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We are facing some significant challenges in the years ahead: an ageing population, increasing numbers of people with complex long-term health conditions, rising expectations and increasing costs.

Our aim is to positively embrace these challenges to ensure people living in Fylde and Wyre have the very best health and health services possible. We welcome with excitement, and a deep sense of responsibility, the opportunity to work together to ensure the best quality care is available to all.

With this in mind, over the last few months we have worked with partner organisations, patients and the public, to develop a vision for the future. Our 2030 Vision for Health and Care in Fylde and Wyre describes how we would like our health services in the future. This long-term view reflects the significant changes required to tackle some of the challenges that we face, and also ensures our plans are aligned with those of our local authority partners, Fylde and Wyre borough councils, who also have long-term strategies.

This document describes in more detail how we plan to make our vision a reality over the next five years. It clearly describes the new care models we are developing with partners and patients which we believe will have the greatest impact on health.

I would like to thank all of those who have contributed to the development of our plans. It was most reassuring that the vast majority of the people we spoke to were in agreement about what our health services should look like in the future.

As you have told us – let's not continue to do what we have always done. Let's be visionary and work together to make sure local people have the best possible health and health services for the years to come. Let's get fit and well for the future together.

Dr Tony Naughton
Clinical Chief Officer
NHS Fylde and Wyre Clinical Commissioning Group
This document sets out in detail how we plan to further develop and improve local health services over the next five years. It builds on our 2030 Vision for Health and Care which provides a framework for how we plan to tackle the many challenges we face to improve health and healthcare in Fylde and Wyre.

People are living longer, and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. For example, patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.

Our aim is to create a health service that supports people to be as fit and well as possible. We also want to make sure that when people are unwell, they can get high quality treatment or advice as close to their home as possible. To do this within the resources available, we believe we need more and better community-based services. This includes using new technology to improve access to services and make it easier to remain at home for longer. People should only need to visit a hospital for specialist treatment – which will free up our hospitals to concentrate on services that only they can provide.

Our vision has been co-designed with local healthcare professionals, with support from public health colleagues and commissioning specialists. It is, of course, underpinned by public health and commissioning data, as well as best practice from across the world. We have also considered a wide range of policy and guidance, including Everyone Counts (NHS England’s five-year planning guide), the health and wellbeing strategies being developed across Lancashire and the plans of our local authority partners.

To develop our vision, we talked to a wide range of partners, patients, the public and their representatives through a series of focus groups, surveys and other mechanisms such as our regular drop-in listening sessions held at libraries and health centres. In total, we spoke to nearly 3,000 people – some about our vision in depth, and some about the issues they are currently facing. As part of this we commissioned independent researchers Ipsos MORI to carry out a representative telephone poll of over 1,000 people. This covered a variety of topics, many of which are outlined in later sections.

This document describes what we are aiming to do over the next five years to make our 2030 Vision a reality. It provides the basis for further detailed planning and will ultimately stimulate change. A more detailed two-year operational plan has also been produced which will be updated annually.

In order to succeed we will need to work together with other organisations, as well as patients and the public. Our partnerships are key, and include local authorities, NHS bodies, the voluntary, community and faith sectors, non-NHS providers, educational and workforce planning bodies, and, most importantly, the public, patients and their carers. These partnerships will have to be reciprocal. While we will continue to involve partners in developing and implementing our plans, we too will need to influence our partners’ plans to really make a difference to the health of the population we serve. Part of this work will be implemented through the Lancashire Health and Wellbeing Board by agreeing how to best spend the Better Care Fund, the shared health and social care budget which aims to improve services for the most vulnerable.

As the change to the current system will be significant, we also recognise the need to work collaboratively with our partner commissioners to ensure that we do not destabilise our current shared providers as they are fundamental partners in providing quality health services both now and in the future.

Figure 1 illustrates how this five-year plan fits with our 2030 Vision, the Better Care Fund and other plans and will be delivered through our new programme management approach.

A summary of our plans over the next five years is outlined on page 6 in ‘Our plan on a page’. An explanation about all of the interventions listed can be found on later pages of this document.
HOW OUR STRATEGIC AND PLANNING PROCESSES ALIGN

Figure 1: How this plan fits with other plans

- Health and Care Vision 2030
  - Our long-term vision for local health services
- Better Care Fund
  - Pooled budget to support integrated working
- Strategic and Operational Plans
  - Five-year strategy and two-year operational plan to secure high quality care
- Financial Plan
  - Detailed financial breakdown of each plan
- Fylde Coast Strategic and Operational Plans
  - Aggregated and aligned plans
- Programme Management
  - Prioritisation, resource allocation and delivery
“We will commission appropriate high quality care delivered in a timely and effective way in the right place and time for the benefit of all patients”

This continues to be the CCG’s mission driven by the following strategic objectives:

- Commission high quality, safe and cost effective services that reduce health inequalities and improve access to healthcare.
  - Effectively involve patients and the public in decision making.
  - Develop excellent partnerships that lead to improved health outcomes.
  - Make the best use of resources.
  - Develop and maintain an effective organisation.

### AMBITIONS

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice, and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

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<tr>
<th>SERVICE AREA</th>
<th>INITIATIVES</th>
<th>OUT OF HOSPITAL</th>
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<tr>
<td>CANCER</td>
<td>• Community-based stoma service.</td>
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<td></td>
<td>• Early diagnosis and greater diagnostic support.</td>
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<td></td>
<td>• Online access for patients to view their personal care plan.</td>
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<td></td>
<td>• Prevention and public awareness campaigns.</td>
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<td></td>
<td>• Multiple survivorship services.</td>
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<td></td>
<td>• Access to alternative therapies.</td>
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<td>CHILDREN AND MATERNITY</td>
<td>• Reduction in smoking and alcohol in pregnancy.</td>
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<td></td>
<td>• Re-design and delivery of the health requirements as part of the Children &amp; Families Bill.</td>
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<td></td>
<td>• Review of pathway for children who are poorly.</td>
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<td></td>
<td>• Increase breastfeeding awareness.</td>
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<td></td>
<td>• Better informing parents on health options and issues.</td>
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<td></td>
<td>• Community paediatric learning disability service.</td>
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<td>END OF LIFE</td>
<td>• Electronic Palliative Care Co-ordination System.</td>
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<td></td>
<td>• Advanced care planning.</td>
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<td></td>
<td>• End of life training/awareness for front line staff.</td>
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<td>• Development and implementation of care plans for all patients identified as end of life.</td>
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<td></td>
<td>• Six steps coordinator.</td>
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<td></td>
<td>• Bereavement support.</td>
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<td></td>
<td>• Hospice at home service.</td>
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<td>• Personal health budget.</td>
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<td>• Implications from the Learning Disability Single Assessment Framework.</td>
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<td>• Learning disability-friendly communities.</td>
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<td></td>
<td>• Annual health check.</td>
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<td>LEARNING DISABILITIES</td>
<td>• Type 1 diabetes structured education.</td>
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<td></td>
<td>• Development of integrated diabetes foot care service.</td>
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<td>• Bronchiectasis service review.</td>
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<td></td>
<td>• Early supported discharge and community stroke rehabilitation service.</td>
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<td></td>
<td>• Patient-centred care plans.</td>
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<td></td>
<td>• Self-management training for clinicians to support on-going self-management.</td>
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<td></td>
<td>• Online health information library.</td>
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<td>LONG TERM CONDITIONS</td>
<td>• Home oxygen assessment and review service.</td>
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<td></td>
<td>• Pre-diabetic structured education.</td>
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<td>• Pulmonary rehabilitation service review.</td>
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<td>• Training for spirometry.</td>
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<td></td>
<td>• Community multi disciplinary teams.</td>
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<td></td>
<td>• Community-based specialist clinicians.</td>
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<td></td>
<td>• Expansion of care coordination service.</td>
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<td>• Integrated insulin pump clinic.</td>
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<tr>
<td>Module</td>
<td>Activities</td>
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<td><strong>MENTAL HEALTH AND DEMENTIA</strong></td>
<td>• Integration with physical health services. • Self-management and education and raising awareness across the voluntary sector. • Re-commissioning of Improving Access to Psychological Therapies service (IAPT) provision. • Re-commissioning of older people’s mental health community provision. • Closing the dementia diagnosis gap. • Increase in practice diagnosis with Cantab mobile.</td>
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<tr>
<td><strong>FINANCE</strong></td>
<td>• Continual financial viability represented as plans that underpin the strategic and operational direction. • Key business and operational plans developed in line with principles of continuous improvement. • Effective identification and management of financial risk. • Delivery of reinvestment opportunities generated from Quality Innovation Productivity and Prevention (QIPP) savings.</td>
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<tr>
<td><strong>PLANNED CARE</strong></td>
<td>• Provision of appropriate diagnostic services. • Development and implementation of a number of tier 2 schemes. • Review primary care skill mix. • Promote and champion procurement of new services. • Changes from review of all pathology tests. • Direct access to diagnostics. • Develop and agree a new pathway for orthopaedics. • Develop and implement planned care strategy as part of the planned care group.</td>
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<tr>
<td><strong>URGENT CARE</strong></td>
<td>• Design and implement care homes commissioning and support plan. • Commission a pilot for the expansion of the existing falls advice and assessment service. • Commission a pilot for a falls and lifting service linked to the lifetime pendant scheme. • Using existing risk stratification tools, build on the current care coordination pilot. • Broaden the scope of existing 999 frequent callers pilot. • Implement the recommendations from benchmark intermediate care review. • Integrate bed and community-based rehabilitation services. • Re-shape and maximise existing community assets and capacity within voluntary sector provision. • Roll-out telehealth systems with high intensity users. • Continuation of existing pilot IV therapies. • Review of community contract provision. • Implement recommendations of hospital discharge review. • Re-commission of community equipment services. • Review all equipment and aids and adaptations. • Redesign intermediate care/rehabilitation. • Integrated single care plans. • Enhanced hospital to home discharge pilot.</td>
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NHS Fylde and Wyre Clinical Commissioning Group (CCG) is the organisation responsible for planning and buying health services in the area to meet patients’ needs. This is known as ‘commissioning’.

Led by family doctors (GPs), the CCG currently serves a population of 151,436 people across approximately 320 sq km of coast and countryside. The majority live in the urban towns of Fleetwood, Kirkham, Lytham St Annes, Poulton-le-Fylde and Thornton, but a significant proportion live in rural villages. There is a wide variation between affluence and deprivation within our boundary.

The CCG receives a set amount of money from the government – around £200million in 2014/15 – and is committed to spending this wisely for the benefit of local people. Our main area of responsibility is to commission hospital and community health services for local people. Another body, NHS England, commissions primary care, specialised services and health services for the Armed Forces. Public Health England and Lancashire County Council commission public health and health improvement services. We work in partnership with these other commissioners to ensure health services are joined up.

We also work in partnership with our neighbouring CCGs. The map below shows how we share a border with NHS Blackpool, NHS Lancashire North and NHS Greater Preston CCGs.

**Key**
- NHS Fylde and Wyre CCG (light blue)
- NHS Blackpool CCG (dark blue)
- NHS Lancashire North CCG (yellow)
- NHS Greater Preston CCG (pale pink)
- NHS Chorley and South Ribble CCG (bright pink)
OUR MISSION

We will commission appropriate high quality care delivered in a timely and effective way in the right place and time for the benefit of all our patients.

OUR GUIDING PRINCIPLES

Our vision for the future is based on six guiding principles, which inform everything we do:

Everyone counts:
We use our resources to benefit the whole community, making sure people are not excluded. We recognise how we all have a part to play in making ourselves and our communities healthier.

Improving lives:
We are committed to improving people’s experiences of the NHS and improving their health and wellbeing. We will work with all our partners to deliver the best outcomes for our residents. We will be honest about our point of view and what we can and cannot do.

Working together for patients:
We put patients first in everything we do. By reaching out to staff, patients, carers, families, communities and professionals outside the NHS, we put the needs of our patients and communities before organisational boundaries.

Commitment to quality of care:
We repay the trust that is placed in us by insisting on quality and striving to get the basics right every time – safety, safeguarding the most vulnerable, confidentiality, professional and managerial integrity, accountability, dependable services and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Respect and dignity:
We value all people as individuals, respect their aspirations and commitment in life, and seek to understand their priorities, needs, abilities and limits. We expect healthy challenge from our Governing Body members and practices as we take up the challenge of providing high quality healthcare services within available resources.

Value for money:
Every act of commissioning commits public money. We aim to ensure every one of these decisions is value for money.

OUR STRATEGIC OBJECTIVES

The following strategic objectives support the delivery of our mission, our 2030 Vision and our five-year plan:

- Commission high quality, safe and cost effective services that reduce health inequalities and improve access to healthcare.
- Effectively involve patients and the public in decision making.
- Develop excellent partnerships that lead to improved health outcomes.
- Make the best use of resources.
- Develop and maintain an effective organisation.
All NHS organisations are facing some very significant challenges. These include more people living longer with complex health conditions, rising expectations and increasing costs.

This is set against a backdrop of flat funding, which will result in a national funding gap of £30 billion by 2021 if health services continue to be delivered in the way they are now. The NHS needs to change to meet these challenges.

In this section we outline in more detail some of the challenges we face.

**AN AGEING POPULATION**

The population in Fylde and Wyre has a growing number of older people. There are already 10% more adults aged over 45 than the national average (52% compared to 42%) and 8% more adults aged over 65 (24% compared to 16%). Figure 2 compares the population structure of Fylde and Wyre with that of England.

*Figure 2: The population structure of Fylde and Wyre with that of England*

Estimated population projections suggest that by 2022 the population of Fylde and Wyre will increase by over 7,000 people to approximately 158,800. The largest increase will occur in the over 70 age group which will rise by 28%, from 25,900 to 33,100. This is in line with the national average. Conversely the young adult (15-30 years) and middle aged (40-50 years) populations are projected to reduce significantly more than the national average. Figures 3 and 4 show the predicted population change for each age group between 2012 and 2022.
Across Fylde and Wyre, the overall growth in the population over the next five years is expected to be 2.58%. The numbers aged under 19 are expected to increase slightly (0.7%), while those aged 60-79 and those over 80 are expected to rise by 5.6% and 12.5% respectively, as illustrated in table 1.
Table 1: Five-year projected growth figures

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Total</th>
<th>% increase - annual</th>
<th>% increase - cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>33,497</td>
<td>33,497</td>
<td>33,506</td>
<td>33,575</td>
<td>33,623</td>
<td>33,744</td>
<td>0.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39</td>
<td>32,301</td>
<td>32,545</td>
<td>32,907</td>
<td>33,183</td>
<td>33,650</td>
<td>33,939</td>
<td>5.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-59</td>
<td>46,700</td>
<td>46,642</td>
<td>46,436</td>
<td>46,264</td>
<td>45,763</td>
<td>45,387</td>
<td>-2.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-79</td>
<td>41,749</td>
<td>42,164</td>
<td>42,582</td>
<td>42,990</td>
<td>43,531</td>
<td>44,086</td>
<td>5.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80+</td>
<td>12,416</td>
<td>12,686</td>
<td>12,966</td>
<td>13,276</td>
<td>13,637</td>
<td>13,965</td>
<td>12.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>166,662</td>
<td>167,534</td>
<td>168,399</td>
<td>169,289</td>
<td>170,204</td>
<td>171,121</td>
<td></td>
<td>0.52%</td>
<td>1.01%</td>
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We already have a comparatively older population than the England average, and this is expected to further increase. By 2018 more than one third of our population will be aged over 60 and nearly one in 10 will be aged over 80.

**DEPRIVATION**

Deprivation is a significant indicator of adverse health conditions. The 2010 Indices of Multiple Deprivation combines a number of indicators (including economic, health, housing, crime and social issues) into a single deprivation score for each small area in England. It allows areas to be ranked and compared according to five levels of deprivation across the country. In Fylde and Wyre, 57% of the population lives within the two most affluent quintiles (a quintile refers to the population being divided into fifths). The proportion of people living in the most disadvantaged areas is less than the national average. However, parts of Fleetwood and St Annes are classified as being among the fifth most disadvantaged areas in England; over 16,800 people within Fylde and Wyre (around 11%) live in these areas.

Figure 5 maps deprivation across the CCG area, and figure 6 shows the proportion of the population living within each deprivation quintile. Within Fylde and Wyre there are two practices with more than half of their population in the most deprived quintile. Conversely, there are seven practices with less than 1% of their population in the most deprived quintile. This means we will need to tailor our models of care and services for the diverse communities we serve.
LIFE EXPECTANCY

Life expectancy has increased in Fylde and Wyre over the last 20 years (figure 7). Although female life expectancy remains greater than male life expectancy at both national and district level, the difference has reduced over this period. In Fylde, male and female life expectancy is higher than the national average. In Wyre it is slightly below the national average. Within the CCG area, there is a 10.6 year difference in male life expectancy between the most and least deprived wards (figure 8). For female life expectancy this difference is 6.4 years. These health inequalities are clearly unacceptable.

Figure 6: The proportion of the population living within each deprivation quintile

Figure 7: Trend in life expectancy at birth: 1991-93 to 2008-10: England, Fylde and Wyre
While it is obviously good news that people are living on average six years longer than they were 20 years ago, they are more likely to develop multiple long-term conditions such as diabetes, heart disease, breathing difficulties and dementia, and require more support from health and care services.

LONG-TERM CONDITIONS

A higher percentage of people in Fylde and Wyre are affected by a long-term health problem than the national average. These include diseases of the heart and blood vessels, diabetes, kidney disease and stroke. The number of people with dementia is also higher than the national average. Our ageing population means that these numbers will increase. We need to work together to prevent ill health and support people with long-term conditions to live healthier lives for longer.

The current major causes of deaths in the area are:
- cancer – 28.1%
- diseases that affect the heart and blood vessels – 27.8%
- diseases that affect the airways – 13.9%
- diseases that affect the digestive system – 4.7%

In addition to this, we have some other problems that we need to tackle. More pregnant women smoke than the national average and we have low rates of breastfeeding. In addition, there has been an increase in alcohol-related harm in recent years both nationally and in some areas locally. It is estimated that the numbers of people who drink at high levels will continue to increase above the national average, potentially resulting in an increase of alcohol-related conditions and associated health and care support.

More detail around the challenges within our service areas is provided within the individual service sections from page 36.
Did you know?
Around 90% of care is carried out in community-based settings, such as your local health centre or family doctor’s surgery. But we spend more than half of the local healthcare budget (54%) on hospital treatment.
FINANCIAL CONSTRAINTS

The costs of healthcare are increasing at a faster rate than the NHS funding we receive. To bridge the gap, the NHS in England needs to make efficiency savings of £30 billion by 2021. This equates to just over £6.2 million for Fylde and Wyre CCG.

We currently receive around £200 million a year from the government to pay for local health services. That’s about £1,300 for every resident. To put this into perspective, a heart bypass operation costs about £8,100, a hip replacement £7,700, and a cataract operation £1,500.

Currently around 70% of the NHS budget is spent supporting and treating the 30% of people who have more than one long-term condition. If we carry on delivering services in the same way this will become unsustainable as the population ages and the numbers of people with long-term conditions rise.

Locally, we spend more than the national average on treatments for musculoskeletal problems, heart and breathing diseases, and cancer and mental health, yet our patients report worse outcomes. This clearly needs addressing.

To make sure we are able to provide sustainable services for future generations, we need to fundamentally change the way services are delivered to address the challenges we face.

IDENTIFYING OPPORTUNITIES TO IMPROVE THE HEALTHCARE WE COMMISSION

The purpose of transforming our health and care system is to ensure that the people of Fylde and Wyre receive the best possible care.

To identify opportunities, we have used a broad range of national and local information tools to develop ambition targets against each of the five outcome domains and seven outcome ambitions, as outlined in NHS England’s planning guidance.

The tools identified below were instrumental in considering our current position and identifying the opportunities for transformational change.

National tools:
- Commissioning for value packs and explorer tool.
- CCG outcomes tool.
- Levels of ambition atlas.
- Operational planning tool.
- Spend and outcomes tool (SPOT).
- Any town.

Local tools and analysis:
- Public feedback surveys.
- Demographic and non-demographic growth analysis.
- Quality, innovation, productivity and prevention (QIPP) benchmarking packs.
- Lancashire ‘diagnostic’.
- Ambition modelling tool.
- Health needs analysis.

The level of our ambition has been based on current performance against England and the group of CCGs most similar to Fylde and Wyre demographically (“Commissioning for Value” group performance). We recognise that these performance groups will be striving to improve their outcomes too. We therefore propose to review all trajectories against these performance groups after two years to ensure we continue to be sufficiently ambitious.

Table 2 shows a summary of our improvement ambitions against the five domains and seven outcome ambitions which are detailed in our two-year and Better Care Fund plans. The delivery of these specific measurable ambitions will be the critical indicators of our success and against which we can track our progress in achieving our vision. Appendix 1 shows in detail how this plan links with the six characteristics of transformational service provision, as described in NHS England’s planning guidance.
### Table 2: Our improvement ambitions

<table>
<thead>
<tr>
<th>NHS OUTCOME FRAMEWORK 5 DOMAINS</th>
<th>7 OUTCOME AMBITIONS</th>
<th>IMPROVEMENT AMBITION</th>
</tr>
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<tbody>
<tr>
<td><strong>DOMAIN 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing people from dying prematurely</td>
<td>1. Securing additional years of life lost for the people of England with treatable mental and physical health conditions.</td>
<td>The rate of potential years of life lost (PYLL) for people with treatable mental and physical health conditions has increased since 2010. Our intention is to reverse this trend by 3.2% in 2014/15, increasing to 7.48% by 2019. The CCG rate is currently in the upper quintile (fifth) nationally and our growing elderly population is more likely to have diseases included in this measure. A 3.2 % decrease in 2014/15, and year-on-year 1% reduction to 2019, is a significant ambition and equates to reduction of potential years of life lost from 2,507 to 2,319 per 100,000 of the population.</td>
</tr>
<tr>
<td><strong>DOMAIN 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancing the quality of life for people with long term conditions</td>
<td>2. Improving the health related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions.</td>
<td>To increase the average EQ 5D score for people reporting to have one or more long-term conditions by 5.4% to achieve above England average by 2019. (EQ D5 is a measure of health outcomes.) Our current position is 71.2 against an England average of 72.75, and the best England quartile average of 75.4 (as at 2012). We will increase our score to 75.02 – an increase of 5.4% – to achieve above the average for England by 2019. Maintain a 67% diagnosis rate for dementia in 2014/15 and 2015/16. We know that our increasing elderly population will mean that we need to increase the number of people diagnosed to maintain 67%. This is also a Lancashire-wide target included within the Better Care Fund. 15% access rate for people who receive psychological therapies by quarter 4 2014/15, with a further 1% stretch to 16% in 2016. We have worked with partners to redesign the model of care in 2013/14 and expect to see improvements in line with our ambitions in 2014/15 onwards.</td>
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</table>
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

To reduce the rate of emergency admissions by 15% by 2019.

It is expected that, considering population and long-term condition growth, demand on urgent care services will increase if alternative models of care are not developed.

5% reduction in the number of unnecessary ambulance conveyances from care homes.

This will help to reduce the burden on the ambulance service (8 minute and 19 minute) and A&E (four-hour) targets and improve patient experience.

Delayed transfers of care will have reduced (per 100,000 population) by 5% (2015 compared to December 2012).

Through the development of our enhanced primary care models we will deliver care and support in the most appropriate setting.

