NHS
North Lincolnshire
Clinical Commissioning Group

North Lincolnshire CCG

Operational Plan: 2016/17

Contents

1.0 Introduction

NHS 5 Year Forward View was published in 2014 and set out a five-year journey for the NHS. It described a future that should have more focus on prevention and public health; patients with greater control of their own care and a breakdown of barriers in how care is provided. To support this new Models of Care have been proposed that describe care delivered in a much more integrated way than currently delivered.

This narrative builds on the CCG's previous annual operational plans and our 5 year strategic plan 2014/15 to 2018/19 and reflects the next stage of our journey.

This document forms part of the North Lincolnshire CCG operational plan for 2016/17 and should be read in conjunction with the finance, activity, resilience, BCF, Transforming care and Primary Care Transformation Fund submissions.

This document represents the operational plan for NL CCG for 2016/17 and also forms year 1 of the Sustainability and Transformation Plan for 2016/17 – 2020-2021. The Sustainability and Transformation Plan builds on this North Lincolnshire plan and plans of the other CCGs within the STP footprint to provide a strategic plan over the larger footprint where collaborative working will enhance the overall system management and delivery. Work continues with the other footprint CCGs to complete a full gap analysis and further develop the STP by June 2016.

2.0 North Lincolnshire CCG's vision

North Lincolnshire health and care organisations have been developing the foundation blocks for our approach to population health management, and considering the implications within this for commissioning and contracting options. Our approach considers existing patient flows for secondary care, possible collaborative commissioning arrangements for elective and unplanned care and the definition of the services our population need access to both in the immediate locality and further afield. This work has resulted in a proposed new model of care which builds on the work already undertaken within Healthy Lives, Healthy Futures (HLHF) and addresses issues identified as part of the HLHF programme

These discussions have built the basis for workshops and agreements over the last month regarding our proposed new model of care. We have considered this model in the light of the inherent issues identified through the work of Healthy Lives, Healthy Futures, and the emerging evidence from national and international sites implementing new models of care. This has resulted in the agreement at Engine Room, Council of Members and Governing Body, and with Local Authority Officers, of our proposed new model of care and the description of the possible modes of delivery to service this model.

North Lincolnshire CCG has considered the models of care set out in NHS 5 Year Forward View (2014) and the emerging national and international evidence around them. NL CCG reflection is that none of these models fully take account of our direction of travel for integrated commissioning and integrated provision with our local authority, our commitment to North Lincolnshire as the 'place' around which our shared efforts across the public sector should be focussed, or align fully to our emerging Care Networks. However, the MCP model provides a sound basis on which to build our approach in combination with the concepts of Viable Smaller Hospitals and Acute Care Collaborative. We have therefore built on the principles of these models to create an approach that best fits our vision and aspiration for population health management through accountable care.

Our plan on a page for 2014/15-2018/19 (appendix 1) sets out our aspirations for the population of North Lincolnshire, agreed with all health and social care partners. The key tenets of this plan map well to the MCP approach to provision of accountable care.

North Lincolnshire CCG's strategic aims are to:

- Continue to improve the quality of services
- Reduce unwarranted variations in services
- Deliver the best outcomes for every patient
- Improve patient experience
- Reduce the inequalities gap in North Lincolnshire
-

The emergent evidence base suggests that the strategic aims above and our planned step changes again align well with an MCP approach as the foundation of our new model of care.

3.0 Meeting the constitutional standards

3.1 Referral to treatment times

NL CCG has failed to meet a number of constitutional targets during the year. This includes 18 week referral to treatment targets. This has not been met for incomplete pathways since September 2016 The main driver behind this indicator is the position locally at Northern Lincolnshire & Goole Foundation Trust (NL&GFT). Significant pressure specialties continue to be Orthopaedics, Ophthalmology and General Surgery. The Trust is undertaking root cause analysis on breaches and recovery actions are monitored through contract meetings. Dialogue with the Trust continues to ensure shared understanding of the reasons for breaches and the appropriate remedial action. The Trust has undertaken detailed work in relation to demand and capacity across specialities and discussions are underway in relation to its impact for contract activity levels and RTT performance as part of the contract negotiations.

