NHS
West Lancashire
Clinical Commissioning Group

Building for the Future

A Clinical Commissioning Strategy to Support the Delivery of Integrated Adult Community Health Services

With you.
For you.

Building for the Future

Executive Support

NHS West Lancashire CCG, like all CCGs across the country, faces significant challenges. With an increasing population and more people living longer, many of whom have long term conditions, the pressures that we face are significant. Added to this of course is the need to reduce cost and improve the quality of the outcomes delivered to our patients.

Achieving all of this requires us to re-think how health and care services are provided. Our "Integrated Commissioning Plan – programme refresh 2013-15" sets out our portfolio of work designed to address our three priority areas:

1. Right Care, Right Time, Safely Delivered
2. Preventing people from dying prematurely
3. Integrated working for better patient experience safety quality of life and reduced inequalities

Our work will result in a significant transformation in the way services are delivered many of which we intend to deliver closer to home ensuing that those patients in hospital belong there. May of our patients could be treated outside of a hospital environment and could perhaps benefit from faster recovery and better outcomes.

To facilitate this treatment of patients out of hospital we must transform primary and community care to meet the requirements of the new model of care. This document sets out our vision for integrated care across West Lancashire which we aim to implement over the next five years. The vision is still in draft form, as we plan to continue our engagement with the public, providers, incumbent staff and our clinical colleagues to shape our collective requirements. It is expected a final version of this document will be available in the autumn of 2015.

This strategy obviously does not start from a blank piece of paper, we have quality services and established providers in our health economy and we are already working with them to deliver our vision of 'Facing the Future Together' and of integrated working through the Better Care Fund. Alongside procurement for community services, this Vision will be achieved through the continued collaborative working with our members, our patients, public, carers and other partners to ensure our priorities and transformation programmes are aligned.

John Caine
Chair

Mike Maguire
Accountable Officer

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Clinical Vision

Being a West Lancashire resident myself, I must confess to having a vested interest in ensuring the health services delivered in the area are the best they can be - accessible, there when I need them, joined up and effective - not only for me but for my family, friends and neighbours.

I have been a nurse for over 30 years, with 26 of those years being spent working in the community. I have had the opportunity both nationally and internationally to witness fantastic care delivery when all parts of the system worked together but also witnessing fragmented care delivering poor patient outcomes and duplication. I am passionate about bringing care closer to home and putting the patient at the centre of all we do, offering right care, right time, right place consistently.

I believe good coordinated care is not dependent on organisational integration but on the people who work within the health and social care system working together for the best outcomes at a patient, community and population level, with common objectives and best use of resources. Separation into community, primary and secondary care does not mean much to patients, people want to be treated and supported within a system that knows them and their needs and be treated with compassion and empathy. Care is care, immaterial of the organisation; it is the people who deliver that care, the quality and outcome that matter. I believe there are skilled and motivated clinicians in West Lancashire working across primary, community and secondary care willing to take up the challenge and deliver truly integrated care.

The intention, as set out in "Building for the Future", is to improve health and wellbeing for the population with a particular emphasis on those with enduring health needs and the elderly population, to reduce health inequalities and to promote choice, control and independence. There is therefore a focus on prevention; early identification and early coordinated intervention, making sure people get the right support at the right time

West Lancashire has significant advantage in the strength of the voluntary and community sectors and the capacity, skills, knowledge of local communities. There is considerable potential for this strategy to build on this, supporting and facilitating individuals and communities to become the co-producers of health and wellbeing rather than the passive recipients of services.

I have heard the same rhetoric for years - "we need to integrate care", "clinically led care", "seamless care transition", "single point of contact", "patient focussed", coordinated and planned", "patient information at your finger tip", "harness technology", "prevention and self- care is key", "multi-disciplinary working" - sound familiar?. We have never before seemed able to turn the rhetoric into a reality.

This is our opportunity in West Lancashire to make the rhetoric become the reality, and over the next five years we intend to work towards delivering our vision of truly patient focused joined up care. We have great ambition and drive to do things differently and we are seeking innovative, driven partners to help us achieve the ambition for our population, together **Building for the Future.**

Claire Heneghan
Chief Nurse
West Lancashire CCG

Building for the Future

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1. INTRODUCTION

The purpose of this document is to outline the clinical strategy for West Lancashire CCG (WLCCG) which supports the delivery of our strategic plan, priorities, business objectives and ambitions in respect of the decision made by our CCG Membership and Governing Body to formerly tender adult community health services. This clinical strategy supports the first phase of service transformation in addressing the needs of the West Lancashire adult population. The strategy focuses on those who are over the age of 65 and those adults who have multiple long term conditions (recognising frailty as a long term condition) who are, or have the potential to be high intensity users of health and social care services. The intention is to proactively commission services to address non-elective care for this particular cohort of patients, moving the delivery of care closer to home. It is anticipated that there will be reduced dependency on acute care services, improved patient flow, a reduction in waiting times and releasing increased existing clinical capacity to address elective care over a five year period.

Public and clinical engagement has led to the establishment of clear commissioning expectations that have determined a radically different scale and pace of transformation within a system of local health and social care providers. This document is to be considered in conjunction with "The Commissioning Process towards Integrated Care", a WL and SF CCG document that outlines the commissioning model that supports delivery of this clinical commissioning strategy and our respective Primary care Strategies. Further strategy documents are to follow addressing the needs of children and young people and families, mental health and well-being and elective care. We will also outline how we intend to address health inequalities and engage with our patients and public.

We acknowledge that there are many priorities that we must address. However, we have identified three main areas for initial focus for 2015/16, which collectively aim to improve service outcomes and reduce clinically unwarranted variation in activity and outcomes, to free up resources for investment elsewhere, where it is needed most, in prevention of ill health and the improvement of general wellbeing.

To summarise, we aim to focus on:

- improving non-elective care - addressing avoidable hospital admission
- improving long-term condition management, with a focus on frailty – shifting from crisis management to prediction, prevention, and self-management
- improving Elective care – reducing clinically unnecessary attendances and outpatient follow up's

We wish to commission services that are patient centered, clinically-driven, outcome-focused, fundamentally different and financially viable. These aspirations are a tall order for any health care provider in the current economic climate, but West Lancashire CCG is ready to move forward with a different approach to commissioning; one which is at scale and pace, with a clear vision and appetite for change. We wish to commission viable service providers with a focus on clinical leadership, patient involvement and a radical move to realising the benefits of integrated care, with general practice as the centre of control as they hold the registered list. Doctors, nurses, allied healthcare professionals and social care colleagues will work together with patient groups and the voluntary sector to improve health outcomes for our residents. Health and social care professional will have the advantage of working in a system where it is possible to access the shared intelligence of the GP registered list to identify and manage the healthcare needs of those patients most at risk and in need of healthcare. They will enjoy the benefits of working in a system with an effective framework already in place for clinical input and service redesign.

Building for the Future

Our local services need to change to respond to a number of significant factors including:

- increasing demand on healthcare as a result of changing demographics
- a requirement to improve the quality of care we deliver leading to a transformation in the way we deliver services
- the current financial constraint facing the NHS and our local health economy
- recruitment and retention of an appropriately skilled workforce

We aim to commission effective integrated care services in partnership via our local clinical senate, local health and wellbeing boards, Local Authority and other appropriate partnership structures. Our goal of developing integrated community services is to:

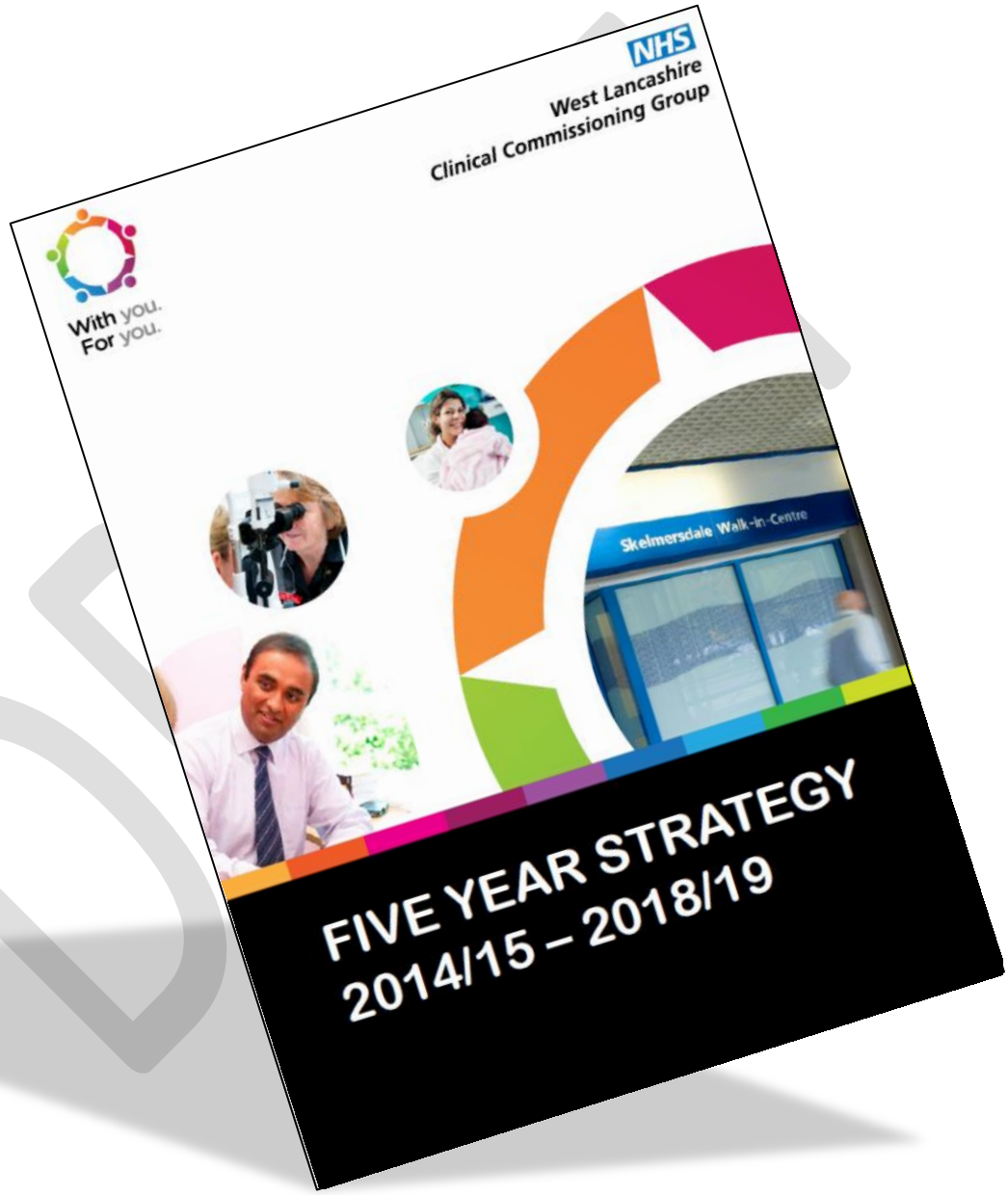
- reduce duplication and ensure joined up care
- improve coordination & communication across care settings
- structure services so they are person centered, timely and responsive to need
- improve outcomes and the patient experience
- enable and promote early intervention self-care and prevention
- support people to live and age well addressing the needs of the frail elderly

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 a system interdependency and alignment in which no single part of the system can afford to let the other fail. We intend to realise the full potential of community services; we view these services as a major driving force and a catalyst for change across the whole spectrum of care. We however, 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.

The clinical strategy and plan to address non-elective care was developed in early 2014 to support the CCGs vision and deliver effective integrated local services at pace and scale under the banner of “Facing the Future Together”. CCG membership and partners, Lancashire County Council (LCC) and Voluntary, Community and Faith Sector (VCFS) have been instrumental in developing the vision.

2. WEST LANCASHIRE CCG'S CLINICAL COMMISSIONING STRATEGY

This vision aligns with WLCCG's 5 year strategic plan and supports delivery of integrated health, social care and voluntary sector services aligning budgets and defining common objectives. As commissioners we feel assured that this strategy reflects the vision and objectives outlined in The NHS Five Year Forward View "High quality care for all, now and for future generations" (NHS England, October 2014)



Strategic plan, priorities and commissioning objectives

Our Vision, as written in our strategic plan, is to ensure the best possible care and health outcomes for our populations and to empower our population to be in control of their own health.

From that Vision we have recognised the CCGs role in the delivery of Integrated Care is to develop a commissioning framework which will describe our vision for integrated services in West Lancashire and which will enable partners to work together, with collective accountability, to provide an integrated model of care, which provides the best possible care for patients whilst meeting the CCGs requirements and which in turn reduces demand for urgent care and thus delivers better value for money.

Our strategic priorities, to effect the necessary change to deliver this integrated model of care, means we will work with the whole health economy to…

- co-ordinate care for individual service users and carers
- support more integrated working with primary care by organising community services around GP practices and population
- work jointly with social care
- transform communication between GPs and specialists and generic services
- collaborate with other local healthcare and social care providers
- measure outcomes and costs and making this information widely available
- provide comprehensive disease management and preventive services to our population including the promotion of Self Care
- develop, promote and utilise the VCFS and community assets to best effect

Our commissioning objectives are to…

- provide high quality services for patients based on best practice
- work with our partners to develop people to have the knowledge, skills and competencies to do their job and support patients/carers to self-care
- seek the views and involvement of patients about how we deliver our services
- deliver services closer to home, offering viable and safe alternatives to hospital care
- manage our finances and business safely and responsibly
- improve performance by acting on good information

Our strategic ambitions for Integrated Care are to…

- add value for patients (defined as quality outcome per £ spent);
- support GPs as providers and commissioners,
- improve population health, and
- reduce avoidable non-elective admissions
- reduce elective referrals in a primary care setting
- proactively manage frailty and long term conditions

Building for the Future

Delivering what is needed

As part of our Better Care Fund plans, in seeking to deliver our 5 year ambition and in considering what the public has told us, we will focus on developing integrated care. We know that through our continuing engagement, patients only want to tell their story once and want to be involved in planning their own care. This is core to the principle of integrated working and person centred coordinated care and is fundamental to the delivery of this strategy.

> *" I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"*
>
> National Voices 2012

Feedback from our engagement events has also given other insights into areas that our residents would like improvement. Here are some examples of feedback received.

