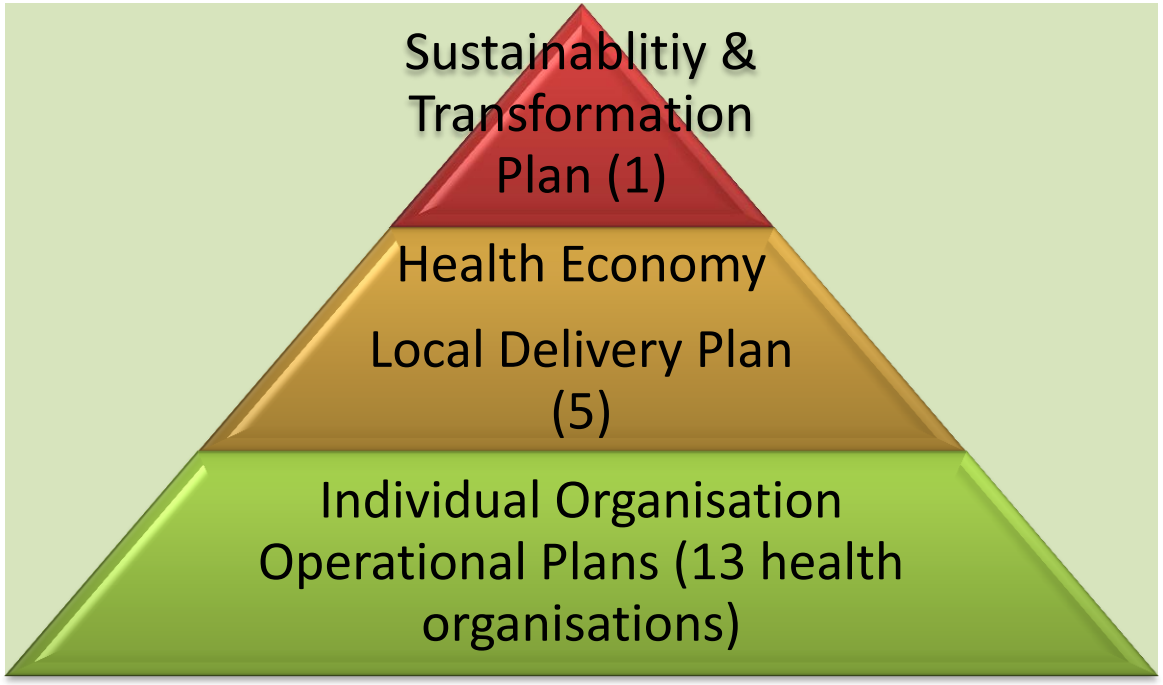
NHS East Lancashire CCG – Operational Plan Narrative – Final

Must Do

STPs

- *Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.*
- *Achieve agreed trajectories against the STP core metrics set for 2017-19.*

NHS East Lancashire CCG operational plan is constructed to deliver our local priorities but is embedded within the aims and objectives of the Pennine Lancashire health and care economy local delivery plan and the Lancashire and South Cumbria Sustainability and Transformation Plan (the STP). The diagram below shows how the plans fit together:-



The Pennine Lancashire Local Delivery Plan is one of five contributing to the overall Lancashire and South Cumbria STP. Over the past two years, commissioners and providers from the NHS, local government and the voluntary sector, have united behind a common purpose of

transforming services across Lancashire and South Cumbria. This has been driven by a shared desire to improve outcomes and experience for citizens, to reduce unwarranted variation in the care received and services accessed, and to respond to increasing pressures on the available resources, be they workforce or financial. This resulted in the initiation of the Healthier Lancashire and South Cumbria Change Programme. The STP which was submitted in October 2016, builds directly on this commitment and collaboration.

All partners have agreed a high level aim for transforming services across the health and care economy and a set of collective priority transformation schemes that will deliver the components of a new system designed to close our identified health and well being; care and quality; and finance and efficiency gaps.

There currently exists three 'gaps' across the STP footprint: a health and well being gap e.g issues relating to alcohol consumption, smoking and poor diet are leading to avoidable long term conditions and emergency admissions to hospital; a care and quality gap e.g. all A&E departments are failing to meet the 4 hour target, cancer survival rates are lower than elsewhere in the country; a finance and efficiency gap - the predicted financial gap across the STP footprint is £572m by 2020/21 but, for example, the Right Care review identified efficiencies totalling £118m across the Lancashire and South Cumbria NHS Commissioners.

The STP priorities are derived from addressing these 'gaps'. For example:

- a greater emphasis on achieving sustainability by accelerating priority initiatives within the local health and care economies e.g. Carter, Right Care
- developing population based care delivery models for e.g Urgent Care
- developing a 'one service approach' to acute services to ensure specialties are delivered at the clinically correct scale
- following a solution design process to deliver the necessary scale of transformational change within the available resource envelope e.g. for Urgent and Emergency Care

The STP sets out ambitious plans to develop a sustainable services platform in respect of developing five local accountable care systems, of which Pennine Lancashire is one, and place based models of care aimed at preventing ill health and reducing the reliance on services provided within acute hospitals. At the same time health outcomes need to be improved but services need to be delivered within the given financial envelope.

Finance
• *Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.* • *Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.* • *Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.* • *Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.*
CCG specific requirements for both 2017/18 and 2018/19 are as follows: • 1% recurrent underspend • 0.5% contingency • 1% non- recurrent spend, of which 0.5% can be committed from the start of the year, the other 0.5% remains un-committed to contribute to the national total risk reserve • Remain within management cost envelope Our main acute provider East Lancashire Hospitals NHS Trust (ELHT) has been set a net control total of £0.8m deficit 2017/18; and £3.6m surplus 2018/19. This is based upon the assumption that ELHT will receive Sustainability Transformation Funding of £11.2m per year from NHS England. The fund will be accessed quarterly in arrears and is dependent upon the Trust evidencing the achievement of the recovery milestones. • Reducing the deficit position • Achievement of the access standards • Progress on transformation The CCG will work with the Trust and NHS Improvement through the planning round to establish a robust, evidence based framework which will be used to prove delivery of these milestones. This framework will also consider the Trust's position in relation to Lord Carter's provider productivity work programme, particularly in those areas where the Trust is considered to be an outlier to the national average performance in each of the metrics.

To support the requirement to return the system to aggregate financial balance for both the STP footprint and Pennine Lancashire Health Economy, the CCG will comply with the business rule in relation to the investment of the 1% recurrent resource, of which we can invest 0.5% non-recurrently.

In conjunction with that, the CCG will be using the Right Care programme and other evidence sources, such as the Atlas of Variation and Programme Budgeting, to identify and deliver savings through tackling unwarranted variation.

We understand that delivering a sustainable NHS for future generations is a core purpose of our role as a CCG. The settlement of 2% growth (i.e. approximately £10m per annum) in 2017/18 and 2018/19 is welcomed; however, there are many financial pressures that need to be managed. The CCG will need to deliver a QIPP plan (savings) of circa £14.6m 2017/18 and £9m in 2018/19. The economy as a whole is financially challenged; therefore there will need to be close alliance with our partners to deliver financial efficiencies and savings with a goal of financial balance for all organisations in the economy.

