**North East Lincolnshire**

**Transformation Plan**

A Place-based Plan for

Health & Care Services

**North East Lincolnshire Place Partners**

North East Lincolnshire CCG Care Plus Group Panacea Federation Core Care Lincs

North East Lincolnshire Council NAViGo Meridian Federation St Hughes Hospital

Northern Lincolnshire & Goole NHS Foundation Trust Focus Independent Social Work Practice Freshney Pelham Federation St Andrews Hospice

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# VISION AND OBJECTIVES

North East Lincolnshire health and care community (Place) has an ambitious and innovative programme for place which is designed to provide the best possible services and achieve the best possible health, care and public sector outcomes for the borough.

Integral to the delivery of this program will be:

* the pioneering and developing partnership between the CCG and the Local Authority to create the union which will become the strategic commissioner for place
* the development of the joint working between all local providers who are coming together to create an Integrated Care Partnership (ICP)
* the developing partnership for more specialist provision through closer working between NL&G and Hull

Developing these 3 strands with the full engagement of key local providers and the commissioners will deliver a shared future which makes the best use of the public sector pound and creates a new reality for our local area.

We are seeking to achieve a stronger economy and stronger communities and to build North East Lincolnshire as an attractive place to live, work, visit and invest whilst tackling the inequalities and the wellbeing deficit prevalent in a number of communities in the borough.

The diagram below gives the high level outline of our vision across North East Lincolnshire and the programme areas we will address to help us achieve this.



For the health and social care system the following aspects of the outcomes provide links to the important contribution the success of this transformation plan will have on the outcomes and the overall wellbeing of the people of NEL.

|  |  |  |
| --- | --- | --- |
| **Outcome** | ***Selected narrative*** | **Link to Plan Objectives** |
| **Learning and Growing** | *This should be a place where all people benefit from life-long learning and where regardless of age, people are fulfilling their potential in NEL. People and their carers are supported to develop skills and confidence in living with long term conditions.**NEL must be a place where we enable children to have excellent school readiness* | * Improving the outcomes for those living with Long Term Conditions (LTCs)
 |
| **Investing in our Future – Sustainable Communities** | *We want North East Lincolnshire to be a place where people are supported to live independently and have access to the means to connect to other people and places.**A place where residents and partner agencies are encouraged and empowered both individually and in partnership to help shape support and contribute to the communities in which they live, work and play. A place where communities support each other and engender a sense of community cohesion and civic pride.* | * Increasing the expertise and support in the community to reduce the need to attend hospital
* Shifting population and workforce attitudes and culture to empower and support individuals to take control
* Ensuring we are changing the way we use technology and digital services
 |
| **Vitality and Health** | *We want people to be informed, capable of living independent lives, self-supporting and resilient in maintaining/improving their own health. By feeling valued throughout their lives, people will be in control of their own wellbeing, have opportunities to be fulfilled and are able to actively engage in life in an environment that promotes health and protects people from avoidable harm.**Access will be made available to safe quality services that:** *prevent ill health,*
* *support, maintain and restore people back to optimal health or*
* *support them with dignity at end of life as close to home as safety allows:*

*Services that are part of an affordable innovative and quality health and social care system which directs resources according to need.* | * Improving outcomes for the population with a particular focus on
	+ Mental health in line with the 5YFV for Mental health
	+ Learning disabilities
	+ Frailty
	+ Cancer Services
* Shaping the future of health and care services through enhanced partnership arrangements between the CCG and Council with a shared leadership team
* Integrating provision of services through providers working together in an Integrated Care Partnership moving towards the creation of an Integrated Care System

Implementing the GP Five Year Forward View and strengthening GP access |
| **Economy and Strength** | *We want North East Lincolnshire to be a place where the local existing and emerging workforce actively participate in learning and employment levels are high.* | * Developing our workforce
* Ensuring our estate is fit for purpose
* Ensuring we are making the best use of the available resources (money, people and buildings)
 |
|
| **Safe and Secure** | *People can access services, when needed, that are safe and individuals and their families are confident in the quality and safety of care provided.**Communities are supportive to and value children, vulnerable people and the elderly.**All families live in good quality housing which is designed to meet a range of different needs, supporting people to be as independent as possible* | * Redesign the future provision of urgent and emergency care, with a particular focus on the delivery of urgent care in North East Lincolnshire
* Ensuring that we have the right quality of service provision in place that is safe and effective
* Achieving the national waiting time standards for RTT, cancer and A&E
* Ensuring that we have the right leadership, systems and culture in place to oversee and assure the quality of services
 |

The narratives are subject to review to ensure they accurately reflect the outcomes different sectors are striving to achieve. A number of indicators are identified for each outcome which are reviewed annually to check that NEL as a place is moving in the right direction. A key area of development is to ensure that the indicators chosen serve to pick up and monitor changes to the inequalities experienced by the people of NEL.

# PLACE CONTEXT

Because of North East Lincolnshire’s geographical location it has a strong history of both innovation and collaboration. It has had to work collaboratively, both within NEL, but also with partners to the south, West and North to ensure that its population can access the services required, and because of NELs demographic it has been forced to think innovatively in order to address issues and ensure its residents can continue to access services locally.

North East Lincolnshire (NEL) has been on a journey for a number of years and is able to demonstrate that through working in collaboration and partnership with others we are better placed to tackle the issues we face. There have been some notable successes:

* children’s services being rated as good in the recent Ofsted inspection
* getting industry to recognise NEL as a place to invest which in turn creates a stronger economy.
* Our integrated mental health services were rated good overall and received an outstanding in relation to caring.
* Our integrated intermediate care service received an outstanding overall rating.
* Our GP practices have started to come together to form federations through which they will be able to deliver an extended range of services going forward.
* There are strong relationships between all key stakeholders across the Town.

However, there are a number of challenges for us to overcome:

* There are significant challenges with recruiting sufficient clinical and other professional staff to the area, including Consultant, GP, Nursing, Therapy, social work, and care staff
* Performance against some of the key National Indicators, in particular RTT, and cancer is significantly below where we would wish them to be and gives rise to a concern about the overall quality and safety of services being delivered in some specialties locally.
* NL&G has a significant financial and quality challenge which needs to be addressed by both internal organisational change and service transformation across the system, both locally and at an STP level.
* NL&G has one of the highest backlog maintenance and critical infrastructure risks in the country, the deteriorating NL&G infrastructure is a significant barrier which has been identified through a detailed 6 facet survey.
* There is a substantial action plan developed to improve services , systems, processes and the financial position within NLG. Whilst this is positive, it will take time and resources to fully implement.

Progress has been made, but we recognise there is still more to do and that this will take time.

The development of the ICP and the closer working between NL&G and Hull should both contribute significantly to addressing the challenges we face.