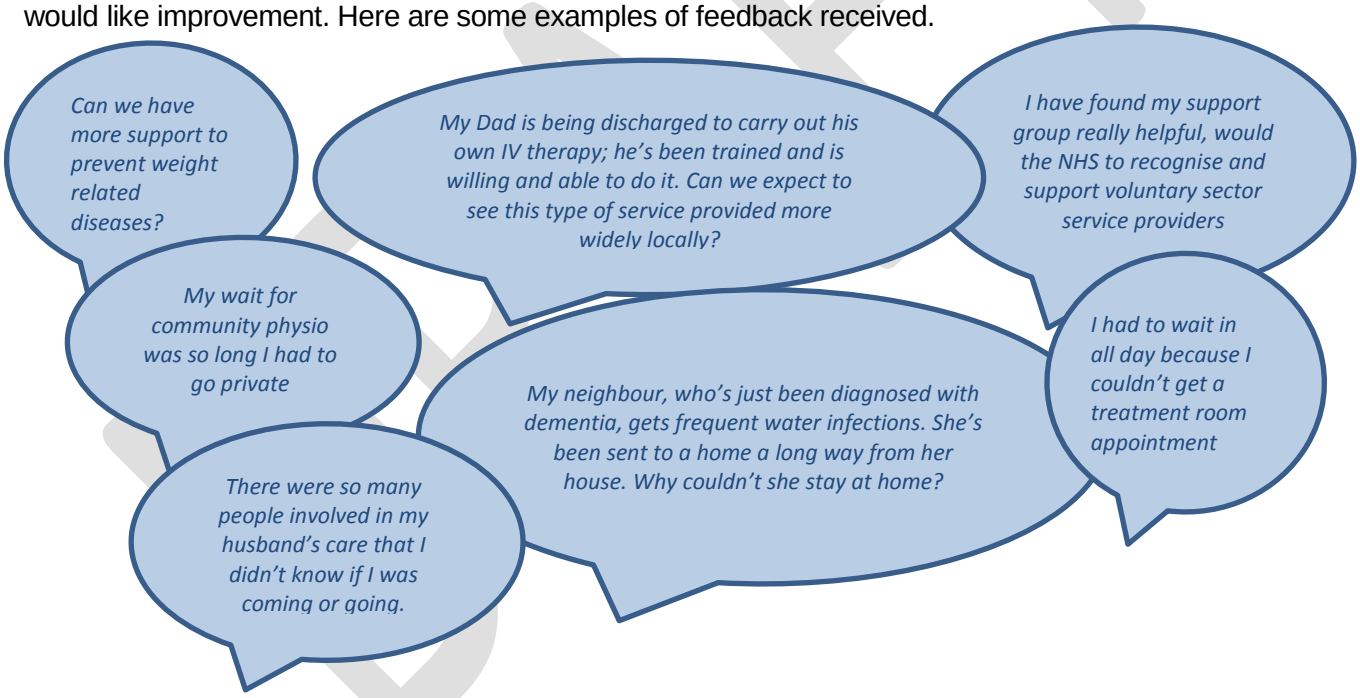


Figure 1 - West Lancashire Residents Feedback

Our aim is to facilitate integrated care across the Borough. Our ambition is that primary, community, social care services, specialist mental and physical health services will be organised to work effectively through our model of integrated care, ensuring patients get the very best person-centered care that they need in the least invasive environment.

3. A COLLABORATIVE APPROACH TO INTEGRATION

The aim of this clinical strategy is to be an integral part of the commissioning framework which describes the services to be commissioned that deliver a high quality and competent clinical workforce focused on reducing non-elective care, collaborating with partners, maximizing patient choice and personalising care by expanding and enhancing the delivery of routine and complex care closer to home or in the most appropriate setting.

Right Care, Right time, Right place.

The objectives of the strategy are to ensure that our commissioned services are:

- integrated, responsive and delivered according to patient / population need in partnership with others
- proactively engaged in community asset building and development
- effective in preventing illness and promoting self- care, health and well being
- focused on improving patient experience and quality of care
- clinically led in planning and delivery
- providing high clinical quality through excellent clinical leadership and governance
- aligned to avoiding unplanned admission to acute care
- effective in facilitating early safe transfer of care

The clinical strategy will be kept under regular review to ensure that commissioned services continually develop and improve in relation to clinical outcomes and quality and are responsive to the needs of the West Lancashire population and commissioning intent. In addition the operating model is also reviewed regularly to ensure that services and functions can respond as quickly as possible to a fast changing, complex and competitive environment.

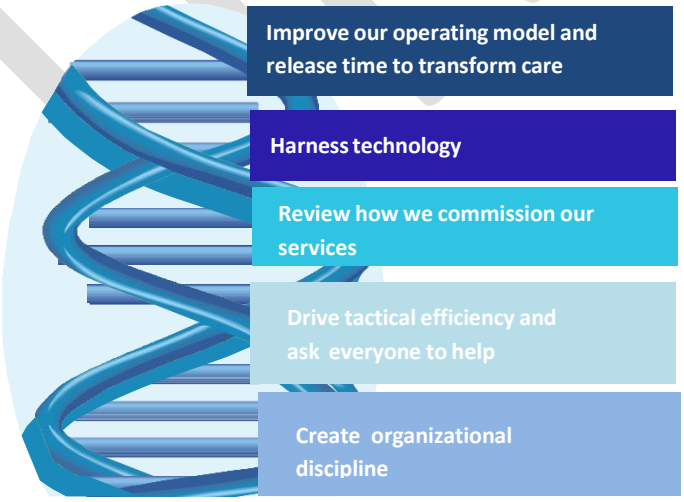


Figure 2 - Adapting to a fast moving environment

To this end, West Lancashire CCG has developed a business transformation model with five transformational goals for its business plan based on a concept which shows services and functions working in tandem and acknowledging that a business metamorphoses over time (see Figure 2 above). We acknowledge that transformational clinical and operational leadership and a cultural shift will be required across the health and social care economy to enable this strategy to be realised. We intend to engage with clinical teams, supporting and enabling them to improve quality and productivity. We will look to our providers to improve operational efficiency, addressing variations and ensuring workforce productivity. We as commissioners intend to do things right and do the right things in priority setting and enabling greater collaboration.

As a CCG West Lancashire has already made steps to achieve the most conducive environment for service transformation and have adopted key productivity approaches. (Kings fund 2010)

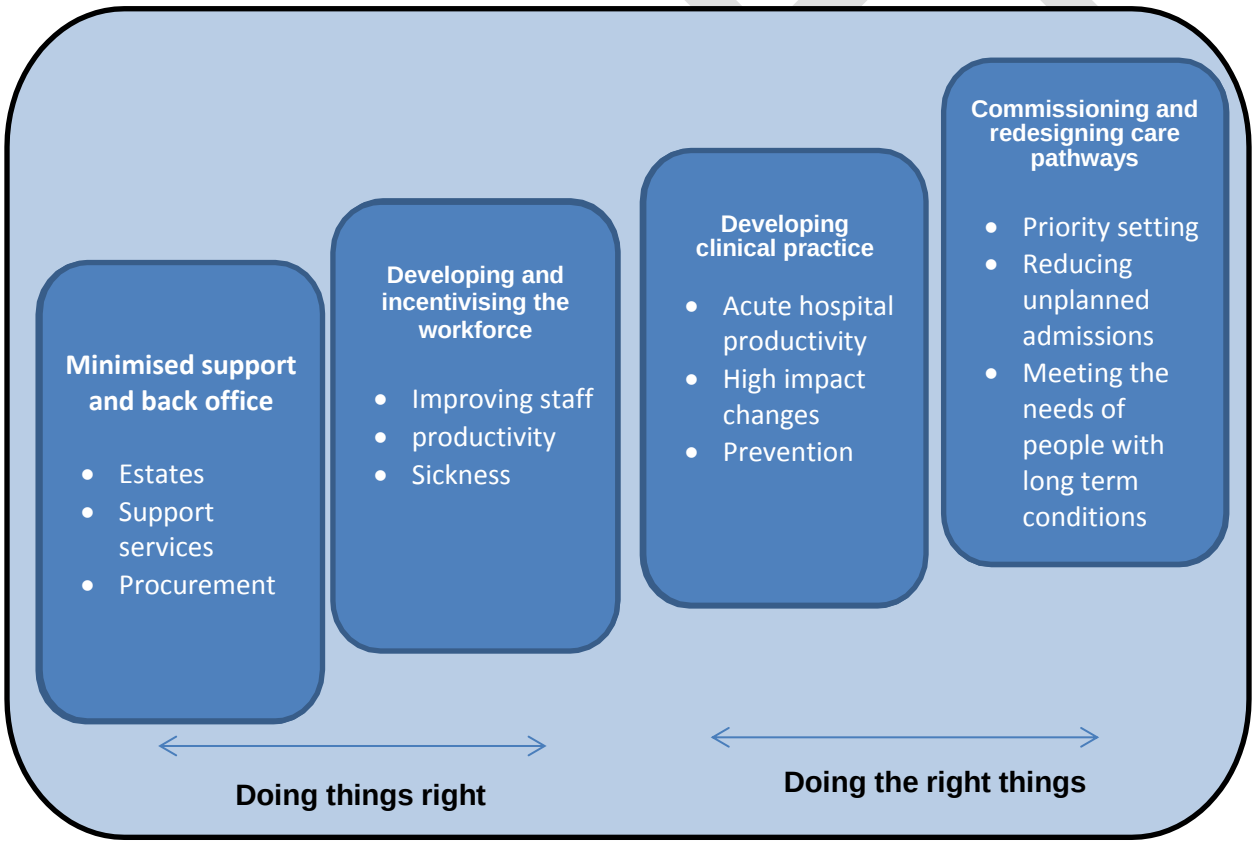


Figure 3 - Key Productivity Approaches

4. A NEW CLINICAL STRATEGY FOR ADULT COMMUNITY SERVICES IN WEST LANCASHIRE

In April 2014, work commenced on a new model of care, within the local health economy. West Lancashire and Southport and Formby CCG's held two membership events in June and July 2014 respectively, inviting the wider constituents of the local health and social care economy to launch "Facing the Future Together" – proposing a vision and a new clinical strategy for West Lancashire, Southport and Formby. A mandate for change was overwhelmingly agreed. We then proceeded with implementation of phase one of the plan to deliver a clinical strategy for transformation. West Lancashire CCG and Southport & Formby CCG continue to work closely together on the vision for future community services and are considering our options for tendering these services.

There is recognition of the changing landscape of care and acknowledgment that primary and community services require growth and development. Primary and Community services can no longer be seen as an add-on to acute care, but a leader and central to the transformation of care. We intend to move care closer to home with the premise that only what needs to be seen in acute care is seen in acute care, everything else is out of hospital. A radical approach will be required if we truly intend to transform the delivery of care. We will continue to develop the model of care with partners and providers over the next 5 years and view it as an iterative process which will allow for evolution over a defined period of time.

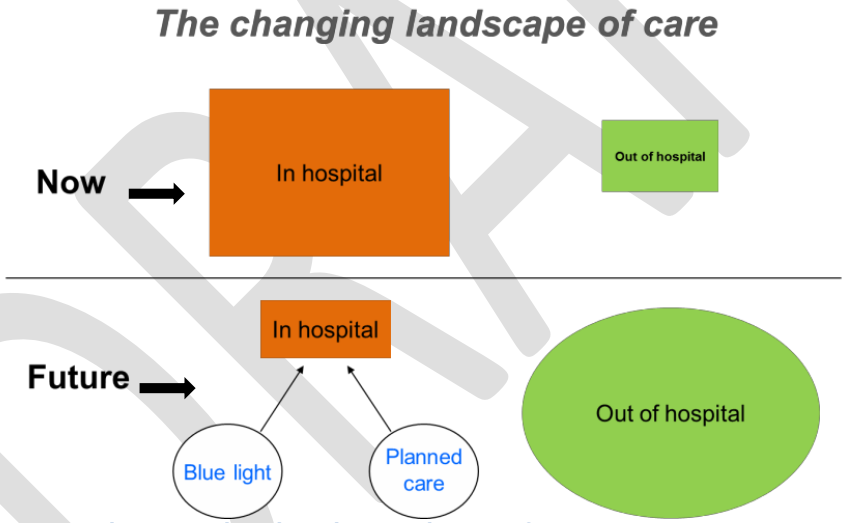


Figure 4 - The Changing Landscape of Care

We propose a new operating model based on five neighbourhood teams to support collaboration and multidisciplinary working and the delivery of integrated care across West Lancashire. The teams will be aligned to integrated care pathways that manage the patient's journey outside of hospital where ever possible. We will expect a seamless approach to support the patient's journey from diagnosis to completion of an episode of care, or alternatively to be supported long term closer to home. For those with long term complex needs we expect a continuum of care through to end of life care. This strategy recognizes that care homes and the third sector are important parts of our health care community and must be embraced and supported as key partners in care.

We appreciate that a cultural shift will be required and espouse the adoption of the Kaiser Permanente philosophy that "unplanned hospital admissions are a sign of system failure", promoting population management, optimization of treatment and a reduction in unacceptable variations in practice across the system.

Building for the Future

The intention is to commission community services that will support the new operating model with defined roles and responsibilities, which will included a significant re-organisation of services at all levels through three work-streams:

i. understand the neighbourhood population needs and commission community services that reflect those needs and agreeing milestones set against patient and system outcomes at a micro level (patient) meso level (pathway / service) macro level (system)

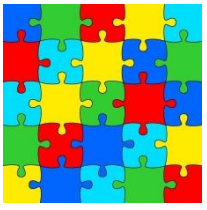
ii. work with partners to establish multi-disciplinary/specialty neighborhood teams with clearly defined collective accountability for care, robust communication and local management arrangements built around practice populations and an asset based approach. The model will value and develop the generalist and ensure access to timely specialist support when needed.

iii. make best use of technology to support communication, self-care, quality, safety and patient experience promoting a personalized approach to care, supported by personal health budgets.

The changing role for healthcare providers within this new system

- All providers are asked to effect a cultural change in services that place a new emphasis on the patient/ carer voice and the way this is incorporated into planning services and their ongoing evaluation. Co-production will be central to our approach with patient articulated outcomes established, at the meso and macro level. At the micro level this will be within individual care plans, undertaken by the most appropriate clinician.
- We recognise general practice as the only place where the impact of all providers on an individual's care can be found, and subsequently reviewed and optimized. The GP registered list provides the means, by which a healthcare economy can tackle health inequalities, personalize care and transform commissioning decisions. Through progressing integration with social care, we hope to overlay social care information, where appropriate, with health care thereby developing a single patient record.
- It is recognised that in introducing new models of care it is essential to incorporate consultant opinion. This will bring a new relationship with primary care – leading to the role of the consultant having increased input into pathway development, education and oversight of the overall model of care. Consultant opinion will also be required to provide support to the management of patients in primary and community care setting.
- The successful integration of services depends on new or extended roles for nurses and allied healthcare professionals both registered and non-registered. The promotion of self-care, disease prevention and management of frailty and long term conditions, the delivery of assessments, an effective diagnostics infrastructure and the deployment of new technologies will rest with these individuals. It is therefore imperative that we have more joined up approach between those working in GP practices, community teams and acute care.
- Close working between health (inclusive of adult mental health) and social care is essential to promote independent living and effectively manage the risks of hospitalisation. It also presents an opportunity to reduce and prevent any duplication of interventions between teams and services. This will promote the effective utilisation of our community assets and help address the wider determinants of ill health in the promotion of wellbeing.

We see all the above as fundamental pieces of the jigsaw which only when they come together collectively will we clearly see the whole picture.



Building for the Future

The proposal for the integrated system of care is a system that is clinically led, collectively accountable to the populations served, driven by quality, partnership working and enabling for both patients and the workforce.

It will use primary care as the cornerstone for a model of care that creates a shared view of patients, to drive health improvements by identifying those most at risk and most vulnerable. This will be supported by care co-ordination of faster more effective access to services, with the use of new, innovative technologies to monitor some health conditions remotely.

