North East Lincolnshire CCG Operational Plan Narrative

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# Introduction

During 2016/17 North East Lincolnshire CCG has made some significant strides forward in relation to a number of areas of service delivery and continues to provide an exemplar model in others. Our work in relation to supporting people with Learning Disabilities is leading the way in the field, with community based care in the locality being the standard operating approach for everyone.

We have also made inroads into the level of non-elective activity, meeting our ambitions for the locality in relation to reductions in non-elective admissions – we are bucking the trend in comparison with our neighbours within the STP area.

We are also making inroads into activity levels as a result of the demand management initiatives we have undertaken – we have the lowest level of referrals in our peer group and have reduced variation across GP practices in referrals. Our community Cardiology service is beginning to take effect and will continue to have impact next year. All of this is reflected in our agreed plans to recover our RTT position, which has been challenging this year.

Equally, there have been challenges related to performance around A and E, reflecting the challenges experienced by our key local provider, NLaG. Following close working together a plan has been put in place to recover the position during 2017/18.

We are proud to be able to say that we are forecasting to achieve financial balance over the next two financial years.

Our work as part of the National Diabetes Prevention Programme is leading the way in this area, with courses targeting patients identified as at risk of developing the disease.

# STP and Operational Plan Links

The Humber Coast and Vale Sustainability and Transformation Plan links closely to the NELCCG Operational plan – these links are outlined more specifically in the section below related to the Nine Must Dos and STP priorities

NELCCG is fully engaged in the development and delivery process for the STP and progressing initiatives which align to the overarching STP priorities.

***Helping People Stay Well*** – NELCCG is working closely with Public Health in NELC on smoking cessation, introducing a structured approach to Social Prescribing, implementing care navigation in primary care, and continuing our community based approach to falls prevention – for example included in our activity modelling are 50 fewer emergency spells related to fractured neck of femur.

We are also undertaking pioneering work in relation to Diabetes prevention.

NEL is one of the first 27 areas across the country to provide the National Diabetes Prevention Programme (Healthier You) aimed at supporting at risk patients, through an evidence-based behaviour change programme to reduce their risk of diabetes.

***Place based care*** – Work is ongoing to refocus primary care activity towards urgent care as well as reducing demand by enabling patients to access alternatives such as community pharmacy through a minor ailments scheme. In addition to this, work is ongoing with a focus on a primary care long term conditions model – reductions in A and E attendances and admissions have been factored into our modelling for activity reduction. Alongside our work to support care homes and the out of hospital urgent care model, we are looking to achieve a 6% reduction in non-elective admissions.

***Creating the best Hospital Care***

Detailed work is ongoing with NLaG to explore service change across Northern Lincolnshire. The recent clinical options event undertaken as part of the Healthy Lives, Healthy Futures programme was part of this process.

***Supporting People with Mental Health problems***

We are actively engaged with our local commissioner colleagues and providers to ensure that we are developing effective prevention and primary intervention services to enable our populations to maintain a good level of mental wellbeing. To this end our commissioning focus will be on community based services with a particular emphasis on reaching out to Black and Minority Ethnic groups to encourage appropriate take up of services.

***Strategic Commissioning***

We are actively engaged with commissioners across the HCV geographical area on planning for “at scale” commissioning particularly for specialties which struggle to recruit sufficient numbers of clinical staff for smaller patches. Priority areas are Dermatology and Ophthalmology – our activity planning reflects the need to rectify current problems with these specialties and deal with recent backlogs.

***Helping People through Cancer***

Significant work has been undertaken to align with STP priorities in relation to early identification of cancers and in particular with relation to waiting times our plans take us towards achievement of national standards with the relevant levels of activity built into our plans.

# Nine Must Dos

## 1. STPs

NELCCG is fully engaged in the STP planning process and has put in place internal mechanisms for ensuring that STP milestones will be met.

The CCG is linked into all of the work stream initiatives outlined in the STP and the relevant actions linked to NELCCG are incorporated into our operational plan

For Example;

***Helping people stay well*** – NELCCG is linked into the development of the Phase 1 programme led by Public Health

***Place based Care*** – Primary care redesign is described in our primary care forward view submission and is actively underway

Pathway redesign regards elective and complex discharge – this is being addressed through our planned care work and urgent care pathway redesign

Social prescribing and community navigation – our social prescribing arrangements are well advanced and due for implementation early in the new financial year. Community navigation plans are incorporated in our approach to primary care

Work to implement the electronic care record is well advanced

NELCCG is fully engaged in the Multi-disciplinary locality team framework design and care market capacity reviews

***Creating the best hospital care*** – NELCCG is actively involved in the review and options appraisals related to acute care and is leading work on Urgent and Emergency care in preparation for roll out from April 2017

***Supporting people with Mental health problems*** – NELCCG is actively engaged in the development of HCV shared standards

***Strategic Commissioning*** – NELCCG is actively involved in the planned strategic review

***Helping people through cancer*** – detailed work is already underway to focus on the 62 day target for lung cancer and improve the pathway and diagnostic model. This builds on the strong position we already hold with relation to waiting times and the performance already achieved in relation to early identification.

