Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on Behalf of NHS South Lincolnshire Clinical Commissioning Group (CCG)

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**22 March 2016**
Subject:	**NHS South Lincolnshire CCG 2016/17 Operational Plan**

Summary:

In addition to aligning our 2016/17 work programmes with the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) we have also used the information provided by our patients, public and stakeholders along with national and local outcomes data such as the Atlas of Variation to create our focus areas for 2016/17. Our commissioning intentions and one year operational plan aim to deliver changes working in partnership and collaboratively ensuring capacity and capability is in place.

Commissioning plans and a joint action plan with Public Health details the work the CCG will carry out during 2016/17, Appendix A

The information presented and attached is still in draft format until final sign off by all parties once completed the full 2016/17 Operational Plan will be available for viewing at http://southlincolnshireccg.nhs.uk

Actions Required:
Confirmation that SLCCG plans meet the needs / outcomes of JSNA / JHWS

1. Background

South Lincolnshire's 2016/17 Operational Plan begins with a current position and a plan to secure patients safety and quality outcomes throughout, forwards to the process SLCCG has taken to produce the plan working collaboratively, engaging, and being transparent and inclusive of all. Using national and local information such as the Five Year Forward View, The Mandate, the JSNA and Commissioning for Value pack the

CCG has, jointly with the Health and Wellbeing Boards, focussed on the needs and service requirements that are most relevant and important to its population.

2. Conclusion

We will achieve the overall system wide transformation described by the LHAC and the five year strategy whilst at the same time deliver the local aims developed in partnership with our population and stakeholders. We will work with our stakeholders and public empowering patients and their carers to commission the best possible outcomes within financial resources available as set out in the summary plan on a page, appendix B.

3. Consultation

SLCCG is committed to empowering patients giving them more choice and control over their condition and health service. The CCG continues to actively engage with all stakeholders, patients and the public using a robust and embedded communications and engagement approach to continuous listening. We proactively ensure the views of all population groups are listened to and fed back into the decision making process in the CCG.

Events held during 2015 asked a range of people to tell us what is important to them when we develop future service priorities. Attendees were from a number of organisations and community groups, such as healthcare providers, local authorities, voluntary organisations and patient representative community groups and they told us that the following were important to them:

- Mental Health: continuing to support with education and learning for both patients and professionals to improve patient experience.
- End of Life Care: Continuing to improve end of life planning with patients; carers; families and friends.
- Proactive Care: Following on from our Chronic Heart Failure; diabetes and stroke prevention work. More education and learning for patients to better self-manage and better prescribing to reduce long term risks.
- Neighbourhood Working: Professionals working better together and locally for a better patient journey.
- More Services at Local GP Practices: Increasing the amount of services that are available at a GP practice
- Cancer Services: continuing to improve local access to services.
- Dementia Care: focussing on earlier diagnosis of dementia and pathways of services after diagnosis.

The CCG has used this feedback to identify and develop our transformation programmes for 2016/17 that will enhance service provision and quality where clinically appropriate, SLCCG 2016/17 work programmes is attached as Appendix C.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	SLCCG Commissioning plans and PH Joint Action Plan
Appendix B	Plan on a Page
Appendix C	SLCCG Work Programmes

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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Appendix A

Commissioned & Planned Services aligned to JSNA and Joint PH Action Plan

The full Public Health profile (an appendix to the full operational plan) provides an overview of the health of the population living in the geographical area covered by South Lincolnshire CCG (SLCCG). It describes key demographics of people living in the area, outlines key health concerns, and highlights areas of health inequalities in SLCCG.

When reading the information it is important to consider the following caveats:

- The data included in the profile is a snap shot of demographic and health data for the time period indicated; and,
- Most of the information used relates to the GP registered population. However, some data sources use ONS population estimates.

Full referencing is provided throughout to enable to reader to access source information.

Key Points

- South Lincolnshire CCG has a lower prevalence of income deprivation, child poverty and unemployment compared with other areas in Lincolnshire and the England average.

- The population has an older profile than other Lincolnshire CCGs and England. There is a higher proportion of people aged 50 years and older.

