



**NHS**  
*North East Lincolnshire  
Clinical Commissioning Group*

# NORTH EAST LINCOLNSHIRE CCG

## Strategic Plan 2014 – 2019

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## Executive Summary

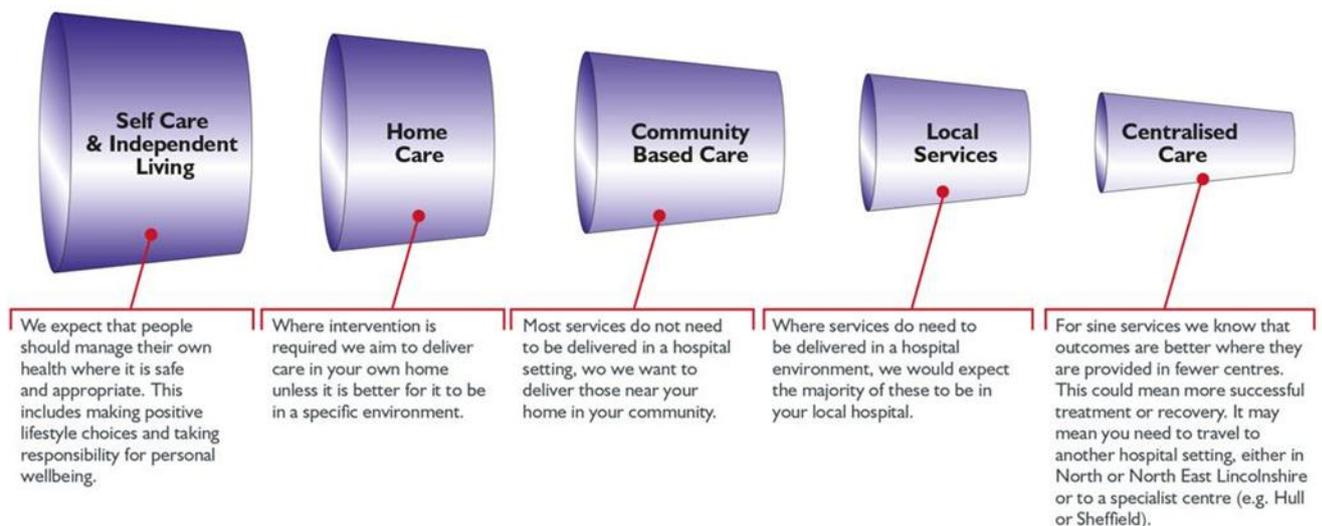
This Strategic Plan sets out our vision for the future of health and health care in North East Lincolnshire for the next five years. As one of the first Clinical Commissioning Groups to be officially authorised in England, we are proud of our reputation as a trailblazer and innovator.

In response to the national picture of public sector funding cuts, our plan reflects a quantum shift in our approach to delivery of health and social care. We recognise that our communities rightly deserve the most up to date and modernised care and we have set out to harness the best in quality and innovation to enable us to continue to deliver the best possible care within the resources that are available now and in the future.

The services we will commission will reflect our vision of transformational change as set out in the diagram below:



## The Shared Vision



In collaboration with local partner organisation, services will reflect the following principles:

Healthcare providers should provide a **comprehensive** service, from supporting prevention and self-care, through community provision, to specialist and tertiary care.

Providers of these services should take an **integrated approach**, so that local people have access to a seamless service

The result will be **higher-quality care**, with more lives saved and more people returned to full health

A further result will be a service that is **affordable** in the years to come

This strategic plan provides an overview of proposed changes and encompasses an alignment of thinking across North East Lincolnshire, reflecting amongst others our own strategies for the following:

- Designing care for the future
- Adult Social Care
- Carers
- Better Care Fund
- End of Life Care
- Violence Against Women and Girls

Our strategic aims are to:

- Empower People
- Support Communities
- Deliver Sustainable Services

All of our commissioning activities are geared around delivering these aims and realising our vision.

Through collaborative working with other local commissioners and providers as well as those further afield, we will deliver lasting change as well as modernised, high quality care for our future generations.

## Introduction

This Strategic Plan sets out our vision for the future of health and health care in North East Lincolnshire for the next five years. As one of the first Clinical Commissioning Groups to be officially authorised in England, we are proud of our reputation as a trailblazer and innovator.

Our strategic plan for the North East Lincolnshire Clinical Commissioning Group provides the underpinning context for how we will develop safe, high quality, affordable health and social care services for our local communities for the next five years. We are committed to a person-centred, integrated model of health and social care provision in partnership with North East Lincolnshire Council, as well as a wide range of local providers and we are committed to working in partnership with our local communities to meet their diverse needs.

The implications resulting from demographic trends, with increasing numbers of older people and younger people with complex needs, is the subject of ongoing debate with little certainty nationally on what models of health and social care will meet future needs and be financially sustainable. Our Clinical Commissioning Group faces the additional challenges of diverse communities within a small geographic area.

In North East Lincolnshire, we are embracing this challenge. Partnership and person-centred care are strong themes throughout this Plan. Government policy continues to move to an ever more integrated model of funding for health and social care. We welcome this as it offers increased potential for people to have real influence over how their health and care needs are met. We will work collaboratively to encourage and enable an ethos of co-production, so we can explore the opportunities offered by new technology such as telehealth and telecare and the introduction of Personal Health Budgets for people with long-term conditions. We are determined to deliver the best possible choice, quality and consistency in health and social care whilst driving down costs and offering real value for money. We will continue to lead the way in the development, adoption and diffusion of innovative approaches in the way we work – to enable the people we serve in North East Lincolnshire to have real and increasing choice and control.

The plan reflects the local and national context within which health and care services need to be commissioned and delivered.

It describes an ambitious programme of work which will move our services to focus on maintaining good health, preventing illness and enabling our local communities to care

effectively for themselves. Reshaping our services to support this vision and ensure that we maximise the resources available to us for delivery of health and care services is the challenge we will meet boldly.

The services we will commission will reflect our concept of the “shift to the left” (as set out in the diagram below) which underpins our transformational change programme, Healthy Lives, Healthy Futures which is undertaken in partnership with North Lincolnshire Clinical Commissioning Group. The “shift to the left” refers to the move from hospital care as the default delivery mechanism for healthcare to the increased emphasis on self-care and independent living.

In collaboration with local services, will reflect the following principles:

Healthcare providers should provide a **comprehensive** service, from supporting prevention and self-care, through community provision, to specialist and tertiary care.

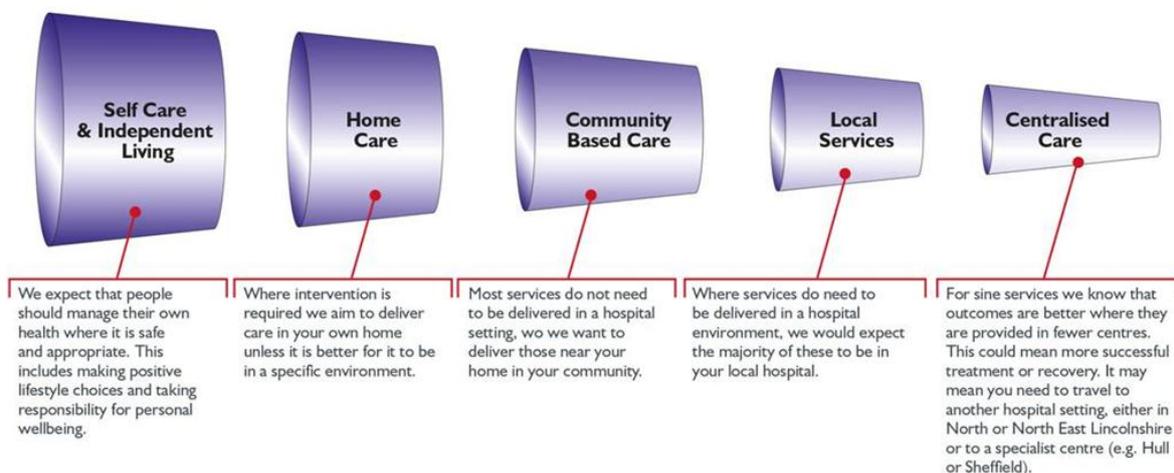
Providers of these services should take an **integrated approach**, so that local people have access to a seamless service

The result will be **higher-quality care**, with more lives saved and more people returned to full health

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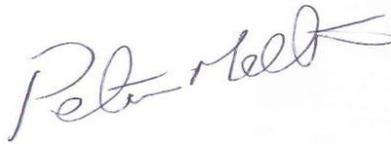
## The Shared Vision



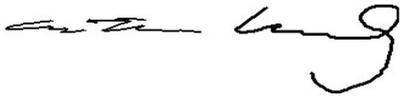
We will achieve this within the context of increasing pressure on public sector funding to deliver more for less and have set out an ambitious vision for health and social care in 2018/19 which will provide up to date, innovative and effective care for our local communities.



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Chair NEL CCG



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## Our Vision, Mission, Values

### Our vision...

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

### Our mission...

We will deliver modernised, up to date health and social care provision which will :

- Empower People
- Support Communities
- Deliver Sustainable Services

### Our values...

#### **Consistency**

*We will ensure people receive consistent outcomes wherever and whenever they need help*

#### **Quality**

*We will ensure people have access to quality services*

#### **Innovation**

*We will innovate when our best practice is not good enough*

## Background and context

Our vision, mission, and values are reflected in our strategic plan on a page (Appendix 1) which provides an overview of our stated intentions, how we will achieve them and how we will manage our work to enable us to reach our goals.

The vision for North East Lincolnshire is for a health and social care economy that enables its citizens to care for themselves, delivers care at home or close to home, offers services which are accessible seven days a week, of the best quality available and are financially sustainable into the future.

Building on our proud track record of innovation and pioneering and our unique position as an integrated commissioner, we will utilise all of these opportunities and skills to deliver services which meet local needs and ensure a strong and thriving health and social care sector in North East Lincolnshire for generations to come.

The context within which we are working presents a range of challenges in relation to meeting the needs of a diverse population.

Our community is made up of a mixture of affluent and deprived areas, a population which is set to increase its proportion of older people, and a geographical location that struggles to achieve economic growth.

Our strategy considers all of these challenges and presents plans to meet the current and future needs of our community and provide a sound footing for sustainability.

There are some principles common to all CCGs in Yorkshire and Humberside, including North East Lincolnshire, which underpin the way services will be commissioned over the next 5 years:

- Quality and safety must be the highest priority
- There will be an increasing requirement for focus on prevention and self-care / independent living rather than reliance on hospital based care
- A small number of hospital services, particularly specialised services, will be commissioned from centralised locations if necessary to improve outcomes
- We will deliver the right care, in the right place at the right time; for example reducing inappropriate admissions to inpatient beds in hospitals and care homes through better management of care in the community.

- We will break down organisational barriers where needs are complex and patient care crosses numerous boundaries, to improve co-ordination and reduce fragmentation of care
- Service providers will be expected to work within the financial constraints of each health community

Local services will go through a process of transformation over the next five years with the whole health and social care economy needing to deliver savings within the context of increased growth.

Our local transformation programme, Healthy Lives, Healthy Futures, is aimed at developing and delivering clinical models and care pathways that will shift the emphasis to self-care and independence, with care in the home and community rather than hospitals or other care facilities. In order to achieve this change, 24 hour, 7 day services will be required across the range of primary, secondary and social care services; and urgent/unplanned care services will be transformed to ensure that services are responsive to unplanned care needs, across a range of environments, so that patients are supported outside of traditional hospital settings.

Planned / elective care services will be streamlined to deliver service improvements and efficiencies whilst providing clinically safe and secure services. This will improve the quality of services and as a result patient experience. Efficiencies released as a result of streamlining can be used to further invest in redesign and improvement including through the Better Care Fund.

Changes to the distribution of healthcare provision between acute and community settings will be modelled at a high level as our strategy develops. Working in collaboration with other local CCGs this will be developed in the coming months and years to ensure that the subsequent delivery meets the current and future needs of our communities.

## Healthy Lives, Healthy Futures

The strategic plan and delivery of the vision for North East Lincolnshire and North Lincolnshire units of planning revolves closely around our joint programme for transformational change, Healthy Lives, Healthy Futures.

During 2012/13 a comprehensive Case for Change was developed as the underpinning rationale for the transformation and an identification of focus for areas of work.

The vision we have set out for the next five years in North East Lincolnshire, working with commissioning partners, local providers, stakeholders and local people is ambitious in its scope and enables local health and social care services to meet the needs of people in the area within the resources available.

A key element of this vision is to enable local people to manage their own health and wellbeing more effectively and to engage with their communities to deliver solutions based on self care and self responsibility.

The programme is linked with similar programmes within the East Riding of Yorkshire and East Lindsey, and the work undertaken to date is the first in a series of reviews that we expect to undertake over the next 5 years in order to achieve our vision.

All of our reviews will be driven by national best practice recommendations around the services we offer, to ensure that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come.

Our vision and direction of travel has been shared and developed with the local Health and Wellbeing Board as well as all the commissioner and provider stakeholders who comprise the Programme Board.