3.2 Emergency care standard 4 hour wait

Achievement of the emergency care standard (A/E four hour waiting time) has been significantly challenged in 2015/16 and is now not achievable in 2015/16. The NL&GFT Trust has failed to meet the A/E waiting time target since October, and whilst this is only slightly lower than target, the Hull and East Yorkshire Hospitals Trust (HEYHT) performance also affects some North Lincolnshire patients.

Reasons for breaches differ at the two Trusts and the CCG is working with both Trusts to understand the trajectories for return to performance. The System Resilience group is well established and is responsible for monitoring and ensuring recovery actions are in place to provide resilience through the whole system. The SRG is working closely with the developing Urgent and Emergency Care Network to understand the required urgent care model going forward.

At this stage of contract negotiations, NL&GFT has set a trajectory to achieve the 4 hour target in quarter 1 and 2, but have currently stated that this will not be achieved in quarter 3 and quarter 4. This requires further exploration before CCG agreement to the trajectories. The System Resilience Group and operational group continue to work with NL&GFT and other providers to improve performance.

3.3 Diagnostics

The CCG breached the diagnostics standard in December 2015. This was caused by a breakdown of the CT scanner at Scunthorpe and the Trust being unable to source short notice capacity elsewhere. In all other months of 2015/2016 the performance has been very strong at between 0.1% and 0.4%. This position was also strong in 2014/2015.

The Trust has previously reported that there is a national problem obtaining additional capacity from mobile CT & MRI scanners, especially at short notice. Therefore, should similar breakdown issues arise again; this may impact on performance but is not expected to be a regular issue. At this stage of the contract negotiation the Trust have committed to meeting the standard throughout 2016/17.

3.4 Cancer

Two week waiting times for breast patients was breached in 2015/16; however the actual number of breaches are small. Feedback from the Trust is that often patients are referred but already are unable to accept an appointment in the 2 weeks e.g. holidays/personal choice etc.

Work is also underway with the commissioners to agree and roll out a leaflet that will be given to each patient by the GP when they are referred via a 2ww pathway (in order to try and reduce patient unavailability due to patient not always being aware of the referral urgency). Performance levels have improved in quarter 3, with only 1 patient breaching in December 2015.

Breaches of cancer –surgery 31 day subsequent treatments are small in number and relate to a mixture of capacity issues at HEY and/or complex diagnostic pathways from NL&GFT to HEYHT. Performance has improved in quarter 3, and linked to both the recovery plan at HEYHT and work on-going between the Trusts to improve waiting times for 62 day pathways we anticipate stronger and achieving performance in 2016/2017.

Breaches of 62 day cancer waiting times are again small in number relate to a mixture of capacity issues at HEYHT and/or complex diagnostic pathways from NL&GFT to HEYHT. Performance has improved in quarter 3, and linked to both the recovery plan at HEYHT and work on-going between the Trusts to improve waiting times for 62 day pathways we anticipate stronger and achieving performance in 2016/2017.

At this stage of the contract negotiation the Trust have committed to meeting the standards throughout 2016/17.

3.5 IAPT recovery rates

Whilst this performance was inconsistent in 2015/16, the recovery rate has now returned to planned levels and it is anticipated that this position will continue.

3.6 Dementia

The overall CCG position as of January 2016 was 63.2%. The practice level data is being reviewed to focus on those practices that still fall below the 67% target, with specific actions planned. It is expected that this will be achieved by quarter 3 2016/17 through targeted support to GP practices and reviewing our approach to support of people in care homes

3.7 Mental Health 6 Week Waits

The provider has confirmed that 6 week wait will be achieved and sustained in 2016/2017. Performance at December 2015 has only just fallen short of the 75%.

4.0 Activity assumptions within the plan

Analysis of initial activity plan submission identified discrepancies compared to NHS England assessment. The forecast outturn position provided by NHSE is approximately 3.4% lower than NL CCG calculated baseline, therefore after including demographic growth that % increases to 4.1% incorrectly.