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**DOMAIN 3**

Helping people to recover from episodes of ill health or following injury

4. Increasing the proportion of older people living independently at home following discharge from hospital.

To ensure that the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services aligns with the Lancashire-wide target of 82%.

Our extensivist and enhanced primary care models of service provision will ensure that patients are supported by coordinated multi-disciplinary teams.

The permanent admissions of people aged 65 and over into residential and / or nursing care homes will have reduced (per 100,000 population) by 4.4% (2014/15 compared 2012/13).

Implementation of the extensivist model of care management to stratify and target those most at risk of losing their independence is likely to decrease the reliance on care homes.

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**DOMAIN 4**

Ensuring that people have a positive experience of care

5. Increasing the number of people having a positive experience of hospital care.

1.5% year-on-year reduction up to 2019 in the proportion of people reporting poor patient experience of in-patient care.

As part of the post-Keogh action plan, it has been agreed that Blackpool Teaching Hospitals NHS Foundation Trust will be in the top 20% of trusts for both NHS average and NHS best scores.

Address issues identified from the 2013/14 Friends and Family Test (FFT) results with the provider and support providers to coordinate the roll out of FFT by the end of 2014/15.

The national Commissioning for Quality and Innovation Framework (CQUIN) will be used to incentivise providers in delivering against this target.
<table>
<thead>
<tr>
<th>6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.</th>
<th>2% year-on-year reduction up to 2019 in the proportion of people reporting poor experience of general practice and out-of-hours services.</th>
</tr>
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<tbody>
<tr>
<td>We offer quality improvement support to primary care and will monitor the impact of this support via the patient experience survey. We will liaise with the Area Team on performance outliers and appropriate strategies for performance improvement.</td>
<td>Maintain a 67% diagnosis rate for dementia in 2014/15 and 2015/16.</td>
</tr>
<tr>
<td>We know that our increasing elderly population will mean that we need to increase the number of people diagnosed to maintain 67%. This is also a Lancashire-wide target included within the Better Care Fund.</td>
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**DOMAIN 5**

**Treating and caring for people in a safe environment and protecting them from avoidable harm**

<table>
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<tr>
<th>7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.</th>
<th>No cases of MRSA in 2014/15 and 2015/16.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% increase in incident reporting of medication error near misses.</td>
<td>2014/15 trajectory of maximum of 31 cases of C.Diff apportioned to the CCG (nationally set target).</td>
</tr>
<tr>
<td>Improvement activities identified in the Blackpool Teaching Hospitals NHS Foundation Trust Keogh action plan.</td>
<td>The MRSA, C.Diff and medication errors targets identified within this strategic plan, in combination with the improvement activities identified in the trust’s Keogh action plan, collectively outline our expected improvement ambition.</td>
</tr>
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</table>
As described in the previous section, we have an ageing population with a growing number of complex long-term conditions.

Our current health and care system is not joined-up, and as such patients do not always have as good an experience of services as we would like. Many of these patients have conditions which are not managed as well as they could be, and so often go to hospital when they could be better supported in a community setting. We also cannot afford to continue delivering health services the way we do now.

To make sure we are able to provide high quality, sustainable services for future generations, we need to fundamentally change the way services are delivered. We have been looking at what works from healthcare systems across the world to assess which new models of care could be successfully implemented locally to improve quality and patient experience and address the challenges we face. These discussions have been informed by a detailed analysis of our current population comorbidities (where someone has more than one long-term condition), age and the associated spend on healthcare.

As shown in figure 9, 48% of Fylde and Wyre’s hospital spend is driven by 4,600 patients – just 3% of the population.

**Figure 9: Hospital spend in Fylde and Wyre for different population groups**
We surveyed more than 1,000 people living in the area:

88% supported having more advice and support to help them better manage their condition at home.

42% of those with a long-term condition said they had a specific health professional who coordinated their care.

25% of those with a long-term condition said they did not know who to contact if they had a question about their care.

86% said they would like to have their follow-up appointments in a community setting rather than in hospital.

While there are clearly problems with the current system, we have successfully implemented new models of care and integrated health and care services to support people to remain healthy and independent.

Our track record of innovative working is evidenced by the following examples:

• Rapid response nursing – commissioning crisis social care

The rapid response nursing team has been commissioned for nearly five years to provide intense short-term nursing provision at home. They have access to social care crisis services and can, where required, secure this directly in order to best support a patient recovering from a temporary short-term illness. This can prevent a hospital admission or speed up discharge. This positive partnership working more recently evolved into Rapid Response Plus.

• Rapid Response Plus

Rapid Response Plus builds on the existing arrangements with the creation of a fully integrated health and social care team providing a point of contact, assessment and referral pathway for GPs and other community professionals working with individuals who need an urgent care response. They provide a rapid assessment (within two hours) and mobilise / coordinate community resources to avoid an acute admission wherever appropriate. Patients can be referred into the team with either a health and / or social care urgent response as required.

• Neighbourhood self-care

We can demonstrate our commitment to prevention through the development and pilot of the Advancing Quality Alliance neighbourhood integrated self-care model. This targets those patients deemed to be at risk of becoming highest dependency users of services and offers proactive support to promote management of their long-term conditions.

The CCG area has been divided into four pilot neighbourhoods with integrated (health and social care) community teams being allocated to each one. These teams work alongside GP practices to improve coordination. Integrated care coordinators support patients across each geographical area.

These coordinators use risk profiling data as an initial screening tool to identify patients who are most likely to become very high intensity users in the next year if they receive no support. The service also offers the opportunity to refer patients who may be frequent users of primary care with a lower risk score, but who require an element of social care input. The team works intensively to empower patients to self-care and to better manage their own conditions. The intervention typically covers a period of 12 weeks, but this is dependent on individual patient needs.

See case study 1 on page 34.
• Community equipment
In the last three years a ‘retail model’ has been developed with Lancashire County Council which allows prescriptions to be written by therapy staff and other health / care professionals to allow the swift provision of the equipment. The prescription is presented to one of several authorised retailers who are also authorised to fit the equipment. There are developments underway to move to a single loan store solution and catalogue of equipment to streamline this process even further.

• End of life services
  
  **Electronic Palliative Care Coordination System**
  
  We are working collaboratively across the Fylde coast to implement an Electronic Palliative Care Coordination System which will allow information to be shared between health and social care services for patients at the end of their life, ensuring they are treated in accordance with their wishes.

  **Hospice at home service**
  
  In partnership with NHS Blackpool CCG and Trinity Hospice, we are launching a hospice at home service which will enable patients to be treated in their preferred place of care.
  
  The service will provide overnight care and support to patients at the end of their lives, as well as their families, to improve the quality of care received and reduce inappropriate hospital admissions.

  **Do not attempt cardiopulmonary resuscitation**
  
  In partnership with NHS Blackpool CCG, Blackpool Teaching Hospitals NHS Foundation Trust, Trinity Hospice and North West Ambulance Service, we have implemented a Fylde coast policy and pathway for ‘do not attempt cardiopulmonary resuscitation’.

• Care coordination – anticipatory care planning
The Fylde coast risk stratification tool is used to identify those at highest risk of non-planned admission or excessive use of emergency services. Since April 2013, the care coordination scheme has enabled those people identified as being very high intensity users of healthcare to have their needs assessed by a GP, community matron or other appropriate professional. Their care is then jointly and proactively planned to ensure, wherever possible, their needs can be met at home with hospital attendance and admission avoided. The anticipatory care plans are held by the local out-of-hours provider and, when necessary, accessed via a single telephone number in order to mobilise appropriate support.

• Speech and language therapy for children
Speech and language therapy is commissioned for children in Fylde and Wyre by a joint service specification with Lancashire County Council. This specification brings together the speech and language requirements from both a health and educational perspective. Having one specification enables the provider to deliver services as efficiently and effectively as possible and ensures that the resource invested is used to best effect in terms of quality and capacity.
As described in the previous sections, the challenges we face, as well as the current models of care, are well understood. This insight informed our vision, which was developed and tested by extensive engagement with a wide range of partners, patients, the public and their representatives.

Engagement mechanisms included a series of focus group, events, surveys, regular drop-in listening sessions held at libraries and health centres, as well as using traditional and new media. In total, we spoke to nearly 3,000 people over a six month period – some about our vision in-depth, and some about the issues they are currently facing. As part of this we commissioned independent researchers Ipsos MORI to carry out a representative telephone poll of just over 1,000 people.

We also used traditional and new media, and through the local press there were 368,000 ‘opportunities to see’ information about the vision. We also used social media to tap into the communications network across our partner agencies.

We engaged the district and county council scrutiny committees, as well as attending numerous meetings and sessions with our local authority partners.

The objectives of the engagement exercise included:

• Giving stakeholders an opportunity to influence our plans.
• Ensuring our priorities were aligned with our partners.
• Supporting the development of our communications and engagement strategy and organisational development plan.
• Developing our ‘public pledges’.
• Further developing our membership programme, the Affiliate Scheme.
• Ensuring we were meeting our statutory engagement duties.

We ran the exercise in two three-month phases:

• Seeking views to develop a working draft of the 2030 Vision document, including a draft series of public pledges against which the CCG’s performance can be measured in future. This was mainly through face-to-face engagement with a range of partners and the public.
• Testing the vision. This involved a wide range of communications and engagement tools to gather qualitative and quantitative feedback.

All of the data gathered was independently analysed and triangulated by the commissioning support unit, and the main themes pulled out. Clinical, commissioning and communication leads at the CCG then spent two days together analysing the data and revising the document. There were some significant changes, and these are summarised in appendix 2.

In addition to this, to support the development of our commissioning intentions for the next two years, we held two stakeholder engagement events. Approximately 40 people attended each session, including representatives from GP practices and the CCG’s Public and Patient Engagement Group. In addition, a panel with patient representation was held to prioritise the intentions. All of the proposed schemes were scored against the public pledges developed as part of the engagement exercise, demonstrating that engagement processes are embedded in decision making.

**KEY THEMES TO EMERGE FROM THE ENGAGEMENT SO FAR**

It was reassuring that the vast majority of the people we spoke to were in agreement about what our health services should look like in future. Our eight priority health areas were also recognised as being areas we should focus on. In general, people agreed that:

• services should be coordinated and integrated;
• there should be more recognition and support for self-care and promotion of personal responsibility;
• information about services and conditions needs to be readily available;
• each locality/community is different with different needs;
• prevention should be given greater prominence;
• the CCG should continue to demonstrate that people can influence health decisions;
• the system needs to provide assurance that older/vulnerable people will be well cared for.
Highlights from the Ipsos MORI poll include:

- High support to move end of life care and rehabilitation to the community; more caution for tests. This mirrors national research about moving ‘clinical’ services.
- High support to move post-hospital care, particularly among parents.
- Strong agreement to give people the tools and freedom to manage their condition, and use of new technologies to do this (86%).
- 86% agree practices should coordinate care; 74% support idea of practices providing different services based on needs.
- People with a long-term condition are less satisfied with information provision than those who don’t have a health problem.
- High support for using technology for transactional healthcare (e.g. repeat prescriptions), with most support from 16-34 age group.
- Less support to use technology for more ‘clinical’ services – getting tests online (62%); online consultation (48%).

NEXT STEPS

- Developing an engagement ‘toolkit’ to embed engagement in the commissioning cycle, including a systematic mechanism to gather ‘You said, we did’ feedback.
- Refreshing the CCG’s communications and engagement strategy based on the learning from the engagement exercise and other insight gathered in the last year. A key action is further developing mechanisms to scale-up and systematise engagement to inform CCG decision making.
- Involving people as we develop more detailed plans.

More details about how we put engagement at the heart of decision making can be found in the ‘enablers’ section on page 78.
Our vision is for a health service which supports people to be as fit and well as possible, and provides high quality, responsive services when they are needed.

As part of our engagement exercise we developed a series of public pledges against which the delivery of our plans can be measured, which in the future will demonstrate how we are doing in implementing our plans. Although these have a 2030 focus they are relevant to support our locally set outcome ambition metrics outlined in our two and five-year plans.

By 2030, you will consistently:

1. Have clear information relevant to your health and wellbeing which is easy to understand.
2. Have the opportunity to live a healthier lifestyle and be supported to keep well both mentally and physically.
3. Be more involved in decisions about health services and your healthcare.
4. Receive safe, high quality healthcare.
5. Have services which are easy to access, timely and appropriate for your needs.
6. Have services tailored to the needs of your neighbourhood.
7. Receive care in a community setting or at home, where appropriate.
8. Be supported by organisations that work together to provide the care and support services you need.
9. Be supported using the most appropriate technology and equipment as it becomes available.
10. Receive value for money from your local health service.
Taking on board all of the feedback, we believe the following is crucial if we are to address the challenges we face:

- Supporting people to keep well both mentally and physically to prevent ill health in the first place.
- More support to help people manage their condition at home to keep as fit and well as possible.
- Better information to support people to make informed choices about their health and healthcare.
- More coordinated and integrated health and social care planned around people’s needs.
- Access to many services seven days a week.
- More community and home-based care.
- Care in hospitals for specialist services only.
- Better use of technology to improve access to services and improve productivity.

We believe that we will only meet the health challenges facing us if people are empowered to make informed decisions about their health and healthcare, and are enabled to participate in shaping the development of health and care services.

We recognise that the way we deliver care across Fylde and Wyre needs to change. We want to make sure that those people who have multiple long-term conditions – the ‘sickest of the sick’ – have much more intensive support from a team of experts who will coordinate all their care. We also want to make sure those people with one long-term condition are similarly supported, albeit in a less intensive way.

For this to happen, the CCG will need to work with its partners as well as the public, patients and their carers to ensure people have the knowledge, skills and confidence to be able to take ownership of their own health and wellbeing. It will also require the relevant organisations to work together to provide joined-up support and care tailored to the needs of individuals and their communities.

GP practices will be at the heart of making these changes happen. As well as coordinating an individual’s care, practices will work with patients and other partners to decide how to best tailor services to meet the needs of local people.

We are now working with practices to agree how they will come together in geographical neighbourhoods to coordinate services, and what support they will need to do this. This will involve practices coordinating doctors, nursing teams, pharmacy, social care, the voluntary sector and other professionals so they deliver a joined-up service in different community settings, including people’s homes. It will also involve practices working in partnership to determine what services are needed to meet the needs of their population. This new way of working has been strongly supported by people living in Fylde and Wyre.

We cannot do this alone. We must strengthen how we work with partner organisations such as local authorities, other commissioners, the voluntary sector and advocacy groups in order to make our vision a reality. We also recognise the enormous contribution of carers, who we consider to be key partners.
The diagram illustrates how health services will be delivered in the future.

**HOSPITAL CARE**
- Care in hospitals when you need specialist care that can’t be provided in a community setting or at home. For example, immediately after a heart attack or a stroke.

**NEIGHBOURHOODS OF GP PRACTICES COORDINATING YOUR CARE**

**Integrated health and social care**
- When you have a more complex and ongoing condition(s). For example, after a stroke when a person needs both medical and social care (e.g. their blood pressure needs managing as well as needing help with eating and bathing).
- Will include support from a variety of agencies such as pharmacy, the local authority and voluntary sector.

**Episodic healthcare**
- When you occasionally need care for minor health issues. For example, when earache in children fails to get better in three days.

**SELF-CARE**
- Support to help you manage your condition at home and keep fit and well. For example, people with a long-term chest condition having antibiotics at home.
- Self-care includes support from a variety of agencies such as pharmacy, the local authority and voluntary sector.
We have spent a considerable amount of time understanding the challenges we face, and identifying opportunities to improve the healthcare we commission.

To really make a difference to the lives of those with long-term conditions, we have been looking at care models that exist across the world which focus on the provision of integrated and coordinated care for patients with the highest needs. There are two models – ‘extensivist’ and ‘enhanced primary care’ – which have been successful in improving quality, outcomes and patient experience with the use of fewer resources.

We are currently working with local partners, with support from world experts, to design and pilot the models locally. They very much align with our 2030 Vision and build on a number of our existing innovative services such as care coordination.

Both models provide specialist, coordinated care and support to two distinct groups of patients:

1. those with multiple complex conditions – ‘the sickest of the sick’; and
2. those with single chronic conditions.

In both models, the care team has holistic responsibility for an individual’s care, acting as the coordinating point across the local health and social care system and holding other individuals and organisations to account with respect to their patients. Moreover, all care decisions are taken by the patient and their carers supported by the lead clinician and their team.

To reflect the feedback from our engagement exercise and our strong desire to work with NHS England to co-commission an improved model of primary care access, we are developing a third model called ‘episodic care’ to support patients with minor health issues (figure 11). We will maximise the use of self-care, community pharmacy, primary care nurses and other similar services to free up GP time and expertise to focus on the provision of enhanced primary care, which we consider to be the GP role of the future.
THE EXTENSIVIST MODEL

This model of care will provide proactive, personalised care ‘wrapped around’ those with multiple complex conditions, i.e. ‘the sickest of the sick’.

The service will support around three per cent of our population (4,600 people) who have multiple long-term conditions, such as heart disease, high blood pressure and respiratory illness.

Nearly half of the healthcare budget for Fylde and Wyre is currently spent supporting these patients. They are, however, frequently not well served as care is often not effectively coordinated. Just as important, care is not as proactive as it could be and often a patient’s condition declines unnecessarily and they end up in hospital as an emergency.

The extensivist model is a very different way of delivering care. Patients – generally the frail and elderly – will have their care managed and coordinated in a very proactive way by a specialised community-based generalist doctor and their team (figure 12). The model is designed to ensure early intervention and proactive prevention, breaking the current cycle of reactive care provision. Care will take place at convenient locations for the patient and in settings designed with their needs in mind (e.g. tailored clinics), with significant care at home.

Figure 12: How the extensivist reorients care around the patient
This model has been shown in other parts of the world to:

- support more effective condition management – keeping patients well for longer and giving them more control of their condition;
- improve patient satisfaction, e.g. 80% of patients would recommend the service to a friend;
- reduce hospital admissions by around 25% and A&E attendances by around 20%;
- when hospital admission is necessary, the length of stay can be reduced by the availability of rehabilitation care managed by the patient’s specialist community-based doctor.

Each extensivist will be responsible for managing a specific group of between 300 and 500 patients. Our initial challenge will be to identify individuals with the skills and interest to be successful in the extensivist role. Additional to this will be the identification and recruitment of the care team, training and development support, integration with current local disease-specific activities and sufficient change management support to establish these radically new ways of working over a short time period.

Patients will remain registered with their own GP who they will continue to see regularly.

THE ENHANCED PRIMARY CARE MODEL

The enhanced primary care (EPC) model will provide proactive, coordinated care for patients with single complex conditions. These are in the middle tier in figure 11 – the level below those of the extensivist model in terms of complexity and need. The support these patients require will vary considerably, e.g. well managed diabetes compared to severe liver disease.

The extensivist model impact¹:

- 90% reduction in falls.
- 80% reduction in amputations.
- 50% reduction in mental health admissions.
- 30% fewer bed days.
- 60% of patients are able to die at home.
- 80% of members refer friends to the programme.
- 20% reduction in costs.

¹: A Call to Action: Transformative Ideas for the Future NHS (Feb 2014)
Similar to the extensivist model, EPC is extremely clear with respect to accountabilities and responsibilities. As outlined in figure 13, an accountable GP, supported by their team, will be responsible for supporting a patient to maintain and improve their health condition. The effective coordination of the multi-disciplinary team surrounding the patient, including health and social care professionals, will improve the proactivity of care, consistency and access. This model often requires a networked GP model (groups of practices working informally together), or alternatives, to ensure timely access for patients on a 24/7 basis.

The model is very similar to our existing, and very successful, neighbourhood self-care pilot which we are continuing to develop through neighbourhoods (case study 1, page 34).
CASE STUDY 1

A Fleetwood couple have had their lives transformed by the neighbourhood self-care pilot.

Launched in June 2013, the service sees care coordinators liaising with GP practices to identify suitable patients with long-term conditions. They then work collaboratively with health and wellbeing support workers to ensure that their care is integrated.

Commissioned by the CCG, the service is run by Blackpool Teaching Hospitals NHS Foundation Trust, Help Direct and Lancashire County Council, and has supported 201 people so far.

Those taking part have an assessment that looks at all aspects of their daily living. Many are then referred or signposted to services or organisations that can help them to better understand their conditions, achieve personal goals relating to independence, address isolation and improve their health and wellbeing.

William and Maureen Tyrer (pictured) have found the help and advice of the team to be “life changing”.

William, 71, has hypertension, heart disease, type 2 diabetes and asbestos on the lungs. His 61-year-old wife Maureen has heart disease, asthma and arthritis in her knees, meaning she falls regularly.

William and Maureen continue to self-manage these long-term conditions by attending regular GP reviews and taking prescribed medication.

Before being seen by the team, William was experiencing black outs and had no confidence to shower unless Maureen was nearby.

The team helped them to successfully submit an application to the local authority for more appropriate bathroom facilities, as well as referring William to an eight-week dietetics management programme to help him better manage his condition. They were put in touch with a carers’ charity so that Maureen could get a break, as well as welfare rights because the couple were not aware of their benefits entitlements.

William said: “I honestly can’t praise them enough, it’s changed our lives and opened doors for us that we never knew were available before they got involved. I really can’t fault them. They’ve been fantastic for us and still phone us now to keep in touch and check how we are getting on.”

Maureen added: “Many people don’t know what’s available to them and the team helped us find out and turned our lives around.”

This way of working has been shown to:

- support patients to remain well for longer; and
- reduce the rate of hospital admission (around 45%) and urgent A&E and minor injuries unit attendances (around 30%).

This substantially offsets the investment in increased outpatient appointments (up around 8%) needed to manage the patient’s condition.

The initial challenge of the EPC model is coordinating the support services required, appointing the nurse case manager and ensuring those involved understanding how this role differs materially from its typical use today in the NHS. Effective delivery of this model is heavily reliant on nurse case manager accountability and acceptance from other parts of the system to ensure that the access and management of patients in other settings reflects the patients’ needs. Given the criticality of this change, we will introduce robust EPC governance, potentially including service level agreements to ensure compliance across the system.

Both the extensivist and EPC models are key to ensuring our primary care services become more proactive.

The initial extensivist model – to be piloted in one of our neighbourhood areas (see page 72) – will focus on the elderly/frail (60 years plus with at least two comorbidities and at least one risk factor).

Effective delivery of these models will impact on activity in secondary care, helping to reduce the current pressure points, and is likely to lead to subsequent further redesign in these areas. This will be supported by additional new models of care such as
hospitalists for urgent admissions and ambulatory surgery centres for a proportion of planned procedures.

As part of the model design work we are assessing the potential activity and financial impact on other services. We recognise and have planned for potential development costs, and do not anticipate any savings being realised in 2014/15 or 2015/16. The design work also involves the identification of new contracting and funding approaches to enable the delivery and sustainability of the models.

**EPISODIC CARE**

This model will support those with minor health issues, such as acute infection (chest, urinary, ear ache), or painful conditions such as nappy rash. We will promote self-care and maximise the use of community pharmacy, primary care nurses and other similar services to free-up GP time and expertise to focus on supporting those with long-term conditions.

**PLANNED CARE**

The planned care model which underpins our 2030 Vision has a strong focus on improving and expanding community-based care with a much wider range of high quality services so that people have easier and earlier access to planned care, with many services available seven days a week. This includes the development of specific tier 2 services in dermatology, ophthalmology and musculo-skeletal (MSK) therapy with other areas to follow. Tier 2 services are community-based intermediate services which provide relatively simple or minor interventions, and act as an interface between primary care and hospitals.