## 2. Finance

The CCG plan is built up from the 16/17 FOT and the recurrent impact of any non-recurrent actions agreed for managing the 16/17 position have been fully taken into account.  The CCG has a planned break-even position against its in-year allocation, and achievement of its control total in both 17/18 and 18/19. Alongside this the CCG is working with other CCGs, local authorities and NHS Providers in the Humber Coast and Vale STP to support the delivery of the local system financial control total. This builds on the work that we have been doing in Northern Lincolnshire over the past couple of years as part of Healthy Lives Healthy Futures and the Northern Lincolnshire Community Finance Plan.

The transformation (QIPP) schemes included in the CCG’s plan, build on the schemes started in 16/17 designed to reduce non elective activity. These schemes were all part of Healthy Lives Healthy Futures and are planned to be rolled out/fully implemented over the next two years, and have been developed using benchmarking information. These schemes are all reflected in the Humber Coast Vale STP plan.

All of these demand management measures have been taken into account in relation to our financial planning and are described in more detail throughout this document

All of these considerations form part of ongoing discussions with providers to ensure efficiency targets are met

Activity Plans have been developed in conjunction with our main provider and NL CCG, to ensure a consistency of approach. This work has been done alongside the financial modelling and capacity planning modelling (being done within NLAG). By adopting this approach it will enable the local health community to understand the deliverability and affordability of the plans.

Further detailed Finance queries are described at Annexe 1

## 3. Primary care

Our plans for delivering the necessary transformation in primary care were submitted as requested. They have been included here for completeness and ease of reference

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## 4. Urgent and emergency care

The A&E Delivery Board is making positive progress on a substantial and effective implementation of the mandated “must do’s” and the Rapid Implementation Guidance(RIG) and this is aligned with the longer term transformational plans being implemented through the local delivery arrangements.

Priorities for implementation of the RIG include:

* Ambulatory Care Unit
* Mental Health Liaison in A and E
* SAFER bundle
* Estimated Date of Discharge/Clinical Criteria for Discharge
* Discharge to Assess
* Step Down capacity

Whilst the value of these initiatives is clearly recognised it is also clear that there are operational issues within the acute provider that have a fundamental impact on recovery of A and E performance. To this end notification of performance concerns are being raised through the NLaG Contract Board to ensure that there is an operational action plan in place that supports A and E improvement in line with the trajectory stated that plans for recovery to the 95% standard by April 2018. The Delivery Board expects pressures through the remaining winter months to impact on this recovery trajectory and to that end has been active in securing a range of additional capacity and/or organisational arrangements to support system-wide pressure management.

These include:

* Additional GP Out of Hours capacity on 3 bank holidays.
* Seek assurance on Bank Holiday therapy capacity.
* Additional Rapid Response in A and E to support GPs over longer hours
* Implement winter Patient Transport Service vehicle
* Implement additional Domiciliary Care Provision
* Discussions with LIVES Community First Response service on community responsiveness and reducing avoidable conveyance.
* Agreed to fund Mental Health liaison post in A and E until end Mar with recurrent funding agreement thereafter.
* Agreed to commission additional block of nursing home beds to support step down arrangements
* Escalation protocol agreed with YAS 111 as per normal annual approach.

The delivery of the four hour A and E standard and ambulance response times will be through a combination of CCG led contract forum action plans with individual providers, through the leadership of the A and E Delivery Board which includes the implementation of the 5 elements of the A and E Improvement Plan and through the on-going ownership and development of elements of the urgent care system by the emerging Accountable Care Partnership. All elements are seen as vital in order that specific operational issues are addressed along with the necessity for best practice to be embedded across the urgent and emergency care system as well as the imperative to implement transformation plans. The recovery of the acute trust performance for 4 hour waits has a trajectory that meets the standard in April 2018.

Through the contract forum, the acute trust must meet the stated milestones in implementing the four priority standards for seven day hospital services. For 2016/17, the implementation of these 4 standards has been the subject of a Service Development Improvement Program (SDIP) which includes meeting the national milestones for self-assessment against the 4 standards and monitored for assurance through the contract process. For 2016/17 the implementation will be part of a full contractual obligation. Progress at the end of 2016/17 will be subject to detailed scrutiny and subsequent action planning. The STP plans and Urgent and Emergency Care Network priorities includes these 4 standards and the three acute trusts within the STP and Urgent and Emergency Care Network will be further subject to the scrutiny of these groups in the implementation progress.

