Operational Plan 2019/21.v1

NHS East Riding of Yorkshire CCG

Better care, more locally, within budget, through transformation
Foreword

NHS East Riding of Yorkshire Clinical Commissioning Group (ER CCG) has made significant progress in improving health outcomes for our local population over the past few years including improving support for people with Diabetes, those in need of Continuing Health Care (CHC), access to talking therapies, reducing waits for children and young peoples services, Mental Health Services and improving access to Urgent Treatment services in the East Riding. Overall, this has resulted in the CCG being rated as ‘Good’ in its latest annual assessment. This plan aspires to continue to build on these successes with partners across the health and care sector.

The challenges that face the CCG and its system partners remain significant. The East Riding covers a large, mainly rural, geographical area with numerous villages and population concentration around a number of market towns, Bridlington being the largest. As with many other areas, the East Riding is challenged by the consequences of an ageing population where more people are now living with multiple long term conditions. The East Riding generally performs well against the England average on a number of health and wellbeing indicators but this masks significant variation and deprivation in some areas, particularly some wards in our coastal communities. The CCG remains challenged financially, spending more on healthcare than it receives through its annual allocation from NHS England, meaning a process of prioritisation has to take place for new and current spending.

The NHS 10 Year Plan sets out a series of broad ambitions and deliverables for the next 10 years. Partnership working at neighbourhood level all the way through to Integrated Care System (ICS) footprints across Humber, Coast and Vale will be critical in delivering many of the ambitions outlined.

The CCG remains committed to delivering its strategic priorities (opposite) and this plan further seeks to improve health care for local people by presenting its operational plans for 2019-21. Whilst further detail is awaited from a number of key reports and reviews, not least of which are those relating to workforce, social care and prevention, the plan has sufficient certainty to set out key deliverables over the next two years, with year 1 in detail. It remains agile enough to respond to changes derived from national policy and guidance.

The CCG has highlighted a number of areas within its current remit that it is committed to improving. Underpinning this work is an aspiration to commission high quality services that meet local health need. This plan will detail where these needs are and how we intend to address them. Each programme of work has detailed delivery plans.

The CCG will work with partners to deliver a range of initiatives that have been mandated nationally as well as blending these with a series of local priorities. It is likely that the CCG will remain financially challenged across the period 2019-21 resulting in the need to deliver savings plans which optimise every £1 spent and focus on helping people to stay healthy and able to manage their own conditions while staying independent.

Our Vision

Better care, more locally, within budget, through transformation

Strategic Priorities

- Support our patients and population to achieve healthy independent aging
- Reduce health inequalities across the East Riding
- Improve the physical and mental health and wellbeing of children and young people
- Work within our financial allocation
- Meet our commitment to deliver improving outcomes in line with our key statutory duties
- Ensure the workforce is equipped with knowledge, skills and capacity
Population Health and Inequalities
East Riding of Yorkshire: Population Health

The NHS 10 Year Plan highlights a number of conditions that are associated with early mortality and morbidity including, but not limited to, cardiovascular disease, mental ill health, respiratory disease, cancer, etc. The charts on this page give a sense of how the East Riding compares to the England average for these conditions and also at East Riding locality level. This section re-confirms previous intelligence that demonstrates where our challenges lie in relation to national priorities and the difference in need in parts of the East Riding.

Our strategic and operational plan seek, with partners across health and care, to improve health outcomes for local people and reduce health inequalities.
East Riding of Yorkshire: Population Health

The challenges for the East Riding evidenced by our data intelligence are:

- There is significant impact on health in terms of lifestyle factors
- In the East Riding lifestyle factors such as diet and exercise are contributing to increases in prevalence of diabetes and cardiovascular disease (CVD) / hypertension
- Prevalence of conditions impacting on premature morbidity / death are more pronounced in areas of deprivation – in particular in Bridlington, Holderness and Driffield and Leven
- Mental ill health is prominent in all areas in the East Riding but again greater in areas of high deprivation and rising in children and young people
- Demand for unplanned care continues to increase
- The number of people aged 65 and over with multiple long term conditions continues to rise at rates above the England average

These challenges reconfirm that our commissioning focus should continue in terms of promoting healthy choices and supporting people to maintain and manage their health related conditions with particular focus on the areas of the East Riding where prevalence is highest.
Strategic Commissioning Intentions
Better care, more locally, within budget, through transformation

Strategic Intentions: 2019-21

The CCG is committed to delivery of its strategic intentions as set out below and using intelligence provided from the Joint Strategic Needs Assessment (JSNA) to enable the right services to be provided to our population in collaboration with partner organisations, to improve the health and wellbeing of local people.

It is increasingly important that we work with local public sector partners to influence the wider determinants of health and make the most of every public £1 spent across the East Riding.

In the coming years we will build on our collaborative work with the Local Authority, NHS Providers, City Health Care Partnership CIC (CHCP), Neighbouring CCGs and other public sector partners to do this.

The summary opposite sets out the different collaborative partnerships we will be working with to deliver our priorities.

2019-21

In any single year it is important to set out clear plans for delivering improvement and to this end we have set out in this document the key programmes and delivery objectives.

The key deliverables for each programmes area set out in more detail in this document are described overleaf.

### At Primary Care Network (PCN) level (where General Practices work together in natural geographical communities serving populations of up to 50,000 people):

- We will work with General Practice to support the development of our emerging PCNs against the key maturity matrix headings of Leadership and Governance, Population Health Management and Care Models, Empowering People and Communities, Care Teams and Clinical Governance, Resource Management and Provider Collaboration.
- We will work with PCNs to secure their sustainability in terms of workforce, efficiency and quality through our developed offer of support
- Support PCN’s with business intelligence, migrating to population health management, to support the delivery of outcomes
- Act as a partner in developing integrated working between General Practice, community services, social care and other providers to enable improved joined up and proactive care for patients, building on the experience of the Primary Care Home model for Holderness.
- Support PCN’s with the implementation and delivery of the Digital Offer to local people

### Across the East Riding (Place) we will continue to work with the Local Authority to:

- Support delivery of the East Riding Place Partnership, with system partners
- Align plans and budgets through the established Joint Commissioning Committee
- Support resilience, prevention and health promotion activities, specifically with regard to weight management and mental health
- Improve children's safeguarding service
- Deliver reduced length of stays for people in hospitals who are ready to be discharged
- Deliver services which help to build personal, community and system resilience and reduce demand on services e.g. Social Prescribing
- Continue to support the development and sustainability of the local Care Market
- Reduce duplication of effort and management costs through single leadership and shared functions

### Across Hull and East Riding we will:

- Support the development of the Provider Integrated Care Partnership (ICP)
- Take lead responsibilities for specific programmes of work to reduce duplication i.e. Cancer, Urgent Care and the Transforming Care Partnership.
- Work collaboratively with Hull University Teaching Hospitals NHS Trust (HUTH), Humber Teaching Foundation Trust, General Practice and CHCP on single specifications for services taking into account the different needs of our populations – through ICP development
- Work together with common providers to be a financially sustainable, high quality area. Where this makes sense across the Humber area and in the North Yorkshire and York area, we will similarly collaborate, recognising where our local people live, work and access services.

### Across Humber, Coast and Vale Health and Care Partnership level we will:

- Work as part of the Humber and North Yorkshire systems on areas such as Transforming Care, for people with a learning disability, Acute Services Reviews with Scarborough and the Humber, Local Digital Roadmap, etc.
- Work on large scale change programmes and take leadership roles on behalf of the whole area, for example in Cancer Care where the East Riding CCG Chief Officer has the Executive Leadership role and the Elective Network that focuses on planned care including MSK, diabetes, etc.
- Work together at this scale to improve workforce numbers and skill mix across the whole area
- To work on digital and technology transformation ‘at scale’ programmes
## Summary Deliverables: 2019-21

### General Practice

#### Deliverables
1. Form Primary Care Networks and agree local delivery plans including the need to deliver the new national service specifications and roles and workforce sustainability.
2. Increase time to care through implementation of the 10 High Impact Changes
3. Increase access and utilisation of appointments
4. Increase MSK First Practitioners in General Practice and reduce acute demand
5. Support General Practice to collaborate effectively with the Community Services Provider

#### Outcomes
1. Improving overall sustainability of General Practice
2. Improving population health outcomes, offer personalisation and embed the Digital agenda.
3. Reduce demand and variation into acute sector and reduce prescribing costs

### Community Services

#### Deliverables
1. Develop a pilot community frailty model in the East Riding
2. Work to develop a new model/pathway in the ER for stroke rehabilitation for implementation after 2019-20.
3. Align Community Services with the emergent PCNs.
4. Support the ‘Health into Care Homes’ offer
5. Strengthen Community Equipment Service to support discharge
6. Work in partnership to enhance falls response.

#### Outcomes
1. Reduce Delayed Transfers of Care and length of stay
2. Reduce Non Elective Admissions
3. Reduce length of stay through better discharge processes

### Collaboration and Integration

#### Deliverables
1. Review, redesign and implement a new model of Intermediate Tier Services, including community bed provision to prevent unnecessary admissions and support hospital discharges.
2. Maximise joint commissioning with ERYC.
3. Develop a refreshed Better Care Programme with ERYC, in line with national guidance
4. Deliver the agreed projects within the Withernsea Steering Group

#### Outcomes
1. Reduce Delayed Transfers of Care and length of stay
2. Reduce Non Elective Admissions
3. Reduce permanent admissions to residential care for people aged 65+

### Planned Care

#### Deliverables
1. Work collaboratively on HCV HCP Elective Care Network priorities including diabetes
2. Deliver agreed outpatient transformation plan enabled by technology
3. Extend and deliver the Community Cardiology pilot
4. Expand and deliver the Community Dermatology service
5. Expand the Health Optimisation Programme
6. Deliver the Prescribing and Buy Your Own Medicines plans
7. Collaborate to deliver the aims of the York / Scarborough and Humber Acute services Review
8. Deliver the agreed trajectories for Constitutional standards

#### Outcomes
1. Reduce outpatient demand into the acute sector and travel for patients
2. Reduce Cardiology and Dermatology demand into the acute sector through improved local offer
3. Deliver the Prescribing savings plan and reduce variation in prescribing

### Mental Health / Autism / Learning Disability

#### Deliverables
1. Increase access to talking therapies services for long term condition patients
2. Deliver plan for improving dementia diagnosis rates
3. Further reduce waits for children’s autism diagnosis
4. Continue to meet waiting times for CAMHS
5. Increase access to talking therapies services in General Practice
6. Develop Adult Eating Disorder Service
7. Deliver improved access to crisis services
8. Reduce the number of people with a LD or autism in an inpatient setting
9. Deliver Care, Treatment Reviews (CTR) and Care, Education & Treatment Reviews (CETR) timescales
10. Increase health checks for people with a Learning Disability and deliver the new standard

#### Outcomes
1. Reduce waiting times for autism diagnosis
2. Deliver the 66.7% dementia diagnosis rates
3. Deliver the CAMHS waiting times
4. Deliver the talking therapies access standard of 22%
5. Deliver 75% annual health checks for people with LD / autism and reduced inpatient waits
### Summary Deliverables: 2019-21

#### Cancer

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Deliver plans to improve national performance waiting times</td>
<td>1. Improve cancer waiting times</td>
</tr>
<tr>
<td>2. Deliver FIT for symptomatic patients across the East Riding</td>
<td>2. Increase rates of early presentation</td>
</tr>
<tr>
<td>3. Reduce variations of referral</td>
<td>3. Increase number of care plans for patients living with and beyond (LW&amp;B) cancer</td>
</tr>
<tr>
<td>4. Increase care plans for patients living with and beyond (LW&amp;B) cancer</td>
<td>3. Progress the continuity of carer model with partners</td>
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#### Maternity and Children

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop continuity of carer in maternity services</td>
<td>1. Patients report improved experience and choice of maternity services</td>
</tr>
<tr>
<td>2. Develop improved community paediatric service with partners</td>
<td>2. Sustainable model for community paediatrics agreed and implemented</td>
</tr>
<tr>
<td>3. Improve choice and experience of maternity services</td>
<td>3. Progress the continuity of carer model with partners</td>
</tr>
<tr>
<td>4. Implement the Saving Babies Lives Care Bundle</td>
<td>3. Progress the continuity of carer model with partners</td>
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#### Emergency and Unplanned Care

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>1. Implement the High Intensity Users model across the East Riding</td>
<td>1. Improve A&amp;E waiting times</td>
</tr>
<tr>
<td>2. Support delivery of the Unplanned Care Delivery Board work programme including implementation of the Same Day Emergency Care model and Primary Care Streaming Service (HUTH only)</td>
<td>2. Increase clinical triage via NHS 111</td>
</tr>
<tr>
<td>3. Support the development of the Primary Care Networks across the East Riding</td>
<td>3. Reduce number of high intensity users in the East Riding</td>
</tr>
<tr>
<td>4. Deliver the A&amp;E constitutional standard</td>
<td>4. Range of benefits from bids including display screens, App Store, etc.</td>
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</tbody>
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#### Technology

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Replacement of IT in General Practice &gt;5 years old, as funding allows</td>
<td>1. Improved personalisation of care through increased choice and control</td>
</tr>
<tr>
<td>2. Upgrade all devices to Windows 10</td>
<td>2. Sustainable IT infrastructure into the medium term</td>
</tr>
<tr>
<td>3. Replace all current Health and Social Care Networks</td>
<td>3. Digitally enabled care home market</td>
</tr>
<tr>
<td>4. Care Home IT programme</td>
<td>4. Range of benefits from bids including display screens, App Store, etc.</td>
</tr>
<tr>
<td>5. GP contract Digital Programme</td>
<td>5. Organisational development to support staff to achieve their potential and the benefits of schemes</td>
</tr>
<tr>
<td>6. Delivery of a range of bids / initiatives across the health and care system including the NHS App, Key messaging in General Practice.</td>
<td>4. Ensure the CCG is configured appropriately for the challenges and demands of the next 5 years.</td>
</tr>
</tbody>
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#### Workforce

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support the ongoing development of the General Practice work force</td>
<td>1. Improved retention and recruitment in General Practice</td>
</tr>
<tr>
<td>2. Support partners to recruit and retain their workforce where possible and implement the APEX tool</td>
<td>2. Development of new roles in General Practice and Community Services</td>
</tr>
<tr>
<td>3. Refresh CCG organisational development plan to ensure the CCG workforce has the capability and capacity to deliver its strategy and operational plan</td>
<td>3. Organisational development to support staff to achieve their potential and the benefits of schemes</td>
</tr>
<tr>
<td>4. Work with partners to ensure their workforce has the capacity and capability to realise the benefit from our plans around new models of care, technology, etc.</td>
<td>4. Ensure the CCG is configured appropriately for the challenges and demands of the next 5 years.</td>
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Delivery Plans for 2019-21

Delivering our Strategic Commissioning Intentions and System Priorities
Delivering our Commissioning Intentions and System Priorities
Delivering Quality 2019-21

QUALITY
The core aspiration of NHS East Riding of Yorkshire Clinical Commissioning Group (NHS ERY CCG) is to commission high quality services that meet local health needs:

‘Better care, delivered more locally, within budget, through transformation’

COMMISSIONING FOR QUALITY
Commissioning involves a series of stages usually conducted in a systematic cyclical process over the course of a year which assist the CCG in deciding what services are needed and whether existing services require review. Quality assurance is integral to that process.

Commissioning high quality compassionate care is at the heart of everything the CCG strives to achieve for the people of the East Riding. Whilst Quality means different things to different people at its simplest, quality is defined as care that is safe, effective and provides as positive experience as possible. The definition of quality sets out three dimensions to quality:

• Patient safety: commissioning high quality care which is safe, prevents all avoidable harm and risks to the individual’s safety; and having systems in place to protect patients;

• Clinical Effectiveness: commissioning high quality care, which is delivered according to best evidence as to what is clinically effective in improving an individual’s health outcomes

• Patient Experience: commissioning high quality care, which aims to deliver positive patient experience ensuring patients are treated with compassion, dignity and respect.

OUR QUALITY OBJECTIVES
• To provide assurance on the quality of all NHS commissioned services
• To ensure that data and information will be analysed and utilised intelligently at all stages of the commissioning cycle.
• To ensure quality is integrated into all aspects of the commissioning cycle
• To improve patient safety across the East Riding
• To improve patient experience of the NHS care across the East Riding
• To ensure that the incidence of healthcare associated infections such as MRSA and Clostridium difficile are reduced, emerging infections are appropriately managed and that cleanliness in our healthcare premises meets the highest standards
• To ensure the continued improvement of quality in primary care
Infection, Prevention and Control
The CCG will work in partnership with all providers, ERYC, public health and other commissioners to drive forward the continued reduction in healthcare acquired infections where care is delivered across the local health economy. The CCG will work collaboratively across the health economy to deliver the requirements of Tackling Antimicrobial Resistance 2019-2024. The CCG is committed to working with others to build on the improved performance in reducing C-Diff cases and continue to remain within national objectives. Work with primary care and care homes to roll out quality improvement initiatives to support the reduction in the number of E-Coli bacteraemia by implementing the “no dip” project. Continue to work towards achieving zero tolerance on MRSA, working collaboratively with providers to identify themes and trends and share learning.

