Lincolnshire Health and Care

5 Year Strategic Plan

DRAFT

Draft contents structure:0210 ALv4

CONTENTS

Section	Subject	Page
	Foreword – Joint statement of all Lincolnshire partners	4
	Executive summary & Plan on a page	4
1	Ambition and vision: Common direction through Lincolnshire Health and Care	6
2	The Lincolnshire context • Population, health Inequalities and disease profile • Overview of strengths and weaknesses of the health and social care economy • Case for Change o Quality o Finance • Provider Landscape o Providers o Workforce • Communications and Engagement o Priorities identified by local people – what people told us o Priorities identified by local practices • Approach to developing the Plan	10
3	Benefits • Improving quality o Improving standards -NHS Constitution o Improving outcomes -Outcomes (NHS Constitution NHS Outcomes Framework) o Financial	28
4	Improvement interventions Our 7 major change programmes ➢ Transforming primary care ➢ Proactive care ➢ Urgent care ➢ Elective care ➢ Women and children's care ➢ Mental health, learning disability and autism	39
5	Enablers • Organisational and workforce development • Information technology strategy • Estate development strategy • The Lincolnshire model of integrated care and application of Better Care Fund • Contracting	81

DRAFT

7	Impact and sustainability • Financial sustainability • Impact on providers	85
8	Financial plan	85
9	Implementation • Governance overview • Phasing of implementation	88
10	Risk Management	92
Appendices	• *Primary Care Strategy* • *Mental Health, Learning Disabilities and Autism Strategy* • *Urgent Care Strategy* • *System Resilience Plan* • *Workforce and Organisational Development Strategy* • *Information Technology Strategy* • *Estate Development Strategy*	

DRAFT

Foreword

Joint statement from all partners regarding intent, values and collective action.

Lincolnshire East Clinical Commissioning Group
Dr Brynnen Chair Massey Gary James Accountable Officer

Lincolnshire West Clinical Commissioning Group
Dr Sunil Hindocha Chief Clinical Officer Richard Childs Lay Chair

South Lincolnshire Clinical Commissioning Group
Dr Miles Langdon Chair Gary Thompson Chief Officer

South West Lincolnshire Clinical Commissioning Group
Dr Vindi Bhandal Chair Alan Kitt Chief Officer

Health and Wellbeing Board
Dr Tony Hill Councillor Sue Woolley
Paragraph to be added outlining support from wider LHAC partners listed below through sign up to LHAC blue print and implementation.

Executive summary

Last thing to be written and will form the bones of the shorter public facing version

DRAFT

Plan on a Page Everyone Counts: Lincolnshire 5 Year Strategy

Vision- A sustainable and safe health and social care system for Lincolnshire

Inputs situations

Quality
Keogh Review: ULHT
Fragmented Services
Workforce issues
Care not always close to home

Finance
Projected £363m recurrent, health and social care budget gap in 2018/19
Rising costs and constrained financial resources

Demographic
Above average disease prevalence: A number of LTC's
Aging population
Lifestyle risk factors e.g. obesity
Greater public expectations

External Factors
Politics (including local and general elections
DH requirements/ policy
FT pipeline
Environment e.g. transport

Identified Programme Budgets (Better Care Fund) (Joint budget for Mental Health, Learning Disability and Autism)
LHAC Strategic Partnership

Resources (from all organisations)
Knowledge Sharing (local initiatives, national and international evidence for change)

Outputs

Public and staff engagement events
Blue Print and progress updates

Joint governance Arrangements
Assurance processes

Expert Reference Groups
Enablers analysis
Business and financial planning
Public consultation requirements

Joint working with NHSE Area Team
Co- Commission Primary Care
Collaborative regionally / sub-regionally for specialist commissioning

Proactive Care	Urgent Care	Elective Care	Women's & Children's	Mental Health, Learning Disability & Autism	Primary Care
A suite of proactive responses to care needs delivered through neighbourhood teams, comprising health and social care working with the local community and voluntary sector	Development of an Urgent Care Network (aligned to Keogh) Possible consolidation to meet future demand from proactive interventions. Single Point of Access Possible single management / commissioning structure.	Improving the way referrals work end to end integration of services. Possible consolidation of elective care services to meet national standards and respond to reductions in activity from proactive interventions	Improve delivery of care needs outlined in the CYPP. Development of 'mild to moderate' pathways delivered closer to home. Possible consolidation to address quality and recruitment issues. Possible single management / commissioning structure	A commissioning and procurement Strategy for Specialist Adult Services, an All Age Autism Strategy and a Crisis Concordat that improve Parity of Esteem & reduce inequalities in outcomes	To develop the role of the GP & enhanced primary care collaborative at the heart of neighbourhoods and communities, keeping the best of current primary care and taking opportunity to deliver integrated services at scale

Outcomes

	Proactive Care	Urgent Care	Elective Care	Women's & Children's	Mental Health, Learning Disability & Autism	Primary Care
Short	Multidisciplinary Neighbourhood Teams launched: (Early Implementers in summer 2014) caring for between 10,000 and 50,000 high risk patients using risk stratification and care management Remaining teams rolled out through phased approach by the end of 2014/15	Design of Improved Single Point of Contact produced. Detailed consideration of changes to site configuration produced in line with above	Specialities identified for early end to end integration. Plans developed for improving referral processes and considerations for site consolidations	Admission avoidance and care coordination improved by pathway development delivered through community teams. Considerations for site consolidation outlined.	Improved access to services by reducing waiting times for IAPT and Early Intervention and increased diagnosis rates for Dementia and Autism	CCG Co-commissioning of primary care Develop new ways of working as part of Neigbourhood Teams
medium		Number of acute beds reduced in line with updated projected forecast reductions Single Point of Contact Operational.	Improvements to referral process reduced elective activity by 20% Increased level of community provision of elective procedures	Paediatric admissions ↓by e.g. 5% to 3% (national average). Consolidation considerations reviewed/ consulted upon Single management/ commissioning structures	Improved Quality of Life by improved access to support from wider community based services and Community Partnerships	Development of Primary Care Strategy GPs come together to provide urgent care as 'hubs' within neighbourhood teams
Long	Interventions delivering against the BCF KPI's e.g. 15%↓in urgent admissions over 75s 20% ↓ residential & nursing placements (TBC) % reduction in 91 day readmissions % reduction in 30 day intermediate care beds Reduction in activity transferred to system objectives will be validated by service areas and approved through finance and operational group		Care/ NHS Constitution standards met. Workforce issues resolved. Reduction in the number of sites providing elective care to improve quality & care closer to home	Enhanced quality of maternity, obstetrics and paediatrics through consolidation. Improved ability to meet Royal College guidelines/ NICE recommendations etc. Improved model for community teams to reduce W&C admissions provide more care in community based services and improve quality	Reduced Excess Mortality levels: through improved health and wellbeing, better access to support and higher proportional spend on Specialist Adult Services	GPs working in new roles as Generalist Specialists Networks of local surgeries complement and collaborate with each other to provide a wider range of diagnostics and interventions

System Vision and Ambition

This five year plan is underpinned by the joint work undertaken across the Lincolnshire Health and Care community under the Lincolnshire Sustainable Services Review and Lincolnshire Health and Care (LHAC).

The ambition is in a short period of time, 3-5 years, to move the Lincolnshire health and care system from being one that faces challenges on quality, safety and sustainability to being a leading edge health and care economy reducing mortality to a level in line with the best 10% nationally.

The aspiration is to develop a system which reflects best international practice and where our citizens can expect improved health outcomes, as well as high levels of positive patient experience

Key areas of impact underpinned in the plan are as follows:

Women and children's
- A 5% reduction of inpatient admissions for paediatrics from the current 8% to 3%
- A 30% efficiency gain saving

Urgent care
- A 50% reduction in A&E attendances of people 75+ and a 50% reduction in inpatient non elective admissions saving 10.5m by 2017/18
- Reducing the number of beds across the Lincolnshire system by 20% by 2017/18
- Reducing the current stock of 1960 by 392 realising 9.9m savings

Proactive care
- Reducing unplanned hospital contact or admissions through improved coordinated care reducing 25% of the current level of A&E attendances for 75+ and 25% of non- elective admissions for 75+ saving £16.3m by 2017/18.
- Reducing the length of stay by improved flow through the acute sector into integrated community teams by 2017 to reduce length of stay by 28% down to an average saving £14.9mn by 2017/18

Elective care
- Reduction in elective activity through referral facilitation, a 20% reduction in elective activity enabling the reduction of around 20 beds across Lincolnshire currently used for elective care
- Reduction in acute activity following the development of community services. An overall 25% cost saving across the main specialties from the re-provision through an evidence based community model. The planned movement of services from secondary to primary care by specialty is as follows:

  - Dermatology 75%
  - Rheumatology 90%
  - Pain management 90%
  - Gastroenterology 80%
  - Respiratory medicine 30%
  - Ophthalmology 90%
  - Clinical haematology 80%
  - Cardiology 40%
  - ENT 80%
  - Urology 66%

DRAFT

- Gynaecology 65%
- General surgery 33%
- Orthopaedics 20%

Primary Care

- To develop enhanced primary care as system leaders through Primary Care Collaboratives at the heart of neighbourhoods and local communities, keeping the best of current primary care and taking opportunity to deliver integrated services at scale where that improves sustainability and outcomes for the local population.

Mental health Learning Disabilities and Autism

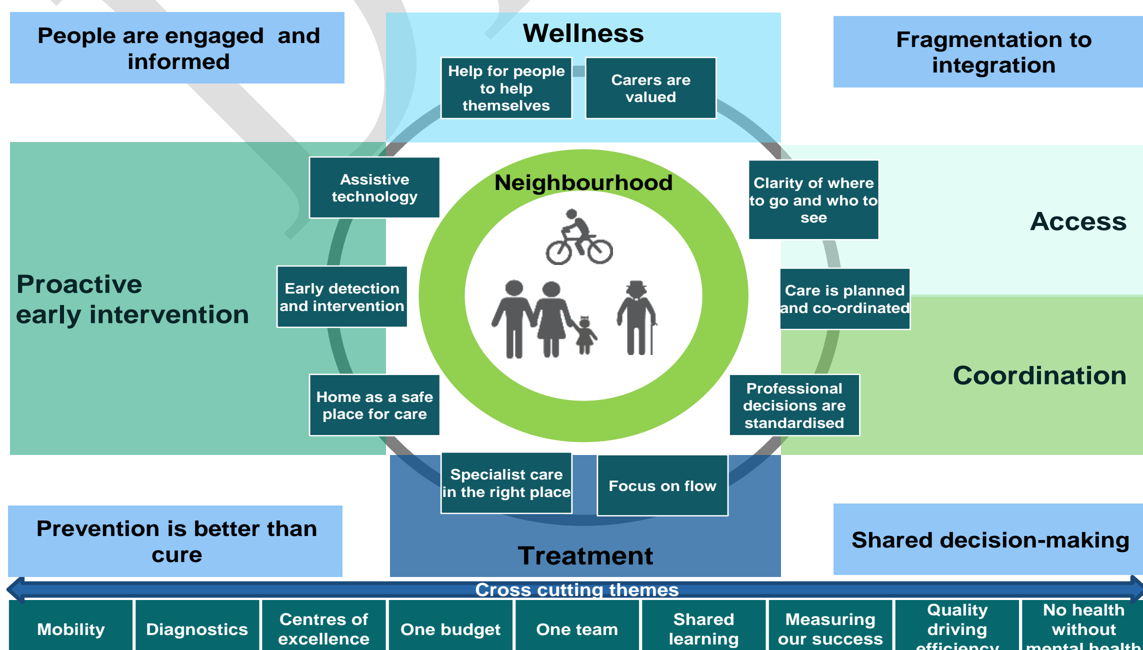
The overall ambition of this programme is to improve the Wellbeing of Adults with Learning Disability, Autism and/or Mental Health needs within sustainable resources. There will be a number of building blocks which underpin the delivery of this strategic objective including:

- Achieving parity or esteem between Mental Health and Physical Health;
- Improving the quality of life and safeguarding of vulnerable adults;
- Joint commissioning arrangements and pooled budgets:
- Strong engagement and involvement of stakeholders;
- Integrated services and strategic partnerships:

Effective prevention and early intervention strategies.

At the heart of the system vision is quality as the driver for efficiency; developing a health and care system that works in a joined up way, focuses on the prevention of ill health, coordination of care and improves clinical and personal outcomes and goals. Care delivered closer to home provided by joint coordinated multi- disciplinary teams underpinned by rigorous case management and surrounded by a support network providing proactive support services that can encourage and foster self-care, community support and increased resilience within our communities. The overarching vision is for a step change in service provision, with a very significant change through reduction of more than 390 beds across the system and the movement of more than 380 staff between current hospital setting and community based services.

The figure below outlines the system vision centred around neighbourhoods.



DRAFT

The key principles for delivery of this vision are;

- People are engaged and informed;
- Services move from fragmentation to integration;
- A focus on proactive care (prevention is better than cure) rather than reactive care;
- Shared decision-making with decisions based on evidence and
- Quality improvement where possible.

By 2017/18 we will;

- Focus on outcomes, safety, quality and experience
- Deliver integrated, personalised proactive care through multi-disciplinary neighbourhood teams
- Deliver measureable results
- Developed innovative roles to attract staff and address recruitment issues
- Improved joint working of health and care professionals - an integrated service for patients
- Work with the public, statutory and voluntary services to support individuals, families and communities in maintaining and improving their own wellbeing
- Be on a trajectory to a stable and financially sustainable position

Delivering the vision

To do this we will:

- Continue to develop our partnership working with all agencies to deliver better system wide outcomes facilitated through our agreed Concordat and shared criteria for success .
- Link to the Joint Health and Wellbeing Strategy aims in particular; help people lead a more healthy and independent life; make the lives of older people better; help people with long-term illness or disability to get good healthcare and make sure all children get the best possible start in life.
- Provide more care in the community – including elective care – with patients able to access the right care in the right place at the right time by the right person.
- Work with NHS Area Team, CCGs and the LMC to support the development of General Practice delivered at scale which will be pivotal to the new model of care. CCGs and the Area Team will determine service model options across the County (not necessarily one size fits all) and determine common principles, incorporating 7 day working and the implementation of Neighbourhood Teams, consistent with the Area Team primary care strategy.
- Provide access to safe and efficient urgent care when this is needed which is responsive and able to deliver rapid access to specialists, diagnostics and follow on care.
- Identify work programmes required to enable this change i.e. transport; technology; estates; workforce and contracting considerations

We recognise that in order to deliver our vision and achieve these ambitions, we will have to take tough decisions as a community with people and residents. The changes will be clinically led and evidence based.

DRAFT

National Vision- The Five Year Forward View

The Five Year Forward View sets out NHS England's strategy for the NHS over the next five years, describing a new relationship with patients and public focused on prevention and self-management, alongside seven new care models for service provision.

The Five year Forward View recognises that further action on demand and efficiency is required at a local level over the next 5 years to reduce the identified £30bn national funding whilst also recognising the financial gap cannot be closed fully without more central funding.

The new care models for service provision avoid a 'national blueprint' however all areas across England including Lincolnshire will need to expand and strengthen primary and 'out of hospital' care. Lincolnshire Health and Care describes what we intend to do to transform services in Lincolnshire, the models outlined give new options for how LHAC could be implemented. CCGs in Lincolnshire will work with NHS England and key stakeholders identify what is right locally.

Overview of the new care models

1. Multispecialty Community Providers
- Extended group of GP practices
- Focal point for wide range of care
- Could employ, or partner with, consultants
- Could take over community hospitals and in time have budgets delegated

2. Primary and Acute Care Systems:
- Single organisation providing primary care, hospital, mental health and community services
- Potential for delegated capitated budget

3. Urgent and Emergency Care Networks
- Integrate between A&E departments, GP out-of-hours, urgent care centres, NHS 111, and ambulance

4. Viable smaller hospitals
- Look at adjusting payment regime
- Examine sustainable staffing and cost structures
- New organisational models building on Dalton Review:
  - Hospital chains
  - Other providers on same site
  - Form integrated provider

5. Specialised care
- Consolidation where there is strong evidence for this
- Networks of services 'over a geography'

6. Modern maternity services
- Review future models of maternity units (report by summer 2015)
- Ensure provider payment systems mothers' choices
- Make it easier for groups of midwives to set up NHS funded services

7. Enhanced health in care homes
- New models of in reach support – working with local NHS, local authorities and care homes
-

To fund new models of care NHS England is to design mechanisms to 'pump prime' new models of care; backed by NHS property assets but this will also need Government funding. The impact of the Better Care Fund will be evaluated before any decisions are made for further roll out.

Commissioning

CCGs can choose to have more control over the wider NHS budget taking responsibility
- For some specialist commissioning services where it makes sense to develop more local integrated commissioning.
- Taking responsibility for co-commissioning primary care services

In addition NHS England will also work with ambitious local areas on limited number of models of joint commissioning between the NHS and local government, including:

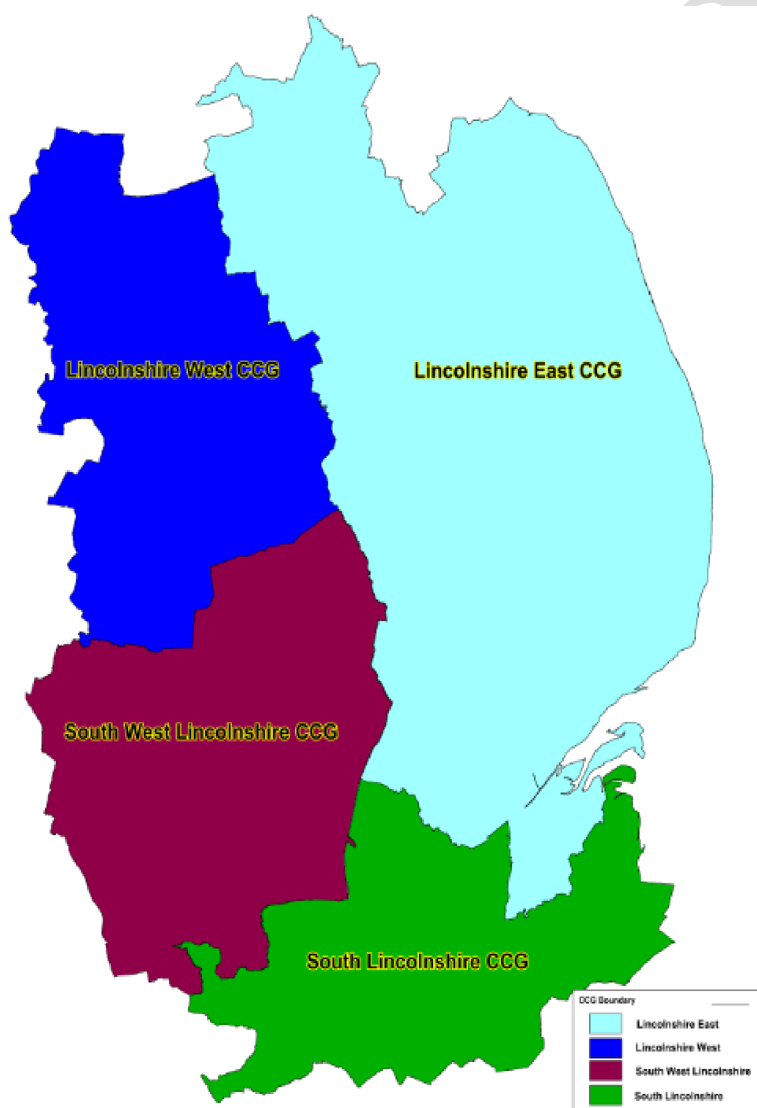
- Integrated Personal Commissioning
- Better Care Fund-style pooled budgets for specific services where appropriate
- Possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards.

Workforce

To support new models of provision Health Education England will work to address workforce gaps, identify education and training needs and invest in continuing professional development to equip staff with skills and flexibility to deliver new models of care. Investment in the primary care workforce will be key.

The Lincolnshire context

Lincolnshire is the fourth largest county in England, covering 5,921 km^2 and is classified as one the most rural counties in England by the Department for Environment, Food and Rural Affairs (Defra). Only the City of Lincoln has been classified as an urban area.



Produced by Commissioning Intelligence, Greater East Midlands CSU
Digital Mapping Solutions from Dotted Eyes © Crown copyright and/or database rights 2012 - Licence Number 100050503 . All rights reserved.

Our population

Lincolnshire County Council's Joint Strategic Needs Assessment (JSNA) informs health and social care planning providing, information on the population and its needs. The Clinical Commissioning Groups in Lincolnshire commission services for 768,688 population.

Lincolnshire Population (768,,688 2014 registered population)

- By 2037, all age groups are projected to grow with the largest increase in 75 years and over (projected to more than double in size between 2012 and 2037 across all CCGs).
- At the 2011 census, the non-white population made up 2.4% of Lincolnshire residents compared to 1.4% in 2001. Despite the increase, the rate remains lower than the national non-white population of 14%.Between 2001 and 2011 the number of Lincolnshire residents who were born outside the UK more than doubled. The majority of recently arrived international migrants came from Eastern and Central Europe and tended to be younger and more economically active than the UK-born residents of Lincolnshire.
- Districts with the highest number of people who are from non-white British backgrounds are Boston, Lincoln and South Kesteven.
- Lincolnshire experienced an increase in the annual number of birth in the recent years. Despite of this increase the birth rates in 2012 were still below the national rates: 63.1 per 1,000 females aged 15-44 in Lincolnshire compared to 64.8 in England and Wales.
- Across the county, 12% of Lincolnshire residents live within areas classified as the 20% most deprived in England. However, although this 'average' deprivation is lower than nationally.
- Unemployment claimants of working age 2% compared with national average 2.5%

DRAFT

opulation by Clinical Commissioning Group

Lincolnshire East 244,731 (2014) (30 GP Practices)	South West Lincolnshire 131,460 (2014) (19 GP Practices)	South Lincolnshire 161,573 (2014) (15 GP Practices)	Lincolnshire West 230, 924 (2014) (37 GP Practices)
Population increase **2012 – 2037** 228,111 262,508 Of which 75+ 24,954 47,170	Population increase **2012 – 2037** 122,003 142,403 Of which 75+ 10,767 23,510	Population increase **2012 – 2037** 141,045 168,961 Of which 75+ 14,252 29,202	Population increase **2012 – 2037** 227,679 257,291 Of which 75+ 19,274 39,079
Population profile is higher than England average for people aged 65+ at 24.4% compared with the national average 16.7%	Population profile is higher than England average for people aged 65+ at 21% compared with the national average 16.7%	Population profile is higher than England average for people aged 65+ at 21.7% compared with the national average 16.7%	Population profile is higher than England average for people aged 65+ at 18.9% compared with the national average 16.7%
Live Births, Rate Per 1,000 women age 15 to 44 Years 66.81	Live Births, Rate Per 1,000 women age 15 to 44 Years 64.7	Live Births, Rate Per 1,000 women age 15 to 44 Years 60.77	Live Births, Rate Per 1,000 women age 15 to 44 Years 60.57
Some of the most deprived wards in Lincolnshire can be found in the East Lindsey and Skegness and Coast Localities	South West Lincolnshire CCG has relatively low levels of deprivation, poverty compared to other areas in Lincolnshire.	Two of the fifteen practices in South Lincolnshire have a higher average deprivation score than England	The most deprived area in Lincolnshire is within the city of Lincoln
10% increase in Eastern European migrants in the Boston area between 2001 and 2011	There is a high proportion of people aged 40-49, and significantly lower proportion of people in their 20s, than the England average	South Lincolnshire has a lower proportion of young people than national average	Lincolnshire West has a higher population of teenagers and younger adults, than the national average
Hidden population of caravan dwellers in the Skegness and Coast locality			
Unemployment claimants of working age 2.04	Unemployment claimants of working age 1.79	Unemployment claimants of working age 1.52	Unemployment claimants of working age 2.64

DRAFT

http://www.research-lincs.org.uk/Population.aspx
Ref. LCC Public Health Intelligence Team, "Country of Birth, Nationality and Ethnicity of Lincolnshire Residents", LRO 2013
http://www.research-lincs.org.uk/LROPresentationTools/UI/Pages/MappingTool.aspx?dataInstanceID=5056
https://www.gov.uk/government/publications/english-indices-of-deprivation-2010

Age and deprivation are key determinant of health need and inequalities. The challenges to achieving good health outcomes reflect those faced nationally. Exacerbating health inequalities, an ageing population, significant projected rises in long-term conditions, lifestyle risk factors e.g. obesity in the young and greater public expectations.

Life expectancy in Lincolnshire

- Female life expectancy is 82 years in Lincolnshire which is comparable to the average female life expectancy across England of 82.2 years (2008- 2012).
- Male life expectancy is 78.3 years in Lincolnshire which is again comparable to the national average of 78.1 years
- Healthy life expectancy from birth is 64.6 for males and females (slightly above the national average)

- Higher than national average life expectancy
- Under 75 mortality rates (standardised rates per 100,000 population aged under 75)
  - Stroke England & Wales 10.66 Lincolnshire 10.24
  - Chronic Obstructive Airways Disease (COPD) England & Wales 11.77 Lincolnshire 10.24
  - Cancers England & Wales 11.77 Lincolnshire 10.24
  - Coronary Heart Disease (CHD) England & Wales 32.71 Lincolnshire 32.94

Life Expectancy Clinical Commissioning Group	Lincolnshire East	South West Lincolnshire	South Lincolnshire	Lincolnshire West
	Average life expectancy Male77.9 years	Average life expectancy Male 79.5 years	Average life expectan-cy Male 79.3 years	Male life expectancy varies from Lincoln at 77.7 years to North Kesteven at 84.2 years.
	Average life expectancy female 81.7 years	Average life expectancy female 83.5 years	Average life expectan-cy female 82.5 years	Female life expectancy varies from Lincoln at 81.8 years to North Kesteven at 83.3 years
	Under 75 mortality rates Stroke 10.66 COPD 12.47 Cancers 12.47 CHD 35.33	Under 75 mortality rates Stroke 6.29 COPD 9.44 Cancers 9.44 CHD 30.61	Under 75 mortality rates Stroke 10.43 COPD 8.36 Cancers 8.36 CHD 31.94	Under 75 mortality rates Stroke 11.08 COPD 9.36 Cancers 9.36 CHD 28.63

Challenges and Issues

The health and social care system in Lincolnshire faces significant challenges. The Keogh review concerns over the quality and safety of some services and the recent Care Quality Commission (CQC) review has resulted in ULHT remaining in Special Measures with further improvement work required. In addition evidence has emerged from the Lincolnshire Health and Care engagement activities that

- services are fragmented
- service models do not reflect published clinical evidence
- unwarranted variation in care,
- some elements of care can be better provided closer to home
- workforce structure, Information Management and Technology (IM&T), payments and incentives, and other factors are not supporting system wide transformational change. –

Recruitment poses significant concerns with many substantive posts filled by locum arrangements and use of temporary staffing remaining high.

- Analysis of published staffing data (HSJ 18th July 14) has revealed that ULHT has one of five hospital sites in the country with the lowest combined day and night nurse staffing levels.
- Recent engagement with primary care teams in Lincolnshire also reflects difficulty with GP recruitment.

DRAFT

For our services to be sustainable we will need to make recruitment and staffing easier which will require the development of new and innovative roles and an increase in the flexibility of working approaches especially for senior clinical staff.

In addition the Lincolnshire County Council is undertaking a major review to meet the implications of the Care Act, and a pooled health and social care budget, the Better Care Fund to the value of £197.30m, has been established to support integrated working through the LHAC programme.

Sir John Oldham, an international expert, speaking an LHAC Care Summit In May 2014 praised Lincolnshire for being at the leading edge of developing plans for a modern health and care system for the 21st century.

"I have to commend the work you have done in Lincolnshire. I am amazed. It would give me a great deal of confidence if I lived in the county that you are going to tackle these problems."

