North Lincolnshire
Clinical Commissioning Group

North Lincolnshire Clinical Commissioning Group Unit of Planning

Plan for the Commissioning of High Quality Services for North Lincolnshire; 2014/15- 2018/19

Contents

1.0 Foreword

This document sets out the five year strategic plan for the North Lincolnshire Unit of Planning and the vision for health services across North Lincolnshire.

It reflects the shared vision for health and care in Northern Lincolnshire as a whole as we work together to ensure future services offer high quality care in a way that is financially sustainable for the years to come. The increasing aged population and the rise in long term conditions presents significant challenges to North Lincolnshire and key to the future sustainability of healthcare is a reduction in demand on services achieved through proactive preventative care.

Our vision for the future is one where people are enabled and willing to manage their own health and accept responsibility for their lifestyle choices. There will be a strong focus on ensuring people have the knowledge and support to self-care, supported by care delivered in community settings where clinically safe to do so. Where people do require hospital care, this will be delivered locally where appropriate, but it is recognised that for some types of care, it is necessary for this to be delivered in a centre of excellence to maintain high quality and deliver value for money. We will focus on the delivery of proactive, integrated care which enables people to maintain or return to independence. The plans reflect the views gathered as part of the 'Keeping well' Experience Led Commissioning (ELC) work and engagement to date on Healthy Lives, Healthy Futures.

We will continue to engage with patients and the public on the future of local health services to ensure they have a powerful voice in shaping services. This will be achieved through our on-going engagement on Healthy Lives, Healthy Futures- our strategic review of future services in conjunction with our partners; North East Lincolnshire Clinical Commissioning Group (NEL CCG), North Lincolnshire Council (NLC) and Northern Lincolnshire and Goole Foundation Trust (NLAG), Rotherham, Doncaster and South Humber Foundation Trust (RDaSH) and through our ELC programmes and the developing patient engagement network.

This plan aims to deliver on the NHS England ambitions and the local ambitions set through the Health and Well Being strategy

In developing this plan, we have reflected on the progress made against the North Lincolnshire clinical Commissioning Group (NL CCG) strategic plan during our first year as a fully authorised CCG. Whilst significant progress has been made against the plans, including continuing to develop community based services and working with partners to integrate services, there is still much work to done in ensuring local health and care services are sustainable in the long term, and are delivered in a way that meets people's needs.

Dr Margaret Sanderson, Signed: 

NL CCG Chair

Mrs Allison Cooke, Signed: 

Chief Officer

NL CCG

Karen Jackson, Signed: 

Chief Executive

Northern Lincolnshire and Goole Foundation Trust

Simon Driver, Signed**:** 

Chief Executive

North Lincolnshire Council

Christine Bain Signed: 

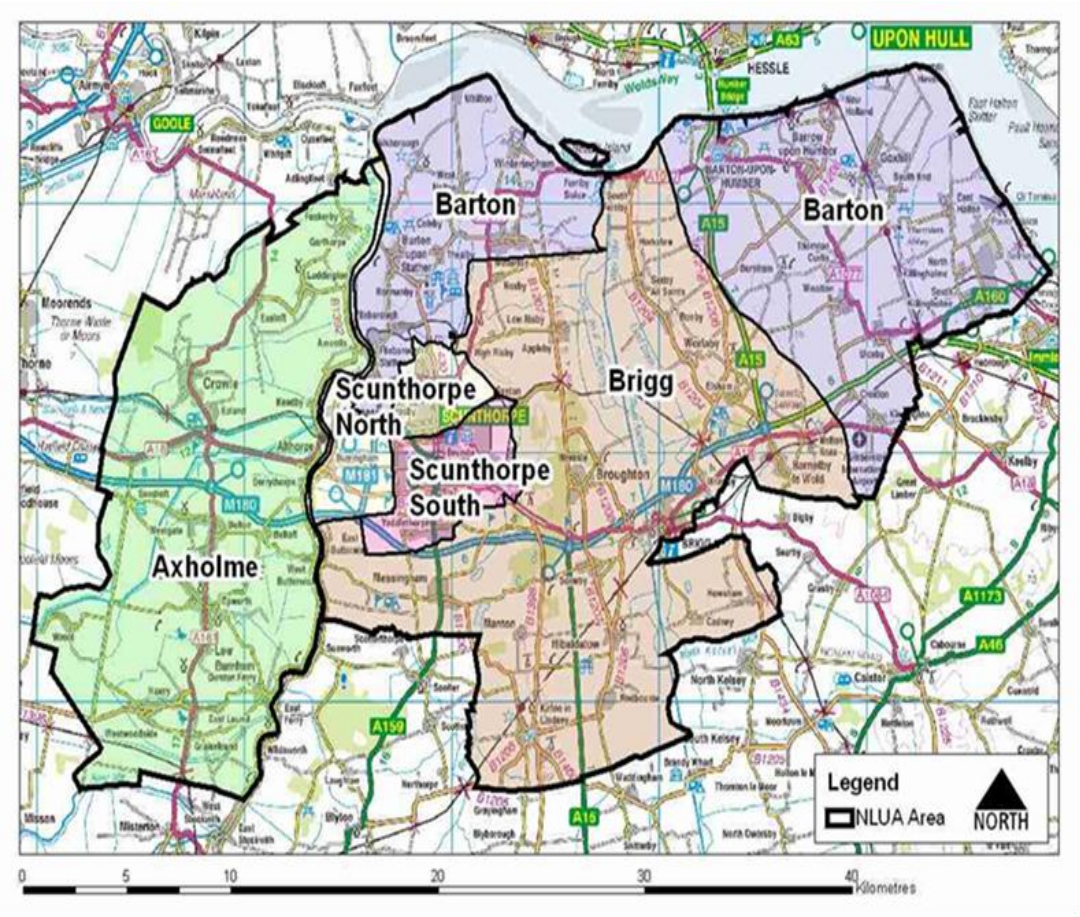
Chief Executive,

Rotherham, Doncaster and South Humber Mental Health Trust

2.0 Introduction

This plan sets out the five year vision for the delivery of health and care services within North Lincolnshire. Developed in conjunction with NLC and NLAG, this plan reflects the shared vision across the health and social care economy.

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).
There are small variations between the CCG and LA boundaries, which are managed within well established arrangements. The small variations are not sufficient to warrant a neighbouring CCG to be part of this plan

North Lincolnshire 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.

3.0 Development of the plan

The plan draws upon the on-going engagement and input of stakeholders and the public into Healthy Lives, Healthy Futures (HLHF) and the work of the integration programme with the local authority and local providers over the last three years. The Integrated Commissioning Partnership (ICP) shapes the future commissioning of integrated services and the Integrated Working Partnership (IWP); commissioners and providers, work together to ensure implementation of the plan. The vision for HLHF is one shared by NL CCG, NEL CCG and NLAG. Within these plans, there are elements which require a joint approach, including public engagement and consultation, however, much of the HLHF vision requires delivery within each unit of planning, such as the shift of services from hospital to community settings. Whilst the vision for community based services is shared, the approach within each unit of planning will differ due to geography, socio-economical differences and provider landscape.

In addition, a stakeholder event, aimed at a wide range of local stakeholders, held on 28th January built on the previous engagements to further inform the plans. Approximately 40 people attended this event, and contributed to further defining plans and identification of barriers to implementation. Following this, plans have been reviewed and revised where appropriate.

Key messages from this process are set out in appendix 1.

NL CCG, with the support of its partners has undertaken significant work during 2013/14 to understand what the local population feel they need to keep healthy and well. The report of this work is available from the CCGs website (http://www.northlincolnshireccg.nhs.uk/data/uploads/publications/experience-led-commissioning/north-lincolnshire-ccg-keeping-well-commissioning-insights-report.pdf) This process of engagement with over 200 members of the local population across 14 different events culminated in a co-design planning event where interested parties came together and produced a graphic illustration of future health and care services. The output of this work closely fits with Healthy Lives, Healthy Futures in that it focuses on keeping people well within their own communities, significantly reducing the requirement for acute care services, underpinned by;

- a single main trusted contact to co-ordinate care,
- joined up care,
- adequate and easy to access peer support and
- tools to support self-care.

This is described by people as *"To keep well, I need to be able to live as independently as possible so I feel in control and can pursue my life purpose (which may well be caring for others), supported by a close social network of family, friends and supportive peers who share and understand my experience. I want one main trusted contact with whom I feel safe, who is linked into or within the health and care 'system' (not necessarily a clinician). I want that person to respect me, listen deeply and support and guide me. I want them to join up*

conversations between services – especially during times of crisis and rapid change in my life - so that I can concentrate on coping and keeping well; doing as much as possible to care for myself with support of my family and friends. This person also needs to understand my story and see me as a person. My mental well-being impacts on my physical wellbeing – and vice versa. Preserving my mobility is especially important because it's about me staying in control and being independent. The NHS has to recognise and invest equally in helping me maintain both my physical and emotional well-being to keep me well. Often talking and being listened to by peer mentors and 'buddies' helps me with the emotional stuff - more than clinical people do."

This is in addition to patient experience work around specific areas of end of life, dementia and long term conditions. The insights from this work form a basis for future commissioning intentions which are radically different, sustainable and meet the needs of the population as they describe them.

There is a strong focus within the plan and nationally on integrated care and the local Integrated Working Partnership, comprising health and social care commissioners, and the main providers for social care, acute, mental health and community services, along with Healthwatch representatives continues to work together to shape services to ensure they are delivered in an integrated way.

3.1 On-going engagement plans

Engagement on HLHF will continue in 2014/15 and beyond as we continue to take forward implementing the vision across Northern Lincolnshire. This will comprise focussed dialogue with local providers and NEL CCG regarding the changes required across Northern Lincolnshire, and a range of offers to the public in shaping the plans for those service areas not requiring consultation and participation in formal consultation where required.

NL CCG will identify the priority areas for application of ELC approach in 2014/15 once the plan is finalised. The output from the ELC work will further inform the detail of service redesign in the future, ensuring plans reflect the person centred outcomes developed as part of the process.

The Communication and Engagement Strategy for NLCCG has been reviewed and approved at the Governing Body on the 10th April 2014. As part of that NL CCG will launch a Public and Patient Engagement Network (Embrace) in 2014/15, developing a database of people who want to engage with the CCG, and then drawing on this resource in further shaping the detail of plans.

4.0 Current situation

4.1 Joint Strategic Needs Assessment; Key Health Challenges

Through the development of the Joint Strategic Needs Assessment (JSNA), NL CCG and NLC have identified a number of key health challenges. These are reflected in the plan for the various life stages. (see section 18.3 – 18.6, appendix 2)

In addition, we 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

4.2 Current performance

Local performance against the rights and pledges set out in the NHS Constitution are monitored within each relevant organisation and overall by the CCG, whilst organisations are meeting most of the rights however, there remain a number of challenges;

Ambulance response times; the current provider is East Midlands Ambulance Service (EMAS) and whilst local performance against the targets is reasonable, the CCG is judged on overall EMAS Trust performance which is below target. NL CCG is currently part of a collaborative commissioning arrangement across all EMAS commissioners, with Erewash CCG as the lead commissioner. The CCG continues to work with the collaborative to secure continuing improvements in response times in North Lincolnshire.

Accident and Emergency 4 hour wait; this target has been significantly challenging during 2013/14, with NLAG not achieving the Q3 target position. However, there is significant focus via the Urgent Care Working Group (which brings together representation from the acute and community services, EMAS, local authority, East Riding CCG and NHS England Area Team) to understand and address the issues impacting on performance against this target. The implementation of the new, integrated urgent care model which commenced implementation in October 2013 and embedding this whole system change will contribute to sustained improvement in performance in 2014/15 and beyond. There is strong commitment within NLAG of the need to move to full implementation of this model within the next few months to support a sustained improvement in the A/E waiting times at Scunthorpe and to bring performance in line with that at the Grimsby site.

HEYT have a number of issues with waiting time performance that have been notified to commissioners and are working with the national Intensive Support Team and Trust Development Agency to identify the underlying cause, size of the issue and resolution. HEYHT has a recovery plan which should deliver against the target by October 2014, however it is likely that there will be further breaches of waiting time standards while the plan is implemented.

As required within the 2013/14 planning submission, NL CCG set out local quality premium targets for 2013/14. These were; thrombolysis of eligible stroke patients, dementia diagnosis rates and reducing non elective readmissions.

Formal data is not yet available to demonstrate NL CCG year end performance relating to thrombolysis of stroke patients, however local data suggests we are on track for achievement.

The dementia diagnosis target is expected to be achieved, although the year end position will not be reported until October. However the achievement of the 67% target within this

plan will be a significant challenge. Analysis of data on non-elective readmissions showed a significant improvement above the 2% target, with an in year reduction in emergency readmissions of 23% against the 2012/13 position.

The CCG has set a local indicator for 2014/15 to improve the timeliness of surgery for patients experiencing a hip fracture. Current local performance is approximately 60% for HEYHT and NLAG; below the national average of 71%. NL CCG has set a target of 75% in 2014/15 of patients having surgery on either the day of, or day after admission. This will take North Linconlshire ot above the current national average.

4.3 Performance against the 5 domains

Performance against the 5 domains in the NHS Outcomes Framework highlights a number of challenges for North Lincolnshire

- Prevent people dying prematurely – local challenges regarding respiratory disease, liver disease and cancer
- Recover quickly and successfully – issues regarding the number of non-elective admissions for conditions that should not normally require admission
- Great experience of care – local challenges regarding response rate for Friends and Family test (FFT), experience of hospital and out of hospital care
- Kept safe from avoidable harm- There were 3 cases of MRSA attributed to North Lincolnshire CCG patients in 2013/14. The CCG narrowly missed achievement of the target for C Diff by two cases in 2013/14.

4.4 The 7 outcome ambitions; targets for improvement

The planning guidance requires CCGs to set a number of ambitions for improvement during the lifetime of the plan; 2014/15 - 2018/19. This section describes the rationale for the ambitions the CCG has set. Appendix 3 shows the targets set.-amend appendix 3

Securing additional years to life for people with treatable mental and physical health conditions – Baseline data from 2009 – 2013 is erratic, resulting in some challenges in setting a target for improvement. Whilst the plan focuses on improving care and outcomes for people, particularly those with long term conditions, this is set against a backdrop of higher than average obesity, smoking and physical inactivity locally compared to the national average and higher levels of coronary heart disease and hypertension

Improving health related quality of life for people with long-term conditions – the CCG aims to achieve a steady improvement in reported quality of life to take the CCG to the upper quartile nationally by 2015/16. Beyond that, we expect a slower level of improvement. There is significant focus during 2014/15 and 15/16 on long term conditions and development of services based on what people have told us they need, however we recognise the challenge of sustaining this level of improvement as the number of people with diagnosed long term conditions increases.

Reducing the time people spend avoidably in hospital through better and more integrated care outside of hospital – a significant focus of the strategic plan is to manage people's needs differently- prevention of ill-health, identifying problems early, managing within a community setting and returning people to their previous level of independence. All these elements will contribute to our challenging target of reducing non-elective admissions. The

target has been set at this level to reflect the reduction in acute sector spend required in order to achieve the pooled budget for the Better Care Fund (BCF). We have set the target for reducing hospital admissions against the 2013/14 baseline as this was significantly higher than the 2012/13 position. We recognise the challenge of this target and will use 2014/15 to start to implement plans set out within the BCF to deliver this.

Increase the proportion of people living independently following hospital discharge – NLC;NLAG and the CCG aim to maintain the current level of performance for people living independently following a hospital admission. This is set against a context of rising numbers of older people and a rise in those with complex needs. We will deliver this through increased access to rehabilitation and reablement delivered through in-patient intermediate tierbeds and in people's own homes. We also expect the proportion of people entering care homes to remain static despite the increase in older population, therefore representing a decrease in real terms.

Increasing the number of people having a positive experience of hospital care – CCG have set a target of steady improvement in the number of people reporting a poor experience of hospital care. The 2013 CQC in-patient survey report highlights scope for improvement in patient experience within the local acute provider;NLAG and CCG will take this forward with the Trust to secure improved experience It is unclear as to what extent the recent Keogh review and media attention on NLAG has impacted on reported patient experience. Based on current data, our target will move NL CCG to the top of the fourth quartile by 2018.

Increasing the number of people having a positive experience of care outside of hospital in general practice and the community – CCG have set a relatively low target of improvement to reflect the recent service changes that some patients may feel are negative. These include the changes to the urgent care model, which will direct patients to primary care where appropriate and the de-commissioning of the non-registered patients primary care service. Patients also vocalise a perception that they cannot easily access primary care, although this varies between practices. However, plans are being implemented that will support and improve experience, including the implementation of Productive General Practice and broad communications about how people can access health services. The plans to support implementation of the accountable GP for over 75s and the unplanned care DES should also contribute to improved experience due to better identification of needs, and assessment and planning of care. In addition, the shift of long term condition care from hospital to primary and community care should improve experience.

5.0 Sustainability

5.1 Current configuration issues

NL and NEL CCGs are served by a single main acute provider; NLAG. The majority of services are provided on both Scunthorpe and Grimsby sites, with a lesser range of services provided at Goole Hospital. North East Lincolnshire has in addition, a wide range of community provider services, whereas within North Lincolnshire, NLAG also provide community services. Mental health services in North Lincolnshire are provided by (RDaSH), with only a low number of small additional service providers locally.