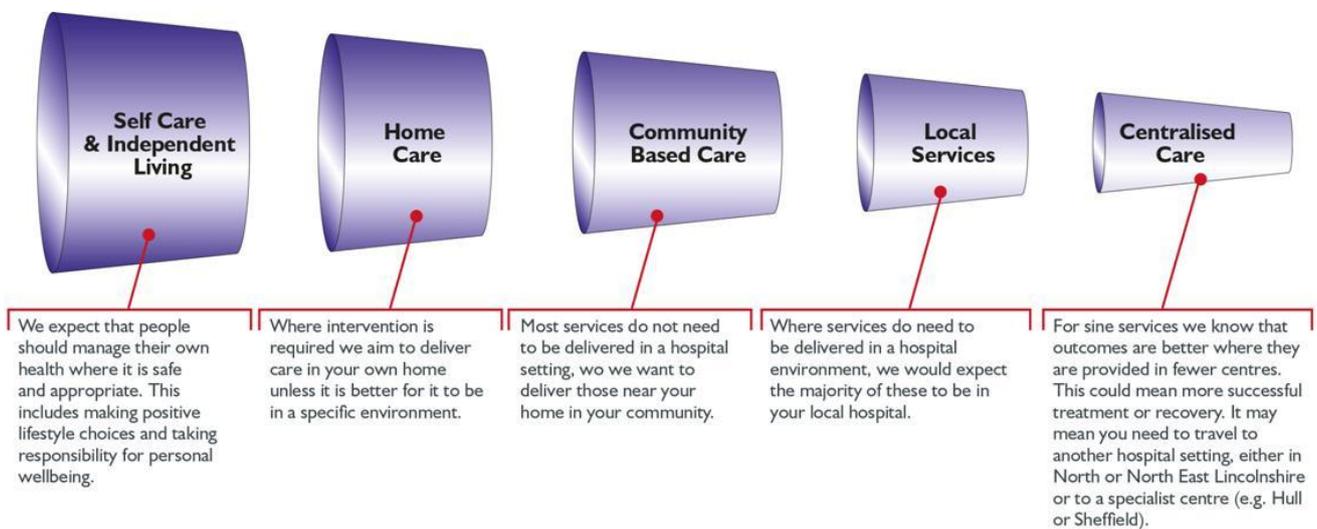
Our vision can be described in the diagrams below which are drawn from the programme and reflect a fundamental shift in the distribution of health and care services and position our community for sustainability into the future.

The programme is actively developing and will continue to establish new models of care and new ways of working for the foreseeable future, ensuring the CCG's vision can be delivered.

The Shared Vision – A Shift to the Left...



The Shared Vision



What sort of changes are we talking about?



## Engagement, co-production and consultation

North East Lincolnshire CCG is a recognised national leader in engagement by embedding public involvement in the commissioning of health and adult social care services. Through a deliberate blend of social marketing approaches, community involvement and community action there is a strong history of collaborative working with local communities. We have long since embedded robust engagement and co-production mechanisms into its commissioning and planning activities and will continue to utilise these mechanisms into the future.

We operate an active community membership scheme (Accord) with over 2500 members, which allows community engagement to be embedded in all decision making. We also have a community forum, consisting of elected Accord representatives, which provides a lay governance function for the CCG and co-ordinates engagement with the wider Accord membership.

The Healthy Lives, Healthy Futures programme of transformational change has been supported by a comprehensive range of engagement activities thus far, ensuring that the proposals coming forward from providers and commissioners are tested out with the general public across the area

Feedback from the first phase of engagement which took place over the summer 2013 has shaped the development of thinking for the programme, for example concerns raised about access to care in relation to transport have resulted in a specific workstream on access and transport for the programme. The Engagement report for the first and second phases describe how public input has influenced thinking and action for the programme.

The engagement process will culminate in a period of formal consultation beginning in June 2014 leading up to final decisions about significant service changes in October 2014.

There is however a contemporaneous process of incremental service improvement which supports the “shift to the left” – the overall direction of travel towards self care and independence and reduction on reliance of formal health and social care interventions.

The changes currently proposed focus on quality enhancements rather than large scale change to deliver financial savings –we recognise that the next phase of development for the programme will need to address the residual projected gap in efficiency gains in order to deliver financial balance and service sustainability within the five year scope of this phase of strategic development for the health and social care economies in Northern Lincolnshire.

## Community based prevention initiatives

We have already commenced work with the local Voluntary and Community Sector (VCS) organisations to stimulate grass roots interventions aimed at enabling people to stay well for longer and remain safely and healthily at home, living independently to a greater age. The initiatives below describe how we are creating the right environment for the “shift to the left” and stimulating the interventions we will need to enable better self-care and independent living.

- Through the creation of a Preventative Services Market Development Board and a Releasing Community Capacity Board we are actively bringing commissioners and providers together to identify current gaps in community resilience and actively stimulating the required activity through seed funding and infrastructure support. This new tier of provision will offer a real alternative to statutory and traditional formal social care services.
- We are also reviewing the way we commission activity in the voluntary and community sector with the intention of providing a clear and well-resourced infrastructure support service that will support all voluntary and community sector organisations whether they be small luncheon clubs or larger social enterprises.
- We will refocus and double our efforts to deliver 300 units of extra care housing across North East Lincolnshire as a real alternative to residential care which will also reduce the number of unnecessary A and E attendances leading to unnecessary admission.
- The creation of new, and expansion of existing, community collaborative initiatives such as the Falls’ collaborative and the COPD collaborative. These community-led models involve patients and service users in the management and co-ordination of their on-going care, retain patients and interested individuals as subject “experts” in particular conditions, and work to develop preventative messages and approaches that are cascaded through networks in the community. This model has proved to be effective in increasing community awareness of early signs and symptoms of disease and developing individuals’ responsibility for their health, reducing unnecessary admissions to hospital.

## Voluntary and Community Sector partnership

We are working with a range of voluntary and community sector organisations in North East Lincolnshire to develop the most effective ways to align our activities.

Through ensuring optimal infrastructure support for the sector locally and closer liaison with key groups and organisations we will develop joint working over the next five years which makes best use of all the resources available to us to support the shift to the left outlined in Healthy Lives, Healthy Futures.

A key element of this will be to ensure that not only are local financial resources deployed most effectively, but that we will make best use of resources available through regional and national funding streams to deliver local benefit.

## Community Services

We will work with partners in North East Lincolnshire to utilise the Better Care Fund to invest in the infrastructure required to set up and run the enhanced and integrated Single Point of Access (SPA), offering all citizens in the area a single destination, telephone number and website for all community health and social care services including intermediate tier, prevention services, assessment, information and advice.

This will deliver;

- *Improved user experience, allow easier access to ready information and advice*
- *The most appropriate response through a multi-disciplinary approach*
- *Reduced delays and duplication in the system*
- *Promotion of self-care and independence*
- *The ability for providers to co-operate rather than simply competing*
- *Efficiencies in the wider system*
- *Smarter hospital discharge through earlier and more rigorous planning*
- *Better co-ordination and integrated case management of the most vulnerable and frequent users of emergency services.*

## Extra Care Housing

We will deliver 300 extra care housing units by 2018, targeted to meet existing demand, across NEL in 5 brand new schemes. Health and social care staff will help set the criteria for entry and case finding based on local modelling. We will also re-shape the learning/physical disability supported living market to deliver new bespoke independent living solutions.

## Equipment services

We will commission and deliver a more accessible and integrated community equipment service promoting independent living through the use of technology, telecare and telehealth solutions.

## Care Home interventions linked to primary care

We will commission a local enhanced service from local GPs to become responsible for named residential and nursing homes within NEL to provide better access to primary care and to cut unnecessary hospital admissions.

## Support for Carers

We will continue to develop comprehensive services for carers so that individuals will be enabled to remain at home rather than access residential or inpatient care. We have recently recommissioned carers services for North East Lincolnshire to enhance quality and scope of service delivery and this redesigned service will be part of our approach to maintaining care at home.

We have commissioned services which will ensure that carers are identified proactively, are enabled to access all financial support available to them and are supported holistically through individualised, person-centred support plans.

## Primary Care

Commissioning and contracting responsibility for Primary Care currently rests with NHS England, however we are working closely with NHS England colleagues to ensure the best possible service configuration for primary care which is fit for the future.

We have 30 GP practices covering a population of approximately 168,000, which is both urban and rural. Over the last 12 years there has been significant investment in the infrastructure resulting in 12 large primary care centres strategically placed across North East Lincolnshire as well as other smaller practices. These provide opportunity for development and to ensure maximum usage in the community for appropriate services.

In order to deliver our vision of best possible care close to home and at home, there will need to be a step change in primary care service delivery with a focus on seven day working. Working in partnership with direct commissioners at NHS England, we will deliver a model of primary care which underpins our vision for the system of the future as described by Healthy Lives, Healthy Futures.

Our localised delivery will align with the commissioning principles set out by NHS England

- Access, including the promotion of self –care and best use of technology
- Workforce –ensuring resilience, developing planning and training
- Responsive and flexible contracting
- Continuity of care
- Integrated care pathways

In North East Lincolnshire there are unique opportunities to respond to the challenge of changing primary care. We already have close alignment between health and social care with integrated services being delivered in the community, but more needs to be done. There is also significant premises capacity that could be better utilised and opportunities for closer alignment between all aspects of primary care as well as integrating some community services.

Our new model for General Practice will expand the scope of and access to services across the range: preventative, convenient, planned, chronic disease and urgent care. It incorporates elements of other models such as the “extensivist approach” (a physician-led community team providing comprehensive and coordinated care to patients with multiple complex medical issues and at high risk of admission). It adopts new organisational arrangements, including a federated practice across the whole borough. The model gives particular weight to those communities with the greatest needs, while still responding proactively to those with reasonable expectations from General Practice. It will provide consistent access and outcomes to all residents, regardless of their community or the

practice they are registered with, thereby making a strong contribution to narrowing the inequality gap.

The model has 3 broad aspects:

1. A consistent standard of service, which meets the core national contract, delivered from each practice site
2. A choice of new guaranteed General Practice services for all residents, , delivered through collaborative working arrangements.
3. Establishing General Practice as the “lead accountable provider” when a collaborative response to a population’s needs is appropriate

A federated General Practice for the area (LINCS) already exists: it includes traditional practices providing core GMS and extended PMS, the practice delivering walk-in services and the practice serving hard-to-reach communities and supported by the urgent and out-of-hours primary care provider. On behalf of its member practices, LINCS will develop work in the following areas:

- Develop new roles, incentives, training and educational arrangements to enhance workforce recruitment to the area
- Work with a leading independent academic institution to identify and evaluate the outcomes, conclusions and transferable lessons
- Expand on the work with NHSIQ on the 7-day services early-adopter scheme and over-65 care
- Measure progress and success in the priority areas, across the domains of quality, patient experience and value-for-money
- Implement a new commissioning arrangement for General Practice, bringing together NHS England, CCG and the Local Authority
- Define a new role for General Practice as a community leader, to boost the overall health, wellbeing and regeneration of the borough
- Champion and promote the use of new technology, to reduce face-to-face interactions and improve access to specialists.
- Engage patients and public more actively in the governance of the project, to address service issues, aspirations and opportunities

The Primary Care model is fully aligned with the local strategy for primary care, and leads to significant improvement in these respects:

## **Improving care for older people – particularly the over- 65 cohort**

Our approach is to integrate the work of primary-care providers with that of other health and social-care providers. Over the next 12 months, we will initiate our programme of identifying and assessing the over-65s, developing management plans and monitoring the care they receive.

## **Promoting continuity of care – the Extensivist model**

A dedicated population-wide team will provide care for complex populations, and ensure a clinically-led coordinated approach, so each patient will be assigned the right professional to serve his/her needs appropriately.

## **Improving overall quality and productivity of local NHS services – e.g. General Practice Urgent Care**

An A and E GP scheme is already being delivered. Since its launch in March 2013, the service has diverted more than 1,800 patients away from A and E. That equates to 24% of all walk-ins during the opening hours of the service. Since February 2014, the service has been operating 7 days a week, and the aim is to integrate it with GP out of hours within the next year.

## **Reducing health inequalities**

The new model for General Practice focuses on consistency and equity of service for the whole population. This includes a range of preventative services, which will work with public health providers where appropriate, and contribute strongly to reducing health inequalities.

The transformation of primary care that we seek to achieve will deliver the following positive changes:

**General Practice at scale with preservation of personal localised service** – in order to develop consistency of service with reduced variation, general practice needs to be delivered on a larger footprint than current practice size. However the service needs to be personalized as both the public and GPs value this aspect of care.

**Maintain the generalist nature of General Practice** – the most important part of General Practice is the generalist nature of the service given, this needs to be preserved for core services.

**Networked/federated/integrated approach** – to get the most cost effective use of existing resources, practices will use a more integrated approach to deliver services which will reduce duplication where appropriate and make better and more consistent use of back office support

**Consistent high quality care** – Core General Practice will focus on delivering a consistent level of service and will be delivered 7 days a week. Where there are challenges for individual practices in delivering this level of service, they will be networked or federated with other practices to ensure consistency.

**Individualised tailored care** – care pathways will be developed around the individual, not just in General Practice but across the health and social care system to ensure that the package of care meets the needs of the individual and is coordinated across the system. Initially the focus will be on those with most complex needs that are frequent users of the system and this is expected to address the needs of the frail elderly and those in the last stages of life.

**24/7 care** – General Practice will be offered on a 24/7 basis as it is now. All aspects of routine care will be delivered on a 7 day basis with urgent Primary Care being managed in an integrated way outside of the hours 8-6.30 pm.

**Proactive care** – where appropriate care will be proactive to help individuals manage their conditions and prevent them getting unwell.

**Coordinated care** – General Practice will act as the coordinator of care for the individual to ensure that the care is owned and managed across the whole care system.

**Continuity of care** – Care will be delivered in an integrated way across primary and community services to ensure continuity of care.

**Technologically enabled** – wherever possible care will be delivered by maximizing the use of technology such as non face to face consultations, use of telehealth and care to reduce travelling and expand capacity

**Outcome focused** – the model will have a set of outcome indicators based on a combination of expected health and care outcomes and patient experience.