Sir John Oldham

Quality case for change

It is well documented (Transforming delivery of health and social care. King's Fund 2012) that nationally there are gaps in quality and safety in the NHS which point to the urgent need to develop new models of care. The separation between general practitioners (GPs) and hospital-based specialists and between health and social care can inhibit the provision of timely and high-quality integrated care to people who need to access a range of services relevant to their needs.

Lincolnshire recognised that it was a system under pressure with examples of local quality issues e.g. performance against peers, outcomes for local residents, variation in practice and fragmented services.

High mortality indicators gave rise to ULHT being one of the Keogh Trusts. Hospital Standardised Mortality Ratio (HSMR) data for 2012/13 resulted in an approximate 10% rise, as was expected. This placed the Trust as a significant outlier compared to other acute Trusts for that period. Following the recent CQC review it has been recognised that ULHT have made significant improvements with mortality rates and is now within expected limits and at their lowest level for 5 years. Patients are noted to be cared for by compassionate and kind staff. They have, however, retained special measures status whilst they continue their quality improvement journey.

It should also be noted that opportunities identified from LHAC to develop a health and care system that works in a joined up way, focuses on the prevention of ill health, coordination of care and improves clinical and personal outcomes and goals, with quality driving efficiency and save money provide a compelling case for change.

Proactive Care

70% of the national health budget is spent on people who have LTCs, of whom 70-80% are capable of self-managing (DH 2011). The recent Intermediate Care Review in Lincolnshire identified a number of issues: high diversity of services across Lincolnshire; high fragmentation in provision; issues around scope, definition and number of services available; high bed provision compared with national average; huge increase in 30 day bed usage with poor patient outcomes.

Return to independence for older people through rehabilitation/intermediate care is above peer average and reductions in hospital admissions occur in patches. There is good development of community based services (including Independent Living Team, Rapid Response, Frail Older People Initiative, Contact Centre).

Lincolnshire has above peer group deaths occurring at home, however deaths frequently occur in care homes (and hospices), with more than expected deaths in hospital This points to some further opportunity to develop end of life care.

Primary Care

90% of on-the-day contacts within the NHS occur in general practice, reflecting the need to focus on developing primary care services to support new delivery models. However current models of primary care are not sustainable, are insufficiently integrated, and quality of estates and interventions are variable. All this is set against a rising population and increasing long term conditions

General practice has absorbed more and more over the last 10 years and in addition administrative burden and regulatory pressures have increased. GP consultations have increased by 40% in the period 2005/08 and are predicted to continue to rise by a further 33% by 2035, compared with 2008

DRAFT

levels. This may be as a result of increasing long term conditions as well as increasing reliance on patients accessing surgeries for minor ailments. The average time a GP spends with each patient is now just under 12 minutes compared with just over 8 minutes in 1993. This reflects the complexity of managing long term conditions that patients are increasingly living with. To such respond increasing complexity GPs need to develop new roles as 'Generalist Specialists'.

One GP in fourteen is aged 65 and two fifths are in the 50-64 age group. According to the BMAs National Survey of GP Opinion 2011 13% of respondents reported an intention to retire in the next two year across the UK. In addition recruitment of GPs is challenging both nationally and locally. Nationally one in five of the current practice nurses is over 55. There is wide variation across Lincolnshire in numbers of GPs per head of population and generally areas of high deprivation have lower numbers of GPS per head of population and 10% of GP practices have just one GP. These single handed practices face particular difficulties moving forward when care is provided 7 days a week.

There is a wide range of primary care premises from purpose build primary care centres to converted houses. At evenings and weekends premises are largely unused

Urgent Care

The general public are confused around the variety of provision of urgent care (ED, MIU, UCC, walk-in-centre etc.) and as a result A& E is often the default and patients are unsure which to access for what medical problem.

As highlighted by the Keogh review, mortality rates are higher than expected the case mix at ULHT. The position has been reviewed again the most recent CQC report. However, some concerns were raised by the CQC as to safety elements of the A&E provision on all three sites. While all three sites were complimented on their caring staff, concerns were raised around the availability of suitably qualified, skilled and experienced staff, and the availability of suitable equipment. There was inconsistency around meeting the four hour target.

East Midlands Ambulance Services (EMAS) are currently not delivering on national response and handover times. EMAS' response time for the Lincolnshire area is greater than the national target of 8 minutes, and so is the number of ambulance handover delays over 30 minutes (15% of ambulance handovers), significantly above national and peer average.

Elective Care

There is a significant outflow of patients from Lincolnshire (particularly in the South) for a number of specialties. Whilst this will be affected by geographical issues, e.g. proximity to other hospitals, it provides an opportunity to review whether improvements to patient experience and published improved outcome data could influence the number of patients using services within the County.

Bed occupancy, and thus pressures, vary across different hospital sites. Some are over-utilised whilst others are under-utilised. Main operating theatre utilisation is below 70% across Lincolnshire.

Review of available performance data against peers (Gloucestershire PCT, Nottinghamshire County Teaching PCT, County Durham PCT, Hull Teaching PCT, Lincolnshire Teaching PCT, North Staffordshire PCT, Eastern and Coastal Kent PCT, Leicestershire County and Rutland) highlighted that:

- ULHT has high activity volumes compared to peers
- Length of stay is above peer average for more than one third of the top 15 ULHT inpatient specialties.
- New to follow up ratios are above peer average for elective Trauma and orthopaedics, clinical haematology, and pain management.
- Outpatient "Did Not Attend" rates are above peer average for 6 out of 15 of the top specialties.
- Some elective specialties have low volumes when considered at site-level, meaning that it is difficult to recruit and maintain specialist skills and staff

Women and Children

Quality concerns that arise within maternity and children's services largely relate to the relatively low volumes of provision across sites. It is worth noting that the aim of reduced admission rates and provision of care in community settings and patients homes wherever possible will likely reduce this volume further.

DRAFT

A comprehensive data pack was developed by the Maternity and Children Network Manager and Lead Nurse, East Midlands Strategic Clinical Network. This highlights a number of outlying areas of practice within paediatrics.

The Lincolnshire Child Health Profile shows that compared with English (and in some instances EU) averages, Lincolnshire has:

1. a greater proportion of children classed as overweight or obese in Reception and Year 6;
2. a higher proportion of births to teenage girls;
3. lower rates of breastfeeding;
4. lower rates of MMR uptake at age 5 and
5. higher rates of hospital admissions for children and young people.

A desktop review against Royal College of Paediatrics and Child Health (RCPCH) Standards indicates that neither Lincoln County or Pilgrim Hospitals meet the standards for:

- a paediatric consultant being present in the hospital during times of peak activity; •all paediatric in-patient units adopt an attending consultant system, most often in the form of a 'consultant of the week' system and
- acute paediatric rotas being made up of at least 10 Whole Time Equivalents (WTEs) and European Working Time Directive (EWTD) compliant.

In the most recent General Paediatric Surgery Review (2013), Lincoln County was rated: green in 2 areas, amber in 14 areas and red in 2 areas. Pilgrim Hospital was rated: green in 7 areas, amber in 8 areas and red in 3 areas.

The most recent CQC inspection has identified potential areas of concern around safety in both Pilgrim and Lincoln. Opportunities for improvement were identified in staffing, staff support and leadership as targets were not met around numbers of maternity staff on shift, which led to unnecessary risk. Maternity services at both sites were identified as requiring improvement. They also identified that whilst policies and procedures reflected national guidance they did not always reflect current practice in paediatrics.

The clinical senate highlighted that maternity volume was low on both sites. During the Expert Reference Groups clinicians raised the need for focus to be placed on the impact of the recent draft NICE guidance (http://www.nice.org.uk/Guidance/CG55/chapter/guidance#planning-place-of-birth) on choice for women within antenatal and intra-partum care when LHAC consider provision of care across sites within the county.

Workforce challenges to support adequate staffing levels, specialisation, training and role development and overcome recruitment pressures are recognised.
Rationalising the number of sites for Women's and Children's Services might promote specialisation and also

Mental health Learning Disability and Autism

Research confirms that people with Learning Disability, Autism and or Mental Health problems are more likely to have poor health and wellbeing outcomes in comparison to the wider general population. In particular Parity of Esteem – identifies the significant inequalities that exist between physical and mental health care. Key areas of inequality for this vulnerable group of people include preventable premature deaths, lower treatment rates and low levels of proportional funding in comparison to physical health care.

Addressing inequalities in outcomes for people with Learning Disability, Autism and/or Mental Health problems will remain a local priority and the areas below are particular areas of focus.

- **Preventable premature deaths**: Whilst Lincolnshire mortality rates for people with severe mental health problems appear to be better than comparator CCG's, reducing excess mortality rates for people with Learning Disability, Autism and/or Mental Health is a key priority given the still significant gap between the mortality rates of this vulnerable group of people and the wider general population. Achieving further improvement against with ambition will require a system wide and targeted approach to improving health and wellbeing with key contributions required from Public Health, Neighbourhood Teams, Primary Care and wider community based services and partnerships. Early Intervention and Prevention strategies will also be essential to success and therefore the contribution from Children's services will also be very important.

DRAFT

- **Better access to Services and Support**: Waiting times for IAPT services has been identified as a local concern in some specific areas and the new national waiting times for Mental Health Services including IAPT and Early Intervention in Psychosis will be key challenges to Lincolnshire providers and commissioners. There is also further work required to ensure Lincolnshire meets target rated of diagnosis for Dementia and the diagnosis of Autism is also an important element of the Lincolnshire All Age Autism Strategy. Without effective diagnosis people are unlikely to get timely access to the support they may need. There is a strong evidence base that health checks for people with Learning Disability and Mental Health Needs may help to improve access to the services they may need, however we are aware that not all Lincolnshire GP's have signed up to related initiatives that support increased rates of annual health checks. A specific area that needs further local consideration is the rate of people open to Care Programme Approach per 100,000 population 18+ as we appear to have significantly less people open to CPA than comparator CCG's.

- **Increase in proportion of funding:** Mental ill health represents 23% of all ill health in the UK - the largest single cause of disability yet only 11% of England's annual secondary care health budget is spent on mental health services. On this basis there will be a need to reflect on local funding allocations and to ensure that proportional spend on Mental Health services is not under represented. We also know that Lincolnshire has relatively low levels of spend on Mental Health and Learning Disability services than some other areas. This is in part attributable to local commissioning approaches but further consideration is required to consider future overall levels of investment in these service areas to ensure there are not inequalities in comparison to other conditions. There is also very limited knowledge of how much is spent on Autism as a condition at a national or local level and therefore we will need to improve our local understanding of this if we are to ensure inequalities are addressed.

Financial case for change

The Financial Gap

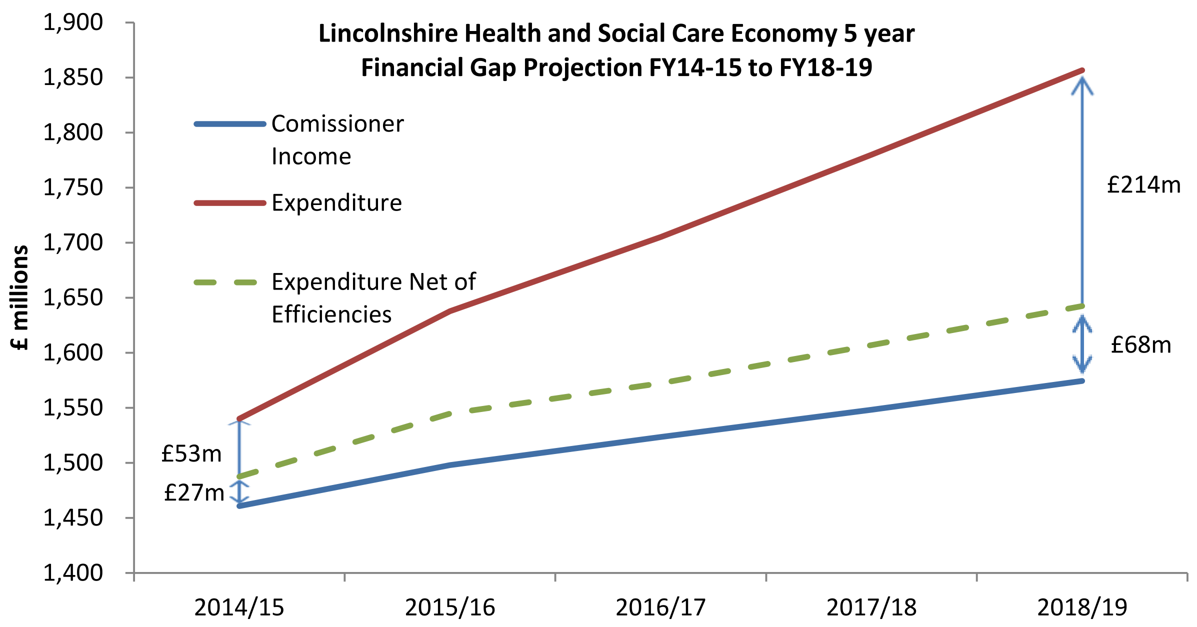
The current forecast of the gross recurrent financial gap in 2018/19 is £282m. This is the combined gross deficit of all providers and commissioners and the relevant part of the surplus from the NHS England Area Team (Primary Care and Specialised Services). This is a gross figure before any planned organisational efficiency savings. Over the period of 14/15-18/19 This headline figure is shown gross in order to avoid the risk of double counting efficiencies. If all nationally prescribed efficiencies, excluding Lincolnshire Health & Care efficiencies are achieved then the gap would reduce to £68m.

Both perspectives on the gap are shown because although organisations are required to plan for the delivery of nationally prescribed efficiencies, future plans are insufficiently detailed to specify how these savings can be achieved. In addition, recent history has shown that not all planned efficiencies have been delivered. The planned efficiencies represent recurrent savings of 2.7% per year across the total health and care 'budget'. During the next phase of work a coordinated plan of cost savings will be developed across all organisations, along with an evaluation of the deliverability of year on year efficiency savings during a period of significant structural change in the health and care system.

The gap has decreased from £105m in the Phase 1 Lincolnshire sustainable Services Blueprint published in 2013. The main drivers of this change are:

- the modelling is now based on the actual, audited 2013/14 financial outturn for all NHS organisations and the draft outturn for LCC (which is currently subject to audit);
- the gap is now forecast at the end of the 5 year planning period in 2018/19 (extended by 1 year from the blueprint);
- the model reflects notified funding allocations for NHS commissioners;
- the gap includes the relevant part of the budget and spending for the NHS England Local Area Team;
- Plans have been aligned, and assumed Lincolnshire Health & Care efficiencies have been excluded.

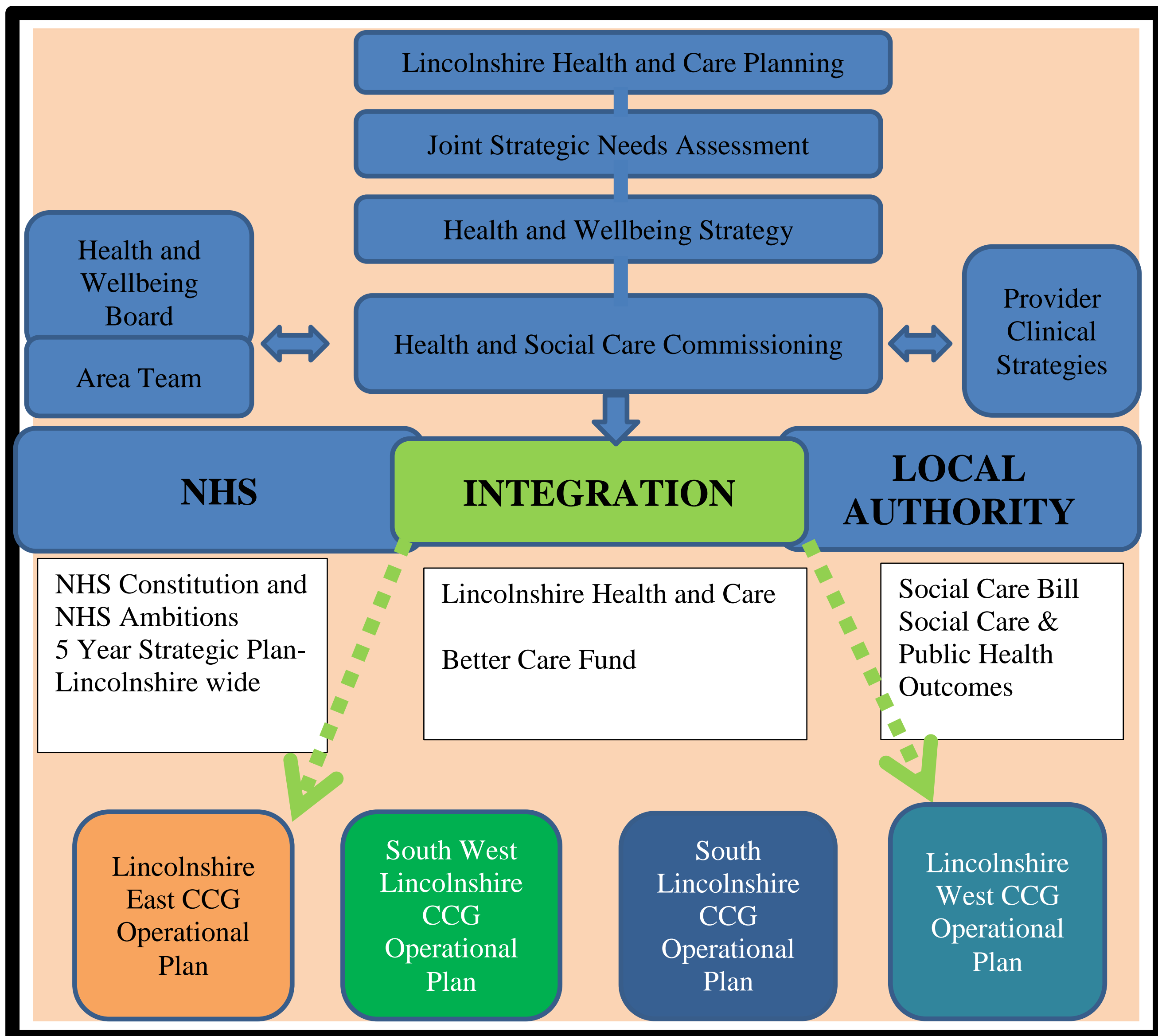
DRAFT



DRAFT

Approach to developing the Plan
System overview

The table below summarises the framework for developing the 5 Year Strategic Plan



Our approach is based upon Lincolnshire Health and Care (LHAC), 5 year Blueprint, which has been agreed by all Four Lincolnshire CCGs, Lincolnshire Health and Well Being Board and the three main NHS providers in Lincolnshire; our understanding of the populations health needs emanating from discussion and consultation with local people, local providers and other stakeholders and through working in close partnership with Local Authorities and Public Health.

Health and Wellbeing Strategy

Joint Strategic Needs Assessment (JSNA) provides indicators to establish current and future health needs of our local population. This in turn, supports better targeting of interventions to reduce health inequalities. The JSNA has informed LHAC, CCG operational plans and the development of the Joint Health and Wellbeing Strategy, which has the key themes of:

- Promoting healthy lifestyles
- Improving the health and well-being of older people

- Delivering high quality systematic care for major causes of ill health and disability
- Improving health and social outcomes and reducing inequalities for children
- Tackling the social determinants of health

Integrated Working: Lincolnshire Health and Care

Blue print (phase 1)

The Lincolnshire Health and Care Programme Board was set up in August 2013 to bring health and social care commissioners and providers together to design a Blueprint for the future model of care. A series of Care Design Groups (CDGs) were held to bring together mixed groups of local care professionals and members of the public, to work out how best to deliver care and deploy resources across organisational boundaries. In Phase 1 three CDGs were held in each of the areas of care defined i.e. Proactive Care; Elective Care; Urgent Care; and Women's and Children's Services.

The programme has worked towards best practice guidance issued in Planning and Delivering Service Changes for Patients. This included two OGC Gateway Reviews, review by the Clinical Senate and changes to the scope of work required to build a detailed proposal that meets revised assurance processes.

We needed to know what worked elsewhere so a comprehensive, documented, evidence library was built up of best practice locally, in other parts of the UK and across the world to inform redesign options. These include evidence from Torbay, NW London, Gwent, Canterbury New Zealand and the Alzira model from Valencia in Spain.
To achieve these benefits, significant effort and collaboration will need to take place across all the LHAC stakeholders.

Detailed design (phase 2)

Phase 2 focused on the detailed design of the model of care envisaged in the Blueprint. Commissioners and providers continued to work together to develop details for the initiatives and started to build a work plan for implementation. This was achieved through another series of three CDGs which involved a wider community of care professionals and members of the public.

Due to the size of the groups and the need to revisit some themes developed during Phase 1 to enhance the broader engagement desired by system leaders the process was supplemented by a number of Expert Reference Groups (ERGs). These are smaller groups of care professionals tasked with answering specific design questions.

The design details informed the enabler work streams, including IM&T, workforce, estates and contracting each of which developed a high-level design for a future state. Each CDG met three times. There were approximately 20 attendees to the elective CDG meetings, 45 for Proactive, 30 for Urgent and 28-30 people who attended Women's & Children's. Representation was from 18 different organisations across Lincolnshire.

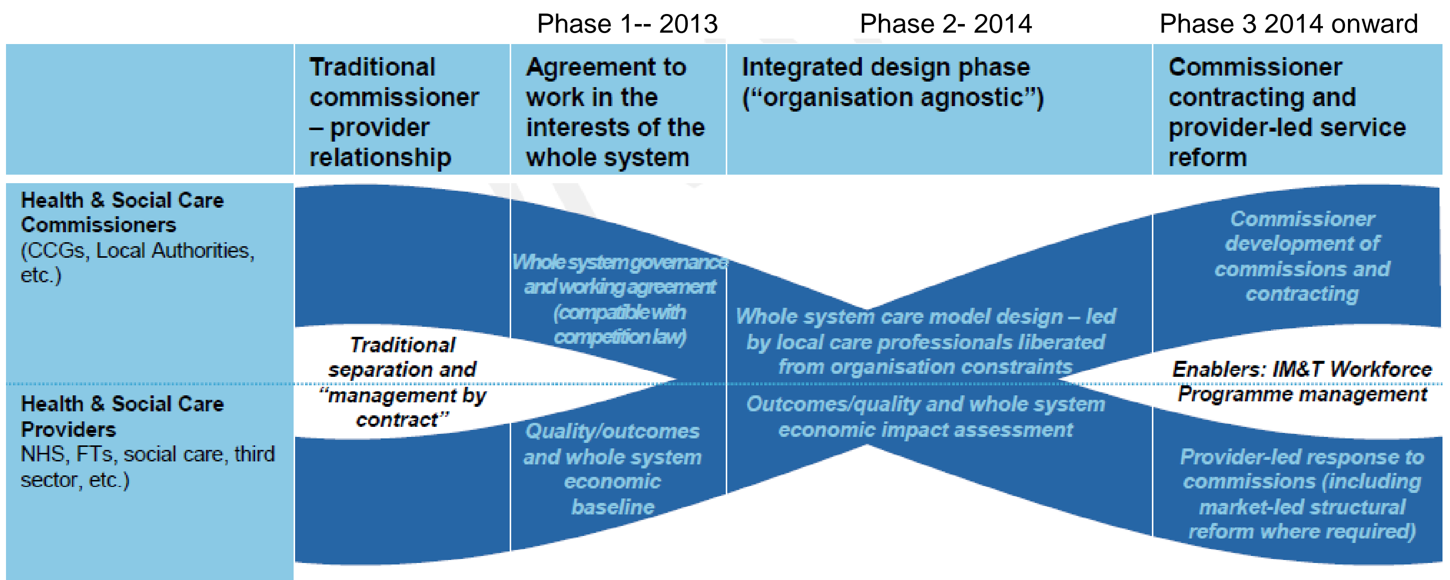
Five expert reference groups met, as an additional Neighbourhood Teams group was formed. There have been 7 attendees of the Elective Care ERGs, 15 for Women's and Children's, 14 for Proactive, 11 for Neighbourhood Teams and 14 for Urgent Care. The groups have met between two and five times depending on need, and representation was available on average from 15 different organisations across Lincolnshire.

Phase 3

Phase 3 focuses on commissioner development of new commissioning intentions and contracting mechanisms working collaboratively alongside, but separate to, provider led service reform.

Design methodology

DRAFT



The Better Care Fund (BCF)

The whole Lincolnshire health and social care economy recognises the need for better integration as detailed in LHAC. The connection between the Lincolnshire BCF and LHAC is critical to the achievement of this ambition. The LHAC is a 5 year plan to transform health and social care in Lincolnshire and the BCF describes the first two years of that plan. In addition all parties have previously agreed to pool funds, where it makes sense to do so. In some areas such as mental health and learning disabilities, pooling agreements already exist, in other areas such as Children, new agreements will be required. It is anticipated that the value of pooled funding will increase from £70.8m in 2014/15 to £197.3m by 2015/16.The LHAC and BCF activity will support the Joint Health and Wellbeing Strategy (JHWS).

Joint Commissioning

Health and social care integration and development of joint commissioning

Lincolnshire CCGs and Lincolnshire County Council have been working together for almost two years to develop robust joint commissioning infrastructure. The advent of the Better Care Fund has meant that this has been able to be incorporated into the joint commissioning arrangements rather than creating any duplication. The current infrastructure for joint commissioning as follows:

1. **Joint Commissioning Board**

   This is the overarching strategic technical group with senior executives from the local authority and CCGs working on the delivery of the Health and Wellbeing strategy and all significant interface issues between health and social care commissioning. It is a venue for both the development of plans but also the escalation of any issues which need to be resolved.

2. **Joint Delivery Boards**

DRAFT

These have been established with dedicated programme managers with accountability to the Joint Commissioning Board and are aligned to the collaborative commissioning arrangements across CCGs and the County Council. These are as follows:

1. Urgent care (reports up through the System Resilience Group)
2. Planned Care (reports up through the System Resilience Group)
3. Women and Children's (covers children's services and maternity across health and social care
4. Proactive Care
5. Specialist Adult Services (covers mental health, learning disability and autism)

Currently in Lincolnshire there are S.75 agreements in place around a number of the areas; mental health, learning disabilities, children's, community equipment. By 1 April 2015 the S.75 framework will have been widened to begin to go beyond the Better Care Fund (in Lincolnshire). As part of the Lincolnshire Health and Care implementation the drive to develop integrated neighbourhood teams bringing health and social care together will be the major driver for operational integration of services. This will include the development of integrated personal budgets across health and social care, single integrated case management and a revised single assessment process which will cover both social care entitlement and NHS continuing healthcare entitlement. There will be some significant challenges around information systems, cultural change, estates and operational and professional management. However, there is a very strong shared vision that goes beyond simple consensus about the potential that this offers. There are currently four developing neighbourhood teams in the first wave, followed by four in the second wave, beginning to develop the foundations for this move.

Throughout the Joint Delivery Boards there are a number of key headlined joint commissioning activities which will take place in the first two years of this plan, these include:

1. Re-specification of procurement of tier 3 CAMHMS service to extend these to a seven day integrated community based service
2. The re-specification and re-procurement of the intermediate layer covering community rapid intervention services and step up step down care at home and in residential settings.
3. The development and proof of concept of increased support services for dementia, including family support services and the development of a support network to enable people with dementia and their families to receive the right level of support after diagnosis. With strong collective leadership arrangements across the local County Council and the Clinical Commissioning Groups there is a strong foundation for the development of what aims to be leading edge health and social care integration.

Communication and Engagement

Approach

Clear communications and engagement are paramount to ensuring that the CCGs in Lincolnshire are the local health leaders.

The CCGs in Lincolnshire are committed to a systematic communication and engagement approach and will deploy a range of tools to ensure meaningful communication and engagement with patients, carers and their communities. The two main tools that will form the basis of the CCG communication and engagement infrastructure will be the Engagement Cycle and the Continuous Listening Model.