We have also identified opportunities to improve productivity and efficiency within planned care by undertaking benchmarking and diagnostic exercises to identify areas where the CCG is an outlier compared to the regional and national average.

The Payment by Results bench marker was used to determine where the health economy was an outlier at point of delivery, specialty and procedural level. The outcome of the exercise was cross referenced to previous diagnostic activities undertaken by Blackpool Teaching Hospitals to ensure that the same areas had been identified consistently. Dermatology, ophthalmology and pain management have been identified as having the highest potential efficiency impact. Work to address this is progressing via the established Fylde Coast Scheduled Care Group.

In addition, we have been working to improve planned care for patients through the Fylde coast 100-day pathway campaign. The aim is to improve quality, patient satisfaction and the appropriate spending of public funds on health services through the development of agreed clinical pathways and processes grounded on the Map of Medicine (a national collection of evidence-based best practice). Objectives include: reducing inappropriate secondary care referrals; reducing variation between referral practices; improving demand management; improving inefficiencies due to inappropriate referrals; and ensuring care is delivered in the appropriate setting. The campaign also seeks to reduce the number of ‘interventions of limited clinical priority’ carried out. A review of existing Lancashire-wide commissioning policies is being undertaken, as well as a clinical audit of the top four interventions.

Moreover, we will drive continuous improvement by undertaking peer review of GP referrals to understand areas of commonality and variation. As part of the process, referrers are asked to identify areas where they feel that performance could be improved and to suggest specific schemes and/or measures which could be put in place, with the aim of reducing variation in referrals between practices and reducing unnecessary referrals to secondary care.

We recognise that the pan-Lancashire discussions taking place around the future of hospital care, informed by the awaited specialised commissioning strategic plan, may re-shape the provision of planned care services across Lancashire. We will continue to actively participate in these discussions.

**CHOICE**

We have developed a patient choice strategy which describes both national and local entitlements for choice. It also outlines what information will be provided and who will support patients to make a choice, together with our vision for choice across service areas.
Within the context of the new models of care described, we have – in consultation with local people – prioritised eight services areas which will have the biggest impact on health.

All of the interventions described in this section have been agreed as being a priority, have a project initiation document, and have had clinical and managerial resource allocated to ensure delivery.

A summary of these interventions cross referenced to NHS England’s five domains and seven outcomes is in appendix 3. The expected impact of these interventions can be found in appendix 4.
WHAT IT IS
Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.

WHAT HAPPENS NOW
- Cancer causes 28% of deaths in Fylde and Wyre. This increases to 40% for people aged over 75.
- Of all of the Lancashire CCG areas, Fylde and Wyre has the highest rate of cancer (2.8%) and the second highest rate in England (the England average is 1.93%).
- The survival rate for cancer in Fylde and Wyre is slightly better than the Lancashire average.
- Residents in the most deprived areas are almost 50% more likely to die when they have cancer than those in more affluent areas.
- The three most common cancers for men within Fylde and Wyre are prostate, lung and bowel. Between 2005 and 2009 the number of men diagnosed was: prostate – 750; lung – 451; bowel – 434.
- The three most common cancers for women within Fylde and Wyre are breast, lung and bowel. Between 2005 and 2009 the number of women diagnosed was: breast – 945; lung – 374; bowel – 361.

OUR VISION FOR CANCER
Ensuring patients receive a faster diagnosis and better treatment.

WHAT WE’LL BE DOING BY 2030
- Fewer people will develop cancer due to better awareness of keeping well and the active promotion of healthy choices, with more people taking responsibility for their own health and wellbeing. This will be supported by teaching cancer prevention in schools.
- There will be a reduction in the number of cancer-related premature deaths of people aged under 75 due to early diagnosis and treatment.
- Waiting times for referrals for suspected cancers will be reduced from the current two weeks to a maximum of one week.
- People will be more aware of cancer symptoms and will be diagnosed earlier, and so the numbers diagnosed through emergency health services (e.g. after going to A&E) will reduce from 25% now to 15%.
- Patients will be given a choice of alternative therapies as part of their treatment (including those to improve mental health and wellbeing, such as yoga).
- Survivorship through motivational training will become part of a patient’s treatment, e.g. regular physical activity has a key role in cancer survival and reducing the risk of cancer returning.
- Patients will be given a choice of support at the end of their treatment, including peer support.
- Technology will be used to better inform and support patients and their families and carers.
- Patients will be able to choose to have their treatment in a community-based setting where appropriate, and will only need to go to hospital for more specialist treatment.
- Primary care staff will have a better understanding of cancer referral pathways through improved education.
- Collaborative working with agencies outside of health such as football clubs and the Fire Service will raise awareness of cancer, encourage screening and signpost patients to appropriate services.
- We will have equalled the cancer five-year survival rates achieved by the best European countries.
- More people will attend screening for different cancers than do now.
WHAT THE CHANGES MEAN FOR...

PATIENTS

- More aware of prevention and early symptoms, fewer people will develop cancer and those who do will present earlier and have a much better outcome.
- More informed to make decisions about their lifestyle, care and treatment options.
- Included in the multidisciplinary discussions about their treatment and care.
- Greater choice about where to access care.
- More informed and supported to manage their condition and symptoms at home, including access to their treatment plan and summary of their treatment via online access.
- Actively supported to stay healthy and take part in individualised exercise programmes.
- Able to play a pivotal role in the development of services.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to available support, including health and care services.
- Will actively encourage people to attend screening.
- Joined-up services will support earlier diagnosis.
- Use of advocacy and support groups to support patients.

SERVICES

- Majority of diagnostics available in community settings.
- Hospitals and GPs working more closely in joint decision making with the patient regarding their care.

NOW

- Catherine, 53, is referred by her GP to hospital with a breast lump.
- She is seen within two weeks and is diagnosed with breast cancer.
- Catherine has her treatment, including chemotherapy, within her local hospital, but is referred to a different hospital for her radiotherapy.
- Catherine’s treatment ends and she is left feeling like she is “falling off the edge of a cliff” – after months of multiple agencies being involved in her care she is now left with routine appointments and feels very isolated.

BY 2030

- Catherine, who has a breast lump, has an appointment with her GP.
- Her GP discusses the choices available to her and they jointly agree that she should be referred to the local breast service.
- Catherine is seen within one week of referral. She attends a multidisciplinary appointment and is told about her diagnosis.
- She works with the multidisciplinary team to develop her treatment and care plan, and has a named contact for the management of her care.
- She attends all her treatment locally and at the end of this has a motivational interview to decide whether she wants to participate in an exercise programme or receive peer support.
- Catherine has had access to her treatment plan at all times.

“It is essential that healthcare professionals and the public work together to reduce the disastrous impact that cancer has on society. This includes social awareness and responsibility as well as clinicians working hard to detect this disease at a much earlier stage.”

Dr Adam Janjua, GP and the CCG’s clinical lead for cancer
## CANCER

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
<th>Timeline: Years (1 – 5)</th>
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| Redesign of community-based stoma service, with potential to have a community stoma clinic in each neighbourhood. | • Patients with a stoma would have their follow-up appointments in a community setting or at home instead of at hospital.  
• Improved patient outcomes, with patients offered practical, psychological, emotional and social support.  
• Better experience for families and carers who would be offered support, information and advice.  
• Integrated community care with district nurses, GPs and other community healthcare professionals. | 1  
2-5 |
| Exploration of an early diagnosis and greater diagnostic support service, with potential for diagnostics within the community. | • Earlier detection of cancer.  
• Reduced treatment costs.  
• Improved survival rates.  
• Reduced mortality.  
• Fewer urgent admissions.  
• Increased access to screening.  
• Better educational training for the general public in relation to health and wellbeing to reduce cancer. | 2  
5+ |
| Online access for patients to view their personal care plan. | • Patients more informed about their condition.  
• Greater ownership from the patient’s perspective. | 3-5  
3-5 |
| Prevention and public awareness campaigns. | • Coordinated approach with Lancashire County Council, voluntary, community, faith sector (VCFS) organisations, sports clubs, supermarkets, etc.  
• Increased public awareness of risks of an unhealthy lifestyle.  
• Reduction in cancer and long-term conditions.  
• Increased motivation to live a healthier lifestyle.  
• Reduction of smoking in pregnancy and smoking-related harm to unborn children. | 1-5 |
| Multiple survivorship services including the Moving Forward programme offering cancer patients the opportunity to enter a physical activity programme tailored to their needs. | • Survivorship rates increase which will make patients feel more empowered and informed.  
• Increase in confidence of patients who have had cancer.  
• Early presentation to a GP, therefore reduced reoccurrence.  
• Improved overall health (e.g. through exercise referral programme).  
• Greater collaboration with VCFS organisations. | 1  
5+ |
| Access to alternative therapies. | • Improved mental health and wellbeing.  
• Patients less anxious. | 3-5  
3-5 |
WHAT IT IS

Children’s services:
All areas of child health, from birth to age 19.

Maternity services:
Care for pregnant women, from conception to between 10 days and six weeks after birth.

WHAT HAPPENS NOW

• 4,200 children are living in poverty in Fylde and Wyre. This impacts on health through poor diet and living conditions.
• One in five expectant mothers smokes during pregnancy.
• Two in five mothers from affluent areas are still breastfeeding their babies at eight weeks. The figure for mothers in deprived areas is one in five.
• Many children are accessing the children’s assessment unit at Blackpool Teaching Hospital for conditions that could be managed in other ways.
• Many children and young people feel that services are not young people-friendly or approachable.
• There are approximately 650 children between the ages of seven and 15 years who have a moderate, profound or severe learning disability or an autistic spectrum disorder.

OUR VISION FOR CHILDREN AND MATERNITY

To ensure high quality, accessible, user-friendly services are available for children, young people and pregnant women. To support children, young people and pregnant women to be aware of their own health and wellbeing and to be engaged in maintaining good health.

WHAT WE’LL BE DOING BY 2030

• Expectant mothers will have more choice about where and how they use maternity services.
• Health promotion services, such as support to stop smoking, will be tailored to individual needs.
• A breastfeeding-friendly community will exist where women are encouraged and supported to breastfeed, and where most mothers are still breastfeeding at eight weeks, giving their babies the best start in life.
• Health and care services for children and young people will be coordinated, and will support their health and social care needs. Services, including sexual health services, alcohol and drug advice and support, will be delivered in child and young person-friendly ways.
• Children and young people will be supported to keep fit and well, both mentally and physically.
• Technology, such as internet-based education and support programmes, will be an integral part of children and young people’s services.
• There will be a seamless transition between children’s and adult support.
• Children and young people with long-term conditions or palliative care needs will have access to a personal health budget to allow them to tailor services to their needs, based on their care plan.
WHAT THE CHANGES MEAN FOR...

PATIENTS

• Children and young people will be more aware of their own health and emotional wellbeing and how to maintain it.
• Better coordinated, community-based services, with technology used to ensure wider access.
• Information and services will be delivered in ways that children and young people feel are accessible.
• Expectant mums will be supported to make choices about where and how they have their care needs met.

PARTNERS

• The promotion and support of good health and emotional wellbeing will be everybody’s business.
• Will signpost to support available, including health and wellbeing services.
• All organisations will have a responsibility to contribute to the health and wellbeing of children and young people.
• More services will be jointly commissioned to ensure joined-up care.
• Agencies will work together to deliver comprehensive, young people-friendly information and support services such as sexual health, drug and alcohol support services.
• Existing schemes and activities for young people will promote health messages.

SERVICES

• Services will be responsive to and driven by the needs of children and young people.
• More creative use will be made of technology and innovation to provide support and information.
• There will be more focus on supporting young people to maintain their own health and emotional wellbeing through proactive education and peer support.
• Services will be provided in a young people-friendly community setting wherever possible.
• Specialist services will be centralised in order to deliver the highest quality of care.

CASE EXAMPLE

CHILDREN’S SERVICES

NOW

• Philip, 14, has diabetes. He is just starting to take responsibility for managing his own condition but he has some worries and questions.
• Philip doesn’t want to talk to his GP as he’s worried his parents might find out.
• Philip feels uneasy about talking to his consultant as he views the consultant as being too old to understand.
• Philip can talk to the diabetes nurse but she can be very busy and he doesn’t want to waste her time.

BY 2030

• The diabetes team at the hospital has introduced Philip to a peer support group where he can talk to other young people about having diabetes and about life in general.
• Philip can contact the diabetes team via various technologies such as text, email and web chat and get the support he needs when he needs it.

“Giving a child a good start in life is the best present we can give. We want our children to have the best possible chance of fulfilling their potential.”

Dr Vellore Chandrasekar,
GP and the CCG’s lead for children’s and maternity services
## SUPPORTING SCHEMES IN THE NEXT FIVE YEARS

### CHILDREN AND MATERNITY

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
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<tbody>
<tr>
<td>Family-oriented smoking and alcohol support and advice during pregnancy for parents and children, with education support from voluntary, community, faith sector (VCFS) organisations. Work with providers who are not commissioned by the CCG to link to and make best use of all relevant services with partner commissioners.</td>
<td>• Reduced smoking during pregnancy. &lt;br&gt; • Fewer complications during pregnancy. &lt;br&gt; • A decrease in smoking at home. &lt;br&gt; • An increase in health outcomes for the entire family. &lt;br&gt; • A positive change in behaviour.</td>
<td>1-5 2-5 1-5 2-5 1-5 2-5</td>
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<tr>
<td>Work with partner commissioners to make sure parents get appropriate health messages and information on health options for children. Ensure consistent messages are delivered across the range of health, social care and education settings.</td>
<td>• An increase in more appropriate self-management. &lt;br&gt; • Changes to child health pathway, with more community provision. &lt;br&gt; • Fewer urgent care attendances.</td>
<td>1-5 2-5</td>
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<tr>
<td>Work with partner commissioners to ensure delivery of appropriate health messages for young people, e.g. sexual health, alcohol abuse, drugs and bullying.</td>
<td>• Improved knowledge among children and young people leading to better health choices and outcomes. &lt;br&gt; • Social media and peer support fully utilised. &lt;br&gt; • Young people know how to access more specialist support as required.</td>
<td>1-5 2-5</td>
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<tr>
<td>Review and redesign a range of health provision for young people of school age to ensure compliance with the requirements outlined in Children and Families Bill 2013 reforms, to be implemented by September 2014.</td>
<td>• Statutory requirements met. &lt;br&gt; • Improved integration of services, joint planning and commissioning. &lt;br&gt; • Improved patient and family experience of services. &lt;br&gt; • Improved transition between child and adult provisions as expectations are better managed and more consistent across the age range.</td>
<td>1 2-5</td>
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</table>
New community paediatric learning disabilities service to address the current unmet needs of patients who have severe or profound learning disabilities, a poor experience of services and difficulty getting a diagnosis or community support. On occasion the need has been so great that funding for out-of-area provision has had to be sought via the ‘individual patient activity’ process. This has meant we have had to spot purchase assessment and/or intervention from neighbouring teams, or fund in-patient assessment and intervention from specialist providers who are out-of-area which can result in children being treated and supported at some distance from their families.

| • Improved assessment, intervention and support for children and young people with severe or profound learning disabilities, including behavioural needs and mental health needs. |
| • Improved management arrangements and family coping strategies. |
| • Decrease in carer and family breakdown. |
| • Reduced need for in-patient and residential placements. |
| • Better transition into adult provision. |
| • Difficulties addressed earlier on in childhood are managed much more successfully than later on in life, which could lead to lower levels of need on transition. |

**Review and redesign pathway for children who are unwell and need to access health assistance.**

| • Redesigned pathway with more emphasis on community provision and self-management. |
| • Less frequent use of urgent care. |
| • Parents have increased confidence in what to do when their child is poorly. |

**Use of VCFS to support and encourage breastfeeding peer support groups.**

| • Increased breastfeeding awareness. |
| • Increased breastfeeding numbers and duration after eight weeks. |
| • Consistent health messages and education. |
| • Existing support better coordinated. |
WHAT IT IS

The care for people approaching the end of life when they are likely to die within the next 12 months.

WHAT HAPPENS NOW

- The CCG has a commissioning responsibility to ensure end of life services for adults aged 18 years and above.
- Home is often the preferred place of care and death for the majority of people and most do not change this preference. However, a substantial minority do not make home their first choice or change their minds.
- Older people are more likely to die in hospital, except in very old age.
- Nearly four out of five people are admitted to hospital once in their last year of life.
- People from the most deprived areas are more likely to die in hospital than those from more affluent areas. Around nine in 10 of those who die in hospital do so following an emergency admission.
- Of those patients with a care plan, 10% die in hospital compared to the 26% who die in hospital who do not have a care plan.
- There is limited access to out of hours end of life care in Fylde and Wyre.
- 98% of those registered on an Electronic Palliative Care Coordination System in England who say they would prefer to die in a care home achieve their preferred place of death. Only 1% of people registered say they would prefer to die in hospital.
- Across England a 10% reduction in the number of hospital admissions ending in death could potentially result in a saving of £52 million.

OUR VISION FOR END OF LIFE

To ensure that high quality services are available in hospitals, care homes and community settings for all patients and carers, regardless of diagnosis, that offer dignity, choice and support in the last year of life.

WHAT WE’LL BE DOING BY 2030

- There will be 24/7 care provision for end of life care.
- Health, social care and other agencies, including hospices and the voluntary sector, will work collaboratively to increase the support available for patients, their family and carers in the community.
- Advance planning will identify those who are approaching the end of life to ensure their wishes are fulfilled.
- Patients, their families and carers will have an informed choice discussion regarding their preferred place of care and death.
- All clinicians will be trained to have end of life and advance care plan conversations with patients and their families.
- An individual’s plan will be sensitive to personal, cultural and spiritual beliefs, and preferences will be shared between health professionals.
- Children with palliative care needs will have access to a personal health budget to allow them to tailor services to their needs, based on their advance care plan.
- There will be improved training for NHS staff and staff employed by care providers, particularly with regard to communicating with patients and their carers.
- Improved access to information and technologies to support patients and their carers.
- People will be offered a discussion about their end of life wishes, and this will include practical aspects such as funeral arrangements and finances.
- The needs of carers will be appropriately assessed, with support offered pre- and post-bereavement from a choice of bereavement agencies.
- Providers of care will be coordinated to ensure a joined-up service and consistent standards.
- The experiences of patients and their families will shape and inform service developments for end of life.
- Patients’ care will be delivered within their home or a community setting where appropriate.
WHAT THE CHANGES MEAN FOR...

PATIENTS

- More likely to have their wishes fulfilled.
- Will have a named person to provide support and coordinate their care.
- Supported earlier and for longer.
- More care and support in community settings.
- Better support for families and carers.
- Improved access to information and technologies.
- Greater openness to end of life within community settings, with increased public acceptance to enable conversations regarding death.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to support available.
- 24/7 care through integrated service provision.
- Joined-up services will support rapid discharge of patients from hospital.
- Support for families post-bereavement.
- Training for health and social care professionals in advance care planning and communication skills.

SERVICES

- Closer working across all providers of care.
- All providers will be appropriately trained and quality assured, including care homes, private sector assisted living, hospices, domiciliary services, practices, community and hospital services.
- Improved communication with patients and carers about death and end of life care, including pre- and post-bereavement support.
- Better management in care homes to ensure patients are not admitted to hospital unnecessarily.
- Individuals will be treated in a hospital when more specialist care is required or where the patient has specified hospital as their preferred place of care/death.
- Clinical nurse specialists will work closely with the primary care team to identify patients at the end of life, and will also liaise with patients and their family/carers to ensure their wishes are fulfilled.

CASE EXAMPLE

NOW

- Judith, 82, is on the palliative care register with her GP practice and has been identified as being in the end stages of life.
- She has an advance care plan in place. However, despite her wishes on the care plan, Judith has repeated urgent overnight admissions to hospital.

BY 2030

- Judith and her family have worked with the appropriate clinician and have developed and agreed an advance care plan.
- Her wishes are to remain at home.
- Through the advance care plan, Judith’s care is coordinated by a multidisciplinary team with multiple care agencies working together, and her care is delivered in her home.

“It is a fundamental right for patients to be allowed to die in a place of their choosing. This can only be facilitated by honest, open dialogue between healthcare professionals and the patient (and their family).

“Everyone deserves to die a good death, free from pain, anxiety and distress. Hopefully by working together we will be able to provide this to every patient in the future.”

Dr Adam Janjua,
GP and the CCG’s end of life clinical lead
### END OF LIFE

<table>
<thead>
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<th>Timeline: Years (1 – 5)</th>
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</table>
| National six steps co-ordinator programme to deliver end of life training to nursing homes, care homes, supported living groups and domiciliary services. | • Patients have a better end of life care experience.  
• Patients’ care will be in the most appropriate setting and they will not be admitted inappropriately to hospital. | 1  
1-5 |
| Implementation of Electronic Palliative Care Coordination System (EPaCCS). | • Fewer inappropriate admissions to hospital.  
• All those involved in the care of a patient will have access to the patient’s care plan, which will include details of medication and preferred place of care. | 1  
1-5 |
| Advanced care planning – ensuring the process of voluntary discussion between individuals and those who provide care, for example nurses, doctors, care home managers or family members, to express some views, preferences and wishes about an individual’s future care. | • Greater patient awareness of choice.  
• Patients/careers involved in care planning.  
• Taboo of death and dying removed.  
• Integrated working.  
• Better communication between all stakeholders including patients, carers and all health and social care professionals. | 1  
1-5 |
| End of life training/awareness for front line staff. | • Improved level of end of life care delivered across all professions, directly engraining a culture of openness towards end of life discussions and care.  
• More efficient delivery of end of life care.  
• Fewer urgent hospital admissions. | 1  
1-5 |
| Bereavement support service to provide pre- and post-bereavement support to patients, their families and carers. | • Greater choice of providers.  
• Awareness of pre- and post-bereavement support available, including specialist support for children and young people. | 1  
1-5 |
| Development and implementation of care plans for all patients identified as end of life. | • Fewer inappropriate admissions to hospital.  
• Patient care will be better managed within the community. | 1  
2-5 |
| Commission pilot for a hospice at home service. | • Patients able to remain in their preferred place of care.  
• Patients able to die in their preferred place of care.  
• Less end of life care in hospital.  
• Better quality care.  
• Integrated working. | 1-2  
1-5 |
LEARNING DISABILITIES

WHAT IT IS
A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently.

Specific learning disability services offer support to people with severe or profound learning disabilities, and specialise in supporting those with challenging behaviour and severe communication needs. People with learning disabilities should also be able to access ordinary healthcare services, such as their family doctor, dentist and hospital outpatient services, who should make reasonable adjustments to accommodate their particular needs.

WHAT HAPPENS NOW
• There are about 500 adults and 650 children with a learning disability living in Fylde and Wyre.
• People with learning disabilities can find it difficult to access ordinary health services and sometimes they might even find themselves excluded from care.
• People with learning disabilities are more likely to experience a number of other health conditions, including early onset dementia, diabetes and diseases of the heart and blood vessels.
• Not all people with learning disabilities have an annual health check and health action plan, and so their health needs and risks cannot be proactively managed.
• The Winterbourne Review (the report into events at Winterbourne View Hospital) identified that people in a specialist learning disability hospital should be supported to leave hospital sooner with proactive support packages tailored to their needs.

