NHS
North Lincolnshire
Clinical Commissioning Group

North Lincolnshire Clinical Commissioning Group

Plan for the Commissioning of High Quality Services for North Lincolnshire; 2013/14

'Right Care, Right Place'

Final version 1.5

Contents

1.0 Introduction

This plan sets out the commissioning intentions of North Lincolnshire Clinical Commissioning Group (CCG) for 2013/14 and our vision for the future. This plan marks the first commissioning plan of the CCG, which was fully authorised in January 2013 and will take full statutory duties from April 2013. The plan has been developed in conjunction with clinical commissioners, the Health and Well-being Board and key stakeholders, including members of practice participation groups. The plan represents the CCG's commissioning intentions relevant to the services it commissions. The CCG will work closely with the NHS Commissioning Board Area Team for North Yorkshire and the Humber and North Lincolnshire Council to understand the commissioning intentions of those organisations and the relevance and impact on NL CCG.

The CCG is committed to implementing a new approach to commissioning ensuring that the experience of patients, families and carers are at the heart of our approach driving the way we commission and change services in the future. We also recognise the need for CCG's to lead and engage the whole health and care system in the commissioning process.

In developing this plan, cognisance has been given to the developing health and well-being strategy (HWBS) for North Lincolnshire, to ensure that this plan contributes to the outcomes set out in the draft HWB strategy

The CCG recognises that the resources available to support the health of the population of North Lincolnshire are limited and is therefore committed to make the best use of all resources to improve the health of the population. That will inevitably result in some difficult choices needing to be made.

The CCG is committed to commissioning safe services for our population that meet quality standards.

Signed:

Signed:

Dr Margaret Sanderson, CCG Chair

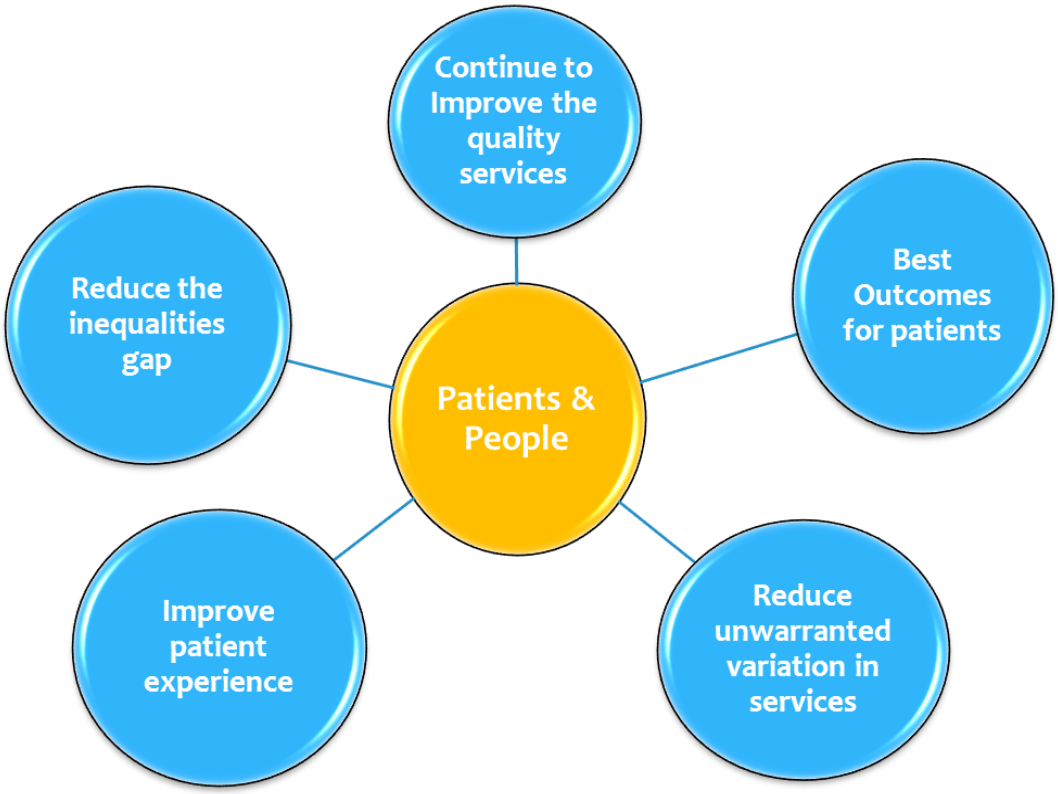
Mrs Allison Cooke, Chief Officer

2.0 North Lincolnshire CCG Mission statement

"To achieve the best health and well-being that is possible, for the residents of North Lincolnshire, within the resources available to the CCG".

2.1 Strategic aims

North Lincolnshire CCG had defined its strategic aims as:



In order to achieve these we will

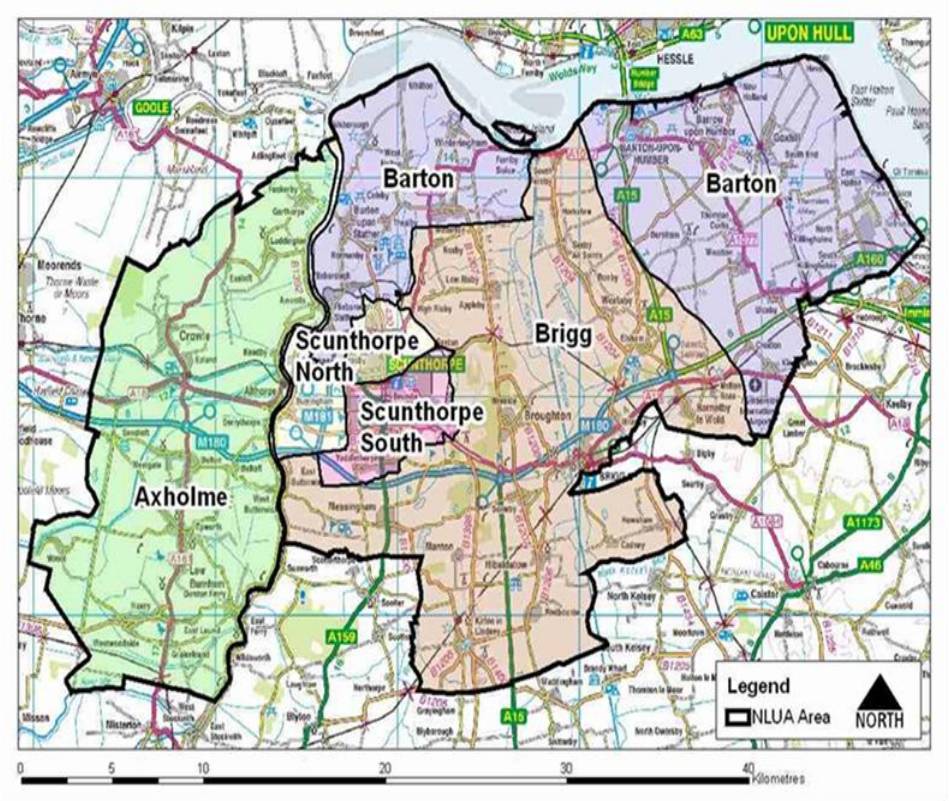
- ✓ Increase effectiveness, efficiency and value for money
- ✓ Tackle waste and duplication across all areas of health care
- ✓ Use the evidence base when commissioning
- ✓ Review services and pathways to streamline them
- ✓ Develop new and existing partnerships across practices and with other health and social care organisations to:
    - Join up services and build on strengths
    - Change culture
    - Influence socio-economic factors
    - Support patient education
    - Support lifestyle changes

2.2 Values

North Lincolnshire Clinical commissioning group have committed within their constitution to the following values;

- Preserve and uphold the values set out in the NHS Constitution
- Treat patients, carers and colleagues with dignity and respect
- Value the input of patients and their carers into the design and delivery of services we commission
- Work with all our Partners for the benefit of North Lincolnshire residents
- Encourage innovation and promote a 'can do' attitude by all, to solve health challenges

3.0 North Lincolnshire health community context



North Lincolnshire CCG comprises 21 practices covering a population of about 167,400 (2012) - an increase of 10% since 2001. It is served by one main acute provider, including Community Services (Northern Lincolnshire and Goole Foundation Trust, NLAG), one specialist acute provider (Hull and East Yorkshire Trust, HEYHT) and one Mental Health provider (Rotherham, Doncaster and South Humber Foundation Trust, RDaSH).
The CCG is coterminous with the Local Authority (North Lincolnshire Council).

The CCG area is geographically large, with more than half of its population living in rural areas. This creates distinct neighbourhoods and localities, each with their own unique characteristics and sense of identity, with different population profiles and needs. For example, the Scunthorpe North locality comprises mainly younger citizens, high levels of rented accommodation, with higher levels of BME residents than elsewhere in the CCG area. Whereas the Axholme locality comprises higher number of more affluent, older people, living in private accommodation, with a higher incidence of long term conditions associated with the older population.

3.1 Key Health Challenges

NL CCG has identified through the development of the Joint Strategic Needs Assessment with North Lincolnshire Council a number of key health challenges

- Smoking in pregnancy and breastfeeding
- Obesity/physical inactivity
- Teen conception rates
- Lung cancer and lung disease
- Premature deaths from cancer,
- Heart disease
- Chronic Long Term Conditions
- Mental health
- End of life care
- Hospital death rates - SHMI

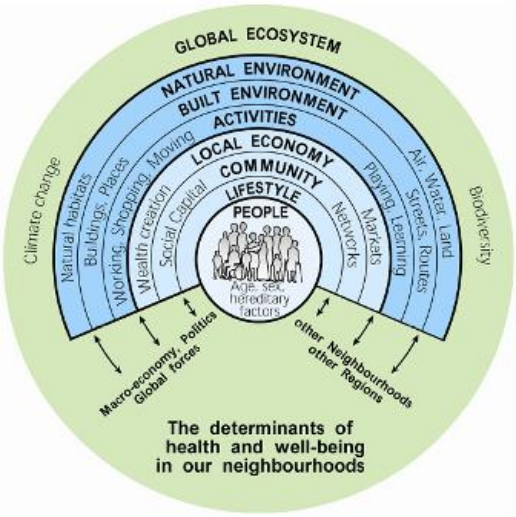
In addition, CCG recognises a number of future challenges which also contribute to shaping the commissioning intentions

- Rising inequalities and widening health inequalities
- Rising prevalence of long term conditions
- Rising complexity and comorbidity
- Shaping the market for home based/personalised care
- Flexibility & choice – equity of access
- Strengthening voluntary and community sector

3.2 JSNA findings

NL CCG recognises that health and wellbeing is the result of a complex interaction of economic, social, cultural, environmental and personal factors, including age, sex, lifestyle behaviours, and hereditary factors, as well as access to effective healthcare.

Figure 1: Wider determinants of health



Source: The Health Map, Barton and Grant, 2006 – based on a public health concept by Whiteread and Dahlgren, The Lancet, 1991

The impact of these factors on individuals and communities can produce differences in health outcomes between different groups. Some of these differences are naturally occurring, such as the difference in incidence of breast cancer between men and women. Others, such as differences in life expectancy between different socio economic groups, are unfair and avoidable, and are referred to as health inequities, (although the term commonly used throughout this document is health inequalities).

These inequities are evident in North Lincolnshire and can be observed right across the life course. The cumulative impact of which is a 10.7 year gap in life expectancy at birth for males, a 9.5 year gap at birth for females, and a 10 year gap in healthy life expectancy. In other words, our most disadvantaged residents are not only more likely to die 10 years before our richest residents; they are also more likely to spend 10 more years in poor health.

This gap in life expectancy is wider than the national average and has not narrowed significantly over the last decade. This is in spite of marked improvements in overall health and wellbeing, and the highest levels of average male and female life expectancy ever recorded in North Lincolnshire.

Life expectancy in North Lincolnshire currently ranges from 71.3 years and 74.7 years for males and females born in parts of Crosby, Town and Brumby wards, to 82.2 and 85.4 years respectively for males and females born in parts of South Axholme and Ferry wards. These differences are mostly avoidable and unfair. There is also a risk that this gap could widen further in the current economic crisis, as the health impacts of recession tend to fall heaviest on the most disadvantaged residents. (JSNA, 2012; http://nldo.northlincs.gov.uk/IAS_Live/jsnahome)

4.0 Contribution to delivery of the Health and Well Being Strategy

The draft Health and Wellbeing Strategy (HWBS) is currently being consulted on by the Health and Well-being Board (HWB). North Lincolnshire CCG, as a member of the HWB has been part of developing the plan and is committed to supporting its delivery. This plan is therefore based on the draft strategy.

The intention of this HWB strategy is to identify the added value of working together to improve outcomes and reduce inequalities, confirm the small number of priorities that we will focus on and set out what each organisation's contribution will be to make the changes happen.

Draft overarching strategic priorities for HWBS

1. **Safeguard and protect** – so that people feel safe and are safe in their home and protected in their community
2. **Close the Gaps** – so that inequalities are reduced across all life stages and all communities
3. **Raise Aspiration** – so that people can access local services and opportunities to help them be the best they can be
4. **Preventing Early Deaths –** so that early detection, prevention and behaviour change linked to the big killers are addressed
5. **Enhance Mental Wellbeing** – so that good mental health and emotional wellbeing enable people to fulfil their potential
6. **Support Independent Living** – so that people are supported and enabled to live independently to achieve improved quality of life

The strategic priorities set out in the Health and Well-being strategy are;

- Address domestic abuse and promote safer communities and safer neighbourhoods
- Address the drivers of family poverty and reduce the impact on families
- Improve life skills for the workforce
- Address social isolation and promote positive communities
- Improve smoking prevention and other causes of preventable ill health
- Support independent living for people with long terms conditions and disabled people through better use of resources

These priorities have been derived from a process of consultation involving a broad number of stakeholders including health and social care professionals, voluntary sector organisations and citizens.