- Life expectancy at birth in the CCG is slightly higher than the England average for males (80.0 compared with 78.9 years), and almost the same for females (83.1 versus 82.8 years).

- The prevalence of cancer, diabetes, coronary heart disease, stroke and respiratory disease are all slightly higher in SLCCG than the England average. This may partly reflect the older age profile of the SLCCG population.

- Emergency admissions to hospital are below the national average and elective admissions are significantly higher.

The profile should be read alongside the Joint Strategic Needs Assessment (JSNA) in order for the reader to consider how the five priority themes of the JSNA link to key health and health inequality concerns in SLCCG. The five priority themes are:

1. Promoting healthier lifestyles
2. Improving the health and wellbeing of older people
3. Delivering high quality systematic care for major causes of ill health
4. Improving health and social outcomes for children and reduce inequalities
5. Tackling the social determinants of health

Services have been and will be commissioned to meet these aims and all commissioning decisions have been endorsed by Lincolnshire County Council, Lincolnshire's CCGs, and District Councils, Health watch Lincolnshire, and Lincolnshire and Leicester Local Office of the NHS Commissioning Board.

All will hold each other to account for ensuring that their commissioning and decommissioning decisions are in line with the Joint Health and Wellbeing Strategy (JHSW) and deliver the outcomes which are included in the five themes.

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3.1 Lincolnshire Health and Wellbeing Board outcomes and services planned and commissioned.

Promoting Healthy Lifestyles

The evidence in the JSNA indicates that smoking is currently the most significant behaviour contributing to poor health and well-being. Most smokers wish to stop and there are interventions which are proven to be effective. The JSNA evidence also indicates that obesity, and its two major components – food and physical activity, is also a major problem. Unlike smoking this is increasing as a risk factor and requires urgent attention. This applies to both children and young people and to adults.

Outcome – People are supported to lead healthier lifestyles

Aims	Commissioning plans / Implemented Services
Decrease smoking	Quit 51 Smoking Cessation Service
Decrease obesity	Dietician referrals/Diabetes Prevention Programme
Increase physical activity	PH Exploring alternative options to deliver physical activity interventions, Health trainers Lincolnshire Sport
Sensible alcohol use	DARTS/Addaction
Improve sense mental wellbeing	Self-referral IAPT

Improving Health and Well Being for Older People

The data illustrates once again the high proportion of older people aged 50 and over living in Lincolnshire and the projections for this proportion to increase over the next decades. This affects not just the obvious issues of health and social care, benefits and pensions, housing and transport, but also prevention of ill-health, promotion of well-being and quality of life, and work and volunteering opportunities.

Outcome – Older People are able to live life to the full and feel part of their community.

Aims	Commissioning plans / Implemented Services
Deliver "wellbeing" support and community health services for older people in Lincolnshire	Making every contact count Vitality - Evergreen Care
Develop a network of "wellbeing" services aimed at supporting older people to live healthier, happier and independent lives	Parkinson Nurse Dementia Support Network Bourne Dementia Support Network Spalding Age concern square hole club Dementia café Butterfield Centre Alzheimer's UK – various clubs across SL Start Afresh Rethink Mind
Ensure services for older people are locally based, cost-effective and sustainable	Parkinson nurse
Use public, private, voluntary and community organisations/groups to provide co-ordinated low level preventative services	Wellbeing Support Network

Delivering high quality systematic care for major cause of ill health and disability

All the reviews of major illnesses illustrate the benefits of prevention, early diagnosis and good management of risk factors and the condition itself. There is clear evidence that systematic care with defined care pathways and protocols which utilise effective interventions will produce better outcomes. The JSNA gives us evidence that this systematic prevention and care is not universally available in Lincolnshire. We must ensure we have in place systematic programmes of risk identification and management, long-term

condition management and management of major diseases such as heart disease, stroke, cancer and diabetes.

