NHS
South West Lincolnshire
Clinical Commissioning Group

Operational and Strategic Plan 2014-2019

CONTENTS

SECTION 1: STRATEGIC DIRECTION

1.1 MISSION

The mission of NHS South West Lincolnshire Clinical Commissioning Group is to be a CCG for the whole community, striving for the continued improvement in health and wellbeing for all residents in our locality. We want to achieve this in partnership with the local population so that we make the right decisions to ensure the best healthcare is provided and needs are met.

1.2 VALUES

In South West Lincolnshire CCG we believe that high quality services need to be accessible to the whole community. Our clinicians are well placed to lead the development of commissioning and quality improvement in the locality – but we can only do this by close working with councils, local people, allied health professionals and care providers to design the very best services. We intend to maximise input and engagement in improving the quality of local health services.

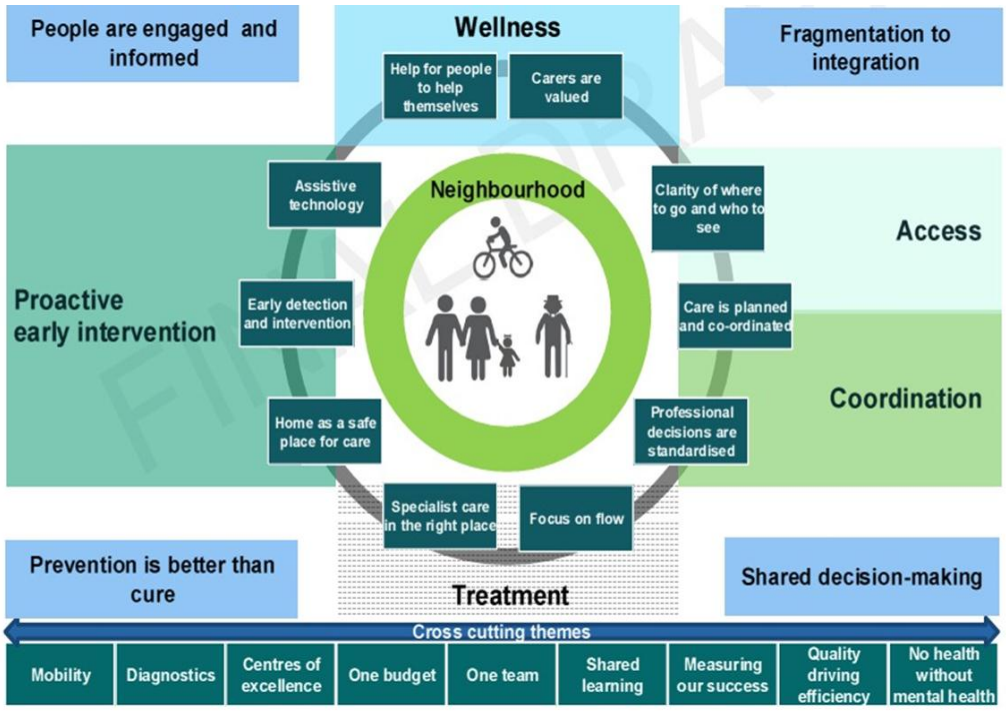
We believe that:

- Patient safety and quality is paramount
- We need to be realistic in our expectations and accept that our resources will never allow us to provide everything for everyone all of the time. We will be open and transparent about the difficult decisions we will have to make and always strive to do the most good for the benefit or our population;
- Services should be local where viable and safe, centralised and accessible where necessary;
- Patients should be at the heart of their health care;
- We will work in an open, honest and transparent manner.
- Integration between primary, community and secondary care services and social care services is critical to the success of health provision;
- Services start at home and our carers are an important part of this.

1.3 STRATEGIC AIMS AND PRIORITIES – PLAN ON A PAGE

The Plan on a Page, below, has been developed by the Lincolnshire Sustainable Services Review Group (LSSR) and has therefore being signed up to and agreed across all Health and Social Care partners in Lincolnshire.

STRATEGIC PLAN ON A PAGE



SECTION 2: HEALTH PROFILE

2.1 HEALTH INEQUALITIES

- South West Lincolnshire CCG has relatively low levels of deprivation, poverty and unemployment compared to other areas in Lincolnshire.
- There is a high proportion of population of people aged 40-49 and significantly lower proportion of people in their 20s then the England average.
- Life expectancy within the CCG is slightly better than the England average.
- Prevalence of cancer, diabetes, coronary heart disease and stroke are higher than the England rates.
- The GP referrals to outpatients and elective admissions are above the England average, but the rate of emergency admission is below the rate for England

Under 75 mortality rates from cancer and cardiovascular disease in South West Lincolnshire CCG are below the rates for England, but the mortality rate from respiratory disease is slightly higher than the national rate. Please note that there are discussions around how those rates are being calculated and the methodology may change in the near future.

Under 75 mortality rates, DSR per 100,000 (2011):

Cardiovascular disease = England (65.6), SW Lincs CCG (55.4)

Respiratory disease = England (27.3), SW Lincs CCG (28.7)

Cancer = England (121.5), SW Lincs CCG (111.8)

The figures below show the average life expectancy for both males and females within South West Lincolnshire CCG and England. It can be seen that the average life expectancy is slightly higher in this CCG compared to England overall.

Average Life Expectancy (2006-2010):

Male = England (78.3), SW Lincs CCG (79.5)

Female = England (82.3), SW Lincs CCG (83.5)

2.2 MAJOR DISEASE

In order to establish the key health problems affecting practices within South West Lincolnshire CCG we have examined the data from the APHO website. If you would like to view the spine charts for each individual indicator they can be accessed via www.apho.org.uk/PracProf/Profile .

Long Term Conditions – Key Points (2011/2012 data):

- Diabetes prevalence is slightly higher than the England average. The prevalence of diabetes has increased compared to 2010/2011 following National trends (6% from 5.6%).
- Coronary Heart disease prevalence is above the England average: 4.3% within South West Lincolnshire compared to 3.4% for England.
- Stroke prevalence is higher than the England rate: 2.2% within South West Lincolnshire compared to 1.7% within England.
- Hypertension prevalence is above the England average: 16.2% within South West Lincolnshire CCG compared to 13.6% in England.
- Psychoses prevalence is below the England average: 0.5% in South West Lincolnshire CCG compared to 0.8% in England. However depression prevalence is above the England average: 13.4% in South West Lincolnshire CCG compared to 11.7% in England.
- Cancer prevalence is above the England average: 2.2% (CCG) – 1.8% (England).The number of Cancer admissions per 1000 is also above the England average, 40.9 (CCG) – 28.6 (England).

Lifestyle – Key Points:

- Obesity prevalence is above the England average, 11.8% (CCG) compared to 10.7% (England), but it's lowest in comparison to the other Lincolnshire CCGs.
- Smoking prevalence cannot accurately be found for individual CCG areas. However according to the Integrated Household Survey by Department of Health, smoking prevalence in South and North Kesteven does not exceed national average (17.3% and 20.0% respectively compared to 20.0% in England).
- The Health and Wellbeing Strategy 2013-2018 stated that "It is estimated that a higher percentage of adults in Lincolnshire smoke than in the East Midlands and England. However, the percentage of people quitting smoking is higher in Lincolnshire than in England."
- Priorities within Lincolnshire according to the Health Profile 2012 (www.apho.org.uk) are obesity, alcohol and tobacco.

2.3 REFERRALS AND ADMISSIONS

- The number of GP referrals to outpatients (1st attendance, per 1000) is above the England average: 195.8 (CCG) compared to 191.7 (England).
- The number of elective admissions (per 1000) is above the England average: 145.5 (CCG) compared to 121.0 (England).
- The number of emergency admissions (per 1000) is slightly below the England average, 85.1 (CCG) compared to 89.0 (England).

SECTION 3: SYSTEM VISION

3.1 LINCOLNSHIRE SUSTAINABLE SERVICES REVIEW (LSSR)

Since August 2013 the Lincolnshire Sustainable Services Review (LSSR) has brought together the health and social care community in Lincolnshire to establish a vision for health and social care provision and to focus on how the people of Lincolnshire can achieve the best health and social care outcomes for the resources available and what care should look like in 3 to 5 years' time.

The overall objective is to collaboratively design and implement a future model of integrated care that will allow the Lincolnshire health and social care system to deliver high quality services within a sustainable financial model.

The partner organisations are: Lincolnshire East CCG, Lincolnshire West CCG, South Lincolnshire CCG, South West Lincolnshire CCG, NHS England (Leicestershire and Lincolnshire Area), Lincolnshire County Council, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services NHS Trust, United Lincolnshire Hospitals NHS Trust and East Midlands Ambulance Service and Health Watch Lincolnshire.

The Plan on a Page shown above provides a pictorial of the direction of travel in terms of the model we will be collectively developing for the provision of health and social care services in Lincolnshire.

3.2 WORK STREAMS & TIMESCALES

The LSSR involves two phases of work:

Phase 1 was carried out between July and October 2013 and produced a Blueprint Design focused on 4 main areas:

- Establishing a vision and objectives, mobilising the team
- The current model of care: agreeing a baseline for how the health and social care economy currently operates:
- The future model of care: engaging clinicians, health and social care professionals and patients and carers in four Care Design Groups to develop design options, followed by modelling to understand

the financial and activity impact of the proposed changes.
- The creation of a roadmap to deliver the changes proposed for consideration.

The Blueprint was approved by the health and Wellbeing Board in December 2013.The Blueprint is only a first step – but will act as a unifying guide against which the planning and performance of each consistent organisation will be held to account.

Phase 2 of the LSSR runs from February 2014 to December 2014, and includes developing robust models for all 4 care groups along with enablers for implementation. There will be a comprehensive pre-consultation and full consultation. Some of the 22 interventions do not need consultation and implementation can therefore begin during 2014/15, the catalyst being the **piloting of a range of 5 to 6 Neighbourhood Teams and the further development of the Urgent Care Plan and seven day working**, which are seen as the key elements of the model of integrated care to avoid unnecessary admission and enable an integrated approach across all providers to care in the community and closer to home.

3.3 KEY VALUES AND PRINCIPLES

To provide a structure for understanding the future model of care developed by the CDGs, the programme team have considered the future model of care in terms of:

- The overall goal – sustainability in Lincolnshire's health and care economy
  - The principles of how the overall goal will be delivered
    - People are engaged and informed
    - From fragmentation to integration
    - Prevention is better than cure
    - Shared decision-making

  - The assets needed to achieve these outcomes. The Future Model of Care will include ten assets designed to drive our four principles and overall benefits:
    - Home is a safe place for care
    - Early detection and intervention
    - Assistive technologies
    - Carers are valued
    - Focus on flow
    - Clarity of where to go and who to see
    - Care is planned and co-ordinated
    - Standardised professional decisions
    - Specialist care in the right place
    - ideas required to achieve the future blueprint

  - The 22 improvement interventions within the following categories
    - Proactive Care
    - Urgent Care
    - Elective Care
    - Women and Children's

3.4 IMPROVING QUALITY AND OUTCOMES

Currently, Health and social care services are commissioned and provided by a number of separate organisations. Service models have developed and evolved based on these partial views of the system, with services being fragmented by organisation boundaries, traditional professional distinctions and separate funding, regulation, physical locations and IT systems.

Care professionals across Lincolnshire have strived to deliver the best possible care within this framework – but it has led to duplication, "hand-offs" of people between organisations, and a lack of clear end-to-end accountability for people's health and social wellbeing. To many patients and members of the public this brings confusion and uncertainty.

The current configuration not only constrains care professionals, but through duplication and uneven

distribution of resources is not financially sustainable and particularly not given the expected growth in the population and increasing older people. Some recent service quality issues also indicate a system under pressure and that reform is required.

The leaders of health and social care across Lincolnshire have come together to focus on defining the right services for Lincolnshire to improve quality and outcomes and deliver services that the population will value and care professionals can be proud of.

3.5 SUSTAINABILITY AND COMMITMENT TO DELIVER

The LSSR does not fully close the affordability gap, but the interventions described and the benefits they will deliver are intentionally realistic, in order to ensure that the proposed service model is achievable and sustainable. There is significant opportunity for the benefits realised to go beyond what is described. In addition it is anticipated that the implementation phase will allow for identification of new possibilities that will help to further close the financial gap.

Integration is national policy and it is essential we get services working together, especially community care, social care, primary care and prevention and early intervention. In light of this, the organisations involved in the delivery of health and social care in Lincolnshire have agreed to work together to design a blueprint for the future delivery of services that would meet the needs of the population both now and in the future, and do so whilst operating under the financial constraints that exist to make the right choices for sustainability, particularly where these choices are difficult and contentious.