Safeguarding Children
The CCG will work closely with the ERYC and other partners to put in place arrangements which ensure compliance to the Children and Social Work Act 2017 in respect of child death review processes and Local Safeguarding Children’s Board. The CCG will develop and embed robust assurance processes in relation to safeguarding across the primary care community ensuring practices are delivering services which safeguard the welfare of those who are vulnerable who are in receipt of services from the practice. The CCG will seek to improve the health outcomes for Children in Care in the East Riding by achieving the statutory timeframe for initial and review health assessments without compromising on the quality of the review.

Pressure Ulcer Working Group
The CCG will continue to build on the collaborative work with providers to ensure that the Hull and East Riding community works together to prevent pressure ulcers, manage existing pressure ulcers, effectively reduce hospital admissions and support pro-active and timely discharge. The work will be underpinned by NHS Improvements revised guidance. The CCG will work with providers to develop robust assurance processes that demonstrates adherence to the guidance and how risk is mitigated to prevent harm from pressure ulcers.

Mortality Reviews
The CCG will ensure learning from the Learning Disabilities Mortality Review (LeDeR) and safeguarding reviews inform the commissioning processes. The CCG will participate in the annual publication of findings from reviews of deaths, capturing learning through a system wide approach to improve the quality of care. The CCG will work collaboratively across primary and secondary care to develop documentation to facilitate the integration of mortality reviews.

Mental Capacity Act
The CCG will ensure arrangements are in place to implement proposed changes to the Mental Capacity (Amendment) Bill due to be passed as Law (by 31 March 2019). The CCG will ensure there are robust arrangements in place for the strategic leadership in leading the changes to the Mental Capacity Act.

Primary Care
The CCG will work with Primary Care to maintain and improve the quality of care provided ensuring the workforce is fit for purpose to deliver the 5 Year Forward View, the NHS Long Term Plan and the 10 Point Action Plan for General Practice Nurses. The CCG will work collaboratively with Primary Care to deliver on the quality development in primary care work plan.
General Practice

Delivering our Strategic Commissioning Intentions and System Priorities
Agree, deliver and implement years 1 and 2 of the East Riding General Practice strategy, likely to include:

- Workload development
- CCG Primary Care funding allocation.
- Increase time to care through implementation of the 10 High Impact Changes
- Increase access and utilisation of appointments
- Increase MSK First Practitioners in General Practice
- Support General Practice to collaborate effectively with the Community Services Provider
- Support the design and delivery of proactive ‘end to end’ pathways, utilising a Population Health Management approach.
- Deliver the Medicines Optimisation programme
- Reduce inappropriate variation and referrals into secondary care where services can be provided locally.

**Activity Impact**

General Practice has significant impact on activity levels across the health and care system. As the ‘front door’ for most of the population, it has the ability to significantly affect the flows of patients into community and acute health services. With planned care particularly, General Practice offers the route into acute hospitals for our population. The sections within this plan relating to Referral to Treatment (RTT) times, Cancer standards, etc. will rely heavily on General Practice playing an appropriate role. We must ensure that those who need services have timely access and alternatives are in place, where appropriate, for those who do not need to go to hospital. General Practice can also be the place where a lot of people come for help that is not related to a medical condition, or do not need to see a GP. In these cases, we will continue to work with General Practice and other partners, through initiatives such as Social Prescribing and Care Navigation, to find people the best place or person to help them.

**Partners and Alignment Considerations**

A tiered model of delivery requires General Practice to operate effectively and efficiently across different population levels. Individual, list-based general practice remains the ‘jewel in the crown’ of the NHS and is highly valued by our local population. However, practices are now being funded to develop partnerships with other practices and partners through Primary Care Networks, to support integrated services designed to address population health needs.

We will support General Practice to operate at a larger population level, through PCNs and possibly Federations, to be an equal part of Integrated Care Partnerships with other providers such as acute trusts, mental health providers, Local Authority partners, community health services and the Voluntary Sector.

**Humber, Coast and Vale Partnership**

HCV Partnership is developing clinical forum to enable clinical decision making to be at the heart of service development. Specifically, the Partnership is developing a workforce strategy with General Practice that the East Riding contributes toward.

PCN’s will have an important role in system leadership and the CCG will support Clinical Directors to deliver this.

Work streams relating to Estate and Digital Technologies have significant impact on General Practice and the CCG is an active partner in this work.

**Transformation Programmes**

Our key transformation programmes for General Practice will support the delivery of the commissioning intentions highlighted above. In particular, the transformation programmes will support delivery of our new GP Strategy.

1. Primary Care Networks – supporting the development of integrated networks across locality footprints in particular collaborative work with community services.
2. Infrastructure - Develop technological solutions to offer people alternatives to traditional models of general practice. Develop an Estates strategy under the ‘One Public’ Estate model and support / facilitate General Practice estate development
3. Workforce development (see section on Workforce later in this document)
4. Workload development - Reducing demand into Primary and Secondary care, releasing time to care
5. Investment – support General Practice and PCN’s through investment as directed by national guidance and seek all new investment opportunities.

**Key Assumptions & Guidance Considerations**

- Continued delivery of initiatives under the General Practice Forward View – including sustainability of workforce, support to develop infrastructure e.g. Primary Care Networks, maximise the potential offered by the new GP Contract.
- Work to deliver a GP strategy for the East Riding that reflects the medium to long term aims for General Practice to enable it to be a lead provider of care in a system of care provision.

**Key Risks**

- Development of Primary Care Networks – relationship building and infrastructure across localities and system partners.
- Capacity and capability within General Practice to develop and implement PCNs.
- Workforce availability for sustainable general practice services.
- CCG Primary Care funding allocation.
Better care, more locally, within budget, through transformation

General Practice: Priorities for 2019-21

NATIONAL

- CCGs to commit a recurrent £1.50/head recurrently to developing and maintaining Primary Care Networks so that the target of 100% coverage is achieved as soon as is possible and by 30 June 2019 at the latest.
- Ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification
- CCG should deliver at least 75% utilisation of extended access appointments by March 2020 (if service went live in 2017/18)
- Where primary medical care commissioning has been delegated, CCGs are required to undertake a series of internal audits that will provide assurance that this statutory function is being discharged effectively
- Creation of weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
- Work with HEE to ensure robust training programmes are in place to adequately support workforce plans
- Ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of 2019/20 sustainability and resilience funding (allocated by NHS England) must be spent effectively by 31 December 2019, with 100% of the allocation spent by 31 March 2020.
- Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes; and that there is a plan to develop the agreed set of required functions by 31 March 2020
- Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme
- Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts nationally, to improve medicines optimisation for care home residents by 31 March 2020
- Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care
- Recruit the share of the additional 5000 doctors and maximise the impact of the over 5000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives.
- Plan specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training; with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2020
- In December 2017, NHSE and NHSCC issued guidance for CCGs on 18 items which should not be routinely prescribed in primary care. CCGs are expected to save up to £114 million per year by 2020/21 compared to 2017/18
- In March 2018, NHSE and NHSCC published further guidance on CCGs on conditions for which over the counter items should not be routinely prescribed in primary care. CCGs are expected to save £93 million per year compared to 2017/18

LOCAL

- Agree, deliver and implement years 1 and 2 of the East Riding General Practice strategy, likely to include:
  - Form Primary Care Networks and agree local delivery plans including the need to deliver the new national service specifications and roles and workforce sustainability.
  - Increase time to care through implementation of the 10 High Impact Changes
  - Increase access and utilisation of appointments
  - Increase MSK First Practitioners in General Practice
  - Support General Practice to collaborate effectively with the Community Services Provider
  - Support the design and delivery of proactive ‘end to end’ pathways, utilising a Population Health Management approach.
  - Deliver the Medicines Optimisation programme
  - Reduce inappropriate variation and referrals into secondary care where services can be provided locally.
The NHS 10 Year Plan seeks to achieve the aims of Triple Integration outlined earlier in this document. National policy continues to promote integration of working between health and care as the best vehicle for personalised, proactive and holistic care and support. The primary vehicle to deliver this model is Primary Care Networks.

Primary care networks enable the provision of proactive, accessible, coordinated and more integrated primary and community care improving outcomes for patients. They are likely to be formed around natural communities based on GP registered lists, often serving populations of around 30,000 to 50,000. Networks will be small enough to still provide the personal care valued by both patients and GPs, but large enough to have impact through deeper collaboration between practices and others in the local health (community and primary care) and social care system. They will provide a platform for providers of care being sustainable into the longer term.

This is not a new concept – the CCG has previously described this ambition as ‘Community Hubs’, however a network more adequately describes the desired relationship where teams work together where it makes sense to do so, following integrated ways of working and co-locating where this improves efficiency and relationships.

The GP Contract published in January 2019 describes how General Practice can / will work in this new model and the resources that will be made available to Networks to make this happen. These changes signal a clear intent to develop PCNs rapidly across 2019-20, laying the foundations for delivery of the key outcomes of the 10 year plan in future years.

The CCG will work with the PCNs and all wider partners to support development of these networks across the East Riding. It is the CCG’s ambition that Primary Care Networks will firstly, deliver the national outcomes framework and the national service specifications. We would also wish to agree a number of key priorities for local communities that address health inequalities. We would welcome Networks also focusing on things of importance to them and their local people that may not be health and care services but that tackle inequalities and the social determinants of health.

### Level Pop. Size Purpose

| Primary Care Network Holderness, etc. | ~50k | • Strengthen primary care
| Place ERY | ~300k | • Collaborative commissioning with Council
| Integrated Care Partnership | ~500k | • Collaborative commissioning and delivery across one or more CCG footprints
| System Humber, Coast and Vale Partnership | 1+m | • Large scale change
| Region | 5-10m | • Agree system ‘mandate’

Each level performs specific functions under the following common headings

1. Leadership, engagement and workforce
2. Care redesign
3. Accountability and performance management
4. Strategy and planning
5. Managing collective resources
Primary Care Network Development: 2019-21

The CCG is currently expecting to support the development of a number of Primary Care Networks over the coming years. Between May and June 2019, practices across the East Riding will agree their network boundaries, constituent practice members, population size and name a Clinical Director for each network. The CCG will be required to submit the applications providing assurance that the network member practices are coterminous, align to recognised communities, have a population size of circa 30,000-50,000 and cover the whole population of registered residents in the East Riding.

The East Riding ‘Fed of Feds’ group has been established for the past 18 months and includes representatives from all of the formal and informal GP networks across the East Riding. Working with the Fed of Feds and the LMC, the CCG will ensure that a bottom up approach to the alignment of practices based on a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community. Holderness PCH are our most established network and are being supported as such. The leadership of the Holderness network have identified gaps against the maturity matrix and are working through an action plan which has resulted in a focus piece of work to prioritise diabetes care. This includes the development of an ‘end to end’ pathway including bloods, recall for re-testing, structured education and self management. The group is developing an MDT approach with secondary care consultants that is accessible to all diabetic clinicians in the community. The Network has set up a task and finish group to update professional and alignment of clinical teams is taking place. In addition, work continues to build relationships across teams, particularly between General Practice in the area and the Community nursing teams.

By September 2019, the CCG will have offered the networks the support to undertake baseline measurement against the maturity matrix, understand gaps and develop an implementation plan to address these gaps. The implementation plan will likely cover leadership development, particularly clinical leadership, organisational development both in terms of culture and behaviours as well as infrastructure that would include IT interoperability, governance structure, clinical policy and procedure. The CCG will support this development through its plans to invest the £1.50 per head. The CCG will support the networks to demonstrate progression along the maturity matrix during 2019-21. This will be supported by the NHSE assurance process that ensures networks have the capability and agreements in place to receive and manage, funding, etc.
Primary Care Network Development: 2019-21

Fundamental to the development of PCNs will be the development of our workforce. The CCG contributes to the HCV Workforce strategy for Primary care which describes how we will build our workforce capacity and capability to meet the current and future needs of our local population. Key objectives includes engaging stakeholders to identify workforce gaps at a PCN as well as East Riding level; valuing and seeking to retain the staff we have; developing and promoting new roles to achieve a multi-professional workforce; attracting new staff and providing local clinical and managerial leaders with thinking space to support PCN delivery models and the development of local responses to new clinical and non-clinical skills, competencies and roles.

The CCG will continue to support General Practice to deliver the elements of all of the 10 High impact changes identified within the General Practice Forward View. The CCG, with General Practice partners, has implemented the actions in full / part in practices across the CCG. This includes an East Riding wide Social Prescribing service which has a link worker in every practice, the care navigation model with training provided to reception staff to signpost to other partners/professionals/self-help. However, for each of those changes there will be options for doing more of this work. We have also introduced a quick start program to a number of practices across the patch and rolled out related training via the Protected Time for Learning (PTL) events to support personal productivity and building Quality of Information (QI) expertise. Again this can continue further and the federations are looking to make another application to the quick start program for help.

Key items that we will continue to progress include:

- Implement the APEX capacity and demand tool into general practice and develop workforce plans based on the outputs;
- Utilise our Protected Time for Learning (PTL) events to continue to deliver our quick start ‘productive General Practice’ programme that seeks to support personal productivity and build QI expertise;
- Embed the Care Navigation model across all practices 2019-20
- Support the ‘digitalisation’ of General Practice (see later section on enablers);
- Install LCD screens in all practices to promote system messages, particularly around healthy lifestyles;
- Developing the architecture, form and function of PCNs;
- Further develop our ‘Gain share’ model that incentivises development of services in the community that supports reductions in demand in secondary care. An examples of this are the MSK practitioners that we are currently embedding in practice and;
- Implement the RAIDR tool to support business intelligence and decision making as a significant step towards Population Health Intelligence.
- Roll out of ‘marginal gain’ projects developed and tested by the CCG’s Primary Care GP Lead
<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone Date</th>
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<tbody>
<tr>
<td>CCGs to commit a recurrent £1.50/head recurrently to developing and maintaining Primary Care Networks so that the target of 100% coverage is achieved as soon as possible and by 30 June 2019 at the latest.</td>
<td>CCG to ensure that all our Primary Care Networks submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES.</td>
<td>6th March 2019 Council of Members meeting to discuss the network boundaries across the CCG. 15 May 2019 each PCN to submit Annex C Network Contract DES Registration Form</td>
<td>£1.50 per head, funded through NHSE</td>
<td>None recognised within 2019-21</td>
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<tr>
<td>Support the development of Primary Care Networks against the long term plan, operational planning guidance, GP contract and PCN maturity matrix.</td>
<td>Agreement of the Primary Care Network boundaries. Appointment of a Clinical Director for each network. Financial mechanisms in place to enable networks to hold funds. PCN Go-Live date. Assessment against the PCN maturity matrix and development of subsequent action plan. Support the national DES for extended roles including Clinical Pharmacist and Social Prescribing Link Worker. Support preparation for the national service specification for Structured Medications and Health in Care Homes.</td>
<td>15 May 2019 15 May 2019 15 May 2019 1 July 2019 September 2019 July 2019 March 2021</td>
<td>Included in the £1.50ph which equates to £457k Included in the £1.50ph Included in the £1.50ph Included in the £1.50ph Included in the £1.50ph</td>
<td>TBC for all schemes</td>
</tr>
<tr>
<td>Ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification. The CCG will potentially have a number of PCNs. One is already established as a Primary Care Home site. They have been provided with data. The remaining network boundaries have yet to be finalised. CCG Staff are actively sourcing information in preparation but this cannot be finalised until the networks have.</td>
<td>The RAIDR tool is being rolled out to all practices currently which provides business intelligence at practice level from primary care, secondary care, prescribing, quality and public health. This will be a significant step toward Population Health Intelligence that would incorporate information from the Council and other system partners. The approach to Population Health Intelligence and the role of Place versus the ICS has also to be clarified to prevent duplication / contradiction. • Complete CCG data analysis and review output • Complete social care data analysis and review output • Provide data pack to networks • Further gain share opportunities to be explored.</td>
<td>1st June 2019 analysis completed 30 June output of analysis shared with networks</td>
<td>Move to Population Health Management will have a cost associated but the scope of service required has yet to be determined.</td>
<td>£385,000 from MSK gain share.</td>
</tr>
<tr>
<td>CCG should deliver at least 75% utilisation of extended access appointments by March 2020 (if service went live in in 2017/18)</td>
<td>Bi monthly contract mobilisation meetings with Yorkshire Healthcare Providers</td>
<td>Achieved</td>
<td>£6 / per head of population</td>
<td>None</td>
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## General Practice: Milestone Plan for 2019-21

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<tbody>
<tr>
<td>Where primary medical care commissioning has been delegated, CCGs are required to undertake a series of internal audits that will provide assurance that this statutory function is being discharged effectively</td>
<td>Agree a process with NHSE and internally. Compliance with audit requirements embedded.</td>
<td>June 2019</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Creation of weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+</td>
<td>Ensure access for diabetes patients to the Health Optimisation programme, Live Well initiative and exercise on prescription are all available. The CCG will explore over 2019-20 opportunities to further promote healthy lifestyles through an extension of the Health Optimisation Programme.</td>
<td>April 2019 – consideration of expansion of Health Optimisation Programme.</td>
<td>tbc</td>
<td>Tbc</td>
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</table>
| Workforce Development                                                     | Agree the ICS Primary Care workforce strategy  
Agree the General Practice Strategy  
Increase the number of doctors and HCPs in general practice  
Strengthen the general practice nursing workforce                                                                                                                                                                                                                                                                  | April 2019  
July 2019  
March 2021 | The eligible maximum pay against which the 70% (or 100% for social prescribing only)  
Clinical pharmacist 2019 20 7-8A £37,810  
Social prescribing link worker Up to 5 34,113  
First contact physiotherapist 7-8A N/A – reimbursement available from 20/21  
Physician associate 20/21 7 N/A - reimbursement available                                                                 | N/A                  |
| NHSE and NHSCC issued guidance for CCGs on 18 items which should not be routinely prescribed in primary care and further guidance to CCGs on conditions for which over the counter items should not be routinely prescribed in primary care. | Rollout of Value Based Commissioning – 50 IFR statements agreed across the Humber  
Communication plan to practices to be drafted                                                                                                                                                                                                                                                                               | April 2019  
2019-20  
2020-21 | 0  
0 | £1.8m  
£1m |

Better care, more locally, within budget, through transformation
Community Services

Delivering our Strategic Commissioning Intentions and System Priorities
Comissioning Intentions

- Develop a community frailty pilot model in the East Riding and provide robust evaluation
- Work to develop a new model/pathway in the ER for stroke rehabilitation for implementation after 2019-20.
- Align Community Services with the emergent Primary Care Networks
- Support the ‘Health into Care Homes’ offer through the Provider ICP in Hessle
- Strengthen Community Equipment service to support discharge
- Work in partnership to enhance falls response.
- Consider need to scope and review the Community services strategy with a view to refreshing as required.