Local Trusts face a challenging financial position in 2014/15 and beyond and are working with local commissioners to design services in a way that achieves financial stability going forward.

With no projected growth in allocation and an ageing population with multiple long term conditions, continuation of current health service models will result in a funding gap of circa £30bn nationally by 2020/21.

For Northern Lincolnshire, this represents a funding gap of approximately £80m by 2016/17. Main drivers impacting on acute Trusts are the tariff deflator, demand growth, and the creation of the Better Care Fund.

Healthy Lives, Healthy Futures is the on-going Northern Lincolnshire programme aimed at achieving an affordable and sustainable health model for the future. This joint partnership with NEL CCG and NLAG is currently developing proposals for public consultation to redesign and centralise some services in order to make these sustainable in terms of both quality and cost. Continued delivery of services within the current configuration is not affordable either for CCGs or the acute trust. Whilst in the longer term, closer working between NLAG and Hull and East Yorkshire Hospital Trust (HEYHT) is expected to develop, in the shorter term, partners need to agree a way of delivering affordable services to the local population which will mean a shift in the range of services currently offered.

In developing plans to shift services from the hospital site to community bases, we are working closely with providers to understand the implications of this shift in terms of the provider's ability to deliver compliant services and maintain on call rotas. The aim of moving these services to a community setting is to deliver care closer to the patient; that does not necessarily mean that patients will not have access to consultant input, it does however mean that the service will be delivered in a different way and clinician roles may change.

6.0 The Vision – A 5 year strategy; Healthy Lives, Healthy Futures

NL CCG set out its mission statement in its 2013/14 commissioning plan and this still stands; "To achieve the best health and well-being that is possible, for the residents of North Lincolnshire, within the resources available to the CCG".

The strategic plan and delivery of the vision for North Lincolnshire and North East Lincolnshire as units of planning revolves closely around our joint programme for transformational change, Healthy Lives, Healthy Futures. The programme aims to secure high quality, safe and sustainable services for the local populations now and for the next 10 years.

During 2012/13 a comprehensive Case for Change was developed as the underpinning rationale for the transformation and identification of focus for areas of work. This work takes into consideration the national and regional work around specialised commissioning, and Strategic Clinical Network developments which may see further centralisation of some services currently delivered within the Humber area for local patients.

The vision we have set out for the next five years in North Lincolnshire, working with commissioning partners, local providers, stakeholders and local people is ambitious in its

scope and enables local health and social care services to meet the needs of people in the area within the resources available.

6.1 Quality and outcomes

Future system configuration will deliver high quality care. Steps are being taken to ensure that system reconfiguration over the next 5 years protects or improves quality of care. Quality and safety form part of the assessment criteria to be used for scoring proposals being considered within HLHF. Service redesign aims to support the improvement in performance against the 7 ambitions across all providers.

Commissioners will hold providers across the system to account for the quality and outcomes of their services through established processes and through the arrangements set out in the BCF plan. Where services are commissioned and delivered on a wider footprint, the Humber and North Yorkshire CCG Collaborative will be actively involved in holding providers to account.

6.2 Patient perspective

The vision puts the patient at the centre of care. Services will be designed to respond to patient needs rather than service needs, with many services delivered in multiple community based settings, supported by appropriate transport services to meet the needs of people with restricted mobility. Patients will value the care they receive, understand their care plan and be motivated to actively contribute through self-management. They will have access to education and peer support to enable this. Patients will feel that health resources are appropriately used and provide value for money to the tax payer, through overall improvements in health literacy and self-care skills. They will be aware of how they can engage with commissioners and providers to contribute positively to service redesign processes.

This patient centred system will mean people;

- feel able to make appropriate lifestyle choices to support their longer term health and prevent illness, and have appropriate information and support to do this.
- are equipped to manage their own health, particularly in relation to management of minor illness and ailments and self-management of long term conditions.
- recognise that mental health and wellbeing is important to their physical health and they can access this close to home, in a variety of ways.
- access most of their healthcare close to their home, but where care in a hospital is required, they are confident that the care is of high quality, regardless of where it is delivered.
- recognise that they may need to travel further afield to access some treatments.
- feel that they are supported to remain independent and in their own home for as long as possible.
- understand who is leading the coordination of their care and that whilst many providers/services may be involved, that care is seamless.

6.3 System configuration

GPs and practices will be pivotal to day to day care. Practices will work with patients to encourage and enable self-care and independence, with the ability to direct people to Well-

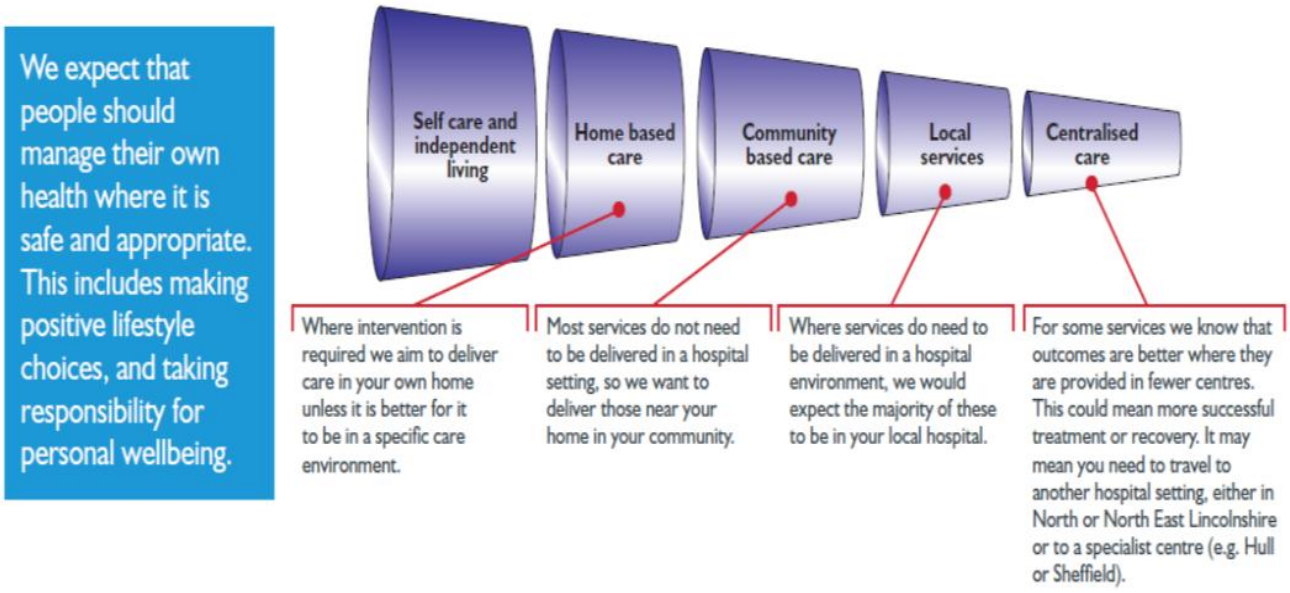
being Hubs for further support on a wide range of health, life-style and care issues and access to a wide range of community based services. This will include the pro-active management of people to reduce the risk of them requiring hospital admission and reducing risk of complications associated with long term conditions. Integrated locality teams will provide on-going care and support to these people to maintain them within lower levels of care.

People will be managed holistically with equal regard for mental and physical health and support people to understand the importance of mental health on physical health and vice-versa.

Where people do require intervention, this will be provided in the home or community setting where clinically safe, supported by rapid access to community teams. The Urgent Care Centre will play a pivotal role in ensuring people receive care within the lowest level of care appropriate to their condition. Within this model, people will be assessed and managed using ambulatory care models and home based care where possible, then supported by locality teams to return to the maximum level of independence achievable for them.

The programme recognises that there will be times when hospital admission in required to provide appropriate care, and where this is the case, will aim to provide such services within Northern Lincolnshire when it is clinically safe to do so. In making this commitment, it is recognised that at times, to ensure a high quality service, care will need to be delivered from hospital sites outside of Northern Lincolnshire. The Healthy Lives, Healthy futures programme focuses on maintaining people at the left hand side of the diagram, supporting them to manage their own health and make appropriate lifestyle choices, and where they develop ill health, support them in managing their condition(s) effectively to maintain their level of health and independence.

The vision can be described in the diagram below which is drawn from our system wide transformation programme, Healthy Lives, Healthy Futures.



A key element of this vision is to enable local people to manage their own health and wellbeing more effectively and to engage with their communities to deliver solutions based on self-care and self-responsibility. This will require the health and social care community to support people to develop health literacy and self-care skills. This includes support and advice on lifestyle choices, skills to recognise and manage minor ailments and injuries and on-going support and education to enable people living with long term conditions to manage their own condition. To support this, staff will need to develop the skills and competencies to deliver consultations using motivational interviewing techniques.

This approach has been built on locally in the development of the North Lincolnshire BCF plan, where there is a strong emphasis on prevention and maximising independence to deliver the outcomes people say they want (Keeping Well and Living Independently, 2013.NLCCG).

Stakeholder sign up to HLHF and the BCF has been achieved through the Health and Wellbeing Board and the working groups of this board; the Integrated Commissioning Partnership and the Integrated Working Partnership. This is underpinned by the North Lincolnshire HWBB Integration Statement. http://webarchive.northlincs.gov.uk/EasysiteWeb/getresource.axd?AssetID=56781&type=full&servicetype=Attachment

The service response to this vision will see key changes over the next five years (these are set out in more detail within the life stages section of this plan, section 18.3-18.7

2014/15 and 2015/16

- Full implementation of the new model of integrated unplanned care embedded
    - Integrated Urgent Care centre at Scunthorpe General Hospital (SGH)
    - Single point of contact in place from October 2013 to become a fully integrated service with Social Work input and enhancing the 7 day offer
    - Clinical decision unit operating fully as an assessment facility and working with primary, community and mental health services to deliver ambulatory care and reducing admissions unnecessarily to hospital
- Creation of a short stay paediatric assessment unit alongside the urgent care centre, supported by an enhanced community children's nursing team
- Services for the frail and elderly being redesigned to provide integrated health and social care responses
    - A wellbeing offer focused around health and wellbeing hubs in each of the five localities in NL
    - Rapid assessment and response services, primary, community and mental health services through a single point
    - Long term care particularly for those with long term conditions, including dementia driven by changes in primary care to introduce risk profiling, care planning and case management supported by care coordinators and the integrated proactive care teams in each locality.
    - Reduction in beds at SGH equating to two wards/30 beds
- Implementation of any changes from Healthy Lives Healthy Futures agreed following public consultation in summer 2014 in relation to ENT and stroke and further engagement on paediatric surgery.

2016/17 to 2018/19

- Proposals across Northern Lincolnshire, North Yorkshire and Humber and Yorkshire and Humber re optimal location of Hyper acute stroke services, emergency care centres in response to Keogh recommendations, specialised services footprints etc will require public consultation in 2015/17 to support the centralisation of services.
- These will then be subject to a managed implementation

Vision beyond 2018/19

- Ultimately services offered locally in North Lincolnshire will provide the care for the majority of the population, however those services identified as best provided as a centralised response in the 'funnel' are likely to be provided on a larger footprint and centralised across the Humber or wider for more specialised services.

6.4 Key Principles

There are some principles which underpin the way services will be commissioned over the next 5 years to deliver this level of transformational change:

- Quality and safety must be the highest priority
- There will be an increasing requirement for focus on prevention and self-care / independent living rather than reliance on hospital based care
- A small number of hospital services, particularly specialised services, will be commissioned from centralised locations if necessary to improve outcomes
- To deliver the right care, in the right place at the right time; for example reducing inappropriate admissions to inpatient beds in hospitals and care homes through better management of care in the community.
- Organisational barriers need to be broken down where needs are complex and patient care crosses numerous boundaries to improve co-ordination and reduce fragmentation of care
- Providers will be expected to work within the financial constraints of each health community

6.5 Core Enabling Themes

In order to deliver this challenging agenda there are some specific enabling work that will need to be undertaken. Some key themes are emerging that are common to all CCGs within North Yorkshire and Humber.

6.6 Improved Access

- Seven day working and 24/7 access to key services and information is required both in hospital services and primary care/community services (meeting the national standards).
- Single Point Access, and/or Single Point of Contact to support appropriate care navigation where individuals and their families/carers are directed to the most appropriate service at the most appropriate time.

- There is a need to increase access to hospice type care for all patient groups (e.g. COPD and heart failure patients and other end of life care, not just cancer patients) and to ensure this is available in a timely manner, in order to reduce admission to hospitals (particularly out of hours).

6.7 Focus on Care in the Community

- Providers will need to work with CCG and local authority commissioners to change the way that acute services are provided to reduce face to face interventions and promote community based care.
- Community services and Primary Care will be strengthened, for example; primary health care teams, community nursing, community based diabetic care, or management of long term conditions to ensure that hospital services are used appropriately.
- A range of different technologies will be harnessed to enable and promote self-care and home-care provision of services where safe and clinically appropriate.

6.8 Improved efficiency for support services / Infrastructure and Staffing

- The workforce needs to be supported to work, through training and professional development, in different ways to support the integration agenda: Communication channels between care homes and the wider health and social care community need to be strengthened and improved.
- Transport and infrastructure will be a key concern for patients if current service locations are changed, and commissioners will need to work with transport companies to use resources as effectively as possible.
- Use of outcome based measurement of care services, rather than process metrics, to ensure that organisations focus on quality of care outcomes rather than timings and volumes.
- IT infrastructure and access to health and social care records must be seamless and timely crossing organisational barriers through the use of technology to ensure better outcomes and efficiencies. This needs to include partner organisations such as Local Authorities, to ensure that we overcome the challenges with sharing and transferring information.

6.9 The national picture

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffs, and the Berwick and Cavendish Reviews.

Recommendations and responses from these reviews have influenced local thinking of commissioners. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised. We will work closely with NHS England Yorkshire and Humber Area Team to support the implementation of their commissioning strategy for specialist services.

The national direction is reiterated by the requirement to establish Operational Delivery Networks (ODNs) which are hosted by providers and whose remit is to support providers to work collaboratively sharing information to narrow variation in quality and costs.

Moving towards a system consisting of networked providers delivering a full range of specialised services between them means that there will be a greater range of providers delivering care for the population of each CCG. For all other provision, hospitals will be expected to utilise generalist-led, multi-disciplinary teams to provide continuous care around each patient for example in-reach/outreach services.

6.10 The local picture

This national thinking has informed discussions between CCGs and hospitals within the local NYH area particularly focussing on how services could be delivered jointly in the future in a sustainable way. It is important to consider the impact on current providers and services which may be adversely affected by removing related services to centres of excellence and the impact on patients who already travel some significant distance within the NYH area and further afield for certain specialist integrated services.

As national thinking moves more towards increased centralisation of specialised services, for quality and safety purposes, it is anticipated that additional services may also be centralised where appropriate in the NYH area, subject to consultation processes. However, it is essential that the impact of further centralisation is modelled and managed appropriately to avoid potential adverse effects to the sustainability of local services (e.g. through loss of skill, difficulties in recruiting) and the accessibility of services for patients.

It is recognised that Providers are aware that the scale of the quality, workforce and financial challenge is too great to achieve in isolation.

As commissioners, CCG is clear that increased centralisation of health care services is unlikely to result in financial savings. In some cases the costs of relocating services to one location may be costly but significant value gained through improved safety and quality. Centralisation considerations are to improve quality and safety.

As the majority of services suitable for centralisation are commissioned by NHS England, NL CCG and other commissioners will need to work closely with the NHS England Specialised Commissioning Team (SCT). The SCT has identified a number of services which have Commissioner Derogation. These are where existing providers are unable to meet the requirements of the nationally mandated service specification, meaning that NHS England and CCGs have a responsibility to define the longer term strategic direction of those services, and potentially procure new providers.

Locally the SCT is undertaking consultation to establish their five year plan. Within the priorities being consulted on there is focus on the following:

- Complex Cardiology Services, with the view to full scale reconfiguration
- Morbid obesity surgery where there is a need for CCGs to commission Tier 3 weight management services to support this priority
- Meeting the national requirements for Vascular Surgery

It is also recognised that in specialties with activity growth greater than 6% a review will be undertaken and these areas will be prioritised for redesign.

7.0 Health and Wellbeing Strategy

The Health and Wellbeing Board (HWBB) approved the first Health and Wellbeing Strategy in April 2013. This plan supports and complements the delivery of that strategy.

The vision for North Lincolnshire is set out in the Health and Wellbeing Strategy it states that "North Lincolnshire is a healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced".

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

Overarching strategic priorities for Health and Wellbeing Strategy

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

8.0 Better Care Fund

The Health and Well Being Board and local partners are committed to integrated working. Our ambition will be achieved by transforming our approach to better care, service delivery and commissioning to ensure a good social return on investment, and ensure that people are provided with support in their homes and in their communities.

This will be delivered by whole systems integration that is owned by all with a shared accountability for achieving positive outcomes and delivering efficiencies across health and social care.

The development of the BCF plan and the supporting Frail and Elderly Implementation Plan are an integral part of the integration programme and as such are a priority for the Integrated Commissioning Partnership (ICP) and the Integrated Working Partnership (IWP). The IWP membership includes representatives of health, social care and wider partners and providers within North Lincolnshire.

