.5 per 1000 live births in 2009. A local action plan has been implemented (although the local implementation group has not recently met).
- The 2011 Harrow Maternity Pathway profile indicates the proportion of babies born with low birth weight is the highest in London and is also significantly worse than England average. However, very low birth <1500g is not significantly different from the England average. Due to this change in outcome further descriptive epidemiology will be completed over 2012.
- Harrow has a good breast feeding initiation rate of 86.1%. (Breastfeeding rates are used as a key indicator of child health and well-being).
- Harrow has one of the lowest levels of child deaths and serious injuries for children.

Source: Harrow Joint Strategic Needs Assessment (June 2012)

Population Needs
JSNA 2012-2016: Health issues – children

Harrow Clinical Commissioning Group

Key stats - Children	
Children (0 – 18)	49,067
Children (16-18)	6,667
Hospital admissions due to injury *(75% of England average)*	533
'Children in need' who received a service from Harrow Social Care Service 2010/11 (per 10k popn 211; statistical neighbour avg 336)	1,071 *[1,636? quoted]*
'Looked after children' at 31st March in 2010/11 *Note: statistical neighbour average is 320*	140
Children with a Care Protection Plan *Note: statistical neighbour average is 198*	161
Identified young carers aged 5-17 in Harrow	634

- **Giving every child the best start in life is crucial to reducing health inequalities across the life course.** The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood.
- Harrow child development under 5 is not as good as the England average according to the National Health Profiles for local authorities.
- Harrow has one of the lowest rates of child deaths and serious injuries from accidents in the country.
- Harrow has lower rates for children in need, looked after children and children with a Care Protection Plan than both the England average and their statistical neighbours.

Source: Harrow Joint Strategic Needs Assessment (June 2012)

JSNA 2012-2016: Health issues – learning disabilities

Key stats – Learning Disabilities	
# of Harrow adults (18 - 64) with a Learning Disability	719
# of people registered with a Harrow GP (18 - 64) with a Learning Disability *Note: may be because patients from outside of the geographical area can be registered with Harrow GP practices.*	844
% of eligible adults with learning disability who received a health check (2010/11)	53%
% of children with moderate learning disabilities	15.5%
% of children known to schools with severe learning disability	3.9%

Learning Disabilities

- Some health problems are more common in people with a learning disability. Epilepsy, heart disease and sensory loss are all higher in a learning disability population. An estimated 50% of people with a learning disability have sensory impairment
- The majority of adults (50%) with learning disability in Harrow live with their family or in residential accommodation (32%) in the borough (July 2011).
- The percentage of children with moderate learning disabilities was 15.5% in Harrow, significantly lower than the England average of 19.8%, but higher than the London average of 12.54% (January 2011).
- The proportion of children known to schools with severe learning disability in January 2011 was 3.9% and not significantly different from the English average of 3.6%.
- The proportion of children with profound and multiple learning difficulty known to schools in Harrow was 1.1%. This compares to 1.2% in London and England.
- Because people with a learning disability have more difficulty than others in accessing treatment for health problems, GPs are supposed to offer them regular health checks.
- In 2010-11, 53% received a health check (higher that the London and National averages).
- There is a higher proportion of hospital admissions among adults with learning disability that happen as emergencies. The proportion of such admissions, excluding psychiatric admissions in 2008-9 was 65% compared to an English average of 54%.

Source: Harrow Joint Strategic Needs Assessment (June 2012)