**Network** - Agreed formal links between practices to provide support and/or mutual benefit to each other

## Dental, Pharmacy and Eye Health

We are working closely with direct commissioners in terms of developing strong pathways for primary care dental provision, pharmacy delivery and eye health proposals which support the shift to the left as defined within the Healthy Lives, Healthy Futures programme.

Liaison with the Area Team and internal discussion has yielded the following thinking for those areas.

For secondary care, the main inpatient dental admissions are for the treatment of dental caries (tooth decay). To reduce admissions to hospital for dental treatment support must be offered to providers to develop effective oral health campaigns. A workforce with a varied skill mix will help with oral health prevention; therefore dental practices will be encouraged to employ dental therapists, dental hygienists, dental technicians and dental nurses as well as dental practitioners. A process will need to be put in place through the Local Dental Network to agree to Patient Group Directive's where appropriate, potentially allowing dental practices to better maximise the skill mix across their practice staff.

To ensure GP Practices can cope with the increase in out of hospital care, pharmacies will be required to play an important role in ensuring they provide services more traditionally provided by GP Practices, the NHS Call to Action identified a need for pharmacies to play a stronger role in the management of long term conditions. Pharmacists will need to be trained in order for these services to be delivered at a high quality; as not all patients visiting a pharmacy will need to be seen by the pharmacist, therefore a greater staff skill mix will be required to effectively deal with the additional workload. For example dispensers could be identified to take on further responsibilities such as the promotion of health lifestyles. NELCCG will be working more locally with pharmacists to understand better what local requirements will be in order to support the shift to the left of transformational change

The Local Eye Health Network was piloted in the Humber region and has been running since 2012. It has been successful in developing training programmes, expanding the skills of optometrists, improving local services and streamlining referrals resulting in fewer GP admissions.

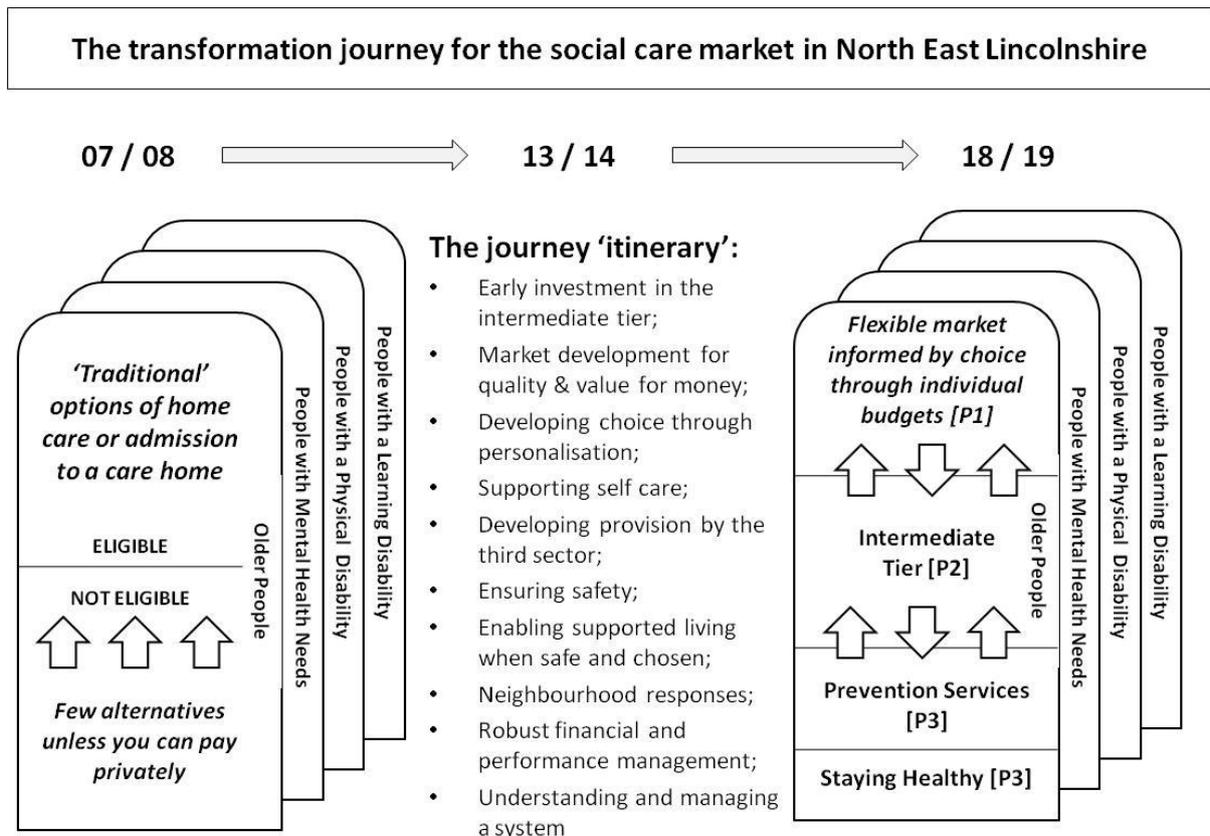
The CCG is working to review the range of services related to Ophthalmology and this review will make recommendations for local service transformations during 2014, informing the strategic changes that will need to be made in the coming years.

## Integration with social care provision

Integral to achieving the “shift to the left”, which is crucial to deliver clinical and financial sustainability for North East Lincolnshire, is an effective and efficient system for Adult Social Care.

The creation of the Care Trust Plus in September 2007 signalled the start of a significant programme of change for Adult Social Care. This integration of commissioning and delivery, positions North East Lincolnshire very well for the proposed increase in joined up mechanisms for care delivery and in particular those related to the Better Care Fund.

A range of improvements to the way in which the local care system operates have already been made. These have delivered improvements in the quality and value for money of services for the residents of North East Lincolnshire. The figure below represents this journey, and the current ‘staging post’, which reflects the ‘itinerary’ for the next 3 to 5 years.



*The transformation journey in North East Lincolnshire*

NELCCG's Strategic Overview of Adult Social Care in North East Lincolnshire describes how the CCG intends to fulfil its delegated responsibilities to ensure that people across the area will continue to receive the care and support necessary to maximise independence, health and wellbeing within the resources available. Whilst the strategy describes the necessary changes in the commissioning and delivery architecture it also describes the continuity in strategic themes:

- Meeting the Demographic Challenge.
- Developing the ASC offering - an offer for all. The introduction of the new priorities framework (use of resources)
- Living within our means and delivering sustainability
- Personalisation, market management and the whole system approach

As part of the on-going development of its Adult Social Care Strategy the CCG will need to incorporate its response to the Adult Social Care white paper, any response to the Dilnot review and on-going or new legal challenges to the way in which Local Authorities determine funding.

## Partnership working with North East Lincolnshire Council

By working together with North East Lincolnshire Council in an integrated way, the CCG believes that it can make more of a difference to the quality of experience of people and children in need of health and social care services by making it simpler to access pathways for care and support to meet the variety of needs in the borough. To make a lasting difference to our communities' health and well being the CCG and NELC need to target their efforts across people's life stages, to begin to build and sustain healthier communities, placing greater emphasis on prevention and well being, and minimising the need for more costly treatment and care options. Together we want to ensure that all people and children in North East Lincolnshire can lead healthy, independent lives and look forward to a healthy and active older age.

The partnership between the CCG and NELC is reflected within a legal partnership agreement that has been established since 2007 and is reviewed and refreshed annually or as required.

### Better Care Fund

In North East Lincolnshire we are adopting a system wide approach to deliver integrated and sustainable services that deliver better quality outcomes for our local population within the available health and social care budgets.

We have been on this transformative journey since the creation of the Care Trust Plus in 2007. The Better Care fund will allow us to protect and invest further in a second phase of integration. It will help us to develop our integration approach more quickly and to greater depth, shifting the emphasis and activity away from hospital settings by investing further in a tier of intermediate and community care pathways.

Our vision is to deliver the right care, in the right place delivered by the right people, as close to home as possible, releasing the capacity and innovation which exists within our community to promote healthy living, self-care and prevention.

The Better Care Programme Board has agreed a set of principles to ensure that the creation of the better care pooled fund and associated transformational work does not negatively impact on any current service or sector. Furthermore, work streams must contribute to the further integration of health and care services in the interest of the patient and service user. Work streams must ensure the most effective use of resources in a manner that supports

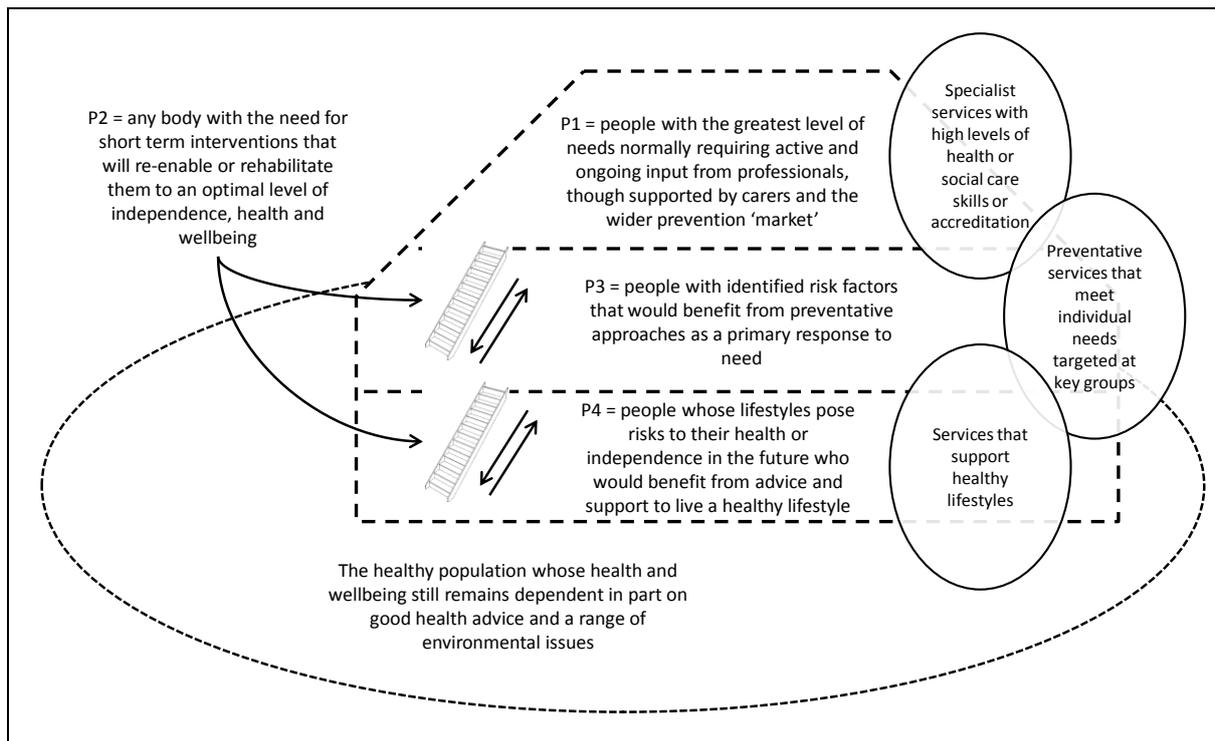
the agreed strategic vision as set out in this document and in more detail in the Healthy Lives Healthy Futures Strategy and the Local Authorities Stronger Economy, Stronger Communities strategy.

The Better Care Fund will be used to invest significantly in an improved health and social care system, changing the way that health and social care services are funded to drive improvements to services for elderly and vulnerable people. This fund and other investments will resource a joined-up health and social care service, shifting the balance of care from a hospital environment to a home or community settings where it is safe to do so, promoting self-care and independent living. It is expected that the secondary care sector will retract as a consequence of the expansion in primary and community care, proving a challenge to all organisations and their staff who will need to work differently and across organisational boundaries to deliver seamless integrated care.

Through the development of an integrated asset based model, we are aiming to ensure earlier intervention to delay or reduce the onset of care needs and to ensure that alternatives to traditional forms of on-going long term care are available via the community and voluntary sector and by individual resilience. In this way, resources can be preserved to meet increased demographic demand and the more complex needs of a more frail elderly population within the borough.

The 'priorities' approach (illustrated below) 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.

In this model, 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 on-going needs might be best described as P1, P3 or P4. Therefore, on an on-going 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.



*The priorities approach*

## Mental Health

In North East Lincolnshire we recognise that we currently have significantly higher rates of inpatient hospital admissions related to a range of conditions from depression to schizophrenia to self harm.

The mental health market in North East Lincolnshire is dominated by statutory NHS provision now delivered by a social enterprise. Most focus and resource is on acute needs; those elements of the market concerned with the early identification of emerging problems and community-based support for those with ongoing problems are less well developed.

Services can be categorised as follows;

- Services for people with common mental health problems
- In-patient, crisis and home support
- Community and acute mental health and memory service: services for people with dementia
- Support in the community
- Employment and training

In line with the vision outlined in Healthy Lives, Healthy Futures and the shift to the left, we will develop more community based reablement interventions, reducing the reliance on inpatient care solutions and enabling people to utilize personal budgets to exercise more control over their own care.

In the next two years we will manage the transition to payment by results for mental health care as well as increasing community based interventions to reduce pressure on secondary care.

Mental health provision will be embedded in the delivery of our integrated single point of access to ensure that there is parity of physical and mental health needs and service users receive an holistic assessment and service offering.

Services for Young People experiencing mental health problems are a priority. We work in partnership with the local authority with CAMHS and have a clear transition strategy for adolescents. We have an early intervention in psychosis team that works with young people commissioned from our mental health social enterprise. Locally, Rethink and Mind have support groups for young people.

We have been working with our mental health provider over the last 18 months in delivering physical health checklists and screening for people who have mental health problems. That has included supporting people with smoke cessation programmes, healthy eating etc. We are actively implementing “no health without mental health” within our culture and practices. This programme will be rolled out within all mental health teams within the next 12 months.