Outcome – People are prevented from developing long term health conditions, have them identified early if they do develop them and are supported effectively to manage them

Aims	Commissioning plans / Implemented Services
Improve the diagnosis and care for people with diabetes	Diabetic Nurse/Hypoglycaemic pathway Weight watchers/Exercise on referral.
Reduce unplanned hospital admissions and mortality for people with COPD	Respiratory nurses Unplanned care. South Holland looked at frequent attenders with COPD and set up individual management plans for them.
Reduce mortality rates from CHD and improve treatment for patients following an MI	CVD Lifestyle checks/Heart failure Nurse Cardiac rehabilitation nurses
Improve the speed and effectiveness of care provided to people who suffer a stroke	Setting up of specialist centres for stroke treatment.
Reduce mortality rates from cancer and improve take up of screening	SLCCG will support the lead commissioner WLCCG for cancer to implement the cancer strategy for Lincolnshire whilst focussing on local improvement areas identified. St Barnabas services Red Cross
Minimise the impact of long term health conditions on mental health	IAPT – Maintaining performance, EIP - Implementing new NICE guidance, access to extended age group.

Improving health and social outcomes and reducing inequalities for children.
The evidence in the JSNA points to deprivation and poverty being major drivers of health inequalities in children and to obesity, smoking, and teenage pregnancy as the main health issues to be addressed.

Outcome – Ensure all children get the best possible start in life and achieve their potential

Aims	Commissioning plans / Implemented Services
Ensure all children have the best start in life by Improving educational attainment for all children	Work with partner organisations to promote wellbeing
Improving parenting confidence and ability to support their child's healthy development.	The CCG is committed to the Operating Framework requirement to increase Health Visitors
Reduce childhood obesity	Work with partner organisations to promote healthy lifestyles, to support reduction in obesity Home Start services for under 5 years old
Ensure children and young people feel happy, and stay safe from harm and make good choices about their lives - particularly the vulnerable and disadvantaged.	The CCG is committed to the increase in health visitors

Tackling the social determinants of health

The JSNA points to worklessness being a highly significant determinant of people's health. Work improves mental health, reduces the likelihood of poverty and increases self-esteem. There are links between health and the quality of work too. The evidence in the JSNA, taken originally from the Economic Assessment, indicates that in certain parts of Lincolnshire this is a major issue for health and well-being.

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Outcome – Peoples health and well-being is improved through addressing wider determining factors of health that affect the whole community

Aims	Commissioning plans / Implemented Services
Support more vulnerable into good quality work	Work with partner organisations to develop and support the vulnerable.
Ensure public sector policies on getting best value for money include clear reference and judgement criteria about local social impact, with particular reference to protection and promotion of work opportunities and investment in workforce health and well-being	Improved pathways of care,
Ensure that people have access to good quality, energy efficient housing that is both affordable and meets their needs	Warm Homes scheme (R2W– Responders to Warmth) Council run

SLCCG, working jointly with Public Health is reviewing the action plan below and will continue the actions set out during 2015 to reduce inequalities and improve patient outcomes.

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3.2 South Lincolnshire CCG Public Health Action Plan 2015/16/17

Action	Objectives	Lead	Timescale	Comments
Commissioning for Prevention – Cardiovascular Disease.	CCG working towards the mature scenario identified in the Framework for Commissioning Prevention.	CCG/Public Health	Ongoing	In some areas the CCG is already working at the 'mature scenario' outlined in the Commissioning for Prevention guidance but currently we would assess ourselves as largely 'Emerging'.
To continue with the local priority measure to reduce the CVD under 75 mortality rate to the England level or below.	QIPP schemes implemented around specific tools for example GRASP AF Tool, IMPAKT Tool and the COPD Tool with specific performance indicators as quick wins to address issues around variation in practice performance for the management of these conditions. This will contribute to reductions in PYLL and U75 mortality rates.	CCG	2016/17	U75 CVD mortality rate of 66.35 (based on 2012 date); target to reduce to 65.47 in 2014 (based on 2013 data); mortality rate achieved was 66.8. Rate achieved in 2014 was 60.8.
Implement GRASP AF tools across all GP practices within the South Lincolnshire locality.	Incorporate prevention measures for example smoking cessation and brief advice as a standard element of commissioning services	CCG	2016/17	The CCG to work with GEM contracting to achieve this.
Implement IMPAKT Chronic Kidney Disease tool across all practices	To ensure that MECC is incorporated into contracts issued to ensure that the prevention and lifestyle agenda is taken forward and a mechanism for recording interventions.	CCG	2016/17	The CCG to work with GEM contracting to achieve this.

