Lancashire North CCG Strategic Plan
2014/15 -2018/19

NHS Lancashire North Clinical Commissioning Group – who we are

The NHS Clinical Commissioning Group (CCG)

NHS Lancashire North CCG was established in April 2013 under the Health & Social Care Act 2012, which amended the National Health Service Act 2006. The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the CCG taking on its full powers. As at 1 April 2013, the CCG was licensed without any conditions.

The CCG is responsible for commissioning planned and emergency hospital care, rehabilitation, most community services and mental health and learning disability services. We are also responsible for engaging with local people to ensure that the services they are paying for meet the health needs of the community.

The 13 practices which form the CCG were originally members of the Lancaster, Morecambe, Carnforth and Garstang Practice Based Commissioning Consortium (PBC) which has provided a six year history of successfully working together to commission services. This number will be reducing to 12 shortly as two of the practices merge.

As the majority of patients from each practice choose the Royal Lancaster Infirmary for their acute hospital care the CCG as a commissioner can have meaningful discussions with our local hospital about services for patients.

However, we also recognise that for some types of acute health care services, a minimum level of throughput is required for hospital services to be considered safe, economical and capable of maintaining expertise and delivering safe care. A population of our size falls below the minimum level needed for some of these services, and we therefore need to work closely with other CCGs to commission some services.

We are therefore working with Cumbria CCG in relation to acute care services, with the other Lancashire CCGs and Lancashire County Council in relation to mental health, Learning Disability and children’s community services and wider networks across the North West for some emergency services. The partners involved can be different for each service and the CCG will look to be flexible in its efforts to achieve the best provision for its population, whilst being mindful of duties in relation to quality, safety and finance.

The CCG is also involved with all of the partners above in Better Care Together – the strategic programme which is aiming to delivery sustainable healthcare to the population of Morecambe Bay. This programme is significant for all involved and is the subject separately
of a full Strategy to be submitted at the end of June. It is referenced throughout this document, but for full details the Better Care Together Strategy should be read in full.

Vision and Principles

Vision

The population of Lancashire North will receive the right care, in the right place, at the right time that promotes prevention, early intervention, optimal management of and faster recovery from illness enabling people to live as independent and productive a life as possible within their local community.

This will be delivered through high quality, sustainable, safe and effective person centred integrated services that follow clear pathways of care and provide a single point of access to enable patients to have greater control over their care.

Community services will be based around natural communities of which Primary Care lists will be the basis. The natural community will use community assets to support self-care, enabling development of local services around a community that link to services provided over a wider geographical area via a co-ordinated approach as required. When patients need tier 2, secondary or tertiary care the patient will be ‘lent’ to these services rather than being referred and discharged.

Commissioning Principles

The CCG has spent time with its practice members considering the key principles by which it will undertake its commissioning responsibilities. The member practices reached agreement that as a CCG:

We will commission services on behalf of the population we serve in which:

- Patients’ needs are paramount and care must meet needs.
- Patient safety and best quality is paramount.
- Care should be convenient and local, within the constraints of 1 and 2 above.
- Organisations and institutions do not exist for their own sake, and are there to fulfil the service’s needs.
- Care needs to be delivered effectively and efficiently.
- Care must be integrated.
- Patients should have choice.
- Patients should be expected to play their part in looking after their health, complying with agreed care plans and using the NHS wisely.

To do this we will:

- Develop and share a long term strategy which has a focus on reducing health inequalities and improving health outcomes for our residents.
- Ensure our decisions are informed by the needs of our population and after engagement with local people.
• Make best use of the resources available to us and balance the books.
• Develop appropriate structures, systems, staffing and skills.
• Deliver a culture and leadership to create a robust and openly accountable organisation.
• Demonstrate inclusivity, openness and transparency that justifies our stewardship of taxpayers’ money.
Development of strategic plan

Lancashire North CCG has developed its vision, aims and associated objectives and outcomes over a number of years. They were refined during 2012/13 as the CCG prepared itself for authorisation and more recently priorities have been tested for their continued relevance to the health and wellbeing of Lancashire North. The development of the current strategic plan has been developed and updated with partners and other commissioners across the varied units of planning in response to the Everyone Counts planning for patients 2014/15 to 2018/19.

Lancashire North CCG in conjunction with its main partners Cumbria CCG and University Hospitals of Morecambe Bay commenced a high profile clinical strategy development programme Better Care Together in late 2012. This programme is sensitive and well known to NHS England, Monitor and CQC. A range of other partners who provide community and mental health services as well as Social Care colleagues are also now heavily involved. The programme is now reaching the stage of Strategic Outline Case (SOC) (by end of June 2014) and underpins the five year strategic plans of all organisations and greater detail on the plans will be available once the SOC has been submitted to NHS England.

Communication and engagement

We know that no individual organisation in our health and social care system can work in isolation, and have been developing our shared strategic vision with our partners for a considerable period.

The Lancashire Health and Wellbeing Board have set a vision for the population of Lancashire and the CCG has taken into account the priorities that they have set. To shape the priorities across Lancashire the Board has held discussions both through the bi-monthly Health and Wellbeing Board meetings (for strategic level direction) and the regular monthly meetings of our Joint Officers Group, where we come together with our partner Lancashire CCGs and the County Council.

There has been extensive engagement with the public, partners and stakeholders regarding the development of the CCG and its commissioning plans and particularly around the development of the Better Care Together programme.

As part of developing our Better Care Together programme a wide ranging engagement work stream is continuing to ensure that the public, patients, staff and stakeholders are able to be involved at all stages of the process and fully engaged in future service design. This engagement programme is being supported by the Lancashire North CCG, Cumbria CCG and UHMB to ensure involvement from as wide a base as possible in working together to understand the views of the communities we serve. As part of this programme a variety of methods have been used to engage with the public and stakeholders so far, see below.
The feedback from this public and stakeholder engagement has been used to inform a series of “Care Design” Groups and a Clinical Summit that took place in April. These events have been clinically led and have resulted in the development of a series of potential “scenarios” for future healthcare. These scenarios will form part of the “strategic outline case”. Subject to approval, further engagement/consultation will take place.

<table>
<thead>
<tr>
<th>Focus groups</th>
<th>Events</th>
<th>Surveys</th>
<th>Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion groups</td>
<td>Listening events</td>
<td>Paper surveys in public places</td>
<td>MP meetings</td>
</tr>
<tr>
<td>Public Reference Group</td>
<td>Town centre information stands Rural events</td>
<td>Paper surveys sent to 10,000 random residential addresses</td>
<td>Overview and Scrutiny Committees and Councillor meetings</td>
</tr>
<tr>
<td>Work with young people</td>
<td>Information bus roadshow</td>
<td>Telephone interviews</td>
<td>Local area partnership meetings</td>
</tr>
<tr>
<td>Focus groups</td>
<td>County Show</td>
<td>Comment cards</td>
<td>Workshops</td>
</tr>
</tbody>
</table>
As part of the on-going Better Care Together process we have also commissioned an independent report from the Consultation Institute on our engagement to date with a view to seeking recommendations for future activity which will meet national best practice.
**Context for clinical commissioning in Lancashire North**

As the local NHS body charged with the commissioning of health care for local people, it is important to understand both the national and local context within which this will be undertaken.

**The Context**

There are a number of challenges facing the NHS nationally, many of which we are experiencing locally in the Lancashire North area. These include actions to improve quality of services, recruiting qualified staff and the need to ensure each pound is spent wisely to improve the health of the population.

Advances in medicine, an ageing population and an increase in those living with long term conditions and complex care needs mean that many people would now prefer to receive their care closer to where they live as an alternative to receiving care in a hospital environment.

Locally we need to ensure that we keep within our allocated budget across all local NHS health services. There is no ‘quick fix’ solution to this challenge, however Lancashire North CCG in partnership with Cumbria CCG and University Hospital of Morecambe Bay NHS Foundation Trust are working in partnership through the Better Care Together programme on developing solutions which are clinically safe and proven for the short, medium and long term.

If the NHS is to continue to meet the needs of the patient now and in the future then radical change to historic ways of working is essential. Patient safety remains the most important part of the day job for the NHS. We know that certain services need improvements now to maintain safe standards. We need to focus on what is best and safest for patients based on the current evidence. For example, University Hospitals of Morecambe Bay NHS Foundation Trust is looking at how they can work with tertiary centres (specialised health services that treat patients with complex conditions) and other specialist centres to strengthen recruitment, education and training and governance systems in neonatal and obstetric services. This will help raise standards and improve outcomes for patients. Therefore the CCG’s overall strategic approach combines a number of elements to enable the transformational changes that need to occur for the organisation to be successful and provide a sustainable health care system for the population of Lancashire North.

**NHS national requirements**

There are a range of national requirements that CCGs must deliver upon, these include:

- CCG statutory duties
- The national planning framework “Everyone Counts: Planning for Patients in 2014/15 to 2018/19”
- The NHS Outcome Framework
- The NHS Constitution
CCG statutory responsibilities

This strategic plan has been developed to ensure it supports the CCG in meeting its duties under the Health and Social Care Act 2012:

- Secure public involvement in planning and consideration of proposals for change
- Promote the NHS constitution
- Act effectively, efficiently and economically
- Act to secure continuous improvement in the quality of services
- Support the NHS Commissioning Board to improve the quality of primary medical services
- Have regard to the need to reduce inequalities
- Promote the involvement of patients and carers in decisions about their healthcare
- Act with a view to enabling patients to make choices
- Obtain appropriate advice from a range of health professionals
- Promote innovation
- Promote research and the use of research
- Promote education and training
- Act with a view to promoting integration

The Mandate from the Government to NHS England\(^1\), which sets out the strategic framework for the NHS, was refreshed earlier this year. Following ‘A Call to Action\(^2\)’, which forecasts a financial gap of around £30 billion by 2020/21, the new planning guidance calls for a five year time frame for planning.

National planning framework- Everyone Counts: Planning for Patients 2014/15 to 2018/19\(^3\), sets out this new longer term approach to planning for both CCGs and for NHS England to support delivery of this mandate.

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NHS Outcomes Framework

The NHS Outcomes Framework\(^4\) and the NHS Constitution\(^5\) set out the goals and responsibilities for commissioners, however there is an expectation that local commissioners will have freedom to develop local solutions.

The NHS Outcomes Framework sets out outcomes for patients that the NHS as a whole is expecting to achieve, these are:

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

Underpinning each of these key outcomes are a set of seven measures on which commissioning organisations will be assessed. Each of the CCG’s strategic priorities has been cross-referenced to the NHS Outcomes Framework.

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NHS Constitution

Sets out the:

- NHS Principles
- Patient and the public: rights, responsibilities and NHS pledges
- Staff: rights, responsibilities and NHS pledges
- NHS Values
Local Needs Assessment

Joint Strategic Needs Assessment (JSNA) is a continuous process by which the Lancashire Health and Wellbeing Board and the Director of Public Health works with partners including the third sector and patient/public groups to identify the health and well-being needs of local people. It has played a central role in the Health and Wellbeing Board development of the Lancashire Health and Well-being Strategy and has informed our evolving commissioning plans.

The JSNA profile for Lancashire North CCG provides a demographic picture of the health of the area we are responsible for. The health profile is mixed:

The CCG covers an area of approximately 780 sq km of coast and countryside and we are responsible for commissioning health services for a local population of around 160,000 people. The majority of the population lives in Lancaster, Morecambe, Heysham, Carnforth and Garstang but a significant proportion lives in rural locations and we have registered patients who live as far south as Broughton near Preston, and as far north as Burton in Kendal.

Indices of Multiple Deprivation 2010

Within NHS Lancashire North CCG, the proportion of the population living in the most disadvantaged areas (18%) is slightly less than the national average. However, parts of Morecambe, Heysham and central Lancaster are classified as being amongst the fifth most disadvantaged areas in England and over 29,000 residents within NHS Lancashire North CCG live in these areas.

The population is generally characterised by a larger proportion of young adults than the England average as it includes the student population at the University of Lancaster. The CCG also has a slightly greater proportion of people aged 65 years and over (18.6%) compared to the national average (16.5%) and a smaller proportion of children aged less than 15 years (14.5% compared to 17.6% nationally).
Estimated population projections suggest that over the next ten years the population of Lancashire North CCG will increase by over 7,000 people to approximately 167,800. The largest increase will occur in the over 70 age group which will increase by 30% from 20,200 to 26,300. This is in line with the national average. Conversely the young adult population (15-24 years) is projected to fall significantly more than the national average. By 2022 the CCG will have 3,000 less young adults, a fall of 12% compared to a fall of only 7% nationally for this age group. The following figure shows the predicted population change for each age group between 2012 and 2022.

The population of Lancashire North CCG is considerably less ethnically diverse than the population of England. Black and minority ethnic groups account for only 8% of the population compared to 16% nationally. Of these 3% are non-British White and 2% are Asian.

Life expectancy has increased in Lancaster district over the last twenty years. Although female life expectancy remains greater than male life expectancy at both national and local levels, the difference has reduced over this period. In Lancaster district, both male and female life expectancies are just over one year lower than the national average. However, life expectancy varies widely within the locality. There is an 11.6 year difference in male expectancy between the most and least deprived areas. For female life expectancy this is 8.5 years. This internal difference has also been increasing over the last few years, especially for males where the difference is now two years greater than it was five years ago.
Premature deaths in our area from a range of Long Term Conditions such as cancer and heart disease are a cause for concern. Cancer and Cardiovascular disease account for 64% of deaths in our locality before the age of 75 years and there is a clear health inequalities gap for premature mortality.

The CCG Outcomes indicators show that Lancashire North is in the bottom quartile for a range of under 75 mortalities including CVD, cancer and liver disease whilst the Lancaster District Health profile shows that life expectancy is lower than the national average with smoking related deaths and early deaths from cancer and heart disease and stroke all significantly worse than the England average.

The area has significantly better than national average figures for weight and adult physical activity, but alcohol and tobacco consumption is higher than the national average.