# PROJECTS AND PROJECT PLANS

# Place based plan on a page

#

**Strategic Developments**

**System Resources**

**Strategic Health and Care Priorities**

 **Acute services**

**Undertake work required to support the Humber Acute services review**

**Specific service changes are detailed within the Strategic Health and Care priorities**

 **Joint commissioning:**

**Leading the development of the JCC for the Humber**

|  |
| --- |
| 1. **Workforce**

**Develop innovative system wide roles & a place based recruitment pack that promotes place** **Develop governance that allows staff to work across providers safely****International GP recruitment** |
| 1. **Digital technology and ICT**

**Integration of EMIS and systmone to enable better care co-ordination****Implementation of a new Mental Health patient admin system** **ERS & Advice and guidance** |
| 1. **Capital and estates**

**Diagnostic scanners – CT & MRI****Refurbishments to support integrated working and Critical care capacity**  |
| 1. **Finance**
 |
| 1. **Population health management and analytics**
 |
| 1. **Leadership & improvement development**

**Revised governance arrangements established to manage the NLG contract****Revised leadership and governance for place****Develop leadership across place** |

|  |
| --- |
| **Cancer****Improvement in 104 & 62 day cancer treatment times****Access to diagnostics** |
| **Mental health****Development of the ADHD and Asperger’s service - diagnostic and support****Increasing access and recovery community based IAPT services inc LTC service****Out of area specialist rehab reduction** |
|  **Urgent and emergency care inc winter** **UTC development****Revised medical model at Grimsby & Ambulatory frailty****Trusted assessor and discharge to assess** |
|  **Elective care inc long term condition mgt****Capacity and demand mapping; daycase to outpatient procedures; Reduce 52 week+ waiters;****Stabilise with a view to reduce follow up backlogs** |
|  **Primary care** **Upskilling reception staff as care navigators****Implementing new roles – physicians associate, clinical pharmacists****Federation development to support at scale service delivery e.g. extended access** |
|  **Maternity / womens and Childrens****Work as part of LMS on future maternity services****Develop a single access pathway for children and young people** |

 **Integrated Care Partnership**

**Development of governance arrangements**

**Demonstrable progress in delivery against 5 key priority areas: Support to care homes; Dementia; community cardiology; End of Life; Integrated Urgent care**

 **Union**

**Development of a revised section 75 agreement**

**Shared leadership structure in place**

**Delivery against the workplan**

 **Quality:**

* **Establish the leadership systems and processes for oversight of quality & identify early deterioration in quality & enable rapid corrective action**

# 3.2 Strategic Developments

# 3.2.1 Joint Commissioning

NELCCG is taking on a leadership role in relation to establishing a Joint Commissioning Committee across the 4 Humber CCGs, which will both support the work of the Humber Acute Services Review, and lead to greater consistency in the outcomes required from services commissioned.

The priorities for 2018/19 are to:

* Establish effective working structures that will enable to 4 CCGs to agree common approaches to support the commissioning of services at a humber level
* Determine a consistent set of minimum commissioner expectations to inform and support the development of proposals for service change as part of the humber acute services review
* Agree a longer term strategy for the commissioning and contracting of services that need to be delivered “at scale”

# 3.2.2 Acute Services

During 2018/19 the priorities for NEL in relation to acute services are:

* To stabilise and maintain (i.e. no deterioration against the end of 2017/18 position) all waiting lists as a minimum, but with an aspiration to start to reduce the total numbers on some lists, in particular those on the follow up backlog
* To reduce the number of 52 week waiters by ½, but with an aspiration to eliminate all 52 week waiters
* To eliminate all 104 day cancer waits
* Improve performance against the A&E 4 hour standard, which will include work identified within the 2018/19 winter plan, in particular a review of the medical model on the Grimsby site
* To actively contribute and support the work of the Humber Acute services review.

More detail in relation to acute services can be found within the strategic health and care priorities and detailed project plans sections of this document

# 3.2.3 Integrated Care Partnership

The providers and commissioners in NEL have agreed to come together to create an Integrated care partnership to address fragmentation in service delivery and ensure that services are built around patient and population need

The following organisations have all agreed to be part of the Integrated care partnership and to working together to improve Health and care services for the NEL population.

****

The ICP have identified the following service priorities for action during 2018/19:

* Support to care homes
* Dementia
* Community cardiology
* End of Live care
* Urgent care, including the rightsizing of the community service to enable them to better respond to the increasing demand for urgent care in the community and avoid attendance / admission to hospital, the development and implementation of a co-located Urgent treatment centre to act as the front door to the hospital, improved discharge planning processes including the further development of an integrated discharge team which will operate on a 7 day basis.

To underpin the above the ICP determined that, in partnership with NELCCG, they would pursue an ‘Alliance model’ which would facilitate the commissioner and providers working collaboratively to achieve the agreed aims and outcomes of specific integrated services or projects. The decision to pursue this model is seen as offering the best opportunity to create co-operation between providers and commissioners with a mutual obligation (and incentive) to act in a way that is ‘best for service’.

Initially the Alliance Agreement will cover Integrated Urgent Care (including the UTC), however, the intent is that the new arrangements will be scoped and designed in a way that will allow further development; enabling other services to be added in the future if desired.

In developing the Alliance framework, significant attention needs to be given to shaping appropriate and robust governance. The Alliance requires a very different approach and has to address how each member organisation will:-

* successfully and safely participate in the new arrangements
* agree joint principles & outcomes
* accept new styles of relationships (between commissioners & providers and across providers) with new levels of transparency
* share risk & reward
* take collective decisions based on the ‘best for service’ principle

Whilst individual organisation governance & sovereignty will remain, there will be a need to address how, for the Alliance requirements, agreement and alignment can be achieved.

The new governance architecture that will be established in year to support all this is currently being scoped and will include:-

* A Strategic Board – to provide vision, direction, leadership, & oversight
* An Operational Board – to drive and deliver against agreed principles, outcomes & specifics
* Integrated Governance – a full supporting suite including; clinical governance, clinical & professional leadership & challenge, risk management, outcome based performance management, financial management & controls etc
* Connectivity to organisational and wider system governance architecture

# 3.2.4 Union

In June 2017 formal decisions were taken by NELCCG & NELC to enhance their existing partnership arrangements. Following considerations of ‘a strategic case for change’, both organisation had concluded that there were significant benefits to pursuing greater integration; not just in terms of positively affecting the shaping and delivery of health & care services, but also for the wider economic, community and well-being benefit for the local population.

Following organisation approvals to proceed with the enhanced partnership arrangements, governance and leadership arrangements were re-shaped with the appointment of a Joint Chief Executive and the formation of a new ‘Union Board’. The high level governance architecture is shown in the graphic below:-



Underpinning these new arrangements is the formal Section 75 Agreement. It has been in place since 2007 but with the enhancement of the arrangements a refresh has been undertaken to ensure that it is ‘fit for purpose’ in terms of current, and is also capable of being extended to encompass future ambitions. The re-freshed Section 75 will be in place in July 2018; it will fully detail, support and enable an ‘integrated commissioning approach’.

To support “the Union”, a single leadership team to operate across the CCG and Council will be established in 2018/19, to further support joint working 2 organisations are currently exploring options to co-locate the 2 HQ’s to enable teams to more fully integrate.

A workplan has been developed which identifies the initial priorities for action in relation to establishing further joint commissioning arrangements and areas where there would be a benefit to working more closely together, for example the comms and engagement.

# 3.2.5 Quality

Quality is what matters most to people who use our health and care services and what motivates and unites everyone working in health and care. The NHS Five Year Forward View confirms a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system.

In NEL our health & social care services face the immense challenge of bringing about improvements in the quality of care at a time of growing financial and workload/workforce pressures. To enable us to meet this challenge we need a coherent, comprehensive, unifying and sustained commitment to quality improvement that is core to our place based plans which will be driven through our ICP.

By quality improvement we mean designing and redesigning work processes and systems that deliver health and social care – however big or small - with better overall outcomes and lower cost, wherever this can be achieved.

Quality and finance are closely related through the many opportunities that exist to deliver better outcomes at lower cost and this has been demonstrated nationally (Kings Fund: Better Value in the NHS 2015). To ensure we engage staff in this quality improvement journey, we need to frame our approaches to financial improvement as a mission to deliver better value.