The delivery of a 24/7 integrated care service for physical and mental health will be through a combination of the work of local transformation plans linked to the work plan of the Urgent and Emergency Care Network. With NEL chairing the Humber, Coast and Vale Urgent and Emergency Care Network and NEL CCG being part of the collaborative commissioning arrangements for future 111 services, NEL will build on local integration progress and connect to the functions and services that are available on a STP/Urgent and Emergency Care Network footprint. The local transformation plans are being focused through the work of the developing Accountable Care Partnership (ACP), focusing on the Urgent Care response via telephone advice services, through further development of the capability of the Primary Care/Community presence with existing A and E services and the further development of the Community Urgent Care Response. Improvements to the capacity and capability of the hospital and community discharge processes are also an essential focus to ensure patient flow measures are optimized. The work program of the ACP is aligned with the Rapid Implementation Guidance work plan of the recently formed A and E Delivery Board – the latter being work that will continue to develop under the ACP. Clinical Hub developments are progressing in the West Yorkshire vanguard scheme and other members of the Humber Coast and Vale Urgent and Emergency Care Network are working to establish arrangements with this Clinical Hub service and on how this fits with local developments where single points of contact exist within localities.

NEL CCG has been engaged with EMAS on their Pathfinder programme that was established to determine where there was potential for an alternative to conveyance – either in place or as a potential service development. A number of priorities emerged that are in line with the CCG’s analysis of conveyance avoidance and these are conveyance from Care Homes, Falls and COPD exacerbations. Whilst EMAS recognise there are workforce issues to address in the assessment of risk and conveyance, there is a clear need for community service rapid response. The following have been identified as key mechanisms to support the reduction in avoidable conveyance:-

• Access to GP/Senior Clinical decision maker in NEL SPA who can access care records

• Support to Care Homes initiative which includes an outcome to reduce 999 calls

• Further development of the Community Urgent Care Response to patient home and Care homes to provide a rapid appropriate alternative to conveyance

We are working with our mental health providers to meet the new targets in partnership with our acute care. The providers have a national CQUIN this year and we are reviewing our crisis pathway in line with the new targets and the Mental health 5 year forward view to ensure parity of esteem across the crisis care for mental health is achieved.

Further investment has been made to help move towards the delivery of the CORE standard for crisis in mental health.

##  5. Referral to treatment times and elective care

The CCG’s performance at the end of November for RTT is set out by specialty in the table below. This position is 2.6% below that at the end of October and has been deteriorating over the last 18 months. Northern Lincolnshire & Goole Foundation Trust (NLAG) have recently sought support from the national Intensive Support Team (IST) who have been working with the trust on their data and have identified critical data quality issues that are likely to lead to a worsening position being reported once these have been quantified.

The trust is currently identifying ENT, Urology, Colorectal, General Surgery and Orthopaedics as where they have significant pressures.

* Orthopaedics is a specific short term gap on upper limb at Grimsby and lower limb at Scunthorpe which could be outsourced immediately if a provider was available.
* Urology is more challenging due to the proportion of cancer referrals but options are being discussed.
* The major issue around ENT relates to outpatient first attendances with 1,700 waiting for a routine appointment and 351 waiting over 18 weeks.

Given these pressures the CCG has developed an action plan to support recovery of the RTT position mainly focussed on sourcing additional capacity with alternative providers. Although there is also work on-going to help manage referral demand,the CCG is successful in having a referral rate within the lowest quartile of CCGs nationally as well as a year on year growth rate in 2016-17 which is much lower than that seen across the region and England.

A combination of these actions as well as the capacity these will free up within NLAG is anticipated to recover the position by March 2018 where the CCG’s performance is back above 92% as per the final column in the table below.

|  |  |  |
| --- | --- | --- |
| **Specialty****(bold = below 92% national standard)** | **Current Performance** | **Forecast performance – March 2018** |
| **Proportion of people waiting over 18 weeks** | **National Centile****(1% = best, 100% = worst)** |
| **Cardiothoracic Surgery** | **100.0%** | **1%** | **100.0%** |
| **Geriatric Medicine** | **100.0%** | **1%** | **100.0%** |
| **Gynaecology** | **98.7%** | **2%** | **98.9%** |
| **Rheumatology** | **96.3%** | **33%** | **96.3%** |
| **General Medicine** | **93.0%** | **61%** | **93.0%** |
| **Neurology** | **92.8%** | **42%** | **92.8%** |
| **Trauma & Orthopaedics** | **92.1%** | **27%** | **96.0%** |
| **Gastroenterology** | **89.1%** | **49%** | **89.8%** |
| **Plastic Surgery** | **87.0%** | **47%** | **92.0%** |
| **Thoracic Medicine** | **85.3%** | **88%** | **90.3%** |
| **Cardiology** | **85.3%** | **81%** | **90.3%** |
| **Urology** | **84.6%** | **91%** | **90.4%** |
| **Neurosurgery** | **83.3%** | **23%** | **92.0%** |
| **Dermatology** | **82.1%** | **97%** | **92.0%** |
| **Other** | **81.0%** | **97%** | **92.2%** |
| **General Surgery** | **77.3%** | **94%** | **92.0%** |
| **ENT** | **69.0%** | **99%** | **84.6%** |
| **Ophthalmology** | **66.2%** | **100%** | **94.5%** |
| **Total** | **80.3%** | **97%** | **92.1%** |

NB As a minimum we will be expecting no deterioration from current position where targets have not yet been met

The following are the key areas that are expected to have greatest impact on improving RTT performance.

