Appendix B

NHS
South Lincolnshire
Clinical Commissioning Group

South Lincolnshire Clinical Commissioning Group

DRAFT One Year Review of 2014 / 2015 / 16

Commissioning Intentions

Contents

Acronyms

Acronym	Meaning
SLCCG	South Lincolnshire CCG
PPG's	Patient Participation Groups
QPEC	Quality and Patient Experience Committee
GEM	Greater East Midlands Commissioning Support Unity
PPIC	Patient and Public Involvement Committee
CSU	Commissioning Support Unit
FFT	Friends and Family Test
PROMs	Patient Reported Outcome Measures
AIRs	Assertive In Reach Team
DTOCs	Delayed Transfers of Care

Introduction

South Lincolnshire CCG (SLCCG) serves a registered population of approximately 161,343. The CCG is made up of fifteen practices across two localities with distinct populations and needs. The Welland locality has seven practices serving a population that is mainly affluent with small pockets of deprivation in larger populated centres. The South Holland locality has eight practices and is more deprived with areas of rural poverty and growing migrant worker and new arrivals communities from EU accession countries.

The CCG will be commissioning services for the populations of Stamford, Bourne, Market Deeping, Spalding, Long Sutton, Holbeach and surrounding areas. The main hospitals serving this population are Peterborough and Stamford Hospitals, Johnson Community Hospital, Queen Elizabeth Hospital Kings Lynn and Pilgrim Hospital, Boston.

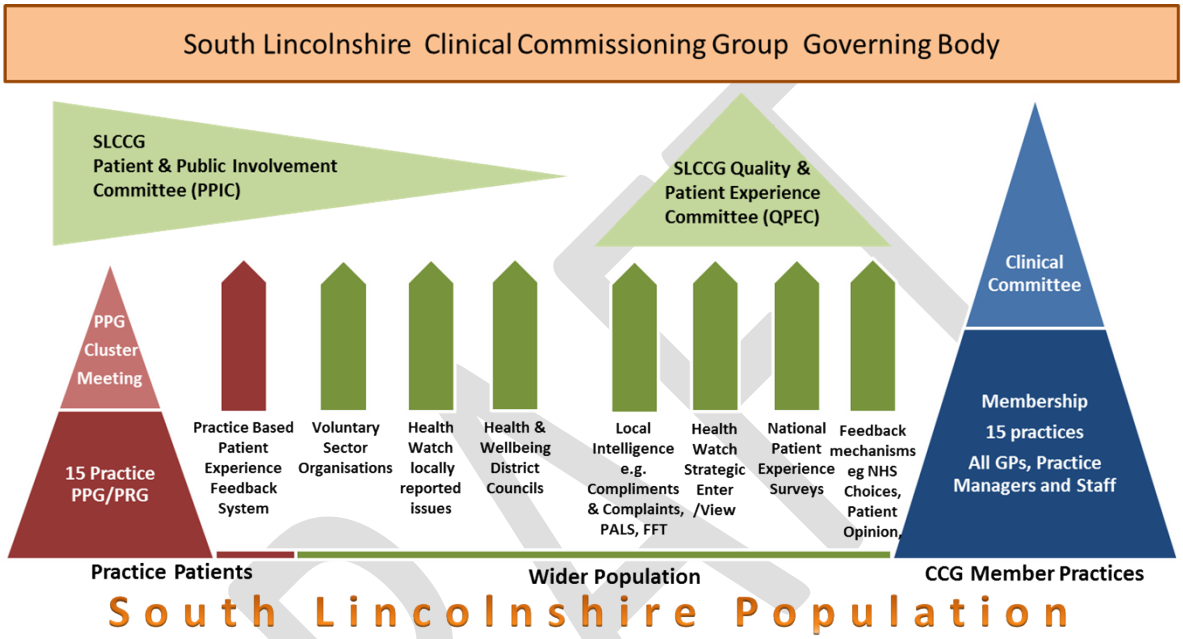
SLCCG are committed to engaging with all of the communities that we serve. New arrivals from the EU form a substantial minority of the South Lincolnshire community and contribute enormously to the local economy. In order to better engage with this group of people, who may find health services hard to understand and use, we have been working with local employers to take health information to their workers. In 2014 South Lincolnshire CCG conducted a health awareness event running over 3 weeks (1 day a week) which also encouraged GP registration.

Commissioning Intentions have been rolled out for 15/16. Some of which have been carried over from previous years, others have been refreshed/changed. SL CCG are still in negotiation with providers, where we are lead commissioners to secure 2015/16 contracts. For full details of commission Intentions please see page 27.

Are patients and the public actively engaged and involved?

Our Systems

The 'Continuous Listening' model depicts how our Governing Body is able to listen to the views, opinions and experiences of the population of South Lincolnshire in terms of our GP practice patients, staff and the wider population enable the CCG.



The two committees that deal with patient and public involvement/engagement as depicted in the model above are:

Quality & Patient Experience Committee

The purpose of the Committee is to regularly review reports on the quality of services commissioned, patients' experiences, specific quality improvement initiatives and any serious failure in quality. It provides assurance to SLCCG Governing Body that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CGG does. In addition to the standardised reporting reviewed by the committee, provider 'focused reviews' are also conducted to ensure the committee are sufficiently sighted on service quality with enhanced granularity.

The patient voice is heard in a number of ways through the Patient and Public Involvement Committee for example formalised patient generated intelligence including complaints, PALS , Healthwatch enter & view reports, National Patient Experience Surveys and Family and Friends Test.

Membership consists of the following:

- CCG Chief Officer (Chair)
- Director of Quality (Executive Nurse)
- Lay member for Patient and Public Involvement.
- 4 x GPs

Patient & Public Involvement Committee

The Purpose of the PPIC is to provide the SLCCG Governing Body with an assurance and scrutiny function in relation to its duties to communicate and engage with patients and members of the public under the Health and Social Care Act 2012. The Committee provides strategic leadership to ensure that patient and public voice is heard and that engagement informs the planning and commissioning of services that meet local population needs and oversee the delivery of the SLCCG Communication and Engagement Strategy. This committee facilitates the two way communication process necessary to achieve greater engagement between these member organisations and the CCG on a continuous basis. Crucially this committee provides the conduit for 'soft intelligence' regarding patients' experiences of services from its constituent members with intelligence from escalated to both the QPEC and Governing Body as required.

The type of Patient voice heard through this committee is informal 'soft' intelligence from each of its constituent members including Healthwatch (patient reported incidents), voluntary sector, local authority and SLCCG PPGs . CCG Listening event reports also go through this committee. The PPIC has developed a link with the Public Health (Healthy Schools) team to have a representative for school aged children as well.

Membership consists of the following

- SLCCG Lay Member for Patient and Public Involvement (Chair)
- 2 Representatives from the Cluster Patient Participation Group
- Voluntary Sector Representatives
- GP Representative for PPI
- 2 Practice Managers' representatives
- SLCCG Engagement Manager
- GEM Engagement and Consultation Manager
- Health and Wellbeing Representatives from District Councils (SKDC/SHDC)
- Healthwatch Representatives
- Lincolnshire County Council Representatives
- SLCCG Quality Representative
- Representatives from the CCG Delivery and Development Team as required

Patient Experience Log

Patient experience that is gathered from all arenas (including patient opinion & NHS Choices) is collated monthly and logged to identify trends and to support with areas that involve more investigation. This log is used at Senior Management Team meetings and supports the wider intelligence gathering for the PPIC.

What we have done

Recruitment of permanent Engagement Manager who's main focus over 2015/16 will be to ensure patient and public voice and experience is recorded and acted upon and to support the CCG with consultation around statutory requirements and localised projects.

Commissioning Intentions Engagement
Summer 2014 First phase - 411 patients and members of the public were spoken with about last years' priorities and how they felt about these. This was done through specific forums (i.e. carers groups/mental health forums/healthwatch events); surveys; market stalls in Bourne, Stamford and Spalding and presence in GP practices.