The BCF plan reflects and builds upon a number of existing programmes e.g. the Frail and Elderly Implementation Plan and HLHF which have included health providers as active participants, together with Local Authority Services and other Social Care Providers including Residential Care and the voluntary and community sector. The plan also draws heavily on the insights from the local population gathered through the Experience Led Commissioning programme 'Keeping Well and Maintaining Independence' and the first phase of engagement on Healthy Lives, Healthy Futures.

In essence people told us that to keep well they need to be;

- In control
- Able to pursue my life purpose (caring for others)
- Supported by a close social network of family, friends who share and understand the experience
- Confident with one main trusted point of contact who is linked to the health and social care system (not necessarily a Clinician)
- Confident that the trusted contact is able to join up conversations within and between services
- Able to concentrate on coping and keeping well and doing as much as possible to care for others with support
- Supported to preserve mobility
- Confident that services will recognise emotional as well as physical conditions

Key messages from the Healthy Lives Healthy Futures first phase of engagement include;

The **focus on relationship based care and not clinical integration,** i.e**.** conversations matter, with people feeling that a trusted point of contact providing seamless care is more important than understanding the integrated model of care.

Independence keeps people well, people want to remain independent for as long as possible and they want to use health services as little as is necessary.

Strong Support Networks, people want to be independent and choose how to live their life, but when they need support the clear message is that this needs to be delivered closer to home, in the community and by trusted family, friends or carers.

Tapping into community and life expertise will yield rewards in relation to increased ownership of those who may be more vulnerable. The engagement demonstrated that there is an appetite amongst the communities and localities to support each other.

A system wide workshop was held on 5th February to develop the Frail and Elderly Implementation Plan. It brought together partners including clinicians, residential and nursing care providers, the acute and community sector, social care, therapy services, GPs and CCG to discuss the strategy and changes required to deliver the Frail and Elderly Implementation Plan. Several scenarios were explored to test the impact of potential BCF investment proposals. Partners have agreed to use the 'Large scale change programme' facilitated by the NHS Improving Quality Team to support the mobilisation of the plan. The first workshop took place on 12th March, attended by a range of providers and partners, including social care, health, GP's, prevention services, EMAS, and voluntary sector

Over the next five years more services will be delivered in the community at the lowest possible point of support and intervention. The Single Organisational Model approach (appendix 4) is being utilised to ensure that support and services are delivered according to need and people are safeguarded and protected with timely and effective support to reduce crises and support a return home / community in an integrated way.

The Single Organisational Model has three core components underpinned by developing community resilience;

- **universal**, early identification, promoting **wellbeing** delivered in **localities**
- **targeted,** early help and assessment, and
- **specialist**, acute services and specialist social work services,

This fits with the vision set out in Healthy Lives, Healthy Futures which aims to maintain people at the lower end of care needs, shifting from the current situation where a large proportion of the money we spend on healthcare is focussed on hospital services to one that focuses on providing more opportunities for people to look after their own health at home and in their local communities.

8.1 Outcomes

Reliance on acute services will be reduced through long-term conditions being better managed in the community; should people require a stay in hospital then this will be for the right reasons. We will continue to invest in what works e.g. reablement teams and build upon our performance in reducing delayed discharges and transfers of care, whilst ensuring that people are helped to regain their independence after episodes of ill health as quickly as possible with clear plans and arrangements for discharge, and as necessary with appropriate community based health and social care services.

Use of residential and nursing care will be for those whose needs cannot be safely met in the community. Our front line workers both health and social care will feel more confident and competent in supporting people to stay well and keep well, and deliver non-acute emergency care in the community.

This will mean that pressures on emergency care in hospitals are reduced as we shift from high-cost reactive services to lower cost preventative services and anticipatory care to avoid people falling into crises.

Metrics and local ambitions have been agreed and submitted as part of the BCF plan. This includes the local measure ‘Proportion of older people offered rehabilitation and reablement’. This is seen as a priority as reablement of patients following illness contributes significantly to maintaining their independence and reducing admissions to care homes.

8.2 Finance

The BCF plan will result in the following pooled budgets by year;

Total agreed value of pooled budget:	**Value**
2014/15	**£4,545,000**

2015/16	**£12,370,000**

In order to achieve the pooled budget in 15/16, NL CCG will need to decommission circa £7m acute sector spend. This will be achieved by reduction in non-elective admissions, A/E attendances and reduced lengths of stay. For indicative purposes, £7m equates to approximately 20% in all admissions.

This will require redesign of services to provide care in the community setting. This is a challenging target, however the plans build on the Healthy Lives, Healthy Futures plan and brings mobilisation of elements of HLHF forward. The use of the NHS IQ large scale change programme will support the local health and care economy in the delivery of these changes with the aim of maximising success.

8.3 BCF Interventions

Following the development of the Better Care Fund plan, there has been a period of focussed analysis and planning to further define the key interventions for 2014/15 - 2015/16. Detailed modelling of impact is underway. Priority interventions and developments are;

- A wellbeing offer to support community response, prevention, early support and self-management of care needs with the establishment of four wellbeing hubs across the community by the end of summer 2014.

- Continued and further investment in reablement (including intermediate care) at the targeted and specialist level to include a new hospital team under one integrated manager with all social care professionals represented including mental health within the hospital operating 7 days from April 2014.

- Integrate NHS and Social Care Systems around the NHS number to ensure that frontline professionals have access the information they need in real time. This will ensure joint care planning can take place and support patient's wishes not to have to repeat their story of care, building on existing care planning, use of risk stratification tools, care co-ordination and multi-disciplinary ways of working and locality teams.

- Building anintegrated, multi-disciplinary support system with GP's, District Nurses and Social work with care homes through the development of a care home support team. This model will aim to;
  - reduce referrals to the Emergency Department, ambulance journeys and overall hospital admissions for preventable conditions.
  - increase the number of patients who have had comprehensive and holistic assessments of their needs and have a written personalised care plan with an identified named professional responsible for their care.
  - increase the number of patients who have experienced an evidenced based dementia and memory assessment and who have received ongoing referral and support if they are identified to be at risk of memory deterioration.
  - provide focussed and targeted training and development to individual homes who have repeated patterns of the cause for referral

- Full implementation of the urgent care model including the use of Ambulatory Emergency Care models to manage people within their own home with appropriate care and support wherever clinically safe to do so

- Development of a time limited support service to provide a rapid and enhanced short term support service to named patients who are at risk of deteriorating and requiring unplanned admission. This will be an integrated health and social care response aimed at avoiding hospital admission and returning the person to their previous level of independence where possible.

- Continued investment in support to carers to keep them well. The investment in carers will be reviewed to ensure we are in a position to implement the changes as a result of the Care Bill.

We recognise that achieving our vision will mean significant change across the whole of our current health and care provider landscape. Whilst GP's play a significant and pivotal role in this, all providers of health and social care services will need to change the way they work. The CCG and Local Authority Commissioners continue to work together to stimulate the market place, and effect the required change to ensure that this happens at scale and pace.

The proposals include the need for investment in community based clinicians and increased services to support acute care in the community. This will involve an up--skilling of the current workforce to enhance their rapid assessment and diagnostic skills; it will involve greater skill mix and the development of new roles and it will result in clinicians working across a range of settings outside organisational boundaries.

Clearly this is an ambitious plan and work is currently underway with NLAG and NLC to define what can be clearly implemented in Phase1 to enhance the current models of service provision, address any significant gaps and test out new models. Phase 2 will then focus on a comprehensive review programme of a number of community services some of which is currently underway such as the Locality Teams with a view to increasing their impact across the system. This will also need to connect clearly with the emerging plans for the care coordination role within primary care to ensure that services are responsive and connect appropriately.

There will however remain the need to ensure the residual acute services are robust in order to ensure that for acute medical and surgical needs the whole population as well a Frail and Elderly continue to be available and people receive the care they need in the right place at the right time with the right management.

The aim of the HLHF programme is to shift the emphasis away from hospital based care by ensuring that people (all ages) are only admitted when they need acute and acute emergency care. The BCF expedites this targeting the frail and elderly population.

The potential reduction in hospital activity has been signalled as part of commissioning and contracting intentions for 2014 to 2016. The impact of the initial investment under the Better Care Fund vision and initiatives will need to be evidenced during 2014/15 through reduced activity to enable the decommissioning of hospital based care to begin.

The SGH site has during the last 12 months seen a slight increase in volume of admissions but a more significant shift in 'acuity' (level of unwellness) of those requiring admission. This

has resulted in periods of pressure for admission and breaches in the 4 hour target. This has been mitigated in part by mobilisation of the new unplanned care service and will be further strengthened by the investment in 7 day working. Marginal rates funding is being utilised to reduce admissions and support early discharge to ease patient flow.

The BCF proposals include the need for investment in community based clinicians and increased services to support acute care in the community in order to support the reduction in admissions.

8.4 BCF Governance

Whilst the initial development of the BCF plan was overseen by the HWBB, BCF governance arrangements are now in place. A joint board has been established, with the inaugural meeting held in March 2014 with equal membership (CCG and NLC. This board is accountable for the mobilisation of the agreed BCF plan, and the delivery of the agreed outcomes, performance metrics and finances.

Future governance arrangements to form part of the section 75 agreement will be developed during 2014/15 to ensure that they can be in place by 2015/16. These will provide the future governance between the CCG and NLC to ensure that the ambitions of the BCF are achieved. The CCG is also working towards going beyond the mandated levels for 2016/17 onwards to maximise economies of scale for BCF to have the biggest impact possible, and has mapped for example, resources spent collectively on frail and elderly persons, which will be monitored as a shadow budget in 2014/15 by the Joint Board.

Financial Risk Sharing arrangements have been agreed in broad terms and will be developed further in order to mitigate any financial and service risk. A risk log is in place and will be reviewed and monitored by the joint board.

9.0 Provider landscape

9.1 Acute Trusts – Current Landscape

North Lincolnshire patients access acute care through a small number of acute providers, namely;

- Northern Lincolnshire and Goole Foundation Trust, with sites in Scunthorpe , Grimsby and Goole,
- United Lincolnshire Hospitals Lincoln site
- Doncaster site at Doncaster and Bassetlaw Hospital Trust
- Hull and East Yorkshire Hospitals Trust

Specialised commissioned services are delivered by Hull and East Yorkshire Hospitals in the main, a small amount via Leeds Teaching Hospitals with children's services commissioned from Sheffield Children's Hospital.

There is also a range of Independent Sector Providers providing mostly elective surgical services.

9.2 Northern Lincolnshire & Goole NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) provides acute secondary health care services to residents of North and North East Lincolnshire, East Riding of Yorkshire and East & West Lindsey, Lincolnshire and also community services in North Lincolnshire. Networked services are provided in collaboration with HEY as the Trust's main adult tertiary service provider, and the trust hosts pathology services (PATHLINKS) for Northern & Greater Lincolnshire (there is currently a review of Pathology Services across the Midlands). NLaG employs approximately 6000 staff, with an annual turnover of £310m.

Diana Princess of Wales Hospital (DPoW)	DPoW has approximately 400 beds, and currently provides a full range of emergency and secondary health care services, including an emergency care centre, intensive and high dependency care.
Scunthorpe General Hospital (SGH)	SGH with approximately 380 beds, provides a full range of emergency and secondary health care services, including an emergency care centre with an integrated model, and intensive and high dependency care.
Goole & District Hospital (GDH)	GDH has approximately 55 beds, and provides a Minor Injuries Unit, and a range of outpatient and diagnostic facilities, supported by SGH. GDH also houses a specialist rehabilitation service offering general medical and surgical rehabilitation.

9.3 Hull & East Yorkshire NHS Trust (HEYHT)

HEY provides a comprehensive range of acute hospital, specialist and major trauma services for approximately 1.25 million people living in the Hull, Yorkshire, East Riding and Northern Lincolnshire area. The trust provides networked services with other providers in the area, including; major trauma, major vascular, neurosciences, cardiology, oral surgery urology, cancer services, and a range of screening services. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services. HEY employs approximately 8,664 staff working across the hospitals and community, with an annual turnover of £495m.

Hull Royal Infirmary	Hull Royal Infirmary is based in the centre of Hull. With 709 beds, it is the emergency centre for the Trust. The A & E department sees 120,000 people each year, and is currently being upgraded. The site also consists of a dedicated Renal Dialysis unit, the Eye Hospital, and the Women's and Children's Hospital. The Clinical Skills facility is also based here.
Castle Hill Hospital	Castle Hill Hospital is based in the rural East Riding. It provides predominantly elective care, with 610 beds. This site includes the award-winning Queen's Centre for Oncology and Haematology, the Centre for Cardiology and Cardiothoracic Surgery (bringing diagnostic and treatment facilities in one state-of-the-art building on the site), and the Centenary Building (Breast Surgery and ENT).

9.4 Doncaster and Bassetlaw

Doncaster and Bassetlaw NHS Foundation Trust provide a range of secondary elective and non-elective care to the North Lincolnshire population – mainly those residing on the western side of North Lincolnshire. The Trust employs approximately 5,200 staff and covers a population of 410,000.

9.5 United Lincolnshire Hospitals

United Lincolnshire Hospitals comprises Lincoln, Boston and Grantham Hospitals and a large number of small community facilities with some of our southern population utilising their elective and non-elective secondary care services. The Trust employs 7,800 staff and provides care for over 650,000 patients per year, with an annual turnover of £400m.

9.6 Rotherham, Doncaster and South Humber

Rotherham, Doncaster and South Humber Foundation Trust provide mental health services for the North Lincolnshire population. There is a small inpatient unit within Scunthorpe at Great Oaks and a range of outpatient services provided from a number of facilities across North Lincolnshire, including 'Talking Shop' . The Trust employs 4,300 staff and provides care for approximately 115,000 patients per year.

9.7 Other trusts providing tertiary or specialist services to North Lincolnshire

Sheffield Children's NHS Foundation Trust provides specialist children's services. Outpatient clinics are undertaken by Sheffield Consultants in Diana, Princess of Wales Hospital (DPOW) and SGH for paediatric surgical and medical specialties. All specialist children's surgery, surgery for children under the age of 2 and children's cancer services are provided by Sheffield Children's NHS Foundation Trust. Neonatal care for babies less than 27 weeks gestation is also provided by Sheffield with plans in place to increase the gestational age for transfer to 28 weeks. Transfers are undertaken by EMBRACE (a specialist paediatric transport service).

Leeds Cancer Centre delivers a comprehensive range of treatments, for Leeds, Yorkshire and the North of England.

10.0 Primary care

NL CCG works closely with NHS England North Yorkshire and Humber Area Team to ensure provision of high quality primary care. The plans for 2014/5 and beyond will see a significant shift in the provision of primary care across North Lincolnshire, with a focus on:

- increased self-care, care in the home, care in community settings and less activity taking place in hospital (HLHF vision)
- BCF vision for care of the frail and elderly builds on this vision and sets a vision to support independence through a 'wellbeing offer' – through voluntary sector and social care with escalation via primary care
- Implementation of coordinated care, linked to the integrated locality teams
- Strategic plans set aim of wraparound care for LTC – personal care plans, integrated management of care with Primary care as coordinators, and a long term vision of whole system LTC model, with the GP as the pivotal clinician

- Reduction in follow up appointments – through LTC management in primary care with consultant and specialist nurse input and advice into care planning
- Increasing consistency of pathways within primary care, resulting in a reduction in variation in practice
- Development of federation across all practices
- Implementation of changes through GP Productive Practice
- Implementation of the unplanned care DES and accountable GP in 2014
- Development of new ways of working, utilising technology to meet additional demands on primary care
- Clear workforce strategy needed with NHS England (NHS E) to reflect future workforce requirements, demographics of GPs, individual and practice plans, and work with HEE re future training and support (NHS E, General Commissioning Principles for Primary Care)
- Quality and performance frameworks and standards
- Primary care IT systems and access to records across the system and by patients
- Maintaining linkages with Local Professional networks such as the Local Eye Network and Local Pharmaceutical Network to draw on their professional expertise into commissioning intentions.

10.1 Primary care education

Education of health professionals is key to delivery of transformational change over the next five years. As care shifts from secondary care into community and primary care, it is essential that staff can access appropriate education to support this. NL CCG will work closely with North Yorkshire and Humber Area Team and Health Education England to understand local education needs and develop appropriate training programmes.

NL CCG will continue to support regular local, time protected education programme for primary care staff.

A Practice Nurse forum has been re-established with the aim of ensuring all practice nurses within North Lincolnshire have access to high quality education and are enabled to share best practice and shape future developments.

11.0 Armed Forces and Veteran Health

North Yorkshire and Humber Area Team (AT) directly commission health services for serving personnel in the Armed Forces and their dependents registered with a MoD Defence Medical Service (DMS) Medical Centre. North Lincolnshire does not have a DMS centre, however there is a local population of service members of the Armed Forces, reservists and veterans.

CCGs are responsible for commissioning all secondary and community services required by Armed Forces' families where registered with NHS GP Practices and services for veterans and reservists when not mobilised. Bespoke services for veterans will also be commissioned by CCGs either individually or through collaborative commissioning arrangements.