DRAFT

The following communication and engagement principles employed by the CCGs are based on best practice. They will form the basis of how Lincolnshire CCGs develop as healthcare commissioners of the future:

- Be open, honest, timely and transparent in all conversations and interactions
- Ensure communication and engagement is meaningful, targeted and integral throughout our business planning and commissioning decision making processes
- Embody the ethos of 'No decision about me, without me'
- Ensure views of our diverse population are represented
- Communication and engagement is everyone's responsibility within the CCG.

Engagement activity has covered the full range from street engagement with the general public, to MP meetings, presentations to Boards and Councillor groups (county and districts), engagement with Healthwatch localities groups, carers and patient groups and local grass roots organisations. We have placed articles in county-wide partner publications that go to all households, as well as setting up a dedicated website with live updated on the programme which had over 2,000 unique hits in the first month. Two staff bulletins have been issued in Phase 2 to staff across all 11 partner organisations.

The first phase of engagement focused on asking a wide range of questions to get feedback and comment on the current health and social care system as well as hearing views on where improvements could be made. The material gathered through engagement has been fed back at a number of key points into the design work to inform the CDGs. Engagement was a feature of each CDG and the Care Summit where the top themes from public engagement were fed back to the audience. The main areas of concern at both LHAC and CCG events were:

- Waiting times for appointments and referrals
- Lack of information sharing (between professionals and between professionals and patients/carers)
- Not knowing what support is available
- Lack of continuity of care (particularly into and out of hospital)
- Positive feedback on good quality care and support

More focussed discussions were held in May and June with a clear focus on testing out some of key areas of work which the Expert Reference Groups are still to clarify. Legal advice has been sought to ensure that the approach to engagement meets the requirements of national guidance and legislation.

Ten staff engagement sessions are being held in the first two weeks of June, organised across the county and designed to allow staff from any partner organisations to be involved in the design and shape of the proposals.

Public acceptability is being considered as a sub-criteria for the options appraisal.

A full public consultation is scheduled for 2015 and the consultation strategy is currently in draft. An external agency will be procured to support with hosting the consultation and undertaking all the data collation and analysis, with a report to the Programme Board which will inform decision making around the final recommendations in January.

Assurance activity in July and August will include scrutiny by Adults, Health and Children's Scrutiny Committees at the County Council and the Health and Wellbeing Board will approve the recommendations following agreement by the Executives of the Commissioning partner organisations.

DRAFT

All of these issues and themes are specifically reflected across all 4 CCGs commissioning intentions, as far as they relate to their resident populations and are an important contributor to the determination of future service proposals through LHAC that are planned to go for formal consultation in 2015

Priorities identified by local people – what people told us

"Change is good, it opens up opportunities." **13 yr old girl**

"Trying to get clinical advice out of hours is a nightmare. The result is we end up taking the patient to A&E" **Paramedic**

"Treating you like an object, in and out with the least possible time and interest in you" **Young person**

Care home provider: "we often get people coming out of hospital without any meds and with no notes or handover in writing – we can really struggle to get prescriptions, sometimes for several days."

"Receiving care can be stressful – it's unsettling having a stranger come in and have to explain your needs every time" **Member of public, Stamford**

"Culture change is really important...professionals must respect each other and be willing to work across organisational boundaries" Provider

"My wife saw 13 different professionals before being diagnosed with pancreatic cancer." **Man in his 80s**

"Convince us that closing hospitals is not dangerous for people who don't live near them and will have to travel further, for longer" **Young person**

The comments raised (to the left) and many others have helped us to develop and introduce Neighbourhood Teams across Lincolnshire. Our neigbourhood Teams will only be effective if everyone working in health and care feels that they are part of the wider Team. We have worked with GPs, our Community, Acute and Mental Health Teams as well as Social Care to launch Neighbourhood Teams in Lincoln City South, Stamford, Sleaford and Skegness.

We continue to listen to patients, carers, and their families and introduce a series of Listening Events which were as a result of the Francis Review of health care. These events give us the opportunity to listen to patient experience whether it be good or bad and to learn from those lessons. To date we have held four of these events which give us valuable data to help shape the future of health and care for the future.

The Engagement Cycle

As part of our Annual Planning cycle we also involve patients, carers and their families as well as wider stakeholders in the development of our commissioning intentions for the coming year. We operate a continual engagement cycle which can be seed to the left.

A continuous listening model for engagement is embedded into CCG processes. This enables us to listen and respond to the population on a continuous basis, not just through specific engagement and

Work to match engagement activities to potential projects has already begun, including the creation of patient participation groups. This will ensure that the appropriate level and approach for public involvement is used for any commissioning decision we make. A best practice model for determining the level of engagement required for specific project proposals is being used to develop the engagement work plan. This involves assessing the likely impact on patients and the likely level of change in commissioning to determine the best approach for public involvement.

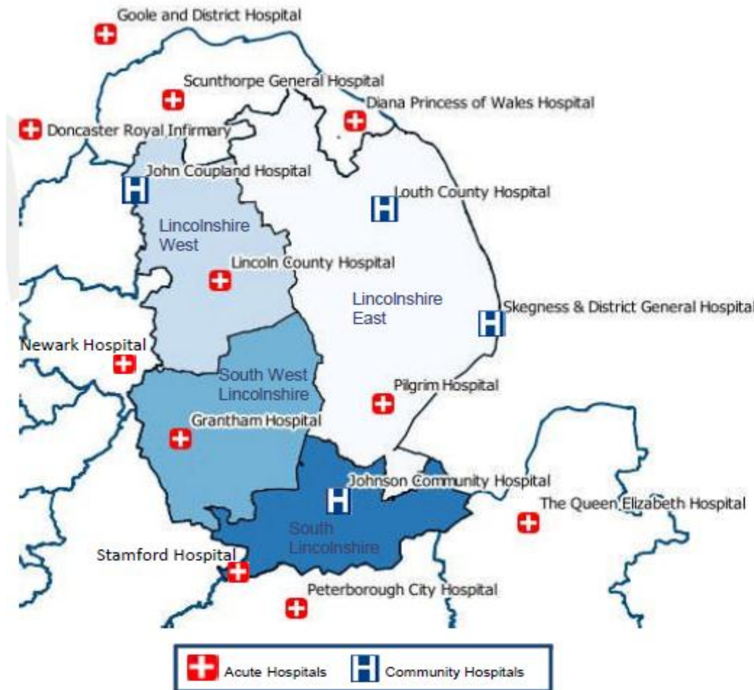
Provider landscape

The table below summarises the main service providers commissioned, by CCG.

PROVIDER	SWLCCG	LECCG	LWCCG	SLCCG
ACUTE TRUST				
United Lincolnshire Hospital Trust	√	√	√	√
Peterborough Hospitals Trust	√			√
North Lincolnshire and Goole Foundation Trust		√	√	
Nottingham University Hospitals	√			
Queen Elizabeth Hospital King's Lynne				
MENTAL HEALTH TRUST				
Lincolnshire Partnership Foundation Trust	√	√	√	√
Cambridgeshire and Peterborough Foundation Trust				√
COMMUNITY TRUST				
Lincolnshire Community Health Services Trust	√	√	√	√
AMBULANCE				
East Midland Ambulance Service	√	√	√	√

DRAFT

Primary Care:
Lincolnshire has 5.7 GPs and 4.8 GP practice nurses per 10,000 people. There are 101 main GP practices across Lincolnshire with 30 in Lincolnshire East, 37 in Lincolnshire West, 19 in South West Lincolnshire and 15 in South Lincolnshire. The primary care budget in FY 2012-13 was equal to £111m.
Acute Services:
The main acute provider in Lincolnshire is United Lincolnshire Hospitals NHS Trust, with sites in Lincoln, Boston and Grantham. The Trust's income for 2013-2014 was £399m and it offers over 1,300 beds. Lincoln Hospital is the largest hospital, with over 88,000 inpatients and 65,000 emergency cases last year.
Community services:
The community provider, Lincolnshire Community Health Services NHS Trust, runs John Coupland Hospital in Gainsborough, Skegness and District General Hospital, Johnson Community Hospital in Spalding and County Hospital Louth. In 2013- 2014 the Trust's income totalled £XXXm and offered 155 beds.
Mental Health and Learning Disability Services
The mental and learning disability provider, Lincolnshire Partnership NHS Foundation Trust, that provides a range of community services and specialist beds the majority of which are collocated on hospital sites. In 2013/14 the Trusts income totalled £95.619m
Social Care Services:
Adult Social Care Services are commissioned by Lincolnshire County Council from a network of providers. In 2013-2014 £XXXm were spent on the provision of adult social care and the Council supported xxx people in residential and nursing care.



The map shows the county of Lincolnshire and location of its main community hospital and district general hospital sites. The shaded areas are the four Lincolnshire CCGs.

Each Clinical Commissioning Group acts as a lead commissioner commissioning services on behalf of the four Lincolnshire CCGs:

Lincolnshire West CCG is responsible for commissioning services from:
- United Lincolnshire Hospitals Trust (Lincoln County, Grantham & District and Boston Pilgrim Hospitals)
- St Barnabas Hospice(End of life care)
- Marie Curie Cancer Care

Lincolnshire East CCG is responsible for commissioning services from:
- Lincolnshire Community Health Services NHS Trust
- Northern Lincolnshire And Goole Foundation NHS Trust
- L.I.V.E.S (Lincolnshire Integrated Voluntary Emergency Service)

South Lincolnshire CCG s responsible for commissioning services from:

- Peterborough and Stamford Foundation NHS Trust
- Ramsay contracts

South West Lincolnshire CCG is responsible for commissioning services from:

- Lincolnshire Partnership Foundation NHS Trust (Mental health, social care and specialist community services
- Mental Health Partnership agreements with Lincolnshire County Council

Workforce

The analysis of the existing workforce profiles, models, staffing spend and productivity across Lincolnshire has highlighted some key challenges, issues and opportunities for the development of future services, including

Workforce Supply challenges:

- Staff recruitment is difficult in many areas, particularly medical staff and GP's
- Supply challenges have driven high temporary staff and locum spend, which also undermines high quality care
- Local recruitment issues are amplified by national shortage of certain professional groups e.g. paediatric staff
- Continuity of services – staff moral/recruitment & retention

Difficulties in attracting and retaining talent:

- Restricted talent pool, with low turnover and minimal highly skilled 'new entrants' to the local health system, particularly in Urgent Care
- Limited (integrated) professional training and education provision.

Workforce capacity limitations

- Lack of senior decision makers in A&E from the start
- Lack of sufficiently qualified and competent staff
- Lack of reliable and responsive emergency midwifery support for EMAS
- Unable to flex resources and capacity to meet system demands
- Existing staffing resource models fail to provide the capacity for development and improvements in delivering truly proactive and preventative care services.

Workforce leadership

- Alignment in the leadership and management of services, pathways and workforce across the system will provide the leverage

DRAFT

Benefits

Improving Quality and Outcomes

Quality and Safety

Lincolnshire West CCG hosts a quality team, and South West Lincolnshire CCG hosted a safe-guarding team on behalf of the 4 Lincolnshire CCGs. Each CCG employs an Executive Nurse on the Governing Body who takes a lead for monitoring quality, (clinical effectiveness, safety, safe-guarding of vulnerable groups and patient experience of service provision), and ensures that quality improvement and incentive schemes such as Commissioning for quality and innovation (CQUIN) improvements are deployed to target and drive up quality.

Through the hosted quality team and network of CCG Executive Nurses, CCGs ensure that recommendations from national inquiries including Francis, Berwick and Winterbourne reviews are appropriately reflected in contracts, service provision and planning. In particular in June 2013, the Keogh Review investigated mortality rates at ULHT and recommended 57 different ways the Trust could improve the quality of services. In July 2013, a risk summit was held to discuss the findings of the Review and to agree an action plan to address the recommendations. Since the summer of 2013, ULHT has been working closely with colleagues to drive forward the implementation of all recommended improvements.

The CCGs actively monitors patient experience, patient safety and clinical effectiveness through Quality and Patient Experience Committees and through contracting mechanisms including quality provider accounts and CQUINs (Commissioning for Quality and Innovation) . In addition to longer term strategic interventions CCG will continue to address a number of high priority areas of historically poor performance including;

- mortality rates and monitoring implementation of Keogh recommendations at ULHT
- ULHT continues to struggle to deliver NHS Constitution performance standard regarding Cancer (31 and 62 day standards, A&E waiting times and 18 week referral to treatment)

In order to ensure the effectiveness of commissioned services regular meetings are held with the providers for whom each CCG has lead commissioning responsibility to discuss clinical performance and quality issues. For other providers for whom the CCG does not have lead responsibility forums are established, to ensure that mechanisms are in place to monitor the effectiveness of quality and safety of those services and receive feedback. Regular review of performance against national and local benchmarks occurs including those in the Quality Schedule, CQUIN performance and assessment of performance against the national CCG outcomes indicators.

Quality reports

Quality reports are published on a regular basis and are presented to CCG's Governing Bodies. These reports include information about safety, effectiveness and patient reported experience both from local and national sources and where possible include comparisons with similar organisations or national standards. Information on most of the data sources utilised to assess quality performance are given below, but are not exhaustive lists.

DRAFT

Monitoring Patient Experience	Complaints
	MP Correspondence
	Patient Advice and Liaison Services
	Net Promoter
	National /Local Patient Surveys
	Assurance Visits (Patient and Carer Feedback)
Monitoring Clinical Effectiveness	Performance data review
	Mortality and Morbidity Data
	Patient Reported Outcome Measures
	National and Local Audit
	National Institute for Clinical Excellence
Monitoring Patient Safety	Serious Incidents
	Adverse Incidents (Independent Contractors and Nursing Homes)
	Safeguarding Alerts
	Thematic Reviews (i.e. Infection Control)
	Proactive and Responsive Provider Visit Programme
	Risk Summits
	Regulator Risk Profiles and Feedback
	HSE
	Police
	NHS Commissioning Board

Performance against NHS Constitution – focus on standards

The NHS constitution gives patients the right to access services within set standard waiting times according to service, treatment type and needs. All CCG plans aim to uphold the principles, values and rights set out in the NHS Constitution.

Current performance against the constitution being delivered by local providers has informed our priorities and commissioning interventions. A summary is provided in the table below.

Description Constitution Indicators	Standard	Lower Threshold	Latest Period 2014/15 Quarter 1	Commissioning Interventions
Referral to treatment (RTT) waiting times for non-urgent consultant led treatment				
18 Week RTT Admitted Pathways < 18 weeks	90%	85%		Elective Care Programme Primary Care Strategy
United Lincolnshire Hospitals NHS Trust			85.2%	
Peterborough & Stamford NHS Foundation Trust			86.5%	
Northern Lincolnshire & Goole NHS Foundation Trust			92.2%	
Nottingham University NHS Trust			94.7%	
Queen Elizabeth Hospital NHS Trust			84.9%	
18 Week RTT Non-Admitted Pathways < 18 weeks	95%	90%		Elective Care Programme Primary Care Strategy
United Lincolnshire Hospitals NHS Trust			92.7%	
Peterborough & Stamford NHS Foundation Trust			96.4%	
Northern Lincolnshire & Goole NHS Foundation Trust			96.7%	
Nottingham University NHS Trust			97.0%	
Queen Elizabeth Hospital NHS Trust			97.6%	

DRAFT

Description Constitution Indicators	Standard	Lower Threshold	Latest Period 2014/15 Quarter 1	Commissioning Interventions
Lincolnshire Partnership NHS Foundation Trust			98.5%	
Cambridgeshire & Peterborough NHS Foundation Trust			34.8%	
18 Week RTT Incomplete Pathways < 18 weeks	92%	87%		Elective Care Programme Primary Care Strategy
United Lincolnshire Hospitals NHS Trust			89.6%	
Peterborough & Stamford NHS Foundation Trust			97.2%	
Northern Lincolnshire & Goole NHS Foundation Trust			96.9%	
Nottingham University NHS Trust			97.7%	
Queen Elizabeth Hospital NHS Trust			96.9%	
Lincolnshire Partnership NHS Foundation Trust			98.2%	
Cambridgeshire & Peterborough NHS Foundation Trust			69.5%	
Number of 52 week referral to treatment pathways	0	N/A		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			0	
Peterborough & Stamford NHS Foundation Trust			0	
Northern Lincolnshire & Goole NHS Foundation Trust			0	
Nottingham University NHS Trust			0	
Queen Elizabeth Hospital NHS Trust			0	
Lincolnshire Partnership NHS Foundation Trust			0	
Cambridgeshire & Peterborough NHS Foundation Trust			0	
Diagnostic test waiting times				
Diagnostic Waits > 6 weeks	99%	94%		Elective Care Programme Primary Care Strategy
United Lincolnshire Hospitals NHS Trust			93.2%	
Peterborough & Stamford NHS Foundation Trust			99.9%	
Northern Lincolnshire & Goole NHS Foundation Trust			100.0%	
Nottingham University NHS Trust			100.0%	
Queen Elizabeth Hospital NHS Trust			99.0%	
A&E 4 hour waits				
A&E Waits Seen within 4 Hours	95%	90%		Urgent Care Programme
United Lincolnshire Hospitals NHS Trust			93.4%	
Peterborough & Stamford NHS Foundation Trust			87.1%	
Northern Lincolnshire & Goole NHS Foundation Trust			96.0%	
Nottingham University NHS Trust			87.6%	
Queen Elizabeth Hospital NHS Trust			91.3%	
Cancer waiting times				
Cancer 2 Week Wait - Suspected Cancer Referrals	93%	88%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			85.5%	
Peterborough & Stamford NHS Foundation Trust			95.7%	
Northern Lincolnshire & Goole NHS Foundation Trust			99.0%	
Nottingham University NHS Trust			90.6%	
Queen Elizabeth Hospital NHS Trust			97.2%	

DRAFT

Description Constitution Indicators	Standard	Lower Threshold	Latest Period 2014/15 Quarter 1	Commissioning Interventions
Cancer 2 Week Wait - Breast Symptomatic Referrals	93%	88%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			59.9%	
Peterborough & Stamford NHS Foundation Trust			97.3%	
Northern Lincolnshire & Goole NHS Foundation Trust			99.4%	
Nottingham University NHS Trust			92.3%	
Queen Elizabeth Hospital NHS Trust			96.0%	
Cancer 31 Day Waits - First Definitive Treatment	96%	91%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			98.0%	
Peterborough & Stamford NHS Foundation Trust			99.7%	
Northern Lincolnshire & Goole NHS Foundation Trust			100.0%	
Nottingham University NHS Trust			95.6%	
Queen Elizabeth Hospital NHS Trust			99.3%	
Cancer 31 Day Waits - Subsequent Treatment - Surgery	94%	89%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			96.0%	
Peterborough & Stamford NHS Foundation Trust			100.0%	
Northern Lincolnshire & Goole NHS Foundation Trust			100.0%	
Nottingham University NHS Trust			97.3%	
Queen Elizabeth Hospital NHS Trust			100.0%	
Cancer 31 Day Waits - Subsequent Treatment - Chemotherapy	98%	93%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			99.2%	
Peterborough & Stamford NHS Foundation Trust			100.0%	
Northern Lincolnshire & Goole NHS Foundation Trust			99.3%	
Nottingham University NHS Trust			96.3%	
Queen Elizabeth Hospital NHS Trust			100.0%	
Cancer 31 Day Waits - Subsequent Treatment - Radiotherapy	94%	89%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			83.9%	
Peterborough & Stamford NHS Foundation Trust			100.0%	
Northern Lincolnshire & Goole NHS Foundation Trust			No Patients	
Nottingham University NHS Trust			99.4%	
Queen Elizabeth Hospital NHS Trust			100.0%	
Cancer 62 Day Waits - First Definitive Treatment - GP Referrals	85%	80%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			80.1%	
Peterborough & Stamford NHS Foundation Trust			88.3%	
Northern Lincolnshire & Goole NHS Foundation Trust			86.9%	
Nottingham University NHS Trust			82.5%	
Queen Elizabeth Hospital NHS Trust			88.4%	
Cancer 62 Day Waits - Treatment from Screening Referral	90%	85%		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			96.1%	

Description Constitution Indicators	Standard	Lower Threshold	Latest Period 2014/15 Quarter 1	Commissioning Interventions
Peterborough & Stamford NHS Foundation Trust			98.5%	
Northern Lincolnshire & Goole NHS Foundation Trust			No Patients	
Nottingham University NHS Trust			92.0%	
Queen Elizabeth Hospital NHS Trust			98.3%	
Cancer 62 Day Waits - Treatment from Consultant Up-grade	N/A	N/A		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			No Patients	
Peterborough & Stamford NHS Foundation Trust			90.2%	
Northern Lincolnshire & Goole NHS Foundation Trust			No Patients	
Nottingham University NHS Trust			No Patients	
Queen Elizabeth Hospital NHS Trust			No Patients	
Category A ambulance calls				
Ambulance Clinical Quality - Category A (Red 1) 8 Minute	75%	70%		Urgent Care Programme
EMAS			74.87%	
Ambulance Clinical Quality - Category A (Red 2) 8 Minute	75%	70%		Urgent Care Programme
EMAS			75.28%	
Ambulance Clinical Quality - Category A 19 Minutes	95%	90%		Urgent Care Programme
EMAS			95.27%	
Ambulance handovers				
Ambulance Handover Delays (EMAS)	0	N/A		Urgent Care Programme
Delays by Minutes	30 - 60 mins	60 mins +	Total	
Lincoln County Hospital	1157	191	1348	
Pilgrim Hospital, Boston	840	136	976	
Grantham Hospital	160	19	179	
Peterborough City Hospital	232	17	249	
Scunthorpe	423	65	488	
Grimsby, Diana Princess of Wales	512	26	538	
Queens Medical Centre, Nottingham	1807	160	1967	
Nottingham City Hospital	124	29	153	
Mixed sex accommodation breaches				
Mixed Sex Accommodation (MSA) Breaches	0	10		Elective Care Programme Mental Health Learning Disabilities and Autism Programme
United Lincolnshire Hospitals NHS Trust			0	
Peterborough & Stamford NHS Foundation Trust			0	
Northern Lincolnshire & Goole NHS Foundation Trust			0	
Nottingham University NHS Trust			18	
Queen Elizabeth Hospital NHS Trust			7	
Lincolnshire Partnership NHS Foundation Trust			0	
Cambridgeshire & Peterborough NHS Foundation Trust			0	
Cancelled operations				

DRAFT

Description Constitution Indicators	Standard	Lower Threshold	Latest Period 2014/15 Quarter 1	Commissioning Interventions
Cancelled Operations - Not Seen < 28 Days	0%	N/A		Elective Care Programme
United Lincolnshire Hospitals NHS Trust			9.7%	
Peterborough & Stamford NHS Foundation Trust			20.6%	
Northern Lincolnshire & Goole NHS Foundation Trust			1.8%	
Nottingham University NHS Trust			1.7%	
Queen Elizabeth Hospital NHS Trust			26.7%	
Mental Health, CPA follow ups				
Mental Health Measure - Care Programme Approach (CPA)	95%	90%		Mental Health Learning Disabilities and Autism Programme
Lincolnshire Partnership NHS Foundation Trust			100.0%	
Cambridgeshire & Peterborough NHS Foundation Trust			96.4%	

Focus on Outcomes – NHS Outcomes Framework

Much of the Government's Mandate to the NHS is focused on the 5 main categories, known as domains in NHS Outcomes Framework, which will be used to hold CCGs to account via the NHS England. The NHS Outcomes Framework reflects the vision set out in the Government's White Paper Liberating the NHS. Its' purpose is to provide a national level overview of how well the NHS is performing; to provide an accountability mechanism between the Secretary of State and the NHS England and to act as a catalyst for driving up quality. Indicators in the NHS Outcomes Framework are grouped around the 5 domains and set out high-level national outcomes that the NHS should be aiming to improve. They focus on improving health and reducing health inequalities:

- Domain 1 Preventing People from dying prematurely.
- Domain 2 Enhancing quality of life for people with long-term conditions.
- Domain 3 Helping people recover from episodes of ill health or following injury.
- Domain 4 Ensuring that people have a positive experience of care.
- Domain 5 Treating and caring for people in a safe environment; protecting them from avoidable harm.

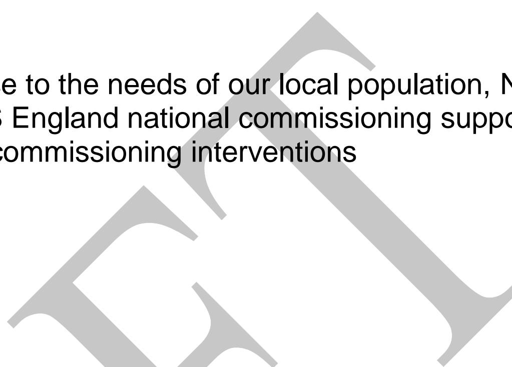
High level outcomes have been translated into measurable national ambitions:-

- Securing additional years of life for people with treatable mental health and physical conditions.
- Improving the health related quality of life of people with one or more long-term conditions, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the community.

DRAFT

- Making a significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.
- Improving health through Making Every Contact Count in taking every opportunity and contact with a health professional to promote a healthy lifestyle and healthy environment
- Reducing health inequalities, ensuring the most vulnerable in society get better care and better services.
- Moving towards parity of esteem making sure that as much focus is placed on mental as physical health and patients with mental health conditions do not suffer health inequalities, because of their mental health conditions or because they don't get the best care for their physical health condition.

Our Strategic Plan has been produced in response to the needs of our local population, NHS England ambitions and LHAC. The following NHS England national commissioning support tools have informed development of our priorities and commissioning interventions



1 Operational Planning Atlas
2 CCG Outcomes Tool
3 Levels of Ambitions Atlas
4 Commissioning for Value Pack

Disease	East CCG	South CCG	South West CCG	West CCG
Asthma	Amber	Amber	Amber	Amber
Atrial Fibrillation	Red	Red	Amber	Amber
Cancer	Red	Red	Red	Amber
Cardiovascular Disease Primary Prevention	Green	Red	Red	Green
Chronic Kidney Disease (ages 18+)	Red	Red	Red	Red
Chronic Obstructive Pulmonary Disease	Red	Amber	Amber	Amber
Coronary Heart Disease	Red	Amber	Red	Amber
Dementia	Amber	Red	Amber	Red
Depression (ages 18+)	Amber	Red	Amber	Amber
Diabetes Mellitus (Diabetes) (ages 17+)	Red	Red	Amber	Amber
Epilepsy (ages 18+)	Red	Amber	Amber	Amber
Heart Failure (2010)	Red	Red	Red	Amber
Heart Failure Due to LVD	Red	Amber	Red	Amber
Hypertension	Red	Red	Red	Amber
Hypothyroidism	Red	Red	Amber	Amber
Learning Disabilities (ages 18+)	Red	Amber	Amber	Amber
Mental Health	Green	Green	Green	Amber
Obesity (ages 16+)	Red	Amber	Red	Red
Palliative Care	Red	Amber	Amber	Red
Stroke or Transient Ischaemic Attacks (TIA)	Red	Amber	Amber	Amber

Source: NHS England CCG Outcomes Tool

The table to the left describes the disease prevalence relative to all CCGS

In addition the NHS England Commissioning for Value Packs (2014) for each CCG identifies opportunities for improvement as part of local planning

Lincolnshire East
Circulation Problems (CVD)
Cancer and Tumours
Mental Health Problems
Gastrointestinal
Respiratory System Problems

Lincolnshire West
Circulation Problems (CVD)
Cancer and Tumours
Mental Health Problems
Musculoskeletal System Problems

South Lincolnshire
Circulation Problems (CVD)
Endocrine, Nutritional and Metabolic Problems

South West Lincolnshire
Circulation Problems (CVD)
Musculoskeletal System Problems
Respiratory System Problems

We will secure additional years of life for the residents of Lincolnshire by establishing a proactive model of care to empower people to make their own positive health and lifestyle choices to improve their health. This approach will also help to improve the quality of life. Care will be delivered closer

to home and in the community through new models of integrated care including multidisciplinary neighbourhood teams, delivering care outside hospital wherever possible.