The notified allocation for East Lancashire CCG for 2017/18 & 2018/19 is £595m and £607m respectively. (Inclusive of the Better Care Fund and Running Cost allocations). This places the CCG as the fourth largest commissioning organisation in the North of England. However, when compared against the calculated target allocation based on the revised funding formula for the programme element of the allocation, the CCG is over target by 2.9% and 3.1% respectively which equates to circa £20m

Key planning assumptions from the NHS Operational Planning and Contracting Guidance 2017-2019 have been reflected in the financial planning templates which are submitted alongside the operational plan.

Financial Sustainability

	£'m
Return of the 2016/2017 Surplus	(13.164)
2017/2018 Planned surplus	7.484
0.5% Contingency	3.043
1.0% to be held for transformation	5.873

Operational Investment must do's

- Increase expenditure within Mental Health that equates to 2% uplift on current year expenditure.
- Invest £3 per head of population in Primary Care over the next two years.

Contract Position

To support the STP process and embed the 'financial reset', the annual NHS planning and contracting round has been streamlined. The default

position is that provider's and commissioner will negotiate and agree two year contracts for 2017/18 and 2018/19.

Contract discussions are progressing with East Lancashire Hospitals NHS Trust for which this CCG is the host commissioner. .

The CCG is also reviewing with East Lancashire Hospitals the different contracting mechanisms available to ensure the final contract is reflective and supports transformation of acute and community services. The focus of these discussions will be agreed actions to identify and implement key schemes (incl. Right Care and Carter review) that will provide financial sustainability across the system.

Running Cost Allowance
The CCGs running cost allowance has reduced slightly to £7.809m which equates to £20.78 per head of population. It is anticipated that the running cost allowance will continue to reduce at about £30k per annum to 2020/21.

Primary Care

- *Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.*
- *Ensure local investment meets or exceeds minimum required levels.*
- *Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of IAPT in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.*
- *By no later than March 2019, extend and improve access in line with requirements for new national funding.*
- *Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.*

The vision for East Lancashire CCG is for high quality sustainable Primary Care Services at the heart of an integrated health and social care system.

In the next two years the CCG will focus on implementing the local aspects of the GP Forward View in order to strengthen General Practice in the short term and support sustainable transformation in the future.

In addition the CCG will work in close collaboration with colleagues at NHSE Lancashire, Health Education England and the CQC to support local adoption and implementation of actions set out in the GP Forward View.

CCG plans include but are not limited to:

- **Improving Access to General Practice Services**

  The CCG will work with GP Federations locally to develop a detailed service delivery model that builds upon wok already undertaken in localities and takes account of the feedback received as part of the formal consultation including details of how the model will vary by locality to meet the needs of the population while ensuring a consistent and sustainable approach across East Lancashire

  Model and Timing

  The CCGs proposal is for Locality Health Hubs in four of the five East Lancs localities that will provide bookable access to GP services between 16:00 and 20:00 hours Monday to Friday and between 9.00 and 13.00 on a Saturday.

  Two of these Locality Health Hubs will also be available from 10:00 and 18:00 hours on a Saturday and Sunday.

  At present the function of a hub(s) is to provide extended routine and urgent access to GP services until 8pm on weekdays, routine access to GP services 9.00 – 13.00 on a Saturday and urgent access to GP services 10.00 – 18.00 on Saturdays and Sundays.

  It is envisaged that over time the Locality Health Hubs will evolve to provide more integrated services within each locality in line with the CCGs wider new models strategy including supporting the development of MCPs

- **Sustainability and Transformation**

  Transformational Support

  The CCG will invest in General Practice with a view to stimulating:

  - The development of 'at scale' providers for improved access and
  - The implementation of the 10 high impact changes to free up GP time and secure the sustainability of General Practice.

  The CCG will support GP Practices, Federations and Providers to work together across neighbourhoods, localities and East Lancs as a whole with a view to developing an at scale provider capable of delivering a new model of extended access to primary care including developing the necessary infrastructure and capacity to deliver the service.

  The CCG will identify time for care champions to spread awareness of the high impact changes and support GP Practices and Federations at locality level to participate in the time for care programme.

  Online Consultations

  The CCG will deliver the online General Practice consultation software system in line with the service specification outlined.

Care Navigation
The CCG will work with West Wakefield Health and Wellbeing to develop and implement a Care Navigation Service across East Lancashire that will support the New Model of Access to Primary Care by providing quality information to patients about the services available enabling patients to make good choices about how and when to access services and to support self-care where possible.

General Practice Resilience Programme
Working with the primary care transformation team, the LMC and STP clinical leads and applying both national criteria supplemented with local CCG intelligence East Lancashire CCG has identified 16 GP Practices as eligible for resilience support.

The CCG felt strongly that the available resilience funding should be used where possible to support groups of practices working collaboratively and as a result advised that the funding allocated for one practice can be used to support resilience across a neighbourhood or locality.

The CCG will continue to work with the transformation team and the LMC to maximise uptake across East Lancashire with a view to creating a stronger more resilient primary care system which in turn will support the sustainable transformation required to deliver primary care at scale.

Workforce
The CCG will continue to work in close collaboration with HEE, The Lancashire Transformation Team, GP Practices locally and the LMC to develop, fund and implement local workforce plans in line with the GPFV and that support delivery of STPs including:

- Develop the capacity of the Primary Care workforce by:
  - Working with GP practices and HENW to ensure appropriate completion of the workforce data collection tool as a baseline assessment of current workforce and workload demands and the use of the data to support sustainable workforce development in areas of most need.
  - Exploring the opportunities afforded by new and developing primary care roles and new ways of working including the development of multi-disciplinary teams and primary care at scale.
  - Working in close collaboration with ELHT and HEE to maximise the effectiveness of the GP Training programme locally including interim milestones that contribute towards increasing the number of doctors working in general practice
  - Exploring available funding streams to support increased capacity including clinical pharmacists and the expansion of IAPT in General Practice.
  - Ensuring effective links with other local project groups including the Primary Care Transformation and Quality Assurance Groups
  - Supporting initiatives to attract, recruit and retain GPs and other clinical staff including locally designed and nationally

available initiatives
- Facilitating an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets

- Develop the capability of the Primary care workforce by:
  - Ensuring GPs are operating at the top of their license, for example through use of clinical pharmacists in a community setting and upskilling other health care professionals to manage less complex health problems;
  - Supporting primary care forums and networks
  - Supporting protected learning times
  - Working with HENW to maximise uptake of the modules available on CPD Apply
  - Managing the CPD Flexible cash allocation from HEE
  - Supporting research

- Developing a sustainable primary care workforce by:
  - Increasing the number of learning environments suitable of for all grades of staff clinical and non-clinical

In addition to tackling capacity, demand and sustainability of the primary care workforce directly, the CCG has introduced a number of innovations that have and will continue to support primary care. Most notable of these has been the development of our prescription for Wellbeing, social prescribing programme. Since 2015/16 we have invested in a Prescription for Wellbeing (Social Prescribing) Small Grants Programme, managed by Burnley Pendle and Rossendale Council for Voluntary Services (BPRCVS), working in partnership with Hyndburn and Ribble Valley Council for Voluntary Services (HRVCVS). The Prescription for Wellbeing approach offers a vision for health services in which we recognise and support the community assets such as family, friends, communities and peer networks that can work alongside each other to support patients to live well.