Improvements in the quality of care occur from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels. They do not come free and will require a substantial and sustained commitment of time and resources which should be reflected within our plan. It needs to include redesign of training, budgeting processes and information systems and requires leadership and cultures that both understand and value quality improvement.

A much more consistent and coherent approach to quality improvement across “place” is needed that learns from both the successes and the false starts of the past. This approach needs to provide the resources and expertise that will enable “place” as a whole to become not only a learning “place” but also a high-performing “place”. Approaches that have demonstrated measurable improvements in quality, cost and safety elsewhere include, but are not limited to the following:

• Cultures in which quality and safety of patient care are valued and leaders at “place” level work together to bring about improvements in care.

• A culture of learning, transparency and trust between partners needs to be established and embedded across “place”.

• A commitment to listening to and learning from, the experiences of patients, service -users and carers, and assuring their full participation in design, redesign, assessment and governance.

• Specific and quantified goals for improving care and improving service-user outcomes, linked to a compelling vision of the future (as in Salford Royal’s ambition to be the safest hospital in England). Quality improvement is based on the internal motivation to deliver the best possible care within available resources rather than a response to external pressures.

• Systematic, transparent measurement and reporting of progress in delivering these goals.

• The use of an established method of quality improvement, supported by training all staff and all leaders in this method.

• Strength of Clinical leadership, teamwork and engagement at all levels together with high quality management support.

• Boards and senior leaders who understand and own their responsibility for quality & safety, and themselves develop deep expertise in quality improvement.

There are some challenges in achieving some of the above in our local context of restoring financial balance and we aim to demonstrate through our plans that quality of care continues to be seen as a priority whilst we stabilise finances. The NHS & social care have to live within their means, and bringing spending into line with our available funding will be done in a way that promotes quality improvement rather than making it more difficult.

# 3.3 System Resources

# 3.3.1 Digital technology and ICT

EMIS and Systmone Integration

We are the national pilot for the integration between S1 and EMIS which will allow EMIS GPs to see their patient records that are stored by other services which use systmone as their patient system. The initial work will focus on integration between EMIS and District nursing records. Following the successful implementation of this element we will then roll this out to other users. Priority will be given to:

* GP Out of Hours
* Community records
* Safe Guarding units
* Hospices

With other units coming on board very rapidly afterwards.

# 3.3.2 Capital & Estates

NL&G is developing its clinical strategy aimed at addressing the fundamental strategic disadvantages faced in relation to delivery of safe patient care within a sustainable financial structure. This will transform services to deliver sustainable acute care for the local population.

The emerging strategy enables the majority of people to continue to access urgent and emergency care within each of the current localities of Grimsby and Scunthorpe. The geographic spread of the local population warrants an urgent and emergency front door on each site.

There are a number of challenges which have thus far prevented the implementation of the emerging strategy. The deteriorating NL&G infrastructure is a significant barrier which has been identified through a detailed 6 facet survey. NL&G has one of the highest backlog maintenance and critical infrastructure risks in the country.

***Diagnostic Scanners***

The diagnostic scanners across NL&G are very old and are not fit for purpose thus exacerbating clinical risk. Diagnostics are a vital part of a patient’s pathway as a hospital cannot deliver safe, efficient care without sufficient, operational, CT and MRI scanners.

Grimsby Hospital is currently without a fully functioning MRI scanner. The deficiencies in the present MRI have resulted in poor image quality and operational delivery is disrupted by regular break down in service. Without further capital investment, continued patient safety risks will remain. The Trust has been compelled to utilise mobile scanners in order to sustain patient demand, at an annual cost of at least £2.8m per annum placing further pressures on the Trusts financial position.

Due to the current patient safety risks, our first priority is addressing the issues relating to MRI at Grimsby hospital.

It is proposed that there are two MRI and two CT scanners (there is currently one CT scanner in place) at the Grimsby sites. The Trust has been successful in securing £4m capital monies from NHS Improvement to contribute to the investment in its scanners.

|  |  |
| --- | --- |
|  | £m |
| 2 static MRI scanners at the Grimsby site | 5.2 |
| 1 CT scanner at the Grimsby site | 1.3 |

***Non-Compliant Clinical Areas, Grimsby***

The infrastructure of significant sections of Grimsby Hospital is not compliant with current building regulations, HBN (Health Building Notes 04-01 and 00-09) and HTM (Health Technical Memorandum) requirements and dementia friendly standards. The poor environment of the medical wards is a significant contributory factor in the increased level of clostridium difficile infections placing safe patient care and good patient experience at significant risk.

The medical wards of most concern are C1 Kendal and C1 Holles. The number of C.difficile cases identified shows a clear disparity between the two main hospital sites with over 80% of cases occurring at Grimsby hospital. This further supports the poor physical environment as a significant risk factor in the dissemination of this infection. Recent data shows up to 20% of patients who develop loose stools are not isolated in a timely manner (<4 hours) at Grimsby hospital due to the lack of isolation facilities.

The bays in these wards do not have clinical wash hand basins in-situ and are not in line with best practice (Winning Ways 2004, NPSA Alert 2004, HBN). As a result staff are not able to perform hand hygiene in line with World Health Organisation 5 moments. In addition to lack of clinical wash hand basins, the wards currently have 6 beds within the bays resulting in patients often being in very close proximity to the adjacent bed space and equipment. The C floor medical wards lack sufficient isolation facilities (8%) for a busy unit that deals with complex frail patients. The sluice is too small for a 26 and 27 bedded ward. The hygiene facilities on the wards are poor and there is no end-suite within the bays.

The Grimsby hospital Coronary Care Unit is housed within a modular pre-fabricated structure, the construction of which was originally intended to be a temporary accommodation solution. This prevents access to the core hospital roof beneath which has caused water ingress into the Critical care unit.

The deterioration of the roof resulted in the loss of the integrity of the fabric of the building surrounding the critical care unit. This is in the heart of the hospital and in periods of high rainfall, caused water to ingress into the A&E resus area and other clinical areas. In order to temporarily address the patient safety issues which stemmed from this issue, NL&G was compelled to urgently relocate the critical care unit.

The ward structures are not compliant with current standards. The need to relocate the critical care unit led to the loss of the decant facility making the deep clean programme impossible to deliver in a timely manner. The patient flow through the hospital is very fragmented. This scheme will minimise the risk of infection currently experienced, stabilise the fabric of the building and will greatly improve patient flow. Investment to reconfigure the clinical areas above enables the bed base to alter materially and enable the emerging clinical strategy to begin to take shape. A bid for £11.86m has been developed to enable the following changes to the Grimsby site:

|  |  |
| --- | --- |
|  | £m |
| Refurbish ward environments to reduce preventable infections and deliver integrated care | 3.2 |
| Remove temporary structure from roof causing damage to building fabric | 1.4 |
| Refurbish derelict area into integrated Critical Care facility | 4.3 |
| Redevelopment of non-compliant clinical wards into multi-disciplinary assessment unit | 4.7 |
|  | 13.6 |

**Finance**

**Need an overall statement in here from Laura re the financial position of the place**

Integrated Care System

As part of the development of the Integrated Care system in North East Lincolnshire Work is underway to;-

1. re-align existing funding within individual contracts from a commissioning perspective, alongside
2. understanding the costs of the services from a provider perspective.

This covers:-

* Support to Care Homes Workstream
* Dementia Workstream
* Cardiology Workstream
* IUC Programme

Fortnightly finance meetings with the finance leaders from all of the provider organisations & the CCG to progress this work.

