Strategic Plan
2016/17

Improving
West Lancashire’s
Health & Wellbeing
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So what has gone well?
By working with the community in Skelmersdale and key partners we secured the Well North programme, known locally as Well Skelmersdale. This is an important piece of the jigsaw in our work to tackle health inequalities and taking up the challenge that NHS England puts to us of achieving a “radical upgrade in prevention”. We have done well in significantly progressing work on digital healthcare, at keeping non elective admissions down and have made good progress across a number of our priority areas – many of which are detailed later. Do also have a look at our annual report which is available at http://www.westlancashireccg.nhs.uk/wp-content/uploads/AnnualReport_2016_v11.pdf.

What remain our biggest health and wellbeing challenges?
We know that we have significant inequality across a range of health outcomes. We still have further to go faster on areas like cancer, cardiovascular diseases, respiratory conditions and mental health. We know we need to bring greater emphasis to tackling avoidable harm, including that brought about by harmful lifestyles. We know we need to get better at risk profiling and upscale our approach to earlier diagnosis.

What are the biggest challenges to address in care and quality?
We still have more work to do in reducing avoidable hospital usage for non-elective (although progress has been made) and elective admissions and we have greater ambitions in further improvements in quality for patients. We know the specific schemes that we need to develop in the year ahead for areas where there are significant quality improvements to make or that we are spending more than our peers. These are reflected in our planned care workstream.

What opportunities do we have before us?
We are reprocuring a number of services including community services and integrated out of hospital urgent care services. We truly believe that this work will bring real change to the model of care locally, a model of care that brings true integration and real transformation in health and care outcomes for local people. Not only does this align to our vision that our Membership of local GP practices have bought into, but importantly this model of care will also help address what we are hearing from our local community. Although this process has caused concern for some, we see this as a major and positive step forward for west Lancashire. If there is one word that will characterise the forthcoming years it is “transformation”. This is transformation that improves outcomes, transformation that improves quality and transformation that brings greater clinical and financial sustainability.

So there is much to do and yet again we are ambitious. However, I am confident that with the experience and expertise we have in our Membership, the CCG staff group, the relationships with our partners and the focus we have on continuing to build our collaboration with local communities that we will indeed continue to succeed.

Lastly we have some changes for the year ahead in our Clinical Executive team. Dr Simon Frampton and Dr Ros Bonsor will be stepping down and Dr Rakesh Jaidka and Dr Vikul Mittal joining us. I would formally like to note my thanks to Dr Frampton who has been with the CCG since its inception and has made a valuable contribution to its form and its development. I would like to also formally note my thanks to Dr Bonsor who has helped ensure that the CCG has made real strides in our work around a number of areas but most notably the vital area of mental health.

As always we welcome your involvement. Get in touch through http://westlancashireccg.nhs.uk/get-in-touch/.

Dr John Caine
Chair, NHS West Lancashire Clinical Commissioning Group
1. Our Transformation Story:  
Our Strategic Goals, Priorities and Areas of Focus

Transformation was a theme in our strategic plan last year. This was channelled through work associated with the Better Care Fund, Care Closer to Home and Facing the Future Together.

Our challenge over the next few years is around radically upgrading our work around transformation. This is transformation that improves outcomes, transformation that improves quality and transformation that brings greater clinical and financial sustainability.

Our vision remains simple; “ensure the best possible care and health outcomes for our population and to empower our population to be in control of their own health”.

We need to ensure we achieve this vision within the resources available to us and as part of the challenge laid before us we have taken stock of our strategic priorities as we knew them last year. We know that broadly they are still the right things for us to be focussing our efforts around but we know that we need to organise our efforts in a way that can achieve greater transformation and our longer term strategic goals of;

- Right care, right time, safely delivered
- Preventing people from dying prematurely
- Integrated working for better patient experience, safety, quality of life and reduced inequalities

In considering the most significant gaps locally, be that gaps in health and wellbeing, gaps in care and quality or gaps in spend we have identified 5 overarching
Our strategic priorities as we have known them nestle within these five priorities. These five priorities allow us to also highlight specific areas of focus that we are either mid-way through implementing or are looking to develop and deliver against.

These are areas where we know through a range of intelligence, such as Commissioning for Value, that we have more work to do and that this work will make a significant contribution to addressing some of the gaps we have.

One change from last year is around children and young people. This area of work has developed greatly in the last year seeing work in 15/16 focus on;
- Establishment of a joint management group with our local hospital. This monthly meeting provides a forum for:
  - Developing our relationship.
  - Monitoring the action plan from the Care Quality Commission and Royal College of Obstetricians and Gynecologists visits.
  - Discussing and progressing the Vanguard new models of care.
- Collaborated with other Lancashire CCG’s and partners in the development of a Transformation Plan for child and adolescent mental health services.
- Working with partners to achieve a metric database focussed on improving outcomes for young people who offend.
- Evaluated the pathway for paediatric asthma.
- Undertook a qualitative examination of breastfeeding to further inform our work.

We now feel this work is in a place, so embedded, that we can take an “all age” approach to our priorities. This feels “right”, especially given the influence the adults in a child’s family unit have upon them. The transformation we achieve for adults we know will impact on our children and young people.

However, there are still some specific areas specific to children and young people that we know require concerted efforts and these are reflected in the detail of our priorities in the following diagram.

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1 The Commissioning for Value pack for West Lancashire can be found at https://www.england.nhs.uk/wp-content/uploads/2016/03/wst-lancash-ccg-cfv.pdf
In reality these areas of focus don’t sit in “boxes” as shown in the diagram.

They will of course impact across a number of the overarching priorities. For example, work we do on primary prevention and earlier diagnosis will impact on outcomes for cancer. Work in delivering Saving Babies Lives will impact on planned care too. It is likely, subject to its development, that Well Skelmersdale will show impact across all five overarching priorities.

Equally, whilst a number of our areas of focus appear “disease specific” we understand the evidence on the importance of taking an integrated approach to chronic disease management and the clustering of risk factors and this is why people centred integration sits at the heart of our transformation work.

Of course there are other areas of work that are still important to us and to which we ensure ongoing efforts. These areas too will make a contribution to the difference in outcomes we look to achieve. Examples of these would include:
- Armed forces health
- Asylum seekers
- Carers
- Domestic abuse
- Learning disabilities
- Violence against women and girls

Equally we continue to progress with our contribution to the Better Care Fund. The top level priorities for year ahead here will impact across all of our work. The longer term plan is to “sit” the Better Care Fund work within the emerging Sustainability and Transformation Plans explained further on. For the year ahead though we will continue to contribute to workstreams to include:
- Intermediate care
- Prevention / wellbeing / public health
- Daily living
- Residential and nursing home care
- Learning disability transforming care
- Children and young people’s emotional wellbeing and mental health

The common theme throughout our plans for large scale transformation was about delivering new ways of working, new cultures and different environments in which to deliver health and care services. Environments that are truly integrated and better equipped to address inequalities.

Some progress has been made but we know that we need to go further. We regularly monitor our performance against key outcomes and present this in our integrated business reports which can be found at http://www.westlancashireccg.nhs.uk/about-us/governing-body/

Enhancing performance and achieving a more ambitious level of transformation will be aided by the development of Sustainability and Transformation Plans. Sustainability and Transformation Plans will show how local services will evolve and become sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision.

To do this, local health and care systems will come together in Sustainability and Transformation Plan “footprints”. For us this is Lancashire and South Cumbria, known as the Lancashire and South Cumbria Change Programme, but importantly we are an associate to the Sustainability and Transformation Plan footprint of Cheshire and Merseyside. The health and care organisations within these geographic footprints will work together to tackle the “triple aim” of narrowing the gaps in the quality of care, the gaps in their population’s health and wellbeing, and the gaps in NHS finances.