**Changes since 2013 CCG JSNA Profile**

The following table shows changes in public health outcomes in Lancashire North since the 2013 JSNA profile was produced.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>2013 CCG JSNA profile</th>
<th>2014 Update</th>
<th>Source/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CCG</td>
<td>England</td>
<td>Year data relates to</td>
</tr>
<tr>
<td>Life expectancy at birth (male)</td>
<td>DHP</td>
<td>77.4</td>
<td>78.6</td>
<td>2008-10</td>
</tr>
<tr>
<td>Life expectancy at birth (female)</td>
<td>DHP</td>
<td>81.3</td>
<td>82.6</td>
<td>2008-10</td>
</tr>
<tr>
<td>Difference in life expectancy between most and least deprived areas (male)</td>
<td></td>
<td>11.6 yr</td>
<td>2006-10</td>
<td>11.6 yr</td>
</tr>
<tr>
<td>Difference in life expectancy between most and least deprived areas (female)</td>
<td></td>
<td>8.5 yr</td>
<td>2006-10</td>
<td>8.5 yr</td>
</tr>
<tr>
<td>Deprivation (Proportion of people living in the 20% most deprived areas in England)</td>
<td>DHP</td>
<td>20%</td>
<td>19.8%</td>
<td>2012</td>
</tr>
<tr>
<td>Smoking related deaths (directly age standardised rate per 100,000 population aged 35 and over)</td>
<td>DHP</td>
<td>259</td>
<td>211</td>
<td>2008-10</td>
</tr>
<tr>
<td>Early deaths – heart disease and stroke (directly age standardised rate per 100,000 population aged under 75 years)</td>
<td>DHP</td>
<td>84.5</td>
<td>67.3</td>
<td>2008-10</td>
</tr>
<tr>
<td>Early deaths – cancer (directly age standardised rate per 100,000 population aged under 75 years)</td>
<td>DHP</td>
<td>123.8</td>
<td>110.1</td>
<td>2008-10</td>
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<tr>
<td>Road injuries and deaths rate per 100,000 population</td>
<td></td>
<td>69.9</td>
<td>44.3</td>
<td>65.9</td>
</tr>
<tr>
<td>Breast feeding initiation (% mothers initiating breast-feeding where status is</td>
<td>DHP</td>
<td>69.6</td>
<td>74.5</td>
<td>70.1</td>
</tr>
<tr>
<td>known)</td>
<td></td>
<td></td>
<td></td>
<td>2010/11</td>
</tr>
<tr>
<td>Teenage pregnancy under 18 (conception rate per 1000 females aged 15-17)</td>
<td>DHP</td>
<td>35.0</td>
<td>38.1</td>
<td>31.7</td>
</tr>
<tr>
<td>Infant deaths (rate per 1000 live births)</td>
<td>DHP</td>
<td>4.5</td>
<td>4.6</td>
<td>3.5</td>
</tr>
<tr>
<td>MMR immunisation by age 2 yrs (PCT data)</td>
<td>HSCIC</td>
<td>89.3</td>
<td>89.1</td>
<td>93.6%</td>
</tr>
<tr>
<td>Obese children (% children in year 6)</td>
<td>DHP</td>
<td>16.2</td>
<td>19.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Excess winter deaths (ratio of excess winter deaths(observed minus expected) to</td>
<td>DHP</td>
<td>18.1</td>
<td>18.7</td>
<td>12.4</td>
</tr>
<tr>
<td>average non-winter deaths aged 35 and over)</td>
<td></td>
<td></td>
<td></td>
<td>2007-10</td>
</tr>
<tr>
<td>Statutory homelessness (crude rate per 1000 households)</td>
<td>DHP</td>
<td>1.9</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Cervical screening (5 year coverage) (PCT data)</td>
<td>HSCIC</td>
<td>76.8</td>
<td>78.6</td>
<td>79.2%</td>
</tr>
<tr>
<td>Indicator</td>
<td>Data Source</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>Child poverty (% of children under 16 in families receiving means-tested benefits and low income)</td>
<td>DHP</td>
<td>19.4</td>
<td>21.9</td>
<td>2009</td>
</tr>
<tr>
<td>Breast screening (3 yr coverage) (Age 53-70) (PCT data)</td>
<td>HSCIC</td>
<td>78.8</td>
<td>77.2</td>
<td>76.9%</td>
</tr>
<tr>
<td>DtaP/IPV/Hib immunisation by age 2 yrs</td>
<td>HSCIC</td>
<td>97.4</td>
<td>96.0</td>
<td>97%</td>
</tr>
<tr>
<td>Hip fracture in 65s and over (directly age sex standardised rate for emergency admissions per 100,000 population aged 65 and over)</td>
<td>DHP</td>
<td>408</td>
<td>452</td>
<td>2010-11</td>
</tr>
<tr>
<td>Smoking prevalence (% adults aged 18 and over)</td>
<td>DHP</td>
<td>23.3%</td>
<td>20.7%</td>
<td>2010/11</td>
</tr>
<tr>
<td>Hospital stays for self harm (directly age sex standardised rate per 100,000 population)</td>
<td>DHP</td>
<td>300.4</td>
<td>212.0</td>
<td>2010-11</td>
</tr>
<tr>
<td>Percentage of maternities smoking at delivery</td>
<td>HSCIC</td>
<td>18.0</td>
<td>13.2</td>
<td>2011/12</td>
</tr>
<tr>
<td>Area</td>
<td>Source</td>
<td>Year1</td>
<td>Rate1</td>
<td>Year2</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
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</tr>
<tr>
<td>Breastfeeding at 6-8 weeks (PCT data)</td>
<td>HSCIC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug abuse (estimated users of opiate and/or crack cocaine aged 15-64 per 1000 population)</td>
<td>DHP</td>
<td>7.5</td>
<td>8.9</td>
<td>2009-10</td>
</tr>
<tr>
<td>Incidence of malignant melanoma (directly age standardised rate per 100,000 population aged under 75 years)</td>
<td>DHP</td>
<td>15.7</td>
<td>13.6</td>
<td>2006-8</td>
</tr>
<tr>
<td>People diagnosed with diabetes (% people on GP registers with a recorded diagnosis of diabetes)</td>
<td>DHP</td>
<td>5.5</td>
<td>5.5</td>
<td>2010-11</td>
</tr>
<tr>
<td>New cases of tuberculosis (crude rate per 100,000 population)</td>
<td>DHP</td>
<td>0.7</td>
<td>15.3</td>
<td>2008-10</td>
</tr>
<tr>
<td>Acute sexually transmitted infections (crude rate per 100,000 population)</td>
<td>DHP</td>
<td>817</td>
<td>775</td>
<td>2010</td>
</tr>
<tr>
<td>Description</td>
<td>DHP</td>
<td>18-21</td>
<td>Year</td>
<td>DHP</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Increasing and higher risk drinking (% aged 16+ in the resident population)</td>
<td>DHP</td>
<td>23.8</td>
<td>2008-9</td>
<td>23.8</td>
</tr>
<tr>
<td>Hospital stays for alcohol related harm (directly age sex standardised rate per 100,000 population)</td>
<td>DHP</td>
<td>1920</td>
<td>2010/11</td>
<td>1920</td>
</tr>
<tr>
<td>Alcohol-specific hospital stays (persons &lt;18y admitted to hospital due to alcohol specific conditions, crude rate per 100,000 population)</td>
<td>DHP</td>
<td>89.9</td>
<td>07/08-09/10 (pooled)</td>
<td>89.9</td>
</tr>
<tr>
<td>Health eating adults (% adults, modelled estimates using Health Survey for England)</td>
<td>DHP</td>
<td>28.6</td>
<td>2006-8</td>
<td>28.6</td>
</tr>
<tr>
<td>Obese adults (% adults, modelled estimates using Health Survey for England)</td>
<td>DHP</td>
<td>20.9</td>
<td>2006-8</td>
<td>20.9%</td>
</tr>
</tbody>
</table>
Prevalence is a good indicator of the burden of disease in the population. Health service activity data such as QOF data does not necessarily present an accurate picture of disease burden, as disease prevalence reported as low could be explained by under-recording or unmet need within the practice population. The Association of Public Health Observatories has published estimates of disease prevalence at practice level to reflect the true burden of disease. In Lancashire North CCG, disease prevalence largely reflects the national rates. The “higher than average” predicted increase in the proportion of older people in Lancashire North expected over the next ten years is likely to result in a “higher than average” rate of increase in the prevalence of diseases affecting older people (including dementia, circulatory disease, diabetes, COPD, osteoarthritis and cancers).

Reduction in unmet need for some conditions can be measured by comparing the numbers of patients on disease registers. The following table compares actual prevalence (i.e. the number of patients on the QOF register) with the expected prevalence (using APHO modelled estimates for disease prevalence) for Lancashire North.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated prevalence</th>
<th>QOF Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2011/12</td>
</tr>
<tr>
<td>CHD</td>
<td>4.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>COPD</td>
<td>2.7%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25.2%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.1%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Source: National General Practice Profiles, PHE

There has been little change in the numbers of patients on disease registers for these conditions over the last year (13/14). A large difference persists between the expected and recorded numbers of patients with hypertension. This suggests unmet need for a large number of hypertensive patients in the population.
Health organisation profiles

Member Practices

NHS Lancashire North Clinical Commissioning Group (CCG) is made up of 13 GP member practices in Lancaster, Morecambe, Carnforth and Garstang (reducing to 12 as two practices merge). There are around 120 GPs working in the area, together with a range of other clinical professionals. The CCG draws its clinical representatives from all the practices in the area. The registered population with the practices is 162,019, though there are a number of residents who are not registered with a practice for whom we are also responsible for commissioning services. We therefore estimate that our commissioning population is probably closer to 170,000 with a recognisable number of tourists, whose health needs we consider and provide for whilst they are within our boundaries.

Table 1 below sets out how the registered population is split between practices. Figure 1 below contains a map showing the location of all 13 practices.

Table 1 – Registered Practice Populations (March 14)

<table>
<thead>
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<th>Practice</th>
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<td>Queen Square Medical Practice</td>
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<td>TOTAL</td>
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<td>Windsor Surgery</td>
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<td>York Bridge Surgery</td>
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Table 1 and Figure 1 show that the practices vary in size from registered populations of over 35,000 to just under 6,500. Not surprisingly, the practices also cover different needs among the population. The geographical distribution of practices is also spread, with the majority being based in the urban areas of Lancaster and Morecambe, but with three practices being located in the smaller market towns of Carnforth and Garstang. The area further to the east and north of the M6 has no practices.
Provider Profile

The range of providers of health services in the area is inevitably smaller than that which might be found in large urban areas. The majority of services provided to the residents of Lancashire North are offered by the following organisations:

- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) – main provider of acute hospital care.
- Lancashire Teaching Hospitals NHS Foundation Trust (LTH) – main provider of acute care for two practices in Garstang and also the provider of regional specialist services such as neurosciences and renal care.
- Blackpool Teaching Hospitals NHS Foundation Trust (BTHT) – main provider of community services in North Lancashire and also the provider of regional specialist cardio-thoracic services.
- Lancashire Care Foundation Trust (LCFT) – main provider of inpatient and community mental health services for all ages.
- North West Ambulance Service – main provider of patient transport services (emergency and non-emergency).
- Primary care is provided by the 12 practices which form the membership of the CCG.
- Third sector – a wide range of charitable, not for profit and voluntary sector organisations provide support services, health promotion and early intervention projects, well-being services and services aimed at supporting people and families to engage in communities and healthier lifestyles.
- Independent Sector - a range of independent sector organisations provide rehabilitation, care homes, nursing homes and home based care and some planned care.

**Other Providers**

The CCG has range of smaller independent and voluntary sector providers. Whilst there is not as great a range as you would find in large urban areas, they are often innovative in the provision of specialist services in the community. Aside from the large providers referred to above the area has:

- 33 providers of community services.
- 38 providers of mental health and / or learning disability services
- 142 providers, providing some form of continuing health care and this will include care homes which account for over 1000 beds in the community within the Lancashire North area.

Whilst monitoring the provision of good quality care is obviously a challenge for the CCG, the current range of other providers gives opportunities to review care and services in the local area and to consider more innovative ways to develop services.

**Benchmarking information**

Each month the CCG collates performance information directly from its providers and from national data sources such as the Health and Social Care Information Centre\(^6\) and NHS England\(^7\) websites. In addition, the CCG commissions the Lancashire and Staffordshire Commissioning Support Unit to provide detailed information on contract activity and performance benchmarking.

Benchmarking information also helps evaluate whether service changes have delivered the intended improvements in comparison to other areas.

NHS Lancashire North CCG uses a number of benchmarking datasets including:

- CCG data pack
- Programme budgeting
- Productivity metrics
- Atlas of variation

\(^6\) HSCIC: https://indicators.ic.nhs.uk/webview/
\(^7\) NHS England: http://www.england.nhs.uk/statistics/
CCG data pack

This pack provides a powerful summary across a broad range of indicators with regard to the CCG. Further analysis of this information will be undertaken during 2014/15 to inform project prioritisation and implementation.

Programme budgeting

Programme budgeting information provides an analysis of spend against outcomes, this helps build an understanding about whether an area is directing enough of its resources to different disease areas and also whether this resource is being used effectively. Further analysis of this information will be undertaken during 2014/15.

The diagram below summarises the cost and outcome data for 2011-12 for each programme budgeting category compared to the national average. (The full spine chart is shown on the following page.) Although Lancashire North is not a significant outlier for outcomes or expenditure for any of the categories compared to England, outcomes are worse in this area compared to the national average for all categories except maternity. In the majority of these cases, outcomes are worse despite comparatively high expenditure rates.

Compared with programme budgeting information for the previous year, outcomes for musculoskeletal system and neurological disease have deteriorated despite continued high expenditure for these categories.
## Performance Indicators

### Overall
- **Overall spend per weighted head of population**
  - Lower: £1,600
  - Worse: £1,700
  - Mean: £1,910
  - Better: £2,140
  - England mean: £2,550

### Mental Health
- **Mental Health spend per weighted head of population**
  - Lower: £220
  - Worse: £234
  - Mean: £278
  - Better: £286
  - England mean: £296

### Circulation
- **Circulation spend per weighted head of population**
  - Lower: £135
  - Worse: £141
  - Mean: £149
  - Better: £149

### Cancers and Tumours
- **Cancer spend per weighted head of population**
  - Lower: £100
  - Worse: £109
  - Mean: £109
  - Better: £109

### Musculoskeletal System
- **Musculoskeletal spend per weighted head of population**
  - Lower: £107
  - Worse: £112
  - Mean: £110

### Gastrointestinal Disease
- **Gastrointestinal spend per weighted head of population**
  - Lower: £80
  - Worse: £90
  - Mean: £90

### Genitourinary System
- **Genitourinary spend per weighted head of population**
  - Lower: £77
  - Worse: £79

### Respiratory Disease
- **Respiratory spend per weighted head of population**
  - Lower: £73
  - Worse: £73

### Neurological Disease
- **Neurological spend per weighted head of population**
  - Lower: £88
  - Worse: £89

### Maternity
- **Maternity spend per weighted head of population**
  - Lower: £63
  - Worse: £64

### Other
- **Primary Care GMS/PMS spend per weighted head of population**
  - Lower: £134
  - Worse: £144

**Z scores**
A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.
The Lancashire and Staffordshire Commissioning Support Unit have provided Lancashire North CCG with a variety of analysis to support identification of potential QIPP opportunities, commissioning for value insight and impact of demographic change and we have reviewed the Any town health system model.