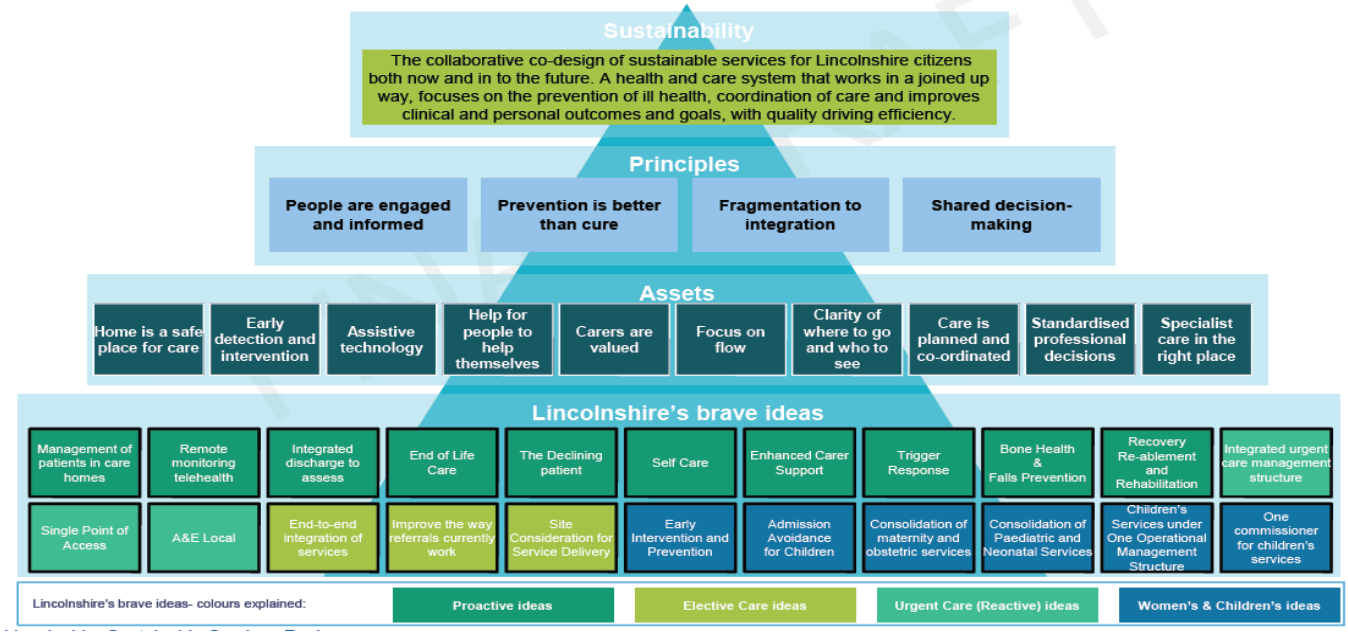
3.6 IMPROVEMENT INTERVENTIONS

In order to achieve the future model of care and the proposed capabilities 22 interventions (as proposed by the Care Design Groups) have been proposed (see diagram below), which include:

- Proactively managing people, particularly those with long term conditions and the frail elderly thereby
- Avoiding unnecessary hospitalisation
- A clear simple response to an urgent need and
- Aligning all urgent care response services under a single operational management
- More consistent access to urgent care thus protecting specialist services
- No longer setting up hospital services in competition with community services
- Safety and quality as the main focus

These will be supported by some key enablers, such as Estates, IM&T, Contracting and Workforce Planning.

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



SECTION 4: OPERATIONAL PLAN

4.1 DELIVERY AGAINST THE FIVE DOMAINS

We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society
We want to make sure that those people with long-term conditions including those with mental illnesses get the **best possible quality of life**
We want to ensure patients are able to **recover quickly** and successfully from episodes of ill-health or following an injury
We want to ensure patients have a **great experience** of all their care
We want to ensure that patients in out care are **kept safe** and protected from all avoidable harm

4.1.1 Performance Against the Five Domains

During 2013/14, performance during the year is reported as follows against the 5 domains of the Outcomes Framework:

Domain 1 Preventing people from dying prematurely (5 Indicators)			
Green – 2	Amber – 0	Red – 3	Blue – 0
Domain 2 Enhancing quality of life to people with long term conditions (5 Indicators)			
Green – 0	Amber – 0	Red – 0	Blue – 5
Domain 3 Helping people recover from episodes of ill health or injury (7 Indicators)			
Green – 4	Amber – 0	Red – 0	Blue – 3
Domain 4 Ensuring people have a positive experience of care (5 Indicators)			
Green – 3	Amber – 0	Red – 2	Blue – 0
Domain 5 Treating and caring for people in a safe environment and protecting from harm (2 Indicators)			
Green – 1	Amber – 0	Red – 1	Blue – 0
Key: Green – achieving, Amber – at risk, Red – not achieving, Blue – where no data is available in 2013/14			

4.1.2 Improvement Intentions

3 out of the 5 Domains have areas of non-achievement, further details are as follows along with intended remedial action.

Domain 1 Preventing people from dying prematurely:

PYLL from Cases Considered Amenable to Health
There has been no improvement and no decline in the figure.
The measures contained within the LSSR Blueprint around prevention will undoubtedly have an impact on reducing the PYLL, for example: Plans for early intervention, alarm systems, self-care, falls prevention, neighbourhood teams and generally much better access to care in the community, to mention some

Under 75 Mortality Rate from Cardiovascular

The CCG's Governing Body has agreed that CVD is a priority for the next 2 years. Based on the performance data, there is significant evidence that improvement is required

The CCG have commissioned a 'deep dive' piece of working, drilling down into the performance data to identify targeted areas for improvement. One of the areas already identified is Diabetes. A project has already commenced to identify issues within the current
Diabetes service and to identify improvements taking into consideration the national model for Diabetes care that has recently been made available.

Under 75 Mortality Rate from Cancer

As for CVD, it has been agreed that there will be a 'deep dive' into the cancer performance information in order to inform further review.

Domain 4 Ensuring people have a positive experience of care:

Patient Experience of Primary Care – GP Out of Hours
We will undertake further analysis of the data and will work with practices and the Out of Hours provider to agree actions required.
Friends and Family Test – Score – Provider 2 – (NUH)
Whilst there has been no improvement in this score, there has been no deterioration either. However, this area clearly needs attention and will be managed through the formal contract management process with NUH and through the CCGs Quality and Patient Experience Committee.

Domain 5 Treating and caring for people in a safe environment and protecting from harm:

Healthcare Acquired Infection Measure (MRSA)
Figure currently sitting at 2 with a target of zero. There has been improvement but clearly needs further improvement. Actions have been identified and the CCGs have appointed a new Infection Prevention and Control lead who will be working directly with providers.

ULHT has a specific action plan in place to manage the risk of patients acquiring MRSA bloodstream infection. Key actions include:

Multi-disciplinary post infection reviews undertaken as per national standard
Root Cause Analysis undertaken to ensure that lessons learned are identified, actions are put in place to address any issues and learning is disseminated throughout the trust.
Invasive device supply company representatives visiting all sites to provide training

The CCG federated IP&C has also produced a service plan (currently out to exec nurses for review) which will ensure that the appropriate assurance is obtained from ULHT regarding their MRSA action plan.

4.2 DELIVERY ACROSS THE SEVEN OUTCOMES MEASURES

The seven outcome measures will be delivered and improved upon through the implementation of the LSSR and the local areas of service development that have been identified as local priority projects over the next 2 years. Some of the projects will be conducted on behalf of the Planning Unit.

The table below shows the projects and identifies the links of each of these to the seven outcome measures.

The LSSR interventions and local service development projects will improve health and reduce health inequalities across Lincolnshire and specifically within South West Lincolnshire.

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
Current Level of Achievement – South West Lincs CCG only		2012 Baseline of 1978.8. 3.2% reduction year on year target. CVD primary contributor	12/13 figure 74.1. 2nd best CCG in County (best 82.3). Above England average 73.1. Target 1% year on year	12/13 Baseline 2075.7. 2nd poorest CCG in County. Above England average. 15% reduction in 5 years. 50% of target to be achieved by end of year 2	Proportion of older people still at home 91 days after discharge from hospital into reablement/rehab services :12/13 Baseline 72.40%. Oct 2015 target 80%	12/13 Baseline 155.8. 2nd highest performing CCG in County. Above England average (reducing target – England 142, our target 142)	12/13 Baseline 6.8. Poorest performing CCG in County. Above England average (reducing target – England 6.1, our target 5.8)	MRSA YTD figure is 2. Target zero.
SOUTH WEST LINCS CCG								
1	CVD Deep Dive	√	√	√	√	√	√	
2	AF Stroke – GRASP Tool	√	√	√			√	
3	Palliative Care Hospice Beds Provision			√		√		
4	Re-commission Diabetes Model of Care	√	√	√	√		√	
5	Mobile Outreach Team		√	√	√		√	
6	Re-Commission Intermediate Care layer for intervention not requiring acute bed			√	√		√	
7	Commission Community Dermatology Service		√				√	
8	Pilot Complex Back/Spinal Opinion Service		√				√	

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
9	Implementation of Care Home Education Project	√	√	√	√		√	
10	Commission movement disorder service, currently a pilot for Parkinson Disease		√	√			√	
11	Shaping Health – Integrated Urgent Care at Grantham inc Children			√		√		
12	Shaping Health - Grantham Ambulatory Care Unit			√		√		
13	Shaping Health - Kingfisher Hub for Children's Services		√	√		√	√	
14	Shaping Health - Repatriation of elective care, development of day case unit (Grantham)			√		√		
PLANNING UNIT LEVEL								
15	Commissioning Cancer Services	√		√		√	√	
16	Improving Access to Psychological Therapies (IAPT)		√					

Ref No.	IMPROVEMENT INTERVENTION	Ambition 1 Securing additional years of life for the people of England with treatable conditions	Ambition 2 Improving health related quality of life of the 15 million+ people with one or more long-term condition	Ambition 3 Reducing the amount of time people spend avoidably in hospital	Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	Ambition 5 Increasing the number of people having appositive experience of hospital care	Ambition 6 Increasing the number of people having a positive experience of care outside hospital	Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals
17	Dementia Pathway Development	√	√	√		√	√	
LSSR								
	PROACTIVE CARE MODEL – NEIGHBOURHOOD TEAM							
1	Management of Patients in Care Homes	√		√			√	
2	Remote monitoring telehealth	√	√		√		√	
3	Integrated discharge to assessment				√	√	√	
4	End of Life Care					√	√	
5	The Declining Patient	√	√				√	
6	Self Care	√	√		√		√	
7	Enhanced Carer Support				√		√	
8	Trigger Response	√	√	√	√		√	
9	Bone Health & Falls Prevention			√	√		√	
10	Recovery, re-ablement and Rehabilitation		√	√	√		√	
	URGENT CARE DESIGN							
11	Integrated Urgent Care Management Structure			√		√		
12	Single Point of Access					√		
13	A&E Local			√		√		

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	ELECTIVE CARE							
14	End to End Integration of Services					√	√	
15	Improve the Way Referrals Currently Work					√		
16	Site Consideration for Service Delivery					√		
	WOMEN'S AND CHILDRENS							
17	Early Intervention and Prevention			√			√	
18	Admission Avoidance for Children			√			√	
19	Consolidation of maternity and obstetric services					√		
20	Consolidation of Paediatric and Neonatal Services					√		
21	Children's Services Under One Operational Management Structure		√			√		
22	One Commissioner for Children's Services		√					

4.3 PARITY OF ESTEEM

Child and Adolescent Mental Health Services (JHWBS-theme 4)

There is a current section 75 agreement in place between Lincolnshire County Council and Lincolnshire CCGs for the provision of Tier 2 and 3 services. Tier 2 CMHS has been fully integrated into local Children's services, however in 2014/15 pilot work will take place in Grantham on the wider integration of children's services including Tier 3 CAMHs.

In 2014/15 Lincolnshire County Council as the lead partner will undertake a re-specification and procurement exercise for tier 3 services to ensure a stronger focus on urgent response and 7 day working.

Parity of Esteem (JHWBS-theme 1,2,3)

CCGs and LCC will review provider contracts over the next 12 months and update contracts to ensure that they contain explicit requirements to ensure parity of esteem including a review of:

Eligibility criteria for services;
Education, training and skills of staff;
Open book accounting with clear understanding of activities that support parity of esteem.

Patients with schizophrenia will on average die 14.6 years earlier, bipolar 10.1 and patients with schizoaffective disorder eight years earlier than the general population. The CCG is working with partners to reduce the health inequalities between people with serious mental illness and the general population including

Making Every Contact Count; pick up patients with physical health conditions that need assessment and treatment early;

Putting in place a local CQUIN to ensure that experts support people on complex medications for severe mental health conditions in the primary health care setting to ensure the effects and side effects of psychotropic medications are routinely monitored and addressed;

Improved access to healthcare and talking therapies;
Ensuring suicide prevention policies are effectively implemented;
Ensuring the Care Programme Approach supports people with severe mental health conditions;
And ensuring positive mental well-being is recognised as being a central part of an individual's good health and care

4.4 IMPROVEMENT INTERVENTIONS – PATIENT SERVICES

4.4.1 Action Plan

The Action Plan below provides further detail on each of the proposed interventions at LSSR level, SWLCCG level and Planning Unit level. Some of the SWLCCG interventions currently underway and ongoing over the next 2 years will feed into the delivery of some of the interventions committed to within the LSSR.