The Sustainability and Transformation Plans will be the co-designed, shared and owned strategic plan for the footprint. They will provide a comprehensive, single case for change. This will include why change is needed – the internally driven reasons and the external factors. At a high level it will outline what the new hopeful and better future for health and care will be, what will change and who will be impacted. It will describe the process that will ensure the changes are co-designed and how the changes will be implemented. It will highlight benefits that are expected as a result of the changes and set out consequences for any delay to these changes.

They will include plans for things where it makes sense to do them at the geographic level of the Sustainability and Transformation Plan footprint (known as “level 3”). It will contain “chapters” on the plan at local health economy level (known as “level 2”). In turn these level 2 plans will be informed by the plans at CCG level (known as “level 1”).

Our “groundrules” as we enter collaboration on Sustainability and Transformation Plans are:
- Transparency and honesty.
- Collaboration across commissioners, providers (statutory, business and third sector) and the public for an approach that is:
  - Co-designed.
  - Co-produced.
  - Co-delivered.
  - Co-owned.
- Taking an informed and evidence based approach to real, transformative change that is place based.
- Thinking out of the box, asking “what box?”
- Enabling change through solution focussed leadership across complex systems.
- Being committed to large scale, long term change.
- Driving a culture of collective accountability

1 For more information on Sustainability and Transformation Plans go to https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/footprints/.
2 For more information on the NHS Five Year Forward View go to https://www.england.nhs.uk/ourwork/futurenhs/
2. Transformation Goal: Transform Planned Care

We know that **GP referrals** have grown year on year by 6% which is higher than the national average of 2.9%.

However, levels have been decreasing in the last 4 months and the assumption is that our current diversion work, for example enhancing services such as anticoagulation and diabetes in primary care and regularly raising referral issues with GPs, is having an effect.

We know that referrals are coming from areas of less deprivation but with older populations indicating less chaotic, more controlled lifestyles but more planned care requirements. Increased referrals and potential capacity issues in secondary care focus around gastroenterology and cardiology.

Schemes we are planning for 16/17 that will temper these pressures including:

- **Dyspepsia pathway** redesigned and relaunched.
- Implementation of a tier 2 cardiology service.
- **Choose and Book** directory of service development and management.

The CCG has also been looking at national benchmark data (Commissioning for Value; Better Care, Better Value) to understand where there is improvement to make in outcomes or where there are financial efficiencies to be made that give the opportunity to invest in other priority areas.

There are a number of areas identified for improvement that will “sit” within priorities which are:

- **Circulation**, delivered through our focus on cardiovascular diseases. Part of the Quality Premium indicator we have selected for the year ahead relates to circulation.
- **Endocrine and metabolic problems**, with a focus on diabetes, delivered through our focus on cardiovascular diseases.
- **Cancer and tumours**, delivered through our focus in cancer.
- **Maternity and reproductive health**, delivered through our work in planned care, urgent and emergency care and community care.
- **Mental health**, delivered through our focus on mental health and dementia.
- **Respiratory**, delivered through our focus on respiratory conditions.

The remaining areas we will look to develop schemes to address the improvements. These are:

- **Musculoskeletal**, delivered through progressing work developed in 15/16 and outlined below.
- **Genitourinary** with a focus on chronic kidney disease. Part of the Quality Premium indicator we have selected for the year ahead relates to chronic kidney disease.
- **Gastrointestinal** including work on alcohol related liver disease.
- **Neurological** with a focus on epilepsy.
- **Trauma and injuries** with a focus on infants, children and young people.
We also have higher levels of outpatient follow up reviews than many other parts of the country in a number of specialties including trauma and orthopaedics, gynaecology and clinical haematology. This is being addressed through work with our main provider, Southport and Ormskirk Hospital NHS Trust.

A redesign of the Musculoskeletal Clinical Assessment Service (MCAS) is well underway to ensure that the right care is delivered for patients in the right place, improve the quality of services for patients and reduce expenditure. In future all referrals for planned musculoskeletal problems will be triaged by MCAS to reduce expenditure. In future all referrals for planned musculoskeletal problems will be triaged by MCAS to determine the most appropriate care required.

A part year effect is planned for 16/17 which we are including in our contracts. Details of these QIPP schemes are being included in our contracts with our providers.

Work on other “consultant to consultant” referrals has been ongoing since 15/16 with Southport and Ormskirk Hospital NHS Trust to understand from whom, to whom. An updated policy is in the process of being agreed with our main provider and the impact will be monitored during the year.

For elective activity, we are currently achieving the waiting times referral to treatment (RTT) targets overall although we want to explore this performance across a number of specialties for sustaining and improving this performance.

We have planned to buy elective outturn plus 2% growth to reflect an expected 2% increase in referrals.

- Establishing a patient/carer group.
- Strengthening our links with partners from social care, voluntary, community and faith sectors, hospitals and hospices.
- Establishing an oversight group with local providers including nursing homes.
- Building on the implementation of the Electronic Palliative Care Coordinated system.
- Building on good work already progressing that enables people to die in their place of choice.

End of Life

We focus here on the needs of people of all ages who are living with dying, death and bereavement working with partners to deliver accessible quality care. The improvements we will look to make in 2016/17 will include:

- Working towards the ambitions of Ambitions for Palliative and End of Life Care 2015 to 2020:
  - Each person is seen as an individual
  - Each person gets fair access to care
  - Maximising comfort and wellbeing
  - Care is coordinated
  - All staff are prepared to care
  - Each community is prepared to help

We have planned to buy elective outturn plus 2% growth to reflect an expected 2% increase in referrals. However, the impact of the schemes already mentioned, amongst others, will impact on elective activity as well as our work on Building the Future Together which will deliver the Commissioning for Value (QIPP) savings. Details of these QIPP schemes are being included in our contracts with our providers.

Autistic Spectrum Disorder Pathway

In 15/16 we worked collaboratively to review the paediatric pathway for Autistic Spectrum Disorder. In 16/17 we will implement this new pathway which will result in reduced waiting times and children and young people going via appropriate diagnostic routes.

Ensuring Best Quality, Sustainable Acute Services where Appropriate

We knew before the announcement of Sustainability and Transformation Plans that there was an urgent need to progress work around the acute sector. This reflects unprecedented demand but also issues around workforce, requirements around seven day working and meeting such standards whilst driving improvements in quality and maintaining safety. We have for some time been part of work focussed on the sustainability of Southport and Ormskirk Hospital NHS Trust. This has served as a positive starting point with a good level of the required due diligence undertaken.

With developments associated with the Sustainability and Transformation Plan we have participated in discussions on the mid Mersey footprint and will be progressing equivalent discussions with north Mersey and Wigan. We are focussed on ensuring a move to a transformed model that has clear benefits for our population. It is a complex area that may involve some difficult decisions but we will work to ensure that these decisions are co-designed, co-produced, co-delivered and co-owned.

We will consider options that allow for acute providers to federate, with clinical teams working together to deliver single or shared services which are clinically and financially sustainable. Bringing focus to acute services on a larger geographical footprint than the CCG allows more opportunities to ensure appropriate numbers of cases to optimise outcomes and a critical mass of clinicians to maintain appropriate rotas for safe, effective and sustainable care. There will also be benefits in the standardisation of care pathways to eliminate unnecessary variation and to drive improvements in quality from economies of scale.

4 For more information on this national strategy please go to: http://endoflife/seeambitions.org.uk/
3. Transformation Goal:
Transform Urgent and Emergency Care

Integrated Out of Hospital Urgent Care Services

We will focus in the years ahead on developing plans for integrated out-of-hospital urgent care services.

The vision will ensure greater consistency of services and integration between out-of-hours and walk-in centres. This will ensure patients receive the right care at the right time in the right place and by the most appropriate clinician and ensure links to ongoing long term condition care (particularly for those with multiple long term conditions) and social wellbeing.