This approach is intended to enable acute hospital services to focus on dealing with appropriate emergency admissions and elective care that requires an overnight stay in hospital. In doing this, specialist doctors and nurses will have increased capacity and more opportunities to work more closely with GPs and community services.

A key feature of the integrated neighbourhood model of care includes empowered clinical leadership through the establishment of neighbourhood multidisciplinary clinical panels to develop and reinforce professional and clinical standards, and over time allocate delegated resources, review results, monitor outcomes, drive quality improvements and, utilise the opportunities presented within the Better Care Fund . The intention being to create self- directed and managed neighbourhood teams with collective accountability for the delivery of care and associated outcomes for the local population built around clusters of GP practices.

The proposed neighbourhood multidisciplinary panel is likely to include membership from GPs, nurses, allied health professionals, mental health, social care, medicines management, management support, commissioner (key account manager) CCG clinical executive team representative, patient representation and other groups significant to that neighbourhood population, such as care home providers and voluntary groups. This approach will align internal CCG resources thereby bringing expertise and data intelligence closer to the patient.

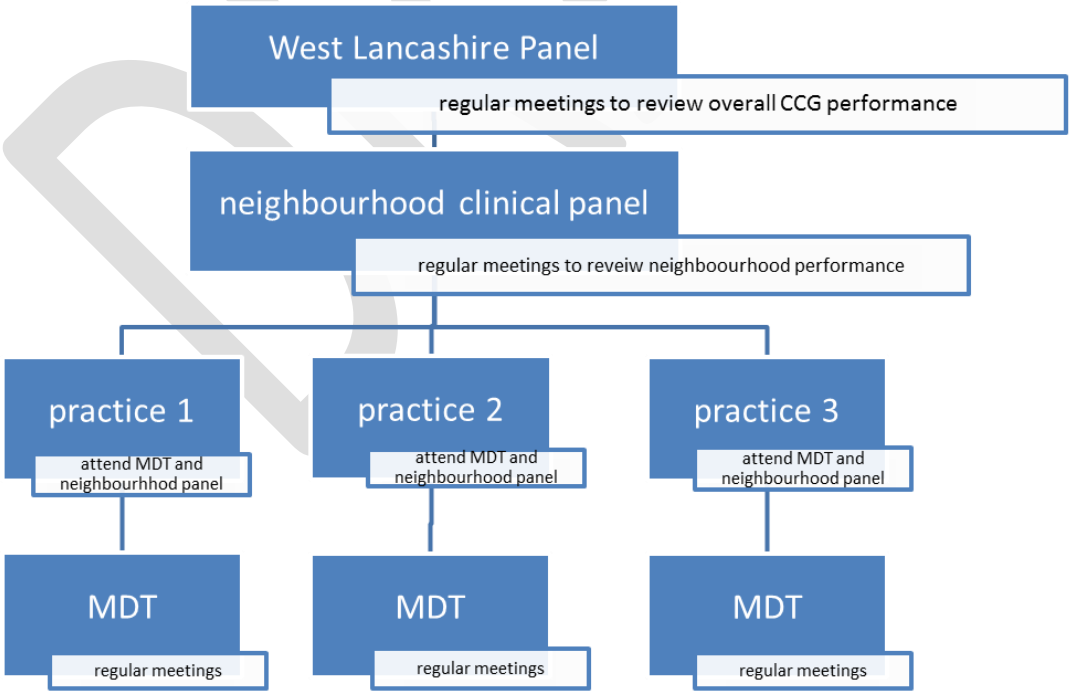


Figure 5 - Proposed Governance Structure

The role of the proposed panels could include:

- allocation of resource to neighbourhoods (with proportion of under spends to be available for re-investment subject to overall CCG financial balance and achievement of statutory targets). It is envisaged these savings will be identified from both elective and non-elective care.
- listening to and incorporating the patient / carer voice and the monitoring of experience at the level of service design and delivery
- the oversight of quality and professional standards relating to their areas
- governance oversight of the neighbourhood system of care, feeding into an overarching governance framework
- mitigation against potential risk to be undertaken at a neighbourhood level where possible with escalation to the CCG Executive Committee
- to act as a multi-disciplinary team to guide complex individual cases and high intensity users of services
- organising the continuing education programme in collaboration with other neighbourhood panels, ensuring high levels of communication and reduction in variation based on best practice
- benchmarking with other neighbourhoods in respect of elective and non- elective care referrals and outcomes
- use local real time data to inform decision making and outcome monitoring.

It is felt that there is a compelling case for doing things radically differently, at scale and pace in order to cope with increasing demand and complexity within finite resources. The priorities are clear in terms of health inequalities and the diseases and conditions we need to be able to tackle in a more patient centered way. Steps are already being taken to work in a more integrated way supported by national and local drivers for change, such as the Better Care Fund, the drive for closer GP neighbourhood working, the 2% directed enhanced service and the £5 per head allocation. We believe there is money in the system to do things differently and improve patient/population outcomes.

Realising the Objectives

Objective	How will this be achieved
To ensure services are patient centered, clinically designed and clinically led	• Simplify services and remove unnecessary complexity • Supporting the work of the neighbourhood panels/ • multi-disciplinary working • Data and information sharing • Doctors, nurses, AHPs, social services and other professionals leading pathways and supporting a shift in care closer to home • Ensure consultant/specialist opinion • New approaches to elective and non-elective care • Needs based 24 hour integrated community services
To provide accessible and population determined local services which are locally accountable	• Neighbourhood models and collective accountability • Wrap multidisciplinary services around the patient including psychological support mental health specialist and generic nursing, AHPs and community assets • Identify those patients with complex needs and target intervention • New models for public involvement and accountability • A new estates strategy that delivers services where they are most needed in buildings which are fit for purpose
To support patients and the public to manage their own health and their access to healthcare	• Use of new technologies – telehealth/care • Health promotion and health screening based on intelligence of GP lists • New admission avoidance and discharge services • Population management and stratification • Making every contact count in promotion of self- care • Informed patients with person specific care plans • Care co-ordination and single point of access for neighbourhood services • Access to extended ambulatory care services • Personal Health Budgets
To work continuously to improve quality and outcomes for patients	• Supporting use and development of the shared care record with real time access to patient information across health and social care • Development of a quality leadership programme • A new system approach to quality reducing variation in practice
Effective use of resources, both financial and human, in a resource constrained environment	• Workforce development and engagement strategy • Integrated services responsive to patients needs • Shift form hospital to community where most appropriate for patient care • Services that provide an alternative to admission to hospital • Access to timely information and coordination • Services that expedites hospital discharge • Discharge to Assess model of care development • Cost Improvement Programmed • Create healthy communities promote self -care focus on prevention • Introduce new services in the community developing advanced skills in the general medical, nursing and therapy workforce.
To form close working relationships with key partners, aligning objectives and incentives amongst commissioners and providers of health and social care	• Neighbourhood care coordinators/ relationship managers • An integrated approach with the support of social care and wider partners • Closer working with care home providers and voluntary sector • Neighbourhood allocations of CCG teams

5. ADDRESSING NON-ELECTIVE CARE CHALLENGES IN WEST LANCASHIRE

In addition to integration ambitions, as commissioners we must also work with our membership and wider partners to seek solutions to reducing non-elective care in West Lancashire as a priority. With this objective in mind, we will work jointly with partners to develop and redesign community services and integrate these with adult social care services, North West Ambulance Service and other care providers in the voluntary and third sector. The aim is to strengthen community services to enable services to care for more complex patients to avoid unnecessary hospital admissions and also expedite hospital discharge. As commissioners, we will require acute and community services to drive a one system approach, proactively managing care and diverting activity from acute to community services as appropriate. This proposal may potentially change the face of community services by making its patient profile more complex. In doing so, we will expect sub - acute provision for a specific cohort of patients delivered by a skilled and competent workforce. The internal and external pathways of care and clinical competence and skills required to deliver this solution will be vital to make the services and patients as safe as possible.

West Lancashire CCG will commission a clinical model that supports seamless patient transition between services and settings that radiates out beyond any new service into existing clinical services. The overall new clinical model (Figure 6) is designed to support seamless transition from hospital based services into community services as well as aligning adult social care services to health teams (addressing both physical and mental health) to support integration and co- ordinated care.

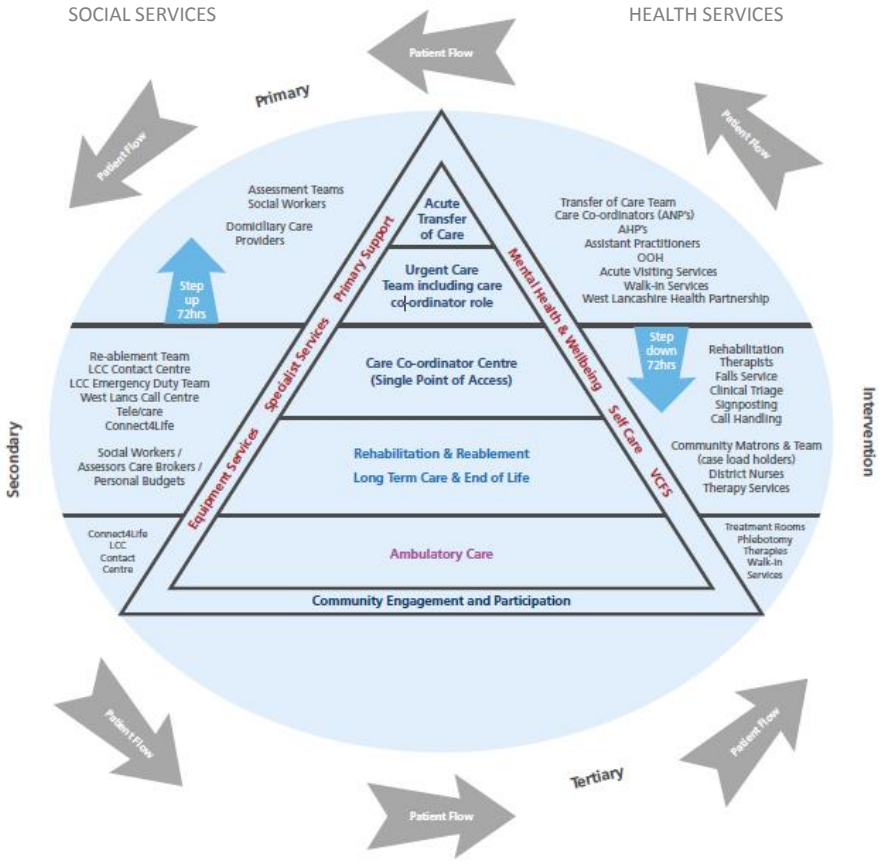


Figure 6 - Proposed Model of Health and Social Care

Building for the Future

An important feature of the clinical strategy is population management which will be underpinned by analysis of practice and public health intelligence. We will develop a system wide approach to data sharing and population stratification. Targeting services to the populations and areas of greatest need; thereby enabling people to reach and maintain optimal levels of independence, health and wellbeing, within an integrated health, social care infrastructure, supported by our community assets. The plan is to facilitate this through the five neighbourhood teams working with local GP practices to manage more care in community and primary care services, a move away from default to hospital based services. However this will require confidence and trust in competence, capability and capacity in the workforce and accurate diagnosis, disease registers and practice population profiles. The approach will take learning from models shown to be effective in promoting health equity, parity of esteem and tackling differences in health outcomes and look to apply these for communities within West Lancashire.

The components of the clinical model of care:

- dedicated hospital transfer of care team
- urgent care services
- recovery, rehabilitative and re-ablement services
- access to timely consultant opinion
- community geriatrician support
- neighbourhood generic and complex care teams managing long term care needs
- improved management of ambulatory care sensitive conditions
- single point of access/ Care co-ordination
- extended treatment room services
- specialist services i.e. IV therapy, LTC nurse specialists

An overview of the model of care that will support transition between services in West Lancashire is set out pictorially in Figure 7 below. The following pages describe in more detail the requirements which are integral to, and which play a pivotal part in a one system approach - from admission avoidance, to attendance at A&E and beyond - in a mutually dependent system of care. This system must recognizes the difference between emergency care needs and urgent care needs and having the ability to prevent the urgent need becoming the emergency need.

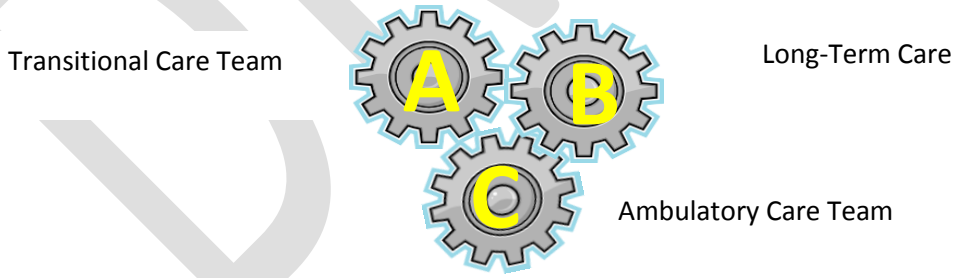


Figure 7 - Three Integrated Care Teams

We envisage three concentric care teams, working as one, with a management structure that supports the delivery of seamless care and transition as determined by patient need. Urgent care response has to be integral to and a pivotal part of, a one system approach from admission avoidance, to attendance at A&E and beyond in A mutually dependent system of care. Developing a system that recognises the difference between emergency care needs and urgent care needs and having the ability to prevent the urgent need becoming an emergency need.

COG A - TRANSITIONAL CARE TEAM

Transitional care encompasses the interface with A&E, Medical Assessment Unit and will be composed of a transfer of care staff (discharge team), urgent care team, intermediate care services, and single point of access and care coordination.

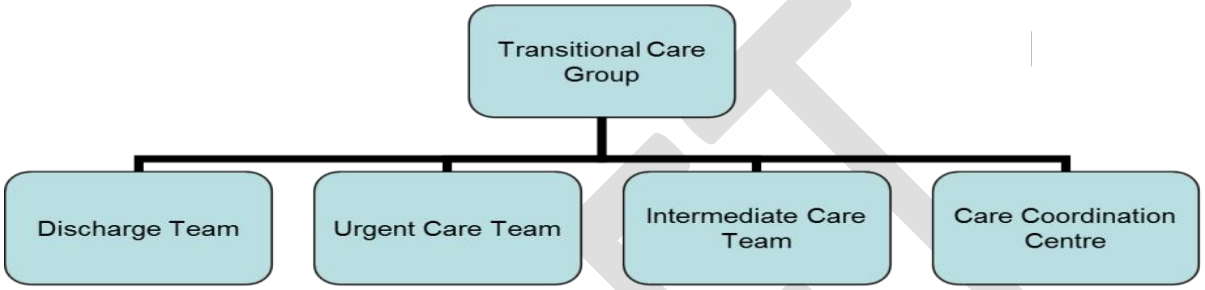


Figure 8 - Transitional Care Team Roles

Integrated dedicated hospital transfer of care team

As commissioners we will expect to see the seamless transition from in hospital services into out of hospital services. We will work with partners and provider's to establish a multi-disciplinary hospital transfer of care team, with a clear objective that no patient has long term care needs determined when in a hospital bed. As commissioners we recognise that in order to facilitate safe transfer of care appropriate resources and communication systems need to be in place. We intend to work with partners and providers to ensure that a "Discharge to Assess" model of care is realised. The intention is to work towards a single point of access to defined services and eventually full care coordination for identified cohorts of patients who will benefit from care coordination.