The consultation on the HWBS is currently underway; any changes as a result of the consultation will be taken into account by the CCG as we implement this plan.

Partners have committed that:

1. they will work together for the benefit of the people of North Lincolnshire
2. strategic plans of signatory organisations will set out how the organisation will fulfil this pledge
3. they will consult with local residents including those who may be hard to reach or live in a community identified by the JSNA as vulnerable or in need on the priorities for their organisations
4. member organisations recognise that their staff are often residents of North Lincolnshire and will seek to model support and behaviour that promotes the health and well-being of their staff in line with the 6 strategic priorities of the HWBS
5. member organisations will ensure their staff are aware of the commitment to work together
6. member organisations will be explicit about the actions they are committing to reduce inequalities and increase well-being and will provide evidence on performance and impact

5.0 Development of the plan

As the first commissioning plan of the newly formed and authorised CCG, NL CCG committed to developing a plan with as broad engagement from stakeholders and public as achievable within the timescales. This plan has therefore been developed with input from a wide range of sources and stakeholders.

CCG recognises that there were limitations in its engagement process within this plan, in part due to the concurrent running of the authorisation process and the need to continue to work on the 2012/13 QIPP priorities to support the delivery of the 2012/13 financial plan.
The engagement of stakeholders has also been challenged by the on-going local authority restructuring and the PCT transition arrangements into future organisations. However CCG have used this process as a learning opportunity for future planning cycles, where it is committed to improving and broadening its engagement in the planning cycle to engage more stakeholders and members of the public.

In addition to engagement of stakeholder organisations through a number of established routes and individual meetings, CCG held a stakeholder event on the emerging plan on 22nd January.
The following organisations were invited, with good attendance;

- Carers Support Centre
- East Midlands Ambulance Service
- Local voluntary organisations
- Lindsey Lodge Hospice
- North Lincolnshire Clinical Commissioning Group (CCG)
- North Lincolnshire CCG Council of Members
- North Lincolnshire Council
- Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- Parish & Town Councillors
- Patient Participation Group members
- Representatives from the Polish Community
- Rotherham, Doncaster & South Humber Mental Health Foundation Trust
- South Humber Local Dental / Medical / Ophthalmic & Pharmaceutical Committees
- Voluntary Action North Lincolnshire
- Who Cares (NL LiNKs)

This plan takes into account the clear and credible plan produced in 2012/13 which supported the authorisation of the CCG, which formed a bridge from the PCT Strategic Plans.

5.1 Transformation and QIPP

This plan sets out a vision that forms the basis of transforming the way the population of North Lincolnshire are supported to manage their health and well-being, support them in maintaining their independence but providing safe, high quality care and interventions when they are needed.
The plan for 2013/14 sets out the steps we are takings towards this this year.
Quality, innovation, productivity and prevention (QIPP) is integral to all the CCG does. We consider all changes of the basis of its delivery and contribution to QIPP as part of the prioritisation framework.
The finance section (Appendix A) sets the productivity gain element of QIPP in 2013/14

5.2 Quality and Summary Hospital level Mortality Indicator

The Summary Hospital Mortality Indicator (SHMI) data, published in October 2011 highlighted high mortality rates at Northern Lincolnshire and Goole Hospitals Foundation Trust. A subsequent independent review, jointly commissioned by North Lincolnshire and North East Lincolnshire CCGs in

2012 by Transforming Health Ltd resulted in the development of jointly owned Northern Lincolnshire SHMI action plan. The mortality rate indicator is considered one of a number of quality markers, and therefore full implementation of the action plan is a key priority for NL CCG during 2012/13 and 2013/14.

Commissioners therefore continue to work closely with NLAG and other providers outside hospital to address the high mortality rates and ensure appropriate actions are in place to secure significant improvements in performance. This work includes a range of challenges and performance reviews alongside the delivery of a comprehensive community wide action plan. The action plan is updated regularly through a SHMI Steering Group. NLAG have now been identified as one of the 14 Trusts across the country which will be reviewed by the Chief Medical Officer. NL CCG awaits further details of how this will be undertaken locally.

6.0 Key priorities for 2013/14

NL CCG has identified a number of key priorities for 2013/14 to reflect the population needs set out in the Joint Strategic Needs Assessment and the Health and Well-being Strategy.
Key to the delivery of future year's plans is to work with partners across Northern Lincolnshire to develop proposals to ensure safe and sustainable services. This partnership working will result in the development of a shared vision of a Future Model of Care that delivers partnership with 'Right Care in the Right Place.

This section summarises the key priorities. More detail is included in the sections that describe the impacts of our plans across each life stage. (section 9)

The key priorities for 2013/14 are;

- Improving quality - working with all providers and the Area Team, ensuring response to Francis and Winterbourne reports, supporting Sir Bruce Keogh's review of NLAG.
- Improving the quality of primary care
- Improving mortality and preventing people dying prematurely
- Improving outcomes for people with long term conditions including focusing on diabetes, chronic neurological disorders, circulatory and stroke.
- Improving care at end of life
- Supporting peoples mental health and wellbeing with a particular focus on Dementia and IAPT
- Improving outcomes for children and improved care for women during pregnancy
- Implementing the Urgent Care model including NHS 111
- Support to carers

Stakeholders had the opportunity through the stakeholder event held on 22nd January to discuss the key priorities and identify specific issues in relation to these. Issues identified are covered in the relevant sections below.

- Improving quality

We will work with all providers and the NHS Commissioning Boards North Yorkshire and Humber Area Team to ensure we take actions to respond to Francis and Winterbourne reports and to support Sir Bruce Keogh's review of NLaG. Actions include;

- implementation of the SHMI action plan in conjunction with providers,
- use of CQUINS and KPIs to improve quality, including; Safety Thermometer, quality dashboard, implementation of 6Cs, management of the deteriorating patient, discharge communication
- development of a safety culture specifically within primary care; increasing the reporting of safety issues within primary care, proving meaningful data on quality issues,
- ensuring the CCG governance arrangements for quality and safety across Northern Lincolnshire is well designed to identify, monitor and address quality concerns, including gap analysis to provide assurance against the approx. 89 commissioner actions in the Francis 2 report. Development of an action plan to address identified gaps. NL CCG are members of the recently established NY&H quality surveillance group, led by the area team
- work with stakeholder organisations including the new Healthwatch, and patients to triangulate information to highlight quality issues.
- quality assurance of provider CIP plans
- review of provider action plans in relation to 6Cs when available
- Continue to implement actions to deliver the concordat, which is also monitored via the local Safeguarding Adults Board. Specific actions include; development of an expert group to embed the ethos of the recommendations, continue to work with the local authority. NL CCG is currently recruiting a Safeguarding Adults Designated Nurse across NL and NEL to ensure implementation of the Winterbourne recommendations

- Improving the Quality of Primary care

We will work with the NHS Commissioning Boards North Yorkshire and Humber Area Team to ensure we take actions to ensure high quality primary care. In addition we will work with member practices to understand variation and seek to reduce unwarranted variation. NL CCG will collaborate with North Yorkshire and Humber Area Team to develop a primary care quality strategy which will include understanding variation in experience within primary care. NL CCG will continue implementation of the primary care actions within the SHMI plan. Implementation of Map of Medicine during 2013/14 will support the delivery of consistent patient pathways across primary care.

- Improving mortality and preventing people dying prematurely

We will work with our partners through the Summary Hospital Mortality Indicator (SHMI) Steering Group to implement the action plan developed following the external review, which was conducted in 2012 by Transforming Health Ltd. (see section 5.2)

As part of the Health and Wellbeing Board we will support actions to deliver against the Joint Health and Wellbeing Strategy key priority of preventing early deaths. We will also work with North Lincolnshire Council as they take on their responsibilities for Public Health, addressing prevention and behavioural change, e.g. smoking cessation and maternal smoking.

- Improving outcomes for people with long term conditions including focusing on diabetes, chronic neurological disorders, circulatory and stroke.

During 2013/14, CCG will focus on the following pathways:

- diabetes
- chronic neurological disorders
- circulatory disease
- stroke

CCG will continue the implementation of the long term conditions strategy agreed in 2012 including:

- Additional support for people to self-care, including access to relevant self-management programmes
- Rolling out risk profiling to all GP practices, enabling practices to identify high risk patients and ensure appropriate care plans are developed in conjunction with the patient
- Making decisions about the use and roll out of telehealth, to ensure that where evidence demonstrates benefits to patient outcomes, telehealth is utilised effectively.
- Embedding the 5 locality based integrated health and social care teams that will be in place by April 2013. This will build on the work to date to ensure the teams work effectively to improve patient outcomes and maximise independence.

We will also implement the outcomes of the Experience Led Commissioning review underway in relation the outpatient experience for those with long term conditions to ensure services are commissioned in a way that meets their needs.

- Improving care at End of Life

CCG will implement the outcomes of the Experience Led Commissioning review of End of Life services underway. We will also work with Northern Lincolnshire and Goole Hospitals Foundation Trust and partners, including Lindsey Lodge Hospice, to implement a new model for specialist palliative care to support a move to Improving Outcomes Guidance (IOG) compliant services and to increase the number of people enabled to die in their preferred place of care, by commissioning

increased home care capacity. This model will also support improved patient and carer experience, with better co-ordinated and integrated care and reduced use of agency staffing.

- Supporting peoples mental health and wellbeing with a particular focus on Dementia and IAPT

CCG will continue to work with partners to implement the North Lincolnshire joint dementia strategy and action plan agreed in 2012 as part of which we aim to increase dementia diagnosis rates. CCG have also identified increasing dementia diagnosis rates as a local quality premium. This increase in diagnosis would identify people at an early stage of disease, enabling appropriate diagnostics and treatment planning, and planning of appropriate support to carers. This support to carers is reflected in the joint Carer action plan (http://www.northlincolnshire.nhs.uk/documents/download1613.aspx), agreed with the local authority. As dementia diagnosis rates increase, CCG will monitor and review the services it commissions to respond to the needs of those with dementia and their carers. This will ensure the commissioned services deliver a high level of quality, supporting the implementation of actions within the SHMI action plan.

We will continue to commission Improving Access to Psychological Services (IAPT) in line with national models, working with our provider RDASH to increase the proportion of people entering treatment, and to improve waiting times from referral to treatment

We will continue our work with partners to implement the joint autism strategy and action place agreed in 2012. Key actions in 2013/14 include asset mapping and development of an autism pathway. Actions in 2014/15 will include review of specifications to ensure outcomes identified within the pathway are delivered and development of joint initiatives in line with best practice.

- Improving outcomes for children and improved care for women during pregnancy

We will develop our approach for children in relation to long term condition management, particularly focusing on the better management of asthma, diabetes and epilepsy in 2013/14, reducing the incidence of hospital admission.

We will commission a revised ADHD pathway to ensure an integrated pathway, with smooth transition from children's to adult services

We will continue to work with NLAG to ensure maternity services deliver to national requirements including implementing the maternity tariff in 2013/14

NL CCG will support the planned research into women's experience of maternity booking, examining the reasons for late booking. It is expected that the findings of this research will support improvements in maternity outcomes through early identification and management of complex pregnancies.

- Implementing the Urgent Care model including NHS 111

CCG approved a new model for urgent care in 2012/13 and is currently working towards implementation of the integrated Emergency Care Centre, which will focus on ensuring patients are seen by the most appropriate clinician in a timely way. The model integrates primary care clinicians and A/E clinicians, and will also integrate with NHS 111 incorporating a local single point of contact and transfer point for NHS 111 calls requiring referral into local services. The redesign of the urgent care pathway will support actions to improve mortality rates, ensuring patients are assessed by the most appropriate clinician, with senior decision makers at the front end of the pathway.

- Support to carers

We will continue to work with the Carers Partnership to increase support to carers in line with the agreed carer's action plan. The action plan will be further reviewed against the findings of some current research with carers to ensure the plan continues to reflect the identified needs of carers.

6.1 Prioritisation framework

NL CCG has developed this plan based on known local commissioning issues, best practice and identified benchmarking opportunities. CCG also recognises that new issues and opportunities will arise in year which may require us to review our plans. CCG has utilised a prioritisation framework in the development of this plan and will ensure it prioritises the areas of most importance by considering all proposals against the following criteria;

- Contribution to strategic aims
- In line with values
- Contribution to moving us towards the 'future models of care'
- Contribution to key priorities
- Contribution to delivering NHS Outcomes Framework
- Contribution to addressing JSNA and JHWS priorities
- Relative impact on elements of value – quality, spend, patient outcomes (QIPP)
- Capacity required – managerial and clinical to both take forward and implement

6.2 Quality premiums

The NHS Commissioning Board has published a CCG Quality Premium (NHS CB; Quality Premium, 2013/14 Guidance for CCGs. Draft -December 2012;) to be adopted by all CCGs. This sets out how the premium will be calculated, based on outcomes in 2013/14 (NHS Outcomes Framework and CCG indicators) and will be paid to CCGs by the NHS Commissioning Board in 2014/15. There are four national measures that all CCGs will be measured on and CCGs have been asked to identify three local measures.

NL CCG identified a list of potential quality premiums which reflect the priorities outlined within this plan, and used the following criteria to assess suitability as a quality premium;

- Fit with CCG key priorities
- Achievability – payment will be judged on outcomes in 2013/14 as against 2012/13 and therefore require actions to be already planned or coming to fruition which are likely to impact on the measure
- Fit with the Joint Health and Wellbeing Strategy Strategic Priorities being consulted on

The three local measures identified have been identified with consultation with the Shadow Health and Wellbeing Board and with key stakeholders including patient and community representatives. 6 areas were proposed to both forums and the three proposed selected by the CCG Council of Members taking account of views.