The Acute Visiting Service takes referrals from North West Ambulance Service pathfinder, Nursing Homes and GP practices for patients who have urgent health issues and that cannot wait for treatment or advice. The service has supported patients to stay at home instead of needing to be taken to hospital for care. This service is part of the vision for Building the Future Together. The Acute Visiting Service saw 519 A&E attendances deflected in the first three quarters of 15/16.

As part of the extra winter pressures funding and previous Care Closer to Home programme, the Community Emergency Response Team (CERT) was established. The Community Emergency Response Team has worked to provide urgent treatment for patients closer to home by providing responsive care to patients in a community setting. The Community Emergency Response Team has also helped to support patients to leave hospital early by supporting patients who require rehabilitation or continuing treatment in intermediate care, getting them ready to return home. This service is part of the vision for Building the Future Together and will become part of Integrated Neighbourhood Teams that support patients in the community. It will work closely with the out-of-hospital integrated urgent care services. In 2016/17 Community Emergency Response Team will include social care staff to enable the team to integrate with Adult Social Care. We will be looking at how the Community Emergency Response Team could enable patients with delirium to leave hospital earlier, as outcomes for patients with delirium are shown to be better when patients are in a home environment. The shape and form of the Community Emergency Response Team will be determined through the dialogue we are having with potential new providers of community services which will result in a new and transformed model of care.

For non-elective activity (excluding A&E) we know that in 15/16 we have had a reduction in our non-elective spells. ONS projections show negligible growth but we have included a more realistic minimal growth figure as part of our planning. The reduction in non-electives is partly due to our proactive work in primary care including the Acute Visiting Service scheme and admission avoidance schemes. As well as the Community Emergency Response Team has been rapidly responding to give intensive support to people in their own homes, or if necessary stepping people up into an intermediate care bed and has prevented patients needing hospital care.
In 2014/15 our intermediate care beds were fragmented and this led to operational issues. In 2015/16 the beds were commissioned together in one care home. This has allowed a local GP practice to support the beds and the Community Emergency Response Team to work closely with the home to provide a collaborative approach to supporting step up and step down patients. This approach has been successful and the services have been extended into 2016/17.

The CCG received additional funding to enable the expansion of the Mental Health Liaison Service in A&E. The funding will mean that in 2016/17 the service will be a 24/7 service and will work in A&E and the hospital wards to support people with mental ill health during their stay and help them access mental health services, if required, on discharge.

Community pharmacy is recognised as a key, frontline health service that can and does provide healthcare and advice as an effective alternative to many busy primary care services and settings in their communities, particularly those of local GP practices. In addition to this they add value as an important triage to emergency services.

Our aim is to enable community pharmacy to play an even stronger role at the heart of more integrated out-of-hospital services that support better health outcomes for patients, provide more personalised care, deliver excellent patient experience, optimise the use of medicines and secure the most efficient possible use of NHS resources. This work forms part of the wider Call to Action that NHS England launched in July 2013.

In 2015/16 West Lancashire CCG Medicines Management Committee reviewed the enhanced services provided by our community pharmacies in West Lancashire, including stocking specialist palliative care drugs and the minor ailments scheme. The minor ailments scheme is designed to enable people with minor health conditions to access medicines and advice they would otherwise visit their doctor for. It allows patients to see a qualified health professional at a convenient and accessible location within their community, and means patients do not need to wait for a GP appointment or queue up for a valuable A&E slot with a non-urgent condition.

It is the intention for 2016/17 to review the function of the minor ailments scheme to move away from a supply function and enable community pharmacy to support patient education and behavioural change; making an important contribution to a radical upgrade in self-care.

This will be achieved by reviewing a number of options;

- Working in conjunction with Well Skelmersdale.
- Greater use of Patient Group Directions to treat common infections such as urinary tract infections.
- Treat longer term minor conditions such as acne and eye conditions.

Paediatric Urgent Care

We know that out of hours cover and A&E liaison for children is an important area of focus for us with A&E attendances for under 5’s and admissions for injury in under 18’s being significantly worse than the England average. We know this has also been identified in Commissioning for Value analysis previously mentioned with specific regard to trauma and injury for children and young people. We will, in 16/17, look to consider schemes that will address this general paediatric urgent care need.

We are looking at models for mental health A&E liaison for paediatrics and out of hours cover. This could cover;

- Out of hours telephone advice line for children and young people and families in mental distress with 24/7 on call rota
- Advice, training and coaching on the management of children and young people with mental health concerns to other professionals in the acute setting
- Undertake bio psychosocial assessment for children and young people identified by acute hospital staff
- Provide rapid response requests for assessment at home, A&E and wards
- Provide brief intervention and signposting
- Develop multi agency care plans post assessment and follow up (next day)
- Facilitate access to 24 hour psychiatry

The outcomes we are seeking to improve by adopting such models would include;

- Improved access to support before crisis point
- Urgent and emergency access to crisis care
- Right quality of treatment and care when in crisis
- Recovery, staying well and preventing future crisis
- Increased engagement with follow up appointments resulting in the reductions of missed appointments
- Improved experience for patients/families and professionals.
Operational Resilience

The System Resilience Group is a multi-agency approach to building better system resilience and to deliver better health outcomes and ensure that people’s urgent physical and mental health and care needs are met with the right response, at the right time and in the right place. The System Resilience Group includes representatives from health, social care, mental health, ambulance service, public health and voluntary sector and is responsible for the system wide winter plan, but also the interaction between services and how they can work together to improve care for patients.

We continue to contribute to the local level Operational Resilience Network whose focus remains on whole system urgent care. The Network also continues to build on the recommendations of the Emergency Care Intensive Support Team report.

The Network has focused on:
- Escalation planning and policies and system testing.
- Progressed work to assess the feasibility of adopting a whole system dashboard following the Snow White model. It provides a real-time view of the local health system and enables patients to receive excellent, timely care.
- Easter planning.
- Reviews of winter and how lessons can be learned to inform future plans.

Southport and Ormskirk Hospital NHS Trust undertakes a weekly review of A&E which builds on the daily reporting and takes account of weekly mitigation.

As part of our work in Sustainability and Transformation Plans, we will look to rationalise the number of System Resilience Groups to simplify and enhance our responsiveness as a system to urgent care issues. We see this as an aid to delivery of the NHS constitutional rights of patients and will facilitate concurrent transformation in planned care.

We have taken learning from 15/16 in terms of our approach to maintaining additional winter capacity given winter monies are included in CCG baselines. The CCG has financially supported additional winter capacity in the Trust since 2013/14, following the Emergency Care Intensive Support Team recommendations. This was supplemented with additional national funding during 2014/15. The full extent of winter funding in 15/16 was used to continue the winter schemes that had been effective and these will be continued in 2016/17.

Ten Clinical Standards

We are working with S&O Hospitals Trust, as part of our contract discussions, to ensure that the ten clinical standards are adopted by the national recommended timescale of 2016/17.

It is acknowledged that this will require new ways of working and the Lancashire-wide Better Care Fund is also a vehicle to help drive this change. The Better Care Fund activity reductions are aligned to our operational plans.

A reduction of 0.6% (2016/17 is West Lancashire CCG’s share of the overall Lancashire requirement. We think this is realistic given the reductions already made in 2015/16.

We will through 16/17 continue to progress work on seven day services. The diagram below gives a flavour of schemes that will help us meet seven day service requirements.

A reduction of 0.6% (2016/17 is West Lancashire CCG’s share of the overall Lancashire requirement).
4. Transformation Goal: Transform Community Services

Building the Future Together; Our New Models of Care

Building the Future Together is our clinical strategy. It has grown from work on Care Closer to Home and Facing the Future Together. It supports the first phase of service transformation in addressing the needs of the west Lancashire population who are over the age of 65 and those adults who have multiple long term conditions who are, or have the potential to be, high intensity users of non-elective care. By proactively commissioning to address non-elective care for this particular cohort of patients it is anticipated that there will be reduced dependency on acute care services, improved patient flow with a reduction in waiting times and increased capacity to address elective care. Further strategy documents are to follow addressing the needs of children and young people and their families, mental health and wellbeing and elective care.