Activity Impact

The need to further develop community based service is drawn out explicitly in the NHS 10 Year plan as a way of providing personalised care and support within or near to peoples homes, preventing ambulance call outs, hospital attendance or admission and, when admission to hospital is unavoidable, to ensure that people come out from hospital as soon as possible. Strong community services will require further integrated ways of working with social care, general practice and mental health services, likely under the auspices of a Primary Care Network. Plans underpinning these principles will result in an activity reduction within secondary care and should facilitate a transfer of funding from secondary to community care. Our intention to remodel our community based stroke service will result in more people having a shorter hospital stay.

Partners and Alignment Considerations

Community services are essential to the emerging Primary Care Network model. The range and depth of services offered under this umbrella-term is significant. However, too often, services work in isolation when we know from our local clinicians that a more integrated, partnership approach is wanted from all areas. We will continue to develop more integrated ways of working with social care and other services to improve the experience of support for patients, allowing them to only tell their story once and to reduce the number of different professionals visiting people on the same day.

STP Collaborative

Community services, particularly the further alignment with social care services, forms a key programme of work within the East Riding Place Partnership.

Key Risks

• Significant links to the aspirations of the NHS 10 Year plan which specifically draws out investment in primary and community services that will grow faster than the overall NHS budget.
• Strong links to the GP Contract and particularly the emergent Primary Care Networks.

Transformation Programmes

1. Continued delivery of the Community services outcomes based contract model
2. Strengthening the community equipment service, facilitating reduction in length of stay and improving efficiency.
3. Development of the Personal Health Budget offer in the community equipment service
4. Continue to deliver years 3 and 4 of the End of Life strategy
5. Expand the enhanced Care Home scheme with GPs; supporting a transition into Primary Care Network management

Key Assumptions & Guidance Considerations

• Lack of progress towards greater integration between community services and social care
• Workforce constraints that restrict the ability of partners to deliver on ambitious new models of care
Community Services: Priorities for 2019-21

NATIONAL
• By 2021 we will remodel our post-hospital stroke rehabilitation model, with full roll-out over the period of this Long Term Plan.
• Long stay patients (those in hospital for 21 days or more) account for 7.3% of admissions and 20.4% of bed-days (as at October 2018). In 2018/19, NHSE set the goal to reduce bed occupancy by long stay patients by 25%, to release at least 4,000 beds compared to 2017/18 figures. Once local goals have been delivered, the aim should then be to reduce the proportion of beds occupied by long stay patients by 40% against the original 2017/18 baseline.

LOCAL
Continue to deliver the Community Services strategy - ‘delivering care closer to home, out of hospital by promoting self-care and utilising local communities to support individuals to retain their independence through:
- Development of a community frailty pilot model in the East Riding and provide robust evaluation
- Work to develop a new model/pathway in the ER for stroke rehabilitation for implementation after 2019-20.
- Aligning Community Services with the emergent Primary Care Networks
- Supporting the ‘Health into Care Homes’ offer through the Provider ICP in Hessle
- Strengthening the Community Equipment service to support discharge
- Working in partnership to enhance falls response.
- Considering the need to scope and review the Community services strategy with a view to refreshing as required.
## Community Services: Milestone Plan for 2019-2021

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|             | **Continue to deliver the Community Services strategy and support integrated working through the emergent PCN model**  
- Develop a new model for Falls Services  
- Develop a pilot Frailty model  
- Improve the assessment and prescribing of medications for people who are unable to self-administer  
- Continue roll out of enhanced service for Care Homes, migrating into the national PCN service specifications.  
- Reviewing the Community Beds model | Continuing to work with the community services provider to deliver the agreed contract.  
Review and refine existing model to enable reduced hospital admission and ambulance call out.  
Implement new service model  
Agree the model for a pilot frailty service  
Implement the new model  
Evaluation of the pilot  
Agree the model between pharmacy and adult social care.  
Training of workforce and Go-live  
Further promotion of the service  
Implementation of the new Care Home Dashboard  
Establish working group, scope of review, etc.  
Act upon recommendations | July 2019  
September 2019  
April 2019  
October 2019  
October 2020  
May 2019  
June 2019  
Ongoing  
April 2019  
May 2019  
September 2019 | Key performance indicators include:  
Falls indicator IAF 104A 1,345  
CCG Level – IOR - Non Elective Admissions (YTD Actual 12/18 – 21,517  
BCF indicator – 8,200 YTD 1/2019 | Key performance indicators include:  
Falls indicator IAF 104A 1,994  
CCG Level – IOR – Non Elective Admissions (YTD Target 12/18 – 21,212)  
BCF indicator – 8,674 YTD 1/2019 | £27m (total contract value of Community Services). | £100,000 (ASC Winter monies) | Tbc |
## Community Services: Milestone Plan for 2019-21

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| Work to develop a new model / pathway in the ER for stroke rehabilitation for implementation after 2019-20. | 1. Business case approved, subject to available funding  
2. Service model developed and agreed  
3. Phased implementation                                                                                                                                         | November 2019        | Length of stay is currently 13.9 days                          | Reduction in length of stay by two days on average to 11.9 days. | To be determined                                                                 | To be determined |
| Expand Personal Health Budget offer to community equipment                  | PHB offer established for NHS CHC Fast track Funding and personal wheelchair budgets, with a small pilot for mental health. Currently scoping further opportunities e.g. community equipment, wigs. East Riding wide event to further promote PWB is currently being organised. | June 2019            | 1110 personal health budgets in place (Q3 2018-19 position)    | 1150 by March 2020                                           | No additional investment required. PHBs focus is on improving choice. | None specified, though utilisation of Disabled Facilities Grant funding to improve functionality of specific wheelchairs can result in reduced care packages, improved independence and quality of life. |
Collaboration, Integration & Better Care

Delivering our Strategic Commissioning Intentions and System Priorities
Commissioning Intentions

- Review and redesign Intermediate Tier bed base to support appropriate hospital discharge
- Continue to maximise joint commissioning with ERY Council
- Develop a refreshed Better Care Programme with ERYC, in line with national guidance
- Deliver the agreed projects within the Withernsea Steering Group

Activity Impact

Many of the initiatives funded through the Better Care Fund (BCF) and improved BCF are designed to prevent people from going in to hospital and, if they do, to enable them to leave hospital as soon as they are medically fit to do so. Therefore, the schemes use hospital attendances, admissions, ambulance call outs and delayed transfers of care as key metrics of success. Since the implementation of the schemes, performance against the DTOC measure has improved significantly based on comparison to the previous year, though it is recognised that more needs to be done to achieve this standard consistently.

Partners and Alignment Considerations

The 10 Year Plan raises the ambition of achieving the Triple Integration of:
- Primary and Secondary care services
- Physical and Mental Health and
- Health and Social Care

The Better Care Fund represents a formal section 75 agreement between the CCG and East Riding of Yorkshire Council (ERYC) to enable joint decisions to be made that will further progress integration between health and social care. The improved Better Care Fund has facilitated a number of initiatives to be progressed. Evaluation is needed to demonstrate efficacy of these schemes and plans are required to provide recurrent funding for those that should be retained.

STP Collaborative

In addition to operational integration facilitated by the Better Care Fund programme and the Community Services outcomes contract, the other main area of work resides with the Health and Social Care Executive Committee (CCG and Council) which continues to seek out closer relationships and opportunities to commission services better together, making best use of the collective East Riding ‘pound’. This work is reflected at the East Riding Place Partnership.

Key Assumptions & Guidance Considerations

- The CCG and Local Authority has approved a joint Better Care Plan for 2017-19, agreed by system partners. Further guidance is awaited to understand the requirements of Better Care in the short to medium term. In the interim, it is expected that performance around Delayed Transfers of Care will be achieved and maintained and other key indicators (ref Community Services section).

Risks & Mitigations

- The key risk associated with the integration and Better Care programme is the ongoing funding from 2020-21 onwards for schemes and initiatives currently being delivered through non-recurrent funding via the improved Better Care Fund.
- Identified gaps in robust evaluation of schemes.

Transformation Programmes

Numerous programmes managed through the Better Care Programme Board – see overleaf
Collaboration, Integration and Better Care: Priorities for 2019-21

**NATIONAL**

- Continue to support the delivery of the Better Care Fund including provision of minimum funding requirements for the section 75 agreement.

- The Government's Better Care Fund Policy Framework and the detailed Planning Requirements will set out DTOC expectations for 2019-20. In order to support planning in advance of these publications, CCGs and Health and Well Being Boards (HWBs) should, as a minimum, plan to continue to deliver the reductions in the Delayed Transfers of Care (DTOC) rate (set out in Annex 3 to the Better Care Fund Operating Guidance for 2017-19) or to maintain their performance if these targets have been achieved already.

- Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans.

**LOCAL**

- **Implement integrated model of intermediate tier** – working in partnership with the Council & Community Services provider to develop a sustainable intermediate tier that will support discharge, prevent non-elective admissions & re-ablement

- **Active Recovery** - to promote and maximise independence with 2 bed based hubs to support hospital discharges and prevent admissions. A review of outcomes is taking place to inform further development of Active Recovery and the community based element of the model.

- **Social Prescribing** - the service is commissioned to meet health and social care needs of residents by enhancing self-care, linking residents/patients in with sources of support within the community, developing community assets and networks made up of 3 elements: assessing (identification of current/future needs and opportunities), linking (motivating and facilitating residents to use available community assets), building (developing existing assets and co-producing new community assets).

- **Care Market** - to support, develop & enhance quality, effectiveness & sustainability of the homecare and residential care market across the East Riding for example considering options for nursing residential care in the future, and the development of Capacity tracker a tool for Care Homes to update their vacancies in real time.

- **Investment in Technology** - to address IT barriers and explore digital opportunities for example the enhanced technology in care homes project will be rolled out to all care homes by March 2020.

- **Winter initiatives** - to support Health & Social Care during the winter period for example with positive step beds available to support discharge for individuals who are medically optimised but awaiting a care package or their care home of choice. In addition winter funding is being used to support the increased use of community equipment and profiling beds in care homes.

- **Personal Health Budgets** – continued development of our PHB offer to support personalisation, control and choice for people

- Implement BCF Plan and develop sustainability/exit plans for post March 2020 – review being held 1 March 2019 to consider progress of current work streams, identify priorities and develop exit plans where required for the remainder of the BCF to March 2020.
## Collaboration, Integration and Better Care: Milestone Plan for 2019-21

<table>
<thead>
<tr>
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<th>Milestone</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Review and implement BCF Plan and develop sustainability/exit plans for post March 2020</td>
<td>Evaluation of the two existing hubs</td>
<td>Review and update of plan completed</td>
<td>Current performance against BCF indicators:</td>
<td>- Delayed Transfers of Care per 100,000 population IAF 9.0</td>
<td>.</td>
<td>IBCF Funding</td>
</tr>
<tr>
<td>- Active Recovery hubs operational in Beverley and Pocklington.</td>
<td>Roll out of home care element of hubs</td>
<td>Full implementation of the High Impact Change Model.</td>
<td>Delayed Transfers of Care per 100,000 population IAF 7.6</td>
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<tr>
<td>- Social Prescribing accessible from GP practices throughout the East Riding.</td>
<td>Roll out to remaining GP practice.</td>
<td></td>
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<tr>
<td>- Care Market &amp; Investment in Technology</td>
<td>Evaluation of service</td>
<td></td>
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<tr>
<td>- Positive Step Beds</td>
<td>Transition appropriate elements to PCN service specification depending on outcome of evaluation</td>
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<tr>
<td></td>
<td>Enhanced technology in care homes to be rolled out to all homes by March 2020</td>
<td></td>
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<tr>
<td></td>
<td>Reviewed as part of the Community Beds model</td>
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<tr>
<td>Deliverable</td>
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<tr>
<td>Review and implement BCF Plan and develop sustainability/exit plans for post March 2020</td>
<td>Review additional resource impact at the end of the extended contract.</td>
<td>Ref Community Services March 2020</td>
<td>ASCOF Indicator Permanent admissions to residential care for people aged 65+ per 100,000 699.8 for 2017/18</td>
<td>ASCOF Indicator Permanent admissions to residential care for people age 65+ per 100.00 - Yorkshire and Humber average from 17/18 - 632.6</td>
<td>IBCF Funding</td>
<td></td>
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<tr>
<td>- Additional Social Work resource</td>
<td></td>
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<tr>
<td>- Red Cross Assisted Discharge Service</td>
<td>Review additional resource impact at the end of the extended contract.</td>
<td>March 2020</td>
<td>ASCOF Indicator - Re-ablement – The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services 86.2 for 2017/18</td>
<td>ASCOF Indicator - Re-ablement – The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services 87</td>
<td></td>
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<tr>
<td>- Integration &amp; Delivery Manager in post to oversee implementation of further integration</td>
<td>Evaluate role and identify recurrent funding</td>
<td>October 20202</td>
<td>Non Elective Admissions into hospital with a length of stay of 21 days or less 1148 to 1/2019</td>
<td>Non Elective Admissions into hospital with a length of stay of 21 days or less 868</td>
<td></td>
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<tr>
<td>Deliver agreed Withernsea and Place Based 'Proof of Concept' projects</td>
<td>Deliver ‘Frequent Flyers’ project (Withernsea Project) and provide evaluation</td>
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<td></td>
<td>Support Children and Young People work stream</td>
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<tr>
<td></td>
<td>Lead the Withernsea Project Group</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Reduction in frequent attenders to general practice and hospital services Improved health and wellbeing of children and young people in Withernsea</td>
<td>Resource in kind</td>
<td>To be determined.</td>
<td></td>
</tr>
</tbody>
</table>
### Collaboration, Integration and Better Care: Milestone Plan for 2019-21

| Deliverable | Key Actions                                                                                                                                                                                                                                                                                                                                 | Milestone                  | Current Performance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | National / Local Target                                      | Investments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Savings                                                                                                                                                                                                                               |
|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Implement integrated models of Intermediate Tier**                                                                                   | Development of project charter to support further development of Intermediate Tier. ERYCCG, ERYC and CHCP will continue to redesign integrated provision of intermediate tier, which will focus on community based services and re-ablement, as well as supporting the implementation of the high impact change model for managing transfers of care. For patients in hospital for 21 days or more, reduce bed occupancy by 25% | Agree updated project charter – April 2019 | Alternative models of delivering the homecare element of intermediate care packages will further support a reduction in DTOCs and the other BCF metrics (see above).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Achievement of the DTOC target for each month of the year. Comparison of performance year on year. Bed occupancy reduced by 25%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Within existing resources                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Project plan in development to identify potential savings.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| For patients in hospital for 21 days or more, reduce bed occupancy by 25%                                                           | Further analysis of data to take place to inform next steps and requirement for new initiatives to support further reduction of LoS 21+. Better Care Fund (BCF) Review to take place 1 March 2019 to inform priorities for the 19/20 financial year (to support re-scoping / development of new schemes where required). Continued monitoring through A&E Delivery Board, BCF Board and overarching governance. | Review - March 2019 | Delayed Transfers of Care per 100,000 population IAF 9.0 Non Elective Admissions into hospital with a length of stay of 21 days or less 1148 to 1/2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Delayed Transfers of Care per 100,000 population IAF 7.6 Non Elective Admissions into hospital with a length of stay of 21 days or less 868 for same period. 25% reduction against the previous year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
Services for Vulnerable People

Delivering our Strategic Commissioning Intentions and System Priorities
Mental Health & Dementia

Delivering our Strategic Commissioning Intentions and System Priorities
Commissioning Intentions

- Deliver 2019-21 agreed action plans in the system wide Mental Health and Dementia Strategy including
  - Increase access to IAPT services for long term condition patients
  - Deliver plan for improving dementia diagnosis rates and the national dementia diagnosis standard of 66.7%
  - Increase access to IAPT services in General Practice
  - Develop Adult Eating Disorder Service
  - Deliver improved access to crisis services
- Deliver the 2019-20 Future in Mind Plan including
  - Continue to meet waiting times for CAMHS

Activity Impact

- Individual plans will demonstrate the different activity impacts associated with the multiplicity of specialist services that fall under the umbrella term ‘Mental Health’. In general, however, the CCG is pleased to be responding to increasing demand for mental health services both locally and driven by national policy. All efforts to reduce stigmas and ensure people get the help they need are welcome.