As part of the Better Care Together programme, significant analysis of the current state has been undertaken and used to inform the care design workshops and the clinical summit. This takes into account recent national guidance, best practice evidence from similar areas and also abroad e.g. New Zealand and USA. This will form a substantial element of the Strategic Outline Case which will be submitted to NHS England by the end June 2014.
Strategic Plans

NHS Lancashire North CCG Strategic Plan 2012/13 – 2014/15

As part of authorisation the CCG developed a strategic plan that forms the basis for this refreshed and renewed strategy.

Lancashire North CCG Priorities

The CCG has incorporated the analysis of health burden; prevalence and outcome against spend into the development of its strategic priorities. This collective evidence leads to a number of challenges for the CCG to consider:

- The need to ensure that pathways are effective and efficient to support the diseases of old age as the population in that category increases and that people are encouraged and supported to take control and manage their own conditions. To supplement this in the longer term, commissioning services to support young people to prevent the illnesses of the current older generations is necessary to prevent a further increase in disease prevalence and the subsequent cost of treatment in future years.
- Commissioning to address health inequalities presents some challenge as the pockets are perhaps smaller than in other areas; targeted work is required to support those who require it whilst not disadvantaging the majority.
- Particular targeted work in some disease groups is signalled, for example related to issues of alcohol consumption, mental health, circulatory diseases, cancer and respiratory disease.

Our CCG strategic plan has six strategic priorities, and a focus on ensuring delivery of the NHS outcomes framework and NHS constitution. The transformational change described in this document will deliver on the seven outcome measures in the planning guidance and ensure parity of esteem:

- Securing additional years of life
- Improving health related quality for people with long term conditions
- Reducing amount of avoidable time spent in hospitals through better integrated care in the community
- Increase proportion of older people living independently at home
- Increase numbers of people having a positive experience of care within and external to hospitals (GP & Community)
- Progress to eliminating deaths in hospitals caused by problems in care

The shift in commissioning and provision of services to new models of care will ensure delivery of these seven outcome measures delivered through its programmes of work detailed in this document. Therefore our CCG priorities have been developed to address the specific challenges that we as a health community in Lancashire North face. These are:
Priority 1 - To improve the health of our population and reduce inequalities in health
We have chosen this priority because our general practices and local health data indicate that there are unacceptable differences in health, heavily influenced by social factors, across our communities. We also believe that in order to address these health differences, we need to work closely with partners on improving the health and well-being of children and young people.

Priority 2 - To reduce premature deaths from a range of Long Term Conditions – with a specific focus on Cancer and Cardiovascular disease
This priority has been identified because our local health data is showing us that this will help us to improve the overall health of the population both now and in the future. Cancer and Cardiovascular disease account for 64% of deaths in our locality before the age of 75 years.

Priority 3 - To develop care services closer to home
Our local residents are telling us that they want to be treated as close to home as possible. We also believe that in order to ensure the long term sustainability of the health community, we need to develop primary and community care services to provide as much care out of hospital as possible.

Priority 4 - To commission safe, sustainable and high quality hospital care
This priority demonstrates our commitment to working with University Hospitals Morecambe Bay and NHS Cumbria Clinical Commissioning Group to ensure the public can be confident in our local hospital services.

Priority 5 - To commission safe, sustainable and high quality mental health care
The CCG is inheriting major changes in the way mental health services are provided and we are implementing these with Lancashire Care Foundation Trust and the other CCGs in Lancashire. Again, local people have told us they are concerned about the quality and effectiveness of these vital local services

Priority 6 - To improve the capacity and capability of primary care services to respond to the changing health needs of our population
Primary care services need to plan carefully to meet the health needs of our residents and be able to respond to our priorities for hospital, mental health and community services. We know how much the public values the wide range of prevention, diagnostic and treatment services delivered through their general practices.

Lancashire Health and Well-Being Strategy

The Lancashire Health and Well-Being Board has membership from across the county, including an Executive GP representative from Lancashire North CCG. The Board undertook a consultation exercise on the vision and priorities for Lancashire. The CCG has aligned its strategic priorities with the priority shifts and priority outcomes of the Lancashire Health and Well-Being Board.

The vision for Lancashire HWBB is
'We want every citizen in Lancashire to enjoy a long and healthy life'

The board has agreed that this will be done through Working together to deliver real improvements to the health and wellbeing of Lancashire's citizens and communities. A set of goals and three programmes of intervention have been agreed. The goals are:

- **Better health** – we will improve healthy life expectancy, and narrow the health gap
- **Better care** – we will deliver measureable improvements in people’s experience of health and social care services
- **Better value** – we will reduce the cost of health and social care

The table below shows the three programmes and their objectives. As part of each intervention there will be a requirement to improve health and care services, improve health behaviours and address the wider determinants of health and wellbeing.

| Starting well | To promote healthy pregnancy  
|              | To reduce infant mortality  
|              | To Reduce childhood obesity  
|              | To support children with long term conditions  
|              | To support vulnerable families and children  
| Living Well  | To promote healthy settings, healthy workforce and economic development  
|              | To promote mental wellbeing and healthy lifestyles  
|              | To reduce avoidable deaths  
|              | To improve outcomes for people with learning disabilities  
| Ageing Well  | To promote independence  
|              | To reduce social isolation  
|              | To manage long term conditions and dementia  
|              | To reduce emergency admissions and direct admissions to residential care settings  
|              | To support carers and families  

Lancaster Health and Well-Being Partnership

The CCG chairs the local Lancaster Health and Wellbeing Partnership, formed originally by the PCT / Lancashire County Council and Lancaster City Council with other partners under the Local Strategic Partnership (LSP). Whilst the LSP has come to the end of its operation, the CCG, PCT and Councils have renewed their commitment to supporting the development of the Local Health and Wellbeing Partnership.

The Lancaster Health and Wellbeing Partnership has identified health priorities for the Lancaster District, which have been received and adopted by the CCG Governing Body and are aligned to the CCG’s strategic priorities.

The Health and Wellbeing Partnership has identified a number of indicators where Lancaster District is worse than the national average and is looking to work to address these:

- Smoking in pregnancy
- Breast feeding initiation
- Hospital stays for self harm
- Alcohol specific hospital admissions for under 18’s
- Life expectancy – males
- Life expectancy – females
- Smoking related deaths
- Early deaths from heart disease, stroke and cancer
- Road injuries and death

The CCG has committed to work in an integrated way with health and wellbeing partners to support these developments both in principle and in practice (through Practice initiatives). The local Health and Well-being Partnership priorities have also been aligned to the CCG’s strategic priorities.

Specialised Services Five Year Strategy

NHS England Specialised Service planning footprint is at a national and regional level. Strategic planning structures have been aligned to a number of area team footprints to ensure that the system plans from each CCG economy and the specialised service plans align and work together as a coherent picture for each ‘patch’.

For LNCCG health economy the Specialised Services strategic plan, will be governed through the NHS England Northwest Strategy Development group which has membership of each of the four Area Team Directors.

The Commissioning of Specialised Services will be set within the context of a whole system transformation which builds on the 6 attributes for high performing systems as set out in the Planning for patients. NHS England will work with partners including Health & Wellbeing Boards and Academic Health Sciences Networks & Centre to ensure transparency and openness of evidence-based commissioning decisions and best practice and innovations are adopted and implemented at scale.
In turn this will:

1. Improve access and quality, reduce variation in clinical outcomes and improve patient experience

2. Consolidate and develop sustainable services based in fewer centres to create networks of excellence, aligned to research and innovation

3. Commission affordable, value for money services which meet national service specifications, thresholds and quality standards ensuring appropriate cost effective care

The national strategy will include statements on the future direction for specialised services. It will also include a description of the objectives and strategic plans for each individual clinical service including innovative ideas for service improvement. Finally it will include NHS England’s detailed response to the UK Strategy for Rare Disease. This strategy is due to go out to public consultation in July 2014 and it is expected that the national strategy will be published in October/November 2014.

Healthier Lancashire

The commissioners of health services across Lancashire are keen to undertake the development of a “Health & 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 both commissioners and providers from both health and social care together with the voluntary sector and other agencies.

It recognises the need to prioritise the strategies across the county based upon our current knowledge however, does not undervalue or underestimate the need for local ownership and implementation. The strategy (‘Healthier Lancashire’) shall be brought together by the Lancashire Leadership Forum but shall be shaped and implemented by those organisations allied to it, including the Health and Wellbeing Boards of Lancashire

The Healthier Lancashire Strategy is being developed to improve outcomes for the people of Lancashire, and consists of 7 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 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 community.

- The Big Conversation: this will aim to engage the public around why Lancashire’s health and care delivery needs to be transformed; to support the development of the strategy by engaging with public and stakeholders and to ensure that thoughts, ideas and concerns are part of decision-making and the strategy development process from day 1.

- 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; 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 and streamlining our efforts.
NHS and Healthcare Commissioning

Lancashire North sits in a particular geography which means that the number of partners and the ‘units of planning’ are varied depending on the agenda being considered. However our overall objective is ensuring that the population of the area receives good quality care and is the most important thing.

The CCGs overall strategic approach combines a number of elements to enable the transformational changes which needs to occur to be successful and provide a sustainable health care system for the population of Lancashire North.

The model for future care sets out the need to focus greater attention on care planning, reducing unnecessary interventions and ensuring those that do happen are timely. The model will move activity from secondary to primary and community care, enabling opportunities for an increased focus on self-care and prevention. Whilst on an individual basis some services are not ‘cheaper’ if undertaken in the community, as a whole the shift is expected to deliver cost and quality benefits, with one of the greater prizes being the longer term sustainability of the system with greater asset building around local areas. The focus on local asset building, promotion and utilisation will ensure optimal access to support for individuals, timely, local and tailored to the individual’s/family’s needs.

To support the development of the strategic vision and the transformational change required a number of commissioning principles have been developed:

- Patients’ needs are paramount and care must meet needs.
- Patient safety and best quality is essential.
- Care should be convenient and local, within the constraints of 1 and 2.
- Organisations and institutions do not exist for their own sake, and are there to fulfil the patients’ needs.
- Care needs to be delivered effectively and efficiently
- Care must be integrated
- Patients should have choice
- Patients should be expected to play their part in looking after their health, complying with agreed care plans and using the NHS wisely.

To enact these principles the planning for different services are undertaken in conjunction with a number of different organisations, but the CCG will ensure that the sum of the parts add up to the whole:

- Local community based and services planned on the Lancashire North footprint with local partners including the City and County Councils, local providers and other commissioners including Cumbria CCG and the Lancashire Area Team for NHS England.
- Secondary acute care services with other Lancashire CCGs and Cumbria CCG.
- Mental health and learning disability services with other Lancashire CCGs, the local authority and providers.
- Children’s services with the Local Authority, Local Children’s Trust, other Lancashire CCGs and providers.
• Specialist Services with NHS England as specialist commissioner of services.
• Support services e.g. NWAS working with other CCGs.

To support this, the CCG has also developed some indicative levels of care to support the planning process which relate to how care may need to be arranged in terms of distance from the patient:

• Level 1 Patients home or temporary home such as Nursing or Care home. In reach services to patients unable to travel (housebound, new mothers), or others where care at home is felt preferable (EOL, unwell children)
• Level 2 Local centre, usually within 15 mins walk (recognising this will not always be possible for more rural communities) this would provide low technology 1to1 services such as straightforward GP consult or medication dispensing, or small group work such as well baby clinics. Further geographic analysis is suggested to examine the present provision and identify any gaps. Some of these services may be offered in shared or non NHS buildings
• Level 3 Community centre, usually within 15 mins drive, for more complex consultations, multi professional input such as chronic disease management, minor diagnostics. Preliminary analysis suggests that 6 centres would be appropriate; Garstang, Carnforth, Lancaster South, Lancaster North, Heysham, Morecambe.
• Level 4 Major ambulatory centre, usually within 30 mins drive, offering extended GP services, services currently provided in hospital outpatient departments, minor injuries, significant diagnostics, and therapies, and minor/intermediate treatments. 2 centres, one in Morecambe and one in Lancaster South would serve the majority of patients in this respect, although further consideration would be needed to an extended range of services. No presumption is made at this stage about the provider of these services.
• Level 5 Local acute hospital services, both for acute and mental health services.
• Level 6 Out of area specialist hospital services, currently represented by services such as major burns, cardiac surgery, or radiotherapy.
Commissioning Programmes

Better Care Together

This is the overarching strategic programme that provides the vision and work programme for Lancashire North and south Cumbria (Morecambe Bay) health economy. Borne out of the financial and quality issues which the Morecambe Bay Health Economy faces the programme will deliver a financially sustainable and high quality care system for the area.

Design Principles

The design principles and commissioning offer are as follows:

- Services will be configured to match patient and population need and demand.
- An agreed area or population will form the ‘unit of care’, it will be based around a natural community supporting GP practice lists as the basis of care.
- Information will be shared electronically to support the HCSM to be as seamless and smooth as possible.
- Over time there should be an increase in self care, supporting the community to support itself when clinical intervention is not required.

Commissioning will offer:

- Best value for money, with cost effective and affordable services within the overall health community context.
- Safe and sustainable services, focused on quality and education of the patient or user to be the owner of their own care.
- Align services with best practice guidance and national standards
- Development of capacity and capability to meet future demand
- Workforce planning, training and career development

The programme itself covers the following elements for both community (including primary care) and acute (secondary care) provision:

- Urgent and emergency care (all unscheduled care) including patients with mental health issues.
- Planned care – including that for patients with complex needs
- Paediatric services
- Maternity Services

Whilst the programme does not cover inpatient mental health or learning disabilities, nor the full wider children and young people’s agenda or continuing health care, how these elements link to the strategic approach is important and has been considered by the CCG together with how other commissioners from the Area Team, Public Health and the Local Authority are included in the programme to ensure approach involvement.

The lead sponsors for the programme are NHS Lancashire North CCG, NHS Cumbria CCG and University Hospitals Morecambe Bay NHS Foundation Trust however the programme is supported by a wide range of partner organisations. These are:
As part of the programme considerable public engagement has been undertaken across the patch which has reshaped the initial scope of the programme i.e.

The Better Care Together (BCT) programme had initially looked at in hospital services and wanted to ensure that pre-consultation engagement work with residents, patients, clinicians, health professionals and key stakeholders was undertaken to help develop future healthcare options.

The BCT team wanted to involve local stakeholders in the pre-consultation phase so that they could actively contribute to the development of future healthcare options rather than solely at a consultation stage.

Therefore Better Care Together engaged with residents and stakeholders from across the Morecambe Bay area of north Lancashire and south Cumbria to feed back their views to those involved with developing the clinical strategy.