CCG obligations in relation to Armed Forces and Veteran health are;

- When posted somewhere new, serving personnel and their families should retain their relative position on NHS waiting lists to remove any disadvantage.
- Continuity of care for all wounded, injured and sick serving personnel on medical discharge from the armed forces when transitioning to civilian life.
- Bespoke veteran mental health IAPT services delivered by a provider with a specialist understanding of armed forces culture.
- Veterans should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

North Lincolnshire has signed up to the Veterans Concordat. NL CCG will continue to work closely with North Lincolnshire Council to encourage identification of veterans and direct them to support. Locally, very low numbers of individuals declare themselves as veterans, however training is in place within service provider organisations to encourage staff to identify veterans and ensure they receive appropriate access to services.

12.0 Parity of Esteem

NL CCG will ensure, within its planning that all people will have access to services which enable them to maintain both their mental and physical wellbeing. NL CCG will commission mental health services on a par with physical health services. The commissioning plan will address the requirements for all providers to provide holistic care, managing the mental health needs of those presenting with physical illness and addressing the physical health needs of those presenting with mental health needs. (see 'growing well' and 'working well' sections). There is a significant focus within the plan on CAMHs, mental health and dementia services. The CCG plans to undertake an Experience Led Commissioning programme within mental health during 2014/15 which will identify what matters to patients and carers and enable the CCG to develop, with patients, carers and providers, person centred outcome measures for incorporation into contracts for 2015/16. This programme may also identify whole system redesign requirements in order to ensure future services meet patients' needs.

There is no planned change to budget allocation for mental health and vulnerable people services. However the CCG will continue to work with providers to secure best value for money. Whilst the finance plan shows a reduction in mental health budget, in real terms there is no significant change. In brief, an element of Mental Health service expenditure has now been classified under a new combined budget for Services for Vulnerable People to more closely match budget and operational management responsibilities. The whole of the Services for Vulnerable people budgeted expenditure has then been mapped to the Continuing Care services line, as Continuing Care services accounts for the overwhelming majority of the expenditure recorded under the Services for Vulnerable People classification.

If Mental Health expenditure was re-classified in line with previous Commissioning plan submissions Mental health expenditure would increase by circa £1.843 Million at 2013/14 prices and over the 5 year plan period Mental Health expenditure in this broadest sense has been maintained, net of the efficiency savings which all NHS services are expected to achieve.

The reduction in the Continuing Healthcare budget reflects the planned efficiency savings associated with timely assessment and reassessment of patients needs and ensuring they receive value for money care packages.

13.0 Information management and technology (IM&T)

NL CCG has developed an IM&T strategy that reflects the national requirements set down by the Government in their Mandate to NHS England and the needs of the local population relating to the implementation of Health Lives, Healthy Futures over the next 5 years.

Activities to deliver all of these requirements will be defined in IM&T delivery plans. The following will be provided by March 2015

- Hospitals ready to accept e-referrals (an element of this is in place in NL via Choose & Book)
- Online access to patient's own health records held by their GP
- Plans in place to link electronic health and care records, to ensure as complete a record as possible of the care received.
- Plans for records to be able to follow individuals, to any part of the NHS or Social Care System
- Ability to book GP appointments and order repeat prescriptions online
- Secure electronic communication with the GP Practice, with the option of e-consultations becoming more widely available
- Routine access to information and advice on the support available, including respite care, for carers of people with long term conditions.
- Significant progress to be made by 2017 for people with long term conditions to benefit from telehealth and telecare – supporting people to manage and monitor their condition at home, and reducing the need for avoidable visits.
- Over the last few years there has been a gradual move to most practices utilising SystmOne as their clinical record, with 14 of the 21 practices now using SystmOne, covering 118,000 patients). SystmOne is also used by Community services and the Hospice. On-going discussions between EMIS and TPP will over the next few years provide greater intra-operability between the two systems.

Mobile access continues to be problematic within North Lincolnshire due to connectivity issues.

Both EMIS and TPP have developed a mobile solution which enables a clinician to work offline for scheduling and accessing patient contacts if connectivity is lost and NL CCG continues to commission through Y&HCSU to deploy wireless networking to support real-time access to electronic records.

13.1 Patient and Public Access to Information

Technical capability to provide direct electronic access to GP records for patients already exists within EMIS Web and SystmOne. Although this is a key requirement for 2015, the majority of practices have already enabled patients to make appointments on-line, request repeat prescriptions and some have electronic communication in place. However, there is a programme of work required that will allow patients to access their full GP record including

working with practices and the public in raising awareness, providing timely communications and ensuring that concerns over security are addressed.

The Digitisation Agenda provides significant opportunities to reduce demand for NHS services by providing access to investigation results, pre and post-operative information, self-diagnosis and treatment information for common complaints and symptoms. There are potentially huge advantages to be gained for providers, commissioners and particularly for the local population, in developing a central patient portal. Whatever approach is taken, it needs to consider future integration with the new "customer service platform" functionality being built by the NHS England, to enable the public to engage with the NHS to provide feedback about care experiences and book appointments. Wider access to records outside of primary care will be supported by the implementation and integration of electronic patient records managed within an IMT locality programme.

13.2 Information Sharing and Integration

There is a need to share information between multiple systems and service providers to facilitate and enable new and improve patient pathways. In addition, the need to work more efficiently is driving healthcare providers to maximise opportunities to improve processes and reduce the administrative "paper chase".
NL CCG has adopted a service model of 5 locality based integrated health and social care teams. Information sharing is crucial for these teams to deliver seamless care and make appropriate health care decisions.

The Summary Care Record (SCR) is now available for large number (approximately 60%) of consenting patients. The focus now needs to be on provision of access to the SCR to improve patient experience and care in the relevant settings. There is the potential and desire within NL and beyond to exploit this as a vehicle to share information to support end of life care.

Due to the significant deployment of SystmOne, information sharing is already supporting clinical care across a wide range of services. There is a need to extend this to share information across EMIS Web and Acute and Provider Services. Development is underway to enable access from an EMIS patient record directly into the SystmOne record and vice versa.

We also need to fully utilise technology currently available to us, for instance NHS mail to support the transfer of clinical documents between clinicians and organisations.

The local Acute Trust has implemented the SystmOne clinical viewer, which provides access to the primary care record in the acute setting. However, to deliver against the government's Mandate "to ensure plans are in place to ensure all patients have an integrated record of their care that can follow them to any part of the NHS or social care system by 2015", it is crucial that we develop a deeper collaborative approach to informatics delivery with our Local Health Community providers and other partners and work together to define a common set of requirements, and plans for delivery. This delivery plan will be developed in conjunction with the Integrated Working Partnership.

The Medical Interoperability Gateway (MIG) is a means of sharing information between EMIS and TPP systems. Using the 'Detailed Care Record' and with appropriate levels of consent in place, information can be viewed across both systems including GP and

community information. An added benefit is that organisations, such as Nursing Homes, can access the clinical record via the internet without having to use either clinical system. There is a cost for usage of the MIG across the patient population, but once purchased it can be accessed in many ways by many different organisations at no additional cost. NL CCG is focussing the initial work on the MIG to support end of life care through special patient notes (see Dying Well section), however plans are in plan to increase the scope of special patient notes during the next 5 years.

All Health services use the NHS number as the key identifier and progress is being made to use the same identifier within social care. Where Specialist Adult Services engage with the NHS to support adults the NHS number is already recorded in the case management systems, in many cases. The Local Authority is committed to using the NHS identifier. A gap analysis of usage is being undertaken to determine where it should be used but is not recorded as standard practice and to achieve consistent implementation as a primary identifier. An action plan has been developed to achieve full implementation by March 15.

13.3 Impact of e-Referrals (Choose & Book v2)

Over the next few years, a new national NHS e-Referral Service will succeed the current Choose and Book service. It will be developed based on feedback from patients and NHS professionals. As the specification for e-Referrals is still being developed, it is not known what the impact of this service will be on systems but the drive is towards a totally paperless solution. NL CCG will continue to monitor progress of e-referrals, but also assess the potential benefit of the use of systems such as 'Map referrals' via Map of Medicine, to enable high quality referrals and a reduction in practice variation through the consistent use of pathways.

Priorities for IM&T programme during 2014/15 – 2015/16 include;

- Implementation of network capability in Care homes during 2014/15 – enabling clinician access to their patients clinical records in the care home, roll-out of SystmOne Care home module to support the sharing of care pathways and aid medicine optimisation of patients in care homes
- Integration between EMIS Web, SystmOne and NLaG (Ascribe
- Deployment of solutions to support integrated working between health, local authority including public health and mental health
- Scope requirements for implementation of video consultations between GP's and patients and clinical staff for remote consultations.
- Rollout Electronic Prescribing System to GP's, building on current coverage to achieve national target of 75% by 2015.
- Work with practices to implement online patient access to clinical records by end 2015
- Implementation of electronic correspondence including e-- referrals, discharge/outpatient summaries by end 2015/16

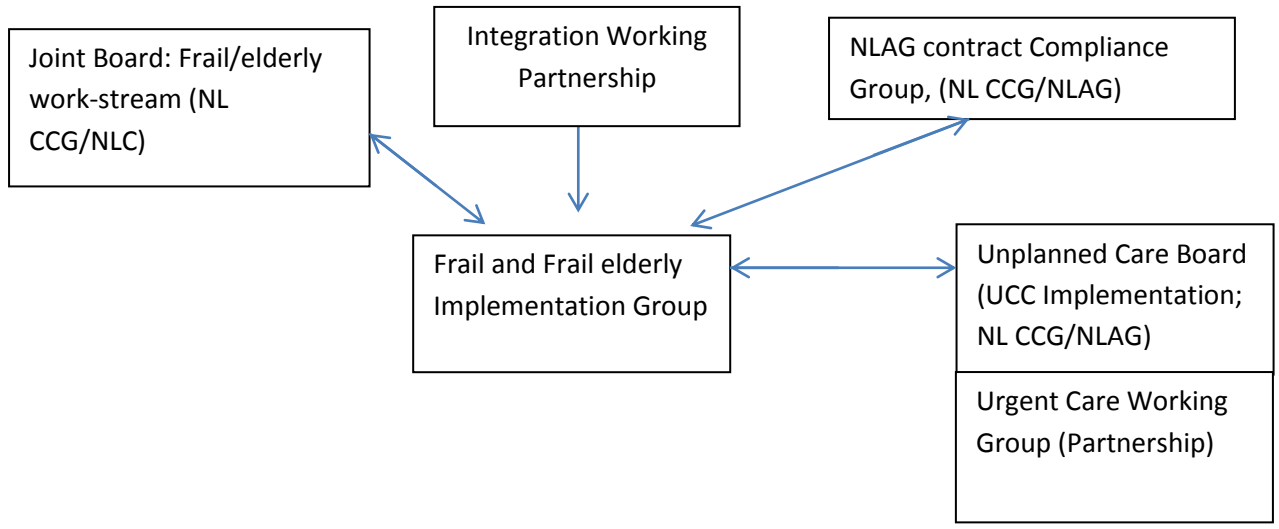
14.0 NL CCG Contracting Approach

NL CCG will work with NLAG to agree a contracting approach which supports their sustainability. This includes agreeing a 2 year contract value, which decreases over time,

therefore allowing the higher contract value up front to support the Trust in achieving and sustaining the required transformational change.

Implementation of the transformational change requires changes across the health and social care system, with all partners working closely together. An implementation structure links with the contract management approach. This transformational change at pace will enable NLAG to reduce the bed base through the reduction in non-elective admissions and the increased use of Ambulatory Care Models and community based services.

14.1 Implementation structure



The contract will be underpinned by strong performance management to ensure delivery of the transformational change.

Clear governance structures are being established across the system to oversee the implementation of the changes required in North Lincolnshire during 2014/15. This will be overseen by 2 key groups

- Frail and elderly implementation group – multi agency
- Unplanned care board – CCG and NLAG

A full implementation plan is currently being developed for the frail and elderly workstream and will support an overall implementation plan alongside the other changes set out.

Delivery against this will be monitored by the Joint Health and Social Care Board for frail and elderly and through the NLAG and CCG contract management structure.

15.0 Quality and Governance

The CCG is committed to working with partners and stakeholders to ensure a robust and consistent approach to commissioning and service provision that provides the highest level of healthcare to the population of North Lincolnshire.To support this commitment the CCG

has an established infrastructure and work plan that places quality and patient safety at the centre of its work. The CCG's Constitution establishes this commitment as integral to the CCG's objectives.

The CCG's Quality Group which reports to the Governing Body is responsible for monitoring and reviewing the quality of services commissioned by the CCG. It is tasked with promoting a culture of continuous improvement and innovation in:

- The safety of treatment and care received by patients
- The effectiveness of treatment and care received by patients
- The experience patients and their carers' have of treatment and care received

To promote quality and safety the CCG has an integrated work programme that includes for example:

- Service provider visits as part of an assurance framework to both monitor and improve patient safety and quality. Provider visits are followed up with a written report that identifies good practice and any areas of potential concern that may require follow up actions.
- Service providers giving an account of the quality of their services, identifying key challenges and plans for improvements at meetings of the CCG Quality Group – one of a range of quality monitoring and reporting systems utilised by the Trust.
- Designated nurses in adult and children safeguarding working to agreed programmes with partner agencies to promote patient safety, enhance learning and improve the quality service provision and patient experience.
- Supporting quality in general practice including facilitation of the Productive General Practice Initiative. The initiative is designed to help general practices to continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations.
- Patient experience – reviewing complaints and Patient Advice and Liaison Service (PALS) data and supporting the implementation of the Friends and Family Test in primary care - including participation in a national pilot to use the FFT question along patient pathways.
- Clinical projects including enhancing clinical pathways that are evidence based and utilise the map of medicine including respiratory services, diabetes and cardiology.
- Reviewing Quality Impact Assessments to ensure planned changes in provision do not impact negatively on patent safety and quality.

The CCG is also working with other local commissioners to develop CQUINs designed to promote innovation and enhance quality. Examples include:

- Dementia

A CQUIN agreed with NLAG will support service provision for people with dementia. It will include the provision of a named clinical lead and roll out of an approved training programme enabling staff to better identify patients requiring specialist support and improve the care they give. A monthly audit of carers of people with dementia to test if they feel supported and help plan better to meet their needs will also be conducted by NLAG. A CQUIN agreed with RDASH will roll out training for staff to support clients with a learning disability and

dementia. EMAS also have a CQUIN aimed at reducing inappropriate referrals for patients with dementia, whilst increasing appropriate referrals or facilitating support in a familiar environment.

- Identification and management of patients with severe sepsis

One of the commonest and least recognised illnesses world-wide; sepsis remains the primary cause of death from infection. This CQUIN will support the wider roll out the Sepsis 6 care bundle into the Medical Assessment Unit and A & E departments at NLAG.

- Audit of discharge letters

An audit will be conducted of discharge letters from NLAG to help ensure high levels of consistency and promote patient safety. An action plan will be produced outlining what improvements will be required. This CQUIN aims to reduce errors including medication errors and enable safer support for the patient through the discharge process.

- Care planning & Risk Assessments

RDASH has a CQUIN that aims to improve care planning and risk assessment through the development of new robust clinical standards and an audit to determine compliance with the standards. It will include crisis management and focus on the explicit inclusion of the relevant standards in the clients care plan.

- Bereaved carers

HEYH is implementing a CQUIN designed to better understand the needs of bereaved carers using a care questionnaire and use the results to better plan for their support. The Trust will provide a report on learning outcomes and changes made to service provision.

- Comprehensive Patient Assessment

EMAS is implementing a CQUIN that will review variations in performance with the patient safety trigger tool and identify critical success factors that will be used to reduce variations in performance across the organisation.

15.1 Provider Cost Improvement plans and Quality Impact Assessments

NL CCG has an on-going and established process for assuring itself around the:

(i.) robustness of its providers' Quality Impact Assessment (QIA) processes which are in place
(ii.) quality impact of its providers' Cost Improvement Plans (CIPs)

This includes the forward reporting of new emerging CIPs through the Contract Management Boards as well as on-going QIA reporting for CIPs in implementation. This is in line with relevant national guidance and is embedded in the contracting and provider performance & compliance framework.. There is regular reporting to and discussion with the CCGs' clinical leads through the Quality Group, and Quality and Service Delivery Group (joint meeting with NLAG) and in turn to the Governing Body. The CCG assurance processes are co-ordinated by the Director of Risk and Quality Assurance with support from CSU contracting, quality & assurance and workforce teams as required.

Detailed discussion around any provider CIPs which the provider or CCG has identified may have a potential negative impact on quality, safety or access is progressed through the Quality Group in order to ensure assurance can be gained that the mitigating plans for that scheme are sufficient or that the scheme is not implemented.

16.0 Workforce

The pace and size of transformational change within the NHS, both in terms of structures/processes/governance mechanisms, but also the manner and fashion in which modern health care is delivered will have significant workforce implications. A summary of the key workforce challenges are presented below:

- **GP workforce**: nationally, planned training volumes are forecast to enable growth to the GP workforce at 2.7% per annum, compared to the average growth over the past 10 years of 2.1. Locally there is an aging GP workforce at a time when the role of the GP is expanding. The level of pathway redesign set out in this plan will impact on wider primary care, including practice nurse staff. Changes are likely to result in a requirement for additional practice nurse capacity with associated training needs. CCG will need to work closely with NHS E to develop a workforce plan which delivers sustainability.

- **Emergency medicine consultants**: sufficient emergency training posts are available; however challenges have been identified in encouraging people to undertake training. In addition, there are significant issues regarding local recruitment.