This approach complements the medical care and treatment that the CCG already commissions, whether this is hospital treatment, GP care, community health services or health promotion. GPs can refer patients with social, emotional or practical needs to a range of local, non-clinical services provided by the voluntary, community and faith (VCFS) sector. These services can include everything from debt counselling, support groups and walking clubs, to community cooking classes and one-to-one peer mentoring. The CCG will continue with the Prescription for Wellbeing scheme in 2017/18, supporting the community, faith and voluntary sector organisations, and drawing on the successes and lessons learned to date. Going forward into the next financial year, it is proposed that the framework is revised to meet specific locality needs whilst continuing to grow and support the grassroots organisations.

Workload

In 2016/17 the CCG introduced a single Quality Framework for General Practice. Phase 1 of the framework launched in April 2016 brought together a number of existing schemes while Phase 2 introduced in July 2016 introduced new investment and quality

improvement initiatives with the aim of:

- Consolidation of existing schemes
- Increasing investment in General Practice
- Reducing the administrative burden on both Practices and CCG
- Sharing of best practice and effective methodologies across the CCG
- Reducing unwarranted variation and improve health outcomes
- Supporting the wider primary care transformation agenda
- Building on essential standards required of GMS Contract, QOF and CQC

A key focus of the Quality Framework for General Practice in East Lancashire is to:

- Identify unwarranted variation, where it exists, understanding the causes of variation and to focus on delivery of improved outcomes
- Support new models of care and new ways of working to respond to this variation

Practice Infrastructure

The CCGs estates investment into Primary Care estate will be aligned to its Primary Care Strategy. The CCG will be looking to increase capacity in Primary Care, improve quality and promote the development of GP Federations and cross-practice working. There will be the need for investment in Primary Care, improvements to the existing Primary Care estate and the provision of opportunities for the development of Federations (this is likely to involve providing flexible space across the portfolio to allow Federations to work outside of their demised practice areas).

NHS England's Estates and Technology Transformation Fund (ETTF) offers the opportunity to bid for funding to allow for increasing capacity and improving quality within primary care. Moving forward, there may be efficiencies identified across the primary care estates, or ways to use the available resource more effectively.

In this respect, the CCG are supporting the taking forward of 2 bids as part of the Estates and Technology Transformation Fund. Through the development of the Strategic Estates Plan, the CCG have identified that investment into community estates provision is required in Barnoldswick and discussions are underway with local partners for options to re-provide the current facility in a new primary and community health facility. In addition the CCG have identified a potential for reconfiguration of the ground floor of Accrington Acorn Health Centre to amalgamate three existing GP premises from the Hyndburn Locality into one central building. The works will enable the GP practice to utilise 12 consulting rooms and the development will promote the increased utilisation of the core estate.

The CCG is engaging with GP members through forums and networks to understand what is important to them. This will then inform the CCG detailed GPFV Plan and Primary Care Strategy going forward.

Pharmacy First Minor Ailments Scheme

The CCG has rolled out the Pharmacy First Minor Ailments Scheme across all localities in East Lancashire which enables patients to access expert advice from their local community pharmacist and receive medication where appropriate free of charge. Uptake of the service has demonstrated avoidance of significant numbers of GP appointments and reduced pressure in primary care and secondary care, including urgent care services. The CCG plans to extend the service to include additional ailments through use of the Patient Group Directive's (PGDs) along with potential inclusion of treatments to manage episodes of care. A respiratory medicines usage review Plus (MUR) service is currently being evaluated, with the potential roll out, dependant on results.

Urgent and Emergency Care

- *Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.*
- *By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.*
- *Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.*
- *Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.*
- *Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.*

A key priority within Pennine Lancashire operational plan is to support the system to restore A&E performance to 95%. Nationally five key initiatives have been mandated, which are proven and effective good practice that can help improve performance, patient safety and reduce waste. The system wide A&E Recovery Plan which is overseen by the Pennine Lancashire A&E Delivery Board, includes three of the five mandated areas (streaming, flow and discharge). The other two initiatives are commissioned on a northwest footprint (111 and 999) and therefore accountability for delivery of these initiatives is with the northwest Strategic Partnership Board. The Pennine Lancashire system has undertaken a stocktake and gap analysis and the 2017/18 plan will focus on ensuring implementation addressing gaps and ensuring consistent and robust implementation.

The recovery plan focuses on short and medium term plans. Whilst these schemes will support recovery of the standard, it is recognised that there are strategic developments required to ensure that the Pennine Lancashire system remains able to sustain a recovered position. The strategic changes required are supported by the national Urgent and Emergency Care Review which has the following vision:

- Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.
- Secondly, for those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.

The plans outlined below reflect these short, medium and longer term requirements.

A&E Rapid Improvement Areas

The table below outlines the three key initiatives within the system plan that are underway to recovery A&E performance. These are system recovery schemes and the CCG is working in partnership with providers to ensure full implementation:

Plans for delivering ED streaming	• Improved productivity in UCCs including Primary Care streaming, triage and coordination • Review of staffing model to build on existing good practice which includes provision of pharmacy (currently at RBH UCC) and physiotherapy (at RBH and BCH UCC) within UCCs • Speciality in-reach to ED and ambulatory care to support streaming and appropriate admission • 24/7 Mental Health Liaison service in place and Royal College review is planned before the end of 2016 to review the model including service capacity. Pennine Lancashire 12 hour breach SOP in place which includes specific guidance on MH related breaches. • Reduced overcrowding in ED through review of Ambulatory Emergency Care, including considering feasibility of CDU type capacity.
Patient Flow	• Implementation of the 'model ward' which incorporates the SAFER principles which includes clinical criteria for discharge (CCDs), expected date of discharge (EDD), ward round checklist and internal professional standards. Full roll out being scheduled for late 2016, early 2017. • Review of clinical flow and standardisation of systems and processes • Maximising impact of discharge lounge • Roll out of Red/Green day work • Roll out of progress chaser model to support simple discharges
Discharge	• Maximising the impact of existing Integrated Discharge Service which micro-manages the complex discharge caseload. • Progression of the DToC improvement work programme (as per national programme) • Collaborative planning taking place to ensure safe appropriate discharge pathways including discharge home through reablement and crisis, intermediate care and intensive home support • Embed Trusted Assessment documentation • Implementation of a Discharge to Assess pathway to ensure that long term decisions are taken outside of the acute setting (particularly targeting a reduction in CHC triggers within and acute setting and delays around home of choice). • Implementation of regular MDTs across the whole discharge and Intermediate care pathway to ensure that whole system flow is addressed.