We will continue to work with local mental health providers in relation to delivery of Improved Access to Psychological Therapies and have identified a risk to achieving the requisite levels of referrals into the service. This risk will be monitored on an ongoing basis.

All of these initiatives are planned to reduce the gap in life expectancy for people with mental health problems.

The CCG actively ensures all our providers follow the requirements of the Mental Capacity Act (MCA) and this is governed in policies and procedures for all commissioned services.

The application of Deprivation of Liberty (DOLS) is monitored via the Risk and Quality panel of which our MCA officer is a member. As well as overseeing all applications for funding, the panel ensures that workers have considered the MCA and that best interest meetings and capacity assessments are undertaken as required.

## Urgent and Emergency care

In North East Lincolnshire we have long focussed on integration of services which has been the basis for the local developments in Intermediate Tier, SPA etc. and these will continue to be developed. A key next stage will be further development of provider networks coming together to deliver the outcomes and efficiencies that will be required, for example the national 7 day working pilot, and opportunities to contract and incentivise these groups to best effect.

Our local model of urgent and emergency care has strong resonance with the national model emerging from the 2013 review of Urgent and Emergency Care.

The key principles of Healthy Lives, Healthy Futures which focuses on the “shift to the left” will enable a more focussed approach to urgent and emergency care and reduced pressure on stretched resources. Significant focus on A and E performance through NHS England and the formal planning and assurance processes that have emerged, have created a useful framework for whole system design and monitoring and we will continue to develop this through the Urgent Care Board.

Whilst these development consider the “response” system, there is an expectation that activity in the response system will be correspondingly controlled by improvements in planned care – in particular the Community Service and Primary Care management of long term conditions and improvements in self-care support.

### A and E activity stabilisation

For the last two years, our GP service in A and E have become well established and are now delivering the planned impact - providing a primary care “see and treat” stream for ~25% of daytime attendees – in turn releasing A and E resources to deal with more specialised care. The longer term cost, provider and contract model will be established in the short term along with further operational integration.

The strategic model for the need and delivery model for Walk-in services and Minor Injuries Units will be consolidated with particular scope for the latter to be developed in primary care centres to address a further cohort of A and E attendees and support the focus away from “always A and E”

Emergency Ambulatory Care developments will be progressed for those attending A and E and the overall fit of this with medical assessment unit functions will be considered to see

what opportunities there are with short stay and diagnostics to improve the consideration by Primary Care and Community Services and, in the other direction, the role of consultant geriatrician for example in the medical assessment unit and links to step-up services.

Ambulance handover performance needs continued work to establish agreed data and responsibilities between EMAS and Diana, Princess of Wales hospital with the potential for introducing contractual penalties but foremost to ensure avoidable delay mechanisms are addressed.

### **Intermediate Tier - Step up**

We have established targets to reduce the level of emergency admissions for those that are in the Ambulatory Care Sensitive Conditions cohort, a cohort deemed as being where the admission is potentially avoidable. These are estimated to account for some 15% of all emergency admissions and where respiratory and heart conditions are the two largest contributors.

Established community rapid response services have been key in dealing with exacerbations at home that might normally have resulted in and A and E attendance and/or an admission and key developments will be to further integrate access and assessment in crisis response services via the SPA, to develop extended capabilities to stabilise and deliver care in the home e.g. IV fluids, rapid homecare services and to specify and develop step-up community nurse led bed capability to extend the scope of those that can be cared for closer to home. This group of developments is the key enabler for any significant shift of care away from secondary care services. These developments will include the consideration of the role of GPs supporting the SPA and/or ambulance services to develop improved intermediate pathways for the care of the deteriorating patient – potentially to overlap with care home medical support - and will include the plan on how 111 and SPA services developments together contribute to the delivery of the urgent and emergency care review notion of the urgent (non-emergency) “smart call” for advice and access to services.

### **Intermediate Tier – step-down**

The timeliness of assessment and service readiness across a multitude of professional groups contributes to potentially avoidable delays in discharge arrangements. This is one of the 4 key “pinch points” that can contribute to reduced flow through the A and E/ward process and thence to A and E performance. We will deliver further improvements, focusing on a SPA service as a key liaison point with Diana, Princess of Wales hospital. In addition Patient Transport Services will be commissioned to for activity surges and support any extended hours under seven day working. One of the key services are Intermediate Care Rehabilitation and Recovery services - we will scale and optimise the outcomes for these services further. The scope to move to a “discharge to assess” model needs to be

considered in order to improve outcomes and optimise the use of these resources. There also needs to be a consolidation of the current number of settings and use of step down facilities ref the current ICF, The Beacon and Bradley House re-ablement and rehabilitation facilities in that there needs to be some flexibility for the provider to use the bed base in a variety of ways to best effect.

We have identified and scaled an improvement target for a defined composite measure of emergency admissions. Some of this target is in the scope of the Intermediate Care – Step up and enhanced home care developments. Further, the SPA developments will be in place and delivering an improved rapid/crisis response service.

A key aim over this period is to re-design and resolve the hospital discharge processes for those who need onward services to ensure that the level of delayed discharges is at a practical minimum. SPA developments will contribute to this as will a change to the structure and content of contractual obligations in respect of the professionals who need to assess and arrange services in a suitable manner. We will also continue to work with partners to improve hospital processes of assessment and liaison so that we have better assurance that patients are medically fit and able to be discharged. This will also require coordination with a revised model for re-ablement and rehabilitation in order to account for the local approach to the “discharge to assess” model for Intermediate Care.

In this period, the provider and contractual arrangements will develop further across the whole spectrum of urgent, unplanned and intermediate care services. These will be based on further integration of delivery as well as developments for provider contracts and incentives.

We will take into account national initiatives and policy, for example, following on from the recent urgent and emergency care review, there will be further designation of specialist emergency centres.

Working with local providers and commissioners and linked in to the Healthy Lives, Healthy Futures programme of work we will determine the footprint of our urgent and emergency care network in the coming year and have already begun detailed modelling and work on

- Patient flows
- Urgent and emergency care facilities and their services
- The urgent care needs of our population
- Preparation for designation

This is supported by our local CCG “Triangle “ for urgent and community care and its engagement in relevant urgent care networks and delivery partnerships.

## Planned Care

The shift to the left described in Healthy Lives, Healthy Futures relies on carefully thought through provision in planned care to contribute to the prevention agenda and to ensure minimal reliance on urgent care. Some of the key areas of focus for planned care are outlined below.

The five year approach for planned care will encompass

- implementation of the diabetes review recommendations
- implementation of the neurological review recommendations
- implementation and full roll out of e-consults
- implementation and full roll out of telehealth for identified patient cohorts
- best possible quality and consistency in GP referrals to secondary care
- more community based services
- GP mentoring scheme to reduce outpatient referrals
- reduction in number of readmissions for acute episodes - COPD patients

## Diabetes

Diabetes is a key priority of North East Lincolnshire CCG and a review of diabetes services has been undertaken to find out what works well and identify any improvements or gaps in services.

The review used both local and national information and feedback from patients and health and social care professionals. Our aim is to provide diabetes services in line with the review recommendations so that in five years we will see dramatic improvements in the prevention of diabetes through raising awareness of the factors that can cause this condition. We will work to ensure the inconsistencies in service delivery for these patients are addressed and that there will be improved joined up working between health and social care staff which will lead to improved patient experience and improved outcomes.

## Neurology

Whilst neurological conditions are small in terms of volume, they are high cost in terms of level of care required and multi- agency involvement. The Neurology Service Review commenced in the spring of 2012 and is specifically established to review the following long term neurological conditions: -

- Multiple Sclerosis
- Parkinson's Disease
- Motor Neurone Disease
- Epilepsy

Over the course of the next five years we will implement the review recommendations to ensure a consistent approach by all health and social care professionals to patients with a neurological disease which will include specialist nurses to work alongside patients and primary and secondary care physicians to ensure the best possible outcome for these patients whether they are hospitalised or are living in their own home. We will raise awareness of these diseases with primary and secondary care, and other social and healthcare professionals. Wherever possible we will try to ensure these patients can be looked after in their own homes following inpatient episodes.

## E consultations

We recognise the need to reduce our number of outpatient referrals both in terms of cost and appropriateness. This can in part be achieved by the use of e-consults. This technology is currently being used by our community skin cancer clinicians who report favourably on the advantages. Additionally, the patient benefits by not having to attend an outpatient appointment unless deemed necessary by the consultant reviewing the e-consult. We are currently reviewing a range of specialities that would be appropriate for the use of e-consults and our five year plan will be to embed this technology across a number of identified specialities.

## Telehealth

Telehealth is an umbrella term for a user friendly piece of equipment which is proven to help patients with long term illnesses to take control and regain their independence. Our current programme of telehealth deployment regards telemonitoring is well advanced.

The equipment is fitted in the patient's home who will then take readings such as blood pressure, pulse weight etc. The readings are automatically sent to a monitoring centre where any abnormal readings are identified. When a reading causes concern a healthcare

professional is alerted to contact the patient and take any necessary action. This can help to reduce the need for the patient to be admitted to hospital, and avoid home or surgery visits. Our five year aim is to ensure as many COPD/Heart Failure patients have access to this technology. We will also look to use this equipment in nursing homes.

### **Reduced variation in GP Referrals**

We will monitor and work with practices that appear to be outliers in terms of referrals to hospital outpatient clinics to reduce the number of inappropriate referrals. We will continue to look to build on work undertaken in 2012 which led to a significant savings on referral and a flattening of the variation curve across the practices within North East Lincolnshire. This will take the form of development of appropriate pathways of care for each specialist area identified, and alternative services or actions that can be taken in a primary care setting to avoid unnecessary referral to secondary care. The CCG will benefit in terms of savings and the patient will benefit by not having to attend secondary care unnecessarily. We will also be providing a more consistent approach across the patch whilst providing mentoring for those GPs who are outliers.

### **Community based services**

Negotiations are ongoing with our local acute trust to enable identified services to be delivered in a community setting. In five years our aim would be to ensure these services are fully operational, enabling better patient experience and generating savings for the CCG in line with the 20% efficiency gains in elective care through a variety of initiatives which include reshaping urgent and specialist care to align with the Healthy Lives, Healthy Futures aims.

### **Reduce acute hospital admissions for exacerbations of long term conditions – COPD**

We will ensure that all patients admitted to secondary care with an acute episode related to COPD will have in place a programme of home based physiotherapy within 72 hours of discharge from hospital in line with national guidelines. The secondary care service will inform the community service of patients admitted and this will be followed up by a hospital visit so that a follow up appointment with the community service physiotherapist is confirmed prior to discharge.

This initiative will not only save the CCG money on repeat admissions, it will also benefit the patient in terms of ensuring continuity of care between the hospital and community setting.

## Maternity and paediatric care

We are committed to high quality, safe, sustainable and joined-up services for women and children. Early Access and the provision of safe, high quality maternity care is crucial in achieving positive health outcomes for mother and baby and the long term healthy development of children.

### The challenges

Year on year attendance by children in Emergency Departments has been increasing. Nationally, over the last ten years, paediatric emergency admissions have risen by 18 per cent and over half of these are via the Emergency Department. At the same time, the overall length of stay for paediatric hospital admissions has fallen, with many children staying under 24 hours in hospital.

According to the Royal College of Paediatrics and Child Health, the contributory factors are complex. They include higher parental anxiety about minor illness, lower thresholds for admission amongst doctors in training, changes in 'out-of-hours' provision in England, and the necessity for Emergency Departments to take early decisions on admission as a consequence of the 4 hour waiting time target.

Arguably, a large proportion of children who attend A and E, and those who are admitted for a short stay, could be better treated in the community however this requires an effective and well-resourced community nursing service which works closely with primary care. Children recover best in their own home and hospital attendance is not always needed for an ill child, however our community nursing service is not fully able to deliver a community based model.

We are outliers in regards to the management of childhood long term conditions such as diabetes and epilepsy.

There has been a significant increase in the number of Children's Safeguarding referrals and the number of Children becoming Looked After compared to the previous years. This increase is much greater than that experienced nationally.

Birth rates have risen locally over the last few years and over the last 10 years the numbers of babies delivered in Grimsby has increased by 40% primarily driven by patient choice with women opting to deliver in the Diana, Princess of Wales hospital unit.

Our local secondary care service is relatively small in scale in terms of both paediatric and obstetric provision. As such there are challenges to the viability (financially and operationally) of these services being provided in two sites and due to size services are not

always provided at times or venues that are convenient for children, women and their families.

There are workforce challenges for the delivery of children's services such as recruiting to middle grade and training posts and maintaining clinical competence and compliance within small district general hospitals.

We have extremely high smoking in pregnancy and teenage pregnancy rates and breastfeeding rates remain very low. We have high levels of maternal and childhood obesity and childhood immunisations uptake has historically been low, although latterly this has much improved.

### **Addressing the challenges**

In response to the challenges we face, our 5-year strategy for maternity and children seeks to commission services which are responsive to patient need, accessible 7 days a week, safe, sustainable, provided in the community where possible with a strong emphasis on self-management and independence.

In December 2012 we opened the Short Stay Paediatric Assessment and Observation Unit; The unit was opened initially as a pilot and following evaluation it has made a significant impact on the reduction in short stay admissions; As such we will fully commission the service and consideration will be given to expansion if required.

In 2013/14 we commenced a review of our paediatric community nursing service and based on this produced a business case to enhance the existing service to ensure that it was fit for purpose and able to deliver a responsive 7 day service; Recruitment for the enhanced service is due to commence in April 2014 and as well as providing responsive community led care it will also assist in supporting children and their families to better manage their long term condition, i.e. diabetes, epilepsy and asthma independently.