Proposed local quality premium priorities;

1. Improving dementia diagnosis rates
2. Reducing emergency readmissions
3. Increasing thrombolysis rates for stroke patients

Improving dementia diagnosis rates

Data produced by the Alzheimer's Society (Jan 2013) showed a local diagnosis rate of 40.7% (based on QOF 2011/12) and the CCG Dementia Prevalence Calculator, against a national average of 46%. NL CCG has therefore set an ambitious target to achieve a 44% diagnosis rate by end 2013/14 ad 50% diagnosis rate by 2014/15. The increase in diagnosis rates should identify those at an early stage of disease. There is investment identified within the carers' action plan to support carers, and this is being reviewed to ensure plans are in line with the recent research into carer needs. Investment is also being made in 2013/14 to develop a Dementia Academy in conjunction with the Local Authority, to raise awareness and provide training for carers.

In addition, NL CCG will commence work in April 2013 to explore people's experience of dementia services and co-design a new model of service to ensure this meets the needs of people within North Lincolnshire.

Reducing emergency readmissions

NL CCG recognise that whilst the overall position on emergency readmissions compares favourably against its peers, the data also demonstrates significant opportunity for improvement in readmissions associated with COPD and epilepsy. NL CCG has therefore set a local quality premium target to reduce readmissions by 2% in 2013/14. Actions are set out within this commissioning plan which describes the service developments relation to these conditions. NL CCG will also ensure through the Service Delivery plans within the contract, that the local acute provider undertakes a clinical review of readmissions to inform service improvements to reduce readmissions.

Increasing thrombolysis rates for stroke patients

There has been significant work undertaken by NLAG to improve stroke care in line with stroke accreditation, and there is a shared stroke action plan. However, recent data (Oct –Dec 2012) shows that only 8% of patients receive thrombolysis, compared to a national average of 11%.The local quality premium will support NL CCG in ensuring change of practice is embedded within the hospital setting, improving outcomes for stroke patients.

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7.0 Sustainable Services

North Lincolnshire CCG is working closely with North East Lincolnshire CCG, North Lincolnshire Council and health providers in Northern Lincolnshire, particularly Northern Lincolnshire and Goole Hospitals Foundation Trust, to undertake a review of health and social care services across Northern Lincolnshire. The aim is to ensure that we design services that;

- Raise the quality of services for our patients
    - Overall quality of care
    - Improve SHMI / mortality rates
- Create care pathways with lower overall cost
    - Support sustainability as demand increases
- Develop the relevant inputs to meet time-critical business planning
    - Support short-term constraints for providers

Key principles agreed by all partners for the review include

- Improves overall quality & outcomes
- Increased prevention & enabling people to self-care
- More services provided in the community, closer to the patient
- Provide 24/7 access to the right level of care or advice
- Deliver a more "integrated" service across providers
- Reduce demand for hospital-based specialist acute care
- Provide specialist acute care at a minimum national scale to ensure safe services

The governance for the review is through a tripartite management group (CCG's and NLAG) supported by a Clinical Stakeholder Board led by Hugo Mascie-Taylor as independent chair.

The timeline for the review is to support engagement with the population of Northern Lincolnshire, frontline staff, GP's, MP's, Councillors etc. during the summer of 2013 to establish changes required and to support a full public consultation should that be needed to take place in the autumn 2013.

As part of this review the NL CCG has described its vision for future models of care which seek to ensure sustainability, providing the right care in the right places to meet patient needs.

The principles underpinning the model are

- Improved outcomes
- Educated patients/self-care
- Right care right place right time
- Primary care of outstanding quality
- Appropriate care 24/7 across the system
- Consistent outcomes 24/7
- Shared decision making - co-production
- Health and social care 1 stop shop in the community
- Concentrate expertise where appropriate
- Specialist model of in-reach rather than outreach
- Care as close to home as possible where it's safe and cost effective to do so
- Make every contact count

The diagram describes a model that seeks to ensure

- Consistent patient focused care
- Empowered patients and public (supported by patients holding the record)
- Services tailored around the patient

It seeks to streamline the patient journey and therefore reduce

- Confusion
- Duplication
- Gaps in services and care
- Lack of consistent 24/7 response

The model describes services across 5 levels

- Level 1 – services accessible across all North Lincolnshire Communities to all residents but not necessarily based in every community
- Level 2 – services organised on a locality basis across the 5 areas of North Lincolnshire to provide care close to home where increased support is required above level 1 and it is safe and cost effective to do so
- Level 3 has been split into 2 parts A and B but both reflect services that would generally be provided once across North Lincolnshire , they may or may not be provided at the same location
    - 3a reflects the response to urgent care needs
    - 3 b reflects those services requiring a 24/7 nursing and medical access
- Level 4 – services that require 24/7 specialist medical care with consultant cover. These may not always be provided within North Lincolnshire but will need to be accessible to our population

Level 5 – services that are defined as specialised, including those often referred to as tertiary and will be only be accessed by a very small percentage of the population. These should be provided in

specialist centres that meet national service specification requirements. Where possible and appropriate services in North Lincolnshire should be working with specialist centres to ensure that patients are able to be repatriated to Levels 4, 3b and 2 at an appropriate point in their patient pathway, which may include rehabilitation and follow up

8.0 Commissioning Plan; cross cutting themes

This section of the plan sets out our intentions for 2013/14 and beyond, and identifies in section 10.1 how these plans link to the national priorities and frameworks. The plan reflects the life stages set out in the JSNA and the Health and Wellbeing Strategy. In addition, this section sets the commissioning plan against the context of Right Care, Right Place as the overall commissioning intention and model of future care.

Implementation of Right Care, Right Place will be delivered over the next 3-5 years, however elements of the model will be delivered in 13/14, with the ground work done during this period to support delivery in future years.

8.1. Quality

Delivery of improvements as set out in the five domains of the NHS Outcome Framework (including compliance with NICE quality standards) and quality indicators in the Operating Framework will be demonstrated principally through the delivery of the NL Commissioning Plan. To support effective service development, CCG will undertake quality impact assessments on all change schemes initiated by both commissioners and providers. The process and methodology for undertaking these assessments is currently being finalised.

Each element of the commissioning plan is aligned to an outcome domain or priority area as set out in the Outcomes Framework thus achieving an organisational focus on quality improvement. The delivery of the programme will continue to be closely monitored, key risks to delivery identified and progress monitored with the use of a dedicated risk register. NL CCG will also review plans to ensure where NICE quality standards exist, these are incorporated into delivery plans. Initial work, in conjunction with NICE implementation team and supported by the CSU will focus on Dementia and the new NICE quality standards due for release on 2nd April 2013

NL CCG is also working in partnership with other local commissioners is developing a range of CQUINS to support delivery against the outcome domains. For example:

Preventing people dying prematurely

As set out in section 6, the Summary Hospital level Mortality Indicator (SHMI) report highlighted high mortality rates at Northern Lincolnshire and Goole Hospitals Foundation Trust. Commissioners therefore continue to work closely with NLAG to address the high mortality rates and ensure appropriate actions are in place to secure significant improvements in performance. This work includes a range of challenges and performance reviews alongside the delivery of a comprehensive community wide action plan.

A CQUIN focussing on embedding the use of National Early Warning Score (NEWS) is being negotiated to improve responsiveness to the deteriorating patient and one based on a stretch to the National Patient Safety Thermometer are being developed. These CQUINS will support the wide range of actions that are being implemented by NLAG and commissioners to reduce mortality rates.

Specific assurance is being sought in relation to clinical performance at Goole Hospital following clinical reviews undertaken as part of the mortality review programme.

The development of enhanced performance monitoring frameworks and regular reporting to the CCG Quality Group and CCG Governing Body will continue supported by the use of the Board Assurance Framework.

Ensuring Quality of life for people with Long Term Conditions

CQUINS are being developed around care bundles to secure service improvements. These include the introduction of a respiratory care bundle with NLAG and continuing for a second year with the pneumonia care bundle for HEY (with a further stretch on trajectories)
A CQUIN is being proposed for our Mental Health Service provider (RDASH) to add a stretch to improve the number of individuals in recovery and exiting their treatments successfully, and a further CQUIN to support improved transition for CAMHs services.

Ensuring people have a positive experience of care

A range of CQUIN‟s are being developed with local providers to further enhance positive experience of care, building upon previous satisfaction targets. This will include a CQUIN on improving hospital discharge planning and a continuing focus on the use of more ‘real time’ patient experience monitoring. Regular reports will continue to be considered by both the Quality Contract Groups and the CCG Quality Group.
NL CCG is also negotiating a CQUIN to support implementation of Compassion in Practice within providers.

In addition, a CQUIN to embed the use of Experience Led Commissioning (ELC) is being developed for use with NLAG and RDaSH, which will provide protected time for ELC practitioners and front line staff to deliver projects in conjunction with the CCG, and to ensure the outcomes from these projects are implemented within the relevant organisations.

Treating and caring for people in a safe environment

A range of CQUINS and KPI's are being developed to support people in a safe environment including one targeted at improving discharge arrangements at NLAG and a further one relating to data on ward staffing levels at NLAG, requiring NLAG, under the duty of candour, to publish information on staffing levels, how they are set and monitored.

NL CCG will continue to monitor via the Quality Group, provider performance against the Healthcare Acquired Infection targets to minimise the number of patients developing healthcare acquired infarctions, and ensuring root cause analyses are completed and action plans developed.

8.2 Quality Impact Assessments and Workforce

The Quality Impact Assessment of Provider CIPs will require a multi-disciplinary approach that links quality & assurance, workforce and contracting. The process and methodology for undertaking these assessments is currently being finalised.

The application of the National Workforce Assurance Framework will be critical in order for commissioners to secure the necessary assurance from providers about the level of current and predicted workforce.

This will Include the monitoring and correlation of performance (activity & financial) against submitted workforce plans and their consideration of productivity, service quality, patient safety, patient experience and affordability.

The development of a key set of robust and relevant workforce KPI's will be a priority in assessing the impact of CIP's and for monitoring the critical contribution of workforce to the safe delivery of quality services that underpin 2013/14 contracts .

These will include;

- Staff in post by whole time equivalent (wte) and headcount
- Ratios of qualified to unqualified staff
- Age / retirement profile and subsequent succession plans
- Vacancy rates and recruitment strategies

- Sickness absence rates and mitigating actions
- Locum, bank and agency spend
- Appraisal systems and processes i.e. percentage of staff having an annual performance appraisal and personal development plan
- Compliance rates for statutory and mandatory training
- Staff survey findings and subsequent action plans
- Evidence of transparent systems, processes and support for raising concerns

It is essential that workforce indicators and any subsequent monitoring of information is triangulated with quality and contracting to ensure that there is a whole systems approach to the quality impact assessment of providers and their services.

Aligning workforce planning and the commissioning of education and training to business planning is a key component of the multi-disciplinary assessment described above. In light of the Winterbourne View and Francis reports and any subsequent recommendations commissioners will need assurance of specific workforce standards and requirements which can then be embedded into Contracts for both NHS and non-NHS providers.

8.3 Risk & governance

The CCG has an agreed risk and governance framework. Central to its management of risk is the Board Assurance Framework (BAF), which has been developed with the support of the CSU. The BAF consists of the highest rated risks identified by the CCG and is regularly reviewed by the governing body, the audit group and the quality group. The current BAF identifies risks rated 12 and above and has been developed with the involvement of the Council of Members, Governing Body and internal audit. A register sit beneath the BAF that identifies lower rated risks that are reviewed regularly by senior officers and if appropriate, are escalated onto the BAF.

The CCG has an approved risk a management strategy in place that identifies staff responsibilities for risk management and the process for the identification, grading and management of risks.

Assessment of current provider performance highlights A/E 4 hour waits as a high risk in 2013/14. Actions are being implemented in 2013 to address this risk in the short term, however the implementation of the urgent care model will address this risk, by providing an integrated urgent care centre, where patients are managed by primary care clinicians where appropriate, and Ambulatory Emergency Care models are utilised to manage patients in the community where it is safe to do so. The implementation plan, using a phased approach is being developed in conjunction with the providers. The model will be underpinned by a single contract and a joint management board including GPs and NLAG.

Delivery of ambulance turnaround times in 2013/14 is considered a risk at this stage of planning, but will be addressed by including within the contract the requirement of East Midlands Ambulance Service to deliver this.

8.4 Community Engagement

The CCG believes the only way it can succeed in delivering high quality services for the community and improving the health of our population is by involving members of the public, partner organisations and member GP practices in the development of services.

It aims to create a culture where local people are armed with the power and knowledge to get involved, participate in and meaningfully contribute to debates about how investment is prioritised. North Lincolnshire Clinical Commissioning Group (CCG) has adopted Experience Led Commissioning (ELC) as its operating model for clinical commissioning so that people's experiences drive the commissioning process. ELC uses active input from patients and carers, frontline staff, user representatives, service providers and clinical commissioners to improve and redesign services.

NL CCG will encourage GP practices to gather insights through Patient Participation Groups (PPGs). The CCG is developing links with these groups through the CCG Board lay representative lead for engagement. PPGs have opportunities to influence at both individual practice level and CCG level through their practice representative on the Council of Members.

In addition, NL CCG will continue to work closely with key stakeholders, including the Health Scrutiny Panel, the Health and Wellbeing Board and the newly commissioned Healthwatch North Lincolnshire.

