FYLDE AND WYRE

HEALTH AND CARE STRATEGY 2030

Our Vision for a Healthier Future

A DRAFT DOCUMENT FOR DISCUSSION

Fit & Well

NHS
Fylde and Wyre
Clinical Commissioning Group

Who we are

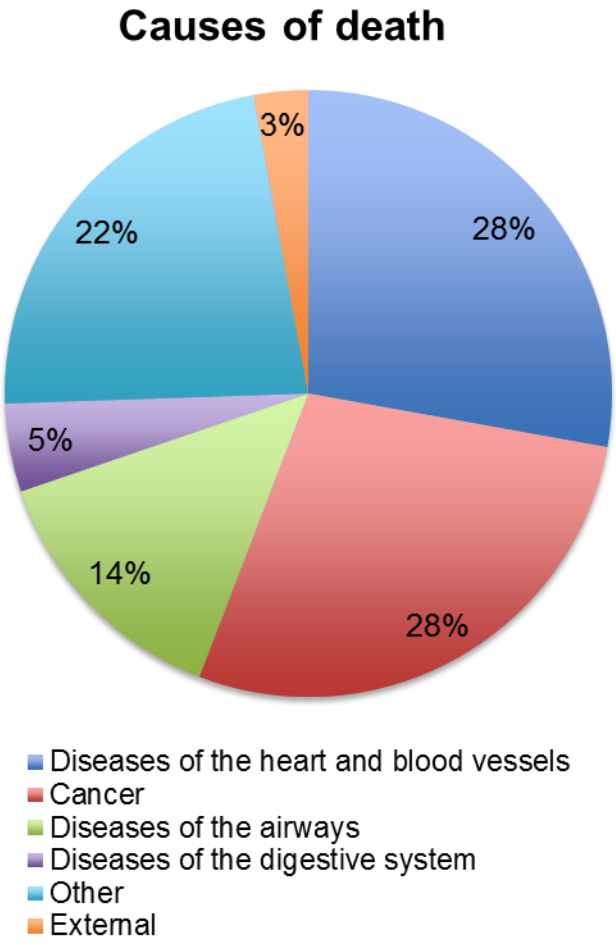
- NHS Fylde and Wyre Clinical Commissioning Group (CCG) is responsible for planning and buying health services in the area. This is known as ‘commissioning’.
- Led by family doctors (GPs), the CCG serves a population of 152,000 people across the Fylde and Wyre area.
- The CCG receives a set amount of money from the government – £196m this year – and is committed to spending this wisely for the benefit of local people.






The challenges we face

- An ageing population – by 2022 there will be 28% more people aged over 70; by 2030 the number of people aged over 85 will have doubled.
- The numbers of people with diseases of the heart and blood vessels, diabetes, kidney disease, stroke and dementia are higher than the national average.
- The numbers with complex long-term conditions are set to rise.



The challenges we face

- Unacceptable health inequalities: in the most deprived parts of Fylde and Wyre men die, on average, 10 years younger than those in more affluent areas. For women the difference is six years.
- We spend more than the national average on treatments for bone and muscle problems, heart and breathing diseases, as well as cancer and mental health, and yet patients report worse outcomes.
- Flat funding will leave a local funding gap of at least £6.2m by 2021 if the NHS continues delivering services in the same way.

We are driven by patient need and ensuring high quality care, but we also need to ensure every penny counts so that we can provide the best care to the maximum number of people.

Developing our vision

- Our aim:
  - to create a health service that keeps people well
  - to make sure that when people are unwell, they can get high quality treatment or advice as close to their home as possible
- We want to develop a long-term vision for health services to tackle some of the significant problems we face.
- Our vision needs to be shared by our partners and the public –
  we can’t do it alone.

Gathering views

- Sought views to develop the first draft of the vision (Oct-Dec 2013). Included:
  - Focus groups for patients and the public
  - Event for partner organisations
  - Many other events and surveys
- Testing vision now:
  - More focus groups
  - Representative telephone survey of 1,000 people
  - Draft document out for comment
  - Use of the media, internet and partner channels

Priority service areas

- Planned care
- Unplanned care
- Long-term conditions
- Mental health and dementia
- Children and maternity
- Learning disabilities
- Cancer
- End of life

Vision for planned care

- Wider range of high-quality services within the community so people have easier and earlier access to planned care, with many services available seven days a week.
- GP practices coordinate health and social care, and have overall responsibility for a patient's care.
- People have the information and support they need to make informed choices about their health and healthcare, and are better equipped to take control of their own health conditions.
- People only go to hospital for treatment that can only be carried out safely there. This means, over time, fewer hospital beds are needed.