Accessing the Urgent & Emergency Care system

The NHS 111 service is critical to ensuring that individuals with urgent care needs get the right advice in the right place, first time and this has been supported by the publication of the NHS 111 Commissioning Standards and further guidance regarding the establishment of a virtual integrated clinical hub. In Pennine Lancashire it is recognised that many patients looking to access urgent healthcare will require a range of services, but most commonly this will be urgent primary care support rather than the services of an Emergency department (both in and out of hours) and there is therefore a key interdependency between the urgent care and primary care transformation programmes. However, for those patients who are unable to access their own GP – because the practice is closed or they are away from home for example, or who are unclear of the right pathway they should follow, NHS 111 should become a prime route into urgent care services. This free to use number is available across England, 24 hours a day, 365 days a year with call volumes now exceeding 1 million per month. The vision set out in the Urgent and Emergency Care Review is for NHS 111 to provide the public with a single entry point to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership. The development of virtual clinical advice is critical to ensuring that patients have access to relevant clinical triage from 111 where appropriate and are streamed into the correct service or can have their health care episode completed through that clinical consultation.

Development of a local clinical hub will provide one single point of access for Pennine Lancashire and it is anticipated that direct access into this clinical hub would be available to 111, paramedics, GPs and other healthcare professionals supporting deflection from ambulance disposition, conveyance and hospital admission. The navigational element to this development will also potentially support step-down from the hospital. The clinical hub will include advice, navigation and care co-ordination functions. The Pennine Lancashire elements of a clinical hub will dovetail with work being undertaken on a northwest and Lancashire footprint, which is seeing elements of the services within the hub being delivered across these larger footprints. In Pennine Lancashire work has commenced in 2016/17 and will be further developed throughout 2017/18 to define the elements of clinical hub services which can be best delivered on a Pennine Lancashire footprint. Current discussions are taking place with the NW team and local providers around testing all relevant calls from Care Homes into the Airedale vanguard and Primary care dispositions through the Clinical advice function aligned to the pathfinder service in Pennine Lancashire.

Urgent and Emergency Care Centres

In Pennine Lancashire there is one A&E department (at the Royal Blackburn Hospital site), two Urgent Care Centres (one each at the Royal Blackburn Hospital and the Burnley General Hospital) and two Minor Injury Units (one at Accrington Victoria Hospital and one at Rossendale). The Urgent and Emergency Review offers the following national vision in relation to urgent care centres 'Urgent care centres are community and primary services offering consistent access to the full range of urgent care services.' In this context the review clarifies that Urgent Care Centres are community and primary care facilities providing access to urgent care for a local population. They encompass Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 A&E Departments". The review of the provision of walk-in facilities has commenced in 2016/17 and this review will lead to a public consultation in 2017/18.

Discharge to Assess

The health and social care system is working towards a consistent discharge to assess model across Pennine Lancashire; currently the model is partially implemented across Blackburn with Darwen and East Lancashire through early supported discharge services and some funding without prejudice decisions for those who trigger CHC. Further work is ongoing with social care partners and providers to ensure that no patients are taking decisions around future needs following an acute episode prior to full recovery and integrated assessment around ongoing needs within an appropriate setting. This objective will be achieved by delivering additional Intermediate care and Reablement capacity through increased investment in MDT assessment activity across the whole pathway driving decreases in length of stay across all Intermediate care settings (Community Hospitals, Intermediate care and Reablement). This will be enhanced by further investment in the Intermediate care bed base and Reablement/Crisis home care provision utilising a new Discharge to Assess service specification which will expand the access into these services. 2016/17 Winter resilience is being used to pump prime this approach with the plan to roll this out permanently through 17/18.

The Trusted Assessment documentation and processes have been agreed with the final version being tested across the health and social care economy this winter.

Locally much work has been done to pull together all relevant providers to develop and agree a consistent policy around patient choice at discharge. The Acute Provider has implemented the nationally released 'quick guide' and patient information leaflets with the local authorities supporting this; final sign-off of the suggested policy remains outstanding however work continues around this and it is anticipated that a system-wide policy will be in place by 17/18.

Health and Social Care Economy Capacity Planning and Escalation Plan

The Safer, Faster, Better document (August 2015) highlights that year round capacity planning and escalation plans are essential for all health care organisations. Local integrated health and social care escalation plans need to clearly define trigger levels for escalation across all organisations and linkages between the escalation plans of partners across the local health community are important, so that mutual support is achieved at times of stress.

In 2016/17 the Pennine Lancashire Health and Social care economy has developed a solid Health and Social Care Economy Escalation Plan. This will form the basis of a continuous cycle of capacity and escalation planning which will aim to ensure the position across Pennine Lancashire remains resilient during periods of increased demand. The Urgent Care Transformation Programme will review these escalation plans to ensure alignment with the recent Operational Escalation Pressure Framework and will continue to build on work already undertaken to monitor, measure and respond to system wide pressures.

Delivery of 75% target for ambulance trusts to respond to Category A calls within eight minutes

The re-design of the Urgent care system through the above actions outlined as part of the Urgent care review is designed to support the reduction of conveyance to our single ED department at the Royal Blackburn Hospital site. Establishing a new structure of Urgent care centres and access points across Pennine Lancashire, improving hear and treat and see and treat models is fundamental through 2017/18 in shifting the performance in these parts of our geography.

Paramedic at Home

The Urgent and Emergency Care Review highlights that research demonstrates that only a small percentage of ambulance conveyances are the result of serious life-threatening illness and injury, requiring treatment at a specialist emergency centre. The remainder of cases are "urgent care", and whilst care needs are urgent, they could be better managed in a care setting which is more appropriate to the patients' needs.

The publication 'Improving referral pathways between urgent and emergency services in England' (November 2015) provides guidance which proposes a number of pathways as an alternative to the current default conveyance to Accident and Emergency (A&E).
This guidance will support a review of existing pathways and opportunities in Pennine Lancashire in 2016/17. This review will be separated into two elements:

- Clinical models to support an increase in the proportion of calls to 999 dealt with via 'see and treat'
- Referral pathways between paramedics and other providers

This review will build on existing work areas which include:

- Locally Ambulance Liaison Officers (ALOs) have been employed to give full time cover, seven days a week within ED to help smooth handovers. Additionally there are imminent plans to implement a rapid handover system within the department which again will help speed up handover processes.

  A vital part of supporting NWAS in their ability to keep people at home is having suitable services in the community that are responsive and able to accept clinically appropriate patients. Work has progressed in 2016/17 to implement a consistent in-hours amber pathfinder response across Pennine Lancashire on a 24/7 basis. This work will be further developed in 2017/18 by the implementation of an enhanced pathfinder, which can accept an expanded range of clinical conditions.

  Falls are a major reason that NWAS receive emergency calls. NWAS data shows that approximately 70% of these patients are then conveyed to hospital with a substantial number of these then being admitted to a ward. Developed early in 2015 a joint initiative between the OT service and NWAS is the Falls Response Service (FRS). This pilot scheme picks up emergency calls from ambulance control and responds quickly to someone who has fallen. Following a full assessment, utilising their joint skills and accessing relevant community services the FRS services is able to reduce conveyance rates down to about 23%. In 2016/17 work has been undertaken to expand this service to a 7 day offer and in 2017/18 it is proposed that this service be reviewed with a view to expanding the scope to include both falls and frailty. On a Lancashire wide basis, work is also taking place to develop a falls pickup service connected to telecare provision, it is anticipated that this will roll out in 2017/18.