Partners and Alignment Considerations

The CCG will continue to work with local mental health providers regarding the developing services, and with other agencies supporting service users including the Police and local VCS. National strategies as well as our own local Mental health and Dementia strategy and Future in Mind plan promote early identification and support for people with emotional/mental ill-health and therefore a range of community partners and others will be key to delivering transformed models of care.

Transformation Programmes

- Mental Health and Dementia Strategy Steering Group
- Mental Health Crisis Care Concordat
- Future in Mind Board
- HCV HCP Mental Health Delivery Board

STP Collaborative

- The HCV has a dedicated work stream for Mental Health that the CCG is an active member of. This work stream has achieved good progress in 2018-19 in reducing the number of people who receive treatment outside of the county and the wider STP footprint. This is not only better for the person and their family / carers but brings funding back into the region.

Key Assumptions & Guidance Considerations

- Five Year Forward View for Mental Health
- Future in Mind
- The CCG will be required to meet the Mental Health Investment Standard however this may not be sufficient to address all issues within 2019-20 meaning some improvements will need to be phased.

Key Risks

- The critical risk to the delivery of the plan is availability of funding. The CCG plans to meet the Mental Health Investment Standard but this does not mean that each of the investments that have been highlighted will be able to be funded in 2019-20.
- CYPEDS target does not allow DNAs to be excluded and with small numbers this means that one person who does not attend means the target will likely be missed in month/quarter.
- Achievement of the dementia diagnosis standard will fluctuate due to imprecise prevalence rates.
Mental Health & Dementia: Priorities for 2019-21

NATIONAL
• By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression).
• At least 50% of people who complete IAPT treatment should recover.
• At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
• At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral.
• At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
• At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.
• At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
• By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
• By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.
• Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
• At least 60% people with a severe mental illness should receive a full annual physical health check.
• Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
• Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.
• The further deliverables for mental health outlined in the technical annex must also be delivered during 2019/20, most notably for: perinatal mental health; all age crisis and liaison services; 50% of early intervention in psychosis services graded at level 3; and reducing suicides.

LOCAL
• Delivery of the Adult Mental Health and Dementia Strategy
• Delivery of the Future in Mind plan
## Deliverable

Implement Years 2 and 3 of the East Riding Mental Health and Dementia Strategy including:

- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
- At least 60% people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services (equates to 15 therapists in ER)

### Key Actions

- **Investment in memory assessment service and post-diagnostic support offer**
- **Develop business case and subsequent service specification**
- **Implementation of new service Procurement**
- **Service in place but recurrent costs required**
- **Agree business case. Commission service**

### Milestone

- Business case approval – April 2019
- Implementation - September 2019
- January 2020
- Q1 2020-21
- New contracts in place by Q3
- Agree budget
- Business case approval – April 2019
- Implementation - September 2019
- Service in place on non-recurrent basis

### Current Performance

- 65.7%
- 23%
- N/A
- Service in place on non-recurrent basis

### National / Local Target

- 66.7%
- 60%
- N/A
- Recurrently funded service
- Part of generic mental health services for adults

### Investments

- £100,000, dependent on financial plan
- To be determined
- Within current budget
- £250,000, dependent on financial plan
- £88,000 in year 1, dependent on financial plan

### Savings

- None predicted for CCG but may be savings for NHS England Specialist Commissioning
- Already achieved
## Adult Mental Health & Dementia: Milestone Plan for 2019-21

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Years 2 and 3 of the East Riding Mental Health and Dementia Strategy including:</td>
<td></td>
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</tr>
<tr>
<td>Expansion of the IAPT service in line with the NHS Long Term Plan</td>
<td>Pathway redesign to deliver minimum performance at lower cost. Reprocurement in progress</td>
<td>New contract(s) delivered by September 2019</td>
<td>Exceeding requirements on all standards</td>
<td>21% of estimated prevalence entering treatment by Q4 2019/20 50% achieve recovery 75% RTT within 6 weeks 95% RTT within 18 weeks</td>
<td>N/A</td>
<td>£400,000</td>
</tr>
<tr>
<td>To further develop our Personal Health Budget offer</td>
<td>Agreement to offer further PHBs to people with mental ill health.</td>
<td>Q4 2019-20</td>
<td></td>
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<tr>
<td></td>
<td>To understand contractual implications of this development.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>To ensure there are safeguards in place to identify people who already have a Personal Budget with the Local Authority.</td>
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</tr>
<tr>
<td></td>
<td>Develop business case and subsequent service specification</td>
<td>January 2020</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Implementation of new service</td>
<td>Q1 2020-21</td>
<td></td>
<td></td>
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<tr>
<td>Commission adult ADHD service</td>
<td></td>
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</tbody>
</table>

**Better care, more locally, within budget, through transformation**
### Deliverable: Meet the national Mental Health Investment Standard.

**Key Actions:**
1. Agree schedule of investment, referencing specifically funding of services outwith the main mental health contract including prescribing, s117 continuing Healthcare, ambulance service, etc.

**Milestone:**
- March 2019

**Current Performance:**
- N/A

**National / Local Target:**
- Achieve the standard

**Investments:**
- £3.4m

**Savings:**
- N/A

### Deliverable: At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.

**Key Actions:**
1. Investment
2. Recruitment, training and implementation
3. Fully compliant March 2020

**Milestone:**
- April 2019
- October 2019
- March 2020

**Current Performance:**
- 84% (though service is not NICE compliant)

**National / Local Target:**
- 56%

**Investments:**
- Nil

**Savings:**
- Nil

### Deliverable: Humberside Police Force Control Room Mental Health Support

**Key Actions:**
- Contract agreed by Humberside Police

**Milestone:**
- Service in place on non-recurrent basis

**Current Performance:**
- N/A

**National / Local Target:**
- £15,000, dependent on financial plan

**Investments:**
- Already achieved

### Deliverable: Individual Placement Support

**Key Actions:**
- Humber Coast and Vale leading across partnership area

**Milestone:**
- To be determined

**Current Performance:**
- N/A

**National / Local Target:**
- N/A

**Investments:**
- £70,000 in 2020-21 (pick up cost subject to successful outcomes and CCG financial plan)

**Savings:**
- None predicted

### Deliverable: For Crisis Resolution Home Treatment Teams (CRHTTs), CCGs must ensure that by the end of 2019/20 all populations have access to services for adults and older adults that are commissioned to meet the minimum functions of: (i) urgent and emergency community mental health assessment, and (ii) intensive home treatment as an alternative to inpatient admission, 24 hours a day, 7 days per week.

**Key Actions:**
- Fully met for adults - service available for older people but not specialist 24/7

**Milestone:**
- Develop transformation programme - September 2019

**Current Performance:**
- N/A

**National / Local Target:**
- Transformation assumed within existing resources

**Investments:**
- Nil
<table>
<thead>
<tr>
<th>Deliverable</th>
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<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver the Future in Mind Plan, including</td>
<td>Perinatal Mental Health standards</td>
<td>Agree budget</td>
<td>Service in place on non-recurrent basis</td>
<td>Recurrently funded service</td>
<td>£75,000, dependent on financial plan</td>
<td>Nil</td>
</tr>
<tr>
<td></td>
<td>Improve Children and Young People Community Eating Disorder Service capacity</td>
<td>Agree business case.</td>
<td>Business case approval – July 2019</td>
<td>95% RTT within 1 week urgent</td>
<td>£36,000, dependent on financial plan</td>
<td>None predicted</td>
</tr>
<tr>
<td></td>
<td>and develop service model to include physical health</td>
<td>Commission service</td>
<td>Implementation - September 2019</td>
<td>95% RTT within 4 weeks routine</td>
<td></td>
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<tr>
<td></td>
<td>Address gap in capacity for CYP ADHD assessment and treatment - transfer</td>
<td>Secure additional capacity to accept transfer from community paediatrics</td>
<td>Service in place April 2019</td>
<td>No national target set</td>
<td></td>
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<tr>
<td></td>
<td>from CHCP - increase take up of shared care by ERYCCG GPs</td>
<td>Expand capacity for 1:1 CBT and increase number of schools offering SMASH</td>
<td>HFT to agree MIND contract at 18/19 outturn volume SMASH in two additional</td>
<td>Local target 18 weeks RTT</td>
<td></td>
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<tr>
<td></td>
<td>Additional capacity for anxiety and depression</td>
<td>Develop business case and subsequent service specification</td>
<td>secondary schools by September 2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic Fatigue services for children and young people</td>
<td>Implementation of new service</td>
<td>N/A</td>
<td>18 weeks RTT</td>
<td>£40,000 part year costs, dependent on financial plan</td>
<td>None predicted in the short term</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q1 2020-21</td>
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<td></td>
<td></td>
<td>N/A</td>
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<td></td>
<td></td>
<td>N/A</td>
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</tbody>
</table>
**Children and Young People’s Mental Health: Milestone Plan for 2019-21**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.</td>
<td>Expansion of SMASH programme to cover all secondary schools and year 6 of feeder primary schools. Additional low level CBT activity either through HEY Mind or through emotional wellbeing workers in schools</td>
<td>Business case approval – April 2019 Implementation – September 2019</td>
<td>34%</td>
<td>To be determined</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Conclude an impact assessment of new performance measures highlighted in the Interim Review of Clinical Standards and feed into commissioning intentions for 2020-21</td>
<td>Undertake impact assessment Develop conclusions into commissioning intentions Undertake cost analysis</td>
<td>June 2019 September 2019 October 2019</td>
<td>To be determined as part of impact assessment</td>
<td>Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services Access within one hour of referral to liaison psychiatry services and children and young people’s equivalent in A&amp;E departments Four-week waiting times for children and young people who need specialist mental health services Four-week waiting times for adult and older adult community mental health teams.</td>
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</tbody>
</table>
Learning Disability and Autism

Delivering our Strategic Commissioning Intentions and System Priorities
Commissioning Intentions

- With our local authority partners the CCG will begin to implement our Autism Strategy, which has recently been engaged upon and is nearing publication
  - Further reduce waits for children’s autism diagnosis
- With our local authority partners the CCG will implement our Learning Disability strategy which is currently out to engagement
  - Reduce the number of people with a LD or autism in an inpatient setting and increase community / home based settings
  - Deliver Care, Treatment Reviews (CTR) and Care, Education & Treatment Reviews (CETR) timescales
- Increase health checks for people with a Learning Disability and deliver the new standard

Activity Impact

- Reduced inpatient activity, in line with Transforming Care projections
- Reduce or eliminate the use of out of area hospital placements
- More effective health checks to reduce unplanned admissions
- Undertake effective mortality reviews and disseminate lessons learned

Partners and Alignment Considerations

- For Transforming Care we work closely with partners across the East Riding, Hull and North East Lincolnshire
- Our key partners in implementing the Autism and Learning Disability strategies are ERYC and Humber Teaching NHS FT
- Primary care are crucial in delivering annual health checks and reducing mortality
- Partnership Boards for Autism and for Learning Disability will be established which include service users, carers, care providers and the voluntary and community sector

STP Collaborative

The Transforming Care Board is currently considering with its STP/ICS partners the future footprint for driving improvements in the future

Key Assumptions & Guidance Considerations

- Improving community provision will reduce inpatient admissions
- Increasing uptake of annual health checks will improve health and reduce mortality

Key Risks

- Availability of funding and resource to deliver the ambitions of the Autism and Learning Disability strategies

Transformation Programmes

- Transforming Care Programme
- Strategy for People with Autism 2019-2024
- Learning Disability Strategy 2019-2024
Learning Disability and Autism: Priorities for 2019-21

NATIONAL

Ensure more children and young people with a learning disability, autism or both get a community Care, Education and Treatment Review (CETR), such that 90% of under-18s admitted to hospital have either had a community CETR or a CETR post-admission

CCGs to ensure that they are represented at CETRs for Children and Young People who are inpatients; and can demonstrate an increase in compliance and quality of C(E)TRs in line with national policy

CCGs to have a dynamic risk stratification process in place with a clear function of identifying those at risk of admission and to ensure that this is reviewed and updated on a regular basis

There is a process in place to proactively identify children and young people and adults who are subject to regular and or prolonged restrictive practices including the use of seclusion/long term segregation and ensure that appropriate safeguarding and review measures are followed

At least 75% of people on the learning disability register should have had an annual health check

Expand the STOMP-STAMP programmes to stop the overmedication of people with a learning disability, autism or both by 2023/24

LOCAL

Deliver year 1 and 2 of the Autism strategy for children, young people and adults including, but not limited to:

- Establish a Partnership Board which oversees the implementation of this strategy
- Improve the efficiency of the pathway for diagnosis for both adults and young people in transition to adulthood
- Develop an agreed ‘post-diagnosis offer’ which is dependent on need
- Carry out reviews of those at immediate risk of admission, where possible putting in place community support that will prevent admissions
- Ensure a smooth transitional process for all children and young people to adult services

Deliver year 1 and 2 of the developing Learning Disabilities strategy
### Deliverable

#### Deliver year 1 and 2 of the Learning Disability Strategic Plan 2019-2022

At least 75% of people on the learning disability register (and identified by NHSE (prevalence related)) should have had an annual health check

- **Key Actions**
  - Complete consultation and finalise strategy
  - Develop action plan
  - Ensure effective monitoring of AHC uptake
  - Deliver training and support to primary care

- **Milestone**
  - As per action plan

- **Current Performance**
  - 68% (2017/18)

- **National / Local Target**
  - 75%

- **Investments**
  - To be determined.

- **Savings**
  - Nil

#### Expand the STOMP-STAMP programmes to stop the overmedication of people with a learning disability, autism or both by 2023/24

- **Key Actions**
  - Continue implementation of STOMP programme
  - Scope need and develop plan for STAMP programme

- **Milestone**
  - June 2019

- **Investments**
  - Nil

- **Savings**
  - Nil

#### Deliver year 1 and 2 of the Strategy for People with Autism 2019-2024

to include improvements to diagnostic waiting times

- **Key Actions**
  - Referenced within the strategy and developing action plan

- **Milestone**
  - As per action plan

- **Current Performance**
  - Average referral time to diagnosis is currently: 47 weeks for adults 92 weeks for CYP

- **National / Local Target**
  - Diagnosis of autism to be received within 6 months of referral

- **Investments**
  - £180,000, dependent on financial plan

- **Savings**
  - Nil

#### Transforming Care Partnership

Continue to reduce the number of people with a learning disability, autism or both in inpatient care

- **Key Actions**
  - Continue actions within transforming care programme, including development of forensic community service

- **Milestone**
  - March 2020

- **Current Performance**
  - Currently 23 beds per million population

- **National / Local Target**
  - 13 beds per million population

- **Investments**
  - Non-recurrent investment from NHS England

- **Savings**
  - None anticipated
Maternity and Children’s Services

Delivering our Strategic Commissioning Intentions and System Priorities

Better care, more locally, within budget, through transformation
Commissioning Intentions

- Integrate physical health monitoring with specialist CYP community eating disorder service
- Procurement of Sexual Health services with ERY Council
- Sustain delivery of the Transforming Care Programme for children and young people, including effective dynamic support register
- Implement Saving Babies’ Lives Care Bundle through Humber Coast and Vale Local Maternity System
- Sustainable diagnosis service for children and young people with autism (ref ER Autism strategy in Autism section)
- Deliver the Future in Mind plan (ref ER Future in Mind Plan in Mental Health section)
- Explore opportunities to improve the sustainability and development of the community paediatrics service including children’s and young peoples therapies
- Develop continuity of carer in maternity services

Activity Impact

Services for children and young people and maternity services are designed to improve pathways and experience for people. The CCG is not anticipating significant shifts in activity from one sector to another. Development of services for children and young people with mental ill health, learning disabilities and autism could enable some transfer of activity from specialist care if early intervention initiatives are successful as planned.

Partners and Alignment Considerations

Partnership working will be critical in delivering the intentions set out in this section, for example with the ER Council for the procurement of Sexual Health services.

Future in Mind and Autism will require support and input from a range of system partners particularly given the focus needed on enabling fulfilling lives within communities.

Community paediatrics has been identified by the emerging Integrated Care Partnership as a priority area of focus across Hull and East Riding. Workforce, pathways and models of delivery will all be explored across 2019-20 to improve the sustainability of this service.

