HILLINGDON CCG UPDATE

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Organisation	Hillingdon Clinical Commissioning Group
Report author	Ceri Jacob, HCCG
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • Integration and development of an Accountable Care Partnership • Primary Care Co-Commissioning • QIPP • Finance
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital strategy • Financial strategy • Shaping a Healthier Future update
Financial Cost	Not applicable to this paper
Relevant Policy Overview & Scrutiny Committee	External Services Overview and Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes this update.

3. INFORMATION

The following section summarises key areas of work the CCG wishes to bring to the attention of the Health and Wellbeing Board.

3.1 Integration update and development of Accountable Care Partnership

Hillingdon's overall aim for integrated care is that the residents of Hillingdon will be able to plan their own care, with their carer or support if needed; with professionals working together to understand their needs and those of their carer(s), so that they have control over services and

that these deliver what is important to them. This will require a shift to planning for anticipated care needs rather than crisis management.

3.1.1 Update on work in progress and key developments.

Older People Model of Care

Integrated Care Planning (ICP) which provides the lower level support in our older people model of care (noted above) was rolled out in Hillingdon via GP networks in July 2015. ICP includes selecting appropriate patients who would benefit from care coordination, development of anticipatory shared care plans coproduced with patients, care coordination and collaborative working with other professionals and partners. Since ICP service commenced, work is underway to further refine and develop this element of the model of care.

Metro health GP Network, are testing a better way of selecting patients for care planning. This includes using a combination of multi-provider risk stratification tools, informed practice intelligence and informed provider intelligence. As these selection tools are refined and linked to real time intelligence, earlier signs of frailty can enable a trigger to earlier support.

Work is progressing to enable networks to track benefits for patients which in turn will help improve the impact of care planning in terms of patient experience and outcomes of care.

In addition to ICP care planning and care coordination, some people will require escalated care and a pilot commenced in MetroHealth GP Network in Nov 2015 comprising a new Care Connection Team (CCT) to support these people. This includes a guided care nurse and care co-ordinator working with the GPs over 2 practices. The GPs, guided care nurse and care co-ordinator are further supported in the pilot by dedicated care of the elderly consultants available on the phone for advice and support. The care connection team will assist GP pilot practices with proactive care of patients, enable the rapid escalation of people in urgent need of support, active case management and daily monitoring of patients. The GP will continue to oversee the whole care pathway.

New Rapid Access Clinics for the Elderly (RACE) have been commissioned by HCCG and provision commenced in August 2015, which can further support patients and clinicians in the community and be accessed by the CCT as part of the pilot.

From January 2016, further support to GP practices will be piloted through a single health and care gateway offering low level support and signposting via the third sector. The single gateway to services provided by the wide range of Hillingdon voluntary and community groups is being managed by H4All, a consortium of the 5 largest third sector provider in Hillingdon. The team will;

- take direct referrals from health and social care professionals to support people with low to moderate social care needs;
- attend the MDTs to ensure appropriate access and support to those requiring a social level of care;
- Primarily identifying residents who are isolated, anxious and de-motivated.

The gateway model has been developed to use a Patient Activation Measurement tool (PAM). This tool provides both a baseline on which to evaluate intervention and support and a measure to target support and resources to people that require it. The service will work with residents to raise their participation and motivation in self-management. It is anticipated that this service will

reduce unnecessary GP appointments, allowing the GP more time to review patients requiring medical care.

Development of the Accountable Care Partnership

The Accountable Care Partnership is Hillingdon CCG's preferred model of delivery for integrated care. Commissioning integrated care from the Accountable Care Partnership will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. Hillingdon CCG and shadow ACP are discussing the scale and pace of this ambition linked to benefits for people in Hillingdon.

The Accountable Care Partnership (ACP) will function (deliver services) in shadow form for a year from April 2016. Prior to this, a memorandum of understanding will enable both the CCG and the providers to test the concepts of commissioning for integrated care including capitation, development of outcomes and coproduction of the model of care.