This pre-consultation public engagement has been used to help inform health professionals who are involved in four clinical work streams for in hospital care:

Clinical work streams have, and are looking at four key areas in for hospital care services:

1. Unplanned care system e.g. emergency care  
2. Planned care system e.g. elective surgery, long term conditions  
3. Maternity services  
4. Children’s and Young Peoples services  

However the feedback from this engagement was that it was important to look at the provision of health and social care services out of hospital at the same time as in hospital services, that the two could not be separated. The Better Care Together programme has now been looking at the out of hospital services and further engagement focusing on this aspect has taken place.
This further engagement has informed a series of care design groups and a Clinical Summit which took place in April 2014 and will be used to develop a series of potential “scenarios” for future healthcare. These potential scenarios will form part of a “strategic outline case” that will provide the rationale/evidence behind the proposed options. This will be submitted to NHS England in summer 2014. Following approval, further engagement/consultation will take place to ensure full citizen inclusion.

The clinical work streams for Out of hospital are:

1. Unscheduled
2. Episodic
3. Complex Needs
4. Children

Initial findings tell us that patients and the public want care to be patient focused, with single points of access, that they want information and support to enable them to look after their own and their family’s health or long term conditions and access to be as close to home as possible.

The model concept above sets out how the CCG and health economy intends to develop services going forward to address the balance between increasing and improving the scale of primary and community care and reducing the reliance on secondary care services. The BCT model will enable a shift towards increasing ambulatory care, day case surgery and shorter lengths of stay (early supported discharge) for elective inpatient procedures. Along with our Better Care Fund proposals the system will move to a patient centred integrated
A care model for not only those patients with complex needs but those who require episodic care.

The key elements are as follows:

- The patient is key to the delivery of the model and is the start and also the centre of the provision. The patient/citizen is the start as they make a number of their own choices which influence both their basic health, but also at what point they seek care. The service can influence them by being more proactive in terms of influencing behaviour and also encouraging the seeking of screening and help – but also providing good *self-care and support information via a community asset based approach*. It is also evident that the amount of self-care which a patient or member of the population is undertaking at any given time will depend on where they are in the care pathway. The circles at the bottom of this diagram demonstrate this – when a patient is fit and healthy (i.e. not really a patient at all) they are undertaking all their own self care and other than being registered with a GP, dentist or buying over the counter medications are not having any input from health care services, although they may be accessing their own range of support and care services. At the other end of the spectrum is the patient who is in a tertiary care setting where whilst they will be part of the care planning the majority and in some cases all of the care provision will be by professionals.

- The core team is the main provision in this model and will take different forms depending on the type of patient (complex needs, children, episodic care or urgent need) (This will be updated once work on Clinical Design Groups has been completed). The key feature of this part of the model is *patient centred care planning and co-ordination* of care. Depending on the reason for being part of the core team caseload provision may be different but the principles will essentially be the same. The second core principle of this team is to move as much *activity from the unplanned pathway to a planned journey* as possible. This will mean ensuring that as much activity and planning takes place during the normal day as possible and that the patient, their carer’s and out of hours contacts have all the necessary information to make decisions and manage choices when issues do occur out of the normal timeframes.

- There are a range of services which in keeping with affordability principles will not be provided at the level of the core team, but will be available in the community to support the core team to deliver the right services to the patient. The core principles here will be *support to the core team* – the care will not be ‘taken over’ by this service – the core team will still co-ordinate the care and ensure that the appropriate care is provided and received.

- At some point during the patient’s journey they may require contact with secondary or tertiary care services; this could be because of a second opinion being required or an intervention which cannot be undertaken in the community. The key principle here is that the patient is not referred to the service and discharged from the core team – *they are lent for the intervention or care* whilst this happens the core team and key professional remains in contact to provide the oversight of the care, ensuring that only those things agreed by the patient and the team take place.
The CCG is in discussion with Lancashire Area team regarding future commissioning of primary care to ensure that they are a fundamental element of the BCT design and that it meets the direction travel identified in Call to Action.

The model for future care sets out the need to focus greater attention on care planning, reducing unnecessary interventions and ensuring those that do happen are timely. The model will move activity from secondary to primary and community care, enabling opportunities for an increased focus on self-care and prevention. Whilst on an individual basis some services are not ‘cheaper’ if undertaken in the community, as a whole the shift is expected to deliver cost and quality benefits, with one of the greater prizes being the longer term sustainability of the system with greater asset building around local areas. The focus on local asset building, promotion and utilisation will ensure optimal access to support for individuals, timely, local and tailored to the individual’s/family’s needs.

The CCG recognises that there is a need to ensure that there is parity of esteem between those who have physical and mental health problems. Much of the work set out above will include those with mental health problems as they have physical and social issues which will lead them into the pathways that will be covered by the work above. In addition, the model will be further developed to incorporate locally delivered mental health services. There is also no reason why those with mental health issues should not also be managed by similar seamless and co-ordinated processes to those described above for those with physical health issues.

The concept of the model has been developed further and broken down into key component parts to enable description and design. Diagram 2 shows the competent parts and the split between unscheduled care, complex care and episodic care. Diagram 3 overlays this with the children’s services, showing that whilst the model is equally applicable to all ages, there will be differences in the services and also level at which these might be provided to support economy of scale.
There are eight co-ordinated “elements” (5 for adults and 3 for children) to the proposed Out of Hospital model:

- **1** - Integrated core team
- **2** - Urgent health and care co-ordination centre
- **3** - Integrated rapid response team
- **4** - Community specialist services
- **5** - Referral support service
- **6** - Integrated children’s rapid response service
- **7** - Children’s integrated planned care service
- **8** - Children’s pathways

The elements fit together in a co-ordinated system of care around the needs of the “whole person”; physical, psychological and social. The model is built on the registered population of a GP practice and thus each registered person is cared for by the integrated core team (1) based around their registered GP practice. As such the core team remains responsible to them and the population from birth to death. This responsibility is to support the individual to manage their physical illnes as well as addressing the social care needs, with supported self-care being a golden thread throughout. Understanding the patients’ needs from their perspective and care planning for that is at the centre of the model.

As set out above a key principle of the model is that where the individual has a care need that has to be delivered outside the core team service; by another community service (4),
secondary or tertiary care, it “lends” the patient to other parts of the system as their needs require, but ultimately remains responsible and continues to co-ordinate the care with the patient and ensure timely return to home and routine care

A new care navigator role will be a critical individual in the new model. The role of the care navigator is to help proactively manage the patient and their journey through their care pathway, ensuring they receive appropriate levels of care in the most appropriate setting, with a focus on providing care in the community and to work across the interfaces with the following responsibilities:

- For being a patient contact point to navigate community, voluntary and statutory services
- To act as a professional contact to discuss patient care plans
- To interface with all hospital services and co-ordinate appointments, replacing some of the current hospital and practice administration

Key to this is being able to get things done, be known to the patient and help them make effective use of the local community assets as well as the health and social care services. This way the patient and their carers will be able to control their own care pathway in a way that makes sense to them.

Whilst a key tenant of the model is to increase the proportion of care than is managed in a planned and proactive way, with each patient being supported to manage their own care as much as possible, it is recognised that patients will have unscheduled episodes of care. Through ensuring that the Health and Social Care Co-ordination Centre (2) and the Integrated Rapid Response Service (3) have access to the relevant information on the patient and their care plan where applicable they will be able to respond appropriately enacting the relevant services for that patient to meet their needs. The co-location of services across primary and community, social care, mental health services are recognised as key to the delivery of this element of the model to ensure appropriate and timely responses, regardless of whether the patient needs on the day primary care and has no other history to take into account or a long standing history and detailed care plans.

Patients who have both complex and episodic needs require opinions of an episodic nature, the final section of the model sets out how support will be made available to primary and community clinicians to manage as much episodic care as possible in the community, so that patients only attend the hospital setting for those things that need the facilities of the hospital. The Referral Support Service (5) sets out a range of tools and supports to enable this to happen, such as Advice Guidance and services provided closer to home.

As suggested above, the model is equally applicable to children and young people, although due to the numbers, economies of scale may mean that teams cover larger numbers.

The future model of care has at its heart a commitment to support a more integrated health and social care service in the coming years. Throughout the clinical design process the groups have kept in mind the linkages between the different care settings. The model aims to improve these links and the patient journeys have been developed to describe how these linkages will operate, these are provided in the Better Care Together Strategy.
The 8 elements are explored in more detail in the Better Care Together Strategy including the service issues to be addressed, desired clinical outcomes, workforce impact and KPIs to measure future service impact. Each element was written in conjunction with the clinical leads and workstream leads, ensuring that each reflected the work done to date and the potential benefits it could bring to the provision of out of hospital services.

A number of enablers will support the delivery these are:

- Compatible connected information technology.
- Sustainable workforce which is working over a 7 day period.
- Estate Development
- High quality commissioning using a range of contracting methods.

There are also a number of barriers to be overcome:

- Being able to fund the changes required – whilst the whole system needs to reduce cost, there is also a need to move cost from the acute to the community and primary care sectors, which may need to be pump-primed.
- There are cultural changes required both in staff and in the public of what and where to expect.
- Significant workforce development is required, with changes to skill mix, structure and location of services.

All of the above issues are covered in the Better Care Together Strategy. Whilst the method of delivery will be flexed depending on the type of service, eg children’s or adults the vision holds true for all.

**Maternity Services**

Maternity services and their future provision has been considered as part of the Better Care Together Programme as a separate work-stream and the detail is included in the Strategy. The Trust provides maternity to a relative small population across three sites and has had well documented difficulties in providing a consistently high quality service over recent years.

One of the key tenants of the work for maternity is to ensure that there are safe and sustainable maternity services for the population. To this end the CCG is working with the UHMBT and Cumbria CCG to commission a Sustainability Partner relationship for the service. There are two parts to this:

- Part one – is for a partner to assist with governance and risk management to improve practice.
- Part two – is to explore ways of jointly utilizing staffing assets.

Greater details in relation to this work are set out in the Better Care Together Strategy.

**Self care**
Moving care from the hospital to community-based service settings, where appropriate, is a vital part of developing a sustainable model for the future delivery of healthcare. Moving care from the community into patients’ own homes may be an even more sustainable approach. The Better Care Together Programme provides an opportunity for a culture shift to place greater emphasis on self-care, which may result in improved health outcomes whilst reducing unnecessary healthcare demand.

Self-care is concerned with reducing people’s dependence on health professionals and increasing their sense of control and wellbeing. The Department of Health defined self-care as:

The actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital.

Self-care therefore includes eating well, exercising, taking medicines appropriately, keeping in good mental health, watching for symptom changes, coping if symptoms worsen and knowing when to seek professional help.

The key to harnessing the potential impact of supporting self-care on improving outcomes and reducing admissions to hospital is to inspire and enable those that deliver health and social care to promote self-care and utilisation of community assets to all their patients. The CCG will be working with Public Health to undertake the following actions and achieve the better outcomes:

1. Supporting self-care is adopted as an integral element of the Better Care Together clinical model
2. The "Core Team" (i.e. the integrated neighbourhood care team within the emerging Better Care Together Model) receives a tailored programme of training and awareness to empower them to promote and champion supporting self care to patients and to health and social care staff.
3. A comprehensive map of existing community assets to support self-care is developed, maintained, advertised and made easily accessible to health professionals and the public
4. Existing interventions to support self-care are reviewed and evaluated with a view to improving their quality and effectiveness
5. Commissioners and providers work together to identify and agree contractual arrangements for new opportunities for supporting care within existing care pathways (e.g. anticoagulation pathway)
6. The self-care aware pilot is extended across all practices
7. Patients, community and voluntary organisations are encouraged and supported to develop community assets

**Better Care Fund**
For Lancashire North this is a sub-set of the Better Care Together Programme. The CCG, and the PCT before it, have a long history of working with Lancashire County Council to commission together to integrate health and care services with the aim of supporting people to remain healthy and independent.

Particular examples stretch back to 2003 when the health commissioned Rapid Response Team was enabled to commission social care funded ‘crisis support services’ to support people in their own homes for 72 hours to prevent hospital admission.

This has been built upon since by the development of joint commissioning of the Transitional Care Pathway, in particular the REACT service which is a multi-professional integrated team, the Intermediate Support Team (IST) which supports peoples with dementia and is again multi-professional and integrated.

Other examples exist around Community Equipment, Mental Health Services and Learning Disability Services. The area has also encouraged the integration of voluntary and statutory services through the commissioning of a 24/7 end of life service which is provided by voluntary and NHS services again through an integrated approach. These examples over recent years have enabled the local health and social economy to stabilise non-elective admissions to hospital which is in contrast to most other areas which have seen an increase and also to support increasing numbers of people at the end of their life to die in their preferred place of care. In LNCCG the percentage of people dying in their usual residence has risen from 42% to 49% since 2010/11. This is above the England average of 44% and the highest percentage for all CCGs in Lancashire.

For the Lancashire North area, the Better Care Fund is a part of Better Care Together focusing initially on the frail elderly, those patients accessing the Transitional Care Pathway and carers. This plan therefore focuses on those areas of work at present – but the wider programme will support a much bigger transformation across the whole system.

The Better Care Fund will continue to develop and enable a single point of access to a range of community based step up/down services (described locally as the Transitional Care Pathway) including provision of an extended hours domiciliary crisis response service across Lancashire North, reablement and community beds offering rehabilitation and recuperation will mean that more people are treated and supported at home, with appropriately trained therapy & support workers.

Availability of pathways to offer alternatives to hospital admission with clear links to community rehabilitation services ranging from minimal to maximal input, presence of a multi-disciplinary Rapid Response Service in A&E & Medical Assessment Units will focus upon admission avoidance, to triage and access Rapid Response and other appropriate community services.

There will be end-of-life care and mental health capacity within transitional pathway services building on the work of the 24/7 palliative care service and the integration of elderly mental health services into the transitional care pathway which again is already underway.

**Care Homes**
Increasingly, some of the most vulnerable people with the most complex needs live in our communities in care homes. In Lancashire North there are over 600 nursing home beds and it is essential that the service users within them are considered as part of the community and have equal access to the benefits realised through our vision in terms of access to the right care at the right time, and the wrap around care afforded by using community assets to develop well-being. They will be an integral part of the care system and plans are currently underway to provide greater support into these homes, through links to NHS providers and links into the natural community within which they are situated. This work will include increased liaison between health and social care commissioners as well as health care professionals and social work staff to ensure that care home providers receive consistent messages to help their care provision.

As we look to increase the number of patients who are cared for in their own home there is a need to support domiciliary providers in a similar way to care homes. There is also opportunity through the recommissioning and zoning of domiciliary home care, to address issues of continuity and improve the quality of the day to day care people receive (that spans basic primary health and social care needs that keep people safe, well and out of hospital). For example, poor hydration and medicines mismanagement often can trigger an admission. The zoning of providers in neighbourhoods and localities should foster true integrated working with providers and the integrated neighbourhood teams case managing those people with complex needs.

**Integrated Quality Improvement**

We are also aware of the increased activity in terms of safeguarding and avoidable emergency hospital admission from citizens living in these settings. Responding to this demand in the same way is no longer sustainable, affordable and in the interests of vulnerable people and we urgently need to shift to a more proactive approach. We would wish to build on current (often single agency) developments that take a quality improvement approach to raising standards and the development of best practice within this sector, by coordinating our interventions via an integrated team approach. This will allow us to have more comprehensive assurances of the quality of provision, an opportunity to reduce duplication, and to maximise the opportunities to conduct individual reviews of citizens in the service.

