Designing care for the future

North East Lincolnshire Plan for Everyone Counts: Planning for patients 2013/14

NHS

North East Lincolnshire
Clinical Commissioning Group

Background and context

The North East Lincolnshire Clinical Commissioning Group plan sets out a unique and innovative vision of health and social care service delivery for the next five years in this locality.

There is a continuing commitment to deliver improvement through the delivery of high standards of care and its stated mission:

Delivering to the people of North East Lincolnshire the best possible independent healthy living through joined up solutions

The values that lie at the heart of the commissioning group's work are:

a) The values contained within the NHS constitution applied to health & care services, but with a particular focus on:
b) Ensuring people receive *consistent outcomes* wherever and whenever they need help **(Consistency)**
c) Ensuring people have access to *quality* services **(Quality)**
d) *Innovation* when best practice isn't good enough **(Innovation)**

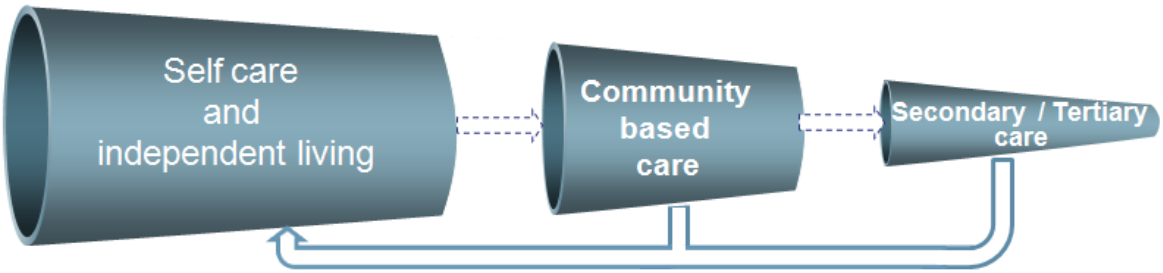
Building on this strategic vision developed during transition in 2012 and responding to external influences and organisational change brought about by the Health and Social Care Bill 2010, the plan reflects the new organisation's commissioning direction for the medium term.

A key element of this will be the work in conjunction with partner organisations across Northern Lincolnshire to ensure that health and social care provision is appropriate and sustainable into the future, meeting the requirements of the £20 billion Nicholson Challenge for the NHS and ensuring that local authority efficiencies are also achieved.

The Sustainable Services Programme will be the main mechanism through which the necessary transformational change will be led and this programme has the support and engagement of all the key players across the area.

Developed in partnership with commissioners in Northern Lincolnshire and providers across the area, the vision can be articulated thus:

i) Comprehensive



We want people to live independent, healthy lives, supporting one another and taking control of their own health. However, when they do need care, they should have ready access to it, by these means:

- Provision of services in the community, closer to the patient, with reduced demand for hospital-based acute care
- Provision of specialist and tertiary acute care, of sufficient scale to ensure safe, quality services

Most importantly, people should be enabled to get back to managing their own health as quickly as possible. This means that services which support patients in their long-term recovery to health are just as important as those which manage urgent health issues.

ii) Integrated
Services should be integrated across providers, with all patients receiving an appropriate response to their needs regardless of the time of day.

iii) Higher-quality
The approach should improve overall quality and outcomes across healthcare services; more lives will be saved and more people will return to full health.

iv) Affordable
Total funding for healthcare delivery will not increase – services will have to meet increasing demands, while the cost of providing those services will have to be met from current funding levels.

What will this mean in practice?

Our vision of healthcare for all our area's residents is that:

- More people will care for themselves, lead healthier lifestyles, and understand and manage their own conditions with appropriate support
- When required, patients will have access to primary care and community-based services in an appropriate way, day or night
- For those who need hospital care, safe services will be made available, following best practices, including treatment by appropriately qualified and experienced specialists
- The right support services will be provided to help patients get back sooner to managing their own health effectively

We will deliver modernised, up to date health and social care provision which will offer high quality, cost effective care in the right place at the right time for patients and service users.

Benefits and Outcomes

The outcomes delivered by these aspirations can be characterised into a number of themes:

- Increasing opportunities for self care
- Making best use of technology and innovation
- Optimising delivery in primary care
- Optimising delivery in secondary care
- Building community capacity to deliver better health and wellbeing

The direction of commissioning for the Clinical Commissioning Group is fully contextualised within the local area and takes account of the holistic landscape of public sector service provision across the patch.

The innovative approaches to community engagement and involvement developed in North East Lincolnshire provide a firm platform upon which to build locally steered and designed services, based on the real input from local people.

As a result of this, local people can expect:

- Services delivered as close to home as possible
- Improved health and wellbeing
- Opportunities to have a say in the design of health and social care provision
- Accessible, non-discriminatory service provision
- Vertically integrated services
- Services that maximise dignity and respect for vulnerable groups

This plan sets out the aspirations for a transformed landscape of health and social care services for North East Lincolnshire meeting the quality and resource challenges facing the area and delivering the highest standards of care for local people.

Design and planning process

In order to arrive at the detailed plans for 2013/14 the process for target setting has been led and overseen by the Council of members, the CCG Partnership Board and Governing Body as well as incorporating consultation and feedback from our Community Forum in relation to our priorities and plans.

Our Triangle groups have articulated priorities for their area of care, the combined result of which in conjunction with the Northern Lincolnshire Sustainable Services

Programme work and the priorities set forth in our Adult Social Care strategy has shaped the organisation's aspirations, target setting, savings and implementation plan for local health and social care services in the short and medium term.

The information from priority and target setting has been fed into the contracting process which is on target to deliver to nationally agreed timeframes, overseen and assured by our Care Contracting Committee

The shape of local services

Our local population is ageing and more people will want more health and social care services in the next few years, so we need to ensure we take these things into consideration in our plans.

The figure below illustrates a model of care across the system that will need to be quantified and worked up into detailed plans in the coming months for the medium term.

Detailed plans have already been developed for priorities in 2013/14 which begin the process of transformation and lay the groundwork for further transformation in the next five years

A key element of the new model is ensuring the widest parts of the wedge are working well to reduce the volume of care required in the secondary and tertiary care sectors.

Providers will be required to both stop some services and take on new/other services and crucial to ensuring effective integration are the enablers of integrated information, an appropriately skilled and sized workforce and optimal use of technology.