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Action	Objectives	Lead	Timescale	Comments
Personalised Care	Implement the My Right Care Tool to be used across all practices using the 'Personal Care and Support Planning Handbook: The Journey to Person-Centred Care'. Engage with patients with regards to the My Right Care App.	CCG/Practices	July 15	The My Right Care web based care planning solution will enable integrated working between all providers and allow for a patients care plan to be shared it the patient consents for this to happen. The My Right Care work will be linked to the 2% risk stratification work.
Engagement with A8 communities	Further engagement events are to be arranged throughout the years to ensure that the CCG engage with A8 communities	SL engagement officer	April 15	Various events have already been held throughout the year to engage with A8 communities and encourage communities to register with a GP and advise on the correct pathways to access health care and inappropriate use of A&E.
Diabetes	The CCG have commissioned a series of diabetes workshops in order to help patients with the condition manage this more effectively. Implement National Diabetes Prevention Programme as part of first wave	SL engagement officer /Health Trainers CCG/PH	Throughout 15/16 and ongoing 16/17	The sessions will be as follows: • Session 1 – An introduction to the course and information on pre-diabetes and diabetes. • Session 2 – healthy eating information, eat well plates, food labelling and portion control. • Session 3 – benefits of physical activity. • Session 4 – grow your own fruit and veg. • Session 5 – Healthy cooking session. • Session 6 – Signposting and referrals

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Action	Objectives	Lead	Timescale	Comments
Implement the 5 high impact interventions identified by the NAO report	To implement the 5 most cost effective high impact interventions identified by NAO report on Health Inequalities: □ Increased prescribing of drugs to control blood pressure □ Increased prescribing of drugs to control cholesterol □ Increased access to smoking cessation services In order to implement the above we need to identify patients and optimise the management of these patients. The CCG will do this by carrying out NHS Health Checks. Public Health and the CCG will continue to the NHSE/PHE intelligence packs to highlight differences in practice performance across a range of disease management areas. This will continue to facilitate a peer review process through the CCG Clinical Committee to address differences in practice performance and explore and share best practice.	Public Health/CCG	Ongoing	All South Lincolnshire practices' have signed up to providing NHS Health Checks.
NHS Health Checks Compliance Audits	This will be a re-audit from 15/16 to: • Ensure Read coding is correct; • Ensure there is a high risk register and that appropriate patients are added to it; • That patients on the high risk register are reviewed appropriately • That patients identified with hypertension etc. are added to the appropriate register and managed accordingly • That staff are competent at providing lifestyle advice • Patients are provided with appropriate literature • Patients are referred to lifestyle interventions as appropriate; • Non-compliant areas are identified and an action plan put in place,	GP Practices/PH	March 17	PH will provide training on giving lifestyle advice for those who have not received it or need a refresher

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Action	Objectives	Lead	Timescale	Comments
Increasing anti-coagulant therapy for AF	Increase the anticoagulant therapy for AF through the implementation of the AF GRASP tool. This will be completed by rolling out training for the use of the tool to all South Lincolnshire practices. We will review if this project has been a success by the following: □ An increase in the proportion of AF patients receiving this intervention □ A reduction in exception reporting for the relevant QOF indicator □ A reduction in acute admissions for strokes associated with diagnosed and undiagnosed AF	CCG	March 16	9 practices have received AF training. 10 practices have received HF training. All practices should have received training.
Clear trajectories for reducing health inequalities	Trajectory for reducing PYLL and Under 75 Mortality Rates	CCG	Ongoing	To achieve a year on year reduction in PYLL and Under 75 Mortality Rates. Actions to achieve this are the same as the commissioning for prevention actions
Premature Mortality Audit	A premature mortality audit to be conducted to identify deaths which were potentially avoidable and identify areas of practice or themes which can be targeted to prevent premature deaths in the future. Brighton and Hove model to be used. □ Audit to be completed within the next 18 months.	Public Health/CCG	16/17	This audit will look at individual patient records to explore common themes which are amenable to quality issues.
MECC (Making Every Contact Count)	□ To encourage all practices to participate in MECC utilise the MECC scheme	Public Health/CCG	Ongoing	
Social Prescribing Model	□ Present evidence based review of community navigator (and similar) models. □ Pilot a social prescribing initiative.	LCC Public Health CCG/LCC PH	Apr 16 Jan – Apr 16	Awaiting date for development session Project being undertaken in Spalding to refer/signpost people with mild mental illness into creative arts projects