The main reasons behind the variance in baselines are:

- The CCG plans are based on Month 8 forecast, NHSE is on Month 6 flex.
- The CCG makes adjustments for Medical Oncology that are different to NHSE
- The seasonal profile used to project is different

4.1 Key shifts in activity

The table on page 8 shows the initial submission waterfall and the amended version as per 02/03/16.

(i) Non-recurrent changes to activity; in the initial submission, the waterfall diagram showed no non-recurrent changes. In the second submission, this has been revised to show the baseline reconciliation. This is due to the pre-populated baseline being based on month 6 and as a result not reflecting the CCG forecast outturn. The month 9 position is much more closely aligned to the FOT.

(ii) Underlying trends in activity including demographic growth.

Growth has been applied across all providers at 0.94% in line with ONS values. In the second submission, this is shown more explicitly in the waterfall diagram. There has been a shift in elective activity out of NLAG during 2015/16, with some activity going to other providers. This is accounted for in the activity plan on the assumption that this shift continues during 2016/17. This shift in particular affects general surgery, urology, ophthalmology, gynaecology and general medicine.

(iii) Transformational change and QIPP initiatives. Our initial submission did not demonstrate the impact of transformational change on acute activity. Our plan and second submission assumes full year effect of the Better Care Fund schemes implemented in autumn 2015 and phased implementation of new schemes. This phasing has been agreed as part of the contract negotiation discussions and is based on best assessment of activity.

		CCG 15/16 Forecast outturn	**Non-recurrent activity changes** This column adjusts for differences in pre-populated forecast based on month 6 and NLCCG forecast.	**Underlying trend and demographic growth** To capture any additional activity as a result of changes in population and underlying changes in trend	**Transformational change** Apply the impact of transformation / allocated efficiency. To include for example: NCMs, UEC, RightCare, Prevention, Self-care and procedures of limited clinical value.	**Policy changes** To capture the impact of new policies, for example hospital 7 day services; primary care access, Cancer, Mental Health.	**16/17 Annual Plan**
E.M.2	Consultant Led First Outpatient Attendances (Total Activity)	51,307	75	327	-2381	0	49,328
E.M.3	Consultant Led Follow-Up Outpatient Attendances (Total Activity)	95,354	1347	822	-23327	0	74,196
E.M.4	Total Elective Admissions (Spells) (Total Activity) [Ordinary Electives + Daycases]	24,564	-719	217	-1646	0	22,416
E.M.5	Total Non-Elective Admissions (Spells) (Total Activity)	20,280	683	157	-2829	0	18,291
E.M.6	Total A&E Attendances	61,443	1433	244	-1354	0	61,766
Submission as per 02/03/16							
E.M.8	Consultant Led First Outpatient Attendances (Specific Acute)	50,265	-507	327	-2381	0	47,704
E.M.9	Consultant Led Follow-Up Outpatient Attendances (Specific Acute)	91,542	-158	817	-23327	0	68,874
E.M.10	Total Elective Admissions (Spells) (Specific Acute) [Ordinary Electives + Daycases]	24,459	-810	217	-1646	0	22,220
E.M.11	Total Non-Elective Admissions (Spells) (Specific Acute)	17,219	622	160	-2829	0	15,172
E.M.12	Total A&E Attendances excluding planned follow ups	61,289	1435	244	-1354	0	61,614

5.0 Addressing the national 'must-do's'

The table below summarises the CCG's current position against each of the nine national 'Must-do's' and describes the planned actions to address these.

National 'must-do'	NL CCG current position	Actions	Outcomes
Development of STP	The STP footprint has been proposed to NHS E as NL, NEL, Hull, East Riding, Vale of York and Scarborough CCG's through the CCG Chief Officers Collaborative. NL CCG has been working closely with NEL CCG, NLAG and local authorities on Healthy Lives, Healthy Futures- the sustainability programme for Northern Lincolnshire. In addition, NL CCG is working with partner CCGs in Doncaster, Rotherham and Sheffield to develop the Transforming Care plan. The STP will build on both of these plans and the Urgent and Emergency Care Network early plans to produce a robust STP by June 2016.	In conjunction with partner CCGs within the planning footprint, contribute to the development of the STP.	Single Sustainability and Transformation plan which reflects the specific and collective issues and priorities of the six CCGs and provides a strategic 5 year plan to deliver sustainable services across the larger footprint
Aggregate financial balance	NL CCG has currently submitted a balanced plan which complies fully with national	The CCG will ensure the minimum BCF contributions are delivered and	Delivery of required 1% surplus and 1% headroom in 16/17 and a 0.5%