Ref No.	IMPROVEMENT INTERVENTION	Progress to Date	Implementation Targets Next 2 Years	Quality/Outcomes Impact
SOUTH WEST LINCS CCG				
1	CVD Deep Dive	CCG identified opportunities for improvements in quality and outcomes for CVD from the Commissioning for Value Pack. Informed by prevalence in: CVD primary prevention Coronary heart disease Heart failure Heart failure due to LVD (left ventricular dysfunction) Hypertension Obesity in age 16+	Deep dive has been commissioned from GEM. Timescale to be complete by end of quarter one.	Tell us 'what' we need to do in order to achieve: Financial - Savings on elective and day case admissions, non-elective admissions and prescribing Quality – improve mortality rates for CVD patients under 75 (11 patients per year) Reduce the number of patients with high blood pressure and high cholesterol (reduce by 185 with high blood pressure and 165 with high cholesterol) Reduce TIA's by 19 Length of stay reduced by 53 patients where patients are spending 90% of their time in hospital rather than in the community
2	AF Stroke – GRASP Tool	GRASP AF tool has been adopted by 18 out of 19 practices. Educational seminars in Jan 2013 and Dec 2013 for clinical practice staff.	The screening and methodology for identification adopted by clinical staff will continue and will feed into the CVD project identified above. Statistics will be obtained to demonstrate impact on prevention	Enabled early identification of patients with AF through routine and opportunistic screening, using recommended methodology and monitoring through the GRASP tool. Resulting in reduction of AF patients who could potentially progress to having a stroke or heart failure. Reduction in prescribing costs through appropriate administration of medication. Avoiding emergency admissions for stroke of 12 per year. Ability to manage AF in primary care setting without referral into acute. QIPP Plan was to reduce stroke admissions by £19,000. Achievement is £12,500 at month 8. Reduction in number by 6 less strokes this year.
3	Hospice Palliative Care Provision	St Barnabas and ULHT are jointly providing 6 nurse-led palliative care beds on the hospital site; supported by GP's – a Hospice in a Hospital. This has stimulated much interest from NHS England due to the unique concept. Building work started	The beds will open in July 2014. Running concurrently is a review of all EOL community services to identify the money flow. Identified that there needs to be changes in clinical behaviour in	Invest to save – initial investment of £109,800 in 13/14. Will remove 50% of deaths in hospital on the Grantham site. Improve patient experience and quality of care

		Jan 2014 and is on schedule for completion to meet opening date of July. Staff selection timetabled for end Feb 2014. Training programme developed to ensure staff are prepared before opening date. Training timetabled in June for GP practice clinical staff.	order to release savings, including earlier identification of palliative care patients. If this is achieved the beds will be self- sustaining in 2015/2016. Work will feed into the LSSR Proactive Care EOL work.	– avoiding patients dying on wards. Patients currently unsupported, along with their carers, in the community or in hospital, will receive a much improved level of support. Ensure dignity of patients at end of life. Will also support patients who require stabilisation during palliative phase but not close to death. Hospice nursing team will be able to outreach to patients within the hospital who still require acute bed based treatment.
4	Re-commission Diabetes Model of Care	Framework review of services undertaken in 2013 to establish current position and to identify gaps and issues with current service provision/model. Diabetes has also been identified in the Commissioning for Value Packs. Identification of LLR model as example of best practice – up-skilling primary care clinical staff to provide level 2 care	Reconfigure services at a countywide level with the recently issued outcome based National Specification (aligned to NICE clinical standards). This work will also integrate with the LSSR Neighbourhood Team implementation. Final approval of the business case will be quarter 1 with implementation in quarter 2. The model is similar to the LLR model Investment in up-skilling practice staff. This work will link into the CVD work as a large proportion of the CVD patients will also have diabetes.	The National Specification is outcome based. Less use of secondary care. The Commissioning for Value Pack identifies: Change of prescribing practice. Resulting in a reduction of costs. Quality improvement for over 500 patients. Reduction in non-elective admissions. Reduction in length of hospital stay. Reduction in outpatient's appointments. Care closer to home through community based provision. Enable and educate patients in relation to self-care, in order to avoid/reduce complications further down the line.
5	Mobile Outreach Team	7 day working 11/2013 as part of community services Rapid Response service Team expanded to 5 03/2013 CCM team aligned to care homes to undertake care home support and education 01/2014	MOT to be included as part of Neighbourhood Team	The MOT has already avoided 206 admissions to acute hospital sites. Future reduced A&E attendances/admissions from care homes as a result of the CCM alignment. More patients referred to appropriate care settings More patients remaining at home with appropriate support packages
6	Re-Commission Intermediate Care layer for intervention not requiring acute bed	Identified that we should have 24 intermediate care beds. We currently have 16. There is an identified lack of capacity in Grantham. Looked at a number of options. Now in	By April we will have commissioned a pilot for an additional 8 beds in Grantham that will not exclude dementia patients.	Plan not to re-open 34 beds currently closed as a result of the Keogh Review at Grantham Hospital resulting in reduction of acute beds and acute admissions.

		discussion with new care home opening in Grantham.		To support the ongoing bed reduction at ULHT on the Lincoln County and Pilgrim Sites. Flow within the hospital will be improved by enabling a step-up into intermediate care and facilitate step-down out of acute hospital beds into intermediate care. Improved patient care and patient experience. Re-ablement and rehabilitation of these patients will enable them to continue to live more independently and avoid/delay the need for social care intervention. Reduce impact on long term placements in nursing or residential care homes.
7	Commission Community Dermatology Service	The CCG have identified due to performance issues with meeting Constitutional standards that there is an opportunity to commission a service in the community.	Complete a business case by end of first quarter for implementation by the end of 2014/15.	Early work identifies that we could reduce Outpatients, follow ups and some treatments in secondary care. Opportunity to use tele-medicine. Care Closer to home
8	Pilot Complex Backs / Spinal Opinion Service	Local services have been explored whilst countywide discussions on a unit level service have not developed in the way the CCG would like locally. The CCG has audited the existing services for MSK and determined the true gap. Spinal Injections have been reviewed and actions taken to ensure these obtain prior approval from all providers.	Sheffield back pain service has been highlighted as best practice and the CCG wishes to adopt similar pathways. Currently discussions underway with a provider regarding a pilot service for 12 months as the current spinal service will cease at the end of May 2014 and that will allow analysis of other linked services.	The CCG CFV pack identifies savings (1.2M) and improvements for MSK services. Since the baseline the CCG has reviewed the LIMMS and AQP MSK service and identifies that the remaining opportunity for improvement will be delivered by a Complex back and Spinal Opinion pathway. This will impact upon prescribing, elective and day case admissions.
9	Implementation of Care Home Education Project	CCM team increased to 3 in March A number of homes identified as having gaps in training demonstrated by higher levels of use of 999 services. (Report available)	By April CCMs are aligned with care homes to conduct Falls, UTI, respiratory assessment and training, ward rounds and advice to staff. All CCMs will be part of the Rapid Response Team so that EMAS crews only have one number to dial 24/7.	To increase the numbers of patients treated at home and decrease ambulance call outs and A&E attendances and admissions. Reduce the number of unscheduled admissions from Care Homes Reduce the number of falls – including recurrent falls Reduce the number of UTI Improvement of quality of care due to increase in staff skills levels Reduce the number of pressure sores occurring (Grade 2-4)

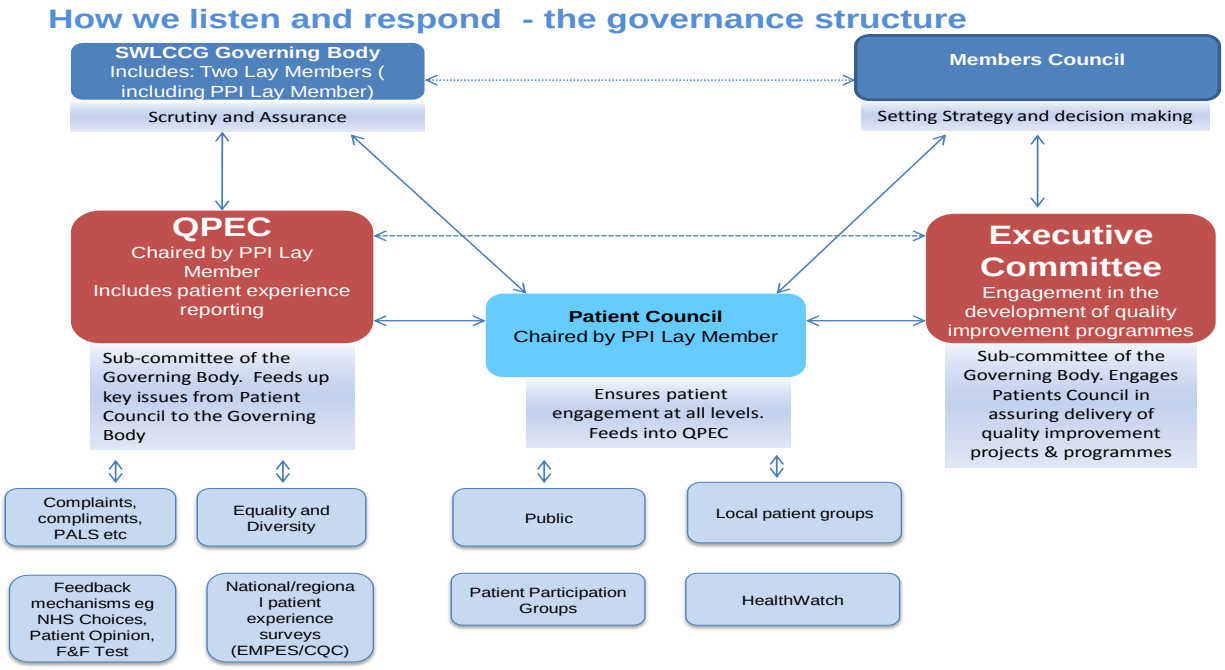
10	Commission movement disorder service, currently a pilot for Parkinson Disease(PD)	PD service started 09/2012 in partnership with Parkinson's UK. CCG agree to continue funding 09/2014 – 03/2015 Review of movement disorder services undertaken by Public Health student	03-09/2014 Identify and agree movement disorder service model Prepare business case for funding for service and to fund PDNS to cover transition period Possible staged implementation to embed the service and ensure it is within the CCG financial envelope	PDNS brought CCG PD services up to NICE standards delivery better quality of care for people with PD. Movement disorder service will bring care closer to home to a wider range of patients with neurological conditions. In the CCG CFV pack there is an opportunity to reduce non elective admissions and prescribing but it is very difficult to quantify the nurse impact due to coding. However we know from national work that by proactively managing PD patients they are less likely to be admitted. Common admissions are falls as a result of medication changes.
11	Shaping Health – Integrated Urgent Care at Grantham inc Children	In order to deliver the integrated front door model building works need to be undertaken at Grantham. Department design is underway and due to complete by the end of March. During 2013/14 there has been a pilot running of a GP in A&E to support A&E staff with decisions to admit, see and treat children with minor illness and treat other patients as a member of the A&E team. Current avoided at month 8 is 299 Dedicated observation/treatment space for children with urgent care needs has been completed and Paediatric nurses will be moved into A&E in March.	Integrated front door department design is underway and due to complete by the end of March. The timeframe for the building work is dependent on the design selected. Work is ongoing to develop operational policy / referral processes / cross organisational working alongside contract discussions.	Reduced emergency admissions for children of 35 per month. Less Ambulance transfers Improved quality of care as children are seen and treated in one department. Multi-Disciplinary Team working to ensure patients are treated by the right professionals first time will enable achievement of A&E Constitution targets.
12	Shaping Health - Grantham Ambulatory Care Unit	In order to deliver the full Ambulatory Care service building work is required. In the meantime to cover winter pressure the first phase of the ambulatory care pathways started in Nov 2013 within the existing A&E and EAU footprint at Grantham Hospital.	Building work due to commence in April 2014 and is to be completed by Aug 2014. Currency and payment regime to be agreed. Operational policy / referral processes / training programme to be developed by a task and finish group during the build time.	Reduce avoidable Emergency admissions and national evidence base by up to 40% The CCGs CFV identifies opportunities for improvements in quality and savings for non-elective admissions in patients that would have an ambulatory sensitive care condition Where patients do need to be admitted early diagnosis provides for better outcomes
13	Shaping Health - Kingfisher Hub for Children's Services	Staff consultations to move nurses to the Integrated Urgent Care Centre and it is planned to move those staff in March.	It is planned to have a 3 phase approach to the children's hub and this would be: Phase 1 – Reconciling all	One stop care for children including the most vulnerable. Better care Coordination

			ULHT activity that was currently going into Boston Health Clinic and could be brought into the Grantham unit. An invitation was to be extended to the other ULHT specialities such as Orthopaedics, ENT to encourage them to hold their Paediatric clinics within the hub. Phase 2 – MDT from LCHS, LPfT. Phase 3 – Lincolnshire County Council – Fully integrated Health and Social Care facility – April 2015	Reduced Waiting times Reduced hospital stays Major contribution to special education needs reforms (SEND)
14	Shaping Health – Development of elective capacity at Grantham including development of a day case unit (Grantham)	Options appraisal undertaken and preliminary work to develop business case completed by ULHT. Awaiting ULHT Investment Programme Board decision for capital investment funding in March,	Once IPB has confirmed the timeline will be agreed.	Improve access, availability and productivity of outpatient and elective care services at Grantham Hospital, where possible offering one stop clinics and day case surgery. This will reduce the numbers of patients required to travel outside of the area and will also reduce the financial burden of paying increased market forces factor for care outside of the county. These services will be available 7 days a week. This will support hospital re configuration as part of LSSR enabling greater concentration on emergency care on one or more of the other Lincolnshire sites.
PLANNING UNIT LEVEL				
15	Commissioning Cancer Services	Current performance in Cancer services and outcomes has been identified by the CCG as an area that requires further analysis and support. The CCG practices have undertaken a review of all breaches of targets and a report is to be completed in March. The CCG has commissioned a deep dive into Cancer to be completed by April 2014.	• Ensure access to treatment (14, 31 & 62 day measures • Individual funding reviews • Access to cancer drugs fund • Adherence to best practice (e.g. chemo protocols) • Prevention through screening achieved and sustained • Breast Screening – Age extension implemented offering screening to 47 to 73 year olds	The CCG CFV pack identifies opportunities in spend and quality that will be tested through the deep dive. Survival rates will be increased owing to early detection and treatment

			• Cervical screening – HPV and test of cure • Bowel Cancer – Age extension has been increased to men and women age 60 to 75	
16	Improving Access to Psychological Therapies (IAPT)	There has been a performance improvement plan in place with LPFT. Performance remains above the national average. Recruitment and retention of staff is challenging but training programmes are in place. Single point of access for mental health services has been implemented as has self-referral.	Service for people with common mental health problems will initially be aligned and then integrated into neighbourhood teams. We will be engaging the market across Lincolnshire to secure additional capacity and increase patient choice.	We expect a 1% per year improvement in uptake of the service and continued improvement in recovery rates.
17	Dementia Pathway Development	Lincolnshire is developing a new Dementia Strategy which will be complete by end of April 2014. Lincolnshire County Council have led a public consultation on the Strategic Priorities for Dementia care.	Following agreement of the final strategy commissioning intentions will be confirmed covering the diagnosis, ongoing support and integration with social care. Diagnosis made either as a GP or memory assessment service pathway Navigator / support worker person attached to patient at time of diagnosis Signposting to network of agencies who provide help and support Advanced care planning and management of difficulties via the memory service at a point when the need becomes apparent	Increase Dementia Diagnosis to 67% Improved Public awareness of dementia Improved identification and early diagnosis Improved Quality of diagnosis Improved support for families/carers Increased self-management CCG CFV pack identifies savings in prescribing and reduction in emergency admissions for over 74 with secondary diagnosis of dementia.