Referral to Treatment Times
• *Deliver the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment.* • *Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.* • *Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.* • *Implement the national maternity services review, Better Births, through local maternity systems.*
EL CCG will continue to implement schemes that will ensure the health economy will improve and meet the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice and that this is sustainable to meet the increasing demand. This will include an emphasis on systematically managing demand and performance of acute scheduled care activity; utilising evidence based initiatives, Right Care, peer review and education to improve the quality of referrals, reduce follow-ups and reduce variation. During 2017/18 the CCG will continue to implement sustainable and innovative improvements within scheduled care by taking on the challenge of streamlining pathways and transformational change, developing new models of service delivery or alternative options of care. This will be informed by demand and capacity modelling, local intelligence, national guidance and benchmarking with an aim to increasing access for patients, improving quality and reducing unnecessary demand on hospital services; ultimately ensuring sustainable and affordable services for our population that meet the NHS Constitution standards. There is 100% utilisation of choose and book in primary care at which point choice will be given to patients. There are also some pathways where there is single point of access and triage of referrals, however, further work is required and ongoing to ensure these specific pathways are 100% compliant with the e-referral target. Pathways include patient choice when a decision has taken place that referral on to a secondary care provider is clinically appropriate. It is recognised that close monitoring and timely interventions will be required to facilitate high performance and that the sustained achievement of RTT is challenging in the context of current pressures within the healthcare system. There is strong collaborative working with ELHT as our main provided and links have been made with other key providers through respective lead commissioners and the STP to support the achievement of these standards for our patients. Through robust monitoring of our plans and continued joint working with our patients, providers and other key stakeholders, it is our objective that we will continue to achieve a sustained improvement in patient experience and the quality services within Pennine Lancashire.

Cancer
• *Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.* • *Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.* • *Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.* • *Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.* • *Ensure all elements of the Recovery Package are commissioned, including ensuring that:* • *all patients have a holistic needs assessment and care plan at the point of diagnosis;* • *a treatment summary is sent to the patient's GP at the end of treatment; and* • *a cancer care review is completed by the GP within six months of a cancer diagnosis.*
The vision and direction of travel for cancer services as a whole is focused on early diagnosis, improving outcomes and improving patient experience. East Lancashire CCG and Blackburn with Darwen CCG have developed a strategic framework for the delivery of cancer services across Pennine Lancashire. This will drive up quality and improve outcomes – aiming to improve one year survival, reduce health inequalities and improve patient experience, while at the same time delivering patient-centred cancer services. Achievement of National Cancer Waiting Time (CWT) standards, Cancer Clinical Priorities within the CCG Improvement and Assessment Framework (IAF) 2016/2017 and NHS Constitution measures, are considered by patients and the public to be indicators of the quality of cancer diagnosis, treatment and care which NHS organisations deliver. Strategies to support delivery and achievement of the above outcomes include: • Strong clinical leadership across primary and secondary care • Structures are in place to manage the development, delivery, quality and performance of cancer services • Engagement and collaboration with Sustainability Transformation Programme (STP) and the North West Coast Cancer Alliance. • Engagement with primary care to ensure quality, standardised referrals. In addition there will be a continued focus on early diagnosis, reduced emergency presentations, supported self-management and cancer care reviews. This is underpinned by education for GPs and practices nurses, promoting shared learning. • A Pennine Lancashire Cancer Plan has been developed in collaboration with providers to provide assurance against the delivery of cancer targets and the wider national agenda. This is updated on a monthly basis and monitored through the Cancer Tactical Group. This plan has been expanded to incorporate required actions to ensure delivery of the '96 recommendations of the Independent Taskforce, by 2020.' • A phased and ongoing implementation of NICE Clinical Guidelines on Suspected Cancer 2015

- In collaboration with providers, a Health Economy 5 year demand model has been developed, quantifying current and projected demand for assessment and diagnostic services for cancer, required across Pennine Lancashire, at pathway and test level. This will support commissioners and providers in planning for increased suspected cancer referrals and diagnostic demand, as a result of the national drive towards earlier diagnosis. It also highlights the likely activity and cost implications of possible demand shifts. It has been recognised that additional diagnostic capacity is required and this is a key element of the ongoing planning process. It should be noted that the greatest risk to delivery of the plan is the potential shortfall in the current available diagnostic capacity. The areas highlighted include radiology, endoscopy and pathology. Estimating and understanding the expected increase in demand on services clearly provides a challenge for both commissioners and providers of cancer services. As such, it will require continued collaborative working across Pennine Lancashire, extending to the wider Lancashire footprint as and when required, to achieve the quality standards and targets set out in the above documents, incorporating the principles of shared vision and service development, along with sharing of good practice and 'lessons learnt'

- ELHT, supported by the two Pennine CCGs, has been successful in becoming one of five national pilot sites for the 'Faster Diagnosis Standard Test Site Project', focusing on the lung and upper GI pathways. In addition, a bid from ELHT, supported by the CCGs to the Diagnostics Capacity Fund has been submitted. Both these bids will support redesign of pathways to facilitate achievement of the 28 day standard and also to increase capacity to support faster access to, and reporting of, diagnostics.

- Breach analysis of the 62 day standard continues on a monthly basis with a focus on near misses and day 104+ breaches across all tumour sites, including root cause analysis and clinical harm review via a defined governance process.

- Cancer Pathway redesign including: Haematology, Lower GI, Upper GI, Lung, Urology and Gynaecology is ongoing. In addition to the above redesign, stratified follow up, and supported self-management of breast patients has been implemented with a view to rolling out this model to prostate and colorectal patients

  The above referral pathway redesign will speed up the process from referral to diagnosis in line with Nice Referral Guidance and the direction of travel outlined in the document 'Achieving World Class Cancer Outcomes 2015 -2016'. The above 'survivorship' pathway redesign moves towards a supported self-management model, improving patient experience and reducing demand on secondary care, with a more effective use of their resources which will be required to meet the projected increasing demand as a result of the NICE Cancer Referral Guidance. All the above work is being undertaken in collaboration with ELHT and has involved Secondary Care Clinicians, GPs, Trust Managers, CCGs and patients.

- The Recovery Package is currently being implemented across all tumour sites in ELHT. This includes Holistic Needs Assessments, Care Plans, Cancer Care Reviews, Treatment Summaries sent to GP at the end of treatment and Health and Wellbeing Clinics. These elements form part of an overall support and self-management package for people affected by cancer with the aim of improving support and the quality of life of people living with and beyond cancer. The Macmillan Cancer Improvement Partnership is working

collaboratively across Pennine Lancashire, focusing on new models of follow up for cancer patients and also community based services to provide information, support (Macmillan Solutions) and health and wellbeing services (Move More Programme) to cancer patients to enable a supported self-management approach to their longer term care.