Stakeholder Event held August – 44 stakeholders representing 34 organisations.

Diabetes
2 x consultation events were held (Welland and South Holland) to look diabetes services and self-management. 55 people attended and gave views on what's good/not good; what they would like to see delivered; what would help them self-manage better? Education and peer Support identified as the key thing needed by patients.

SLCCG have since taken the opportunity to work with the Patients in Control programme (funded through NHS England and being led by Kent CSU). To work with patients to understand what peer support and education should look like from their point of view.

SLCCG identified funding opportunities for this work (NHS Challenge Innovation Fund and recent NHS E money, 3 year project) working in collaboration with health trainers to deliver 4 x events per year across our area regarding healthy eating, cooking and growing (of food) and exercise for diabetics and pre diabetic patients.

A8 Community
Extensive engagement work carried out by the CCG working in partnership with local employers with high proportion of A8 employees. 3 x whole day events held within Bakkavor to raise awareness of GP registration and working with partnership agencies to deliver health checks and health promotion (including Phoenix stop smoking team and Early Prevention of Cancer Team).
235 people attended the event
222 people undertook a health check (94.5%)
21 people undertook a TB questionnaire (9%)
23 new A8 registrations with with a SLCCG GP (10%)
Further events planned for March 15.

Listening Events
All 4 Lincs CCG have a programme of 'Keogh style' listening events across the county (4xper year) one in each CCG.

Carers & Young Carers Roadshows
SLCCG have developed links with the Lincolnshire carers and young carers partnerships and have been invited to participate in the yearlong programme of roadshows to facilitate engagement opportunities which will enable this extremely valuable voice to be heard.
A real example of how the continuous listening model has enabled the patient voice to influence our plans is highlighted in the flow diagram below:

Patient Feedback regarding CCG Commissioned Services

Flow of Information

Example

A PPG raised, through the Cluster PPG, that they felt Carer's were not listened too in the discharge process and in care planning for the cared for.

Individual Patient Stories; Information form Healthwatch monthly reports the feedback from local groups; collated information from Patient Opinion and NHS Choices. Information from PPG Cluster Group

The Patient and Public Involvement Committee discussed this and felt that as a number of similar organisations and groups had raised this, it should be escalated for discussion at the Quality and Patient Experience Committee

Added to the Patient Log – reviewed by the Patient and Public Involvement Committee – does this issues/multiple concerns warrant investigation and/or escalation

The case was given to the Quality and Patient Experience Committee, who suggested that it become part of the conversations for contract incentives next year.

Issues have been discussed and a task & finish group has agreed to look at this in more detail to pose the queries to Quality and Patient Experience Committee

Carer's are an important part of patient care and therefore a contract incentive is to be added to neighbourhood teams next year to give carer's more input/say.

Escalated to Quality and Patient Experience Committee for response

This information was fed back to the Patient and Public Involvement Committee – who were extremely pleased that something raised by a PPG would now have a positive impact for carers in South Lincolnshire.

Response from Quality and Patient Experience Committee sent to Patient and Public Involvement Committee for wider distribution

Quality Assurance

Quality remains our priority and therefore we have a range of systems and processes to proactively manage the services we commission.

Bi-monthly quality reports are produced for the CCG Quality and Patient Experience Committee with escalation to CCG Governing Body as required. This report consists of a dashboard detailing information including Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium Difficile (CDiff) rates, numbers of new serious incidents and safeguarding concerns. This is supported by a narrative document describing, by exception, the detail behind the numbers in the 'dashboard', together with relevant actions and patient experience information.

Commissioned services are managed via a quality schedule within all contracts. This allows performance management and monitoring of quality and patient safety metrics and indicators (including benchmarking data). There are a variety of sanctions and incentives which can be and are used to secure continuous quality improvement.

In accordance with guidance issued by the National Quality Board, Review of Early Warning Systems in the NHS, SLCCG utilises an early warning system which includes not only the analysis of core data from a wide range of services, but also feedback from patients (derived through complaints), incidents, GPs and the public, to indicate that an issue affecting the safety or quality of care may need to be further investigated.

Further, in accordance with the National Quality Board recent guidance, How to Organise and Run a Rapid Response Review, the CCG is able to organise a rapid Response Review in response to concerns. This may also include mobilising a visiting team to assess the service concerned.

If any part of the local system indicates that there may be a serious quality failure within a Provider organisation which cannot be addressed through established and routine operational systems, a risk summit may be triggered in conjunction with the CQC and/or NHS England Area Team, in line with the National Quality Board guidance on How to Organise and Run a Risk Summit.

Assurance visits to providers up to quarter two are listed in the table below.

Date	Provider	Level of Review	Reason for review	Reviewers	Summary of findings
23.06.14	St Barnabas Hospice, Lincoln	Level II	general quality assurance	Infection Prevention & Control South Lincolnshire CCG Lincolnshire East CCG	**Positive Factors** • Positive patient experience • Patient centred well organised model of care • The environment was found to be clean and staff were clearly engaged in IP&C processes. The facilities and environment met with HTM/HBN specifications **Further assurance sought:** • minor changes to equipment storage (moving clean items out of 'dirty' rooms) would further enhance the high standards observed
24.06.14	Lincolnshire Partnership Foundation Trust **Site:** Peter Hodgkinson Centre	Level II	Assurance re Infection Prevention & Control	South Lincolnshire CCG	**Areas for further improvement** • There were issues relating to both Criterion 2 and 6 found across the site and some non-infection issues were also noted including: • Cold chain not monitored appropriately (Outcome 9 Medicines management). • Archived patient information found in various cupboards on the wards (Outcome 21 Records management).
30.06.14	United Lincolnshire Hospital Trust **Site:** County Hospital Accident and Emergency, Surgical Emergency Admission Unit and Waddington Ward	Level II	Assurance re Infection Prevention & Control	South Lincolnshire CCG	**Findings on visit against criterion 2 & 8** **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.** **A&E** – Uniform policy was being adhered to. Commodes inspected were clean and the sluice tidy. Generally there were no issues identified during the visit of any concern. **Surgical Equipment Assesment Unit** – Staff stated the nurses station was cleaned by night staff each shift. Moving the PCs/monitors revealed very large amounts of dust the length of the back of the nurses station which would have taken several days to build up. Drip stand in store room found dirty to under surface of base. In a clinical room there was an orange bag in the bin, this colour is for infectious clinical waste and the contents were various paper products. **Waddington Ward** – Toilet seat raiser had a green is clean sticker from 7 days previously, although clean to the eye, these items should be cleaned at least once daily and after each use. Two IV giving sets had been disconnected from the patient and left hanging on dripstands at the side of the beds. Intermittent infusions should be either left connected or disposed of after each use. Five dripstands were inspected all were found dirty to the under surface of the base. Several Greasby pumps were also found dirty, some had green is clean stickers in situ, the names of the persons who signed these were given to nurse in charge on