**Disabled Facility Grants**

Aids, adaptations to homes and equipment to support and enable independent living are essential if patients and service users are to be support effectively. Lancashire County Council, the CCG and Lancaster District Council will continue to work together to develop the delivery of a comprehensive range of aids and adaptations, utilising disabled facility grants and other funding to support independence and improve outcomes for service users. There is a commitment to work in accordance with the Annex to the NHS England Planning Guidance, delegating the indicative minimum district budget allocations (as published by the DCLG for 2015/16), to support delivery of the statutory duty of the strategic housing authorities in relation to adaptations for the disabled. There is a recognition and a commitment from all partners to work together to further improve integration and co-
ordination of services which promote independence and equity, enhancing outcomes for customers and maximising value for money.

**Home Care**

LCC is currently undertaking a major exercise in recommissioning and procurement of its Home Care services for older people and people with a physical disability. Over time this will encompass all the services delivered by registered Home Care providers in Lancashire including mainstream home care, reablement and crisis response services. This work is being managed on a countywide basis and covers about 5000 service users, 4500 staff and about £50M of expenditure per year.

However, at the conclusion of the procurement process later in 2014 and new Home Care contracts are awarded the intention is to develop a much closer collaborative relationship between the group of Home Care Providers and local Commissioners and Providers of both Health and Social Care services. The new commissioning arrangements will involve fewer providers holding contracts for up to 7 years with the county council, organised into zones which are broadly coterminous with the boundaries of Clinical Commissioning Groups. The benefits include, for example, the potential for strategic and operational partnership with emerging Neighbourhood Teams of health and social care staff, leading to a more integrated response to the needs of individuals.

Many people rely on these home care services to support them during times when they are recovering, or need support in a crisis situation or need longer term support and so through the BCF funding we will need as a priority to ensure that the current level of service is protected in the face of provider's cost pressures and local authority funding reductions. Indeed it would be better if the capacity and capability of these services is increased to ensure more people can be supported at home outside of hospital or residential / nursing homes. Through the BCF process we will start to develop clear plans for this capacity and capability to be grown.

**Telecare**

LCC will begin to re-commission and procure the key elements of Telecare infrastructure during 2014 to serve the whole of Lancashire. There is considerable scope for expanding and improving Telecare service across Lancashire. The most important potential benefits of Telecare accrue to individuals and their family in terms of improved risk management, peace of mind and responsiveness to emergencies, However the financial benefit from a successful Telecare service will accrue as much to the NHS as to the Council and so it is intended to have a joint investment in the service, ensuring it is funded for growth, and that staff across the local NHS and LCC provider organisations are fully engaged and trained in the deployment of Telecare.

A joint single performance review monitoring process for measuring the impact and efficiency of the services including joint IT services, Incorporation of the utilisation of re-ablement, telecare / telehealth /telerehabilitation, Clear defined links to personal budgets, housing, other services, private and third sector within the pathway. These changes will
result in people being supported to manage their health and any long term conditions so they are less likely to need to visit A&E and/or be admitted acutely due to an exacerbation of their condition.

Carers

Carers are an essential part of the caring process and provide more care and support to people than any other group. In order to recognise this contribution and to ensure that carers receive the appropriate support and services LNCCG and Lancashire County Council are committed to the further development of carer services as set out in the Lancashire Carers Strategy around agreed areas of work.

These are:

- Carer’s assessments
- Access to breaks
- Health and emotional wellbeing
- Provision of information

In partnership with carers through the various carer forums we will develop a more community focused system which should provide support to carers in the right place at the right time so that they are enabled and empowered to care for their loved one.

Continuing Health Care

A significant number of our vulnerable older people or those with physical difficulties are cared for in care homes. Lancashire North has 700 registered nursing home beds. Ensuring the quality of care for this group of the population is key to improving care standards and removing activity from secondary care. The CCG is committed to working with the Local Authority to improve care in care homes and supporting this sector to play a leading role in managing the care of our elderly population.

The CCG is an outlier on the number of people who are put through the CHC process and those which are accepted – higher than other CCGs in Lancashire. Whilst the CCG supports the concept that those who are at their most vulnerable and have a primary health need should be supported by Continuing Health Care, this significant difference has a financial impact that the CCG needs to understand, both in terms of the staff time in undertaking assessments and in the cost of placements. There can also be a restrictive element to placing patients on CHC that prevents them from accessing other sources of care which might enable them to have a better quality of life. The CCG will work with its provider Lancashire CSU to understand this issue and to also ensure that the approach to CHC supports the wider CCG objectives, including the implementation of the Personal Health Budget guidance which will give patients greater choice when they wish to have it.

Children’s services
The wider children’s agenda covers a number of services and pathways, many of which are now commissioned by a range of different commissioners. The CCG is committed to working with partners through the networks across Lancashire and Lancaster and Morecambe to improve the outcomes for children.

In addition to the specific work included in Better Care Together, the CCG will over the period of the plan:

- Implement the Special Educational Needs guidance set out in the Children and Families Act (see collaborative section for more detail).
- Work with CCGs and the local authority locally and specialist commissioning to ensure that pathways for children with mental health problems are smooth, seamless and provide a good quality service mental health.
- Work with other CCGs to improve pathways for children with ASD and ADHD.

**Learning Disabilities**

In addition to the work described in the collaborative section which the CCG is undertaking with other CCGs to ensure improved inpatient services for those with learning disabilities, the CCG is also ensuring through its own processes that the issues raised by the Winterbourne Review are addressed. Plans are in place to re-accommodate a number of long stay patients and to work with Lancashire County Council to address the difficulties which are presented by Ministry of Justice orders to re-accommodating other long-stay patients.

In addition the CCG will be working to develop a longer term strategy for those with learning disabilities to increase the provision and support in the community.

**Mental health**

**Older People’s Mental Health Services**

Whilst some older people with mental health problems will have similar issues to younger adults, the need to ensure that their physical health is considered is much greater. Enabling the link to the Holistic Care Model of better care together for this group of patients is key so that both their sets of needs can be supported.

For those with dementia the issues are similar, but the aetiology of the disease means a different set of services are required to support them. The CCG will continue to work to ensure that those with dementia receive a diagnosis so that they can access the relevant treatments and services. The CCG will also consider how the Holistic Care Model should be adapted or extended to meet the needs of this client group.

**Adult Acute and Rehabilitation Mental Health Services**
The Lancashire CCGs have been working together for a number of years to transform the inpatient services for those with mental health problems. This work has included a review of the number of inpatient beds required and improvements which can be made by reducing that number, concentrating the smaller number one specialist site and increasing the support within the community to enable this. The CCG uses the Stepped Care Model (attached) to underpin its consideration of mental health services and discussion is underway to ensure that this model is linked to the holistic model of care described above to ensure and improve parity of esteem.

In order to complete the transformation of adult mental health services a number of parts of the pathway need to be transformed:

- Access to support at levels 2 and 3 of the stepped care model needs to be improved. This area of work will lend itself to linking with the Holistic Care Model which has been developed as part of the BCT programme and will help to link the agenda of physical and mental health more fully. (above)
- Following a crisis or inpatient episode as with physical problems, those with mental health issues require support and a period of rehabilitation. There are many forms of rehabilitation at different levels of need. The Lancashire CCGs and Lancashire County Council have commissioned a review of this area of provision, which will enable a re-commission of these services. The new models will again need to fit with the Holistic Care Model designed as part of BCT.
Access to crisis services needs to be highly responsive in the same way as for any other urgent or emergency situation. Specialist mental health crisis services will continue to be the focus for access to emergency services, but will need to link more fully with the local developments for BCT relating to urgent and emergency care and integrate into the Health and Care Co-ordination Centre.

**Lancashire Collaborative Programmes**

By working in partnership across the 8 Lancashire CCGs and their partners to enable the delivery of the Lancashire strategic vision for health and social care the CCG is further enabling the overall key strategic aims.

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 the following diagram:

*Lancashire Collaborative Commissioning – proposed model*

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, whilst operational projects were defined as being initially less than 12 months in duration.
Strategic Work Programmes:

Mental Health Reconfiguration

Our vision for Mental Health and Dementia services across the Lancashire health economy is to ensure appropriate access and treatment for people with mental health problems and ensure they have timely and effective help at the right place and right time.

The Lancashire CCGs are undertaking a significant mental health acute reconfiguration; in partnership with Lancashire Care 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 inpatient capacity. The CCGs are in the third year of a 5 year programme of transition and so far have achieved £9million of savings of a total £15million 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 inpatient mental health facilities. This resulted in the 15 existing in-patient units being reduced to 4 more appropriate, modern facilities.

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

1. Single Point of Access (SPOA) to ensure that access to mental health services is managed through a single point; this is currently not functioning well. Over 50% of admission into the acute mental inpatient services present through Accident and Emergency (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.

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
- 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 IST and NHL function in all areas, aligning with integrated neighbourhood team developments and ensuring all gaps are addressed in 2014/15 through specific transition plan.

**Child and Adolescent Mental Health Services (CAMHS)**

The Lancashire Child and Adolescent Mental Health Service 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 8 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.

**Learning Disability Programme**

The Learning Disability programme is focused on 3 main workstreams:

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:

   - Development of Learning Disabilities provider framework
   - Development of assessment & treatment services at Calderstones
   - Undertake engagement with service users, carers and families
   - Support the development of a revised provider business model and organisational form

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 Report 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
• Developing and monitoring an improvement plan

3. **Children/ Special Educational Needs & Disabilities (SEND)**

Inequitable service provision across Lancashire has been identified by Ofsted and the CQC 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.

**Diagnostics/ Pathology**

As new tests come in, and with an aging 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 & Pathology programmes looks to reconfigure pathology services including the laboratory testing element of the cervical cytology screening programme and pathology diagnostic services in the community, by developing a service specification for the pathology services which reflects current best practice.

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 review of service provision in support of 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 DA pathology
- Report on level of variation in use of diagnostic tests across Lancashire
- Agreement with providers on the process to address any variation
- Agreement with providers of Lancashire-wide disease specific testing algorithms

**Operational Work Projects:**

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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 achieving greater value for money, improved procurement pathways and quality of service.

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

Over all we expect to provide a singly 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 streamlines pathways for equipment provision.

Stroke/ TIA/ 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 a real opportunity to be transformational around 7 day working and potentially drive major reconfiguration.

The implementation of AAA 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.

NHS England Direct commissioning

The following section reflects the work that the Lancashire Area Team intends to undertake with regard to its direct commissioning responsibilities. The CCG will be working with the AT to ensure that from a commissioning perspective they are part of the Better Care Together implementation process as they pay a critical role in ensuring that the delivery of primary care at scale is achieved. The Better Care Together model will only work effectively if primary care is enabled to deliver the model to its full extent. The Better Care Together Strategy sets out in greater detail the governance proposals for the future.

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 includes 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 7 day primary care services at scale by working in neighbourhoods and integrating with social care services. This will be achieved through support of 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 6 characteristics of high quality care set out in “GP – A Call to Action”.

Health & Justice Direct Commissioning

Prison health care across the Northwest has previously been commissioned in different ways and this is reflected in current patterns of provision which can, in some parts of the area appear fragmented. Our vision is to establish an integrated system with a single prime provider responsible for the provision of all health care within prisons and perhaps across clusters. Eventually we would envisage that we will commission four to five main contracts.

In addition, given that we are 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 ‘inpatient’ provision.

In the North West we will, “work together with partners to achieve excellence in Health & Justice outcomes for the Northwest”

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

In particular the expected outcomes of implementing the single operating framework and commissioning intentions for each of the areas that we cover we will see an end state of:

**General Prison Healthcare**

- quality of offender healthcare services improved and equivalent to those in the community
- All prison health contracts are compliant with NHS standard contracts.
- There are comparable standards of quality and care across all AT area prisons
- Prisoner’s health and (social care) needs are met

**Secondary Care**

- The need for appropriate escort and bed watches is reduced by the implementation of alternative access to services e.g. Telemedicine and prison based clinics.
- Activity and spend on secondary care is reduced and replaced with care closer to home.

**Substance Misuse**

- effective offender health substance misuse strategy in place and being delivered
- quality of offender substance misuse services improved
- Substance misuse contracts compliant with NHS standard contracts.
- Comparable standards of quality and care across all prisons

**Secure Children’s Homes** (x3 across the NW, Merseyside and Manchester, 1 Merseyside SCH to close May 2014)

- Transfer of NHS commissioned healthcare completed.
- Commission high quality NHS comparable services within secure children’s homes
- Improved commissioning capability
- Improved high quality clinical governance
- Improved care pathways

**Immigration Removal Centres** (x1 Manchester airport)

- Comparable standards of quality and care as in the rest of the NHS

**Sexual Assault Services** (x1 Manchester, x1 Lancashire, X2 Merseyside (Adult and Paediatric))

- Transfer of SARC commissioning to NHS offender health commissioning as a part of the transfer of police health commissioning, in partnership with key agencies and based on NHS standard service specification and contract.
- Improved health and reduced inequalities in health care
Liaison & Diversion

- Achieved national roll out across all AT police custody suites and courts against a national service specification and NHS standard contract.
- Continuity of care across pathways and back into the community
- Offender health needs are known and provided for by appropriate treatment services.
- Offenders are diverted from the CJS when appropriate.
- Effective planning which is aligned to an investment strategy

Police Custody Suites (4 Police Force Areas)

- Transfer of the commissioning of health care in police custody to NHS via Offender health commissioning.
- NHS commissioned police custody healthcare.
- Improved care pathways, through improved access to wider clinical expertise and integration with wider community based services.
- Strengthened clinical governance arrangements
- Equity of access to healthcare and a reduction in health inequality

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 JSNAs and local health profiles, the 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 5 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 Lancashire Area Team.

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.
The key challenges nationally and locally include:

- 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
- Increase in patient expectations

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. All of which should be driven by the work of the Health and Wellbeing Boards.

Armed Forces & Veteran Health Direct Commissioning

On 01 April 2013, NHS England, as part of its portfolio of directly commissioned services, became responsible for the commissioning 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 2 MoD Medical Centres; Preston Fulwood 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.

The model will support commissioners and providers of services to:

- Improve patient access
- Encourage transparency and choice
- Ensure patient involvement and participation
- Identify better data to drive improved outcomes and better commissioning
- Deliver higher standards and safer care.