Population Needs
JSNA 2012-2016: Health issues – older people

Harrow Clinical Commissioning Group

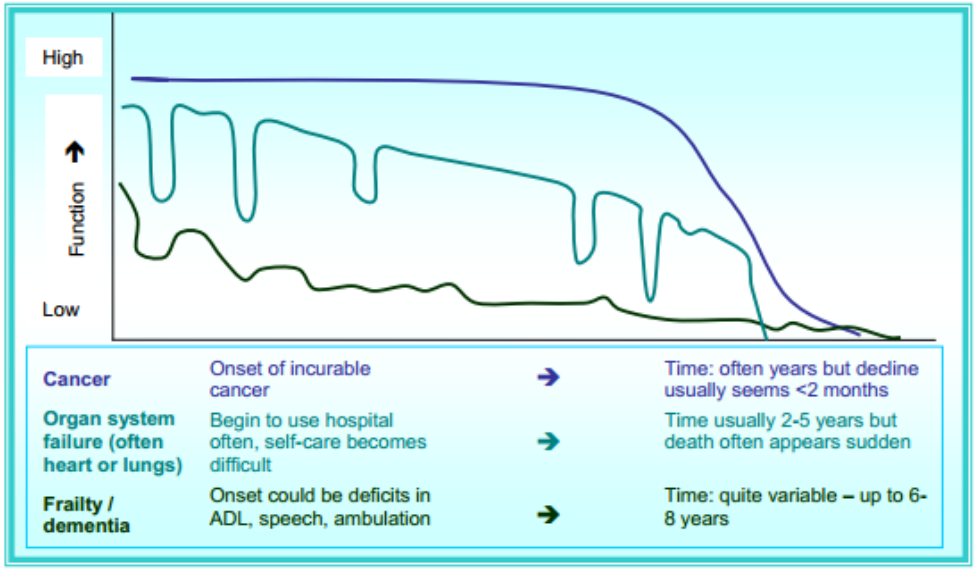
Key stats – Older people	
Older people (65-84)	26,619
Older people (85+)	5,787
Social care support for 65+	4,605
- Community based service	4,007
- Residential care	362
- Nursing care	236

Older People

- At 14%, Harrow has a greater proportion of older people in the population than our neighbouring boroughs, London as a whole and England as a whole (12%).
- In the context of an increasing older population, improved longevity and financial constraints of the public sector, it is important to consider this group in the population.
- Index of deprivation affecting older people in Harrow is higher that England average (20.7% v 18.1%).
- Of the total 6,608 adult clients who receive social care provided by the Harrow Council, two thirds (4,605) were 65 years old and over.

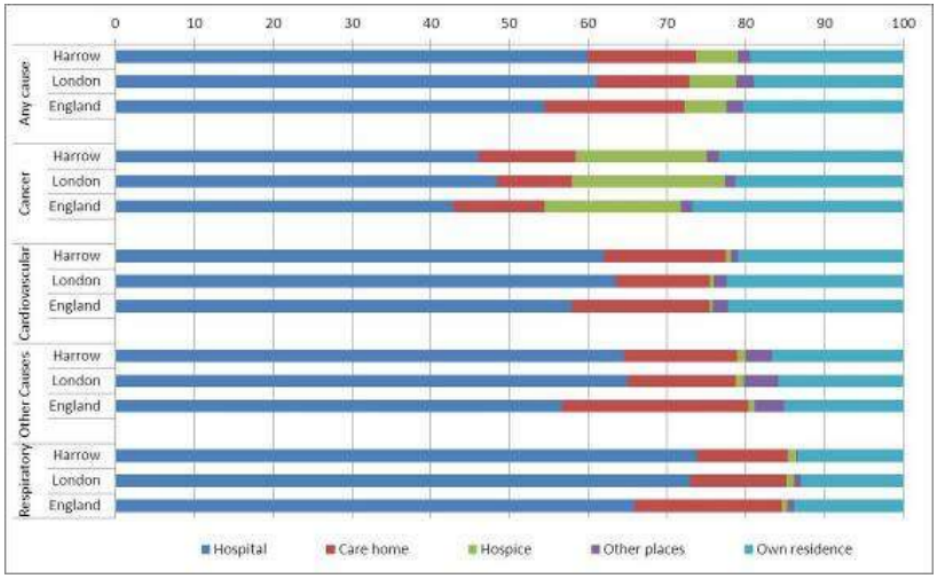
Source: Harrow Joint Strategic Needs Assessment (June 2012)

Figure 310 Trajectory for different conditions



Source: Gold Standards Framework

Figure 311 Place of death by underlying cause



Source ONS

- The Gold Standards framework suggests that deaths can be allocated to three broad groups:
  - cancers;
  - organ system failure; and
  - multiple organ failure/ frailty/ dementia.
- These different groupings are characterised by different typical trajectories towards the end of life which affect how a person is able to function and therefore the degree of support that they may need.

- **In Harrow a greater percentage of deaths in all categories occur in hospital than is seen in England as a whole.**
- But lower than in London, with the exception of deaths from respiratory disease.