Five long-term objectives for communications and engagement will support this approach:

1. Have a community that is well informed and interested in its own health
2. Ensure our partners and other key interested parties are kept informed.
3. Effectively engage and communicate with member practices
4. Have supported and well-valued staff who are well informed and engaged
5. Actively engage with local providers and secondary care clinicians

NL CCG plans to redesign Dementia services utilising the ELC approach during 2013/14, but will seek to utilise the ELC approach in all its commissioning plans to ensure they reflect the needs of patients**.** This will include using the ELC approach to some of the engagement on ‘Right Care Right Place’.

8.5 Variation in patient experience within primary care

NL CCG has three relationship managers who each work with seven practices to support them in performance management, pathway development and reducing unwarranted variation. Each relationship manager covers practices within a locality, enabling them to understand specific needs of localities and share best practice between practices. Practices are developing inter-practice agreements which will define the ways in which practices will hold each other to account. We will work to improve consistency of response to patients through working with member practices to share good practice, compliance with agreed pathways, and make best use of alternative services. Patients should be able to expect the same experience regardless of the practice they register with.NL CCG will implement Map of Medicine during 2013/14, which will support the delivery of consistent pathways within primary care.

8.6 Urgent care

In addition to the implementation of NHS 111 in March 2013, NL CCG has agreed a model for delivery of unplanned care which focuses on managing people in their community setting wherever this is clinically safe. This reduces the need for people to be admitted to inpatient beds and maintains independence as much as possible. NL CCG has, within the unplanned care model specified the use of Emergency Ambulatory Models to care for a broad range of patient pathways, which are evidence based. NL CCG will continue to work with the current provider to ensure the implementation of the unplanned care model, early in 2013/14.

Current service providers were engaged in the development of this model along with other key stakeholders such as the local authority, ambulance service and mental health provider. As such, there is good support for the model across the health and social care economy. This model will integrate current A/E services with GP Out of Hours services and walk in primary care access. The service will interface directly with NHS 111 via the local Single Point of Contact. The specification for the urgent care service was developed along-side the developing NHS 111 specification to ensure full integration between the two services. Both services will utilise the same Directory of Service (DoS), ensuring patients are directed and managed in the most appropriate setting, by the most appropriate clinician.

Where people develop conditions which require prompt medical intervention, outside the scope of primary and community nursing care, they will be seen locally within the Emergency Centre of the local District General Hospital. The focus within this setting will be to ensure people are treated by the most appropriate clinician, educated and accurately assessed for suitability to be managed on an Ambulatory Care Pathway, which enables them to be managed within their home setting. The new model incorporates a range of key performance indicators on the use of ambulatory models.

An essential component of the model is a Clinical Decision Unit, which will provide an area of clinical assessment and diagnostics to support decision making. Prompt access to diagnostics is essential to the prompt diagnosis and management of the acutely ill patient, supporting the provider in getting the patient on the appropriate pathway and discharged to community care at the earliest opportunity.

Implementation of this model will result in a reduction in the number of non-elective admissions accompanied by patients remaining in the Clinical Decision Unit for short periods of time whilst undergoing assessment and planning of ambulatory care. The model will also support a reduction in the number of people accessing long term care in a care home by ensuring patients maintain their independence, supported by short lengths of stay and input from the integrated locality team. This will ensure that as many people as possible are able to return to their own home, with appropriate support to live independently.

Alongside the implementation of the urgent care model, the development of the Major Trauma Network will move into phase 2 from April 2013.This will see all major trauma cases transferred directly from scene to a major trauma centre where travel time is less than 45 minutes. In cases where travel time exceeds 45 minutes, patients will be stabilised at a local trauma unit, prior to transfer on to a major trauma centre.

NL CCG will continue to work with the NHS Commissioning Board to support the implementation of the hub and spoke model for Yorkshire and the Humber. NHS Commissioning Board is responsible for the commissioning of major trauma centres which for North Lincolnshire residents will usually mean Hull Royal Infirmary for adults and Sheffield Children's Hospital for children. The CCG is responsible for commissioning Trauma Units; Scunthorpe General Hospital locally. Providers will work together through an Operational Delivery Network for Major Trauma to integrate care.

Key actions for 2013/14 relating to this will include the development of a repatriation policy for transfer of patients from the major trauma centres back to the local trauma unit once the patient is deemed medically fit for transfer, and the development of a rehabilitation pathway to ensure patients get appropriate rehabilitation for their needs, improving patient outcomes and long term independence.

8.7 Ambulance services

NL CCG contracts with East Midlands Ambulance Service for both emergency and patient transport services. EMAS performance against both response and handover times is challenging. Delivery of the ambulance handover targets will be incorporated into the contract, however CCG is not the lead commissioner for this service and is therefore engaged with other commissioners to ensure incorporation of the target and financial penalties for non-delivery is within the contract. NL CCG has

committed additional funding in 2012/13 to improve handover times, funding a HALO post within Scunthorpe Hospital.

NL CCG will continue to closely monitor performance and quality of service delivered by EMAS and will assess benefits of commissioning directly rather than via led commissioner arrangements.

9.0 Plan across the life stages

9.1 Starting well

The implementation of the PbR pathway tariff for maternity services from April 2013 will support the local provider to deliver services in a way which best responds to women's needs, and enables them to focus on the early management and prevention of complications of pregnancy, thus improving maternity outcomes. Smoking status at time of delivery is still significantly higher in North Lincolnshire at 19.38% compared with 13.52% (England average). Smoking rates at delivery is one of the main priorities within the Health and Well-being Strategy, and NL CCG will work with the local authority to reduce smoking rates during pregnancy.

NL CCG expects that whilst the implementation of the pathway tariff will support Trusts to redesign the delivery model, NL CCG expects that in doing so, quality of care is at least maintained and where possible increased.

9.1.1 Care across communities

The CCG models of care describe a model where the majority of women access their pre conceptual care within the community setting, close to home. There are few notable exceptions to this, e.g. women with diabetes, whose pre-existing medical condition means that in order to ensure the best outcome, they require specialist medical care in the pre-conceptual period.

In line with the draft Health and Well-being Strategy, CCG aims to ensure that women planning a pregnancy manage their own health well pre-conceptually, and identify their pregnancy at an early stage to enable on-going clinical assessment and management. This means that they are supported and can access a variety of public health initiatives such as smoking cessation and weight management pre- pregnancy and during pregnancy which will contribute to positive birth outcomes. These aims will be delivered in conjunction with partner agencies such as the local authority following the transfer of the public health function to the local authority in April 2013.

NL CCG is commissioning research into the views of pregnant women on current maternity services The principal objectives of this study are to increase our understanding of what would help more pregnant women in Northern Lincolnshire, including younger women in disadvantaged groups, and those from BME communities to

- access maternity services as early as possible in their pregnancy
- adopt healthy behaviours in pregnancy and
- specifically for women who smoke and/or are exposed to smoke during pregnancy, what they think would help them to quit, avoid passive smoking pre and post delivery

Routine antenatal care will be delivered within the community setting in conjunction with the midwifery team, with the aim of identifying early those complex pregnancies which may need specialist input. North Lincolnshire has commissioned specific support services for young mums, to improve pregnancy outcomes and improve child development during the early years. Work in 2013/14 will focus on improving access to parenting support antenatal and postnatal, and improved access to services by 12 weeks 6 days of pregnancy.

NL CCG expects those women with additional needs to be identified early on the pregnancy pathway and referred to appropriate services such as the family nurse partnership team – a team who support first time mums under the age of 20 years.

CCG will work closely with North Lincolnshire Council and NHS Commissioning Board in ensuring children get the best start in life by reducing maternal smoking, increasing breast feeding and immunisation rates. It will continue to work with the Maternity Services Liaison committee to ensure the user voice is heard and able to influence service developments.

9.1.2 Care within localities

Those women requiring additional support during pregnancy and the early years should be supported within the locality, either within their home setting or local community setting. The Family Nurse Partnership will bring socio-economic benefits as well as improved pregnancy outcomes as these young women are supported to become economically self-sufficient as well as to improve their health and the health and development of the child.

CCG will work with providers to develop the model of care to ensure this is sustainable across Northern Lincolnshire to provide access for community births for non-complex cases. Whilst such births can be managed within Midwifery led units and in patients' own home, access to Consultant led facilitates are required should the birth become complicated.

In light of the green paper; Support and aspiration: A new approach to special educational needs and disability - A consultation, CCG will ensure children with disabilities receive appropriate assessment and education, health and care plan to ensure an integrated approach to assessment and care

planning. An action plan for implementation will be developed in conjunction with the local authority and education

9.1.3 Specialist Medical care

CCG will commission safe midwifery services which provide access to consultant led services where required. The services required will include access to consultant led outpatient appointments and assessments to urgent admissions for delivery, either expected or because of complications.

There will be a small number of patients who require specialist facilities and care for more complex pregnancies, with tertiary care requirements for highly complex pregnancies. The majority of these will be identified at an early stage of pregnancy and therefore planned for.

NL CCG will continue monitoring of maternity quality issues following recent untoward incidents to ensure root cause analysis is completed and actions implemented to prevent recurrence.

CCG will continue to commission access to hospital services to meet the needs of the acutely ill child, working with tertiary providers in line with national guidance to ensure the best outcomes.

Key actions

Intentions	Timescale	Outcomes
Implementation of national tariff for Maternity services	April 2013	Improving women and their families experience of maternity services
Review maternity services to be clear on the future model of care		Services commissioned in a way that best meets the needs of the population to maximise safety and quality within available resources
Develop action plan in response to research on maternity services	December 2013	Services commissioned in a way that meets needs of women, increasing early booking of pregnancy, improved pregnancy outcomes, contributing to bringing still-birth rate to national average
Development of a joint action plan across health, social care and education to deliver an integrated approach to care planning for children with disabilities		All children with disabilities have an integrated assessment and care plan

9.2 Growing well

9.2.1 Care across communities

The JNSA highlighted a lack of formal pathways into adult services for people with autism or Asperger's Syndrome. CCG will work with partner organisations to develop pathways in line with the agreed Autism strategy for Adults (2012) to ensure people with autism transition safely from children's to adult services.

CCG is required to implement personal health budgets by 2014; therefore key actions within 2013/14 will be development and implementation of an action plan for delivery. In addition CCG will review wheelchair and equipment provision, moving towards 'Child in a chair in a day', and ensuring access to appropriate equipment to need the needs of children and young people to maximise their independence.

9.2.2 Care within localities

CCG will continue to commission a CAMHs service and will assess the need for a local CAMHs service for children and young people with learning disability to reduce the number of out of area placements for this group of people. CCG are in the process of reviewing the ADHD pathway and service specification in relation to the prescribing and monitoring of ADHD medication. This work will continue into 2013/14.

CCG will work with the local authority to ensure a responsive service to Looked After Children, including CAMHS, medical nursing advice and support to fostering and adoption. This will include review of funding in line with access to specialist services out of area and 'responsible commissioner' guidance.

9.2.3 Urgent Care

Children and young people will access urgent care through the new urgent care model described in section (8.6). There is already an established model for assessment of children and this is incorporated into the new urgent care model. This supports a period of specialist assessment and observation without the need to admit the child, and facilitating an early return home where clinically appropriate.

9.2.4 24/7 Medical and nursing care

NL CCG will review current services, revising specifications where required for diabetes, epilepsy and asthma, particularly to address variation in outcomes across the pathway. This will also cover a review of the paediatric nursing specification, and expanding this to include palliative care and end of life care.

Key actions

Intentions	Timescale	Outcomes
Developing approach for children in relation to LTC management, including review of wheelchair and equipment provision and 'child in a chair in a day'		Commissioned services reflect the NICE quality standards where these are available. E.g. Epilepsy in children. Increase in proportion of children receiving a wheelchair in a day
Commission a revised ADHD pathway	December 2013	Revised service operational by December 2013

9.3 Living and working well

9.3.1 Care across communities

Preventing premature deaths
The JSNA identified higher than average rates of adult obesity, adult smoking (smoking prevalence in adults is still significantly higher at 23.5% compared with 20.7% (England average)) and physical inactivity

There are significant social inequalities in take up of adult cancer screening amongst disadvantaged groups. Deaths from all cancers (in the under 75's) is reducing, though at 122.05/100,000 it remains higher than the England average. There are above average death rates from smoking related diseases including lung cancer and chronic lung disease, which contribute directly to lower than average male life expectancy and a 10 year gap in life expectancy between 10% richest and poorest residents. There is rising lung cancer incidence and premature deaths amongst women which threaten to widen the social gap in female life expectancy. In addition there is rising alcohol related diseases, deaths and admissions to hospital.

CCG will support and work with the local authority Public Health team and NHS Commissioning Board and all providers to promote awareness of screening programmes for relevant patients, particularly in relation to cancer screening. This should result in an increased uptake of screening

programmes in the relevant age groups, leading to earlier detection and treatment, and improved outcomes. One of the priorities of the Health and Well-being strategy is to reduce smoking prevalence, and the CCG will work with the local authority to support this plan through primary care and all its providers.

Managing long term conditions

Many people of working age within North Lincolnshire have a long term condition, which with good self-management and early intervention will not prevent them from continuing to work. NL CCG aims to maximise a productive quality of life of people with long term conditions, and to support this, CCG aims to deliver as many services as practically and safely possible, close to its communities, focussing on supporting people to maintain a healthy life and support them in managing their own care.

People will be encouraged, supported and equipped to self-care, with access to a variety of self-management programmes to meet their needs. Support to people with long term conditions will be available through their local pharmacist who will offer medication reviews and assessment and guidance in inhaler technique for respiratory patients and General Practice; who will offer a broad level of primary care services and long term condition management.

