

**North East Lincolnshire CCG**

**on behalf of North East Lincolnshire CTP**

**NORTH EAST LINCOLNSHIRE CCG**

**COMMISSIONING INTENTIONS**

**2013/14**



**Introduction**

Commissioning intentions for 2013/14 are currently in draft form and will be worked up in further detail in the coming months.

Current intentions are underpinned by the Local Implementation Plan, the North East Lincolnshire CCG Market management strategy, the Local Joint Strategic Needs Assessment and the Northern Lincolnshire Sustainable Services programme

**Local strategic context**

NELCCG is responsible for ensuring that a wide range of health and social care services are available for the people of NEL. Our strategic role as commissioner at the centre of the local health and social care economy is in essence twofold; ***one to commission and procure a range of health and social care services on behalf of local people and second, to empower individuals to directly procure services which meet their particular need.***

In order to do this effectively, we need a vibrant health and social care market made up of a range of providers covering all sectors that provide quality and value for money for all care and patient groups – one missing piece of this jigsaw would have a significant impact on other parts of the system and therefore also on our ability to sustain the local market. The most effective and efficient way to achieve this plural and dynamic local care and support market that reflects our strategic vision is to:

1. Agree as a CCG a clear picture of what the future care market has to look like to deliver sustainable quality care closer to home.
2. Agree a set of principles and actions that will manage this continued transformation.
3. Achieve a common understanding of what the drivers are in terms of demographic and community-expressed need, legislation, available resource and policy.
4. Agree how we communicate this message on an ongoing basis to the provider market.
5. Establish a clear idea of what “market intelligence” is required, i.e. what is the information we need to help us to manage the market effectively, ensure we create internal systems and procedures that allow us to continually update the market intelligence.

While health and social care differs in the type of services commissioned and provided, and while different funding arrangements clearly exist between the two, the vision described in both health and social care strategies & the constrained financial context within which both will need to be delivered are substantially the same. Both strategies seek to ensure that those with the most complex needs have access to the best possible services and that we create a system where we address the wider determinants of ill-health and care dependency as early as possible to mitigate the need for long term care within the resources available.

**The priorities framework**

It is helpful therefore to look at the Adult Social Care “Use of Resources Policy” as a way of explaining this strategy to the health and social care market as a whole. It will allow us to quantify and describe the type of services needed in each “category”. In brief, while some Local Authorities have decided to rigidly limit social care eligibility to those with the most critical needs (which has a direct impact on health systems and provision), NEL have taken a different approach to ensure we have a collective whole system and integrated approach. Central to promoting a “whole system” of integrated and affordable care, the local “use of resources” priorities framework *(April 2011)* introduced four categories of support which ensures the system as a whole is able to offer something to everybody - corresponding with need. This also allows us to deploy our professionals appropriately, concentrating our resources at the most vulnerable and complex.

The ‘priorities’ approach enables us to quantify the number of people likely to have similar needs and therefore consider the size of the market that might be needed to respond to these needs. It is important to note, however, that whilst there will be a relationship between each group of people and the market sector that responds to this need it is not necessarily the case that specific services will only meet the needs of one group of people. For example, someone with ‘P1’ needs, i.e. the most complex, might access support from a service predominantly set up to provide preventative support, which might, for example, be facilitated by a personal budget.

This is illustrated in Figure 1 where needs and service responses can be seen to have a strong relationship but are not totally equivalent. It is also important to note the ‘transitory’ nature of ‘P2’ needs. This means that intermediate tier services can and will be accessed by people whose ongoing needs might be best described as P1, P3 or P4. Therefore, on an ongoing basis the local population can be comprehensively described as needing either encouragement to healthy lifestyles and a healthy environment; more targeted health and wellbeing advice and specific preventative support; or support for significant and complex needs.



Figure 1 A generic framework for identifying needs and market responses

The priorities approach underpins our thinking in relation to the creation of commissioning intentions for 2013/14.

The translation of strategy into practical action and managing the shift towards earlier intervention, prevention, and optimal use of primary and secondary care is embedded into the CCG’s planning processes.

The planning round provides the link from previous QIPP initiatives and Local Operating Plan workstreams into the 12/13 Local Implementation Plan and future aspirations for delivery. Overlaid on this is the partnership work integral to the Northern Lincolnshire Sustainable Services Programme (SSP).

Appendix One describes the four themes within the SSP and the jointly agreed direction of travel in relation to those areas of work.

Localised intentions evolved using our “Triangle” model of engagement and co-production are illustrated below.

This model reflects the engagement model of inclusive planning and consultation developed in the last two years by the Care Trust Plus and now adopted by the CCG to ensure proper engagement by clinicians and members of the community in planning processes.