* Additional activity is being commissioned from St Hugh’s Hospital which will increase their referral capacity by 43% compared to the most recent 12 months. This activity will be focused on many of the specialties currently underperforming (Ophthalmology, Orthopaedics, ENT, Dermatology & General Surgery)
* Commissioning new provider for Ophthalmology who will take new referrals
* NLAG sub-contracting provider of Ophthalmology services
* New provider of Dermatology services starting in April

We have adopted a number of approaches from the Demand Management Good Practice guide to ensure sustained delivery, including:

* NEL CCG and NL CCG have undertaken a joint procurement for a community dermatology service. The service specification details the need for the new provider to up-skill GPs to manage patients in primary care (if appropriate) with the aid of teledermatology thus reducing the level of first outpatient appointments and subsequent follow ups
* The CCG is planning to undertake a peer review to ascertain which specialities have high rates of consultant to consultant referrals.
* The local General Practice Quality Scheme has a focus on reducing variation in referrals across NEL CCG practices. Each practice has an individual target rate to achieve, which, if delivered, will realise a 5% reduction in GP referrals.

There are 2 key challenges to achieve 100% of e-referrals; availability of appointments at the main provider and confidence in the administration systems.

**Capacity Plan**

The provider has a capacity management plan in place. In addition the number of appointments requiring to be published by the provider, on a monthly basis, in order to create adequate capacity for GP’s to book has been identified. The lowest performing specialties will be targeted as the priorities.

**Process Review**

The provider has recently introduced a central referral gateway, to ensure that all referrals are received and managed consistently.

A communication has been shared with GPs and practices advising of the new process, and the plan to increase capacity across specific specialties, and to emphasis that all referrals are to be made using e-RS as the default.

Referral templates have been reviewed and standardized across all services and these have been configured on Primary Care Clinical Systems, and can be prepopulated with data to reduce variation, ensure completeness of information and simplify the process for referrers.

The provider is reviewing their internal processes for publishing slots and booking from the “defer to provider” list.

The providers are working with NHS Digital to develop integration between e-RS and their EPR to streamline internal processes.

There are plans in place to re-establish an e-RS operational group across primary and secondary care to enable issues to be discussed and resolved in an open forum, this will involve representation from NHS Digital to access examples of good practice and advice.

e-RS is regular discussed at practice manager meetings and utilization rates are shared to encourage “friendly” competition (although capacity is the main obstacle rather than the processes in place at the practice)

The CCG is working closely with its main acute provider (NLaG) to review pathways and processes with a view to achieving an average first to follow up ratio of 1:1.6 (currently 1:2.2) across specialities. 3 specialities have been chosen to review – urology/cardiology/rheumatology

NLaG will work with the CCG in 2017 to determine which specialities could be managed in primary care

In order to achieve the Better Births ambitions, The National Maternity Transformation Programme Board will support and scrutinise how we, as local commissioners with our providers, come together to enact delivery. In some cases this will be done at place / CCG level whilst other ambitions can only be achieved across our wider Sustainability and Transformation Plan footprint, Humber Coast and Vale.

The overarching aim of Better Births is to improve the outcomes for mother and her baby, as such four measures have been included in our CCG Improvement and assessment framework: These are Neonatal mortality and stillbirths, Maternal smoking (at time of delivery), Women’s experience of maternity services and Choice in maternity services

Seven Early Adopter STP sites have been selected to trial innovative approaches to achieve the vision set out in Better Births, the learning from these will inform the future of maternity care within North East Lincolnshire.

Working across the whole of Northern Lincolnshire (NELCCG, NLCCG and NLaG NHS FT) we have developed an action plan to oversee our progress against the recommendations of Better Births, this is monitored on a monthly basis by the Northern Lincolnshire Maternity Commissioners Forum and additionally by Northern Lincolnshire Maternity Partnership Board; This will, in turn, feed into the emerging local maternity system across our STP footprint so that patients experience a consistent level of care no matter where they choose to access services.

## 6. Cancer

The Cancer Alliance will be acting as the delivery arm of the STP Cancer Plan. The cancer element of the STP plan is aligned to delivery of the cancer taskforce recommendations. An initial piece of work reviewing the STP cancer work plan against the 96 recommendations has been undertaken and is attached for information.

The NEL CCG cancer service lead and GP clinical lead is represented on the Cancer Alliance Board and will actively work together across organisations to implement the Cancer Task Force Recommendations.

The STP cancer plan also contains potential for simplified arrangements between providers and commissioners.

The Northern Lincolnshire (NEL and NL CCGs) multi agency Cancer Locality Group (chaired by the GP clinical lead) will update its existing work plan to ensure it underpins the STP priorities and delivers at North and North East Lincolnshire level.

The cancer work stream of the STP is working together with the acute and specialist work stream re diagnostics. Initially providers are tasked with undertaking demand and capacity reviews and these are underway. They are also advising of estimated gaps in kit such as CT and MRI for the next 5 to 10 years so that the capital and estate impact can be quantified. As part of this we will also be looking at GP direct access.