Figure 1. Accident and Emergency attendances, by age for 2007-2010

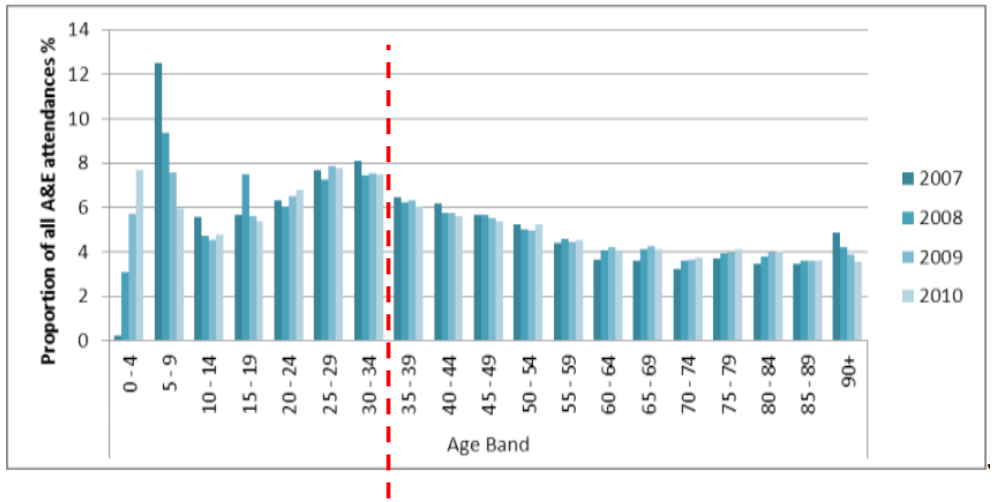
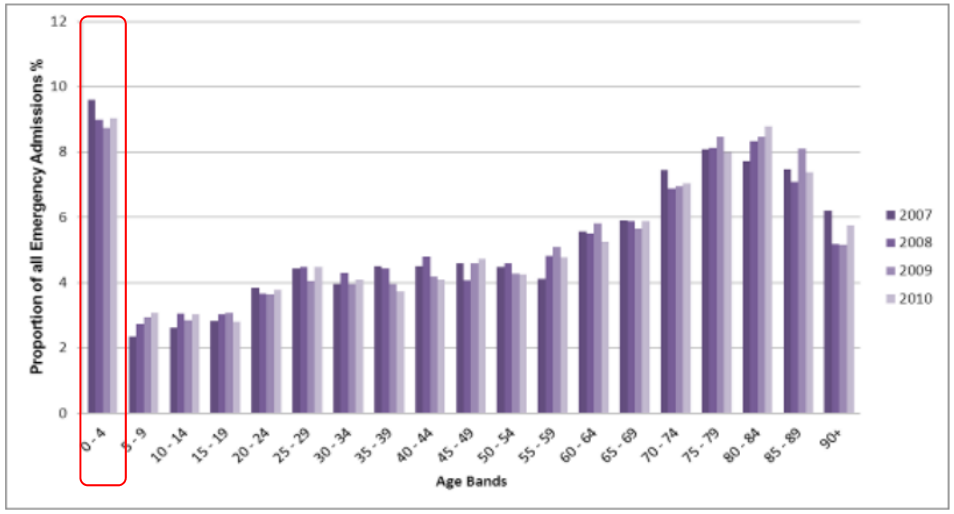


Figure 313 Emergency Admissions by age, 2007-2010



- [Would be useful to update these to end 12-13].
- Note attendances for children and <35 years. Primary care access?

- Note admissions <5 years.

Population Needs
Stakeholder engagement event – 19th June 2012

Harrow Clinical Commissioning Group

The key message emerging from last year's stakeholder engagement event, across many services, was the **need for greater coordination, collaboration and communication**.

A number of discussion questions were presented to participants. Key themes from these discussions are summarised below.

Out of Hospital Strategy

- A very positive response to the messages delivered by the CCG because the current system isn't working (i.e. fragmented care).
- There is a need for strong integration between services, visible care, and strong case management.
- Need to ensure the community infrastructure is robust.
- Ideas are good but key now is implementation and participation.
- Need more involvement from voluntary sector who treat people in homes.

Health and Wellbeing Strategy

- Working closely with relevant stakeholders is the top priority.
- Long term conditions are a priority.
- Good emphasis on children's services; must support parents.

Feedback on specific services

- **Children's services**: collaboration between voluntary, Local Authority and Mental Health sectors with paediatricians is vital.
- **Care of the elderly**: currently there is a lack of integration and communication between organisations / providers.
- **Dementia**: integration between health, social care and voluntary services is as important as education and awareness.
- **End of life**: how to communicate difficult messages and provide people with choices and make sure you deliver on those choices e.g. choosing where to die.
- **Mental Health**: integration of health and social care services is critical, but this is a long way off – need a holistic approach.
- **Safeguarding:** need to avoid silos – need good communication between Local Authority, Public Health and CCGB.
- **Primary Care**: GPs need to examine how to work in collaboration with fellow health professionals to deliver services within financial envelope.
- **Prevention:** Preventative care starts with Public Health.