9.3.2 Care within localities

For people requiring referral to secondary care services, the CCG will work with the local secondary care providers to commission 'advice only' referrals, enabling GPs to seek specialist advice to appropriate action without necessarily requiring a hospital assessment. This, coupled with ensuring follow-up is minimised to that where there is a clear and documented clinical need which requires specialist input, will ensure patients feel the value of hospital visits and improve patient experience, whilst delivering services in the most cost effective manner. This will support the delivery of the financial plans of both commissioner and provider organisations.

Recognising that for a number of patients, on-going specialist assessment and monitoring will be required, CCG will ensure that where clinically appropriate, patients will be assessed without the requirement to travel, i.e. non face to face contacts. This will require utilisation of a number of means including telephone contact, tele-monitoring and telemedicine. This brings potential benefit to a large number of people, reducing the need to travel, particularly benefitting those in rural areas

CCG will also commission more community based services, making them accessible to those who work and who would otherwise need to take time off work to attend hospital appointments. We will work with providers to implement plans for delivery of services seven days per week which reflect patients' needs. This will increase accessibility and support patients to access healthcare proactively.

Learning disabilities

CCG will work with the local authority to complete actions relating to the Winterbourne View report as set out in the Concordat. CCG will complete the review on all patients currently in out of area placements and by April 2014, ensure a joint plan is in place with the local authority to ensure high quality care and support services for all people with learning disabilities, autism, mental health conditions or challenging behaviour, in line with best practice

Mental Health

2013/14 will see the introduction of PbR tariff for mental health. Implications in 2013/14 are being managed through an income and expenditure agreement.

NL CCG recognises that mental health and wellbeing is an essential component of ageing well, and that people with long term conditions and often growing social isolation have mental health needs. The CCG will work with partners to ensure that all services commissioned for people with mental illness are in line with the Department of Health Framework for Mental Health - No Health Without Mental Health.

People within North Lincolnshire have access to psychological support through Improving Access to Psychological Therapy (IAPT) services. Whilst IAPT services have already been implemented within North Lincolnshire, with 15% of the population entering treatment, there are local concerns regarding waiting times for the current service. We will continue to commission Improving Access to Psychological Services (IAPT) in line with national models, working with our provider RDaSH to ensure access is maintained and to improve waiting times from referral to treatment. We have set a focus on those people with long term conditions throughout 2012/13 and this will continue into 2013/14.

CCG will continue to work with its partners, through the Autism Partnership Board to implement the agreed autism strategy and action including addressing transition from children's to adult services. Work in 2013/14 will focus on asset mapping and development of an autism pathway.

Pathway specific plans;

CCG will review current provision of adult diabetes services and how these can be delivered within a community setting. CCG recognises that the number of people with diabetes is growing and many of these are people of working age, often with young families. The CCG will develop a diabetes pathway which best meets the varying needs of the diabetic population, encouraging self-management, providing clinical management within their locality and ensuring patients are not

managed within a hospital setting for longer than clinically required, enabling them to be discharged to the care of their own GP for on-going management with a clear treatment and escalation plan.

During 2013/14, NL CCG will complete the scoping of a community based urology service, managing a wide range of urological procedures within a community setting, and reducing the number of patients having to attend a hospital site for outpatient assessment and management. This will improve ease of access and patient experience, bringing care closer to the patient, whilst supporting the acute provider to implement their facilities plans.

During 2012/13, NL CCG has taken forward the procurement of a community based pain service under Any Qualified Provider, due to commence in April 2013/14. This is expected to offer a range of providers for patients, offering a holistic multi-disciplinary approach to pain management. This plan has been developed in direct response to patient and clinician feedback on the current services available. In addition, CCG plan to commission a Musculo-skeletal service during 2013/14, with a requirement that the providers work together to ensure an integrated pathway where patients move from one provider to another. This integrated pathway will ensure seamless transfer between providers, resulting in improved patient experience, consistent information to patients and reduced duplication of activity and information giving.

CCG will review the evidence base for long term follow-up of cancer patients to ensure pathways are evidence based in relation to the value of follow-up, commissioning services in a way that responds to patient's needs, e.g. access to advice when a patient requires advice rather than a regimented follow-up plan which the patient does not value.

9.3.3 Urgent Care

CCG recognises that some patients will continue to require access to urgent care services to manage acute health episodes. NL CCG plans for urgent care services are set out in section 8.6. Data shows a high number of patients requiring urgent care have long term conditions. The LTC strategy is aimed at improving the management of long term conditions to reduce exacerbations. When patients do require urgent care, they will be supported to return home as soon as possible and return to independence.

9.3.4 24/7 medical and nursing care

NL CCG will continue to commission medical and nursing care, working with providers to ensure the use of enhanced recovery programmes to reduce length of stay and improve post-operative outcomes. These actions will contribute to quicker return to independence for patients, reducing the need for social care input following admission, and enabling them to live independently.

Where patients need a hospital admission, CCG will ensure, through contractually agreed CQUINs, that practices receive timely, accurate and concise discharge letters with clear management plans and a clinical rationale for follow-up. This will increase quality of care through clear and accurate communication of patient needs and an improved patient experience.

CCG will ensure close working between hospital teams and the integrated locality teams, to facilitate early discharge with community based health and social care support where required. The integrated health and social care teams have been established during 2012/13 and CCG expects these teams to become fully functional by April 2013.

Key actions

Intentions	Timescale	Outcomes
Commissioning of appropriate self-management programmes to support people with long term conditions. This will include generic and condition specific programmes	September 2013	All patients with a long term condition will be offered an appropriate self-management programme
Implementation of all actions set out in the Winterbourne Concordat: development of an expert group	April 2013	Organisations can demonstrate recommendations are embedded in practice
Ensure access to IAPT service meets needs of the population, including waiting time from referral to first appointment	March 2014	75% patients seen within 4 weeks of referral by March 2014 15.5% of population entering treatment by March 2014.
Implementation of autism strategy-asset mapping and development of autism pathway	March 2014	Approved autism pathway
Development and implementation of a community based urology service	March 2014	Implementation of new model by March 2014. Delivery of care within a community setting
Development of a community based diabetes service, reducing number of patients requiring specialist follow-up and increasing the number of patients successfully self-managing	September 2013	Implementation of new model. 40% of diabetes patients currently under specialist follow-up managed in primary care
Implementation of a community based pain service	June 2013	All new referrals (approx. 500p.a.)for chronic pain offered a community based service, providing a multi-disciplinary self-management approach
Development of a service specification for a community based Musculo-skeletal service		Specification complete by September 2013, followed by procurement phase

9.4 Ageing and retiring well (65+)

The implementation of 'Right Care, Right Place' will ensure that people who are ageing, and are therefore more likely to have at least one long term condition, receive most of their care in the community setting where this is clinically appropriate.

9.4.1 Care across communities

Self-management

People will be encouraged, supported and equipped to self-care, with access to a variety of self-management programmes to meet their needs. Support to people with long term conditions will be available through their local pharmacist who will offer medication reviews and assessment and guidance in inhaler technique for respiratory patients and General Practice; who will offer a broad level of primary care services and long term condition management. NL CCG have, in conjunction with the local authority, introduced the Expert Patient Programme during 2011/12 and continuing in 2012/13 and will continue to expand this service along with other models such as the roll-out of COPD manual – a cognitive behavioural self-management programme, pulmonary rehabilitation and the DAFNE and DESMOND diabetes programmes, to give people a range of programmes to choose from, appropriate to their condition.

Risk profiling

2013/14 will see the completion of implementation of risk stratification for long term conditions. General practices will use a risk profiling tool to identify those people at high or increasing risk of deterioration of their condition, implement management plans and identify and refer people to appropriate interventional services to support people to manage their condition better.

Whilst the implementation of the risk profiling tool has commenced in 2012/13, this will continue through 2013/14, with the aim of all practices implementing and utilising the tool to identify people at increased risk of a deteriorating long term condition by March 2014. Having identified the people at risk, practices will target relevant review and interventions at these people to improve the management of their health, reducing the risk of deterioration and non-elective admission. The information gained from this process will also be utilised to identify commissioning needs in the future.

Dementia

The Joint Commissioning Strategy for Dementia Care Services in North Lincolnshire 2011-2016, developed in conjunction with the North Lincolnshire Council and following consultation with local stakeholders including carers, aims to deliver on the four national priorities;

- Good quality early interventions and diagnosis
- Improved quality of care in general hospitals
- Living well with Dementia in care homes or at home
- Reduced use of antipsychotic medication

The early detection and management of dementia is a priority for NL CCG. With a growing aged population, the number of people with dementia is set to rise. Whilst there is currently a predicted 2070 people in North Lincolnshire with dementia, this is expected to increase to 2,770 by 2020 and 3,900 by 2030. The current diagnosis rate for NL is 40.7% and CCG aim to increase this to 44% by 2013/14 and to 50% by 2014/15 and forms one of CCG's local quality premium priorities. This increase in diagnosis would identify people at an early stage of disease, enabling appropriate diagnostics and treatment planning, and planning of appropriate support to carers. This support to carers is reflected in the North Lincolnshire Joint Carer action plan, agreed with the local authority.

Whilst progress has been made to support patients with dementia, including the roll-out of telecare jointly with the local authority to support the maintenance of independence, and the commissioning of services from the Alzheimer Society, the CCG supports further developments including the commissioning of a Dementia Academy to provide education and support to carers of people with dementia, this includes both staff and personal carers.

This reflects the plans set out in the joint Dementia Strategy, working closely with the local authority to ensure all care providers across health and social care have the skills and competencies to recognise and care for those with dementia. The trajectory set for improving dementia diagnosis rates reflects the significant work and lead time to set up the dementia academy.

This approach will;

- create a single point of access for local people by linking all areas of good practice together and promoting collaboration,
- improve community understanding and acceptance with Alzheimer's Society support
- use local businesses to support access to the BME community to raise awareness,
- reach 'hidden carers' within the local population through raising employer awareness and promoting business benefits of involvement, and
- promote the Big Society agenda for future sustainability and community ownership

During 2013/14, CCG will review the current service provision for Dementia utilising the Experience led commissioning approach and where required, revise its strategy to ensure it reflects the needs identified by patients and carers (including staff) of people with dementia.

Use of technological solutions to support healthcare delivery

For many people with long term conditions, the use of technology has the potential to make a significant difference to their experience of care, enabling them to monitor their physiological measurements at home on a regular basis, with this data reviewed remotely by a clinician. This also promotes patient self-management. NL CCG has committed within their care models to utilise technology to support patient care. This will result in an increase in the number of ageing people accessing and utilising health services in a different way to the traditional model and will require healthcare staff to support them in this transition to ensure they feel safe and supported. Such technology is likely to include the use of tele-monitoring, monitoring people's vital signs in the home, and digitally transferring this information to a clinician to review, and telemedicine, enabling people in care homes to be assessed by their GP, nurse or Consultant remotely, reducing the need to transfer people from care homes to a practice or hospital for an assessment. CCG will agree its approach to the use of technology supported care by March 2013, with implementation plans being developed in 2013/14.

9.4.2 Care within localities

Whilst North Lincolnshire CCG is committed to the commissioning of services in a way which supports people in their own home, it recognises and plans for delivery at a locality level – across all five localities for those people needing more support such as access to integrated locality teams for nursing and social assessment and care, therapy services and some mental health services. This approach to commissioning is in recognition of the challenges associated with delivering more specialised services across a large geographical area, and therefore to maximise efficiencies in service delivery, these services will be delivered within localities. For ageing people, this means that they will access therapy services, nursing teams and integrated teams who operate in a specific locality area. This will ensure providers can deliver high quality of services, gaining the economies of scale associated with working across a wider area. This will also enable provider staff to develop specialism interests which will improve outcomes for patients.

Care of older people

NLCCG have committed to undertaking a review of the care of the elderly population, building on the recent work undertaken to ensure all residents of care homes have a thorough clinical assessment and medication review, ensuring plans are in place to manage the patient in a crisis, and where relevant, at end of life. The aim of this work has been to support care homes to manage patients during crisis, instigating pre- planned actions. However this work to date has only covered patients who are resident in care homes and NL CCG recognise that this work needs to be broadened to cover all elderly people to support them in maintaining independence – hospital admission reduces patient independence, especially in older people. CCG will review the outcomes of this

current work and develop a model for care of older people during 2013/14 for implementation by 2014/15. This new service model will ensure patients and their carers, regardless of care setting have clear care plans, including escalation and end of life plans, reducing unnecessary hospital admission, thereby maintaining independence for as long as possible.

In addition to this, NL CCG will continue to work with North Lincolnshire Council to improve the experience of people living in care homes, ensuring that care homes are supported to deliver high quality care which is responsive to the changing needs of individual clients. This is particularly relevant for NL CCG for those patients who become acutely ill. NL CCG will work with NLC to ensure care homes can identify early any patient deterioration, and understand what the response should be on a client by client basis, underpinned by the regular clinical assessment and planning described above. This work to understand the experiences of people in care homes has already commenced however CCG recognises the need to extend this work during 2013/14 to improve the experiences of people living in their own home with domiciliary care support to ensure care workers recognise ill health in their clients and are supported through care plans to take appropriate action.

NL CCG is one of the early adopters of personal health budgets and will implement these for relevant patients in receipt of continuing healthcare, during 2013/14. This will offer patients greater choice of the care package they receive and the provider of that care, enabling them to ensure it meets their needs. This should significantly improve patient experience and give them greater control over their care.

Integrated health and social care teams

The continued delivery of an integrated approach to care through five locality based integrated health and social care teams will mean that people receive seamless care without the delays associated with inter-referral between health and social care services. The full implementation of this model by April 2013 and continued delivery beyond is critical to the management of the ageing population.