A transformed primary care system, aligned with community and acute care will also enable a shift away from the hospital environment, and coupled with improvements in urgent care interventions will contribute to the reduction of avoidable deaths due to poor care.

The local health outcomes will be achieved through a variety of interventions across health and social care, within urgent, elective, proactive, mental health learning disabilities and autism, women and children's and primary care.

Trajectories have been set to achieve best practice identified within the CCGs Commissioning for Value packs, when compared against the average performance of the best 5 similar CCGs, in those service areas where there is potential for significant improvement in health outcomes, resulting in potential lives saved, countywide, per year within 5 years and which include:

Condition	**Potential lives saved per year**
Cancer	57
Circulation	95
Respiratory	29
Gastro-intestinal	25

The table below summarises the primary trajectories we will use to measure the impact of our plans.

DRAFT

NHS Outcome ambition	Measure	Organisation	Baseline		% Improvement in 2 years	% Improvement in 5 years	Improvement intervention
			Performance	Year			
1. Securing additional years of life (target will be reviewed following recent national guidance)	Potential years of life lost from causes considered amenable to health	**Lincolnshire**	**2089**	2012 (12/13)	**4.2 (min)**	**7.0 (min)**	*Primary Care Proactive Care*
		ELCCG	*2385*		*4.2*	*7.0*	
		LWCCG	*2133*		*7.2*	*10.0*	
		SWLCCG	*1979*		*4.2*	*7.0*	
		SLCCG	*2036*		*9.2*	*16.0*	
2. Increase quality of life for people with long term conditions	Health related quality of life for people with LTCs	**Lincolnshire**	**72.8**	12/13	**2.0**	**4.8**	*Primary Care Proactive Care*
		ELCCG	*71.0*		2.0	5.1	
		LWCCG	*72.6*		1.1	1.9	
		SWLCCG	*74.1*		2.0	5.1	
		SLCCG	*75.7*		3.0	7.0	
3. Reduce the time people spend unnecessarily in hospital	Composite emergency admissions indicator	**Lincolnshire**	**2045**	12/13	**7.1**	**15.0**	*Primary Care Proactive Care Urgent Care*
		ELCCG	*2141*		*7.5*	*15.0*	
		LWCCG	*2043*		*6.0*	*15.0*	
		SWLCCG	*2076*		*7.5*	*15.0*	
		SLCCG	*1919*		*7.5*	*15.0*	
4. Increase the proportion of older people living independently at home following discharge from hospital	Proportion of those over 65 who were still at home 91 days after discharge	**Lincolnshire**	**74.6**	13/14	**5.3**	Indicator not developed to 5 years	*Primary Care Proactive Care*
5. Reduce the number of people reporting poor or very poor hospital care	People reporting poor patient experience of inpatient care	**Lincolnshire**	**120.7**	12/13	**3.5**	**7.4**	*Elective Care Urgent Care*
		ELCCG	*124.4*		*3.6*	*6.3*	
		LWCCG	*125.1*		*4.9*	*11.6*	
		SWLCCG	*125.1*		*3.3*	*7.3*	
		SLCCG	*108.3*		*1.8*	*4.0*	

DRAFT

NHS Outcome ambition	Measure	Organisation	Baseline Performance	Baseline Year	% Improvement in 2 years	% Improvement in 5 years	Improvement intervention
6. Reduce the number of people reporting poor or very poor primary care	Poor experience of general practice and oput of hours	**Lincolnshire** *ELCCG* *LWCCG* *SWLCCG* *SLCCG*	**5.3** *6.0* *4.9* *6.6* *3.6*	12/13	**3.8** *3.3* *4.1* *6.1* *0.0*	**8.6** *8.3* *10.2* *12.1* *0.3*	*Primary Care Proactive Care*
7. Make significant reduction in avoidable deaths in hospital (indicator in development nationally)	Cases of MRSA	**Lincolnshire** *ELCCG* *LWCCG* *SWLCCG* *SLCCG*	**10** *4* *3* *2* *1*	13/14	Nil target	Nil target	*Elective Care*
	Cases of Cdiff	**Lincolnshire** ELCCG LWCCG SWLCCG SLCCG	**172** *65* *43* *21* *43*	13/14	**7.0 (in 1 year)** 7.7 (in 1 year) 2.3 (in 1 year) 4.8 (in 1 year) 11.6 (in 1 year)	Targets set annually by NHSE	*Elective Care*
8. Parity Of Esteem	75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral	**Lincolnshire** *ELCCG* *LWCCG* *SWLCCG* *SLCCG*	New target for 15/16	13/14	**75%** *75%* *75%* *75%* *75%*	Targets to be set by NHSE	*Mental Health Learning Disabilities and Autism*
	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral	**Lincolnshire** ELCCG LWCCG SWLCCG SLCCG	New target for 15/16	13/14	**95%** *95%* *95%* *95%* *95%*	Targets to be set by NHSE	*Mental Health Learning Disabilities and Autism*

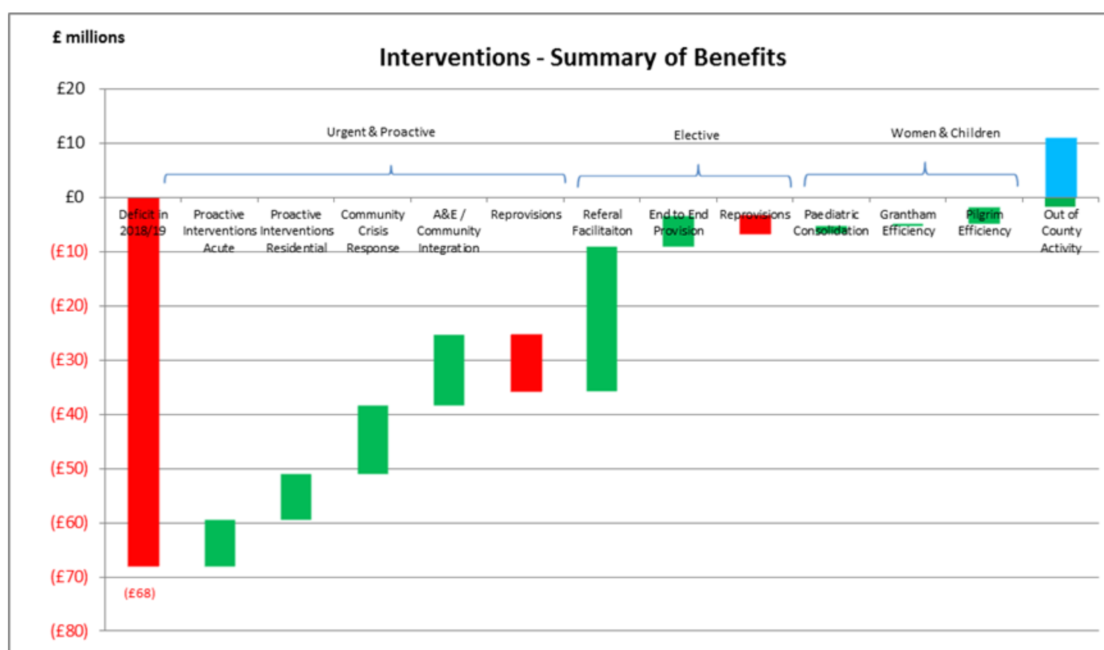
DRAFT

NHS Outcome ambition	Measure	Organisation	Baseline		% Improve-ment in 2 years	% Improvement in 5 years	Improvement intervention
			Performance	Year			
	More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.	**Lincolnshire** ELCCG LWCCG SWLCCG SLCCG	New target for 15/16	13/14	**50%** *50%* *50%* *50%* *50%*	Targets to be set by NHSE	*Mental Health Learning Disabilities and Autism*
	Dementia Diagnosis	**Lincolnshire** ELCCG LWCCG SWLCCG SLCCG	*49.5%* *48.4%* *50.5%* *48.4%* *50.6%*	13/14	**67%** *67%* *67%* *67%* *67%*	**70%** *70%* *70%* *70%* *70%*	*Mental Health Learning Disabilities and Autism*

DRAFT

Interventions: Summary of Financial Benefits

The waterfall chart below sets out the benefits that will be realised in order to bring the overall system financial position back into balance by 2018/19.



Improvement interventions – our major change programmes

With the exception of primary care each CCG has taken responsibility to lead a change programme on behalf of Lincolnshire CCGs

Programme	CCG lead / LCC
Primary care	Lead at CCG level
Proactive care	LWCCG
Urgent care	LECCG
Elective care	LWCCG
Mental Health, Learning Disabilities and Autism	SWLCCG
Women and children’s care	LCC

Primary Care

In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. Improving primary care across Lincolnshire is a core part of each work stream within the LHAC programme.

Ambition	To develop enhanced primary care as system leaders through Primary Care Collaborative at the heart of neighbourhoods and local communities, keeping the best of current primary care and taking opportunity to deliver integrated services at scale where that improves sustainability and outcomes for the local population.

DRAFT

Change/ improvement interventions	GPs will move away form 10 minute appointments to become more like general specialist consultants, some of whom will have special interests which complement each other (working alongside specialist consultants in the community to support Integration of end-to-end services for a specific medical condition or group of conditions). The primary care/ community multidisciplinary workforce will expand and develop alongside. Networks of local surgeries that complement each other will collaborate (across each other's lists) to provide continuity of care and a wider range of diagnostics and interventions within neigbourhood teams and may bring functions together and manage them jointly through federations. General Practitioners will come together to provide urgent care through federated approaches to the management of urgent care e.g. hubs within the footprint of neighbourhood teams that include extended access to wider community teams. Primary care will develop its prevention offer to deliver more proactive services • Healthchecks • Screening • Early diagnosis, and intervention particularly focusing on vulnerable groups • Risk stratification of the over 75s • Management of minor ailments by pharmacies
Impact on quality, access, healthcare outcomes	Improved access to high quality integrated primary care and wider out-of-hospitals services 7 days per week, with more services available closer to home More effective management of long term conditions and proactive interventions impact on the following targets • Potential years of life lost from causes considered amenable to health • Health related quality of life for people with long term conditions • Composite emergency admissions indicator • Proportion of people who are still at home 91 days after discharge • Reducing poor experience of general practice and out of hours • Dementia diagnostic rates Improved health outcomes, equity of access, reduced inequalities Groups of practices working together will increase the scale, scope and efficiency of general practice Greater alignment between incentive schemes in primary care and outcome measures Reduced variation in quality of primary care as measured by • QOF or locally defined schemes • Prescribing • Compliance with NICE guidelines •

DRAFT

Enablers	***IM&T*** Adopt new technologies to improve access, convenience for patients Integrated patient record ***Workforce*** Working with Health Education England we will aim to; • Attract expand & train more primary care staff • Develop the professional skill mix of general practice and increasing multidisciplinary working • Invest in new roles ***Contracting*** Primary care is currently commissioned by Area Teams and CCGs have shared responsibility for ensuring the quality of primary care and commission enhanced services and local quality incentive schemes. Primary care co-commissioning is one of a series of changes set out in the 5 Year Forward View which enables integrated out of hospital services based on local communities and development of new models such as Multispecialty Community Providers and Primary and Acute Providers. Co-commissioning allows for local flexibilities for contracts and incentives schemes to enable innovation and integrated local solutions. Through co-commissioning CCGs will be able to choose to take one of 3 levels of responsibility for commissioning primary care from • greater involvement in primary care decision making • Joint commissioning arrangement with the area team through a committee in common • Delegated commissioning arrangements ***Estates*** Estates strategy will be developed in line with neighbourhood teams and the requirement to deliver out of hospital services working with GPs and CCG membership bodies and partners. ***Transport*** Primary care provides comprehensive local access which is valued by local communities and it is our ambition to retain this. We will consider transport issues as we develop urgent care hubs within neighbourhoods.
Investment costs and benefits	The shift in resources from hospital care to community along with improved efficiencies will support development of primary care. Co-commissioning will allow CCGs to commission more flexibly across primary community and secondary care.
Timeline for implementation	**Short Term** January –March 2015 NHS England will support CCGs to move towards co-commissioning and by April 2015 new primary care co-commissioning arrangements will be in place Develop new ways of working as part of Neighbourhood Teams in 2014-2015 **Medium Term** Develop Primary Care Strategy and Primary Care Estates Strategy

DRAFT

Risks and mitigation	CCGs are already handling conflicts of interests as part of their day to day work. Potential for conflicts of interests will increase as CCGs take on greater responsibility for commissioning primary care. CCGs will strengthen internal control and assurance measures in line with the NHS England national assurance framework to manage increased risk such as changing the structure of decision making committees.

Story Box

Gosberton South Lincolnshire CCG

The surgery uses a sensitive digital touchscreen test on a tablet for detecting the earliest signs of memory problems. The test enables clinicians to perform quick, accurate and easy dementia assessments; differentiate between a memory problem and a mood disorder; and make appropriate referrals to secondary care.

Patients identified as 'at-risk' via the primary care list are invited in for a memory test which is administered by a trained healthcare assistant. All 'red' and 'amber' patients are followed up with a blood test, ECG and an appointment with a GP (if required). All patients were given an information leaflet about the test prior to the appointment. Overall, there has been very positive feedback from patients.

Grantham

As a carer Ms G needs good access to primary care. The GP practice in Grantham provided a good service offering a range of services including district nurses, chiropodists etc. is open until 8 during the week and some Saturdays. The Practice is also attached to a community centre and close to a bus stop making it easy to get to.

Proactive Care

People with long term conditions now account for 70% of cost and activity in the healthcare system. Most people over 65 have more than one long term condition, yet the system is one of specialisms that look after a person's specific health need and not the person as a whole. With ageing comes a combination of long term conditions and frailty which together lead to a decline in performing everyday tasks and to live independently at home Episodes of acute illness and trigger factors such as loneliness or bereavement can lead to social isolation and speed up that decline. Many studies and surveys nationally and internationally provided evidences that many of these factors that contribute to dependency can be managed effectively in delaying the onset in loss of independence for many people over 65.

Principles for the Proactive Care Model:-

•Co-ordinated health and social care delivered in a multi-disciplinary team focussed around primary care and patients/service users

•Multi skilled team members who would be able to carry out a generic assessment to establish health and social care needs

•Locality/neighbourhood/geographical delivery care closer to home

•Enabled by technology and agreement between organisations to share patient/service user consented data

•Interfaces with specialist and acute services

•Ensuring parity in caring for the local population's physical and mental health, by the promotion of activities in local communities

Our approach is to support people to reach their optimal well-being, in relation to physical, mental/psychological and social wellbeing through establishing a properly resourced proactive care service focused around **neighbourhood teams** that draws on the knowledge and skills of primary care, community and mental healthcare, social care and with support and close working relationship from acute and community hospital expertise

DRAFT

PROACTIVE CARE	
Ambition	The ambition of the programme is a significant and incremental shift away from the acute hospital care and towards the community care. The aims of proactive care are: • Improved ways of working in integrated community multidisciplinary teams in Neighbourhoods with primary care at the heart of those teams • Proactive identification of patients through risk health and social care stratification • Treating people in community rather than in hospital where possible • Improved ability to self-care and promote independence. Better integration with other parts of the system (particularly urgent and intermediate care and mental health care) ***'The aim of the neighbourhood teams is fundamentally quite simple; by working in a multidisciplinary way to provide more joined up care, people will be treated and cared for closer to home where possible, lengthy hospital stays will be avoided, and readmission will be reduced.'***
Change/ improvement interventions	Active case finding, **risk stratification** and management of targeted groups linking the existing wellbeing and lifestyle services to Neighbourhood Teams to focus on building community assets and resilience, promoting self-management and wellbeing **Self-management and enhanced carer support** applied across the whole spectrum of need, from active, independent, mostly healthy citizens (universal public health) through to those individuals who require a level of care and support such as people diagnosed with long term health conditions (targeted prevention). Development of a neighbourhood profile/local **"Directory of Services"** which includes all statutory and third sector services provided within the neighbourhood that links to a Lincolnshire wide directory of services. **Neighbourhood Teams** (Initially the population size between 10,000 and 50,000) based around GP practices to provide multi-disciplinary delivery of proactive care. There will be a consistent Lincolnshire wide operating framework agreement working with people in their own homes and in care homes providing early proactive intervention through to end of life care. The Neighbourhood Teams will be multidisciplinary health and social care teams and include GPs; community matrons/complex case managers; practice nurses; rehabilitation/ reablement workers; mental health workers; social; and care navigators and others. **Specialist teams** will work over a larger footprint than one neighbourhood team, e.g. rapid response, community geriatrician, therapists, specialist mental health teams, clinical specialists including palliative care, etc. The Neighbourhood Team will operate a **Single Point of Contact** to coordinate and enhance responses with an aim to avert hospital admission and support early discharge. Development of the concept of **"trusted assessor"** linked to access to community equipment and tele-care/ tele-health and a core generic assessment. Development of an **Intermediate Care Layer (**and pooled budget). **Discharge to assess**, to be developed (building on work underway in MRET initiatives) alongside the role of **community hospitals** where appropriate and the Intermediate Care inpatient facility. **Development of Clinical Leads** (for example General Practitioners with special interest) to work alongside community geriatricians and wider NT to further enhance the team skill base and knowledge of the management and care of the identified patients. Particular focus is re-

DRAFT

	quired to provide medical over-sight for care and nursing homes within the neighbourhood, building up relationships and providing guidance and support to the staff to care for their residents who may have additional presenting needs, preventing hospital admission.
Impact on quality, access, healthcare outcomes	Neighbourhood teams are the critical interface to instigate and foster collaboration between other services, health and care professionals and local communities. The outcomes and benefits will promote greater self-care, self-management, personal responsibility, active citizenship, healthy lifestyles and valued and supported carers (both as carers, and in their own right, as parents, children, partners, friends and members of local communities). **Securing additional years of life for people with treatable mental health and physical health conditions** Reduce potential years life lost: 7% improvement by 2018 Reduce demand for future health and care services. • **Emergency Admissions and A&E attendances** – fewer situations where a journey to an acute hospital is required (nationally prescribed reduction 3.5% overall/over 75s reduction agreed in Phase 1 – 15%) • **Admissions of older people to residential care** – 4.7 % reduction in line with Phase 1 assumptions and nationally prescribed indicators and locally agreed target • **Proportion of older people still at home over 91 days after admission** – increase by 5.3 % in line with Phase 1 assumptions and nationally prescribed indicators and locally agreed target **Patient Experience Metrics** – reduction in the number of people reporting poor or very poor hospital care by 3.5% and primary care by 3.8% in line with nationally prescribed indicator as well as specific local requirements Greater collaboration between local government and health Individuals are empowered to live more independently, by supporting them to manage their care more effectively by early identification and provision of support Core delivery of care plans over a 7 day period, with appropriate level of out of hours provision for community nursing and access to specialist teams Reduced duplication results in increase in the amount of patient facing time and fewer professionals for the families to work with.
Enablers	***IM&T*** • Risk Stratification tools; Currently a variety of risk stratification tools are in use and there is a desire to combine these • Access to shared records will be progressed through IM&T group • The Lincolnshire Overarching Information Sharing Protocol provides partner organisations with an agreed framework at high level for this sharing of information as appropriate with the patients consent or in response to a statutory obligation. This is to ensure that patients receive the best possible care and treatment, e.g. shared multiagency care plans that enable all professionals to follow patients as they move through the system and timely access to assessment, treatment planning, results, referrals, equipment, appointments and prescribing. • Training for Neighbourhood Team members of current and future technology will be built in to the organisational development plan (see workforce section from page 92).

DRAFT

Workforce

- Workforce: profile of multidisciplinary teams and associated organisational development to support roll-out
- The development programme uses the model of distributed leadership, and one of the broad aims is to have "confident and empowered staff in every seat".
- Specific initiatives include: The Inspirational Leadership programme (aimed at top 160 leaders); Making a Difference (a staff designed, leader led cultural change programme); increased clarity of roles and responsibilities including introduction of role profiles, revised performance review process and behaviour framework; targeted leadership courses; cultural barometer; and staff recognition, development of the role of GPs in coordinating care
- There are recruitment shortfalls for key professional groups e.g. Community geriatrician, GPs across the county. Further understanding of the workforce and funding requirements for this function are to be developed.

Contracting

- Development of contracting framework and assessment of options (from status quo to single commissioner/ provider)

Estates

- Review of current running costs; improved utilisation; estates plan for new /changes to estates to provide bases for teams

Transport

- Efficient travel arrangements for members of the team will be developed as a result of learning from Neighbourhood Team early adopters

Investment - costs and benefits

It has not been possible at the time of writing this report to fully cost the NTs. Workforce profiling will go a large way to completing this task alongside consideration of non-pay costs such as estates and IM&T as we work with the early implementer sites. The contracting model will also be reviewed as part of the specification development.

The current financial projections have identified the financial case for change jointly for proactive and urgent care, as shown in the table below:

Proactive & urgent interventions	£m
Acute interventions	8.6
Proactive interventions	8.4
Community crisis response	12.7
A&E Community integrations	12.9
Re-provision	-10.4
Total	**32.2**

Timeline for implementation

Configuring and deploying the NTs in the 4 Early Implementer Sites (EISs), NT and Proactive ERGs has commenced with a targeted intervention approach largely for the over 65s which moves towards a population based health approach over planned tranches of implementation.

The neighbourhood teams will design a portfolio of care pathways based around the Phase 1 interventions. Initial development of these pathways has begun with work underway on self-care and enhanced carer support and end of life care. A new way of managing children with mild to moderate care needs at home and opportunities to opti-

DRAFT

	mise proactive care for children within existing frameworks is also in development. Roll out of remaining NTs across the county building on lessons learned is outlined below The table below summarises the phasing of implementation **Short Term** Forming and developing structures for Neighbourhood Teams **Medium term** Integrating Neigbourhood Teams with primary care Re- procure and implement Intermediate care and rapid response **Long Term** Co-location of staff
Risks and mitigation	Current commissioning frameworks are unlikely to be the most effective way of procuring new models of proactive care. Commissioning/ contracting options will be developed and assessed e.g. single commissioner/single provider to remove some of the barriers and perverse incentives within existing contractual frameworks to effective integrated working. Ability to recruitment and retain an effective workforce is historically challenging. Addressing this challenge is central to workforce and organisational development programmes.

Story box

'Being able to recuperate closer to home improves quality of life'.

Mrs H who lives in Mablethorpe had a virus which left her with a troublesome cough for a month after so decided to visit her GP who took a blood test. The GP then called Mrs H back for a second blood test, and subsequently Mrs H was admitted to hospital in Nottingham for an operation. Nottingham is a four hour round trip from Mablethorpe, so after the operation and 12 days in Nottingham, Mrs H was transferred back to Louth Hospital, 15 miles from home, to recuperate.

Louth Hospital is a community hospital and includes an Urgent Care Centre, as well as a Day Care Assessment Unit and two consultant led wards, enabling Mrs H to recuperate closer to home after the acute phase of her illness, as well as benefitting from discharge planning closer to home.

Mrs H said she couldn't speak highly enough of Louth Hospital, having spent a month there recuperating. The main advantage for her was the proximity to her family and friends coupled with good nursing care and good food.

'Integrated care closer to home'

***Mrs A** was referred into the Neighbourhood Team in Lincoln City South due to a number of falls at home over several days and her family were increasingly concerned about her due to her frailty and confusion. However they also respected their mother's wish that she did not want to go into residential care as she is very independent.*

The district nursing team visited Mrs A and subsequently engaged other Neighbourhood Team members who arranged for Home Care, grab rails and walking aids to aid Mrs As mobility. As a result of the neighbourhood team no further intervention has been necessary.

Care Homes

After multiple stays in hospital, the MR C was due to be discharged to a care home, his wife not aware of the levels of care the home provided and no assessment from social services prior to discharge or once at the care home. The care home was not appropriate to deal with patients' needs.

Mr C was readmitted to hospital and on the next discharge sent to the home with the correct care (residential with nursing).

With the inception of neighbourhood teams the CCG has recognised that a lack of knowledge around

Draft

these services is missing and no directory of service available to advice.

Support with training for neighbourhood teams and to compiling a directory of services is being developed; this will strengthen the teams and ensure patients are referred to the most appropriate service first time.

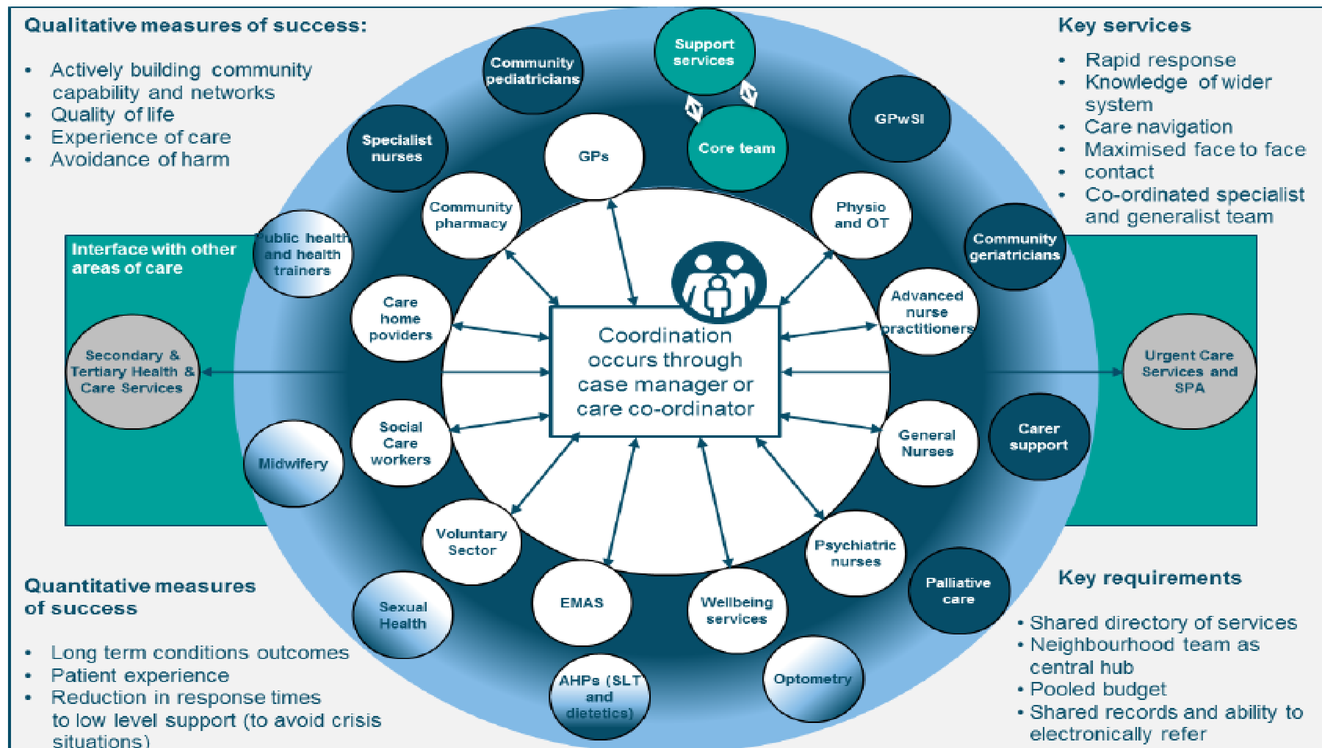
In this instance the patient sadly passed away and therefore would not have benefitted from this service improvement.
However for those patients who may be in a similar situation they will have more opportunities where professionals let them know about other services.

As more patients are supported through neighbourhood teams to encompass them at the heart of their care and service, the benefits of cohesive working will become apparent. Professionals on neighbourhood teams will understand the services available and how to access them.