Mental Health

The CCG plans to invest an additional £2m in Mental Health in 2018/19 to meet the Mental Health Investments Standard (including LD & Dementia), this equates to a 6.4% year on year increase.

# 3.3 Strategic Health and Care priorities

**Urgent and Emergency care / Winter Plan for 2018/19**

In preparation for winter 2018/19, NEL has learnt from the experiences, successes and issues identified during winter 2017/18 and is starting to plans in place now that will help with both the management of winter, but will also support the longer term safety and sustainability of the urgent and emergency care services. It has been agreed at the A&E delivery Board that the plan will be broken down into 4 phases which will align with the 4 quarters of the year, with the intention of having the majority of the schemes developed and implemented in time for winter. It has also been agreed that Introducing new schemes and ways of working when staff are at the optimum capacity with emergency care (during Quarter 4) should be avoided, therefore Qtr 4 activity will be about imbedding and testing service resilience.

As in 2017/18 the plan has been broken down into 3 areas:

* Pre-hospital / integrated Urgent Care
* In Hospital &
* Discharge and onward care

Hospital avoidance / Integrated Urgent Care

This work stream includes all of the Primary Care and Community service elements that combine in an integrated urgent care system. Its constituent elements that provide for demand management in terms of providing the right care in an appropriate setting and directly impacting on A&E attendees.

|  |  |  |
| --- | --- | --- |
| **Scheme (Priority)** | **Summary** | **Lead** |
| **Conveyance Avoidance Pathways (2)** | Building on learning from winter 2017/18, community rapid response services will work with EMAS to refine alternative pathways access for EMAS for instances where their clinical assessment indicates that there is not a requirement for conveyance to an A&E department.This will focus on scope and timeliness of response and on education of EMAS crews on access to alternative pathways. The response will focus on use of clinical advice and service access through the NEL SPA.  | Jane Miller CPG  |
| **Community Urgent Care Capacity (1)** | Avoidance of A&E attendance/admissions will be enhanced through the rightsizing of existing SPA/community rapid response services (workforce), through enhancement of preventative and urgent response initiatives for residential care homes and through the implementation of communityIV services. | Jane Miller CPG |
| **Urgent Treatment Centres (1)** | NLaG and CCG will work with provider colleagues to develop an Urgent Treatment Centre (UTC).The UTC model follows the national specification and will be co-located with the DPoW A&E. A proposed enhancement to the national UTC model is that the UTC will act as the “A&E front door” in that walk-in attendees would not access A&E services without being assessed in the UTC. It will also be able to attend to some patients who arrive by ambulance.The UTC will be a GP led multi-disciplinary team integrated with acute diagnostics and ambulatory service and builds on the current co-located PCS and GPOOH services and the lessons learned with this year’s deployment of nursing and social care staff in the A&E department.The UTC will be operating at full capacity by June 2019 (NHS tranche 4 site) and will be fully functional but operating at 50% capacity by October 2018.  | Anna Morgan CCL |

**In Hospital**

Initiatives to improve flow and bed capacity management in the hospital for those who are admitted.

|  |  |  |
| --- | --- | --- |
| **Scheme** | **Summary** | **Lead** |
| **Ambulance Handover (2)** | The trust will continue to work closely with EMAS to improve handover times to minimise the impact that ED overcrowding and pressure can have on releasing ambulance crews in a timely way. This is monitored through the 6 times a day operational sitrep, and ED Ash matrix. The organisations will continue to embed and improve the ‘Fit to sit’ programme of work, as well as strengthen the identification and communication alerts of the deteriorating patient during he handover process  | NLaG - Medicine |
| **Bed modelling – NlaG (1)** | Building on the baseline model that demonstrates that if no changes were made to models of care, the trust requires a further 11 beds each year, plus the 50 escalation beds the trust has been using throughout quarter 4. The baseline will be refreshed at the end of Quarter 1. The system will model through proposed service changes to help to inform a right size. | NLaG – Strategy & Planning |
| **Patient Flow, Escalation and Surge (1)** | The Patient Flow/Escalation and Surge policy will be reviewed following feedback from users, and refined further to ensure robust and timely response is clear for all staff. A new operational flow team structure which was reviewed during 2017/18, will be proposed for implementation prior to Q3. This will strengthen leadership of the sites, operational and emergency planning, and increase staffing in a planned way for the predicted peak in activity between the hours of 4 and 8pm. | NLaG – Operations Centre |
| **Elective Care (1)** | To mitigate any impact on RTT performance, all specialties will, where appropriate, front load pathways by switching elective activity to either day case or additional outpatient activity during January and February.NLaG will minimise inpatient routine surgery, and focus on cancer work, and clinically urgent cases post Christmas until the end of February. Demand will be reviewed regularly to ensure that elective activity is programmed in line with capacity and existing pressures. This will ensure that consultants are freed up for decision making and will create capacity for emergencies.In addition all areas will need to ensure a proactive approach throughout the winter period to reviewing elective procedures in order to avoid cancelling patients on the day of admission, which results in both poor patient experience and places further pressure on services to fulfil the 28 day guarantee for last minute cancellation. | NLaG – Operations Directorate |
| **Revised medical model at DPOW (1)** | The revised model will streamline the process of care for non-critically ill medical patients with complex problems, including patients who have medical illnesses but present with conditions where it is unclear as to the need for immediate intervention. The assessment unit will provide the single portal for entry into assessment for care for all acutely ill medical patients as it does currently. Those that require longer term specialist review will be moved to a specialist ward, however those that require more than an assessment will be moved through to a short stay ward which will have a LOS maximum of 72 hours. This will enable specialty specific bed to remain available for those that are of a higher acuity. It will also contribute to reducing outliers onto surgical wards affecting flow. | NLaG – Medical Director |
| **Ambulatory / Frailty (1)** | Increasing zero LOS with the objective of a combined surgical, medical and frailty ambulatory unit will be developed throughout 18/19 into one facility, and provide an improved journey for our patients, including GP direct referrals as a matter of course rather than attending ED. | NLaG – Medicine / Surgery |
| **Red to Green/SAFER (1)** | SAFER actions will be undertaken in the lead up to winter, organising scheduled activity to support early decision making. Throughout winter there will be a step up in the intensity and scrutiny of the ‘Red2Green’ programme in order to ensure an increased focus on reducing delays. | NLaG - Medicine |
| **Escalation Beds (2)** | The other schemes in the plan should reduce if not negate the use of escalation beds. However, the system has agreed we still need to have a mitigation plan should they be required in order to keep the bed occupancy at a reasonable level. The constraints of staff vacancy rates and the Trusts financial position significantly narrow the scope of what is achievable. , , This will need to be tightly controlled and closely monitored in order to ensure that it is closed down as soon as the immediate pressures on beds subsides. | NLaG – Operations Centre |

**Discharge and onward care**

This work stream includes all of the measures that reduce DToCs, improving flow and bed capacity management. It incorporates the measures in the national 8 High Impact Change model for reducing DToCs. Whilst DToCs remain a statutory measure, this work stream includes the key principle of a system wide focus on discharging quickly those who are medically optimised and a shift of their remaining care and assessment needs out of hospital.