- **Consultant grades**: there are vacancies in the consultant grade and a relative lack of popularity at recruitment to middle-grade medical training.

- **Community based services**: required to deliver care to more acutely ill patients in a community setting, requiring different skills sets to those generally available in both current community and secondary care teams.

- **Nursing**: Availability of trained nurses and advanced care practitioners- the local acute Trust has already recruited two cohorts of nurses from Spain, with other providers also looking to foreign recruitment.

- **Ageing workforce**: The workforce across North Yorkshire & Humber is ageing. As of October 2013 approximately 20% of the workforce are aged 55+ and hence close to or eligible for retirement. The workforce of today is in general terms the workforce we will have in ten years' time; in ten years approximately 55% of the current health and social care workforce will be aged 55 and over. This has implications around leadership and development, coaching and loss of skills across the area. This calculation does not account for any new entrants to the workforce.

- **Increased 7 day working**: In order to align 7-day working across primary, community and secondary care there will be the requirement to develop multi-disciplinary teams equipped to support clinical decision making and to deliver an urgent and emergency care service to match the changing needs of the population.

Education portfolios will need to accommodate the delivery of the skills and competencies required to deliver a 7-day service across the sectors.

- **Integration with social care**: There is a large gap nationally in the skills/training/education of social care staff in comparison to health staff. Approximately 40% of social care staff nationally have no qualifications; therefore if social care provider staff are to support the reduction in unnecessary admissions to hospitals there will need to be a detailed local analysis of skills and competencies to inform plans to educate/up skill this staff group. Whilst the social care sector has a common induction programme which could be adapted for this reason, the high turnover of staff makes the retention of knowledge/experience less likely. Two thirds of social care providers are independently run therefore the intentions of such providers may at times be contradictory to the NHS. Locally a degree of integration has been achieved between health and social care teams, with the aim of streamlining process, reducing duplication and up-skilling of staff.
  There are however a number of cultural challenges to address such as language, organisational, financial and professional barriers.
  The NHS IQ programme for the Frail/elderly work-stream will provide an opportunity to explore and address some of these issues and create a template for future change.

North Lincolnshire faces particular recruitment challenges in relation to clinical staff, in part due to its geography in relation to national centres of excellence. These challenges cut across all health disciplines, with providers looking to foreign recruitment to bridge the gap. This brings further challenges in relation to potential language barriers, development needs, social isolation for recruits and retention of staff.

NLAG is working jointly with HEYHT to develop an approach which increases responses to adverts and provides a network approach to service delivery to support smaller specialties in particular to provide a robust rota. The acute trusts have internal detailed workforce plans, however it is recognised locally that there is a level of uncertainty regarding longer term workforce requirements due to the lack of clarity at present of the longer term regional vision, for example in relation to regional stroke and urgent care reconfigurations.

17.0 Innovation

The CCG acknowledges the critical role innovation will make as a catalyst in delivering the scale, pace and challenges of transformation and levels of ambition required in patient outcomes, quality & safety, performance and efficiency of services.

Innovation is the most significant enabler which commissioners and providers can use to plan sustainable and fully integrated health and social care services into the future and ensure the improvements in clinical and patient experience outcomes outlined in their trajectories.

To this end the CCG along with its partners will look to cultivate and embed innovation throughout every stage of the commissioning cycle and planning processes. It will ensure every willing stakeholder is enabled to contribute to the development of new ideas and adoption of existing relevant innovations.

The aim will be to maximise the positive impact of innovation across:

- Commissioning practices and approach - develop the highest quality commissioning, decision-making and resource allocation underpinned by patient-centred research-based evidence and innovation
- Engagement and empowerment – sharing and accessing information with patients, public, staff & providers to enable 24/7 integrated working & care planning; and collaboration with all key partners (including other CCGs and industry) in order to drive key research themes
- Clinical practice – using technologies, devices, medications, therapies, equipment & treatment strategies
- Models of care and systems of service delivery - including pathway redesign, configuration of services, estates and assistive technology

This will require the CCG to address innovation in the following three ways when looking at every programme of transformation, service development or action plan to drive meeting their ambitions:

- Revisit all areas of identified variation and outliers in outcomes (e.g. through QOF and Commissioning for Value analysis) and assess progress with implementing best practice and innovations which are known to have a demonstrable improvement on outcomes (e.g. enhanced recovery programmes; NICE guidelines and quality standards, and TAGs (Comply or Explain regime); WHO Safer Surgery Checklist; Productive services; NHS Quality Improvement programmes)

- Assessment of progress with providers adopting the evidenced, high impact innovations and emerging/ early adoption exemplars (e.g. Innovation, Health & Wealth 6 High Impact Innovations & 108 potential high impact innovations; Yorkshire & Humber Academic Health & Science Network and Improvement Academy high impact innovations in stroke prevention in AF patients & mortality review programme; Anytown Tool

- Identification of key new and emerging innovations through horizon scanning for adaption and adoption, alongside key research priorities to focus on which could structure and drive the local R&D strategy

This focus and commitment will require dedicating significant time, leadership and resources in order to make innovation a reality and drive meaningful adoption and diffusion in practice. NL CCG and partners will continue to build on recent developments and improvements such as the establishment of e-clinics which have proved successful within mental health services, and will scope the opportunity for use of web and app based services to support other pathways such as unplanned care and long term conditions.

18.0 Improvement interventions

This chapter describes the key improvement interventions over the next 5 years, against the 6 improvement characteristics;

- Citizen inclusion and empowerment, including use of the NHS number as identifier/online GP booking etc
- Wider primary care, delivered at scale
- Modern model of integrated care
- Access to the highest quality urgent and emergency care
- Step change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Use of the NHS number is covered within the IM&T section. Wider Primary care at scale is covered in a single, generic section. This section is broken down by life stage to provide a read across to the JSNA, starting well and growing well, working well, aging well and dying well. A summary of the key interventions and their contribution to ambitions, characteristics of change and QIPP is shown in appendix 5.

18.1 Prioritisation model

In order to undertake a robust approach to prioritisation of plans, a prioritisation tool was developed and used to assess proposals. In developing proposals, impact viability templates were developed to describe financial and quality benefits for the proposals, timescales for deliver, barriers to delivery and fit with strategic direction (appendix 6).

18.2 Wider primary care, provided at scale

Access to primary care advice and support across both week days and weekends is key to patients being able to manage their own health, yet access support in a timely way. NL CCG is currently supporting practices to undertake a programme of improvement utilising Productive General Practice. As part of this programme, practices will seek views of patients using their services and will also complete a module which will support them to improve capacity management.

NL CCG will support practices to develop their future vision which reflects the CCG Commissioning plan, including a move to whole system, integrated provision for people with long term conditions which will require practices to work differently in the future. The recently mobilised urgent care model provides access to GP input over the 7 day period for urgent needs. North Lincolnshire practices have been developing a plan for a single federation of practices and the CCG will work with them as providers to support good primary care access across the county.

Redesign of services for people with long term conditions and the implementation of the accountable GP for over 75s will mean that the GP practice is pivotal to supporting people to keep well. Practices, either individually or with other practices will need to be creative in developing solutions to provide this level of care to patients. The CCG has developed plans for investment of the £5 per head for over 75s within primary care as the Elderly Care Fund and practices are currently responding to the service specification issued.

Life stages

18.3 Starting well and growing well

The JSNA highlights a number of issues relating to maternity and early years;

- Birth rates rising fastest amongst poorest 20% for whom health literacy and maternal and infant health outcomes are poorest
- Higher teenage conception rate and higher percentage of births to teenage girls than the England average
- Lower breast feeding rates (initiation and at 6-8 weeks) than the England average
- The proportion of women smoking at time of delivery is significantly worse than the England average
- Low caesarean section rates compared to national average
- Recent increase in still births although review of cases showed no issues related to clinical practice
- Continuing and widening inequalities in maternal and infant health outcomes, however, North Lincolnshire has good update of childhood immunisations.
- higher than average unscheduled hospital admission rates for children and young people with epilepsy and asthma
    - Abortion rates amongst young people have fallen, although repeat abortions have risen.
    - Up take of HIV testing in Sexual Health clinics amongst eligible groups remains above average
    - Teen conception rates have fallen to their lowest level and are much closer to although still significantly above national rates

However, hospital admissions for alcohol related conditions and self-harm in under 18yrs is slightly lower than the England average. North Lincolnshire has good update of childhood immunisations and lower than average chlamydia rates. GP Long Acting Reversible Contraception (LARC) fitting rates remain high and are the highest in the country. Numbers of LARCs fitted continues to increase.

Public Health Intelligence, in close collaboration with other partners, will be leading on undertaking further research and analysis on specific areas that have been idientfied as gaps in knowledge through the JSNA and other needs analysis including;

- Maternal and perinatal mental health
- Children and young people's emotional health, wellbeing and mental health
- Children and young people with disabilities and complex health needs
- Children and young peoples admissions for long term conditions and accidental/non-accidental injuries

The developing plan reflects the on-going discussions through the ICP. There is a strong focus on conception to children aged two years and plans also consider the NHS England Public Health agenda, with NHS E Public Health representation on the ICP.

The Northern Lincolnshire Maternity Partnership is working on developing a strategy to further decrease smoking rates. Recent developments within midwifery have included the introduction of routine carbon monoxide monitoring, in line with NICE guidelines. In addition to the priority work streams around stillbirths and smoking in pregnancy, further development work is being initiated by NLAG around improving bereavement support and introducing new technology into the community. A discrete, time – limited piece of work is also to be commenced by NEL CCG and NL CCG, around a full service review, which will include

reviewing current community provision, partnership working etc. This piece of work will hope to further review the role of; Midwives within Children Centers, specialist pathways - including teenage pregnancy, drug misuse, smoking in pregnancy, community antenatal and postnatal provision and joint partnership working practices, including the introduction of Early Health Assessments.

North Lincolnshire's Children and Young People's Plan provides the strategic direction for the transformation of services for children, young people and their families to transform the vision 'Safe Children and Young People, Supported Families and Transformed Lives' into reality. As such, 6 Strategic Priority Outcomes have been agreed, these include;

- Raise Aspirations - children, young people and their families are empowered to make positive choices to help them be the best they can be
- Children and Young People feel safe and are safe – children, young people and their families feel safe in their home and protected in their community
- Best Start – positive parenting so that children thrive in their early years
- Close the Gaps – inequalities are reduced across all vulnerabilities and all communities (including between the most and least well off)
- Celebrate and Engage Children and Young People – children and young people are valued as part of the community and their achievements and contributions are recognised and celebrated
- One Vision, One Workforce - services are child centred, focussed on improving outcomes and integrated at the front line

In addition, the ambitions of the North Lincolnshire HWBS and , Early Help Safeguarding and Local Safeguarding Children's Board, demonstrate a shared commitment of priority areas across health and social care organisations within North Lincolnshire. As such, priority areas have been agreed, with the focus for development throughout 2013-15 being:

- Conception to two where we have an ambition to integrate services to identify and offer support to all pre-birth to two year olds enabling them to have the best start in life
- Vulnerable children, to identify and facilitate positive change for those at risk from, emotional abuse, neglect, domestic violence and exploitation
- Young people and families who are at risk of repeating a generational cycle of dysfunction and disadvantage manifested in offending and anti-social behaviour, non-school attendance, worklessness and the need for high cost services to have a single and outcome focussed plan that creates change.

Further areas highlighted for integrated approach to improvement of outcomes include;

- Support for the pilot of the integrated 2 to 2.5 years of age developmental check in advance of the statutory requirement to implement this in 2015
- Information sharing that would lead to an increase in the number of children being registered and reached by Children's Centres
- Embedding the requirements of the Healthy Child Programme (HCP) 0-19 years across all agencies and partnerships.
- Inclusion of Young Carers in the Carers Strategy in order to develop a whole life approach to caring responsibilities.

- All agency commitment to Early Help Assessments, particularly midwifery and inclusion of Early Help Assessments, and a sustained model of prevention as KPIs in all commissioning and contracting arrangements including adult services in order to reduce avoidable referrals to specialist services.
- Provision of consistent support to meet the needs of children and young people with complex health and medical needs including overnight short breaks for disabled children and young people.
- Consideration of a local and comprehensive service to children whom need medical examinations as a result of abuse and exploitation
- Establish and expedite the physical and mental health offer to children and young people who require urgent access and specialist assessment not available locally, i.e those within the Youth Justice System and/or Public Law outline.
- Continue to explore collaborative commissioning arrangements to ensure that children and young people with complex needs and behaviours that challenge can be met locally, avoiding the need for out of area placement provision
- Establish a commissioning process and pathway for children whom display Harmful Sexual Behaviour who require specialist assessment, therapy and treatment over and above local provision
- Ensure that the needs of Care Leavers are fully met in the mental health service specifications as per NICE Guidelines.

NHS England PH team will need to work closely with NLAG to complete audit and gap analysis of the Child Information System during 2014/15 to ensure high quality data is available to support child health.

NLC and NL CCG both have commmissioning responsibilities relating to sexual health. Both organisations, in conjunction with service providers will progress the sexual health agenda with the aim of improving the sexual health and wellbeing of the whole population. by;

- Securing good quality intelligence across the health system with governance arrangements managed through HWB that will hold commissioners to account
- Ensuring ongoing service developments, informed by quality intelligence, are co-designed and address the wider determinants of sexual health, securing positive sexual health outcomes for North Lincolnshire in line with the national ambition.
- Ensuring quality prevention, screening and treatment services are delivered where, when and how the population will access them; supported by high quality sustained marketing, associated brand and quality standards.

- *Citizen inclusion and empowerment*

The Healthy Lives, Healthy Futures programme has identified that current maternity outcomes are good across both hospital sites and there is therefore currently no plan to centralise maternity services on a single site. However, in conjunction with North East Lincolnshire and the current provider, NL CCG will review the current service over the next 3-5 years to ensure high quality services are maintained at both sites.

As part of the working well programme, NL CCG engaged with a wide range of people with children, including young mothers via the children's centres within Scunthorpe Town and through schools for children with additional needs. NL CCG will scope the impact and

deliverability of using ELC to gain insights on the experience of children with long term conditions and their parents during 2014/15. This work-stream will also support the work of the Public Health Intelligence team regarding children and young people with complex health needs and long term conditions.

- *Modern model of integrated care*

The Health and Wellbeing Board has agreed three priorities for integration, including services for conception to two years and teenagers 13-19yrs).

Partners across North Lincolnshire Children's Partnership are reviewing the delivery of the Healthy Child Programme 0 -5yrs, working closely with NHS England NYH area team as the current commissioner of health visiting services and the Family Nurse Partnership to prepare for the transfer of commissioning responsibility to North Lincolnshire Council from October 2015. NLAG is the current provider of Family Nurse Partnership and will need to work effectively with NHS England to ensure there is adequate capacity to deliver the service in line with performance targets.

Work will also focus on perinatal health including mental health and addressing the issues associated with smoking and obesity in pregnancy and low breast feeding rates. This partnership work will build on the work already commenced by NLAG to improve breast feeding rates, with work focussed on the two worst performing wards. The NHS England PH plans for the implementation of additional new-born and antenatal screening during 2015/16 will also require coordination between NHS E and NLAG as the provider of maternity services.

In addition, the integration agenda will focus on the development of integrated care pathways, commencing with diabetes and asthma pathways in 2014/15. This is in response to increased activity associated with paediatric admissions. Agreement of pathways will reduce variation within primary care and secondary care and improve experience. Development of the pathways will also ensure the Children's Community Nursing Team investment is achieving the desired outcomes in terms of reducing non elective admissions and improving outcomes and experience of the child and family.

The commissioning responsibility for the Healthy Child Programme 5 – 19 (school nursing) transferred to local authorities in April 2013. NLC has worked closely with NLaG (who currently provide the school nursing service) through the contract management process to agree a new revised service specification for 2014/15 to meet the requirements of the Healthy Child Programme. The Council will be recommissioning a new school nursing service from April 2015. The national and local aspiration is for the school nursing service to continue to provide school-aged vaccination and immunisations in order to ensure a coordinated and integrated public health nursing service and seamless provision for CYP. NLC have worked closely with NHSE to develop a proposed approach to jointly commissioning school nursing, the Healthy Child Programme and vaccination and immunisations to ensure that they continue to be provided as a single service by a single provider. This integrated approach will be key to delivery of immunisations targets for childhood flu, with implantation of immunisation in school years 7 and 8 in Autumn 2014, HPV and Adolescents school booster programmes.

Work during 2014/15 will also include addressing Special Educational Needs and Disabilities (SEND) implications arising from the Children and Families Act 2014 in conjunction with the local authority.
This will include;

- Introduction and implementation of 0 – 25 Single Education, Health and Care Plans (replacing statements of SEN) with a consistent approach to rights of appeal across education, health and care
- Publication of a local offer and a requirement to jointly commission services
- Scoping of increased capacity requirements for CCG to administer reforms and provider services (particularly Occupational Therapy, Speech and Language Therapy and Physiotherapy) to deliver identified level of required provision
- The offer of personal budgets
- The establishment of a dedicated medical / clinical officer (DMO / DCO) with delegated powers of decision making relating to health services in 0 – 25 Single Education, Health and Care Plans

If a health need is identified within the plan, the CCG has a statutory responsibility to provide a service. It is predicted that there will be a pressure on key therapy and CAMHS services, in relation to assessment, administration and decision making, reassessment for transition from statements to 0 – 25 Single Education, Health and Care Plan and the provision of therapies and other health services over the age of 16 years .