OUR VISION FOR LEARNING DISABILITIES
Ordinary and specific learning disability services will work together to bring the appropriate expertise and skills to meet a patient’s needs. People with learning disabilities and their carers will have the information and support they need to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE’LL BE DOING BY 2030
• Those with learning disabilities will be supported to develop lifelong positive emotional and physical health.
• All services will make reasonable adjustments to support people with a learning disability, e.g. providing information in a variety of formats including pictorial leaflets, or offering the first appointment of the day to those who may find any wait distressing.
• Health risks and needs will be proactively managed, and those with a learning disability will have an annual health assessment and a health action plan.
• Services will respond to the needs of the individual, bringing the appropriate expertise and skills to the patient rather than the patient having to move between teams.
• Patients will be admitted to hospital less frequently and for shorter periods.
• There will be a seamless transition between children’s and adult support.
• The community will be ‘learning disability aware’, where people with learning disabilities are accepted and are able to engage in all aspects of community life.

“I would like them [local health services] to listen more and be more understanding.”
Service user, September 2013

“The service is good, but they need to make better adjustments and use large print.”
Service user, September 2013
WHAT THE CHANGES MEAN FOR...

**PATIENTS**

- Patients, their families and carers will be provided with appropriate information and support to maintain good health.
- Much better access to services, with staff who understand about learning disabilities.
- More use of appropriate technologies and innovation to provide support and information.

**PARTNERS**

- Will promote and encourage healthier lifestyles.
- Will signpost to support available.
- More services will be jointly commissioned to ensure joined-up care that reflects the complex mix of health and social care required.

**SERVICES**

- Services will make reasonable adjustments to meet the needs of people with learning disabilities.
- Services will be responsive to an individual’s needs, bringing the required skills and support to the patient rather than the patient having to move between teams.
- Only the most specialised and intensive support will be delivered in hospital, and patients will be admitted less frequently and for shorter periods.
- Community and specialist services will have excellent links, which will enable good planning and a seamless transition between services.

CASE EXAMPLE

**NOW**

- Susan, 36, has Down’s syndrome and lives in supported housing. Her carer takes her to see her GP as she is unwell and feverish.
- Susan is also diabetic and on tablet treatment.
- The GP sees Susan and diagnoses that she has a chest infection. She gets better with antibiotics.
- The GP will see Susan whenever needed but the carers are often unsure of what to do if she is unwell and they need to consult the practice very often, usually at short notice. The carers do not always bring Susan for her regular diabetic check-ups as she is afraid of doctors and nurses.

**BY 2030**

- The GP sees Susan and diagnoses a chest infection. He invites Susan and her carers to attend for an annual health check when she is better.
- At the health check the GP writes a health action plan for Susan. This gives information on what symptoms Susan may experience and how the carers will manage.
- The carers have clear plans so they know when to consult a GP. They also understand all the regular check-ups that Susan needs.
- Susan gradually becomes comfortable attending the practice as she is invited in for sessions to let her become familiar in that setting.

“Individuals with learning disabilities have a wide range of problems and are prone to develop serious medical conditions. They have the right to access medical and social care as they need it. We are committed to raising awareness of their needs and ensuring that appropriate adjustments are made to accommodate them in all the local services. We are working with partner organisations to ensure that our communities understand the needs of these individuals and go out of their way to meet those needs.”

Dr Kath Greenwood, GP and the CCG’s clinical lead for mental health, dementia and learning disabilities
## SUPPORTING SCHEMES IN THE NEXT FIVE YEARS

### LEARNING DISABILITIES

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
<th>Timeline: Years (1 – 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure adherence to the Winterbourne obligations:</td>
<td>• Improved patient experience.</td>
<td></td>
</tr>
<tr>
<td>• personalised support;</td>
<td>• Patients only admitted to hospital if they have a clinical need to be there.</td>
<td>1-3</td>
</tr>
<tr>
<td>• comprehensive community packages of care tailored to the needs of the individual (via a personal health budget); and</td>
<td>• Fewer urgent hospital admissions.</td>
<td>1-5</td>
</tr>
<tr>
<td>• care planning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual health check and action plans in place for all patients.</td>
<td>• Proactive management of patients’ health needs.</td>
<td>1-2</td>
</tr>
<tr>
<td>Education event to encourage practices to deliver the health check.</td>
<td>• Patient and carer empowered in self-management.</td>
<td>2-5</td>
</tr>
<tr>
<td></td>
<td>• Fewer A&amp;E and urgent care attendances.</td>
<td></td>
</tr>
<tr>
<td>Potential implications from the learning disability self-assessment framework which helps benchmark the processes and services we have in place.</td>
<td>• Awaiting the outcome of the most recent assessment which may identify areas that require further work and improvement.</td>
<td>TBC</td>
</tr>
<tr>
<td>Reasonable adjustments made in settings such as clinical care to develop learning disability-friendly communities.</td>
<td>• Better patient experience.</td>
<td>2-5</td>
</tr>
<tr>
<td></td>
<td>• Increased public awareness.</td>
<td></td>
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<tr>
<td></td>
<td>• Decrease in the use of clinically-driven specific learning disabilities services.</td>
<td>3-5</td>
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</table>
WHAT IT IS
A long-term condition is a health problem that can’t be cured, but can be managed by medication and other treatments, e.g. diabetes, heart disease, stroke and respiratory disease.

WHAT HAPPENS NOW
- Around 30% of people living in Fylde and Wyre have at least one long-term health condition.
- More people have diabetes, heart disease, high blood pressure, stroke, kidney disease, asthma and respiratory disease than the England average.
- Patients with long-term conditions tell us that they do not feel supported in managing their condition.
- There is not a coordinated approach to the management of patients with more than one long-term condition. This particularly affects people over 65 years old with diabetes who can have as many as five other long-term conditions.
- Care across health, social and voluntary services is fragmented.
- People are referred to hospital for the majority of their care because provision is not fully available in the community.
- People with long-term conditions affecting the brain and nervous system attend hospital more often and stay in hospital for longer than the national average.
- There are currently some examples of good practice, but they are not applied consistently across the different parts of the healthcare system.
- There is no consistent focus on screening people at risk of developing a long-term condition to support early prevention.

OUR VISION FOR LONG-TERM CONDITIONS
Community-based services, particularly general practice, will play a central role in proactively supporting patients with long-term conditions through high quality, integrated and personalised care. People will have the information and support they require to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE’LL BE DOING BY 2030
- Everyone with a long-term condition will have a care plan, which provides information about their condition and empowers them to self-manage and make decisions about their care. It will be available electronically and linked to their GP health record. The care plan will be available to the organisations involved in a person’s care, ensuring that the same information is used to inform decisions.
- Practices working across neighbourhoods will coordinate a broad range of care in a community setting, including in a patient’s own home, working with community services, social care and expert clinicians.
- Healthcare professionals will have the tools to identify patients at high risk of their long-term condition worsening. Patients will be supported to stop their long-term condition getting worse.
- Thanks to improved community services, fewer people will be admitted to hospital. When people need to receive hospital care, it will be for as short a time as possible and their discharge will be supported by the community team.
- Healthcare professionals will be supported so they can confidently signpost people to a wide range of clinical, self-help, self-management and healthy lifestyle support.
- Telehealth will be regularly used by individuals to monitor and manage their condition at home.
- A continually updated list of services and information to support long-term conditions management will be available.
- Carers will have access to the same support and information as people with long-term conditions. Carers will also receive a joined-up assessment to identify their needs and any support required.
- People with long-term conditions will have access to a personal health budget to allow them to tailor services to their needs, based on their care plan.

“We currently look at what is provided in hospital first and then what can be provided in the community. We should be looking at what can be provided in the community first and then what must be provided in the hospital.”

Local resident, November 2013
**WHAT THE CHANGES MEAN FOR...**

### PATIENTS
- Active participation in decisions about their care.
- A named person who is responsible for making sure their needs are met.
- More care at home and in a community setting, with active support to stay healthy.
- Earlier identification of problems through long-term condition screening.
- Living a healthier more empowered life.

### PARTNERS
- Will promote and encourage healthier lifestyles.
- Will signpost to support available, including health and wellbeing services.
- Integrated teams will work together to support people with long-term conditions and identify people at risk of becoming ill earlier.
- Will support to help people use technology.
- Existing support networks around individuals and families will be strengthened.

### SERVICES
- A greater focus on prevention, health promotion and self-care.
- Increased and broader-ranging services delivered in the community, including diagnostics.
- Better use of technology to widen access to services.
- Only the most specialised and intensive treatment will be delivered from hospital.

**CASE EXAMPLE**

#### NOW
- Jack, 43, goes to see his GP complaining of tingling in his hands and often feeling extremely thirsty.
- After visiting his GP, Jack is diagnosed with type 2 diabetes.
- Jack struggles to manage his diabetes and subsequently is prescribed insulin.
- Following a trivial injury Jack develops complications linked to his diabetes and is admitted to A&E.

#### BY 2030
- Jack accesses a single point of information about diabetes and has an informed discussion with his named GP about his care.
- Jack and his GP put together a care plan, which includes advice from a community-based diabetes specialist.
- Following discussion with his GP, Jack is referred to a self-management course to learn how to use insulin.
- Jack sends monitoring information to his GP and neighbourhood team from home using telehealth equipment. His condition is managed remotely to ensure he remains well.

“Our patients and their carers have to manage all aspects of their lives, with their unique challenges. Our role as clinicians will be to listen to their concerns, to use our skills to offer them advice on the options available and guide them to the best treatment for their individual needs. This will be a long-term partnership, involving a range of resources in our community.”

Dr Peter Benett, GP and the CCG’s clinical lead for long-term conditions

“Services do ‘to’ not ‘for’ and do not take into account the rights and wishes of the individual. They see an illness not a person.”

Local resident, November 2013
## SUPPORTING SCHEMES IN THE NEXT FIVE YEARS

### LONG-TERM CONDITIONS

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
<th>Timeline: Years (1 – 5)</th>
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</thead>
</table>
| Type 1 diabetes structured education to support patients in the self-management of their condition. | • Improved quality of life for people with type 1 diabetes through a better understanding of their condition and self-management techniques.  
• Reduction in activity, and therefore cost, in primary and secondary care due to people being empowered to manage their own condition. | 1-2  
2-5 |
| Commission new home oxygen assessment and review service.                            | • Improved quality of life for people requiring oxygen at home to support the management of respiratory conditions.  
• Improved quality in prescription of oxygen as people will be effectively triaged by a respiratory nurse before oxygen is prescribed.  
• Patients already prescribed oxygen will receive a regular assessment to ensure dosage is correct, increasing quality and patient safety.  
• Fewer hospital admissions due to better control of long-term respiratory conditions through prescribed oxygen in a patient’s home.  
• Adheres to British Thoracic Society guidelines. | 2-3  
3-5 |
| Pre-diabetic structured education for anyone identified with pre-diabetes.           | • Improved health through early identification of pre-diabetes and supporting people to avoid diabetes.  
• Better education on how to achieve a healthy lifestyle and the effects of diabetes.  
• Reduced prevalence of type 2 diabetes.  
• Long-term cost savings by reducing diabetes prevalence. | 1-2  
2-5 |
| Commission new integrated insulin pump clinic.                                      | • Patients empowered to self-manage and make decisions about the care of their long-term condition.  
• Fewer primary and hospital attendances. | 2-3  
3-5 |
| Development of new integrated diabetes foot care service.                            | • Overall improvement in the quality of care for people with diabetes.  
• Patients less likely to develop active foot disease.  
• Fewer urgent hospital admissions and amputations.  
• Reduced costs to the NHS. | 2-3  
3-5 |
| Commission new service specification following pulmonary rehabilitation review.      | • Reduced health inequalities.  
• Improved service quality.  
• Reduced waiting times for the service (currently 8-12 months). | 2  
2-5 |
<table>
<thead>
<tr>
<th>Description</th>
<th>Expected Outcomes</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| Updated GP practice staff training for spirometry (a test which diagnoses lung conditions). | • Improved spirometry provision in line with locally revised chronic obstructive pulmonary disease (COPD) pathway.  
• Reduced need for patients to attend outpatient appointments for spirometry, therefore reducing costs. | 2-5       |
| Bronchiectasis service review, with recommendations implemented (bronchiectasis is a long-term lung problem). | The options appraisal for a bronchiectasis service has not yet been completed and therefore it is not possible to outline the expected outcomes. | 2-3 3-5   |
| A new, fully embedded early supported discharge service and community stroke rehabilitation service with formal specification in place; to replace current provision which is through individual therapy services. | • Reduced hospital stay for people who have had a stroke.  
• Reduced delayed transfers of care.  
• Fewer urgent re-admissions.  
• Improved therapy outcomes.  
• Fewer admissions to long-term care. | 1-2 2-5 |
| Commission and develop a new health library of information accessible online by patients and professionals. | • Patients empowered to make informed decisions.  
• Clinicians able to update and refresh knowledge of conditions and identify resources available to support patients. | 4 4-5 |
| Joint working with multi-disciplinary teams as part of the neighbourhood development to provide patient-centred care plans devised by patients, carers and clinicians to support long-term conditions management. | • Patients more empowered.  
• Prevention and anticipatory care planned.  
• Better signposting to support available.  
• Improved quality.  
• Integrated teams. | 1-2 2-5 |
| New community-based specialist clinicians and training for existing local healthcare professionals to deliver new models of care. | • Improved communication between primary and secondary care.  
• Improved quality of care.  
• Earlier and more confident discharge of patients from hospital.  
• Effective use of consultant/specialist time. | 1-2 2-5 |
| Training for clinicians to support on-going self-management. | • Patients supported to better self-manage their conditions. | 1-5 2-5 |
| Expansion of care coordination service. | • Care coordinated and unavoidable admissions reduced. | 1-2 2-5 |
WHAT IT IS
Mental health refers to a person’s condition with regard to their psychological and emotional wellbeing. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities.

WHAT HAPPENS NOW
- The NHS in Fylde and Wyre spends more than the England average on mental health, but achieves poorer outcomes.
- The number of people with dementia in Fylde and Wyre is higher than the national average, and this is set to rise as the population ages.
- Access to the right mental health support can be complicated and may often involve waiting for too long.
- Services are fragmented; patients and health professionals find them difficult to navigate.
- Patients have to move between different teams and services in order to have their needs met.
- Mental health services are often not integrated with other health services.

OUR VISION FOR MENTAL HEALTH AND DEMENTIA
The support of good mental health and wellbeing will be central to all healthcare. Support for mental and physical health will be delivered through coordinated community-based services. People will have the information and support they need to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE’LL BE DOING BY 2030
- Mental health outcomes in Fylde and Wyre will be better than the national average.
- There will be just as much focus on improving emotional and mental health as physical health, with people supported to develop lifelong positive emotional health.
- Mental health support will be an integral part of all health and care services, available 24/7.
- In order to improve access and navigation, there will be one single point of entry to mental health services for people of all ages.
- Services will respond to the needs of the individual, bringing the appropriate expertise and skills around the patient.
- Technology, such as internet-based support programmes, will be an integral part of mental health support.
- The transition between children’s and adult support will be seamless.
- Fylde and Wyre will be a ‘dementia-friendly community’ where people actively encourage those with dementia to participate in community life.

CASE EXAMPLE DEMENTIA

NOW
- Beryl, 72, has some short-term memory problems. She thinks that this is just part of getting old. She lives with her husband, Fred, who is her main carer.
- Beryl’s condition deteriorates and Fred finds it hard to cope.
- They eventually visit the GP and are referred to the memory clinic. Beryl is started on medication and they receive some help from a dementia adviser.
- Fred tries to take Beryl out as much as possible but finds that it is very difficult to go shopping or to a café. The other customers and staff don’t understand the problems and treat Beryl very impatiently.
- Fred finds it too difficult so rarely goes out any more. He has to find help with shopping and he and Beryl become socially isolated.

BY 2030
- Fred and Beryl see a poster in their surgery about the importance of an early diagnosis of dementia. They see the GP at an early stage, are referred to the memory clinic and receive a lot of support.
- Beryl responds well to treatment and they attend dementia cafés and other activities with peer groups.
- Most of the cafés and supermarkets in the area are ‘dementia friendly’ and Fred finds that if Beryl does behave strangely or becomes distressed when they are out people are kind and understanding.
- The couple are able to continue going out and Fred is able to do his own shopping, taking Beryl with him.
WHAT THE CHANGES MEAN FOR...

PATIENTS

• More aware of their own emotional health and how to maintain it.
• More aware of what help and support is available and how to access it.
• Better access to self-help and self-management support.
• Access care from home or in a community setting rather than at hospital.
• Support available 24/7.
• Increased education to improve good mental health.

PARTNERS

• The promotion and support of good mental health and emotional wellbeing is everybody’s business.
• Will signpost to support available, including health and wellbeing services.
• Will identify and support individuals at risk of developing mental health issues.
• More services will be jointly commissioned to reflect the complex mix of health and social elements within mental health and emotional wellbeing.

SERVICES

• Greater focus on keeping people well.
• Patients admitted to hospital less frequently and for shorter periods.
• Specialist services centralised in order to deliver the highest quality of care.
• Only the most specialised and intensive treatment delivered from a hospital setting.
• Community and specialist services have excellent links, which enable good planning and a seamless transition between services.
• More creative use made of technology and innovation to provide support and information.

CASE EXAMPLE MENTAL HEALTH

NOW

• Jimmy, 48, has work-related stress. He is feeling very low and can’t cope at home or at work.
• Jimmy goes to see his GP because he feels very down and often just doesn’t want to get up in the morning.
• The GP has diagnosed Jimmy with a reactive depression, encourages Jimmy to have some psychological support, refers him to the local psychological therapies (IAPT) service and prescribes Jimmy some anti-depressants.
• Jimmy initially feels better but his mood worsens as he has a long wait to be seen for his talking therapy. He needs a higher dose of anti-depressant and is off work for many months.

BY 2030

• The GP has diagnosed Jimmy with depression and refers him to the local IAPT service, which holds sessions in the GP practice.
• The GP also gives Jimmy the details of the IAPT service website where he can access information and help. As the service is so immediate Jimmy declines anti-depressants.
• The IAPT service calls Jimmy later the same day to assess him. He is seen within two weeks and has regular treatment sessions. He accesses a peer support group. He doesn’t need anti-depressants and is back to work within a few weeks.

“We are committed to improving access to psychological therapies for people with all types of mental health problem. We are working closely with providers to develop innovative services that can be accessed by patients at any time from their own homes. We are committed to helping patients manage their mental health with appropriate support.”

Dr Kath Greenwood, GP and the CCG’s clinical lead for mental health, dementia and learning disabilities
## SUPPORTING SCHEMES IN THE NEXT FIVE YEARS

### MENTAL HEALTH

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
<th>Timeline: Years (1 – 5)</th>
</tr>
</thead>
</table>
| Improve integration of mental health services with physical health services. | • More holistic approach to managing long-term conditions.  
• Pro-active support, including care coordination.  
• Parity of esteem (mental health given as much focus as physical health). | 1-5  
2-5 |
| Raise awareness of mental health needs through education and publicity. | • Patients empowered to self-manage and seek help proactively.  
• Specific self-help information given routinely. | 3-5  
3-5 |
| Review existing Improving Access to Psychological Therapies (IAPT) services, including Big White Wall (web-based provision), and re-commission recommended IAPT model across Fylde and Wyre. | • Improved patient experience, with more timely access to the service.  
• Conditions supported in early stages leading to a reduced need for complex interventions. | 1-2  
2-5 |
| Re-commissioning of older people’s mental health community provision to fit with the neighbourhood model. | • More holistic approach to long-term conditions.  
• Pro-active support including care coordination.  
• Parity of esteem. | 1-2  
2-5 |
| Combine existing mental health contact points to develop a 24/7 all-age single point of access. | • Fewer A&E attendances because of a more responsive service. | 3-5  
3-5 |
<table>
<thead>
<tr>
<th>Overall description</th>
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<th>Timeline: Years (1 – 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investing in the service to ensure more people are diagnosed to a level proportional with the high numbers of older people within Fylde and Wyre.</td>
<td>• Increased diagnosis rates will ensure that patients and their carers get the appropriate support that they require.</td>
<td>1-2 2-5</td>
</tr>
<tr>
<td>Introducing the use of Cantab Mobile, a memory assessment software that can be used within GP practices to promote active screening for dementia by practice staff.</td>
<td>• Increased diagnosis rates will ensure that patients and their carers will get the appropriate support that they require.</td>
<td>1-2 2-5</td>
</tr>
</tbody>
</table>
| Build a dementia-friendly community by increasing education and awareness of dementia across the whole community, working with partner agencies and organisations including the voluntary sector. | • Better patient experience.  
• Better post-diagnostic support for patients and carers.  
• Better management of patients with dementia.  
• Increased understanding of dementia across communities.  
• A reduction in the number of carers reaching breaking point.  
• Fewer A&E attendances for acute episodes. | 2-3 3-5                  |
***WHAT IT IS***

Planned care involves routine services with pre-planned appointments. These could be provided in a hospital or a community setting such as a health clinic, GP surgery or in a patient’s own home.

***WHAT HAPPENS NOW***

- There have been improvements in waiting times and increased choice for patients in recent years.
- Patients are often seen in hospital when they could receive their care sooner in more convenient community settings.
- Many patients undergoing treatment feel their care is not coordinated and are frustrated that one person doesn’t have overall responsibility for supporting them.
- 62% of the people we spoke to said they would like tests such as ultrasounds and MRI scans carried out in the community.
- Many patients are often not supported to maintain a healthy lifestyle or self-care, and as a result of this are more likely to need an operation or treatment in the future.
- Patients need the NHS every day, yet evidence shows that the limited availability of some health services at weekends can have a detrimental impact on outcomes.
- Many carers do not feel supported.
- Many people do not know about the range of services on offer because the information available can be confusing.

***OUR VISION FOR PLANNED CARE***

Our vision is to make sure that patients are seen by the right person in the right place at the right time by high quality, coordinated services that fit around their needs.

***WHAT WE’LL BE DOING BY 2030***

- There will be a much wider range of high quality services within the community so people have easier and earlier access to planned care, with many services available seven days a week. This will include the expansion of ‘one-stop shops’ and diagnostic tests.
- GP practices – which will have overall responsibility for a patient’s care – will be supported by teams to enable them to coordinate health and social care services.
- There will be much better information available so that patients and their families are able to make choices about their health and care, and know what services are available and how to access them.
- Patients will be able to leave hospital sooner after their treatment to recover, where possible, in their own home due to better community-based support. This will mean a significant reduction in follow-up hospital outpatient appointments, which will be done instead in a community setting or at home.
- Healthcare providers and patients will be able to access information about patients’ health, so reducing possible errors and avoiding patients having to give the same information many times.
- To make sure the quality of care improves, services will be required to rigorously implement nationally and locally agreed best practice. This may mean that some highly specialised care is centralised at specific hospitals where more expertise is available more of the time.
- The new hospital appointment booking system, the NHS e-referral service, will improve the quality of the referral experience for patients, and better support clinicians and administrative staff.
WHAT THE CHANGES MEAN FOR...

PATIENTS

• Will have the information and support they need to make informed choices about their health and healthcare.
• Will have timely and coordinated care, planned around their needs.
• Will be better equipped to take control of their own health conditions.
• Will have improved access to many services, seven days a week.
• Will have less need to go to hospital due to improved community-based support.
• When hospital treatment is needed, will increasingly be admitted, treated and discharged on the same day.