					nights to action with Sister. The manual sphygmomanometer cuff holder had high levels of dust inside and the feed pump which was also stored in this holder had obvious feed drips on its sides. There were high levels of dust to the floor edges of the room. On inspection of the stock there were numerous examples of out of date items. Emergency trolley was dirty and dusty to top. In each area of the ward the waste bins had been pushed so far back to the wall that they were actually raised off the floor, rendering the foot pedal inoperable. This was also damaging the fabric of the walls with chips to plaster and paintwork evident. Shower curtain and tray were noted to have brown staining. Two commodes were found dirty, one with substantial blood droplets to the under surface. Neither had green is clean sticker attached. 2 x sharps bins were open i.e semi-closure mechanism not being used. The floor at the back of the fridge was dusty. Underneath the step used to house sharps bins was dusty with a vial of medication and plastic twist caps were also on the floor in this area. Checking the storage drawers revealed two instruments which had both been sterilised several years previously, one of these also had a tear to the packet. **Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.** **A&E** – There were two episodes of inappropriate use of PPE (Housekeeper emptying bins not wearing apron and porter washing down trolley not wearing apron). Uniform policy was being adhered to. **Surgical Equipment Assessment Unit** – There did not seem to be an understanding of: *"the nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout a shift"* Health & Social Care Act (2008) Criterion 2, this was being interpreted as nurse in charge responsible for the physical act of cleaning. There were several occasions witnessed when activities which required apron and gloves e.g. bed washing, waste handling were undertaken by staff only wearing gloves. Hand hygiene was not performed immediately on removal. In one case items were searched for at nurses station prior to hand hygiene with obvious potential for multiple surface contamination. There were high levels of dust and debris behind the fridge. There was dust and debris on worktop behind hypo box. Commodes all clean and labelled appropriately. Sharps bins were located on the floor and there was no use of the temporary closure mechanism **Waddington Ward** – Staff were welcoming and apart from one student who had a long ponytail dangling down her back and a staff nurse with stoned earrings, not adhering to uniform policy.
08.07.14	Peterborough and Stamford Hospitals Foundation Trust	Level II	Assurance re Infection Prevention &	South Lincolnshire CCG	**Positive Factors** • PSHFT is currently above the national average for urinary catheter insertion rates and Some clinicians are recording both electronically and on paper based systems whereas others are using either one or the other.

			Control and assurance re catheter management		• For all of the catheters checked, there were complete daily monitoring charts in place. **Areas for further improvement** • There seemed to be some information missing for some patients mostly in relation to reasons for insertion this is being looked into • In relation to the environment, some key issues were noted and the organisation is aware of the findings.
30.07.14	Lincolnshire Community Health Sservices **Site:** Louth Hospital	Level II	Infection Prevention & Control	South Lincolnshire CCG Lincolnshire East CCG	**Areas for further improvement** • Wide scale inappropriate use of orange 'infectious waste' sacks on Louth Hospital site. • Planned refurbishments are scheduled for 2015 on Carlton and Manby Wards, but not planned in the Urgent Care Centre.
11.08.14	Lincolnshire Community Health Services **Site:** SE Respiratory Service	Level I	15 Steps challenge review	South Lincolnshire CCG Lincolnshire East CCG Lincolnshire Community Health Services Non Executive Director	**Positive Factors** • Good use of patient surveys to try to reduce the number of patients not attending appointments • The team were extremely positive and passionate about their service. They had an excellent understanding of the risks and appeared confident to escalate concerns when appropriate. **Areas for further improvement** • The nurses felt they would like the opportunity to support the TB nurse service. Team to consider 7 day working
26.08.14	Lincolnshire Community Health Services **Site:** Skegness Hospital	Level II	Infection Prevention & Control	South Lincolnshire CCG East Lincolnshire CCG	**Areas for further improvement** • Some general cleanliness issues were noted at this site. It was noted that the Matron has responsibility for Louth and Skegness with a consequence of reduced time on each site. • The Infection Prevention and Control presence is also reduced with only 1 visit every 2 weeks
19.09.14	**Lincolnshire Community Health Services** Johnson Hospital **Site:** Welland ward	Level II	Assurance re safety thermometer pressure area	South Lincolnshire CCG East	**Positive Factors** • The ward sister identified they were making good progress against the on-going action plan • Care of the deteriorating patient had been addressed in the previous action plan and the ward sister is regularly auditing compliance against the NEWS monitoring tool • A newly appointed advanced nurse practitioner now works Monday – Friday to support the

			care and VTE prevention	Lincolnshire CCG	medical staff with prescribing and patient assessments • A medical ward round takes place at 12.30 Monday – Friday by 2 general practitioners • All patient bays are deep cleaned weekly • There is a health care support worker folder in use promoting better continuity of care • Newly appointed band 7 who is enthusiastic and motivated to support improvement and drive change . **Areas for further improvement** • The ward sister identified they were making good progress against the on-going action plan • Care of the deteriorating patient had been addressed in the previous action plan and the ward sister is regularly auditing compliance against the NEWS monitoring tool • A newly appointed advanced nurse practitioner now works Monday – Friday to support the medical staff with prescribing and patient assessments • A medical ward round takes place at 12.30 Monday – Friday by 2 general practitioners • All patient bays are deep cleaned weekly • There is a health care support worker folder in use promoting better continuity of care • Newly appointed band 7 who is enthusiastic and motivated to support improvement and drive change
21.09.14	United Lincolnshire Hospitals Trust **Site:** Pilgrim Wards 5A & 9A	Level ll	Assurance re Infection Prevention & Control	South Lincolnshire CCG West Lincolnshire CCG	**Findings on visit against criterion 2 & 6** **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.** 5A – There were no major issues identified during the visit. 9A – There was no domestic waste bin, the only bag being tiger stripe; as a result hand towels were being disposed of in the wrong waste stream. There should be no clinical waste, infected or otherwise, being disposed of in a clinical room. The tote boxes on the shelves had high levels of dust on the moulded edges. There were 26 syringe fillers found out of date in the storage bins. Three sharps trays were found on the shelves dirty. Three vials of flucloxicillin were found loose in a plastic box on top of one of the cupboards. The back of the worktop was dusty with obvious debris. The worktop underneath the medicines fridge was extremely dusty (cross to indicate depth of dust found) **Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.** 9A – Waste management; this was particularly problematic with high use of the blue pharmaceutical plastic bins as sharps bins. Staff were disconnecting needles from syringes and then using the wrong colour bins for disposal of these. Notices on the window for staff to follow had incorrect information typed onto them, this notice had been created at ward level, it was not from facilities.

2014 to 2016 Commissioning Priorities - Progress

During 13/14 patients told us the things important to them:

- Preventative services
- Care delivered locally
- Patients seen quickly
- People encouraged to take responsibility for their own health
- Make communication between organisations better
- Treat patients with compassion and support them and staff to get involved

This informed our commissioning priorities for the following two years SLCCG continues to take these forward and improvements have already been seen in areas such as;

- Revising pathways of care to support care close to home –Peterborough Hospitals now provide chemotherapy in Spalding Community Hospital saving patients and their carers travel.
- Movement to best practice in referral and patient management – SLCCG have continued to roll out Pathfinder tool and now look to improve usage across the CCG.
- Expansion of patient choice through Any Qualified Provider (AQP) where market conditions indicate this represents good value for money- AQPs have been successful and increased local provision has already started in ophthalmology, community surgical treatments and physiotherapy.
- Cancer Pathways review – Certain cancer pathway are being reviewed to make sure the reliance upon hospital care is retained at a necessary minimum, whilst at the same time working to support the longer-term 'survivorship' work to support and empower patients and their families to feel more confident once their active cancer treatment has ended.
- Improving End of Life Care – As part of county-wide work, we are focusing on the palliative and end of life care that patients currently have to make sure the patient, their families/carers receive the right level of support to plan ahead more, when this is at all possible. When this is not possible, we are improving the communication and working relationships between our local services in our community to avoid any unnecessary delays to ensure our patient and carer experiences are as positive as possible.
- Improving patient access and experience for Mental Health and Learning Disabilities – SLCCG has secured Cantab mobile an app that is used in primary care to diagnose patients with dementia enabling patients and carers to proactively access support services and plan for future needs, recently commissioned dementia management support for Stamford neighbourhood team and looking to expand. A CAT car has been commissioned via EMAS. The car will respond to urgent calls received by the call centre for patients who have fallen but after assessment over the phone do not need hospital admission. The Car is staffed with a paramedic and Emergency Care Assistant who will attend the scene and provide a full assessment. They will also ensure that the patient is taken home or to a place of safety. If hospital attendance is needed the crew will call for an ambulance to convey the patient to hospital. Also a Triage car is currently in the pilot phase, managed by EMAS the car is staffed by a Mental Health Nurse and a paramedic. The car will respond to all urgent calls which do

not require an A&E admission. Early results show good rates of both diversion and outcomes which do not result in use of policy custody or admission to hospital. The Crisis Concordat Declaration has been written and signed up to by the main stakeholders. An action plan to support this is in development and will be published in March 2015. This is a whole community approach to Mental Health Care.