We will continue to progress the work already started in addressing barriers in timely safe transfer of care, acknowledging the key contribution of Local Authority, care home, voluntary, and third sector providers. We do not consider it appropriate to determine on- going care needs when in an acute hospital bed, we believe everyone has a bed and that is in their own home, every opportunity should be taken to discharge to assess giving sufficient opportunity for recovery, rehabilitation and reablement**.**

Urgent care team supporting patients in transition

West Lancashire CCG wishes to invest in the community services 'offer' for urgent and enhanced care services. We intend to commission a service that aims to:

- provide viable, safe alternatives to attending A&E and subsequent admission when clinically appropriate
- provide the appropriate level of skilled and competent staff clinically assess, differentially diagnose, prescribe if necessary and complete an episode of care, demonstrating autonomous practice

- provide up to 72 hours of intensive support for a targeted population
- work seamlessly with district nurses and or community matrons to support case managed patients if intensive support is needed to avoid an admission
- further integrate with adult social care to provide a step up, step down facility (home or within a bed base)
- provide targeted anticipatory, preventative care in partnership with others
- facilitate timely transfer of care when clinically appropriate
- deliver on-going care within specified care pathways in community settings
- operate 24/7 services as appropriate with full integration with GP out of hours providers and other providers of urgent care and walk in services
- work in partnership with NWAS Pathfinder scheme
- care homes form part of our health economy and we expect support from urgent and enhanced care services to care home residents.

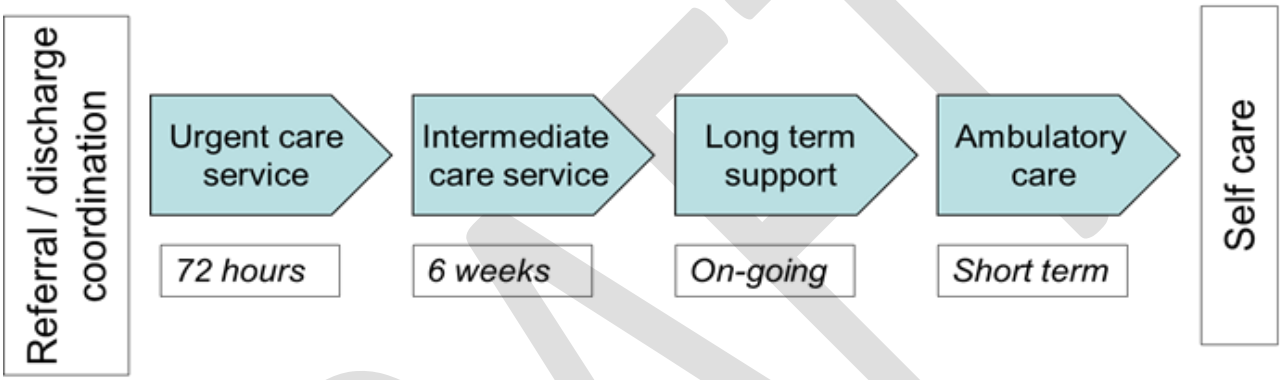


Figure 9 - Urgent Response function

We see the urgent response function as an essential component of the whole system approach to admission avoidance in preventing the urgent becoming an emergency. The urgent care element of the service will provide a nurse led multi-disciplinary, community based service which is proactive, dynamic and skilled in first contact assessment and care, demonstrating autonomous practice with the primary aim of (wherever possible), preventing unnecessary hospital admissions and admissions into long term care. This service will be supported by the appropriate IT infrastructure to ensure communication and safe practice.

We will agree with the successful provider the capacity required to intensively support an agreed number of patients in any given 72 hour period. Providing initial and on-going clinical and social care assessment, observation, co-ordination of care, support and a management plan, patients will then be managed within appropriate pathways. It is accepted that in that 72 hour period the patient may:

- be stabilised with an episode of care completed
- require hospital admission
- further recovery, reablement and rehabilitation
- transfer into the neighbourhood long term/complex care service for ongoing care
- transfer into ambulatory care services

Building for the Future

It is envisaged that up to 72 hours of intensive assessment and support will allow time for future care needs to be considered, providing an alternative to acute admission as a default. It is also recognised that 72 hours is a maximum period of stabilisation or transfer on. However it may be clinically appropriate to complete an episode of care earlier depending on patient need.

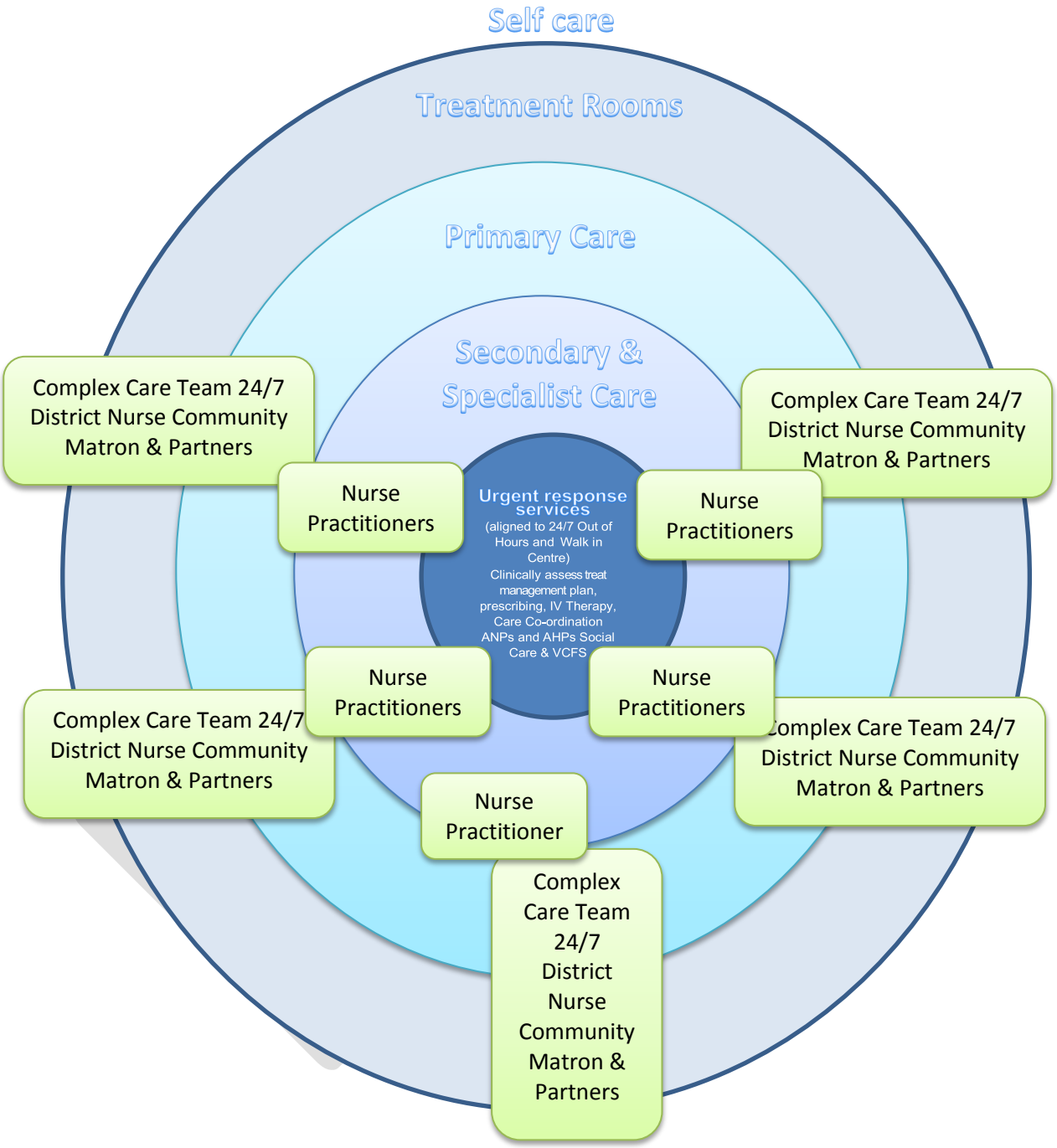


Figure 10 - Neighbourhood Community Health Services Model for W Lancs

For those patients that require transitional support to either help them achieve independence or plan for appropriate long term / complex care needs, community services will extend its approach to recovery, reablement and rehabilitation services to support the local integrated model in West Lancashire through its urgent and complex/ /long term care function.

Building for the Future

We envisage that services are provided by multi-disciplinary neighbourhood teams that include expertise from recovery, reablement and rehabilitation services, physiotherapy, occupational therapy, social care assessors, social care outreach and intermediate care practitioners. Care will be provided either in the patient's own home or from a bed-based unit for those patients who can be safely managed in the community, with clinical and or therapy interventions. We would support a model that limits the need for transition between services as it operates under the one system umbrella as a means of overcoming restrictive referral processes and organisational and professional boundaries and ensures a seamless continuum of care.

Care Homes

As previously stated we see care homes as part of our health care community contributing to the neighbourhood needs based profile. We recognise that some of our most frail and elderly population reside in care homes. We intend to ensure that the same level of care and support is offered regardless of care environment to both residents and staff. For the residents this means equal access to specialist services and care planning for staff this means an invitation to be part of the neighbourhood network with access to development opportunities.

There will be dedicated clinical and therapeutic support for care home residents, with all residents having clinical care plans including advanced care plans addressing end of life wishes. Care plans will also include anticipatory management of long term conditions such as chronic obstructive pulmonary disease (COPD) and heart failure should there be deterioration. The plan will also include psychological and clinical parameters to indicate when urgent access to primary or acute care is needed. Care plans will be shared with the neighbourhood team, for ongoing management and review. Care plans will also be accessible to Out of Hours services and North West Ambulance Service.

COG B - LONG TERM CARE TEAMS

Commissioned services are expected to effectively manage those patients with multiple health and social care needs through multi-disciplinary neighbourhood teams (MDT) in West Lancashire. The service will be expected to play a major role in supporting the seamless transition for patients between primary care, community care, social care and acute services as would be expected in a one system approach, providing seamless wrap around care. We recognise that teams will be comprised of a wide range of practitioners including district nurses, community matrons and support staff, social workers, occupational therapists, physiotherapists, speech and language therapists, dieticians specialist nurses, mental health, support workers and social care, composition dependent on the population need. We would expect management structures that support integration and enable a unified approach, encouraging all members of the team to take collective accountability for the care delivered.

Each GP practice is expected to have a designated neighbourhood team contact to lead the development of effective working relationships and provide assurance around continuity in patient care. They will also provide detailed practice and neighbourhood level reporting and attend MDTs and be represented on the neighbourhood clinical panel.

GPs will expect to be informed of patient admissions and informed when patients are discharged. In addition to this personalised management plans will be in place for all patients who are case managed or need support with care coordination. Those patients being cared for by the service will have a comprehensive care management plan and have an identified clinician who takes key responsibility for the co-ordination of the individuals care and supports navigation through the system.

Access will be available to a range of health and wellbeing related services such as psychological wellbeing services, the new Lancashire Integrated Wellness service, as well as a local directory of relevant voluntary and community sector services that provide support for carers and patients. We are also working with Lancashire County Council (LCC), private and voluntary sector home care providers, we see great benefits in this close working relationship to further reduce problems in transition of care.

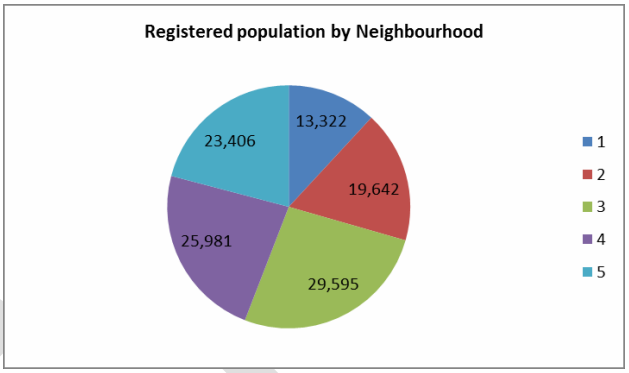
It is recognised that no two neighbourhoods will be the same in relation to staffing levels and skill levels required to meet a particular populations needs, this will be dependent on disease profiles, care homes, demography and health inequalities including wider determinants of health. (See Appendix A for more details). It is expected that the community workforce has a basic skill level in all the core areas such as long term condition management and prevention, tissue viability, frailty, dementia, medicines administration inclusive of intra-venous therapies, problems with activities of daily living, through to end of life care ranging from novice to specialist. It is essential that neighbourhood teams have access and support form specialist clinicians. In Skelmersdale, for example, we know we have high levels of non-elective activity due to COPD, we would therefore expect that every member of the neighbourhood team had a base line knowledge of COPD it's causes and management, with access to a community matron as the advanced generalist, who in turn has access to a specialist respiratory nurse. We are also aware that the health inequalities in Skelmersdale require a different approach and level of health and psychosocial support overall; the team will have to be supported and resourced to reflect those particular needs, drawing on community based assets.

West Lancashire Population

There are 111,946 people registered with a GP in West Lancashire.

West Lancashire's 5 general practice neighbourhoods

1. Tarleton, Hesketh Bank and Banks
2. Burscough and Parbold
3. Ormskirk and Aughton
4. New Skelmersdale and Upholland
5. Old Skelmersdale and Beacon Primary Care



Practice	Practice Name	Neighbourhood
P81177	VIRAN MEDICAL CENTRE	1
P81710	TARLETON GROUP PRACTICE	1
P81772	NORTH MEOLS MEDICAL CENTRE	1
P81096	PARBOLD SURGERY	2
P81138	BURSCOUGH FAMILY PRACTICE	2
P81646	LATHOM HOUSE SURGERY	2
P81674	STANLEY COURT SURGERY	2
P81014	ORMSKIRK MEDICAL PRACTICE	3
P81041	PARKGATE SURGERY	3
P81045	THE ELMS SURGERY	3
P81695	AUGHTON SURGERY	3
P81727	COUNTY ROAD SURGERY	3
P81039	MANOR PRIMARY CARE	4
P81084	HALL GREEN SURGERY	4
P81121	DR JL JAIN	4
P81208	DR SK SUR	4
P81758	MATTHEW RYDER CLINIC	4
P81112	BEACON PRIMARY CARE	5
P81136	DR A BISARYA	5
P81201	ASHURST PRIMARY CARE	5
P81764	DR J MODHA	5
P81774	DR A LITTLER	5

Table 1 - West Lancs GPs in each neighbourhood

Locality 3 has the largest population compared with the other localities in West Lancashire. Locality 1 has the smallest population overall. In terms of age distribution, all of the localities are similar; however, locality 3 has the highest number of patients over 65 years (please see appendix 1 for supporting public health data)

COG C - AMBULATORY CARE

Ambulatory care services are for those patients who can access services in a nearby clinic or treatment room. For example, this might include ear care services, leg ulcer services, IV therapy and district nursing treatment rooms. It is our intention to support extended opening hours and access to more clinic settings to limit the need for transition between providers. We will expect services we commission, to promote better self-management, disease management, case management and lifestyle interventions using ambulatory care services. It will be a priority for community services in West Lancashire to develop and provide targeted approaches that prevent acute exacerbations and the need for emergency hospital admission.