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CCG: NHS South Lincolnshire 2016/17 operational plan on a page **Appendix B**

Three key areas of focus for the 15/16 operational plan

1. **Improving Quality and Outcomes**
2. **Delivering patients constitutional rights and pledges**
3. **Delivering local integrated services including preventative and personal care planning support**

Access

SLCCG with our health and social care partners will work to deliver standards in Lincolnshire and Cambridgeshire; the SRG's are supported by planned, cancer and urgent care boards.

A&E CCG schemes, neighbourhood teams, care planning, Transitional care and CAS implementation, admission avoidance in A&E and discharge planning current performance 94.8%

Winter resilience continued investments in proven schemes, discharge team in PSHFT, IC beds, clinical assessment & treatment car, frailty pathway & unit, AIR at QEH

RTT Capacity commissioned to sustain reduction in backlogs and achievement of RTT standards, CCG current performance 93.8%

Cancer –additional capacity commissioned with alternative providers to ensure access available to patients, whilst working with challenged Trust to recover performance, CCG currently underperforming in 62 day upgrade 90.7%

Diagnostics –Commissioned to continue achievement of standard and increase provision through AQP.

IAPT –Targets set to continue achievement of standard including new waiting time targets.

Early Intervention in Psychosis New guidance to be implemented, target achievement Q2 and sustained.

Dementia Continue to achieve national standard, practices have use of CANTAB tool for early identification, Dementia support co-ordinator working with neighbourhood teams and support services commissioned with voluntary sector

Early intervention –MECC encompassed in contracts, audit analysis used to share good practice, diabetes education programme

Primary Care- use new models to commissioning localised, integrated care, address variation, inequalities, and increase access over weekends.

Outcomes

Delivery across the five domains and seven outcome measures

Improving health - The CCG and PH are gaining commitment to use the principles of Making Every Contact Count to provide meaningful brief lifestyle interventions to support patients to live healthier lives and contribute to the prevention agenda. This will be done in conjunction with Local Authorities commissioning lifestyle services for example stop smoking service.

Reducing health inequalities – In partnership with PH to ensure the five most cost effective high impact interventions on health inequalities are implemented. All practices are providers of NHS Health Checks providing a means of identifying previously undiagnosed patients with or at risk of CVD, diabetes and CKD, Deep dive of CfV pack focuses on diabetes, MSK and respiratory, actions will be put in place where required. Preventative diabetes education continues and increased provision has been secured. Clinical quality reports will be produced and shared with all practices to track progress against performance. Learning from the Health checks projects in

Parity of esteem – physical health care has been embedded into contracts to help reduce the health inequalities between people with serious mental illness and the general population. Quality schedule updated to include monitoring and management of physical health needs. Investments in MH include dementia, increased service provision of Psychiatric Liaison within PSHFT and Pilgrim hospitals.

Focus on increasing personal health budgets

Quality

Patient safety –Quality Schedules are reflective of areas of risk and the CCG ensure organisations report performance against these. Clinical harm or near misses are reported to both commissioners and to patients & relatives as per the NHS Constitution. Investigations & lessons learnt are shared. CQUINs used to incentivise Harm Free Care through Safety Thermometer improvement goals. Whole health community approach to HCAI and CCG current C Diff performance is on target at present

Patient experience –Continuous Listening Model implemented to ensure robust mechanisms in place which enable patient experience to influence our plans and drive improvement. Patient experience log compiled from all soft intelligence available such as PPGs, patient opinion, Healthwatch & listening events. Friends & Family Test utilised across all relevant providers and performance monitored at both trust & ward level. Rigorous approach applied to the management of complaints and the triangulation of soft intelligence.