- Review of Diabetes services to improve community access. Following the patient involvement meetings of March 2014 and the internal review of Diabetes Services patients informed us they wanted local access to services; peer support and more education to self-manage. The implementation of Neighbourhood Teams will support in more localised services. In addition we have secured additional funding to run 4 interactive educational sessions to encourage innovative ways to manage diabetes, the sessions will cover various topic including dietary advise, physical activity and managing the condition.
- Review of pathways into acute care – Work continues on pathways with secondary and primary care clinicians taking the lead.

Other areas the CCG has progressed on during 2014/15 are:

- **ENT** – Procurement during 2014/15 has secured a minor ENT service bringing appropriate services into the community, creating better access for patients and carers.
- **IBS / IBM management** –Faecal Calprotectin testing for the diagnosis of IBS / IBS in order to reduce the requirement to send patients to secondary care for invasive diagnostic testing has been introduced
- **Stroke prevention** – Identification of patients with Atrial Fibrillation using GRASP –AF Tool is currently being rolled out across the CCG practices. Patients identified at risk of a stroke using a CHADS2 scoring system are then prescribed anti-coagulation to reduce the risk of a stroke.
- **Chronic Heart Failure management** – To increase the number of patients on Heart Failure Registers prescribed ACE Inhibitors to reduce hypertension. All South Lincolnshire CCG GP Practices were offered the opportunity of 'up skilling training' on the management of heart failure. 8 out of 15 practices participated in the training. The CCG are now in the process of rolling this training out to the rest of the practices.
- **Dementia Strategy** – Review of services to improve and increase support and levels of intervention for patients and carers. Key achievements in 2014 were the launch of the Cantab Mobile which is a tablet based application that can be used by any health care professional to help in the diagnosis of Dementia. The Delivery and Development Manager has also undertaken the Dementia Friends training and will become a Dementia Champion and will encourage others to participate in the Dementia Friends Scheme. The focus in 2015 will be working with GP Practices who are within the bottom quartile of screening rates to encourage them to utilise the tools that are available to screen patients for Dementia, therefore optimising their Dementia Diagnosis rates.

We aim to continue delivery of NHS national frameworks, constitution, JSNA and H&WB strategies. SLCCG remain focused on the five domains below, the schemes that are delivering effective outcomes, started in 2013 will continue throughout 2015/16 regularly reviewed and where required altered to deliver the local populations needs.

Domain	Title	Further information	Updates / things done
Domain 1	Preventing People from dying prematurely	Early diagnosis Improving early management in community settings Improving acute services and treatment Preventing recurrence after an acute event	Cantab Mobile – identifying dementia early Support for patients and carers commissioned through neighbourhood team
Domain 2:	Enhancing quality of life for people with long-term conditions	Improvements in primary care Putting patients in charge and giving them ownership of care Co-ordination and continuity of care	Neighbourhood teams being rolled out across CCG, high risk patients identified by GPs, assessed by MDTs and patients having care plans discussed with their practices
Domain 3:	Helping people to recover from episodes of ill-health or following injury	Avoidable admissions to hospital need to be addressed Right support at the right time Effective joined up working between secondary and primary care High quality care and efficient care for people in hospital Co-ordinate care and support for people following discharge from hospital	Neighbourhood teams linking with assertive in reach teams, commissioned by CCG, to get patients out of hospital quickly and receive the community support needed to stay at home. Additional funding for independent living team to assist the above. Increased funding for rapid response teams to avoid unnecessary admissions and increased GP support in the community supporting patients in intermediate care. Joint meetings to review and improve pathways are held monthly between PSHFT, SLCCG GPs and C&PCCGs
Domain 4:	Ensuring People have a positive experience of care	Rapid comparable feedback on the experience of patients and carers Building capacity and capability in both providers and commissioners to act on feedback Assess the experience of people who receive care and treatment from a range of providers in a co-	Patient experience is gathered from a number of sources; direct from patients; Healthwatch; online; PPGs and the Cluster PPG and these are reported through PPIC. This enables us to look for trends and seek more information on specific areas and escalate to QPEC for action. Some

		ordinated package	successes this year have included identifying the need for a Carer's CQUIN and identifying delays in outpatient GP letters and resolution has been sought for both.
Domain 5	Treatment and caring for people in a safe environment and protecting them from avoidable harm	Reducing the incidence of avoidable harm Improving the safety of maternity services Delivering safe care to children in acute settings Patient safety incident reporting	Movement of maternity services for Welland patients to be provided by one Trust to stop fragmentation of service is being planned to start April 2015.

For the latest position with regards to performance for the CCG on the 5 domains please follow the below link:

http://southlincolnshireccg.nhs.uk/key-documents/cat_view/14-key-documents/16-governing-body-meetings

Key actions in which the CCG are working on for the Outcomes Framework where performance is below the standard are as follows:

Potential Years of Life Lost – The CCG are working with the local Public Health England Team to analyse the performance of this standard against the 5 year trajectories set and recovery actions/rates will be agreed if and where appropriate.

Mortality Rates including Respiratory Conditions– Public Health England along with CCG Clinical members of the Governing Body have conducted data analysis in order to identify and trends in data which may explain the deterioration in performance. The first round of analysis has shown no trends. Public Health are now looking at the data in more detail particularly looking at deaths from specific diseases, particularly within the CVD umbrella. The local Public Health team have confirmed that numbers are fairly small, particularly from respiratory disease and at practice level. Public Health's initial view is that the deterioration in performance is due to multiple components and there are large variations between practice performance. Public Health are currently gaining commitment to use the principles of Making Every Contact Count to provide meaningful brief lifestyle interventions so we support patients to live healthier lives and contribute to the prevention agenda. This needs to be done in conjunction with commissioning lifestyle services such as stop smoking services and weight management. The aim is to find patients with undiagnosed disease and those who are at increased risk (which we will do using NHS Health Checks); and then optimise the management of those who have been diagnosed with for example heart disease, diabetes and CKD. Interventions that the CCG have put into place to tackle some of the above issues are the GRASP AF tool and the IMPAKT tool for CKD. It is hoped that this will in the short term improve performance.

CVD – The CCG are currently working within GP practices to increase practice use of GRASP AF tools and clinical management training. This will reduce the risk of stroke and/or death from heart failure. For prevalence numbers please see appendix 1. This will result in 31 less strokes as well as a reduction in elective and non-elective procedures. Using the information from Commissioning for Value Packs targeting quality improvement and high cost spend.

The CCG has chosen to focus on Cardio Vascular Disease in terms of commissioning for prevention. This is the disease area which makes the greatest contribution to the CCG's Potential Years of Life Lost and Under 75 mortality rates. In terms of the steps highlighted in the Commissioning for Prevention Call to Action (Appendix 6), the CCG is working towards the mature scenario detailed on page 13 of the A Call to Action: Commissioning for Prevention document and in some specific areas, is operating at that level.

The CCG has continued with the local priority measure to reduce the Under 75 mortality rate to the England level or below. In 2013/14 the standard for South Lincolnshire CCG for CVD mortality rates was 73.2 DSR per 100,000. During that year the CCG reduced to 66.80. In 2013, the South Lincolnshire U75 mortality rate from Cardio Vascular Disease (DSR) standard was 73.2/100,000 registered patients. The CCG achieved 66.8. Analysis of data locally and through the East Midlands Cardio Vascular Disease Strategic Clinical Network has identified a number of areas where specific initiatives such as the GRASP AF tool and the IMPAKT Chronic Kidney Disease tool has been implemented to provide an opportunity to contribute significantly to this priority and these are in the process of being implemented.