Delivering Joined up Solutions

Extending independence so that people become morbidly ill at a later point and for a shorter period of time in their life. More service users will have needs met at this level, which will absorb a significant part of the demographic pressures from the rising population

- Targeted support for people who are having a difficult period in their life and need access to signposting, listening and support (initially focused on areas of deprivation)
- Implementation of Dementia Model – Alzheimer's Society
- Gathering insight into vulnerable and frail population's views on what they require to maximise independence
- Improved support in Pharmacy setting (e.g. Minor Ailments Scheme)

Maintaining and /or returning to independence through short term interventions & re-enablement and consistent & proactive support to prevent deterioration

- Implementation of Expert Patient Programmes
- Implementation of Extra-care housing developments
- Supported living arrangements
- Independence Plans for vulnerable and/or frail – sets out what needs to be in place to allow service user to live as independently as possible (in response to insights gathered at community level)
- Access to specialist support and advice for service users in home and residential care settings
- GP input to Care Homes to support proactive management of patients
- Improved access to GP services for urgent care
- Integrated Case Management of service users with chronic diseases/long term conditions, to ensure maximum independence and a radical shift from unplanned to planned care
- Technology solutions to support service users requiring the level of intervention appropriate to this level, ensuring care is maintained as close to home as possible
- Improved access to low level mental health interventions
- Improved access to diagnostics to support management in primary care/community setting

Providing consistent & proactive support to maintain independence for service users & providing a rapid response /access to urgent care when a crisis occurs on a seven day a week basis

- Personal budgets to support service users to source services that meet their needs
- Technology solutions to support service users requiring the level of intervention appropriate to this level, ensuring care is maintained as close to home as possible
- Intermediate Tier for step-up and step-down care, which will include a significantly redesigned system which is capable of managing high levels of demand, as well as surges in demand. This will require integrated multi-professional management, including medical (GP), Allied Health Professionals and Social Care.
- Improved management of service users at end of life to enable them to stay at their normal place of residence and/or hospice, in line with individual preference
- Delivery of integrated urgent care in and out of hours (in line with urgent care strategy) including ambulance/paramedic services
- Expansion of non-face to face communication between clinicians and patients in place of appointment, wherever clinically safe to do so, and utilising technicians to maximise capacity and efficiency
- Additional support to GPs for community management of service users through enhanced access to Specialist Nursing (13/14 = Neurology – Parkinson's and Epilepsy)

Access to consistent, high quality, specialist care that delivers consistent out-comes within the most appropriate facilities &settings

- Safe, high quality Maternity services available consistently to the population (with a view to resolving question of single or multiple site services)
- Safe, high quality, hyper-acute Stroke Services available consistently to the population
- Ensuring services are configured to deliver top quartile standards, outcomes and performance

Community Led Support	Prevention & Re-enablement	Active Intervention & Management and Crisis Management	Active Specialist Intervention and 24/7	Tertiary Care

Enablers: Appropriately size, skilled and resilient workforce; Information systems; Technology enabled care

Our Triangles (Clinical lead, Lay lead, Management lead) have identified specific priorities they would like to see from now until 2015 – these are reflected in our Plan on a Page – Appendix 1.

Key pieces of work – from March 2013

Moving towards 24/7 working across the system

e.g., the hospital will be able to discharge patients easily 7 days per week, and the community services will be able to receive them equally as easily

Radical shift from unplanned to planned care

-Better management of Chronic disease/Long Term conditions

e.g., a large proportion of unnecessary face to face follow up visits will be done in different ways (via telephone or remote consultation)

- Reducing dependency on services through self care and community based care

e.g. agreeing care plans once a year with patients which give them ownership and responsibility for their own care

Development of Extra Care Housing

Safe, high quality housing with support for vulnerable older people which enables them to live independently for much longer

To realise the best possible configuration for quality maternity services for North East Lincolnshire

Ensuring we deliver best quality maternity services locally

Improve the care for people in the last stage of life ,

e.g. *enabling people to stay at home or in the hospice rather than having to go into hospital unnecessarily*

National priorities for delivery

- Moving to Payment By Results in Mental health, and reshaping services to take account of this to ensure sustainability
- Shift to Personalisation of budgets in the medium term – people will be able to choose the type of care and services they wish to buy
- Implementation of NHS 111

Enabling themes of work

- Best possible ways of working for prescribing
- Supporting Carers and Communities – involving wider support networks in patient care
- Having a joined up emergency response service instead of many different ones
- Improved signposting into relevant services
- Technology-enabled care , - using technology to support health and social care services, including shared patient information
- Access to diagnostics – getting tests when you want them and where you want them
- Work on wellbeing and prevention, including screening and changing lifestyles
- Supporting people to live independently as long as possible
- Ensuring our provider contracts are designed to give the best possible outcomes

Each of these high level items is supported by a range of initiatives and projects. Some of these projects relate to NEL specifically and others apply across Northern Lincolnshire, supported by the Sustainable Services Programme and its related mechanisms

Partnership working

Work is ongoing in relation to the linkages with the Health and Wellbeing Board. The CCG has been actively involved in priority setting with the Health and Wellbeing Board, whose final sign off for plans will take place at the end of January 2013.

Collaborative commissioning arrangements

There are a number of areas where working with other CCGs will not only be desirable, but essential if the CCG is to deliver against some of its objectives, in particular delivering sustainable services.

Particular areas where collaboration (Collaborative Commissioning Criteria) has been identified as being advantageous are:

- Where the CCG commissions from providers who have multiple CCG customers,
- for example Hull and East Yorkshire Hospitals NHS Trust;
- Where a service / pathway is accessed by more than 1 CCGs population & therefore any changes to it would potentially affect other areas of care; for example Northern Lincolnshire and Goole Hospitals NHS Trust; and the Diana Princess of Wales site, in relation to East Lincolnshire CCG.

- Where there is a risk to financial balance resulting from low volume high cost activity, where it might be that there are only one or two individuals with the condition.
- As part of the establishment of any collaborative arrangements the CCG will need to ensure that:
- There continues to be a clear line of accountability between the CCG and the provider(s)
- The strengths of current lead and associate contracting arrangements are maintained whilst weaknesses are addressed
- The arrangement supports stronger relationships between Commissioners and Provider - allowing potential for greater delivery of commissioning intentions
- The arrangement maximises commissioner capacity things are done only once
- The arrangement allows for a consistent approach to be taken across all commissioners whilst allowing for variation to meet individual CCG requirements
- financial risks are mitigated where appropriate.