The first 0 – 25 Single Education, Health and Care Plan will be implemented in September 2014 and there will be a process in place to transfer all children with statements over to the new plans by 2018. All young people aged 16 and over with a Learning Difficulty Assessment are required to transfer to a 0 – 25 Single Education, Health and Care Plan by 2016. This work will commence September 2014, The Local Authority, in conjunction with partners need to publish a transition plan by 1st September 2014.

The new Special Educational Needs Code of Practice: 0 to 25 years gives greater emphasis to emotional, social and mental health difficulties (replacing behaviour, emotional and social difficulties). During 2014/15 NL CCG, in conjunction with the local authority will review current service provision for those children and young people with SEND - including those educated out of area - with the aim of providing services in area. Provision will need to work within the context of a graduated response to meeting unmet need and the single organisational model. Placing children and young people out of area is a significant cost to all partners and not in the interest of the young person or their family.and we need to understand the reasons for requiring specialist external provision across education, health and care. This will include market assessment and development to enable new models of service provision to be implemented in 2015/16 and beyond to meet local needs.

The local CAMHs service, provided by RDaSH has recently been reviewed and a revised service specification is under development, with expected implementation date by September 2014. Developments within the specification include a learning disabilities model for CAMHs and provision of intensive support to those people who would otherwise require a

tier IV bed. Nationally and locally, there is limited availability of CAMHs Tier IV capacity which places pressure on local services that are unable to refer children on to appropriate services.

Key work areas for teens include;

- Expedite the physical and mental health offer to young people who require urgent access and specialist assessment not available locally, i.e those in the Youth Justice System and or Public Law Outline.
- Continue to explore collaborative commissioning arrangements to ensure that children and young people with complex needs and behaviours that challenge can be met locally, avoiding the need for out of area placement provision
- Establish a commissioning process and pathway for children whom display Harmful Sexual Behaviour who require specialist assessment, therapy and treatment over and above local provision
- Ensure that the needs of Care Leavers are fully met in the mental health service specifications as per NICE Guidelines.
- Establish a learning disabilities model for CAMHs.

These work areas will be further defined and agreed by the ICP, including timescales and desired outcomes.

- *Access to the highest quality urgent and emergency care*

NL CCG and NLAG have recently agreed a new service model for non-elective paediatric assessment and community nursing. These models will be implemented in 2014/15 and will result in increased capacity within the community Nursing Team to support the management of both acute conditions and long term conditions, complex continuing care, end of life and neonatal care within the community. Whilst this is initially a uni-disciplinary model, there will be a further development of a multi-disciplinary model over the next 3- 5 years.

A short stay assessment unit for paediatrics will also be developed, enabling children to be assessed within an appropriate unit, avoiding an admission where clinically appropriate, underpinned by a local tariff structure. This model will release funding to invest in increasing capacity within the Community Nursing Team.

Overall the implementation of these models will;

- Improve the management of children with long term conditions, improving self-management/parental management and reducing non elective admissions through access to community nurses specialised in care of children with long term conditions such as epilepsy, diabetes etc.
- Increase the capacity to support early discharge, with an emphasis on reducing the requirement for children to stay longer than four hours within the assessment unit
- reduce un-necessary hospital visits for care that can be provided within the community and increase the number of children cared for at home
- Provide case management and leadership for children with continuing care and complex care needs
- Tackle the current high level of non-elective admissions for epilepsy and asthma through the provision of an appropriate assessment model

- *Step change in the productivity of elective care*

During 2014/15 as part of the Healthy Lives, Healthy Futures work, North and North East Lincolnshire CCGs will consider the future of elective paediatric surgery. The level of activity at each site is low and therefore continuation of service at both Scunthorpe and Grimsby sites is not considered sustainable from a safety and quality perspective. Further engagement with the public is planned, to run alongside the formal consultation on stroke and ENT services (commencing June 2014). Timescales for implementation of change will be dependent on whether formal consultation is required. A decision is expected from the Programme Board, Council of Members and CCG Governing Body in October 2014. CCG will continue to engage with the Health Scrutiny Panelregarding consultation requirements.

- *Specialised services concentrated in centres of excellence*

The period of further public engagement on future configuration of paediatric surgery commencing June 2014, will inform the decision making process regarding the centralisation of paediatric surgery on a single site within Northern Lincolnshire in the short term. Specialist surgery is already provided by Trusts outside of Northern Lincolnshire. Longer term plans are linked to the review of specialist services which may result in a further shift of surgical activity outside of Northern Lincolnshire in order to ensure the continued availability of paediatric surgical skills and competencies. CCG and NLAG will work with NHS England in the review of specialist services and implementation of actions arising from engagement or consultations regarding any further centralisation.

18.4 Working well

There are a number of health issues relevant to the working age population. North Lincolnshire has higher than average rates of obesity, smoking and physical inactivity, including those amongst pregnant women, along with higher than average prevalence of high blood pressure and Coronary Heart Disease in the population.

There is lower than average offer and take up of smoking cessation per head of population. In addition, there are significant social inequalities in take up of adult cancer screening amongst disadvantaged groups.NL CCG therefore need to work closely with NLC Public Health team and NHS England Area Team Public Health team to tackle these issues which create a growing burden to the NHS. North Lincolnshire Council are currently re-commissioning obesity (Tier 2) and smoking cessation services, to go live in 2014/15 and NL CCG will contribute to the specifications for each of these services.

Health Checks have a key role to play in the early identification of risk of heart disease, stroke, kidney disease and diabetes enabling people to adopt a healthier lifestyle and improve their health related quality of life, living better for longer with their condition.

NLC now responsible for commissioning NHS Health Checks and in North Lincolnshire there is a total eligible population of 53,005 people aged between 40 and 74 years (2013-14). It is expected that 100% of that population will be invited for a health check every 5 year period with an expected 50% take up aspiring to 75% take up. These measures are stated indicators for health improvement within the public health outcomes framework for England 2013-16.

The number of people offered a Health check in North Lincolnshire 2013-14 was 7092 (13.4% of the eligible population) with 4022 receiving a health check which equates to 56.7% of those offered. Whilst there has been an increase in health checks of 17% on the previous year, NLC aims to progressively increase the numbers invited over the next 5 years by 20%.

Many people develop and are diagnosed long term conditions whilst still of working age and most want to be able to continue to work and live well with their condition, with care delivered around their needs. Plans over the next two years will focus on further development of community based long term condition services. This will build on the work started in 2013/14 to develop respiratory, diabetes and circulatory services, delivered in the community setting, with integrated pathways across primary and secondary care.

The vision over the next 5 years will see a move towards more holistic and integrated approach to management of long term conditions, using the House of Care model, delivering;

- Reduction in avoidable admissions
- Service delivery approach which manages the person rather than the disease, improving the patient experience
- Prevention of avoidable illness, with consideration given to the impact of long term conditions on mental health
- Increased patient self-management and patient led goal setting
- Improved access to IAPT and support for mental wellbeing for people with long term conditions and development of proactive services, promoting and supporting mental health and wellbeing, including building personal resilience and self-confidence.

- *Citizen inclusion and empowerment*

The plans have been informed by the insights gained from NLCCG Keeping Well and Long Term Conditions Experience Led Commissioning programmes. Within this programme of work, people identified that they want to understand their conditions and how they can manage their illness, but need support to do this. They feel that whilst structured training programmes can be helpful, they also want every contact to be an opportunity for education and support and that peer support can also be valuable in enabling them to self manage. This approach is therefore being built into service specifications to ensure commissioned services reflect patients' needs and include person centred outcomes.

We will scope the impact of using Experience Led Commissioning with mental health service users in early 2014/15

- *Modern model of integrated care*

Whilst many of the working age population feel they need little pro-active health care, there are a smaller number of people who have more complex needs and require the input of a wide range of health and social care professionals in order to keep them well. Some of these people with very complex needs fall within the remit of the Frail/Elderly approach covered in the Better Care Fund plan. Others will fall into the remit of the already implemented Integrated Care teams, in place across all five localities. Work will continue during 2014/15 to ensure that the Integrated Locality teams deliver the agreed outcomes, providing

integrated health and social care, pro-actively managing those people identified as at risk and facilitating discharge and reablement.

North Lincolnshire patients do not currently have access to tier III obesity services, and in its absence cannot access bariatric surgery. To date it has not been clear which organisations have responsibility for the commissioning of tier 3 obesity services, however NL CCG will consider the recent recommendations of the national working group ' Joined up clinical pathways for obesity' that tier 4 services are commissioned by NHS England, tier 3 by CCGs and tiers 1 and 2 by local authorities. CCG commissioning of a tier 3 service is likely to result in a cost pressure as yet unclear.

- *Access to the highest quality urgent and emergency care*

Following the redesign of the urgent care model, plans for 2014/15 will strongly focus on work with the public to inform and raise awareness of how to access care appropriately and how to assess and self manage minor injuries and ailments. This will result in a reduction in activity through the urgent care centre for minor cases. For those people within the working age population national evidence (Focus on Accident and Emergency; Health and Social Care Information Centre, December 2013) shows that those age 16-32 are more likely to attend A/E with approximately 64% self referring. There is a strong link between A/E use and mental health, with mental health service users more than twice as likely to use A/E services and non-Mental Health users. It is therefore essential that the Urgent Care Centre can provide responsive, holistic care for these people. There are also very predictive attendance patterns for a number of reasons for presentation including sports injuries, road traffic accidents, assault and self harm. Nationally, over 60% of this age group are discharged from A/E either with GP follow-up or no follow-up, only 20% are admitted. In addition approximately 18% of people surveyed (Healthwatch England, 2014) claim to have used A/E for non-emergency care outside of primary care opening hours.

Work is planned to assess locally how people navigate around the urgent care system, what information they use and how they find it. This will help define the communication and awareness raising programme for urgent care.

For those people who do attend the Urgent Care Centre, the redesign should facilitate prompt assessment and management planning, with discharge home using ambulatory care models where appropriate. NL CCG will continue to work with the acute Trust to ensure the benefits of the urgent care specification are delivered. The ability of the acute Trust to recruit medical and nursing staff remains a challenge and NL CCG are supporting the work of NLAG to consider alternative recruitment strategies and staffing models, including joint appointments with Hull and East Riding Trust.

- *Step change in the productivity of elective care*

NL CCG will work with NLAG as its main acute provider to secure productivity efficiencies in planned care, including reduction in length of stay through effective 7 day working and enhanced recovery.

18.4.1 Cancer

Currently people with a GP suspicion of cancer are referred to the acute trust, attending either the Scunthorpe or Grimsby hospital site for diagnostic tests and assessment.

Treatment is provided either within Northern Lincolnshire or Hull and East Yorkshire. A small number of patients with rarer cancers will be treated outside of North Lincolnshire.

Plans over the next two years will focus on improving early detection of cancer and reducing variation in referral patterns. This has the potential to increase the demand for some diagnostic investigations. Implementation of the bowel scope screening programme (a one-off test around the age of 55) in 2016 will, over time increase the demand for sigmoidoscopy and colonoscopy and will require NHS England PH team to work closely with local public health and CCG teams to promote uptake and ensure robust capacity planning for any increased demand on other services as a result.

NL CCG will work with NL Public Health teams to support the raising of cancer awareness in the population. NL CCG will focus some education capacity at early diagnosis of cancer using appropriate assessment tools and pathways. NL CCG aims to achieve a 50% reduction in follow-up by 2018/19. This will be achieved through working with Northern Lincolnshire and Goole Foundation Trust to develop risk stratified pathways, and implementation of holistic needs assessment and management plans during 2015/16 and 2016/17. NL CCG will continue to work closely with service providers and NHS England Specialist commissioning teams to ensure continued delivery of waiting times targets without impact on non-cancer waiting times.

18.4.2 Mental Health

During 2014/15, NL CCG will develop with partners, processes to undertake systematic reviews of all suicides and undetermined deaths to map hot-spots, support risk identification and implement strategies to reduce suicide. NL CCG will continue support for the implementation of primary care chaplaincy and mental health promotion work to reduce risk of mental illness through:

- Joint working with Public Health team lead
- Mapping existing mental health promotion activity
- Review use of Mental Health First Aid training
- Consider mental health employment/mental health workplace workstream

NL CCG plans to achieve a small increase in the number of people accessing IAPT.This is due to the current high level of access and achievement of the recovery target. The current service is nationally acknowledged as a high performer and its performance is being used as a model by the national IAPT intensive support team in discussions with IAPT commissioners nationally.

There is a recognised risk that significantly increasing access may result in a reduction in the proportion of people achieving recovery. However we will work with the third sector to develop capacity for low level and peer support to complement the IAPT service and provide step-down support.
During 2015/16, NL CCG will complete benchmarking of access to current mental health services for all groups, with particular emphasis on BME, veterans, perinatal, and substance misuse groups, and will use this information to re-focus services as required to ensure equality of access.

NL CCG aims to work with providers to improve the physical health of those people in mental health inpatient units during 15/16 onwards by raising staff awareness of physical illness, with a focus on obesity and substance misuse.

18.5 Ageing Well

North Lincolnshire has a higher than average age profile, and a significant ageing population living in rural areas, with limited availability of public transport. The majority of older people beyond retirement age have at least one long term condition, and a significant number have two or more conditions. This population is also prone to experiencing social isolation and associated depression due to the changes in family structures and living alone. Loneliness and social isolation have a significant impact on a person's health and wellbeing. People with limited mobility and ability to travel and older carers are at greater risk of social isolation. Additionally, their level of well-being affects recovery from illness and injury and higher well-being associated with decreased mortality risk.

The key interventions for 'ageing well' are set out in the BCF plan (see section 8). This plan describes the investment into community based services which will result in more people being managed in the community setting during periods of acute illness, but also provision of proactive preventative care which enables people to keep well, manage their own health and live independently. The BCF plan dovetails with the requirement for an accountable GP for each over 75 year old and plans for the use of the Elderly Care Fund, £5 per head for over 75s.

We have set a clear vision for the next five years which will result in a significant shift in care being provided in the community, either in the patient's own home, or close by in an appropriate setting. The GP will be the accountable clinician for the over 75s and care will be designed to ensure an integrated and timely response, drawing on the current systems such as the Integrated Locality Teams, the systems developed as part of the BCF plan that maximise patient independence through community hubs, 7 day services, increased and timely access to equipment, nursing and therapy support and social care. In addition, the use of the risk profiling tool will become embedded in day to day practice, supporting the multi-disciplinary teams to identify and manage those at risk or increasing risk of deterioration.

Within the next two years, attention will be focussed on the implementation of years one and two of the BCF and implementation of the agreed plans for the use of the £5/head accountable GP funding, known locally as the Elderly Care Fund.

- *Citizen inclusion and empowerment*

The plans have been informed by the insights gained from NLCCG Keeping Well, Long Term Conditions and Dementia ELC programmes. People tell us that they want support to keep well, that having a purpose and a social network keeps them well and independent, that they want holistic care from a lead professional who understands and can manage their multiple conditions, and that good care is relationship based. People tell us they want to be involved and manage their own condition, but they need help to do this. This help includes providing and mentoring them in their condition to ensure they have the understanding and confidence to make decisions – this may be help from health professionals, voluntary sector of peers.

The BCF plan will develop locality based hubs which provide a wide range of universal, preventative health and care services aimed at maximising health and independence. This provision will maximise use of the voluntary sector in providing this support and will actively contribute to addressing social isolation.

This will ensure that those not yet experiencing higher levels of need but whom may do so in the future are supported to remain healthy, independent and well. Locally we recognise that isolation and feelings of isolation have a long term detrimental impact on physical and emotional wellbeing, therefore we will empower local people through befriending, mentoring and self-management.

The proportion of people with dementia is increasing and NHS England has set ambitious targets for the proportion of people with dementia who have a diagnosis. NL CCG has previously performed well at dementia diagnosis, however this new target is challenging. This will be addressed by increasing public awareness of dementia and the roll-out of a self-assessment tool, using a simple questionnaire. This will be accompanied by implementation of an electronic diagnosis tool within primary care. This tool will identify those people with mild cognitive impairment, who can be managed within primary care, reducing the number of referrals to the Memory clinic for non-dementia diagnosed patients. This in turn will free up capacity for the additional activity created by increased screening.

The developing plans for the accountable GP for over 75s will support this by ensuring consistency in care, with management overseen by an individual clinician.

- *Wider primary care, provided at scale*

Access to primary care is pivotal to delivering efficient, high quality care to older people. A key part of the frail/elderly strategy and long term conditions strategy includes risk profiling of patients and proactive management to prevent further deterioration and reduce risk. The developing Federation of practices within North Lincolnshire will provide further support by increasing access within each locality across 7 days. This is important for our older population, particularly those in rural areas who often wait until a Monday to seek advice and in the meantime have deteriorated sufficiently to require admission. Access over 7 days should improve patient outcomes, help prevent patient deterioration and have a small impact on reducing non-elective admissions.

- *Modern model of integrated care*

Proactive, targeted support will enable people to return to independence, prevent further decline and reduce non elective admissions.