PARTNERS

• Will promote and encourage healthier lifestyles.
• Much better coordination between all service providers, e.g. health, social care and the voluntary sector.
• Will help to signpost patients and their families to the most appropriate services.
• Will provide support to help people better self-care and manage their conditions.

SERVICES

• GP practices will take responsibility for coordinating a patient’s care.
• Hospitals will only see patients for specialist treatment, with very specialist treatment centralised in centres of excellence.
• The availability of services seven days a week in the community will shorten waiting times.
• Joined-up health, social and voluntary care will be available as part of one clinic.
• Health treatments and services will be in line with nationally and locally agreed best practice.

CASE EXAMPLE

NOW

• Peter, 52, makes an appointment with his GP with knee pain after his knee gave way while jogging.
• He sees his GP who refers him to an outpatient clinic at the hospital for assessment.
• Eight weeks later Peter attends his hospital appointment and is told he needs an MRI scan.
• Six weeks later Peter attends hospital again for a scan.
• Peter then attends the hospital for a further follow-up appointment to receive the results of the scan. Peter is told he requires investigative surgery and is booked onto the waiting list.

BY 2030

• Peter sees his GP who books him in for a one-stop shop assessment and diagnosis clinic at a local health centre.
• One week later Peter attends the clinic and has an MRI scan.
• The next day the results of the scan are sent to his GP.
• The GP shares the results with Peter and they discuss treatment options.
• Peter considers the benefits and drawbacks of surgery with his GP and makes the decision to proceed with surgery.

“We want to improve every patient’s experience by ensuring that they are seen at the right time in the right place by the right person. We are particularly excited about the opportunities provided by new technologies to support patients to choose and manage their care.”

Dr Tom Johnson,
GP and the CCG’s clinical lead for planned care
## PLANNED CARE

<table>
<thead>
<tr>
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<th>Timeline: Years (1 – 5)</th>
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</table>
| Move diagnostic services into community settings where appropriate (pilot specific diagnostic tests prior to full roll out across neighbourhoods). | • Improved patient access to tests.  
• Improved patient experience.  
• There may be an unintended increase in demand/activity for diagnostic tests as they will be in more convenient locations. Further work needs to be undertaken to assess the potential impact/increase in activity. | 1-2  
2-5 |
| Centralise triage management service for referrals to specialist services (tertiary care). | • Patients and carers signposted to the most appropriate service in a timely manner.  
• Fewer unnecessary hospital attendances.  
• Further work needs to be undertaken to understand the impact. However, it is anticipated that number of referrals will decrease as community/tier 2 schemes are better used. | 3-5  
3-5 |
| Development and implementation of the following tier 2 schemes:  
• ophthalmology;  
• dermatology; and  
• expansion of musculo-skeletal service. | • Improved access for patients.  
• Improved patient experience.  
• Fewer referrals to hospital.  
• Increased financial efficiencies.  
• Care closer to home. | 1  
2-5 |
| Further areas for development of tier 2 services are likely to be identified over the five-year strategy period. | | |
| Develop and agree a new pathway for orthopaedics. | • Improved access for patients.  
• Improved patient experience.  
• Dependent on outcome of scoping exercise there will be a potential shift of joint injection from hospitals to community settings. | 2-3  
3-5 |
| Develop and implement a planned care strategy as part of the Fylde Coast Scheduled (Planned) Care Group. | • The planned care strategy will align to our five-year plan and 2030 Vision and will ensure that patients are able to access a greater range of services in the community closer to home. | 1  
2-5 |
| Implement changes following a review of all pathology tests. | • Reduced duplication of tests and diagnostic imaging. | 2-3  
3-5 |
Promote and champion procurement of new services and pilots which increase choice, quality and competition.

- Improved service quality.
- Broader range of quality services closer to people’s homes.
- Better value for money.
- Procurement exercises may have an impact on existing hospital providers and the range of services which are provided in a hospital setting.
- There is likely to be a broad range of procurements to shift hospital activity into the community and also re-procurement of existing community services.
URGENT CARE

WHAT IT IS

Urgent care cannot reasonably be foreseen and therefore must be available 24 hours a day. Provision includes support to people at home, in short-term residential settings, urgent or emergency GP appointments, 999 ambulance services and emergency (A&E) hospital treatment.

WHAT HAPPENS NOW

- The level of urgent care on the Fylde coast (e.g. ambulance call outs and A&E attendances) is rising, with A&E attendances up by 4% compared to 2011/12 and emergency admissions up by 2% in the same period.
- The disjointed pattern of services and poor information available can be confusing. This can result in many people using services that are not appropriate for their needs.
- Considerable work has been undertaken across Fylde and Wyre to reduce avoidable emergency hospital admissions, such as:
  - Rapid Response Plus – an integrated health and social care access and assessment service for individuals who need an urgent response and may otherwise go to A&E and/or be admitted to hospital.
  - Care Coordination Scheme – care planning with people who have long-term conditions and are most likely to be admitted to hospital. A patient’s needs are identified in advance, and they are able to access advice and treatment 24/7 if they begin to feel unwell.
  - Frequent 999 callers’ prevention – an advanced paramedic identifies those individuals who are at greatest risk of needing to go to A&E via a 999 call and coordinates multi-agency support with GPs, housing providers and social services when required. This has resulted in an 88% reduction in 999 calls among the top 50 most frequent callers across the Fylde coast, which has been sustained for eight months.

OUR VISION FOR URGENT CARE

People who need urgent care will receive consistently high quality services in the right place, at the right time. Wherever possible, services will be joined up between health and social care and provided seven days a week in a person’s home or local community.

WHAT WE’LL BE DOING BY 2030

- By building on these recent developments, a wider range of high quality services will be available within the community and in patients’ homes to reduce the need for people to have to go to hospital for urgent or emergency care. As well as fewer A&E attendances, there will be a reduction in the number of people who are re-admitted to hospital soon after discharge and a reduction in ambulance call-outs.
- Services provided by different agencies will work together to ensure joined-up care.
- People identified as likely to need urgent care will have a joint assessment and a named health or care professional to help them stay well and better manage their condition.
- There will be much better information available so that patients and their families know what services are on offer and the easiest way to access them.
- There will be more joint health and social care services based in the community designed to promote self-care, wellbeing and support frail patients in need of rehabilitation or recuperation. This will allow more people to remain living independently at home for longer, and return home sooner after being in hospital.

“We must plan for a sustainable NHS which is fit to meet the future needs of our growing ageing population. I see most urgent care being provided in the community by enhanced multidisciplinary teams coordinated by GPs, with only the most seriously ill being managed in hospital by major emergency departments.”

Dr Rob Smyth, GP and the CCG’s clinical lead for urgent care
WHAT THE CHANGES MEAN FOR...

**PATIENTS**
- Much less likely to be admitted to hospital as an emergency, unless absolutely necessary.
- 24/7 health and social care support at home.
- Improved access to general practice.
- Holistic care and support to meet all needs.
- Better access to integrated rehabilitation and recuperation to enable longer independent living.
- Much better understanding of the services available and how to use them.

**PARTNERS**
- Will promote and encourage healthier lifestyles.
- Will help to signpost patients and their families to the most appropriate services.
- Teams from different organisations will work proactively together to make sure patients are supported in a community setting or at home.
- Will help to ensure patients and their families know how to access the services available.
- Better support in care homes to ensure residents are not admitted to hospital unnecessarily.

**SERVICES**
- Staff will work flexibly across traditional boundaries, focusing on the needs of their patients rather than the organisation.
- Delivery of more services outside of hospital.
- GPs working closer together and integrating with social care and community services.
- Fewer 999 calls by supporting those most at risk of emergency admission.

CASE EXAMPLE

**NOW**
- George, 83, visits his GP who diagnoses a urinary tract infection and prescribes antibiotics.
- In the pharmacy George seems confused. An ambulance is called and he is taken to A&E.
- George is admitted to hospital; his strange surroundings make him even more confused.
- Four weeks later George is still in hospital with both his physical and mental state having deteriorated.
- George has had various assessments and is now awaiting discharge to a permanent residential care home.

**BY 2030**
- George is feeling unwell and visits his GP who prescribes antibiotics for a urinary tract infection. She refers George to his neighbourhood health team as he doesn’t appear to be coping.
- George’s immediate health needs are managed by the rapid response nursing team who maintain contact and treat him in his home.
- A team of health and social care professionals work with George to identify how he can be supported to remain as independent as possible.
- George receives six weeks’ reablement in his home, attends voluntary groups twice a week and continues to have his care needs coordinated by a named health professional.
## SUPPORTING SCHEMES IN THE NEXT FIVE YEARS

### URGENT CARE

<table>
<thead>
<tr>
<th>Overall description</th>
<th>Expected outcomes</th>
</tr>
</thead>
</table>
| Design and implement care homes’ commissioning and support plan.                     | • Better quality of care in care homes.  
• Fewer urgent admissions from care homes.  
• Fewer episodes of end of life care in hospitals.  
• Improved patient experience.  
• Needs increasingly met at home and in the community.  
• Fewer 999 calls.  
• Fewer residential care placements.  
• Increased financial efficiencies.  
• End of life care in preferred place of care.                                             |
| **Timeline:** Years (1 – 5)                                                           | **Implementation Impact**                                                                                                                                                                                           |
| **2**                                                                                |                                                                                                                                                                                                                     |
| **2-5**                                                                              |                                                                                                                                                                                                                     |
| Commission a pilot for the expansion of the existing falls advice and assessment service to: | • Increased awareness of falls and falls prevention.  
• Reduced risk of initial and repeat falls.  
• Access to the falls advice and assessment service for all those who fall.  
• Fewer ambulance call-outs, A&E attendances, and urgent admissions due to falls.  
• Improved long-term outcomes for older people.                                           |
| • receive referrals from all primary care, community and third sector organisations; and |                                                                                                                                                                                                                     |
| • provide community falls prevention events.                                            |                                                                                                                                                                                                                     |
| **Timeline:** Years (1 – 5)                                                           | **Implementation Impact**                                                                                                                                                                                           |
| **1**                                                                                |                                                                                                                                                                                                                     |
| **2-5**                                                                              |                                                                                                                                                                                                                     |
| Commission a pilot for a falls lifting service linked to the Lifeline Pendant Scheme. | • Fewer ambulance call-outs and conveyances to hospital due to falls (estimated to save around 430 ambulance call outs per year).  
• Fewer A&E attendances and urgent admissions due to falls (estimated to prevent 260 A&E attendances per year).  
• Increased referrals into the falls advice and assessment service.  
• Reduced risk of repeat falls.  
• Improved long-term outcomes for older people.  
• Reduced costs to the NHS.                                                              |
| **Timeline:** Years (1 – 5)                                                           | **Implementation Impact**                                                                                                                                                                                           |
| **1**                                                                                |                                                                                                                                                                                                                     |
| **2-5**                                                                              |                                                                                                                                                                                                                     |
| Implement recommendations of hospital discharge review.                               | • Reduced delayed transfer of care.  
• Improved patient experience.                                                           |
| **Timeline:** Years (1 – 5)                                                           | **Implementation Impact**                                                                                                                                                                                           |
| **1**                                                                                |                                                                                                                                                                                                                     |
| **2-5**                                                                              |                                                                                                                                                                                                                     |
| Review all urgent and emergency services to assess seven-day availability and draw up plans for future commissioning arrangements in line with recent guidance. | • More people assisted to manage their own long-term condition.  
• Fewer A&E attendance and ambulance calls.  
• Fewer non-elective admissions.                                                          |
<p>| <strong>Timeline:</strong> Years (1 – 5)                                                           | <strong>Implementation Impact</strong>                                                                                                                                                                                           |
| <strong>1</strong>                                                                                |                                                                                                                                                                                                                     |
| <strong>2-5</strong>                                                                              |                                                                                                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th>Action</th>
<th>Expected Outcomes</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| Build on the current care coordination pilot to include social care risk factors and increase the number of people with anticipatory care plans. | • Fewer non-elective admissions.  
• Improved self-management of conditions.  
• Information available to support the development of new models of care. | 1-2  
2-5 |
| Broaden the scope of existing 999 frequent callers pilot to identify more individuals who could benefit from a proactive, person-centred anticipatory approach. | • Fewer 999 calls.  
• Fewer ambulance conveyances.  
• Fewer non-elective admissions.  
• Improved self-management of conditions.  
• Information available to support the development of new models of care. | 1  
2-5 |
| Re-commission community equipment services.                           | • Improved provision of community equipment services to reduce urgent admissions.  | 1-2  
2-5 |
| Review provision of all equipment, aids and adaptions to ensure a smooth pathway. | • Streamlined approach to the provision of aids, adaptions and equipment.         | 1-2  
2-5 |
| Implement the recommendations from the intermediate care review to ensure sufficient capacity within residential rehabilitation (nurse and non nurse-led). Includes reshaping existing residential recuperation and community therapy. | • Fewer non-elective admissions.  
• Reduced length of stay and delayed transfer of care.  
• Fewer admissions to long-term care.  
• Reduced demand for long-term community-based care packages.  
• Increased independence and positive outcomes for individuals. | 1-2  
2-5 |
| In line with intermediate care review recommendations, consider development of plans to integrate bed and community-based rehabilitation services. | • Ensure individuals independency is maximised.  
• Reduced permanent admissions to residential care.  
• Maximise individuals recovery time in non-bed based settings. | 1-2  
2-5 |
| In line with the development of a neighbourhood model scope, re-shape and maximise existing community assets and capacity within voluntary, community, faith sector (VCFS) provision. | • Fewer permanent admissions to residential care.  
• Maximise individual's recovery time in non-bed based settings.  
• Increase in personalised community support.  
• Detailed local knowledge and expertise available to patients and partners.  
• Fewer delayed transfers of care. | 1-2  
2-5 |
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Expected Outcomes</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| Re-design intermediate care/rehabilitation (including nurse and non-nurse led) and including the hospital discharge pathway. | - Improved patient experience.  
- Fewer non-elective admissions.  
- An increase in needs met at home and in the community.  
- Fewer 999 calls.  
- Fewer residential care placements.  
- Increased financial efficiencies.  
- Fewer delayed transfers of care. | 1-2, 2-5 |
| Roll out telehealth systems to support high intensity users, e.g. in care homes, extra care schemes. | - Decrease in emergency admissions.  
- Fewer 999 calls.  
- Improved patient experience. | 3-5, 3-5 |
| Integrated single care plans for those identified as higher risk of hospital admissions linked to the Better Care Fund. | - Fewer non-elective admissions.  
- Improved self-management of conditions.  
- Information available to support the development of new models of care. |          |
| Continuation of the existing Fylde coast community IV therapy pilot during 2014/15. The pilot is being reviewed this year which will evaluate the service and include details of potential further developments which need to be considered. | - Evaluation awaited, although a wider roll out of the scheme is anticipated. | 1-2, 2-5 |
| Fylde coast enhanced hospital-to-home discharge service pilot.           | - Improved patient experience.  
- Fewer non-elective admissions.  
- Fewer residential care placements.  
- Fewer delayed transfers of care. | 1-2, 2-5 |
We are working on new models of care to ensure greater integration of health and care services. There are two new ways of working that will support the successful implementation and delivery of these models of care: neighbourhoods and the Better Care Fund.

As already described, GP practices across Fylde and Wyre are currently coming together into geographical neighbourhoods to coordinate the health and care services tailored to the needs of their population. Following a number of all-practice events, four neighbourhoods have emerged. The practices have considered both their population’s health needs and geography when deciding the neighbourhood boundaries.

**Figure 14: Factors taken into consideration when deciding the neighbourhood boundaries**

1. Population need
2. Local authority neighbourhood footprints
3. Practice/local context
4. ‘Efficient’ population size
5. ‘Natural’ geography

The four neighbourhoods are:

- **Fleetwood neighbourhood**
  - Dr Ali Practice, Belle View Surgery, Broadway Medical Practice, The Mountview Practice and Waverley Surgery

- **Kirkham neighbourhood**
  - Ash Tree House Surgery and Kirkham Health Centre

- **Lytham and St Annes neighbourhood**
  - Fernbank Surgery, Holland House Surgery, Ansdell Medical Practice, Clifton Medical Practice, The Old Links Surgery, Park Road Medical Practice and Poplar House Surgery

- **Poulton-le-Fylde, Thornton and Over Wyre neighbourhood**
  - The Thornton Practice, The Village Practice, Beechwood Surgery, Carleton Practice, Over Wyre Medical Centre, Queensway Medical Centre and Lockwood Avenue Surgery
Figure 15: Map illustrating which practices belong to each neighbourhood
NEIGHBOURHOOD CONCEPT

There is the potential for the neighbourhoods to offer accessible and responsive services that extend well beyond what is currently available in general practice. These services will have general practice at their core, with practices working hand-in-hand with a range of other services that people need to access from time to time. Practices will help people navigate through these services and will retain a key role in coordinating care in different settings.

Practices have identified the following as being key to the success of the neighbourhood concept:

- practices working at scale;
- opportunities for developing innovative new models of care in collaboration with partners;
- focus on out-of-hospital services based around registered populations;
- tailoring services to meet the needs of local communities;
- integrating and coordinating health and social care.

In addition three potential neighbourhood roles have been distinguished:

1) Commissioners of care
   - Shaping what services are commissioned both in individual neighbourhoods and across neighbourhoods.
   - Assessing population needs.
   - Reviewing the use of resources.
   - Identifying what needs to change.
   - Engaging with the public and partners.
   - Working with other community organisations.

2) Collaborators or integrators of care
   - Working with partner providers to re-shape and integrate services in response to population needs.
   - Care planning and coordination, particularly for patients with complex conditions such as mental health, long-term conditions, elderly patients with complex needs and end of life care.

3) Providers of care
   - Opportunity to re-shape core practice services in individual practices or across practices in discussion with commissioner(s).
   - Opportunity to improve efficiency (for example, sharing back office support) and improve quality (for example, shared training and development and peer review).
   - Opportunity to implement new services such as new models of care for people with long-term conditions, out-of-hours care, community-based diagnostics and consultations with specialists.
   - Opportunity to implement new emerging organisational models such as networks and federations.

While a neighbourhood will be able to influence the shape of services, it is important to note that the CCG will remain the statutory, accountable body. It is also important to stress that patients will continue to have the same relationship with their registered practice as they do now.

In recognition of the member practice support for neighbourhoods and the pivotal role of neighbourhoods in delivering our 2030 Vision, we have provided support to practices to continue their engagement in the development and management of neighbourhoods during 2014/15.

As each neighbourhood evolves they will begin to involve other key partners such as community nurses, local authorities, pharmacy and the voluntary, community and faith sector.

They will also work with the public, patients and their carers to make sure they are able to participate in shaping the development of health and care services.

NEIGHBOURHOOD COMMISSIONING PRIORITIES

We have supported individual neighbourhoods to identify their priorities, within the context of the 2030 Vision using the prioritisation framework in figure 16.
Each neighbourhood has identified its top two priorities; these are summarised in table 3 below and are aligned to our 2030 Vision.

Table 3: The top two priorities for each neighbourhood

<table>
<thead>
<tr>
<th>neighbourhood</th>
<th>Vulnerable housebound and care home patients</th>
<th>Vulnerable housebound and care home patients</th>
<th>Community nursing provision</th>
<th>Improve access for minor ailments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poulton-le-Fylde, Thorton and Over Wyre</td>
<td>Doppler tests within practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lytham, St Annes, Freckleton and Ansdell</td>
<td>Leg ulcer and dressing service</td>
<td>Same day services for minor illness/injury</td>
<td></td>
<td>Neighbourhood team for long-term condition management (high risk patients)</td>
</tr>
</tbody>
</table>
The appropriate commissioning expertise is being provided to each neighbourhood to support the further scoping of the priorities in accordance with the CCG’s standardised commissioning cycle.

In addition, the Lytham and St Annes neighbourhood has agreed to pilot the extensivist model of care (see page 30). This particular neighbourhood was chosen due to the number of patients with multiple complex conditions and the immediate availability of accommodation.

**BETTER CARE FUND**

The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together.

The fund was introduced in September 2013 and charged CCGs and local authorities to:

- integrate resources and services;
- be coordinated around the individual and the family;
- deliver improved quality and efficiency; and
- ensure that the majority of care is delivered outside of hospital where this is appropriate.

This is in the context of the significant reductions required in public sector spending and a drive to accelerate the pace and scale of the required change. The need for consistent seven-day primary care underpins this vision and was set out in the Prime Minister’s Call to Action to encourage general practice to think innovatively around an extended and expanded model of primary care.

While the Lancashire County Council footprint for the Better Care Fund contains complex boundary challenges and interrelationships, there is great commonality in terms of principles and models of care that are being driven forward.

Our joint BCF submission – developed through the Lancashire Health and Wellbeing Board – sets out an ambitious approach to the integration of health and care across the CCG area. The approach will improve outcomes for individuals by keeping more people at home and reducing the requirement for long-term care and unnecessary hospitalisation. This is consistent with best practice guidelines and the expressed preferences of our population. Our approach includes the segmentation of client groups, focusing on frail elderly in the first instance, and includes adults with complex mental health needs and learning disabilities and children. The BCF is also central to our programme of QIPP (quality, innovation, productivity, prevention) as the fund describes vital opportunities to reduce the number of attendances in hospital and unplanned admissions and to shift funding from hospital to integrated care closer to home.

The high impact changes and initiatives which are explicitly linked to our BCF are set out in the ‘Summary of our schemes’ in appendix 3 on page 94. They address issues of self-care; high quality planned care, ambulatory care and urgent care; disease and case management approaches.

The Better Care Fund plan provides the opportunity to accelerate and maximise locality models through the application of pooled budgets across health and social care – ensuring that benefits of the ‘at scale’ approach are inputted across the whole system – and risks are understood and mitigated across the system.

The complexity across the Lancashire arrangements is mitigated with the use of the locality delivery plans which focus the strategic interventions at the levels that are most likely to succeed – addressing the realities of patient flows and capacity and demand management factors – while building a common approach to community infrastructure across the system.

The locality plans therefore define in more detail the components of an overall vision. What success looks like for this Better Care Fund plan is made up of packages of success that come together to create an overall improvement.

The Better Care Fund plan is being developed in a challenging and emergent context (it will take hard work to become more agile and collaborative) and the outcomes will be greater for being hard earned. The first year will test and stretch the new relationships being forged on a never- tried-before footprint for this area. All partners are striving to understand and assimilate the conditions, requirements and critical success factors in this new context and therefore it is expected that while the mechanics of system working will need to be built over the year, the vision of the partners will provide the anchor for this innovative approach in Lancashire.
There are a number of enablers that are key to delivering a transformation programme of the magnitude described.

13.1 ORGANISATIONAL DEVELOPMENT

We fully recognise the role that the CCG has to play as a leader of culture change. We will need to work with and influence our partners across health and social care to deliver our ambitious plans and achieve the transformational change we have described.

This role begins internally and we are currently refreshing our organisational development (OD) plan to support the delivery of our vision.

The OD plan is based on insight gathered from a variety of sources, including a stakeholder survey commissioned by NHS England as part of the assurance process; the survey of 1,004 people across the area undertaken to inform our 2030 Vision; a Governing Body appreciative appraisal process; various internal audit reports; the learning and development needs of staff to emerge from our staff appraisal process; and staff focus groups.

Analysing this data has helped us to better understand our organisational culture, climate, capability and capacity and, in doing so, identify where it is best to focus our limited OD resources.

Our OD efforts must focus on enabling staff to have a line of sight between what we want to achieve in our strategic vision and how they contribute towards achieving these goals.