In order for the ACP to work collaboratively, it is developing a new joint governance structure to enable the ACP to make decisions, allocate funds, manage performance, and hold each other to account for delivering outcomes. The ACP shadow board is leading this work, and have appointed a Programme Director to commence in January 2016. An ACP development group will support this work stream.

Further detail on development of the ACP can be provided at a future Health and Wellbeing Board if required.

Enablers

a) Capitation:

Work on capitated budgets for 15/16 includes:

- Scope of overall payment model design
- Collection of activity and spend data assigned to population groups
- Analysis and review of baseline activity and finance
- Reconciliation and creation of a preliminary draft shadow budget

Next steps by April 2016

- Development of contract framework for shadow budget
- Development of a framework for risk and reward sharing
- Sign off by provider Boards and HCCG Governing Body

From April 2016

- Payment to providers will be on the current contractual basis
- A notional capitated budget will be set at beginning of year
- The financial impact on commissioners and providers that would have occurred if the new payment model were fully in place against the notional budget will be tracked.

b) Outcomes:

A common outcomes framework for the Older People model of care is under development, which builds on existing frameworks such as BCF and ICP and will enable a common set of indicators and measures for the whole Older People integrated model of care.

A technical group is currently developing and aligning these indicators, metrics and KPIs so that the impact of the Older People's model of care can be tracked and evaluated.

Commissioning for population level outcomes will require the development of:

- System outcomes –is the care system delivering our vision for older people in a sustainable way
- Clinical outcomes – is the care delivering improved health and care outcomes for the population group
- Patient experience and reported outcome - do people feel sufficiently supported by the health and care system; "nothing about me without me".

c) Shared data and records:

All partners will be a signatory to an Information Sharing Agreement (ISA), and have now signed up to these agreements.

Hillingdon is a pilot site for "Patient Knows Best" an information sharing platform that will enable patients and all professionals to see and update care plans. This is planned to pull data directly from each providers own system. The pilot will commence in October 2015 for 3 months.

A new care record template is now operational with all GP networks

A Business intelligence tool (WYSE) has been developed to support planning, mobilising and delivering integrated care, including GP practice level dashboards and performance tools.

3.1.2 Governance arrangements from December 2015

Governance for whole systems integration in Hillingdon has been reviewed to support moving into the mobilisation and testing stage (figure 1). These governance arrangements will enable dual assurance to both the HCCG Governing Body and the ACP Shadow Board, whilst overseeing progress and outcomes from the programme work -streams. These arrangements will commence in December 2015.