There is a Yorkshire and Humber intention to procure a PAC system that will initially support shared viewing of images and later potentially, also shared capacity for diagnostics and reporting. The Humber, Coast and Vale providers are linked into this. A decision will need to be made regarding whether this system is best used Yorkshire and Humber wide or on Humber Coast and Vale footprints.

The providers are looking to develop an alliance, sharing diagnostic capacity and saving on the cost of outsourcing. We will be looking to design a new model of sustainable diagnostics and the solution to this will need to fit urgent and emergency care ambitions as well as with any redesign that results from the acute and specialist work stream.

The 62 day cancer standard has not been consistently met during 2016, however we are looking for sustained improvement from Quarter 3 and our local provider has in place a Cancer Delivery Plan to address this which the CCG monitors through existing performance mechanisms. This will be a standing item at the cancer locality group.

We work with our local provider to monitor Somerset data on a monthly basis and every reason for delay in 31/62 day pathway is detailed and discussed to see what improvements can be made.

We have an agreed provider IPT policy in place that will support the identification and removal of barriers to achieving 62 days. Additionally, the pathways work (including lung) and the high value pathways work across Yorkshire and the Humber should support streamlining of pathways and adherence to best practice, enabling patients to move more effectively through the system.

A piece of work reviewing current achievement against 28 day diagnosis has been undertaken and actions required as a result of this will be identified through the cancer STP work stream and taken forward.

In addition to the diagnostic program of work mentioned above which will increase the capacity within diagnostics to support earlier diagnosis, other work includes:

The work of the lung element of the cancer STP aims to increase the proportion of lung cancers diagnosed at Stage 1 and 2 and to match the current best in England. Similarly, we would hope that further work on the high value pathways across Yorkshire and Humber will drive improvements in early diagnosis, (through reviewing the place of diagnostics in each pathway) quality of care and consequently survival rates.

We will continue to support primary care to refer suspected cancers cases early via the 2 week wait system through the use of site specific 2 week wait forms (developed by our Cancer Clinical leads and provider colleagues).

Our GP clinical lead and Cancer Research UK facilitator have provided GP training in cancer related issues via the GP Educational Development forum.

Cancer Practice Profiles are reviewed and our GP Cancer Clinical lead discusses performance/offers advice at 1:1 meetings with practices and will continue to monitor for improvement.

All GPs are able to access cancer related information via a cancer specific portal.

We will continue to support our Cancer Collaborative and work with CRUK to develop community champions that can increase public awareness of signs and symptoms of cancer and the need to present early.

The STP plan contains the intention for implementation of risk stratified pathways for breast, prostate and colorectal patients. This is being taken forward by the Northern Lincolnshire Macmillan Recovery Project with progress monitored through the project steering group. The team also has strong links with the HCV wide Living with and Beyond Program and is awaiting the recommendations of the Yorkshire and Humber colorectal group regarding risk stratification for those patients.

The STP section on digital enablers contains the need for sharing information on holistic need and treatment summaries. The ambition is to make the recovery package available to all people living with and beyond in 2017/18. A baseline assessment of what is in place across the region is being undertaken by the network. There are both CCG and STP level groups in place to support advancement of this agenda.

The Northern Lincolnshire Recovery Package is rolling out the use of holistic needs assessment in each MDT from November – this includes assessment after initial diagnosis and also 6-12 months diagnosis. The roll out of treatment summaries has also commenced.

In terms of cancer care reviews, we have developed a task and finish group (led by our cancer clinical lead GP) with representation from primary and secondary care to drive this forward and are reviewing the connections that need to be made through primary and secondary care. The task and finish group will continue until the system is in place.

## 7. Mental Health

Access to IAPT to at least 19% will be a challenge. It will require additional staffing, which is expected to be funded through additional monies identified for supporting this aspect of the MH5YFV and the GP 5YFV, which defines IAPT workers as more engaged at primary care level. Development of additional capacity within our already accredited service which will be based in primary care will contribute in part towards this target.

In order to improve the experience and access to children and adolescent mental health services we have undertaken workforce development and increased public awareness of the service. This will be supported by the development of guidance and assessment function of the Families First Access Point across universal – tier 2 pathways. In addition the implementation of an enhanced Early Help Model for social, emotional and behavioral support will be undertaken. Models of resilience are also being built in for children and young people and we will be implementing a revised consultation model to support universal services. Bespoke interagency models are being developed to access the most vulnerable groups. An evaluation program of the community eating disorder service will be taking place. The up-skilling programme of the current workforce across universal targeted and specialist services will be completed. This will enable us to achieve the ambition of at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019. NEL is signed up to a CYP IAPT area and training has commenced

Continued monitoring of this standard and ensuring awareness of the priority, and enabling further support to the local model through flexibilities in future funding negotiations

Individual Placement and support to engage in employment is currently offered through Tukes which offers a range of interventions, training, and support. This includes enabling new opportunities through a Garden Centre and Nursery to add to the profile of catering, cleaning, and home improvement opportunities. Developments in the Hope Court rehabilitation model sees the therapy model support people under their care to access voluntary and employment opportunities in charity and other sectors including retail, which is expected to contribute to improvement. Other opportunities are being explored to further ensure 25% increase by April 2019.

