The QIPP initiative (England) and addressing the recession

Background

In his 2008/2009 annual report the Chief Executive of the English NHS, David Nicholson said that the NHS should be ‘prepared for a range of scenarios, including the possibility that investment will be frozen for a time. We should also plan on the assumption that we will need to realise unprecedented levels of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over three years.’ His report continued to say that productivity gains would be achieved by quality improvements and innovation. This was reaffirmed in the Pre-Budget Report and the NHS Operating Framework for England for 2010/11 and has been termed both the quality and productivity challenge and the QIPP (Quality, Innovation, Productivity and Prevention) initiative.

QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate. By assessing reforms against the four components – Quality, Innovation, Productivity and Prevention – the NHS is meant to provide better quality services in the most productive and cost effective way possible, making the best use of the potential of innovation and targeted investment in prevention. The four QIPP elements can be seen as both distinct and inter-related. There will be initiatives which focus on particular elements or which bring some or all of the components together.

The Department of Health (DH) believes that the characteristics of a sustainable NHS are care closer to home, earlier intervention, fewer acute beds, more standardisation by reducing variation, empowered patients and reduced unit costs. These priorities were outlined in NHS 2010-2015: from good to great. Preventative, people-centred, productive and the NHS Operating Framework. The QIPP programme aims to support the NHS to meet these challenges.

QIPP is an attempt to avoid slash and burn cuts, by focusing on ‘quality’ and the other components. It is intended to ensure that the economic climate does not change the focus (as outlined in High Quality Care for All by Lord Darzi) to put quality (defined as clinical effectiveness, safety and patient experience) at the heart of the NHS. As stated by Jim Easton, the DH National Director for Improvement and Efficiency, ‘Just closing beds or losing staff is not a QIPP response.’ However there remain concerns that QIPP is a euphemism for cuts.

QIPP at the national level

QIPP is organised at a number of different levels which are meant to be mutually reinforcing and supportive. Jim Easton, the DH's National Director for Improvement and Efficiency is the overarching lead for QIPP.

As part of QIPP the DH is looking at shaping national levers and enablers. So far this has led to adjustments to the Payment by results tariff which were outlined in the Operating Framework. This includes the stipulation that any emergency activity that occurs above a contracted baseline in 2010/11 will only attract 30 per cent of the relevant tariff payment. This policy is designed to encourage better, more integrated planning and more care in the community, thereby meeting QIPP aims, by disincentivising emergency activity via non-payment.

Two of the national levers or enablers that are consistently referred to are the GP and the consultant contracts. It has been reported that as part of QIPP, Strategic Health Authority (SHA) directors and DH officials have discussed reforms to primary care contracts including greater powers to "fire" GPs and manage performance and variation in service costs across Primary Care Trusts (PCTs). It was also reported that in this discussion SHA directors voiced their concerns that smaller practices cannot deliver required productivity improvements because they are 'less able to share administration, host additional services, and take on commissioning functions.'

The DH has recently launched guidance for PCTs on taking systematic approaches to raise the bar on quality standards in primary care to help contribute with the Quality and Productivity Challenge. The guidance encourages PCTs to 'adopt a sustained and systematically strong stance in challenging GPs whose performance has been persistently unacceptable' particularly by 'maximising the use of contractual sanctions.' The BMA is concerned that contractual levers should be used as a last resort to force failing practices to improve and that there should be greater emphasis on encouraging and supporting good performance. The BMA has also been concerned at attempts to reduce the time consultants can spend on supporting professional activities and non clinical duties. Jim Easton has flagged national pay and pensions as a workstream for the second phase of QIPP.

In 2009 QIPP: Establishing the Evidence project was developed to collate and expand the evidence of how to improve quality whilst making efficiency savings nationally. It aimed to solve the problem of disparate current evidence and provide a structure for further evidence development. The quality and productivity evidence base has now been launched as a specialist collection on NHS Evidence.