	business rules. Contract discussions with providers continue. The CCG is finalising its QIPP plan to reflect the requirements within the finance plan.	agree a QIPP plan to deliver financial balance.	contingency. BCF plan in line with the BCF minimum expenditure target.
Develop and implement a plan to address the sustainability and quality of general practice	Initial strategy is being revised to reflect local priorities. The draft of this will be available by end of March 2016 Priorities include; workforce, sustainability and development of new models, estate, access, delivering primary care at scale and development of care networks. There are key cross cutting themes including quality, IM&T	Development of strategy	Agreed 5 year strategy to develop primary care
Achieve and maintain access standards for A/E and ambulance waits	Year to date position: Trust; 93.6% SGH: 93.1%, however SGH performance has been stronger than the overall position over Q3. Delivery of the A/E target remains a challenge locally as it does nationally. There has been high A/E attendance during the winter months, however the Trust expected to deliver on the 4 hr target during Q1 and Q2, recognising that Q3 and 4 remain challenging months subject to	On-going work with the acute Trust to achieve and maintain 4 hour standard including public communication plan, increased senior decision making capacity within the Trust to increase weekend discharges and improve patient flow, increased escalation bed capacity. This support will be	Delivery of 4 hour target Increase weekend discharges to 80% of those on a weekday

	increased demand due to seasonal factors EMAS Ambulance performance across all 3 standards is below threshold. A19 performance for the year will not be achieved.	evaluated in Spring 2016 as part of the System Resilience work plan Continue to work with EMAS to reduce conveyance rates. Commission pilot of a falls response service, utilising Fire and Rescue service capacity to provide an immediate response of clinically trained personnel and home safety checks	 Increased hear and treat and see and treat rates Reduction in conveyance for falls
Improvement and maintenance of referral to treatment standard	At month 9, the CCG is failing all RTT standards. The main driver for this is the local Acute Trust position with significant pressures in orthopaedics, ophthalmology and general surgery	Work with the acute Trust to understand the declining performance against the service demand using the capacity and demand tool. Ensure contracts reflect 15/16 patient flows which is to a wider range of providers than previously seen	Agreed contracts which reflect patient flows. Understanding for both commissioner and providers of the capacity required to deliver the plans
Delivery of 62 day cancer wait standard and	Performance during 2015/16 has been inconsistent, however the breaches relate to a	Continue to work with acute Trust to ensure remedial actions are	Consistent achievement of cancer waiting times targets

improve one year survival rates	small number of patients. Route-cause analysis process in place to identify actions required	implemented – monitored through the contracting route with assurance via the SRG	
Achieve and maintain 2 access standards for mental health, and achieve and maintain dementia diagnosis rates	Shadow monitoring in place, with formal monitoring from April 2016 Current performance: IAPT 18wk target; achieving 99.2%, IAPT 6 wk target: 70.9% in December- a reduction from 76.7% in November, due to high service demand in December. Recovery rate 68.1% in December. First episode of psychosis is currently achieving 100% seen within 2 weeks Dementia diagnosis: NL CCG achieved 63.2% as of January 2016.	Continue to work with provider to understand issues relating to delivery of targets and ensure robust monitoring and reporting in place. IAPT continues to perform well, although demand is high. Actions focus on reducing waiting list clearance time. The CCG will engage with Improvement Support Team for support on clearance times. The CCG will work with practices to provide targeted support to improve dementia diagnosis rates	Consistent delivery of waiting times targets to demonstrate good access to services People with dementia are diagnosed and offered support in a timely way
Transforming care for LD – enhanced community provision	The CCG is working with Doncaster, Rotherham and Sheffield CCG's as the Transforming Care footprint and is currently refining plans to gain	Implementation of action plan to ensure suitable local provision of services is available to further	People are cared for close to home where suitable services can be provided, reducing the number