These proposals are overseen by the CCG Governing body and subject to strong confirm and challenge processes. Once agreed, they will be incorporated into the Local Implementation Plan for 2013/14.

**Conclusion**

Whilst detailed plans for 2013/14 remain to be developed and finalised, the underpinning strategic context and direction of travel is well-evolved and informs the thinking across the organisation. This places NELCCG in a strong position with recognised processes to realise its short and medium term goals.

**Triangle priorities**

| Triangle | Intentions | Rationale/description |
| --- | --- | --- |
| Older People | Reduce the use of antipsychotic medication for people with dementia  Align GP/primary care to Long term Care Homes and the housebound | Achieve NHS NOF targets around prescribing of Anti-psychotics  Improve quality of life and end of life care  To ensure and maintain appropriate access to primary medical care for patients that are residing in or have moved into a local Care home or are housebound and are physically and/or functionally unable to access services routinely in the community without enduring significant distress or discomfort.  Reduce hospital admissions and unnecessary movements from home to home |
| Planned Care | Continued work on Ophthalmology services (first phase in 2012/13)  Continued work on hospital outpatient activity | Implement a service model that can continue to deliver a quality service whilst accommodating increasing demand, decreasing funding, and changes to the way treatments are delivered  Implement new pathways to manage referrals that are made between A&E to other services to ensure appropriate use of services and cost effectiveness (and those made between one Consultant to another) |
| Urgent and Unscheduled Care | GP and Hospital “integration” in A&E  Urgent Care Dashboard & Risk profiling in Primary Care  Telehealth  “111” access for all urgent care | Working together to avoid unnecessary hospital admissions and delays to appropriate treatment  Identifying and intervening with those starting to use services  frequently and those who are at risk of doing so in the future  Home based telemonitoring to improve long term condition management and contribute to future service use avoidance  Providing a single point of access and assessment for all urgent care services, complementing 999 for emergencies |
| Wellbeing and Prevention | Sexual Health Procurement  Seasonal Flu programme  Static Breast Screening Unit – Cromwell Road | A fully integrated contraceptive and sexual health service for young people and adults which is accessible and responsive to the needs of our resident population in order to address the increase in STIs and abortion rates.  Looking to achieve a 75% uptake of seasonal vaccine for 65 years and above, a 70% uptake (working towards 75% by 2013/14) for those at risk groups 6 months to 65 years including ‘well’ pregnant women  No hospital admissions as a result of seasonal flu for any of the at risk groups as defined by the CMO letter  Service will be offered out of one dedicated site replacing the existing mobile vans which can be difficult to access for a number of patients and equipment will be upgraded in line with national requirements |
| Disability | Continue with the development of the Learning Disability Market Reshaping Project.  Development of the Mental health functional commissioning strategy in line with No health without mental health. | Reduced admissions to residential care & increased provision of supported living  All people have access to individual budgets and they is choice in the market to purchase provision.  Any current residential care service is fit for purpose and is commissioned effectively with clear outcomes for the individuals.  People manage their own support as much as they wish, so that they are in control of what and how support is delivered Early intervention and prevention  More choice and control over service delivered. |
| Prescribing and medicines management | Continue to develop best practice as common practice with regards to medicines management | Continue to commission / support the provision of cost-effective, high quality, safe, appropriate and evidence based prescribing ensure most appropriate allocation of resources and provide the best quality care for patients.  Increase number of care pathways with secondary care |
| Women and Children | Better control and management for Children with Long term conditions in the Community  Review the outcomes of the Paediatric Pilot in A&E and agree the design and implementation of the future model | We are in the lowest performing quartile for paediatric diabetes and epilepsy; we need to enhance the Community Paediatric Nursing provision in relation to specialist diabetes & epilepsy, the benefit of this is that in the short term children & their families are better able to manage their own care and in effect this will prevent avoidable admissions and reduce the time spent in hospital for under 19’s. To achieve this we are considering enhancing the current community team and / or incentivising those practices that ‘buy into the service’  The main focus of the pilot is to ensure that children and young people receive high quality care in the appropriate place at the right time; Ensuring we deliver quality care and timeliness of assessments to the appropriate service along with a demonstrable reduction in admissions and better use of appropriate services in the community. |