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| --- | --- | --- |
| **Scheme** | **Summary** | **Lead** |
| **Trusted Assessor & Discharge to Assess (1)** | Discharge to Assess pathways will be fully implemented by November. The step-down pathways for moving rehab/LTC assessments from acute beds either home or to a community setting for full assessment and to receive some elements of care that need not be delivered in an acute setting must be active and resilient and be provided for patients who are medically optimised. This will have a direct impact on DToCS for Intermediate Care pathways, and the ultimate aim for the system is to achieve zero DToCs and target 90% of medically optimised patients being discharged within 24 hours. | Jane Miller CPG |
| **Community Ward (1)** | To develop a community ward staffed by community nursing and a GP to provide an interim step down for patients who are medically optimised who would otherwise remain in a hospital bed. This is part of the reshaped services required to deliver Discharge to Assess (D2A) and Trusted Assessor | Jane Miller CPG  |
| **Out of Area Patient Delays (2)** | There are delays in securing out of area team assessments and repatriations for Lincolnshire patients. These delays are not reflected in DToC performance for the Northern Lincolnshire system but have a notable impact on NLaG bed capacity, at the DPoW site which receives some 20%+ of it’s unplanned admissions from Lincolnshire. This year the system will work with the Lincolnshire providers in developing robust and timely information and actions.  | Andy Ombler CCG |
| **Transport (2)** | The system are reviewing some elements of the patient transport service requirements to ensure they are fit for purpose in peak periods.  | CCG |

# PROJECT PLANS

The table below summarises the projects & workstreams as outlined within our Plan on a Page on page 8:

* 1. Strategic Health & Social Care Priorities:

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| Strategic Developments |
| Title | What are we doing | Actions for this year | How will it impact |
| Outcomes | Quality of care | Finance | Workforce Activity |
| Strategic Commissioning | Creation of enhanced partnership arrangements between the CCG and Council with shared Leadership team. | Map outcomes and targets against the agreed outcomes framework as part of the development of strategic plan for placeDevelopment of Strategy for Place, working with NELC as joint strategic commissioner of 'Place'  | Be at the forefront of developing quality services that are effective, efficient & innovative; utilising best practice where it exists, or being confident to innovate and design where necessary | A joint approach by commissioners to quality improvement with shared systems for quality oversight and assurances. Be better to shape consistent, quality services that respond to all sectors of our community | Maximise the NEL £ via joint commissioning initiativesAchieve organisational and financial sustainability (stronger together) | Provide a single, focused leadership team able to better identify opportunities, manage risk and drive efficiencies that add value via ‘smarter’ working |
| Integrated Care Partnership (ICP) | Integrated provision through ICP moving towards the creation of an Integrated Care System | Establish shared understanding and expectations between commissioners and the collective providers within the ICPEnsure preparation for delivery of ICP - service specifications, governance, engagement and other implementation actionsImplementation of ICP priorities, i.e. Dementia, Support to Care Homes, Community Cardiology, End of Life Care, Urgent care.Agree key principles and a method of quality Improvement for the ICP, including a commitment to listening to service users and setting specific and quantified goals for improving care & service-user outcomes, linked to the ICP priorities. | Locality Integrated care delivered by partners working together under an alliance contract, which will mean all providers work collectively towards success. Increased delivery of services out of the hospitalNew models of care in line with Five Year Forward View/Next Steps | Develop a learning culture of quality and patient safety that is owned at all levels in Place.  | Realignment of resources (total pathway approach) to supportPatient flow both in & out of the hospital. Delegated responsibility for providing or commissioning services designed to deliver on the outcomes set out within an alliance contract between the ICP and the Strategic Commissioner for NEL |  |
|  |
| Strategic Health and Care Priorities |
| Title | What are we doing | Actions for this year | How will it impact |
| Outcomes | Quality of care | Finance | Workforce Activity |
| Long Term Conditions (LTCs) | Improvement in the management of long term conditions for all life stages including support for those with mental health and cancer.  | Remodel the Disabled Facilities Grant pathway by actioning the required recommendations for changeEnhance community based interventions for long term conditions building on work around COPD & diabetes. Support prevention initiatives such as Care navigators in Primary care, wellbeing coaches & social prescribing. Support to voluntary & community sector to optimise income, capacity and capability and deliver grass root prevention initiatives and increase referrals to this provisionRoll out the support to care homes initiative across NELFalls prevention roll outDevelop a sustainable service for cardiologyRoll out a programme of education for cardiology and diabetes across primary and community care and in COPD for community teams Continue development of advice and guidance in managing cardiology patients for primary care cardiology Roll out an awareness and early identification programme for COPD in targeted areas Roll out myCOPD App Roll out extended access including additional provision of Long Term Condition clinics during extended access | Improving the outcomes for those with long term conditionsIncreasing the number of individuals who feel supported to manage their own careShifting care out of hospital Patient is seen by the person with the most appropriate skills and competencies, in the right environment to meet their clinical needs, at the right timePatients are managed within national Referral to Treatment standardsEffective management of patients following an unplanned admission Improved clinical outcomes for patientsReduced overall mortality attributable to cardiology disease Decreased spend on acute care for cardiology Improved timely access to diagnosticsReduce the gap between expected and actual COPD prevalenceFor people living in residentail care by: Aligning community provision to care homes. Reviewing medicines management in care homes to ensure that staff are able to manage increasingly complex prescriptions/ conditionsImplement improved IT and connectivity across all commissioned homes, developing access to NHS.NET email, WebV to deliver better communications between acute care and residential careReview advanced care planning and deliver a standardised approach to this across NEL to improve consistency and understanding of future care needs and reduce the number of unneccessary transports to A&EImplement the NHS Vanguard Red Bag scheme to improve communication and dignity when residents are admitted to acute units.  | Improved effectiveness and efficiency of services.Improved service user experience | Social Prescribing planned to deliver £182k by 2021 | It is anticipated that there will be greater integration between those primary care based teams and those services supporting ‘Long-Term Conditions’. |
| Urgent and Emergency Care | Working with the UECN and STP to redesign the future provision of urgent and emergency care , with a particular focus on the delivery of urgent care in North East Lincolnshire | Develop integrated urgent care specCoordinate intermediate care developmentDevelop single point of access further to deliver specific enhanced functions for all urgent (non-emergency) careDeliver improvement to rapid response at home to urgent careImplement Urgent Treatment CentreEstablish MODT(Multi-organisational Disciplinary Team) on hospital siteThe NEL UTC implementation project will be addressing system requirements to ensure that the SystmOne module in the UTC can deliver the ECDS.ECDS will be reviewed to see if there are any additional UTC metrics required to be supplied locally | To reduce attendees to DPoW A&E.Realising financial efficiencies of multi-provider working in an ICP Increased patient satisfaction of service received when attending A&E through streaming to appropriate serviceMoving to a true 7 day model for all elements of Urgent CareTimely discharges from hospital site as a result of 7 day MODT(Multi-organisational Disciplinary Team)Urgent Treatment Centres (UTCs) to implement the Emergency Care Data Set (ECDS) by Oct 2018 | Review and update medical model at DPOW  | Overall aim for minimum of cost neutrality based on average attendance tariff versus cost of additional staff in community etc. | GP already funded but funding required for A&E streaming nurse and PCS clinical nurse. |
| Mental Health | Delivering the 5YFV for Mental health, either with partners across HCV or elsewhere or in place depending upon the service | Mental Health STP - reviewing out of area for complex dementiaEnhance perinatal mental health services, and transition, across the Humber and wider STP footprint as part of the development of a hub & spoke model which integrates both Specialist & local Community TeamsPhase 2 development of Specialist Rehab Pathway for adults with complex mental health ensuring closest, least restrictive delivery settingADHD & Asperger’s diagnostic and support service (NAViGO/Care Plus Group partnership) as part of ‘Building the Right Support’Early Intervention in Psychosis – funding received to ensure services meet NICE guidancePhysical health monitoring for SU with Anti-Psychotic MedicationIncreasing access and recovery targets for community based IAPT services and embedding of the Long Term Conditions serviceTo ensure that the emotional health and wellbeing service model reflects the direction and plans of "future in mind", the 0-19 programme, and the mental health 5-year forward view. | Reduced need for complex dementia patients to access costly out-of-area placements; increased patient/carer satisfaction; increased consistency, quality and safety of careIncreased access to place-based Perinatal MH services for local women through development of specialist teams; reduced MH Crisis admissions; improved access to Psychological TherapiesReduced out-of-area placements; reduced crisis admissions; improved quality and safety of care; improved quality of life for SU; improved community integration and effective Out of Area budget management (in light of funding changes for low secure)Improved access waiting times & community-based support for Service users and carers living with ADHD/Asperger’s (originally only a diagnostic service) It will develop a clear link with Primary Care in respect of shared care. It will provide differing levels of training, including autism awareness.Improved local access to Early Intervention Practitioners for CYP aged 14-35 through recruitment of additional specialist practitioners; improved workforce skill base through training in CBT for PsychosisImprovement or maintenance of good physical health through monitoring of BMI, smoking history, blood pressure, glucose & lipids (Lester Tool) for those taking antipsychotic drugsImproved LOCAL resilience underpinned with effective, rapid-access support services which take account of the most vulnerable.Suitably qualified and developed staff, better integrated with physical colleaguesGreater accountability and transparency through multi-agency working and collaboration | We will be transforming Mental Health services through implementing the Mental Health Five year Forward view. The resultant improvements are expected to positively impact on outcomes not only for Service Users and their families/Carers but also for the MH workforce and enabling the local community better, faster, more integrated access to place based services.  | Expected savings will be realised not only within MH service delivery but will in tandem impact positively on physical health costs within ACP boundaries. For example, improved, faster access will reduce crisis care, A&E admissions and the need for self-harm in-patient admissions to the general hospital.Reduction in out of area financial costs and better services within NEL (currently £1.4 million) | Perinatal service development is funded through STP joint bid (secured) – will be a need to recruit to the local ‘spoke’There will be a need to recruit and train within the Early Intervention in Psychosis Team (funding secured) |
| Cancer | Delivering the national cancer strategy in partnership with HCV Cancer Alliance | Renewed cancer action plan in place to assist in meeting the 62 day targetAudit cancer 2ww referralscontinued monitoring of patients more than 62 days and those more than 104 days. delivery of new clinical pathways in line with NEL RightCare programme.continued oversight of performance at Planned Care Boardto be continued. | Increase in early diagnosisAchievement of 62 days & reduced 104 days. | Reduction in unnecessary hospital attendancesImproved effectiveness and timeliness of servicesImproved service user experience  | New NHSE guidance has been issued which will lead to our transformation funding being reduced by up to 50% if we do not meet the 62day target in May, June and July this year. This change in direction has caused real concern for the HCV Cancer Alliance who have had to revisit their initial bids and make substantial cuts – particularly when recruitment of staff is involved. HCV are currently looking to fund additional diagnostics and radiology.  |  |
| Maternity, Women’s & Children’s Services | Determine overarching direction of maternity and paediatric services as part of Wave 2 Humber Acute Review (HAR) Implementing Better Births – Five Year forward View for maternity servicesEnhancing access to Perinatal mental Health services as part of the Five Year Forward View for Mental Health ServicesDeveloping a single access pathway for children and young people | Oversee local maternity & paediatric services performance and delivery plans and ensure this links into HARDevelop a paediatric service specification for acute ward; PAU, Community nursing and Phlebotomy clinicsDevelop plans as part of the LMS to ensure that our future maternity system is safe, sustainable and meets the vision laid out in Better Births and the 5YFSecure WAVE 2 funding for HCV STPSet up HCV PNMH Governance and Contract monitoring BoardStart to develop a hub and spoke model of delivery across the STPLaunch the Single Access PilotReview and evaluate pilot based on the voice of CYP and their carers | Improved choice, personalisation and continuity.Improved patient outcomes and clarity and consistency of services providedincreased choice, personalisation, continuity, safety and sustainability across the STPProgress to the ‘halve it’ ambition of halving rates of stillbirth and neonatal death, maternal death and serious brain injuries during birth by 50% by 2030 Reduction in the variation of access to perinatal mental healthSeamless, accessible patient focused PNMH pathways across the STP patchC&YP have early access to universal services and effective care navigation to more specialist provision if needed | Improved patient experience and outcomes.Improvements in safety and service qualityClear and measurable KPi’sImprovements in patient experience and pathways of careLearning from incidents, and are sharing this across the LMS Improved patient experience and outcomesC&YP receive the right care when they need it | Sustainable future model across the Yorkshire and HumberImproved effectiveness and efficiency Efficient and sustainable model of maternity servicesIncreased access to early intervention rather than crisis careReduction in unnecessary referrals to specialist services and assessment | A more competent and confident workforce, with the correct capacity and skills mix. Workforce have appropriate capacity, skills and knowledge A more competent and confident workforce, with the correct capacity and skills mix. Appropriately skilled and competent workforceImproved knowledge across health, social care and education workforce |
| Development of Primary Care | Implementing the GP 5 year forward view | Primary Care workforce development: HCV GP International Recruitment Programme; Up-skilling of Reception staff (Care Navigation); Implementing new roles (Physician’s Associate, Clinical Pharmacists, Developmental Post-CCT GP training roles); expansion MH therapists in primary care (see MH section)New Models of Care: ‘at scale’ working within Federations; Development of services across broader footprint including management of LTC and complex service users; extended access; enhanced community pharmacy servicesWork with ICP in understanding alignment of practice groupings with other community services New ways of working: Digital solutions (patient online, online consultation, email consultation, video consultation); improved record sharing (EMIS and Sys1 integration pilot). | Improved access for the local population More resilient and sustainable primary care servicesReduced duplication and more effective use of resources | Improved proactive management of LTC patientsQuicker access to right service/professional first timeMore care delivered in local setting | CCG non-recurrent funding is being invested to support all areas of work, as part of the nationally mandated £3 per head transformation funding.Additional increase in recurrent funding to reflect annual uplift and to support new local schemes.  | 10 additional GPs through International recruitment campaign4 Physicians’ AssociatesAdditional nurses for at scale LTC and complex case management (number tbc)5 Clinical Pharmacists119 Care Navigators1 GPwSI (GP Post-CCT role) |
| Palliative and End of Life Care | ICP leading work as a local priorityCo-ordinating a range of strategic and task groups to deliver local strategy. Review and refresh the local strategythrough the Northern Lincolnshire Multi-agency group developing a single system and standardised approach around governance for patients. Working with other stakeholders in primary care, care home, dementia services and urgent care to establish good principles of end of life care are embedded | Working in partnership to raise the profile of services people can access.Continuing with a communication s plan to raise the profile of End of Life care with the public. Reviewing resources across the wider provision of palliative and end of life care (primary care, social care, secondary care and voluntary sector) and identify systems to improve access and availability by utilising a flexible and dynamic approachEmbed prognostic indicators in relation to end stage diseases and frailty Finalise the rollout of a single anticipatory prescribing regime across organisations.Review and revitalise the need for advanced planning including ceiling of cares, DNACPR and ADRTIncrease the number of people on the Palliative Care Register and ensure this is recorded on the patient recordDevelop the use of the Summary Care RecordRoll out Care in the last days of life document across locality to provide consistency and quality in care at the end of life with the regular use of an integrated plan of care.Training workforce Increase the use of technology to remotely provide specialist palliative care and support to patients, families, and other care providers To take a joined up approach to system development as palliative and end of life care threads through many of the other workstreams. | Reduce inappropriate admissions to hospitalImprove access to care to enable more people with non-malignancies diagnosis including frailty receiving palliative care Enable more people to die in the place of their choosingPeople and families achieving what’s felt as a good death enable good bereavement | early recognition and advanced planning for care will provide more effective care and improved experience of service user and family.  | Socioeconomic impact on good death achieving good bereavement outcomes | Increase the knowledge and skills across locality workforce |
| Elective / Planned care | Patient AdministrationPTLs and bookingCapacity and DemandFollow up care & specialty plansProspective process of clinical harm | Introduce call remindingERS implementationAdvice and guidance Clinical leadership and revised oversight structure in place Agree principles for prioritising capacity and improving waiting listsImplement actions identified to increase capacity / reduce demand across initial 8 specialtiesRole out capacity and demand model into all other specialties – with Orthopaedics being the first to be doneImplement best practice for large volumes in key specialties e.g. telephone follow upStandardise pathways utilising righcare / GIRFT for Gastro, Ortho, Gen Surg & OphthalmologyFragile services – Urology, ENT & Haematology to be managed as part of STP/HASR Systems and processes put in place to support “business as usual management of:>104 cancer waits>52 week waiters | Increased clinic slot utilisationReduced DNAsIncreased no of people able to be treated in communityBetter management of lists and patient treatment prioritisationSystem wide agreement to avoid disputes Capacity gaps identifiedIncrease in capacity to stabilise , with a view to then reduce backlogs of patients waiting | Reduction in risk of potential clinical harmAreas of risk due to ongoing lack of capacity identifiedReduction in risk of clinical harm.Improved patient experienceBest practice / improved quality of careSystematic review and learning from new instances of long waiters to pick up potential harm earlier in the process | Productivity gainsReduced number of outpatients required |  |
| Dementia | The ICP is leading as a priority.Our plan for Dementia in particular aims to transform our approach and pathways in alignment with the NHS England Well Pathway for Dementia | Dementia is one area of key focus for 2018/19 and the include:Dying wellLiving wellSupporting wellDiagnosing wellPreventing wellkey projects for the year which will move us forward in our transformational journey | Achieving/maintaining diagnosis rateAccessing post diagnostic support and care planningMaintaining independence in the communityAvoiding unnecessary hospital admission and readmissionSupporting preventionEncouraging dementia friendly communitiesAccessing cognitive stimulation therapyEnabling appropriate antipsychotic drug prescribingFacilitating advance care planning | Improved patient and carer experienceMore effective and efficient services |  |  |