Long Term Conditions –The current long term conditions that the practices are working on are Cardiovascular Disease; including heart failure and atrial-fibrillation, Chronic Kidney Disease including acute kidney injury and diabetes. A one to one working programme of action for all South Lincs GP's is currently being developed to support them with early identification of patients at risk, better management of onset long term conditions and adopting best clinical practice. The CCG has adopted the IMPAKT tool which has been implemented across all GP practices and this will improve the identification and management of CKD patients. This will introduce clinical best practice of onset CKD and a slowdown of progression to end stage renal failure.

Cancer –All Lincolnshire CCGs will view cancer as a long term condition and ensure patients are not disadvantaged as a result. The work streams needed to successfully deliver on improving outcomes are outlined in the 2014-16 Cancer Operational Plan (Appendix 3):

- Primary care
- Acute care
- Sub-acute care
- Neighbourhood care

Lincolnshire CCGs will work to reduce the number of 'premature' deaths (under 75 years old) in the 'key' tumour sites where CCGs appear higher than the national average:

- Malignant melanoma
- Oesophageal
- Prostate

Proportion of people feeling supported to manage their condition – As part of the LHAC work the CCG has established 2 Neighbourhood Teams and identified and will roll out to a total of 6 Neighbourhood Teams across the South Lincolnshire CCG area. The Neighbourhood Teams will bring together the health and social care organisations on a regular basis to identify and put in place whole system care plans for vulnerable patients.

Diagnosis of people with Dementia – SLCCG have implemented the cantab mobile tool to assist with early diagnosis of Dementia and are encouraging practices to utilise the dementia quality site. Progress reports are taken to Governing Body and Clinical Committee meetings each month. Dementia friend training has been completed by some officers and we are looking to have a dementia champion which will then be rolled out across the CCG.

Emergency admissions for acute conditions that should not usually require hospital admission – The CCG are currently working with Public Health and have identified key areas of work. The CCG will continue to work with Public Health England to develop an action plan and this will then be taken to GP Practices. This work will be completed by August 15.

PROMs – PROMs are included within the Quality Schedule and providers are monitored on PROMs performance and are asked for reports where performance is poor.

GP out of Hours – A highlight report of GP Patient Survey Report has been developed and has been taken to Governing Body. Actions are being developed where appropriate.

A target to increase patient satisfaction has been submitted within the first draft of the unify template submission for GP in Hours services. See Appendix 2.

FFT – The CCG incentivise participation and improvements via the national CQUIN and use the Quality Schedule to monitor performance.

Patient Safety Incident Reporting – This standard is a CQUIN for 15/16. The CCG work closely with the provider in relation to reporting of patient safety incidents and will liaise with the provider to determine any underlying reasons for reported safety incidents appearing the be below the baseline. The CCG has signed up to the 'Sign up to Safety Campaign' and has made organisational pledges as part of this. The organisation is active member of the East Midlands Academic Health Science Network Patient Safety Collaborative.

MRSA/CDIFF – The CCG employ a Head of Infection, Prevention and Control who's role is part of the federated quality function. The Head of Infection Prevention and Control works closely with providers to monitor HCAI incidents to proactively prevent occurrences and ensure that full RCA's are undertaken when incidences occur.

Pressure Ulcers – The CCG uses the National Safety Thermometer CQUIN to incentivise a reduction in pressure ulcers in community and acute settings. Pressure ulcers are also monitored in the quality schedule of providers.

Constitutional Rights and Pledges

Below is the latest performance dashboard for the NHS Constitutional Standards:

Indicator	Description	Baseline Period	Baseline	Standard/ Target	Lower Threshold	Latest Period	Latest Data	YTD	Trend
EB1	RTT - Admitted Patients	2013/14	91.0%	90%	85%	Jan-15	88.6%	88.3%	⇧
EB2	RTT - Non-Admitted Patients	2013/14	96.5%	95%	90%	Jan-15	94.4%	95.4%	⇩
EB3	RTT - Incomplete Pathways	2013/14	96.3%	92%	87%	Jan-15	94.4%	94.4%	⇧
EB4	Diagnostic Test Waiting Time	2013/14	99.7%	99%	94%	Jan-15	99.1%	99.4%	⇩
EB5	A&E Waiting Time - % of people who spend 4 hours or less in A&E	2013/14	94.9%	95%	90%	Jan-15	85.5%	91.2%	⇩
EB6	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent GP referral for suspected cancer	2013/14	96.3%	93%	88%	Dec-14	94.9%	94.7%	⇔
EB7	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2013/14	92.6%	93%	88%	Dec-14	90.9%	91.6%	⇩
EB8	Cancer 31 Day Waits - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2013/14	98.2%	96%	91%	Dec-14	100.0%	98.0%	⇧
EB9	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2013/14	96.6%	94%	89%	Dec-14	94.7%	97.0%	⇩
EB10	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is an anti cancer drug regimen	2013/14	100.0%	98%	93%	Dec-14	100.0%	100.0%	⇔
EB11	Cancer 31 Day Waits - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2013/14	97.5%	94%	89%	Dec-14	93.8%	96.8%	⇩
EB12	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2013/14	86.2%	85%	80%	Dec-14	94.3%	82.6%	⇧
EB13	Cancer 62 Day Waits - % of patient receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2013/14	88.9%	90%	85%	Dec-14	100.0%	98.4%	⇧
EB14	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2013/14	100.0%	100%		Dec-14	100.0%	100.0%	⇔
EB15 i	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time (EMAS)	2013/14	71.3%	75%	70%	Jan-15	68.6%	71.8%	⇩
EB15 ii	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time (EMAS)	2013/14	71.5%	75%	70%	Jan-15	65.2%	70.5%	⇩
EB16	Ambulance Clinical Quality - Category A 19 minute transportation time (EMAS)	2013/14	93.8%	95%	90%	Jan-15	90.5%	92.9%	⇧
EB15 i	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time (CCG)	2013/14	61.4%	75%	70%	Jan-15	69.8%	63.8%	⇧
EB15 ii	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time (CCG)	2013/14	63.8%	75%	70%	Jan-15	60.6%	63.8%	⇩
EB16	Ambulance Clinical Quality - Category A 19 minute transportation time (CCG)	2013/14	86.0%	95%	90%	Jan-15	84.9%	85.3%	⇩

Every One Counts Supporting Measures are below:

Indicator	Description	Baseline Period	Baseline	Standard/ Target	Lower Threshold	Latest Period	Latest Data	YTD	Trend
EBS1	Mixed Sex Accommodation (MSA) Breaches	2013/14	8	Zero Tolerance	NA	Jan-15	0	1	⇔
EBS2	Cancelled Operations - % of patients not re-admitted within 28 days (PSHFT)	2013/14	13.9%	0%	NA	Q3	4.7%	14.0%	⇧
EBS3	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	2013/14	99.0%	95%	90%	Q3	100.0%	96.5%	⇧
EBS4	Number of 52 week Referral to Treatment Pathways	2013/14	1	Zero Tolerance	NA	Jan-15	0	2	⇔
EBS5	Trolley waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (PSHFT)	2013/14	0	Zero Tolerance	NA	Jan-15	0	0	⇔
EBS6	Urgent operations cancelled for a second time (PSHFT)	2013/14	0	Zero Tolerance	NA	Jan-15	0	0	⇔
EBS7 i	Ambulance handover time - Number of handover delays of over 30 minutes (Peterborough City Hospital)	2013/14	360	Zero Tolerance	NA	Jan-15	130	894	⇩
EBS7 ii	Ambulance handover time - Number of handover delays of over 1 hour (Peterborough City Hospital)	2013/14	23	Zero Tolerance	NA	Jan-15	20	119	⇧