DRAFT

Neighbourhood Teams

The emerging Neighbourhood Teams model is shown below:



In August 2014 four early implementer sites were identified as follows: Stamford, Sleaford and District, Lincoln City South and Skegness and Coast. Learning from each of the sites will inform the roll of the neigbourhood teams in each CCG and across Lincolnshire

Urgent Care

There are a range of sites providing Urgent Care in Lincolnshire, which are located across the county. The distribution of attendances indicates that Lincolnshire patients predominantly rely on A&E departments for Urgent Care services. The case for change has highlighted that to provide modern high quality urgent care the current configuration of services is not clinically sustainable. The quality case for change was confirmed by the CQC report and Regional Clinical Senate. In order to ascertain how a future state would be different from the current state in Lincolnshire, the Urgent Care Expert Reference Group has worked together to define what current provision looks like (see diagram below).

DRAFT

Current state – urgent care delivered from hospital sites

Out of county	Lincoln	Boston (Pilgrim)	Grantham
MTC	M / EC	M/ EC	HY

Lincoln City	Louth	Skegness
UCC	UCC	UCC

Spalding (Johnson)	Gainsborough (John Coupland)	Stamford and Rutland	Sleaford
MIU	MIU	MIU	MIU

There is currently no major trauma centre in county, the nearest sites being Sheffield, Nottingham and Addenbrookes. In addition, it was recognised that using the revised definitions meant that there was currently no major emergency centre in Lincolnshire although Lincoln County functions largely as such but lacks key components required, e.g. vascular surgery which is currently provided at Pilgrim Hospital in Boston (though under review in line with specification requirements).

There was acknowledgement that Grantham Hospital currently performs some of the functions of an emergency centre, without offering the full scope of services that would be expected for the site to be termed as such under new definitions from Keogh.

To this end Grantham services have been described as a hybrid site in the current state, which sits between the urgent care centre and emergency centre descriptions

To provide safe and sustainable services to the population we will need a new model. The LHAC Urgent Care Design Group explored the opportunities to improve the provision of urgent care by enhancing proactive care, and hence reducing the demand on urgent care and improving overall health outcomes. Two main ideas were discussed

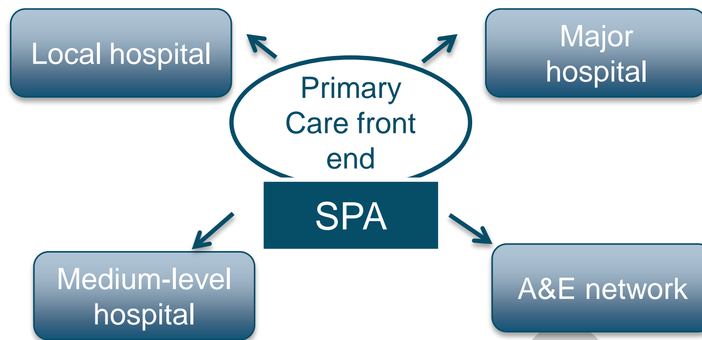
- a network of urgent care response with local provision of care, supported by a central triage and crisis response service,
- a "Single Point of Access".

The Care Design Group aligned the definition of urgent care provision to Keogh recommendations, and considered the services required at each level and location to develop models of urgent care provision taking into consideration safety, clinical deliverability (including clinical adjacencies), local needs, impact on patient choice and financial viability.

Ambition	Enabling a network of safe and sustainable urgent care response
Change/ improvement interventions	**Urgent Care Network** Rather than lots of services run by different organisations without single co-ordination – from out of hours primary care to A&Es, Lincolnshire will align all of the urgent care response services under a single operational framework with simplified ways to access these services. By drawing together all urgent care services under one umbrella, Lincolnshire will be able to have a safe service, and afford to preserve the geographical access points to urgent care services and make best use of the workforce available. Urgent care network is defined as three different levels: major emergency centre, emergency centre and urgent care centres. The exact number and configuration of these levels of care across Lincolnshire are in the process of being defined, and will emerge from the imminent guidance expected from NHSE and through public consultation process in late spring 2015. **The Single Point of Contact** This SPA model supports the new model of urgent care services with a primary care front end which actively manages urgent care need of patients and professionals and provides

DRAFT

<table>
<tr>
<td></td>
<td>
a higher level of efficiency



The Single Point of Contact is an essential part of creating a network of urgent care response that provides patients urgent care services in a safe, sustainable and cost efficient way. Patients will be directed to the place of care that is most suitable both in terms of safety and efficiency using a directory of services. The Single Point of Contact will have the functions of navigation, triage, deployment, efficient capacity management across services within the system and assist discharge planning from hospitals. This will also support a more proactive response to perceived urgent need and will work with mental health and social care triage mechanisms.

When accessing the system the person is signposted by the SPA through a predefined pathway to the correct service. The SPA will bring together three points of a system which currently exist in relative isolation (Urgent (111, OOH, Walk-in etc.), Emergency (999, A&E), and Proactive care. All services currently have a flow of referrals between them with the public and professionals having to individually contact these services. The philosophy behind the SPoC is that users would make one contact with the service when in need of a crisis response, be that through a professional, through 111, or through existing providers of care, and after this stage the SPoC would ensure they receive the appropriate outcome without leaving the system.

Not all the current access points would sit within the SPoC, although those that retained their individual function would have access to the services that SPoC provides. There are initially suggested to include the Contact Centre, LPFT's Mental Health Single Point of Access; out of hours (health); Marie Curie rapid response; quadrant nursing response and the Wellbeing service single point of access.

The SPoC will also be involved in active discharge planning, to coordinate the services which are required to be put in place to allow patients to leave hospital and return to the community when it is clinically safe to do so, with appropriate social care and medical support in place, in a timely manner.

The functions of this service will include:

- Referral, advice and information
- System navigation
- Triage
- Deployment of care
- Capacity management (require a system that logs resources and capacity across the system; tracks patients)

Supported discharge
</td>
</tr>
<tr>
<td>Impact on quality, access, healthcare outcomes</td>
<td>
Integrated Urgent Care Network

- Allows more flexible deployment of resource to higher utilised areas (consultants deployed to "virtual wards" rather than being aligned to organisations)
- Provides consistent services across the county
</td>
</tr>
</table>

DRAFT

	• Allows flexible provision of services across primary and secondary care according to patient needs • Allows better coordination between acute, community and primary care • Allows flexible provision of services across primary and secondary care according to patient needs (emergency and urgent care centres will consist of GPs, A&E consultants, consultant nurses etc., all working as urgent care clinicians) • Provides alternatives to A&E to absorb demand growth • Improves quality as patients will access the appropriate service, rather than the first they get to • Provides consistent services • Reduces A&E admissions and bed days • Care will be delivered in the most appropriate setting • Providers can more easily plan their routine services, knowing that urgent care demand risks are being managed in an integrated way under a separate delivery model **Urgent Admissions** Reduction in emergency admissions from 2013/14 baseline by 15% by 2018) Increase in the number of people who receive "see and treat" care regardless of care setting Increase in the number of people who receive care in their "normal place of residence" and remain in that care setting Reduction in ambulance conveyances to hospital Increase in zero length of stay in hospital Reduction in A& E attendances
Enablers	***IM&T*** • Internet connectivity in the community setting • Single method of communicating the patients care plan across all urgent care services including Lincolnshire County Council • ***Workforce*** • Workforce – ability to recruit and retain specialist workforce, e.g. Consultants in Emergency care (A&E Consultants), Emergency Care Practitioners and Advanced Nurse Practitioners • Workforce – to recruit and retain the workforce for community services including Neighbourhood teams and wider primary care having specialist capacity and capabilities as an alternative to urgent care • Education and training of workforce with rotation of staff through all emergency and urgent care services • Change management programme that addresses changes in culture, behaviour and practice • Leadership across the emergency and urgent care system as opposed to within single organisations • Single training and education programme so staff can have a "passport" of skills and

DRAFT

competences so they are a mobile workforce in Lincolnshire

Contracting

- Urgent care demand is unpredictable at small scale (but is predictable at large scale), therefore contracting will be used to incentivise a more federated approach to urgent care across providers, where risk is shared and peaks and troughs managed.
- There is a view that in order to achieve clinical safety and financial sustainability in urgent care services, that an integrated, networked service would be desirable, e.g. lead provider model. The risk and benefits sharing between commissioners and all providers needs to be fully explored before any final decision is made.
- Develop a new contracting currency that measures the patient outcome and system performance opposed to individual organisation performance. This includes a financial risks and benefits sharing model.

Estates

Bruce Keogh in his 'Urgent and Emergency Care Report' (November 2013) identified three basic options; major emergency centres (MECs); emergency care centres (ECCs); and urgent care centres (UCCs). UCCs will provide services of different levels of acuity depending on local needs and comprise existing UCCs, minor injury units and walk-in centres.

At the time of writing there has been further clarification regarding MECs which are now called Specialist Emergency Care Centres (SECCs) and may include major trauma provision and have limited numbers across the country (40 to 70). This change and its potential impact will need to be considered during the next phase of work.

A long list of possible scenarios was developed through CDGs and ERGs and was reviewed (for clinical safety and viability) by NHS England's Clinical Senate in July 2014, and a subsequent short list produced. This short list is currently being analysed for activity shift, impact on travel time and financial impact prior to any formal consultation in 2015.

Transport

- Transport - travel time will be reduced for patients and carers as care will be provided more locally where possible.
- Additional/ enhanced support from emergency transport (EMAS) to support service change will be required, e.g. transfers between acute sites
- Transport of patients across community settings will be considered as more people will be cared for in the community and not require transfer to hospital

Investment costs and benefits

It has not been possible at the time of writing this report to fully cost the NTs. Workforce profiling will go a large way to completing this task alongside consideration of non-pay costs such as estates and IM&T as we work with the early implementer sites. The contracting model will also be reviewed as part of the specification development.

The current financial projections have identified the financial case for change jointly for proactive and urgent care, as shown in the table below:

Proactive & urgent interventions	£m
Acute interventions	8.6
Proactive interventions	8.4
Community crisis response	12.7
A&E Community integrations	12.9

DRAFT

Re-provision	-10.4
Total	**32.2**

Timeline for implementation

Implementation to commence from 2014 – 2015, this is likely to commence with phased implementation of the Single Point of Access. It would be realistic to expect that this could be completed in the short to medium term, i.e. the next two years.
Public consultation on options for Urgent Care Centres will be undertaken in 2015. Implementation of a preferred option for site consolidation is likely to take place in the longer term, i.e. over the next three to five years.

Summary of the phasing of implementation

Short Term

Phase 1 – Hear and Treat Clinical Assessment Service

Medium Term

Grantham hospital opens the integrated service (named to be agreed) – estate dependent

Single Front Door and Clinical Navigation Service in Hospital PLUS Consultant led admissions only
Start to implement Ambulance Strategy

Longer Term

LCH and PIL open their integrated service (name to be agreed) estate dependent

Phase 2 –Hear and Treat Clinical Assessment Service

Risks and mitigation

- Implementation will be dependent on the outcomes of public consultation in 2015. However, there is a medium level of confidence in the ability to implement a Single Point of Access.
- Confidence around implementation of site consolidation is less certain due to range of options being proposed, patient, public and political acceptability of these and costs associated with implementation of each.
- Patient often choose the shortest distance to travel to an urgent care/ most convenient service or in the instance of more serious injury may go out of county therefore centralising some services does not mean that patients will follow . Therefore scenario planning is required to ensure additional financial pressures are not created by new models of care.
- There is only one “pool” of workforce across organisations. Often staff are taken from one service to another. The development of an integrated approach to urgent care, and integrated workforce will promotes the transfer of knowledge and skills between staff.
- Life threatening emergency care needs should not be diluted by the focus on urgent care and the right facilities and expertise must be available to maximise outcomes.
- The large geographical area covered within the county and
  - a road network consisting of many single lane carriageways which are speed restricted, resulting in travel times between towns and villages being relatively high. This impacts on both staff transport and patient transport
  - Ability to provide services in rural areas with lower volumes
- Existing estate capacity and ability to ‘host’ new requirements in urgent care (across the range of site options)
- Availability of robust data to support change.

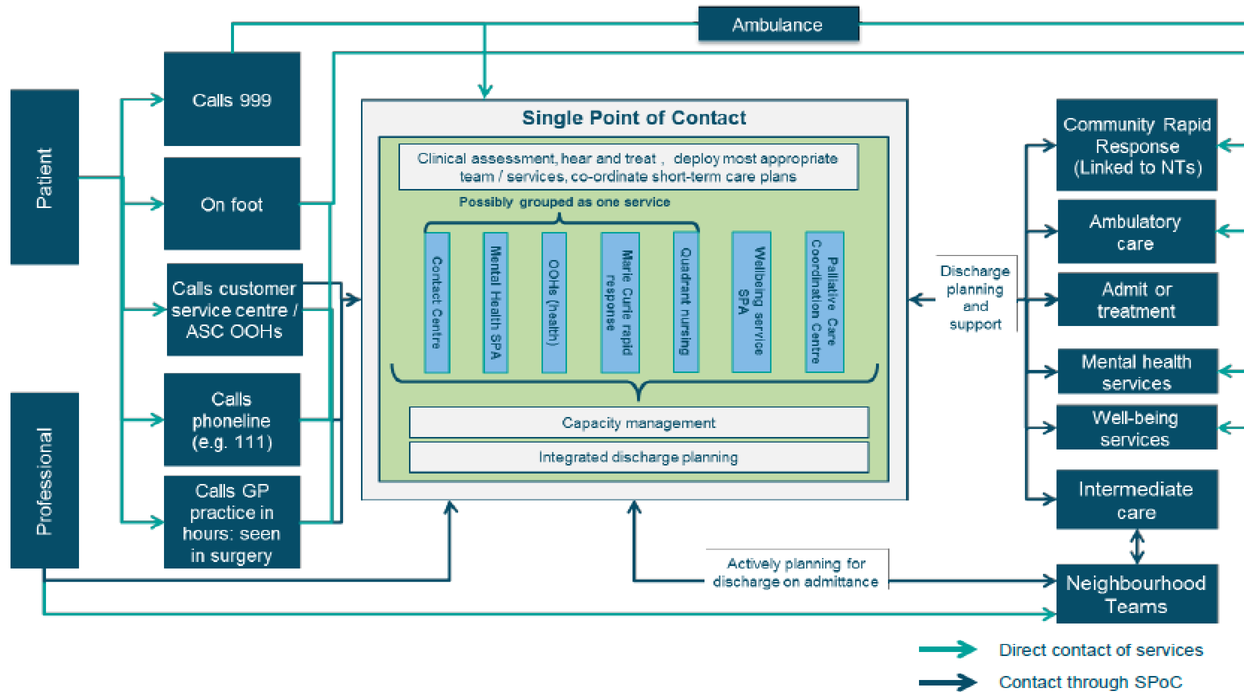
DRAFT

Story box

Integrated Services – 'The Triage Car'

'*Within Lincolnshire Partnership foundation Trust a mental health triage care has been established. This is managed jointly between East midlands Ambulance and a mental health nurse. It has reduced the need (and costs) for ambulance or police escorts for patients, as this triage car can attend, assess and transport patients*

The figure below outlines the model for the Single Point of Contact.



Elective Care

The vast majority of elective care in Lincolnshire is provided by the United Lincolnshire Hospitals NHS Trust (ULHT). Services are provided at three main hospitals and four community hospital sites, including medical, surgical, paediatric, obstetric and gynaecological services. Details of the existing sites are set out below.

Site	Details of services provided
Pilgrim	Elective care for patients in South and South East Lincolnshire, including recently upgraded ICU, endoscopy unit and MRI scanner
Grantham	Elective care for patients in Grantham and the local area
Lincoln	Elective care for patients in the city of Lincoln and the North Lincolnshire area. Currently developing a new heart centre, with two new cardiac catheter laboratories and a short-stay unit.
Louth	Inpatient beds for surgery, medicine and orthopaedics. Recently added a new £1.1 million endoscopy unit.
John Coupland	An inpatient facility, a Minor Injuries Unit, Outpatient Department, Theatre and Surgical Daycare Unit as well as a range of community services.
Skegness and District	A new day hospital, Outpatients Department, improved Accident and Emergency Department, medical wards and GP beds.
Johnson	A Minor Injuries Unit, outpatient beds, inpatient beds, and an X-Ray Department

During Phase 1 of the LHAC Programme, a number of issues were identified in relation to elective care – these included:

- Enhancing quality and range of services provided within Lincolnshire, thus reducing where possible the flow of patients to out-of-County providers.
- To address differences in volumes of elective activity across elective sites, and bring this in line with benchmarks.
- Provide a more cost-effective, integrated elective care service across a number of specialties

From this, the Elective Care Design Group (CDG) identified the need for a single end-to-end service commissioned for a particular patient group, service or specialty, including all of the acute and community aspects of the service. The group specifically considered how such initiative would apply to fifteen specialties. They also identified the need for an overall referral structure to support referring clinicians on deciding the appropriateness of referrals, together with simple guidelines developed community-wide to aid GPs and feedback loops between GPs and specialists. High-level site considerations on the principles that need be considered when analysing where services should be provided was also identified as an area for development.

Ambition

- A single "end-to-end integrated service" commissioned for a particular patient group / service / specialty – including all of the acute and community aspects of the service, taking into account safety and quality issues concerning activity volume.
- Primary and secondary care shared care model for all elective (including cancer)
  - Improved access to advice from secondary care for GPS
  - Direct access to diagnostics to enable right first time referrals to secondary care
  - Flexible capacity within secondary care to accommodate patient need whether this be suspected cancer or RTT
- Care is provided as close to the community as possible by strengthening local diagnostic services, use of community hospitals and development of risk stratified follow up protocols
- Ensure minimum disruption to elective services caused by increased urgent care demand

Change/ improvement interventions

End-to-end Integration of Services

An overview of the model and some of the issues to be addressed is outlined below

Intervention	Issues to be addressed	What will be different in the future?
End to end integration	• Inconsistencies in primary care work-up • Higher than necessary volume of activity focused in acute settings • Medical led model of care with limited input from MDTs	• Extend existing good practice • Build relationships • Build a multi-professional skilled workforce with new roles
Improving the way referrals work	• Patchy use of clinical guidelines & best practice • Variation in systems for peer to peer review • Number of inappropriate/incomplete referrals • Multiple systems in use	• Standardise practices • Maximise opportunities for education • Increase the number of appropriate referrals
Site considerations	• Difficulty providing full rota cover across multiple sites • Inefficiencies in the absence of dedicated facility for elective work • Volumes of activity and thus productivity varies across sites	• Promote enhanced specialisation • Promote efficiencies on main sites • Allow patients being cared for closer to home in the majority of cases

DRAFT

These issues need to be reviewed with primary and secondary care colleagues to support the development of prioritised operating plans that will promote the principles of:

- Shared Care
- Primary Care Diagnostic
- Self-Management
- Risk Stratification for both referrals and follow up
- Care closer to home
- Minimise the impact of variance in urgent care

From a survey undertaken in June 2014, Specialty Leads indicated that a range of activities would be possible to bring about further integration within their specialty, in line with the model for integration descried overleaf. The integration initiatives which have been suggested as appropriate/possible across each specialty are listed below.

Breast surgery
Cardiology
Clinical & medical oncology
Clinical haematology
Dermatology
ENT
Gastroenterology
General surgery
Gynaecology
Ophthalmology
Orthopaedics
Pain
Respiratory medicine
Rheumatology
Urology

Establish baseline data that will facilitate prioritisation to maximise the impact for patients through developing integrated care pathways.

Holistic Care

To further enhance elective care services it is recognised that wider psychological interventions would support patients with improved self-management. Given this it is proposed to develop the capability within neighbourhood teams of staff with basic psychological skills.

DRAFT

Impact on quality, access, healthcare outcomes

Based on responses to the questionnaire from Specialty Leads, the most likely quantifiable outcomes/impacts of integration will be:

- Improved prognosis/outcomes for patients
- Reduce demand for non-admitted services
- Improved utilisation of secondary care capacity to support patient's suspected of cancer and those requiring secondary care intervention
- Better than patient's constitutional rights
- Overall higher patient satisfaction and improved patient 'journey'
- Potential cost savings due to care delivered in a most cost efficient setting (based on international example such as the Bundle Payment Systems in Stockholm*)
- Improve patient experience

	• Strategic re-design of elective care services should be considered and evaluated in order to realise the following benefits: • Improve productivity for elective care (hot/cold site mix) • Create Centres of Excellence Improved outcomes by utilising national guidance and best practice • Overcome workforce and recruitment issues • Minimise the need for patients to travel to main sites for the majority of their care
Enablers	**IM&T** Developments in technology can be used to facilitate improved patient experience, reducing travel for both clinicians and patients and as a primary facilitator of shared care. The following are examples of opportunities that will be explored to enable the provision of a dynamic and responsive elective care service. • Development of e.g. video conferencing, tele-consultations and photo diagnosis • Integration of records across primary and secondary care including electronic record and information sharing protocols for sharing of patient data. • Providing better information for patients • Enable staff to work in local communities / remotely • To improve referral pathways • Provide access to clinical tools to facilitate diagnosis / referral As an enabler IM&T development will be informed by the co-design of service models, processes will be tested thoroughly and information governance arrangements will need to be further developed to ensure that the optimum benefits for patients and clinical staff. As the use of technological solutions to aid the provision of care increases, it will be necessary to develop the IM & T infrastructure throughout Lincolnshire to facilitate optimum use. Issues regarding connectivity will be critical to enabling the effective use of IM&T. **Workforce** Workforce has been identified as the most critical factor to success including development of capability and capacity and working relationships across organisational boundaries. Facilitating the development of elective care services will require : • Forwarding planning with respect to manpower planning • Development of skills and competence of the workforce to work differently • Effective transition management • Local / Network / regional virtual team developments • Changes in work locations – for example hospital teams could increasingly spend time working in community bases • Extended role development • HR frameworks that enable cross boundary working • Neighbourhood teams having specialist capacity • Most pre and post-operative care (not procedures) being provided locally • Job planning for clinical teams will need to include time to support service triage, provision of advice and training and engaging in service development • Administration and management structures

DRAFT

Time from GPwSI and consultants will be required for the triage of referrals at various stages of the improved processes. This will need to be facilitated by administrative and managerial support.

Contracting

It is likely that in the future, elective care services and in particular diagnostic support will be provided by multiple providers both from within Lincolnshire and in other areas of the region. To ensure that service provision is integrated and reliable it will be essential to have effective arrangements to manage the 'supply chain' These new arrangements will require the development of new contracting models that reflect the interdependency of independent provider organisations and promote collaboration that is focused on the needs of patients.

Contracting processes will need to provide the long term security to encourage organisations to commit to local service delivery and continuous improvement but flexible to accommodate the shift of activity as services evolve and develop. Within the contractual framework it will be necessary to ensure that data is available to facilitate the evaluation of the effectiveness of local services and to enable the health community to collectively be responsible for provision of services that are value for money.

Estates

The capital estate of providers across Lincolnshire has been developed on an ad hoc basis to reflect the pressures at any point in time. In order to provide an effective service provision it will be necessary to review and develop the capital estate, on the acute hospital sites, at community basis and in primary care facilities so that it facilitates effective service delivery.

Capital investment programmes will need to be developed in order to ensure that the life span of equipment is carefully managed and that clinicians have access to reliable and modern facilities to fulfil their clinical roles.

Site configurations and the locations of service will need to be evaluated in order to ensure that they facilitate elective care but also that disruption to elective service , caused by urgent care pressures, is minimised.

Increasingly surgical interventions will become day cases procedures and subsequently rehabilitation support, follow up consultations etc will be delivered in community locations and managed through the Neighbourhood team and the development of a shared care model. Given this, along with developing the elective care facilities on the main hospital sites it will be necessary to develop accommodation in the community for consultations, rehabilitation / therapy interventions etc.

Transport

Travel time will be reduced for patients and carers as most care prior and post-surgery will be provided locally. Careful management of job plans will also ensure that travel time is well managed and as such minimises the impact on the clinical time available to suppor patients.

Whilst the development of community services will reduce the travel time for the majority of patients, there will be some services that are delivered at main hospital sites or in out of area locations. Given the poor public transport infrastructure in Lincolnshire, consideration will have to be given to how to support patients to attend treatments outside of their local community.

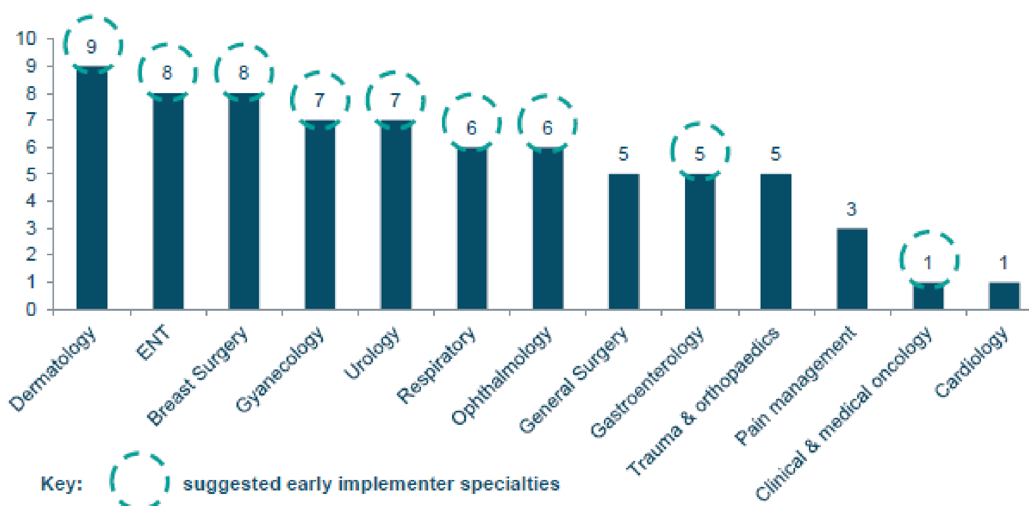
DRAFT

Investment costs and benefits	The current financial projections have identified the financial case for change as shown in the table below: Elective interventions — £m Reduction in elective activity — 26.7 End to end provision by specialty — 5.7 Re-provision — -3.2 Total — 29.1 As shown, the investment costs estimated as being required are £3.2m. Final costs and benefits will be developed within the Proposal document. Some costs are likely to be incurred in implementing improved processes – for example, peer review and specialist triage is likely to take around 3-5 minutes of specialist time (for example from a GP, consultant or other senior decision maker) per referral, and this will need to be factored into any cost savings which might be achieved. In addition, a supporting IM&T system will be required to support improved processes.
Timeline for implementation	Improvement of all elective service is a continuous process and as such local teams will develop local programmes to enhance local provision. Decisions made in the short term should, where possible be aligned to the future strategic plan. Given this in some specialities it will be possible to initiate service improvement programmes with immediate effect. More significant service redesign programmes will require robust planning and full stakeholder engagement and as such it is anticipated that a phased implementation programme will be developed. This programme will identify interdependencies both within the elective programme but also with the other work streams so that critical paths are identified and resources are used to realise the greatest impact. The wider programme of implementation is anticipated to commence from XX 2015 – this is likely to commence with early implementer specialties rolling out end-to-end integration and improved referral processes. It is expect that full implementation of end-to-end integration and improved referral processes could be completed in the short to medium term, i.e. the next one to two years. Formal public consultation on options for site considerations for Elective Care will be undertaken in 2015. Implementation of a preferred option for site consolidation is likely to take place in the longer term, i.e. over the next three to five years. Based on the responses to the questionnaire from Specialty Leads, the chart below shows the level of confidence within each specialty around implementation of end-to-end integration, along with those which were willing to be considered as early implementers. It was agreed by the ERG that it would be pragmatic to roll out integration on a phased basis, starting with those specialties (perhaps two or three such specialties) which are most confident through to those with less confidence. In order to realise the greatest improvements for patients whilst decisions regarding prioritisation will be informed by this information they will be primarily informed through a wider and comprehensive assessment of the benefits and risks.