Vision for unplanned care

- Improved access to community-based services and better use of technology, e.g. telehealth, to support people at home.
- Joined-up health and social care services.
- People likely to need urgent care actively supported to stay well.
- Better information so people know what services are on offer and how to access them.
- Fewer people going to A&E / using emergency services who don't need to.

Vision for long-term conditions

- Everyone with a long-term condition has a personal care plan accessible by all relevant agencies.
- General practice coordinates a broad range of care in a community setting, including in a patient's own home.
- Healthcare professionals focus on identifying people at risk of developing long-term conditions.
- People have access to a wide range of clinical and healthy lifestyle support, including self-help and management programmes.
- Telehealth used by individuals to monitor and manage their condition at home.
- Fewer people admitted to hospital. When they are, it is for as short a time as possible.

Vision for mental health & dementia

- Greater focus on helping people stay well.
- People mainly access care from home or in a community setting, with support available 24/7. Support via the internet integral to the service.
- Specialist services centralised to deliver the highest quality of care.
- Seamless transition between children's and adult support.
- Fylde and Wyre – a 'dementia friendly community'.

Vision for children and maternity

- Better coordinated, community-based services, with technology used to widen access.
- Seamless transition between children's and adult support.
- Expectant mums supported to make choices about where and how they have their care needs met.
- Health promotion services, such as support to stop smoking, tailored to individual needs.
- More babies still breastfed at eight weeks.

Vision for learning disabilities

- Greater focus on supporting people with a learning disability to keep well.
- More services jointly commissioned to ensure joined-up care.
- All health services make reasonable adjustments to meet the needs of patients with a learning disability.
- Practices proactively identify and manage health risks for their learning disability patients.
- Seamless transition between children's and adult support.

Vision for cancer

- Fewer people develop cancer due to better awareness of keeping well; supported by teaching cancer prevention in schools.
- Waiting times for referrals for suspected cancers reduced from the current two weeks to a maximum of one week.
- Patients managed within community-based settings where more tests and treatments are carried out.
- A named healthcare professional has responsibility for an individual's care.
- Survivorship through motivational training – part of a patient's treatment.

Vision for end of life care

- Advanced planning to identify those approaching the end of life to ensure their wishes are fulfilled.
- Strengthened community-based teams to support patients to die according to their wishes.
- Improved training for NHS staff and staff employed by care providers, particularly with regard to communicating with patients and their carers.
- People offered a discussion about their end of life wishes.
- The needs of carers appropriately assessed, with support offered pre- and post- bereavement.
- Providers of care coordinated to ensure a joined-up service and consistent standards.

Summary

- There are a number of common themes:
  - more support to help you manage your condition at home and keep fit and well
  - better information to support you to make choices about your health and healthcare
  - more coordinated and integrated health and social care planned around your needs
  - access to many services seven days a week
  - more community and home-based care
  - care in hospitals for specialist treatment only
- We think that GP practices should be at the heart of delivering these changes.
- As well as coordinating your care, we think practices should be able to decide how to tailor services to meet the community's needs.

Summary

HOSPITAL CARE

- Care in hospitals only where it is not safe for you to be treated in your home or community

COMMUNITY-BASED SERVICES

- More community-based services, many run seven days a week

GROUPS OF PRACTICES

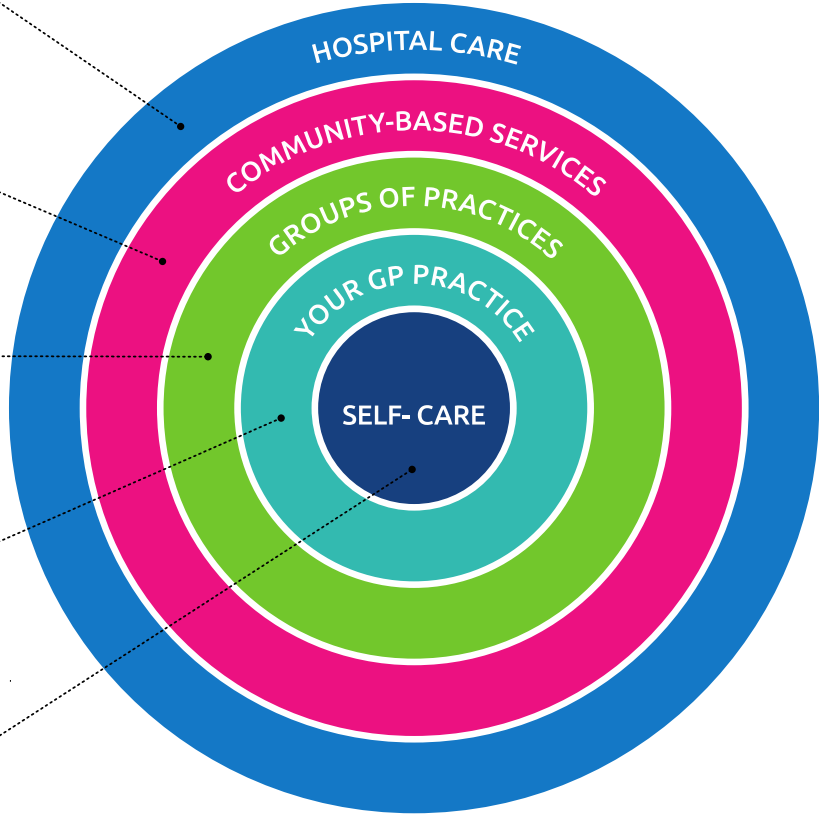
- Groups of practices coordinating community-based care to make sure services meet the needs of the local population