Services to be commissioned are:
• All community and secondary acute and mental healthcare for families registered with a Defence Medical Services (DMS) GP, in line with the principles of a common commissioning policy for NHS England.
• All non-combat related community and secondary healthcare for Serving Personnel, Mobilised Reservists and Families registered with Defence Medical Services (DMS) GPs. In line with the principles of no disadvantage and a common commissioning policy for NHS England, with the exception of services normally commissioned by or provided by DMS including:
  o In Patient Mental Health – normally commissioned by DMS from South Staffordshire and Shropshire FT
  o Community Mental Health – normally commissioned and provided by DMS
  o Community rehabilitation
• Services are commissioned in line with the requirements of the armed forces covenant:
  o Prosthetics
  o IVF for those with infertility as a result of injuries on operations
  o Mental Health

There are a number of changes expected over the next few years which will impact on the needs of the Armed forces these include:

• The withdrawal of Armed Forces personnel from Afghanistan,
• Rebasing of service personnel returning from British Forces Germany
• Plans for the increased use of Reservists

Based on these changes, the key priorities for commissioning are:

• Working in Partnership
• Information, Activity & Finance
• Contracting
• CQUINs
• QIPP
• Service Redesign:
  o Alcohol
  o Domestic Violence
  o Discharge/ Transition Management
• Service Review:
  o Wisdom Teeth Extraction
  o Rheumatology
  o Dermatology
  o Termination of Pregnancies
  o CHC
• Choose & Book
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 provider (North West Ambulance Service – NWAS). These outputs were then 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 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:

**Conveyance**
- Reduce conveyance to AED
- Increase Hear & Treat
- Increase See & Treat

**Healthcare Professionals**
- Develop standards to include Triage & eligibility, Type & Priority (possible bureau approach) & engage with GPs

**Avoidable admissions**
- Support for those >75 years and those with complex needs, including those in nursing & care homes

**Outcome measures**
- Develop a series of measures for use in year 2 which focus on impact on the patient
GP OOHs

- Develop a relationship with GP OOHs

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, to name some examples.

Partnership Working

The CCG works in partnership across a wide range of organisations and agendas. We recognise that no one organisation can commission or deliver the range of services required to improve the health and wellbeing of the population of Lancashire North however because of our geography the partners may be different for different areas of work.

Lancashire Health and Wellbeing Board (HWBB)

The CCG is actively participating in the Lancashire Health and Wellbeing Board which has membership from across the county, including an Executive GP representative from Lancashire North CCG. The CCG strategic plan is aligned to the HWBB strategy and the CCG is a member of the Lancashire Health and Wellbeing Joint Officer Working Group which reports directly to the HWBB and is responsible for supporting the delivery of the strategy.

Lancashire North Health and Wellbeing Partnership

Recognising that the determinants of health; who we are, our chosen lifestyles, where we live, work, play and socialise will determine our health and wellbeing, the CCG has adopted a collaborative approach with partners to develop both a long term and short term approach to preventing people from dying prematurely and to address the health inequalities in our area.

The local Health and Wellbeing Partnership, is chaired by an Executive GP representative of the CCG and allows the local partners from all sectors to share priorities and collaborate with other partner agencies. Four of the six CCG strategic priorities are aligned to both the Lancashire Health and Wellbeing Strategy and the local health and wellbeing plan.

Safeguarding Boards

We work closely with our partners through the Local Safeguarding Children and Adult Boards to monitor the safety of the more vulnerable members of our community. The Lancashire Safeguarding Children and Adults Boards have the responsibility for ensuring that all of the partner agencies work together to protect those adults and children who are at risk due to their age, disability, frailty or mental health problem from harm, abuse, exploitation and wilful neglect. The boards have a wide remit across prevention, quality and standards and child and adult protection and abuse.
The Better Care Fund will provide funding to implement Adult Safeguarding Boards on a statutory funding and Board members are developing proposals for the additional support that will be required to provide Board infrastructure and quality assurance capacity to meet the expectations of the Care Act.

Local Authority

For local health and well-being issues, Lancaster City Council and Wyre Borough Council are important collaborative partners, but for upper tier issues such as social care and children’s services, Lancashire County Council is a key partner. The CCG has built on its previous good relationships with Lancashire County Council, and Lancaster City Council through a variety of forums and also through regular meetings to discuss key health and wellbeing issues relevant to Lancashire North.

CCG Network

The CCG is an active member of the Clinical Commissioning Group Network which brings together the CCGs across Lancashire to ensure that, where required, a collaborative approach is taken.

The CCG is already heavily involved in the development of collaborative approaches to commissioning services across Lancashire, which is being led by the Lancashire CCG Network. The CCG Network has already been involved in some of the biggest programmes of change such as the Mental Health inpatient bed re-configuration which through its lead GP has helped to shape both locally and across Lancashire.

For issues related to acute care for much of our population, NHS Cumbria CCG is a key commissioning partner together with the providers in the Morecambe Bay area.

Urgent Care Network

Urgent Care Network has worked collaboratively with neighbouring CCGs to oversee a number of projects and continues to work with the hospital trust, social and community services to improve discharge planning and reduce delays.

The CCG has worked with partners; including social care, across the health economy over recent years to develop the transitional care pathway which is aimed at reducing avoidable admissions to hospital, keeping people out of hospital by offering care at home and in other settings and ensuring appropriate rehabilitation on discharge from hospital. The pathway has reduced the increase in non-elective admissions and helped to improve the achievement of the A/E 4 hour target and the patient’s experience of care. The CCG will continue to work with the same colleagues over the next period to further enhance this pathway and continue to commission services to support it. The CCG also has plans to commission a review of the pathway in conjunction with social care colleagues to understand how patients with dementia and function mental health problems can be helped to access the pathway.
Delivering on outcomes, parity of esteem and reducing health inequalities

Delivering on outcomes and our approach to performance management

Our CCG strategic plan has six strategic priorities, and a focus on ensuring delivery of the NHS Outcomes Framework and NHS Constitution. The transformational change described in this document will deliver on the seven outcome measures in the planning guidance and ensure parity of esteem:

- Securing additional years of life
- Improving health related quality for people with long term conditions
- Reducing amount of avoidable time spent in hospitals through better integrated care in the community
- Increase proportion of older people living independently at home
- Increase numbers of people having a positive experience of care within and external to hospitals (GP & Community)
- Progress to eliminating deaths in hospitals caused by problems in care

The shift in commissioning and provision of services to new models of care will ensure delivery of these seven outcome measures delivered through its programmes of work detailed in this document. Our two year operational plan reflects a number of planning assumptions which support the delivery of this plan. Activity levels for 2014-15 are based on the forecast outturn of 2013-14 and include:

- Growth as a result of an ageing and increasing population
- Changes to planned activity as a result of any national cancer awareness or other public health campaigns
- Reductions in activity as a result of several commissioning intentions
- The impact of any contract level action plans agreed with providers.

The forecast activity levels for 2015-16 take into account the above factors with the exception of contract activity plans.

The CCG is planning to deliver its constitutional commitments and is taking a number of key actions in relation to IAPT, Avoidable and Emergency admissions to ensure that performance improves; The impact of planned procurements and the lead time for any significant changes have been factored into the plan.

With regards to the clinical outcome measures, the CCG has set a baseline ambition of bringing any under-performance in line with the national average. This ambition takes into consideration the local challenges with regards to disease prevalence and deprivation which result in the CCG being an outlier on a number of key standards. This results in the CCG having a challenging start point for improvement. The CCGs ambitions for outcome improvements beyond the next two financial years will be influenced significantly by the outcomes of the Better Care Together work programme.
Lancashire North CCG has developed its Performance Management Framework based on the national CCG assurance process which includes the following key domains:

- Quality
- Constitutional Commitments
- Clinical Outcomes
- Finance

Each month the CCG collates performance information directly from its providers and from national data sources such as the Health and Social Care Information Centre and NHS England websites. In addition, the CCG commissions the Lancashire and Staffordshire Commissioning Support Unit to provide detailed information on contract activity and performance benchmarking. The CCG Governing Body is provided with a detailed report which shows the actual performance against targets along with clear narrative on any improvement or recovery plans.

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8 CCG Assurance: http://www.england.nhs.uk/ourwork/commissioning/assurance/

9 HSCIC: https://indicators.ic.nhs.uk/webview/

This information is published on the CCG website and shared with local stakeholders. The first year, 2013-14, has been a challenging year for the health economy and the CCG’s focus has been on maintaining good performance and supporting the Better Care Together work programme so that sustainable long term solutions can be found for areas of challenge. Key areas of challenge include:

- **Accident and Emergency 4 Hour Target**
  Historically, Lancashire North has faced a number of significant challenges in delivering this standard for patients. During 2013-14 the CCG, along with the
University Hospitals of Morecambe Bay, the Local Authority and other stakeholders, has implemented an action plan aimed at improving the speed of discharge, improving community service capacity and streamlining access through A&E.

- **Waiting Times for Planned Treatments**  
  Significant work has been undertaken with local providers to understand the level of current and future demand for services with particular reference to Trauma and Orthopaedics and General Surgery. For 2014-15 the CCG will also focus on improving capacity for Ophthalmology and Gastroenterology.

- **Cancer 62 Day Targets**  
  The CCG is working with local providers to ensure that diagnostic pathway for patients is fast and effective and that unnecessary delays are avoided when transferring patients between Provider for treatment.

- **Ambulance Waiting Times**  
  The CCG is working closely with the North West Ambulance Services (NWAS) to reduce ambulance waiting times and to ensure that the service is applicable for the geography and population of Lancashire North.

- **Health Care Acquired Infections**  
  The CCG has reported a reduced number of Clostridium Difficile infections over the previous year however it has not achieved its ambitious stretch target for the year. Further actions are planned in 2014-15 to further improve this performance.

Alongside the national targets the CCG has identified local priorities for the improvement of outcomes. During 2013-14 the CCG has:

- Supported Lancashire County Council in increasing the number of Health Checks offered and delivered.
- Reduced the number of Asthma related admissions for patients less than 19 years of age.

Looking forward, the CCG will reinforce its focus on ensuring that core standards are delivered and that measureable improvements in outcomes are achieved. The CCG has committed to further improving the number of Psychological Therapies delivered, ensuring a parity of esteem for mental health services. Alongside improvements in planned care services, the CCG has committed to making measureable reductions in the number of avoidable admissions and the number of readmissions to hospitals within 30 days of discharge.

**Parity of esteem**

The CCG values the commissioning of mental health services equally with those for physical health and a key priority is the commissioning of safe, sustainable and high quality mental health care.
Transforming mental health services is a major focus to tackle health inequalities. A mental health problem increases the risk of physical ill health - currently, men with a severe mental illness die on average 20 years earlier than other people; women 15 years earlier. They have higher rates of cancer, heart disease, respiratory disease and diabetes. People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems.

The CCG recognises that reforming mental health services are key to reforming the health and care system to meet the needs of our population. Access to primary and community care for physical and mental health issues should be comparable. Therefore, our vision for Better Care Together - Out of Hospital work stream will integrate the mental and physical health services helping improve the recognition and diagnosis of mental health conditions, including dementia.

We are also working in partnerships with CCGs across Lancashire to improve clinical services for adults and children with mental health issues and to ensure that their physical health needs are met at the same time as they receive treatment for their mental health needs. (described in previous pages)

**Reducing Health Inequalities**

Commissioning to address health inequalities presents some challenge for the CCG as the pockets are perhaps smaller than in other areas; therefore targeted work is required to support those who require it whilst not disadvantaging the majority. The CCG has incorporated the analysis of health burden; prevalence and outcome against spend into the development of our strategic priorities. This collective evidence leads to a number of challenges for the CCG to consider.

Recognising that the determinants of health; who we are, our chosen lifestyles, where we live, work, play and socialise will determine our health and wellbeing, the CCG has adopted a collaborative approach with partners to develop both a long term and short term approach to preventing people from dying prematurely and to address the health inequalities in our area.

Based on the updated JSNA, our partners in Public Health at Lancashire County Council have made some recommendations to support the Lancashire North health economy in addressing the health inequalities evident in our population.

**Priorities**

The biggest impact on health inequalities can be made if there is a focuses on:

- Reducing smoking prevalence
- Reducing smoking in pregnancy
- Reducing the incidence of self-harm
- Reducing the incidence of drug misuse
- Preventing falls in people aged 65 and over
- Increasing the proportion of mothers who breast feed their babies
• Reduce excess alcohol consumption and alcohol related hospital admissions, especially in people aged <18
• Reducing premature mortality from cardiovascular disease and stroke
• Case finding – Hypertension
• Improving self-care, health and health service literacy

Recommended actions to address identified priorities

Reducing smoking prevalence
- Make every contact count (staff trained in brief interventions and extended brief interventions to support behaviour change)
- Make referral to SSS a fundamental part of pathways in and out of secondary care;
- Work in partnership with LCC and practices to improve uptake of NHS Health Checks and appropriate referral/follow up. (NHS Health Checks programme has a huge potential to support CCGs in their priority role for earlier detection of disease)
- Work with the local Health and Wellbeing partnership to develop and implement a local action plan for tobacco control

Reducing smoking in pregnancy
- Make every contact count (staff trained in brief interventions and extended brief interventions to support behaviour change)
- Make referral to SSS a fundamental part of pathways in and out of secondary care

Reducing premature mortality from cardiovascular disease and stroke
- Support audits of GP performance on identification and management of hypertension
- Work in partnership with LCC and practices to improve uptake of NHS Health Checks and appropriate referral/follow up. (NHS Health Checks programme has a huge potential to support CCGs in their priority role for earlier detection of disease)
- Work in partnership NWAS and BHF to roll out increased access to AEDs and training in out of hospital CPR as this has the potential to double survival rates from out of hospital cardiac arrest
- Ensure that contracts specify increased training requirements for CPR for all NHS provider staff
- Work with local practices to improve appropriate management of people identified at high risk of CVD (including compliance with NICE guidance; use of GRASP risk assessment tool for AF
- Ensure adequate capacity of TIA services
- Work across local health communities to explore potential scope to concentrate specialist care into hyper-acute stroke services
- Use contracting levers to promote use of Intermittent Pneumatic Compression sleeves in stroke patients
- Ensure service specifications in contracts require services to be delivered in line with NICE guideline on MI with ST segment elevation
- Through contract specifications with NWAS encourage ambulance crews to take nSTEMI patients directly to a cardiac centre
➢ Commission capacity in cardiac rehabilitation to meet local need and use contracting levers to encourage utilisation in under-represented groups
➢ Use contracting levers to encourage providers to establish Early Supported Discharge unit for stroke patients

**Case Finding - hypertension**
➢ Support audits of GP performance on identification and management of hypertension
➢ Work in partnership with LCC and practices to improve uptake of NHS Health Checks and appropriate referral/follow up. (NHS Health Checks programme has a huge potential to support CCGs in their priority role for earlier detection of disease)

**Reducing the incidence of drug misuse, AND Reduce excess alcohol consumption and alcohol related hospital admissions, especially in people aged <18**
➢ Work with Public Health in LCC to develop a local strategy for reducing substance misuse

**Increasing the proportion of mothers who breast feed their babies**
➢ Use contracting levers to systematically operationalize the approach to breastfeeding in maternity services so that it becomes the norm

**Reducing the incidence of self-harm**
➢ Promote the Five Ways to Well-being in the local practices. Ensure CCG and individual practices sign as partners in the Decade of well-being
➢ Contribute commissioning representation to the Public Mental Health Steering Group to progress alignment of commissioning and partnership work.