# LEADERSHIP AND GOVERNANCE

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| --- | --- | --- | --- |
| **Senior Responsible Officer** | Dr Peter Melton | **Programme Lead** | Helen Kenyon |
| **Clinical Lead** | Joe Warner | **Finance Lead** | Laura Whitton |
| **Communications Lead** | Lisa Hilder |  |  |

The workstreams are managed through:

• Oversight through Senior Responsible Officers for each workstream which we will look to bring together to oversee place delivery

• Strategic Commissioning is supported by the shared Leadership team across the CCG and the Local Authority which will report to the Union Board.

• Integrated provision is delivered through the ICP Board.

• Working together across the Humber we are part of a number of groups which support our governance and delivery of our plans.

o A&E Delivery Board

o Planned Care Board

o Patient Safety

o Finance

o Humber Acute Services Review Steering Group

o Humber Joint CCG Commissioning Committee

# Finance

The NEL place faces significant financial challenge over the coming 12 months, this is across all organisations but in particular in relation to the Acute Hospital.

Integrated Care System

As part of the development of the Integrated Care system in North East Lincolnshire Work is underway to;-

1. re-align existing funding within individual contracts from a commissioning perspective, alongside
2. understanding the costs of the services from a provider perspective.

This covers:-

* Support to Care Homes Workstream
* Dementia Workstream
* Cardiology Workstream
* IUC Programme

Fortnightly finance meetings with the finance leaders from all of the provider organisations & the CCG to progress this work.

Mental Health

The CCG plans to invest an additional £2m in Mental Health in 2018/19 to meet the Mental Health Investments Standard (including LD & Dementia), this equates to a 6.4% year on year increase.



Primary Care

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| --- | --- |
| ***FULLY DELEGATED CONFIRMED ALLOCATION (effective from Apr 18)*** | ***Plan £'000*** |
| *General Practice - PMS* | *16,775* |
| *General Practice - APMS* | *771* |
| *Premises cost re-imbursement* | *6,243* |
| *Other premises costs* | *4* |
| *Enhanced services* | *362* |
| *QOF* | *2,312* |
| *Other GP services* | *1,136* |
| ***NHSE COMMISSIONED TOTAL*** | ***27,603*** |
|  |  |
| ***NHS NORTH EAST LINCOLNSHIRE CCG COMMISSIONED*** | ***Plan £'000*** |
| *Locally Commissioned Services* | *3,171* |
| *GP Training & Recruitment* | *90* |
| *Local Quality Scheme* | *300* |
| *Other Primary Care expenditure\** | *740* |
| ***NEL CCG COMMISSIONED TOTAL*** | ***4,301*** |
|  |  |
| ***NORTH EAST LINCOLNSHIRE COUNCIL COMMISSIONED*** | ***Plan £'000*** |
| *LARC fits and removals* | *110* |
| *Health checks* | *86* |
| *Stop smoking service* | *40* |
| *Substance misuse* | *125* |
| ***NELC TOTAL*** | ***361*** |

\*Includes GPFV mandated £3 per head & additional transformational support funding

# PERFORMANCE

In terms of key performance measures the details below describe the elements of performacne which underpin the CCG’s and the place based aspirations for 2018/19



# RISKS

In terms of managing the risks associated with overall delivery of the place based plan, each initiative has identified risks, mitigations and owners as described in the following pages

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| **INTEGRATED CARE PARTNERSHIP (ICP)** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
| Contracting Arrangements | Procurement process for ICP expected 2019/20 | Work to plan for this across partnership alongside pushing forward development of ICP at pace and scale  | Jane Miller |
| Service Delivery | Failure to effectively deliver priority service redesign schemes to key milestones. | Board meetings fortnightly/ on-going monitoring of priority projects. Additional programme support procured | Jane Miller |

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| **CANCER** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
| Increase in early diagnosis | Ability to engage the public in awareness raising and case finding  | Close working with NEL team who have significant experience in this. Advice sought from other areas engaged in case finding. | Pauline Bamgbala  |
| Achievement of 62 days | Release of funding from national team (ability to meet 62 days/ release of funding on quarterly basis) | On-going dialogues with national team to understand the requirements and give assurances/ HCV working with providers to develop recovery and implementation plans | Pauline Bamgbala |
| Workforce & Engagement | Clinical workforce – engagement and lack of overall staffing | Working across STP to recruit and retain staff collaboratively, increase opportunity for homeworking, clinical leads (primary and secondary care) in place across all work streams to support clinical discussion.  | Pauline Bamgbala |