YOUR GP PRACTICE

- Identifying your needs and coordinating your health and social care

SELF-CARE

- More support to help you manage your condition at home and keep fit and well



Engagement to date

- Email distribution using comprehensive stakeholder list – including member practices, patient interest groups, VCFS, councillors, and MPs
- Face to face engagement with Fylde, Wyre and Lancashire County councils – OSCs and officers
- Presentations to Fylde and Wyre Health and Wellbeing Partnership, PPE Group, GP practice managers, staff and Council of Members
- Provider workshop – 27 attendees; GP practice event – 97 attendees
- Engagement with schools – 110 children (Kirkham)
- Community engagement – listening cafes, focus groups – 320 people
- Enquiry line responses – 36 responses
- Qualitative engagement and feedback from approximately 1,800 people
- Quantitative feedback (MORI) – 1,004 people

Key themes

- Broad support for the strategy/vision
- Is a 16 year strategy sustainable or realistic? (in context of change – political, financial, medical, technological, etc.)
- The strategy is strong on the “what” but not on the “how”
- Prevention needs to be given greater prominence
- Many partners are relied upon but not referenced (councils, VCFS, patient interest groups)
- CCG will need to demonstrate that people can influence health decisions
- Services need to be coordinated and integrated

Key themes

- Information about services and conditions needs to be readily available
- Transport provision needs to be a key consideration in all developments
- Waiting times need to be improved
- Needs to be more recognition and support for self care and to promote personal responsibility
- Need to recognise that each locality/community is different with different needs

Stats from MORI: 1,004 interviews

- 85% – local NHS provides a good service (cf. 77% in *Public Perceptions of the NHS*)
- 78% – national NHS provides a good service (cf. 66% in *Social Care Tracker*)
- Perception of quality directly related to how informed a person is
- Good service: 'No problems' (35%); Good quality of care (25%); Efficient (20%); Good GP (19%); Good GP access (11%)
- Poor service: Poor hospital care (29%); Poor GP access (21%); Wait too long for GP apt (21%); Poor GP service (16%)
- 60% have heard of the CCG. BUT only 6% know 'a great deal'; 17% 'a fair amount'; 23% 'just a little'
- 78% heard of health challenges; 42% 'a fair amount'; 22% have not
- Awareness higher from 55-74 year olds and higher social grades

Experiences of coordinated care

- 21% have a long-term condition (LTC); 15% are unpaid carers
- 75% with LTC know who to contact about their care; 42% have a specific health professional
- 54% have a regularly reviewed care plan; 33% do not
- 43% have to repeat medical history when they see a health professional; 47% do not

Providing community-based care

- 83% support practices working together to address NHS challenges – 54% ‘strongly support’
- Support higher where people are more satisfied with NHS services (85% cf 70%), and where people are younger
- Huge support to move end of life care and rehab to community; more caution for tests. Mirrors national research re moving ‘clinical’ services
- High support to move post-hospital care, particularly among parents
- Strong agreement to give people tools and freedom to manage their condition, and use of new technologies to do this (86%)
- 86% agree practices should coordinate care; 74% support idea of practices providing different services based on needs
- 33% support measures to ‘reduce hospital beds’ – greatest opposition in 55-77 age group

Communication and engagement

- People with LTC are less satisfied with information provision
- 63% likely to speak to a health professional (most trusted = GP; 57% would make an appointment); 45% internet. Very few look at local sources of information, e.g. the media
- Older residents more likely to want to talk to a health professional; younger residents more likely to use the internet
- High support for using technology for transactional healthcare (e.g. repeat prescriptions), with most support from 16-34 age group
- Less support to use technology for more ‘clinical’ services – getting tests online (62%); online consultation (48%)
- Over 75s: 28% wouldn’t find any technological applications useful
- People with LTC also not as supportive

Choice

- Choice of GP surgery – 92% say it's important; choice of hospital 88%
- People with LTC more likely to want choice of hospital consultant compared to those who don't (75% cf. 67%)
- People generally confident to choose a GP surgery and hospital
- 81% think choice of treatment is important, but only 67% feel confident making a choice – need to support patients understand options and pros/cons
- People likely to speak to GP re choice (52%), then non-NHS websites (20%); friends/family (19%); NHS websites (13% NHS choices; 11% other; 6% local hospital)
- Older people – speak to GP; younger people – websites