It is recognised that true integration and coordination of care (not just services) is imperative to deliver quality and excellence for the west Lancashire population. Our strategy is underpinned by the principle of collective accountability, collective leadership and collaboration with all services and sectors to deliver optimum patient care. We support an integrated and coordinated approach to care with organisations and services forming alliances, partnerships and networks, creating an environment promoting a system interdependency and alignment in which no single part can afford to let the other fail. We recognise that change management must be based on a proportionate attitude to risk, with an awareness of the need for reasonable safeguards without resorting to unreasonably bureaucratic measures and complicated governance structures and processes that may stifle innovation.

We aim to have a focus at neighbourhood level on;
- Improving non-elective care, addressing avoidable health and care use.
- Improving long term condition management, with a focus on frailty, shifting from crisis management to prevention, prediction and self-management.
- Improving elective care, reducing clinically unnecessary attendance and outpatient follow ups.

We wish to commission services that are person centred, clinically driven, outcome focussed, financially viable and ones fundamentally different from the traditional model we have become used to. We are ready to progress a different approach to commissioning, one which is at scale and pace, with a clear vision and appetite for change.

Our new model of care will focus around;
- Transitional care, encompassing the interface with A&E and Medical Assessment Units, composed of transfer of care staff, urgent care teams, intermediate care services with a single point of access and co-ordination.
- Long term care, driven through integrated multi-disciplinary teams at the neighbourhood level.
- Ambulatory care, for patients who can access services in a nearby clinic or treatment room.

As such Building the Future Together will make a significant contribution to the transformation we aspire to in planned care and urgent and emergency care. We will, through 16/17, be relentless in progressing implementation of Building the Future Together including assessment of how our model of care “fits” with the emerging Sustainability and Transformation Plan vision and intentions.

If you want to read more about how we are Building the Future Together please go to http://www.westlancashireccg.nhs.uk/wp-content/uploads/Building-for-the-Future-Sept-2015.pdf.
Maternity Vanguard

In 15/16 we became a joint partner with Cheshire and Mersey CCG’s in the Improving Maternity Experience Programme, now the Vanguard programme. Vanguard status was achieved in 15/16 in Cheshire and Merseyside for maternity, neonates, gynaecology and children and young people. This is an important step towards delivering the NHS Five Year Forward View and supporting improvement and integration of services. Each Vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

The Cheshire, Merseyside and West Lancashire Partnership Vanguard’s aim is to develop high quality, clinically and financially sustainable whole system model of care for Women and Children’s Services and will be vigorously progressed in the year ahead.

We will also ensure that we have schemes in place to address opportunities highlighted in Commissioning for Value.

Primary Care Transformation

Primary care is key to driving changes to enable wider transformation of health and care services and systems. There is the need for real development if primary care is to fulfil its potential at the heart of transformed out of hospital systems.

We will look to rapidly progress this area focussing on collective clinical consensus on:
- Our plan for sustainable general practice.
- The requirements for improving primary care infrastructure, including estates and premises.
- Building on our work around IT with further consideration of the wider use of technology.
- Workforce innovations.
- Link across to our working on the ten clinical standards including seven day services.
- Undertake a baseline assessment of our current position against where we aspire to get to in transformation.
- Addressing access with particular regard to tackling inequalities.
- Opportunities for radically upsaling self-care, linked to our work around primary and secondary prevention.
- Identifying opportunities for improving quality, including patient experience and tackling unwarranted variation.

- Greater clarity in the role of primary care in context of Building the Future Together, integrated out of hospital urgent care services and ensuring best quality, sustainable acute services where appropriate.
- The relationships and behaviours needed to achieve transformation, communications, engagement and participation.

As part of this work we will consider opportunities for working at scale.

Saving Babies Lives

We will through 16/17 maintain work with progressing Saving Babies Lives and its four elements:
- Smoking cessation interventions.
- Foetal movement monitoring.
- Improved cardiotocography interpretation.
- Improved detection of growth restricted babies.

We are involved with a range of partnerships that will make a positive contribution to this important area of work. For example, work through the Lancashire Tobacco Free group is resulting in a cohort of midwives to receive training in risk perception with specific regard to working with expectant parents to better understand the risks of smoking in pregnancy and of second-hand smoke in sudden unexpected deaths in infancy. Our continued work with public health will see continued collaboration with partners to further advance work to improve breastfeeding rates.

Paediatric community care

We intend to assess community provision for children and young people as part of a broader piece of work with regard to acute provision. This will inform a way forward for improving quality in care and outcomes for children and young people. We will look, as part of this work, to implement a Consultant Community Paediatric clinic.

5 For more on the Vanguard programme go to https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/
5. Transformation Goal: Transform Outcomes in the Most Challenging Long Term Conditions

All of these areas of focus are ones in which we know that we need to go further, faster.

Our Programme on Cancer

In 2015/16 we made significant improvements.

- **Patient experience** work with regard to uptake for breast cancer screening. This work is still ongoing but the measurement will be to increase uptake in all practices areas, aiming for 70% as a minimum standard with a target of 80%. We have 10 GP practices in West Lancashire that do not achieve 70%.

- Worked with our local hospital to achieve the 62 day performance target. The local provider achieved 85% of patients being treated by day 62 across all 4 quarters in 14/15. Improvements were seen with the lung cancer team achieving quarter 3 in 15/16 for the first time in over a year, due to the introduction of straight to CT scan from chest x-ray and the introduction of endobronchial ultrasound. This allows patients to be treated closer to home as prior to this development patients would have to travel to Liverpool Heart and Chest Hospital NHS Foundation Trust.

- Significant progress in our Macmillan work, appointing a project manager to lead the Living Well and Beyond cancer programme, establishing a physical activity programme for cancer patients and a Macmillan patient group.

- Began work with our local hospital to look at electronic holistic needs assessment as part of the recovery package programme with Macmillan. This is for patients with lung, urology, gynaecology and skin cancers. It is a simple questionnaire that is completed by the person affected by cancer. It allows them to highlight the most important issues to them at that time, and this can inform the development of a care and support plan with their nurse or key worker.

- Held a cancer education event for primary care. 61% practices attended with very positive feedback.

- Recognised as having good one year survival rate. MPs on the All Party Parliamentary Group on Cancer reported patients in our area showed the most improvement nationally in one-year cancer survival rates between 2011 and 2012. For west Lancashire the figure was 72.2% against 70.1% in 2011. Survival rates were already above the national average of 69% and the figures also showed west Lancashire in the top 10 best performing areas of the country for this area.

For the year ahead we will focus on improving:

- Awareness of the signs and symptoms of cancer.
- Referral and access for diagnostic investigations for cancer.
- Treatment and care.
- Living well with and beyond cancer.
- Patient experience.
For continuity in this challenging area, our aims remain the same as 15/16;
- Closely align the programme on prevention to support targeted work on modifiable risk factors.
- Continue to increase awareness of cancer signs and symptoms and upscale our work in earlier detection of cancers.
- Progress service improvement across key tumour groups, colorectal, gynaecology, haematology, head and neck.
- Improve the quality of life for those living with, or who have had cancer and their families.

For the year ahead we have made an addition to our aims for recognition of and referral for suspected cancer in children and young people.