- Patient engagement throughout the cancer pathway is key to ensuring diagnosis and treatment is carried out in line with national, recommended standards. Analysis of why the required standards are, in some cases, not met has highlighted that 'patient choice' is one of the many contributory factors to delays. A patient and public awareness/engagement project group has been established to implement and evaluate a variety of interventions throughout the pathway to improve patient awareness and engagement and also to involve patients/carers at every opportunity in future service development. The intention is also to develop a wider Patient Engagement Strategy focusing on improved patient experience.

From the above it is evident that close monitoring and timely interventions will be required to facilitate achievement of the above and that the sustained achievement of above standards is challenging in the context of current pressures within the healthcare system. There is strong collaborative working with ELHT and links have been made with other providers through respective lead commissioners, STP, Cancer Alliance to influence and support the achievement of these standards for the patients in Pennine Lancashire. Through robust monitoring of our plans and continued joint working with our patients, providers and other key stakeholders, it is our aspiration that we will continue to achieve a sustained improvement in patient experience and the quality of cancer services within Pennine Lancashire.

Mental Health

- *Deliver in full the implementation plan for the mental health Five Year Forward View for all ages, including:*
  - *Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;*
  - *More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;*
  - *Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.*
  - *Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline.*
  - *Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases.*
  - *Reduce suicide rates by 10% against the 2016/17 baseline.*
- *Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.*
- *Increase baseline spend on mental health to deliver the Mental Health Investment Standard.*
- *Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS*

implementation guidance on dementia focusing on post-diagnostic care and support.

- *Eliminate out of area placements for non-specialist acute care by 2020/21.*

Commissioners are working to implement the 5 year forward view recommendations locally via the Pennine Lancs Transformation programme and also are actively engaged with the Lancashire wide Sustainability and Transformation Plan (STP). All activity is focussed on the strategic direction for mental health to ensure compliance and best prospects for East Lancs CCG to meet local and national objectives and targets.

The LCFT Early Intervention Service has been a demonstration site for this new national target and as a consequence the service is meeting the referral to treatment 2 week target currently at 96%.

The Improving Access to Psychological Therapies (IAPT) prevalence target has been met collectively in East Lancs through services commissioned from Lancashire Care Foundation Trust (LCFT) Mindmatters and the voluntary sector-led Community Wellbeing Service (LWC).

Pennine Lancs CCGs (East Lancs and Blackburn with Darwen) have been successful in a national bid to host an IAPT Long Term Conditions pilot the aim being twofold

i) To redesign the current model and align mental health services within primary care and community services
ii) To assist in the 20/21 target increase from 15% prevalence met to 25%

The pilot has commenced and in the first year patients identified with CoPD will be targeted. We already have IAPT psychological wellbeing practitioners (PWP) based in GP surgeries. The objective here is following diagnosis access to a PWP will be seamless and non-stigmatising as the referral will not necessarily be purposely into a 'mental health' service. In the second year other long terms conditions will be included in the pilot such as diabetes.

The East Lancs Dementia local enhanced service for 16/17 will sit with in the Primary Care Quality Framework. A three month patient review is built into the service delivery which will improve support for those with a diagnosis and their carers.

The average wait is currently 8.6 weeks to be seen and the average Referral to Diagnosis is currently 24.3.

The Memory Assessment Service (MAS) is undergoing a service redesign across Pennine Lancashire.

The aim is to reduce waiting times, so that the referral pathway is seamless. Further education is taking place with GP practices in pre-referral information to reduce the number of referrals that should be sent elsewhere.

Skill mix is being reviewed, to allow nurses to use a consultancy model more consistently throughout LCFT. This will result in:

a) A reduction from referral to diagnosis;
b) A more efficient way of harnessing nursing capability;

c) A freeing up of consultants for more complex cases and;
d) A more timely, individualised response for the person.

Commissioners attend the monthly Lancashire wide, Performance Improvement Sub-Group meeting which oversees the 3 target areas as above. LCFT provide performance activity reports for the meeting and there is opportunity for commissioners to scrutinise and keep close to the development of the services so that any foreseeable issues can be mitigated.

Based on programme budgeting data the CCG is already investing above the national average on mental health services. We do however, need to understand how this level of investment is impacting on patient outcomes and direct new investment to those services which can help improve those outcomes. We are also mindful of the impact of recommissioning of services by Lancashire County Council and the effects that may have on services in particular lower level mental health services aimed at support and prevention.

Within the CCG baseline, the CAMHS transformation fund is now recurrent. For EL CCG, this equates to £700k and this will form part of the increased investment in mental health services.

CCG colleagues will be working with specialised commissioning colleagues to improve service efficiency in tertiary mental health services. To that end, the CCG will be supporting Lancashire Care Foundation Trust (LCFT) in its expression of interest in the new model of care for secondary care providers to manage the care budgets for tertiary mental health services.

People with Learning Disabilities

- *Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.*
- *Reduce inpatient bed capacity by March 2019 to 10-15 CCG-commissioned beds per million population, and 20-25 NHS England-commissioned beds per million population.*
- *Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.*
- *Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.*

A Pan-Lancashire plan, 'The Right Track', was produced in September 2015 as part of the national "fast track" programme. The Lancashire Collaborative Commissioning Board has established a steering group to direct the development and implementation of the plan.

Following the fast track plan submission in October, 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 care 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 remains the focus 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 two years.

This work across Lancashire continues to be led by a transformation programme management office team implementing the plan signed off by Lancashire Health and Wellbeing Boards and CCG Governing Bodies. The work is being driven by the Steering Group and progressed operationally by sub-groups and a commissioner's network. A confirm and challenge group has been established to ensure co-production of the work programmes is achieved throughout.

We are working towards development of an integrated health and 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.

The acquisition of Calderstones Partnership NHS Foundation Trust by Mersey Care NHS Foundation Trust was completed on 1 July 2016. The CCG, as lead commissioner for non-secure services delivered the necessary actions to meet the contractual governance requirements and continues to be lead commissioner for this service.

A consultation on the re-provision of beds on this site is expected to be launched in the near future by NHS England.

On an individual patient level, the CCG continues to work with individuals and their carers to support the discharge of long stay hospital patients and to prevent unnecessary hospital admissions for those with learning disability or autism through the Care Treatment and Review process. At 31 October 2016 there remain 18 patients who are in hospital and were inpatients on 1 April 2014. Robust support and processes are in place to expedite discharges where appropriate. Of patients discharge there is currently no reported incidence of re-admission.

The CCG has also worked closely with Lancashire County Council to develop a contractual framework for providers of supported living.