Our local provider, Leeds Partnership Foundation Trust has a community eating disorder service which NEL CAMHS can access through spot purchasing arrangements. NEL incidences of Eating Disorders remain very low.

We are currently working with our local Public Health team to re-visit the local Suicide Prevention Plan, building on priorities set out in the ‘National Suicide Prevention Strategy’ and existing and emerging evidence around suicide such as from the ‘National Confidential Inquiry into Suicide and Homicide by People with Mental Illness’.

For Adult Mental Health - Ensuring access to Crisis Response and Home Treatment Team and Liaison function to ensure standard will be reached consistently will require significant additional resource and re-working of pathway and service model. Whilst some additional funding is expected through investment in MH at STP level, this is unlikely to be sufficient allocation in real terms locally

The delivery of the Mental Health Investment Standard is a high priority for NELCCG. The investment plan sets out how this is to be achieved.

The dementia diagnosis rate for North East Lincolnshire at the end of September 2016 was 72.4%; this is higher than both the requirement of 66.7% and the national rate of 67.5% at the end of the same period. The local dementia steering group put together a new dementia clinical pathway – this was designed to be compliant with all required legislation, and to simplify the referral process from within the pathway and has been recently implemented.

Currently out of area placements for acute mentally ill adults only occur for specialist placements (eg. PICU). For adults with organic illness, such as dementia, placed on acute wards out of area, NELCCG is developing a plan in partnership with NAViGO to modify existing pathway and skills within care home market provision, and to explore potentials to increase availability of ‘acute dementia beds’ within local footprints.

We have a clear action plan to reduce our out of area placements for non-acute specialist care over the next 6 /12 months by 50% and we will be achieving this with the development of a locked rehab unit and a new supported living service which will be a step down for people within a rehab unit

From the 1st December 2016 we have commissioned another acute bed for older people based on the last year’s activity, the CCG feels confident that this will reduce out of area placements for older people who require acute care.

## 8. People with Learning Disabilities

NELCCG is an integrated commissioner of Health and Adult Social Care, enabling an enhanced level of community provision. This has seen the development of a predominantly Supported Living model for people with LD, underpinned by Personal Budgets and Person Centred Planning. Never having had acute LD facilities, people with acute high level of need are necessarily placed out of area, with subsequent challenges in returning back to area. The Out of Area Care Coordinator is most beneficial in enabling this. NELCCG is part of Humber Transforming Care Plan. The primary focus for NELCCG from Humber TCP is the development of acute specialist provision that is responsive to need.

NELCCG already has low LD in-patient bed use due to its community model. The TCP plan has identified the number of people NEL will support to community placement, and NELCCG is monitoring these cases closely. For those that are able to return to community, individual plans are developed and needs mapped in consideration of time to support people to ‘get to the point of discharge’. NELCCG is within agreed parameters in achieving this target

We are working with partners to review the commissioning and provision of health checks for people with learning disabilities with the aim of ensuring that take up is improved by 2020.

We have developed an accessible information approach for vulnerable people, and have worked with our main providers to gain assurance.  We will continue to ensure via contract monitoring assurance that reasonable adjustments are made. As part of the learning disability mortality review we will ensure that all reviews are held and any practice issues raised will be addressed.

Further detail on the Humber Transforming Care Plan can be found at

<http://www.hullccg.nhs.uk/pages/transforming-care-partnership-learning-disability-vision-and-plan-2016-19>

The trajectories for achieving primary care health checks are articulated under the quality section.

## 9. Improving quality in organisations

The CCG has worked on the development of its quality strategy over recent months which provides the organisation with a framework on which to base our approaches to improving quality across all of our commissioned services as well as our own focus on quality internally within the CCG. This also includes quality in respect of social care as well as health care due to the partnership arrangements in place with the Council locally. The strategy will make clear the CCG’s approach when a provider is in special measures or under Enhanced Surveillance.

The CCG is developing Quality Profiles for each type of provider which will enable the CCG to regularly monitor the significant quality measures and provide early warning signs of decreasing quality. These profiles will be used by all CCG Officers including the quality team and service commissioners in quality meetings, contract meetings or for the sharing of intelligence.

Where providers are not performing well in respect of quality measures, the CCG works in a supportive way with the provider around agreed objectives to effect positive improvements and we have example of where this work has made a difference e.g. work undertaken with a local provider of acute care to increase incident reporting.

The CCG is engaging with other CCGs across the STP to share approaches and resources for measuring and supporting quality improvement

The CCG ‘s Quality Team is undertaking a review of the recommendations and quality measures suggested within “Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (NHSE 2016)” to determine how these recommendations can be utilised to build into existing quality monitoring of safe and sustainable staffing across all specialty areas e.g. acute hospital services, mental health services etc.