As noted above we have experienced high levels of safeguarding referrals which has impacted in the large increase in Children becoming Looked After (LAC); because of this and concerns around the timeliness of LAC health Assessments we reviewed the service in 2013, we have now re-specified the service and adjusted the establishment to ensure that it is able to meet current and future need; Recruitment for the service is again due to commence in April 2014.

Given the increase in birth delivery rates locally along with continuing issues around early access, smoking in pregnancy, obesity and low levels of breastfeeding the Maternity Partnership Board have recommended a review of maternity services across patch (Northern Lincolnshire); The review is scheduled to commence in September 2014. The outcomes of this review will inform commissioning activity during the upcoming period.

## End of Life Care Strategy

We are committed to the delivery of high quality patient and family centred end of life care. Our local End of Life Care strategy, developed in 2012 'Good Grief - Living as we die, dying as we live an Integrated approach to providing choice, control and dignity' shared a vision that, in partnership, we will provide high quality personalised services, supporting people and their families to be cared for how and where they wish to be before, during and after death. The strategy is to develop community based services which are based on need and not diagnosis.

### Achieving a "Good Death"

What constitutes a "good" death can vary significantly between individuals, and a key role of assessment and care planning is to identify personal priorities and wishes.

For many, a good death will include:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in the company of close friends and /or family.

Dying in the place of their choice is strongly linked to whether a patient has a "good death".

A study taken in 2010 shows that the majority of people reported they would prefer to die at home with hospice as the second choice accounted for 89%. The study also showed that as age increased, a preference to die at home decreases in favour of dying in a hospice.

Ensuring that the patient dies in their preferred place is beneficial for the quality of care the patient receives and for the family in knowing that their loved ones wishes were met.

Care services for people at the end of their lives and for their carers and families will be of a high quality and must be delivered in recognition of the physical, psychosocial, emotional and spiritual well-being of the individual and their carer.

Service must be well co-ordinated and communication between services as well as to people and their families is paramount.

Over the last year we have seen substantial amount of work on reviewing and developing services to meet the needs of our local population. One of the first major service

developments was the innovative partnership between Care Plus Group, Marie Curie and St Andrew's Hospice which saw the launch of a new service called the Haven service.

Over the next few years significant work will continue around the End of Life Care six outcomes.

**We will achieve our vision by:**

**Communication:** To increase public awareness and provide accessible and sensitive information for people and their carer's, improving sharing of information with partner organisations, professionals, patients and their families.

**Choice and control:** To provide choice to people in both the delivery of care and care environment, supporting people to maintain control of their care and to be involved.

**Consistency:** To provide 24hr equitable access to a range of community services and other resources including, equipment to support people and their carer's when needed, at the end of their life and into their bereavement.

**Carers:** Recognise the important role of the carer and the impact of bereavement upon them. Ensure carers are offered holistic support throughout and beyond.

**Care:** Personalised approach to the delivery of best practice care from an effective and responsive workforce.

**Commissioning:** Smarter more effective and innovative commissioning, which ensures better outcomes for individuals, cost effectiveness and public involvement.

## Domestic and Sexual Violence and Abuse

In North East Lincolnshire the level of need in relation to Domestic Violence and Sexual Violence is significantly higher than in other geographical areas. 32% of violent crime incidents recorded are domestic violence related in North East Lincolnshire, which is 14% above the national average of 18%.

This equates to 3,538 incidents related to Domestic Violence per annum (reported to the Police). We know that women are assaulted on average 35 times before they report to the Police, (British Crime Survey) therefore the actual incidence and prevalence is significantly higher.

The number of rapes reported to police locally in the year 2011 to 2012 was 359.

The effect on children and young people witnessing domestic abuse has far reaching consequence. It impacts negatively on their ability to thrive physically and mentally. Services in North East Lincolnshire are ensuring that everything is done to protect children witnessing domestic abuse and young people in abusive relationships. The Local Authority Domestic Abuse Plan links to the Children and Young People's Plan 2011 to 2014 and its priority outcomes around domestic abuse and neglect.

Domestic Abuse has a considerable impact on the health and well-being of the victim as well as that of their children. The direct and immediate physical effects of domestic abuse can include injuries such as bruises, cuts, broken bones, lost teeth and hair, miscarriage, stillbirth and other complications of pregnancy. Long-term domestic abuse may cause or worsen, chronic health problems of various kinds, including asthma, epilepsy, digestive problems, migraine, hypertension, and skin disorders. Domestic abuse also has an enormous effect on mental health, and may lead to an increased use of alcohol, drugs and other substances.

Tackling this issue which has far reaching impacts on women and children is a priority for joint work in the area, informed by our recent local health needs assessment which will inform commissioning around future services to intervene earlier, prevent harm and reduce health impact.

Our priorities for action will include:

- **Working in Partnership** to ensure the health community is part of the coordinated response to domestic violence and abuse and health needs are represented and addressed
- **Training** our workforce to ensure our response to abuse is best practice and appropriate safeguarding is taking place
- **Recording and Sharing of Information** to allow recognition, early intervention and coordinated response
- **Referral Pathways** are in place to allow signposting of women into appropriate services for care, support and safety
- **Tackling disadvantage** is considered as a central part of any response to domestic violence and abuse
- **Employees** of health agencies are supported with issues of domestic violence and abuse
- **Children and Young People** who are affected by abuse or violence are appropriately safeguarded and supported
- **Ask the question** so that every opportunity is afforded to allow a woman to disclose abuse or violence

These priorities will be set within a framework of Prevention, Provision and Protection linking in to the overall strategy of the “shift to the left” in terms of reducing incidence and need for crisis intervention.

## Improving Quality

### Quality in healthcare provision

Quality, along with innovation and consistency is one of the core principles of NELCCG. The CCG has robust processes in place for managing the quality agenda and driving forward its ambitious agenda for transformational change in delivery of quality and embedding a quality approach to commissioning and delivery of services in all of its activities

To reflect our corporate way of working in “triangles” and the priority placed on quality, we have recently appointed a Clinical Lead for Quality, Governance and Caldicott Guardianship and a lay member to work with our strategic lead for quality and experience.

Our work builds in responses to national trends, policies and reports related to quality, for example:

The Francis report - a stocktake of providers has been undertaken in the last 6 months and this has included a close scrutiny of their actions plans resulting in a good level of assurance that they are fit for purpose.

Our own action plan has been reviewed and has been successfully subject to scrutiny by the East Coast Audit Consortium.

Winterbourne View report – We have implemented a robust internal mechanism to ensure all the recommendations have been considered and actioned. There are now no placements outside North East Lincolnshire.

Berwick Report-our Quality Contract Compliance meeting receives reports from the provider and these are scrutinised and actioned to form part of ongoing commissioning intentions.

### Patient safety

There is a local group which reviews Serious Untoward Incidents (SUIs) monthly in order to identify and address trends in patient safety concerns. All of the SUIs are scrutinised and subject to root cause analysis

Further engagement has taken place with providers to ensure compliance with national reporting requirements and there has been an increase in provider compliance in meeting 9 and 12 week deadlines. The CCG has also commissioned the CSU to undertake external clinical review on the relevant action plans.

## Patient experience

We have set measurable ambitions to reduce poor experience and increase positive experience of care across all of our providers. We are using the levers available through CQUINs to facilitate this

For example, the acute hospital Trust has a CQUIN as follows:

- 90% or more of patients will recommend the Trust to family and friends
- 95% of staff will be satisfied with the quality of the care or service they deliver to each patient/client group.

These indicators are headline indicators, however they form part of a wider suite of information required from providers which give a more holistic picture of improvements in patient experience, including for example outcomes and trends related to complaints.

We have agreed the CQUINS (Commissioning for Quality and Innovation ) payments with local providers for the forthcoming financial year.

In summary these are

- Full delivery and achievement of the national CQUINS for 2014/15
- Full delivery and achievement of “patient experience” CQUIN for 14/15 – particularly in response to the new targets of Friends and Family Tests
- Implementing and full achievement of the dementia screening tool aligned with leadership around dementia
- Implementation of the Sepsis 6 care bundle
- A reduction in the number of pressure sores ( specifically grade 3 and 4)
- Year on year reductions in the number of patients diagnosed with Clostridium difficile
- An audit and linked improvement plans to the quality of discharge letters

In order to ensure focus on current issues, the mechanisms we have established to monitor and review quality will be responsive to emerging issues and take appropriate action as required.

## Compassion in Practice and staff satisfaction

Compassion in Practice is being picked up as part of the Acute Trust Nursing strategy which is based on the 6 Cs and audited internally and by the CCG.

Staff satisfaction reviews are built in to the work around patient experience – amongst other things, staff are asked whether they would recommend their hospital to Friends and Family. Vacancy rates are also monitored as well as actual levels of staffing at ward level compared to recommended levels of staffing

To support the delivery of the quality agenda, a series of commissioner led visits to all providers have been planned in the next two years, these visits are led by a clinician and supported by a lay member who has a specialist interest in the particular area visited. The visits utilise the “15 Steps” approach and are structured in such a way as to be both enquiring and proactive in approach. The commissioner-led visits are a mix of announced and unannounced interactions which help to form a view of quality of care and staff and patient satisfaction levels. Reports of the visits form a key part of our bi monthly Clinical Quality Committee and inform actions related to our quality agenda.

## Safeguarding

There are designated professionals in place for safeguarding for both Children and Adults. These are commissioned in line with local need.

The CCG continues to support the Local Safeguarding Children Board (LSCB) with attendance of the designated professionals, Lead GP and Safeguarding lead and continues to contribute to the running cost of the LSCB. Regular updates are provided on compliance to minimum safeguarding standards. Updates are provided to the LSCB on changes within the health sector. Minimum standards including capacity of designated professionals is monitored closely. It is the intention to continue to sustain the same level of investment of named and designated professionals.

The CCG is actively engaged with the local authority in its work to deliver the prevent agenda, ensuring training of relevant individuals and clear routes for reporting concerns.

## Seven day service clinical standards

Our secondary care has produced a seven day working action plan which will form part of the Service Development Implementation Plan which has been accepted. Progress against this plan will be monitored as part of contract monitoring arrangements and will ensure the Trust stays on track and updates the action plan as necessary. In this way we will ensure that not only will seven day working progress, but relevant clinical standards will be met and maintained.

## Quality in Care homes

A Quality Framework has been developed to drive up quality of care for those residing in local care homes. All homes that we commission with will go through this rigorous process of scrutinising their approach to providing high quality of care for their residents. Following completion of a self-assessment document each home is visited by a Contract Officer who formally verifies and completes the Quality framework. Once all homes have undergone the process, Awards of Gold, Silver and Bronze will be granted with an additional “quality premium” being made to those homes achieving these categories. This scheme will be instrumental in driving up the quality of care afforded to the most vulnerable members of our community, whilst also affording us the opportunity to reshape the market

The overall strategic direction of travel is for high-quality provision within a market which is sized appropriately to respond to differing levels of demand within the context of achievement of the shift to self-care and independent living.

## Key milestones for delivery of transformational change

The overall direction of travel for North East Lincolnshire is clearly set out in the vision and more granular aspirations for areas of care. Detailed plans are in place for initiatives that will deliver specific service changes in the next two years and there are key milestones mapping out further aspirations for delivery in the remaining three years of the plan

Of necessity, these are at a higher level, however they provide a road map towards delivery of the overall picture of transformational change required to achieve realisation of our vision.

As progress is made towards achievement of these milestones and as time progresses, the road map will be further developed and updated.

These milestones are set out at Appendix 2.

## Improving Outcomes

The quality and outcomes measures that the local health and social care community are looking to improve over the next five years are laid out in the table below:

Ambition area	Metric	Proposed attainment by 18/19
1	Potential years of life lost from conditions considered amenable to healthcare	2669.8
2	Health related quality of life for people with long-term conditions	73.2
3	Avoidable emergency admissions – composite measure	1896.0
4	Proportion of older people living independently at home following discharge from hospital	88.4%  This has been set at LA level through the BCF for 2014-15
5	Patient experience of inpatient care	127.3
6	Composite indicator comprised of (i) GP services, (ii) GP Out of Hours	4.9
7	Hospital deaths attributable to problems in care.	Measure Under development. No quantifiable ambition at this stage

Our ‘triangles’ have developed plans for improving outcomes and have been integral to setting the quantifiable ambitions set out in the LIP operational template using local analysis available to them (described below). This has subsequently been signed off at the our Delivery Assurance Committee which includes community and clinician representation.

Our Community Forum (elected members from Accord) have been engaged and involved in setting priorities, co-producing plans and endorsing ambitions for improvement in outcomes

Information was collated from a range of national resources such as the 'Level of Ambition Atlas' as well as local data to support the development of plans and trajectories. Local 'information packs' were produced around each outcome focussing on the definition, national standards, baseline data, historic trends and benchmarking.

The JSNA has informed the Joint Health and Wellbeing Strategy which sets out plans that will contribute to improving outcomes. Much of the JSNA has identified specific cohorts (e.g. patients with certain conditions, living in certain areas registered with particular practices etc.) where we will focus resources in order to improve outcomes for them.

## Health inequalities

The reduction of health inequalities is a key concern in North East Lincolnshire where the gap in life expectancy between the most and least affluent wards is more than 10 years. Working closely with the Public health team in the local authority, we receive regular updates on issues related to health inequalities and incorporate the information into its commissioning plans.