As a small organisation, staff working across teams will be crucial to meet our goals and will require more from staff in terms of stretching their skills and coaching people to reaching solutions. We will need to help leaders to be great mentors and coaches to develop other staff both on a 1:1 basis and through team coaching, promoting organisational responsibility.

Our OD plan is a live document and will be regularly reviewed and refreshed over the next five years.

The main areas which support the delivery of our vision are as follows:

1. System leadership
   - Further developing communication styles to meet the needs of differing audiences, enabling and creating opportunities to listen, learn and influence the system more effectively.
   - Understanding and nurturing talent across the system, enabling more robust talent forecasting, management and succession planning.
   - Continuing to develop and articulate governance arrangements to improve still further stakeholder confidence in our ability to execute and deliver improved health outcomes.

2. Organisational leadership
   - Ensuring a shared vision for the neighbourhood model for all internal and external stakeholders, with alignment to personal objectives as appropriate.
   - Creating and proactively articulating a clear line of sight for all employees between their personal objectives and corporate vision, objectives and priorities.
   - Developing our leaders’ abilities to hold themselves and others to account, influence without authority, effectively collaborate and partner with external organisations, thus creating more ‘porous’ organisations, working relationships and working patterns.

3. People management
   - Aligning behaviours of staff with our organisational values.
   - Harnessing and maximising the impact of the existing knowledge, skills, values and behaviours within the organisation.
   - Developing a coaching culture that promotes responsibility, accountability and ‘honest conversations’.

13.2 IT – DELIVERING BETTER CARE THROUGH THE DIGITAL REVOLUTION

Connecting clinicians and patients through the effective and innovative use of information technology is essential in helping us deliver our vision.
We are committed to ensuring that high quality clinical information is accessible in an integrated, shared clinical record, in real time, at the point of care.  

**Our key informatics aims over the next five years include:**

- Working across Lancashire to provide better care through systems integration, interoperability and information sharing across all providers and general practices encompassing primary, community, secondary, out of hours, social care services and the voluntary, community and faith sector (VCFS).
- Providing a detailed shared local care record integrating GP, community, acute and out of hours patient information in order to direct appropriate care at the appropriate location, preventing unnecessary or avoidable hospital admissions.
- Introducing electronic clinical correspondence between all care settings to assist with timely and accurate information availability at the point of care, promoting better communication and turn-around times across the health community.
- Creating personalised care plans for people with long-term conditions, linked to their GP health record.
- Improving access to a digital ‘front door’, via CCG and GP practice websites to transform the way patients, carers and families access information about NHS services and provide self-management.
- Exploring assistive living, telecare and telehealth initiatives and technologies where there is proven benefits to patients’ wellbeing.
- Improving patient empowerment through technology to give patients access to check results, book appointments and see their own health records with the added ability to share their information wider with voluntary, community, faith sector organisations if they wish.
- Continuing to work with GP practices to ensure summary care records are implemented in line with patient wishes so that information about medicines, allergies and adverse reactions is available nationally in emergency care settings.
- Working with GP practices and community pharmacies to ensure electronic prescriptions are available to those patients wishing to use this service, reducing the number of times patients have to visit pharmacies or surgeries.
- Continuing to work with all care providers to ensure NHS numbers are used as the unique patient identifier to promote the effective flow of information between primary and secondary care.

In addition, we are mindful of advancing technological developments. Recent studies indicate that 61% of all new ‘wearable technology’ (from watches to Google Glass) is health and wellbeing related. A recent Ofcom survey highlighted that 27% of adults and 47% of teenagers in the UK own a smartphone. This opens up a world of possibilities for the future of technology-supported self-care. This includes simple blood pressure monitoring without having to come to the surgery, to an application that takes diabetes readings, combines it with your

**We spoke to more than 1,000 people across Fylde and Wyre:**

87% want to use technology to find out how to access services.

78% want to receive reminders about appointments via text message.

76% want to book healthcare appointments online.

62% want to receive test results online.

56% want to use apps to manage their health and healthcare.

48% want to have an online consultation with a healthcare professional.

61% want to access their health records online.
recent physical activity and makes dietary recommendations and a shopping list based on those factors.

We have recently partnered with the bigwhitewall.com, an emotional wellbeing and support online service, and we are working with a software vendor using iPads to detect early signs of dementia in patients as part of a practice assessment.

13.3 ESTATES

We are acutely aware that the implementation of the new models of care and interventions outlined earlier will require the appropriate estates infrastructure. We are fortunate to have inherited the provision of a largely modern primary/community infrastructure within several of our neighbourhoods and we have plans in place to develop new or redevelop existing infrastructure for the remaining neighbourhoods. We are working with NHS England, local authority and NHS Property Service partners in respect of these developments. We have also commissioned an independent review of estates provision across Fylde and Wyre within the context of our 2030 Vision and to inform the consideration of approaches to services and estates commissioning.

13.4 WORKFORCE

We are working collaboratively with our providers to ensure that their organisational strategies define how they are going to attract, develop, retain and reward people to support the delivery of our vision.

In order to meet the challenges and opportunities ahead it is vital that the right people with the right skills, values and behaviours are in the right jobs.

Across the local health economy we require a coordinated workforce approach so that services are delivered flexibly enough to support the development of new and innovative roles and skill mixes. There will need to be training and development for new roles, and it is important that all staff are involved in, and are supported through, this change.

The shift towards a more preventative model of care will also require the whole workforce to be able to deliver public health interventions, and we will work collaboratively with our providers and public health colleagues to ensure this happens.

We are working proactively with Health Education North West, the Local Medical Committee and NHS England to implement a workforce data repository and planning tool to log current capability and capacity.

The tool will:

• provide us with an overview of the workforce across the whole system;
• allow us to test new models of care and understand their impact on current workforce and capacity;
• provide evidence and quantified changes to enable our organisations to develop appropriate responses to manage these impacts; and
• enable system-wide planning through the use of a common language to understand workforce requirements.

We will use this to model and shape the needs of the future workforce, while at the same time identifying local issues, establishing local priorities and generating ideas for transformational change in healthcare.

To be successful we will need a robust staff engagement programme. Clinical leadership will be key to this, brought together through the Clinical Leadership Forum.

A move to seven-day working is imperative. An initial assessment the cost of seven-day working with our main provider Blackpool Teaching Hospitals NHS Foundation Trust does not appear to be prohibitive when considered in light of savings to on-call payments. Further work will be done to ensure that all providers are engaged in this move as appropriate to ensure the sustainability of the strategy.

In particular, we will work closely with NHS England to secure the workforce required to support our three new models of care.

We also recognise that a pan-Lancashire workforce plan will be required to enable strategic reconfiguration and service realignment across all service providers.

13.5 QUALITY

Quality is a core component of the commissioning process. As part of our quality activity we do ‘deep dive’ quality assurance visits on providers. This involves triangulating multiple sources of information such as data around complaints, public opinion, performance, incidents, infection rates and staffing ratios. Our quality programmes link with
Healthwatch, the Care Quality Commission and Monitor.

With regard to general practice, we use an online reporting system called Datix to monitor incidents and concerns. Each practice is required to produce a quality improvement plan to demonstrate year on year quality improvements. This is published on their websites.

We are developing a process to challenge behaviours and practices which fail to deliver compassionate care, and ensure their swift resolution where they do occur. The intent is a no blame learning culture where continuous improvement is considered business as usual.

### Francis Report

Like all CCGs, we spent much time reviewing the recommendations of the Francis Report that resulted from the Mid Staffordshire NHS Foundation Trust Public Inquiry. We are responsible for ensuring that all of our contracted providers have action plans in place relating to the Francis recommendations, and we have developed an action plan to ensure all recommendations are implemented locally.

This plan also incorporates a response to the Berwick Report (2013) focusing on the main problems in the NHS that affect patient safety, including openness and transparency and the engagement and training of staff who deliver care. The workstreams identified in this document respond to Berwick’s recommendation to recognise with clarity and courage the need for wide systemic change.

There are a number of ways by which we effectively monitor the safety and quality of the care delivered by contracted providers through contracting arrangements.

### Keogh

As a result of the Francis Report, the government analysed hospital death rates and found that 14 hospital trusts, including Blackpool Teaching Hospitals NHS Foundation Trust, had consistently high rates over a two-year period. In June 2013, the Trust was subject to a Keogh investigation visit to review the care and treatment being provided. While it was recognised that death rates may serve as a warning sign, the review also looked at wider potential problems affecting the quality of patient care and treatment.

This valuable review highlighted a number of areas where the Trust was performing well, along with areas to focus on to improve standards. The Trust was one of three of those reviewed that was not put in special measures. As a CCG, we are accountable to NHS England for monitoring and ensuring implementation of Keogh action plans, and work collaboratively with other external regulators such as Monitor and the Care Quality Commission.

The Trust is working through its action plan created following the Keogh review and more recent Care Quality Commission inspection findings. We have collaborative arrangements with Blackpool CCG to monitor and report to NHS England’s Quality Surveillance Group on assurance.

### Winterbourne

We have reported to the Area Team and NHS England on at least a quarterly basis, the progress being made against the Winterbourne Concordat requirements. The CCG has met regularly with the contracted community learning disability team to ensure that the relevant providers and services are working towards well planned and safe discharge. In addition, we are working with other CCGs in Lancashire to plan and manage the development of community services which support people with learning disabilities and autism to live fulfilling lives in the community with less need to become a hospital in-patient.

### 13.6 FINANCE: DELIVERING A SUSTAINABLE NHS FOR FUTURE GENERATIONS

Like any public sector organisation, the CCG needs to have an ethos for ensuring probity and control. We must also be proactive in managing risk.

Our chief financial officer leads the promotion and delivery of good financial management so that public money is used appropriately, economically, efficiently and effectively.

As a new organisation, we are developing and enhancing our financial systems, controls and processes so that we can fulfill our responsibilities for managing public money and also identify and manage the risks that can potentially undermine our strategy or long-term viability.

Stewardship is further enhanced by the role of the various committees of the Governing Body – Remuneration, Audit, and Finance and Performance – which triangulate work to ensure a comprehensive system of board-level controls and assurance.

Our financial plan for the five years beginning 1 April 2014 is premised around supporting the clinically-led
commissioning of health services that deliver local health priorities and quality improvements to services and outcomes. Our financial plans will be revised to reflect how our 2030 Vision is put into practice.

Our generic approach to budget setting has been on the premise that the 2013/14 outturn on contracts should be funded at that level in 2014/15 onwards, unless it can be demonstrated that actions to reduce that level of financial commitment can be taken. In addition, demographic changes have been recognised together with a number of important policy aims for development aligned to the service provision within neighbourhoods.

Two year allocations to CCGs have been made to support certainty around financial planning. In line with all CCGs nationally, we have received an uplift to our recurring allocation for the next two financial years. The specific uplift for 2014/15 is 2.14% and for 2015/16 it is 1.7%. This equates to £4.2m and £3.4m of growth respectively. During 2015/16 a further allocation estimated at £3.68m that is currently provided through NHS England will be routed through the CCG. In essence these uplifts will support the development of health resources that form part of the Better Care Fund.

Our allocations in 2013/14 have been subject to various changes and challenges. Some of these challenges remain extant:

- prescribed (specialist) services commissioned by NHS England continue to be queried in terms of historical financial allocations between CCGs and NHS England;
- NHS Property Services recharges have to date not been based upon actual consumption but on historical bases, which are known to be flawed;
- NHS England directly commissioned services continue to be queried in terms of historical financial allocations between CCGs and NHS England, together with potential risk shares and delegated responsibilities.

Our opening recurrent programme allocation of £196,071k has been changed over the course of the financial year. These changes total a net reduction of £992k (due to specialised commissioning, public health and secondary care dental) to give a closing recurrent allocation of £195,079k. It is important to understand this recurrent basis as it forms the financial start point for the introduction of the new CCG funding formula that took effect on 1 April 2014.

Significant work has been undertaken to understand

our financial baseline and how it supports the quality and value of services that are commissioned. During our inaugural year the principle of ensuring that organisational change was not detrimental to service provision has been enshrined. This feeds into ensuring the stability of current services and their funding/service quality levels before entering into wider stakeholder dialogue over how services are reshaped in future.

**Improving quality and productivity while best using our financial allocation**

In 2014/15 we must make minimum net recurring savings of £3.3m in order to fund the demand pressures in hospital, community and continuing healthcare and to fund a reasonable level of development in out-of-hospital care.

A fundamental building block of our quality, innovation, productivity and prevention (QIPP) programme is re-allocative, i.e. to generate investment monies through efficiencies which will then be used to fund future investments that better align to priorities in our strategic plans and objectives. Over the five-year period there is a QIPP requirement each year of between 1% and 1½ % of our allocation (between £2m and £3.3m).

The programme has a significant emphasis on hospital activity shift with an underpinning financial principle of resource following activity. The target in 2014/15 needs to be delivered by projects that align to the two-year operational plan but also develop into projects that will see full year effect in 2015/16 continuing to deliver this plan.

The minimum target to be delivered in 2014/15 is £3.3m, but it is always prudent to over compensate on effective schemes when planning. Initial scoping of viable schemes has suggested a figure of £5.8m is achievable; however, this accounts for the tariff deflator applied to Payment by Results contracts.

Our financial allocations over the five-year period are shown in table 4. From 2014/15 the allocation basis is more reflective of age rather than deprivation, which in turn is more representative of the Fylde and Wyre demographic. Taking into account the efficiency and cost pressures of providers there is real growth available for investment by the CCG.
Table 4: Our financial allocations over the next five years

<table>
<thead>
<tr>
<th>Financial position</th>
<th>Revenue resource limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent</td>
<td>198,709</td>
</tr>
<tr>
<td>Non-recurrent</td>
<td>2,818</td>
</tr>
<tr>
<td>Total</td>
<td>201,527</td>
</tr>
</tbody>
</table>

One of the key challenges is ensuring that funds allocated to Fylde and Wyre on this basis are spent within our boundary of responsibility and not pooled across other geographies where deprivation may be given the greater priority.

Significant work is currently being undertaken to understand how our plans and the focus on neighbourhoods will realign to new models of provision and consequently how these will map into contracts.

As we deliver our 1% surplus target each year it is assumed that this value will ‘roll forward’ meaning that we will largely be able to spend our annual allocation in full. We have increased our target surplus to 1.4% in 2014/15 as agreed with NHS England, adding an additional £800,000 with the understanding that we will use this in 2015/16 in the further development of local authority joint services.

13.7 COMMUNICATIONS AND ENGAGEMENT

We have developed a number of ways of engaging with local people to gather their views:

- Our Public and Patient Engagement Group meets monthly and includes representation from disadvantaged groups, the voluntary sector, disability representatives, Healthwatch, carers and older people. The group’s views are fed into the Quality Improvement and Governance Committee, which reports to the Governing Body, and so is part of the CCG’s official governance process.

- Patient participation groups are based at 19 out of 21 GP practices and meet regularly to discuss a range of local issues.

- Our Affiliate Scheme is a membership scheme open to individuals and organisations. Nearly 800 members receive regular updates, invitations to focus groups and work closely with commissioners and in their communities as health champions.

- Listening events are held regularly, giving people the opportunity to share their views and experience of NHS services. These one-to-one, drop-in sessions also seek the views of local people in order to influence commissioning intentions.

We also communicate with patients, the public and their representatives through a number of mechanisms such as at meetings, via traditional and new media such as our website and Twitter, and through our partners’ communications channels.

We believe that the engagement we have undertaken so far has provided solid foundations for the development of our 2030 Vision. We are now shifting our focus to ensure robust engagement in the implementation of our new models of care and initiatives. We are currently refreshing our communications and engagement strategy to reflect this, and the very rich insight gathered through the engagement exercise carried out to inform our 2030 Vision.
The implementation and governance arrangements around our five-year plan will be decided on the basis of the most appropriate planning footprint. We principally work across the following footprints:

- Neighbourhood;
- CCG;
- Fylde coast; and
- Lancashire.

**NEIGHBOURHOOD**

Section 12 describes our local neighbourhood concept and the differing neighbourhood roles. We consider neighbourhoods to be a key vehicle to shape and deliver our vision, in particular our new models of care.

We also want to work closely with NHS England to co-commission the episodic model of care and support primary care providers to consider alternative ways of working, such as networks or federations.

**CCG**

We will continue to commission services on a CCG footprint, where appropriate responding to individual neighbourhood population needs and reducing inequalities for health or access. Our clinical chief officer chairs the Fylde and Wyre Health and Wellbeing Partnership which has been actively engaged in shaping our 2030 Vision and this plan.

**FYLDE COAST**

We work closely with our Fylde coast partners, in particular NHS Blackpool CCG and Blackpool Hospitals NHS Foundation Trust, via a range of established and effective arrangements. These include the Fylde Coast Commissioning Advisory Board chaired by our clinical chief officer.

**LANCASHIRE**

We are actively working with the Lancashire CCG Network and NHS England to pursue strengthened collaborative or co-commissioning arrangements across the county. We consider that the Lancashire Leadership Forum has a pivotal role to play in understanding and making sense of CCG and NHS England’s commissioning plans, their combined impacts on providers and the future shape of acute services across Lancashire. We expect the Lancashire Health and Wellbeing Board will take an increasing role in these discussions.

More information about how we coordinate work across the system is outlined in appendix 5.
Our 2030 Vision will be delivered via a number of formal governance mechanisms at different unit of planning levels as outlined below:

15.1 CCG GOVERNANCE (INTERNAL)

Delivery of our overarching vision requires a means of translating our intent into operational plans, workstreams and individual programmes and projects.

This is particularly important due to the multi-agency nature of our ambition and therefore requires a robust programme approach. We have a new programme management office (PMO) which ensures a sufficient level of control and grip of governance and assurance, as outlined in figure 17.

Figure 17: Governance processes related to the project management office
The internal governance arrangements and programme structures are underpinned by a single ‘dataset’ (spreadsheet) that presents the progress in a dashboard. This provides a RAG rated assured view of progress to objectives within seven principal areas that demonstrate the ‘health’ of the work programme and the projects within it.

The process reports progress up and feedback down, allowing informed decision making at the Governing Body and committees and risk/issue management by the programme teams.

15.2 FYLDE AND WYRE HEALTH AND WELLBEING PARTNERSHIP

The core purpose of the Fylde and Wyre Health and Wellbeing Partnership is to lead the strategic coordination of health and wellbeing priorities and commissioning across the local authority, the NHS and public health to secure better outcomes for the population of Fylde and Wyre, better quality of care for patients and better value for the taxpayer.

The partnership is also the body overseeing any responsibilities delegated by the statutory Lancashire Health and Wellbeing Board.

This partnership board consists of representatives from the following organisations:

- the CCG;
- Fylde Borough Council;
- Wyre Borough Council;
- Healthwatch;
- housing (registered social landlords);
- the Council for Voluntary Services;
- Lancashire County Council public health; and
- co-opted members as deemed appropriate or necessary.

15.3 FYLDE COAST GOVERNANCE

It is recognised that the scale, challenge and importance of the transformation across a Fylde coast footprint also requires a robust governance structure.

The Fylde Coast Commissioning Advisory Board consists of representatives from the following organisations:

- the CCG;
- NHS Blackpool CCG;  
- Blackpool Teaching Hospitals NHS Foundation Trust;
- Blackpool Council;
- Lancashire County Council; and
- Lancashire Care NHS Foundation Trust.

The board has a remit to coordinate the development of an overarching strategy for the provision of healthcare across the Fylde coast, recognising individual member responsibilities for the commissioning and provision of healthcare. Workstreams include: out of hospital care, urgent care, planned care, Keogh action plan implementation and cost improvement implementation.

15.4 LANCASHIRE GOVERNANCE

15.4.1 Lancashire Leadership Forum

The Lancashire Leadership Forum enables all leaders across health and social care to meet to identify shared issues and priorities. The forum is made up of the eight CCGs, the five health trusts in Lancashire, the three upper tier local authorities, Public Health England, NHS England Area Team and the Midlands and Lancashire Commissioning Support Unit (CSU).

The forum is not an executive body and works closely with the three health and wellbeing boards, the CCG Network and the emerging network of provider trusts. (The CCG Network is where CCG chairs, clinical and non-clinical chief officers, and chief operating officers come together to, among other things, agree collaborative commissioning priorities across the county and oversee the collaborative work programme.) The Lancashire Leadership Forum links to the Lancashire's local government chief executives, academic institutions, the CSU and workforce partnerships.

We are actively participating in the following Lancashire Leadership Forum workstreams:

- single version of the truth;
- big conversation;
- digital health;
- collaborative leadership;
- in-hospital care;
- out-of-hospital care; and
- neighbourhood pilots.

Please refer to appendix 5, section 11 for more information about these workstreams.
15.4.2 Lancashire Health and Wellbeing Board

We are an active member of the Lancashire Health and Wellbeing Board which is run by Lancashire County Council. It is a forum for leaders from the health and care system in Lancashire to work together to improve the health and wellbeing of the local population and reduce health inequalities.

Board members work together to understand the local community’s needs, agree priorities and encourage commissioners to work in a more coordinated way. As a result, patients and the public should experience more joined-up services from the NHS and their local council in the future.

We have contributed to the development of the board’s vision and joint health and wellbeing strategy. This vision is that every citizen in Lancashire will enjoy a long and healthy life.

Our collective agreed goals are to:

- improve healthy life expectancy;
- narrow the health and wellbeing gap for the population of Lancashire; and
- deliver measurable improvements in the experience of health and social care services, and to reduce the cost of such services.

We are represented on the board by one of our Governing Body members who is also our clinical lead for long-term conditions. Our chief operating officer works with colleagues on the Joint Officers’ Working Group, which is a sub-committee of the board. The board has been closely involved in the development of our 2030 Vision and this five-year plan. To shape the priorities and confirm the direction of our plans we have held discussions both through the bi-monthly board meetings and the regular monthly meetings of the Joint Officers’ Working Group.

We know that no individual organisation in our health and social care system can work in isolation, and we have been developing our shared strategic vision with the board and other partners for a considerable period. This is a two-way process where we have been contributing to the joint health and wellbeing strategy and this in turn has influenced our thinking and delivery plans. The health and wellbeing strategy is being delivered through three programmes: starting well, living well and ageing well. These programmes have been co-produced and thus are owned by the Fylde and Wyre Health and Wellbeing Partnership and we are jointly responsible for the successful delivery of the strategy.

The health and wellbeing strategy seeks to:

- shift resources towards interventions that prevent ill health and reduce demand for hospital and residential services;
- build and harness the assets, skills and resources of local residents and communities;
- promote and support greater individual self-care and responsibility for health; making better use of information technology and advice;
- commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care;
- make joint working the default option; and
- work to narrow the gap in health and wellbeing and its determinants.
As described, we have thoroughly assessed the challenges we face and the opportunities available worldwide to address these challenges.

Through this process we have identified a number of new, innovative models of care which we believe will improve services, health outcomes and the experience of our patients and their families. To inform and refine our thinking we undertook an extensive engagement exercise with patients, the public and partners. The outcome of this engagement has given us a solid foundation to build on, as well as a mandate for the principles underpinning our plans.

We are in an excellent position to be able to realise our vision. We have strong clinical leadership, with all of our 21 practices engaged through the Council of Members and other forums. Each of our service areas has a clinical lead who is committed, alongside our skilled staff, to making a difference. We cannot do this alone, and to this end have spent much time developing excellent joint working arrangements with our partners, including those on the Health and Wellbeing Board. This is apparent in the results of the recent stakeholder survey commissioned by NHS England which found that we had scored above the national average in all 28 domains tested. These included questions around engagement, working relationships, effective communication and leadership. The survey asked stakeholders whether we had the right plans and priorities in place; 83% agreed (compared to 59% nationally). Moreover, 81% said they had confidence in our ability to deliver our plans and priorities (compared to 68% nationally).