Nested table from the "Investment costs and benefits" row:

Elective interventions	£m
Reduction in elective activity	26.7
End to end provision by specialty	5.7
Re-provision	-3.2
Total	29.1

DRAFT



Risks and mitigation

- The large geographical area covered within the county and a road network consisting of many single lane carriageways which are speed restricted, resulting in travel times between towns and villages being relatively high. This impacts on both staff transport and patient transport
- Existing estate capacity and ability to 'host' new requirements in both primary and secondary care
- Transport requirements
- Patient, public and political acceptability of changes proposed
- Ability to provide services in rural areas with lower volumes
- Ability to attract and retain high quality workforce
- Availability of robust data to support change
- Implementation will be dependent on the outcomes of public consultation in Autumn 2014. However, there is medium to high levels of confidence in the ability to implement end-to-end integration and improved referral processes across most specialties. Confidence around implementation of site consolidation is less certain due to range of options being proposed, patient, public and political acceptability of these and costs associated with implementation of each.
- Low uptake of midwife-led care compared with benchmark areas
- Changing landscape of provision within Lincolnshire, due to the closure of Grantham's midwife led unit
- Potential for child population to increase in the area in the next 5 years
- Low uptake of some vaccinations.
- Many children travelling out of county for paediatric services
  Multi-site provision of paediatric and neonatal services across Lincolnshire, with lower than optimum occupancy/ activity levels.

Story Box

Lincolnshire West CCG

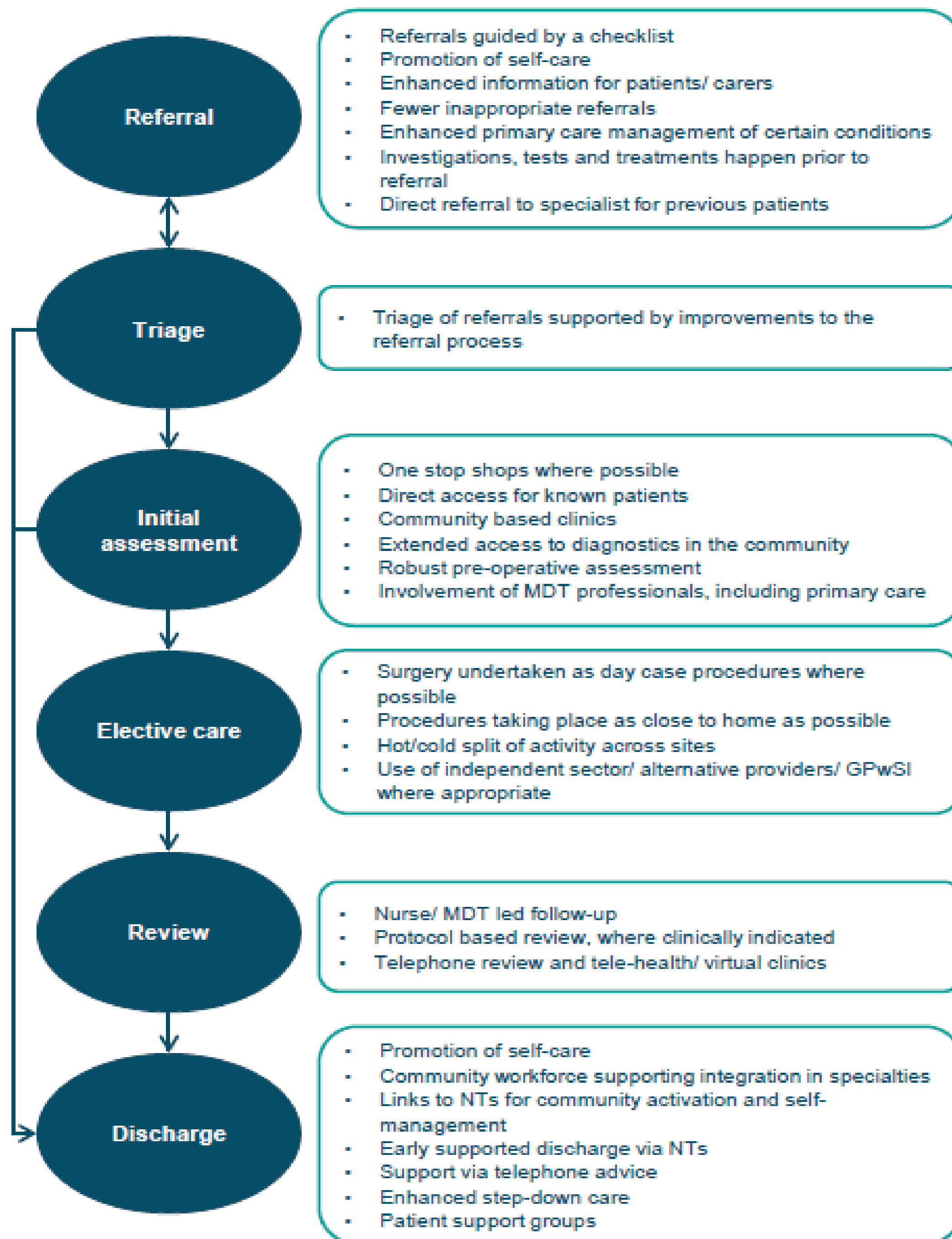
This CCG has a Referral Management Centre (RMC) in place for four specialties with a high volume of referrals and CCG spend. The RMC undertakes clinical triage of referral information, coding outcomes and booking patients via Choose & Book. The CCG is piloting a move to electronic referrals, considering the addition of other specialties with 18 week pressures, and investigating use of Map of Medicine. Outcomes have been variable – for example, in dermatology, there was a 30% reduction in referrals from the introduction of the RMC in September 2013, however in gynaecology and urology, there is only one GPwSI, so the extent and number of referrals being triaged are more limited.

South Lincolnshire CCG

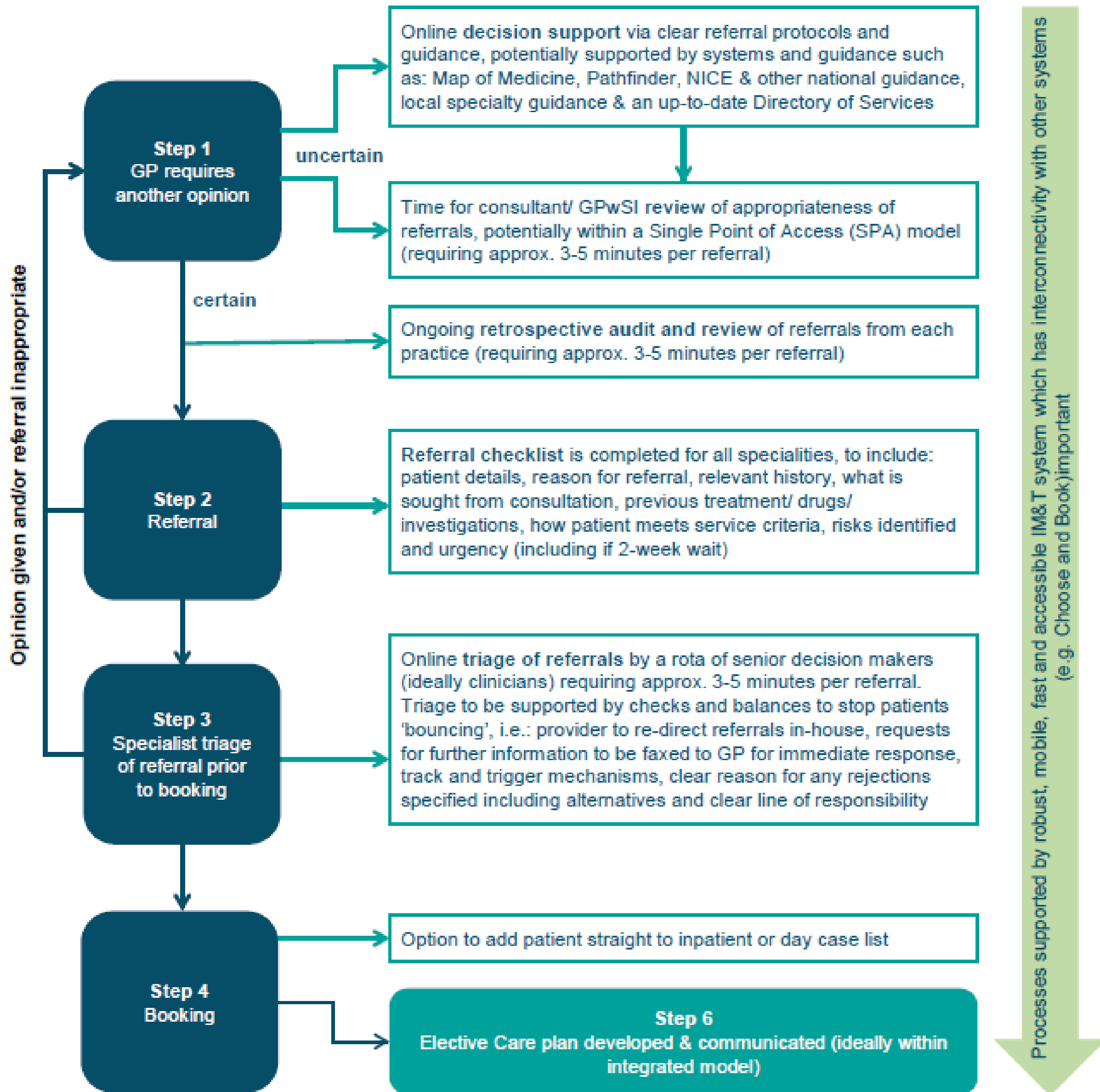
DRAFT

This CCG has developed a web-based referral and information site with one provider, consisting of electronic pathways and proformas which are supported by regularly updated guidance. Forms are held in a central repository and use a mainly tick-box approach which saves time for the referrer and ensures the letter gets to the right place quickly (via email). The system is continually developing through monthly pathway development meetings – recent discussions have included the potential to set up remote/ virtual clinics for neurology, nephrology and dermatology and the development of an app. Benefits have included ongoing professional education (through links to latest guidance), time saved for referrers, reduced variation and standardised referral information.

End to end integration of services: The Model of Integration



Improving the way referral work - As a result of the CDGs and the ERG meetings (including a survey of ERG members to identify best practice), a high-level model for the referrals process (encompassing peer review, referral facilitation and specialist triage) has been developed as shown in the figure below.



Focus on Cancer

We will continue to work with the Strategic Clinical Network for **cancer** and providers to support the delivery of any new or additional projects that deliver local, regional and national goals. During 2014/15 our priorities are to ensure access to treatment (14, 31 and 62 day measures) and cancer drugs, prevention through screening, individual funding reviews and adherence to best practice, in accordance with the countywide cancer strategy, *Improving Outcomes for Cancer*.

<table>
<tr><td>Ambition</td><td>The 'Forward View' is the clearest vision of developing cancer services into the future. The view of cancer care recognises prevention, diagnostics and consistent treatment/care as key to improving outcomes. Helpfully the linkage between public health and local government partners is highlighted for cancer prevention. The faster diagnosis section implicitly promotes training and education with the use of the decision support tool from Macmillan. Screening extension and improving uptake of bowel cancer screening is specifically mentioned. There is a line recognising that people need to be supported to visit their GP at the first sign of something suspicious.

The role of smaller hospitals and expanding primary care to allow more chemotherapy delivered in the community is specifically referenced. In addition the cancer recovery package highlighting support and after-care in the community are seen as key to effective care.</td></tr>
<tr><td>Change/ improvement interventions</td><td>One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten tears, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap. So improvements in outcomes will require action on three fronts;
• Better prevention
• Faster diagnosis
• Better treatment and care for all

• There is still more work to do to identify the reasons for better survival rates in other countries; if we are serious about wanting to improve we must understand what exactly needs to be addressed and what sort of joint working will be required
• Delivering improved survival rates has cost implications; more people means greater expenditure. So it is important to be open and honest and make appropriate savings where we can
• It takes time to bring about change, particularly the cultural change required so that people are encouraged to present earlier to their GP when they have signs and symptoms of Cancer and for the GP to swiftly refer them to Secondary care; raising awareness will have an impact on all services involved in diagnosing and managing Cancer. Any future planning must take into consideration the likely increase in numbers of Cancer patients
• Service developments such as introducing new screening programmes on the advice of the UK National Screening Committee (UK NSC) or developing new diagnostic services, must be planned and introduced in a sustainable and safe manner; informed and realistic planning must include sensible discussions about what is going to be needed and what is affordable
• There are clear opportunities to integrate commissioning even further. The national Call to Action aligns to the local LSSR and delivery of the national Outcomes Frame-</td></tr>
</table>

DRAFT

	works as they have both recommended integration and integrated measures; ***it should be possible to develop an even stronger and more competent 'shared' workforce, from both 'health' and 'social care' backgrounds*** • Existing organisational boundaries/barriers will need to be challenged consistently to ensure the delivery of required outcomes of any service; ***partners may feel vulnerable as roles merge and evolve as a result of planned changes***
Impact on quality, access, healthcare outcomes	Cancer survival within the Lincolnshire population although improving, presents a major challenge and there is still much to achieve. We know future demand is likely to exceed current capacity of services, and therefore we need to make best and better use of the resources we have. It is important that the Lincolnshire Clinical Commissioning Groups (CCGs) continue to plan for these changes, by ensuring good practice is spread across the health and social care communities, using the potential driver of the Lincolnshire Health and Care (LHAC) care design groups to drive innovation and improvements in shared care arrangements and approaches to steer integrated team service delivery models and management structuring (see Five year Forward View). We all need to encourage and drive the cultural shift to empower patients and carers to self-manage their care with a greater focus on recovery, health and well-being and reablement after Cancer treatment. Changing the way in which people with long-term conditions, including Cancer survivors, are supported is an outcomes framework priority and also a financial priority to meet the increasing demand and currently unfunded cost pressures. Low levels of support can be provided by joint working between health, social and volunteer/charitable organisations. Some complications of Cancer and its treatment can be reduced with simple actions, whilst complex issues and side-effects will require specialist services. Historically held attitudes towards how patients have been 'looked after' needs to change. LHAC provides us with this opportunity over the coming months. The future does not just pose challenges, but opportunities to provide an excellent health and wellbeing service; not just an illness service where we must get better at preventing disease, but to: • ***Self-management -*** Give people greater control over their health and view cancer as any other 'long-term condition'. People with cancer may also need mental health and social care coordinated support. • Tumour specific stratified pathways of care should assist in improving patient experience since they allow each patient greater choice in how their care and follow-up is managed. The estimated net saving in England is £86 million, or £214,000 per 100,000 population. For a total Lincolnshire population of around 746,000 this equals a possible saving of £1,596,440. • Develop effective preventative approaches - ***raising awareness*** • Physical activity: In March 2013 Sport England made a grant of £0.5 million to Macmillan in order to improve the opportunities for sports for people who are living with Cancer, and the Lincolnshire pilot is now underway. ***10.3% of adults in Lincolnshire are physically active*** (Compared to England average of 11.2%) • Embrace new technologies – ***innovation*** • ***Integration – faster diagnosis and a more uniform treatment of cancer is needed.*** Service and pathway redesign work has the greater potential to align itself with other complementary work streams. For example there should be a greater emphasis acknowledged around the synergies between resilience planning for planned care along with cancer services. Integrated service redesign should be

DRAFT

	aligned to Primary, Secondary Care and LHAC agreed priority specialities (i.e. Breast services, Urology, Dermatology, Upper and Lower GI and Lung). ***Remote monitoring -*** is a term used to describe how a specialist can book and monitor surveillance tests for patients who have completed treatment for Cancer, without the need for a face to face appointment. Its main role is to support low risk patients via a self-management pathway. Remote monitoring systems should hold sufficient information to enable the clinician to manage the patient without the need to access case notes.
Enablers	• While there have been important improvements, more needs to be done. We must continue to: • Increase awareness to prevent Cancers • Reduce mortality rates • Improve survival rates by completing the age extension of the breast and bowel screening programmes • Improve waiting times to Cancer treatments, ensure access to the latest surgical techniques, respond to new guidance for rare Cancers, provide greater consistency across a range of treatments and ensure equity of access to Cancer drugs • Improve the quality of life of Cancer survivors, acting upon information from the national PROMs survey to develop the services needed • Reduce emergency admissions by providing better proactive support (e.g. for patients on chemotherapy) and ambulatory services (e.g. for symptom control) • Increase day case or single overnight stay surgery (e.g. for breast Cancer) • Reduce lengths of stay through introduction of Enhanced Recovery programmes (e.g. for colorectal, urological and gynaecological surgery) • Reduce further treatment through promotion of supported self-management following Primary treatment • Be more responsive to people living with and beyond Cancer; support care as close to home as possible and provide access to appropriate psychological support during and beyond the Cancer journey to support patients in making choices for their end-of-life care • Improve patient experience through taking action on the issues identified as from the latest national Cancer patient experience survey
Investment costs and benefits	• Direct Access to Diagnostics (access to endoscopy and chest x-ray, non-obstetric ultrasound and MRI brain) • Specialised commissioning (with radiotherapy and chemo). Survivorship; community keyworker integrated pathway management (in line with LHAC) to successfully realise shifts in referral patterns and more non-acute management of cancer journeys/follow-up. Investment costs to be accessed via funding bid to Macmillan.
Timeline for implementation	End of 2015/16 (as per current 2 year operational plan for cancer)
Risks and mitigation	• Potential shift in existing organisational boundaries, roles and function (AT, SCN, Primary Care, Specialised Commissioning and CCGs). Integrated commissioning/ pooled budgets/joint funding. • Cancer Drug Fund will be consulting "on a new approach to converging assessment and prioritisation processes with a revised approach from NICE". Latest update (Nov 2014) www.england.nhs.uk/2014/11/12/cdf-eval • Workforce availability and retention within Lincolnshire; escalation to a more regional focus and approach to ensure sufficient capacity/skill is available Success of existing Acute Providers to provider excellent cancer services; mitigated by implementation of contract levers and more supportive working relationships

DRAFT

Story Box

Ms D is from a small market town in South Lincolnshire and has terminal cancer. The family and Mrs wanted to spend as much time together over the coming weeks/months as the diagnosis was terminal, and Mrs D was undergoing radiotherapy.

Ms D was initially told that radiotherapy services were unavailable at Peterborough City Hospital and that she would need to travel to Addenbrookes for treatment. This caused stress and anxiety as it was prolonged travel time and cost.

Work was underway to develop appropriate radiotherapy treatments within Peterborough City Hospital. After 2 months receiving radiotherapy services at Addenbrookes Ms D was referred back to Peterborough City Hospital that was now able to provide the service Ms D needs more locally to home reducing stress at such a difficult time, and meaning family could visit more frequently. Ms Ds family reported that the care on the ward at PCH was 'second to none'.

Local people have told us they are very keen on having more services like this locally, which can only strengthen the access, support and health networks for local people.

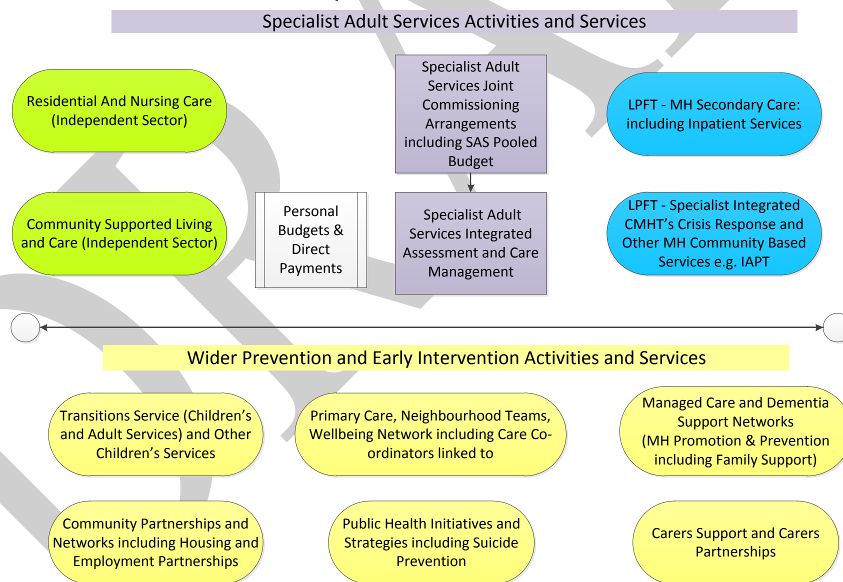
Mental Health, learning Disabilities and Autism

CCGs in Lincolnshire face a challenge in providing mental health, learning disability and autism services which are sustainable and have parity of esteem with physical health care, given an environment of increasing demand and constrained resource. However these challenges will be addressed through both joint commissioning and wider integration of Health and Care services.

The integration of Health and Care Services builds upon the programme of work completed in 2012-13 and 2013-14 "Transforming Mental Health Services in Lincolnshire". This includes in particular, the move from ward based services to more streamlined community based services, the integration of community mental health teams and the establishment of a single point of access to the local mental health trust mental services. There has also been good progress in integrating Tier 2 CAHMS with wider Children's Services in Lincolnshire and work is now in progress to further integrate Tier 3 provision.

South West Lincolnshire CCG, South Lincolnshire CCG, Lincolnshire East CCG and Lincolnshire West CCG in partnership with Lincolnshire County Council (LCC) have already established integrated commissioning arrangements for Mental Health, Learning Disability and Autism Services in Lincolnshire.

The joint commissioning partnership has recently appointed an Assistant Director for the Joint Commissioning of Adult Mental Health, Learning Disability and Autism Services, which is the first of such new appointments in the Country since the introduction of Clinical Commissioning Groups. The joint Mental Health, Learning Disabilities and Autism (Specialist Adult Services) post will lead on the development of an integrated commissioning team consisting of professionals employed across Lincolnshire CCG's and Lincolnshire County Council. The Integrated team will lead on the development and realisation of the Joint Commissioning Strategy for Mental Health, Learning Disability and Autism and will also play a key role in shaping the development of the LHAC programme which will include pooled budget arrangements to facilitate the benefits of integration and the realisation of Parity of Esteem.

Mental Health, Learning Disability and Autism Adult Services	
Ambition	The overall ambition of this programme is to improve the Wellbeing of Adults with Learning Disability, Autism and/or Mental Health needs within sustainable resources. There will be a number of building blocks which underpin the delivery of this strategic objective including: • Achieving parity or esteem between Mental Health and Physical Health; • Improving the quality of life and safeguarding of vulnerable adults; • Joint commissioning arrangements and pooled budgets: • Strong engagement and involvement of stakeholders; • Integrated services and strategic partnerships: • Effective prevention and early intervention strategies.
Change/ improvement interventions	The diagram below illustrates for Mental Health, Learning Disability and Autism services the services and activities which would be centrally managed via the Specialist Adult Services joint commissioning team (above the line) and examples of the wider Early Intervention and Prevention activities that would require a system wide approach to managing demand and performance improvement (below the line). The below the line activities will require the Specialist Adult Services joint commissioning team to commission through influence and to build strategic relationships and partnerships with key stakeholders to widen the asset base for improvement.  Key Interventions **Commission integrated health and social care provision** through a pooled commissioning budget arrangements Prevention, early diagnosis & intervention through integrated working with **Neighbourhood teams** • Ensure we case find and register people with mental health conditions, dementia, learning disability and autism on primary care registers. Provide timely early diagnosis and intervention, health checks and ongoing referral to services to support self-management, healthy lifestyles and wellbeing (e.g. smoking cessation, reducing

	obesity, physical activity, sexual health) • Build on the success of the managed care network to continue developing a thriving third sector network of support; • Mental health workers such as community psychiatric nurses are integrated into core neighbourhood teams (including the intermediate care layer) alongside specialist teams that will work over a larger footprint than one neighbourhood team, e.g. psychologists, therapists, clinical and social care specialists etc. • Integrated **Single Point of Contact** to coordinate and enhance responses. • **Practitioners within NTs** will provide training and advice to enhance the wider team skill base and knowledge of the management and care of the identified clients. **Crisis Concordat**: The concordat is about how local signatories work together to deliver high quality responses when people of all ages with mental health problems urgently need help. It spells out what needs to happen in anticipating and preventing mental health crisis wherever possible and making sure effective emergency response systems operate in localities when crisis occurs. The concordat is arranged around • Access to support before crisis point • Urgent an emergency access to crisis care • The right quality treatment and care when in crisis • Recovery and staying well and preventing future crisis **Improving awareness and focus on the duties within the Mental Capacity Act** Where difficult decisions may need to be made in balancing the patients' rights to make decisions about their care and treatment with the right to be protected from harm, and requiring others to act in the patient's 'best interests' where they lack capacity for a particular decision. **Draft Commissioning Strategies** will be developed for Mental Health Learning Disability and Autism during 2014-2015 and co-ordinated into an Adult Specialist Services Strategy which will be consulted on during spring / summer 2015 The Joint Commissioning Strategy will inform local commissioning and procurement intentions and will unite a number of linked Service Strategies including the recently published Lincolnshire Dementia Strategy, the Lincolnshire All Age Autism Strategy (which will be consulted on later in 2014-15) and related Strategies being developed via local Public Health teams to include the Mental Health Promotion Strategy and Suicide Prevention Strategy for Lincolnshire.
Impact on quality, access, healthcare outcomes	Mortality Mandate from the Government to NHS England1, to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole". Key areas for action Autism include: • Increased diagnosis; • Enhanced training for carers and professionals; • Improved information and signposting; • Better access to generic services; • Improved targeting of prevention and early intervention support initiatives; • Closer co-production; • Greater awareness of Autism as a local priority.