4.4.2 Citizen Participation in Service Design, Change and Own Care

As a leading local healthcare commissioner, South West Lincolnshire Clinical Commissioning Group (CCG) is committed to ensuring that our patients and citizen drive decisions about their health care. The CCG has appointed a Patient and Public Engagement Lay Member and established a Patients Council to act as a diverse reference group to enable the citizens of South West Lincolnshire to make an effective contribution to the prioritisation, design, planning and commissioning of health care services in alignment with the CCGs strategic objectives. The Patients Council ensures that mutually advantageous relationships develop between the CCG, Healthwatch and local Patient Participation Groups to help shape the most effective health services for the local population. The PPG representatives, as part of the governance arrangements for the CCG, hold listening events within their respective groups and wider practice populations and real time report any issues, ideas or experience of local health care. The Patients Council reports directly to the Governing Body.



Through its Shaping Health for Mid-Kesteven programme the CCG has already made significant progress consulting and involving the local communities in decisions about care and getting public feedback on a range of issues including treatment choices. To ensure a sustained and meaningful dialogue a continuous listening model has been developed based on the patient engagement methodology employed by Keogh in response to 'Transforming Participation in Health and Care'. The CCG webpage has also been developed to encourage real time feedback, 166 tweets issued – 43,993 potential impressions, 37 new followers on Twitter – 38%increase since Quarter 1 and 71 Facebook posts issued – 29,900 potential impressions. Patient choice, involving patients and carers in decisions about care and the duty of candour are mandatory measures through the quality schedule in place with providers and are monitored through a programme of annual quality visits. The CCG monitors NHS Choices Patient Opinion at GP, Mental Health & Learning Disability & Acute Care level.

4.4.3 Wider Primary Care, Provided at Scale

Primary care has huge potential to contribute to the delivery of our ambitions, particularly relating to proactive care. The Director for Primary Care Direct Commissioning at the Area Team has joined the Lincolnshire Joint Commissioning Group with all CCGs and Lincolnshire County Council which is leading the Strategic Commissioning to underpin the LSSR.

The LSSR is absolutely clear that primary care and general practice is at the centre of the neighbourhood team model. This will mean that new models of joint commissioning and new contractual frameworks and increased strategic coordination will be needed across the CCG, Area Team and County Council.

The CCG has historically; using Quality Premium (QP QOF), enabled primary care to focus on pathway changes that improve the quality of care in which primary care has a role. Over the years, this has moved from small scale to larger scale projects which have directly improved quality and cost.

The CCG has met with member practices to start the discussion about the role that primary care could have and their response to the Call to Action. In recognition of their role and its importance in the overall system, the practices wished to develop a strategy for primary care.

In 2013 the Sleaford and District GPs have been working on a vision for primary care that not only covers core general practice but more broadly that of urgent care, diagnostics, neighbourhood team and shift from secondary care to community for appropriate services. This vision is well placed to meet the needs of the neighbourhood team approach for the area and supports the proactive, urgent and elective part of the LSSR. The vision is currently being developed into a model/blueprint for Sleaford and will be enabled by non-recurrent transformation money. This ensures suitable estate is available in conjunction with the local district council and NHS England from the services it commissions. As part of the development a pilot of non-emergency urgent care in primary care based on the learning from the Corby model will be implemented in 2014/15 to evaluate the impact particularly on ambulance conveyance to Lincoln County Hospital.

The strong message from the public during our Shaping Health consultation was that they wished us to focus on care closer to home and that for Sleaford area services could be delivered as a satellite of Grantham Hospital.

In 2013 the NHSE Area Team (AT) communicated with CCGs regarding 7 day working in Medical practices to support winter pressures. This has supported work the CCG was undertaking to pilot services to support winter pressures delivered by primary care such as the Urgent Care Hub Sleaford; self-management of care home patients with care planning at the heart.

Apart from dental services, the AT only commission ‘core’ services from primary care contractors. CCGs and Local Authorities commission any additional services. We have been working closely with NHS England on the development of Sleaford and ensuring that it fits the emerging strategy for primary care.

The GMS Contract Changes for 2014/15 include some that may impact in this area, particularly the named co-ordinating GP. There will also be a new DES to cover admission avoidance/pro-active case management etc. The CCG has planned two events across all practices to facilitate the planning work required for this.

4.4.4 A Modern Model of Integrated Care

The LSSR has determined that when aggregated, the 22 interventions create a strategically different integrated model of care, a greater proportion of which is provided out of acute hospital settings, with care professionals working across organisational and professional boundaries.

The CCG formally consulted with the public through its Shaping Health Programme in 2013. Some elements of the models of care focus on integration in terms of managing patients in the community with fast access to acute care or diagnostics when needed.

The CCG was part of the long term national QIPP programme which focused on Risk Profiling, Integrated Teams and Self-Management. The biggest barrier to effective implementation has been

identified that primary health and social care teams were needed and that couldn't be delivered unless the teams were locally based. The CCG is planning in 2014/15 to bring forward the neighbourhood team implementation from LSSR - an essential requirement to advance the care for people with long term conditions either multiple or singular.

Other schemes that the CCG has commissioned support a rapid response (Mobile Outreach Team) to patients so that they can be managed in the community. This has been very successful and will be a key part of the neighbourhood team model.

A new palliative care unit will be opening in July 2014 which will improve the end of life care for patients many of which may have a long term condition such as heart failure that is palliative. These beds will ensure that patients receive the very best end of life care in a hospice style environment with support.

The CCG has been participating in the national LTC programme since October 2011. The goals of the programme are to achieve a 20% reduction in emergency admissions, 25% reduction in length of stay for people with LTC, and an improved patient experience. The programme consists of 3 key drivers – risk profiling, integrated neighbourhood care teams, and self-care/shared decision making. The programme requires all 3 drivers to be implemented. As part of this programme a risk profiling tool, successfully developed by NHS Devon was implemented and currently sits on the Datawatch Dashboard. This dashboard can be accessed by all Lincolnshire practices. In April 2013, a model of integrated neighbourhood care teams was implemented. This is also aligned to the implementation of the new risk profiling DES, where the integrated neighbourhood care teams meet regularly to discuss the results from the risk profiling screening and identifies those patients who would most benefit from direct care management. The work to fully implement the final driver on self-care / shared decision making has been delayed due to the data sharing issues.

4.4.5 Access to the Highest Quality Urgent and Emergency Care

Our vision for urgent and emergency care aligns with the principles outlined in Transforming urgent and emergency care services in England. We have a vision of a responsive urgent care system where patients are helped to select from a range of care options that are tailored to the degree of need.

Patients currently struggle to navigate the urgent care system and too often default to accident and emergency as the service offer they understand and know how to access. Simple navigation to a range of options is a crucial component of a new urgent care service.

NHS 111 is the key navigator to the urgent care response, and we will increase the directory of services for urgent care and move toward directly bookable access via the NHS 111 service. Hospitals will be the reserve for the most urgent of cases, with a range of accessible alternatives available and embedded in communities.
Where people have serious and life threatening needs they will be met through a network of local, intermediate and tertiary centres.

The Future Service Model

A wider range of urgent care options:

Urgent care was one of the four design streams of the Lincolnshire Sustainable Services Review (LSSR). A group of clinicians from all key providers were joined by patient representatives and service leads to explore the options and produce the blueprint for urgent care in Lincolnshire. Although this work pre-dated its publication, the blueprint aligned very well with the principles in the Transforming urgent and emergency care services in England report, envisioning a system of main and subsidiary urgent care centres, which the design group labelled 'NHS Local'.

The blueprint calls for one integrated urgent care service which will replace the current often confusing array of primary care, out of hours, walk in centres, accident and emergency, and community resources.

We will increase the role of non-hospital services and clinicians, and continue our drive to get patients to the most appropriate clinician as early as possible in the pathway. This will increase the role of general practitioners and emergency care practitioners in the urgent care system. More patients will

see a primary care clinician and only those of greatest or specialist need will progress to hospital services or access them directly.

Pro-active care to reduce the demand on hospitals

An important part of the urgent care reform is to reduce the number of people reaching crisis and accessing urgent care systems. A second group of the LSSR looked at Pro-active care - services focussed on patients with known needs who require pro-active management and intervention to escalate care where necessary and reduce the risk of crisis, and to reach out promptly when patients have a greater need. A key component of the pro-active care model is the introduction of neighbourhood teams to provide integrated primary and community based management of patients. We will increase the amount of pre-emptive care planning, and introduce named clinicians for patients with long term conditions. The aim of the pro-active system is to prevent patients reaching crisis wherever possible, and thus reduce the number of patients needing to access the urgent care system.

We will continue to develop alternatives to conveyance to hospital and provide our ambulance service with a range of options where hospital services are not required but an urgent response is necessary.

Emergency response services

It is very challenging to provide emergency first response services in a large rural County such as Lincolnshire, with our very dispersed population and poor road infrastructure. We will continue our investment and development of community first and co-responders, working closely with our ambulance provider on new service models. We believe that rural areas need novel answers to the first response challenge. We are working with our ambulance provider, fire and rescue service and County Council to push the boundaries of co-responding, aiming for a first response that is more tailored and embedded in our communities.

Progress During 2014-15

The Lincolnshire Sustainable Services Review Phase Two:

LSSR phase one has already reviewed the urgent care system in Lincolnshire and involved a wide range of clinicians and stakeholders in developing the blueprint for future services. Current services and patient flows were analysed and initial analysis of the implications of revised urgent care systems were explored. These were presented at a clinical summit at which 200+ clinicians and stakeholders reviewed the blueprint and confirmed their support for moving forward. The ground work has thus been completed for further progress on specific design work during 2014-15.

In January 2014 we will appoint the consultants to support phase two of the LSSR. Phase two will complete the detailed design work on all four work streams (urgent care, pro-active care, planned care and women and children's care) which is important because urgent care systems must be aligned with the design decisions across the whole system. Phase two will determine:

- The location and design of urgent care facilities
- The implications for patient flow and access
- The services provided at each level of the urgent care system

Major Trauma Management

During 2014-15 Lincolnshire will implement the requirements of the major trauma network including the conveyance and transfer of patients to the tertiary centre and role of Pilgrim Hospital Boston and Lincoln County Hospital inpatient stabilisation and management.

Urgent Care Development

Lincolnshire will continue the progress already made in reforming urgent care management and in particular increasing the role of primary care clinicians. This is already well established in Grantham, established and developing in Boston, and under consideration in Lincoln. We will focus on our successful NHS 111 service and significantly increase its role in patient navigation, investing in further

DOS (Directory of Services) management capability and participating in the national work programme to extend the NHS 111 service contribution.

Governance and Leadership

Lincolnshire has an active Urgent Care Working Group (UCWG). The Chairman is the Accountable Officer of the lead CCG supported by a Director of Urgent Care and a programme management office. The UCWG has representatives from all key stakeholders including hospital, community, mental health, ambulance, social services, emergency patient transport services, all four Clinical Commissioning Groups and the County Council. The UCWG has delegated authority to manage the investments and programmes of work in urgent care. Investment of MRET funds will be through the UCWG and focussed on schemes that reduce and manage demand for urgent care.

Local Operational Detail

The CCG can evidence its commitment to this methodology by its proactive role as a member of the Lincolnshire Urgent Care Board programme of work in Lincolnshire, which involves all stakeholders in the planning and delivery of urgent care services, and recognises whole system interdependencies. The result is that we will commission pathways of care, rather than ad hoc services which are peculiar to individual organisations.

Locally, the CCG as part of the Shaping Health programme has two key models that directly impact Urgent and Emergency care. These models have been through full public consultation and therefore already determine the footprint locally for urgent and emergency care. The requirement going forward is to be clear clarity on the network that the Grantham unit sits within particularly as part of phase 2 of LSSR.

- Integrated A&E Care Centre Grantham
- Acute Medicine model including community care

The CCG urgent care leads have played an active role in the Urgent and Emergency Care Review, feeding in how this could work in small district general hospitals like Grantham. The model of care is designed to ensure that patients have the majority of their urgent care need met locally. It is recognised that some patients need to go to specialist units (Super A&Es) where appropriate for events such as stroke and trauma.

Previous audits have shown we know that the majority of patients flowing into Grantham Hospital are medical and therefore need a medical consultant physician rather than an A&E consultant that specialise in trauma. By having a skill mix of A&E and medical staffing, patients would get the right care by the most appropriate health care professional first time. This then directly supports the acute medicine behind the front door.

4.4.6 A Step-Change in the Productivity of Elective Care

Delivering the 20% productivity challenge

The CCG has reviewed the Right Care information and identified areas that require further analysis to determine what service re design could be undertaken. There is already work underway to increase the range and access of services provided under a community surgery scheme which is currently in procurement.