**Preventing falls in people aged 65 and over**
➢ Promote increased utilisation of the Falls Service commissioned by Lancashire North CCG to:
   o Undertake multifactorial falls risk assessment for older people to identify those most at risk
   o Refer older people at risk of falling to exercise programmes to improve muscle strength and balance
   o Assess the safety of the home environment
   o Raise awareness of how to mitigate the risk of falling
   o Liaise with primary care to implement clinical interventions to reduce risk, e.g. medication review and modification, treatment of low blood pressure, Vitamin D and calcium supplementation, treatment of correctable visual impairment

**Improving self-care, health and health service literacy**
➢ Use contracting levers to
   o optimise utilisation of health and wellbeing services
   o optimise education of patients in self-management and appropriate use of health services
Make every contact count (staff trained in brief interventions and extended brief interventions to support behaviour change)

The local Lancaster District Health and Wellbeing Partnership (chaired by the Executive GP Patient and Public Engagement) have identified the reduction of premature deaths related to lifestyle choices as a priority action. Members of the partnership will work together to implement the current action plan and contribute to the wider Lancashire actions identified in the health and Wellbeing Board Strategy identified earlier in this document. To date the CCG has commissioned Alcohol Liaison Service, weight management service, falls service and

The CCG will continue to work closely with other commissioning organisations to ensure the provision of accessible, multi-tiered, evidence based services to address these risk factors, developing clearly communicated and easy to understand seamless pathways. There is a need to ensure that these pathways are effective and efficient to support the diseases of old age as the population in that category increases and that people are encouraged and supported to take control and manage their own conditions. To supplement this in the longer term, we will commission services to support young people to prevent the illnesses of the current older generations thus preventing a further increase in disease prevalence and the subsequent cost of treatment in future years.

The CCG has undertaken an analysis of QOF data that shows that there is a gap between expected prevalence and registered prevalence for a variety of conditions, markers and lifestyle factors that may result in a premature death e.g. hypertension. The CCG has worked with Primary Care professionals to understand and respond to the local level of unmet need (currently 48%). Understanding that prevention is better than cure and early diagnosis leads to better outcomes, the CCG, through its member practices, has supported Public Health at Lancashire County Council in the provision of a comprehensive NHS Health Check Service which ensures that the eligible population is invited to have a health check. Lancashire North CCG has the highest rate of completed Health Checks in Lancashire. Building on this approach the CCG, working with member practices and through our partnerships we will move to a prevention and wellbeing focus e.g.

As part of the Better Care Together programme a work stream related to self-care has been identified and early discussions around supporting Make Every Contact Count (MECC) as part of this will ensure that there are opportunities for both the community, voluntary and faith sector and health professionals to identify risk factors for long term conditions.

Going forward we intend to improve early detection through raising awareness, education and improved screening. We will also focus on supporting those already diagnosed and on improving access to services by delivering them, more accessibly, in the community.

Focus on Quality

Lancashire North CCG has a duty to commission on behalf of our residents with a view to securing continuous improvement both in the quality of local health services and the
outcomes these services provide. This should take place in order to meet the needs of the local population and within the resources available to the CCG.

Our responsibility to improve quality is shared across the NHS - shared with NHS England, the leadership of organisations providing care, with healthcare regulators including the Care Quality Commission, professional regulators and with all healthcare professionals working in their clinical teams.

The CCG therefore embraces the single definition of quality adopted by the NHS in 2008 and which is now enshrined in legislation through the Health and Social Care Act 2012. This sets out three dimensions of quality, all of which must be present in order to provide a high quality service:

- **Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual’s health outcomes;
- **Safety** – quality care is care which is delivered so as to remove all avoidable harm and risks to the individual’s safety; and
- **Patient experience** - quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs and with compassion, dignity and respect.
This Strategic Plan and the CCG’s strategic priorities have also been linked directly to the NHS Outcomes Framework. This sets out the national outcomes that all commissioners and providers of NHS-funded care should be working towards. The framework builds on the definition of quality by setting out five overarching outcomes or domains, which capture the breadth of what the NHS should be striving to achieve for patients.

The CCG has placed particular emphasis on designing a governance system which can collect, analyse and act upon concerns raised by local clinicians and patients based on their experience of the services commissioned by the CCG. This information can be linked with other intelligence available to the CCG about the quality and performance of local services and used to address problems at an early stage with individual providers.

We know our local hospital, Royal Lancaster Infirmary, part of University Hospitals Morecambe Bay (UHMBFT), has received criticism about some of its standards of care so we are committed to working with our clinical colleagues at UHMBFT to put this right. Our strategic plan outlines the way in which we are approaching this, investing in the shorter term to ensure services are safe and of high quality today but also working with our local hospital to make sure these services remain that way in the future through better care together.

Mental health services for our population are sometimes perceived by those using them to be poor. We are therefore involved in redesigning the service to deliver more care out of hospital, closer to home where patients’ family friends and carers can support them more easily. The CCG has made a commitment to this and to raising the awareness of and early diagnosis of mental health conditions as well as concentrating on reducing inappropriate anti-psychotic prescribing and living well with dementia.

The CCG developed a formal Quality Strategy which sets out how the organisation will discharge its duties to commission services which are capable of continuous improvement. Commissioning safe local services is a guiding principle agreed by the CCG’s Membership Council. To achieve this, there is an expectation that the organisation learns from its predecessor organisation as it establishes its governance and leadership arrangements, its policies, systems and processes. More details on these are summarised below.

**Governance**

The CCG has developed and agreed a constitution with member practices which is intended to govern all of its core duties and responsibilities. The constitution provides for the establishment of a Quality Improvement Sub-Committee of the CCG Governing Body. This group is charged with ensuring the CCG develops an integrated approach to quality improvement into all aspects of its commissioning activity.

The CCG’s integrated approach defines:

- our leadership arrangements for quality improvement,
- our approach to risk management,
- the monitoring of clinical effectiveness, patient safety and patient experience
our engagement with member practices and patients about their experience of local services.

As the major programme of work for the CCG, the Better Care Together programme also has its own governance structure with clear lines of accountability as illustrated in the diagram below.

**Leadership**

The CCG’s Governing Body has identified clear leadership arrangements for quality improvement. To embed clinical leadership for quality improvement at the heart of the organisation, a lead Executive GP reports to the Governing Body. The Chief Financial Officer/Director of Governance also has defined executive leadership roles for the corporate governance of the organisation. Both Executives are supported by a GP Clinical Lead who will work closely with the wider CCG management team to integrate the organisation’s systems, policies and intelligence into a clear framework.

**Policies, Systems and Processes**

The CCG has taken the necessary actions to build its policies, systems and processes to be established as a statutory organisation from April 2013. This work builds on the work of predecessor organisations and will evolve to reflect the nature and priorities of a clinically led commissioning organisation. These arrangements have been approved by the Governing Body and then subjected to on-going review by the Quality Improvement Committee.
There is a particular emphasis on having a system which can collect, analyse and act upon concerns raised by local clinicians and patients based on their experience of the services commissioned by the CCG. This information can be linked with other intelligence available to the CCG about the quality and performance of local services and used to address problems at an early stage with individual providers.

There is also a commitment to work jointly with Cumbria CCG to commission for quality improvement (CQUIN) through the contracting process with University Hospitals of Morecambe Bay, focusing effort and investment on key priorities such as timely clinical information and effective discharge arrangements.

The CCG will also develop a clear set of measures and outcomes to monitor the delivery of the Strategic priorities identified in this plan.

**Francis Inquiries**

Lancashire North CCG has taken very seriously the findings from both the initial and subsequent Francis Inquiries into the devastating failings at Mid Staffordshire NHS Foundation Trust. Significant clinical and management leadership time has been dedicated to reviewing the CCG’s position in regard to the inquiries’ findings and recommendations. Specific areas of work associated, in particular, with improved feedback mechanisms have been implemented across general practice with planned roll out to acute, community and social care providers. Work in this area is closely monitored via the Quality Improvement Committee. Our response to the Francis report can be accessed on our website at: [http://www.lancashirenorthccg.nhs.uk/download/corporate-documents/Response%20to%20Francis%20Report.pdf](http://www.lancashirenorthccg.nhs.uk/download/corporate-documents/Response%20to%20Francis%20Report.pdf)

**Winterbourne Review**

In 2012/13, Lancashire developed a register of patients and clients of assessment and/or treatment services and undertook a review of all patients with a learning disability or autism in inpatient beds. Lancashire County Council and the Commissioning Support Unit, in partnership with the CCG review these placements regularly. In addition, a representative from the service attends all reviews for the people who are the responsibility of NHS England Specialist Commissioning for medium secure services. This allows local services to have fullest possible notice and time to prepare for their discharge once treatment has been completed. With regard to the people with a learning disability or autism currently being care for in inpatient settings, plans for 2014/15 are to ensure robust care plans are successfully implemented to ensure that individuals can be placed within community and that they are supported to have fulfilling lives.

**Medicines management**

The CCG strategy for prescribing and medicines optimisation seeks to support the delivery of the organisation’s strategic vision to secure safe, high quality health services in partnership with professionals and patients. The strategy supports the continuous
improvement of prescribing and the management of medicines to secure better outcomes for patients within the context of the current financial challenges facing the NHS and the CCG.

**Approach to Communication and Engagement**

The CCG is committed to developing effective and sustainable relationships – with our patients, carers, the public and partners in health, social care and the voluntary and community sector.

CCGs are required by law to:

- Involve the public in planning and development of services.
- Consult on commissioning (buying) plans.
- Act with a view to secure the involvement of patients in decisions about their care.
- Promote choice.
- Ensure efficient, cost-effective services.

The statutory duties of CCGs include promoting the NHS Constitution, driving up quality, reducing inequalities and the involvement of individual patients, carers and representatives. These four challenges are being addressed by the CCG and are enshrined within the CCG’s governance arrangements to ensure that public involvement is directly correlated to the planning of services.

The commitment to ensuring that citizens are fully included in all aspects of service design and change and that patient’s are fully empowered in their own care is set out in the CCG’s Communication and Engagement Strategy. This is available to view on our website. [http://www.lancashirenorthccg.nhs.uk/about-us/publications/](http://www.lancashirenorthccg.nhs.uk/about-us/publications/)

This strategy sets out a flexible framework for our communication and engagement activity, which is an integral part of the way we do business. It supports the delivery of our commissioning activities, and is closely aligned with our constitution and organisational development plan.

This is overseen by the CCG Communication and Engagement Strategy Group chaired by our Executive GP and our Governing Body Lay member lead for patient and public engagement. Support for the delivery of this strategy is through the CCG operational group with support from the Lancashire and Staffordshire Commissioning Support Unit. The Strategy sets out the way we, as an organisation, will engage with our patients, public health professionals and stakeholders.

**Patient, public and stakeholders**

Patient and community involvement is a top priority for us in order to effectively commission (buy) and oversee local services that meet the needs of local people. Over the last year we have ensured that we have engaged and listened to patients and our
communities to reflect those needs in our commissioning activities through a variety of different forums.

Our passion for working with partners and small organisations within our local community has been demonstrated with a commitment to support a network of third sector organisations. The network will be chaired by one of our Governing Body lay members. We also recently hosted a large event for all local third sector organisations. This provided an opportunity to engage and involve the organisations. We presented and discussed our future plans as well as gathering ideas and feedback from attendees.

A patient membership organisation “My NHS” has been developed to ensure that individuals and organisations can be kept informed and be provided with opportunities to be engaged in the review and commissioning of local services. We have mapped our communities and through our approach to equality and inclusion aim to ensure that all our communities and particularly those with protected characteristics are able to engage with the CCG and health economy.

Our member practices have Patient Participation Groups and we will aim to develop closer links between these groups and the CCG.

As part of developing our Better Care Together programme a wide ranging engagement work stream is continuing to ensure that the public, patients, staff and stakeholders are able to be involved at all stages of the process and fully engaged in future service design. This engagement programme is being supported by the Lancashire North CCG, Cumbria CCG and University Hospitals Morecambe Bay NHS Foundation Trust to ensure involvement from as wide a base as possible in working together to understand the views of the communities we serve. As part of this a variety of methods have been used to engage with the public and stakeholders so far e.g. focus groups, events, surveys and meetings. As part of the on-going process we have also commissioned an independent report from the Consultation Institute on our engagement to date with a view to seeking recommendations for future activity which will meet national best practice.

Healthwatch Lancashire is the local consumer champion for healthcare services. We are working alongside local Healthwatch representatives to further understand the needs and opinions of local people. Communities have the right to be involved in decisions about your health and social care services and Healthwatch provides that opportunity. We believe that by sharing experiences and ideas with Healthwatch our residents and our communities can influence the way services are run. A representative of Healthwatch attends our Quality Improvement Committee and from April 2014 will attend our Governing Body.

**Clinical Engagement**

Member Practices have, throughout the year, played a significant role and had a notable impact on progress towards achieving the health priorities of the local community. GP Clinical Leads have been appointed to a number of work streams established in response to identified key priorities e.g.

- Urgent Care Network
- Scheduled Care
• Developing services to avoid unplanned admission to hospital
• Redesigning pathways of care in areas for services such as stroke
• Work to improve access to mental health services
• Work to develop dementia care services

Through the Better Care Together Programme in Lancashire North there has been widespread clinical engagement, through facilitated clinical design groups. These groups have worked together to develop optimal clinical models, and to plan for their implementation.

Throughout the year member practices have had the opportunity through the Membership Council and Governing Body to consider the progress and performance of the CCG in relation to the health priorities of the local community, the CCG’s strategy, and its commissioning plan. Regular reports on the CCG strategy, core performance and Better Care Together are received at both the Membership Council and Governing Body.

In conjunction with its member practices, the CCG has begun to assess the implications for primary care services of the future health needs of the population. With an initial focus on future workforce planning and estates issues, the CCG will work with each practice to identify how primary care services may respond and develop over the next three to five years, specifying the core requirements for practice pharmacy support, building on existing evidence of good practice and ensuring effective and efficient use of medicines.

**Approach to Equality and Diversity**

The CCG produced its first Equality & Inclusion Annual Report in January 2014. The report set out how the CCG has demonstrated ‘due regard’ to the public sector equality duty’s three aims since April 1st 2013 and provides evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually. The Equality & Inclusion Annual Report has been published on the CCG website.

To advance equality and eliminate inequality and discrimination, the CCG will continue to utilise the Equality Delivery System Performance Framework both for itself and through embedding this into contracts for all its providers.