STP Collaborative

Whilst there are specific requirements for maternity and children’s services in the East Riding, the nature of these services often means operating across wider geographies than the county. The CCG is a partner in the STP Local Maternity System where a number of the intentions will be delivered including the Saving Babies Lives bundle.

Key Assumptions & Guidance Considerations

- Improve number of people reporting they were offered choice in maternity services
- Reduce the number of maternal smoking at delivery

Key Risks

- Achievement of the national IAF standards relating to choice, breastfeeding and smoking
- Availability of workforce and funding for the delivery of children and young peoples services

Transformation Programmes

- LMS programme board and delivery board - delivers the Better Births programme across the STP and locally
- Children and Young People’s mental health regional programmes – set the criteria for Future in Mind work plan delivery
- ICP approach to community paediatrics with CHCP, Hull CCG, HUTH and ER CCG.
**Maternity and Children’s Services: Priorities for 2019-21**

**NATIONAL**
Continue work to deliver expansion in the capacity and capability of the CYP workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based-interventions

A further 1,000 children a year to be treated for severe complications relating to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. These services will prevent children needing more invasive treatment

Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings

75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout their pregnancy, labour and postnatal period

Support work to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025

Start to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies

Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit

Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2020, 35% women receive continuity of the person caring for them during pregnancy, during birth and postnatally

Roll out the Saving Babies Lives Care Bundle during 2019

Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan

**LOCAL**
Sustain and develop the Community Paediatric Service

Children and Young People’s mental health, autism and learning disabilities are captured in those sections earlier in this document.
## Maternity and Children’s Services: Milestone Plan for 2019-21

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A further 1,000 children a year to be treated for severe complications relating to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. These services will prevent children needing more invasive treatment.</td>
<td>Further guidance required to establish.</td>
<td>Further guidance required to establish</td>
<td>Baseline to be established</td>
<td></td>
<td>Nil</td>
<td>None</td>
</tr>
<tr>
<td>Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Tba</td>
<td>Baseline to be collected in 19/20</td>
<td>&quot;More&quot; women give birth in midwifery settings by 2021</td>
<td>Nil</td>
<td>none</td>
</tr>
<tr>
<td>75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout their pregnancy, labour and postnatal period</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Tba</td>
<td>Baseline to be collected in 19/20</td>
<td>75% receive continuity of carer</td>
<td>Nil</td>
<td>None</td>
</tr>
<tr>
<td>Support work to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Tba</td>
<td></td>
<td>50% reduction by 2025</td>
<td>Nil</td>
<td>None</td>
</tr>
<tr>
<td>Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Not agreed</td>
<td>Q2 15.9%</td>
<td>9.7% national ambition</td>
<td>Nil</td>
<td>None</td>
</tr>
<tr>
<td>Deliverable</td>
<td>Key Actions</td>
<td>Milestone</td>
<td>Current Performance</td>
<td>National / Local Target</td>
<td>Investments</td>
<td>Savings</td>
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<tr>
<td></td>
<td>Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2020, 35% women receive continuity of the person caring for them during pregnancy, during birth and postnatally</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Not agreed</td>
<td>Small pilots in place – below 20%</td>
<td>35% receive continuity of carer by March 2020</td>
<td>To be determined.</td>
</tr>
<tr>
<td></td>
<td>Roll out the Saving Babies Lives Care Bundle during 2019</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Not agreed</td>
<td>Unknown – current data available is at provider not commissioner level</td>
<td>50% reduction in still birth by 2025</td>
<td>Assume this is in maternity tariff/aligned incentive payment</td>
</tr>
<tr>
<td></td>
<td>Looked After Children health</td>
<td>Business Case approval</td>
<td>May 2019</td>
<td>August 2019</td>
<td>April 2020</td>
<td>£25,000 year 1, dependent on financial plan</td>
</tr>
<tr>
<td></td>
<td>Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan</td>
<td>Participate in Humber Coast and Vale Local Maternity System initiatives</td>
<td>Not agreed</td>
<td>All women have personalised maternity care plan by March 2021</td>
<td>To be determined.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hull &amp; East Riding review of children’s physical healthcare services</td>
<td>Transfer of community paediatric medical service to HUHT</td>
<td>Contract transfer April 2019</td>
<td>N/A</td>
<td>N/A</td>
<td>Up to £400k, dependent on financial plan</td>
</tr>
<tr>
<td></td>
<td>Hull &amp; East Riding Children’s Integrated Care Partnership</td>
<td>ICP established April 2020?</td>
<td>N/A</td>
<td>Board established</td>
<td>ICP established</td>
<td>To be agreed</td>
</tr>
</tbody>
</table>
Continuing Health Care

Delivering our Strategic Commissioning Intentions and System Priorities
Commissioning Intentions

- Continue to commission individual care for people who are eligible for fully funded NHS care
- Review the current arrangements for the commissioning, brokerage and contracting of care in partnership with the Local Authority
- Continue to implement the personalisation agenda ensuring that individuals who are receiving a care package in the community are offered a personal health budget and are informed of their notional budget
- Commission sustainable nursing and care home provision
- Commission sustainable independent supported living care packages in the community
- Implement the National Service Improvement Plan recommendations to address unwarranted variation in CHC and improve systems and processes
- Continue to achieve the national quality standards for CHC

Activity Impact

- Reduction in nursing home placements
- Increase in people being cared for in the community with more complex needs
- Lack of specialist provision for people with complex needs, learning disabilities and with behaviour that challenges

Partners and Alignment Considerations

- The relationship with the Local Authority is key in the contracting of services.
- Close alignment and integrated working with the LA
- Acute Trust particularly in respect of discharge and the initial assessment of CHC
- Development of the market with the independent sector
- Close partnership working with NHS providers
- Provider organisations both NHS and independent sector

STP Collaborative

- Partnership working with other CHC providers within the STP to benchmark and standardise practice
- Share good practice within the STP

Key Assumptions & Guidance Considerations

- By achieving the national quality standards, patients will have an improved experience of CHC
- Implementation of the key deliverables in the CHC Service Improvement Programme will create efficiencies and address unwarranted variation in CHC

Key Risks

- Lack of market development and availability of specialist provision
- Growth in need for fully funded NHS care due to ageing population and rise in complexity of need
- Issues of quality in the independent sector

Transformation Programmes

- NHS CHC Strategic Improvement Programme
- Refreshed national framework
Continuing Health Care: Priorities for 2019-21

NATIONAL

THE NHS CHC STRATEGIC IMPROVEMENT PROGRAMME

• NHS England has established a national NHS CHC Strategic Improvement Programme to contribute towards the transformation and efficiency goals of the Five Year Forward View
• National improvement priority

The aim of the collaboration:

• To bring together local leaders with national partners and subject experts to co-create a collaborative improvement support system that leads to: access to benchmarking data that is otherwise not available from routinely collected sources to provide insight to inform the approach to supporting transformation and efficiency in the commissioning of NHS CHC
• Identification of best practice and understanding of efficiency opportunities
• The development of a national set of standard operating procedures and the testing of spread of these
• Rapid and continuous improvement in the commissioning and delivery of NHS Continuing Healthcare (NHS CHC) in a small number of CCGs (the “Development Group”)
• Swift spread of learning to all other localities across England
• A significant contribution to the goals of the NHS Continuing Healthcare Strategic Improvement Programme.

REFRESHED CHC NATIONAL FRAMEWORK

NHS CHC Quality Standards

Implementation of the Liberty Protection Safeguards (LPS)

• The CCG will be the ‘Responsible Body’ for authorising care ‘arrangements’ giving rise to a DoL under Continuing Health Care outside a hospital. This means that the CCG will now be responsible for facilitating and holding authorisation records in respect of all cared for people in the community, in residential placements and in any other setting apart from in a Hospital.

LOCAL

• Develop an education programme to increase and improve understanding of CHC
• Roll out training for CHC to all stakeholders who may refer for CHC assessment following on from the refreshed CHC National Framework
• Implement the recommendations from the NHS CHC Strategic Improvement Programme
• Continue to offer personal health budgets to those people receiving care in their own homes and ensure that each person is aware of their notional budget.
• Work with the East Riding of Yorkshire Council and contribute to the work in developing the local care market.
• Implementation of the Liberty Protection Safeguards at local level,
<table>
<thead>
<tr>
<th>Deliverable</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Continue to deliver the National Quality Standards for CHC</td>
<td>Monthly % referrals completed within 28 days - More than 80% of referrals should be completed within 28 days</td>
<td>Monthly reporting to NHSE</td>
<td>89% Achieved</td>
<td>80%</td>
<td>None</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>Quality Premium CCG’s must ensure that less than 15% of all full NHS assessments take place in an acute hospital setting</td>
<td></td>
<td>0% Achieved</td>
<td>Less than 15%</td>
<td></td>
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<tr>
<td></td>
<td>Incomplete referrals exceeding 28 days by 12 to 26 weeks/ or 10 or more cases delayed by 12 to 26 weeks</td>
<td></td>
<td>12 to 26 weeks - 0</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>The NHS states that anyone who is eligible for NHS Continuing Healthcare funding has the right to have a Personal Health Budget (PHB). A PHB will offer greater choice and control in the way care needs are met. From 1 April 2019 NHS England expect Personal Health Budgets to be the default model of delivering all NHS CHC funded home care packages.</td>
<td>Distribution of information leaflets to all people receiving community care packages</td>
<td></td>
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<tr>
<td></td>
<td>Communication to all individuals explaining personal health budgets and their indicative budget</td>
<td>Current documentation to be updated to capture the data with regards to PHBs</td>
<td></td>
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<tr>
<td></td>
<td>The CCG will be the ‘Responsible Body’ for authorising care ‘arrangements’ giving rise to a DoL under Continuing Health Care outside a hospital. The CCG will need facilitate the authorisation of a deprivation of liberty and will be responsible for the holding of authorisation records in respect of all cared for people in the community, in residential placements and in any other settings apart from in a Hospital.</td>
<td>Date of implementation to be confirmed as it is still going through the parliamentary process but could be as early as Autumn 2019</td>
<td>No applicable</td>
<td>An increase in numbers of people requiring an authorisation under the new rules</td>
<td>No anticipated savings</td>
<td></td>
</tr>
</tbody>
</table>
Acute Services

Delivering our Strategic Commissioning Intentions and System Priorities
Planned Care

Delivering our Strategic Commissioning Intentions and System Priorities

Better care, more locally, within budget, through transformation
**Commissioning Intentions**

- Work collaboratively on HCV HCP Elective Care Network priorities including diabetes, Cardiology, ENT, MSK, Respiratory, Ophthalmology, Maternity, Urgent Care and General Medicine
- Deliver agreed outpatient transformation plan enabled by technology
- Expand and deliver community MSK services
- Extend and deliver the Community Cardiology pilot
- Expand and deliver the Community Dermatology service
- Expand the Health Optimisation Programme
- Deliver the Prescribing and Buy Your Own Medicines plans
- Collaborate to deliver the aims of the York / Scarborough and Humber Acute services Review
- Deliver the agreed trajectories for Constitutional standards namely Referral to Treatment, long waiters and Diagnostics. Prepare for the changes to standards highlighted in the Clinical Standards Review Interim Report

**Activity Impact**

Unlike unplanned and emergency care, national and peer benchmarking (e.g. Right Care) shows that the CCG is historically a high user of planned care services. To bring this performance into line with peer benchmarking, the CCG has invested considerable time in supporting General Practice and secondary care to design alternatives for people needing specialist opinion, investigation or treatment. Success has been achieved in a number of areas including the introduction of advice and guidance, implementation of the Health Optimisation Programme, community based models for services such as Dermatology and Cardiology among others. Collectively, these schemes have reduced GP referrals into secondary care considerably, meaning people are being given more appropriate advice, support and care. Opportunities continue to exist to reduce demand into hospitals for outpatient consultation, diagnostics and interventions and the CCG will continue to work with partners to reduce this activity.

**Activities around planned care continue to be delivered largely through the Elective Care Network and the three Planned Care Boards across the HCV that underpin this. The Network focuses on specialties where there is significant opportunity across all CCGs / providers or where the required action only makes sense to take place at a large scale. This includes aligning commissioning statements across the four Humber CCGs.**

Governance around the Elective Care Network and the Planned Care Boards, specifically the interface between the two, could be improved and the CCG will work with STP colleagues to support this.

**STP Collaborative**

**Key Assumptions & Guidance Considerations**

1. The elective care 18 week waiting lists as at 31st March 2019 cannot deteriorate by March 2020
2. Local growth assumptions for elective care are flat after the application of QIPP to mitigate demand and contribute towards cost efficiency
3. No person waits over 52 weeks for planned surgery
4. Any person waiting over 6 months should be contacted and offered choice of alternative provider

**Partner and Alignment Considerations**

The Aligned Incentive Contract model between East Riding and Hull CCGs and HUTH is now entering its third year. Removing the perverse incentive to increase activity has helped to foster improved relationships and closer clinical working to develop new models of care and transformational ideas.

However, whilst demand into acute trusts has decreased, waiting lists continue to be high with some specialties facing significant workforce and capacity constraints. Equally, a renewed focus must be given by all partners to focus on areas that improve quality and safety, removes cost from the system, not just reduces demand and avoids expenditure.

**Transformation Programmes**

- HCV HCP Elective Care Network covering – Cardiology, ENT, MSK, Diabetes, Respiratory, Ophthalmology, Maternity, Urgent Care, General Medicine, Paediatric Medicine, Outpatient transformation
- Reducing variation in referral / demand through Community Dermatology and Cardiology services
- IFR Thresholds including the Health Optimisation Programme
- Right Care – Respiratory, Cardiovascular and MSK
- Outpatient Transformation
- Humber and Scarborough Acute Services Reviews

**Key Risks**

- Reducing demand but unable to reduce cost base within acute providers
- Alignment of policy / procedure across 6 CCG areas
- Releasing resource from Acute Trusts to reinvest in other areas of the system (to follow patients)
- Diagnostic capacity constraints impacting negatively on elective performance.
- Workforce availability to deliver elective activity
Planned Care: Priorities for 2019-21

NATIONAL
- Achieve the constitutional standards relating to Planned Care; namely the Referral to Treatment, long waiters and Diagnostic target
- Ensure all patients on an active 18 week pathway are offered choice of alternative provider if waiting 26 weeks for treatment.
- Achieve a reduction in face to face outpatient appointments of a third of current baseline
- Prepare for the impact of the changes to constitutional standards highlighted in the Clinical Standards Review Interim Report.

LOCAL
- Focus on agreed Elective Care Network pathways including MSK, Diabetes, CVD, Respiratory, etc.
- Continue to deliver Advice and Guidance across specialties in a phased approach
- Reduce demand in areas where cost can be released quickly utilising various methodologies including Model Hospital, Right Care, Getting It Right First Time (GIRFT)
- Extend and deliver the Community Cardiology pilot
- Expand and deliver the Community Dermatology service
- Expand the Health Optimisation Programme
- Deliver the Prescribing and Buy Your Own Medicines plans
- Collaborate to deliver the aims of the York / Scarborough and Humber Acute services Review
- Explore development of a non-cancer lymphoedema service
## Planned Care: Milestone Plan for 2019-21

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
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</table>
| No more than 1% of patients should wait six weeks or more for a diagnostic test’ | • Maximise efficiency and productivity within the current diagnostic capacity.  
• Additional sessions as required / affordable  
• Implementation of new diagnostic capacity | 2019-20  
2019-20 March 2021 | 5.8% | 1% | Investment in new diagnostic capacity including scanners and scopes. Funded through STP capital funding. | Potentially some reduction in additional sessions. Not confirmed |
| Building on the expectation that providers will deliver March 2019 waiting lists at the March 2018 level, all providers to reduce their waiting list during 2019/20. | • Continue to deliver capacity to meet current activity levels. To hold the waiting list position and reduce marginally.  
• Reduce referral variation within and between practices  
• Reduce follow up attendances and consultant to consultant referrals | March 2020 | Waiting list total = 26,164 | Waiting list total = 26,163 | Nil | Nil |
| No patient will wait more than 52 weeks for treatment | • Continued improvement to process and procedure  
• Continue to enact demand management actions  
• Reduction in referral variation  
• Increasing the Utilisation of Advice & Guidance/ RAS  
• Implementation of best practice guidance for C2C  
• Next 5 highest independent acute referral practices  
• Outpatient Transformation programme | March 2020 | 16 | 0 | Nil | Nil |
| Every patient waiting 6 months or longer for a surgical procedure to be contacted and offered the option of care at an alternative provider | • Resource requirements understood  
• CCG to support providers to develop a Standard Operating Procedure documenting the process of handling requests or amend Access Policy to reflect. | February 2019  
April 2019 | Not applicable | 100% of eligible patients offered alternative appointment. | tbc | Nil |
| Conclude an impact assessment of new performance measures highlighted in the Interim Review of Clinical Standards and feed into commissioning intentions for 2020-21 | Undertake impact assessment  
Develop conclusions into commissioning intentions  
Undertake cost analysis | June 2019  
September 2019  
October 2019 | To be determined as part of impact assessment | Maximum wait of six weeks from referral to test, for diagnostic tests  
Defined number of maximum weeks wait for incomplete pathways2, with a percentage threshold. OR Average wait target for incomplete pathways. | N/A | N/A |
## Planned Care: Milestone Plan for 2019-21