	NHS E assurance. NLCCG currently has very low use of inpatient beds. The focus for the CCG and North Lincolnshire Council within the Transforming Care Plan is therefore to ensure maintenance of that position with a focus on community support	reduce number of people in inpatient beds where appropriate	managed as inpatients
Develop and implement affordable plan to improve quality	This forms a key part of the CCG's Operational plan and Healthy Lives Healthy Futures. The CCG will continue to work with organisations to understand the issues faced and those identified in CQC reports and other reviews and monitor implementation of resulting action plans through its Quality Group –a sub-group of the Governing Body. In relation to avoidable mortality the CCG has an agreed community mortality plan and is working closely with NL&GFT.	Continue to monitor and review the quality of commissioned services through its Quality Group and work with providers to seek assurance on quality issues. Established working arrangements in place to review causes of mortality. Work will continue to identify mortality themes and develop actions to address.	The CCG is assured on the quality of its commissioned services and has robust processes in place to monitor and respond to provider quality issues.
Hospital services meeting	Whilst there has been some progress locally in	Reassessment of current delivery	Patients receive consistent, high

4 priority clinical standards 7 day per week- Progress towards 7 day services: 25% of the population has access to acute hospital services 7 days per week and 20% has enhanced access to primary care.	developing services over 7 days, we do not fully meet the clinical standards across all acute services. There has been progress in improving access to diagnostics over 7 days and presence of senior decision makers over 7 days and timely consultant review. Primary care provision over 7 days is limited; however this is supported by GP out of hours services over evenings, weekends and bank holidays. The CCG is not currently planning to make a significant shift in year in the context of the sustainability plans.	against the 10 clinical standards Work in conjunction with NHS England to encourage uptake of extended hours enhanced service as part of the wider primary care development agenda	quality care 7 days per week.

6.0 Progress against 2015/16 plan

Life stage	2015/16 plan	Progress to date	Plan for 2016/17
Starting well/ Growing well	Midwifery service specification	Specification completed	Monitoring of KPIs
	Understanding the needs of children with long term conditions and their	This work in is progress	Completion of ELC programme and co-design of pathways for implementation in

	families using Experience Led Commissioning Approach (ELC)		spring 2016.
	Development of CAMHs transformation plan	Plan completed	Implementation of plan
Working well	Development of long term conditions pathways which reflect the views gathered through LTC ELC programme;	Respiratory procurement to commence in 2015/16 Diabetes model of care fully implemented Cardiology procurement to commence in 2015/16 Musculoskeletal procurement to commence in 2015/16 Neurological conditions Rheumatological conditions	Mobilisation of new provider of Community Respiratory services Mobilisation of new provider of community cardiology services Mobilisation of new provider of community MSK CATS service Work to commence in 2016/17. Evaluation of Community based Parkinson's Nurse role Work to commence in 2016/17
	Chronic wound care model	Development of service specification and business case.	Mobilisation of new model of care
	Develop model for tier 3 obesity services	Service commissioned by NL CCG from April 15. Monitoring of outcomes in place.	NL CCG to take responsibility for commissioning of Tier 4 services. Work to focus on integrating the pathways, evaluation of current Tier 3 service and re-procurement of Tier 3.

	Urgent care model	Model implemented, however not all benefits realised. Urgent and Emergency Care Network established and developing plans Model being reviewed against the urgent care standards	Continued monitoring and working with provider to ensure benefits are realised
	Systemic review of all suicides and develop strategies to reduce	The CCG and RDaSH jointly commissioned an independent review of inpatient mental health services – report approved by Governing Body. North Lincolnshire wide Suicide review group, of which NL CCG is a member, continues.	Independent review completed. CQC report published and RDaSH has developed a robust action plan in response. NL CCG to monitor implementation of plan
	Co-design mental health services for adults through the use of ELC programme	Implementation of action plan commenced	Full implementation of action plan and monitoring of impact
	Equity of access to IAPT services	Benchmarking completed. Performance generally good against waiting times and recovery, although demand is high. Clearance time is currently 10.9 weeks.	Exploring opportunity to request Improvement Support Team review and develop action plan.
	Communication and education regarding early detection of cancer	Training programme delivered to Primary Care staff continued. Appointment of Macmillan GP facilitator	Work programme for GP facilitators to continue. Awareness raising in conjunction with public health teams.