Further development and implementation of community based services during 2014/15 and 15/16 will shift care closer to home. For older people living in rural areas, this will make services more accessible, and close attention will be paid to developing specifications that ensures this is the case. In the development of service specifications, insights from recent engagement work have been utilised, supplemented by additional, specific engagement where required, to ensure the services reflect people's needs.

Specific interventions include implementation of a community based Muskulo-skeletal service, long term condition services supported by the implementation of risk profiling, comprising circulatory conditions, neurology, diabetes, respiratory and chronic wound care

services. NL CCG is currently finalising the model for these services, to deliver on the 'House of Care' model (King's Fund, 2012). This will include how they can be delivered to ensure a holistic approach, using the GP as the key clinician, drawing on the expertise of consultants and community teams as required. The aim of these models is to ensure the pathway is seamless from a patient perspective, with care provided by multi-disciplinary teams, focussing on enabling self-management, personalised care planning and patient goal setting. Care will be pro-active with specialist advice available to the GP practice when required via telephone or email access to consultant teams. The risk profiling tool will support better anticipatory care by identifying those patients at increasing risk of deterioration, enabling input from the integrated team to manage the patient back to a lower level of risk. Follow-up appointments will take place only when required and patients will recognise the value these add.

North Lincolnshire implemented integrated locality teams during 2011/12 and continues to work with partners to ensure these teams deliver the planned benefits in terms of outcomes for patients. These multi-disciplinary teams, including links with GPs are viewed as key to the success of the 5 year plan. The implementation of the risk profiling tool across North Lincolnshire will support and enable primary care and the locality teams to manage patients who are at increasing risk of deterioration. The teams will be required to work in an integrated way, to ensure the smooth and timely discharge of patients into a community setting as soon as it is safe and clinically appropriate as well as pro-actively managing those people identified as at increasing risk. The roll-out of this tool has been significantly delayed within North Lincolnshire due to national information governance issues, which are currently being resolved. The CCG is in a position to rapidly roll this tool out once all IG issues have been resolved and there is a high level of enthusiasm within primary care to utilise this.

NL CCG will continue to work closely with NLC, RDaSH and other partners to ensure high quality, community based care is available for people with dementia and their carers. NL CCG will draw on the findings of the ELC work on dementia and co-design with patients and carers information and support services to address their needs. Carers specifically talk about feeling lost, frustrated and unsupported at present and highlight that it is often lack of awareness and information on likely care needs that create problems. Carers need advice and support on what to expect and how to access services pro-actively to avoid crisis. Actions in 2014/15 will build on the work of the Dementia Academy to provide access to training for carers, health and care professionals. In partnership with North Lincolnshire Council and providers NL CCG will seek to ensure dementia awareness training is mandated for all local care providers, ensuring staff have the skills and competencies to recognise patient needs and manage these appropriately.

- *Access to the highest quality urgent and emergency care*

Despite all best attempts, there will be times when people need hospital care due to the severity of their condition, or specific care requirements. On such occasions, NL CCG aim to provide this within Northern Lincolnshire, however, where people need specialised care, this may be provided outside of Northern Lincolnshire. The aim of this decision is to ensure that patient safety is always paramount.

Key to the stepped change in models of care to deliver the required reduction in non-elective admissions of 22% by end 2015/16 is the development of community based services to manage people with acute illness within a community setting either under the care of a

consultant team or primary care. Implementation of preventative services needs to run in parallel but it is acknowledged that these services will have a lead time before they demonstrate impact in terms of avoiding admissions through better preventative care.

NL CCG has already, during 2013, redesigned the urgent care model to provide an integrated service, focussed on rapid assessment, treatment and discharge, underpinned by education on how to appropriately access urgent care. This is an important change for North Lincolnshire- national data suggests approximately 50% of over 64s who attend A/E are subsequently admitted. The model aims to manage people using ambulatory emergency care pathways where appropriate, following a period of assessment and planning, to return them to the community at an early stage, with continued care delivered by a consultant led team. This helps older people in particular by preventing decompensation associated with hospital stay.

NL CCG has committed to increasing provision of therapy led rehabilitation services to ensure that all those people requiring rehabilitation following a period of illness or injury have access to an appropriate level of service. This may be within a bedded unit in the community or provided directly into people's homes.

Plans emerging from the Dementia ELC work completed during 2013/14 will focus on diagnosis, provision of information and support to people and their carers, consistency in quality of care and improved hospital based care, ensuring patient needs are understood and met. Nationally, data shows that people admitted to hospital who also have dementia experience a longer length of stay than those without dementia. Locally, a diagnosis of dementia was also shown to be associated with increased mortality in the SHMI reports. This will support a reduction in length of stay for people with dementia and reduction in mortality. NL CCG will work with both the local acute provider and the Mental Health provider to ensure that staff have an appropriate level of knowledge and competencies to enable them to provide high quality care to people with dementia. NL CCG has developed a CQUIN with the acute Trust to ensure the trust responds to the findings of patient engagement. This will build upon the work NLAG has already undertaken in response to the Keogh review and the mortality review.

- *Step change in the productivity of elective care*

See working well section

- *Specialised services concentrated in centres of excellence*

NL CCG has recently agreed with partners- NLAG and NEL CCG, to temporarily centralise hyper-acute stroke services at SGH. This was in direct response to identified quality issues at the Grimsby site. This centralisation was successfully completed in November 2013. However, the permanent solution will be consulted on with the public.

The longer term vision for stroke services will be considered as part of a wider review of stroke services across Yorkshire and the Humber. NL CCG will take an active part in that review and the implementation of recommendations.

Major trauma services and vascular services are already centralised within the Humber region, with activity taking place at Hull and East Yorkshire Trust. Further centralisation of some services may be required to maintain quality and safety as, partly due to its

geographical location, Northern Lincolnshire and Goole Hospitals and local community based services face significant recruitment challenges.

NL CCG will continue to work with NHS England Area Team, Strategic Clinical Networks and the Operational Delivery Networks to develop and implement pathways. Local providers will be expected to respond to commissioner specifications and are working proactively to establish closer clinical networks and support joint integrated working in preparation for any changes that may be required.

18.6 Dying well

In 2012, there were 1673 registered deaths in North Lincolnshire, accounting for approximately 1% of the population. Just under two thirds of these, (65%) occur amongst people aged 75+ years, and 35% amongst people aged under 75 years. Currently, 42% of people die at home or in care homes in North Lincolnshire compared with 38% nationally. The proportion of older people who approach end of life in care and nursing homes continues to rise. Each year there are on average 580 premature deaths (under 75 yrs of age) in North Lincolnshire, of which more than half, (61%) are of men. More than a third of these early deaths, 43%, are from cancer, just under 1 in 5 (19%) from heart disease and stroke, 11% from respiratory disease and 6% from liver disease.

- *Citizen inclusion and empowerment*

The strategy for end of life care for North Lincolnshire has been revisited and the action plan revised following the completion of the ELC work during 2013/14.The implementation will continue during 2014/15. Key actions will be a programme of communication to increase awareness of choices at end of life, roll-out of advance care planning using a locally designed model, co-designed with patients and carers as part of the ELC work, and the development of plans for the implementation of electronic sharing of information across service providers using special patient notes (SPN).

- *Wider primary care, provided at scale*

The current end of life action plan comprises a number of actions to support patients in their preferred place of care until death. This is supported by a range of end of life training for staff, including primary care staff, that includes Advance Care Planning and Gold Standard Framework. This will ensure practice staff have the skills and competencies to support patients and their carers. Where patients need care out of hours, the implementation of special patient notes will ensure all other relevant services have access to key information relating to that patient to enable care to be planned in accordance with patient wishes.

- *Modern model of integrated care*

Implementation of Special Patient Notes will enable those providers caring for people at end of life to have access to key information relating to the care plan for that patient. This access should support health and social care teams deliver the plan of care in line with patient wishes. This will support delivery of integrated care with all providers referring to a single patient led plan.

The developments set out within the BCFplan will further support people in care homes at end of life through additional support to care homes to raise the quality of care, ensure all

patients have an appropriate care plan and staff have the skills and competencies to provide high quality care.

A key priority for end of life care is the development of an integrated service specification for end of life care. This will focus on integration across service providers. With funding already agreed in 2013/14, NL CCG will work with the acute Trust to explore network approaches to support the recruitment of a Palliative Care Consultant.

In late 2013 NLAG implemented a Home Healthcare Team to provide support to people in their own home at end of life. The benefits of this will be fully delivered in 2014/15.

- *Access to the highest quality urgent and emergency care*

Whilst NL CCG are not outliers in terms of the proportion of people who die in hospital, there are a number of people who are admitted in late stages of life and this can diminish the experience for both patient and family. During 2013/14, NL CCG made additional investments into Community Services to increase capacity within teams caring for people at end of life. This should reduce the need for admission to hospital due to the provision of integrated, planned home care. NL CCG will evaluate the impact of this and the recently appointed end of life care co-ordinator in terms of the proportion of people dying in their preferred place, with an advance care plan. This investment also includes a pilot of additional community support into care homes to care for residents at end of life with the aim of preventing admission in the last stages of life.

- *Step change in the productivity of elective care*

see working well section

19.0 Contingency

One of the key risks is failure to deliver the reduction in activity in advance of the winter period. We will work with our partners over the coming months to ensure we have available adequate community based capacity to maintain the safety of patients outside of hospital
The Joint Board will take lead responsibility for contingency planning, supported by the Frail/Elderly Implementation Group and the Surge Planning Group who will develop and implement robust plans.

There are recognised financial risks and contingencies built into the financial plan.

20.0 Risks

The risks associated with both the BCF plan and the commissioning plan have been assessed.
The main risks identified to date are set out below.

Better Care Fund:

- Sufficiency of demand/prevention management initiatives/services
- Acute/Emergency admissions do not reduce at NLAGFT
- Delays in delivery from existing additional resources (mainly non-recurrent) NHS spend of £10.5m,
- Deployment of technology,

- Workforce for 7 day services
- Contract models, penalties and incentives,
- Approach to risk sharing
- Management and expert capacity to develop and implement the plans (capacity & capability)
- Local government funding reductions
- Unresolved data sharing issues
- Any destabilising of providers
- Performance funding and managing performance risk
- Destabilising statutory adult social care provision

Commissioning Plan;

- Workforce – ageing workforce, high risk of retirements and loss of experience at time that shift in approach requires increased skills and experience in Primary care
- Outside hospital premises – little or no scope for expansion – not all premises fit for purpose
- Demographics changes/population growth – Lakes development
- Primary Care Funding - pace of change in relation to new PMS contract
- Provider response and pace of change
- Capacity for implementation
- Potential change of priorities in key stakeholder organisations
- Healthy Lives, Healthy Futures does not deliver the scale of change required within the next 5 years

21.0 Activity Plan

		E.C.3	E.C.11	E.C.4	E.C.5	E.C.6	E.C.7-8
Activity Trajectories		Elective FFCEs	Total Referrals	Non-elective FFCEs	All first outpatient attendances	All Subsequent Outpatient Attendances (All specialities)	A&E
2014/15	April	2066	4573	1353	3903		
	May	1968	4355	1398	3717		
	June	2066	4573	1353	3903		
	July	2263	5008	1398	4274		
	August	1968	4355	1398	3717		
	September	2164	4790	1353	4088		
	October	2263	5008	1398	4274		
	November	1968	4355	1353	3717		
	December	2066	4573	1398	3903		
	January	2066	4573	1398	3903		
	February	1968	4355	1263	3717		

March	2164	4790	1398	4088		
2014/15 Plan	24990	55306	16464	47202	62626	58229
13/14 Forecast Outturn	25932	55901	17408	48317	85028	59312
13/14 Plan	25406		18135	53662		60922
12/13 Outturn	25155	54955	18009	53133		60319

The following table illustrates the activity outputs for elective and non-elective care.

21.1 Triangulation

The activity plans have been triangulated with the finance plan and Better Care Fund. NL CCG will triangulate this data with the provider ProvComm uploads and further refinements will be made following this process.

22.0 NHS NL CCG FINANCIAL PLAN COMMENTARY - 2014/15 TO 2018/19

22.1 INTRODUCTION

This commentary supports the 5 year Financial Plan submission to NHS England by 4th April. A short summary of the figures in board report format are shown at Appendix 1.

The commentary below for the first two years is broadly in line with previous papers/submissions, with the outer years added as new sections under each heading.

First Two Years: 2014/15 to 2015/16

For 2014/15 the CCG has a commissioning / programme budget allocation of £205,754m (£212,741m 2015/16) and a Running Cost Allowance (RCA) of £4.212m (£3.785m 2015/16) as per the Planning framework and NHS England announcements and letter of 31 January 2014.

The plan originally assumed a carry forward of the CCG 2013/14 surplus of £4m which is still expected to be achieved. However, we have been advised locally that only £2-3m of the B/fwd surplus is likely to be returned to the CCG in 2014/15, with a further £1-2m in 2015/16. For the purposes of this plan submission the figure of £3m for CCG use, on the basis that up to £1m is at risk and any shortfall would be covered by other contract flexibilities (following recent finalisation of contracts) and a possible reduction in reserves. As a last resort, marginal rates funding will need to be used to cover any remaining shortfall with implications on the level of change and momentum that can be achieved in advance of the introduction of BCF, further impacting on the 2015/16 financial plan.

Subject to approval, any B/fwd surplus funds drawn down will be used to support transformation/ integration for example on: transition to Healthy Lives Healthy Futures (HLHF), new models of care and the development of ambitious joint operational plans under the Better Care Fund (BCF).

For reference, the forecast outturn for 2013/14 (as at month 9) has also been included on the financial plan submission. The 2014/15 figures are based on estimated contract values and best indicative values of activity including values for service growth in community and continuing care services in particular, proposed adjustment to Specialist

Commissioning for HEYT, and latest QIPP proposals. This has been extrapolated forward for 2015/16.

Last Three Years: 2016/17 to 2018/19

For the last three years of the 5 year finance plan, the programme expenditure budget allocations are based on NHS England's CCG Allocation Growth projections 2016/17 to 2018/19, with the assumption that no growth or change in Better Care Fund (BCF) additional allocations/investments from 2015/16 can be presumed at this stage. However the CCG intends to look to pool more than the mandated figure with NLC from 2016/17 onwards if possible. This will be a decision made by the Joint Board for Health and Social Care Services (Frail and Frail Elderly) in 2014/15 (hereafter referred to as Joint Board).

For RCA allocations, reference was made to the NHS England publication entitled "Calculation of CCG Running Costs Allowances 2014-15 to 2018-19", and the indicative RCA allocations per head of population over the 5 year period. Though this document indicates an expected reduction in the RCA allocation per head of population from £22.07 in 2015/16 to £21.53 in 2018/19, the CCG's financial plan has been based on its RCA remaining at the 2015/16 figure for the last 3 years of the planning period, because the growth in the CCG's resident population is forecast to grow at a similar rate to offset the cash reduction in the per capita RCA.

22.2 OVERALL FINANCIAL DUTIES

First Two Years: 2014/15 to 2015/16

The CCG has planned to achieve the required 1% surplus overall in both years, on a recurrent basis, subject to delivery of the QIPP programme and management of other risks for 2015/16 as well.

The plan template however, indicates a surplus of 1.47% in 2014/15 at £3,144k (which is 47% higher than in the first draft plan) because NHS England has indicated that they wish the CCG to defer their usage of £1m of the 2013/14 b/fwd surplus until 2015/16, and have used the mechanism of the CCG generating a higher in year surplus (rather than making an in year deposit of funds) to achieve this aim. However, operationally, there should be no impact on planned service delivery which results from this presentational change in reporting the CCG's year-end performance.

The underlying recurrent position reflects the month 6 return to the Area Team. The financial plan template probably overstates the underlying recurrent position, as it starts from 2013/14 forecast outturn (and necessitates an intermediate validation check against the exit run rate in the underlying CCG's position c/fwd from 2013/14) rather than simply starting from the CCG's baseline budget position. In addition, the CCG's recurrent position is also affected by the additional non-recurrent spend required to support the level of ambition for 2015/16.

As required, the CCG has a plan to invest 1.5% (£3.086m) of its recurrent allocation, non-recurrently in 2014/15, as well as setting aside 1% of its recurrent allocation (£2.058m) to establish the "Call to Action Fund". This means that the CCG has 2.5%

non-recurrent “headroom” in total for 2014/15, which then falls back down to 1% for 2015/16 (£2.127m). These are held in reserve as earmarked funds.

In overall terms the non-recurrent resources must cover expected financial risks and support investment in a more integrated health care system that is able to work 7 days a week.

This will include “joining the dots” between HLHF, BCF andnamed GP (Elderly Care Fund), to ensure the capacity is in place to reduce admissions/length of stay to/in Hospital in 2015/16. A joint Frail and Elderly Implementation Group including providers and stakeholders has been established to ensure the new ‘system’ is in place as soon as possible in 2014/15. This will include a joint implementation plan with NLAG to live within the resource available and incorporated within the SDIP (Service Delivery and Improvement Plan) of the contract and business cases to area team for use of non-recurrent monies. The system will require the best possible return/impact from this non-recurrent investment and detailed, jointly owned, project managed action plan to ensure a safe transition.

The general headroom will be used first to support the delivery of “safe services” as well as non-recurrent spend relating to transformational change in readiness for 2015/16.