Other overarching concerns

- How to navigate and access services, e.g. "urgent care".
- Public transport links and accessibility for disabled users.
- Dislike of uncoordinated reviews with patients, uncoordinated patient records and conflicting messages from different medical professionals.

Populations needs – an additional perspective...

Harrow Clinical Commissioning Group

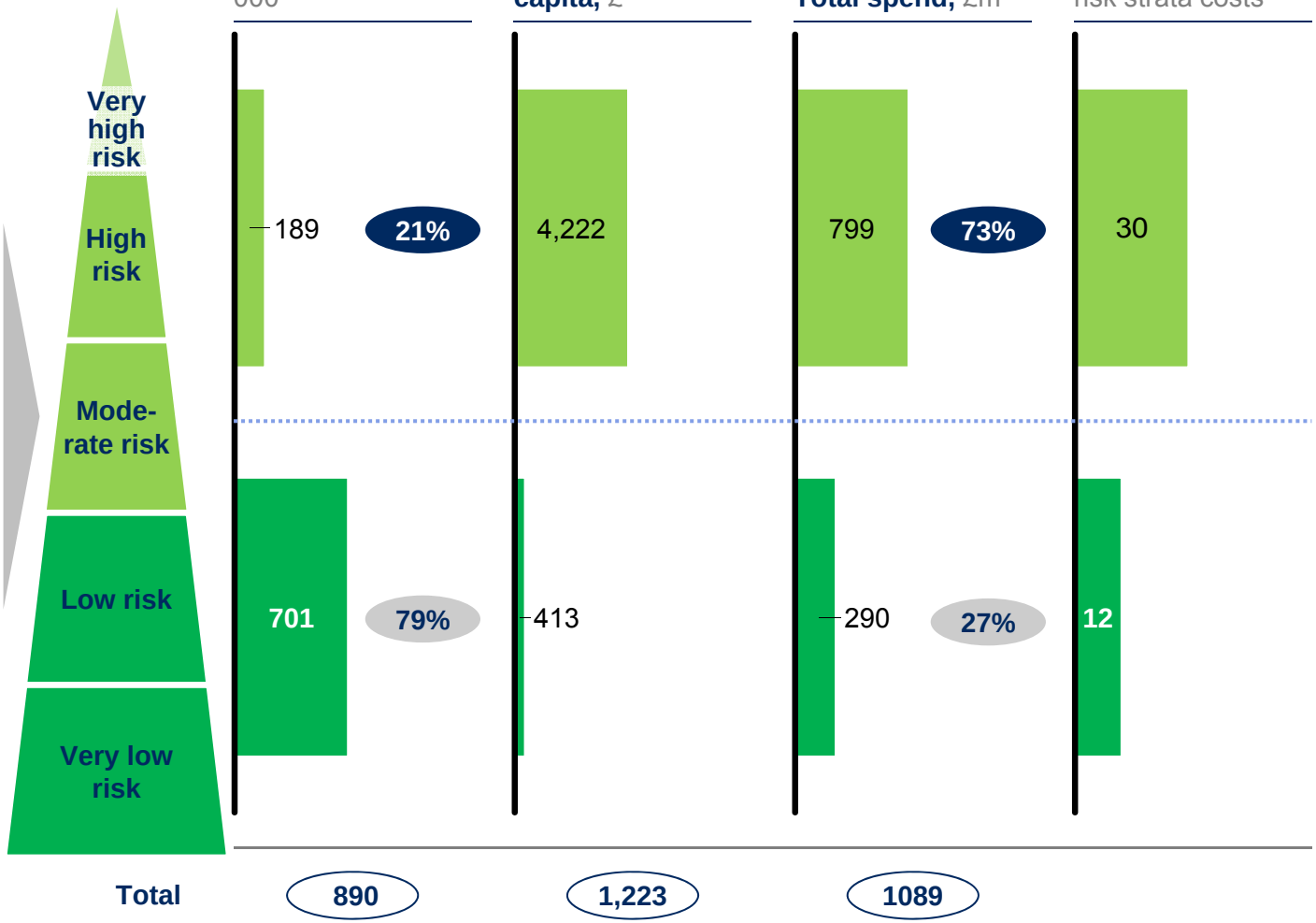
Analysis in North West London shows that the ~20% highest risk population consume ~75% of health and social care resources.