There are a number of improvements we will look to achieve in 2016/17;
- Establish a venue for the Macmillan Information and Support Centre including developing pathways with the voluntary, community and faith sector and the local authority as part of the system of support, embedded in the community, for patients and families living with and beyond cancer.
- Bring the physical activity programme out of the hospital and into the community.
- Continuing to make improvements in patient and carer experience, building on from the established Macmillan group, drawing this patient and carer voice into our service redesign.
- Establishing self-management pathways for patients commencing with prostate and colorectal cancer.
- Continuing to work with local hospitals to achieve the 62 day cancer target, using monthly performance meetings, attending the targeted list meetings of Southport and Ormskirk Hospital NHS Trust and pathway work as highlighted earlier.
- Reviewing capacity and developing pathways for quicker access to diagnostic investigations.
- Working collaboratively with neighbouring CCG’s to transform care for cancer patients and families to ensure there are pathways in place for shared cancer priorities of survivorship and acute oncology.
- Continuing to improve one year survival rates through working in partnership with public health and NHS England on national cancer campaigns, working with the clinical lead to influence primary care with regard to NICE referral guidelines for suspected cancer and rigorously managing performance with regard to key targets.
- Beginning to work to improve a definitive cancer diagnosis within 28 days of being referred by a GP.
- Proceeding with breast cancer services locally.
- Ensuring we have schemes in place to address opportunities highlighted in Commissioning for Value.
- Continue to be active participants in the Strategic Clinical Network for Cancer including;
  - Reviewing diagnostic capacity with specific regard for implementation of NICE guidance.
  - In 5 years look at join up some services with those for other long term conditions.

Our Programme on Respiratory

In 2015/16 we made some progress.
- Enhanced our capacity for this important area by recruiting a respiratory nurse specialist with responsibility for progressing this area of work.
- Established regular clinical respiratory meetings, which has led to joint work to improve access to near testing for arterial blood gas analysis.
- Started to develop specific patient group directives.
- Started to establish a database of patients on long term non invasive ventilation.
- Developed strong relationships with community groups, matrons, ward based teams and the wider multi-disciplinary team for respiratory.
- Began work on integrated pathways.
- Developed apps for patients with Asthma/COPD to aid self-management.
- Identified the need for step down clinics from consultant to specialist nurses and step up from GP/primary care, which will reduce hospital consultant contacts and appointments.
- Reviewed the home oxygen assessment service and identified gaps in service provision and addressed key issues, for example, addressing the issue of poor access to processing arterial blood gas samples which will improve assessment process and reduce wastage of staff time.

There are a number of improvements we will look to make in the year ahead;
- Earlier diagnosis of COPD.
- Building our relationship and linking closely with smoking cessation services to establish clinics on the same site/day (as far as possible) to aid earlier diagnosis and improve outcomes for those with a diagnosis.
- Tackling avoidable health and care costs (including avoidable admissions) for COPD.
- Improving access for patients and their families who experience respiratory conditions. This will include close working with Well Skelmersdale to address inequities in access to services for different groups of our population including moving relevant services such as pulmonary rehabilitation, oxygen and respiratory clinics into the community and providing home support for the housebound.
- Bringing care closer to home.
- Implementing an Integrated Community Respiratory Service that will be measured against CCG/Pathway performance.
- Ensuring the voice of children and young people and their active participation informs work on new standards.
- Ensuring we have schemes in place to address opportunities highlighted in Commissioning for Value.

- Implementing a framework for educating key stakeholders covering all common aspects of respiratory care. Basis for education will be underpinned by all current national and local guidelines as previously described. This will also include training around clinical pathways.
- Developing a business case for a gold standard spirometry service.
- Innovating through utilising technologies such as FLO, a simple telehealth mobile phone texting service that motivates for behaviour change and supports self-management.
- Continuing to improve transition of care for children and young people with respiratory conditions into adult services.
- Ensuring the voice of children and young people and their active participation informs work on new standards.

Cardiovascular Disease

The main risk factors of cardiovascular diseases include tobacco use, physical inactivity, an unhealthy diet (particularly low intake of fruits and vegetables and high salt intake), being overweight or obese and harmful alcohol use. These areas will be a focus in our prevention workstream detailed later on.

Cardiovascular diseases are also linked to other health conditions such as hypertension, diabetes, high cholesterol, overweight and obesity. Risk also increases with age and males are more likely to develop cardiovascular diseases at an earlier age than women.

Atrial fibrillation is a common and serious condition, affecting at least 1.8% of the population, rising to over 6% in people aged over 65 years. As the population ages, prevalence is increasing. People with atrial fibrillation are five times more likely to have a stroke and have an increased risk of premature death, resulting in enormous personal, social and economic cost. Prevention of stroke is the main aim of management of atrial fibrillation.

Atrial fibrillation is under-diagnosed and the use of oral anticoagulants is inadequate. There is an urgent need to improve diagnosis and to encourage better uptake and adherence to oral anticoagulation drugs. The percentage of patients in West Lancashire with diagnosis of atrial fibrillation is currently 2%, this is slightly higher than the national average of 1.8%. West Lancashire CCG has made significant progress in identifying and treating patients with atrial fibrillation at risk of stroke. 691 patients across West Lancashire have been identified as not taking an oral anticoagulant. This will form part of the practices medicines optimisation work plan for the year.

It is valuable to note that 13 of our 22 practices provide anticoagulation time in range, well above the national target of 65%. The GRASP-AF tool is used on an on-going basis with primary care to help GPs assess the risk of atrial fibrillation related stroke and effective management of atrial fibrillation and hypertension in patients in line with NICE guidance.

Hypertension is one of the leading risk factors of premature death and disability, and can lead to conditions including stroke, heart attack, heart failure, chronic kidney disease and dementia. Public Health England estimates that 3,200 patients in west Lancashire with hypertension are not controlled to the quality and outcome frameworks audit standard of 150/90. Treatment of hypertension will form part of the medicines optimisation work plan.

As part of our work on prevention we will consider some of the key approaches to reduce hypertension such as;
- Reducing salt consumption and improving overall nutrition of the population.
- Improving calorie balance to reduce excess body weight at population level.
- Personal behaviour change on diet, physical activity, alcohol and smoking.

We have a significantly higher prevalence of hypertension than the England average. This could be interpreted as a positive and an indication of efficient diagnosis and increased patient awareness.

However there is more to do and we continue to actively participate in the Lancashire and South Cumbria Change Programme’s Stroke Review workstream and Stroke Services Project within the Shaping Selston Governance Framework and the Healthy Liverpool Governance Framework where our priorities include;
- NHS Health Checks. In west Lancashire the percentage of people who were eligible for a health check and were offered on in 2014/15 was up 3.6% from 2013/14. The percentage of people who were offered a health check and who took up the offer was 61.3%, up 8.6% from 2013/14. The England percentage was 48.8%. We know we have further to go in increasing uptake in our more deprived communities.
- Identification, diagnosis and management of atrial fibrillation and hypertension.
- Patient and public awareness.
- Workforce, training and education, including offering training in 16/17 to diagnose and manage hypertension in the community. This training will be targeted at staff in primary care.
- Patient information.
- Early supported discharge.

We also know 10% of emergency hospital admissions for CVD in Lancashire were of west Lancashire residents with it being likely that many of these were people living in our more deprived areas. Emergency admissions in this context can be used as a proxy for the effectiveness of the management of this group of conditions, either by primary care, community care, social care or patients themselves or a combination of these. We know that better integration is linked to managing this more effectively and Building the Future Together will help bring improvements, impacting on this workstream but also our urgent and emergency care workstream. Our work on diabetes continues. We continue to commission the DESMOND Walking Away from Diabetes Prevention Programme provided by Skelmersdale Community Food Initiative (SCFI) and the Local Adult Diabetes Type 2 Mentorship Programme for diabetes specialist nurses for the GP’s and practice nurses in the locality. We expect this programme to achieve a measurable reduction in variation in management and care for people with diabetes. In addition, part of the Quality Premium indicator we have chosen for the year ahead relates to diabetes.