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<tr>
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</tr>
</thead>
</table>
| Ensure patients will have direct access to MSK First Contact Practitioners | • Roll out of MSK FCP currently taking place.  
• Full coverage to be achieved.  
• ESCAPE pain pilot implemented | Ongoing | 50% by August 19  
100% by March 2020 | £385,000 | £385,000 |
| IFR – Commissioning Statement Alignment | • Creation of a single Humber CCG Commissioning Statement Pack  
• Implementation of the electronic IFR referral system | July 2019 | 96 statements to be aligned | Nil | £1,279m |
| Develop opportunities for supporting more people to live healthy lives through extension of the Health Optimisation Programme (HOP) | • Options appraisal for the extension of HOP  
• Organisational approval of preferred option  
• Implementation of new scheme | March 2019  
April 2019  
July 2019 | October 2017 – February 2019  
• 500 referrals  
• 54% showed improvement in their Warwick Edinburgh Mental Wellbeing (WEMWB) Score  
• 60% demonstrated weight loss and positive change in BMI | April 2019-March 2021  
• 960 referrals  
• 60% improvement in WEMWB  
• 70% demonstrate weight loss and positive change in BMI | £145,000 | To be confirmed |
| Roll out the Community Cardiology and Dermatology service pilots | • SWAN cardiology pilot extended  
• Evaluation of the cardiology pilot - for procurement decision  
• Dermatology - full coverage to be achieved  
• Advice & Guidance and tele derm to be introduced | March 2020  
July 2020  
April 2019  
July 2019 | Cardiology data (Mth10) – Acute:  
1st Opts -228  
FUPs -42  
Diagnostics -94  
Day Cases -32  
Non EL adms – 8  
Dermatology data (Mth 10) – Acute:  
1st Opts -539  
FUPs -541  
Outpatient Procedures -675  
Day Cases -114 | • Assessment stage | Nil | As per QIPP report |
### Planned Care: Milestone Plan for 2019-2021

<table>
<thead>
<tr>
<th>Deliverable</th>
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<tbody>
<tr>
<td>Support delivery of the Elective Network priorities and deliver those programmes where ER CCG is the lead organisation e.g. Diabetes,</td>
</tr>
<tr>
<td><strong>Key Actions</strong></td>
</tr>
<tr>
<td>4 Humber CCGS IFR Commissioning Statements alignment programme</td>
</tr>
<tr>
<td>Wave 1 - 54 commissioning statements aligned</td>
</tr>
<tr>
<td>Wave 2 – 42 commissioning statements</td>
</tr>
<tr>
<td>VBC Checker to be operational Cardiology</td>
</tr>
<tr>
<td>Agreement on a community cardiology model</td>
</tr>
<tr>
<td>Roll out of Advice and Guidance</td>
</tr>
<tr>
<td>A&amp;G has been available in NHS e-Referrals from April 2017.</td>
</tr>
<tr>
<td>All three acute providers offer this service.</td>
</tr>
<tr>
<td>National CQUIN 2017-19 states specialties that account for 75% of GP referrals to provide A&amp;G by March 2019.</td>
</tr>
<tr>
<td>Wave 1 – 54 commissioning statements aligned</td>
</tr>
<tr>
<td>Wave 2 – 42 commissioning statements</td>
</tr>
<tr>
<td>VBC Checker to be operational</td>
</tr>
<tr>
<td>Cardiology</td>
</tr>
<tr>
<td>Agreement on a community cardiology model</td>
</tr>
<tr>
<td>Explore the development of a non-cancer lymphoedema service</td>
</tr>
<tr>
<td>Develop business case and subsequent service specification</td>
</tr>
<tr>
<td>Implementation of new service, dependent on financial plan</td>
</tr>
<tr>
<td>Achieve a reduction in face to face outpatient appointments of a third of current baseline</td>
</tr>
<tr>
<td>Alignment with HUTH CRES plans</td>
</tr>
<tr>
<td>Implement the Consultant 2 Consultant Good practice guidelines</td>
</tr>
<tr>
<td>Roll out of Shared decision making -clinicians and patients work together to select tests, treatments, management or support packages, based on evidence and the patient’s informed preferences</td>
</tr>
<tr>
<td>MDT To design an integrated pathway – COPD</td>
</tr>
<tr>
<td>Use technology to reduce follow ups – virtual clinics</td>
</tr>
<tr>
<td>Collaborate to deliver the aims of the York / Scarborough and Humber Acute services Review</td>
</tr>
<tr>
<td>Collaboration with key partners</td>
</tr>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Red lines agreed in internally and communicated</td>
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Better care, more locally, within budget, through transformation

Cancer

Delivering our Strategic Commissioning Intentions and System Priorities
Commissioning Intentions

- Achieve the national, constitutional cancer standards, reducing waiting times for patients.
- Address areas of high prevalence / late presentation within the East Riding
- Implement risk stratification of follow up activity
- Reduce the number of lives lost to Cancer in the East Riding and increase number of healthy lives, free from cancer
- Implement FIT test for low symptomatic bowel cancer across the East Riding
- Increase number of cancer patients with a care plan.
- Align work to improve cancer services with the Humber and Scarborough Acute Services Reviews
- Improve outcomes and experience for people diagnosed and living with and beyond cancer

Activity Impact

The initiatives being undertaken will ensure people are seen and treated within the appropriate timeframes. Significant increases / decreases in activity are not envisaged.

Partners and Alignment Considerations

Delivery of the cancer standards requires close partnership working between the CCG, General Practice and acute trusts. In addition, the role of the Cancer Alliance in developing and delivering these schemes is significant as they will act as leaders in the system to provide support to ensure plans are delivered and coordination.

To tackle late presentation and prevent cancers in Neighbourhoods, the CCG will work with the Cancer Alliance, Local Authority partners including Public Health and the emerging Primary Care Networks. The population health intelligence presented earlier demonstrates that every area of the East Riding has a higher prevalence that the England average and that smoking continues to be a significant cause of cancer in certain areas and in certain demographic groups.

Transformation Programmes

1. Cancer Alliance Programme of work
2. Targeted approach in the East Riding to reduce late presentation and support early diagnosis

STP Collaborative

Cancer is a significant issues for the whole of the HCV HCP. A dedicated work programme has been set up, run by the Cancer Alliance and lead by the Chief Officer of ER CCG. Dedicated funding is available to the Alliance to deliver improvements.

Key Assumptions & Guidance Considerations

The CCG is forecasting achievement of all of the cancer standards in 2019-20 with the exception of the 62 Day standard. Whilst the reasons for non-achievement of this standard over a long period are multi-factorial, the role played by lack of diagnostic capacity is significant. Therefore, as with the 1% diagnostic standard referenced in the Planned Care session, we anticipate some marginal improvement in 2019-20 but will not achieve the target until the new capacity is realised in 2020-21.

There are also some significant risk associated with the Breast 2ww standard but the CCG is working closely with the Alliance to ensure delivery.

Key Risks

- Release of capital money nationally to fund new diagnostic capacity
- Implementation of the new scanners / diagnostics and potential loss of activity during this time.
- Breast 2ww pathway.
Cancer: Priorities for 2019-21

NATIONAL

• At least 93% of patients who receive an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should have their first outpatient attendance within a maximum of two weeks.

• At least 93% of patients with breast symptoms who receive an urgent GP referral for suspected cancer should have their first hospital assessment within a maximum of two weeks.

• At least 96% of patients should wait no more than one month (31 days) for their first definitive treatment, from the date a decision to treat is made, for all cancers.

• At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is surgery.

• At least 98% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is drug treatment.

• At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is radiotherapy.

• At least 85% of patients receiving an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should wait no more than two months (62 days) for their first definitive treatment, for all cancers.

• At least 90% of patients with an urgent referral from an NHS cancer screening programme should wait no more than two months (62 days) for their first definitive treatment.

• From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer

• Radiotherapy and Genomics therapy are also 19/20 requirements.

• Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020

• Extend lung health checks (already piloted in Manchester and Liverpool)

• From 2019, we will start the rollout of new Rapid Diagnostic Centres (RDCs) across the country

• Implement a stratified approach for follow up for breast cancer in 2019 and prostate and colorectal cancers in 2020 (expanding to all cancers which are clinically appropriate in 2023). From 2019, we will begin to introduce an innovative quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer

• Redesign of the UGI Rapid pathways.

• The rollout for FIT in screening is also a short term deliverable (and increased uptake of screening).

• Improvement in stage 1 and 2 diagnoses.

LOCAL

• Address areas of high cancer prevalence within the East Riding
# Cancer: Milestone Plan for 2019-21

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<thead>
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<tbody>
<tr>
<td>The CCG anticipates achievement of all cancer standards in 2019-20 (albeit with some risks attached), with the exception of the 62 Day Target. The CCG will support the delivery of the submitted Cancer Alliance Plan for 2019-20</td>
<td>Identify any remaining issues identified through IST pathway tool that can be addressed and agree plans and timescales to resolve these. Maximise efficiency and productivity within the current diagnostic capacity. Additional sessions as required / affordable Implementation of new diagnostic capacity</td>
<td>September 2019</td>
<td>2019-20</td>
<td>tbc</td>
<td>Improvement in all cancer waiting time targets</td>
<td>Investment in new diagnostic capacity including scanners and scopes. Funded through HCP capital funding and Cancer Transformation Fund. Potentially some reduction in additional sessions. Not confirmed</td>
</tr>
<tr>
<td>The reasons the 62 day target has not been achieved sustainably for a long period of time is multifactorial. However, the lack of access to diagnostics in a timely manner is a significant contributing factor to non-achievement of the standard.</td>
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<tr>
<td>Address areas of high cancer prevalence within the ER, aiming for earlier diagnosis and avoiding late presentation</td>
<td>Multi-agency approach to targeting high prevalence through Primary Care Networks with support from Public Health and the Cancer Alliance. Understanding of current activities / provision Development of plan to address high prevalence / late presentations</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>nil</td>
<td>Long term – not currently quantified</td>
</tr>
<tr>
<td>Conclude an impact assessment of new performance measures highlighted in the Interim Review of Clinical Standards and feed into commissioning intentions for 2020-21</td>
<td>Undertake impact assessment Develop conclusions into commissioning intentions Undertake cost analysis</td>
<td>June 2019</td>
<td>To be determined as part of impact assessment</td>
<td>Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening. Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening. Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.</td>
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</table>
Emergency & Unplanned Care

Delivering our Strategic Commissioning Intentions and System Priorities
Better care, more locally, within budget, through transformation

Commissioning Intentions

- Achieve the existing NHS Constitutional Standards relating to emergency and unplanned care namely A&E 4 hour wait and ambulance standards.
- Review the CCGs Urgent Care Strategy
- Support the delivery of the Humber and Scarborough Acute Services Reviews
- Implement a High Intensity User Service
- Support delivery of the Unplanned Care Delivery Board work programme including:
  - Implement Same Day Emergency Care model, where appropriate
  - Implement the Primary Care Streaming Service at HUTH
- Embed Integrated Urgent Care across the East Riding and wider system, with partners.

Activity Impact

Nationally, unplanned and emergency demand on hospitals continues to cause significant quality concerns and poor experience for patients. The A&E 4 hour wait standard is often seen as a barometer for how well a system is performing and how well people are flowing through the system. The CCG benchmarks comparatively well in relation to its peers for emergency and unplanned care. However, there remains room for improvement and many of the initiatives within this section, and in others, seek to reduce emergency and unplanned admissions as far as possible whilst also trying to support people to leave hospital as soon as it is practical to do so.

Partners and Alignment Considerations

Continue joint work with partners in the acute Trusts, community and mental health service and social care to systematically triage, stream and signpost patients to support prompt treatment. Increase collaboration with local authorities and home care sector to reduce DToCs. Work with Ambulance partners to support sustainable achievement of ambulance standards and embedding NHS 111 as the entry point for Integrated Urgent Care.

STP Collaborative

Continue to work proactively as part of the Urgent Care Network and local A&E Delivery Boards.

Continue to support the Acute Services’ Reviews taking place across the Humber and in Scarborough.

Develop and embed Integrated Urgent Care across the emergency and urgent care pathways.

Transformation Programmes

1. A&E Delivery Board for Hull and East Riding and Scarborough and York
2. Unplanned Care Network
3. Integrated Urgent Care Transformation (regional)

Key Assumptions & Guidance Considerations

- Adherence to national guidance on the Integrated Urgent Care Specification
- Adherence to regional guidance around the provision of clinical advice services, NHS111 and direct booking, as well as 7 day working and revision of ambulance pathways
- Local growth assumptions for non-elective care are flat after the application of QIPP to mitigate demand and contribute towards cost efficiency

Key Risks

- BCF long term funding for schemes supporting the delivery of urgent care.
- Increases in demand
- Levels of clinical acuity
- Availability of social care and care home places
Emergency & Unplanned Care: Priorities for 2019-21

NATIONAL

Achieve the existing NHS Constitutional Standards relating to emergency and unplanned care namely A&E 4 hour wait and ambulance standards.

Respond to anticipated changes to constitutional standards expected during 2019.

Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care (SDEC).

CCGs yet to implement a High Intensity User support offer for demand management in urgent and emergency care will be required to establish a service in 2019/20.

Providers should focus attention on shorter lengths of stay to reduce the time for which patients are hospitalised and should set local targets for reduction in 7-day or more and 14-day or more lengths of stay in 2019/20.

Commissioners and providers will also be expected to support the ‘right place, first time’ approach by appropriately resourcing the Directory of Service (DOS), ensuring accurate profiling and a reduction in ‘A&E by default’ selections on the DOS to less than 1% by March 2020.

Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020.

Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.

Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020.

Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.

By 2023, CAS is to typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

Continue to rollout the seven-day services for four priority clinical standards to five specialist services (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the seven-day services four priority clinical standards in hospitals to meet the overall ambition of 100% population coverage by 2020/21.

LOCAL

Support the delivery of the Humber and Scarborough Acute Services Reviews.

Review the CCGs Urgent Care Strategy.

Proactive delivery of system escalation and management.

Ability for Primary Care to flag when they are under pressure e.g. OPEL system for General Practice.

Support the development of PCNs as required.

Embed locally the Integrated Urgent Care model.

Participation / delivery of UECN / A&E Delivery Board work programmes for Hull and East Riding and York and Scarborough.
# Emergency & Unplanned Care: Milestone Plan for 2019-21

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
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</table>
| Deliver the NHS Constitutionals targets relating to emergency and unplanned care, specifically the A&E 4 hour wait and ambulance standards | - Delivery / participation in A&E Delivery Board programme work streams  
- Annual system agreed work programme for each board in place  
- Alignment of system work programme when revised A&E performance standard review is published  
- Respond to the forthcoming options appraisal for the proposed changes to the Front Door model at HUTH  
- Regional ambulance turnaround work programme (CCG leading for HCV) | April 19 – March 20 | 73.4% | 95% all Trusts | Nil | Nil |
| CCGs yet to implement a High Intensity User support offer for demand management in urgent and emergency care will be required to establish a service in 2019/20 | - Discussions held at HCV UECN  
- Discussions held with Right Care Project charter developed  
- Business Case  
- Mobilisation plans  
- Evaluation | April 19 – March 20 | No service in place | HIU service established by March 2020 | To be determined | TBC |
| Providers should focus attention on shorter lengths of stay to reduce the time for which patients are hospitalised and should set local targets for reduction in 7-day or more and 14-day or more lengths of stay in 2019/20 | - Agreed metrics in place across the system  
- Partners working in an integrated way to deliver  
- Provider trajectories for the delivery of complex discharges | April 19 – March 20 | | Agreement in place | tbc | tbc | TBC |
<table>
<thead>
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| Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment  | IUC Core CAS will be in place via NHS 111, links to local GP OOH, UTCs  
Under development - Mental Health SPA and full community services SPA – to be limited to IUC Core CAS | Mobilisation of new NHS 111 contract by 1st April 2019                | 41%                                                             | 50%+ maintained by March 2020                                                             | TBC          | Nil     |
| Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020 | • Direct booking into GP OOH in place  
• UTCs and extended access prepared for when technical solution is available  
• Plans to technically enable general practice  
• NHS 111 specified to deliver  
• Local providers specified to deliver  
• Requirement included into the GP Contract from 2019 | No later than March 2020                                           | HCV – January 19 40.9%                                              | 40% by March 2020                                                            | TBC          | Nil     |
| Continue to rollout the seven-day services for four priority clinical standards to five specialist services (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the seven-day services four priority clinical standards in hospitals to meet the overall ambition of 100% population coverage by 2020/21 | Determine up to date baseline for HUTH, York and NLAG (most recent information is from 2016/17)  
Align the baseline to the acute clinical strategy reviews that are being held and the acute services reviews. | March 20                                                               | To be established                                                     | 100% across all four priority areas by March 2020                           | TBC          | TBC     |
| Commissioners and providers will also be expected to support the ‘right place, first time’ approach by appropriately resourcing the Directory of Service (DOS), ensuring accurate profiling and a reduction in ‘A&E by default’ selections on the DOS to less than 1% by March 2020. | Dedicated CCG DoS Lead  
Systematic review of DoS profiles established  
Links into the regional DoS learning in place  
Participation in national DoS pilot | March 2020                                                           | To establish current baseline                                       | 1% by March 2020                                                            | Nil          | Nil     |
| Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020 | Agreed to part fund regional single provider for IUC MDS and mobilise  
Requirement to provide local data is included within contracts | 1st April 2019                                                       | Current baseline to be established.                                   | 100% by March 2020                                                            | Nil          | Nil     |
<table>
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<tr>
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| Support the delivery of the Humber and Scarborough Acute Services Reviews | CCG representation at Humber and Scarborough Review programmes established.  
Engagement of clinical, commissioning leads and others as required.  
Co-ordination of any required public consultation arising from case for change. | April 19 – March 20 | N/A                | Cases for change to be agreed – date TBC   | TBC         | TBC     |
| Review the CCGs Urgent Care Strategy                                       | Undertake a desktop review of the existing strategy, highlighting outcomes that have been achieved and where further action is still required.  
Determine with the SLT that a revised strategy is required | July 2019            | N/A                | N/A                                          | None required to review and refresh the strategy if required. | Not applicable. |         |
| Proactive delivery of system escalation and management                     | CCG co-ordination on behalf of system partners of the Hull and East Riding system escalation responses.  
CCG co-ordination on behalf of system partners of the Hull and East Riding system seasonal planning and delivery requirements.  
Permanent recruitment to B4 post  
CCG participation in the system escalation responses for NLAG and York/Scarborough.  
CCG participation in the system seasonal planning and delivery requirements for NLAG and York. | April 19 – March 20 | Established and in place | N/A                                      | To be confirmed | Nil     |
| Ability for Primary Care to flag when they are under pressure e.g. OPEL system for General Practice | Piloting Primary Care OPEL reporting with the established PCH to be live by March 19  
Evaluation of pilot and seek to roll out across all practices  
Integration with PCNs | March 19 – April 20 | No practices currently live with OPEL Reporting | 100% of practices live with OPEL reporting. | TBC         | NIL     |
## Deliverable: Conclude an impact assessment of new performance measures highlighted in the Interim Review of Clinical Standards and feed into commissioning intentions for 2020-21