2010/11; CWHH

Combined NWL health and social care dataset created

All patient/ users given score based on risk of hospital admission within next year

Key risk drivers are age and number of LTCs



Conclusions

- Analysis shows what clinicians have long suspected – that ~20% of the population (most at risk of an admission) drive ~75% of the costs
- Combined view demonstrates that both health social care both spend dis-proportionate amounts of their budget on the same patients
- Overlap an opportunity for health and social care commissioners to work together to jointly commission across the whole system

SOURCE: Whole Systems project, HES 2010/11, NHS Reference Costs, NWL data centre

Appendix B –
Detailed financial figures by workstream

QIPP plan initiatives - all workstreams

Harrow Clinical Commissioning Group

Initiatives *(all figures £k)*	Total Gross Opp (3 Yr to 16/17)	Total Reprovision (3 Yr to 16/17)	Total Net (3 Yr to 16/17)	In-Year Net (14/15)	In-Year Net (15/16)	In-Year Net (16/17)
Integrated care	15,322	6,084	9,238	794	2,641	5,804
Integration of primary, acute, social and community care	15,322	6,084	9,238	794	2,641	5,804
Planned Care	11,727	5,642	6,085	2,359	2,704	1,023
Outpatients at lower cost - stretch	7,428	5,571	1,857	929	929	0
Referral management	1,537	0	1,537	777	760	0
Elective & day case admission variation	1,514	0	1,514	0	757	757
EOLC pathway, including CMC roll-out	781	0	781	258	258	266
Acute Direct Access	229	0	229	229	0	0
Respiratory pathway, including Pulmonary Rehab	238	71	167	167	0	0
Unscheduled Care	6,467	1,897	4,569	2,512	1,477	580
Rapid Response & Home Care (STARRS) - >1,700	2,530	1,404	1,126	704	422	0
Improve A&E Flow	1,085	0	1,085	358	358	369
Improve Acute Flow	902	263	639	214	214	211
Rapid response and home care - ACS stretch	584	0	584	584	0	0
Expand Ambulatory Emergency Care	574	0	574	574	0	0
Rapid Response (STARRS) - growth	668	230	438	0	438	0
NHS 111	92	0	92	45	46	0
Urgent Care Centre / A&E Demand Management	33	0	33	33	0	0
Adult Mental Health	3,083	322	2,761	1,403	875	483
Enhanced Primary Mental Health Care	975	322	653	216	216	222
Implementation of Mental Health panel	600	0	600	300	200	100
Redesign of Roxbourne Complex & Annex	600	0	600	300	300	0
Repatriation of Learning Disability clients (formerly PEP)	450	0	450	250	100	100
Mental Health growth	180	0	180	59	59	61
Liaison Psychiatry Service Funding Re-allocation	165	0	165	165	0	0
Shared Care prescribing protocols	83	0	83	83	0	0
Mental Health West London / BEH contract review	30	0	30	30	0	0
Medicines Management	2,612	155	2,457	866	870	721
Medicines Management	2,312	155	2,157	716	720	721
PbR Excluded Drugs Review	300	0	300	150	150	0
Continuing Care	2,493	575	1,918	926	401	591
Implement Dementia Strategy (leading to reduction of IP CC beds)	1,150	575	575	58	86	431
Woodland Hall recharge	399	0	399	399	0	0
Section 117	319	0	319	0	159	159
Review of Section 28A patient funding status	311	0	311	155	155	0
Non Eligible Continuing Care	278	0	278	278	0	0
Shared Lives	37	0	37	37	0	0
Community	801	0	801	291	285	225
Community budget growth	367	0	367	122	122	122
Productive Community Health Services	309	0	309	103	103	103
Community Paediatrics	125	0	125	66	59	0
Children's Services	512	73	440	72	183	185
Integrated Pathway for Complex Children	291	73	218	72	72	74
CYP - Asthma	126	0	126	0	63	63
CYP - Year of Care	95	0	95	0	47	47
Grand Total	**43,019**	**14,748**	**28,271**	**9,224**	**9,436**	**9,611**

Appendix C –
Additional workstream backing data

Top 20% (Integrated Care): key financial planning assumptions

Harrow Clinical Commissioning Group

Potential impact is Integrated Care unclear; however, existing sources have been triangulated to CCG's planning assumptions. These will need to be refined as (i) better local and national evidence is understood and (ii) as we see the results of changes that are implemented.

The existing evidence was reviewed in order to understand the potential impact of Integrated Care on acute activity. A reasonable mid-point has been used as the basis of Harrow's planning assumptions.