Improving Organisations
• *All organisations should implement plans to improve quality of care, particularly for organisations in special measures.* • *Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.* • *Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.*
The CCG continue to work to ensure the delivery of safe, personalised and effective care to all within East Lancashire. This can be demonstrated through the publication of the ELCCG Quality Strategy 2016 – 21 which sets out the approach to quality in the commissioning and monitoring of services. It builds on the work from the first 3 years as a CCG. The CCG has been at the forefront of developing robust quality assurance mechanisms across the health and care economy, building on experience from being involved in the Keogh Review process. The CCG and its partners have made significant progress over this time and now needs to develop and protect high quality services in an ever increasingly challenging environment. The strategy forms the blueprint for the quality team in how the CCG will commission and monitor services whilst describing the various mechanisms that are in place to assure quality. We have developed jointly, achievable and appropriate CQUIN and Quality schedules with providers taking into account CCG and health economy priorities and areas that require a whole system approach to quality improvement. The challenging targets are set to promote a culture of quality and safety and ensuring that there is a focus on reducing avoidable harm and improving quality of care. ELCCG actively manages the CQUIN & Quality Schedule within the contract with its providers, and for those organisations for which ELCCG is Lead Commissioner there are monthly meetings to review and analyse data and information. Associate commissioners are invited to participate in these meetings. National CQUIN guidance has been released for 2017/19 and sets the CQUIN value at 2.5% as in previous years. The CCG are working closely with providers to agree these national indicators and where applicable develop local metrics that focus on innovation and stretch relevant to the national, regional and local priorities. The CCG works closely with providers to measure and assist in improving efficient use of staffing resources to be able to deliver safe, sustainable and productive services. It is essential that we work together to deliver a single shared goal to maintain and improve quality, to improve health outcomes within financial resources available. This is achieved locally through strong, effective nurse leadership across the health and care economy that works together to ensure the development, support and retention of a workforce that has the right skills, values and behaviours in sufficient numbers and in the right places. There is transparency and openness in the reporting, investigation and actions on incidents between the CCG and providers where the CCG is the host commissioner. Culturally, we use strong partnership working to improve patient outcomes and we draw on patient and public engagement –to harness soft intelligence through feedback from Locality forums, patient participation groups, social media platforms, and patient involvement in the development of quality markers for commissioned services.

In addition we triangulate the Friends and Family test performance for all our providers and the comments made by staff and patients with the aim to improve patient experience and identify good practice that can be shared.

Complaints monitoring is a key agenda item for discussion at each provider Quality Review meeting and allows the CCG to understand patient experience and themes/trends. Constructive challenge is provided where appropriate and cluster reviews are proactively undertaken where a theme or trend is identified with the development of a co-ordinating action plan and monitoring undertaken through audit and CCG Provider Quality Walk-arounds.

Mortality is discussed at monthly quality meetings with Provider, and an avoidable Mortality annual publication has been confirmed at the relevant Quality meetings that are held monthly. A CCG officer attends the ELHT monthly Mortality Steering Group and the Clinical Effectiveness Committee.

Ultimately our approach is for a supportive collaborative working arrangement in place for relevant Providers which includes robust governance arrangements, triangulation of intelligence/data with quality contract submissions and patient and public involvement to with the aim to improve the quality of care.

Maternity

- *CCGs and providers should come together in local maternity systems to design and deliver maternity services improvements in line with the recommendations in the national maternity review, Better Births.*

Local Maternity Services are provided in line with the Five Year Plan in that they offer a choice of birth place including home birth, Midwife-Led units and an Obstetric Unit which is co-located with a Midwife-led Unit. The ethos of the service is to promote where possible 'normal birth' with reduced risk of medical intervention. This culture has resulted in positive feedback, and improved outcomes for local families, with a caesarean section rate which is lower than the national average.

The Maternity Service Liaison Committee (MSLC) is well established across Pennine Lancashire and offers a forum where CCGs and providers can come together across the local maternity care systems to deliver service improvements. The Hospital Maternity dashboard is shared here alongside CQC reports, Friends and Families Test, Breastfeeding rates, Smoking in Pregnancy Rates and more. On piece of work which has been led by the MSLC is a review of perinatal mental health services. This has revealed that a significant number of women felt unsupported in the antenatal stages of care. In addition, the review found that there little co-ordination, nor leadership within the midwifery service to support improvements. A small amount of funding from the CAMHS transformation allocation has been provided to midwifery services to review current practice and make recommendations going forward for service improvement.

The CCG is keen to improve outcomes for stillbirth and bereavement care. A CQUIN has been implemented based on the NHS England Care Bundle 'Saving Babies Lives'. This proposes 4 quality improvement measures that will make impact on stillbirth rates:

- Intrapartum Care
- Smoking in Pregnancy Action Plan
- Reduced Foetal Movements
- Growth scanning for babies small for gestational age

The first year was an implementation phase and this year will be a focus on evaluation and impact. A part-time Bereavement midwife has been appointed to improve care pathways and long-term outcomes for families who have experienced a loss.

An action plan has been put in place following the recommendations from Better Births. A collaborative way of working has been established between Commissioners and Providers of Maternity Care across the STP footprint. This has enabled the submission of a bid to NHS England to become a National Maternity Review; Early Adopter site of which Lancashire STP have got to through to the second stage. If successful, initiatives include; Personalise Care Planning and Improving Postnatal Care/Transition to Health Visitor and GP.

A bid has also been submitted to NHS England on behalf of Lancashire to the Perinatal Mental Health Community Development Fund. If successful, this will be provided by 4 Specialist Community Perinatal Mental Health Teams in line with recommendations set out in the Mental Health 5 Year Forward View. The Strategic Clinical Network has supported the bid and continues to support clinical pathway alignment across the STP footprint as we await hearing if this has been successful.

Diabetes

- *Develop and implement plans to tackle obesity and diabetes, including referring 500 people per 100,000 population annually to the National Diabetes Prevention Programme and improving GP participation in the National Diabetes Audit.*

Diabetes has been identified as a priority area for service improvement due to a number of factors including: variation in commissioning arrangements across different localities within the same geographical area; variation in outcomes; inequity in service delivery and variation in the historical allocation of resources across localities within the same geographical area.

Engagement and ownership is essential to redesigning and improving services. This has begun through protected learning events involving all stakeholders, sharing data on outcomes and resources with associated comparative charts, agreeing the need or case for change and developing a Task and Finish Group to provide leadership and drive to make the change.

Delivery of the new integrated service model has begun through development of an implementation plan with clear timescales. This was followed with the creation of robust service specifications for the individual elements of the service with input from all task and finish group members including: consultants, DSNs, practice nurses, podiatrists, dieticians, GPs, pharmacists, Diabetes UK, business managers and most important patients. Alongside this, the CCG are running a variety of courses to upskill the primary care workforce including: Diabetes diploma, HCA updates in collaboration with Bradford University plus a bespoke insulin start-up course in collaboration with Leicester University for those practices intending to deliver the enhanced, specialist service. A fundamental element of the specialist service specification is to provide mentorship and training to primary care with the intention of developing a resilient workforce going forwards.

Prevalence, need and resources have been considered across each locality to ensure resources are deployed to support patients with diabetes equitably. The new service model ensures that all patients will have access to the same standards of care with the intention of narrowing the gap in variation and improving outcomes across all practices.

The consideration of activity data, costs and accommodation have played an important role in aligning outcomes with best practice and determining affordability of the new service model. Largely focussing on shifting an element of activity from the hospital setting to the community through a hub and spoke model. This is intended to reduce variation in outcomes; reduce DNA rates; and improve the patient experience through providing care closer to home.