Equality and Diversity

The CCG is working with seldom heard groups such as the A8 community, the homeless, travellers, ex-offenders and young people recently leaving care to understand the challenges and barriers to accessing primary care, with the aim of seeking solutions to improve uptake of primary care.

Safeguarding – Central federated function for safeguarding which enables a concerted resource and capability to meet the requirements of the accountability and assurance framework for protecting vulnerable people. Strategy developed designed around core themes including governance, education and training, monitoring and disseminating learning, and strengthening processes to ensure effective partnership working. The key priority is on ensuring the protection of vulnerable people, and setting quality improvement

Staff satisfaction –Continuation of requirement in relation to the Staff Friends & Family Test & ongoing monitoring proxy measures of staff satisfaction such as turnover on a regular basis.

Seven day services – The CCG will continue to work on the delivery of seven day services, working with providers to implement the clinical standards. Care bundles and pathways being developed to secure 7 day services.

Response to Transforming Care

Service requires re-engineering to prevent admission and maintain patients safely within the community. Service required for transforming care requirements for children and young people. There are coordinated CTRs based on clinical need of the patients. It is proposed that the transforming care partnership should be developed through the Autism/ LD transformation board which is already in place as many of the same issues and priorities will be developed through this board already. Engagement events are scheduled.

Reconfiguration – There is a clear emphasis on reconfiguration to develop high quality sustainable services and SLCCG are fully engaged in the LHAC

Delivering value

- Financial resilience and value for money rigorously pursued through transformation.
- Financial plan delivers 1% surplus, £2.04m in 2015/16.
- The CCG's underlying surplus in 2015/16 is planned to be 1.3%
- Planned investment in mental health in accordance with parity of esteem expectations
- 0.5% contingency held to mitigate against unforeseen financial pressures.
- Activity commissioned sufficient to meet population growth.

2015/16 PCF Schemes have been through a clinical review for effectiveness by

Transformation programmes, reconfiguration plans and reprocurement

- Development of neighbourhood teams
- Movement of Maternity Services for certain practices to stop fragmentation of service
- Care closer to home includes procurement of community ENT Audiology and Ophthalmology.
- Dedicated Parkinson's Nurse to care for and enable patients to proactively manage their condition.
- Interactive educational sessions for diabetes patients to encourage innovative ways to manage their condition
- Management of CVD in primary care
- Management of respiratory in primary care
- Review of all MSK services

Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
CVD	GRASP AF	CCG	Opportunity identified through East Midlands Strategic Clinical Network. Evidence base NICE Clinical Guidelines for identification and treatment of AF.	To reduce the number of hospital admissions for Stroke caused by Atrial Fibrillation and avoid preventable deaths by identifying patients diagnosed with AF who are not currently on anticoagulation and assisting in identifying patients not currently diagnosed. Scheme measurement is reduction stroke non elective admissions and practice data reported through the GRASP AF Tool monthly. The HRG used for this scheme measurement has been removed from those used to measure the cardio vascular disease scheme to avoid double counting.	3 year programme commenced April 2015
	GRASP HF	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Assessment has been supported through Public Health CVD Deep Dive, Best Practice and Evidence Based interventions with clinically identified improvement opportunities through SLCCG Clinical Committee	Best Practice management of Heart Failure Patients to prevent admission to hospital using the GRASP HF tool supported by upskilling. Wider CVD scheme of work currently in development including Self Management Support, Pre Diabetic Education Programme and pathway design. Scheme measurement is reduction in Coronary Heart Disease, Problems of circulation & Problems of Rhythm Inpatient Activity (The HRGs used for this scheme are those aligned to CfV Circulation) and practice data reported through the GRASP HF Tool monthly	3 year programme commenced April 2015
	Clincal Upskilling	CCG			Programme throughout 16/17 aimed at Nurses and GPs to support transformation schemes
	NHS England Diabetes Prevention Programme	County wide			April 16
	Patient Self-Management and Support Working with HOPE (hearts of positive energy)	CCG			CCG is working with HOPE to understand the scope for 16/17
Respiratory	GRASP COPD	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Quality Improvement opportunities identified through East Midlands Health Science Network - Respiratory	Best practice management of COPD in general practice using the GRASP COPD tool supported by upskilling. Scheme measurement is reduction in Problems of the Respiratory System Inpatient Activity (The HRGs used for this	3 year programme commenced April 2015
	Clinical Upskilling	CCG			Programme throughout 16/17