DRAFT

	• Mortality rates for people with Severe Mental Health problems; • Assessment and Care Management (to be comparable with Lincs LD performance); • Proportion of People with Severe Mental Health problems in Employment; • Proportion of People with Severe Mental Health problems in Stable Accommodation; • Dementia Diagnosis rates (contribution to CCG plan targets); • Data Quality and reporting; • waiting times for some services. 75% of people needing "talking therapies" for conditions such as depression will access treatment within 6 weeks, with 95% starting treatment after a maximum waiting of 18 weeks from 2015/16 onwards Patients suffering more serious problems such as psychosis will be offered treatment within two weeks of referral from 2015/16 onwards By 2016 at least 50% of people experiencing a first episode of psychosis will wait no longer than two weeks for treatment.
Enablers	***IM&T*** • Access to shared records will be progressed through IM&T group • The Lincolnshire Overarching Information Sharing Protocol provides partner organisations with an agreed framework at high level for this sharing of information as appropriate with the patients consent or in response to a statutory obligation. This is to ensure that patients receive the best possible care and treatment, e.g. shared multiagency care plans that enable all professionals to follow patients as they move through the system and timely access to assessment, treatment planning, results, referrals, equipment, appointments and prescribing. ***Workforce*** Review of capacity of existing LPFT contract and assessment and care management and neighbourhood teams. Identify Lincolnshire training needs analysis for Autism, Mental Health and Learning Disabilities and roll out associated training offer. ***Contracting*** Development of a Pooled Budget for Mental Health Services to complement the existing Learning Disability Pooled budget which will enable integrated procurement and contract management strategies that support delivery of integrated services across health and social care. The specifications within each of the contracts are to be reviewed and re-specified during 2014-16. Decisions linked to LHAC and wider re-procurement strategy will then be considered appropriately as part of the re-specification work. The Specialist Adult Services Joint Commissioning team already has an established pooled budget facilitated through Section 75 arrangements for Adult Learning Disability which incorporates risk sharing arrangements for 2014-15. Work is now in progress to extend the Section 75 arrangements to include pooled budgets for 2015-16 which will incorporate funding for Adult Mental Health, Learning Disability and Autism Services. The pooled budget will incorporate Better Care Fund (BCF) priorities and a proportion of BCF funding as well as core funding from Lincolnshire County Council and the Lincolnshire CCG's. Similar pooled budget arrangements are also being developed in parallel to this work in relation to the Women's and Children's Joint Commissioning arrangements which will incorporate CAMHS and SEN reform commitments. ***Estates*** The Specialist Adult Services Commissioning team will seek to become co- located. The

DRAFT

	Specialist Adult Services Commissioning Team will seek to become co- located during 2015-16 to facilitate further evolution of the Joint Commissioning Model
Investment costs and benefits	11% of commissioning budgets are spend on MH services whilst mental health conditions account for nearly ¼ of disease is. There is an ambition to increase proportional investment I Mental Health and Learning Disabilities and autism over the period of the 5 Year Plan. However savings will also be required with £800k being the saving target for 2015-16. The Integrated arrangements outlined in summary above will give a much clearer focus on shared local priorities for Mental Health, Learning Disabilities and Autism as well as the opportunity for further improvements to value for money which will help to sustain local services and standards of care going forward.
Timeline for implementation	The drive for integration and efficiency to provide high quality, evidence based care will be taken forward through the Lincolnshire Health and Care (LHAC) programme and specialist services (mental health, learning disability and autism) are an integral part of that development. In addition to LHAC a Joint Commissioning Strategy for Mental Health, Learning Disability and Autism is currently being developed under the governance of the Lincolnshire Joint Commissioning Partnership arrangements to provide specific focus on local and national priorities which will include the cross cutting priority theme of Parity of Esteem. It is the intention to consult on the draft strategy early in 2015. In parallel to this work the CCG's and LCC are also developing a Lincolnshire's Carers Strategy in 2014-15 which will also consider Parity of Esteem. **Short Term** Complete and consult on Specialist Adult Services Commissioning Strategies (including All Age Autism Strategy) **Medium term** Review specifications of Neighbourhood Teams, Public Health, Carers and Children's Services Contracts to confirm contribution to Parity of Esteem agenda. To have reviewed and increased the level of proportional funding for Specialist Adult Services as a % of all local spend.
Risks and mitigation	Demand for Specialist Adult Services and increases in complexity of care are out-running increases in local levels of funding. Proportional levels of spend on Specialist Adult Services will need to be reviewed in order to facilitate investment in Early Intervention. Clearer contributions to meeting increases in demand are required in the specification of public health services, neighbourhood teams, children's services and other community activities.

Story Box

'Mental Health: Integrated working in the Neighbourhood Team'

Mrs B is a 77 year old lady living alone in Lincoln and her nearest relative (her son) lives in Devon although aware of her current issues. Mrs B is already known to the community nursing team who visit twice weekly to change her dressings and they noted general deterioration in her condition. Mrs B was becoming forgetful and agitated at times. Mrs B started turning up at her GP surgery without an appointment in a confused state and had experienced severe weight loss over the last year. Mrs Bs memory was assessed by the Community Psychiatric Nurse (CPN) as part of the Primary Care Memory Assessment and Management Service and a joint assessment of her needs was carried out by her CPN and social worker at home.

Mrs Bs review was brought forward to the neighbourhood team. Medication was then commenced for a previously undiagnosed condition and more regular visits have now commenced as part of a whole package of care and implementation of attendance allowance.

DRAFT

Women and Children's

During Phase 1 of Lincolnshire Health and Care, a number of issues were identified in relation to Women's and Children's Services, these included:

- Low uptake of some vaccinations.
- Many children travelling out of county for paediatric services
- Multi-site provision of paediatric and neonatal services across Lincolnshire, with lower than optimum occupancy/ activity levels.
- Low uptake of midwife-led care compared with benchmark areas
- Changing landscape of provision within Lincolnshire, due to the closure of Grantham's midwife led unit
- Potential for child population to increase in the area in the next 5 years

In 2013/14 there were 7,185 paediatric non-elective admissions across ULHT. 52% of non-elective paediatric admissions across ULHT were for less than 1 day. General paediatrics accounts for the largest proportion (81.7%) of non-elective admissions across ULHT.

High admission rates are in part due to a lack of specialist paediatric services equipped to provide advice at the point of service, as GPs and A&E staff do not have easy access to paediatric advice.

In Lincolnshire 8% of children are admitted to hospital each year compared to 3% of children nationally (Data provided by the East Midland Strategic Clinical Network). Further work is underway to understand the impact of coding on this statistic however, there is still a significant opportunity to improve.

Paediatric, neonatal and obstetric care are provided by ULHT (for acute emergency, elective and maternity care), although some services for women and children are also provided by LCHS and LPFT, along with out of county providers. Further details of existing provision and service volumes are set out in the table below.

Service	Details of services provided
Paediatrics	• Outpatients activity takes place across the three main sites (Lincoln, Boston and Grantham), along with five other facilities (John Coupland, Holbeach, Johnson Hospital, Riverside and Skegness). • In 2013/14 there were 9,197 in-patient admissions across ULH (Lincoln and Boston) and 7,185 non-elective admissions. 52% of non-elective admissions were for less than 1 day. • General paediatrics accounts for the largest proportion (81.7%) of non-elective admissions, followed by Trauma & Orthopaedics (9.4%) and General Surgery (6.6%). Maxillo-facial surgery, ENT, Urology, General medicine, Psychology, Dermatology and Ophthalmology collectively account for 2.3% of non-elective admissions.
Neonatology	• Neonatal bed occupancy averaged 53% in Lincoln in 2013/14 (based on 28 beds) and 52% at Pilgrim (based on 12 beds). • There were total of 52 babies transferred out of Lincoln (44 clinical and 8 non-clinical) in 13/14 and 60 babies transferred out of Pilgrim (20 clinical and 2 non-clinical) in 13/14 and 29 babies transferred into Pilgrim (all were non-clinical) in 2013/14.
Obstetrics	• Consultant led obstetric outpatient activity takes place at the three main sites (Lincoln, Boston and Grantham) and four other locations (John Coupland, Johnson Hospital, Louth and Skegness). In addition, midwife outpatient activity also takes place at the three main sites and two other locations (Johnson Hospital and Skegness). • In 2013/14 there were 5,673 births across ULH, of which 62% (3,528) were at Lincoln and 35.8% (2,033) were at Pilgrim. The remainder were at Grantham, although this unit closed in Autumn 2013. • Across the Trust 61% if births were midwife-led and 39% were consultant led. • In 2012/13 there were a total of 13 in-utero transfers out from Lincoln and 15 in-utero transfers out from Pilgrim.

There is broad agreement that admission avoidance for children is a priority area, to reduce high levels of potentially avoidable admissions.

Other priority areas for women and children's are:

Disability – the Children and Families Act 2014 requires CCGs to jointly commission services for children with special educational needs and their families in response to identified need via the JSNA and Local Offer.

CAMHS – the increasing prevalence of self-harm and mental distress in young people and recent National scrutiny of the commissioning of services to support these young people has led to review of CAMHS in Lincolnshire

Health Visiting – the transfer of the commissioning responsibility for 0 – 5 public health nursing has provided an opportunity to re-commission health visiting alongside school nursing to provide a comprehensive 0 – 19 service.

Ambition	• Early Intervention and Prevention • More integrated delivery and commissioning • Prevention of avoidable admissions for children, including those with mental health problems • Sustainable hospital services that are configured to deliver optimum quality and safety standards
Change/ improvement interventions	Neighbourhood Teams • Admission avoidance for children (incorporating virtual models for multi-disciplinary working and networks) • A focus on early intervention and prevention will help to manage demand downstream to coordinate care in an anticipatory way. Targeted interventions will promote self-management and empower families through easier access to non-traditional points of contact; and reduce duplication and demand on specialist services. It is also anticipated that admission avoidance schemes will result in a reduction of short stay hospital admissions that may be dealt with more effectively in a non-hospital setting for children. The needs of women outside of pregnancy, child birth and supporting child and family development will be supported through the proactive care model and delivered through Neighbourhood Teams. • Neighbourhood teams having specialist capacity and capabilities to deal with children Significant work already done or underway (outside of LHAC) around universal, targeted and safeguarding services to deliver the Children and Young People's Plan (http://microsites.lincolnshire.gov.uk/children/partners/cypsp/cypp/). The transfer of the commissioning responsibility for 0- 5 public health nursing provides an opportunity to review the role of Health Visitors and School Nurses in relation to neighbourhood teams as well as a potential role in admission avoidance by providing front door services in A&E and potentially other venues. The joint commissioning requirement within the Children and Families Act provides an opportunity to explore greater integration of the assessment and ongoing support for children with disabilities up to the age of 25 – ie integration across health and social care and children and adults services. CAMH services are currently under review by Lincolnshire County Council to address gaps in Tier 3 and 4 services with a view to developing a Tier3+ model to provide an improved crisis response and increased care provided in county. This will involve investment in different ways of working and potential co-commissioning with NHS England to achieve an integrated service across Tiers 1-4. Developments at Tier 1 could potentially involve an evolved mental health/wellbeing role for all professionals working with children (Tier 1/2). Phase 1 also identified options around the consolidation of consultant led and midwifery led units on the same site (24/7 consultant available at all times) or consultant led and midwifery led unit on separate sites (24/7 Consultant cover at one site). Consolidation was also highlighted as a possibility around paediatric and

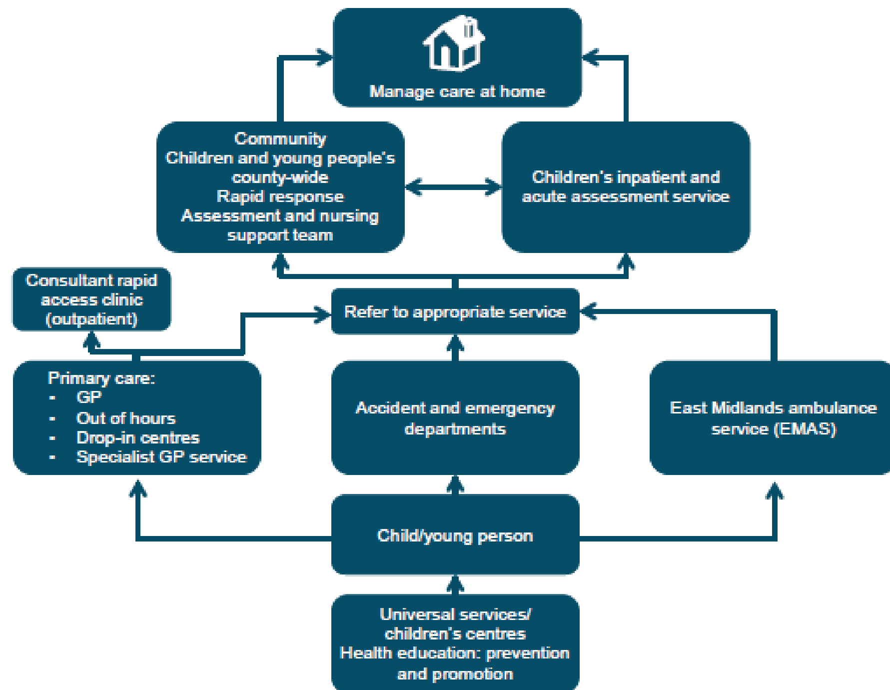
DRAFT

neonatal services, including acute care, ambulatory care / paediatric assessment services, surgical units and Neonatal units

Admission Avoidance

Development of the Mild to Moderate Pathway – supporting admissions avoidance for children

The emerging model is outlined below. It is recognised that the area where the most development will be required is within two particular boxes: community and children and young people's county wide rapid response, assessment and nursing support team and consultant rapid access clinic (outpatient).



Site consolidation for obstetrics and paediatrics

Service review and consultation with stakeholders has highlighted that maintaining the status quo for Women's and Children's Services is not acceptable on grounds of clinical quality and safety. There are three proposed main options which are being discussed and refined by the Women's and Children's Services Expert Reference Group. All options developed are under the assumption that:

- Care would be delivered locally where possible, through specialist outreach into Neighbourhood Teams, and local provision of antenatal care (by midwives and shared care with the GP)
- Consultation with specialists may occur at a local level.
- Only in-patient/ day-case procedures and births (with the exception of home births) occur at the main site(s).

Impact on quality, access, healthcare outcomes

Greater alignment of services currently provided to deliver The Children and Young Peoples Plan with improved coordination and liaison between services.

- General services for women (outside maternity and obstetric care) to be improved through delivery of the proactive model of care.
- The model for paediatric admissions avoidance will: Provide care closer to home & promote care in the best place;
   1. Provide opportunities for SPA & rapid response;

	2 Extend current provision; 3 Enhance GP involvement in paediatric care • CQC concerns are addressed as part of ULHT Quality Improvement Journey and LHAC programme • Promote enhanced specialisation • Promote efficiencies on main sites • Allow patients being cared for closer to home in the majority of cases with sub-acute services delivered through a community model • Reduction in numbers of referrals to CAMHS from ULHT by 39% • Reduction in the number of referrals for self harm by 38%
Enablers	***IM&T*** • IT enablement, including internet connectivity in the community setting • Integrated care records and shared information across organisations – including enabling the greater use of single point of access across agencies ***Workforce*** • Workforce development (specialist workforce, enhanced roles) within neighbourhood teams and midwifery. • Clear management structure and career development opportunities • Joint health and social care workforce with shared values • Ability to up-skill workforce through increased interaction with different providers. • Inclusion of GPs, potentially through a 'virtual' locality team. ***Contracting*** • Development of new joint commissioning models to support change • Lead provider contract, single governance structure and longer commissioning for timeframes (e.g. 3-5 years). • Co-commissioning with NHS England for the whole CAMHS pathway – tiers 1- 4 • Strategic oversight of all children's services to a single organisation / single responsibility for contract. ***Transport*** • Travel time will be reduced for patients and carers as more care will be provided in local settings, utilising for example hub and spoke models for mental health services. • Consolidation of acute services will result in the need for appropriate provision of transport to access specialist services.
Investment costs and benefits	The current financial projections have identified that changes are unlikely to make a significant contribution to the system-wide financial deficit The current financial projections have identified the financial case for change as shown in the table below: Women's & children's interventions — £m Paediatric Consolidation — 1.4 Grantham Relocation — 0.4 Maternity Consolidation — 2.9 **Total — 4.8** Benefits associated with Grantham relocation are likely to have already accrued by Phase 2, as the midwifery led unit at Grantham has closed.

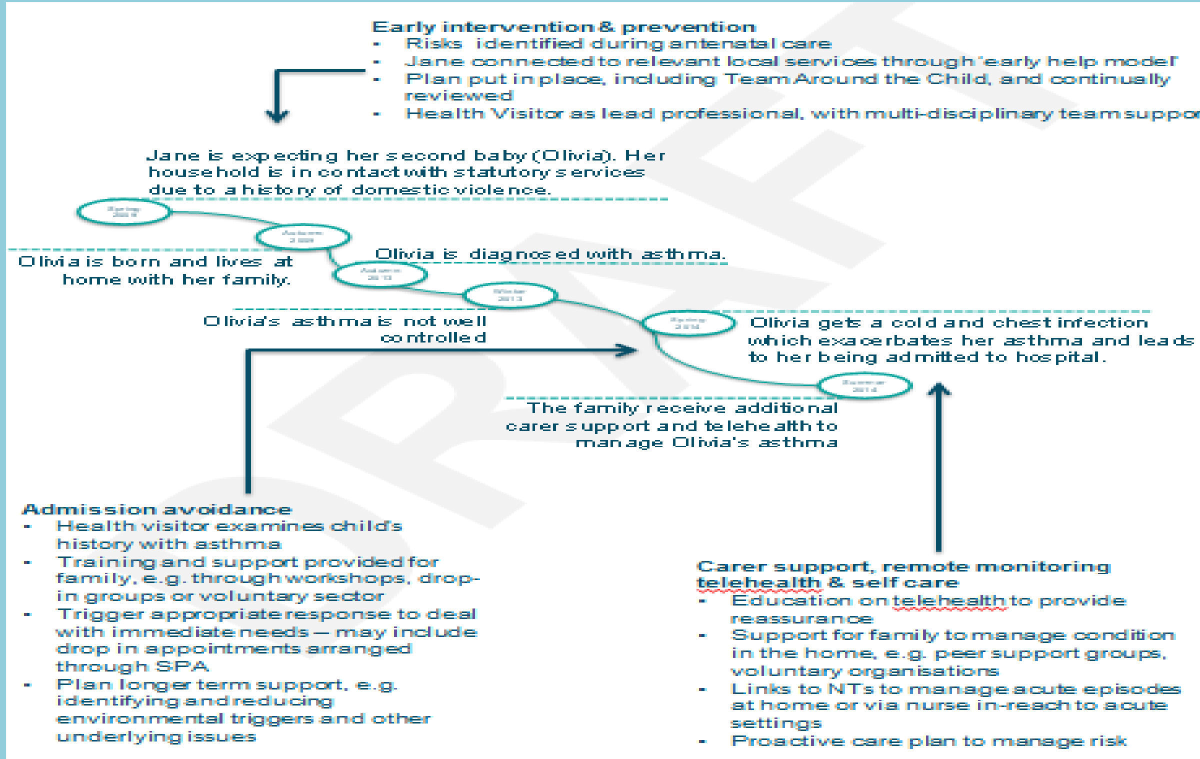
DRAFT

	No re-investment costs have been calculated for site consolidation at this stage, however some are likely to be incurred particularly to progress consolidation of sites. For neighbourhood teams for children, a re-provisioning cost of 30% of the benefits have been assumed to provide additional funding to expand proactive services (these costs are included within the re-provisioning costs for the main proactive care/ Neighbourhood Teams work stream). Final costs and benefits will be developed within the Proposal document
Timeline for implementation	The supply and development of health visitors has significantly improved following a development programme in response to the NHS "Call to Action". In order to progress the development of NTs and to improve care for other target groups e.g. the over 65s the ERG agreed to take a specific focus on women and children out of scope for the first wave of NTs. However during early engagement with GPs there is an expressed preference for inclusion of health visiting as a core part of the NT. Further work is therefore required to better understand optimal alignment or integration of these services with NTs as the programme progresses towards a population based rather than targeted model of delivery. Implications for the transition of health visiting from NHS England Area Team to LCC in 2015 will also form part of the future considerations. A pathway for admission avoidance by managing mild to moderate care needs closer to home and in an "out of hospital" setting wherever possible is in early development. **supporting admissions avoidance for children** pathway will continue to be further developed through the work of the sub group and ongoing ERG development of this model Determining the size, structure and geographical remit of the teams to operate across the County Identifying where the capacity and capability for these teams will come from Development of a Memorandum of Understanding (in development currently) and governance arrangements to support the set up and running of these teams As the design develops cost, benefits and implications for enabler will be established Features of these potential teams which will also be explored further will include: The potential for GP early evening clinics Winter services for children Tackling obesity within the female population (including pregnant women) and children (a number of initiatives are already underway but would benefit from greater coordination and collaboration) Services to be available for children as part of a wider NT/proactive care approach, such as Health Visiting and CAMHS Longer term plans to bring about an integrated children's service (potentially including single management and commissioning structures for children's services). • Public consultation on options for Women's and Children's Services to be undertaken in 2015. • Implementation to commence from September 2015 –short to medium term, i.e. the next one to two years, given that early implementer sites for these teams for adults is likely to commence in September 2014. Implementation of a preferred option for site consolidation is likely to take place in the longer term, i.e. over the next three to five years. Summary phasing of implementation is listed below

DRAFT

	Short Term Implementation of new CAMHS spec **Medium Term** Re-commissioning of HV/SN Integration of services for SEND **Long Term** Site Considerations
Risks and mitigation	• Services currently being delivered by a range of providers across a single pathway eg children's community teams sit within the ULHT, however some elements of key budget control e.g. equipment are held by other community providers. • The large geographical area covered within the county and a road network consisting of many single lane carriageways which are speed restricted, resulting in travel times between towns and villages being relatively high. This impacts on both staff transport and patient transport • Existing estate capacity and ability to 'host' new requirements in obstetric and paediatric services, and in primary/ community care • Patient, public and political acceptability of changes proposed • Ability to provide services in rural areas with lower volumes • Ability to attract and retain high quality workforce • Availability of robust data to support change Implementation will be dependent on the outcomes of public consultation in 2015. However, there is a medium level of confidence in the ability to implement neighbourhood teams for children's services. Confidence around implementation of site consolidation is less certain due to range of options being proposed, patient, public and political acceptability of these and costs associated with implementation of each.

Story Box



DRAFT

Specialised Services

NHS England directly commissions specialised services. The Health and Social Care Act 2012 gives Ministers responsibility for deciding which elements of specialised services should be commissioned directly by NHS England rather than by CCGs. Ministers take advice on these decisions from the Prescribed Specialised Services Advisory Group (PSSAG), a multi-disciplinary Department of Health Committee. The portfolio of 145 services is highly heterogeneous. Some sixty or so services are truly specialised, including those for very rare diseases. However, many services are not particularly rare and others are provided nearly everywhere in the country.

In April 2014 NHS England established a task force for specialised commissioning that has identified that some services would be better commissioned in partnership with CCGs rather than in isolation of the local services with which they are inextricably linked.
Over the coming years, we intend to move towards a more differentiated approach, more appropriate to the different types of services, identifying three broad tiers of commissioned services:
 Tier 1: Nationally commissioned services - Rare diseases, as well as a small number that need to be planned nationally (for example, specialised infectious disease centres)

 Tier 2: Co-commissioned services – These are services not routinely delivered in every CCG or in every local hospital, but which are delivered in many localities across England and need to be sensitive to that defined geography, which may cover three or four CCGs in some cases, or thirty or forty in others. These services will be co-commissioned alongside CCGs from April 2015.
 Tier 3: Devolved services – Over time to fully devolve some services to CCGs or groups of CCGs. These are services provided in most localities. For these services, there are opportunities to redirect funding upstream – for instance, to help patients tackle their weight before it becomes a serious problem

We will be working closely with and supporting the NHSE Area Team to determine the way forward for the commissioning of specialised services. We will support their strategic ambition to build a sustainable, co-ordinated approach to specialised services in the East Midlands and to concentrate specialised services in centres of excellence.

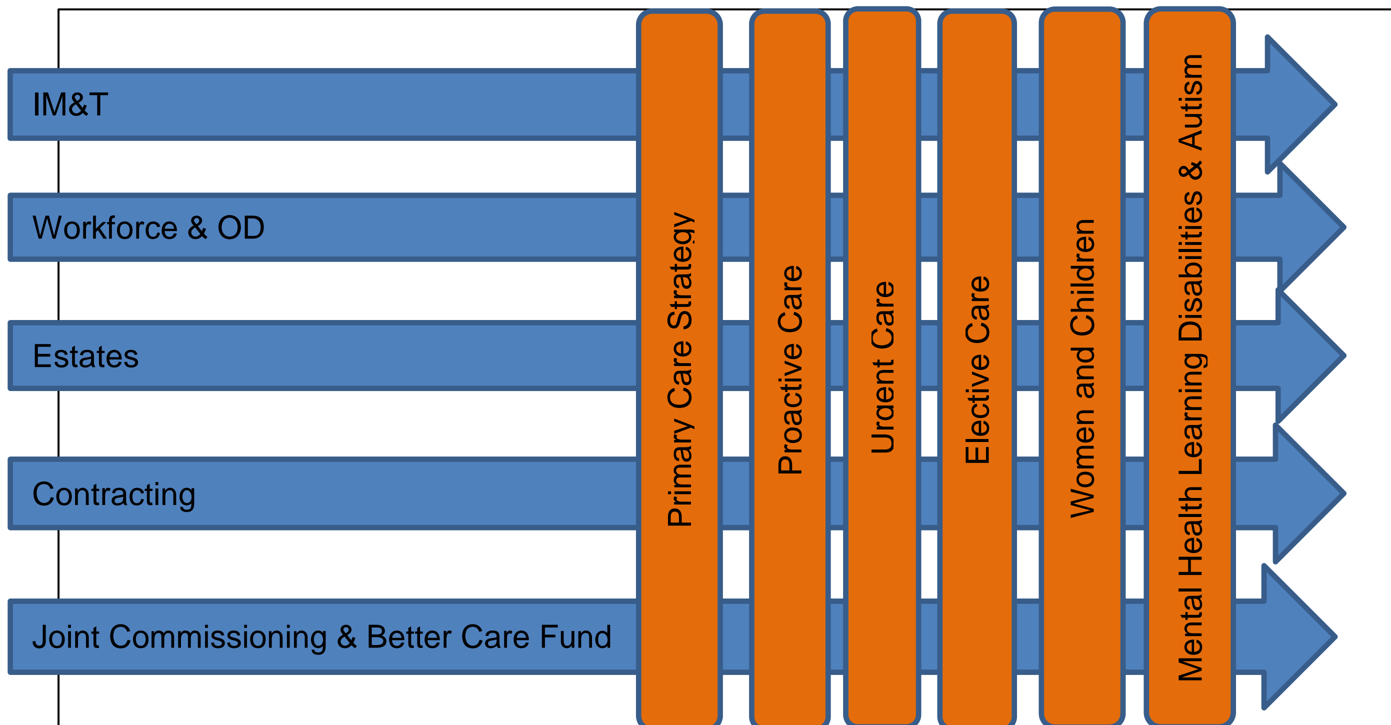
Programmes of work include the review and scoping of existing services. Any changes to service delivery and pathways will reflect best practice and secure local access where possible. However, it is recognised that for some, care is best delivered in centres of excellence e.g. stroke and trauma. The integrated care model for Lincolnshire meets the national direction for emergency care and will be further developed within the LHAC proposal for consultation.

It is recognised that a risk to the existing in county services (predominantly breast and vascular), is the potential for the removal of derogation arising from the national drive towards centres of excellence.

There are a number of specialist services that the Area Team and CCGs have identified are better integrated with CCG commissioning at a local level such as Child and Adolescent Tier 4 inpatient services and bariatric surgery. Work is underway to develop detailed plans and timelines for transfer of services to CCGs.

DRAFT

Enablers



Details of enablers are outlined under each programme and over view is described below

Estates
Initial scoping of estates was undertaken as part of phase 2. A resource has been employed to build on current work based on a phased output. Output 1 In order to understand the ability to flex estates to respond to emerging clinical service models the current phase of work is supporting urgent care expert reference group and the acute trust strategy implementation. Output 2 which runs in parallel to output 1To review validate and complete baseline data from phase 2 status report determine use of all current health buildings based on Location, size, Utilisation, current costs, costs/m2, tenure, % bookable space, site management (ie fully serviced) current services provided, current challenges (ie maintenance) physical condition, functional suitability, quality, compliance with statutory requirements, development opportunities, population served. Output 3To align future models with output 2 information determining property investment and disinvestment. Output 4 Implementation of plan defined from output 3 Timescale Data collection complete by 22nd December 2014Estates workshop to validate data collection Jan 15 Output available for clinical model input Feb 15

Workforce
Workforce modelling is in progress building on output of phase 2. The Model for neighbourhood team has been identified and further work is in progress to validate this in December 2014 with input to financial validation. Baseline workforce data across all organisations is currently being reviewed and will be validated along with primary care data in December 2014.Workforce modelling from acute trust to include CIP plans will be inputted to the workforce board. A workforce modelling tool is in development supported by LETC in conjunction with Nottinghamshire. Urgent and proactive workshops have been held.