The CCG Partnership Board is due to receive a presentation regarding the CCGs approach with all providers at its January 2017 meeting.

The CCG will use existing quality work streams to progress and build in joint working to address issues or gaps in respect of safe and sustainable staffing.

The CCG is having discussions with other CCGs across the STP in relation to this work to share approaches.*.*

There is a new joint strategic group that has developed during 2016 between the main acute provider – (NLaG) – and the CCG and other community partners. Its focus is on Mortality as well as improving clinical outcomes for patients. Further engagement of GPs is required for this agenda and is currently a priority.

The strategy addresses mortality and clinical outcomes in specialist areas where there are high numbers e.g. respiratory, cardiology, sepsis, stroke, End of Life, gastroenterology and liver disease, still births, and the areas of mental health and learning disability are also included in our strategic approach as a CCG.

The strategy includes a thematic analysis of issues relating to (1) Prevention, (2) Diagnosis, (3) Treatment in respect of the specialist area, to support the development of improvement plans and pathway development.

The group jointly and regularly reviews case notes of patients that have died within 30 days of hospital discharge or within 30 days of admission. A significant amount of learning has occurred from the case note reviews resulting in plans for commissioners and all providers.

A CCG specific mortality strategy group focuses on actions required by the CCG and reports to the Quality Committee.

A new LeDeR process is in place for mortality reviews of people with learning disabilities.

We are currently undertaking a piece of work to understand more about the local LD health check figures, as anecdotally local GPs believe that the rate should be higher than the reported figure. Working with local practices, we will ascertain whether the reported rate is a result of reporting issues or issues with service delivery. This is expected to be completed by the end of January 2017. If it is found that the current reported rate is an issue relating to service delivery, we will have an understanding of what those issues are and will develop a programme of support with local Practices to bring about an improvement in the rate of health checks. We are currently working with the local Council and NHS England to review the commissioning of health checks more generally, and will include LD within this work if there are service improvements that need to be made.

The trajectory for these health checks between from April 2017 onwards is

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Year | Q1 | Q2 | Q3 | Q4 |
| 2017/18 | **41.00%** | **43.00%** | **46.00%** | **50.00%** |
| 2018/19 | **53.00%** | **56.00%** | **59.00%** | **63.00%** |
| 2019/20 | **66.00%** | **69.00%** | **72.00%** | **75.00%** |

# Narrative Rationale for activity and performance

**Activity**

**Planned care**

NELCCG has seen relatively small level of growth in referrals in 2016-17 (0.6%). This is compared with the national growth rate of 4.2%. There has been a local reduction in GP referrals of 1.6% to date. Underlying trend and demographic growth rates have been applied in line with this level over the next two years. This growth rate is likely to be lower than others and the STP as NELCCG has traditionally seen lower population growth than its neighbours.

Outpatients and elective admissions activity is expected to follow trend with referrals, however, additional activity has been factored in to reflect activity required to sustain 18 week performance once the current underperformance has been recovered. The CCG have commissioned additional activity from St Hugh’s Hospital in 2017-19 to the value of £2.5m which will support many of our underperforming specialties (Ophthalmology, Orthopaedics, ENT, Dermatology and General Surgery). In addition to this for Ophthalmology the CCG will be contracting with a new provider, New Medica to take new referrals and NLAG will continue to sub-contract with another provider taking on their new referrals.

There will also be some transformational work being undertaken on outpatient follow ups with the impact of a scheme focused on reducing follow up rates around three key specialties (cardiology, urology and rheumatology) and this has been modelled in.

It should be noted as well that planned care activity lines have been adjusted due to the difference in the number of working days between years as advised by NHS E.

**Unplanned care**

Despite seeing an increase in A&E attendances in 2016-17 (5.1%), this was lower than that seen nationally (5.6%) and has not translated in to a corresponding increase in emergency admissions. In fact over the same period NELCCG has realised a 2.8% reduction in admissions whilst there has been a 3% increase across England.

Again underlying trend and demographic growth rates have been applied in line with historic levels and therefore are likely to be lower than the STP anticipated growth.

The final element modelled in to our activity plans is the impact of the CCGs QIPP schemes. Most notably these are:

* Support to care homes
* Developing the out of hospital urgent and emergency care system
* Enhancing LTC support in the community
* Reducing falls

The table below sets out the stages of activity modelling and breaks these stages down in more detail than that shown in the waterfall table in the national template. For reference the waterfall table structure has been included to help reconcile the two tables.