To date the CCG has :

- Become a member of the Humber and North Yorkshire Commissioning Collaborative.
- Is in the process of agreeing the collaborative arrangements and leads for each of the providers where multiple CCGs within the Collaborative are commissioning from them
- Agreed with East Lincolnshire CCG that we will continue with the collaborative arrangement entered into by the CTP and Lincolnshire PCT, and therefore reflect the patient flows into Grimsby & in particular the Diana princess of Wales hospital site, but discussions continue in relation a similar arrangement for Care Plus.
- Entered into an agreement with North Lincolnshire CCG around the work associated with Sustainable services across Northern Lincolnshire
- continued to work within the collaborative arrangements put in place to commission services from East Midlands Ambulance Service.
- Produced an External Financial Risk Sharing Policy for use where appropriate between CCGs to help manage the risks associated with low volume high cost treatments for individuals

QIPP

Our programme for QIPP for 13/14 has emerged from the process of priority setting for the next financial year and the development of robust and relevant business cases for implementation of targeted initiatives.

A strong theme and focus for our QIPP plans for 13/14 has been quality, noting the current issues identified in North East Linconshire for mortality and SHMI and moving further towards our aspirations of top quartile performance across the board.

Focussed initiatives for the following all contribute to our agenda for raising quality whilst saving money:

- Best possible care for the last stage of life – holistic care to enable people to remain at home for as long as possible in the last year of life and to die in their place of choice. We anticipate that this will be part of the range of measures put in place to impact positively on local mortality figures
- Development of specialist Neurology nursing services to support patient self care pathways and reduce consultant led appointments
- Development of non face to face follow ups in a range of specialties aimed at improving patient experience and reducing the cost of this aspect of clinical care
- Development of services delivered by the voluntary and community sector aimed at reducing the need for health and social care support and enabling people to remain at home for longer rather than become dependent on long term care

Our focus on quality extends to our key providers from whom we will be seeking assurance that their Cost Improvement Plans will not have an adverse impact on the quality and safety of their service delivery. Our continuing dialogue via our Contract Quality sub group provides a review mechanism to assure on development of CIPs and impact on quality. Our clinical lead officer leads on the local mortality action group in conjunction with the hospital trust and community service providers

We will require providers to submit their own internal assurance which will include sign off from their Medical/Clinical Director/Director of Nursing as well as their Board. We will review this assurance process and take a view on its robustness and the content of the plans in order to assure ourselves of the sustainability of quality and safety of service provision locally.

Our QIPP plan for health expenditure is illustrated below:

Scheme	Value (£'m)	Transactional/ Transformational	Type of Care
GREEN "RAG" RATED SCHEMES			
End of Life Full Home Support	0.63	Transformational	End of life
End of Life Care Facilitator for Care Homes	0.08	Transformational	End of life
Non-Invasive Ventilation at home	0.17	Transformational	Community
Baseline budget rebasing- Prescribing	1.00	Transactional	Prescribing
Continuing care pooled budget management	0.50	Transformational	Long term conditions
	2.38		

AMBER "RAG" RATED SCHEMES			
Parkinsons Disease Specialist Nurse	0.05	Transformational	Community
Epilepsy Specialist Nurse	0.05	Transformational	Community
Diabetes TeleMed	0.05	Transformational	Diagnostics
Community Paediatric Nursing	*0.04*	Transformational	Community
Paediatric Assessment unit	*0.14*	Transformational	Community
Community prevention initiatives	*0.06*	Transformational	Community
Dementia prevention	*0.10*	Transformational	Community
	0.49		
RED "RAG" RATED SCHEMES			
Tighten threshold to services (Low Priority Procedures)	0.25	Transactional	Planned Care
	0.25		
TOTAL	**3.12**		

Being:-

Transformational	1.87	60%
Transactional	1.25	40%
	3.12	

key to RAG ratings:

Green	=	Full plan in place & agreed
Amber	=	Outline plan in place
Red	=	No implementation plan

Triangulation of Finance, activity and workforce

Triangulation and provision of assurance regards read-across between strategic commissioning intentions, activity and performance trajectories and organisational engagement and sign off is being co-ordinated through an integrated process of granular service level business planning linking in to the tactical delivery of CCG identified priorities.

All proposals relating to commissioning intentions, QIPP savings and maintenance of quality and performance have been reviewed through the lens of internal planning frameworks and clinical and community engagement mechanisms to ensure focus and clarity on implementation of the initiatives and provide Board level assurance on the plans.

Ensuring our local health and social care workforce is appropriately sized and skilled remains at the heart of our aspirations and planning processes.

In relation to the hospital based workforce in particular and its significance for sustainability of services in Northern Lincolnshire, triangulation has been prioritised by including the Director of HR and OD for the hospital Trust as part of the Sustainable Services management group..

In terms of the workforce modifications required in adult social care, business cases agreed with the Local Authority and local providers are well advanced and will result in workforce modifications leading to more community based services rather than secondary care focussed interventions.

NHS 111

We continue to work with the regional programme and service providers to launch a 111 service in North East Lincolnshire in accordance with the March 2013 targets.