During the Shaping Health Programme of work we have identified the need to improve access, availability and productivity of outpatient and elective care services at Grantham Hospital, where possible offering one stop clinics and day case surgery. This will reduce the numbers of patients required to travel outside of the area and will also reduce the financial burden of paying increased market forces factor for care outside of the county.

The CCG has reviewed the Right Care information and identified areas that require further analysis to determine what service re design could be undertaken during the next two years which will all have detailed business cases approved by the Executive Committee. These are in back pain, dermatology,

diabetes and movement disorders. There is already work underway to increase the range and access of services provided under a community surgery scheme which is currently in procurement.

The CCG has procured Map of Medicine for 2014/15 which is designed support the optimisation of care by providing access to comprehensive, evidence-based guidance, and clinical decision support at the point of care. Map of Medicine care pathways offer the opportunity to improve the way commissioning of health care is planned and delivered locally.

As part of the LSSR our key recommendation of the blue print is to consider an alternative framework for commissioning including lead providers and capitation based budgets. The international evidence suggests this will improve quality and costs effectiveness. Implementation will be agreed as part of phase 3 but will require close working with NHS providers and regulators.

4.4.7 Specialised Services Concentrated in Centres in Excellence

The CCG undertook a service review and redesign project called Shaping Health for Mid Kesteven which was subject to a National Clinical Advisory Team assessment prior to a full public consultation. The models of care reflect best practice and secure local access where possible but recognising that for some conditions care is best delivered in centres of excellence. Examples of this are Stroke Care and Trauma.

The Integrated Urgent Care Model specifically meets the national direction from the Emergency Care review and ensures local urgent care is delivered close to home in a wider network of Super A&Es. Children's Urgent Care will move into this model and admissions for children where they need overnight support will be in centres that have full Paediatric cover.

Further development of this will become evident as part of phase 2 of the LSSR.

4.4.8 Convenient Access to Everyone

The CCG is dedicated to providing services that are local and accessible whilst mindful that it may be in the patient's interest to travel to a centre of excellence for some of their care.

During the Shaping Health consultation in 2013, the public gave their blessing to one of several proposals for the CCG to reconfigure disparate children's services into one children's hub based at Grantham hospital. This will ensure that patients have access to a range of services under one roof and have merged acute care with community care.

The GP practices participate in the design and redesign of treatment pathways as part of the QOF QP programmes of work which bring services once provided in the hospital to a primary care setting. The CCG, in collaboration with the other Lincolnshire CCGs is currently involved in a county wide review of a number of enhanced services that are either currently provided in the main by primary care but had the opportunity to extend provision. The intention is to coordinate these services into one contract with a number of services included that GP practices will commit to delivering. This collaborative approach will ensure that there is parity of delivery across the county but also that the services are accessed locally.

In order to improve patient access to Mental Health services, SWL CCG in collaboration with the other Lincolnshire CCGs and in partnership with Lincolnshire County Council has established integrated commissioning arrangements for Mental Health and Learning Disability Services in Lincolnshire. A joint Assistant Director for the Joint Commissioning of Mental Health and Learning Disability Services has been appointed and this is understood to be the first such new appointment in the Country since the introduction of Clinical Commissioning Groups. The joint Mental Health and Learning Disabilities post will lead on the development of an integrated team focused on delivering agreed priority outcomes and through the development of joint commissioning strategies.

During 2013/14 a number of service changes were implemented, most notably:

- Integration of community mental health teams
- A single point of access to mental health services.

Lincolnshire has also recently agreed a new Dementia Strategy which will help to improve outcomes

and progress integrated and where possible local pathways further in 2013/14 and 2014/15.

During 2014/15 the CCGs and Lincolnshire County Council will develop a joint Mental Health Commissioning Strategy.

We will commission services that are as accessible as possible and engage with as many people as we can in the process of designing and commissioning those services, focussing our engagement on those groups of people who are seldom heard.

A great deal of work has been completed over the last 12 months to improve value for money in relation to Learning Disability Services. Good progress has been made against National and Local Outcomes and other KPI's. Unit costs are well performing and Integrated Assessment and Review performance has also increased significantly. A recent peer review has fed back that the local winterbourne plan is robust and there are no outstanding items form the recent stock take to action.

However the joint commissioning team will be developing a Joint Commissioning Strategy for Adults with Learning Disability in 2014-15 with the ambition to make further progress against priority outcomes including parity of esteem. The strategy will also be informed by priorities identified as part of the Big Health Events help in August 2013 as well as the LD and Autism self-assessments. Key areas to be incorporated into the strategy will include:

- Increased Quality of Life
- People feel and are safe
- Promoting Independence, Choice and Control and a reduced dependence on Residential Care
- Enhanced co-production and local engagement
- Greater range of learning disability services and skill mix within teams to support clinical interventions within the community
- Greater focus on the interface with primary care and Acute care which will support increased access to Health Checks for people with learning disability
- Improved transitions linked to Support and Aspiration

In addition

- Ensuring robust quality assurance and monitoring of placements so that individuals are cared for in the most appropriate and least restrictive environment
- The review and implementation of the joint Autism Strategy for Children, Young People and Adults

BENEFITS

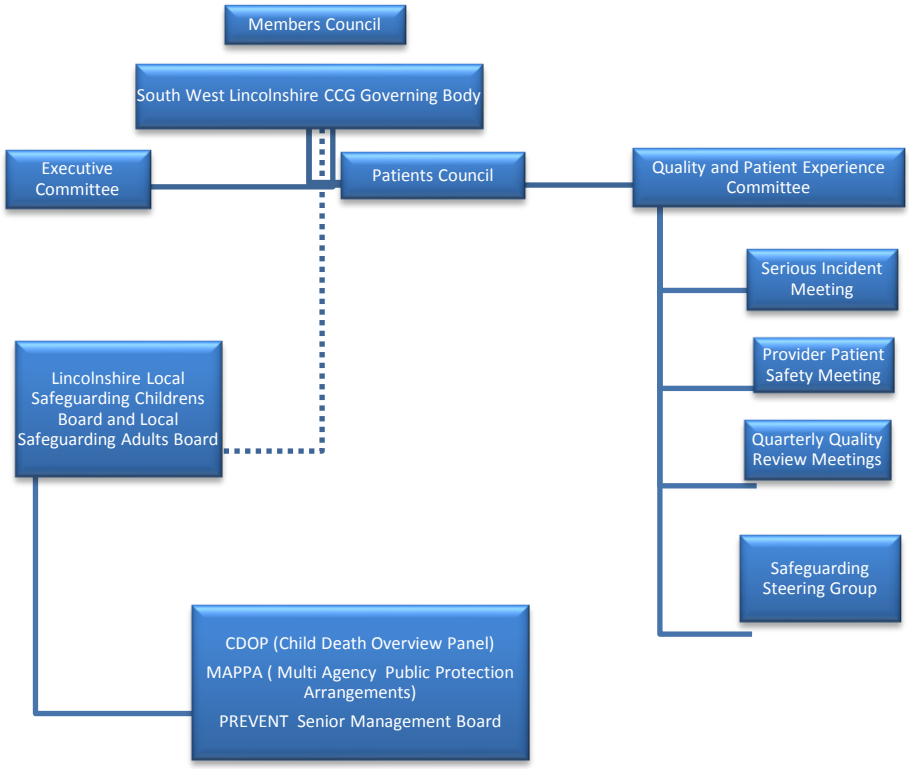
- Securing additional years of life in adults with mental health conditions and or Learning Disability with treatable mental and physical health conditions
- Improve health related quality of life for adults with mental health conditions who have a long term condition;
- Accessible, equitable, high quality mental health services for the people of Lincolnshire ;
- Adults with mental health conditions have Improved health outcomes and timely access to greater range of pathways;
- Adults with learning disabilities have Improved health and care outcomes;
- Adults with learning disabilities have greater support to access annual health checks and number of health checks completed increase
- Learning disability out of area inpatient placements reduced;
- Increased % of adults with learning disabilities supported to live independently;
- Increased number of adults with learning disabilities receiving direct payments;
- Introduction of integrated commissioning unit to improve integration of learning disability, mental health and Autism services.

4.5 IMPROVEMENT INTERVENTIONS – QUALITY

4.5.1 Response to Francis, Berwick and Winterbourne View

In response to Francis, Berwick and Winterbourne the Governing Body has focused on how we assure the quality of care we commission on behalf of our patients and population. Our revised quality assurance framework detailed below will ensure that the organisation is clinically led and publically

accountable and reflects our commitment to focus on cultures and behaviours as much as the transactions we need to make to ensure quality assurance and quality improvement.



The process of quality assurance of commissioned services has a number of component parts which are inter-dependent. These include Contractual Quality elements (Quality Schedule, Nationally Specified Events and the Information Schedule) and CQUINs. Our local clinical focus provides us with the opportunity of extending the depth of 'soft' intelligence with other sources such as complaints, comments, media reports and patient stories that added together form a comprehensive picture of the safety of patients accessing care. The Federated Patient Safety Team triangulates all available data to inform the quality review process for each provider. This helps us to ensure that we are consistent and robust in our scrutiny of service quality with our providers. The Clinical Quality Review Meetings with providers, along with clinical quality visits, ensure a focused approach to quality and uses this information to both celebrate quality improvements and provide challenge and leadership where organisational culture, behaviour and practice does not promote safe and effective care. We will use information to take demonstrable action with providers where the quality and safeguarding of patients is compromised, including channelling through the contract review mechanism and, where necessary, de-commissioning care.

Need a local take on this but also need to refer to the strategic plan (Planning Unit wide) to ensure consistency.

The duty of candour is discharged through the organisations quality assurance framework. Patient focus including safety, experience and clinical outcomes is a core part of Governing Body Meetings held in public. The Governing Body use patient stories to inform decisions at Board level. Health watch are active members of the Governing Body, Quality and Patient Experience Committee and Patients Council. The CCG as a member of the Quality Surveillance Group routinely and methodically shares information and intelligence on the quality of services commissioned. Through Quality Schedules the CCG ensures that Providers adhere to:

- nationally mandated components of the NHS Constitution
- embedding cultural barometer measures and improvement plans
- appropriate processes are in place to ensure improvement in staff satisfaction against the NHS Staff Experience survey
- and that a suite of workforce indicators are monitored on a quarterly basis

Progress in response to Winterbourne is monitored through the organisations Quality and Patient Experience Committee .Partnership arrangements are in place for the delivery of a joint Health & Social Care Learning Disability Self - Assessment Framework. Patients and key stakeholder were engaged in self assessing progress against current plans and the following priorities have been identified for 2014/15:

- A Learning Disability excellence award run by self-advocate groups similar to the Keep Safe scheme for towns
- Increasing in the number of GP's offering annual health checks;
- Expanding coverage of annual health checks through alternative provider models
- Expanding the Learning disability primary care liaison service to be able to offer more service and health action plans as well as complex work
- Explore the commissioning of learning disability community based assertive treatment service (CAST) to take on transitions i.e. 14+
- Commission community based rehabilitation provision expanding current model to reduce hospital lengths of stay
- Establish an Autism liaison service based on the model of 'green light' for mental health
- Developing Autism registers within primary care through QOF or LES
- Introducing Autism screening process in primary care support a diagnostic Pathway
- Transition review process not just for Children but for older adults as well
- Expanding Acute liaison service to 7 days a week
- Increased Mental capacity act training for doctors
- Reviewing transport options that are available in each area and make it more consistent
- Better support for those not able to get a service to get support and employment
- Broadening provider contracts to include people with LD and carers in staff recruitment

The delivery of the Health & Social Care Learning Disability Self - Assessment Framework is monitored by the Local Safeguarding Adults Board.

4.5.2 Patient Safety

The CCG'S Quality Assurance Structure and processes ensure that when people access services their safety is prioritised. The commissioning and contract processes include sections relating to requiring providers to adhere to all legal and regulatory standards to ensure patient safety. The organisation has detailed quality schedules with all provider organisations with a number of key performance indicators (KPIs) relating to patient safety, including, but not exclusively:

- serious incident reporting (including never events)
- medicines management
- Safety Thermometer
- compliance with the hygiene code
- compliance with essential standards for CQC
- safeguarding (including whistle-blowing)
- and the reporting of all risks above an agreed threshold.

These KPIs are monitored on a quarterly basis through the respective provider's quality contract review group. A monthly CCG Patient Safety Meeting takes place with providers to gain further assurance on actions to mitigate risk to patient safety, experience and outcomes where they arise.

The Governing Body receives monthly quality performance reports and quarterly patient safety and patient experience reports (including complaints). The Quality and Patient Experience Committee scrutinises thematic reviews of complaints, serious incidents, PALs, NHS Safety Thermometer– pressure ulcers; falls in care; urinary infection and treatment for new Venous Thromboembolism (VTE) and friends and family test and a programme of external audits is also undertaken by the CCG.

The CCGs Federated Patient Safety Team receives all serious incident reports and the Executive Nurse oversees and signs off RCAs and associated action plans which input from Clinical Members of the Quality and Patient Experience Committee where the issues relate to medical management. GP Practices in South West Lincolnshire are playing an increasingly important role as both commissioners and providers of health care. Whilst these services are commissioned by NHS England, South West

Lincolnshire CCG supports and encourages the development of primary care and the quality of service provision. The CCG is establishing a Member Clinical Governance Group to encourage and engage Member Practices in promoting patient safety. A programme of annual Quality Review Visits will seek to further engage General Practice in the quality agenda and patient safety incidents and preventing and reporting harm will form part of this dialogue with practices.

4.5.3 Patient Experience

South West Lincolnshire CCG values the views and experiences of patients and carers and reported care outcomes that have been provided by patients accessing the services commissioned. Patient Experience is embedded into the quality schedule with all providers through a number of key performance indicators including, but not exclusively:

- improvements in patient survey results;
- progress in respect of the providers patient experience work plan;
- improvement in patient and service user reported measure of respect and dignity in their treatment;
- improvement in overall satisfaction with care;
- Friends and Family Test;
- Complaints;
- And involvement in decisions about treatment.