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CCG FOT | Non-Recurrent Activity Changes | Underlying Trend and Demographic Growth | Transformational Change | Policy Changes |  |
|  |
| FOT | Working days adj | Underlying trend and demographic growth plus Sustain 18 weeks | Transformational Change (QIPP schemes) | There are no changes applied here for NELCCG  |  |
|  |
|  |
|  |
|  |
|  |

# Risks to not agreeing contracts with Providers

The contract position for our key providers is summarised below:

NLAG – The CCG has finalised the contract baseline model after sorting out a number of technical issues on HRG4+ and the changes to the IR rules. This had delayed the ability to drill down in to some of the technical changes the CCG wants to see. These are still being worked on to validate and agree the changes, while significant they are not material. The CCG and Trust have agreed the majority of savings from QIPP with a relatively small value of QIPP left to agree through evidencing what has started in 16-17 and the consequential full year effect for 17-19. The significant element which still needs to be agreed is the actual cost of resolving the RTT backlog, and the mechanism for ensuring that additional new activity is not sent to NLAG in addition to transferring activity to the Independent sector (therefore causing the CCG financial issues). Both parties will be working on this in January as the Trust finalises its work with the IST. The CCG does not see this as a barrier to agreeing a contract value with the Trust and will be operating a PBR contract. The end date for agreement is 31st January 2017.

EMAS – The contract has seen a substantial rise in value related to benchmarking work done by Deloittes. The CCGs have been attempting, alongside this value increase, to obtain substantially improved performance on Red 1 Red 2 and A19 performance. However this has not been agreed as part of the mediation process. The increase in value is supporting underlying financial issues and the Trust argued they would need substantially more investment to deliver to target. The Trust is now part of the Sustainability and Transformation funding process so will be agreeing a control total and performance trajectories with NHSI, but we will not see sustained improvement in 17-19, and the key achievement will be stabilization of the performance. This will continue to be a source of challenge to the Trust who are now covered by the double jeopardy rules so CCGs cannot penalize for underperformance, and that will only be done via the STF process by NHSI. NEL CCG has agreed to support the contract value for 17-18 and the 22 commissioners are looking to a one year contract to fundamentally review EMAS cost base following the Deloittes review.

Navigo – The CCG and Navigo have addressed a number of underlying issues around the funding required by the provider. These include the issue of pressures from out of area placements and the number of changes identified in the mental Health 5 year forward view which Navigo will have to provide. The CCG has closed the gap in the funding requirement which just leaves a small value to address around capital bids and funding for specific service pressures eg. Drugs costs. The CCG expects that these issues will be agreed and that a contract will be signed.

All other contracts have an agreed financial value and CQUINs, where applicable, in place for 2017-19.

# Annex 1 Finance queries

North East Lincolnshire CCG is meeting all business rules including 0.5% allocated on a recurrent basis for contingency and 0.5% uncommitted in relation to the risk reserve.

1. The CCG is showing a nil net risk position; it would be expected at this stage in the planning process that any risk around the impact of HRG4+ would be shown as an unmitigated risk.

From the activity modelling we have done to date the actual change in price is not significantly different to the allocation adjustment, therefore we have not included a risk.

1. Demographic growth on acute of 2.2% appears to be on the high side when compared to other CCGs in the North. Can the CCG confirm the nature of this and whether this is its intention?

The 2.2% included the impact of RTT, for comparison we have transferred the RTT element to Activity Growth non demography column.

1. In addition to demographic growth on acute the CCG have identified further cost pressures of 0.2%. Can the CCG confirm the nature of these and whether this has been included in contract negotiations.

This related to RTT and for comparison we have transferred the RTT element to Activity Growth non demography column.

1. The CCG is showing a 2.1% QIPP on acute spend. Can the CCG confirm how discussions are progressing with the trust around confirming acceptance of this QIPP into the contract? Given the scale of these reductions it would be useful to understand what risk management arrangements are in place in the event of non or partial delivery.

These schemes are ones that started in 16/17 and as such the Trust is aware of them. Whilst they have been fully factored in to the contract negotiations as yet the figures have not been agreed by NLAG.

1. In addition to demographic growth on MH the CCG have identified further cost pressures of 2.0%. Can the CCG confirm the nature of these and whether this has been included in contract negotiations.

Additional funding required to cover cost pressures within our main provider ( Navigo) to support their sustainability, and also requirements of MH five year forward view.

1. The CCG have identified £1,126k non recurrent investment in community contracts. Can the CCG confirm the nature of this and whether this has been included in contracts for 17/18?

This has not been included in the contracts but is required for non recurrent costs associated with the service change programmes we have in place in both years.

1. The CCG have identified NR cost pressure in PC other of £250k. Can the CCG confirm if this is in relation to the GPFV £3 per head ?

Yes it is.

1. The CCG have identified £550k NR investment in other programme services. Can the CCG confirm the nature of this investment?

This investment is required for non recurrent costs associated with the service change programmes we have in place in both years

1. We note the CCG has £1.5m of unidentified QIPP, what progress has been made in identifying schemes to close this gap and does the CCG expect to have this finalised by 23rd December submission?

There is a confirm and challenge process being undertaken with QIPP leads to assess whether the current savings have enough stretch without being unrealistic. In addition a number of potential areas have been identified by budget holders which we are assessing over the next few weeks to form a view as to the level of savings they will deliver. We do not envisage this will be complete by 23rd December 2016.