Trend Key: ⇔= Little or no change, ⇧= Improvement, ⇩= Deterioration

For a full update and narrative for areas below the standard please see the Board Report using the following link: http://southlincolnshireccg.nhs.uk/our-governing-body/governing-body-papers?view=docman

Whilst ensuring delivery of the NHS Constitutional rights identified during 2014/15 some high priority areas of poor performance have required direct attention in partnership with Peterborough and Stamford Hospitals NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust. These are:

- **Cancer services** : Future work with ULHT will continue to concentrate on the various tumour site pathways and their contribution toward the overall sustained improvements to deliver the mandated 14, 31 and 62 day treatment standards (including application of national guidance and best practice (i.e. cancer drugs fund and chemotherapy protocols) and also prevention initiatives through the cancer screening programmes (breast, bowel and cervical) and Early Presentation of Cancer (EPOC) development team. This pathway specific work will deliver and aim to sustain the improvements in current levels of delivery for these standards.
- **EMAS** – SL CCG have a number of schemes in place in order to improve EMAS performance at a South Lincolnshire level; these are EMAS CAT car, EMAS Mental Health Car, Amvail Crew. SL CCG has met with EMAS to discuss further initiatives which could be implemented to improve performance. We are currently awaiting for business cases/proposals from EMAS. There is also a ring fenced ambulance crew operating within the South Lincolnshire area along with the pilot scheme involving the fire and rescue service.
- **Stroke services**: through health checks, rapid access to Transient Ischemic Attack (TIA) clinics, hyper acute stroke assessment and treatment in Boston and Lincoln with dedicated stroke wards and early assisted discharge to ensure services are fully implemented and delivering better outcomes for the people of Lincolnshire. The Executive Nurse and a SLCCG GP visited PSHFT to review the stroke pathway and a quality assurance visit report was

produced following this detailing any areas for improvement. The SLCCG Performance Manager has also completed Sentinel Stroke National Audit Programme (SNAP) and collated the results of main providers into a report which went to Clinical Committee.

- **Health care acquired infection:** The CCG's federated Infection Prevention and Control Team have developed an action plan detailing the specific assurance elements pertaining to reduction of HCAIs using the 10 criterion detailed within the Health and Social Care Act (2012) Code of Practice on the prevention and control of infections and related guidance. The action plan is split down between providers and this is monitored on a monthly basis with progress reports produced and sent to the CCG monthly.
- A programme of planned visits is scheduled with all providers in relation to the 10 criteria and Infection Prevention and Control. Responsive visits are also implemented whenever needed.
- The CCG Infection Prevention and Control function has provided numerous full day training sessions to Primary Care and commissioned providers. Since March 2014, there have been 6 full day sessions delivered with 5 more planned in quarter 4 2014/15. This effectively enables practices and providers to have dedicated Infection Prevention and Control Link Champions within their own environment to raise standards and support colleagues.
- Ongoing work is being completed to eradicate MRSA and CDIFF wherever possible. All cases of MRSA and CDIFF are subject the RCA and thorough investigation in conjunction with providers and clinical teams.
- **Mixed sex accommodation:** to complete the progress towards the elimination of mixed sex accommodation
- **A and E waiting :** Working with system resilience groups to improve patient flow by increasing integration with primary care services, improving access to primary care and working with the provider of the 111 service to continue to reduce demand and improve the patient experience. Development of Neighbourhood Teams and implementation of further community schemes to support PSHFT to achieve the A&E 4 hour wait standard.
- **Cancelled Operations –** SL CCG are monitoring provider's cancellation rates and this performance is linked to the wider system performance issues which are addressed via the SRG's for both Lincolnshire and Peterborough. SLCCG have also commissioned a dedicated Assertive In Reach Team (AIR's) to ensure the timely discharge of patients and reduce delayed transfers of care (DTOC's) which increases flow within the hospital therefore creating capacity.
- **Ambulance Handover –** Performance is monitored by SL CCG and also via SRG's for both the Lincolnshire and Peterborough System. The CCG actively work with EMAS and the Trust to improve handover performance and have funded the implementation of inbound screens which are currently being implemented. EMAS are invited to attend both SRG's and again would feedback any issues for action.
- **18 week referral to treatment waiting**: building on the steady improvements in reduced waiting lists and improving access the ambition is to not only deliver but surpass national standards. To maintain the momentum of the recent Operational Resilience work which has recently been completed in order to reduce backlogs.

Attention will be maintained throughout 2015/16 with a view to going beyond what is 'acceptable' to further develop and sustain high quality services. The constant review of the recovery plans and trajectories will ensure delivery of the national quality standards.

Finance

Delivery of the Financial Position in 2014/15

The CCG is forecast to deliver its planned surplus of £1.9m in 2014/15. This has required the management of a number of risks including additional pressures arising from unexpectedly high activity levels.. This pressure has been managed in year through the reprioritisation of expenditure plans and the non-recurrent application of contingencies. The 2015/16 financial plan addresses the financial pressures and makes allowance for the actual growth incurred.

5 year financial plan

Planning Assumptions

The CCG's financial plan complies with, and incorporates all of the suggested key metrics and assumptions within the national guidance; Everyone Counts: Planning for Patients 2014/15 to 2018/19. The key metrics delivered and the planning assumptions used are set out in the table below. In particular, the CCG's financial plan delivers a 1% surplus and at least a 1% risk adjusted surplus in each of the 5 years (based on recurrent, non-recurrent and running costs allocations). The CCG's underlying surplus exceeds 2% in each year.

Within the financial plans the CCG has used local assumptions on population growth. These are based on ONS projections but are informed by the demographic growth evident within GP practice populations. This has resulted in higher population growth than suggested by other sources. The financial plan incorporates tariff changes as highlighted in guidance. The two key areas of expenditure, GP prescribing and continuing health care, that have historically incurred additional growth (above demographic growth) have also been uplifted by 4% and 2% respectively each year.

	2014/15	2015/16	2016/17	2017/18	2018/19
Key Metrics	**%**	**%**	**%**	**%**	**%**
Allocation Growth	**2.56**	**1.96**	**2.09**	**2.09**	**2.56**
Surplus	**1**	**1**	**1**	**1**	**1**
Underlying surplus	**3.11**	**2.25**	**2.58**	**3.62**	**4.96**
Non recurrent headroom	**2.0**	**1**	**1**	**1**	**1**
Contingency held	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
Planned QIPP	**2.1**	**1.93**	**1.0**	**1.0**	**1.0**
Uplift Assumptions					
Health Cost Inflation – acute	**2.5**	**2.9**	**4.4**	**3.4**	**3.3**
Health cost Inflation – non acute	**2.8**	**3.1**	**4.6**	**3.6**	**3.5**
Provider sector efficiency	**-4**	**-4**	**-4**	**-4**	**-4**
Demographic growth	**1.82**	**1.72**	**1.65**	**1.59**	**1.53**
Prescribing growth	**4**	**4**	**4**	**4**	**4**
Continuing Health Care Growth	**2**	**2**	**2**	**2**	**2**

Non Recurrent Funds

The business rules set within planning guidance require CCGs to invest funds from a number of non-recurrent sources. These include the establishment of a fund for headroom and funds recovered from providers for the financial consequences of the Marginal Rate Emergency Tariff (MRET) and unavoidable readmissions. The CCG's financial plan provides for these sums in full and sets out the key areas where it is expected that these sums will be reinvested.

Non recurrent headroom

In 2015/16 the CCG's financial plan provides for 1% non-recurrent expenditure. Of this, £1.2m is required to fund the national continuing healthcare risk pool. The remaining balance is required for transformation and the CCG has committed the total of this sum to supporting the implementation of the Lincolnshire Sustainable Services Review. Specifically, this is expected to be invested to meet the double-running costs likely to be incurred by providers whilst the service changes associated with the review are established.