Performance, Quality and Outcomes are embedded within the service specifications through a range of specific process and outcome measures. These will be monitored quarterly to assess performance over time to determine where improvements are being made. It is recognised that these may change over time dependent on achievement of targets and impact on patient outcomes.

Mobilisation of the new service model began on 1st September 2016 and with a phased implementation over the coming 12 months. Investment in the community, intermediate service has resulted in recruitment of an additional diabetes specialist nurse alongside a GP with a specialist interest in diabetes. EMIS community has been set up within the community hubs which enables direct access to the patient's clinical record and enables activity to be recorded according to pre-defined criteria. Once mobilisation is fully implemented a Diabetes Governance Committee will monitor performance and outcomes over time.

Seven Day Services

- *Building on the delivery of the four priority standards for seven day hospital services by completing implementation for a further 25 percent of the population by the end of 2017/18 and ensuring that other health economies are on track to complete implementation by the end of 2019/20.*

Pennine Lancashire CCGs and East Lancashire Hospital Trust (ELHT) are working collaboratively to ensure delivery of the four priority clinical standards for 7 day services.

The four clinical standards are as follows:

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging

Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols

Standard 8: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.

A caseload audit has been undertaken by the Trust and CCG against the four clinical standards to establish a baseline position. This has given a clear sense of the gaps in 7 day provision, as well as highlighting some areas where further analysis of the caseload data is required. The most significant gap is for diagnostics which is due to gaps in weekend provision of routine and urgent CT, MRI and ultrasound scans. Over winter 2016/17 expansion of elements of 7 day diagnostics is being supported with a view to evaluating the impact and developing a sustainable solution in 2017/18.

Personal Health Budgets

- *Commissioners should make progress on implementing Mandate commitments that 50,000-100,000 people will have Personal Health Budgets in 2020/21 and set trajectories for this purpose.*

The CCG is working with other CCGs across Lancashire, supported by the Midlands and Lancashire Commissioning Support Unit to improve the local offer for Personal Health Budgets (PHBs). As from April 2016 patients from the following additional patients groups will be considered for Personal Health Budgets;

- Adults and Children who do not qualify for NHS Continuing Healthcare, but who have been assessed as eligible for a package of care jointly funded by health and social care.
- Adults with learning disabilities and/or autism eligible for a jointly funded health and social care package (excluding those clients who are already in any pooled fund arrangements).
- Children and young adults with Education, Health and Care Plans including those in transition between children and adult services.

In 2016/17, the CCG participated in the NHS England PHB End of Life Pilot and learning from the pilot will be incorporated in the implementation of plans for 2017-19 to ensure that the CCG reaches the commitment in the Mandate to have at least 375 CCG patients in receipt of a PHB by 2020.

A CCG strategy for PHBs will be adopted by June 2017 and which is anticipated will be closely aligned to the operations of its localities and integrated personal commissioning in addition to improving the offer for the current cohort of patients eligible for PHBs.

In 2017/18 the CCG will concentrate on reviewing the infrastructure for PHB delivery to ensure robust and sustainable arrangements and processes are embedded in local systems to meet the increase in demand and the need to expand choice. Therefore, as illustrated below the numbers of individuals in receipt of a PHB will grow incrementally in the first year.

	No. of individuals in receipt of PHB within the Quarter			
Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2017/18	25	30	40	50
2018/19	70	95	115	150

Continuing Healthcare

- *Improving processes to provide speedier assessments for patients and to implement emerging best practice; and mainstream delivery model for NHS Continuing Care and continuing care for children.*

During 2016/17 the CCG has reviewed its assurance of the local CHC process by completion of the national Continuing Healthcare Assurance Tool and will be developing action plans to improve assurance and compliance. The action plans will be continued to be implemented and monitored in 2017/18 when it is anticipated that the system will also be used to capture service user feedback.

Together with Blackburn with Darwen CCG the CCG will be holding a whole system process improvement event in January 2017 for Pennine Lancashire to review roles and responsibilities across the CHC pathway to improve the experience of patients, carers and professionals. The CCG is piloting discharge to assess provision over Winter 2016/17 which will inform future commissioning of services.

The outcomes of the two initiatives will support the CCG's plans to meet the Quality Premium measure relating to CHC:

- That in more than 80% of cases, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the check list (current benchmark using quarter 4 2015/16 published data is 75%)
- Less than 15% of all full CHC assessments take place in an acute hospital setting (data not routinely collected and benchmark being calculated)

Wheelchair Access

- *CCGs should set out improvement plans to halve the number of children waiting 18 weeks by Q4 2017/18 and eliminate 18 week waits for wheelchairs by the end of 2018/19.*

This is an NHS England commissioned service. No involvement from CCG Commissioner.

Better Care Fund

- *Via the Better Care Fund (BCF) planning guidance, all CCGs to work with local authority partners at a Health and Wellbeing Board level to pool budgets and develop and agree an integrated spending plan for using their BCF allocation.*

The Lancashire Better Care Fund (BCF) for 2016 /17 has built upon the 2015/16 plan to ensure stability and consolidation. The Lancashire BCF covers 21 schemes within the plan which vary little in outward appearance from those seen in 2015/16 but will be stronger in how they deliver. The financial requirements for the plan have changed little and the total Lancashire BCF pooled budget was agreed at £91,419 million and is hosted and managed through a Section 75 agreement by Lancashire County Council.

This approach is agreed across all BCF partners and reflects the changing planning environment, and focusses on addressing the issues around hospital admission avoidance and safe, timely discharge. It also enables partners to best manage resources at a time of continuing financial uncertainty and increased system pressures.

The Lancashire BCF 2016/17 aligns with all CCG and Lancashire County Council operating plans being now part of "business as usual"

planning.

The 2016/17 BCF sees significant strengthening of the input of the City and Borough Councils and Voluntary sector that will bring a whole new set of skills and resources into delivering its priorities and schemes. This is a major step in taking the BCF to the next level as it will, in 2016/17, explore and take opportunities to tap into what each of these sectors can offer especially around prevention and supporting independence in peoples' own communities.

The focus of the plan continues to address the centrally identified priorities and prescribed metrics of:

- Delayed Transfers of Care
- Non elective admissions (reducing emergency admissions to hospital)
- Permanent admissions of older people to residential and nursing care homes
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

The requirements for the BCF 2016/17 include 2 new national conditions:

- Requiring local areas to agree to fund NHS commissioned out of hospital services
- Agreement on local action plan to reduce Delayed Transfers of Care (DTOC)

The approach taken in Lancashire and agreed by the Lancashire and South Cumbria Urgent and Emergency Care Network is for DTOC local action plans to be developed at A&E Delivery Board level i.e. focussed around the acute health care providers.

The development of the partnership that supports the development and delivery of the Lancashire Better Care fund continues and includes working together on joint financial reporting. The aspiration is to have a single format that is available for each partner to use as it sees fit internally and that also meets the requirements of reporting into the Lancashire BCF governance structure i.e. the BCF Steering Group and Health and Wellbeing Board.