Particular areas for concern in North East Lincolnshire include:

- **Cardiovascular disease-** there has been a big reduction in mortality in the last 20 years but the inequality gap remains, increasing incidence of diabetes
- **Cancer-** survival rates are lower in North East Lincolnshire, there is a wide inequality gap for cancer mortality
- **Smoking-** some of the highest rates of smoking in the country, very high smoking in pregnancy rates, rates falling in younger people
- **Child Health-** some improvements but continuing concerns of low numbers breastfeeding, obesity in reception year children and teenage pregnancy, especially in areas of deprivation

## Equality and Diversity

We are providing local leadership in relation to equality and diversity, bringing together local commissioners and providers to align activities and objectives in response to the Public Sector Equality Duty to deliver optimal benefit to local groups with protected characteristics and tackle recognised health inequalities.

Key pieces of work centre on inequalities related to age, race and disability, with a focus on under fives, over sixty-fives, dementia and access to service for people whose first language is not English.

Our Equality and Diversity Action Plan incorporates and builds on the requirements of EDS2 in order to address local need.

## Contracting

We recognise that in order to progress to an outcome based commissioning organisation the barriers in patients' ability to navigate provider pathways needs to significantly change. We have already through integration with Adult Social care delivered a better ability to manage both a patient's health and social care needs through commissioning appropriate providers, but the next step needs to move the environment further as different providers across acute and community are held accountable for the complete patient journey.

Conflicting organisational requirements can often be at the detriment of the patient as each party tries to solve its own capacity or delivery targets at the expense of somewhere else in the system. This means that overall the patient receives a poorer service as the best and most appropriate support may not be provided as other targets e.g. bed capacity become a priority.

We will be looking to commission services from providers based on pathways and outcomes, such that providers will need to work together through Alliance contacts, joint ventures or risk shares so that the patient and outcomes are managed. Savings to the whole health economy from avoided admissions, early discharge, intermediate care and supported self-care at home can be divided up amongst providers to ensure all benefit from the system wide change.

Individual commissioning by service users under Personal Health Budgets will mean more patients will want to commission services to encompass all stages of their care, and they will not want to have to navigate a multitude of providers to do so. Vertical integration of services is not a necessity as the patients still need choice and efficiencies in the systems still need to be developed but it is envisaged that these contract models will move the ability to manage patients' needs more appropriately in the future.

## Secondary care configuration

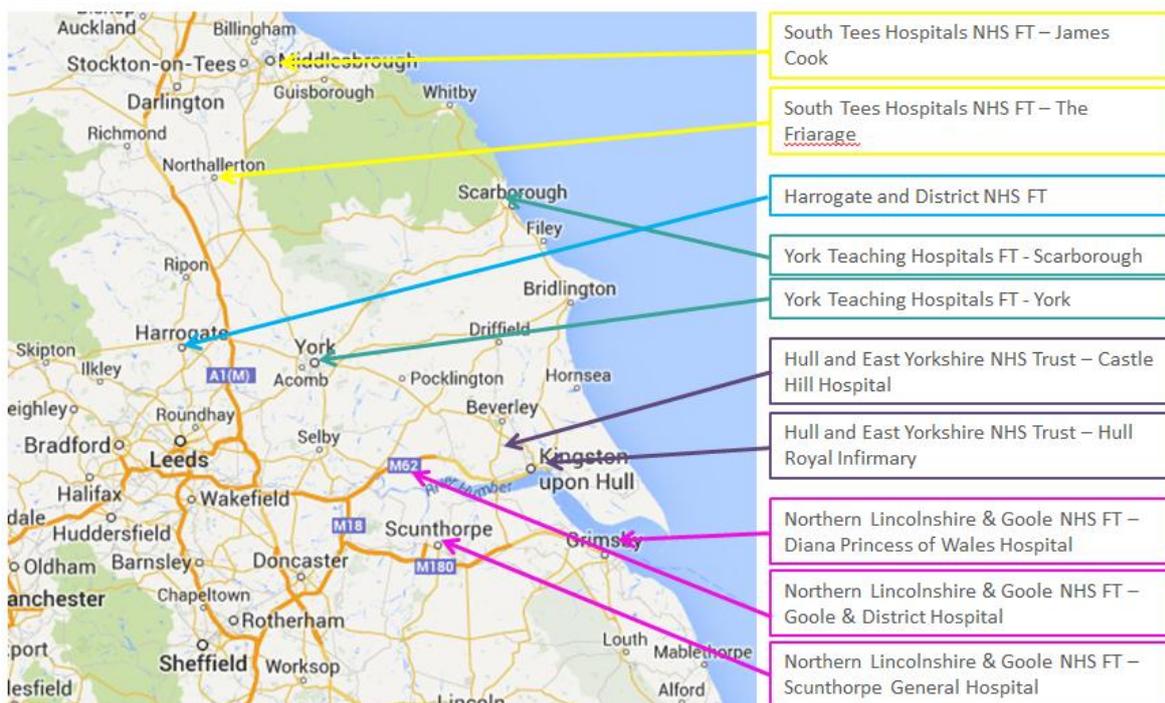
Working in partnership with our local acute provider, Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) as well as Acute trusts further afield, it has been recognised that the current organisational configuration is unsustainable in the long term. Work has already begun to consolidate clinical networks and move towards joint medical appointments across NLAG and Hull and East Yorkshire Trust in order to optimise the attractiveness of roles and therefore aim for the best quality of workforce. This direction of travel will gain pace over the medium term as consolidation of low volume specialist care continues to develop.

## Overview of the Provider Landscape

Hospital services within the North Yorkshire and Humber (NYH) geographical area are provided by five main acute hospital trusts; South Tees Hospitals NHS Foundation Trust (STH), Harrogate and District NHS Foundation Trust (HRD), York Teaching Hospital NHS Foundation Trust (YTH), Hull and East Yorkshire Hospitals NHS Trust (HEY), and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).

Specialised commissioned services are delivered by South Tees FT for the northern population, Hull for the majority of the southern region, with Leeds and York taking cases from the York catchment population. In addition to these main providers some specialist children’s care is commissioned from Sheffield Children’s Hospital.

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



## Hull and East Yorkshire NHS Trust

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

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

## Northern Lincolnshire and Goole NHS Foundation Trust

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

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

## Additional tertiary or specialist services to North East Lincolnshire

Sheffield Children’s NHS Foundation Trust provides specialist children’s services. Outpatient clinics are undertaken by Sheffield Consultants in DPOW and SGH for paediatric surgical and medical specialties. All specialist children’s surgery, surgery for children under the age of 2 and children’s cancer services are provided by Sheffield Children’s NHS Foundation Trust. Neonatal care for babies less than 27 weeks gestation is also provided by Sheffield with plans in place to increase the gestational age for transfer to 28 weeks. Transfers are undertaken by EMBRACE (a specialist paediatric transport service). Leeds Cancer Centre delivers a comprehensive range of treatments, for Leeds, Yorkshire and the North of England.

## Key Principles for acute reconfiguration

As part of the “shift to the left” articulated within the Healthy Lives, Healthy Futures programme reconfiguration of our local secondary care provider’s services and potentially their organisational constructs will be essential.

Reduction in reliance on secondary care enabled by prevention, earlier intervention and more robust care based in the community will result in a sustainable model of health and social care for the area.

The first steps towards this are underway as part of Healthy Lives, Healthy Futures with new models of care proposed for

- Ear, Nose and Throat
- Paediatric Surgery
- Stroke

In the medium term, further more radical shifts in the delivery of secondary care will be considered in conjunction with CCG partners in NYH in order to arrive at the optimal configuration of care for the area.

## Productivity enhancement for elective care

Working in collaboration with local acute providers we will develop a range of initiatives aimed at increasing productivity for elective care by 20%. This productivity gain will be a key element of delivering the requisite efficiency savings associated with Healthy Lives, Healthy Futures and is currently being negotiated with our local provider.

Some of the ways in which we will seek to achieve this productivity gain with them will include:

- Work to re-engineer and streamline pathways of care
- Use of e-consultations to reduce outpatient appointments
- Consideration of different commissioning models for low-risk procedures

## Core enabling themes

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

### Improved Access

- 7 day working and 24/7 access to key services and information is required both in hospital services and primary care/community services (meeting the national standards)
- Single Point Access, and/or Single Point of Contact to support appropriate care navigation where individuals and their families/carers are directed to the most appropriate service at the most appropriate time
- There is a need to increase access to hospice care for all patient groups (e.g. COPD and heart failure patients and other end of life care, not just cancer patients) and to ensure this is available in a timely manner, in order to reduce admission to hospitals (particularly out of hours)

### Focus on Care in the Community

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

### Improved efficiency for support services / Infrastructure and Staffing

- The workforce needs to be supported to work, through training and professional development, in different ways to support the integration agenda: Communication channels between care homes and the wider health and social care community need to be strengthened and improved

- Transport and infrastructure will be a key concern for patients if current service locations are changed, and commissioners will need to work with transport companies to use resources as effectively as possible
- Use of outcome based measurement of care services, rather than process metrics, to ensure that organisations focus on quality of care outcomes rather than timings and volumes.
- IT infrastructure and access to health and social care records must be seamless and timely crossing organisational barriers through the use of technology to ensure better outcomes and efficiencies.

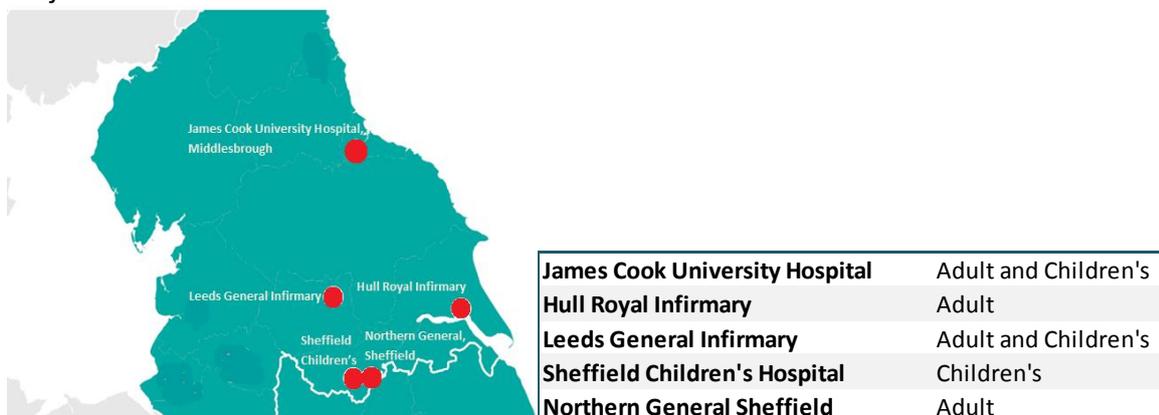
## Specialised Services

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

Recommendations and responses from these reviews have influenced local thinking of commissioners. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

Examples in the North Yorkshire and Humber region of centralised services include major trauma, procedures relating to Primary Percutaneous Coronary Intervention and vascular interventions already commissioned through specialist commissioned services.

Major Trauma Centres in the area are shown below:



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

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

Improvement in technology may also have an impact on how care is delivered. For example most health consultations and diagnosis could be delivered in local primary centres and the home, as modern technology allows specialists to consult virtually from a small number of large specialist hospitals; and better understanding of genetic medicine could result in more tailored personalised care preventing long term health problems.

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

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

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

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

Whole-system changes to existing health and social care services will be required if commissioning intentions and national recommendations are to be implemented. This may include reconfiguration or organisational boundaries.

As the majority of services suitable for centralisation are commissioned by NHS England, Commissioners will need to work closely with the NHS England Specialised Commissioning Team (SCT). The SCT have identified a number of services which have Commissioner Derogation. These are where existing providers are unable to meet the requirements of the

nationally mandated service specification, meaning that CCGs have a responsibility to define the longer term strategic direction of those services, and potentially procure new providers.

Locally the Specialised Commissioning Team is undertaking consultation to establish their five year plan which is due to be published by the end of spring. Within the priorities being consulted on there is focus on the following:

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

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

## Armed Forces

Across NHS England North region, the North Yorkshire and Humber Area Team (AT) directly commission health services for serving personnel in the Armed Forces and their dependents registered with a MoD Defence Medical Service (DMS) Medical Centre. Whilst there is no DMS medical centre in North East Lincolnshire, we will ensure we liaise appropriately with providers to care for veterans living in our area and comply with the requirements of the Armed forces Covenant.

## Enablers

### IM and T

We have a commitment to achieving all the national requirements set out in Everyone Counts with regards to the optimal use of IM and T

By March 2015

- Hospitals should be ready to accept e-referrals
- Patients should have online access to their own health records as held by their GP
- Plans should be in place to link electronic health and social care records, to ensure as complete a record as possible of the care a patient is receiving
- Plans should exist for electronic records to be able to follow individuals to any part of the NHS or Social Care System
- Patients should be able to book GP appointments and order repeat prescriptions online

- Patients should be able to securely communicate electronically with their GP Practice, with the option of e-consultations becoming more widely available
- Routine access to information and advice about the support available, including respite care, for carers of people with long term conditions.

We will make significant progress by 2017 for people with long term conditions to benefit from telehealth and telecare – enabling people to manage and monitor their condition at home and thereby reducing the need for avoidable visits.

By 2018 the NHS should be paperless; meaning that the patient should have complete digital records so their health information can follow them around the health and social care environment.

We will achieve this in utilising a number of approaches

### **Clinical Systems and services**

Practices in North East Lincolnshire use one of two hosted GP Systems; EMIS Web or SystmOne. This will provide a firm foundation on which to build strategies for system integration and development and information sharing.

Delivery of national priorities has continued to progress and we will continue deploying the Summary Care Record (SCR) to provide information on allergies, medications and significant conditions, Electronic Prescribing (EPS2) to enable GPs to supply electronic prescriptions to patient nominated pharmacies and GP2GP to enable the electronic transfer of records between practices.

Significant investment has been made in telehealth equipment for use in patient homes and in nursing and residential homes.