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Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
			Network and SLCCG Respiratory Clinical Lead.	scheme are those aligned to CfV Respiratory) and practice data reported through the GRASP HF Tool monthly.	aimed at Nurses and GPs to support transformation schemes
	Review Pulmonary Rehabilitation	CCG			CCG currently scoping provision for population
	Health Foundation Expression of Interest to take part in regional spread of Community asset based respiratory clinics	CCG		As above, however in addition, Univeristy evaluation is bult into the project itself. key impact areas of the project; □ Transformational change in patient reported quality of life. □ Increased mental well-being □ Improved ability to self-manage. □ Reduced unplanned admissions. □ New model of service delivered in co-production.	SLCCG submitting and EOI to take part in this programme 26th February
Genitourinary	IMPAKT CKD	CCG	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. Assessment has been supported by East Midlands Clinical Network Best Practice and Evidence Based interventions with clinically identified improvement opportunities through SLCCG Clinical Committee	Best practice management of CKD in general practice using the IMPAKT tool supported by upskilling. Scheme measurement is reduction in Genito Urinary Inpatient Activity (The HRGs used for this scheme are those aligned to CfV Genitourinary) and practice data reported through the IMPAKT Tool monthly.	3 year programme commenced April 2015
	Care Home Educator	CCG			Commenced Q2 15/16
	Clinical Upskilling	CCG			Programme throughout 16/17 aimed at Nurses and GPs to support transformation schemes
	Practice variation UTI emergency admissions	CCG			April 2016

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Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
Neurology	Neurological Services	Countywide	Opportunity confirmed through SLCCG Commissioning for Value Pack using Right Care methodology	Still being scoped as deep dive due for review in March 16.	Deep Dive Commissioned from GEM CSU to be discussed at planned care meeting in March 16
MSK	Transformation of MSK	Countywide	Opportunity identified through SLCCG Commissioning for Value Pack using Right Care methodology. CCG working with National MSK Network and fellow CCGs to identify potential solutions.	SLCCG currently has high spend and poor outcomes for MSK with a large opportunity to improve in both. Scheme measurement is reduction in CFV Chronic Pain, Problems due to Trauma & Injuries & Problems of the Muskuloskeletal system Inpatient Activity (The HRGs used for this scheme are those aligned to CfV MSK)	Deep Dive reviewed by CCM in January 16. Scheme currently being worked up.
Dementia	Dementia Identification and Community Support	Countywide	National Priority	Maintain achievement of dementia target	Ongoing
Care Closer to Home	Community Surgery Scheme (increased usage)	CCG	SLCCG are low users of the CSS service, opportunity identified through review of activity.	Maximise use of existing CSS providers/procedures across all SLCCG GP Practices. Usage of CSS by practice will be monitored and report by CI monthly	Ongoing
	Community Surgery Scheme (additional)	Countywide	Opportunity to increase services provided through CSS identified through appropriate review.	Increase opportunity for patients to access services closer to home. Measurement through useage of schemes once live.	Additional schemes currently being progressed anticipated start date July16
	Concordia ENT service Increase access	County Wide	SLCCG usage of the scheme has been identified as	Increased usage of ENT service. Measurement through CI data reports on service.	April 16
	Adult Hearing Services	County Wide	Scheme piloted in SWLCCG. Lincolnshire CCGs to take forward during 16/17	Improved access to audiology services for Hearing Aid Devices in closer to home. Measurements as per pilot in SWLCCG, linked to patient experience and reduction in acute services spend.	Countywide planned care group currently scoping opportunities for each CCG.