If our first year has been focused on laying the foundations, the second year and beyond must be about harnessing the talent, enthusiasm and commitment of our staff, members, partners and the public to deliver our ambitious plans. We are hugely excited about the improvements to services, care and outcomes we believe we can make, and will work tirelessly to make it happen.
APPENDIX 1: HOW THIS PLAN LINKS WITH THE SIX CHARACTERISTICS OF TRANSFORMATIONAL SERVICE PROVISION

We have outlined within this five-year plan how will ensure that we have a high quality, sustainable health and care system which is underpinned by the six characteristics of transformational service provision as defined in the guidance: Everyone Counts: Planning for Patients 2014/15 to 2018/19. The six characteristics are:

1. **Citizens are fully included and patients are fully empowered in their own care**

   We have described throughout this document how our vision and plans have already been developed and will continue to be implemented with engagement at the heart of all decision making.

2. **Wider primary care at scale**

   We have demonstrated our commitment to developing a sustainable model of primary care and care closer to home based on a neighbourhood approach tailored to community needs. Self-care is at the heart of our approach.

3. **Modern model of integrated care**

   We have clearly outlined our plans to progress our neighbourhood model, building upon our existing basis of care planning and risk stratification. GP practices will lead the coordination of care within a multidisciplinary, multiagency approach.

4. **Highest quality urgent and emergency care**

   We have outlined the considerable amount of work already carried out to reduce avoidable emergency hospital admissions, but recognise the areas of concern within our current system. Our aim is for people to receive high quality services in the right place at the right time with seven-day integrated provision within their home or local community.

5. **A step change in the productivity of planned care**

   Our vision for planned services will ensure that patients only visit hospital when absolutely necessary, receiving as much of their care within a community setting as is appropriate. When a hospital visit or stay is necessary, it will be for as short a period as possible.

6. **Specialised services concentrated in centres of excellence**

   We are working closely with our partner specialised commissioners to consolidate and develop sustainable services based in fewer centres. This will create networks of excellence aligned to research and innovation across our Lancashire strategic footprint, and ensure that specialised commissioned services are provided in a way that delivers world class care for our residents.
Outcomes from the 2030 Vision engagement exercise

<table>
<thead>
<tr>
<th>YOU SAID…</th>
<th>WE DID…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping to keep people well should be a top priority.</td>
<td>We agree, which is why health promotion, education and supporting people to self-manage their conditions is a common theme.</td>
</tr>
<tr>
<td>Learning disabilities should be specifically addressed in the strategy.</td>
<td>We have included learning disabilities as a specific priority.</td>
</tr>
<tr>
<td>85% of those who took part in our telephone survey said people should be given the tools and the freedom to manage their long-term condition.</td>
<td>A very strong theme in this document is strengthening community-based support to enable people to better manage their conditions and stay as well as possible.</td>
</tr>
<tr>
<td>People need better information so they know what services are available and how to access them.</td>
<td>We agree, which is why better communication – including the use of new technologies – is a key theme in this document.</td>
</tr>
<tr>
<td>A strategy looking to 2030 is not realistic. It also needs to have more about how you will actually achieve your vision.</td>
<td>The 2030 Vision is meant to set out a high-level vision for the future that will be our ‘guiding path’. Our detailed two- and five-year plans set out how we aim to achieve our vision, and these contain measurable targets.</td>
</tr>
<tr>
<td>The CCG won’t be able to achieve its vision alone.</td>
<td>You are right, and this is why we have endeavoured to involve partner agencies in the development of our plans. We have also strengthened the narrative about partnerships in the document.</td>
</tr>
<tr>
<td>There is no mention of sexual health services, alcohol or substance misuse services.</td>
<td>The CCG does not commission these services. However, we do work with our partner commissioners to make sure services are joined up. This has been given particular mention in relation to children and young people.</td>
</tr>
<tr>
<td>Prevention of ill health needs greater prominence.</td>
<td>Many people said this, and we do agree that supporting people to live healthier lives should underpin all of our work. People need to be empowered to take responsibility for their own health, and this was very much supported in the conversations we had with you.</td>
</tr>
<tr>
<td>Diabetes and stroke should be discrete priority areas rather than be under the heading ‘long-term conditions’.</td>
<td>Both of these illnesses affect large numbers of people locally and are priority areas for us. We had to give this document a structure, which is why they are under the heading ‘long-term conditions’, but this does not in any way diminish their importance.</td>
</tr>
<tr>
<td>Don’t use NHS jargon, and give definitions where possible.</td>
<td>We have tried to write our 2030 Vision document in plain English and have given definitions for the different service areas and have included a glossary.</td>
</tr>
<tr>
<td>YOU SAID…</td>
<td>WE WILL…</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Care is often fragmented, and the different agencies providing services are not coordinated – this needs to change, and services need to be joined up.</td>
<td>This is why we think a named person should be responsible for coordinating an individual’s care – 86% of those who took part in our telephone survey agreed.</td>
</tr>
<tr>
<td>People at the end of their lives want more choice, and families/carers need better support.</td>
<td>Health professionals will have better training to enable people to have their wishes fulfilled. Carers will be offered pre- and post-bereavement support.</td>
</tr>
<tr>
<td>Services should be tailored to the needs of individual communities.</td>
<td>Practices working across geographical neighbourhoods should coordinate community-based services in their area, and make sure these are tailored to the needs of the local population – 74% of those who took part in our telephone survey agreed.</td>
</tr>
<tr>
<td>Health problems, e.g. cancer or long-term conditions, need to be identified earlier.</td>
<td>Screening and better support for those deemed at risk have been highlighted as important ways to make sure problems are found as early as possible.</td>
</tr>
<tr>
<td>Carers are vitally important. Their contribution needs to be reflected, and they need more support.</td>
<td>We believe carers are key partners. Our telephone survey revealed that 15% of people class themselves as unpaid carers, although we believe this to be an underestimate of the true picture. We want all carers to have a joined-up assessment to identify their needs and specific support requirements.</td>
</tr>
<tr>
<td>Concern that GP practices would not have the capacity to coordinate people’s care or services across geographical neighbourhoods.</td>
<td>We are working with GP practices at the moment to develop this new way of working, and as part of this we will agree what level of support they will need to ensure they are effective in the future.</td>
</tr>
<tr>
<td>There needs to be better after-care and support in the community after patients have been discharged from hospital.</td>
<td>Providing better community-based health services is a key part of our plans. Our vision is that people will leave hospital sooner due to better community-based support, with follow-up outpatient appointments carried out in a community setting as well.</td>
</tr>
<tr>
<td>People should take more responsibility for their own health – the NHS can’t be expected to do everything.</td>
<td>We aim to widen access to self-help, self-management and healthy lifestyles support. We think everyone should do their bit to keep as fit and well as possible.</td>
</tr>
<tr>
<td>Access to mental health services is poor, and better information about mental health and dementia services is needed.</td>
<td>We aim to commission a single entry point for mental health services for people of all ages to improve access. We also want as much focus placed on mental health as physical health.</td>
</tr>
<tr>
<td>Support for people with learning disabilities is variable across all services, suggesting that health professionals lack knowledge about the needs of people with learning disabilities.</td>
<td>We will work with health providers to ensure that appropriate support is available to meet the needs of people with a learning disability.</td>
</tr>
<tr>
<td>We need to ensure palliative care is available for children and young people.</td>
<td>We agree and will use the development of personal health budgets to enable the tailoring of support to meet the needs of children and young people. Our local hospice provides services and support to children funded through charitable donations and some national funding. We will ensure that anything we develop links appropriately to these services.</td>
</tr>
<tr>
<td>43% of people with a long-term health condition say they have to repeat their medical history every time they see a health professional.</td>
<td>Everyone with a long-term health condition will have a care plan, which will be linked to their GP record and will be available electronically. This will be available to all of the organisations involved in a person’s care.</td>
</tr>
</tbody>
</table>
Table 5: Summary of improvement ambitions against five domains and seven outcomes with supporting schemes aligned to unit of planning

Key: Fylde and Wyre CCG / Fylde Coast / Better Care Fund (BCF) / Lancashire / North West

<table>
<thead>
<tr>
<th>NHS OUTCOME FRAMEWORK 5 DOMAINS</th>
<th>OUTCOME AMBITIONS</th>
<th>SUPPORTING SCHEMES</th>
<th>IMPROVEMENT AMBITION</th>
</tr>
</thead>
</table>
| DOMAIN 1 Preventing people from dying prematurely | 1. Securing additional years of life lost for the people of England with treatable mental and physical health conditions. | • Cancer: early diagnosis and greater diagnostic support; prevention and public awareness campaigns; survivorship; access to alternative therapies.  
• Children and maternity: family approach to smoking and alcohol during pregnancy with VCFS educational support; community paediatric learning disability service; increase breast feeding awareness.  
• Learning disabilities: annual health check and action plans; education event; learning disability-friendly communities.  
• Long-term conditions: home oxygen service review; integrated insulin pump clinic; integrated diabetes foot care service; pulmonary rehabilitation service review; spirometry training; bronchiectasis service review; early supported discharge and community stroke rehabilitation service; prevention and anticipatory care planning; pre-diabetes education*; health library*; clinician self-management training.  
• Dementia: closing the diagnosis gap; increase practice diagnosis; increase post diagnostic support in a dementia-friendly community.  
• Urgent care: care homes commissioning and support plan; 999 frequent callers scheme; redesign of intensive care/rehabilitation.  
• Implementing enhanced primary care model of care.  
• Ageing well: promoting independence; reducing social isolation; supporting carers and families.  
• North West Ambulance Service: develop patient outcome measures.  
• Offender care: equivalency of substance misuse support.  
• Specialised commissioning: trauma and head (adult neurorehabilitation pathway improvement; location of major trauma centres); neonatal services.  
• Collaborative programmes: stroke/TIA (mini-stroke)/vascular. | • The rate of potential years of life lost for people with treatable mental and physical health conditions has increased since 2010. Our intention is to reverse this trend, by 3.2% in 2014/15 and 7.48% by 2019. |
### DOMAIN 2
**Enhancing the quality of life for people with long-term conditions**

2. Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>Community-based stoma service; survivorship; early diagnosis and greater diagnostic support.</td>
</tr>
<tr>
<td><strong>Children and maternity</strong></td>
<td>Community paediatric learning disabilities service.</td>
</tr>
<tr>
<td><strong>Learning disabilities</strong></td>
<td>Annual health check*; learning disability-friendly communities.</td>
</tr>
<tr>
<td><strong>End of life</strong></td>
<td>Six steps coordinator; Implementation of the Electronic Palliative Care Coordination System (EPaCCs).</td>
</tr>
<tr>
<td><strong>Long-term conditions</strong></td>
<td>Diabetes schemes*: education programme; integrated insulin pump clinic; diabetic foot care service.</td>
</tr>
<tr>
<td><strong>- roll out tele-health systems</strong></td>
<td>Pulmonary rehabilitation service review; COPD and home oxygen service review.</td>
</tr>
<tr>
<td><strong>- personal health budgets</strong></td>
<td>Health library*</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Re-commission 'improving access to psychological therapies'; older people's mental health community provision; integration with physical health; self-management programme; Big White Wall.</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>Improving diagnosis of dementia; better post-diagnostic support.</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Care homes commissioning and support plan; risk stratification tools; re-commissioning community equipment services.</td>
</tr>
<tr>
<td><strong>Implementing the extensivist and enhanced primary care models.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Formation of strategic response to the special educational needs and disabilities agenda where the collective resource allocated to learning disabilities is brought together.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Specialised commissioning</strong></td>
<td>Cancer and blood commissioning and support plan; paediatric neurorehabilitation; internal medicine (cystic fibrosis, cardiac, vascular and respiratory service review, acute kidney injury, inherited metabolic disorders).*</td>
</tr>
<tr>
<td><strong>To increase the average EQ5D score (a measure of health outcomes) for people reporting to have one or more long-term conditions by 5.4% to achieve above the England average by 2019.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Maintain a 67% diagnosis rate for dementia in 2014/15 and 2015/16.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>15% access rate for people who receive psychological therapies by quarter 4 2014/15, with a further 1% stretch to 16% in 2016.</strong></td>
<td></td>
</tr>
</tbody>
</table>
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

- Cancer: community-based stoma service.
- Children and maternity: better informing parents on health options and issues; redesign of ‘poorly children’ pathway; breast feeding health education; lifestyle education during pregnancy and early childhood.*
- End of life: six steps coordinator; EPaCCs; staff training; end of life care plans; community palliative care service.
- Learning disabilities: Winterbourne obligations; annual health check and action plans; education event.
- Long-term conditions: diabetes self-management education*; home oxygen service review; insulin pump clinic; diabetes foot care service; spirometry training; community-based specialist clinicians; self-management training for clinicians; care coordination.
- Mental health: mental health 24/7 single point of access; redesign of IAPT.
- Planned care: development of tier 2 schemes*; redesign of orthopaedic pathway including joint injections; planned care strategy; review of primary care skill mix; direct access to diagnostics.
- Urgent care: care homes commissioning and support plan; falls advice and assessment service; falls lifting service via pendant lifeline; seven day urgent and emergency services; expansion of risk stratification tool for anticipatory care; 999 frequent callers; review of community equipment services; implementation of intermediate care review; redesign of intensive care rehabilitation; roll out of telehealth; IV therapies review.
- Implementing the extensivist and enhanced primary care models.
- Existing admission avoidance schemes widened across the Fylde coast.
- Neighbourhood configuration of services.
- Integrated health and social care supported by the community and voluntary sector.
- Digital health strategy: neighbourhood pilots; out of hospital care.

- To reduce the rate of emergency admissions by 15% in 2019.
- 5% fewer unnecessary ambulance conveyances from care homes.
- Delayed transfers of care from hospital reduced (per 100,000 population) by 5% (2015 compared to December 2012).
• Admission avoidance: expanding step-up and crisis support; increasing capacity and responses of integrated community services; redesign of A&E ‘front doors’ to offer supportive alternatives to A&E; Rapid Response Plus service; seven day service and better self-management for long-term conditions; enhanced reablement and rehabilitation services; targeted focus on ambulance pathways, care homes and alcohol interventions; local area coordination to tackle triggers of admission; consistent, high quality home care; end of life care planning and mental health capacity in intermediate care services; single point of access to intermediate care and urgent intervention services.

• Reduced length of stay/delayed discharge/transfers of care: improved patient flow; multi-professional access to intermediate/short term social care; seven day discharge with accessible shared care plans; complex discharges managed by neighbourhood teams; rapid response nursing team.

• North West Ambulance Service: reduced conveyance to A&E; develop health professional triage for avoidable admissions of people aged under 75 years; develop relationship with GP out-of-hours.

• Offender care: telemedicine and prison-based clinics to reduce escort and bed watch.
4. Increasing the proportion of older people living independently at home following discharge from hospital.

- End of life: six steps coordinator; care plans; community palliative care service.
- Long-term conditions: early supported discharge and community stroke rehabilitation service; community multi-disciplinary team; pulmonary rehabilitation service review.
- Mental health: integration with physical health services.
- Urgent care: falls lifting service via pendant lifeline; hospitals discharge review design; expansion of risk stratification tool for anticipatory care; review of community equipment services; aids and adaptations review; intermediate care and community assets review; redesign of intensive care rehabilitation; roll-out of telehealth; Red Cross pilot.
- Implement the extensivist and enhanced primary care models.
- Existing admission avoidance schemes widened across the Fylde coast.
- Neighbourhood configuration of services.
- Integrated health and social care supported by the community and voluntary sector.
- Digital health strategy.
- Reduced reliance on long-term domiciliary and residential care: support for carers; expansion and mainstreaming of reablement responses; moving the assessment function for complex cases out of hospital; enhancing equipment and adaptations; re-commissioning domiciliary care and integrated working; consideration of housing needs as part of hospital discharge planning; growth of extra care sheltered housing; integrated case manager approach.
- To ensure that the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services aligns with the Lancashire-wide target of 82%.
- Permanent admissions of people aged 65 and over into residential and / or nursing care homes will have reduced (per 100,000 population) by 4.4% (2014/15 compared 2012/13).
DOMAIN 4
Ensuring that people have a positive experience of care

5. Increasing the number of people having a positive experience of hospital care.

- Cancer: online access for patients to view their personal care plans.
- Children and maternity: Children and Families Bill-related redesign.
- End of life: advanced care planning; end of life training for staff.
- Learning disabilities: Winterbourne obligations.
- Long-term conditions: early supported discharge for stroke; patient-centered care plans.
- Planned care: direct access community diagnostics; ‘any qualified provider’ procurement; orthopaedic pathway; scheduled care strategy.
- Urgent care: care homes commissioning and support plan; hospitals discharge review redesign.
- Work within the hospital setting will focus on planned and unplanned surgery; specialist diagnostics; and treatment of acute exacerbations unable to be managed in the community settings.
- In-hospital care and acute service reconfiguration.
- Offender care: secure children’s homes.
- Mental health: North West child and adolescent mental health services tier 4; secure mental health review.
- Armed Forces and veteran health: services commissioned in line with requirements of the armed forces covenant.

- 1.5% year-on-year reduction up to 2019 in the proportion of people reporting poor patient experience of in-patient care.
- Address issues identified from 2013/14 Friends and Family Test (FFT) results with providers and support providers to coordinate the roll-out of FFT by the end of 2014/15.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

- **Cancer**: online access for patients to care plans; access to alternative therapies; survivorship.
- **Children and maternity**: review of pathway for children who are poorly; Children and Families Bill-related redesign.
- **End of life**: advanced care planning; bereavement support.
- **Learning disabilities**: Winterbourne obligations.
- **Long-term conditions**: patient-centred care plans*; diabetes education*; spirometry training.
- **Mental health**: older people's mental health community provision; re-commission IAPT provision.
- **Dementia**: improving diagnosis rates and post-diagnostic support.
- **Planned care**: 'any qualified provider' procurement.
- **Urgent care**: care homes commissioning and support plan; seven day urgent and emergency services; expansion of risk stratification tool for anticipatory care; benchmark intermediate care review; roll out of telehealth; personal health budgets.
- **Implement the extensivist and enhanced primary care models.**
- **Existing admission avoidance schemes widened across the Fylde coast.**
- **Neighbourhood configuration of services.**
- **Integrated health and social care supported by the community and voluntary sector.**
- **Offender care**: equivalency with community-based care; liaison and diversion schemes; improved police custody suites.
- **Armed Forces and veteran health**: service review and redesign (alcohol, domestic violence, discharge/transition management).
- **Collaborative programmes**: mental health reconfiguration; dementia reconfiguration; child and adolescent mental health services integrating with Lancashire County Council; learning disabilities programme; diagnostics/pathology service review; community equipment pathway and procurement review*.

- **2% year-on-year reduction up to 2019 in the proportion of people reporting poor experience of general practice and out of hours services.**
- **Maintain a 67% diagnosis rate for dementia in 2014/15 and 2015/16.**
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

- Compliance with the epic3 national guidelines for preventing healthcare-associated infections in NHS hospitals in England – requirement included in 2014/15 contracts. Action plan in place which describes how we support primary care to reduce the likelihood of C. difficile caused by primary care, particularly prescribing practice.
- Lancashire healthcare-associated infections leads regularly meet with public health infection prevention nurses.
- Lessons learned from MRSA root cause analysis investigations from a range of providers across Lancashire shared by commissioning support unit quality leads.
- Clinical advice received from Public Health Lancashire infection prevention leads.
- CCG support pharmacist function: support to practices is now on a service specification with Blackpool Teaching Hospitals. A part-time pharmacy adviser has been appointed by the commissioning support unit to support the CCG in all medicines-related activity.
- Public health infection prevention nurses undertake rigorous root cause analysis / post infection reviews and distribute lessons learned.
- Local quality requirement described in the 2014/15 contract quality schedule, the trust will review departments for their reporting rates and their harm rates. Local discussions will continue to take place to identify issues and seek improvements.
- Insight (Datix) enables real time reporting of all aspects of avoidable harm identified within primary care, but which may occur in any setting. These are responded to directly after seeking medicines management advice, as required.
- Other providers monitored through the commissioning support unit (CSU) and reported by exception. The CSU provides quarterly provider reports for associates to contracts. Exceptions are highlighted to the CCG.
- No cases of MRSA in 2014/15 and 2015/16.
- 5% increase in incident reporting of medication error near misses.
- Deliver improvement activities identified in the Blackpool Teaching Hospitals’ Keogh action plan.
- 2014/15 trajectory of maximum of 31 cases of C.Diff apportioned to the CCG (nationally set target).
The previous sections identified our intentions, associated timelines, expected outcomes and alignment to our improvement ambitions.

Our plans will continue to evolve and as each intervention progresses through the commissioning process we will become increasingly clearer about its impact. This may mean that we forecast to over-achieve our ambitions, or that we forecast to underachieve and will identify additional interventions to ensure we deliver.

We have worked closely with independent commissioning experts GE Healthcare Finnamore to develop and test our initial impact analysis which is shown below. Unsurprisingly this has re-affirmed that we have further work to do to refine our analysis.

**URGENT HOSPITAL ADMISSIONS**

We aim to reduce urgent hospital admissions by 15%¹ in addition to mitigation of population growth by 2018/19. Figure 18 shows the difference between the ‘do nothing’ scenario (including population growth impact²) and the real term decrease we aim to see over the next five years.

**Figure 18: Trajectory for urgent admissions 2013/14 to 2018/19**

**Assumptions**

1. 15% reduction on 2013/14 actuals.
2. Population growth assumptions are 105.2% over 5 years by 2018/19.
We have shaped our ambition by identifying particular cohorts of patients that will benefit from this change. Their contribution to our overall ambition is shown in figure 19.

**Figure 19: Programmes to reduce urgent admissions by 2018/19**

**Assumptions**

- **Cancer:** All 2013/14 admissions, age >=19 for diagnosis codes C00.0-C97x.
- **Long-term conditions (LTC):** All 2013/14 admissions, age >=19 for diagnosis codes for multi-diagnosis (diabetes (ICD-10 codes E08-E13), stroke/TIA (G45), renal disease (N10-N16), chronic lower respiratory disease including COPD and asthma (J40-J47), cardiac disease: coronary heart disease (I20-125), hypertension (I10-I15) and heart failure (I50)).
- **Paed:** All 13/14 within paediatrics specialty.
- **End of life (EoL):** 78% age>74 admissions not already captured within cancer and/or LTC cohort.
- **Other:** All admissions not contained within above listed cohorts.
Figure 20 shows the link between our high level ambition, the cohorts of patients we will target and the programmes of delivery that will deliver the change for those cohorts.

**Figure 20:**

Key:

- Ambition
- Service area
- New models of care
- New ways of working
A&E ATTENDANCES

Our overall ambition is to reduce A&E attendances by 8%¹ (to include the mitigation of population growth) by 2018/19². Figure 21 shows the difference between the ‘do nothing’ scenario (including population growth impact²) and the real term decrease we aim to see over the next five years.

Figure 21: Trajectory for A&E attendances 2013/14 to 2018/19

**Assumptions**

1. 8% reduction on 2018/19 predictions.
2. Population growth assumptions are 105.2% over five years by 2018/19.
Figure 22 shows the link between our high level ambition, the cohorts of patients that will benefit, and the programmes of delivery that will deliver the change for those cohorts.