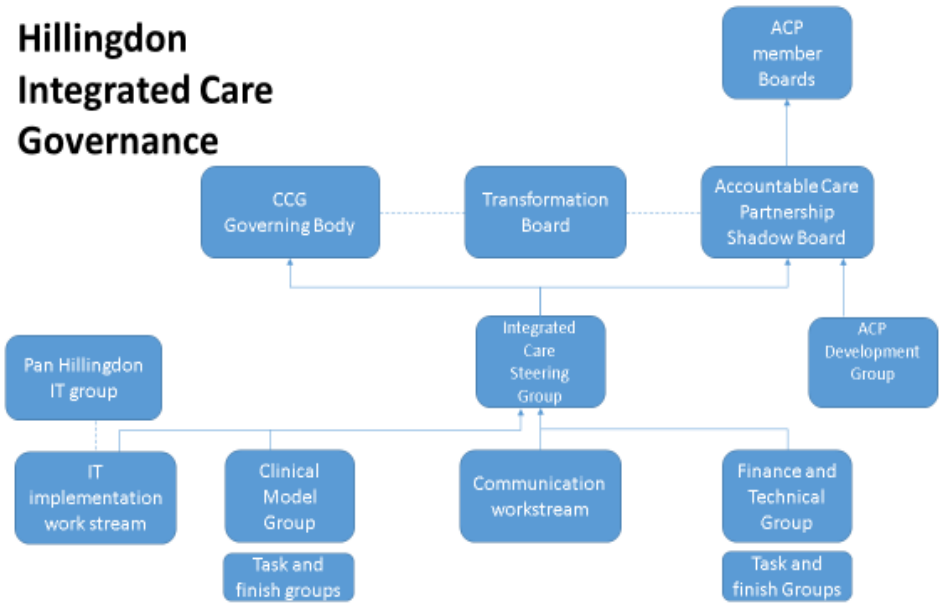

Figure 1

3.2 Primary Care Co-Commissioning

Hillingdon CCG entered Primary Care co-commissioning arrangements with NHS England in April 2015. Currently co-commissioning primary care is restricted to General Practice. Dentists, Pharmacists and Optometrists continue to be wholly commissioned by NHS England.

Each CCG that has entered co-commissioning arrangements must form a Joint Committee with NHSE. Originally it had been proposed that the eight North West London (NWL) CCG Joint Committees would meet in common with each CCG also having a local sub-group to take work forward. It has now been agreed that Joint Committees should be held locally and only meet in common where necessary to secure strategic alignment across NWL. Terms of Reference and membership of the local group have now been amended to reflect this change.

A key area of focus for the committee at the moment is implementation of a new model of care for GP practice that will support GPs to work in a networked fashion and to be part of an integrated care delivery system. The new Model of Care will meet quality requirements set out in the London primary care Strategic Commissioning Framework for example, access to GPs.

A second key area of work is the Personal Medical Services (PMS) review. GPs in Hillingdon work under one of three different contracts:

- GMS (General Medical Services) – nationally negotiated
- PMS (Personal Medical Services) – locally negotiated with premium funding allocated to support specific service initiatives
- APMS (Alternative Provider Medical Services) – locally negotiated and the contract can be held by a non-GP who employs salaried GPs.

In Hillingdon the majority of GPs working with a GMS contract. There are 10 with PMS contracts and 1 with an APMS contract.

The PMS review is being led by NHS England who are carrying out a value for money assessment on services provided via the premium fund (£1m across PMS practices). The CCG will be responsible for agreeing how any premium funding released should be utilised to support service delivery and quality in general practice.

A fuller report on both of the above areas can be provided at a future Health and Wellbeing Board if required.

3. 3 QIPP (Quality, Innovation, Productivity, Prevention)

The CCG's plan for QIPP for 2015/16 is valued at £7.746m and at Month 6 we are currently predicting a Forecast Outturn of £6.361m. The forecast outturn has been improving each month and we expect that trend to continue through the delivery of the following mitigating actions:

- **Intermediate Care:** We expect to negotiate with The Hillingdon Hospital (THH) that any patient taken home with a Zero Length of Stay via either the Homesafe or Rapid Response Teams will not be counted as an admission and will attract the local tariff for admissions avoided. This scheme also links to the Better Care Fund.

- **Ambulatory Pathways:** The ambulatory activity for adults through the AEC (Ambulatory Emergency Care) Pathway and EGAU (Emergency Gynae Assessment Unit) continues to over-achieve and we are seeing increasing numbers each month. In addition, we have agreed with THH to open up Surgical and Paediatric Ambulatory Pathways which will significantly reduce non-elective admissions in this area and contribute to the CCG's QIPP.

- **Community Services/Equipment:** Having successfully completed a number of procurements we are set to exceed our QIPP whilst improving the service provided to patients and service users associated with Wheelchairs and Pressure Relieving Mattresses. We are also seeing an improving position associated with our Community Dermatology Service which is now seeing >200 patients per month. Lastly, our joint work with LBH around Community Equipment is starting to show results with a reduction in the expected spend in this area.