The quality schedules are monitored via quarterly quality contract review meetings with the provider. Any areas where compliance falls below agreed thresholds is escalated through the contract performance process and action plans are put in place with the provider to achieve compliance within agreed timeframes.

The Quality and Patient Experience Committee retains oversight of achievement of positive patient experience and the Governing Body receives a monthly Quality Indicators Dashboard within includes patient experience indicators i.e. Friends and Family Test, Primary Care patient experience, Hospital Care Patient Experience, PROMS, Mixed Sex Accommodation Breaches. The patient experience information we gather is used to help us understand how patients feel about the services we commission, what may need to change and any improvements proposed by patients and service users. This information is used as an evidence base to support and inform future commissioning decisions and service redesign.

To focus on improving patient experience of the quality of primary care an Annual Quality Review Programme will commence in 2014which will be subject to constant review and development. In the first annual cycle it is proposed to focus on practice visits targeting specific quality areas highlighted from existing quality data sources. Practice Activity Reports utilising data originated from the Secondary Uses Service (SUS), where available, will be utilised to support a dialogue with the Practice. Practices will be chosen at random and each visit will be specific to the practice and flexible enough to cover any quality areas identified for discussion. The visits will seek to:

- Explore the practice and the CCG's aspirations for quality improvement as distinct from contract compliance
- Agree quality improvement priorities by practice
- Support the development of high quality and equitable primary care services that improve patient outcomes, experience and safety and support the direction of travel for the future provision of services in primary care

A Quality Dashboard will be introduced to:

- highlight areas where support may be required
- provide a systematic framework for measuring quality in General Practice, bringing together existing data streams into one comprehensive tool and sharing best practice
- identify any significant deviation from average outturn, to act as a mechanism for initiating dialogue with the practice , in order to offer support and solutions

The outputs from the 2014/14 Annual Quality Review Programme will be used to recognise good

practice and identify where further support can be given to Member Practices as outlined in Figure 1 below.

The CCG will seek to develop Practice Peer Review and a buddying system through Members council to support continued improvements in the quality of primary care.

4.5.4 Compassion in Practice

Delivery of Compassion in Practice Plans is led by Executive Nurses across the Lincolnshire Health economy and embedded into the quality review processes with providers. There is an agreed plan on a page for the delivery of agreed priorities across the Action Areas identified in Compassion in Practice including:

- Integrated working across the whole health economy (health, social care and voluntary sector) to deliver improved outcomes for the frail elderly and in dementia care
- A shared understanding across the whole health economy about the patient and public experience of care
- Patient and public experience of care influences changes to care and services
- Celebrate and share positive experience of care in relation to the 6Cs
- Transparency around quality of care through using metrics which enable benchmarking across all sectors
- Skills, competence and experience of Band 7 nurses in relation to sustaining quality of care
- Focusing on positively managing local nursing talent and succession planning
- A vision for Nurse leadership in Primary Care locally
- Consistency in the recruitment, induction and training of Bands 1-4
- Ensuring that workforce plans reflect local service requirements
- Ensuring staff roles and skills and competencies reflect service needs
- Developing opportunities to support sisters, charge nurses and team leaders in their leadership roles
- Ensuring regular listening to staff and open feedback is a core part of improving care for patients
- Focusing on building staff resilience

The implementation of Compassion in Practice Plans are overseen by the Quality and Patients Experience Committee.

The 6Cs are: Care, Compassion, Competence, Communication, Courage and Commitment

The 6 areas of action are:

- Help people to stay independent, maximising well-being and improving health outcomes
- Work with people to provide a positive experience of care
- Delivery high quality care and measure impact
- Build and strengthen leadership
- Ensure the right staff, with the right skills in the right place
- Support a positive staff experience

4.5.5 Staff Satisfaction

Positive staff experience has a significant impact on patient experience, safety and outcomes. Through our quality contract monitoring arrangements with providers we ensure that the expectations outlined in 'How to ensure the right people, with the right skills, are in the right place at the right time' are embedded in practice. This comprises of a suite of workforce indicators monitored on a quarterly basis including; rate of sickness, staff turnover, vacancy, agency/bank usage rate, baseline establishment for the organisation including, breakdown by staff group and breakdown by directorate/function/locality, as relevant per provider. Providers must be able to demonstrate that they are using appropriate and safe workforce models to ensure that you have the right workforce configuration and that the organisational culture encourages them to perform their job to the best of their abilities. Through quality contact monitoring and professional oversight including walkabouts the CCG ensures that Providers adhere to nationally mandated components of the NHS Constitution, embed cultural barometer measures and improvement plans; and have appropriate processes are in place to ensure improvement in staff satisfaction against the NHS Staff Experience survey.

4.5.6 Seven Day Services

Secondary Care

In order to take the move to seven day working in unscheduled care forward across all sites operated by United Lincolnshire Hospitals NHS Trust a number of key pieces of work have been identified:

In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. This built on work done in 2011 to define a set of standards for unscheduled care that has already resulted in the redesign of a number of services and mortality reduction.

Building upon this dialogue and taking account of draft standards for 7 day working published by NHS England; guidance from learned bodies (e.g. Royal colleges and Professional organisations), and experience elsewhere across the NHS a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group leading this initiative for the Trust. The purpose of the scrutiny will be to:

- Ensure that the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay Ensuring that any proposed increase to the cost of delivery is justifiable.
- It should be recognised that the principal objective of this initiative is to deliver the benefits. That said it must also be noted that the move to seven day working for unscheduled care will not, of itself, increase income to the Trust. Therefore, in addition to ensuring that any increased cost of delivery is justifiable the Trust will also:
- Explore with commissioners the scope for either recurrent or non-recurrent financial support to assist with the any increased costs that cannot be accommodated within a national tariff structure that is not based on a model of 7 day working across the NHS
- Explore the financial benefits of reducing length of stay, contractual penalty avoidance, etc… that may be made possible by these changed ways of working.

Ultimately the business case for a move to seven day working setting out both costs and benefits will need to be approved by the Trust Board. It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it as part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in hospital, their own homes or other settings.

Discussions will therefore take place with neighbouring NHS organisations (Ambulance, Community & Mental Health service providers) as well as Social Care providers to explore what change may be necessary within their service delivery to maximise the benefits delivered through this initiative. A move to seven day working for unscheduled care across the hospitals operated by ULHT is a significant and important development for both the public and staff affected. It is therefore important that communication is timely and effective. The key audiences identified are:

- The media and general public
- Public leaders, e.g. MP's, Health and Wellbeing Board and Health Overview & Scrutiny Committee
- Neighbouring organisations across the Health Community (see section 3.3)
- Staff-side organisations
- Employees of ULHT

Communication will take place with each of the audiences identified.
The Trust is committed to at least one site within the Trust commencing the delivery of seven day unscheduled care services in April 2014, with all other sites operational by the end of June 2014".

At this point in time South West CCG is looking to support the acute hospital 7 day working via the ½% national tariff uplift.

Community Services

Lincolnshire Community Health Services NHS Trust is committed to delivering high quality, safe services throughout the 7 day working week.

To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered. This has been detailed in our 5 year QIPP programme, which was approved by the Trust Board in December 2013. 2 of the 5 themes within the programme are associated with improving productivity and releasing additional clinical by utilising existing resource more effectively. A wider consultation process across LCHS will be commenced April 2014 in line with the QIPP Programme, to address the workforce changes necessary to continue the delivery of high quality patient services throughout the 7 day week.

In the shorter term, immediate actions have been taken to restructure elements of the community nursing resource to work across both the 7 day and 24 hour periods in support of the programme of admission reduction schemes being trialled in the county. Initial funding is in the process of being secured to support particular elements of the trial, which is being viewed as a 'proof of concept' model. The recruitment drive supporting these schemes has been based on a seven day working week, signalling a shift in the organisation's commitment towards a goal of standardising all future clinical appointments throughout the trust.

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.

A review of our existing community work force is being undertaken, which will be shared with the Trust Board and Commissioners in early 2014 and is underpinned by detailed service line reporting evidence.

The aim of this review is to ensure a baseline safe staffing levels are established in the community. Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

In parallel work is being under taken to through our current and future workforce planning, to recruit and retain a much more flexible workforce which can be fully utilised according to need such as; maximising bed occupancy, reducing length of stay and the management of increasingly complex patients being cared for in the community. The organisation also intends to implement new ways of working which require employees to work across a number of geographical areas as well as over seven days per week. This will ensure the future workforce is able to deliver the ambitions of the organisation's clinical strategy and be underpinned by the introduction of annualised hours contracts as well as the availability of a more robust bank system to supplement the existing workforce in times of increased need.

Primary care

In 2013 the NHSE Area Team (AT) communicated with CCGs regarding 7 day working in Medical practices to support winter pressures. However CCGs had already formulated their plans, including the use of any additional funding to support winter pressures elsewhere in the system.

Apart from dental services, the AT only commission 'core' services from primary care contractors. CCGs and Local Authorities commission any additional services. That being said, and with the national imperative for 7 day working, NHS England has just launched the 'Prime Minister's Challenge Fund: Extending Access to General Practice'. I have attached a communication regarding this initiative that provides more detail. We already have a number of Community Pharmacies throughout Leicestershire and Lincolnshire that provide services 7 days a week. The Pharmacy Needs Assessment (PNA) that is led by the Local Authority will no doubt include the need for availability of services over 7 days in future iterations. We also have a number of dental practices that provide 7 day a week services. Currently the Primary Care Strategy is under development and will include 7 day working.

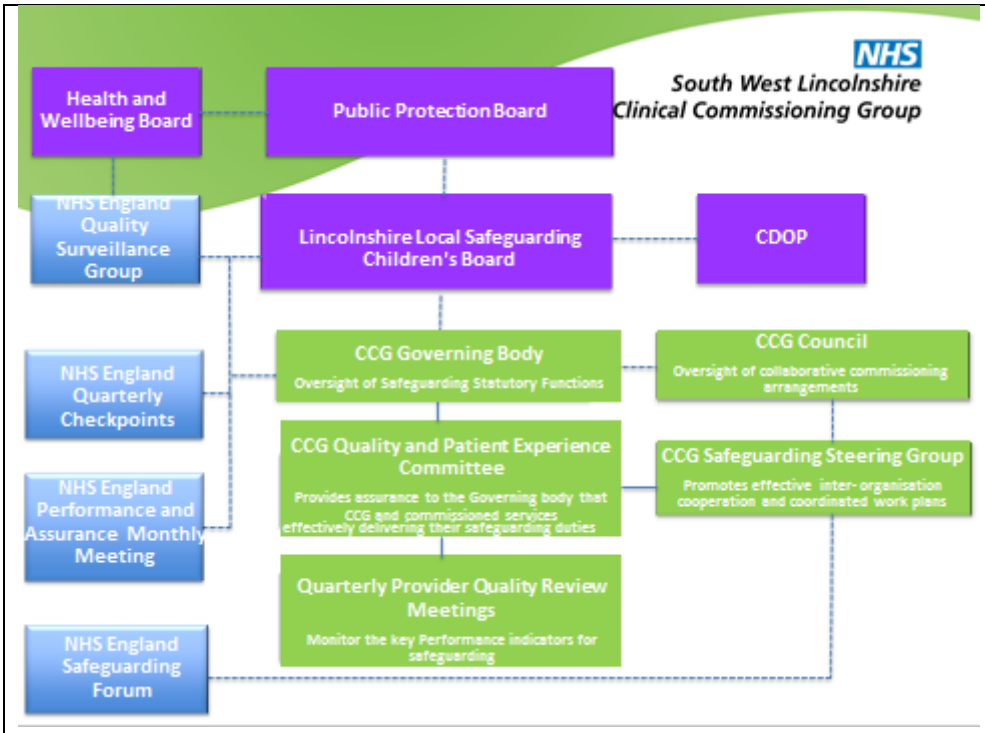
The GMS Contract Changes for 2014/15 include some that may impact in this area, particularly the named co-ordinating GP. There will also be a new DES to cover admission avoidance/pro-active case management etc. We are awaiting further details and plans for this service will need to dovetail with CCG plans.

Mental Health and Learning Disabilities

Lincolnshire Partnership Foundation Trust (LPFT) has an on-going commitment to the ensuring high quality, easily accessible and timely health and social care service provision across Lincolnshire. This is currently being achieved by a combining a number of established and newly developed services with continued innovation and partnership working always high priorities. The Single Point of Access for LPFT now provides one dedicated contact number for all Trust services and is available 24 hours a day, 7 days a week. 7 day services are provided by the Crisis and Home Teams, Rapid Response Teams and the Lincoln HIPs team to both provide care in the community, early discharge and admission avoidance. These services closely link to on-call medical staff, the wider Trust services such as the Integrated Community Mental Teams (7 days a week when required) and the wider health and social care community including the Emergency Duty Team (EDT).

4.5.7 Safeguarding

The CCG are active members of the Local Safeguarding Children's Board, Local Safeguarding Adults Board, Multi Agency Public Protection Arrangements, PREVENT Steering Group and Public Protection Board. Figure below identifies the assurance processes for safeguarding adults, children and young people.



A Safeguarding Steering Group is in place which facilitates and coordinate a culture that embraces safeguarding as everybody's business and ensures that the organisations from which services are commissioned provide a safe system that safeguards children and adults. The Group promotes and assists effective inter-organisation co-operation in order that statutory health bodies operating Lincolnshire co-operate and discharge their statutory responsibilities effectively relating to Safeguarding children, young people and adults at risk.