National work is underway to support NHS Boards to govern effectively in the context of the QIPP challenge. The National Leadership Council's Board development workstream is designing a national Board and Inter-Board Diagnostic and Development Framework that will focus on partnership working. It is being created with the involvement of NHS leaders, representatives from local government, and academics. The framework is meant to be a regionally adopted programme that reflects local needs for establishing inter-Board collaborative work that addresses the QIPP agenda. In addition, every SHA is establishing a Quality Observatory and an Innovation Fund. These are designed to help clinical teams identify the best opportunities for improving quality and productivity. The Quality Observatories are to be a first port of call for anyone seeking comparative information on quality care in their region. SHA Innovation Leads are in place to help NHS organisations make a wider contribution to meeting the QIPP challenge by resourcing and implementing ideas through their Innovation Funds, and signposting to appropriate support to take innovations forward.

a. Five Senior QIPP advisers

Five leads from the NHS and the private sector have been appointed as 'Senior QIPP advisers' to support Jim Easton and the QIPP agenda. They are to design, operate and support some of the complex work that will underpin and take forward the QIPP programme across England. They are:

- **Sir John Oldham** – National Clinical Lead for quality and productivity (GP and member of the National Quality Board) will lead work to shape national clinical work programmes including long term conditions, urgent care and integration of care between health and social care.
- **Joyce Drohan** – Director for SHA programmes (from Astra Zeneca) will focus on SHAs and ensure that they each prepare a robust QIPP plan which will be implemented by the SHAS QIPP Lead.
- **Maxine Power** – National Improvement Advisor, (formerly from the Salford NHS Foundation Trust and the North West Improvement Alliance) will advise on building organisational improvement capability and how best to support all the work programmes from an improvement perspective.
- **Mohamed (Mo) Dewji** – National Clinical Lead for primary care development (GP and Clinical Director of Strategy at South Central SHA).
- **Philip DaSilva** – National QIPP lead for primary and community services (with a nursing background and a previous PCT Chief Executive) will focus on commissioning development of primary care with an aim to achieve high quality and productive care.

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3 West, D. Managers demand power to fire GPs, Health Service Journal, 11 March 2010.

4 DH, Systematic approaches to ‘raising the bar’ in primary care: what has been done to improve quality overall and specifically in those underperforming, 5 March 2010 at p1.

5 DH, Systematic approaches to ‘raising the bar’ in primary care: what has been done to improve quality overall and specifically in those underperforming, 5 March 2010 at p4.

b. 12 National workstreams

A national programme of 12 workstreams has been established to support clinical teams and NHS organisations. The workstreams are focusing on commissioning and pathways, provider efficiency and system enablers. Each workstream is to produce a national plan stating how they will support improving health quality whilst identifying real cash savings.

There is little detail on the DH website relating to the work of each of the workstreams. The remits of the workstreams also appear to be changing over time. For instance, in March 2010, Jim Easton wrote to SHA Chief Executives to explain that a new approach to preoperative, perioperative and postoperative care of patients undergoing surgery called ‘Enhanced Recovery’ will be included within one of the national QIPP programmes – but did not state which one. However, the strategic direction of the workstreams is underpinned by the NHS Operating Framework and Good to great.

Commissioning and pathways workstreams

These workstreams are meant to support commissioners to commission for quality and efficiency through improved clinical pathways and the decommissioning of poor quality services. While not all pathways currently have a dedicated national workstream, all conditions and pathways will be affected by the QIPP agenda.

Safe Care – led by Maxine Power (National Improvement Adviser, DH)

Good to great makes safer care a priority for the NHS. It highlights the need to strengthen the regulatory system and reduce the number of incidents resulting in serious and long lasting harm to patients. It outlines the NHS’s initial focus as eliminating avoidable cases of C.difficle, venous thrombo-embolism (VTE) and pressure ulcers.

In January 2010 Ms Power told the Health Service Journal (HSJ) that in the area of safety a programme of cash releasing improvements would be launched which all organisations should sign up to. The aim is for the NHS to be delivering the safest care in the world by 2013. The programme will identify the next wave of safety challenges, including tackling priorities such as venous thrombo-embolism and pressure ulcers.

Right Care – led by Sir Muir Gray (Chief Knowledge Officer of the NHS, DH)

This workstream is focusing on achieving better value by decommissioning poor services and referral management. Sir Muir Gray has said that there will be greater scrutiny (including the publication of an ‘atlas’) of whether and where unnecessary operations and follow-ups to elective surgery were being carried out. This workstream is also looking at options to better inform patients’ decisions about what treatment to choose. Sir Muir Gray is also working on preventing new services being commissioned and decommissioning those not providing good value.

The National Institute for Clinical Excellence (NICE) has also recently shifted its emphasis to identifying areas where savings can be made. NICE has reviewed its national cost estimates and created cost saving guidance.

Long-Term Conditions – led by Sir John Oldham (National Clinical Lead, Quality and Productivity, DH)

In relation to long-term conditions Good to great focused on better support for self care and family carers to avoid hospital admissions. The Operating Framework also emphasised better case management, personalised care planning, supporting people to self care, and making the best use of emerging assistive technology.