This approach will support people to live independently in the community for longer, supported by community and voluntary sector support.

NL CCG will seek to further support people with long term conditions by implementing within 2013/14, a framework for care planning which ensures all people with long term conditions have a single integrated care plan which focuses on their priorities. This approach will support people to self-manage, recognising the aspects of life which will motivate people to self-manage, with consultations delivered using motivational techniques. The implementation of a single care plan approach is an essential component of the integrated locally team approach. NL CCG will agree an approach and plan for achievement within 13/14.

The CCG will work with providers via the Integrated Working Partnership (a sub group of the Health and Well-being Board) to gain support for implementation, utilising the contracts as a lever to implementation. In developing the approach, NL CCG will seek to utilise technological solutions wherever possible to facilitate integrated plans across multiple providers.

Long term condition management/planned care services

NLCCG will commission services that support people to maintain their independence to live in their own homes where possible, however CCG will work with partner organisations, particularly the local authority and care home providers to ensure that if people need to move to a care home, they will be able to access care homes close to where they live, and that the care homes will provide a consistent level of high quality care. It will continue the work already started to develop care home standards and in conjunction with the local authority, and utilise contract levers and key performance indicators to improve the consistency of care across all care homes. This work will provide care home providers with the support and information they need to ensure they manage people in care homes well, and understand when and how to seek clinical support for their residents, to provide early intervention and reduce unplanned admissions.

NL CCG will work with local providers to ensure that high volume outpatient services are, where clinically appropriate, delivered at a locality level. This aims to improve patient experience by providing services closer to home, in accessible, community venues. This will include those services where all or part of the diagnostics can be provided within a locality setting. NL CCG recognises that not all services are appropriate for this model of delivery, particularly where patients need specific diagnostics as part of the pathway. In these cases, the relevant specialised diagnostics will need to be delivered from a single location within North Lincolnshire. Disease specific pathways which NL CCG will commission in this format in 13/14 are improvements in the community respiratory services to ensure all relevant patients receive home oxygen assessments and reviews, alongside pulmonary rehabilitation or an alternative cognitive behavioural therapy approach such as the COPD manual. These improvements will support the reduction in urgent admissions for COPD and improved self-management.

CCG will commission revised foot screening services to increase the proportion of diabetic patients receiving foot screening in line with NICE guidance and a NICE compliant service for patients with increased risk of foot damage. This will mean that diabetic patients receive their regular foot screening within general practice, but with more specialist advice and assessment available within the community setting, with specialist services available for those with the most complex needs.

Work has already commenced on reviewing current provision of ophthalmology services, aiming to deliver outpatient services in the community wherever clinically appropriate, for example long term monitoring of eye conditions such as glaucoma and age related macular degeneration. This will be

implemented during 2013/14. This will mean the people with these conditions, which mainly affect older people, will receive this care closer to home, improving convenience, reducing the need for travel to the hospital site.

A review of current circulatory services has commenced in line with plans to develop community based services which reflect population needs and the national cardiovascular disease strategy due for release in Spring 2013. This will build on the already commissioned community cardiology service to provide integrated pathways for cardiac conditions. These pathways will incorporate patient self-management programmes, improving patient self-management and thereby reducing avoidable hospital admissions.

Carers

NL CCG has agreed with the local authority a Carers plan, which includes investment in a range of initiatives to support carers. In addition, it has recently commissioned research no the needs of carers within North Lincolnshire. The final report of this research is imminent. NL CCG will review the findings of this research against its current plans to ensure the plans reflect carer needs.NL CCG will continue to support carers through its work within the Carers Partnership.

9.4.3 Urgent care

People at this life stage are at increased risk of requiring urgent care due to acute illness. Many of these admissions will relate to a long term conditions, but some will be single acute illnesses. See section on urgent care (section 8.6).

9.4.4 24/7 medical and nursing care

Evidence shows that when older people are admitted to hospital, this has an adverse effect on their levels of independence, therefore any protracted hospital stay can reduce their potential to return to their previous level of independence. Services will therefore be designed in a way that reduces their length of stay and promotes a return to independence, with or without additional rehabilitative support, relative to the patient's needs. CCG will work with the local authority to ensure those patients who require low levels of reablement, can secure this either within their own home, where safe to do so, or within a bedded community unit if required. In addition, CCG will work with the local authority to develop a new service specification for Intermediate care rehabilitation services.

NL CCG will continue the work with the local authority to complete the review commissioning of residential and nursing home care, with the aim of shaping the market to reflect population needs and to improve quality of care in nursing and residential homes. The CCG will invest in 2013/14 in continuing healthcare to ensure assessments and regular reviews are delivered in a timely way,

which will ensure people receive the appropriate level of care according to their needs. This will contribute to QIPP savings plan.

Where people need to be admitted into hospital for acute illness, they will have access to the appropriate level of skilled and specialised individual to meet their clinical need. For the majority of patients, this will be available within their local hospital, however, in order to ensure sustainable health provision in the future, NL CCG will as part of its options appraisal on future configurations, consider whether some specialist services will only be available at a fewer number of sites. NL CCG, via the use of CQUINS will encourage the acute provider to improve care for people with dementia, and expects NLAG to continue its Dementia Champion training and improve services for people with dementia.

NL CCG will continue to work with the acute Trust to improve the quality of care across a range of pathways to ensure good patient outcomes. This includes stroke services where NL CCG will work with NLAG to ensure delivery of the Stroke action plan and accreditation standards are met and maintained. This includes delivery of 24/7 thrombolysis service at Scunthorpe from 1st April 2013. NL CCG will work with NLAG in the options appraisal for a primary site for thrombolysis and high risk TIA management.

Key actions

Intentions	Timescale	Outcomes
Implementation of the urgent care model	Phased from April 2013	Single, integrated access to urgent care. Impact on approx. 60,000 patients p.a.
Implementation of Risk Profiling tool across Primary care	March 2014	50% practices using tool by June 2013. 75% practices using tool by March 2014
Agreement of a framework for patient centred care planning	June 2013	50% patients with a long term condition will have an integrated care plan by March 2014
Agree approach to the use of technology within healthcare including tele-monitoring and telemedicine	March 2014	Agree approach by April 2013 100 patients with LTC to be utilising tele-monitoring by March 2014
Completion of a review and development of a model for management of long term neurological conditions	June 2014	Service model which meets the needs of the population and meets NICE quality standards, improving outcomes and experience for people with long term neurological conditions
Completion of service review of care of the elderly and development of a service specification	June 2014	Implementation of new model by June 2014
Development and implementation of a	March 2014	Implementation of new model by March 2014. Delivery of care within a community setting

community ophthalmology service		
Implementation of a revised model for diabetic foot screening	April 2013	All patients with diabetes (9200) receive annual foot screening
Embed the 5 locality based integrated health and social care teams by April '13	April 2013	All patients benefit from integrated services and joint assessments
Work with partners to implement the joint dementia strategy and action plan agreed in 2012 as part of which we aim to increase dementia diagnosis rates	March 2014	1024 (44%) patients to be diagnosed by March 2014
Work with providers to implement the outcomes of the experience led commissioning review underway in relation the outpatient experience for people with multiple Long Term Conditions	March 2014	Implementations of the key improvement challenges identified in the work
Review the Carer's action plan in light of the recommendations of the report into support needs of carers within North Lincolnshire	June 2013	Action plan revised based on research findings

9.5 End of Life

NL CCG already has both a palliative care strategy and an end of life strategy, approved in 2012 and will continue to work with the cross partner implementation groups to ensure delivery of the resulting action plans during 2013/14 and beyond.

In agreeing the end of life strategy, CCG have set an ambition to improve the availability and quality of end of life care in North Lincolnshire, reduce unnecessary admissions to hospital and improve choice at end of life. The CCG aims to deliver the following outcomes through its End of Life Commissioning Strategy

-Ensuring timely conversations about end of life with patients and carers
-Enabling people to die in the setting of their choice with appropriate care

-Ensuring access to care and support over any 24 hour period for those approaching end of life and their carers.
-Providing age appropriate responses and services
-Reducing avoidable admissions to hospital
-Ensuring practitioners have access to accurate and timely information to support patient care
-Ensuring patients, carers and support services have access to specialist advice if appropriate
-Ensuring practitioners have access to adequate resources including medications and staffing at the times required, supported by appropriate guidelines, policies and procedures
-Ensuring we have a skilled and competent workforce across the health and social care community

Whilst a number of actions set out in the original action plan have been achieved, further focussed action is required during 13/14 to ensure improvements are sustained. Progress against this action plan is monitored by the Palliative Care and End of Life Strategy Group.
Key actions in 2013/14 are;

- Implementation of a locality wide end of life register providing details of the care plan for patients accessible to all relevant care providers
- Implementation of the business case for improving specialist services, to provide increased capacity within the community team for delivery of patient care at end of life, access to Consultant Palliative Care support and psychology support in line with Improving Outcomes Guidance.
- Continued education across primary, secondary, community and independent care home providers to improve the skills and competencies of staff dealing with people at end of life. This includes training to care home Managers and staff, Gold Standards Framework and Advanced Care Planning training for primary care staff and Advanced Care Planning training for community and hospital staff.
- Ensuring appropriate access to specialist nursing and Allied Healthcare Professionals within the palliative care and cancer/LTC pathways.

The CCG committed to using the Experience Led Commissioning (ELC) approach to End of Life care during 2012/13 in order to better understand the needs of the local population in relation to end of life care, so whilst the End of Life strategy has already been agreed, it will be revisited in light of the completion of the ELC project to assess its continued relevance and revise its commissioning intentions if required.

9.5.1 Care across communities

North Lincolnshire Clinical Commissioners aim to ensure patients die in their preferred place of care wherever possible. It aims to do this by ensuring people approaching end of life are identified and placed on an end of life register, and have a care plan developed in conjunction with the patient and

carers. Currently North Lincolnshire has only 10% of its population on an end of life register compared with a regional average of 17%, suggesting patients are either not being identified as approaching end of life or identified but not registered. To facilitate this, NL CCG will ensure the relevant staff are trained and supported to discuss and plan end of life care and choices with patients. This will be delivered by expert resources within North Lincolnshire, working closely with North East Yorkshire and Humber Clinical Alliance (and emerging Strategic Clinical Networks) and Skills for Care to ensure consistent approach across the network to ensure equity in standards of care, including in care homes. Plans are in place to deliver education across primary, secondary and community care during 2012/13 and 13/14, complementing current education to care homes delivered during 2012/13. CCG will support the collation of data beyond this training to monitor its success, and will continue to commission a GP educator in end of life to ensure sustainability of education during 13/14 and 14/15.

The use of the risk profiling tool across all GP practices during 2013/14 will support the identification of people with long term conditions who are reaching the end of life stage, and as such the tool can then facilitate a review of the patient's management and development of an end of life plan. The CCG have recently coordinated the roll-out of a DNAR (Do not attempt resuscitation) form across the health community and will monitor during 2013/14 the success of this. This form is recognised and supported by all provider organisations involved in end of life care, including care homes to ensure where end of life and DNAR plans are in place, these are adhered to.

NL CCG will continue to work with provider organisations to identify and implement a single locality wide end of life register to ensure up to date care plans can be shared across all relevant providers. There have been significant challenges both locally and nationally to date in implementing a single locality register due to the number of differing patient information systems in use across primary, secondary and community services, which has delayed the original timescales for implementation. NL CCG will continue to explore all opportunities and the learning from other sites in order to make this a reality over the next two years.

The end of life strategy identifies the need to review current service provision for psychological care and bereavement care and during 2013/14 NL CCG will review current bereavement service needs and commission services to deliver local population needs. It will also work with NLAG to implement the business case for improvement of specialist services, including increase of psychology provision to end of life patients

9.5.2 Care within localities

NL CCG endeavours to support people at end of life who choose to remain in their own home, to do so for as long as possible, and given the care needs of this group of patients, will continue to draw on the community resource to deliver this. The integrated locality teams are pivotal resources in the care of people at end of life and the integrated way of working and coordination of care is essential

in ensuring both patient and carers feel safe and supported. Much of the care for people at end of life will continue to be delivered by the Community nursing teams within localities, supported by more specialized community staff such as community palliative care nurses who work with community teams and the GP to manage patient symptoms to enable them to remain at home.

The implementation of these should all significantly increase the number of people dying in their preferred place of care and contribute to reducing the number of people dying in hospital. Whilst the number of people within North Lincolnshire is slightly lower that the national average (52% in NL vs. 55% nationally), the end of life strategy set a target to reduce hospital deaths by 2% per annum. This will equate to an annual reduction in hospital deaths of 33 patients, and is used as a proxy indicator for patients dying in their preferred place of care.

Where a person at end of life cannot be managed within their own home, through personal choice or carer issues, the integrated team will work with patient and carers to identify the most appropriate placement for the patient, including hospice and care homes, with respect for patient choice. Hospital is considered in most cases to be the least appropriate setting for people at end of life. Hospital environments, with a focus on acute care are immensely stressful for both patient and carers, with carers often deeply affected by the experience. Where patients do need residential or nursing care at the end of life, the coordinated approach delivered by integrated teams should provide a seamless transfer of care, with consistent end of life plan in place.

9.5.3 Urgent care

The End of Life strategy sets out an ambition to improve the availability and quality of end of life care in North Lincolnshire reducing unnecessary admissions to hospital and improve choice at end of life. Achievement of this should mean that patients and carers feel supported at end of life, and thus the risk of need for urgent care should be minimised. However, should a patient need to be admitted to an acute hospital bed at end of life, the integrated locality team will work with the acute hospital to facilitate early discharge, ensuring all support packages are in place prior to discharge.