Working in partnership with Local Government bodies and other NHS and non-NHS Providers of Health and Social Care to tackle health inequalities, the CCG will also ensure that all commissioning decisions are fair, equitable, proportionate and robust.

The CCG has embedded equality risk management into the equality analysis process, has adopted the Pre-PEAR Assessment Toolkit which allows the CCG to be assured of the risks associated with decision making in four areas; equality, privacy, human rights and quality, thus allowing the CCG to have an integrated approach to embedding equality into core functions.

The CCG has an Equality and Diversity Policy which identifies the CCG’s commitment to equality of opportunity for all employees ensuring that they receive fair, equitable and consistent treatment and that employees, and potential employees, are not subject to direct or indirect discrimination. Where employees identify as having a disability or long term condition, as set out in the Equality Act 2010, access audits and reasonable
adjustments are put in place to support the employees. The CCG also carries out fair and equitable access to recruitment this means that where an applicant indicates they have a disability or long term condition as set out in the Equality Act 2010 reasonable adjustments are put in place to support the applicant.

Our Equality Strategy and Annual Reports are accessible via the CCG website at: http://www.lancashirenorthccg.nhs.uk/about-us/equality-diversity/equality-delivery-system/

Approach to Organisational Development

We are committed to ensuring the CCG is fit for purpose as the statutory body to commission healthcare and deliver all associated duties on behalf of our local population. NHS Lancashire North has an approved OD Plan to help achieve this. It sets out the means by which we affect all aspects of organisational working and all staff to become self-improving to deliver improved health, wellbeing and healthcare for the population of Lancashire North. The plan is intended to be a working document that is regularly refreshed.

Our OD Priorities

- Undertake a training needs analysis for all staff members
- Update the CCG’s OD Plan
- Promote a culture of innovation and learning
- Continue Board development

As part of our approach to improving quality and through the Better Care Together programme we will support workforce remodelling, working with the Local Education Training Board, Universities and providers to ensure that we have the right skill mix to deliver our ambitions.

Approach to Innovation and Research

Research is essential to support continuous improvements in quality, efficiency and patient outcomes across healthcare. We are committed to using evidence-based research in our service developments and improvement interventions, drawing on experience and best practice internationally and within the UK. We work with the Academic Health Science Network to support this approach and develop our knowledge base.

As part of the Prime Ministers Challenge Fund: Improving access to General Practice five general practices in Morecambe were successful in their ‘Opening Doors-Aligning and Integrating Health and Care Services (Morecambe)’. This pilot project will provide an opportunity to test some of the clinical design processes being discussed by the clinical design groups as part of Better Care Together.

Approach to Corporate Citizenship

Lancashire North CCG is committed to creating an organisation that takes sustainable development and carbon reduction seriously. Over the next few years the CCG will develop
a Sustainable Development Management Plan which will include activities of energy reduction, waste management, staff involvement and best practice procurement. This approach to sustainability will enable us to continue to deliver on the 10 key areas set out in the NHS Carbon Reduction Strategy 2009.

The CCG is committed to maximising social value through ensuring the commissioning of sustainable quality services that provide not only value for money but ensure added value for the communities they serve. This will stand the CCG in good stead for ensuring the inclusion of social value impact assessments in all future commissioning decisions.

**Resources**

The NHS LNCCG budget for services is £195,658,000 and £3,753,000 for running costs in 2014-15. Following extensive review and consultation, NHS England agreed a new funding formula for local health commissioning based on more accurate, detailed data and including a deprivation measure specifically aimed at tackling health inequalities. The new methodology has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare. The new ‘fair shares’ allocation formula sets the Lancashire North CCG budget over the 5 years of the strategic plan as follows:

**Allocation summary**

<table>
<thead>
<tr>
<th>Year</th>
<th>Growth %</th>
<th>Allocation per head</th>
<th>Programme allocation</th>
<th>Running cost allocation</th>
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<tr>
<td></td>
<td></td>
<td>£</td>
<td>£'000</td>
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<td>2.14%</td>
<td>1,213</td>
<td>195,658</td>
<td>3,753</td>
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<td>2015/2016</td>
<td>1.70%</td>
<td>1,226</td>
<td>198,984</td>
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<td>202,566</td>
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<tr>
<td>2017/2018</td>
<td>1.70%</td>
<td>1,350</td>
<td>206,010</td>
<td>3,369</td>
</tr>
<tr>
<td>2018/2019</td>
<td>1.70%</td>
<td>1,372</td>
<td>209,512</td>
<td>3,369</td>
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**Business rules**

The business rules published in the planning guidance are included in the plan for 2014-15 and 2015-16 as follows:

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<tbody>
<tr>
<td>Surplus</td>
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<td>1% = £2.02m</td>
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<td>0.5% = £1.01m</td>
<td>0.5% = £1.01m</td>
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<tr>
<td>Non recurrent</td>
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<td>2.5% = £4.89m</td>
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<td>1% = £2.02m</td>
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<tr>
<td>Better Care</td>
<td></td>
<td></td>
<td>£10.46m</td>
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</table>
Running Costs

Running costs are planned and anticipated to be within the allocations for each of the five years of the strategic plan. Pay and non-pay inflation have been factored into the planning assumptions along with funding of other known pressures.

Planning assumptions

Published alongside the planning guidance is the Call to Action technical paper. This sets out the key financial and activity assumptions that underpin the £30bn challenge that was published in July 2013. This guidance, together with some additional local work, has been reviewed to develop these assumptions further for the CCG’s financial plan.

The core financial planning assumptions over the next five years are therefore as follows:

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<tbody>
<tr>
<td><strong>Acute</strong></td>
<td>Demographics</td>
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<td>3.40%</td>
<td>3.40%</td>
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<tr>
<td></td>
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<td>(4.00%)</td>
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<tr>
<td></td>
<td>Non demographics</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Non acute</strong></td>
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<td>0.27%</td>
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<td>0.25%</td>
<td>0.25%</td>
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</tr>
<tr>
<td></td>
<td>Pay and prices</td>
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<td>Efficiency</td>
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<tr>
<td></td>
<td>Non demographics</td>
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<tr>
<td><strong>Prescribing</strong></td>
<td>Demographics</td>
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<tr>
<td></td>
<td>Pay and prices</td>
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<td>Efficiency</td>
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<tr>
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<td>Non demographics</td>
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<tr>
<td></td>
<td>Efficiency</td>
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<tr>
<td></td>
<td>Non demographics</td>
<td>1.42%</td>
<td>1.40%</td>
<td>0.86%</td>
<td>0.86%</td>
<td>0.86%</td>
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</table>
Local position and alignment

Expenditure on health services in LNCCG covers acute, mental health and community services, primary care, prescribing, continuing care, ambulance and urgent care services and a number of independent and voluntary sector contracts. For many of these contracts, the CCG is an associate to a lead contract held by another CCG. We have close working and contract management arrangements in place with all providers and this is particularly important in working with acute, mental health, community, social care and primary care partners in agreeing plans to deliver the required outcomes of the Better Care Fund. Considerable work has been undertaken to ensure congruence of strategic plans and that the CCG vision is a joint and shared one.

Statement of Financial Position (Balance Sheet)

The financial plan templates include a detailed statement of financial position, previously known as the balance sheet. This includes details of assets, liabilities and taxpayers’ equity and reconciles to the cash plan. We hold non-current assets, previously known as fixed assets, relating to furniture and IM and T items.

Cash

We are expecting to manage cash within the resource allocation available and the financial plan demonstrates this.

Contracting

The NHS standard contract remains the form of contract which commissioners must use for all contracts for clinical services, other than primary care. Commissioners are expected to enforce the standard terms of the contract, including the application of penalties. Identified QIPP schemes and Better Care Fund modelling has been done to activity level and included in contract level baselines where these are known. We are working closely with our providers to ensure alignment of strategic and operational plans and that contracts support and enable the transformational change required.

Better Care Fund

The £3.8 billion national Better Care Fund that comes into operation in 2015/16 is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of the people that need it most and is a key driver for long term financial sustainability. CCGs must include in their plans the actions they will take in 2014/15 to create the funding required to make the Better Care Fund affordable when it is introduced in 2015/16.

The total CCG contribution in 2015/16 is £10.462m, which includes £3.312m relating to the funds previously transferred directly to social care from the NHS under $256 arrangements.

The Better Care Fund will be managed through a distinct pooled budget with Lancashire County Council and will be governed by the Health and Wellbeing Boards. Formal
agreements will enable the creation of the pooled budgets and transfer of funds from social care to health to contract for agreed services.

A proportion of the fund will be performance related with payments linked to progress against national metrics, such as delayed transfers of care and avoidable emergency admissions. Hospital emergency activity is expected to fall to generate the savings required to resource the Better Care Fund so local plans are focussed on this area of activity.

Financial sustainability

Ensuring financial sustainability is about finding ways to raise the quality of care for all in Lancashire North to the best possible standards. Fundamentally, this requires a significant shift in activity and resource from the acute hospital sector to the community. There are a number of mechanisms that will drive delivery of this including:

- **Better Care Together** – This is the overarching strategic programme that provides the vision and work programme for Lancashire North and south Cumbria (Morecambe Bay) health economy. Borne out of the financial and quality issues which the Morecambe Bay Health Economy faces the programme will deliver a financially sustainable and high quality care system for the area.

- **Better Care Fund** - the funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, particularly by reducing emergency admissions. Investment in and reconfiguration of existing community services will provide a robust alternative to hospital admission, reducing the volatility of non-elective acute activity and subsequent financial impact.

- **Productivity** - there is a planning expectation for acute providers to aim to deliver productivity improvement over the next 5 years. Productivity is about having the opportunity and ability to treat more patients with better outcomes at the same or lower cost.

- **Efficiency** - this relates to delivering the same service for less cost, time or resource and is a key driver for financial sustainability. It is essential that all parts of the system are innovative, ambitious and transformational in their plans for delivering care in order to help ensure long term financial sustainability.

- **Funding mechanisms** - NHS England and Monitor have joint responsibility for the payment system for NHS services and they have indicated their intention to review funding mechanisms to ensure they truly support improving outcomes. They will focus on twin themes of operational improvement and creating new patterns of care. The funding and payment system is critical to ensuring financial sustainability for the whole health system.

- **Excellence in performance** - commissioners are not in a position to be able to pay for quality and performance that does not deliver the best possible care for patients. Creating an environment and culture where all health, social care and third sector
stakeholders can work together to deliver this is critical to helping ensure long term financial sustainability.

- Financial governance – excellence in financial governance in the CCG is key to ensuring financial systems and processes are robust. This will ensure that financial planning, reporting and management are well controlled and directed and that investments and QIPP schemes are subject to appropriate challenge and approval.

People

NHS Lancashire North CCG will obtain the required capability and capacity to deliver its aims and objectives from a combination of:

- staff employed directly by the CCG
- staff within functions that are shared with another organisation, e.g. another CCG
- staff within functions of Midlands and Lancashire Commissioning Support Unit (CSU). Some of these staff will be based centrally away from NHS Lancashire North CCG and their work managed by CSU. While some staff will be embedded with CCG employed staff and their work directed by the CCG.

Organisational development

Over the last year a programme of organisational development has been put in place to address the priority development needs identified in the Organisational Development (OD) Plan. The programme has been designed to:

- Support the development of the strategic and commissioning plans.
- Enable the Executive and other Clinical leads to expand their knowledge and expertise.
- Enable the development and understanding of the team of GPs and commissioning staff working together.
- Ensure that the initial work programmes support the delivery of longer terms goals

The CCG will continue to address the needs set out in the OD Plan as the organisation develops over the coming months and in particular will need to develop its staff to ensure their capacity to undertake the roles of the CCG.

IM&T

Lancashire North has developed informatics services as described in the current Informatics strategy. This has been facilitated greatly by close clinical collaboration with UHMB and its informatics service, Morecambe Bay Health Community Informatics.

The main thrust of these developments has been better access to clinical information to support a patient’s care wherever and whenever they use health services. Key to achieving this has been the delivery of detailed clinical information between general practice and other providers. Detailed summaries including diagnoses, medication and allergies are
available in out of hours services, accident and emergency departments, the local acute medical unit and hospital pharmacy. Documentation now flows more effectively to general practice. The introduction of key infrastructure in the last year will allow the delivery of all clinical document types produced in the local acute trust to arrive electronically in a timely and efficient manner. Communication between consultant and GP has also been streamlined with the introduction of an advice system providing a robust and secure route for conversations around a patients care.

In turn these initiatives support the wider CCG strategic goals. In particular they facilitate better understanding of patients’ needs at the point of care and protects them from avoidable harm. They bring care closer to the patient removing potentially unnecessary outpatient attendances and increasing the value of those outpatient appointments which do occur.

This increasingly complex sharing of clinical information introduces an absolute requirement for more robust information governance. Currently the data controllers have logs detailing all remote accesses to their systems. This needs to be further enhanced to manage the increasing volume and diversity of the data sharing.

The CCG has a proven track record in developing palliative care. This will be further enhanced by the completion of the Electronic Palliative Care Coordination System. The sharing of a patient’s wishes and associated care plan across the health community will further enhance the delivery of appropriate care to these most vulnerable patients. NWAS have been approached to further extend the reach of this information.

The introduction of ePIG (electronic prognostic indicator guidance) further supports the identification of these vulnerable patients. In conjunction with the Urgent Care Dashboard these deliver powerful tools for primary care. The CCG has ambitions to use these models in other areas of care to benefit a wider population.

Underlying this clinical element is a strategy to improve the core infrastructure and systems to provide increasing interoperability and economies across the whole IT estate. Network infrastructure and hardware is being refreshed and core operating software has been upgraded. Clinical software across primary and community care is also rapidly converging. Once again Palliative care services are at the forefront of these projects. In turn these will provide opportunities for more integrated care closer to the patient’s home. The CCG has been part of a successful joint bid to develop data warehousing capacity to meet the ever increasing requirements for both performance and management information.

The Better Care Together programme will define our future strategy. Significant work with our partners in this project has produced a clear roadmap to support the care needs of our population both now and in the future. Solutions will need to support self-care, the creation and delivery of care plans to vulnerable patients with long term conditions and the efficient management of patients requiring episodic care. The requirement for an integrated care record sits prominently in this model. The CCGs achievements to date in delivering shared records and the Lancashire wide work on the patient record exchange service are clearly elements which can contribute to this vision.

Lancashire North CCG has made demonstrable progress in enabling clinicians to access patient information in a timely manner wherever the patients presents in the system. There are clearly articulated ambitions to extend the use of informatics to deliver effective care pathways around the patient. These include self-care and access to more complex packages
of care. In conjunction with this is a clearly understood requirement to develop both performance and management information to assure both quality and effective delivery. Finally Information governance continues to be developed to allow secure confidential access to medical records that conforms to the patient’s wishes.