Patient access

- Adults with high temp/sore throat – 30% NHS 111; 19% walk-in-centre; 7% A&E
- Why? Quick advice (20%); don't know options (18%); repeat what done before (13%)
- Child with high temp/sore throat – 34% walk-in-centre; 30% A&E; 29% NHS 111
- Why? Quick advice (23%); don't know options (16%); staff experienced (10%)
- Parents more likely to know about options available OOH

You said, we did…

You said…	We did…
Helping to keep people well should be a top priority	Health promotion, education and supporting people to self-care – a key theme
Care is often fragmented, and the different agencies providing services are not coordinated	A named person from your GP practice will be responsible for coordinating an individual's care – 86% of those who took part in our telephone survey agreed
Learning disabilities should be specifically addressed	Learning disabilities is now a specific priority
85% of those who took part in our telephone survey said people should be given the tools and the freedom to manage their long-term condition	We will strengthen community-based support to enable people to better manage their conditions and stay as well as possible

You said, we did

You said…	We did…
Need better information about services and how to access them	Better communication – including the use of new technologies – is a key theme
People at the end of their lives need more choice, and families/carers need better support	We are proposing better training for health professionals, and pre- and post-bereavement support for carers
Stroke and diabetes should be specific areas of focus	Both of these affect large numbers of people locally and are priority areas for us. We had to give the document a structure, which is why they are under the heading ‘long-term conditions’, but this does not in any way diminish their importance
Services should be tailored to the needs of individual communities	Groups of GP practices will coordinate community-based services; these services should be tailored to the needs of the local population – 74% of those who took part in our telephone survey agreed

You said, we did

You said…	We did…
Health problems, e.g. cancer or long-term conditions, need to be identified earlier	We want to boost screening and support for those at risk
The CCG won't be able to achieve its vision alone	We have endeavoured to involve partner agencies in the development of our plans. We have also strengthened the narrative about partnerships in the document
Carers are vitally important. Their contribution needs to be reflected, and they need more support	Carers are key partners. Our telephone survey revealed that 15% of people class themselves as unpaid carers. We want all carers to have a joined-up assessment to identify their needs and specific support requirements
A strategy looking to 2030 is not realistic. It also needs to have more about how you will actually achieve your vision	This document is meant to set out a high-level vision for the future that will be our 'guiding path'. We are developing detailed two and five year plans which will set out how we aim to achieve our vision, and these will contain measurable targets

You said, we did

You said…	We did…
Concern that GP practices would not have the capacity to coordinate people's care or services across neighbourhoods	We are working with GP practices at the moment to develop this new way of working, and as part of this will agree what level of support they will need to ensure they are effective in the future
There needs to be better after-care and support in the community after patients have been discharged from hospital	Providing better community-based health services is a key part of our plans. Our vision is that people will leave hospital sooner due to better community-based support, with follow-up outpatient appointments carried out in a community setting as well
People should take more responsibility for their own health – the NHS can't be expected to do everything	We aim to widen access to self-help, self-management and healthy lifestyles support. We think everyone should do their bit to keep as fit and well as possible
There is no mention of sexual health services, alcohol or substance misuse services	The CCG does not commission these services. However, we do work with our partner commissioners to make sure services are joined-up and this has been given particular mention in relation to Children & Young People

You said, we did

You said…	We did…
43% of people with a long-term health condition say they have to repeat their medical history every time they see a health professional	Everyone with a long-term health condition will have a personal care plan which will be linked their GP record and will be available electronically. This will be available to all of the organisations involved in a person's care
Access to mental health services is poor, and better information about mental health and dementia services is needed	We aim to commission a single entry point for mental health services for people of all ages to improve access
Support for people with learning disabilities is variable across all services, suggesting that health professionals lack knowledge about the needs of people with learning disabilities	We will work with Health Providers to ensure that appropriate support to meet the needs of people with a learning disability is available.
Don't use NHS jargon!	We have tried to use plain English, and have included a glossary
Need to ensure that palliative care is available for Children & Young People	We agree and will use the development of personal health budgets to enable the tailoring of support to meet the needs of children & young people. Our local hospice does provide services and support to children which is funded through charitable donations and some national funding. We will ensure that anything we develop links appropriately to their provision

Next steps

- A final document outlining a shared vision for the future will be published in April 2014.
- The document will include a ‘you said, we did’ section so people can see how their views made a difference.
- We will involve people as we develop detailed plans.
- Welcome your thoughts on our strategy, and how we strengthen our communication and engagement processes.

Contact us

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