Our Programme on Cardiovascular Disease

Our priorities for 16/17 include;
- Diabetes education programme.
- Offer information, advice and education to all west Lancashire GP practices.
- Explore use of technology to support patients to manage their condition.
- Implementation of Solution Focussed Shared Decision Making (SFSDM) to support patient activation and self-care.
- Ensuring we have schemes in place to address opportunities highlighted in Commissioning for Value.
- Assessing our readiness and undertaking any required preparatory work for implementation of the national diabetes programme.
Our Programme on Mental Health and Dementia

We have made great strides in 15/16 in our work around mental health. We have:

- Developed a wide group of local partners from schools, colleges, health and social care, voluntary sector and others to help us to understand the issues around our current children and young people’s mental health services. Our partners have also helped us to develop the CCG elements of the Lancashire Children and Young People Resilience, Emotional Wellbeing and Mental Health Transformation Plan.
- Worked with Lancashire Care NHS Foundation Trust to develop a national pathfinder pilot to understand the impact of Routine Enquiry into Adversity in Childhood in General Practice.
- Met the dementia diagnostic rate national ambition.
- Worked to sustain progress around increasing access to psychological therapies for common mental health disorders.
- Worked with our local adult mental health teams to understand our “single point of access”: working towards streamlining referral systems, improving data flow, and offering choice/self-referral.

For the year ahead we will focus our efforts around:

- Unblocking our share of the Lancashire block contract for mental health services (in shadow form during 2016/17).
- Working towards a new understanding / re-balancing of resources across children and young people, adult and older adult mental health services that will support the development of a capitated commissioning approach for the people of West Lancashire, regardless of age.
- Investing in prevention and early access to treatment, rather than dealing with the consequences and cost of unidentified and untreated mental health.
- Working with our local population, encouraging them to share their stories of mental health and to understand mental health.
- Applying the principles of, and working to support, the Well Skelmersdale programme to actively engage with the people of West Lancashire.
- Building relationships and trust, creating a stronger sense of local services for local people, managed by local people to meet local needs. Encouraging and testing creativity and innovation within and between services.
- Developing a suite of outcome measures and quality standards for mental health that support and drive our improvement efforts across the community, within contract specifications and within the CCG performance management system.
- Acknowledging the significant contribution primary care makes to mental health services, ensuring that where responsibility is transferred between providers, this is recognised, agreed and remunerated.
- Improving transition of care for children and young people with respiratory conditions into adult services.
- Ensuring we have schemes in place to address opportunities highlighted in Commissioning for Value.
6. Transformation Goal: Transform Outcomes for Those Experiencing the Most Challenging Health Inequalities

The CCG has a history of tackling health inequalities and working on prevention.

We know that it is estimated that healthcare interventions directly influence about 15-20% of the gap in life expectancy with a greater influence coming from the wider (social) determinants of health. We are committed to using our commissioning responsibilities to reduce inequalities. This is vital when we know that health and care systems are facing unprecedented demand due to an ageing population burdened by increasing long term conditions and multiple morbidities.

We have, through 15/16, focussed on a number of areas to include;

- Improving access to healthcare: particularly for the most vulnerable and those that don’t routinely access health services even when they need them. This time last year we had started a piece of work focussed on Skelmersdale which was done to help us have a better understanding of these groups so we can flex our commissioning accordingly. You can find out more about what we have learned from this work here: [http://www.westlancashireccg.nhs.uk/introducing-a-new-report-the-seven-wards-a-focus-on-skelmersdale/](http://www.westlancashireccg.nhs.uk/introducing-a-new-report-the-seven-wards-a-focus-on-skelmersdale/)

We have drawn this learning into the further development of Building the Future Together, the reprocurement of community services and a number of our other key areas of work such as respiratory:

- Asset based approaches and co-production of solutions: an asset approach is firmly embedded in our way of working. This includes collaboration with the voluntary, faith and community sector. It has a cornerstone of securing Well North, known locally as Well Skelmersdale.
- Integration of care and services: will have continued to drive this through the ongoing development and implementation of our clinical strategy Building the Future Together and specifically our new ways of working that will be realised through the reprocurement of community services and integrated out of hospital emergency services.
- Started to focus on tackling unwarranted variation in care and outcomes, producing GP practice level data packs to include activity data and data comparing numbers on disease register to estimated disease prevalence. This is an important stepping stone to “finding the missing thousands”.
- Started to progress the co-location of services to include Psychological Wellbeing Practitioners, Wellbeing Workers and Social Care.
- Worked with partners to undertake the CLeaR assessment [8] which has aided our understanding of the current position for West Lancashire against best practice in tobacco control.
- Considered the health and wellbeing of our own staff by undertaking an audit due to report 16/17.

Our local ambition going forward is a simple one. We want healthy environments for healthy living.

In 16/17 our overarching objectives will focus around;

- A fully integrated approach for radically upsampling prevention including a systematic upgrading in self care. This will include protecting good health and preventing ill health, working collaboratively to enhance conditions protective to health and wellbeing.
- Earlier diagnosis in key long term conditions with a particular focus on those experiencing extreme exclusion.
- Addressing inequities in access and outcomes for key services so people are better supported to manage their own condition and prevent avoidable health and care costs.

We will;

- Work collaboratively with the public, community leaders, the voluntary, community and faith sector, public sector and business sector to deliver against Well Skelmersdale.
- Bring greater emphasis to tackling avoidable harm, including that brought about by harmful lifestyles.
- Further integrate a prevention focus across our other priorities, especially work to transform outcomes in the most challenging long term conditions as detailed earlier.
- Delivery through commitment to fully integrated partnerships, using them as a vehicle to upscale work on primary and secondary prevention including that related to alcohol (harmful drinking), diet, physical activity, smoking and wellbeing. We know there are significant challenges before us for example, around alcohol related harm and children with excess weight.
- Delivery to the commitment to developing fully integrated communities (at neighbourhood and street level).
- Look to transfer 5% of health and care system investment from treatment and care in acute settings to prevention and long term condition management in neighbourhoods.
- Enhance risk profiling and case finding in primary care supported by a multi-disciplinary approach at an integrated neighbourhood level. Using this for earlier diagnosis, providing personalised care to those who need it most but also for modelling possible demand in the future.
- Tackling unwarranted variation in care and outcomes.
- Look for further ways to enhance social prescribing including through use of digital technology.
- Continue to use our commissioning responsibilities to ensure we make every contact count [9].
- Look to further utilise our active participation in the West Lancashire Health and Wellbeing Partnership as a key forum for collaboration around key areas of prevention, at primary, secondary and tertiary levels.
- Collaborate with the prevention workstreams being developed as part of the Sustainability and Transformation Plans, including playing our part in ensuring a step change in patient activation and self care.

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[8] To read more about this go to: [https://files.wordpress.com/2012/02/ref-6-closing-the-gap-finding-the-thousands.pdf](https://files.wordpress.com/2012/02/ref-6-closing-the-gap-finding-the-thousands.pdf)

[9] For more information on Making Every Contact Count please do to: [http://makingeverycontactcount.co.uk/](http://makingeverycontactcount.co.uk/)
We are committed to this work for long term because we are ambitious about turning the dial on premature mortality. We believe this is doable. We know that takes time though and to demonstrate our impact and support our enthusiasm we will look to quantify measures for:

- **Worklessness**: not measured by unemployment alone but considering outcomes relevant for those who are on a journey to become “work ready”.
- **Resilience**: Suggested examples to start the discussion (not exhaustive) would include Connor-Davidson Resilience Scale, the Resilience Scale for Adults and the Brief Resilience Scale[10].
- **Wellbeing**: considering use of health economic tools such as EQ-5D[11] for self-reported measures of health and wellbeing.
- **A narrowing of the prevalence gap**: taking account of the focus on those who are experiencing extreme exclusion, those seldom seen and heard by health and care services who may be living with co-morbidities and undiagnosed conditions.
- **Avoidable health and care costs**: particularly giving consideration to be support around frailty, those with long term conditions, frequent attenders and high intensive service users.
- **Mobilisation of the community around health**.