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| **Project Charter: Securing Sustainable Services – Home and Community Based Care** | | | | | |
| Problem Statement | | | Workstreams to achieve objectives | | |
| What is the Problem? | Reducing overhaul demand on community and secondary care services | | ROADMAP | More services provided in the community, closer to the patient  Standards which ensure equity of access across all patient groups  Expand Telehealth care models  Renegotiate home oxygen contracts  Review PMS contracts  Manage Adult Social Care demand and reshape supply | |
| Where is it happening? | Grimsby and Scunthorpe | |
| When is it happening? | |  | | --- | | Ongoing | |  | | |
| Who is the customer? | Patients/Carers  Health and Social Care Economy | |
| Vision | | | Scope and Risks | | |
| The Northern Lincolnshire Home and Community based Care theme has recently developed and ratified a Blueprint for home and community based care. The Blueprint is clinically led and has been developed by local stakeholders and with national guidance on best practice for improving quality and efficiency across the whole system of home and community based care. It has been designed to achieve service transformation and system change across pathways in order to realise a shift of associated resources from secondary and intermediate care to community based commission.  The Blueprint is programme managed and monitored by the Northern Lincolnshire Sustainable Services Management group. | | | S  COP  E | In Scope | Out of Scope |
| Goals as above across Northern Lincolnshire | Outside of Northern Lincolnshire |
| R  I  S  K  s | Identifying robust data to measure outcomes  Securing sustained clinical buy in across primary and secondary care for each of the initiatives  Commissioners outside Northern Lincolnshire following a different model | |
| Outcomes | | | Team and Stakeholders | | |
| Deliverables | | By Date | Manager: Karen Jackson | | Clinical Lead: Dr Peter Melton |
| * More services provided in the community, closer to the patient * Telehealth - Year on year comparison of admission/attendance data for supported patients * Increase of self-care opportunities | | March 31st each year | Team Members:  Geoff Lake Jake Rollin  Michelle Barnard Bryony Simpson  Dr Etuwewe C Phillips  Dr Beer K Fanthorpe  Mr Chawla D Smith  Jane Ellerton Angie Smithson  Prof C Sewell Mike Rymer  Caroline Briggs Tim Fowler  Fergus McMillan Nick Stewart  Richard Falk | | Stakeholders:  Northern Lincolnshire Sustainable Services Management group  Health and Social Care Economy partners |

**Appendix One**

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| **Project Charter: Securing Sustainable Services – Reducing Duplication of Care** | | | | | |
| Problem Statement | | | Workstreams to achieve objectives | | |
| What is the Problem? | Duplication of diagnostic tests across the system | | ROADMAP | Setting targets to reduce the number of duplicated tests within specified time periods  Standards which ensure equity of access across all patient groups  Reducing outpatient follow-ups  Reducing consultant to consultant referrals  Improving discharge planning | |
| Where is it happening? | Primary, community and Secondary Care | |
| When is it happening? | |  | | --- | | Ongoing | |  | | |
| Who is the customer? | Patients/Carers  Health and Social Care Economy | |
| Vision | | | Scope and Risks | | |
| The Northern Lincolnshire Reducing Duplication of Care theme has recently developed and ratified a Blueprint for reducing duplication of care. The Blueprint is clinically led and has been developed by local stakeholders. It has been designed to achieve service transformation and system change across diagnostic pathways in order to realise a reduction in use of resources across the system.  The Blueprint is programme managed and monitored by the Northern Lincolnshire Sustainable Services Management group. | | | S  COP  E | In Scope | Out of Scope |
| Goals as above across Northern Lincolnshire | Outside of Northern Lincolnshire |
| R  I  S  K  s | Identifying robust data to measure outcomes  Securing sustained clinical buy in across primary and secondary care for each of the initiatives  Commissioners outside Northern Lincolnshire following a different model | |
| Outcomes | | | Team and Stakeholders | | |
| Deliverables | | By Date | Manager: Karen Jackson | | Clinical Lead: Dr Margaret Sanderson |
| * Ensuring streamlined diagnostic pathways * Reduce excess bed days (percentage to be agreed) * Reduce outpatient follow-ups (percentage to be agreed) * Reduce consultant to consultant referrals (by 5% by 10/11 levels) | | March 31st each year | Team Members:  D Smith Anthony Fitzgerald  Pete Wisher Karen Griffiths  Jane Ellerton Craig Holmes  Tim Fowler M Ahmad  D Woosnam C Cunningham | | Stakeholders:  Northern Lincolnshire Sustainable Services Management group  Health and Social Care Economy partners |