The CCG is establishing processes for agreement on appropriate use of the Re-admissions penalty, Marginal Rates and Call to Action funds (held non recurrently in reserves) to deliver the required change in the system. This means funding support for developing new models of care across a number of providers. This will support measures to reduce non elective and avoidable hospital admissions/ better discharge planning and enhancing the effectiveness of the new urgent care model to deal with all year round, not just winter pressures.

Business cases are required to utilise all of these earmarked funds and are being developed in agreement with our Providers to take to the HLHF Management Board/equivalent oversight group and the UCWGs for approval for onward submission to the Area Team of NHS England, as soon as possible after the end of April. 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, though a 2 week turn-around of business case approvals is expected.

The £1.8m BCF for 2014/15 held in reserves has been created from old s.256 re-ablement and carers support funding. It is now assumed that 0.3% (£634k) for BCF in 2014/15 will go direct to LAs and not through CCGs. This fund increases to £11m in 2015/16 (£12.3m including capital grants for social care and disabled facilities to be received directly by NLC).

£0.845m has also been recurrently set aside for the Named GP ‘Elderly Care Fund’ based on £5 per head of registered GP population as per the guidance in 2014/15. This attributes funds to individual Practices on the basis of the number of 75+ aged patients they had at Sept 2013 (the most recent list size information). The funds are contained within a specific earmarked CCG reserve.

It was decided at Council of Members on 27th March that the approach will be to develop one 'outcomes based' service specification that will offer practices a degree of flexibility to meet the needs of their practice population. The development of this is being taken forward with GP input to agree what those outcomes should be and some general principles to underpin the specification.

An estimated £4.40 per head is held in reserves for a proposed levy for former PCT provisions nationally equating to £0.68m as requested by the Area Team.

The contingency budget for both 2014/15 and 2015/16 is currently planned to be maintained at £2m (0.94% in 2014/15 falling to 0.92% in 2015/16). The £2m figure has been recurrently created but will be shown as applied non-recurrently each year in the external plan returns in line with the guidance received. Pressures exceeded the contingency in 2013/14 mainly due to budgets in the wrong place/rebasing and growth in acute and continuing care spend etc. Therefore a further risk reserve (of £1.4m in 2014/15 and £5.3m in 2015/16) which is held for these pressures as well as for the potential removal of previous contract ceilings, in year cost pressures, NHS Property Services (NHSPS) "void recharges" to CCG's, investment in HLHF and QIPP slippage, for example.

Governance arrangements for the release of contingency and risk reserve will be agreed at the CCG Engine Room.

Last Three Years: 2016/17 to 2018/19

Again the CCG is expecting to maintain a 1% underlying surplus throughout the remaining three years of the financial plan.

In addition, as the CCG's plans for HLHF/BCF, integration and sustainability of the whole local health economy start to 'go live', the CCG is anticipating that it will maintain a similar level and use of non-recurrent funds (e.g. headroom, marginal rates, BCF, named GP fund, etc.) as established in 2015/16 to ensure delivery in the medium term.

The Full Five Years: 2014/15 to 2018/19

Please note that throughout the full 5 year period of the Commissioning plan the CCG is maintaining and in fact increasing its investment in Mental Health services, though a change in the way that expenditure in services for Vulnerable People is reported (to reflect Continuing Care requirements and service delivery arrangements) means that more expenditure is now reported as "Continuing Care" rather than "Mental Health" within the accompanying financial plan template.

22.3 RUNNING COST ALLOWANCE (RCA) EXPENDITURE

First Two Years: 2014/15 to 2015/16

The CCG's Running Cost budget is within the RCA supplied. The allowance is £4.212m for a population of 169,395 and is effectively a reduction to only £24.86 per head. Per the letter of 31st January 2014 the revised RCAs for 2015/16 is 10% lower at £3.785m, only £22.13 per head per the finance plan template. This means that the impact of

incremental drift and any other 2014/15 inflationary increases will have to be absorbed by CCG, CSU as well as NHSPS and each organisation will have to contribute to meet the 10% RCA efficiency target reduction in 2015/16.

By relative size, the existing base RCA from 2013/14 is split three ways: £1.814m (53%) for the CSU, £2.254m (43%) for the CCG and £162k (4%) for NHS Property Services (NHSPS). However, it is assumed that external income for spare accommodation in Health Place should be obtained by NHSPS to marginally reduce the share of the CCG's RCA which is used by them. At this stage, an element of the CCG's RCA is being used non-recurrently to ensure that the organisation has some flexibility to respond to this RCA challenge, e.g. via funding set up costs as well as skill mix changes made in year.

However, there is significant risk in the ability of the CCG to deliver these savings in the context of the management capacity required to deliver more ambitious plans around HLHF and BCF and this is reflected in the risk section of the template. The reductions in RCA to 2018/19 down to £3.771m (£21.55 per head for the CCG) need to therefore be worked through over the next few months with these organisations.

Last Three Years: 2016/17 to 2018/19

It is assumed that the CCG will be able to stabilise its RCA expenditure over the last 3 years of the financial plan, because as the nominal rate of RCA per head of population is forecast to fall, this will be broadly offset by an equivalent increase in the CCG's population base. At this stage, it is also expected that the organisational split of the RCA between CCG, CSU and NHS PS will remain broadly the same as in 2014/15 and 2015/16.

22.4 DEMOGRAPHIC ASSUMPTIONS

First Two Years: 2014/15 to 2015/16

Based on ONS population projections, 0.72% population growth has been used for 2014/15 and 0.71% for 2015/16 for the NLAG contract only specifically earmarked for use in Community Services. As the Finance plan template does not allow selective distribution of growth to individual providers within the same category of healthcare (e.g. Community Services), this funding was initially shown as demographic growth but presented finally in the submission as transferred to non-demographic growth on Community Services in line with the CCGs commissioning intentions. In addition the activity modelling to support planned contract expenditure reflects the current activity case-mix down to specialty level, and latest Payment By Results (PBR) guidance.

Last Three Years: 2016/17 to 2018/19

In the same way as the first two years, demographic growth has been calculated on the acute contact and transferred to Community Services for each of the last three years. The total growth funding attributed to Community services of £500k each year explicitly exceeds pure demographic growth, and is provided to assist with the increased service configuration which will be required in order to ensure that the health economy remains sustainable in the medium term.

A total of £500k per annum growth (in excess of pure demographic growth) is also included to deal with the anticipated demand for Continuing Care, which is over and above the 5% inflationary uplift which is in excess of "raw" demographic growth over the period.

22.5 FINANCIAL UPLIFT ASSUMPTIONS

All Years: 2014/15 to 2018/19

In accordance with the Planning framework the CCG has based its financial uplifts on the following table:

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation Growth	2.14%	1.70%	1.80%	1.70%	1.70%
Inflation					
• Secondary Care & General	2.8 - 2.2%	2.7%-2.2%	4.4%	3.40%	3.30%
• Prescribing	7.00%	7.00%	7.00%	7.00%	7 .00%
• Continuing Healthcare	4.0%	4.0%	5.0%	5.0%	5.0%
Provider Sector Efficiency	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%
Tariff Deflators					
• Acute Services (Non CSNT Provider)	-1.50%	-1.50%	-0.4%	-0.6%	-0.7%
• Acute Services (CSNT provider)	-1.20%	-1.30%	-0.4%	-0.6%	-0.7%
• Non Acute Services	-1.80%	-1.80%	-0.4%	-0.6%	-0.7%
CQUINs change	0%	0%	0%	0%	0%

It is important to note that:

- A simpler version of this table has been used in the finance plan submission, with adjustments to overcome the "blanket allocation" of the same uplifts to all providers forced by the template.

- The CCG has used 7% for Prescribing and 4% (rising to 5% from 2016/17 onwards) for Continuing Healthcare, taking into account all relevant factors and in agreement with the budget holders, before QIPP.

- In 2014/15 and 2015/16 the nominal increase in the net efficiency factor for non-acute services is slightly larger than for acute services. This is because an allowance has been made to allow acute providers to comply with the recent recommendations of the Francis & Keogh reports.

The impact locally of new PbR rules on the CCGs contracts (in conjunction with the Specialist Commissioning defund) is still being worked through. However, this risk to the CCGs will need to be addressed via the contingency and risk reserve which has been set based on 2013/14 experience and expected pressures. Any contract flexibility in 2014/15 will go towards any shortfall in the B/Fwd surplus form 2013/14. Budgets will be updated in year to reflect finalised contracts, individual final uplifts and confirmed B/fwd surplus etc.

22.6 CAPITAL ASSUMPTIONS

First Two Years: 2014/15 to 2015/16

The CCG would like to support a bid by 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 HLHF and new models of care. The CCG will therefore work with the Area Team to develop a business case. NHS England have retained GP IT funding, but for the purposes of this plan it is assumed that a non-recurrent allocation for GP IT will be made to the CCG during the financial year, at a similar value as in 2013/14 – and so GP IT is expected to have a neutral impact on this plan. However, new guidance needs to be reflected upon and Governing Body advised accordingly. The CCG has also made a bid for its own IT needs to NHS England for 2014/15, but this will not be required as it was funded and actioned from 2013/14 national capital slippage.

Last Three Years: 2016/17 to 2018/19

Once the HLHF project has progressed beyond the public consultation phase, it is expected that the capital requirements of the local health economy will become clearer, and a firmer bid for capital resources and Area Team support will be made from next year, as part of the annual financial plan refresh exercise.

A small IT replacement programme for CCG staff of £25k has been included for 2018/19.

22.7 COMMISSIONING INTENTIONS

First Two Years: 2014/15 to 2015/16

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, Commissioning for Value and monitor guidance re transformation of services 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 HLHF.

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 2013/14 month 9 contract monitoring information. There will be opportunities to access this resource for investments for jointly agreed schemes via business case to the Area Team per narrative section 2.
Financial impact of non-payment for readmissions	Non-payment for 30 day re-admissions is not modelled back into the contract baseline non-recurrently in line with the issued guidance, although overall contract cash envelopes are to be finally agreed and use of penalties will be agreed with partners. This is shown in reserves. Funding for post discharge support and re-ablement services has been separately earmarked from recurrent resources.

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. • Demographic growth based on ONS information • 2.5% CQUINs
CQUINS payments	Tariff guidance has been adopted at 2.5%
Better Care Fund	The Section 256 Agreements for Social Care and Re-ablement funding will be incorporated into the s.75 pooled budget called BCF, along with carers support funding. This agreement will be subject to review and assurance process with the CCG and the LA and a governance process has been developed for decision making around the fund via a Joint Board. H&WB will monitor to ensure benefits and outcomes are achieved. The final BCF template will be submitted separately following sign off by NLC and NLCCG in March, which includes broad plans stretching the level of ambition, timescales, metrics, governance and risk management arrangements.

Last Three Years: 2016/17 to 2018/19

At the moment the last three years of the financial plan assume a continuation of the CCG's direction of travel, as established by 2015/16. The annual JNSA refreshes will be used when available to amend the implementation of these plans in due course, as appropriate.

22.8 QIPP AND INVESTMENT PLAN

First Two Years: 2014/15 to 2015/16

The Table below provides a summary of the CCG's QIPP and Investment plan for 2014/15 (and 2015/16).

QIPP CATEGORY	2014/15 GROSS VALUE £000s	2014/15 INVESTMENT £000s	2014/15 NET VALUE £000s	2015/16 GROSS VALUE £000s	2015/16 INVESTMENT £000s	2015/16 NET VALUE £000s
Focused on Acute Care	3,790	220	**3,570**	630	0	**630**
Focused on Non Acute Care	3,071	196	**2,875**	2,316	196	**2,120**
BCF de commissioning	-	-	0	6,346	6,346	**0**
Total QIPP Schemes	**6,861**	**416**	**6,445**	**9,292**	**6,542**	**2,750**

The QIPP schemes planned for 2014/15 and 2015/16 reflect the net savings that the CCG feels is realistic but stretching, within the context of HLHF and BCF. Internally

the CCG is reporting the QIPP savings both gross and net, and will feed out investment funds to service areas as appropriate. However in the template they are automatically shown net within the service line where the QIPP impact is expected, from the start of the financial year.

CCG investments are mainly centred on delivering the identified QIPP schemes for 2014/15 and 2015/16 and those required in the guidance to establish in 2014/15 a "Call to Action Fund" of 1% (£2.058m), and (£6,346k) for BCF schemes to deliver the £11.0 m of acute de-commissioning savings in 2015/16 . The CCG is also working towards going beyond the mandated levels for 2016/17 onwards to maximise economies of scale for BCF to have the biggest impact possible, and has mapped for example, resources spent collectively on frail and elderly persons, which will be monitored as a shadow budget in 2014/15 by the Joint Board.

The full year effect of additional staffing to facilitate faster and improved pathways in Continuing Healthcare, 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, risk profiling as an enabler, and to facilitate community diabetes services for people with long term conditions.

An updated process for review and 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 £0.25m has been planned for, of which the majority will support new models of care, held in general reserves.

Last Three Years: 2016/17 to 2018/19

Detailed QIPP schemes for 2016/17 onwards are being developed, but the level of QIPP is broadly set at £2m in 2016/17 increasing to £2.25m in 2017/18 onwards to allow for in year cost pressures and generating further investment for change to deliver HLHF, support further reconfiguration/integration etc.

22.9 FINANCIAL RISKS AND MITIGATION STRATEGIES

First Two Years: 2014/15 to 2015/16

The key risk is in delivering the changes required in the system in the timescales i.e. BCF, HLHF etc. In particular the assumption of an immediate return on investment and sufficient capacity in primary care.

Specific outstanding risks to be finalised / confirmed include:

- Confirmation of brought forward surplus from 2013/14
- Resolution of outstanding issues with NHS England e.g. HVs/HEYT specialist/walk in services costs re. Market Hill.

- Local impact of PbR/contract modelling
- Local impact of new Specialist Commissioning rules on providers (and confirmation of no revisiting of baselines)
- Potential national risk pool contribution for Trusts in difficulty in 2015/16
- Allocations - Distance from Target/Pace of change in future years

In addition, general risks remain as in previous years around QIPP delivery/ implementation of HLHF/ New models of care/ BCF, 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
- Transition costs e.g. HLHF/ decommissioning to release BCF resources
- Increasing Continuing Care claims/ package costs for vulnerable people.
- Resource reduction, reduced financial freedoms, non-recurrent flexibility and management resource/capacity etc.

These risks will be mitigated through a track record of internal review, tight financial control, risk and contingency reserves, increased partnership working and transformation, use of contract levers and incentives and OD 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:

- The retention of a contingency fund of circa 0.9% in each year, which is in excess of the 0.5% minimum contingency level in the guidance.
- The creation of a risk reserve for general risks of £1.44m in 2014/15 (£5.4m in 2015/16), in addition to the earmarked reserves for re-admissions, general headroom, the Call to Action Fund, Marginal Rates, and the Elderly Care Named GP Fund.
- However, £3.086m of non- recurrent resources (i.e. the normal headroom) has had to be used to create this reserve & balance the plan.
- Wherever possible QIPP will be incorporated within contracts.
- Risk sharing with other CCGs in 2014/15 (e.g. main acute contracts with Humber, as well as NHS111 across Yorkshire & Humber- tbc).
- Risk sharing (or gain sharing) within contracts – e.g. a contract ceiling on the main acute contract (tbc) and other informal arrangements with providers. If

this is not achieved the risk reserve will be used to cover the potential additional activity.

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

This Financial plan will be developed further in line with the development of the Strategic 5 year plan due 20th June (final draft). It is also expected that for our unit of planning (North Lincolnshire) plans will be aligned as much as possible with the plans of Co commissioners, Providers and NLC as contracts and section 75 (BCF) are agreed/signed. Leadership of the organisations are committed to this and project plans reflect the milestones for this work.

Impact analysis also needs to be undertaken around the CCG's distance from target (as well as the new social care/primary care formulas).

Last Three Years: 2016/17 to 2018/19

Whilst the CCG obviously lacks detailed knowledge of new risks which may arise during the last three years of the financial plan, a prudent approach has been followed (based on past experience and to offset the significant risk associated with BCF & NLAG decommissioning). Therefore, the CCG has still retained a similar, but increased level of risk reserves above contingency, as follows:

- 2016/17 - £5,144k,
- 2017/18 - £8,772k and
- 2018/19 - £10,245k

22.10 CONCLUSION

Overall the CCG's 5 year Financial Plan is as challenging as previous years. However, the key message is that the CCG with partners need to work at pace to design and deliver the scale of change required in the local health and social care community. The challenge is to make contract arrangements for transformation and integration in 2014/15 and beyond, count. If in 2015/16 activity reductions are delivered to pay for BCF (and sufficient capacity can be mobilised in primary, community and social care, a significant risk) the remaining years should be easier than in the preceding ones.

However, with the case nationally for BCF being unproven in delivering an immediate rate of return and the need to deliver change over the long term for HLHF, there is a significant risk the impact will knock into 2016/17 and beyond requiring careful management. Hence a level of QIPP and risk reserves have been assumed that would reflect this in part, or if not needed, provide further potential investment funds for change.

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23.0 Appendices

Appendix	Title	Attachment
1	Key messages from engagement on strategic plan	appendix 1
2	JSNA Key Issues	Appendix 2
3	The 7 local ambitions	Appendix 3
4	Single Organisational Model	Appendix 4
5	Summary of key interventions and impacts	Appendix 5
6	Prioritisation tool report	Appendix 6