**Key Actions:**
- Undertake impact assessment
- Develop conclusions into commissioning intentions
- Undertake cost analysis

<table>
<thead>
<tr>
<th>Milestone</th>
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<th>National / Local Target</th>
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</thead>
<tbody>
<tr>
<td>June 2019</td>
<td>To be determined as part of impact assessment</td>
<td>Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&amp;E departments).</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>September 2019</td>
<td></td>
<td>Time to emergency treatment for critically ill and injured patients.</td>
<td></td>
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<tr>
<td>October 2019</td>
<td></td>
<td>Time in A&amp;E (all A&amp;E departments and mental health equivalents).</td>
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<td></td>
<td></td>
<td>Utilisation of Same Day Emergency Care.</td>
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## Deliverable: Support delivery of the Unplanned Care Delivery Group work programme including:

**Hospital wide improvement Programme to include the standard that 'Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care (SDEC)'.**

**Key Actions:**
- Determine current baseline of performance and definition of SDEC as York, NLAG and HUTH all have functions similar to this.
- Agree the model to be implemented
- Requirement included into contract from 2019
- Agree robust phased implementation plan with agreed milestones
- Develop and agree service specification

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<tr>
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<tbody>
<tr>
<td>March 2019</td>
<td>Work underway to determine current baseline.</td>
<td>Acute admissions discharged on the day of attendance will increase from a fifth to a third.</td>
<td>Tbc</td>
<td>Tbc</td>
</tr>
<tr>
<td>March 2019</td>
<td>Model identified by Unplanned Care development Group and agreed by all SRO's</td>
<td>Minimum 20% patients streamed to primary care area</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>April 2019</td>
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<td></td>
<td></td>
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<tr>
<td>May 2019</td>
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<tr>
<td>April 2019</td>
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Enablers

Delivering our Strategic Commissioning Intentions and System Priorities
Technology

Delivering our Strategic Commissioning Intentions and System Priorities
Better care, more locally, within budget, through transformation

Technology has impacted every area of our lives. However, within the NHS, a proliferation of systems and the scale of change required over different sectors has resulted in the service struggling to realise the benefits inherent within technology that people have embraced in other walks of life. Technology is really about 1) Infrastructure – making sure the hardware (boxes and cable) are up to date, serve a purpose and offer safe governance of peoples records; 2) Interoperability – systems in different sectors need to talk to each other to allow people and professionals to access a common record to make the best decisions and; 3) People facing – how technology can be used to book appointments, improve choice and control, prevent duplication, etc.

This ‘Digital first’ approach is now at the centre of the NHS 10 Year Plan. It is envisaged that the appropriate use of technology will free up capacity across the system, improving choice and personalisation of services, support a more efficient and agile workforce and ensuring contractual requirements. Particularly, there is a clear ambition to reduce outpatient appointments within secondary care by a third by offering people technologically enabled solutions.

**Commissioning Intentions**
- Replacement of IT in General Practice >5 years old, as funding allows
- Upgrade all devices to Windows 10
- Replace all current Health and Social Care Networks
- Care Home IT programme
- GP contract Digital Programme
- Delivery of a range of bids/initiatives across the health and care system including the NHS App, Key messaging in General Practice.

**Activity Impact**

Technology has impacted every area of our lives. However, within the NHS, a proliferation of systems and the scale of change required over different sectors has resulted in the service struggling to realise the benefits inherent within technology that people have embraced in other walks of life. Technology is really about 1) Infrastructure – making sure the hardware (boxes and cable) are up to date, serves purpose and offer safe governance of peoples records; 2) Interoperability – systems in different sectors need to talk to each other to allow people and professionals to access a common record to make the best decisions and; 3) People facing – how technology can be used to book appointments, improve choice and control, prevent duplication, etc.

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**Partners and Alignment Considerations**
- Digital First programme as an overarching transformation programme to address the ambitions of the 10 year plan
- Digitalisation of records will require a particular programme of work to manage the significant resource and time requirement
- Workforce development – to ensure that our professionals feel confident and competent in utilising technological solutions
- Engagement with the public to ensure that people are aware of and choose to utilise the right services for them

**STP Collaborative**
- Our approach to the utilisation of technology will be through our established Humber Local Digital Roadmap (LDR) programme and the Local Health and Care Record Exemplar (LHCRE) programme for Yorkshire and the Humber

**Key Assumptions & Guidance Considerations**
- Resource availability to support deployment and commissioning
- Determine of the NHS App will enable consultation to be provided.

**Transformation Programmes**
- Digital First programme as an overarching transformation programme to address the ambitions of the 10 year plan
- Digitalisation of records will require a particular programme of work to manage the significant resource and time requirement
- Workforce development – to ensure that our professionals feel confident and competent in utilising technological solutions
- Engagement with the public to ensure that people are aware of and choose to utilise the right services for them

**Key Risks**
- IT procurement in year
- Windows 10 and N3
- Availability of funding to support the new digital agenda
- Significant number of priorities to be achieved as part of the GMS contract and the 10 Year Plan
- Workforce preparedness
Technology: Priorities for 2019-21

NATIONAL

- Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by October 2019
- Work across the STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models to sustainably reduce the number of patient visits in line with the goal of reducing the number of outpatient visits by a third over the next five years
- During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in The Future of Healthcare.
- By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.
- In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.
- Ensure that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019
- All CCGs in England should ensure patients have access to a clinical consultation with their GP practice online. CCGs are expected to work with their practices to ensure that by March 2020, 75% of practices are offering online consultations to their patients
- New patients will have full access to their records electronically in year and will be able to add to it by 2020
- Following a clinical triage, 1 in 3,000 per population will be able to directly book from NHS 111
- Practices will need to have a designated lead for data protection or devolve to the CCG
- Care plans are to be updated on the Summary care Record in / near to real time
- Fax machines will be decommissioned by 2020
- Each practice will need a central practice email registered.
Technology: Milestone Plan for 2019-21

The NHS 10 Year Plan and the new GP Contract represent a significant step change in the way technology will be used in the NHS. Many of the new deliverables are challenging and represent a significant amount of time and resource to enact. In the coming months we will develop a work plan with our partners in the Humber LDR and the Yorkshire and Humber LHCRE.

Simultaneously, the impact of these changes on our professionals and local people cannot be underestimated. Engagement with professionals will be key to ensure that technology is seen as a benefit, supporting the workforce to work more efficiently and to remove some of the frustrations people feel on a daily basis. This will not simply happen by presenting people with a mobile device or improving a system; we must ensure that people understand the benefits of the technology and are capable and confident in its use. If we fail in this regard, we will not realise the intended benefits for our local people or the system.

We recognise the need to undertake engagement with our local people regarding the Digital First offer. In the East Riding we have a demographic that is skewed towards a more elderly population. Whilst we will not fall into the trap of saying that older people do not use technology, we have listened to what people have told us in recent engagement sessions and have heard that using technology for health purposes will not be right for some people. Therefore, we will continue to offer people different choices and support those who want to use technology through a variety of means to develop capability and competency.

We will support the HCV HCP to develop consistent communications for our workforce and local people in this regard.
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<tbody>
<tr>
<td>Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by October 2019</td>
<td>• CCG Workstream to be developed&lt;br&gt;• Requirement to be fed into LHCRE Programme</td>
<td>• Workstream launch&lt;br&gt;• LHCRE requirement understood</td>
<td>• Fact finding underway</td>
<td>• Solution deployed by October 2019</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Work across the STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models to sustainably reduce the number of patient visits in line with the goal of reducing the number of outpatient visits by a third over the next five years</td>
<td>• Management of process managed by STP Digital Board&lt;br&gt;• Workstream to be included in STP Digital Strategy</td>
<td>• Digital Strategy Created&lt;br&gt;• Local leads identified&lt;br&gt;• Proposals for transformation developed</td>
<td>• External Service to develop Strategy procured and engaged&lt;br&gt;• STP board maturing</td>
<td>• Strategy developed and accepted&lt;br&gt;• Proposals agreed by local delivery board</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>Improved Record Sharing between professionals within Health &amp; Social Care</td>
<td>• Identify tactical solutions to provide record sharing solutions across settings&lt;br&gt;• SCR deployed in Social care by May 2019&lt;br&gt;• Engage with LHCRE programme</td>
<td>• SCR deployed&lt;br&gt;• Common minimum data set agreed for shared records via YHCRE</td>
<td>• IG &amp; RA Process for social care access to SCR agreed with NHSD&lt;br&gt;• SCR Pilot in Hull successfully Launched&lt;br&gt;• EROY Council have seat on YHCRE technical board</td>
<td>• SCR deployed in Social care by May 2019&lt;br&gt;• YHCRE to add social care data by 2022</td>
<td>LHCRE matched Funding</td>
<td>TBC</td>
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<tr>
<td>By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system</td>
<td>• Ensure that IT provider meets standards via contract management process</td>
<td>• Supplier assurance accepted</td>
<td>• Regular Contract meetings in place&lt;br&gt;• Procurement process for new IT contract underway</td>
<td>• Assurance accepted by Summer 2019</td>
<td>TBC</td>
<td>TBC</td>
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<tr>
<td>In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation</td>
<td>• Connect with the Yorkshire and Humber Local Health Care Record Exemplar Programme which is implementing Population Health systems across the Region&lt;br&gt;• Agree data sets to be shared&lt;br&gt;• Widely Socialise solutions</td>
<td>• System chosen&lt;br&gt;• Data Sets Agreed&lt;br&gt;• Engagement process agreed</td>
<td>• LHCRE Funding awarded&lt;br&gt;• System Planning underway</td>
<td>• Population Health solution deployment planned by Dec 2019</td>
<td>LHCRE matched Funding</td>
<td>TBC</td>
</tr>
<tr>
<td>Deliverable</td>
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<td>By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices</td>
<td>• Continued Deployment of CP-IS system</td>
<td>• CP-IS available in all care settings</td>
<td>• CP-IS is currently configured to be populated by LA systems&lt;br&gt; • CP-IS available to Safe Guarding teams via the national SCR Portal</td>
<td>• Extend rollout of CP-IS to other care settings&lt;br&gt; • Work with system suppliers to develop direct integration with CP-IS</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>By 2023/24 every patient in England will be able to access a digital first primary care offer</td>
<td>• Ensure supporting Infrastructure is in place&lt;br&gt; • Identify solution sets&lt;br&gt; • Agree engagement plan&lt;br&gt; • Online services improved</td>
<td>• Solution set agreed&lt;br&gt; • Business Change process agreed&lt;br&gt; • Comms Plan actioned&lt;br&gt; • Online Presences improved</td>
<td>• Funding streams being identified&lt;br&gt; • NHS Digital Patient Online Tools are being promoted</td>
<td>• Patient online services further promoted&lt;br&gt; • Digital solution set identified &amp; in place to support Digital First Primary Care Offer</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Ensure that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019</td>
<td>• Agree Go-live date&lt;br&gt; • Agree Comms Plan</td>
<td>• Activation plan agreed</td>
<td>• Go-live date agreed for mid April with NHS England&lt;br&gt; • Comms to practice being designed</td>
<td>• System Live in soft launch by Mid April&lt;br&gt; • National communications begin in September</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All CCGs in England should ensure patients have access to a clinical consultation with their GP practice online. CCGs are expected to work with their practices to ensure that by March 2020, 75% of practices are offering online consultations to their patients</td>
<td>• Ensure supporting Infrastructure is in place&lt;br&gt; • Identify solution sets&lt;br&gt; • Agree engagement plan&lt;br&gt; • Online services improved</td>
<td>• Solution set agreed&lt;br&gt; • Business Change process agreed&lt;br&gt; • Comms Plan actioned&lt;br&gt; • Online Presences improved</td>
<td>• Funding streams being identified&lt;br&gt; • Waiting on NHS England Guidance&lt;br&gt; • Fact Finding Pilots underway</td>
<td>• Patient online services further promoted&lt;br&gt; • Digital solution set identified &amp; in place to support Video Consultations</td>
<td>TBC</td>
<td>N/A</td>
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Workforce

Delivering our Strategic Commissioning Intentions and System Priorities
Workforce

Commissioning Intentions

- Support the ongoing development of the General Practice workforce
- Support partners to recruit and retain their workforce where possible
- Refresh CCG organisational development plan to ensure the CCG workforce has the capability and capacity to deliver its strategy and operational plan
- Work with partners to ensure their workforce has the capacity and capability to realise the benefits from our plans around new models of care, technology, etc.

Activity Impact

The need for a skilled and sustainable workforce is an absolute requirement that underpins all of the developments set out in this plan. Without this, the system will continue to struggle to deliver activity, develop staff and further enable them to support our patients and local people.

Many areas are challenged in this regard. The CCG will support the programmes of work seeking to address these issues and recognises that it can potentially offer the greatest value in General Practice. The CCG will support General Practice to offer a varied workforce who can ensure that people attending their practice can see the most appropriate person for their needs and release time to care for GPs. The CCG will also formulate an offer to PCNs that will include workforce and leadership development to enable PCNs to deliver activity at scale.

Partners and Alignment Considerations

We will work with our partners in provider organisations who continue to be challenged with significant vacancies across a range of specialties both in and out of hospital. The CCG will work through our established structures to support these developments e.g. the East Riding Place Partnership and the HCV HCP Workforce Work stream.

General Practice workforce remains a continuing issue where the CCG plays a more significant role. The CCG will continue with supporting retention and recruitment of roles into General Practice including overseas recruitment. The CCG, through its General Practice Strategy, will continue to support General Practice and the public to develop and promote alternative roles through Care Navigation and communication messages, aligning with the national alternative role reimbursement scheme.

The CCG will also support the workforce and leadership development of the emerging Primary Care Networks.

Transformation Programmes

- STP Workforce Programme
- STP Primary Care (General Practice) Strategy development
- Development of the PCNs against the published Maturity Matrix
- Reimbursement of alternative roles national programme

STP Collaborative

The CCG is an active participant in the STP Workforce work stream which works at scale to address STP issues. In addition, the CCG is contributing toward the STP’s Primary Care (General Practice) Strategy for workforce.

Key Assumptions & Guidance Considerations

- Support the development of PCN’s in terms of workforce capability and capacity in line with the requirements of the GP Contract.
- Support the delivery, where appropriate, of the Workforce Implementation Plan from NHSE once published.
- Consider the capability and capacity of the workforce to undertake the deliverables set out in this plan in all initiatives.