- **MSK:** We continue to work with THH around reducing elective Musculo-Skeletal (MSK) activity and hope that this will be reflected in an improving QIPP situation. However, further to discussions with THH we are seeking to procure a new Community Chronic Pain Service that will have a major impact on Secondary Pain Activity associated with the hospital and in particular with Spinal Injections. Lastly, we are working with THH to develop a new Rheumatology Service although we do not expect this to generate any QIPP directly we do expect a much better service to patients in terms of access and for GPs to help them manage patients in the community, something that we are addressing through a 'Near Patient Testing' LES (Local Enhanced Service) that will focus on DMARDS (Disease Modifying Anti-Rheumatic Drugs).

- **Older People:** Our work to support Older People is increasing in pace with Rapid Access Care of the Elderly Clinics now available to augment our existing Care Homes, Falls and Fracture Liaison Services and our Intermediate Care Services. We will be developing plans for expanding this area of focus in 16/17 and beyond.

- **Long Term Conditions:** We are reaching the point at which our major Long Term Condition programmes (Cardiology, Diabetes and Respiratory) start to realise benefits and this is already supported by the success of our Empowered Patient Programme (EPP) which is exceeding the expected run rate and supporting our strategy for Secondary and Tertiary Prevention. The majority of benefits associated with LTCs will be realised through 16/17 and beyond and this area forms a major part of the CCG's emerging Prevention Strategy.

- **QIPP 16/17 & Beyond:** The CCG is now working up the detail of the new QIPP Schemes for 2016/17. In addition, the NWL CCGs are working to create a 5 Year QIPP View so that the financial sustainability of the entire sector can be assessed and joint activities planned where needed across a longer time period.

3.4 Financial position

The CCG's financial plan for 2015/16 is to deliver a 1% surplus (£3.482m) and to remove the underlying deficit. The plan is based on the following key deliverables/assumptions:

- Funding from NWL Strategy of £10.3 m plus THH Transitional Support of £3m
- Local QIPP Plan delivery of £7.7m (£8m in 14/15)
- Delivery of 15/16 Acute Activity Plan

Overall, at month 6, the CCG's in-year's position is a YTD planned surplus of £1.741m and a forecast surplus of £3.482m which is in line with plan. The CCG is currently facing some financial pressures on its Acute budget (£1.9m FOT over performance at month 6 arising from the shortfall in QIPP highlighted above and other pressures in Rehabilitation services and Critical Care) as well as in its Mental Health Placements budget and GP Prescribing. These pressures are currently being managed by some underspends elsewhere in the CCG's budget (e.g. reduction in Property Charges) and by the release of reserves.

As a result the achievement of the underlying break-even for the CCG by the end of the year remains challenging and this is still reliant on the delivery of the 2015/16 acute activity plan and the continuation of the NWL Financial Strategy funding into 2016/17.

Tables 1 to 4 below summarise the current position.

Overall Position

	Outturn			YTD Month 06		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Programme Costs:						
Revenue Resource Limit	341,867	341,867	(0)	167,771	167,771	0
Net Programme Costs	(338,385)	(338,635)	(250)	(166,030)	(166,030)	(0)
Surplus / (Deficit)	3,482	3,232	(250)	1,741	1,741	(0)
Running Costs:						
Revenue Resource Limit	6,194	6,194	0	2,898	2,898	0
Net Running Costs	(6,194)	(5,944)	250	(2,898)	(2,898)	0
Surplus / (Deficit)	0	250	250	(0)	(0)	0
CCG Surplus / (Deficit)	3,482	3,482	0	1,741	1,741	(0)