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Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
Prescribing	PMOS supported efficiencies	CCG	The Prescribing and Medicines Optimisation Service (PMOS) have completed an initial review of national and local priorities and have produced a recommended list of Prescribing QIPP initiatives for action in 2016/17. The review considered information around patent expiries, product pricing, product availability and new guidance.	The Prescribing and Medicines Optimisation Service (PMOS) have completed an initial review of national and local priorities and have produced a recommended list of Prescribing QIPP initiatives for action in 2016/17. The review considered information around patent expiries, product pricing, product availability and new guidance. Measured through PMOS standardised monthly reporting.	Ongoing
	PINCER Trial To test intervention aimed to reduce prescribing errors in Primary Care	CCG	Prescrining errors in General Practice are an important and expensive preventable cause of illness, hospitalisation and deaths.	PINCER trial developed to study whether a pharamcist led IT-based intervention could reduce medication error rates within the primary care setting. As a research trial all measures will be as per protocol.	Discussion at Prescribing Committe
	Optimise Rx	CCG	Fellow Lincs CCG successfully implemented during 14/15. Opportunity for SLCCG efficiencies assessed using results of this. Optimise RX suggestions are based on best practice, safety and cost.	Roll out of Optimise RX tool. Optimise RX is a piece of medicines optimisation software which is a delivery mechanism for providing national best practice and local formulary advice to clinicians at the point of prescribing. Prescribing efficiencies realised are reported through the software for each practice monthly. Software is constructed to ensure no double counting.	Ongoi ng

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Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
	Medicines Wastage Scheme	CCG	The Steering Group on Improving the Use of Medicines noted that "Repeat prescribing accounts for 60-70% by cost and 80% by volume of prescription items dispensed in primary care. Around half of all registered patients receive repeat prescriptions and the rate is rising In the paper 'Evaluation of the Scale, Causes and Costs of Waste Medicines' (2010), York Health Economics Consortium and School of Pharmacy University of London estimates that wasted medication amounts to a cost of £300 million per year and:"…includes an estimated £90 million worth of unused prescription medicines that are retained in individuals' homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are disposed of unused by care homes."	Reduction in Wasted medication, measures built into the scheme.	Currently being scoped inernally
Mental Health / Parity of Esteem	ADHD Adult (PoE)	County			Phase one BC accepted Unlikely to progress phases 2&3
	CAMHS (PoE)	County	Transformation plan	Access to Eating disorders and IAPT for C&YP	
	ImROC alignment with nhts	County	Refocussed to ICMHT and ImRoc links to NHTs		
	ADHD child	County	Part of transformation plan for Child and family service not phase one		Needs whole pathway review
	Step 4 Pyschology	County	Access is low and waits very long. Demand exceeds capacity		Redesign proceeding but challenged
	Mental Health Triage Car (PoE)	County		Improved access and quality	Ongoing

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Programme	Scheme	CCG or County Wide	Case for change – clinical evidence Patient feedback	Ambition to improve outcomes/ quality and measure	Scheme start date
	Section 136 (PoE)	County		Better quality care increased beds 1-2. C&YP protocol in place	New suite due to open February – increased staffing recruited
	Chronic Fatigue Service (PoE)	County			Non –recurrent support?
	Anorexia Day Programme	County			Ongoing
	Mental Health Liaison Services for Acute hospitals (PoE)	County			Service agreed in mobilisation phase
	Open Dialogue	Project in CCG			Further development required.
Neighbourhood Teams	Development of two Neighbourhood teams in SLCCG	Countywide	LHAC Blueprint	Outcome measures currently being devised through countywide implementation group	Localised Implementation plan – aligned to the countywide plan - being progressed
Clinical Assessment Service	Implementation of Clinical Assessment Service	County wide	The original planning assumptions were based on the LHAC blueprint documents. During the first weeks of the Proof of Concept, a revision of the impact of the Clinical Assessment Service has been undertaken owing to: - A better understanding of the information and data used to make the original assumptions - The technical and workforce changes required to deliver an integrated model	The Clinical Assessment Service is a component part of the Lincolnshire Recovery Plan to fully achieve NHS Constitution Standards. It is an enabling service and forms part of the Lincolnshire Health and Care (LHAC) programme. It comprises all the clinical elements of the Hear and Treat services currently in place within the system.ie EMAS, NHS111, Out Of Hours. Success measures include standard activity such as A&E attendances and non-elective admissions.	Commenced Nov 15

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