By operating alongside care groups for complex needs and recovery, reablement and rehabilitation, services will be in stronger position to co-ordinate the more effective response for the management of ambulatory care sensitive conditions. These include cardiac failure, diabetes, hypertension, respiratory disease and angina. The proposed model will give the West Lancashire health and social care economy the opportunity to address ambulatory care sensitive conditions throughout the three care groups utilising evidence based pathways of care from prevention through to end of life care.



West Lancashire CCG is committed to developing tri-partite working arrangements between the Clinical Commissioning Group, Lancashire County Council social care and acute providers adhering to the principles of collective accountability whilst still maintaining a viable health economy. Part of the remit of this tri-partite arrangement will be to reduce variation and support system wide cost savings by maintaining wellness and independence in the community. Integration of health and social care and aligned objectives and financial resource will be used as a vehicle to support this ambition supported by the Better Care Fund.

6. COLLABORATIVE APPROACH TO THE ACHIEVEMENT OF OUTCOMES

West Lancashire CCG is looking to work with patients and providers to jointly develop metrics which focus on the achievement of outcomes across the five NHS domains (NHS Outcomes Framework 2014/15). The five domains are:-

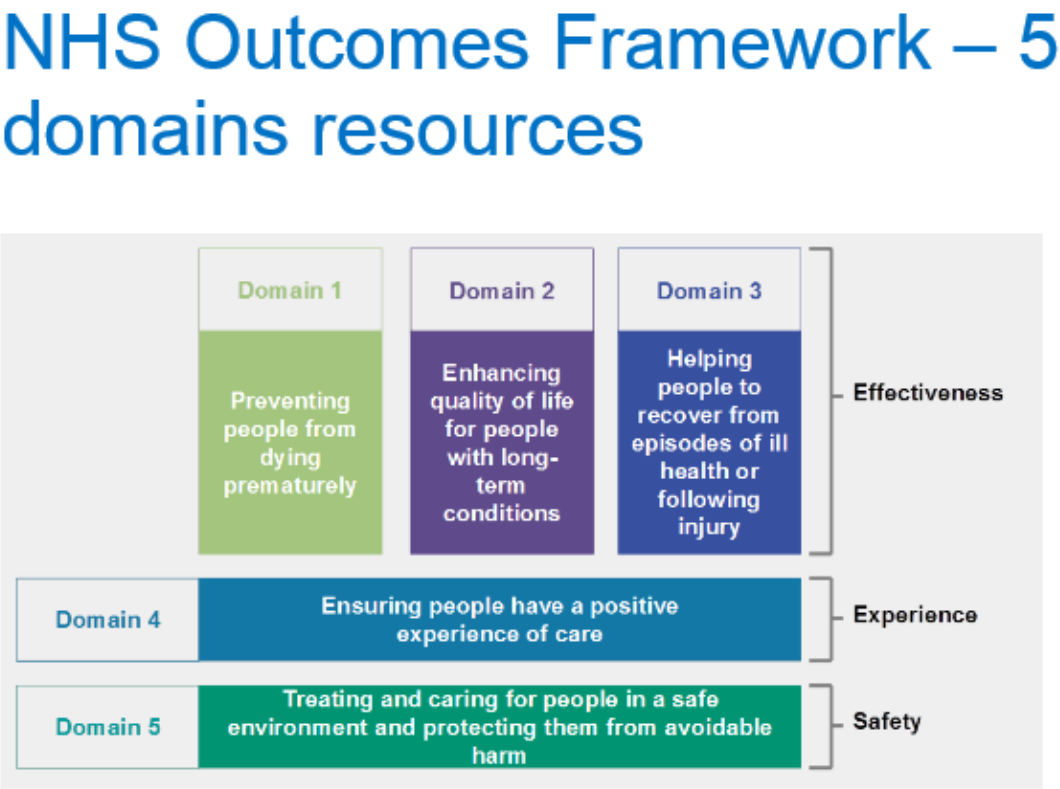


Figure 11 - NHS Outcomes Framework 5 Domains

This work will begin at our bidder event in September 2015 and will continue through the tendering process and onwards after the appointment of the provider(s).

7. WHOLE SYSTEM APPROACH TO REDUCING NON-ELECTIVE CARE

In taking a collective whole system approach to non-elective care management West Lancashire CCG aims to realise a reduction in non-elective attendance and admission of 2379 by 2018/19. (This number to be realized is based on evidence from other areas where models such as those described in this Vision document have been implemented.)

In order to progress to this point, the following table indicates the admissions to be avoided in a phased approach. We would expect the following admissions avoided per neighbourhood per day by 2018/19 as a minimum to release investment and reduce non elective costs Table 2 describes the expected West Lancashire CCG reduction.

Neighbourhood	Reduction per Day
1. Tarleton, Hesketh Bank and Bankes	1
2. Burscough and Parbold	1
3. Ormskirk and Aughton	2
4. New Skelmersdale and Upholland	1.5
5. Old Skelmersdale and Beacon Primary Care	1.5

Table 2 - Proposed Non Elective Reduction for W Lancs CCG

8. SYSTEMS AND PROCESSES TO SUPPORT TRANSITION BETWEEN SERVICES

A robust range of measures (by this we mean systems and processes) will be expected to support transition between services for patients. These include:

a) use of a joint single assessment processes
b) care coordination and single point of access
c) enhanced data and information sharing arrangements with all partners in care
d) new approaches to addressing cross boundary issues
e) workforce -Developing extended roles for clinicians and practitioners
f) use of telehealth and telecare
g) information technology / Enabling the Vision – systems that talk to each other
h) improving public health and addressing health inequalities
i) collective leadership, accountability

a. Use of joint single assessment processes

A single assessment process (SAP) will be expected to be utilised in West Lancashire in order to support patients transferring between acute, community health and social care services. Adult community services will be required to use the SAP in their first contact with patients with complex needs and those being case managed. It is anticipated that this process will be developed with input from senior leaders within adult social care and will be suitable for use across a range of practitioners including community matrons, district nurses, physiotherapists, occupational therapists and social work practitioners. Reducing duplication of the questions asked of patients, standardising information collected in the interests of all healthcare professionals and supporting a coordinated approach for patients transferring between health and social care services. As community services move towards providing more 'in-reach' care, when a patient on the community services case-load is admitted to hospital, the single joint assessment process information is expected to also follow the patient into hospital and out again.

b. Care coordination and a single point of access

A key element of future strategic direction is to further develop its single point of access for the health and social services within West Lancashire with a plan to move towards a care co-ordination service for the population of West Lancashire who would benefit from this approach.

The first phase of this strategy is to develop a 'Single Point of Access' for health services. The single point of access provides the gateway to all referrals entering the integrated health system. There will be a process of professional (health and social care as the service develops) screening and triage of referral to ensure the patient accesses the right care pathway at the right time. This will support patients receiving the right care in the most appropriate setting in a timely manner.

The single point of access will standardise the front end of referral management for the service user and will enable patients/carers and healthcare professionals to have one point of contact for queries about/for people accessing the services. The single point of access will also provide the link for the National 111 service that will be directing people through local services.

The aim is to move from a single point of access to providing a care co-ordination service for West Lancashire. A care co-ordination service will be a clinically led service that will eventually co-ordinate community healthcare referrals through the care pathways. Case managers will be

responsible for assessing service users' needs using a single assessment process, assigning care via care pathway delivery and assessing progress over time. The service will act as a contact point for service users and healthcare professional queries and will be able to actively signpost both patients/clients and healthcare professionals to the right service.

The care co-ordination service will co-ordinate both elective and aspects of non-elective care (or urgent care) for the population and have close links with primary and secondary care to ensure support for patients in preventing admission and supporting discharge.

A clinical triage system will be required to support community services is diverting hospital admissions and managing system referrals into urgent and complex care services (as outlined above).

Through the use of population health data the care co-ordination service will operate to co-ordinate a preventative approach to management of health and social care needs promoting healthy behaviors to 'at risk' groups.

c. Enhanced data and information sharing arrangements

Our approach recognises the GP registered list and practice level data as the place where the impact of all providers on an individual's care can be found, recorded and subsequently optimised in the interests of seamless care for patients. Use of the GP registered list is the predominant means by which a healthcare economy can provide personalised care, tackle health inequalities and provide a more seamless transition between services for the most vulnerable groups of patients.

We will enable West Lancashire CCG's data analysts to work with public health to establish population profiling that examines prevalence of conditions on a practice by practice basis. This local intelligence will be used to inform workforce planning and ambulatory care service improvements. The working agreements between West Lancashire CCG, Lancashire County Council adult social care and acute providers will accelerate the delivery of this programme of work and maximise the benefits of overlaying GP data, community services data and social care data.

West Lancashire CCG will continue to support Lancashire County Council adult services in West Lancashire in its wider working with GPs and acute partners to formalise appropriate data sharing agreements. This work is progressing well.

d. New approaches to addressing cross boundary issues

In relation to patients who are registered with a West Lancashire GP, but who live in a different borough, we intend to commission services that offer a domiciliary visit if required up to a two mile radius outside of the CCG boundary. If the patient lives further than that specified we would expect to see reciprocal arrangements between local providers of services to ensure consistency in the delivery of patient care.

e. Developing extended roles for clinicians and practitioners

Successful support for the most vulnerable groups of patients is dependent on measures within workforce planning training and development to establish new or extended roles for nurses, allied healthcare professionals, social workers and social care providers. To enable the transformation

and mobilisation of extended roles, West Lancashire CCG is committed to maximising the knowledge, skills and competencies of all clinical and aligned staff in order to provide a high level of support for those most vulnerable patients with long term conditions and complex health needs in order to deliver care across services and professional boundaries. We will expect to see the development of the three core functions within the workforce first contact, continuing care and public health, central to other key skills and components as outlined in the diagram below.

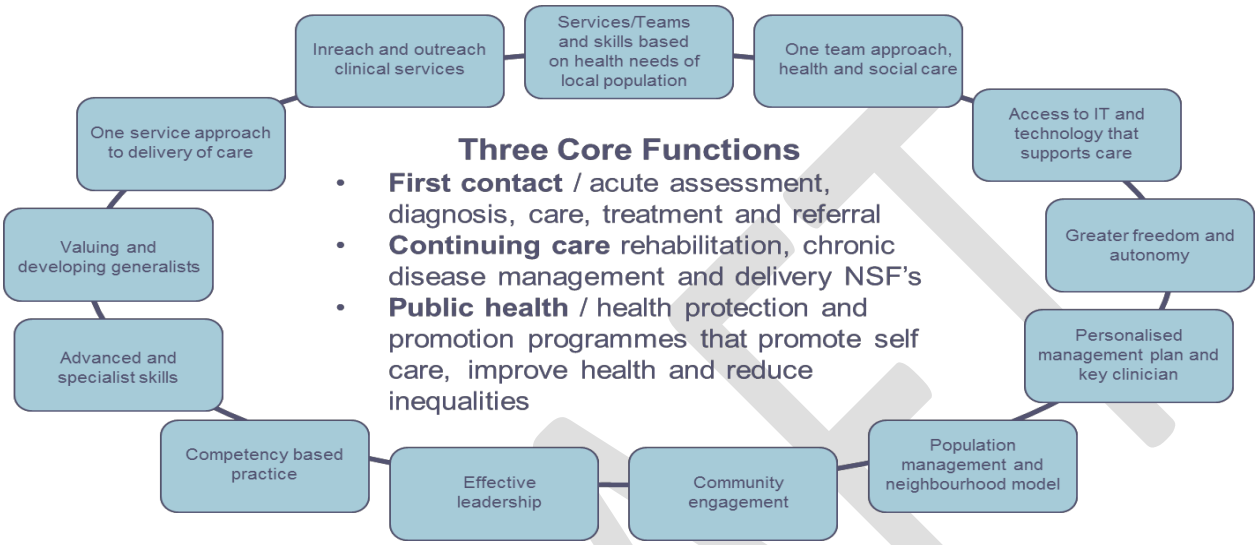


Figure 12 - Three Core Workforce Functions

West Lancashire CCG will support the development of advanced general nursing, urgent care nursing, and specialist nursing, allied healthcare professional roles and non-registered support staff. We would expect to see clinical leaders emerge supported and enabled to provide education, leadership and a strategic approach to service development, who support other nurses, therapist and supporting staff in improving the quality of care for patients with long term conditions. They will set standards and provide accessible knowledge base for specific conditions for the general nursing and therapists to enable patients to self-manage their own conditions. This approach values and develops the generalist along with the specialist, thereby reducing the need for transition into other services and demonstrating autonomous practice.

We intend to work in partnership with providers, local higher education institutes and Health Education North West to support us in designing a transformational education programme, utilising the skills escalator concept in order to develop a skilled sustainable workforce. With our partners, we aim to ensure that West Lancashire is an attractive place to live and work, ***Building For The Future Together.***

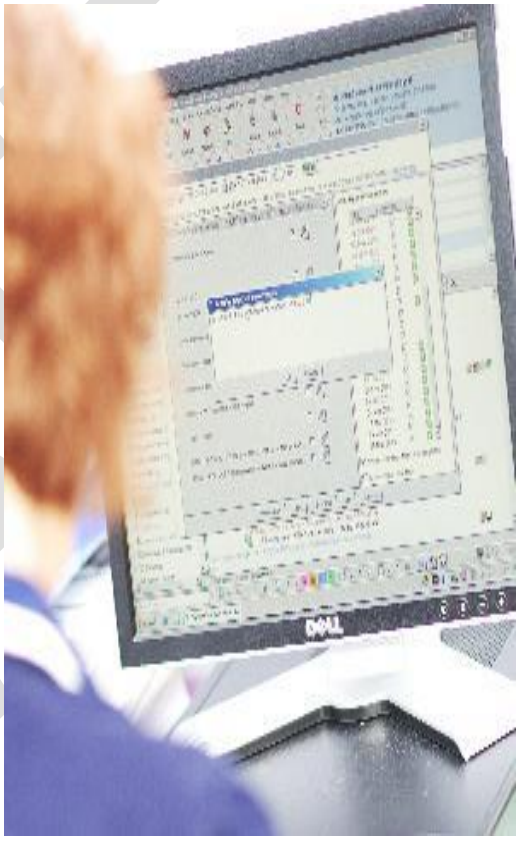
f. Use of telehealth and telecare

Telehealth and telecare is being used in parts of the regional health economy strategy to extend the reach of clinicians with remote monitoring of patients. We are keen to move quickly with extensive deployment of telehealth and are in the process of developing a project plan with input from across our geographical footprint to define patient cohorts for targeting, using an appropriate risk stratification tool. In addition, new working arrangements with social services in West

Lancashire will lead to increased signposting to telecare products that support elderly people to live independently in their own home with dementia or at risk of falls. Work is continuing within West Lancashire to understand how these measures can be used more systematically to support vulnerable West Lancashire patients and ease transition between services

g. Information technology / Enabling the Vision

The use of information technology to support service transformation is a high priority for West Lancashire CCG and forms part of a detailed Information Management & Technology Strategy which has already been communicated across the health economy.