### **Patient and Public Access to Information**

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

The Digitisation Agenda provides significant opportunities to reduce demand for NHS services by providing access to investigation results, pre and post-operative information, self-diagnosis and treatment information for common complaints and symptoms. There are

potentially huge advantages to be gained for providers, commissioners and particularly for the local population, in developing a central patient portal. Whatever approach is taken, it needs to consider future integration with the new “customer service platform” functionality being built by the NHS CB, to enable the public to engage with the NHS to provide feedback about care experiences and book appointments. Wider access to records outside of primary care will be supported by the implementation and integration of electronic patient records managed within an IMT locality programme.

## Clinical Access and Use of Information

Mobile access continues to be problematic due to connectivity issues. Within the CSU’s supported estate, wireless networking continues to be deployed to support real-time access to electronic records.

Both EMIS and TPP have developed a mobile solution which enables a clinician to work offline for scheduling and patient contacts if connectivity is lost.

There is a range of supported devices available to take full advantage of mobile and agile working. Facilities for externally managed devices or “Bring your own device” (BOYD) devices accessing internet services via our wireless are also provided.

## Information Sharing and Integration

There is a need to share information between multiple systems and service providers to facilitate and enable new and improve patient pathways. In addition, the need to work more efficiently is driving healthcare providers to maximise opportunities to improve processes and reduce the administrative “paper chase”.

The Summary Care Record (SCR) is now available for approximately 60% of consenting patients and a requirement for practices to upload their information to the SCR will be included in contracts moving forward. The focus now needs to be on provision of access to the SCR to improve patient experience and care in the relevant settings. There is the potential to exploit this as a vehicle to share information to support the End of Life Care, a local CCG priority.

Due to the accelerated deployment of SystemOne, information sharing is already supporting clinical care across a wide range of services. There is a need to extend this to share information across EMIS Web also.

The Medical Interoperability Gateway (MIG) is a means of sharing information between EMIS and TPP systems. Using the ‘Detailed Care Record’ and with appropriate levels of consent in place, information can be viewed across both systems including GP and community information. An added benefit is that organisations, such as Nursing Homes, can access the clinical record via the internet without having to use either clinical system. There is a cost for usage of the MIG

## Workforce

The workforce implications of the radical shift in delivery of care across our region cannot be underestimated. Future trends and needs in terms of skill mixes, medical, Nursing and community based staff will emerge from the development of new models of care.

In July 2013 all the main secondary providers in Yorkshire and Humber submitted workforce plans to the Local Education and Training Board. This included forecasted establishment and newly qualified numbers, flagging of workforce risks and a narrative with comments from Chief Executives, Nurse/HR/Medical directors.

Providers highlighted a number of risks and issues around:

- *Training/recruitment* in Psychiatry, A and E, GP, Anaesthetics and General Medicine (Consultant level); advanced nurse practitioners
- *Reduction in training numbers* (Surgery Anaesthetics and Core Medicine);
- *Gaps in medical recruitment / rotas* (Acute and Emergency Medicine and medical specialities), leading to *high locum spends*

Workforce plans submitted to Health Education reveals:

- GP workforce: planned training volumes are forecast to enable growth to the GP workforce at 2.7% per annum, compared to the average growth over the past 10 years of 2.1. Providers are projecting a decreased demand for newly qualified GPs. This projection is tangential to CCG concerns around an aging GP workforce across the region. The reduction in training numbers for core medicine may enable to development/uptake of advanced practitioners roles across the region.
- Emergency medicine consultants: sufficient emergency training posts are available, however challenges have been identified in encouraging people to undertake training.
- Consultant grades: there are vacancies in the consultant grade and a relative lack of popularity at recruitment to middle-grade medical training.

## Implications of the Yorkshire and Humber health and social care workforce

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

In order to align 7-day working across primary, community and secondary care there will be the requirement to develop multi-disciplinary teams equipped to support clinical decision

making and to deliver an urgent and emergency care service to match the changing needs of the population. Education portfolios will need to accommodate the delivery of the skills and competencies required to deliver a 7-day service across the sectors.

The risk of the ageing workforce in North East Lincolnshire is a priority issue. Historic difficulties in recruiting and retaining sufficient GPs in the area are likely to require innovative approaches in order to meet need. The extended training time for GPs (approximately 10+ years) adds an extra dimension of complexity. The role of GPs as commissioners needs further exploration. In particular a more thorough understanding of GP business skills, workforce planning capabilities etc needs to be undertaken. This, coupled with more multi-disciplinary approaches to staffing will likely provide the sustainable solution required. An integrated approach to health and social care in the community will also denote that GP practices will need to form partnerships/relationships with social care providers. There are opportunities to develop nurses (or admin/clerical staff) into more business type roles.

There is a large gap in the skills/training/education of social care staff in comparison to health staff. Approximately 40% of social care staff have no qualifications; therefore if social care staff are to reduce unnecessary admissions to hospitals there will be a need to educate/up skill this staff group. Whilst the social care sector has a common induction programme which could be adapted for this reason, the high turnover of staff makes the retention of knowledge/experience less likely.

Two thirds of social care providers are independently run therefore the intentions of such providers may at times be contradictory to the NHS. A culture change will be necessary for any form of integration between health and social care to be successful along with aligning of processes, financial and governance structures.

The move towards an integrated health and social care system may benefit from experiences/learning of multi-agency (or multi-disciplinary) team working within the children's sector. In particular learning from social pedagogical approaches and vulnerable children would be beneficial. A team around the patient approach may be most appropriate, led by a lead-professional (someone with advanced skills across a wide-range of disciplines). Such an approach would require a change of culture, new training/development approaches, rotational training programmes, development of a common induction programme and shared language. Social care workers will need to have basic understanding of health issues and have the confidence to either manage patients directly, or have access to a specialist nurse for referral purposes (either directly or virtually).

The move towards community settings may have an impact on the staffing numbers available for 24/7 staffing and out of hours care. This will have an adverse effect of increasing bank/locum costs in order to meet safe/appropriate staffing levels. To mitigate this risk health staff may be required to work across both community and secondary care settings, possibly on a rotational basis.

The move towards a greater level of self-care, assisted by technology, will require that staff are appropriately trained and have the confidence to use/manage/support the technology. Such skills and abilities could be built into training/CPD programmes for new staff. Existing staff would need to undergo training as appropriate.

There is much work still to be done to better understand and define the required roles, skills and knowledge required to deliver an integrated health and social care workforce of the future. For example there may be opportunities for advanced nurse practitioners (assuming appropriate supply) to undertake tasks traditionally allocated to junior doctors, hence enabling reallocation of time/resources amongst junior doctors in secondary care.

In essence the future workforce of North East Lincolnshire in line with North Yorkshire and Humber needs to be:

- Flexible (both in terms of roles/duties performed and location of service)
- Adaptable (to undertake new/alternative roles across different settings)
- Informed (to either make the right decisions or refer for appropriate advice)
- Resilient (to deal with both the change to working conditions but also culture)
- And supported with appropriate governance structures that enable new ways of working across health and social care without compromising quality of care and patient safety.

## Financial Sustainability

### Outturn

The CCG made a surplus of £6m (3%) in 2013/14. Over the next 3 years the CCG plans to reduce its in year surplus by £4m so that by 2016/17 the surplus will be £2m (1%). The surplus is then planned to be maintained at 1%.

### Reserves

	note	2014/15	2015/16	2016/17	2017/18	2018/19
		£'m	£'m	£'m	£'m	£'m
Contingency (1%)	(1)	1.10	1.13	1.14	1.17	1.21
Better Care Fund	(2)	-	1.00	1.00	1.00	1.00
Activity		0.60	0.60	0.60	0.60	0.60
Legacy e.g. SCG	(3)	0.75	0.75	0.75	0.75	0.75
Prescribing		0.58	0.58	0.58	0.58	0.58
Earmarked Reserve (tariff)	(4)	-	-	3.00	2.50	2.50

(1) The contingency will be used non recurrently in each year to fund pressures that arise in year, with the use of the contingency funding having to be agreed by the Partnership Board

(2) The Better Care Fund; Contingency funding, over and above the Better Care Fund Allocation, to be used non recurrently in year if Better Care Fund schemes do not deliver the level of planned savings

(3) Legacy; To cover any residual risk in relation to Specialised commissioning activity allocation adjustments agreed e.g. HEY, NLAG

(4) Earmarked Reserve (tariff); tariff not as per national planning assumptions in 2016/17 – 2018/19 e.g. provider efficiency requirement less than 4%, NHS pensions pressure.

## Underlying Position Risk

	2014/15	2015/16	2016/17	2017/18	2018/19
	£'m	£'m	£'m	£'m	£'m
Potential risk value	1.61	1.01	1.01	1.01	1.01
Mitigations	1.68	1.37	1.14	1.17	1.21

The total of the reserves and contingency in each of the years exceeds the level of assessed risk. Risk will be monitored closely in year and reported routinely to the Delivery Assurance Committee.

### Key planning assumptions and alignment of plans with providers/key stakeholders

**Tariff;** as per the national planning assumptions.

**Acute activity Growth;** this has been calculated using demographic change weighted by age; alongside a trend analysis of the population going back 5 years. The population was split into age bands and growth was applied to the activity for the age band.

**Continuing Care;** activity has been based on trend analysis over the past couple of years, alongside the average length of stay, starters and leavers.

**Prescribing;** inflation of 4% has been applied alongside an estimate of the year on year activity growth (based on activity trends over the past 2 years)

**Pensions Impact;** The pensions impact of 0.7% in 2015/16 has been built into the plan as a cost pressure. The further 1.4% pension pressure for 2016/17 has been included as a risk when assessing the level of “earmarked reserves” required in 2016/17.

**£5/head (Older Peoples Fund);** £0.8m funding has been ring fenced for this in the 2014/15 plan. We are working with the area team re the implications of the changes in the PMS contract, so as to understand whether the services that supported long term care management that were previously funded as part of the old PMS contract will continue to be funded as part of the new PMS contract. If they are not, then this fund would be used to continue them. If they are, then further schemes would be developed to further support long term care management.

The assumptions used by the CCG for the first 2 years of the plan have been shared with our 3 main providers (NLG, Care Plus Group and NAViGO) via the South Bank Directors of Finance meetings and 121's with the organisations. The longer term vision has been shared as part of the Healthy Lives Healthy Futures work.

### Overview on QIPP schemes and risk to delivery

Plans are well developed for the first 2 years of the plan and schemes will be monitored routinely at the CCGs Delivery and Assurance Committee. The QIPP plans that affect NLAG in 2014/15 have been built into the activity modelling that has been shared with NLAG as part of the 2014/15 contract negotiations and the impact of these schemes has been recognised by NLAG.

Work is on-going to develop the detailed QIPP plans for 2016/17 – 2018/19 and this will be done alongside the Healthy Lives Healthy Futures Programme.

The main risks to delivery of QIPP schemes:-

- Inability to draw down 2014/15 surplus as planned, leading to delays in transformation programme
- Maintaining the financial stability of all providers during the transformation, which will involve significant change across the whole system and involve a number of providers

### Description of plans in place for non-recurrent expenditure

Non recurrent funding (Headroom and brought forward surplus) is to be used to support:-

- Provider sustainability; whilst the transformational changes are taking place
- Healthy Lives Healthy Futures Transformation Fund; double running costs whilst QIPP schemes being rolled out and/or one off costs associated with implementation
- Pump priming of schemes to support ASC/integrated working ahead of 2015/16
- CHC Legacy risk share

Marginal Rate and Re-admissions funding is to be used to support schemes that will reduce the level of emergency admissions e.g. End of Life Palliative Care scheme, Community COPD

## Innovation

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

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

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

- revisit all areas of identified variation and outliers in outcomes (e.g. through QOF and Commissioning for Value analysis) and assess progress with implementing best practice and innovations which are known to have a demonstrable improvement on outcomes (e.g. enhanced recovery programmes; NICE guidelines and quality standards, and TAGs (Comply or Explain regime); WHO Safer Surgery Checklist; Productive services; NHS Quality Improvement programmes)
- assessment of progress with providers adopting the evidenced, high impact innovations and emerging/ early adoption exemplars (e.g. Innovation, Health and Wealth 6 High Impact Innovations and 108 potential high impact innovations; Yorkshire and Humber Area Health and Science Network Improvement Academy high impact innovations in stroke prevention in AF patients and mortality review programme; Anytown Tool)

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

This focus and commitment will require dedicating significant time, leadership and resources in order to make innovation a reality and drive meaningful adoption and diffusion in practice.