Key Risks

- Availability of training / qualified vacancies
- Attracting people to the area
- Retaining people / developing the workforce
- Access to funding
Workforce: Priorities for 2019-21

NATIONAL

- Work with HEE to ensure robust training programmes are in place to adequately support workforce plans
- Ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of 2019/20 sustainability and resilience funding (allocated by NHS England) must be spent by 31 December 2019, with 100% of the allocation spent by 31 March 2020.
- Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes (e.g. e-learning resources held by HEE); and that there is a plan to develop the agreed set of required functions by 31 March 2020
- Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme
- Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts (funded by the Pharmacy Integration Fund, with support from NHS England Regional Independent Care Sector Programme Management Offices), to improve medicines optimisation for care home residents by 31 March 2020
- Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care
- Recruit the share of the additional 5000 doctors and maximise the impact of the over 5000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives.
- Plan specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training; with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2020

LOCAL

- Formulate an offer to Primary care Networks to support leadership and workforce development against the PCN maturity matrix
- CCG organisational development to deliver its refreshed 5 year strategy.
- Support system partners where possible to recruit and retain their workforce
- Support HCV HCP strategies and plans at a Place level
- Promote East Riding as a place to work
<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes (e.g. e-learning resources held by HEE); and that there is a plan to develop the agreed set of required functions by 31 March 2020</td>
<td>Workforce Plan in place to address training needs and retention of primary care workforce. Information and opportunities regarding training and on-going professional development will be communicated to all primary care workforce.</td>
<td>GP/primary care workforce strategic plan produced March 2019</td>
<td>Local initiatives are in the workforce strategic plan</td>
<td>End of 2020</td>
<td>Staff time, practice relationships, New Hub and Post £80K</td>
<td>N/A</td>
</tr>
<tr>
<td>Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme</td>
<td>Planning at STP level via attend Integrated Care Workforce development Group (STP wide) To set up training hubs</td>
<td>NHS Ten Year Plan Due by 2023</td>
<td>Several recruited or in place.</td>
<td>NHS Ten Year Plan Due by 2023</td>
<td>Staff time, practice relationships,</td>
<td>N/A</td>
</tr>
<tr>
<td>Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts (funded by the Pharmacy Integration Fund, with support from NHS England Regional Independent Care Sector Programme Management Offices), to improve medicines optimisation for care home residents by 31 March 2020</td>
<td>Working with NHS England and local practices to deliver. Need to coordinate with elements of 10 year plan</td>
<td>March 2020</td>
<td>Several recruited or in place.</td>
<td>March 2020</td>
<td>Funding for posts from HEE Support costs</td>
<td>N/A</td>
</tr>
<tr>
<td>Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care</td>
<td>Ten Point Action Plan for General Practice Nursing. Workforce Plan in place to address training needs and retention of primary care workforce. Collaboration with HEE, NHSE and HEIs to ensure equity in uptake of training and development opportunities for nurses.</td>
<td>During 2019/20</td>
<td>Good links with local Hull University. Experience of education and research bursaries. Large number of mentors trained.</td>
<td>March 2020</td>
<td>bursaries and mentor training £50K</td>
<td>N/A</td>
</tr>
<tr>
<td>Recruit the share of the additional 5000 doctors and maximise the impact of the over 5000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives</td>
<td>International Recruitment work with Integrated Care Workforce development Group (STP wide)</td>
<td>Taster weekend held 7th Dec 2018 for 2 GPs one of whom will qualify in 2019, the other in 2020</td>
<td>Tried a wide variety of strategies including promoting HCV, Offering educational bursaries, GPwSI training also HYMS increased intake</td>
<td>Apex inform numbers recruited</td>
<td>Funding from NHSE for international recruitment</td>
<td>N/A</td>
</tr>
<tr>
<td>Plan specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training, with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2020</td>
<td>Working with Integrated Care Workforce development Group (STP wide)</td>
<td>Fill of scheme under discussion with local trainers</td>
<td>Tried a wide variety of strategies including promoting HCV, Offering educational bursaries, GPwSI training</td>
<td>Yearly figures</td>
<td>Educational bursaries £10K a time ? *5 = £50K</td>
<td>N/A</td>
</tr>
</tbody>
</table>

83
<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key Actions</th>
<th>Milestone</th>
<th>Current Performance</th>
<th>National / Local Target</th>
<th>Investments</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with HEE to ensure robust training programmes are in place to</td>
<td>To attend Integrated Care Workforce development Group (STP wide) To set up training hubs</td>
<td>GP/primary care workforce strategic plan produced March 2019</td>
<td>Local initiatives and place are in the workforce strategic plan</td>
<td>Plans to be developed in alignment with the NHS Ten Year Plan RE: Workforce</td>
<td>Relationship time</td>
<td>N/A</td>
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<tr>
<td>adequately support workforce plans</td>
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<tr>
<td>Ensure that the local practice development plans continue to identify</td>
<td>Apex installed in GP practices with consent to have access to data produced Practice Level Planning Primary Care Network level Planning STP level planning</td>
<td>All Practices have Apex installed. Apex fully functional and data shared with CCG</td>
<td>Relying on installation of Apex workforce tool to provide information from which plans can be developed</td>
<td>Plans to be developed in alignment with the NHS Ten Year Plan RE: Workforce</td>
<td>Staff time, practice relationships</td>
<td>N/A</td>
</tr>
<tr>
<td>those practices who need more intensive and immediate support to</td>
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<tr>
<td>stabilise, build their resilience and become sustainable. 75% of 2019/20</td>
<td></td>
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<tr>
<td>sustainability and resilience funding (allocated by NHS England) must be</td>
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<td>spent by 31 December 2019, with 100% of the allocation spent by 31 March</td>
<td></td>
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<tr>
<td>2020.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Organisational development and alignment with delivery of the refreshed</td>
<td>Complete and approve CCG 5 year strategy Refresh organisational development plan in line with new strategy. Implement recommendations as appropriate.</td>
<td>July 2019</td>
<td>In development</td>
<td>Strategy in place</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5 year strategy for the CCG, building on existing work relating to</td>
<td></td>
<td>September 2019</td>
<td>Current plan in place</td>
<td>Revised plan in place</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>leadership and talent management</td>
<td></td>
<td>March 2021</td>
<td>Current plan in place</td>
<td>Achieve measures identified in the OD plan</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
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</tr>
<tr>
<td>Formulate an offer to PCNs for workforce and leadership development</td>
<td>Assess current position against the PCN maturity matrix Develop and implement actions accordingly</td>
<td>June 2019</td>
<td>N/A – though some workforce and leadership development happening</td>
<td>Improvement against maturity matrix</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td></td>
<td></td>
<td>December 2019</td>
<td>N/A</td>
<td></td>
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</tr>
</tbody>
</table>

Better care, more locally, within budget, through transformation
Finance, Activity & Delivery Plans for 2019-21

Ensuring a sustainable future

Better care, more locally, within budget, through transformation
Finance, Activity & Delivery Planning: 2019-21

Funding

2019 reflects the start of the longer term planning for the NHS with a refresh of the funding formula with the aim of making them more responsive to extremes of health inequalities and unmet need. In addition the allocations received by the CCG were set to cover the impact of the 2018/19 pay awards and changes to the structure of the national prices paid for the provision of healthcare services (national tariff). The guidance also sets out its expectations that allocations were set so that CCGs can meet their commitments to the mental health investment standard and further commitments to increase funding for primary medical and community health services. Alongside there have been a number of changes to the central financial support regime which sees acute provider tariffs amended to incorporate £1bn of Provider Sustainability Funding (PSF) which will be phased out over the following years of the long term plan.

For the CCG the changes result in an overall uplift to its core funding of 5.19% in 2019-20 against which the CCG has been set a target (or control total) of making a £2m surplus from its 2019-20 allocation which will be used to reduce the historic debt forecast to be £2.5m at the end of 2018-19 financial year. Working in conjunction with our providers of healthcare we have calculated that the CCG growth funding of 5.19% enables the CCG to pay the price increases (tariff uplift) set out in guidance but does not provide any additional funding to deal with the demographic impact of an ageing population or allow for improvements in performance. The reality of the funding settlement creates a difficult financial and performance environment as public and partner expectations have been raised by headlines of significant funding growth for the NHS overall.

Activity and Performance

Given the difficult financial position of the CCG, we have been working with our main acute service provider to identify specific service investments that are required to maintain and/or marginally improve current performance. These are limited and are priority areas where the changing profile of the CCGs population is placing specific pressures on the provider. In regard to our other acute providers we continue to work collaboratively to identify priorities and manage costs whilst maintaining performance.

Within the planning guidance there is a requirement of the CCG to invest in Mental Health services at a rate over and above the levels of funding allocated to the CCG. Whilst this targeted investment will help improve services in this area it creates additional pressures on the CCG finances. We will need to work with system partners to ensure Value for Money from this additional investment.
Savings and Demand Management

Working in collaboration with our providers has enabled the CCG to improve its underlying financial position to the point where 2018-19 returns the CCG to in-year financial balance. This turnaround has been achieved primarily through managing additional demand, looking at alternative pathways, reducing waste and value based commissioning. This theme continues going forward with schemes

- developed in conjunction with acute providers which are supported by amended care pathways and/or changes to contracted activity
- opportunities identified via analysis of Right Care, procedures of limited clinical value, implementation of thresholds
- associated with decommissioning and re-provision of schemes in different sectors

A summary of our identified savings for 2019-20 are presented below.

<table>
<thead>
<tr>
<th>QIPP Schemes</th>
<th>Savings £'000</th>
<th>Investment £'000</th>
<th>Net £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Intervention</td>
<td>3%</td>
<td>(352)</td>
<td>150</td>
</tr>
<tr>
<td>Planned Care</td>
<td>22%</td>
<td>(2,271)</td>
<td>558</td>
</tr>
<tr>
<td>Commissioning Statements Impact</td>
<td>12%</td>
<td>(1,279)</td>
<td>-</td>
</tr>
<tr>
<td>Unplanned Care</td>
<td>1%</td>
<td>(137)</td>
<td>-</td>
</tr>
<tr>
<td>BCF</td>
<td>0%</td>
<td>(42)</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4%</td>
<td>(432)</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>19%</td>
<td>(1,920)</td>
<td></td>
</tr>
<tr>
<td>Community Equipment Service</td>
<td>2%</td>
<td>(200)</td>
<td></td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>6%</td>
<td>(580)</td>
<td></td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>30%</td>
<td>(3,023)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(10,236)</td>
<td>708</td>
</tr>
</tbody>
</table>
Finance, Activity & Delivery Planning: 2019-21

Risks

There are a significant number of risks going into 2019-20 and the CCG currently has agreed a plan which aims to deliver its control total but has not identified circa £3m of savings required to bridge the gap between expenditure and funding. Whilst the CCG has a good track record of programme delivery and cost management, this gap presents a significant financial risk above and beyond that associated with mobilising and implement identified schemes. Key risks identified at this draft planning stage include

- Circa £3m of unidentified savings
- Agreement of contracts with providers. Whilst Aligned Incentive Contracts share risk and reinforce collaborative behaviours their block nature limits any opportunity for further reductions in-year
- A number of providers have identified activity plans in excess of those reported within this plan
- The CCG has assumed a number of additional allocations which have yet to be confirmed
- A number of budget areas remain inherently sensitive to external factors e.g. stock limitations and wage increases
- Primary Care budget shortfall

Running Costs

The CCG is currently operating within its current and future (reduced) Running Cost envelope and will need to ensure it can deliver the necessary changes within its current establishment.

Estate

The CCG has been working with partners on Estates with an objective to provide a fit for purpose, flexible and cost efficient health estate across the East Riding that will facilitate service transformation, delivery of high quality health and social care services and is sustainable. This has been supported with funding support from the NHS Estate and Technology Transformation Fund (ETTF), business as usual funding and the HCP capital funds to date. Moving forward the new NHS capital funding regime is still evolving and therefore uncertain.

We will need to work closely with Clinical Directors for each Primary Care Network to ensure estate investment is aligned, supports and enables transformation of services within the respective new service strategies based around each locality to facilitate enhancement and new models integration of primary, community and social care and delivers fit for purpose healthcare facilities. This will be done taking a strategic approach to develop a program of modernisation, rationalisation, increased efficiency and reduced premises costs to align with the HCV HCP Strategy and Capital investment planning to maximise opportunities for external funding support within the East Riding, along together continued to engagement with other public sector partners as part of the East Riding One Public Estate programme.
**Aligned & Collaborative Planning**

In the last two years the CCG has worked in conjunction with its main acute provider and Hull CCG to develop the Aligned Incentive Contract (AIC) which at its heart brings all parties together to work jointly on releasing the opportunities available. The AIC has a fixed financial value and moves away from a cost and volume arrangement (Payment by Results) the key advantages of the AIC are:

- Commitment to System Wide Improvement
- Incentives to reducing activity
- Joint responsibility – ensuring patients receive the right care in the right setting as efficiently as possible.
- Single Monitoring system

This has required a revised governance structure and a different way of working which is place based delivering:

- Refocus from transactional to transformational in order to provide clinical and financial sustainability
- Focus on value – cost, efficiency, effectiveness across the whole pathway
- Transparent working
- Equitable contracting arrangements and allocation of resource
- Greater collaboration through joint planning, joint savings plans and shared success and or risks

It is the CCGs ambition to operate under similar AIC arrangement with all its key providers and whilst traditional block (or fixed value) contract arrangement exist for other providers less amenable to a cost and volume approach the benefits and advantages of working in this way are established in the Collaborative Working Contracts for both the Mental Health and Community Service providers in the East Riding.

**Place System Plans**

During 2018-19 there has been a real focus on the development of Place plans, working across public sector organisations. Improved system working at a place level will underpin the delivery of the financial recovery plan. A number of work streams have been agreed that will deliver enhanced efficiency and effectiveness, including workforce, IT and One Public estate to maximise the use of public assets. In addition there is a strong partnership with the Council to build on collaborative commissioning opportunities that improve the quality of services and value for the public purse. To further enhance place based working the CCG and East Riding of Yorkshire Council have agreed to further strengthen the close partnership working by establishing a Joint Committee made up of Elected Members and officers of the Council and Governing Body Members of East Riding CCG including GP clinical members. The aim will be to get alignment of:

- joint strategic plans and priorities;
- delivery of joint commissioning plans and functions
- spending priorities, budgets and risk sharing arrangements
Governing Body Oversight
The Governing Body meets in ‘Committee’ as the Quality, Performance & Finance Committee (QPFC) to have explicit reference and focus on financial performance recognising the challenging financial position. The ‘Committee’ reviews key issues and receives assurance on finance, performance and quality with a role of oversight and challenge to the savings & efficiency plans particularly progress on the material changes needed to delivery financial recovery. The Governing Body has dedicated time to Financial Recovery and this increased the challenge has helped develop strategy and approach to recovery.

Delivery Board
The Senior Leadership Team also has a monthly Delivery Board (SLTDB) meeting which reviews, challenges and supports delivery of the CCGs financial recovery plans. To enhance wider engagement and draw on the experience and knowledge in the healthcare system membership is drawn from NHS England Finance, Senior Finance Leaders and the Local Authority. In addition the CCGs Lay Member with responsibility for Finance & Governance have an open invitation to the meetings. The Board reviews progress at individual initiative (project) level and ensures overall programme level direction is aligned to the CCGs key priorities and leaders with delegated authority are taking all steps necessary to drive forward plans to deliver the transformation needed at pace. External reviews of the CCGs governance and Programme Management in both 2017 & 2018 have reported positively on these arrangements and progress to date indicates success in managing the financial position.

Clinical Leadership
Clinical leadership is a key mechanism required to deliver financial recovery. Our GP leads have agreed to focus their time on leadership to specific savings programmes and to provide leadership at the Council of Members and other peer to peer meetings. This has service the CCG well over the last two years but needs to be reviewed in light of the recently announced reforms to Primary Care contract. The CCG Governing Body has approved a programme of work to look at governance in this respect. Whilst progress has been made the two main areas for savings opportunity still reflect remain in planned care and prescribing and these will continue to be driven forward by the Clinical Leaders supported by relevant management.
Finance, Activity & Delivery Planning: 2019-21

Governance and Leadership

Programme Management
The Director of Performance Delivery and Planning ensures that there is a robust grip on programme delivery through Programme team meetings. The SLT Delivery Board then delivers oversight, challenge and manages any escalations and issues.

The CCG has a well-documented and robust strategic planning process with strong programme management supporting it. The process aligns operational, QIPP and other planning processes to ensure integrated operational planning and enables structured planning and delivery of the CCG’s commissioning strategy through the delivery of priority programmes and projects. The CCG’s assured programme management approach ensures rigour in delivery of the organisations programmes and projects to support delivery of its strategic objectives.

Project Charters are used to determine the nature and scope of projects and signed off by the SRO and relevant stakeholders. The process for monitoring and reporting is mature within the CCG with a clear reporting structure. The Senior Leadership Team Delivery Board (SLTDB) meets monthly with attendance from both CCG staff and clinicians, as well as key personnel from other organisations.

Risks and issues are documented within programme specific Status Reports and reviewed throughout the governance process. The reports provide a summary to the SLTDB of the status of programmes and projects and detail progress against key milestones and performance and are held within the PMO file structure.

Governance Structures
- Governing Body in Committee as QPFC
- Senior Leadership Team Delivery Board
- Programme Team Meetings

Programme Management
- Director of Planning, Performance & Primary Care
- Assistant Director of Planning & Performance Delivery
- Planning & Programme Delivery Manager
- PMO Programme Delivery Manager

Better care, more locally, within budget, through transformation