DRAFT

The key challenges and recommendations for the local health economy of Lincolnshire include:

Challenges	Recommendations for a strategic workforce plan
1. The **'big supply challenge'** reflecting the inability to recruit talented and skilled clinical staff including A&E consultants, paediatric nurses, GPs, nurse practitioners and allied health professionals.	• 'Core' training and rotational programmes across both acute and community settings to increase overall workforce adaptability. • Define career pathways within and across professions to retain and incentivise the workforce through career advancement.
2. Developing **strong leadership** to empower staff when delivering new models of care and driving quality improvement through new working practices.	• Partnership working to effectively coordinate health and social care staff. • Effectively resource a leadership and OD programme to support Neighbourhood Teams (NTs) and whole-system transition.
3. Optimising **workforce capacity** through the effective deployment and utilisation of staff across staff groups to increase workforce productivity and efficiency.	• Enhance the core skills and competencies of staff across professions to achieve a more flexible and agile workforce, through a combination of on-the-job and off-the-job training. • Minimise redundancies by exploring all available options for upskilling and redeployment.
4. Introducing **integrated health and social care roles and implementing new ways of working** to deliver whole-system transformation.	• Engage staff in the design and implementation of new roles and ways of working. • Build on existing workforce initiatives that have worked well e.g. independent living teams.
5. Establishing truly **integrated education and training provision** to ensure the workforce is fit for the future.	• Consider training provision offered across primary care, community, mental health and acute setting, and plan how to best align resources. • Redesigning of core skills training for professions across organisational boundaries e.g. nursing, therapies.
6. **Breaking down organisational boundaries** and developing shared values and culture.	• Engage staff to understand where communication barriers and silo-working exist within and across organisations and develop realistic solutions. • Development of a shared strategic workforce and organisational development plan

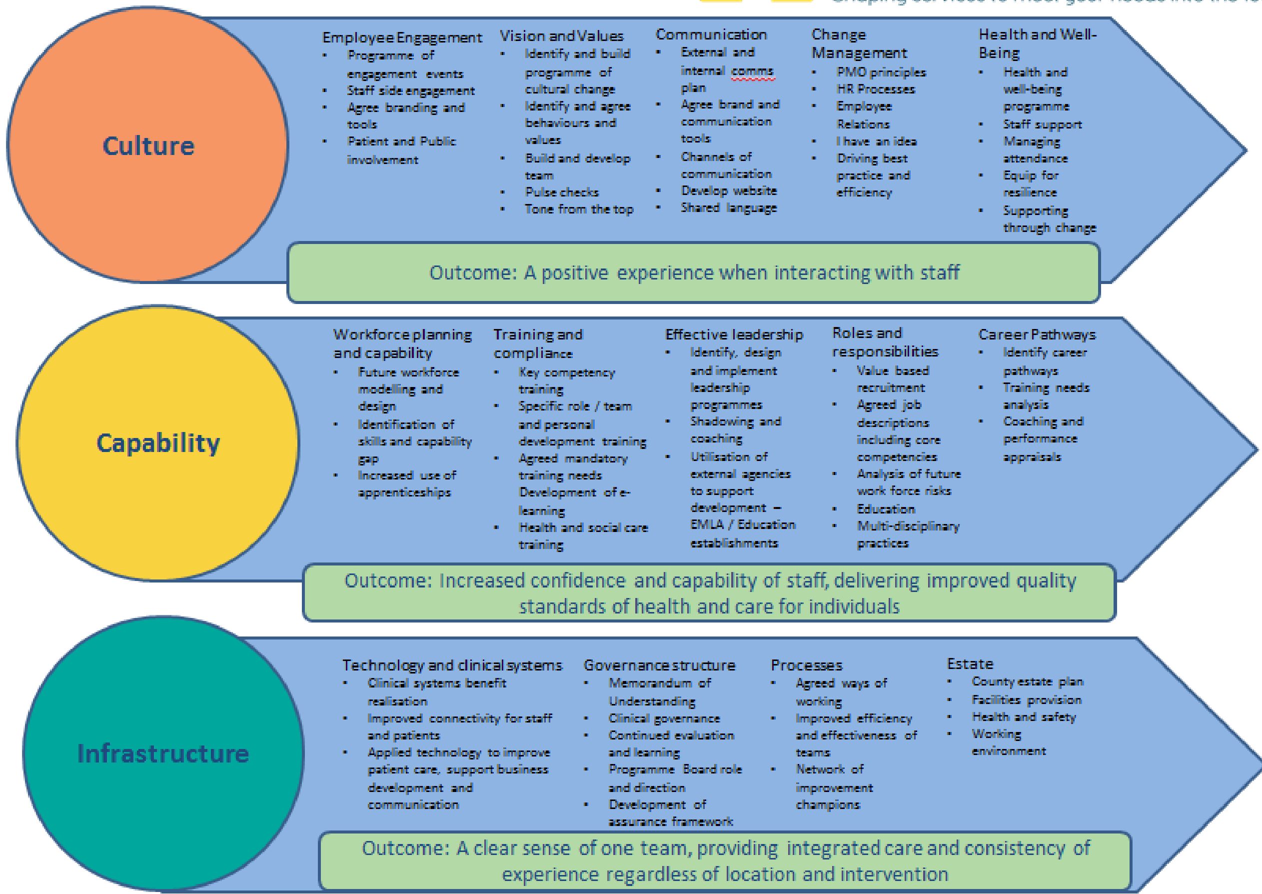
Lincolnshire Health and Care 92

The one page organisational development strategy has been put together by an OD sub-group of the LHAC Workforce Board. The strategy has been developed to reflect the full spectrum of OD support for the LHAC programme as a whole, but with an understanding that the initial focus is likely to be around Neighbourhood Teams.

DRAFT

Organisational Development Strategy – August 2014

Lincolnshire Health and Care
Shaping services to meet your needs into the future



DRAFT

Transport
A modelling tool was produced in phase 2 and further work is being undertaken as part of acute options appraisal. EMAS and NTL input will support options appraisal

Contracts
Proposals for progression of this enabler will be reviewed 25th November by joint commissioning Board. Facilitated workshop will be held with economy leaders (commissioners and providers) on the 3rd December to consider the 5 year forward view models.

IM&T
Long term road map was produced in phase 2
IM & T enabler group meeting planned for December focussed on review of whole system care planning software (includes demonstration)
Single consent form sign off for neighbourhood teams. This has been designed with support from county wide information governance group.

Joint Commissioning and application of the Better Care Fund

The Better Care Fund

The Better Care Fund was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and Councils are already doing. A detailed proposal outlining how the better care fund will be used to transform local services through the Proactive Programme, Women and Children's

Programme and Mental Health Learning Disability and Autism Programme is currently being developed for 2015/16 and will be submitted to approval to NHS England as part of the Assurance Framework. In particular the process looks at whether plans met the national conditions:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

In addition, 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 disability services. It is a strategic objective that by joint commissioning at scale, in line with LHAC, 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 efficiencies to bridge the anticipated gap between available resources and likely demand over the next 5 years. This ambition is reflected in the scale of the pooled budget across health and social care.

Summary funding arrangements in Lincolnshire are listed in the table below.

Organisation	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Total agreed value of pooled budget (15/16)
	£'m	£'m	£'m
Local Authority Social Services	£15.40		
Lincolnshire East CCG		*£16.19*	
Lincolnshire West CCG		*£14.50*	
South Lincolnshire CCG		*£9.81*	
South West Lincolnshire CCG		*£7.90*	
BCF Total	**£15.40**	**£48.40**	**£197.30**

The governance arrangements for overseeing of the BCF are described in the following table, which also describes the national performance measures against which the BCF is expected to perform.

Metrics	Metric measurement	Delivery Board responsible	Outcome/ benefit
Admission of older people to residential care	Based on admissions to council funded permanent long term care and will be monitored through the Proactive Care Group	Proactive Care Delivery Board	There will be a reduction in admissions to permanent long term care over and above the estimated growth in population, through integrated care , neighbourhood teams, 7 day working and prevention schemes.
Proportion of older people still at home over 91 days	Measures and benefits to individuals from reablement, intermediate care and rehabilitation following 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 care , neighbourhood teams, 7 day working schemes.
DTOC from ULHT acute hospital (including health and	Based on ONS population statistics for 18 years and over and is measuring health and social	Urgent Care Delivery Board	There will be a reduction in the DTOC over and above estimated growth in population. This

Metrics	Metric measurement	Delivery Board responsible	Outcome/ benefit
social	care reasons for DTOC from main acute hospital. Monitoring monthly through Unscheduled Care Board.		will support an easing of pressure on acute hospitals.
Avoidable emergency admissions	Awaiting national baseline information	Urgent Care Delivery Board	Integrated car , neighbourhood teams, 7 day working schemes should support a reduction in avoidable emergency admissions.
Patient experience	Awaiting national publication	Proactive Care Delivery Board	All schemes should support an improvement in patient experience of health and social care.
Proportion of people feeling supported to manage their condition	Based on GP survey questionnaire	Proactive Care Delivery Board	All schemes should support an increase in the proportion of people who feel that they are supported to manage their long term condition.

DRAFT

Impact and sustainability

Impact on providers-None yet fully determined

Financial plan

The costs of delivering care will increase significantly over the next 5 years as a result of population growth , ageing and medical inflation. The result is that if services continue to be delivered as they are now, current estimates are that by 2017/18 there will be a gap of £282m, between available funding and the actual costs of delivering health and social care in Lincolnshire.

High and low scenarios have been determined for benefits realisation. It was agreed that both scenarios are achievable, although the outcomes will be contingent upon how the implementation of initiatives will be prioritised and co-ordinated and how additional improvement activity within constituent organisations is prioritised and aligned with the 4 key Care Design Areas. This will in some instances involve the decommissioning of certain interventions.

Financial Modelling Shows a Growing Gap in Funding

In the low scenario the combined interventions modelled reduce the gap from £282m to circa £1.5m in 2017/18. In the high scenario the combined interventions modelled across all 4 Care Design Groups reduce the gap from £282m to a surplus circa £11m in 2017/18, as illustrated below.

Current Position (Before LHAC)

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Commissioner Income							
- CCG		918,745	926,591	957,248	976,452	995,004	1,014,731
- LAT		249,119	248,090	254,528	260,842	267,077	273,478
- Council		301,658	286,011	286,227	286,227	286,227	286,227
- Total		**1,469,522**	**1,460,692**	**1,498,003**	**1,523,521**	**1,548,308**	**1,574,437**
Expenditure		1,483,415	1,470,407	1,507,655	1,523,875	1,539,439	1,560,700
Aggregated Lincolnshire "PLC" position	**Aggregated Plans**	**(13,892)**	**(9,714)**	**(9,652)**	**(353)**	**8,869**	**13,737**
Remove cummulative CIPS/QIPPS							
: LAT			(998)	(1,198)	(1,423)	(1,799)	(2,528)
: CCGs			(19,305)	(37,498)	(53,228)	(69,359)	(85,886)
: Council			(7,132)	(15,084)	(24,331)	(33,806)	(43,414)
: Providers			(34,316)	(59,005)	(76,888)	(101,920)	(127,080)
Aggregated Position excluding CIPs/QIPPs		(13,892)	(71,465)	(122,438)	(156,223)	(198,015)	(245,171)
Alignment issues			(8,000)	(17,426)	(25,571)	(33,438)	(36,849)
Gross Position	**Do Nothing GAP**	**(13,892)**	**(79,465)**	**(139,864)**	**(181,793)**	**(231,453)**	**(282,021)**
Non LHAC CIPs\QIPPs							
: LAT			998	1,198	1,423	1,799	2,528
: CCGs			19,305	29,012	36,097	43,539	52,260
: Council			7,132	15,084	24,331	33,806	43,414
: Providers			32,487	55,076	70,924	93,671	115,946
Net Financial Position pre LHAC Savings	**Net Position Pre LHAC**	**(13,892)**	**(19,544)**	**(39,493)**	**(49,019)**	**(58,638)**	**(67,872)**
Non LHAC CIPs\QIPPs % of expenditure		0.00%	-4.08%	-3.33%	-2.90%	-2.81%	-2.74%

LHAC Interventions AFTER FULL IMPLEMENTATION

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Proactive & Urgent							
Savings			**43,767**	**44,663**	**46,499**	**48,238**	**50,120**
Reprovisions			10,759	10,979	11,431	11,848	12,292
Elective							
Savings			**35,465**	**35,836**	**36,771**	**37,433**	**38,097**
Reprovisions			3,547	3,584	3,677	3,743	3,810
Women's & Children's							
Savings			**5,474**	**5,475**	**5,548**	**5,575**	**5,600**
Reprovisions			-	-	-	-	-
Out of County Commissioner Activity							
Savings			**15,000**	**15,000**	**15,000**	**15,000**	**15,000**
Total							
Total Savings			**99,707**	**100,974**	**103,817**	**106,246**	**108,817**
Reprovisions			14,306	14,562	15,108	15,591	16,102
Net Savings - BEST CASE 85%	**LHAC Savings after Implementation**	-	**72,591**	**73,450**	**75,403**	**77,057**	**78,808**
Net Savings - WORSE CASE 71.6%		-	**61,147**	**61,871**	**63,516**	**64,909**	**66,384**
Implementation ramp up	**LHAC RAMP UP**	0%	0%	30%	45%	70%	100%
LHAC Savings based on ramp up							
Net Savings - BEST CASE				22,035	33,931	53,940	78,808
Net Savings - WORSE CASE				18,561	28,582	45,436	66,384

Revised Position (Post LHAC) - Best Case Scenerio

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus \ (Deficit)	**Forecast Lincolnshire PLC position after LHAC - Best Case**	**(13,892)**	**(19,544)**	**(17,458)**	**(15,087)**	**(4,698)**	**10,935**

Revised Position (Post LHAC) - Worse Case Scenerio

		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus \ (Deficit)	**Forecast Lincolnshire PLC position after LHAC - Worse Case**	**(13,892)**	**(19,544)**	**(20,932)**	**(20,436)**	**(13,201)**	**(1,488)**

DRAFT

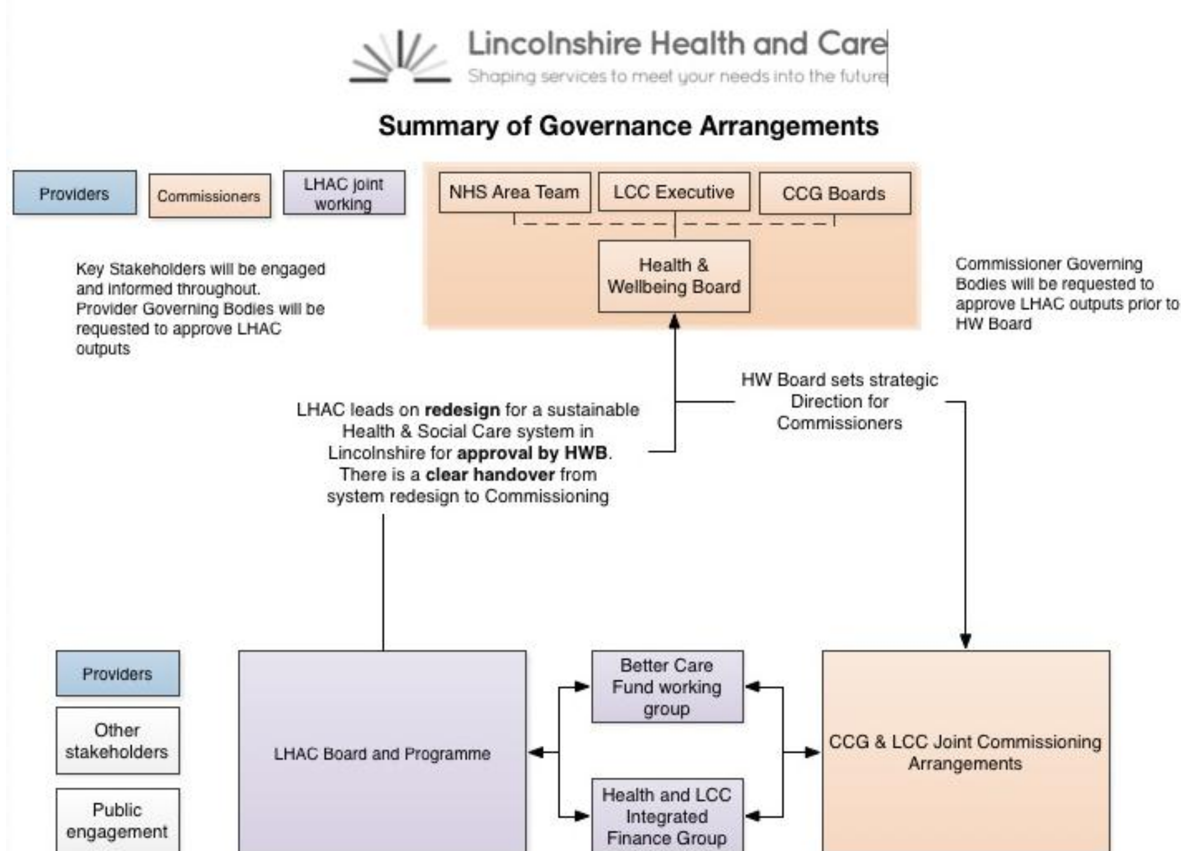
Notes

- Double running costs are not currently included
- Effect of Increased capital expenditure not shown
- Effect of Increased Interest costs due to additional funding requirements not included
- No redundancy, impairment, and other closure costs included
- Implementation ramp up will need to be refined during detailed financial analysis

Implementation

Governance

The Lincolnshire Health and Care Programme (LHAC) is an extremely ambitious programme for change across the Lincolnshire Health and Care system. This requires commitment from all parts of the system. Governance arrangements are summarised in the table below.



All parts of the system are included in the governance arrangements, with Healthwatch providing a patient perspective. These arrangements are supported by a Concordat that sets out agreed standards of behaviour between partners in adopting an 'organisationally agnostic' approach i.e. everyone focusing on improving the safety, quality and sustainability of the system for the benefits of users rather than focusing on benefits for their own part of the system. Governance links to Lincolnshire's Better Care Fund (BCF) plan. The BCF is fully integrated with the LHAC programme approach.

The LHAC Senior Responsible Officer (SRO) is Dr Tony Hill, the Director of Public Health for Lincolnshire who is in turn supported by the Programme Team, including a Programme Director and a Special Adviser (Health).

Programme governance is delivered through a range of channels including:

- Weekly meetings with the programme team looking at delivery and risks in the system
- Weekly updates to the LHAC Board
- Monthly formal LHAC Board meetings with the leadership community (leaders are asked to cascade to their own organisations)
- Regular communication events, briefings and written updates from the LHAC Board Chair have been undertaken for staff, public and the media and there is a website at lincolnshirehealthandcare.org
- Reports and attendance at both Overview and Scrutiny Committee and Health and Wellbeing Board.

Extensive stakeholder engagement with clinicians, managers, social care professionals, councillors and patient representatives has been undertaken during phase 2 to achieve the "buy in" and "bottom up" design

DRAFT

required if sustainability is to be achieved. Four Care Design Groups (CDGs), with extremely wide ranging membership, were established to develop a 'long list' of transformational, 'brave ideas' to improve service delivery and worked up into transformational models of care. The CDGs were large 'task and finish', groups including all stakeholders: Health and social care commissioners and providers, patients and public representatives, clinicians from all sectors and relevant service areas and voluntary sector.

During June and July the proposals from the CDGs are considered by Expert Reference Groups which are much smaller groups of clinicians, again from all sectors, with the expertise to transform the proposals into workable pathways.

The long list will then be evaluated in accordance with the evaluation criteria approved by the LHAC Board and the ensuing shortlist of options will be considered for approval by the Board prior to public consultation, starting in 2015.

Potential options identified within the LHAC Programme have been "sense checked" by both Healthwatch representatives on the Programme Board and by patient and carers representatives who have actively participated in the design process. The programme governance process facilitates alignment with the Health and Well Being Board and therefore the Joint Health and Well Being Strategy.

Throughout the process there have been and will continue to be regular updates to both commissioners and providers boards, with attendance at many external forums, LINCA, District Councils and other independent sector organisations

The Health and Wellbeing Board is consulted at all key stages and the Board signs off the key iterations of the programme. The LHAC Programme Director attends all HWB meetings. All NHS boards have formally supported the direction of travel.

Service areas that fell outside of the LHAC Programme remit, predominantly mental health, learning disabilities and autism, and primary care are being integrated into Governance arrangements as part of phase 3 so that all strategies dovetail into and are consistent with any implications of the LHAC programme and contribute to the overall transformation of services and the financial position.

The planning and governance processes for **mental health learning disability** services in Lincolnshire, are long standing and traditionally robust. The Specialist Services Delivery Board is currently overseeing the revision to the existing Mental Health and Learning Disability and Autism Strategies and ultimately reports to the Joint Commissioning Board.

The Commissioning of primary care for Lincolnshire is changing as a result of the opportunity for CCGs to take on responsibility for Co-commissioning of primary care. Each CCG will submit and expression of interest in January 2015 and the Governance structure and primary care strategy in each CCG will be proportionate to the degree of responsibility each CCG adopts (from Greater involvement in primary care decision making, through to joint commissioning arrangements or delegated commissioning arrangements).

Phasing

The Joint Commissioning Board is receiving a paper on 25 November on resourcing and capacity for the LHAC programme that will result in a revised timetable. This section will be updated following that meeting.

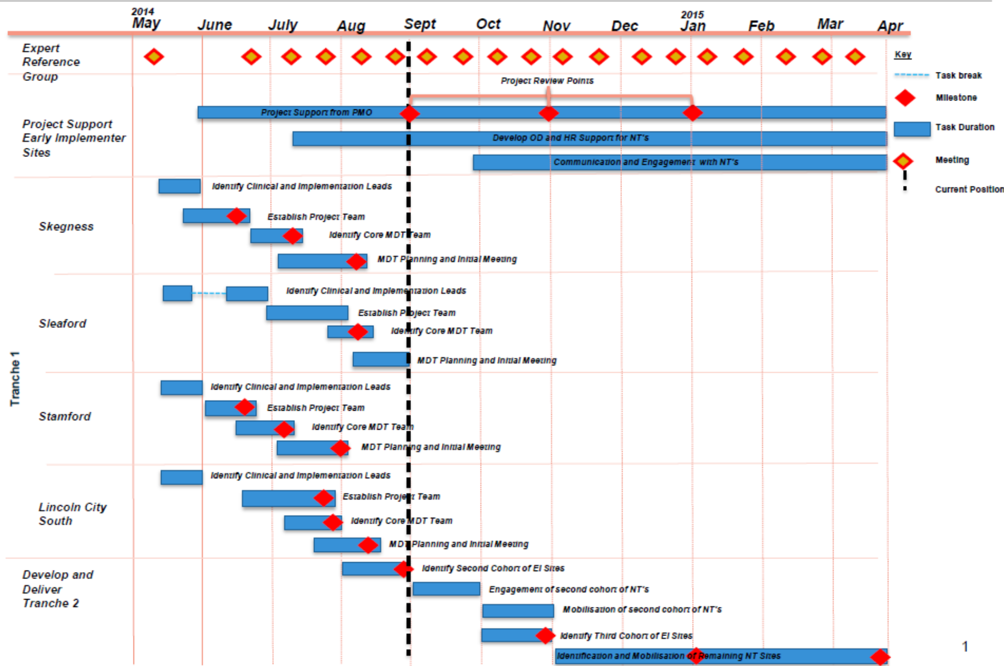
Phasing of the Neighbourhood Teams

DRAFT

Lincolnshire Health and Care

Shaping services to meet your needs into the future

Neighbourhood Team Plan



DRAFT

Risks

NHS commissioners will bear a significant financial risk if the local changes are not successful in reducing demand for hospital care.

Risks

NHS commissioners will bear a significant financial risk if the local changes are not successful in reducing demand for hospital care. The table lists the high scoring risks of 8 and above.

Risk No	Risk Type	Risk Description	Existing Controls	Current Risk Score		
		Risk Description		Probability	Impact	Score
01	Economic / Financial / Market	The detailed design groups describe a model which does not deliver sufficient whole system base budget savings and the forecast deficit is not mitigated	Design groups and supportive analytics will focus on clinical and customer quality in the context of widening deficit. Delay in validating the widening gap raised as an issue Finance group have an agreed plan to support financial validation of the models	3	4	12
02	Strategic / Commercial	Failure to engage and consult fully with all interested parties within the currently profiled timescale	Communication and engagement Strategy in place and being actively implemented. Staff roadshows have been undertaken. 2-weekly Neighbourhood team communications commenced. Neighbourhood team FAQ's have been prepared to be uploaded to the website	2	4	8
03	Organisational / Management / Human Factors	Service providers, voluntary sector and community groups are unable to respond adequately to the remodelling of commissioned services to achieve the vision.	Organisationally agnostic approach involves Providers in co-design. Care design groups will include providers to ensure sufficient lead in time for them to respond. Commissioners will need to clearly articulate commissioning intentions	2	4	8
07	Economic / Financial / Market	Failure to ensure ownership of all of the financial modelling	The finance group is meeting regularly and has produced a work plan to support financial validation of interventions. LHAC lead was employed in August	2	4	8

DRAFT

Risk No	Risk Type	Risk Description	Existing Controls	Current Risk Score		
		Risk Description		Probability	Impact	Score
08	Organisational / Management / Human Factors	Failure to include programme risks from partner perspectives	2nd Leadership master class on 4th June identified areas that require action. Action plan produced following leadership workshop against the 6 principles Risk log shared with programme board members for comment.	3	3	9
09	Political	European elections might have an impact on our ability to consult	Closed			0
011	Strategic / Commercial	Disparate stakeholder views leading to difficulty in making key decisions	Inevitable that there will be disagreement. Ensure we can act within framework in 'Planning & Delivering Service Changes for Patients' Utilise assurance framework for guidance Governance framework in place	3	3	9
012	Strategic / Commercial	Poor access to data	Significant data is available collected from phase one and phase two to date.	2	4	8
013	Economic / Financial / Market	Insufficient financial and other resources	Budget identified up to March 15 for PMO.	3	4	12
014	Economic / Financial / Market	Pressure on quality of deliverables by the need to act quickly due to worsening financial forecasts	Revised timescale currently under consideration.	3	4	12
015	Organisational / Management / Human Factors	Failure to lead change management within programme constituent organisations	Workforce Board have OD/HR sub group accountable for development of OD strategy and plan	3	4	12
016	Organisational / Management / Human Factors	Failure to manage the scope of the programme	Defined activity is focussed on four groups of Proactive, Urgent, Women and Children and elective activity.	3	3	9
017	Organisational / Management / Human Factors	Loss of programme intelligence due to staff changes	programme board to decide on required resourcing by October board	4	3	12
19	Political	Failure to progress to full consultation on all elements of design due to National Elections	Local indications that consultation on major hospital reconfiguration may be stalled	3	4	12

Risk No	Risk Type	Risk Description	Existing Controls	Current Risk Score		
		Risk Description		Probability	Impact	Score
21	Organisational / Management / Human Factors	Failure to integrate whole systems organisational development	Whole system organisational development strategy being coordinated by Workforce Board which includes LHAC cross organisational membership OD operational support for early implementers in place Workforce sub group accountable for delivery of plan currently focussed on NT's	3	4	12
23	Strategic / Commercial	Failure to address workforce recruitment and retention issues	Workforce board interface with LETC for long term learning and development planning	3	4	12
24	Economic / Financial / Market	Organisational savings take precedence over LHAC implementation	NHSE requirement to align QIPP and CIP savings to include whole systems programme. LCC savings not included or aligned	3	3	9
25	Strategic / Commercial	Failure to design whole system proposal which mitigates financial deficit	Current proposal includes whole system savings such as QIPP and CIP. Finalisation of the design is currently being planned through Programme Directors and Finance Group all supported by enablers. JCB leads allocated to all groups to support progress	3	3	9
27	Economic / Financial / Market	Whole systems transactional savings are not delivered in line with QIPP and CIP targets	Turnaround group established to manage QIPP and CIPP planning and performance	3	3	9
29	Economic / Financial / Market	Limited financial capacity in the health economy leading to delays in revalidating financial position and concerns about ability to validate financial impacts of the proposal for change	Finance Officers fully engaged with costings work but significant time pressures on all. Additional capacity appointed Defined work plan in place	2	4	8
34	Political	Delayed consultation	Media protocol in place which includes support from Jon Grubb to provide expert advice and co-ordinated approach	3	3	9

DRAFT