Work is on-going across a number of streams:-

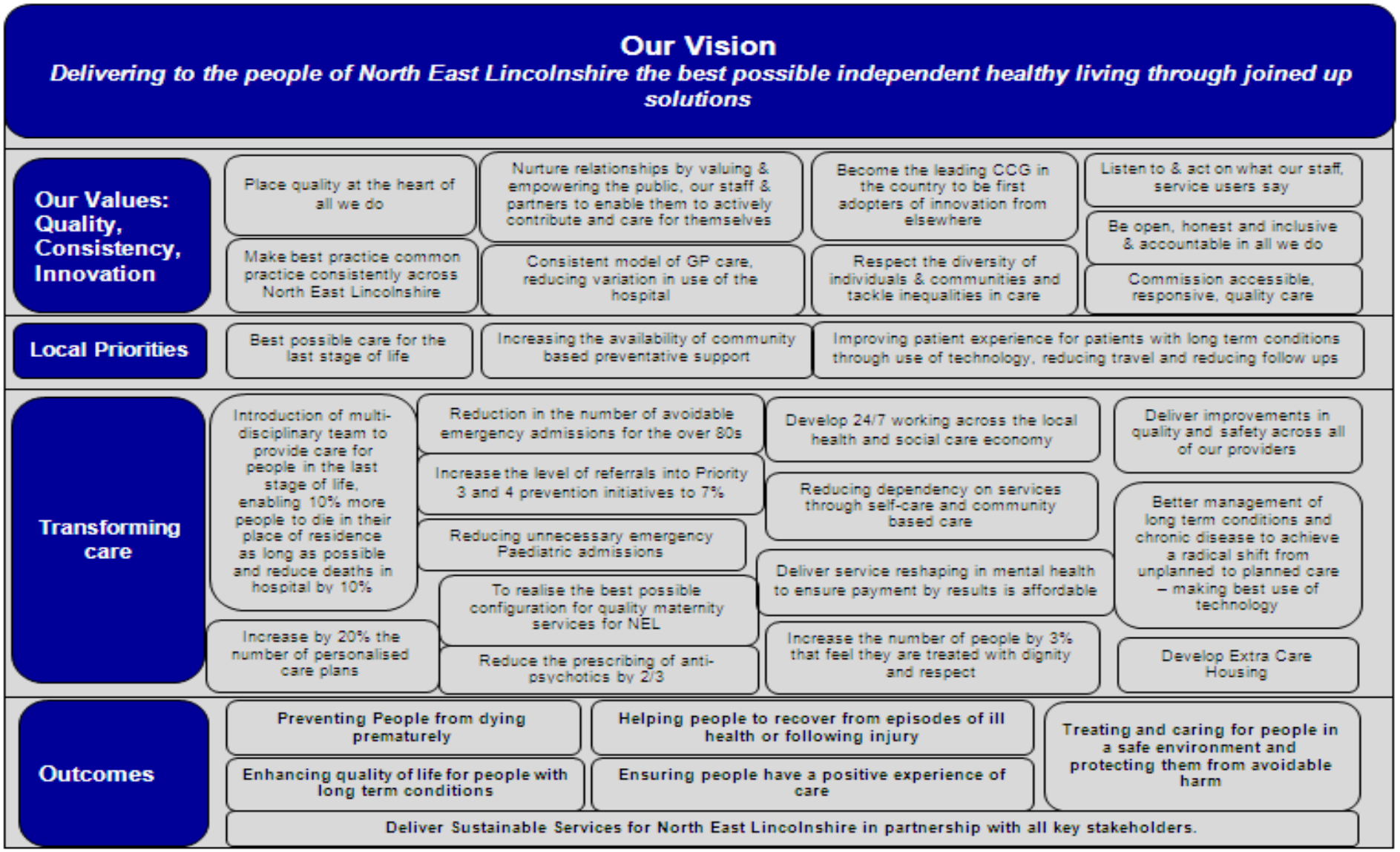
- February 2013 DoH assurance “test” on the 111 Clinical Governance and Quality Assurance submission
- Generation and testing of the North East Lincolnshire Directory of Services (DoS)
- Establishing the telephony and data transfer facilities in conjunction with the 111 provider (Yorkshire Ambulance Service)
- On-going engagement with providers re the impact and their role in 111
- Further development of the proposed Governance arrangements

Conclusion

This plan sets out the CCG’s approach to delivery of *Everyone Counts: Planning for Patients 2013/14* and provides assurance on the consistency and alignment of QIPP plans with activity, finance and workforce plans.

The plan demonstrates the ownership and buy-in of key stakeholders such as the North East Lincolnshire Council through the Partnership Agreement to the transformational journey the CCG has embarked upon. This Partnership will be key to delivery of QIPP plans ensuring sustainable services for the future for the residents of North East Lincolnshire.

Appendix 1: Plan on a Page



Appendix 2 Financial commentary

1) Overview of Financial Position
Planned delivery in 2013/14, including FCOT, risks, opportunities, non recurrent matters etc.

The CCG plans to make a surplus of £2.026m (2%) in 2013/14. Any investment required to support the achievement of both local & national 13/14 targets has been fully built in

A number of high level risks (section 5) have been identified. This is not a comprehensive of all financial risks but those which have been assessed as most critical in terms of likelihood and impact. The robust risk management processes already established with the CTP will continue within the CCG.

The plan has some significant risks and savings expectations, but the plan and organisation also has:

• Reasonable levels of contingency funds

• Prudent assumptions on growth, inflation and activity

• Strong track record of financial management

• Positive underlying position (surplus)

• Access to partnership funds

• Robust performance management processes

• Positive partnership working arrangements with NELC and NL&G FT

Contingency (£1.07m); the funds that have been identified will be used non-recurrently in year. Should their use prove to be required recurrently, they will be reinstated in the following year as a priority with a consequent reduction in planned new investments

2) Financial Plan 2013/14 (including key assumptions

2a) key assumptions on commissioning intentions, tariff impact/changes, service developments, use of readmissions and re-ablement funds, risk pooling arrangements (source and applications)

Key assumptions :-

• Net impact of tariff; a 1.1% reduction against the 2011/12 prices has been assumed

• Net impact of non-tariff; a 1.1% reduction against the 2011/12 prices has been assumed

• Readmissions funding; minimal impact for us (circa £250k), funding used to provide non recurrent support to NLAG to facilitate the development of efficiencies within the provider contracts given the overarching 4% efficiency savings requirements from NHS providers

• CQUINS payments ; for planning purposes it has been assumed that CQUINs will be fully achieved and therefore payment will have to be made at 100%

• Social care funding (£2.7m) and re-ablement funding(£1.0m); this funding is fully committed ;

North East Lincolnshire council has notified us of their intention to utilise the £2.7m social care funding to mitigate the potential adverse impact on ASC services resulting from reductions to council funding streams and grants.

The £1.0m funding is intended to be used to:-

- Develop enhanced rapid response to support front ending at the hospital
- To strengthen AHP support to the front end
- To enhance capability in the intermediate tier to support dementia patients
- To fund transport support in the community to support hospital avoidance & short stay

• Prescribing; a net uplift of 5% has been applied, comprising 1.4%% inflation (2013/14) and 3.6% for activity growth & the full year effect of 2012/13 price changes.

• Continuing Care; the figures included in the plan are based on activity modelling that has been carried out and takes account of historic trends, demographic changes and the tight management controls that have been put in place.

• Acute Activity; the figures included in the trajectories are based on activity modelling that has been carried out and takes account of historic trends, demographic changes and the impact of QIPP schemes. With regard to demographics, we use the Exeter system to compare 5 year age population profiles year on year. The demographic changes are then applied to age/sex specific HRG's e.g. paediatric, elderly, ,maternity and then proportion applied to non-specific e.g. gen surgery, to get an overall age/sex demographic change.

- The JSNA & Atlas of Variation have been utilised to identify priorities and opportunities for QIPP

Commissioning Intentions have been issued and a timetable is in place with regard to getting contracts finalised and signed. The key risk to delivery of contract sign off is around providers receiving confirmation of income levels from SCG & other non CCG Commissioners relating to income that was previously received from the CTP.

2b) Underlying recurrent position including detail on use of 2% non-recurrent funds, proposals for access to historical surpluses, reserves, other non-recurrent items

The CCG has an underlying recurrent position of £6,360k (3.16%)

The plan assumes that the CCG will receive its fair share (based on CCGs portion of the CTP budget) of the CTPs 2012/13 surplus & SIF, this equates to £1,694k.