Summary of evidence

	Source	Pts considered	A&E att	NEL adm	Elective	Outpatients	Notes
1	ICP Business Case 13/14	Elderly & diabetes	3%	5%	n/a	n/a	Impact in 2013/14 only
2	Whole System Integrated Care - upper range	'Top 20%'; c.46k pts	40%	40%	20%	20%	'What if?' - cost reduction scenarios
3	Whole System Integrated Care - lower range	'Top 20%'; c.46k pts	25%	25%	15%	15%	'What if?' - cost reduction scenarios
4	NESTA - average	Various	32%	32%	32%	40%	Average of 51 studies reviewed
5	NESTA - best evidence	Various	25%	6%	6%	30%	Average of best evidence
	Proposed planning scenario?		*25%*	*20%*	*10%*	*20%*	

Applying these assumptions to Harrow's baseline 12/13 activity suggests the following gross savings.

	Activity (12/13)	3 Year Growth %	Projected Activity (16/17)	'Top 20%' % total activity	Projected IC Activity (16/17)	Avoidance %	Avoided Activity (16/17)	Cost per (£)	Gross cost avoided (£k)
A&E att	54,042	15.8%	62,556	71%	44,415	25%	11,104	116	1,288
NEL adm	20,229	15.8%	23,416	96%	22,479	20%	4,496	2083	9,365
Elective	35,914	15.8%	41,572	71%	29,516	10%	2,952	1020	3,011
Outpatients	260,745	15.8%	301,824	71%	214,295	20%	42,859	138	5,915
Total									**19,578**

Additional costs avoided in OOH and Social Care .

Reprovision costs were estimated as follows: assuming an average additional cost of proactive IC = £170 per pt, = total cost for 46k Pts = £7.8m

Net impact (acute only costs) = £19.6m - £7.8m = £11.8m

Continuing Care: benchmarking

Harrow Clinical Commissioning Group

While a proportion of savings in Continuing Care are expected from a number of specific efficiencies (e.g. C. £400k from recharging for out of borough patients in Woodland Hall), regional benchmarking also supports the potential to reduce Continuing Care costs in Harrow.

London Funded Care Benchmarking Analysis (Quarter 3 2012/13

XXX	Results	Barking & Dagenham	Barnet	Bexley	Brent	Bromley	Camden	City & Hackney	Croydon	Ealing	Enfield	Greenwich	Hammersmith & Fulham	Haringey	Harrow	Havering	Hillingdon	Regional Average
Cost YTD ('000) per 10,000 Weighted Population	Fast Track	162.4	26.3	31.8	14.7	35.0	18.9	4.7	38.9	30.2	17.6	33.8	30.1	11.8	15.3	181.7	3.3	**39.4**
	Learning Disabilities Adult (under 65)	4.3	59.8	31.3	72.6	18.8	77.8	38.0	1.9	51.6	111.4	56.6	131.7	157.7	118.0	10.1	32.1	**50.8**
	Learning Disabilities Adult (65 plus)	11.8	6.3	0.0	6.2	0.0	0.4	0.1	0.0	4.4	2.1	2.0	10.6	9.0	12.0	0.0	7.3	**2.9**
	Mental Health Adult (under 65)	13.9	32.3	0.0	73.1	6.8	56.6	7.9	10.8	43.4	16.3	28.4	4.2	25.9	29.3	7.5	2.7	**14.9**
	Mental Health Adult (65 plus)	12.5	129.0	83.2	27.0	31.0	148.1	47.6	49.2	29.5	9.3	46.7	56.3	61.5	101.9	51.8	69.0	**62.1**
	Physical Disabilities Adult (under 65)	54.3	52.5	29.5	25.5	43.4	50.1	68.4	85.5	52.8	63.4	36.7	60.0	69.3	71.5	23.5	92.7	**59.2**
	Physical Disabilities Adult (65 plus)	80.8	88.2	45.7	14.5	35.5	91.0	81.4	98.3	84.2	73.0	26.6	72.1	58.6	44.8	50.2	44.5	**75.4**
	Unable to split	4.7	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.7**
	Total CHC Packages	344.7	394.4	221.6	233.6	170.8	443.0	248.2	284.6	296.1	293.2	230.9	365.1	393.8	392.7	324.7	251.6	**305.4**
	Total - All CHC Costs	345.2	395.5	225.3	243.9	180.7	443.3	253.2	295.0	297.2	293.2	247.7	365.7	394.1	410.3	326.6	267.8	**309.2**

Result greater than 50% above average