Urgent Care – led by Sir John Oldham (National Clinical Lead, Quality and Productivity, DH)

Both Good to great and the Operating Framework emphasise the need for patients to be seen in the most appropriate care setting rather than relying on emergency services. Sir John Oldham has said that out-of-hospital centres will be essential for quality and productivity but have often been badly planned. He is encouraging a cohesive and strategic view about what services are available in geographical locations as part of constructing a system where patients with urgent problems are guided to the most appropriate service as reverting to a reliance on accident and emergency services would be bad for reducing costs and improving quality.

End of Life Care – led by Sophie Christie (Chief Executive, Birmingham East and North PCT)

Both Good to great and the Operating Framework reiterate the desire to increase access to palliative care and enabling more end-of-life care to be delivered in people’s homes to reduce inappropriate admissions through the ambulance service. It is expected that this workstream will also build on the End of Life Care Strategy announced in July 2008.

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7 West, D. Improvement Tsar warns SHA’s to ‘refresh’ Darzi visions urgently, Health Service Journal, 14 January 2010 at p5.
Available at http://www.hsj.co.uk/news/policy/improvement-tsar-warns-shas-to-refresh-darzi-visions-urgently/5010313.article

8 West, D. QIPP leads reveal hit list, Health Service Journal, 28 January 2010 at p5.
Available at http://www.hsj.co.uk/news/primary-care/qipp-leads-reveal-hit-list/5010826.article

Available at http://www.hsj.co.uk/news/acute-care/ae-alternatives-confuse-the-public/5012910.article
**Provider efficiency workstreams**

These projects are to support providers to respond to the commissioning changes and efficiency pressures by transforming their business.

**Back office efficiency and optimal management – led by Tony Spotswood (Chief Executive, Royal Bournemouth and Christchurch Foundation Trust) and**

**Procurement – led by Philippa Slinger (Chief Executive, Berkshire Healthcare Foundation Trust)**

The Government’s 2009 Operational Efficiency Programme set out the scope for efficiency improvements across the public sector in back office functions, IT, property and collaborative procurement. These were reinforced by *Putting the frontline first: smarter Government* which set out new comparator benchmarks for some back-office functions and announced an aim to reduce consultancy spend by 50 per cent and marketing and communications spend by 25 per cent. *Good to great* also underlined the importance of NHS organisations reducing their back-office management, procurement and estates costs in the coming years. It is assumed that these workstreams will be looking in further detail at how the NHS will achieve savings in these areas.

**Clinical support – led by Dr Ian Barnes (National Clinical Director of Pathology, DH)**

This workstream has also been referred to by Jim Easton as ‘clinical support rationalisation’ and has an initial focus on pathology. A number of initiatives relating to pathology are already underway within the DH in response to the *Carter Review of NHS pathology services*. In this role Dr Barnes has publicly discussed the role of Clinical Directors in delivering QIPP; encouraging innovation at directorate level and changing the culture to empower staff to innovate and change systems.

**Supporting staff productivity – led by Lorraine Foley, (QIPP Lead, NHS Institute for Innovation and Improvement)**

The *NHS Institute for Innovation and Improvement* has developed *Productive Series*, a number of productive tool kits for working environments such as wards and community hospitals. The Series aims to support NHS teams to redesign the way they manage and work and consequently achieve significant improvements – predominately in improving quality while reducing costs. It is expected that this workstream will focus on the systemic adoption of the Productive Series and evidence based productivity improvements.

**System enabler workstreams**

**Primary care contracting and commissioning – led by Dame Barbara Hakin (Chief Executive NHS East Midlands)**

This workstream is to identify features of high quality primary care, improve the way the NHS commissions primary care and reduce unwarranted variation. This focus on reducing variation in primary care may see renewed pressure for greater standardisation of GP referral rates.

Much of the QIPP programme relies on reducing referrals to hospitals, better care for long-term conditions and moving services into the community. All of these aims (which are also outlined in the Operating Framework) are dependent on primary care services, which is why this workstream is referred to as a ‘system enabler’.

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QIPP at the regional level

QIPP leads have been appointed within each SHA to develop their regional response to the quality and productivity challenge. The contact details of each SHA QIPP lead are available on the DH website.

Regional plans are to set out what needs to be done to meet the quality and productivity challenge over the period 2011/12 to 2013/14. They are also to outline how changes will be implemented and the processes and governance structures required. Each SHA is to work with its local NHS organisations to develop its QIPP plan. The SHA QIPP planning process is meant to enable regions to identify the size of the financial challenge and the opportunities that exist to meet this. Final SHA QIPP delivery plans, in line with other planning requirements set out in the Operating Framework, were to be submitted to the DH for assessment by the end of March 2010.