MRET and Readmissions

The CCG has provided in full within its 5 year plan for the sums withheld from providers in relation to MRET and readmissions. The sums are withheld non-recurrently although since the establishment of MRET funds have been applied to fund schemes designed to reduce emergency admissions and avoid readmissions. Where these schemes have been deemed to be successful the plan assumes that they will be continued and the relevant sums be reinvested

Better Care Fund

In 2015/16 the Better Care Fund will be established. The CCG's financial plan identifies the additional resources received and also sets aside the required expenditure element of its allocation. (£3.087m and £9.810m respectively in 2015/16).

The BCF presents a real opportunity for efficiencies to be delivered through integration and the Lincolnshire CCGs are working closely with the Council to maximise those opportunities. As a result the CCG is contributing an additional £12.5m of services and resource into the fund over and above the minimum level set out. These additional resources represent current expenditure levels associated with mental health services where it is believed that integration and the pooling of resources can derive real benefits for patients together with financial efficiencies.

Risks

The CCG recognises that there are a number of risks inherent within its plans. These largely relate to the risks of activity exceeding the expected and contracted for levels. There are also risks that the QIPP programme fails to deliver the expected financial efficiencies. Risks also exist in areas where growth has historically been seen such as in continuing health care and prescribing. The CCG has endeavoured to ensure that the financial plan includes the financial impact of all likely financial impacts however a level of uncertainty must remain. To mitigate this, the CCG has established a contingency reserve of 0.5% in each of the 5 years. The CCG's programme management approach to QIPP will also identify at an early stage any schemes that are not delivering so that remedial action can be taken.

Overview of QIPP schemes

In 2014/15 the CCG is forecast to under deliver on its overall QIPP target by £375k. For the remainder of the QIPP programme some schemes did not deliver as planned, others were scaled up and new schemes were implemented to compensate. The impact of the under delivery means that the overall QIPP challenge in 2015/16 has been reassessed to approximately 2% of the CCG's resource limit which equates to circa £4m. Thereafter the CCG plans to deliver 1% QIPP in each financial year, largely through the benefits offered through the LSSR.
There are a large number of schemes that contribute to the overall QIPP programme and these are in differing stages of development however, fully worked up plans deliver 75% of the overall target. The CCG has used the information provided within the Better Value packs to identify the remaining areas on which to focus to ensure overall delivery of the target.
Delivery of QIPP remains an area of risk to the CCG as it exists in a health economy where its two main providers are financially challenged. Nevertheless, the CCG is working closely with those providers to identify areas where efficiencies can be driven out of the whole system rather than cost-shifting between providers and commissioners. From late 2014/15 the Lincolnshire Sustainable Services Review (LSSR) is expected to impact and this is a key strategy that will address the total financial challenge assessed to exist within the County. At this stage the full impact of LSSR has not been factored into plans however, the investment required to secure delivery has been identified as the main call on transformation funds set aside by the CCG in 2015/16.

The CCG has put in place a robust governance process around the development, implementation and monitoring of all service developments and improvement schemes including QIPP. Every potential scheme is developed in accordance with the CCG's business planning process and are initially scoped and prioritised at the CCG's Clinical Committee. Every QIPP scheme must be aligned to and contribute towards the CCG's overall strategic objectives and is signed off by the Governing Body. The overall delivery of the QIPP programme is monitored by the Governing Body.

Summary and Financial Sustainability

The 5 year financial plan supports the delivery of the CCG's strategic and operational intentions. It does this within the constraints of the resources available to it. The financial plan demonstrates how the CCG must direct its resources in the early years to identify and implement strategic change in order to deliver a sustainable financial position within the lifetime of the plan.
Key to the delivery of the plan are the QIPP schemes that will create service changes and deliver a model of care that is more efficient and better for patients. The Lincolnshire Strategic Services review will be a major driving force behind the redesign of services within Lincolnshire and its outcomes are expected to deliver significant reductions in acute care. The importance of the LSSR to the CCG's financial sustainability is reflected in the application of the majority of the transformation funding available within the financial plan to support its delivery and implementation.
In addition to this, South Lincolnshire CCG is mindful that the majority of its acute patient flows are to providers outside the county. Therefore, the CCG has identified further QIPP schemes that impact directly on its other major acute providers. Similarly, the investments funded from MRET and readmissions penalties are applied to schemes that impact on all providers accessed by the CCG's population.
Achievement of the QIPP targets in previous years and in 2015/16 provide the financial capacity to support the establishment of the BCF in 2015/16. The BCF will then be used to facilitate further efficiencies within the health and social care sectors through the closer integration of services.
The BCF and the LSSR provide the two key mechanisms through which to deliver the strategic change necessary to ensure the longer term financial sustainability of the CCG as well as the wider Lincolnshire health economy. The LSSR will identify the necessary service changes while the BCF will

provide the vehicle through which those changes can be transacted.

Provider Commissioning Intentions

2015/16 Commissioning intentions have been sent out to providers and SLCCG are currently in negotiation with providers, where we are lead commissioners, to secure 2015/16 contracts.

Context

The Lincolnshire CCGs are, with local partners, currently implementing our five year strategic plans through the transformational Lincolnshire Health and Care Programme (LHAC). LHAC, and the delivery of sustainable health economy-wide improvements in service quality and efficiency, are the main contractual priorities for 2015/16.

The LHAC process will drive commissioner investment, disinvestment and cross sectional resource shifts on an on-going basis. Any material changes will be subject to the appropriate notice, engagement and consultation as required.

Principles

The overarching principles that CCG's intend to employ are as follows:

- The recurrent activity forecast outturn of the 2014/15 contract (once agreed), as revised for agreed recurrent CV's, shall serve as the baseline for 2015/16. In particular, the FYE of recurrent changes agreed for 2014/15 will be carried forward into 2015/16. Commissioners will expect to see the impact of national, non-recurrently funded activity initiatives undertaken during 2014/15 clearly removed from the baseline.

- The PbR Code of Conduct will apply at all times. Any provider proposed changes or corrections to counting or coding must be agreed in advance with commissioners and comply with national data definitions and information standards.

- For nationally priced services, payments above mandatory tariff will not be made except through local tariff modification applications supported by Monitor.

- Any provider proposed changes to non-mandatory tariff areas must be accompanied by robust minimum data set and subject to audit. In line with guidance we may seek to risk-share the impact of changes that have a significant financial impact.

- Improvements in data quality to support better patient care, demand and capacity planning, and resource utilisation are supported. However, improved coding and counting is not intended to lead to activity and cost inflation.

- Any proposed service changes must be supported by agreed clinical pathways and service specifications. This requires 12 months shadow monitoring and cost analysis. Providers should not initiate service developments unless these are formally requested or agreed by CCGs.

- The NHS Standard Contract mandatory terms and conditions will apply at all times. Where flexibility is permitted this will be agreed within contract negotiations and adhered to throughout.

- Commissioners will expect that national guidance and policy for the provision of data and information to enable the robust management of patients and services to be adhered to at all times.

- The Commissioners Prior Approval policy shall be adhered to at all times. The commissioners will not pay for treatments within this policy that have not received prior approval or met the clinical thresholds.

- CCGs will seek to implement, where relevant, the findings of any Payment by Results Annual Audit Report by the Audit Commission. Any changes required from this will be reflected in the recurrent starting position from 1 April 2015.

- CCG commissioning intentions are in advance of the publication of the National Outcome Framework (or its equivalent) and final CCG budget allocations for 2015/16. As such, these intentions are subject to change as and when this information is available.

- Final PbR guidance and tariff for 2015/16 are not yet available. Commissioning intentions, as stated, are based on 2014/15 information and are therefore subject to change as and when national guidance becomes available.