The areas that we are currently looking to use the non-recurrent funding are:

- Sustainable services review implementation and transition costs – priorities and costs agreed through sustainable services review programme arrangements

- Service transformation - as set out in annual plan including quality improvement and QiPP delivery
- Health and Wellbeing board priorities
- Transition risks:
    - unforeseen costs – funding for non-recurrent impact and/or bridging finance where recurrent issues need time to resolve
    - planned double running/non recurrent costs
- Contribution to collaborative risk pool establishment
- Market development initiatives e.g. building community capacity (self-support)

2c) Planned running cost split between CCG and CSU

	£'000	£/head
CCG	2,902	17.70
CSU*	1,198	7.30
Allowance	4,100	25.00

*The total amount, including those services to be provided to Adult Social Care, planned to be spend with the CSU is £1.6m (£9/head)

Allowance has been made for incremental drift in setting the budgets

3) Key bridging movements from 2012/13 FCOT to 2013/14 plan

- Activity Growth (across acute, community, prescribing & continuing care) £3.2m
- Supporting Strategic Change £1.8m
- Creation of a risk reserve re impact of NHS restructure £1.0m
- Increase in level of in year surplus to 2% (from 0.5%) £3.0m
- Cost pressures £1.5m
- QIPP savings (£3.1m)

4) QIPP - Overview of QIPP schemes and associated risks to delivery

The table below provides a summary of the CCGs 2013/14 QIPP plans

Scheme	Value (£'m)	Transactional/ Transformational	Type of Care
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5) Key financial risks and opportunities in 2013/14
Include description of mitigations in place to cover downside financial risk

The table below summarises the CCG's key financial risks;

Risk	Value £'000	Probability	potential value of risk	Recurrent/ Non Recurrent
Transition Issues				
Propco	50	50%	25	Recurrent
SCG	1,000	50%	500	Recurrent
Other transition issues including allocations	3,000	50%	1,500	Recurrent
GP changes (Dr Borchi)	100	50%	50	Recurrent
Prescribing	560	50%	280	Recurrent
Activity	1,000	25%	250	Recurrent
Continuing care				
-LD transitions	300	75%	225	Recurrent
-retrospective cases (client still alive)	340	50%	170	Recurrent
-growth	200	25%	50	Recurrent
Retrospective cases (not covered by 12/13 provision)	1,000	50%	500	Non Recurrent
ASC Balance Sheet	3,250	25%	813	Non Recurrent

Partnership agreement - pressures on LA (ASC) - Potential for NELC to come back in year for more savings	2,000	25%	500	Recurrent
QIPP/Sustainable Services delivery	1,000	25%	250	Recurrent
CSU impact on savings cost / unforeseen costs compared to assumptions	50	25%	13	Recurrent
			5,125	

The mitigations in place to cover the downside financial risk are:-

- Utilisation of contingency funding to be approved by the Partnership Board, with the first call against it being to fund continuing care retrospective claims settled in 13/14 that haven't been provided for in 12/13.

- Ring fenced reserves have been set up as follows:

	£'000
- Activity	600
- Prescribing (NICE)	500
-Transitions	300
-Impact of NHS restructure	1,000
-Other transition issues including allocations	1,500
-Retrospectives cases (where the claimant is still receiving care)	170
	4,070

Any remaining risk would be managed via non recurrent measures.

A financial risk sharing policy has also been established across the four Humber CCGs from 1.4.13 (as approved by NEL CCG board in January 2013)

6) Key capital schemes

Overview of capital requirements, purpose, link to wider strategic objectives etc.

4 areas have been identified;

Primary Care - roll out of Pods (post evaluation of pilot scheme)£370k

Scheme to:

- Enable patients, without clinical supervision, to perform their own tests which post directly and instantaneously into their patient record. So supporting patient access as well as engaging and educating patients in their own health.

Community Equipment Store £300k

Scheme to:

- Enable us to house the community equipment store in a fit for purpose site, the current site is not fit for purpose.
- Support a retail model for community equipment
- Support re-ablement & rehabilitation key providers health & social care

- Supports NLAG savings plans regarding consolidation of their estate

Intermediate tier service development (£500k)
Scheme to***:***

- Improve patient / service user experience
- Reduce the number of stages in the patient journey
- Enhance the step down service from the acute setting & so support the prevention of readmissions to hospital

Block Capital – Athena HQ building (£50k)
Scheme to:

- maintain HQ building up to standard as required in the lease

Appendix 3 NELCCG Proposed activity, priority and performance plans for Everyone Counts

Context

Rather than imposing targets, the NHS CB expects CCGs to develop their own local priorities through their input into the Joint Health and Wellbeing Strategy. However, with assumed liberty comes public responsibility and CCGs are expected to set out real ambition in their plans. *Everyone Counts: Planning for Patients 2013/14* asks each CCG to identify three local priorities against which it will make progress during the year. These priorities will be taken into account when determining if the CCG should be rewarded through the Quality Premium.

Plans should be built on the assumption that no indicator contained within the national NHS Outcomes Framework or the CCG Outcome Indicator Set deteriorates. The focus of planning should lie on maximising health gain for the population.

Formal submission to support *Everyone Counts: Planning for Patients 2013/14*

To support assurance of CCG performance measure plans, every CCG will make a formal submission to the NHS CB, by sharing with their Area Team, covering:

- Self-certification of commitment to delivery of the rights and pledges of the NHS Constitution, Mandate and Clostridium difficile objective; ***Current position: Assurance given***
- Self-certification of assurance that provider cost improvement plans are deliverable without impacting on the quality and safety of patient care; ***Current position: Provider cost improvement plans under review***
- Trajectory for dementia diagnosis rates and Improving Access to Psychological Therapies (IAPT) - proportion of people entering treatment;
- Trajectories for three locally selected priorities;
- Activity trajectories for 4 key measures – elective finished first consultant episodes(FFCEs), non-elective FFCEs, first outpatient attendances, A&E attendances;

Below are the plans proposed by the relevant Service Lead:

Incidence of Clostridium Difficile infections (Lead: Eddie McCabe)

Although there is not a requirement to submit a monthly phased plan, the CCGs objective is to have 32 or less incidences of clostridium difficile during 2013-14 and therefore the proposed trajectory is set out below in Table 1. The NHS Commissioning Board will monitor the CCGs delivery of this target based on an equal phasing over the 12 months so the phasing set out below will highlight issues internally before the NHS CB become concerned.