The safeguarding Adults Assurance Framework, Markers of Good Practice For Safeguarding Children and PREVENT are embedded into all provider contract monitoring processes.

The Federated Safeguarding service ensures that the CCG meets its statutory requirements for safeguarding children, young people and adults. A number of key priorities have been identified aligned to our partnership arrangements which will ensure the CCG establishes clear lines of responsibility and accountability for safeguarding children, young people and adults at risk and has a comprehensive performance framework with particular emphasis on identifying and embedding best practice. They are:

- Ensure arrangements for safeguarding adults, children and young people are robust and fully integrated into existing clinical governance processes.
- Ensure safeguarding training and development programmes are in place, monitored and evaluated for all commissioned services and CCG Member Practices.
- Monitor dissemination and evaluate outcomes of all SCR action plans and SILPs of both single and inter-agency action to receive assurance that plans have been implemented.
- Strengthen processes and systems to ensure effective contribution to partnership arrangements

To ensure that commissioners meet their statutory requirements across Lincolnshire an external review of the designated functions has been commissioned to ensure that the current designated arrangements are fit for purpose and will going forward enable robust safeguarding arrangements to be delivered. This is supported by the LLR and Lincolnshire NHS England Area Team, and associated CCGs. The objective of this review is to assess the current arrangements for discharging the designated functions (Safeguarding Children and Looked After Children) against statutory requirements and existing best practice to inform the future design and delivery model of the designated functions.

5.0 SUSTAINABILITY AND DEVELOPMENT

5.1 Research and Innovation

We will promote research and the use of research by:

- Delivering the statutory duties with respect to research, as an individual organisation or as part of a collaborative with neighbouring CCG's.
- Ensuring that when appropriate, providers have processes in place to facilitate recruitment of patients into research studies.
- Considering the need for commissioners to have in place a process to meet the treatment costs of research for patients who are taking part in research funded by Government and research charity partner organisations.
- Ensuring the best available research evidence is used when commissioning services.
- Ensuring that the responsibility for research and the use of research evidence is clear at a level equivalent to Governing Body level with operational responsibility delegated as appropriate.
- Proactively engaging with local partners who promote and support research, including the local NIHR Clinical Research Networks and the emerging Academic Health Science Networks.

We will promote innovation by having plans in place or under development to:

- Specify local priority areas in line with the current NHS Operating Framework for the NHS in England;
- Consider how local flexibilities in the use of tariff might be used to incentivise innovation;
- Take steps to ensure strong leadership and accountability for innovation within the CCG;
- Facilitate partnerships with public and private sector organisations and patient networks and organisations to enable local innovation and its diffusion;
- Be an active partner in the local Academic Health Science Network

The Governing Body Secondary Care specialist is the CCG lead for research, education and training.

5.2 Financial Position and Delivering Value

As a statutory body, the CCG receives an annual allocation from NHS England to fund the healthcare services it commissions. The allocations have been announced for the next two years and are as follows:

South West Lincolnshire CCG
Notified Allocations

	13/14	14/15	15/16
Allocation (£'000)	144,767	147,865	150,450
Total Growth		2.14%	1.75%

The national funding formula calculates that South West Lincolnshire CCG (SWLCCG) is over target, and has therefore allocated the minimum growth to cover population increases and inflationary pressures.

The CCG has been informed that allocations for 2016-17 to 2018-19 should be assumed as follows:

South West Lincolnshire CCG
Allocation Assumptions

	16/17	17/18	18/19
Growth Assumption	1.80%	1.70%	1.70%
Allocation (£'000)	153,080	155,756	158,479

The planning guidance "Everyone Counts: Planning for Patients 2014/15 to 2018/19" sets out some requirements of CCGs in its financial plans. These commitments are outlined below along with the financial impact for the CCG.

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation (£'000)	147,865	150,450	153,080	155,756	158,479
BCF allocation (£'000)		2,499	2,499	2,499	2,499
Contingency (minimum)	0.50%	0.50%	0.50%	0.50%	0.50%
Impact on SWLCCG (£000)	763	787	800	814	827
Cumulative Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	1,525	1,574	1,600	1,627	1,655
Non-Recurrent Spend	2.50%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	3,697	1,505	1,532	1,558	1,584
Allocation remaining (£000)	141,880	149,083	151,725	154,262	156,843

The allocations detailed above note the additional £2.5m BCF (Better Care Fund) allocation which shall come directly to the CCG in 15/16 against which expenditure has been committed in conjunction with the BCF plans agreed by the Health and Well Being Board. The CCGs actual contribution to the BCF pool of resources is £18.3m.

The allocation remaining in each year will be used to purchase healthcare services for the population of South West Lincolnshire (in 2014/15 this is £142m).

In 2014/15, the requirement to spend 2.5% of resources on a non-recurrent basis includes a 1% (£1.5m) fund to be used for transformation.

The CCG is also required to drive efficiency in the use of its resources and to make Quality Innovation Prevention and Productivity (QIPP) savings. In 2014/15 the value of savings is £2.856m and £2.833m in 2015/16. The schemes that have been developed for implementation in 2014/15 have been built up by GPs on the Executive Committee and have been assessed for their likely QIPP impact, covering quality improvements as well as activity and financial changes. The schemes focus on moving activity from the acute hospitals into the community setting. The implementation of Neighbourhood teams will commence during 14/15 to support closure of acute hospital beds, which is an early implementation of the LSSR strategy.

The details of the 2 year Sip schemes are detailed below:

QIPP	14/15	15/16
Prescribing	-£500.0	
Spinal Injury	-£250.0	
MSK Follow up	-£130.0	-£50.0
Dermatology	-£160.0	
Cardiology - reduced new referrals (Ambulatory ECG monitoring)	-£58.0	-£20.0
DVT Ddimer	-£89.0	-£20.0
Paediatrics reduced admissions (expansion A&E bays)	-£170.0	
Development of local tariff - Independent Sector	-£200.0	
Full Year Effect 2013-14	-£527.0	
Care Home Education	-£150.0	
LSSR Neighbourhood teams - reduced admissions via intermediate care expansion	-£200.0	-£250.0
LSSR Neighbourhood teams - reduced admissions via supported community care	-£200.0	-£2,000.0
LSSR Neighbourhood Teams - Reduction to XBD for Long term conditions	-£120.0	-£300.0
LSSR Neighbourhood teams - XBD reduction via intermediate care expansion	-£100.0	-£192.0
	-£2,854.0	**-£2,832.0**

The Lincolnshire Sustainable Services Review (LSSR) (as detailed in section 1) is the main vehicle for driving system change and efficiency in the period covered by this plan. Beyond the development of the Neighbourhood teams, there is unlikely to be a major financial impact in 2014/15 as the first changes start to happen. The wider health economy savings will start to come through in 2015/16. Detailed workings of these savings have not been completed yet, and are part of the stage 2 work being undertaken during 2014.

The Better Care Fund was announced in June as part of the 2013 Spending Round. It requires CCGs to work more closely with the Local Authority to transform services to ensure more integration of care and support. South West Lincolnshire CCG is working with Lincolnshire County Council and the other Lincolnshire CCGs to develop plans for the Lincolnshire Better Care Fund. SWLCCG will be contributing £18.3m to the pooled fund from 2015/16. This contribution will support:

- the development of Neighbourhood teams,
- greater integration of intermediate care services,
- seven day working,
- extending current pooled fund arrangements for Mental Health and LD services
- funding enablers for LSSR

SWLCCG has budgeted for all emergency admissions at 100%. 30% of this will be paid to the acute trusts for admissions over the 2008/09 baseline. The remaining 70%, supporting admission avoidance has been put into a reserve at a value of £1.7m. This will be invested in demand management schemes to reduce emergency admissions, which will be agreed with the Urgent Care Working Group and published on the CCG website.

The CCG planned programme expenditure can be broken down as follows :

Programme Expenditure	13/14 (forecast)	14/15	15/16
Acute	82,299	82,736	81,045
Mental Health	14,915	14,656	15,264
Community	10,728	12,849	15,696
Continuing Care	7,138	7,439	8,073
Primary Care	23,141	25,221	25,933
Other Programme	6,148	4,140	6,106
Total Programme Costs	144,370	147,041	152,117

The expenditure in the table above includes the BCF 15/16 allocation of £2.5m and excludes the required contingency.

The running cost allocations and are estimating 14/15 £24.73 and 15/16 £22.11 per head of population. The CCG will run its administration function within confirmed running cost allocations.

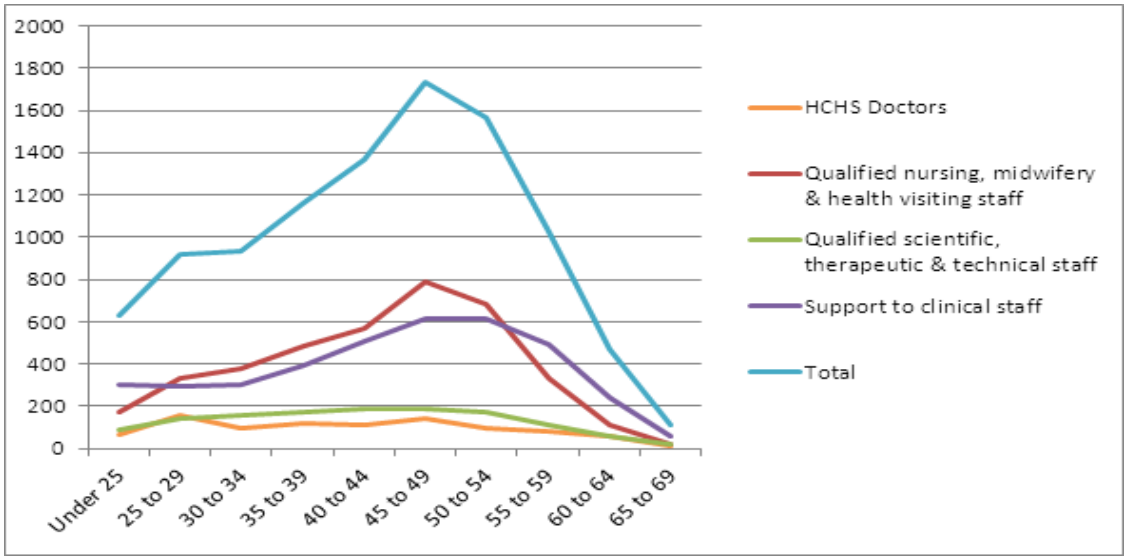
Risks to delivery

The key risks to delivery of this plan are:

- the effective delivery of the CCG's QIPP programme and associated transformation projects
- the early implementation of the first stages of the Lincolnshire Sustainable Services Review
- the risk of growth in acute hospital admissions
- poor quality data received from providers to understand the real position
- legal constraints on the use of patient data to validate payments to providers
- the effective delivery and continuous improvement of commissioning support services - to be provided by Greater East Midlands Commissioning Support Unit (GEM)
- the effective agreement and operation of the Lincolnshire CCG's Collaboration Agreement and the performance of providers in delivering the outcomes targeted by national and local plans.

5.3 Workforce

The profile below shows the numbers of the existing medical/clinical workforce by age group and indicates that there are significant numbers of staff (almost 50%), who are aged 45+. The clinical support workforce has an older age profile and relatively few numbers of staff aged below 35, which may impact on the ability to 'grow our own' in the future.



Key Challenges

- Recruitment and retention of qualified staff, particularly medical staff and GPs, this is reflected in high temporary and locum expenditure
- Lincolnshire has an ageing workforce in key professional groups
- Lincolnshire generally has an ageing population and therefore demand for older people's services will increase
- Lincolnshire is a 'net exporter' of young people who leave the county and don't return
- Amongst the 18 – 49 age group qualification levels are generally lower than the national average; this is more acute in the east of the county
- Amongst the professional/technical workforce the majority of people are employed in the public administration, education and health sector

Key Opportunities

- Ageing workforce is an opportunity to transform the workforce provided there are effective succession plans in place
- There is some inward migration of young families to the county and there may be opportunities to bring some of these people into the healthcare workforce
- Increased healthcare provision at the University of Lincoln may attract young people to stay in the county
- Opportunities to link health and wellbeing work in deprived areas with return to work schemes
- Marketing of Lincolnshire across the country to attract highly skilled professionals to the county – possibility of linking to areas of over-supply
- Optimising the deployment and utilisation of workforce capacity
- Implementing new ways of working – traditional roles currently dominate

Implications of the LSSR

- Analysis by PWC suggests that there is a significant workforce productivity gain possible through system redesign. This has been quantified at approx. 18m per annum.
- As part of the workforce analysis of the LSSR it has been identified that the Lincolnshire community spends 10 million more that its peer group on agency staffing
- The emerging model of neighbourhood teams will require new skill sets, mind-sets and cross professional structures to make sure that integrated local teams provide safe, effective coordinated care.
- The culture within the workforce is both a challenge and an opportunity. The LSSR suggests that to deliver our aspirations will require a workforce which is flexible, resilient and is not confined by organisational boundaries or traditional views of the care system.
- One of the major changes which will become clear in phase 2 will be the need to develop a community based generic care workforce delivering health and social care interventions.

5.4 Points of Service Delivery (Estates)

The LSSR identifies the requirement to ensure the provision and availability of 'fit for purpose' Estates as one of the key enablers for change.

- It is acknowledged that a significant amount of Lincolnshire's estate is in poor condition or unfit for its current purpose with significant cost implications assigned to maintenance backlog (further work to quantify this is yet to be done as part of the LSSR work)
- Models of care remain largely designed around buildings
- Consideration must be given in Phase 2 of the LSSR to how innovative estates management within Lincolnshire's health and social care economy can facilitate fundamental change, help to improve efficiency, move more care out of hospitals and exploit new technologies.