There have been various media reports as to what is contained within the SHA QIPP plans. These have included reports that proposals could lead to 10 per cent of NHS staff being sacked in some areas, the loss of thousands of hospital beds, a reduction in the number of ambulance call outs and medical professionals being replaced by other health staff. There have been reports that three SHAs are planning to reduce their workforce by 30,132 staff or an average of 8.7 per cent of their workforces. It has been reported that some savings are to be made in London by patients reaching doctors and services through the internet and email rather than GP surgeries and in Yorkshire and Humber by diverting patients to teleservices such as NHS Direct.

Whichever proposals are actually developed and implemented, given the scale of the financial challenge and the QIPP focus on making large scale changes to the way the NHS currently works, they will undoubtedly be controversial. Detailed information on what each region and the DH are proposing is expected after the General Election on 6 May 2010.

QIPP at the local level

The DH is keen to have local clinicians actively involved in the QIPP agenda. In March 2010, the DH released The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians, co-sponsored by Professor Sir Bruce Keogh (NHS Medical Director), Dame Christine Beasley (Chief Nursing Officer), Karen Middleton (Chief Health Professions Officer), Professor Sue Hill (Chief Scientific Officer), Dr Keith Ridge (Chief Pharmaceutical Officer) and Jim Easton. This resource is intended to motivate clinicians to become actively involved by raising the possibility that ‘if we do not respond to this challenge there is a real risk that the need to cut costs will overtake our best intentions to improve care for our patients.’

The document argues that clinicians make decisions every day which have an impact on how the NHS budget is spent and asks each health professional to look at their daily clinical practice and identify where making changes will lead to better care for patients as well as eliminating waste.

It also outlines a number of local level case studies such as:

- **Yeovil District Hospital NHS Foundation Trust** – enhanced recovery programme in elective bowel surgery reduced patients’ return to normal from weeks to days saving bed days.

- **Oxford Radcliffe Hospitals** – transformed the blood transfusion process by creating an electronic transfusion management system that is simpler, safer and more efficient.


17 Swinford, S & Pasmore G, 225,000 public workers to be axed, The Sunday Times, April 18, 2010. Available at http://www.timesonline.co.uk/tol/news/politics/article7100957.ece

The next phase for QIPP

Jim Easton has said that there will be a second phase for QIPP and that it is expected that work will begin on the second phase in the second quarter of 2010. Currently there is little information available about this second phase on the DH website.

The workstreams envisaged for this second phase are:

**Commissioning and pathways**
- Acute – elderly, complex patients
- Planned care (cancer, heart, and other)
- Mental health
- Maternity and newborn
- Child Health
- Staying healthy

**Provider efficiency**
- Estates rationalisation
- Efficiency in community services

**System enablers**
- Supply side reform (Foundation Trust pipeline)
- Clinical reconfiguration
- Arms length bodies
- National pay and pensions
- Training volumes and cost
- Social care integration
- System levers review
- Innovation
- Capability and support
- Communications and engagement

The BMA will be closely monitoring the development of these workstreams. Reforms to the reconfiguration process have already been proposed from within the NHS. For instance in their First Stage Report, NHS London wrote that ‘developing proposals for service change, consulting stakeholders on those proposals and implementing agreed service changes takes too long and is expensive. A speedier approach to reconfiguring services needs to be developed, where necessary in partnership with the Department of Health and the Cooperation and Competition Panel.’

BMA Activity

The national Social Partnership Forum, of which the BMA is a member, has agreed to a set of principles to guide the social dialogue required to meet the challenges ahead. These are:

- Build and maintain respect for social partners at national, regional and local level;
- Be clear about appropriate governance;
- Aim for inclusivity;
- Cooperate for whole-system solutions;
- Work within and build on existing policy commitments; and
- Work to retain confidence in the NHS.

These principles are also in line with David Nicholson’s four principles of change: co-production (working in partnership with the NHS, local authorities and key stakeholders); subsidiarity (where necessary the centre will play an enabling role but wherever possible, the details of implementation will be determined locally); clinical ownership and leadership (staff as active participants and leaders); and system alignment (where needs are aligned around the same goals).

The BMA continues to monitor the QIPP programme as it develops and as the trade union for doctors and medical students the BMA will actively stand up for the interests of its members as Government policy unfolds.

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