9.5.4 24/7 medical and nursing care

This level within the models of care includes, for end of life patients, access to specialist advice- this may be in the form of advice from Palliative Care team to the GP or access to the Hospice as either a day care or inpatient care episode. NL CCG will ensure it commissions appropriate support and advice from the palliative care teams to support patients being managed in the community. In all cases, the focus is on managing the patient in line with their stated preferences and ensuring patient and carers feel supported. It will ensure that staff are equipped with the appropriate skills and competencies to provide high quality end of life care, utilising appropriate tools to support care planning, such as the Liverpool Care Pathway.

NL CCG will continue to commission specialist palliative care from the local Hospice, however it will use the Experience Led Commissioning approach to understand the needs of the local population and refine its commissioning intentions accordingly to ensure all patients receive high quality care. This work will conclude in April 2013, and will generate further commissioning intentions relating to end of life care.

Key actions

Intentions	Timescale	Outcomes
Implementation of actions arising from End of Life Strategy including access to palliative care consultant	March 2013 (Palliative Care Consultant by October 2013)	Improved patient experience and easy access to appropriate support
Implementation of actions arising from Palliative care strategy -Compliance with NICE Supportive and Palliative Care guidance -development of directory of Palliative Care Services -Access to 24/7 specialist palliative care advice	March 2014	Compliance with Improving Outcomes Guidance
Work with providers to implement the outcomes of the Experience Led Commissioning review of EoL services	December 2013	Improved patient experience of end of life services
Review of bereavement service needs	October 2013	Clear understanding of commissioning requirements relating to bereavement care services

10 Delivery plan

10.1 Indicators

The matrix below demonstrates the links between the key actions and the relevant indicators.

	Key priorities	Improving quality and experience	Improving the quality of primary care	Improving mortality and preventing people dying prematurely	Improving outcomes for people with long term conditions	Improving care at end of life	Supporting people's mental health and well being	Improving outcomes for children	Improved care for women during pregnancy	Supporting carers	Implementation of urgent care model including NHS 111
CCG strategic aims	Improving Quality	x	x	x	x	x		x	x		x
	reduce variation	x	x		x	x		x	x		x
	best outcomes for all	x		x	x	x	x	x	x		x
	improving patient experience	x	x	x	x	x	x	x	x	x	x
	reduce inequalities				x		x	x			
5 Offers	7days/week	x		x							x
	more transparency	x		x							
	pt participation				x	x	x			x	
	data & informed commissioning	x									x
	higher standards	x	x	x			x				
CCG Outcome indicators	preventing premature deaths	x	x	x	x			x			x
	QoL for LTC pts	x	x		x		x			x	x
	recovery from ill health/injury	x	x	x	x		x	x			x
	ensuring positive experience of care	x	x	x	x	x	x	x	x	x	x
	protect from avoidable harm	x	x	x	x			x	x		x

	Key priorities	Improving quality and experience	Improving the quality of primary care	Improving mortality and preventing people dying prematurely	Improving outcomes for people with long term conditions	Improving care at end of life	Supporting people's mental health and well being	Improving outcomes for children	Improved care for women during pregnancy	Supporting carers	Implementation of urgent care model including NHS 111
Constitutional measures	18/52 waits	x	x		x						
	diagnostics 6/52	x	x		x						
	A/E 4 hr waits	x									x
	2 week waits	x	x	x							
	31 day cancer waits	x	x	x							
	62 day cancer waits	x	x	x							
	Cat A ambulance times	x		x							
	mixed sex accommodation	x									
	Cancelled ops	x									
	mental health f/up 7/7	x					x				
	52 week waits	x									
	A/E trolley waits>12 hrs	x									x
	no op cancelled for 2nd time	x									

	Amb handovers 15 mins to A/E, + 15 mins turn around	x		x							x
	Key priorities	Improving quality and experience	Improving the quality of primary care	Improving mortality and preventing people prematurely dying	Improving outcomes for people with long term conditions	Improving care at end of life	Supporting people's mental health and well being	Improving outcomes for children	Improved care for women during pregnancy	Supporting carers	Implementation of urgent care model including NHS 111
Quality premiums	Years of life lost - amenable to healthcare	x	x	x	x		x	x			
	avoidable emergency adm	x	x		x	x					x
	Friends and Family	x		x					x		x
	Health acquired inf. MRSA/C Diff	x		x							
	Increasing dementia diagnosis	x	x				x			x	
	reducing emergency readmissions	x									x
	Stroke Thrombolysis	x		x	x						x

10.2 Finance Plan

Financial Plan assurance and commentary

10.2.1 Introduction

For 2013/14 the new CCG has a commissioning budget allocation of £195.881m and a Running Cost Allowance of £4.23m as per the Planning framework and NHS Commissioning Board announcements.

The plan assumes a carry-forward of the PCT 12/13 surplus which is still expected to be achieved. The CCG's share of the surplus in accordance with NHSCB policy has been notified as £1.836m. The plan assumes all this funding will all be drawn down and spent to support transformation i.e. the Strategic Services Review (SSR) and new models of care in 13/14.

A financial summary of the plan is shown in Appendix A. The figures are based on estimated contract values and best indicative values of activity e.g. for specialised services transferring to the Commissioning Board.

10.2.2 Overall financial duties

The CCG has planned for the required 1% surplus overall.

A 2% recurrent surplus is planned for and will be maintained subject to delivery of the QIPP programme and management of other risks.

As required, the CCG has a plan to invest 2% (3.9m) of its recurrent allocation, non-recurrently in 2013/14. Essentially, it will be used to support local QIPP investment as well as non-recurrent spend relating to transformational change in support of developing new models of care across a number of providers including NLAG e.g. urgent care as part of the SSR . Business cases are being developed in agreement with our Providers to take to the SSR Management Board for approval for onward submission to the Area Team of the Commissioning Board. The speed with which these are approved by the Area Team may affect the ability to deliver the full year effect of savings planned and the cost of financing them externally.

In addition the CCGs Running Costs is within the £25 ceiling. The allowance of £4.23m for a population of 168,400 is effectively only £24.55 per head, split £1.884m for the CCG and £2.346m for the CSU. This allocation has received no uplift for 13/14, and it is assumed that external income for spare accommodation in Health Place or alternative premises can be sought for the 16 office based staff within the CCG. A national pay award of 1% has been assumed for costs in 13/14 and a budget reserve provided to cover expected staff increments.

The contingency budget is currently planned at £2m, to reflect proposed contract ceilings, non-contract activity overspends, other pressures such as continuing care and risks in the new system. The £2m figure has been recurrently created and effectively represents 39% coverage of QIPP

schemes. Governance arrangements for the release of contingency will be agreed at the CCG Committee.

10.2.3 Demographic assumptions

Based on Public Health advice an average of 1% population growth has been used based on ONS statistics, within the contract modelling. In addition the activity modelling to support planned contract expenditure reflects population trends and changes reflected in current case-mix down to specialty level.

10.2.4 Financial uplift assumptions

In accordance with the Planning Framework the CCG has planned for the following uplifts net of efficiencies:

CCG allocations net growth	-1.7%
Provider Tariff change	-1.1 to -1.3%
Non-tariff price change	-1.3%
CQUINs change	0%

The impact locally of PbR on the CCGs contracts, in conjunction with the SCG defund is still being worked through. However, the minimum level of risk on the CCGs is currently assessed to be about £0.5m which is covered off by a contract reserve.

10.2.5 Capital assumptions

The CCG would like to develop a bid, estimated to be around £1m, in conjunction with its member practices and co-commissioners at the Area Team for a Primary Care capital grant to obtain premises and IT systems in particular in a number of localities, to support the outcomes of SSR and new models of care. The CCG will therefore work with the Area Team to develop a business case.

10.2.6 Commissioning Intentions

The JSNA, which itself reflects on population changes, has been used to identify needs and priorities for the population of NHS NL CCG which GP members were consulted on. In addition, benchmarking information, using ONS, Atlas of Variation etc., was used to ensure both investments and QIPP opportunities were maximised within the CCGs financial framework. It has also aided the development of proposals for future models of care to support SSR.

10.2.7 Expenditure Assumptions

Assumption	Approach in plan
30% marginal tariff for non-elective activity & use of the 70% top slice	The top-slice has been incorporated into the finance plan in line with guidance, using 12/13 month 8 contract monitoring information. There will be opportunities to access this resource for investments for jointly agreed demand management schemes via business case to the Area Team. This funding would be used to fund new expenditure to support demand management in the delivery of future models of care.
Financial impact of non-payment for readmissions	Non-payment for 30 day re-admissions is modelled back into the contract baseline non recurrently, although overall contract cash envelopes are to be finally agreed and use of penalties will be agreed with partners. Funding for post discharge support and re-ablement services has been separately earmarked from recurrent resources. A reduction in re-admissions is expected given this is likely to be a local target for the quality premia.
Contract sums	The contract envelopes are based on: • the case mix from the last 12 months (i.e. activity which spans two financial years, so this is not technically out-turn). • The latest PBR Tariffs • The last PBR rule changes. • 1% demographic growth based on ONS information • 2.5% CQUINs
CQUINS payments	Tariff guidance has been adopted at 2.5%
Social Care and Re-ablement funding	A Section 256 Agreement is in place confirming transfer of Social Care resource up to 12/13 and re-ablement funding for 13/14 and 14/15 to the Local Authority. This agreement will be subject to review with the CCG and the LA Agreed plans in place confirm utilisation to support admission avoidance and early discharge, dementia care and other long term condition management and will continue to be challenged and monitored through established joint Boards and agreed governance framework to ensure agreed benefits and outcomes are achieved.

10.2.8 **QIPP and Investment Plan**

The Table in Appendix B provides a summary of the CCG's QIPP and Investment plan for 2013/14.

The QIPP schemes planned for 13/14 reflects the net savings that the CCG feels is realistic, but stretching, within the context of SSR.

The investments mainly centre on delivering the identified QIPP schemes for 2013/14.

The provision of additional staffing to facilitate faster and improved pathways in Continuing Care, will not only improve the quality and responsiveness of services for patients, but also produce efficiency savings on the cost of inappropriate care packages for the CCG. The remaining investment is targeted on implementing an 'advice only' process across NLAG for Respiratory / COPD services, and investment in risk profiling as an enabler.

An on-going process for identification of QIPP schemes has been agreed with the CSU re horizon scanning and governance processes using all available information and linking into the Relationship Managers with Practices in the CCG.

A non-recurrent QIPP investment reserve of £0.5m has been planned for, of which the majority will support new models of care.

Other investments include £1.002m growth in adults and children's continuing care growth as well as additional carer's support of £350k.

10.2.9 Financial Risks and mitigation strategies

Specific outstanding risks to be finalised / confirmed include:

- Local impact of PbR
- Local impact of new SCG rules on providers
- Continuing Care retrospective claims (provision in 12/13 accounts)

In addition, general risks remain as in previous years around QIPP delivery/ implementation of SSR/ New models of care, plus:

- Engagement of the wider GPs in: clinical commissioning, changing primary and secondary clinical behaviour
- Underlying cost/activity growth above those modelled in the plan
- Investments not delivering the required improvements/savings

- Resource reduction e.g. Non return of 'top sliced' funding, incorporating within existing baselines, reduced freedoms and non-recurrent flexibility etc.

- Transition, set up costs and management capacity.

- Continuing Care retrospective claims, for which a provision of at least £2.3m is expected to be made in 12/13 accounts representing a 12.5% success rate.

These risks will be mitigated through a track record of internal review, tight financial control, planning and contingency resources, increased partnership working and transformation, use of contract levers and incentives and organisational development work with CCG and GPs. It will be this ownership that ensures the changes to healthcare are delivered within the Commissioning Plan.

Specific risk mitigation strategies include:

- Contingency of 1% recurrent resource.

- Contract risk reserve in Ear Marked Provisions held recurrently for impact of local tariffs and NHS 111 as well as some non-recurrent resource to support non recurrent in year investment e.g. to support Quality/ potential further impact of SCG (specialised services).

- Wherever possible QIPP will be incorporated within contracts.

- Risk sharing with other CCGs in 13/14 (e.g. main acute contracts with Humber, as well as NHS111 across Yorkshire & Humber) and principles and governance structures have been drafted ready for discussion with members.

- Risk sharing within contracts – e.g. a contract ceiling on the main acute contract and other informal arrangements with providers regularly discussed.

- 3 Relationship Managers working with Practices to support budget and performance management, identify opportunities including around pathways and reducing unwarranted variation.

10.2.10 Conclusion

Overall the CCGs Financial plan is challenging, however NHS North Lincolnshire has a track record of tight budget and reserve management, which coupled with the engagement of GPs as Clinical Commissioners and support from Relationship Managers should give the CCG a proper chance to succeed.

10.3 Activity plan

The following table and graph illustrate the activity outputs for elective and non-elective care. These outputs include QIPP impacts for Outpatient Follow-up Reductions and Non-Elective COPD Spell Reductions.

The Outpatient Follow-up plan is modelled to move North Lincolnshire into an Upper Quartile Performer position for the new to review ratio, which will be written into the local Acute Contract.

The Non-Elective COPD plan is targeted at a 10% reduction in this area.

The figures do include Growth and the impact of the National Commissioning Board and Local Authority services that will not be commissioned by CCG on both the 12/13 outturn and 13/14 plan lines.