The CCG is working closely with its key partners in the national Innovation, Health and Wealth team, the regional Innovation Hub (Medipex), the Academic Health and Science Network (AHSN), the Area Team, the NYHCSU, PHE and the National Institute for Health Research and Development (NIHR) to develop and embed the objectives and best practice outlined in:

- (i.) NHS England Research and Development Strategy (draft) [August 2013], and
- (ii.) NHS England Strengthening Leadership and Accountability for Innovation: A Practical Guide for Governing Bodies and Provider Boards (Innovation Health and Wealth 2013) as follows:

Innovation areas to embed	Actions required:	Tools, resource or partners for support:
<b>Fitness for purpose – OD, culture, staff, tools and resources</b>	<ul style="list-style-type: none"> <li>• Self diagnostics for CCG to identify current clinical and management leaders and innovation strengths and weaknesses</li> <li>• Assess current capacity, infrastructure and effectiveness against each stage of the innovation process</li> <li>• Strengthen leadership and accountability through identification of a lead Director for Innovation to champion and drive innovation, as well as a clinical lead to champion research with regular updates to Governing Body</li> <li>• Access advocacy and external advisors to stimulate and drive</li> <li>• Implement a culture across the CCG that values, supports and incentivises learning from innovation and research</li> </ul>	Innovation Scorecard IHW Commissioning Assembly (clinical leads)
<b>Embedding Innovation in Commissioning</b>	<ul style="list-style-type: none"> <li>• Review and refresh how the innovation cycle can be embedded throughout all structures, staff, processes and programmes of work</li> <li>• Create an end to end system to deliver innovation– designing a defined and co-ordinated approach for embedding innovation</li> <li>• Developing people and their skills, competencies and ability to:               <ul style="list-style-type: none"> <li>○ use tools to understand and evaluate research evidence</li> <li>○ work collaboratively embedding research into practice and service evaluation</li> </ul> </li> <li>• Allocate sufficient resources to both manage the overall innovation system and project management of the innovation work programme (including across relevant multi-disciplinary teams)</li> <li>• Ensure research and innovation is a primary function aligned to patient care and experience and embedded in PMO approach</li> <li>• Identify all relevant partners nationally, regionally</li> </ul>	Innovation expertise from NHS Quality Improvement including NHS Change Model



Innovation areas to embed	Actions required:	Tools, resource or partners for support:
	and locally which can provide support, expertise, tools, learning, engagement and collaboration to help the CCG in embedding innovation and accessing evidence-based practice	
<b>Promotion of research and evidence-based practice</b>	<ul style="list-style-type: none"> <li>• Increasing participation in research through single system of research approvals and costing commercial studies</li> <li>• Work with providers, PHE and other partners to allocate and grow capacity to identify research opportunities and undertake research and evaluation across the whole patient pathway which improve patient outcomes and delivery</li> <li>• Development of a R and D strategy clearly linked to sustainable future health and care model which drives local innovation</li> </ul>	Work with the National Institute for Health Research and Development Committee and local networks to embed research into practice
<b>Access concept development and horizon scan</b>	<ul style="list-style-type: none"> <li>• Support learning from user feedback, incidents, audits and clinical reviews</li> <li>• Ensure patient, carer and staff participation in identifying priorities for research or concept ideas</li> <li>• Ensuring patient participation in all research programmes for which they are eligible/ practicable (this is a national planning objective)</li> <li>• Systematic, continuous and far-reaching horizon-scanning and health and care system scanning to identify innovative new ways of working/ practice for each relevant pathway</li> <li>• Assess each provider in relation to the scale and progress of innovation being undertaken and identify areas where there is a shared agenda and direction</li> <li>• Share local CCGs' ideas, implementation and lessons learnt</li> </ul>	<p>Establish Innovation 'Hub/ Incubator' pilot sites for health and social care staff within organisations to drive concept development (e.g. Hull 2020 Innovation Hub bid to RIF)</p> <p>Assess against Innovation Roadmap</p> <p>Experience-led commissioning</p> <p>PHE (CFV; QOF analysis)</p> <p>Work with NHYCSU</p>
<b>Collaboration and Partnership</b>	<ul style="list-style-type: none"> <li>• Collaborate and co-ordinate with neighbouring CCGs with shared providers/ similar health inequalities/ variations in unmet need and aligned transformational programmes – identify key</li> </ul>	AHSNS Medical Deaneries Universities NYHCSU



Innovation areas to embed	Actions required:	Tools, resource or partners for support:
	<p>opportunities for research topics and innovation than can be explored and resourced collaboratively (e.g. funding opportunities and bids, co-development/testing/evaluation, learning, early use and dissemination)</p> <ul style="list-style-type: none"> <li>• RandD Strategy which is shared, triangulated against other RandD strategies across the NY and Humber CCGs with the support of the NYHCSU</li> <li>• Work with Innovation Hub to enable connecting with academia and industry and facilitate commercialisation including small business research initiatives</li> <li>• Work to build trust between NHS and industry</li> <li>• Forge partnerships with innovative providers</li> </ul>	<p>Regional learning groups</p>
<p><b>Adoption and Diffusion of Innovation (radical/leap innovation or multiple innovations)</b></p>	<ul style="list-style-type: none"> <li>• Strengthen compliance and spread of best practice, especially where mandated and reinvigorate adoption and adaptation of the evidenced high impact innovations</li> <li>• Business Case development for each innovation scheme and Action Planning for implementation with adequate programme management support</li> <li>• Work with AHSN to rapidly advance ideas into practical products and services and speed up adoption into practice and wider uptake at quicker pace and scale</li> <li>• Tools and upskilling for staff to rapidly translate innovation into practice and service developments</li> <li>• Promotion of innovations to 3<sup>rd</sup> parties</li> </ul>	<p>NHS Change Model – Spread of Innovation component (NHS Spread and Adopt tool)</p> <p>Anytown Toolkit</p> <p>CQUINs QIPP Service redesign Contracts</p> <p>IHW Strategy for UK Life Sciences recommendations</p> <p>NICE Implementation Collaborative</p> <p>PRASE – patient reporting and action for a safe environment</p> <p>Interactive learning tools for safety</p>



Innovation areas to embed	Actions required:	Tools, resource or partners for support:
<b>Address Barriers to Success</b>	<ul style="list-style-type: none"> <li>• Fear of change and need to protect status quo;</li> <li>• fear of failure (most innovations have 3-10% success rate)</li> <li>• Entrenched behaviours</li> <li>• Systems barriers</li> <li>• Risk adversity</li> <li>• Lack of ability/ empowerment to drive and deliver change</li> <li>• Professional and organisational resistance/ reluctance</li> <li>• Narrow funding streams</li> <li>• Onerous regulatory and tendering processes – need non-conventional evidence-based methodologies of evaluation</li> <li>• Fragmented procurement leading to marketing delays and exclusion of smaller companies</li> <li>• Chronic lack of implementation experience across the NHS</li> <li>• Fragmentation between NHS organisations</li> <li>• Lack of appropriate incentives</li> <li>• Access expertise in health service improvement and behavioural change</li> </ul>	<p>NHS Technology Adoption Centre</p> <p>Association of Healthcare Industries</p> <p>WSD programme on telehealth – lessons learnt</p>



## Conclusion

This strategic plan sets out bold and challenging ambitions for health and social care in North East Lincolnshire for the next five years.

The challenges facing North East Lincolnshire as a local health and social care economy reflect the national context and picture of responding to the needs a population with increasing demands within a static resource envelope.

Maintaining and increasing quality of care without disproportionate investment is a challenge for commissioner and provider alike and will require best use of all the innovative approaches we can muster, those developed close to home and those adopted from elsewhere.

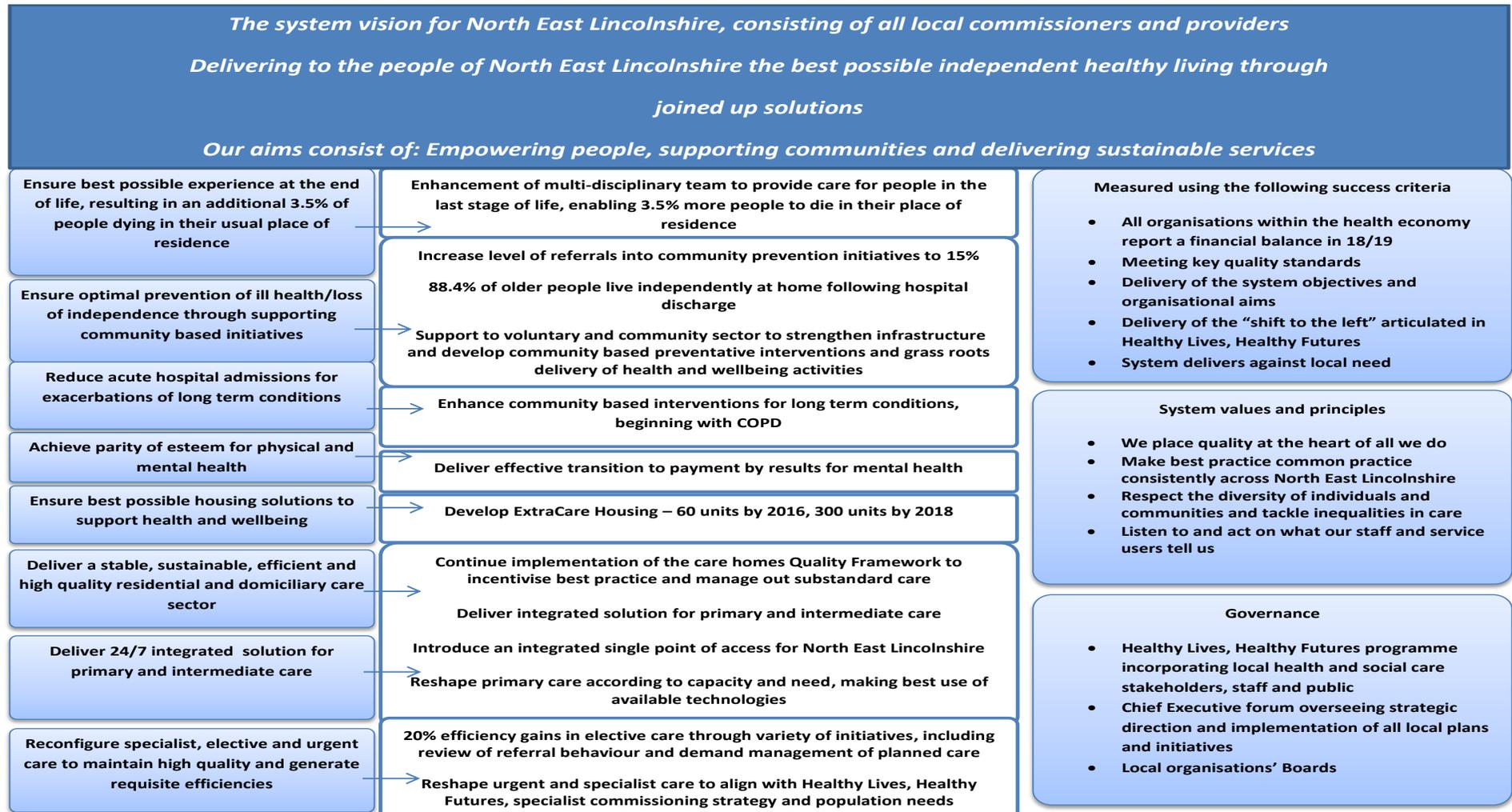
Caring for those with health and social care needs safely, with compassion and in a timely, accessible, affordable way must be the bedrock of our work and must continue unabated during this period of intensive development.

Our transformational change programme, Healthy Lives, Healthy Futures, undertaken in partnership with commissioning colleagues and local providers forms the foundation for our strategic vision and delivery of a radical reshaping of care towards preventing ill health and enabling our citizens to care for themselves appropriately and effectively when they do become unwell.

Self care and independent living is becoming more widely recognised as the aspiration and the necessity for the coming years and our efforts must turn to making this a reality.

Working collaboratively, making use of all available resources and opportunities, we will realise safe, high quality services which are financially sustainable and fit for the future.

## Appendix 1 – Strategic Plan on a Page



## Appendix 2 – Key Milestones to transformational change

Change elements	2014/15	2015/16	2016/17	2017/18	2018/19
Healthy Lives, Healthy Futures	<p>Undertake formal consultation in relation to</p> <ul style="list-style-type: none"> <li>• Hyper Acute Stroke</li> <li>• ENT</li> </ul> <p>Refresh and reboot programme objectives and arrangements</p> <p>Identify second round of service changes</p>	<p>Implement first round of service changes</p> <p>Undertake any necessary communications, engagement and consultation in relation to second round of service changes</p>	<p>Implement second round of service changes and identify residual service change requirements</p>	<p>Continue implementation of service change</p>	<p>Continue implementation of service change to deliver the shift to the left</p>
Service redesign	<p>Review and reframe model of urgent and intermediate care</p> <p>Commission and implement an integrated single point of access</p> <p>Design new model of primary care (to include pharmacy and eye health providers)</p> <p>Continue to retract and reshape the market for residential and domiciliary care</p> <p>Deliver 7 day services</p>	<p>Implement new model of urgent and intermediate care</p> <p>Design further service changes focussed in planned care</p> <p>Establish and implement new model of primary care</p> <p>Continue to retract and reshape the market for residential and domiciliary care</p>	<p>Transformation of services in planned care, supporting reduced demand in urgent and intermediate care</p> <p>Continue to retract and reshape the market for residential and domiciliary care</p>	<p>Optimal market for specialist residential and domiciliary care</p>	

Change elements	2014/15	2015/16	2016/17	2017/18	2018/19
	<p>Deliver first ExtraCare Housing scheme (60 units)</p> <p>Establish first round of initiatives linked to self care and independent living</p>	<p>Continued development of ECH schemes</p> <p>Continue implementation of initiatives for self-care and independent living</p>	Continued development of ECH schemes	Continued development of ECH schemes	<p>Finalise delivery of ExtraCare Housing (300 units)</p> <p>Public expectation shifted to include more self care and independent living</p>
IM and T	<p>Establish and implement e-referral</p> <p>Establish and implement e-consults in 4 key specialties</p> <p>Pilot Visimeet/Skype delivery of GP consultations in patients' own homes</p> <p>Implement consistent access to appointments online in primary care</p>	<p>Enable mobile working across a range of service teams</p> <p>Expansion and rollout of mechanisms for non face to face consultations</p>		Delivery of paperless working across the health and care system	
Innovation	<p>Continue to deploy service improvements linked to Digital First</p> <p>Continue to deliver progress against Innovation, Health and Wealth</p>	<p>Continue to embed locally grown and adopted innovation in commissioning practice</p> <p>Embed telehealth and telemonitoring solutions to a variety of pathways</p>	Integrate emerging innovations into onward planning		New health and care system incorporates a range of pioneering solutions to delivery of health and care