**Figure 22:**

- Ambition
- Service area
- New models of care
- New ways of working
OUTPATIENT APPOINTMENTS

Our overall ambition is to reduce outpatient attendances by 9% (to include the mitigation of population growth) by 2018/19. Figure 23 shows the difference between the ‘do nothing’ scenario (including population growth impact) and the real term decrease we aim to see over the next five years. This is broken down by specialty.

Figure 23: Trajectory for outpatient attendances 2013/14 to 2018/19

**Assumptions**
1. 12.2% reduction on 2018/19 predictions.
2. Population growth assumptions are 105.2% over five years by 2018/19.
We have shaped our ambition by identifying particular cohorts of patients that will benefit from this change. Their contribution to our overall ambition is shown in figure 24.

**Figure 24: Programmes to reduce outpatient attendances by 2018/19**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Reducing Attendances 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambition</td>
<td>7816</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>3032</td>
</tr>
<tr>
<td>ENT</td>
<td>820</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1249</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>358</td>
</tr>
<tr>
<td>Dermatology</td>
<td>800</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1557</td>
</tr>
</tbody>
</table>

**Assumptions**

1. Numbers displayed in figure 24 are the reduction in annual appointments in 2018/19 against ‘do nothing’ scenario, including population growth.
Figure 25 shows the link between our high level ambition, the cohorts of patients we will target and the programmes of delivery that will deliver the change for those cohorts.

**Figure 25:**

---

Key:

- **Ambition**
- **Service area**
- **New models of care**
- **New ways of working**
PROCEDURES OF LIMITED CLINICAL VALUE

Our overall ambition is for a reduction in procedures of limited clinical value (PLCV) of 10% \(^1\) (which includes mitigation of population growth) by 2018/19. Figure 26 shows the difference between the ‘do nothing’ scenario (including population growth impact \(^2\)) and the real term decrease we aim to see over the next five years.

**Figure 26: Trajectory for ILCV 2013/14 to 2018/19**

![Graph showing trajectory for ILCV 2013/14 to 2018/19](image)

**Assumptions**
1. 10% reduction on 2018/19 estimates
2. Population growth assumptions are 105.2% over five years by 2018/19

TOTAL PREDICTED ACTIVITY REDUCTIONS

<table>
<thead>
<tr>
<th>Intervention</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent admission reduction</td>
<td>15%</td>
</tr>
<tr>
<td>A&amp;E attendance reduction</td>
<td>8%</td>
</tr>
<tr>
<td>Outpatient appointment reduction</td>
<td>10%</td>
</tr>
<tr>
<td>Procedures of limited clinical value reduction</td>
<td>10%</td>
</tr>
</tbody>
</table>
A particular focus of our impact analysis has been working with Fylde coast partners and global consultants Oliver Wyman to model the impact of the extensivist and enhanced primary care models. Again, our initial analysis is shown in table 6. This is being refined on a weekly basis as the design team progress the patient risk stratification approach, clinical service model.

The basis of our strategy is to ensure that we are able to deliver appropriate healthcare for the Fylde and Wyre population in a shift away from a hospital based care provision to address the challenges faced. The expectation is that this will not generate significant cost savings or cost increases however the significant shifts in models of care will alter where costs are incurred within the system and in order to effectively manage this a change to the financial flows across the local health economy will be required.

Table 6: Assumptions on the pace and scale of implementation

### Extensivist impact

<table>
<thead>
<tr>
<th>POD</th>
<th>Expected activity reduction - total</th>
<th>Timescale range to see benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient</td>
<td>25%</td>
<td>12 – 36 months</td>
</tr>
<tr>
<td>Day case</td>
<td>25%</td>
<td>12 – 36 months</td>
</tr>
<tr>
<td>Out patient</td>
<td>20%</td>
<td>6 – 18 months</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>20%</td>
<td>6 – 18 months</td>
</tr>
</tbody>
</table>

### EPC impact

<table>
<thead>
<tr>
<th>POD</th>
<th>Expected activity reduction - total</th>
<th>Timescale range to see benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient</td>
<td>45%</td>
<td>12 – 48 months</td>
</tr>
<tr>
<td>Day case</td>
<td>0%</td>
<td>12 – 48 months</td>
</tr>
<tr>
<td>Out patient</td>
<td>-8% (i.e. increase)</td>
<td>6 – 18 months</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>30%</td>
<td>6 – 18 months</td>
</tr>
</tbody>
</table>

The design team for the extensivist and enhanced primary care model is now up and running and looking at patient stratification approaches which will shape the service model design. This detailed work will allow us to review and revise our assumptions over the coming months.
APPENDIX 5: COORDINATING OUR WORK ACROSS THE SYSTEM

CONTENT
1 Specialised commissioning
2 Lancashire priorities
3 North West Ambulance Service
4 Primary care direct commissioning
5 Health and justice direct commissioning
6 Public health commissioning
7 Armed Forces and veteran health direct commissioning
8 Collaborative programmes
9 Strategic work programmes
10 Operational work projects
11 Healthier Lancashire

1. SPECIALISED COMMISSIONING

The vision for specialised commissioning is to consolidate and develop sustainable services based in fewer centres to create networks of excellence, aligned to research and innovation.

We are working with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider, recognising that there is a need to change the provider landscape in order to deliver services designed around patients and carers, and ensure our specialist centres are used to treat the most sick.

National thinking around hospital-based care has been influenced through high profile reviews such as the Francis review of the failings at Mid Staffordshire NHS Foundation Trust, and the Berwick and Cavendish reviews. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

Engagement and local knowledge will inform local strategy development ensuring that specialised services will:

- be commissioned to deliver quality, better outcomes and value;
- have a qualified workforce to enable better equity of outcome and access and offer sustainable quality against standards;
- be value for money;
- be based on integration of care networks; and
- take account of interdependencies and care bundling (the grouping of care models or pathways which are similar).
2. LANCASHIRE PRIORITIES

Locally the specialised commissioning team is undertaking consultation to establish their five-year plan which is due to be published by the end of the autumn (2014). Within the priorities being consulted on there is focus on the following:

2.1 Mental health
- Develop North West children and adolescent mental health service tier 4 system review and potential procurements.
- Review secure mental health.

2.2 Cancer and blood
- Compliance with improving outcome guidance standards and any procurements as a result.
- HIV commissioning arrangements.

2.3 Trauma and head
- Adult neurorehabilitation services whole care pathway model, better capacity management.
- Major trauma centres: alignment with specification and co-location (time/distance for required services), viability of multi-centre model.

2.4 Internal medicine
- Cystic fibrosis capacity.
- Cardiac services: specialised services review; surgery and devices.
- Vascular services: compliance with standards and reconfiguration and any procurement as a result.
- Respiratory services.
- Acute kidney injury.
- Inherited metabolic disorders.

2.5 Women and children
- Neonatal services.
- Paediatric neurorehabilitation.

3. NORTH WEST AMBULANCE SERVICE

The paramedic emergency service commissioning intentions for 2014/15 were produced in collaboration with the 33 CCGs in the North West (NW), by utilising the governance framework agreed within the memorandum of understanding between the CCGs and the NW Ambulance Commissioning Team (ACT).

Consultation and engagement was carried out with each group within this framework, the starting point being the clinical development group. Following preparatory work and consultation, a NW workshop was held in December 2013, which was well attended by both commissioners and the provider (North West Ambulance Service – NWAS). These outputs were used to finalise the commissioning intentions document, which was agreed by the Ambulance Strategic Partnership Board (SPB) in January 2014.

The commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee ‘Urgent and Emergency Services’ report (July 2013), and the Keogh ‘Urgent and Emergency Care Review’ (November 2013). Both reports describe emergency services (PES) as having a changed role within an enhanced system of urgent care, a role where conveyance to hospital will be one of a range of clinical options open to ambulance services.

We require incremental changes over the coming years, in order to allow PES to become “mobile urgent treatment centres” (Keogh, 2013). These key required changes are summarised below:

3.1 Conveyance
- Reduce conveyance to public access defibrillators.
- Increase hear and treat.
- Increase see and treat.

3.2 Healthcare professionals
- Develop standards to include triage and eligibility, type and priority (possible bureau approach) and engage with GPs.

3.3 Avoidable admissions
- Support for those aged above 75 and those with complex needs, including those in nursing and care homes.
3.4 Outcome measures

- Develop a series of measures for use in year two which focus on impact on the patient.

3.5 GP out-of-hours

- Develop a relationship with GP out-of-hours services.

The commissioning intentions then informed the 2014/15 contract negotiations. The contractual model for 2014/15 encourages a significant step towards the required strategic change, by incentivising through CQUIN a reduction in conveyance. This will allow NWAS to build on the progress they have already made with commissioners over recent years, developing and implementing initiatives such as the urgent care desk, pathfinder, referral schemes into primary care and targeting frequent attenders.

4. PRIMARY CARE DIRECT COMMISSIONING

There is an increasing recognition that primary care will have to change to meet the needs of the population and the challenges described in this document. Both nationally and locally, general practice and wider primary care services are experiencing increasingly unsustainable pressures.

Through the development of the Healthier Lancashire Strategy, part of which including the out of hospital strategy, we will support these transformational changes in primary care. Across Lancashire we have a set of objectives for primary care, aimed at improving access, satisfaction, quality and outcomes across medical, pharmacy, dental and eye care services.

We have agreed locally to a number of key themes to achieve transformational change include the need for new models of service delivery, which includes general practice working at scale in neighbourhood teams integrated with wider primary care and social care services.

Our vision is: “A sustainable model of primary care which delivers consistent high quality outcomes for patients”.

We will work towards seven-day primary care services at-scale by working in neighbourhoods and integrating with social care services. This will be achieved through the Better Care Fund, GP contract changes, local improvement schemes and our neighbourhood approach.

We are aiming to provide integrated out of hospital services to deliver consistently better outcomes for our patients across the region by reducing unwarranted variation in the quality and provision of services. To do this we will work collaboratively and cohesively with local communities, partners and colleagues, ensuring our strategy is based on patient and public insight to reflect the six characteristics of high quality care set out in “GP – A Call to Action”.

We have expressed an interest in primary care co-commissioning, and will work with NHS England to develop our plans.

5. HEALTH AND JUSTICE DIRECT COMMISSIONING

Prison healthcare across the North West has previously been commissioned in different ways and this is reflected in current patterns of provision which can, in some parts of the region, appear fragmented. The aim now is to establish an integrated system with a single prime provider responsible for the provision of all healthcare within prisons and perhaps across clusters. NHS England envisages it will eventually commission four to five main contracts.

In addition, given that NHS England is now commissioning across a larger area and as part of a national organisation, there will be opportunities to take advantage of new economies of scale to work with providers and explore potential new models such as, for example, secondary care in-reach, mobile diagnostics or different models of ‘in-patient’ provision.

Priorities are to:

- ensure that specifications for commissioned services are in line with national guidance (e.g. NHS Outcomes Framework, Public Health Outcomes Framework, Securing Excellence);
- support local and strategic partnership arrangements; and
- ensure all commissioning is guided by robust health needs.

6. PUBLIC HEALTH COMMISSIONING

The changing demographic of the population currently experienced is set to continue in the coming years. More people are living longer and will have a greater call on health services and the consequences of poor lifestyle
choices will have an impact on the services commissioned. Using the available data sources, the geographical and topic specific joint strategic needs assessments (JSNAs) and local health profiles, the Lancashire Area Team understands the health inequalities and inequities across Lancashire and has taken into account the findings from the Marmot Review that stressed the importance of giving children the best start in life to reduce health inequalities and associated mortality and morbidity and life expectancy.

There is evidence to suggest that preventative health services have lower coverage and uptake amongst the more deprived and vulnerable population groups. For public health programmes that are currently achieving the section 7a baseline, the priority for the five-year plan will be to reduce variation, both locally across Lancashire but also between the Lancashire position and the best performing area teams in the country. For public health programmes that are currently achieving the minimum / acceptable standard, improving outcomes, coverage and uptake will be a priority for the Lancashire Area Team.

6.1 Health inequalities

Where relevant, a series of health equity audits should be undertaken for programmes to identify groups and areas with lower coverage and poor outcomes. This will assist the Area Team to develop an action plan to address health inequalities. The Area Team also requires acute and community sector service providers to assess inequalities in their services, develop action plans and improve access and coverage for vulnerable and deprived groups.

6.2 The key challenges nationally and locally include:

- a growing population;
- increased demand on commissioned services;
- increasing pressure on NHS financial resources, which will intensify further from 2015/16;
- challenges to improve coverage and uptake of disadvantaged groups;
- inequalities in service delivery; and
- rising patient expectations.

6.3 Response to the challenges

The public health commissioned services, in many areas, is dependent on the services delivered by partners. It is recognised that for any transformational change to take place, public health primary and secondary prevention interventions must be in place, awareness raising about the programmes and encouraging the uptake of these services and applying the principles of Every Contact Counts to take advantage of the opportunities to provide a public health intervention must be undertaken. All of which should be driven by the work of the health and wellbeing boards.

7. ARMED FORCES AND VETERAN HEALTH DIRECT COMMISSIONING

On 1 April 2013, NHS England, as part of its portfolio of directly commissioned services, became responsible for the commissioning of some health services for those individuals who are under the care of Defence Medical Services (DMS) GPs. This includes serving members of the Armed Forces, their families, veterans and reservists. Services are commissioned through a single operating model, providing a national approach to strategic planning and oversight.

NHS treatment for those Armed Forces personnel and families returning from overseas will be commissioned by the Armed Forces Area Team in which the provider of the care that they receive is located. In Lancashire there are two Ministry of Defence medical centres: Fulwood, Preston and Weeton.

It is the objective of NHS England to ensure that the commissioning of services is organised in such a way as to provide the best possible patient outcomes and avoid any geographical or organisational variation that may have existed previously, whilst maintaining essential stakeholder relationships.

8. COLLABORATIVE PROGRAMMES

By working in partnership across the eight Lancashire CCGs and their partners to enable the delivery of the Lancashire strategic vision for health and social care, we are further enabling the delivery of our vision.

This is achieved through the delivery of shared programmes of work currently governed through the CCG Network, via recommendations from the Collaborative Arrangements Group (CAG). However, the proposed model (currently under discussion) for Lancashire collaborative commissioning is re-presented in figure 27.
Figure 27: The proposed model for Lancashire collaborative commissioning

Key:

CSU: commissioning support unit
AT: area team
Spec comm: specialised commissioning
LA: local authority
PMO: programme management office
BI: business intelligence
CMT: contract management team
The key focus areas for the CAG are split into strategic work programmes and operational work projects. Strategic work programmes are defined above as being at least 12 months in duration, while operational projects are defined as being initially less than 12 months in duration.

9. STRATEGIC WORK PROGRAMMES

9.1 Mental health reconfiguration

Our vision for mental health and dementia services across the Lancashire health economy is to ensure appropriate, timely access and treatment for people with mental health problems.

The Lancashire CCGs are undertaking a significant mental health acute reconfiguration in partnership with Lancashire Care NHS Foundation Trust (LCFT). The new service model aims to treat people with mental health problems in specialist community mental health teams and reduce the requirement from mental health in-patient capacity. The CCGs are in the third year of a five-year programme of transition and so far have achieved £9million of savings; savings of £15million are due by 2017. The transformation programme would then undergo a period of evaluation to ensure all outcomes have been met.

The programme began in 2006 with an extensive consultation process on in-patient mental health facilities. This resulted in the 15 existing in-patient units being reduced to four appropriate, modern facilities.

Although good progress has been made, there are still challenges and the main priorities are:

1. Single point of access to ensure that access to mental health services is managed through a single point; this is currently not functioning well. More than half of admission into the acute mental in-patient services present through A&E and are unassigned.

2. Unscheduled mental health care pathway: there is a requirement to redesign a number of current teams to introduce one single pathway to ensure better quality outcomes for patients whilst reducing duplication.

9.2 Dementia reconfiguration

In early 2013 the mental health reconfiguration programme moved on to look at dementia, and conducted another public consultation process focussed on moving the majority of dementia care closer to home or in the community.

The vision for dementia care across Lancashire is:

- good quality early diagnosis, intervention and on-going support within dementia-friendly communities;
- living well with dementia in care homes and the community and reduce the use of antipsychotic medication;
- improved quality of care in general hospitals; and
- improved quality of care in specialist hospitals.

Dementia in-patient services will now be consolidated onto one site (The Harbour, Blackpool) which is a brand new in-patient facility, due to open in March 2015.

Although good progress has been made, there are still challenges and our main priority currently is in dementia specialist community services. We plan to review the overall implementation of independent support teams and care home liaison function in all areas, aligning with integrated neighbourhood team developments and ensuring all gaps are addressed in 2014/15 through a specific transition plan.

9.3 Child and adolescent mental health services

The Lancashire Child and Adolescent Mental Health Service (CAMHS) is in the process of restructuring and integrating with Lancashire County Council to provide a comprehensive and consistent service across the county that meets the nationally set quality standards. This involves a refresh of the strategy, a review of current services leading to new service specifications and models and the oversight, monitoring and delivery of eight workstreams.

Our aim with this programme is to increase access and provide 24/7 services, agree an integrated CAMHS/psychology service, implement and monitor a local and national reporting system and provide developmentally appropriate services for young people over the age of 16.

9.4 Learning disability programme

The learning disability programme is focused on three main workstreams:

9.4.1 Enhanced support services

We are currently undertaking a review of the enhanced support services through current and future state mapping techniques. We will be supporting the establishment of a multi-agency steering group for the project allowing
us to develop and implement a new referral process and pathway.

**Our main outcomes for this workstream will be:**
- the development of a learning disabilities’ provider framework;
- the development of assessment and treatment services at Calderstones;
- to undertake engagement with service users, carers and families; and
- to support the development of a revised provider business model and organisational form.

9.4.2 Self assessment framework

Following the recommendations made by the Winterbourne Report, we have identified the need to redesign our learning disability service to ensure that patient needs are met and improved outcomes are delivered.

To achieve the recommendations, we will put in place systems for ensuring the quality of service provision.

**We will do this by:**
- revisiting our service specifications and implementing new, seamless service models;
- establishing the means of monitoring performance and standards;
- agreeing processes to provide links and smooth transition for patients between services; and
- developing and monitoring an improvement plan.

9.4.3 Children: special educational needs and disabilities (SEND)

Inequitable service provision across Lancashire has been identified by Ofsted and the Care Quality Commission which, as a group of CCGs, we have committed to address. We are therefore conducting a review of services, which will include the checking of compliance with national standards, and will make recommendations for areas of potential service improvement.

In addition to the review, we will be looking to implement a single service specification for tier 2 and 3 services and to develop and deliver support for care pathways in and out of services.

9.5 Diagnostics and pathology

As new tests come in, and with an ageing population with multiple conditions, there is a need to rationalise, determine where efficiency and cost savings can be made, and have agreement around use of tests, technology and good practice.

The diagnostics and pathology programme looks to reconfigure pathology services by developing a service specification which reflects current best practice. This includes the laboratory testing element of the cervical cytology screening programme and pathology diagnostic services in the community.

As part of this programme we will develop standardised activity reporting and payment for direct access pathology services, benchmark practice utilisation of services and undertake a review of service provision in support of the wider Lancashire strategy.

**The expected outcomes of the programme are:**
- common list of tests across all Lancashire providers with consistency in naming and units of measurement;
- updated specification for direct access pathology;
- report on level of variation in use of diagnostic tests across Lancashire;
- agreement with providers on the process to address any variation; and
- agreement with providers of Lancashire-wide disease specific testing algorithms.

10. OPERATIONAL WORK PROJECTS

10.1 Community equipment re-procurement

The CCGs aligned to Lancashire County Council have identified opportunities to consolidate purchasing power for community equipment services across the area to achieve greater value for money, improved procurement pathways and quality of service.

This programme will develop, mobilise and monitor a plan to bring the current service provision from three providers down to one. This will include the specification development, financial analysis and procurement/ framework establishment for the service.

We expect to provide a high quality service based on a
Lancashire-wide service specification and contract which ensures value for money through the buying power of a single provider. This will deliver improvements across the whole service, giving us an increased ability to re-use and re-purpose high cost equipment as well as develop streamlined pathways for equipment provision.

10.2 Stroke/ TIA (‘mini-stroke’)/ vascular

This programme has been identified as initially less than 12 months in duration on the basis that it is currently subject to a scoping exercise which will be reported to the CAG in June 2014. It is anticipated that the stroke review will offer an opportunity to be transformational around seven-day working and potentially drive major reconfiguration.

The implementation of the AAA (abdominal aortic aneurysm) screening programme is cited as a ‘must do’ in the NHS Operating Framework, focusing attention on the establishment of specialist interventional centres. We intend to establish three specialist vascular interventional centres covering the region, linked by a vascular network. This will in turn, identify pathways and commissioning issues and priorities for individual CCGs.

Our stroke/ TIA review will identify a best practice service model, assess our current service provision against this and recommend further service improvement or transformation opportunities to achieve a high quality stroke service for the population of Lancashire.

11. HEALTHIER LANCASHIRE

The commissioners of health services across Lancashire are keen to undertake the development of a health and care strategy across the county which will build upon the work undertaken by the Lancashire Improving Outcomes Board and more recently, the Lancashire Transition Group.

We recognise the need to bring together the shared ambitions of commissioners and providers from both health and social care with the voluntary sector and other agencies.

We recognise the need to prioritise the strategies across the county based upon our current knowledge; however, we do not undervalue or underestimate the need for local ownership and implementation. The strategy (‘Healthier Lancashire’) will be brought together by the Lancashire Leadership Forum, but will be shaped and implemented by those organisations allied to it, including the health and wellbeing boards.

The Healthier Lancashire strategy is being developed to improve outcomes for the people of Lancashire, and consists of seven main projects, as outlined below.

- In-hospital care: this project is a clinically-led assessment of opportunities to improve patient outcomes through provider collaboration for the provision of specialist and hard to recruit to services. The three main drivers are improved outcomes, clinical sustainability and financial sustainability.

- Out-of-hospital care: this project seeks to improve outcomes for patients who no longer require an acute hospital bed but who would benefit from further treatment or therapy delivered in a non-acute setting. The project would seek to provide health and social care support which cannot be provided in a person’s own home. It will address the long standing problem of hospitals (physical and mental health) being unable to discharge patients who require further rehabilitation, therapy or intermediate care in a timely fashion due to a lack of suitable alternatives.

- Neighbourhood pilots: all CCGs are developing a neighbourhood and locality approach for multi-disciplinary teams and multi-agencies to work within the community.

- The Big Conversation: this aims to engage the public around why Lancashire’s health and care delivery needs to be transformed; support the development of the strategy by engaging with public and stakeholders; and ensure that thoughts, ideas and concerns are part of decision-making and the strategy development process from day one.

- Digital health: this is about designing a new digital plan for Lancashire, which will harness digital technology to promote wellness and self-care; improve access and efficiency and offer new ways of accessing and delivering care.

- Single Version of the Truth: this will involve creating a public document which sets out the position for health and social care in Lancashire for the period 2014 – 2020. It will include information on money, workforce, health outcomes, service sustainability and estates, and provide background information.

- Collaborative leadership: this is about finding a collaborative team approach to address this strategy and work together across organisations, streamlining our efforts.
If you need this booklet in another format or language, please contact the customer care team on:

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