	Dermatology services	Full mobilisation of service with current provider during 2015/16	Procurement of new provider of comprehensive, community based dermatology service during 2016/17
Ageing well	Achievement of Dementia diagnosis rates	Work programme delivered. Achieved 63.2% as of January 2016.	Work plan to continue through 2016/17 to achieve diagnosis rate including targeted support to GP practices to improve diagnosis rates and review of model for support to care homes.
	Implementation of actions from ELC Dementia programme	Engagement programme completed. Partnership working through the Dementia Alliance to implement shared action plan	Full implementation of the plan
	Implementation of Better Care Fund schemes	Full implementation of a number of schemes to reduce non-elective admissions and reduce length of stay including; 7 day social workers, RATL (Emergency Care Practitioner service), FEAST (Frail and Elderly Assessment Unit) including Older People's Mental Health Liaison and Well Being Hubs	Continuation of plan, with focus on development of care home support and linking into the Care Network developments. Complete development of community equipment model and associated procurement and mobilisation. Evaluation of schemes implemented to date
	Carer Strategy development	Strategy agreed and implementation in progress	Complete implementation
	Patient Transport Services	Procurement of new provider to be completed	Mobilisation of new provider(s)

		in 2015/16	
Dying well	Development of an integrated end of life service specification	Specification not yet developed	Development of the integrated service specification and agreed implementation plan
	Implementation of special patient notes	Continue to assess opportunities to develop EPaaCs solution that works for all GP practice systems	Solution to share data across relevant organisations to support end of life and palliative care

7.0 New plans for 2016/17

Life Stage	**Summary plan**	**Expected Outcomes**
Starting well/Growing well	Evaluation of Children's Community Nursing model	Assessment of benefits realised and further service development if required
	Implementation of the CAMHs Transformational plan	Improved access to support for young people, reduced waiting times, improved outcomes, reduction in children and young people receiving care out of area
Working well	Re-procurement of community pain service	Commissioning of a service which better meets the needs of patients
	Implementation of Learning Disabilities: Transforming complex care plan	Ensuring people can access care close to home where this can meet their needs. Development of local solutions to meet people's needs

	Access to Mental Health crisis beds	People in crisis can be cared for close to home without the need for hospital admission where this can safely be avoided
	Development and implementation of dual diagnosis pathway for people with mental health needs and substance misuse issues	Access to integrated assessment and joint management plans, improving patient outcomes and experience
	Implementation of Diabetes Prevention programme	Improved patient outcomes through prevention and early diagnosis
	Prevention and early management of Cardiovascular disease (Familial hypercholesterolemia, GRASP AF etc)	Improved patient outcomes through prevention and early diagnosis
	Procurement of community based dermatology service	Award of contract to new provider and service mobilisation
	Procurement of community based respiratory service including home oxygen and pulmonary rehabilitation	Award of contract to new provider and service mobilisation
Ageing well	Development of new models of care to support the frail and elderly including improved GP support into people living in care homes, use of tele-health to support people in care homes and education and support to care home staff	Improved outcomes through proactive care, increased quality through workforce development and improved efficiency through the use of technology
	Pilot of scheme to develop alternative primary care offer. Development of Practice Health Champions who are recruited and supported as a group to work closely with their General Practice to create new ways for patients to access non-clinical support	Increased levels of confidence and wellbeing within the practice population, improved levels of knowledge of health and wellbeing
	Reduction in variation of care through alternative referral model to include triage of referral with; advice to referrer, non face to	Reduction in variation of patient experience, increased efficiency through use of alternatives to face to face consultation

	face and face to face consultation	
Dying well	Full roll-out of Gold Standard Framework across all practices	Improved patient experience, reduction in avoidable admissions at end of life
All Life Stages	Development and implementation of Care Networks. Improved co-ordination and integration of care through new out of hospital models of care; person centred, needs led, prevention focussed, delivered by integrated health, social care, third sector teams.	Prevention of ill health, reduction in health inequalities and improvement in quality and outcomes.
	Development of technology solutions and other solutions to support self -management of long term conditions	Patients feel informed and supported to enable them to manage their condition
	Review of Urgent care model against Commissioning Standards for Integrated care	Development of a service model which reflects the commissioning standards and links to the strategic plan of the Urgent and Emergency Care Network
	Development of primary care enhanced services: General Practice, optometry and pharmacy services	Access to enhanced primary care services providing increased value for money. The services offer added benefit to the patient
	Development of model and business case for social prescribing	Reducing hospital attendances and admissions through improved well-being