Table 1 – Incidence of C Diff proposed trajectory

2013									2014			2013/14 Total
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2	2	2	2	3	3	3	3	3	3	3	3	32

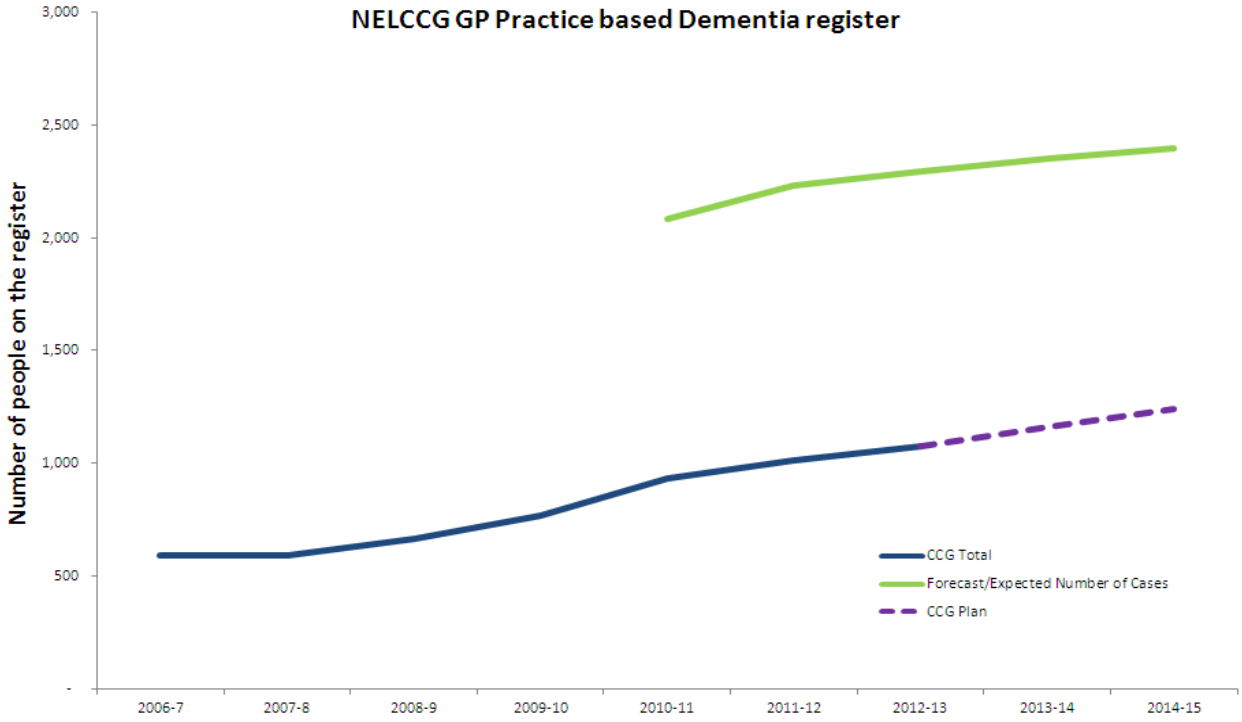
Dementia diagnosis rate (Lead: Jeanette Logan)

The plan for this measure was discussed at the Older People triangle meeting on 9th January 2013 where the following plan was proposed. The plan looks at increasing the CCGs dementia register by 85 and 84 people in 2013-14 and 2014-15, respectively. This will mean a 2.5% increase year on year. Table 2 below sets out this plan and the chart in Figure 1 shows progress made in identifying people with dementia since 2006-7 and has been extrapolated using the planned trajectory for the next two years.

Table 2 - Dementia diagnosis rate proposed trajectory

	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2012/13	1,073	2,294	**46.8%**
2013/14	1,158	2,349	**49.3%**
2014/15	1,242	2,398	**51.8%**

Figure 1 – Dementia diagnosis rate trend and planned trajectory



Although we don't have benchmarking information available to us on this specific measure we do have information on the registered number of people with dementia as a proportion of

our total population. The chart in Figure 2 shows that the NELCTP rate is statistically significantly higher than the England average and is the sixth highest in our ONS Cluster of Manufacturing Towns. Figure 3 demonstrates the trend in this rate between 2006-7 and 2011-12 for NELCTP compared to the national, regional and statistical peer group and reveals a growth greater than that of its comparators taking NELCTP from a rate below these three groups in 2006-7 to above in 2011-12.**Figure 2 – Proportion of the population on a GP practice Dementia register for 2011-12**