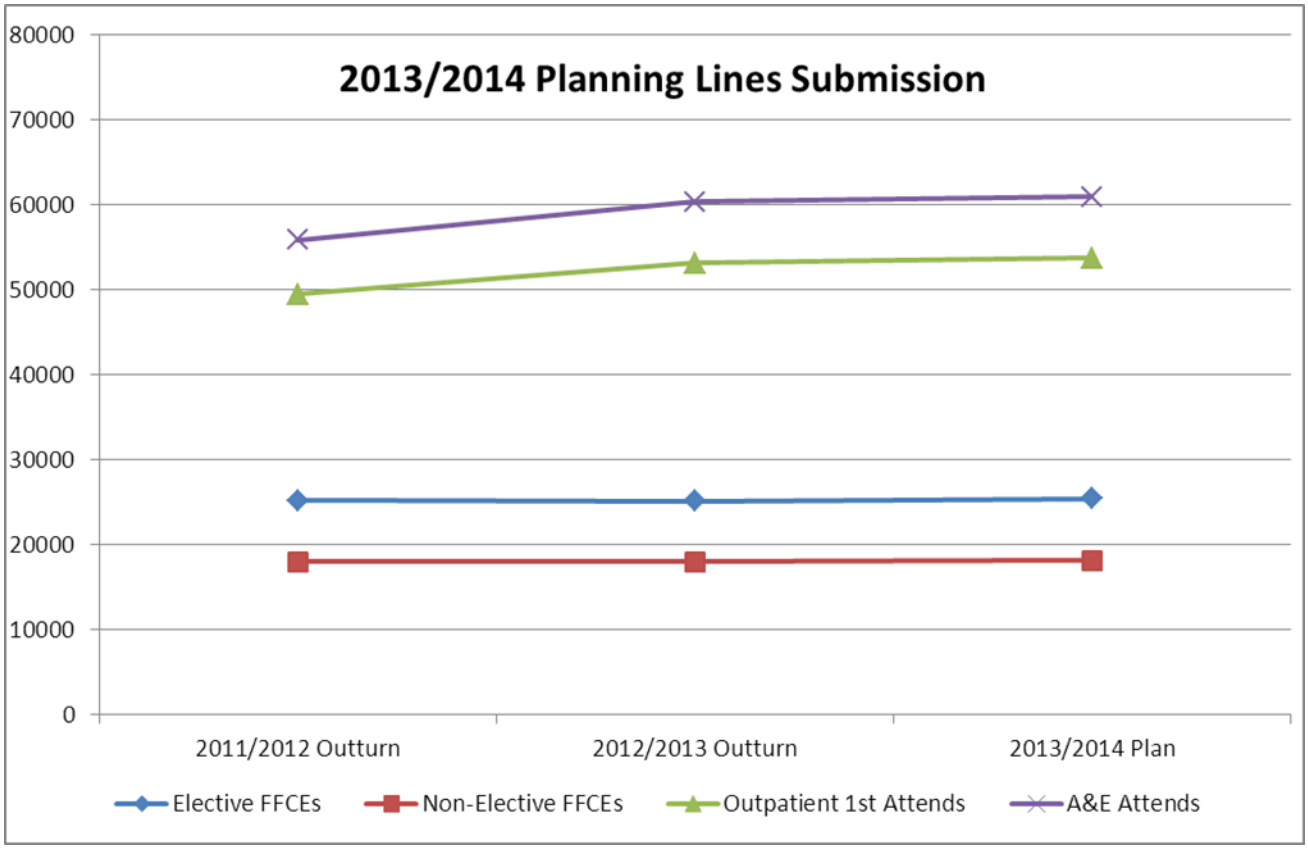
Trajectory Submission at 28th March 2013

		National Submission Requirement			
		CB_S3	CB_S1	CB_S2	CB_S4
Activity Trajectories		i) Elective FFCEs	ii) Non-elective FFCEs	iii) First Outpatient Attendances	iv) A&E Attendances2
2013/14	April	2092	1491	4419	
	May	2092	1540	4419	
	June	1993	1491	4209	
	July	2292	1540	4840	
	August	2092	1540	4419	
	September	2092	1491	4419	
	October	2391	1540	5051	
	November	2092	1491	4419	
	December	1993	1540	4209	
	January	2192	1540	4630	
	February	1993	1391	4209	
	March	2092	1540	4419	
2013/14 Plan		25406	18135	53662	60922
12/13 Outturn		25155	18009	53133	60319
12/13 Plan		24953	18001	47889	58409
11/12 Outturn		25230	17977	49424	55819

10.3.1 Triangulation

We are currently refining our detailed activity models for 2013/14. We have undertaken a range of analyses on the initial output from our modelling to consider projected activity and check consistency with overall QIPP and financial plans, investment, and strategic aspirations. Growth assumptions have been sense checked for consistency with the projections included in external analysis of likely health community demand which has been undertaken to inform the South Bank Sustainable Services Review.

The following chart illustrates the planned activity levels in comparison with previous years. Further refinements of this will be made following detailed planning discussions taking place.



QIPP has not been built into the Outpatient 1st Attendance position. There is a small amount of growth (approx. 1%) built in to reflect population growth.

Total elective activity is expected to follow the general pattern of referrals and outpatient first attendance activity. Whilst day case activity is expected to decrease over the period as work

transfers to an outpatient setting, we expect a small increase in the number ordinary (inpatient) admissions reflecting general growth and an increasing requirement for more complex surgery.

Due to the modelling of unplanned care not yet being in sufficient detail, it is not possible to demonstrate the change in demand and service on Non-Elective FFCEs and A&E attendances. There is an amount of activity that will move to the NHS Commissioning Board, offset by an approximate 1% growth in activity. At this stage, the position is shown relatively stable.

10.4 Performance

The table below demonstrates current performance against the NHS Constitution Indicators, based on latest position (as at Feb 2013)

Everyone counts Reference	Description	Baseline information - North Lincs		2013/14 Standard
		Month	Position	
CB_B1	Referral to Treatment (RTT) pathways within 18 weeks for admitted patients	January	96%	> or = 90%
CB_B2	Referral to Treatment (RTT) pathways within 18 weeks for non-admitted patients	January	98%	> or = 95%
CB_B3	Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	January	97%	> or = 92%
CB_B4	Patients waiting 6 weeks or more for a diagnostic test	January	0.14%	< 1%
CB_B5	Patients who spent 4 hours or less in A&E	February	95.50%	95%
CB_B6	Patients seen within two weeks of an urgent GP referral for suspected cancer	January	98.48%	> or = 93%
CB_B7	Patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	January	92.46%	> or = 93%
CB_B8	Patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis	January	99.26%	> or = 96%
CB_B9	Patients receiving subsequent treatment for cancer within 31-days - Surgery	January	97.42%	> or = 94%
CB_B10	Patients receiving subsequent treatment for cancer within 31-days - Drug	January	100%	> or = 98%
CB_B11	Patients receiving subsequent treatment for cancer within 31-days - Radiotherapy	January	97.23%	> or = 94%
CB_B12	Patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	January	90.55%	> or = 85%
CB_B13	Patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	January	100%	> or = 90%
CB_B14	Patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	January	86.70%	> or = 90%
CB_B15_01	Category A (Red 1) 8 minute response time	February	71.74%	75%
CB_B15_02	Category A (Red 2) 8 minute response time	February	74.02%	75%
CB_B16	Category A 19 minute transportation time	February	93.63%	95%
CB_B17	Mixed Sex Accommodation (MSA) Breaches	February	0	0
CB_B18	Cancelled Operations	February	0.02%	<1%
CB_B19	Patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	January	98.6%	at least 95%
CB_S6	Zero tolerance of over 52 week waiters	January	None as a commissioner	0
CB_S9	No waits from decision to admit to admission (trolley waits) over 12 hours	February	None as a commissioner	0
CB_S10	No urgent operation to be cancelled for a 2nd time		Not currently reported	0
CB_S7	All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes	February	SGH Av handover time 21:23 Av post handover time 16:19	Financial penalties for delays over 30 minutes and over an hour

*Data reports performance at SGH site rather than by commissioner. Commissioner level data not available

Whilst overall performance on the A/E four hour wait is achieved, this target has not been consistently achieved at the Scunthorpe site during 2012/13. NL CCG considers that the implementation of the urgent care model will address the current performance issues relating to urgent care, increasing the number of patients managed by Ambulatory models, reducing the need for hospital admission, and by ensuring the appropriately skilled staff are present within the urgent care centre to manage attendees appropriately. The service specification and key performance indicators will support the delivery of these outcomes. NL CCG currently meets weekly to address the A/E performance issue and will continue this, drawing on the findings of the ECIST review in March 2013 to ensure good practice and performance is embedded

Performance reporting against the Ambulance response targets shows that overall the EMAS performance is poor, however, within North Lincolnshire, performance has been better than the overall position. East Midlands Ambulance Service is currently developing its plans following the recent consultation on ambulance station provision. Once this information is known, NL CCG will work with the provider to ensure the service model is able to respond consistently to category A response time targets.

The latest performance report shows a dip in performance around cancer waiting times, however the number of patients is very small, therefore a single patient breach can result in a significant dip in percentage achievement.

APPENDIX A

NORTH LINCOLNSHIRE CLINICAL COMMISSIOING GROUP (CCG) 2013/14.
FINANCE PLAN SUMMARY & MAIN BUDGET FUNDING ENVELOPES

1) NET EXPENDITURE SUMMARY

The last standardised Finance plan submission before formal agreement of NHS contracts, at the end of February 2013, was based on the following resource and expenditure projections:

		Recurrent	Non Recurrent	Total
		£000s	£000s	£000s
*	Available Resources (Programme & Running Costs)	200,111	1,836	**201,947**
*	Total Expenditure	187,798	12,149	**199,947**
*	**Surplus**			**2,000**

However, taking into account the element of recurrent income which has been utilised to fund non recurrent expenditure, the CCG's financial position can be more accurately summarised as follows:

		Recurrent	Non Recurrent	Total
		£000s	£000s	£000s
*	Available Resources (Programme & Running Costs)	192,525	9,422	**201,947**
*	Total Expenditure	187,798	12,149	**199,947**
*	**Surplus**	**4,727**	**-2,727**	**2,000**
		2.5%		**1.0%**

The breakdown of gross expenditure by main budget area is shown below.

2) GROSS EXPENDITURE SUMMARY

		DESCRIPTION	RECURRENT BUDGET 2013/14 £000S	NON RECURRENT BUDGET 2013/14 £000S	TOTAL BUDGET 2013/14 £000s
A)	**PROGRAMME BUDGETS**				
	1	Acute NHS contracts (including Ambulance services)	113,821	6,156	119,978
	2	SCG Defund	-11,975	0	-11,975
	3	Acute contracts - Other Providers (Non-NHS, including Voluntary Sector)	563	0	563
	4	Acute Services - Other	1,597	0	1,597
	5	Non Contract Activity	1,267	750	2,017
	6	Out of Hours Services	2,034	0	2,034
	7	Enhanced Primary Care Services	362	0	362
	8	Non Practice Specific PPA Costs	1,084	0	1,084
	9	Practice Based Pharmacy Costs (Prescribing)	29,953	0	29,953
	10	NHS North Lincolnshire Community Provider Services	11,006	0	11,006
	11	Private & Voluntary Sector Services (Including : Continuing & Funded Care etc)	18,558	0	18,558
	12	Local Safeguarding of Adults & Children	166	0	166
	13	Main Mental Health Contract - RDASH	13,463	0	13,463
	14	Exclusions - Contract Based & Mental Health	395	0	395
	15	Mental Health - Non Contract Activity	217	0	217
	16	Pooled Learning Disability Services	423	0	423
	17	Pooled Mental Health Services	298	0	298
	18	Other Community Based Services	2,318	0	2,318
	19	All Other Commissioned Services	884	0	884
	20	QIPP	-5,144	0	-5,144
	21	Commissioning Budget Efficiency Savings	0	-1,135	-1,135
	22	Technical & Provision Costs	766	3,200	3,966
	23	Contingency	1,513	500	2,013
	24	Non Elective Marginal Rate Investment Reserve (subject to AT Business Cases)	0	2,678	2,678
		Total	**183,568**	**12,149**	**195,717**
B)	**RUNNING COST ALLOWANCE BUDGET COSTS**				
		Total CCG and CSU charge against RCA (including Prop Co Charge).	**4,230**	**0**	**4,230**
	TOTAL EXPENDITURE		**187,798**	**12,149**	**199,947**

Appendix B

QIPP PLAN SUMMARY 2013/14

	TOTAL		
	GROSS £000S	INVESTMENT £000S	NET £000S
Transactional Productivity and Contractual Efficiency Savings			
Long Term Conditions	-815	238	-577
Urgent Care	0	0	0
Planned Care	0	0	0
End of Life Care	0	0	0
Mental health	0	0	0
Primary care productivity	-155	37	-118
Community services	0	0	0
Referral management	0	0	0
Diagnostics	0	0	0
Direct access	0	0	0
Medicines use	0	0	0
Prescribing	-1,415	0	-1,415
Decommissioning ineffective procedures	-1,500	0	-1,500
Other	-1,359	0	-1,359
Sub-total	**-5,244**	**275**	**-4,969**
Transformational Service Re-design and Pathway Changes			
Long Term Conditions	0	0	0
Urgent Care	0	0	0
Planned Care	0	0	0
End of Life Care	0	0	0
Mental health	0	0	0
Primary care productivity	0	0	0
Community services	0	0	0
Referral management	0	0	0
Diagnostics	0	0	0
Direct access	0	0	0
Medicines use	0	0	0
Prescribing	0	0	0
Activity shifts	-199	24	-175
Prevention	0	0	0
Other	0	0	0
Sub-total	**-199**	**24**	**-175**
Totals	**-5,443**	**299**	**-5,144**