8.0 Alignment of plans with providers

NL CCG is working closely with provider organisations, lead commissioners (where applicable) and its CSU to understand forecast out-turn position and plan activity for 2016/17. This includes an open book approach to gain a shared view of planned activity levels and trajectories.

Regular meetings are held with NLAG as our main provider enabling robust dialogue and challenge of each party on plans and assumptions. This contract is the CCG's most significant risk in this contracting round due to the financial challenges faced by the Trust and its ability to generate cash releasing savings in a timely way following service redesign. This is being managed though open book working and sharing of robust service change plans and trajectories, underpinned by a memorandum of understanding across the local health system

NL CCG is not the lead commissioner for ambulance services. The CCG continues to work with the lead commissioner and associate commissioners to progress contract discussions with East Midlands Ambulance Service (EMAS); however there remains a risk that this contract will not be signed by end of March 2016. Dialogue continues with the provider to understand implications of the contract being devolved to county level. The EMAS offer for 2016/17 is at significantly greater cost that the 2015/16 contract. The provider faces a number of sustainability issues, however despite previous investments has struggled to improve performance and as a Trust it does not expect to deliver on response times during 2016/17, with the exception of Red 2 which it plans to achieve by Q2.

There are no significant concerns regarding other CCG contracts and the ability to sign contracts by the end of March 2016.

Appendix 1

The North Lincolnshire Plan

Vision: North Lincolnshire is a healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced. People achieve the best health and well-being that is possible, delivered within the resources available. More care is delivered in or close to people's homes. People feel able to self-care and are supported to do so. Services are proactive in their approach to enable people to remain independent for as long as possible

Striving to develop;

Aspiring people

Inspiring places

Ambitions	Interventions	Timescale	Outcomes
Securing additional years of life **Reduction of 150 years of life lost per 1000 pop by 2018/19**	LTC self-care,	2015/16	People live longer, with a better quality of life
	Whole system approach to LTC care	2015/16	
	Early cancer diagnosis	2016/17	
Improving health related quality of life for people with Long Term Conditions **To achieve and maintain position within the upper quartile nationally**	Community based LTC care- respiratory/diabetes/circulatory	2014/16	People feel in control and can access support when needed, leading to increased quality of life
	Whole system approach to LTC care	2018/19	
	Implementation of risk stratified follow-up pathways for people with cancer	2016/17	
	Increased dementia diagnosis rate through improved screening and awareness raising, with provision of appropriate support, delivering the actions from ELC Dementia programme	2015/16	
Increase proportion of people living independently at home following hospital discharge	Better care fund plan; preventative care, rehabilitation, integrated care delivery	2015/16	
Reducing emergency admissions by 11.5% by end 2015/16	Build on the increased Children's Community Nursing service through co-design using ELC for children with long term conditions	2015/16	People care cared for in a safe environment, whilst reducing admissions to hospital
	Increase in proportion of non-elective attendances managed using Ambulatory Emergency Care pathways	2015/16	
	Implementation of the BCF plan; RATL, Care Homes Liaison, Hospital Social Workers, FEAST	2014/16	
Increase proportion of people having a positive experience of hospital care year on year	Primary and Community based care, Quality measures, CQUINs Elderly care fund plan, Whole system approach to long term conditions	2015/16	Positive patient experience
Making significant progress towards eliminating avoidable deaths in hospital by problems in care	Quality measures , CQUINs,	2015/16	Positive patient experience

Step changes to delivery		
Reduction in acute care capacity – beds and outpatient facilities	Increase in primary, community and social care capacity – delivered in integrated way	New approaches to commissioning and provision