Table 1

Year to Date Variances

08G Hillingdon CCG Month 06	Year to Date Variance £m	Commentary on Year to Date Variance
QIPP Variance - Acute	-0.405	Mainly THH non-elective admissions schemes.
QIPP Mental health Commissioning	-0.048	
Other Acute Commissioning	-0.013	
Continuing Care	-0.046	
Prescribing	-0.087	
Community	-0.031	
QIPP Variance Total	**-0.63**	
Acute SLA	-0.388	Primarily relates to an overspend with THH. Other overspends include Frimley, Barts, RBH and East & North Herts.
Prescribing	-0.450	Overspend on GP Prescribing of (£414k) based on 15/16 profile. Actuals for July were higher than forecasted.
Mental Health Commissioning	-0.065	Placements overspent by (£333k) based on Caretrack data, offset by Other of £232k which relates to investments.
Sub-Total Adverse Variances	**-0.903**	
Other Acute Commissioning	1.085	Driven by underspend on NCAs £722k, Re-Admission Credit Reserve £308k, THH Other £153k, UCC THH Main Contract £70k, offset by overspend on UCC NCAs (£139k) and Mount Vernon Beds (£124k).
Continuing Care	0.066	Mainly relates to an underspend on Personal Health Budgets of £35k and CHC Adult Fully Funded £24k offset by overspends on CHC Children (£29k) and Funded Nursing Care (£19k).
Community	0.133	Mainly relates to underspends on Other QIPP Reprovision Schemes £59k, Intermediate Care £46k and Community Services - NCAs £30k mainly offset by overspends on Community Equipment (£16k) and Hospices (£14k).
Corporate & Estates Costs	0.032	Mainly underspends in Estate Charges of £201k fbased on 15/16 Property Services cost schedule, WSIC £40k and GPIT £39k, offset by overspends in QIPP Provision (£177k), Safeguarding (£53k) and SaHF Transformation Funding (£17k).
Primary Care	0.217	Driven by underspends on ICP Project £103k, Primary Care Investments £91k and Local Incentives Schemes £28k.
Running Costs	0	
Sub-Total Released Reserves/Underspends	**1.533**	
Total	**0.000**	

Table 2

Forecast Outturn Variances

08G Hillingdon CCG Month 06	YTD Variance £m	Forecast Variance			Commentary on Position
		Projected (Straight Line) £m	Adjust £m	Forecast Outturn Variance £m	
QIPP Variance - Acute	-0.405	-0.810	-0.147	-0.957	
Mental Health Commissioning	-0.048	-0.096	0.048	-0.048	
Other Acute Commissioning	-0.013	-0.026	-0.001	-0.027	
Continuing Care	-0.046	-0.092	-0.014	-0.106	
Prescribing	-0.087	-0.174	-0.072	-0.246	
Community	-0.031	-0.062	0.060	-0.002	
QIPP Variance Total	**-0.630**	**-1.260**	**-0.126**	**-1.386**	
Acute SLA - Non QIPP	-0.388	-0.776	-0.175	-0.951	
Prescribing	-0.45	-0.900	0.177	-0.723	
Mental Health Commissioning	-0.065	-0.130	-0.494	-0.624	Relates to Mental Health Investments where spend is planned for latter part of the year.
Sub-Total Adverse Variances	**-0.903**	**-1.806**	**-0.492**	**-2.298**	
Other Acute Commissioning	1.085	2.170	-0.108	2.062	
Continuing Care	0.066	0.132	-0.067	0.065	
Community	0.133	0.266	-0.220	0.046	
Corporate & Estates Costs	0.032	0.064	0.588	0.652	Largely relates to 14/15 Property Services creditor for an onerous lease on Kirk House which is expected to be released later in the year creating an underspend of £582k.
14/15 Creditors Balance	0	0.000	0.296	0.296	Unutilised 14/15 creditors relating to CIS.
Primary Care	0.217	0.434	-0.121	0.313	
Running Costs	0	0.000	0.250	0.250	Unutilised Reserves.
Sub-Total Released Reserves and underspends	**1.533**	**3.066**	**0.618**	**3.684**	
Total	**0.000**	**0.000**	**0.000**	**0.000**	