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**Tertiary Prevention**  
Intensive individual interventions  
Assessment based  
Improving quality of life for those with diagnosed condition(s)

**Secondary Prevention**  
Targeted interventions  
Those identified “at risk” risk profiling – earlier diagnosis  
High efficiency

**Primary Prevention**  
Protecting good health  
System wide interventions  
Popular approach  
Preventative and proactive  
Broad community focus including neighbourhoods

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The group is chaired by escalate requiring improvements, and who have been identified as support decisions about how best to nursing and domiciliary care providers. Have been identified from residential, from a variety of sources where concerns group. The group receives information agency, collaborative information sharing Radar which is a confidential, multi-

In addition we are actively involved with Collaboration which is being delivered with colleagues at Edge Hill University and subjects such as dementia and respiratory have also been covered. This work also supports the recommendations of the Cavendish Review (2013) into Healthcare Assistants and Support Workers in the NHS and Social Care in relation to both nursing homes and practice staff. We have actively engaged with general practice and nursing homes in respect of the newly implemented Nursing & Midwifery Council revalidation requirements.

A web based interactive page has been developed to improve communication and support for the non-medical clinical workforce in primary care. This enables nurses and healthcare assistants to access information such as training, Nursing and Midwifery Council revalidation, meeting notes and a discussion forum. The page is constantly updated and the intention is to formally evaluate its use and impact. The Neighbourhood Learning project, funded by Health Education North West is being delivered jointly between the CCG and the Faculty of Health and Social Care at Edge Hill University. The programme supports the development of the NHS, Social Services, community and voluntary sector workforce to meet the needs of the local population of Skelmersdale, with an emphasis on the delivery of integrated care provision that promotes health and wellbeing. This work is being drawn into the Well Skelmersdale programme.
Collaborative Commissioning Forum Development

Following the Chief Inspector of Hospitals (CQC) inspection of Southport and Ormskirk Hospital NHS Trust in November 2014, (report received May 2015), a Collaborative Commissioning Forum has been established in order to ensure a system wide approach in addressing areas for quality improvement which can then be monitored in one place.

Maternity services received an inadequate rating as a result of the CQC inspection. An extensive action plan is in place that is being monitored and supported by the CCG. A number of additional external reviews of maternity services have also been undertaken following the CQC report the outcomes of which form part of the overarching action plan relating to the Trust.

The development work being undertaken will sit alongside the local Vanguard for maternity services detailed earlier. The intended outcome for the Vanguard proposal is to reduce variation and improve outcomes. Drivers for the Vanguard are:

- Increased demand on services and the presentation of women and babies, children and young people with more complex needs who require more care and support.
- Variation in the experience of people who use the services and also in clinical outcomes of safety and quality.
- Challenges in managing transition between services and level of need and from children to adult focussed services.
- Organisational boundaries that are getting in the way of collaboration to deliver improvements in services and real change.
- Workforce challenges including recruitment, retention, retirement, skill mix and deployment of staff.
- Ability of services to meet regulatory and other clinical standards.
- Financial sustainability.

CQUINs have been developed in partnership with Southport and Formby CCG that will support quality improvement in key areas such as maternity services, living with and beyond cancer and electronic discharge. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers’ income to the achievement of local quality improvement goals.

Patient Experience

West Lancashire Patient Experience Group was established in July 2015 and includes representatives from the CCG’s Quality Team and Communication & Engagement Team as well as from West Lancashire Council for Voluntary Services, HealthWatch and GP practices. This group is responsible for ensuring:

- The public, patients and carers in West Lancashire are heard.
- Patient experience links into and shapes service redesign.
- Effective channels of communication and networks are in place to ensure we can engage with local people on our key priorities and also listen to the priorities emerging from local groups and communities.

Patient experience from issues and complaints, Healthwatch reports, My View, focus groups and other sources will be used to provide assurance in the form of a quarterly report to the Quality & Safety Committee that themes are identified and that any lessons identified are learnt and embedded.

The Clwyd-Hart Review (2013) Putting Patients Back in the Picture looks at how complaints made by patients, their carers and representatives are listened to and acted on by hospitals. The recommendations cover

- Improving quality of care.
- Improving the way complaints are handled.
- Ensuring independence in the complaints procedures.
- Whistleblowing.

The Clwyd-Hart Review emphasises calls made thorough previous reviews for openness, honesty, transparency, culture change and for providing feedback to be made easier; for patient’s carers and relatives to be able to do this on their terms rather than those created by the NHS. We will be monitoring these themes internally and externally for those we commission from.

Safety

We as a CCG have signed up to the Sign up to Safety patient safety campaign which harnesses the commitment of staff across the NHS in England to make care safer. We will monitor our compliance with our agreed pledges and will also promote the principle of the campaign with colleagues including general practice and care homes. Our local Trust has also signed up to this initiative and we will also monitor their compliance.

As a health economy it is vital that we investigate incidents that could cause harm to ensure that lessons identified are learnt and the mitigated incident is not repeated. This CCG promotes an open and honest culture, and is now working much closer with neighbouring CCGs and providers to ensure all serious incidents are managed appropriately. Recurrent themes when they are identified are escalated to the Quality & Safety Committee who request further assurance from the provider.

The CCG fully supports the Trust in developing the Patient Safety Collaborative approach to address key areas of quality and have seen some success in work towards pressure ulcer prevention following this approach.

Safeguarding Adults and Children

We have further invested in our Safeguarding resource to support the growing demands relating to adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards. Through our Safeguarding designated nurses for adults and children we fully support, in partnership with Lancashire County Council, the work of the Children and Adults Safeguarding Boards. The CCG is working to support the local Trust in delivering improved safeguarding standards and continuing professional development relating to safeguarding of adults and children.
Learning Disabilities
Transforming Care

A pan-Lancashire plan, “The Right Track”, was produced in September 2015 and as part of a fast track programme. Following the fast track plan submissions, in October 2015 a national plan “Building the Right Support” was published, which commits to a national reduction in the number of in-patient beds for the Learning Disability and/or Autism population, moving to a model of caring for the majority of this population in homes, not hospitals.

It is recognised that some in-patient facilities will still be required for the population in Lancashire; however a new integrated model has been outlined within the plan. This would be delivered by integrated community teams, offering a core service to all patients from hubs with a regional service providing opportunity to purchase any required additional support to develop individualised packages of care.

Development of community support services will be required to transform care for those with learning disabilities who present challenging behaviour, from a reactionary approach to a proactive and preventative approach. Positive behaviour support services; assessment, treatment and discharge facilities; crisis support teams and respite care are included in the plan, to deliver the required transformation over the next three years.

In addition to transforming the service model for new patients, or those currently cared for in the community, there is also the requirement to transfer as many of the current in-patient cohort as possible into community care packages. In order to achieve the number of discharges case managers will be responsible for ensuring that progress is made at pace, and to commence a discharge plan on admission process for new in-patients going forward. Currently West Lancashire CCG has 3 patients within an in-patient setting who are planned to be discharged into a community setting by the end of 2016/17.

We are working towards development of an integrated health and social care pooled resource arrangement in Lancashire that will enable funding to transfer with the patient. As a starting point a dowry proposal has been developed and work is ongoing to agree a fair and transparent method, to support funding for patients in the future across health and care.
8. Our Enabling Priorities

Communication, Engagement and Participation

Our communication, engagement and participation remains a cross cutting enabler for us that is integral to everything we do.

As a NHS commissioner, from the early days we demonstrated our commitment to involving our stakeholders by defining our strapline “With You, For You”. We understand how the local community feels about their local NHS, and recognise their interest in understanding how public money is used to support their health and wellbeing locally. With that in mind, we ensure we not only listen to the views of those using the health services day to day, but that we also remain transparent about how we are considering their views and importantly, what our current plans and priorities consist of. That is why, despite having no national requirement to do one, each year we produce our strategic plan, share it widely and make it available on our website.