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| **Project Charter: Securing Sustainable Services – Integration of Care** | | | | | |
| Problem Statement | | | Workstreams to achieve objectives | | |
| What is the Problem? | Health and Social Care needs to be integrated across the system | | ROADMAP | Integrated health & social care models, coordinated by multi-professional teams  Pro-active care planning and in-reach services to keep vulnerable groups out of hospital  A framework for integration and joint working across primary, community, secondary care  Standards which ensure equity of access across all patient groups  Management of continuing care  Developing alternative dementia care models  Reshaping Women and Children’s Services | |
| Where is it happening? | All providers – Social, Primary, Community and Secondary Care | |
| When is it happening? | |  | | --- | | Ongoing | |  | | |
| Who is the customer? | Patients/Carers  Health and Social Care Economy | |
| Vision | | | Scope and Risks | | |
| The Northern Lincolnshire Integration of Care theme has recently developed and ratified a Blueprint for integrated care. The Blueprint is clinically led and has been developed by local stakeholders on best practice for improving quality and efficiency across the whole system to achieve integration. It has been designed to achieve service transformation and system change to deliver integrated pathways in order to provide a seamless service wherever service users enter the system.  The Blueprint is programme managed and monitored by the Northern Lincolnshire Sustainable Services Management group. | | | S  COP  E | In Scope | Out of Scope |
| Goals as above across Northern Lincolnshire | Outside of Northern Lincolnshire |
| R  I  S  K  s | Identifying robust data to measure outcomes  Securing sustained clinical buy in across primary and secondary care for each of the initiatives  Achievement of savings on continuing care | |
| Outcomes | | | Team and Stakeholders | | |
| Deliverables | | By Date | Manager: Peter Melton | | Clinical Lead: Dr Liz Scott |
| * To provide more joined up services across the system across providers by (percentage to be agreed) * Improvement in quality indicators for Women and children’s services (to be agreed) * Continuing care savings target (percentage to be agreed) | | March 31st each year | Team Members:  Dr Woosnam C Cunningham  Nick Stewart Jane Ellerton  Graham Hayes Lynne Hall  Bryony Simpson Karen Fanthorpe  Jeanette Logan T Filby  W Mueller Allison Cooke | | Stakeholders:  Northern Lincolnshire Sustainable Services Management group  Health and Social Care Economy partners |

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| **Project Charter: Securing Sustainable Services – Alternative Care** | | | | | |
| Problem Statement | | | Workstreams to achieve objectives | | |
| What is the Problem? | Preventing avoidable admissions to secondary care | | ROADMAP | Admission avoidance achieved through a variety of initiatives including  GP “Front-ending” of A and E  Developing ambulatory care pathways  Review and revision of pathways for admission avoidance into secondary care  A and E signposting/assessment to reduce attendances  Practice intelligence support – RISC Dashboard  Redesign Unplanned Care (Secondary Care Impact)  A framework for integration and joint working across primary, community, secondary care  Standards which ensure equity of access across all patient groups  Reduction in prescribing costs  Achieve SCG QIPP savings | |
| Where is it happening? | DPOW, Scunthorpe general Hospital | |
| When is it happening? | |  | | --- | | Ongoing | |  | | |
| Who is the customer? | Patients/Carers  Health and Social Care Economy | |
| Vision | | | Scope and Risks | | |
| The Northern Lincolnshire Alternative Care theme has recently developed and ratified a Blueprint for alternative care. The Blueprint is clinically led and has been developed by local stakeholders and with national guidance on best practice for improving quality and efficiency across the whole system of unplanned care. It has been designed to achieve service transformation and system change across unplanned care pathways in order to realise a shift of associated resources from secondary to community provision.  The Blueprint is programme managed and monitored by the Northern Lincolnshire Sustainable Services Management group. | | | S  COP  E | In Scope | Out of Scope |
| Goals as above across Northern Lincolnshire | Outside of Northern Lincolnshire |
| R  I  S  K  S | Identifying robust data to measure outcomes  Securing sustained clinical buy in across primary and secondary care for each of the initiatives  Commissioners outside Northern Lincolnshire following a different model | |
| Outcomes | | | Team and Stakeholders | | |
| Deliverables | | By Date | Manager: Allison Cooke | | Clinical Lead: Dr Liz Scott |
| * Reduction in admissions by 1% from current position (by commissioner) * Reduce avoidable admissions from care and nursing homes (percentage to be agreed) * Achieve percentage reduction in Primary Care prescribing costs * Modernising ambulatory care services and reducing unnecessary demand | | March 31st each year | Team Members:  Helen Kenyon C Cunningham  Sue Rogerson Dr Beer  Andy Ombler Mr Chawla  Tunde Ashaolu D Smith  Rakesh Pathak Julie Wilson  Fergus MacMillan Arun Nayyar  Andrew Stead Rachel Staniforth  Jane Ellerton Mike Rymer  Caroline Briggs Pete Wisher  M Urwin Helen Phillips  Richard Falk | | Stakeholders:  Northern Lincolnshire Sustainable Services Management group  Health and Social Care Economy partners |