The integrated care model acknowledges the GP as the patient's agent for access to NHS services. GPs account for 90 percent of all patient interactions with the NHS and know their patients' needs best. The community service provider is expected to support general practices, in accessing the information they need, quickly and efficiently in order to support patient care.

High quality health and care services depend on having good information. The document "Liberating the NHS: An Information Revolution" (2010) sets out proposals to improve the information available to patients to enable genuine shared decision making - "no decision about me, without me". To improve communication between patients, GPs and West Lancashire CCG, it is expected that the community service provider will develop a communication strategy that focuses on transparency, including, as a priority, a directory of services that informs patients about what is available in the community, who can access the services and when and how.

The information revolution aims to transform the way information is accessed, collected, analysed and used by the NHS and social services. To meet this challenge, the CCG understands that the community service provider will have access to a single electronic patient record for the hospital and community to be implemented in 2015 and that interfaces with GP and social care systems. All of West Lancashire GPs use the EMISweb system with which we would expect the community service provider's IT solution to be interoperable.

In the spirit of transparency, the community service provider is expected to provide all West Lancashire CCG's general practices with their capitation allocation of district nursing and active case management teams, as well as information on existing activity, and provide activity reports (contents to be agreed), so that practices can see how resources are being used for their patients.

West Lancashire CCG expects that the community service provider will provide all general practices with a flexible package of community services that best meet the needs patients of the individual practices within a neighbourhood. As commissioners we will work in partnership with community service providers to design services that are responsive to practice health profiles. The CCG Executive have asked the GP membership to consider their priorities for community services in the light of this approach, including potentially using freed up identified resources to invest in new services in due course.

h. Improving Public Health and Addressing Inequalities – Harnessing our Community Assets

We believe that public health is everybody's business and as responsible commissioners, West Lancashire CCG is committed to promoting health equity, improving health outcomes and addressing health inequalities for the populations we serve. The CCG is committed to a health promoting philosophy and making every contact count (www.hphnet.org). This means integrating health promotion and quality primary, secondary and tertiary prevention into our services and changing the culture of health care towards inter-disciplinary working, transparent decision-making and with active participation of patients and partners.

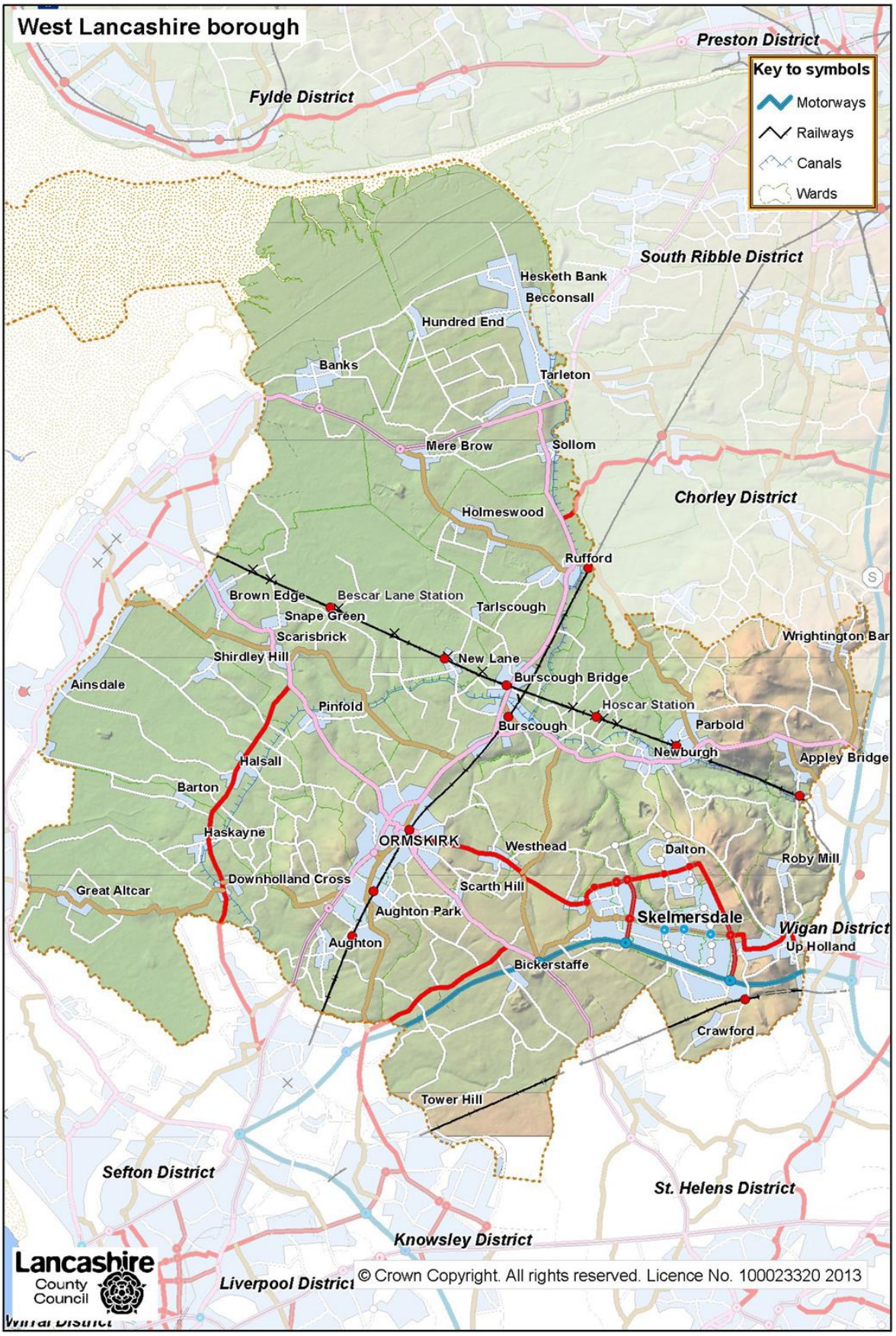
The CCG is committed to putting a community asset based approach at the heart of transformation and in how health and care services are commissioned and provided. Asset-based community development (ABCD) is a large and growing movement that considers local assets as the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions like the CCG, asset based community development draws upon existing community strengths to build stronger, more sustainable communities for the future. ABCD moves away from the traditional assessment of communities in terms of needs, issues and deficits and instead focuses on talents, capacity, skills and opportunities and looks to harness these to build resilience and coping strategies, increasing social capital and developing better ways of providing services, ultimately all contributing to improve health and well-being and reducing inequalities at a local level. ABCD is an approach that facilitates development of community orientated primary care, application of clinician led pathway development and management and systematic involvement of the voluntary, community and faith sector (CVFS). The latter is a critical enabler for supporting the public sector to improve its accessibility to seldom seen, seldom heard groups and as one of the CCG's key partners. We are fortunate in West Lancashire in that we already have a well-established and proactive VCFS, which is an excellent foundation to build on neighborhood work which has already commenced.

The CCG is committed to improving the uptake of disease prevention public health programmes such as immunisation and screening to achieve early diagnosis. The CCG expects that the community provider will play its part in the delivery of this prevention and health improvement plan.

West Lancashire covers an area of 347 square kilometers and has 25 local wards. It is a district of contrasts containing a number of small towns and villages that offer a very good quality of life; the geographical spread of West Lancashire means that c ommunity provider must cover a large area to reach the local population, with parts being of a rural nature, along with a county market town, Ormskirk and the area of our highest health inequalities, Skelmersdale.



Building for the Future



Building for the Future

Skelmersdale in the east of the borough, is a relatively new town developed in the 1960s; it is the focus of a master plan to create a new heart in its town centre bringing in new facilities that local people want to see.

Of the seven wards that make up Skelmersdale;

- Six are within the most deprived 20% nationally
- Four are within the most deprived 5% nationally

In two of the Skelmersdale wards over 45% of children (aged 0-15) are living in income deprived households – overall five of the wards experience the proportion of children living in income deprived households as significantly worse than the England average.

All seven of the Skelmersdale wards are significantly worse than the England average for the proportion of adults aged 60 or over living in pension credit (guarantee) households .i.e. older people in deprivation. (See Appendix 2 for more details)

From a health perspective the CCG is actively pursuing a Well North bid; this is a programme funded by Public Health England which helps develop and test innovative approaches to improve the outcomes of those with the poorest health and most complex lives. It focuses on understanding and building on community strengths and working with communities to develop projects of importance to them which in the long term can be sustained within them. We have great ambitions for Skelmersdale and will expect the community provider to support the CCG in improving health and wellbeing outcomes here and across the Borough.

Given our geographical spread, it is important to make every patient and service user interaction, a health and self-care promoting experience, (Every Contact Counts) in a workforce culture of enablement rather than disablement**.** As such, all front line staff should be offered training in health promoting and self- care principles for example level one smoking cessation advice, which includes referring people who want to give up smoking to specialist stop smoking services.

West Lancashire CCG commissions services to encourage people to live healthy active lives. In joining forces with local councils and by flexing the community services workforce to match practice health profiles, we expect the community provider to actively assist in addressing issues related to health inequalities. We recognise that high quality of care for all means that we must bridge the health gap between people with mental health problems and the wider population, supporting parity of esteem. Addressing mental health and psychological needs will improve the quality of life for the individual, and may also reduce costs related to "physical" long term conditions, e.g. from heart failure, chronic obstructive pulmonary disease and diabetes. People must be assessed and treated holistically for their health problems, rather than by providing separate services for physical and mental disorders. Psychological services are crucial to this and will form a core part of the neighborhood offer, ensuring a parity of esteem for mental health alongside physical health.

i. Collective Leadership – a joined up approach to true integration

A collective leadership approach requires organisations to develop individuals and teams, able to work collaboratively for the greater good of the populations they serve. This approach aligns with and supports the concept of collective accountability.

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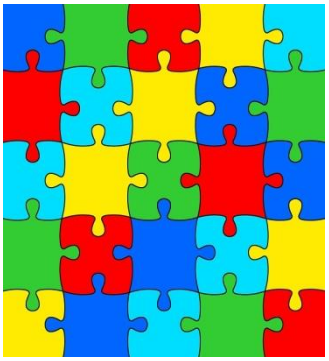

Collectively we know we are all working towards the same common goal: to improve outcomes for the population of West Lancashire. Across West Lancashire, there are various pieces to the jigsaw, which are inextricably interlinked in terms of their overarching aims and objectives. We know that if these various strands come together, it will create a greater whole.

Examples of this are where the CCG is currently working collaboratively with wider partners on various exciting and innovative programmes. These include, but aren't limited to,

- The Early Action work with Lancashire Constabulary which has a clear line of sight to the prevention agenda and aims to target individuals within communities before they reach that tipping point.
- The Neighbourhood Learning Network project, in conjunction with Edge Hill University, the purpose of which is to further develop the knowledge and skills of our local practitioners to support the development of care provision within a neighbourhood. Again, a clear line of sight with the development work around our Integrated Neighbourhood Teams.
- Finally, the Focus on Skelmersdale project which links to the Well North methodology and which focuses on understanding and building on community strengths and working with those communities. As part of this project, we now have intelligence down to lower super output area (L.S.O.A) so we are able to begin to truly understand, at a granular level, about particular communities across the seven wards of Skelmersdale and therefore tailor our approaches accordingly to ensure the best outcomes.

Alongside the programmes set out above we are also working with

- VCFS to develop even further our assets in the community and their use in promoting health and wellbeing.
- NWAS to improve our understanding of the use of our non elective facilities and to find the most appropriate place for our residents to receive their care
- West Lancashire Borough Council to jointly focus on improvements in West Lancashire such as the Community safety priorities etc.
- Our Mental Health providers to ensure integration acorss health and social care.

We aslo continue to work with our other wider partners, such as NHS England, Lancashire Health and Wellbeing Board, etc to joinlty deliver our vision and strategic priorities.

Building for the Future

9. IS THE TIME RIGHT?

The political climate is favorable. There is a shared vision and a history of collaboration within the local health and social care economy. We are joining together on an organisational and service delivery level supported by the Better Care Fund.

We are working hard to reduce barriers between all parts of the NHS, general practice and the independent sector. We acknowledge there are differences in culture, processes and basic goals, we are working through this and plan to continue with organizational development programmes accordingly.

Professional leaders and senior managers are united in seeking to radically improve the health and wellbeing of our population at scale and pace.

Our overall objectives are clear and realistic; we believe the population outcomes are achievable.

We recognise that resources are important both financially and most importantly in relation to the work force. We have the financial resource to drive change in community services and we will work hard to engage and enable staff to be part of the change process generating ownership.

We are aware that change fatigue can bring problems and generate uncertainty; we will work hard to maintain relationships, build teamwork, commitment and planning for organizational development.

We will build on shared values in order to develop collective trust as we move forwards. We will endeavour to minimise potential professional tribalism and philosophies and generate a common language maintaining what's best for the patient at the center of thoughts and discussion.

We will ensure the right people with the right skills are engaged and involved, reaching out to stakeholders and the population.

We recognise that communication, communication, communication is essential at every level.

We will have clear roles and responsibilities throughout this process and beyond with regular contact of key individuals to ensure joint working.

Management accountability and professional leadership are clearly defined.

We are committed to an IT strategy that is shared and to the co-location of key staff

We will commit to joint training and development to aid team building. We aim to minimize misunderstandings, prejudices and other differences as we move forward together,

We will benchmark and continually check progress to ensure we remain on track. If things need changing we are flexible and adaptable enough to do so.

10. CONCLUSION

The redesign of services outlined in the commissioning clinical strategy recognises that we need a community service provider dedicated to developing and delivering community services as the primary place and point of care and fit for today's NHS, with the ability to harness technology and the flexibility to respond to demands of the future. Collaboration, responsiveness, flexibility and the ability to deal increasingly with people at all life stages with long term conditions, frailty, dementia, long term conditions and co-morbidities are a prerequisite to providing care in West Lancashire. Our new approach to integration and proactive transition is planned to ensure a seamless journey for patients between stages in care internally and with external partners. The new models of care are designed to support this intent.

Supporting transition between voluntary, private social and healthcare services will increasingly become core business to any provider. It will also mean that our patients will be more complex as we work to prevent hospital admissions and expedite discharge.

The clinical strategy will be continually reviewed and evaluated. This will include looking again at the impact on the West Lancashire health system, the clinical skills needed to meet requirements, assessing the needs of the local population and the appropriateness of the models of care and operating model. It is likely to further explore assisted technology, prevention and care coordination agendas.

It is recognised that this document is an overarching strategy which will require partnership working across commissioners and providers within the health economy. We intend to build on existing foundations to develop and implement the model which in turn will lead to better health outcomes for our population. To deliver truly integrated care it is evident that this can be best achieved by **"Facing the Future Together".**

Claire Heneghan
Chief Nurse
September 2015

NHS
West Lancashire
Clinical Commissioning Group

West Lancashire Locality Profile 2014

Version 3; October 2014

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Overview

West Lancashire is split into 5 Localities:

1 Tarleton, Hesketh Bank and Banks
2 Burscough and Parbold
3 Ormskirk and Aughton
4 New Skelmersdale and Upholland
5 Old Skelmersdale and Beacon Primary Care

The localities are based on registered practice populations. Beacon practice data has added to Old Skemersdale . West Lancashire has 'worse than average' results for the level of alcohol related stays for under 18's, breast feeding and smoking in pregnancy. In West Lancashire there are more estimated adult smokers than the average for England.