SECTION 6: ACTIVITY

6. ACTIVITY

The activity trajectories are profiled in the table below

Activity	2014-15	2015-16	2016-17	2017-18	2018-19
Elective Admissions - Ordinary Admissions	3,505	3,542	3,580	3,618	3,655
Total Elective Admissions - Day Cases (FFCEs)	14,262	14,416	14,570	14,722	14,875
Total Referrals	39,927	40,357	40,788	41,214	41,641
Non-elective FFCEs	11,644	11,534	11,308	10,969	10,528
All First Outpatient Attendances	37,779	38,187	38,594	38,997	39,401
All Subsequent Outpatient Attendances	78,223	79,067	79,911	80,746	81,581
Total	**185,339**	**187,104**	**188,750**	**190,265**	**191,681**
Activity Growth compared to previous year		100.95%	100.88%	100.80%	100.74%
Population	130,957	131,845	132,745	133,652	134,564
Population Growth compared to previous year	100.65%	100.68%	100.68%	100.68%	100.68%

It is important to note that the location of the activity will change in line with the LSSR strategy to move activity away from the acute hospitals into the community setting. The specific provider impact will be further determined in the next phase development of the LSSR blue print turning vision into reality.

SECTION 7: BETTER CARE FUND

7. BETTER CARE FUND

The Lincolnshire CCGs and Lincolnshire County Council have formally agreed to proceed with revised joint commissioning arrangements across proactive care, children and maternity, mental health and learning disabilities services. It is a Strategic objective that by joint commissioning at scale in line LSSR we will achieve a significant improvement in quality and outcomes (more individuals cared for closer to home and maintaining their independence for longer); additionally generating sufficient efficiencies to bridge the anticipated gap between resources available to health and care economy and likely demand beyond 2016. This ambition is reflected in the scale of the pooled budget across health and social care.

Section 4 outlines the wider benefits to patients resulting from the BCF implementation and the wider LSSR strategy. The governance for overseeing the implementation and monitoring of the BCF is defined below. With reference to the national performance measures, the BCF is also expected to deliver against the metrics noted in the table below:

Metrics	Metrics measurement	Delivery Board Responsible	Metrics outcome / benefit
Admissions of older people to residential care	Based on admissions to council funded permanent long term care and will be monitored through both the proactive care board	Proactive Care Delivery Board	There will be a reduction in admissions to permanent long term care over and above estimated growth in population through integrated intermediate care, neighbourhood teams, 7 day working and prevention schemes

Proportion of older people still at home over 91 days	Measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode. Data is available on an annual basis and will be monitored through the proactive care board	Proactive Care Delivery Board	An increasing number of people will be maintained to live at home through integrated intermediate care, neighbourhood teams and 7 day working schemes
DTOC from ULHT acute hospital (including health and social)	This is based on ONS Population stats for 18 years over and is measuring health and social care reasons for DTOC from main acute hospital (ULHT). The monitoring will be undertaken on a monthly basis via the unscheduled care board	Unscheduled Care Delivery Board	There will be a reduction in the DTOC over and above estimated growth in population. This will support an easing of pressures on acute hospital beds.
Avoidable Emergency Admissions	Awaiting national baseline information	Unscheduled Care Delivery Board	Although the baseline figure is not yet available intermediate care, neighbourhood teams and 7 days working should support a reduction in emergency avoidable admissions
Patient Experience Metrics	Awaiting National Metrics publication	Proactive Care Delivery Board	All the schemes should support an improvement in patient experience of health and social care
Local metric - Proportion of people feeling supported to manage their (long term) condition	This measure is based on the GP patient survey question 'In the last 6 months, have you received enough support from local services/ organisations to help manage your long term condition	Proactive Care Delivery Board	All the schemes should support an increase in the proportion of people who feel that they are supported to manage their long term conditions

The metrics across Lincolnshire Health and Social care system are being monitored against the performance improvements noted in the table below. The weighted capitation of South West Lincolnshire population approximates 16.5% and we expect to see an equitable improvement within our CCG as part of the Lincolnshire wide improvements defined as follows:

Metrics		Current Baseline (as at….)	Performance underpinning	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	816	N/A	785
	Numerator	1217		1301
	Denominator	149150		165597
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.40%	N/A	80%
	Numerator	653		800
	Denominator	902		1000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	**131**	**128.3**	**127.2**
	Numerator	5279	6787	4487
	Denominator	575467	587782	587782
		April 2013 - October 2013	(April -	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		BASELINE DATA TO BE PUBLISHED JAN 2014	(April - September	(October 2014 - March 2015)
Patient / service user experience		Pending national	N/A	Pending national publication
Proportion of people feeling supported to manage their (long term) condition - ***Query on baseline data o/s with CCG's***	*Metric Value*	63%		64%
	Numerator	9418		9600
	Denominator	14933		15000
		July 2012 - March 2013	*N/A*	*July 2014 - March 2015*

SECTION 8: FINANCIAL PLAN

8.1 FINANCIAL PLAN SUMMARY

South West Lincolnshire has a balanced detailed financial plan for 2014/15 and 2015/16. Strategic financial plans for 2016/17, 2017/18 and 2018/19 are also in balance. The plans provide for a planned year-end surplus of 1%. The CCG's plan assumes the return of the 1% achieved in 2013/14 of £1.467m.

The plan is compliant with all aspects of the NHS England planning guidance, providing for a 0.5% contingency reserve. The CCG's QIPP programme for 2014/15 and 2015/16 totals £2.8m in each year, equating to 2% of CCG programme resources net of contingency. In 2014/15, the requirement to spend 2.5% of resources on a non-recurrent basis includes a 1% (£1.5m) fund to be used for transformation. The non-recurrent investments are aimed at improving the quality of services, and bringing care closer to home via the development of Neighbourhood teams.

70% non-elective marginal rate resources have been assumed to be available for reshaping the delivery of the non-elective care pathways across the county in preparation for winter and in support of the LSSR. These plans require approval by the Urgent Care Working Group.

The key risks to delivery of this plan in 2014/15 are:

- The effective delivery of the CCG's QIPP programme and associated transformation projects
- The risk of growth in acute hospital admissions in particular over the winter period.
- Uncertainty regarding the transfer of resources with regard to Continuing Healthcare retrospective claims
- Dementia trajectories being higher than those anticipated to date.

8.2 REVENUE RESOURCE LIMIT

The RRL (excluding BCF allocation in 15/16 is noted in the table below

South West Lincolnshire CCG
Notified Allocations

	13/14	14/15	15/16
Allocation (£'000)	144,767	147,865	150,450
Total Growth		2.14%	1.75%

8.3 KEY PLANNING ASSUMPTIONS AND ALIGNMENT OF PLANS

The following key assumptions underpin the financial plan

- The commissioning intentions to embed plans outlined in the BCF and LSSR will come to fruition within the required timeline to develop capacity within the community setting and release resources from the acute sector.
- The national tariff impact/changes and national statistical population growth assumptions will apply.
- Planned surplus will be available in the following year
- 70% MRET funds will support re-shaping of non-elective care pathways as agreed by the Urgent Care Working Group, in preparation for winter and in support of the LSSR
- QIPP schemes will deliver in a timely way.
- The contingencies are sufficient to manage risk within reasonable parameters.
- The re-procurement of CSU services ensures provision of a responsive support service which delivers the service required.

8.4 HIGH LEVEL FINANCIAL PLAN

The high level financial plan is detailed in the table below:

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation (£'000)	147,865	150,450	153,080	155,756	158,479
BCF allocation (£'000)		2,499	2,499	2,499	2,499
Contingency (minimum)	0.50%	0.50%	0.50%	0.50%	0.50%
Impact on SWLCCG (£000)	763	787	800	814	827
Cumulative Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	1,525	1,574	1,600	1,627	1,655
Non-Recurrent Spend	2.50%	1.00%	1.00%	1.00%	1.00%
Impact on SWLCCG (£000)	3,697	1,505	1,532	1,558	1,584
Allocation remaining (£000)	141,880	149,083	151,725	154,262	156,843

8.5 OVERVIEW OF QIPP AND RISK TO DELIVERY

South West Lincolnshire CCG has identified a £2.8m QIPP programme for 14/15 and 15/16, which is 2% of programme allocation adjusted for contingency. For 2014/15, the CCG QIPP programme is focussed on reducing avoidable hospital admissions and appropriate prescribing, particularly in relation to the CCG's frail elderly population, in respect of ambulatory care conditions and in relation to long term conditions.

For 15/16 the QiPP savings are centred on implementation of the 5 LSSR early implementers in particular Neighbourhood Teams to reduce acute hospital pressures (in particular non elective).

8.6 RISK

For 14/15 the magnitude of risks is identified it the table below and equates to £1,275k. In 15/16 the level of risk is estimated at £1,473k. In both years the risk is being mitigated by the 0.5% contingency reserve and the activity management reserve.

Risks	Full Risk Value 15 £'000	Probability of risk being realised	Potential Risk Value £'000	Proportion of Total %	Commentary 15
Acute	2,000	50.00%	1,000	78.43%	Overperformance of non-electives, particularly over winter in Acute Trusts. There have been data issues with ULHT during 2013-14 which may continue into the new year, and have an impact upon accurate modelling.
CHC	500	25.00%	125	9.80%	Uncertainty regarding the transfer of resources with regard to retrospective settlements on 01/04/2014.
Other Prog.	300	50.00%	150	11.76%	Increased impact of Dementia over and above that which can be reasonably anticipated to date.

8.7 PLANS FOR USE OF NON-RECURRENT INVESTMENT

A summary of the 14/15 schemes for utilising non-recurrent monies is detailed below. In 15/16 the non-recurrent funds are planned to be used in their entirety to support implementation of the LSSR including rolling out Neighbourhood Teams at scale across the CCG.

14/15 schemes	headroom £'000	MRET £'000
Primary Care schemes & Business Case for Diabetes	£520	
Primary Care Clinical Involvement in LSSR	£250	
Establishment Neighbourhood teams	£950	
Over 75's Primary Care	£627	
Dementia	£200	
CSU procurement	£150	
Expansion Intermediate Care (care home beds)	£350	
SEND project	£200	
Implementation of LSSR/preparation for winter		£1,749
Sleaford Primary Care project	£450	
	£3,697	£1,749

8.8 STATEMENT OF FINANCIAL POSITION

The financial plan details monthly profiles of the SOFP and presents a balanced position in both years.

8.9 CASH

The CCG is awaiting the cash resource limit to be confirmed and is estimating £128.2m for 14/15 and 15/16. The details of the cash monthly profiling is detailed within the financial plan and includes a balanced cash flow with an average monthly carry forward surplus of £518k for the first year.

8.10 CAPITAL

There are no defined or resourced capital schemes at this point in time.

					Outputs 2014/15 and 2015/16				
Project	**Description**	**Start date**	**Milestones**	**Performance indicators**	**Quality**	**Activity**		**Cost savings £000's**	
						14/15	**15/16**	**14/15**	**15/16**
Service contact point (Single Point of Access) (Lincolnshire Community Health Services / Lincolnshire Partnership Foundation Trust)	This scheme is now fully operational and delivers two Service Contact Centre's operational by 18/11/2013 merging to one at some stage during 2014.	18th Nov 2013		• A&E conversion rate	Hospital avoidance	5% less A&E attends		TBD	
Ambulatory Care Centres (United Lincolnshire Hospitals)	Now fully operational and delivers a discrete Ambulatory Care Unit on the Pilgrim, Lincoln and Grantham sites with high quality patient care, good clinical outcomes, and an excellent patient experience	From November 2013		• Readmission rates	Hospital avoidance	12 fewer admissions/day Lincolns and Boston and 5 at Grantham (3%)		TBD	
Rapid Response (Lincolnshire Community Health Services / Lincolnshire Partnership Foundation Trust)	Now fully operational and delivers a reduced number of people conveyed to hospital unnecessarily - accepting patients from EMAS/GPs at the patient's 'front door' - offering choice of avoiding A&E.	18th November 2013		• Nos. on caseload not admitted by day 91 following referral	Reduced delayed discharge.	5.2 referrals /day		TBD	

Increased Adult Social Care Workforce capacity in acute sites (Lincolnshire County Council)	Teams now in place and functioning well. Are enabling smoother discharge process, increased capacity, collaborative working, and support for 7 day working and working as part of MDT discharge team.	November 2013		• DTOC • Attribution to ASC within upper quartile • % of home support packages within 48 hours of referral	Care closer to home in reablement or rehab services	5% increase I home support packages		TBD	
Increased domiciliary care (Lincolnshire County Council)	Additional agency staff now recruited providing 900 hours / week x county of care worker support. To increase DCW in community to expedite discharge, reduce avoidable admissions, prevent readmissions, and promote independence.	November 2013		• % at home after 91 days of discharge • Reduced admissions to residential/ nursing homes per 1000	Reduced DTOCs	TBD		TBD	
Hospital Psychiatric Liaison Service (HIPS) Lincolnshire Partnership Foundation Trust)	Teams already in place and contributing to reduction in breaches in A&E waiting crisis referral. Facilitating improved discharge, keeping patients at home and serves pts of all ages.	November 2013		• Achievement of national CQUIN standard for assessment rates	'Feel Safe' safeguarding referrals	Reduced LOS to <8 days average		TBD	
Increase acute physician cover for Grantham emergency admission unit (United Lincolnshire Hospitals)	Now fully implemented and provides senior daily review and increase discharge on AEU. Provide medical senior decision making in A&E Consultant carrying a phone during working hours to be available for GPs for admission avoidance advice.	November 2013		• Rate of non-elective admissions for people defined within a defined set of conditions.	Hospital avoidance	Part of 5% reduction in emergency admissions OPD and managed with advice		TBD	