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| **LONG TERM CONDITIONS** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
| Community Specialist Support and up-skilling of primary care staff | Inability to recruit substantively to Consultant post within community cardiology serviceInability to transfer funding from acute care to reflect shift in activityLimited capacity of specialist staff to deliver training to primary care staff  | Work with local trust to redesign pathway, supported by RightCare programme, to secure Consultant input to communityEngage in System Improvement Board and CEPSecure dedicated sessions as part of CCG clinical lead arrangements | Sarah Dawson |
| General Practice Federation LTC teams & development of integrated working with other agencies | Inability to recruit to new posts within general practice federation LTC teamsDiffering cultures and attitudes may affect ability to effectively work together in integrated wayCapacity constraints within general practice affect ability to implement change | Shared staff across federations reduces risk of gaps and ensures greater resilience of serviceLocal CCG training programme for nurses and HCAs being developedJoint development activities to be facilitated Transformation funding for general practice to support ‘at scale’ working | Sarah DawsonJulie Wilson |
| Diabetes Education Programme extension | Difficulty recruiting health care professionals and lay educators who meet the criteriaEmbedding change in primary care referrals may be slowRisk that the demand exceeds capacity  | Ensure all appropriate staff are aware of the opportunity and the benefits to being an educator; Ensure opportunity is clear and that it is marketed through all available routes Strong engagement plan prior to commencing the change and utilisation of a mixture of methods to promote and raise awareness; Monitor initial referrals and work with non-referrers to understand and address barriers; Promote widely to patients Have flexibility within the programme to increase/decrease the number of courses depending on demand; Flexibility to train up the additional educators earlier than planned if demand requires | Sarah Dawson |
| National Diabetes Prevention Programme | Risk that demand exceeds capacity | Work with national team to understand flexibility for accessing additional sessions | Sarah Dawson |
|  |  |  |  |
| **MENTAL HEALTH** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
| To reduce the spend on out of area care for individuals with mental health needs from NEL and  in 2017/18.  | NHS England return more people from Secure placements placing onus on local providers | Joint appointment of Out of Area Placement officer to oversee programMonthly meetings between Navigo, CCG, and NHSE to monitor potential cases and discharge trajectories | Angie Dyson & Mike Reeve |
| Introduce Liaison Psychiatry in line with the NHS Five Year Forward Plan across Northern Lincolnshire to move towards delivering core 24  | NLCCG currently have significant financial challenge, restricting contracting options, significant challenge in gaining pace to change, but awaiting new guidance from NHS England to see at funding opportunities  | Navigo & NELCCG have offered to work with RDASH and NLCCG and NL&GFT to explore a Northern Lincolnshire solution | Mike Reeve, Angie Dyson, NLCCG |
| Increase access to IAPT services within NEL to meet the targets set via the NHS | challenge in gaining access to and sign-up from GP practices to enable accommodation in practices | CCG working with Primary Care to ensure appropriate access is seen as a priority | Angie Dyson |
| Review of Dementia care within NEL as set out with the ICP Project Initiation Document (PID) | Action plan developed with key priorities across the life plan  | ICP Governance framework will create suitable consultation process that has the potential to facilitate unified approach. | Angie Dyson |
| Reviewing physical health checks and medication management across vulnerable groups (including those with enduring mental health and learning disabilities) to ensure appropriate levels of “safe” shared care across NEL | Enabling sufficiently diverse access to meet a wide range of requirements at sufficient scale to be sustainable | Joint working groups set up with CCG, Navigo, and Primary Care to map need and uptake for future pathways | Angie Dyson |
| Humber Transforming Care Plan | The Partnership does not meet the transfer of care requirements from NHSE | Ongoing engagement and liaison with a clear plan for each discharge in each area | Humber partners |
| Development of preventative model of care for Children and Young People enables better access for a wider range of people requiring emotional wellbeing or mental health support | Insufficient breadth of skill in Services offering Early Help and support | Wider workforce analysis and increased training opportunities | Michelle Thompson |
|  |
| **PRIMARY CARE** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
|  Immediate and practical assistance to support general practice resilience and sustainability | Current capacity constraints may impact on ability to engage in developmental / transformational work. | Draw on immediate support from NHS England for Vulnerable practice fund and GP Resilience programme, where appropriate to practice. Make best use of protected time for conversations regarding general practice development | Julie Wilson |
| Immediate and practical assistance to support general practice resilience and sustainability | Practices unable to maintain resilient primary care workforce. | Ensure practices have opportunity to be supported through GP Resilience Programme  | Julie Wilson |
| Finance | Funding constraints could limit ability to deliver on some aspects. | Utilise current year non-recurrent funding to support development. Ensure CCG financial planning includes elements of funding identified within this plan. Request support from additional national funds | Julie Wilson |
| Finance | Increased indemnity costs associated with new models of care. | Ensure new NHS England scheme from April 2017 is taken up. | Julie Wilson |
| Communications & Engagement | Patient and public opposition to plans for new models of care, particularly primary care at scale. | Early engagement. Continued, on-going engagement, making effective use of Accord membership, Community Forum, PPGs, and working with Healthwatch | Julie Wilson |
| Technology Developments | IT Transformation lagging behind required pace of change. | Agree and implement interim solutions to support record sharing (viewer solutions/enhanced summary care record), in line with Digital Roadmap plans | Julie Wilson |
| Premises | Premises: Current ETTF bids for premises upgrades may not align with hubs for new federations. | Revise PIDs for premises schemes scheduled for 17/18 if necessary | Julie Wilson |
| Workforce | Inability to recruit. | Work with NHS England, STP colleagues & LMC on GP international recruitment campaign. Utilise existing non-recurrent funding to support recruitment initiatives.  | Dr Ekta Elston |

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| **URGENT CARE** |
| **Project** | **Risk** | **Mitigation** | **Owner** |
| Finance | As IUC work stream leads develop plans for implementation, each is likely to produce a workforce plan that adds costs and which will not necessarily demonstrate equivalent savings through efficiency or activity reduction.  | ICP Board and ICP Finance Group to ensure that workforce plans, investment, recurrent costs etc. are within the ICP Urgent Care overall budget set by working towards a capitated envelope for Urgent Care. | TBC |
| Workforce | In addition to simple recruitment pressures there are a number of areas within IUC development where the use of the existing workforce will need to be altered under new arrangements. In particular, the UTC development will require agreement on the use some of the current A&E clinical workforce and collaboration with the GP federations to secure sufficient capacity. | ICP IUC Board has lead identified to support workforce issues/development. Individual plans include specifics on workforce development. Support of CCG and ICP Board. | Kerry Campling |
| Urgent Treatment Centre | UTC implementation will require rapid agreement with NLaG on the use of estates (e.g. current A&E reception, minors and GPOOH location )  | Support of A&E Delivery Board to ensure timely agreements in line with the requirements of the Winter Plan inclusive of a UTC. ICP IUC Workforce lead to engage with NLaG  | ICP UTC Lead (Anna Morgan) ICP Workforce Lead (Kerry Campling) |
| Discharge and onward care | D2A will require multiple pathways to be addressed with overall therapy resources being key in the effectiveness of out of hospital assessment and rehab delivery | Therapy resource model to be addressed in the context of the current NLaG/CPG SLA and recruitment initiatives | Andy Ombler/Jane Miller |

# CONCLUSION

Public sector partners in North East Lincolnshire have a solid track record of working collaboratively for the benefit of local people and this plan sets out key the vision and mechanisms through which we will work collaboratively to achieve the best possible outcomes for the local residents.