Population

There are 111,946 people registered with a GP in West Lancashire. Locality 3 has the largest population compared with the other localities in West Lancashire. Locality 1 has the smallest population overall. In terms of age distribution, all of the localities are similar, however, locality 3 has the highest number of over 75s.

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Locality	Total Pop	0-4	< 19s	65+	75+
1	13,322	554	2,724	3,067	1,265
2	19,642	905	4,110	4,446	1,872
3	29,595	1,237	6,242	6,819	3,217
4	25,981	1,686	6,657	3,931	1,599
5	23,406	1,332	5,569	3,947	1,701
CCG	111,946	5,714	25,302	22,210	9,654

West Lancashire has more over 65 year olds compared to England were 16.7 % of the population are over 65 years old. The average age of West Lancashire's population is increasing, as documented in the 2009 West Lancashire Borough Council report 'An Aging Population in West Lancashire'. The proportion of over 65s is set to rise to 27% of the population by 2035 for West Lancashire.

Locality 4 has proportionally more 0-4s than the CCG overall. Localities 1 and 2 have proportionally less under 19s than the CCG average. The proportion of over 75s is higher than average in locality 3 and lower than average in locality 4.

Locality	Total Pop	0-4	< 19s	65+	75+
1	12	4	20	23	9
2	18	5	21	23	10
3	26	4	21	23	11
4	23	6	26	15	6
5	21	6	24	17	7
CCG		5	23	20	9

Higher than average
Lower than average

Based on Interquartile range and median for CCG

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Deprivation

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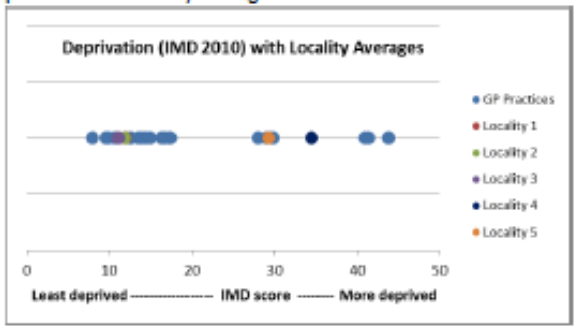
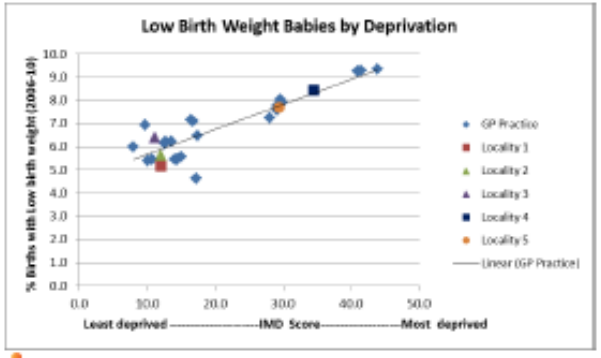
While the level of deprivation across West Lancashire is lower than the national average, there is a range of deprivation across West Lancashire, with the northern areas being more affluent and the southern areas being more deprived. The chart below shows the range of GP Practice deprivation and locality averages.



The proportion of low weight births increases with increasing deprivation across West Lancashire.



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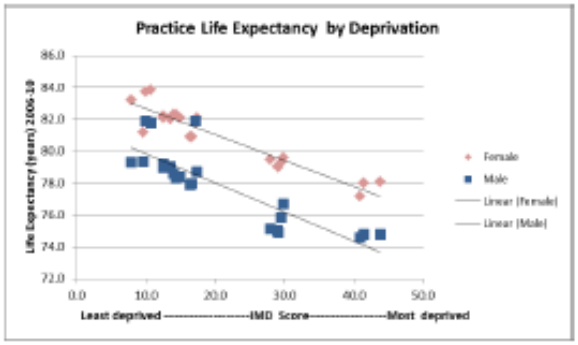
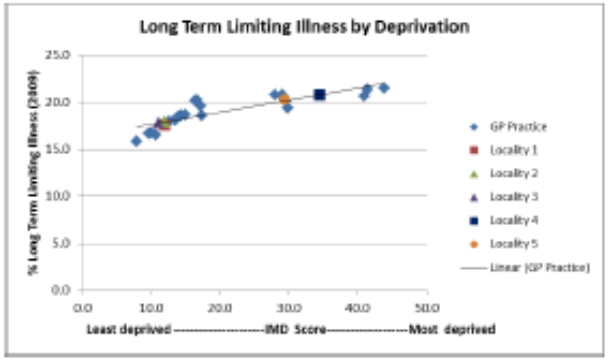
The chart below shows that life expectancy is lower in the most deprived practices, and that the life expectancy gap between men and women is also wider in the most deprived practices.



The proportion of people with a Long term limiting illness increases with increasing deprivation across West Lancashire.



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Disease Prevalence

Individual GP practice registers have been aggregated to give disease prevalence for each locality. It is important to note that the average will not show variations within each locality.

Overall the CCG has higher prevalence of Asthma, CHD, Stroke and COPD than nationally. West Lancashire also has a higher than average hours of care provided by unpaid carers than Lancashire and England. The table below shows how disease prevalence differs by locality.

	CHD	Stroke	Diabetes	High BP	Depression	COPD	Asthma	Cancer	Osteoporosis
Locality 1	3.9	2.2	6.5	18.8	7.1	2.2	6.1	2.5	0.1
Locality 2	4.1	2.1	6.0	17.1	4.6	2.2	7.2	2.1	0.2
Locality 3	4.1	2.1	6.0	14.3	5.9	1.7	6.4	2.6	0.3
Locality 4	3.7	1.7	6.3	13.7	5.9	2.3	6.4	1.7	0.3
Locality 5	4.3	1.8	7.1	17.0	6.5	3.0	5.9	1.9	0.2
WL CCG	3.9	2.0	6.2	15.3	6.8	2.1	6.4	2.2	0.3

Higher than average
Lower than average

Based on Interquartile range and median for CCG

Dementia Prevalence

West Lancashire has a higher prevalence of dementia than the national average. Recent data shows West Lancashire has diagnosed 58% of the expected dementia prevalence and that there are approx. 126 patients missing from registers. Localities 2, 3 and 5 have the highest dementia rates compared to other localities.

	Dementia
Locality 1	0.55
Locality 2	0.80
Locality 3	0.93
Locality 4	0.47
Locality 5	0.83
WL CCG	0.75
National	0.64

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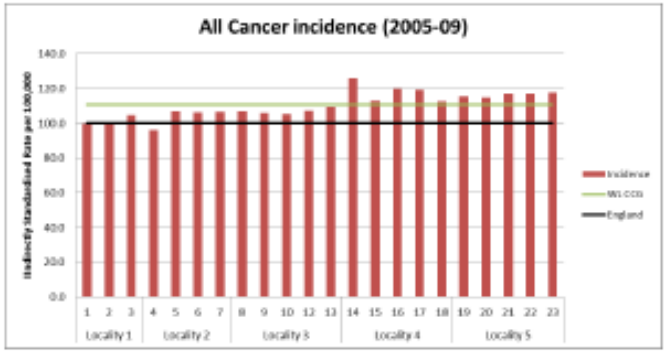
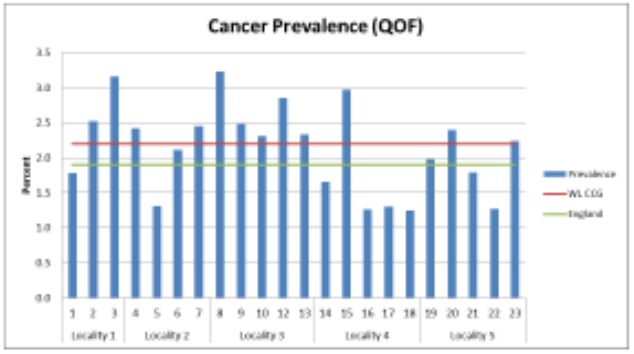
Cancer

West Lancashire CCG prevalence of cancer is higher than the national average. (2.04% compared to 1.8%). Incidence is also above national average. Breast prostate and Skin Cancers have the highest incidence in West Lancashire, but are all under the national incidence rate for these cancers, suggesting they are under reported. In West Lancashire more localities have higher incidence rates. Conversely, prevalence is higher in more affluent localities,.

Mortality from Cancer is reducing, however, West Lancashire has the highest death rate when compared to it's peer CCGs. Lung, prostate, colorectal, and oesophageal cancers are those with mortality rates higher than the national average.





Lifestyle

In West Lancashire the level of hospital stays for alcohol related harm is significantly worse than the national average. However, this level is significantly lower that the North West average. Smoking rates are higher in the most deprived localities. Binge drinking is also higher in the more deprived localities. Obesity is slightly higher in more deprived localities. The table shown is survey data

	% Smoking	% Obesity	% Binge Drinking
Locality 1	12	13	23
Locality 2	12	11	24
Locality 3	15	9	24
Locality 4	24	15	24
Locality 5	22	15	26
CCG	17	12	24

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Unplanned admissions

There is variation across localities in the rate of unplanned admissions. Admissions have been split into those for patients over and under 65 years old, this is because over 65 patients are more likely to have long term conditions and pre-existing complexity than under 65 patients.

Locality 1 had the highest rate of unplanned admissions for respiratory conditions when compared with other localities and the CCG average. Locality 2 had significantly fewer admissions for Respiratory and Cardiac conditions than the CCG average. This is despite locality 2 having high prevalence of asthma and average prevalence for CHD, Stroke and high blood pressure.

13/14 FOT Crude Rate per 1000 under 65s

Practice	Respiratory NEL	Cardiac NEL	Digestive NEL
Locality 1	5.1	7.8	10.0
Locality 2	2.1	4.0	7.2
Locality 3	2.4	5.2	7.8
Locality 4	3.5	5.7	8.8
Locailty 5	4.5	7.4	10.6
WL CCG	3.3	5.9	8.7

Significant difference from CCG average

Digestive unplanned admissions were higher in locality 5 and lowest in locality 2 for under 65s.

Localities were not significantly different from each other in terms of over 65's unplanned admissions. Locality 4 had a significantly lower cardiac unplanned admission rate than the CCG average, perhaps due to the prevalence of CHD and stroke being low in this locality. Locality 3 had the highest rates of admission for digestive conditions in over 65s and was significantly higher than the CCG average.

13/14 FOT Crude Rate per 1000 over 65s

Practice	Respiratory NEL	Cardiac NEL	Digestive NEL
Locality 1	28.1	41.7	25.1
Locality 2	32.5	42.8	21.4
Locality 3	41.0	40.2	33.3
Locality 4	39.0	28.3	20.0
Locailty 5	30.2	37.3	25.7
WL CCG	34.8	37.8	25.7

Significant difference from CCG average

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Source: Admissions data is from SUS, all other data in this profile is from the National General Practice Profiles produced by Public Health England http://fingertips.phe.org.uk/

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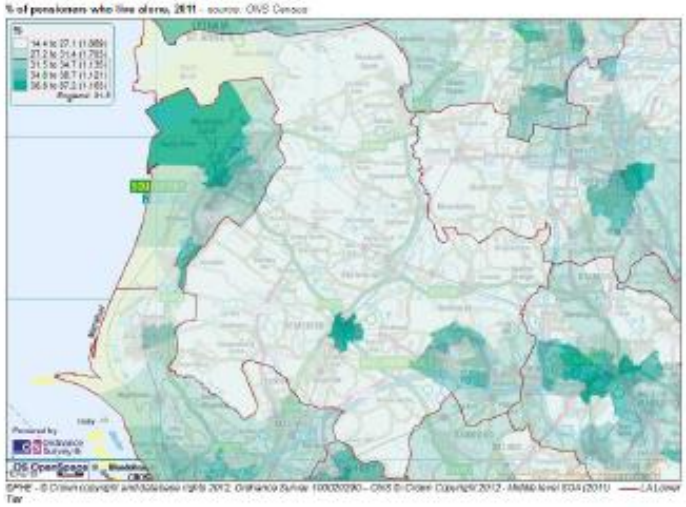
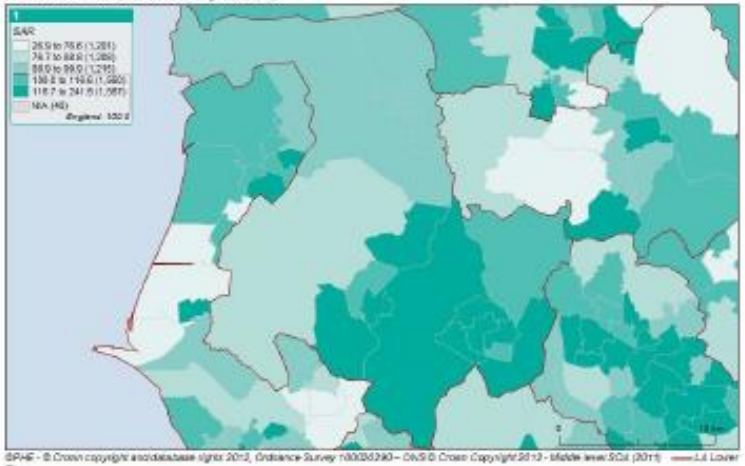
Older people

The Map below shows the proportion of pensioners that live alone are higher in Skelmersdale and Central Ormskirk. Rates of admission for Hip Fracture are highest in the South and East.





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Maps

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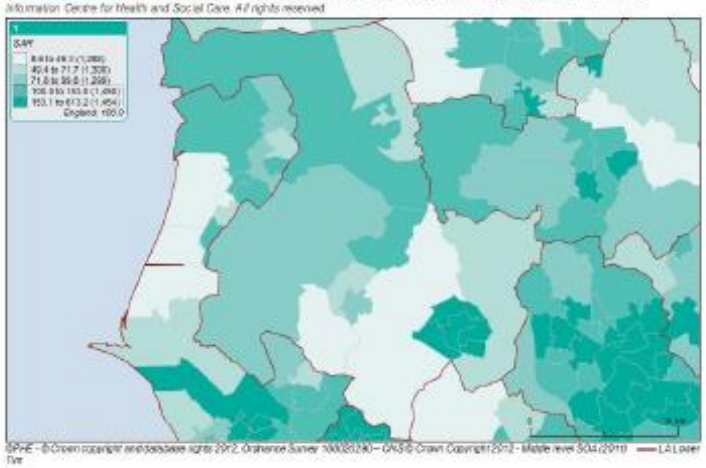
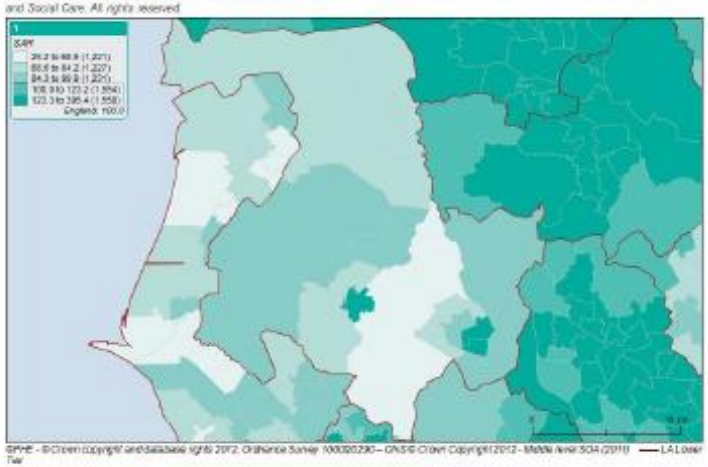
Emergency hospital admissions for chronic obstructive pulmonary disease, standardised admission ratio, 2006/7 - 2010/11 - *source: PHOs (now part of Public Health England), produced from Hospital Episodes Statistics (HES). Copyright © 2012 The NHS Information Centre for Health and Social Care. All rights reserved.*



The map to the left shows COPD admissions are highest in Skelmersdale and the north of the Borough. Areas to the north also have high rates of admission for COPD.