Our community health services re-procurement is an example of how we continue to utilise communication, engagement and participation. Within this process, we have and continue to into the year ahead, involve all of those impacted by this re-procurement, in a number of ways, such as:
- Involvement sessions with incumbent staff (following on from engaging with them about our vision in 14/15).
- Bidder days with third sector and patient/public representation.
- Visioning events with core stakeholders.
- Regular dialogue and decision making with GP practices.
- Frequent stakeholder briefings with the Health Overview & Scrutiny Committee, local authorities and other key partners.
- Visits to local community groups supporting those patients and carers living with long-term conditions.
- Public surveys and patient story forms welcoming views and experiences of using local services.
- Digital presence and updates through local community blogs, social media and CCG/stakeholder websites.
- Production of public facing materials such as Frequently Asked Questions and infographics explaining the process.
- Dedicated web page with regular updates on the process, timeframes and slides/storyboards from events.
- Patient/public events across all localities in west Lancashire.
- Regular coverage in local newspapers and community publications sharing information and welcoming views.
- Hosting events with local CVS to encourage involvement from third sector and other community groups.
- Annual public listening events.
- Updates via our governing body meetings.
- CCG staff procurement Q&A sessions.

Our My View group continues to be the best way to get involved in the CCG. You can sign up online http://www.westlancashireccg.nhs.uk/myview/ or by contacting us directly. There is no obligation to do anything when you join our patient/public group. You will receive a regular bulletin from us with the latest news, event information and surveys. If you tell us what areas of health you are interested in, when specific pieces of work come up on areas of interest to you, we will invite you to become more involved in our work as appropriate.

Our communication channels vary as we understand that everyone receives information in different ways, for example, some people remain predominantly at home, others may have no access to the internet and others may access most health information through their GP practice. We ensure this diversity in terms of communication across our community is recognised and therefore considered and reflected across all of our communication and engagement activity. Therefore, although the CCG remains active on social media and the website remains one core source of information, we also continue to use more traditional ways of communication via the local media and through village magazines and of course through word of mouth. Furthermore, we also work closely with community groups, the third sector and other partners to ensure we are reaching those people who are more isolated and less engaged with their local healthcare.

Information Technology

We have made significant progress against this priority more detail for which can be found in our Information Management and Technology strategy http://www.westlancashireccg.nhs.uk/wp-content/uploads/IMT-Strategy-Refresh-FINAL-14-Dec.pdf

Integrated Care Records

During 2015/16 we have been working hard to deliver our vision for Integrated Care Records. In particular, we have supported the Southport and Ormskirk Hospital NHS Trust with the procurement of a new Community Patient Record. The product selected (EMIS Community) creates the capability for a fully integrated care record across both Primary and Community Care.

For the year ahead we intend to build upon this;
- July 2016, will see the first phase of our Integrated Care Records Project Completed as we will have a fully integrated Primary and Community Care Record in place.
- By May 2016, we will have a business case completed to connect to and share patient data across a range of other providers including hospitals, specialist community services and the Local Authority.
- By the end of 2016 we expect to be electronically sharing patient records across a range of organisations.

Electronic Referral Management

Reducing paper and moving to a fully electronic state for the management of referrals has been one of our priorities. Significant progress has been made in this area by working closely with GPs and provider organisations. Between June and November 2015 we saw the utilisation figures of the E-Referral Service (Choose and Book 2) rise from 71% to 91% and this continues to rise.

During 2016/17, we will continue this on this journey to ensure that we have a fully electronic and efficient referral management process.

We will do this by:
- Continuing to review referral management processes across clinical pathways by working in partnership with our providers.
- Adopting emerging capabilities from the new E-Referrals service and embedding this capability into clinical practice.

Enabling Service Reconfiguration through technology

We have through the last year been developing a number of areas of work where digital and assistive technologies are making a contribution to improving outcomes related to a number of our strategic priorities.

- With the improvements we have made to General Practice IT Infrastructure involving the use of cloud based GP IT Systems and Telephony, we are able to innovate in the way primary care services are delivered in the future including the capability to offer telephone video appointments where this may be appropriate to do so. During 2016/17 we will begin to offer this service as changes are made to the way primary care is delivered.
- We are working with our provider organisations to implement FLO, a simple SMS based telehealth system designed to support patients with long term conditions or to help with health and well-being coaching. By April 2016, FLO will be used to support patients with both heart failure and respiratory conditions. We plan to continue the deployment of FLO to other services throughout the year.
During spring 2016, we will be trialling the capabilities of Rally Round, a technology designed to link carers to individuals requiring support. We are working very closely with the Council for Voluntary Services to ensure this is a success.

We have been working with Southport and Ormskirk NHS Hospitals Trust to redesign musculoskeletal Services. This programme of redesign will also see the introduction of digital technology to support patients to self-management and better understand their condition and will offer prescribed exercises for the patient allowing them and their carer to track progress. This technology will be in place in the spring 2016.

During 2016 we will continue to assess the capabilities of emerging digital technologies and how they could be adopted to improve care and outcomes for a range of conditions. This work will help inform our future digital roadmap for enhancing care delivery.

Local Digital Roadmaps

We will, through 16/17, continue to play our part in the Lancashire and South Cumbria Sustainability and Transformation Plan digital roadmap. Much of our work to date is in line with this development which is focussed on;

- A five year vision for digitally-enabled transformation.
- A capability deployment schedule and trajectory, outlining how professionals will increasingly operate “paper-free at the point of care” over the next three years.
- A delivery plan for a set of universal capabilities, detailing how progress will be made in fully exploiting the existing national digital assets.
- An information sharing approach.
9. Finance

We have received 3% extra funding which equates to an additional £4.3m for 2016/17. However this money has to cover a number of national requirements (including hospital tariff price increases), local budget pressures from the previous year, and estimated growth in patient activity as demand for health and care services increases year on year.

Therefore it is critical that we not only improve quality and outcomes but also achieve greater value for money in everything we do. The following table represents the efficiency savings expected in 2016/17 by improving the quality and productivity of a range of services. The overall target of £3.9m is critical to ensuring the CCG delivers its financial targets over the next 12 months.

For more information go to our financial plan for 2016/17 which can be found at http://www.westlancashireccg.nhs.uk/wp-content/uploads/Agenda-pack-22.03.16.pdf.

<table>
<thead>
<tr>
<th>Transactional Productivity and Contractual Efficiency Savings</th>
<th>Savings (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>570</td>
</tr>
<tr>
<td>Commissioning for Value / Right Care Right Value</td>
<td>265</td>
</tr>
<tr>
<td>Outpatient attendance reductions</td>
<td>165</td>
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<tr>
<td>Estates review</td>
<td>100</td>
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<tr>
<td>Contract coding challenges</td>
<td>375</td>
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<tr>
<td>Packages of care review</td>
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<table>
<thead>
<tr>
<th>Transformational Service Re-design and pathway Changes</th>
<th>Savings (£)</th>
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</thead>
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<tr>
<td>MSK Redesign (including MCAS)</td>
<td>449</td>
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<tr>
<td>Learning Disability discharges to community placements</td>
<td>375</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>Primary Care (Care Homes)</td>
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<tr>
<td>IT Strategy Schemes</td>
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<tr>
<td>Other Non-NHS schemes</td>
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<tr>
<td>Community Gynaecology Service</td>
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<tr>
<td>Community Dermatology Service</td>
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<tr>
<td>Revised Individual Patient Activity System</td>
<td>2350</td>
</tr>
</tbody>
</table>

| Total                                                         | 3,883       |
10. Want to Know More?

If you’d like to know more or feel you could contribute to areas of our work then please do get in touch.

You can do this by:

- Joining My View (our patient/public group) by filling out a form found at http://www.westlancashireccg.nhs.uk/myview/ Please state any particular areas of health that you are interested in.

- Coming along to one of our public listening events which are held across West Lancashire. These are promoted through our website and other local channels but please ask us when the next ones are planned for.

- Emailing us as myview@westlancashireccg.nhs.uk.

We very much look forward to hearing from you.