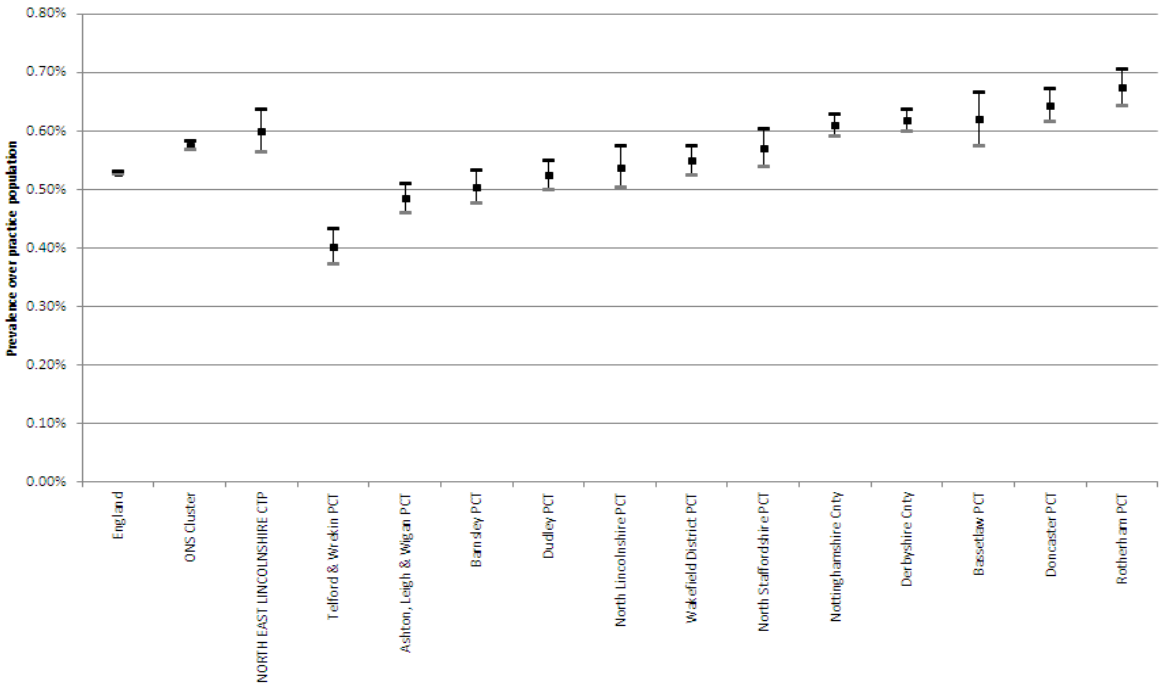
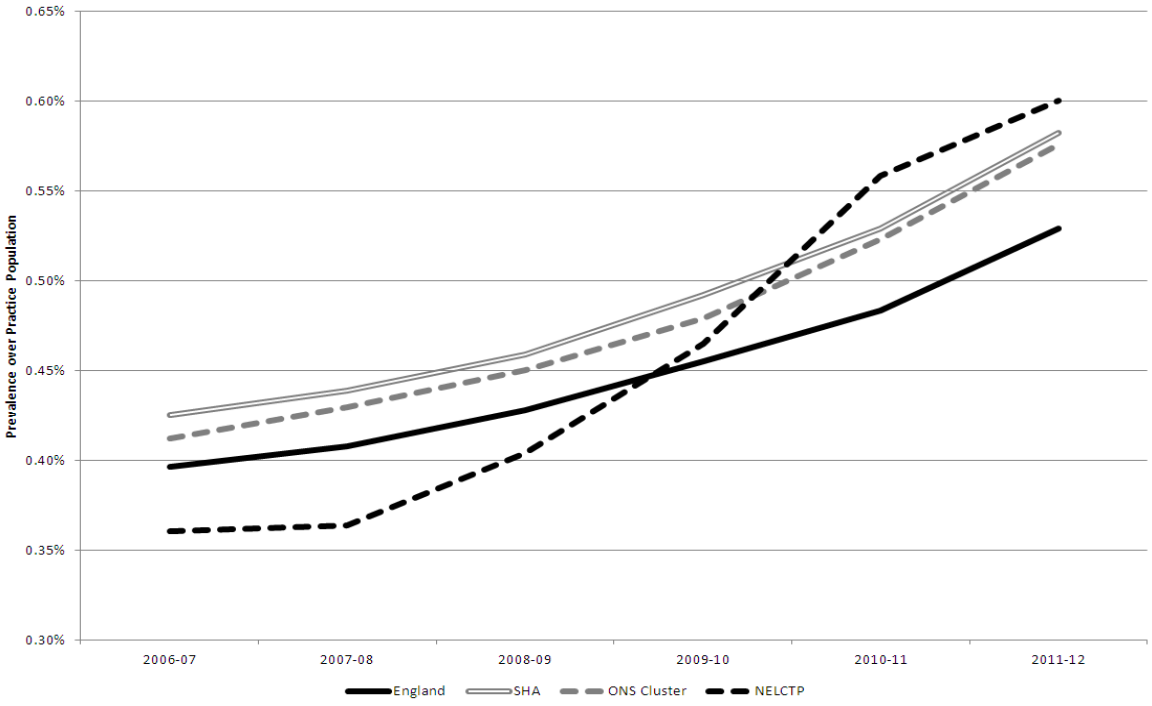


Figure 3 – Trend in proportion of the population on a GP practice Dementia register



Improved access to psychological therapy: The proportion of people that enter treatment against the level of need in the general population (Lead: Angie Walker)

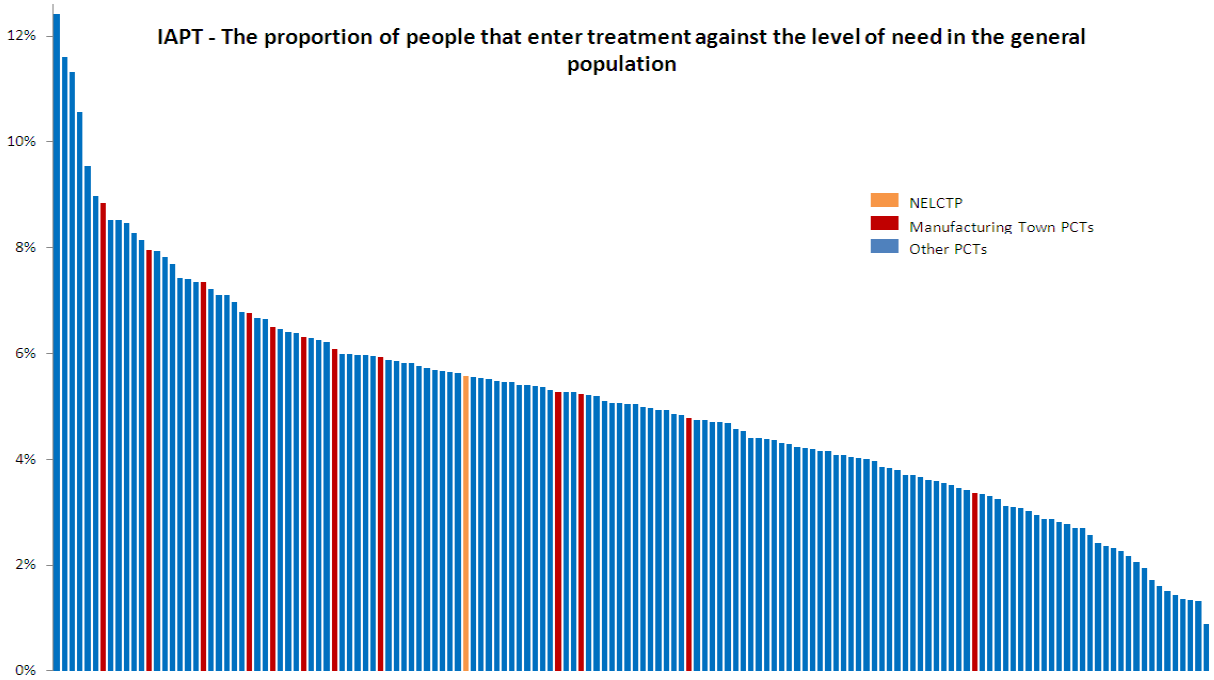
The plan for this measure was discussed with the Service Lead for Disabilities and NAViGO on 10th January 2013 where the following target set out in Table 3 was proposed.

Table 3 - Proposed trajectory

	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey)	Proportion
2013/14	2,582	18,340	**14.1%**

The mandate anticipates the completion of the full roll-out of the access to psychological therapies programme by 2014/15. This states that the proportion of people who have depression and/or anxiety disorders who receive psychological therapies in line with NICE guidelines in each quarter of 2012/13 should be higher than the proportion in the previous quarter and by 2014-15 at least 15% is achieved and, when achieved maintained. The NHS CB will expect CCGs to commission services with that roll-out in mind. Performance has dropped from 13.4% in 2011-12 to a forecast position of 11.2% in 2012-13. With the above mandate in mind it is believed that performance needs to go beyond those levels seen in 2011-12 in order to be on target to achieve 15% by the following year.
Figure 4 below shows how NELCTP compare to other PCTs in respect of 2012-13 performance at the end of September 2012 and although above the national average NEL have gone from top quartile in 2011-12 to upper middle in 2012-13 to date.