Table 3

Forecast Outturn Actuals

08G HILLINGDON MTH 06	YTD £m	Forecast Spend			Commentary on Adjust Column
		Projected (Straight Line)	Adjust £m	Forecast Outturn £m	
QIPP YTD - Acute	(3.022)	(6.044)	(1.384)	(7.428)	Some schemes due to commence 1.10.2015
QIPP YTD - Continuing Care	(0.010)	(0.020)	(0.006)	(0.026)	Relates to CHC Procurment of complex children scheme starting 01.07.15 and CHC Patient Review.
QIPP YTD - Prescribing	(0.673)	(1.346)	0.072	(1.274)	Prescribing Scheme to be brought back on track.
QIPP YTD - Mental Health	(0.095)	(0.190)	(0.048)	(0.238)	Relates to Shifting settings of care scheme.
QIPP YTD - Community	(0.087)	(0.174)	(0.023)	(0.197)	Relates to Community Rehab Equipment scheme from 01.07.2015.
QIPP YTD - Re-provision (excl outpatient ophthalmology)	1.134	2.268	1.173	3.441	QIPP Reprovision Schemes to be spent in latter part of the year.
QIPP YTD - Running Cost	(0.320)	(0.640)	0.001	(0.639)	Relates to a target reduction in Running Costs
QIPP Total	**-3.073**	**-6.146**	**-0.215**	**-6.361**	
Acute SLAs - Non QIPP	96.298	192.596	1.330	193.926	This is due to phasing of SLA contracts and seasonal adjustments.
Continuing Care	9.478	18.956	(1.696)	17.260	Relates to a year end provision for continuing care appeals and the full amount of retropsective provision risk share contribution is in ytd position.
Other Acute Commissioning	14.412	28.824	(2.005)	26.819	THH SaHF Paeds Reconfiguration and maternity one off payment of £3m has been paid in full. The expectation for Mount Vernon Beds is that the contract ceased in September. Re-admissions spend is planned in the latter half of the year.
Winter Pressures	0.045	0.090	0.984	1.074	£0.98m Winter Resilience - this is in-year contingency for winter schemes to be spent from November onwards.
Mental Health	11.169	22.338	1.079	23.417	£0.8m investments and £0.15m Eating Disorders and Planning to be spent in the second half of the year.
Corporate & Estates Pressures	2.636	5.272	(0.637)	4.635	14/15 Property Service Creditor for the onerous lease on Kirk House will be released into the position in the latter part of the year.
Prescribing	18.211	36.422	0.266	36.688	GP Prescribing forecast based on IPP report. Local drugs phasing includes Seasonal factors - Flu etc.
Primary Care	1.928	3.856	1.805	5.661	Proposed ICP Project, Primary Care Investments, GP Network Development and Local Incentive Schemes planned for the second half of the year.
Community Services	14.605	29.210	1.264	30.474	Better Care Fund and Other QIPP Reprovision Schemes to be spent in latter part of the year.
Sub-Total	**165.709**	**331.4166**	**2.175**	**333.593**	
SLA - Acute Contracts Risk Reserve	0.000	0.000	2.993	2.993	Additional provision for in year investment in schemes to reduce emergecy admissions and re-investment of contract penalties.
Contingency	0.000	0.000	1.705	1.705	Contingency not utilised in year to date position.
14/15 Creditors Balance	0.000	0.000	(0.296)	(0.296)	To be released in the latter part of the year.
Sub-Total Released Reserves and underspends	**0**	**0**	**4.698**	**4.402**	
Running Cost	3.218	6.436	0.147	6.583	Largely relates to unutilised reserves of £0.261m.
Net YTD Spend	**168.93**	**337.85**	**7.02**	**344.58**	

Table 4

The full Month 6 report can be accessed via the following link.
http://www.hillingdonccg.nhs.uk/publications2

4. FINANCIAL IMPLICATIONS

QIPP: - the forecast outturn at M6 for 15/16 is £6.361m against our target of £7.746m.
Financial Plan: - the CCG is forecast to achieve its financial plan for 2015/16.
Integrated care: - the expectation is that the Older People model of care will provide savings of approximately £1.5m

5. LEGAL IMPLICATIONS

None in relation to this update paper.

6. BACKGROUND PAPERS

- North West London 5 Year Strategic Plan
- Hillingdon CCG Out of Hospital Strategy
- Hillingdon CCG Operating Plan 2015/16
- London Primary Care Strategic Commissioning Framework