Consequent to the final two bullet points above, the CCG's reserve the right to bring forward other issues/proposals for discussion during negotiations.

Priorities

The commissioning intentions for 2015/16 will seek to embed and sustain the service improvements made during 2014/15 and include:

- An increased focus on health, wellbeing and fitness, health improvement and health checks

- Reducing Health inequalities

- Revising pathways of care to support care close to home

- Movement to best practice in referral and patient management

- Expansion of patient choice through Any Qualified Provider (AQP) where market conditions indicate this represents good value for money. In particular, South Lincolnshire CCG plan to continue implementing AQP operational guidance to the NHS extending patient choice of provider in the following areas:
    - Gynaecology diagnostic procedures
    - Cataract procedure
    - Expansion of minor ophthalmology treatments
    - Expansion of minor orthopaedic treatments

    - Expansion of podiatry treatments
    - Urology procedures

- Cancer Pathways review

- Improving End of Life care

- Continue to work with Peterborough & Stamford Hospitals Foundation Trust on the clinical strategy for Stamford

- Improving patient access and experience for Mental Health and Learning Disabilities

- Review of Diabetes services to improve community access

- Review of pathways into acute care

In addition to the above priorities the CCG will continue to focus on the following areas during 2015/16 with the aim of implementing service redesign and improvements:

- ENT – Bringing appropriate services into the community, creating better access for patients and carers.

- Dermatology – Develop primary care expertise via formal training in the diagnosis and treatment of dermatological conditions, in order that patients are not unnecessarily referred to hospital, including the assessment of the use of assistive technology to support this.

- Working with A8 Communities- This work stream is to provide better information, support and communication with the A8 communities to encourage appropriate use of the healthcare system improving quality of life for patients and carers.

- Stroke prevention - To identify patients with Atrial Fibrillation using GRASP – AF Tool. Patients identified at risk of a stroke using a CHADS2 scoring system are then prescribed anti-coagulation to reduce the risk of a stroke.

- Chronic Heart Failure management – To increase the number of patients on Heart Failure Registers prescribed ACE Inhibitors to reduce hypertension.

- Dementia Strategy – Review of services to improve and increase support and levels of intervention for patients and carers.

<u>30 Day Emergency Readmissions and Marginal Rate Emergency Threshold (MRET)</u>
CCGs await national guidance on the application of 30 Day Emergency Readmissions and MRET. We are expecting to manage these in line with national guidance and PbR Guidance for 2015/16.

<u>Contract value and unit cost of activity</u>
As stated in our intentions for 2014/15 CCGs will continue to progress plans to increase their investment in community and sub-acute healthcare services and to reduce their relative investment in acute services for 2015/16.

Appendix 1
CVD Prevalence

The prevalence of AF across South Lincolnshire is 3,164 (1.98%) the aim is to get to 3,195 (2.00%). If we can reach the target and treat 85% of those patients with anticoagulation we can prevent 31 strokes.

Appendix 2
Planning Document

GP – Patient Experience

(a) Satisfaction with the Quality of Consultation at a GP Practice –

The aggregated % of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice

Numerator ***% of patients who answered positively to at how good the doctor or nurse was:***

(1) At giving you enough time
(2) At listening to you
(3) At explaining tests and treatment
(4) At involving you indecisions about your care
(5) At treating you with care & concern

Denominator ***Total no. of patients responding to the questions***

Success ***Plans should show an annual improvement***

Planning assumptions

Targets have been set based on the average scores (%) of the last two GP Surveys and have been set to show an improvement based on the annual position.

Indicator - The Aggregated % of patients who gave positive answers to 5 selected questions in GP Survey about the Quality of appointments at the GP Practice	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Average from Last 2 Surveys	Target for 2015/16
% of patients who answered positively at how good the doctor or nurse was at:					
(1) Giving enough time	0.91	0.88	0.88	0.88	0.89
(2) Listening to you	0.92	0.89	0.88	0.89	0.89
(3) Explaining tests & treatments	0.90	0.88	0.87	0.87	0.88
(4) Involving you in decisions about your care	0.85	0.84	0.82	0.83	0.83
(5) Treating you with care & concern	0.90	0.87	0.86	0.86	0.87
Aggregate (Score out of 500)	448	435	432	433	436

The calculation for above is as follows: Survey data is at CCG level

Numerator:	***Denominator:***
Total number of "good" & "Fairly good" responses for each individual question	***Total number of responses at CCG Level (GP + Nurse) minus "doesn't apply" for each individual question***

(b) <u>Satisfaction with the Overall Care received at the Surgery</u> –

Patient satisfaction: Satisfaction with the overall care received at the surgery

Numerator	***No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of your GP surgery?***
Denominator	***No. of patients responding to the question "Overall, how would you describe your experience of your GP surgery?***
Success	***Annual improvement***

<u>Planning assumptions</u>

Targets have been set based the Jan-Mar 2014 & July – Sept 2014 Surgery and an uplift of 1%.

Satisfaction with the Overall Care received at the Surgery	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Prediction based on 1% uplift	No. of extra responses required
Numerator: No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of your GP surgery?	2403	2289	2221	2265	44
Denominator: No. of patients responding to the question "Overall, how would you describe your experience of your GP surgery?	2664	2609	2545	2545	
% of patients who gave positive answers to the Question	90%	88%	87%	89%	

(c) <u>Satisfaction with the Overall Care received at the Surgery</u> –

Patient satisfaction: Satisfaction with Accessing Primary Care

Numerator	***No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of making an appointment?***
Denominator	***No. of patients responding to the question "Overall, how would you describe your experience of making an appointment?***
Success	***Annual improvement***

<u>Planning assumptions</u>

Targets have been set based the Jan-Mar 2014 & July – Sept 2014 Surgery and an uplift of 1%.

S Lincs					
Satisfaction with Accessing Primary Care	Jan-Mar 13 and Jul-Sept 13	Jul -Sept 13 and Jan-Mar 14	Jan-Mar 2014 and Jul-Sept 2014 (data released 8/01/15)	Prediction based on 1% uplift	No. of extra responses required
Numerator: No. of patients who answered "very good" or "fairly good" to the question: Overall, how would you describe your experience of making an appointment?	2067	1931	1928	1947	19
Denominator: No. of patients responding to the question "Overall, how would you describe your experience of making an appointment	2625	2524	2478	2478	
% of patients who gave positive answers to the Question	79%	77%	78%	79%	

Appendix 3

Cancer Operational Plan

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Appendix 4

Dementia Trajectories

Practice	Dementia ES sign up	Cantab Sign up	"Gap" to ambition - updated Dec 14	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Abbeyview	Y	Y	18	41.1	44.4	45.2	44.76				
Beechfield	N	Y	51	38.5	41	43.6	43.04				
Bourne Galletly	Y	Y	3	64.2	63.6	65.3	67.02				
Deepings	N	N	66	38.5	41.5	42	47.14				
Gosberton	Y	Y	18	50.5	49.4	50.4	49.94				
Hereward	Y	N	0	69.4	67.9	70.6	72.85				
Littlebury	N	N	12	60.2	56.4	58.2	59.93				
Long Sutton	Y	Y	47	4308	44.5	50.6	50.67				
Moulton	N	Y	35	26.9	29.2	29.7	29.48				
Munro	Y	Y	0	69.8	71.1	72.3	71.94				
Pennygate	N	N	0	150	168	172.4	186.47				
Sutterton	Y	Y	21	28.3	29.2	29.5	29.36				
St Marys	Y	Y	0	63.3	65.4	68.5	70.77				
The Little Surgery	Y	Y	10	33.3	37.9	45.1	57.32				
The New Sheepmarket Surgery	N	Y	48	39.8	40.7	41.6	41.45				

Appendix 5

Dementia Report to Governing Body

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Appendix 6

A Call to Action: Commissioning for Prevention

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