The map to the right shows CHD admissions are shown to be highest in parts of Skelmersdale and Central Ormskirk. Rates across West Lancashire a relatively low.

Elective hospital admissions for coronary heart disease, standardised admission ratio, 2006/7 - 2010/11 - *source: PHOs (now part of Public Health England), produced from Hospital Episodes Statistics (HES). Copyright © 2012 The NHS Information Centre for Health and Social Care. All rights reserved.*



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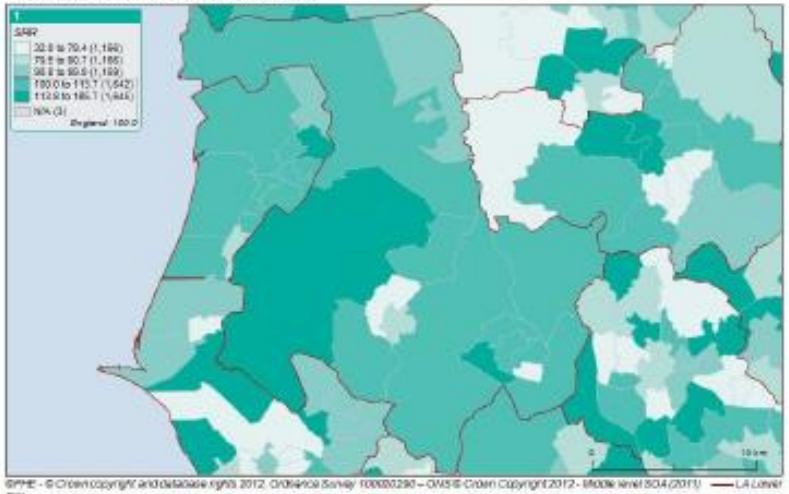
New cases of breast cancers, standardised registration ratio, 2005-2009 - source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository



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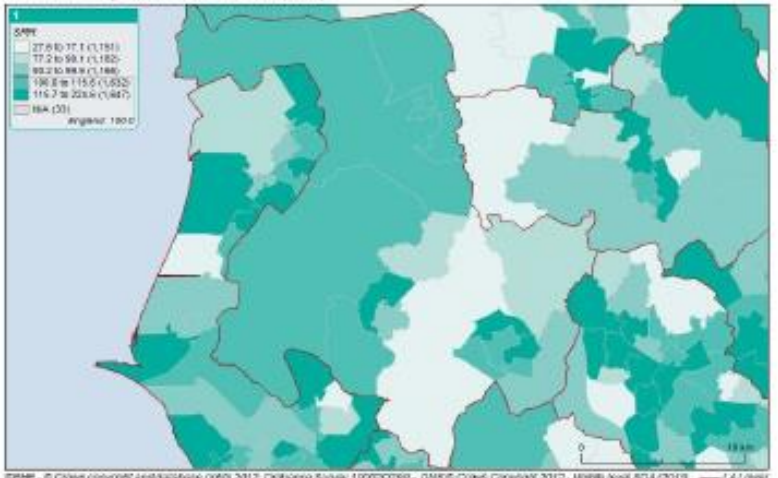
The map to the left shows Breast cancer incidence (new cases in a given time period) is highest in locality 3. and parts of Skelmersdale. However, there is high incidence across West Lancashire.

New cases of colorectal cancers, standardised registration ratio, 2005-2009 - source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository



The map to the right shows Colorectal cancer incidence (new cases in a given time period) is highest in parts of Skelmersdale and Ormskirk ,with North and West areas having moderate incidence.

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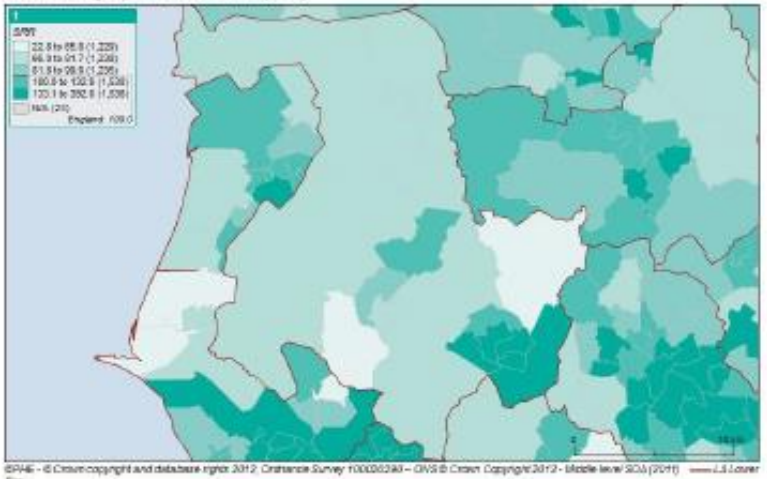
New cases of lung cancers, standardised registration ratio, 2005-2009 - source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository



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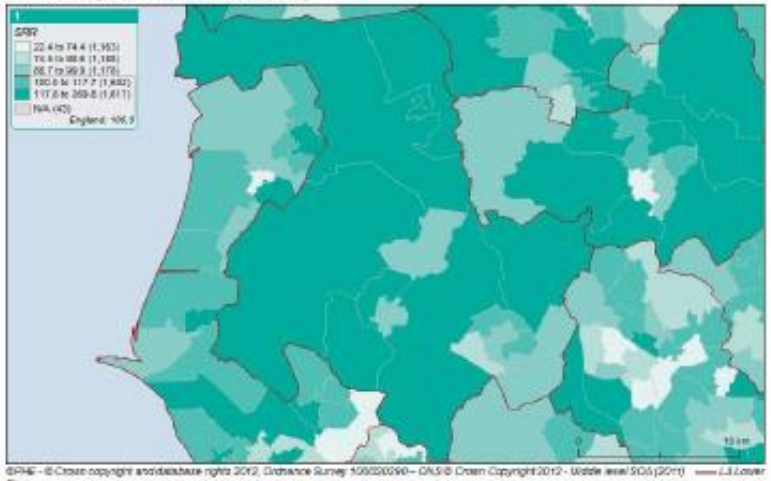
The map to the left shows Lung cancer incidence (new cases in a given time period) is highest in Skelmersdale and Burscough.

New cases of prostate cancers, standardised registration ratio, 2005-2009 - source: UK Association of Cancer Registries (now part of Public Health England), National Cancer Data Repository



The map to the right shows Prostate cancer incidence (new cases in a given time period) is high across West Lancashire, with Skelmersdale and Burscough having lower rates. Perhaps this is due to Life Expectancy of males in more derived areas being lower than more affluent areas, because prostate cancer tends to affect older men.

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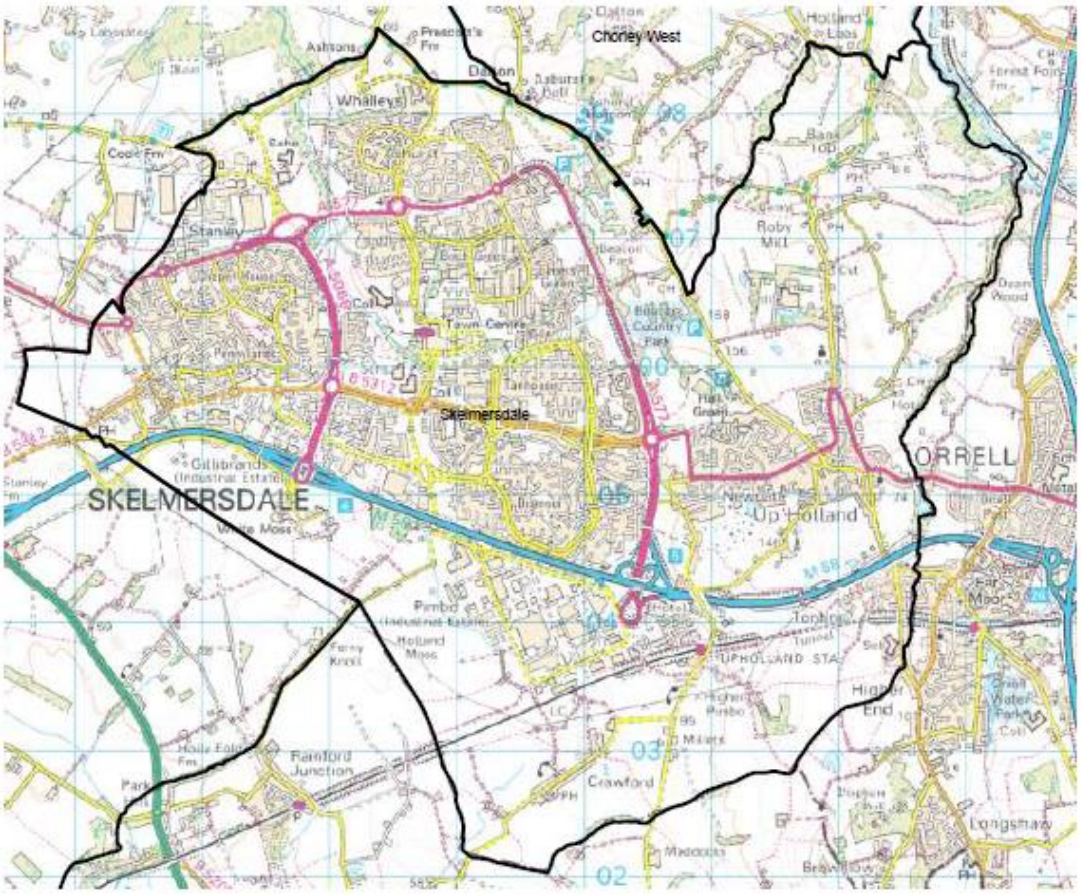
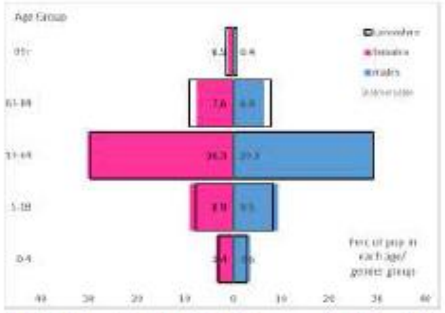
APPENDIX 2 Skelmersdale Profile

Baseline area needs assessment for **Skelmersdale** (7)

Skelmersdale has a relatively young population, primarily families with children (with limited resources), challenged neighbourhoods with lower income and social renters. There is a large variance in deprivation in this area. There are poor health outcomes, although this SPA has less fuel poverty possibly due to newer housing stock having central heating. There is poor access to housing and services.



Socio-demographic profile



Mosaic group		% House holds	Key features	Channel
M	Family Basics	29.17	Families with children; Aged 25 to 40; Limited resources; Some own low cost homes; Some rent from social landlords; Squeezed budgets	Mobile Landline
O	Municipal Challenge	16.36	Social renters; Low cost housing; Challenged neighbourhoods; Few employment options; Low income; Mobile phones	Post

Ethnicity:	White – 98.2%		BME – 1.8%				**Population:** 41,911	
Deprivation:	Avg	33.1	Min	7.8	Max	68.9	Large variance within the SPA	

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Baseline area needs assessment for **Skelmersdale** (7)

Baseline needs assessment

Key: the 34 SPAs were split into fifths from best to worst value for each indicator with seven SPAs in each fifth except the middle fifth which contains six SPAs. The colours are:

Worst fifth	2nd worst fifth	Middle fifth	2nd best fifth	Best fifth	Unrated

To live a healthy life

Baseline indicator	Unit	This SPA	Lancashire	England
Life expectance at birth (males)	Years	75.7	77.7	78.9
Life expectance at birth (females)	Years	80.0	81.7	82.8
All age, all cause mortality	Rate (DSR)	1,223	1,031	-
Emergency admissions	Rate (DSR)	13,453	11,035	-
Obese reception age children	Percentage	11.7	9.4	9.4
Obese year six children	Percentage	23.7	17.7	19.1
Self-reported health bad or very bad	Percentage	7.6	6.3	5.5
Activities limited a lot	Percentage	11.2	9.8	8.3
People providing 50+ hours unpaid care per week	Percentage	3.3	2.7	2.4
Proportion of pensioners living alone	Percentage	31.9	31.2	31.5
Disability-free life expectancy males. **District value**	Years	60.3	-	61.7
Disability-free life expectancy females. **District value**	Years	62.4	-	64.2
GP recorded prevalence of mental ill-health. **CCG value**	Percentage	0.7	1.0	0.9
GP recorded prevalence of depression. **CCG value**	Percentage	7.5	8.2	6.5
Self-reported wellbeing (SWEMWBS)	Mean score	22.4	22.9	-
Multiple health compromising behaviours	Percentage	42.6	35.9	-
Neighbourhood needs index (level of community safety need)	Rank (of 34 areas)	10	-	-

To live in a decent home in a good environment

Baseline indicator	Unit	This SPA	Lancashire	England
Proportion of dwelling stock in low council tax bands (A or B)	Percentage	80.5	56.9	44.3
Households with no central heating	Percentage	1.2	3.6	2.7
Households in fuel poverty	Percentage	8.6	10.8	10.4
Barriers to housing and services	Mean score	18.2	13.8	-
Median house price	Median price (£)	£99,575	£134,698	£219,736
Vacant dwellings. **District value**	Percentage	3.2	21410.0	610123.0
Net additional dwellings. **District value**	Number of dwellings	370	2710	136610

To have employment that provides an income that allows full participation in society

Baseline indicator	Unit	This SPA	Lancashire	England
Educational attainment key stage 2	Percentage	78.7	80.6	-
Educational attainment key stage 4	Percentage	53.0	59.1	-
Percentage with no qualifications	Percentage	29.4	23.6	22.5
Working age benefits clients	Percentage	21.6	95,650	4,155,370
Children living in poverty	Percentage	27.7	18.8	21.8
Median annual income	Median income (£)	£22,561	£26,646	£28,465
Claimant count	Percentage	19.3	1.2	1.9
Young people not in employment, education or training	Percentage	5.8	4.7	-
Gross value added. **NUTS-3 value**	£ (millions)	£21,088	£21,088	£1,297,667