Figure 4 – PCT comparison for April to September 2012.



Activity Trajectories (Lead: Julie Wilson & Andy Ombler)

The trajectories below have been modelled by adding relevant growth to our 2012-13 forecast outturn and then applying the impact of LIP/QIPP schemes. Two schemes have been factored in against these plans and the results are the trajectories set out below (Table 4).

Table 4 – Activity Trajectories

		CB_BS6	CB_BS1	CB_BS5	CB_BS10
Activity Trajectories		**i) Elective FFCEs**	**ii) Non-elective FFCEs**	**iii) First Outpatient Attendances**	**iv) A&E Attendances**
2013/14	**April**	1977	1218	3167	
	May	1982	1254	3162	
	June	2153	1222	3694	
	July	2196	1261	3431	
	August	2028	1247	3077	
	September	2126	1317	3582	
	October	2132	1337	3291	
	November	2136	1171	3472	
	December	1819	1251	2876	
	January	2095	1220	3237	
	February	2014	1213	3292	
	March	2300	1337	3730	
2013/14 Total		24958	15048	40011	49969
2012/13 Forecast Outturn		24712	14718	39615	48703
Forecast growth in 2013/14		1.0%	2.2%	1.0%	2.60%

Local Priority 1 – Non Face-to-face outpatient follow-up appointments (Lead: Julie Wilson)

For detailed plans to improve the use of technology enabled care for diabetic medicine follow –ups, please refer to the relevant LIP bid. The proposed method for how this outcome is measured is set out below in Table 5.

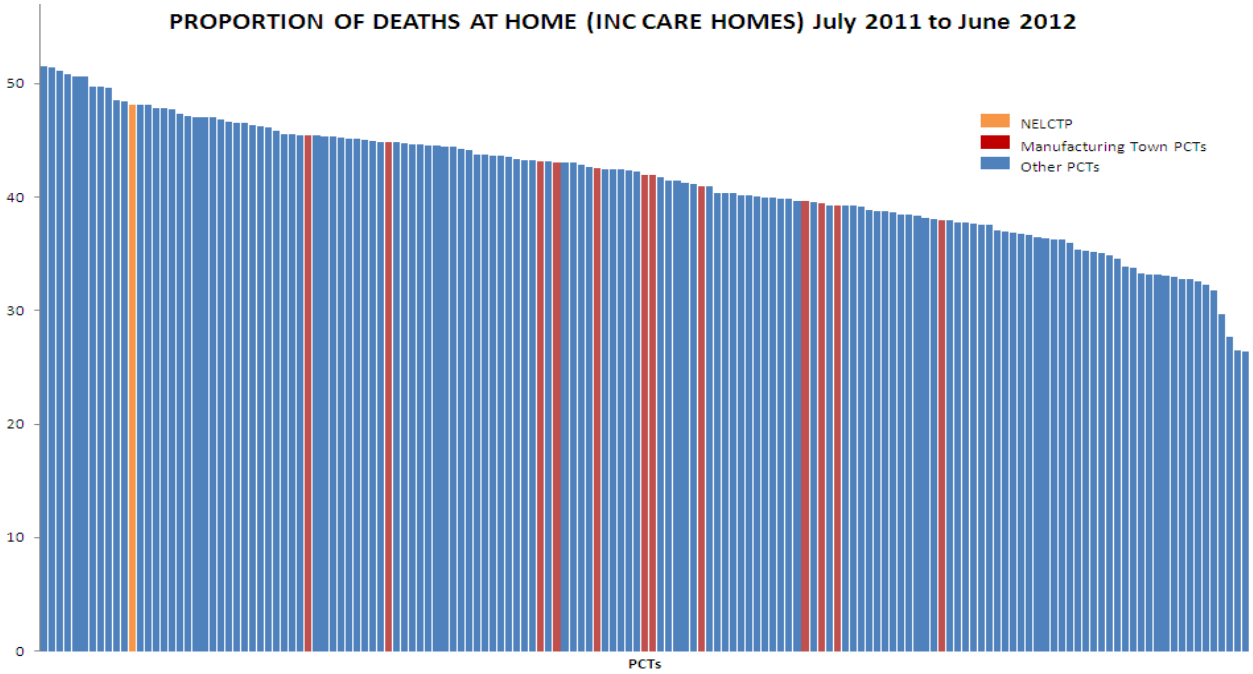
Table 5 – Proposed target

	2013/14		
Denominator Cohort Method	**Numerator**	**Denominator**	**Measure**
Proportion of NLAG medical outpatient follow-up appointments delivered in a non face-to-face setting.	583	37,033	1.6%

Expressing the progress against all medical specialty follow-up appointments doesn't portray that progress against developing technology enabled care is as significant compared to expressing it against diabetic medicine alone. However, using this method will enable us to count non face-to-face contacts for other medical specialties that the CCG may make progress on.

Local Priority 2 – End of life care: Proportion of people dying at home (including care homes) (Lead: Lisa Revell)

Performance for July 2011 to June 2012 was 48.1% for NELCTP. This was top quartile and the CTP had the 12th highest rate of 151 PCTs (see Figure 5 below). Despite this, further improvements around end of life care are still a priority locally and a target of 50% is proposed for 2013-14. A number of mechanisms are being put in place to achieve this and for further details please refer to the appropriate LIP bid documentation and the End of Life Care Strategy.**Figure 5 – Comparator Chart**



Local Priority 3 – Increasing the availability of community based preventative support solutions (Lead: Jake Rollin)

The A3 service provides a vital first point of contact for a range of health and social care responses. In relation to the Transformation Programme, it is important to isolate those activities that will affect outcomes and that combine to deliver the overall re-shaping of the local system. This priority focuses on the number of people who are 'signposted' to P3 or P4 services, which would be expected to rise significantly as these services are developed and genuine alternatives are made available.Table 6 below sets out the proposed trajectory for this measure in 2013-14. Current performance for Q1 & 2 2012-13 is at 2.3%.

Table 6 – Proposed phased target

	2013/14		
Period	**Numerator**	**Denominator**	**Measure**
Q1	140	3,500	4.0%
Q2	210	3,500	6.0%
Q3	280	3,500	8.0%
Q4	350	3,500	10.0%
2013-14	**980**	**14,000**	**7.0%**