

Lancashire & South Cumbria STP

April 15 template submission

FINAL v 4.2



Key information on the footprint

Name of footprint: 4. Lancashire & South Cumbria

Region: North

Nominated lead of the footprint: Dr Amanda Doyle, Clinical Accountable Officer, Blackpool CCG

Contact details: Amanda.Doyle@blackpool.nhs.uk 01253-951227

Organisations within footprint:

Organisations by Local Delivery Plan footprints

Central

Greater Preston CCG
 Chorley & South Ribble CCG
 Preston City Council
 Chorley Council
 South Ribble Council
 Lancashire Teaching Hospitals FT

Fylde Coast

Blackpool CCG
 Fylde & Wyre CCG
 Blackpool Teaching Hospitals FT
 Blackpool Council
 Fylde Council
 Wyre Council

West

Southport & Ormskirk Hospitals
 West Lancs CCG
 West Lancashire Council

North

University Hospitals Morecambe Bay FT
 Cumbria Partnership FT
 Lancashire North CCG
 Cumbria CCG (South)
 Cumbria County Council
 Barrow-in-Furness Council
 Lancaster City Council
 South Lakeland Council

Pennine

Blackburn with Darwen CCG
 Blackburn with Darwen Council
 East Lancashire CCG
 East Lancashire Hospitals Trust
 Burnley Council
 Hyndburn Council
 Pendle Council
 Ribble Valley Council
 Rossendale Council



Overarching Organisations

Lancashire County Council
 Calderstones/MerseyCare Trust
 Lancashire Care FT
 NHS England
 North West Ambulance Service

Section 1: Leadership, governance & engagement (1)



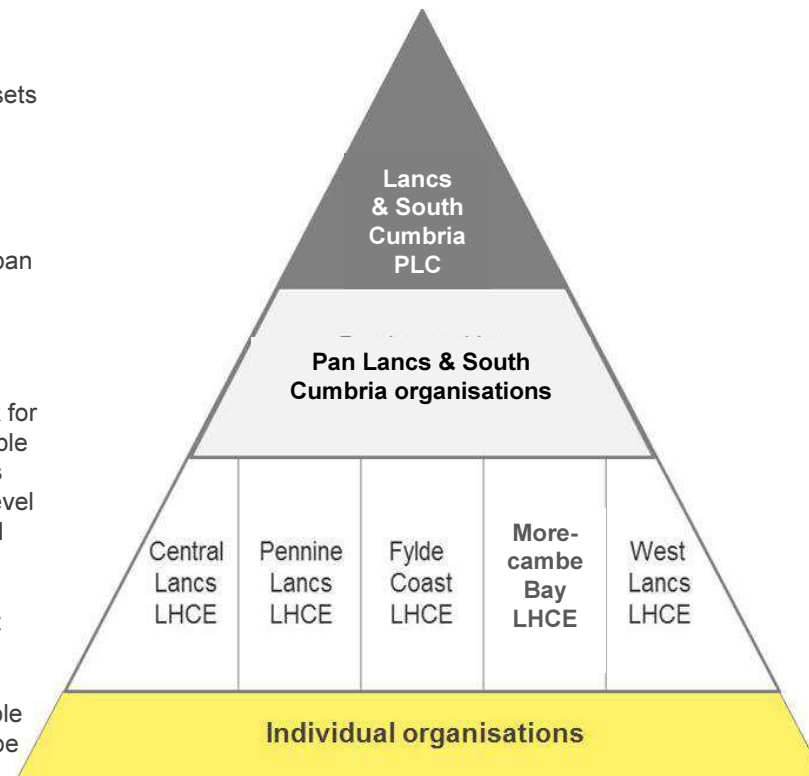
Collaborative leadership and decision-making

Healthier Lancashire & South Cumbria

As health and care organisations across Lancashire and South Cumbria (L&SC) we have organised ourselves to work in an unprecedented collaboration to co-design, implement and deliver the changes required to transform the health and care services; to ensure services are delivered to meet the needs of our local populations, and actually ensure improved health outcomes, but that are prioritised within existing financial allocations. Our ambition is to see a radical large scale system change in health and care in L&SC, underpinned by the combined long-term commitment of organisational leaders across L&SC. We're doing this to deal with the financial, demographic and outcome challenges being felt more acutely in our area than elsewhere in England and consequently needing urgent, unified attention.

The L&SC Sustainability and Transformation Plan 2016-21 will be an early output of the Healthier Lancashire & South Cumbria programme, setting out the case for change, priorities for collective action and plans for mobilisation of the solution design phase of the HL&SC programme. HL&SC will need to be built upon the commitment of the providers, commissioners, local government and other partners within each of our five localities to deliver the change required to better meet local needs through their local delivery plans (LDPs). The success of the L&SC STP will depend upon the alignment of its vision, ambition and priorities with the opportunities for collective action within the LDPs, and the effective focus of our combined efforts at the right level of the HL&SC triangle.

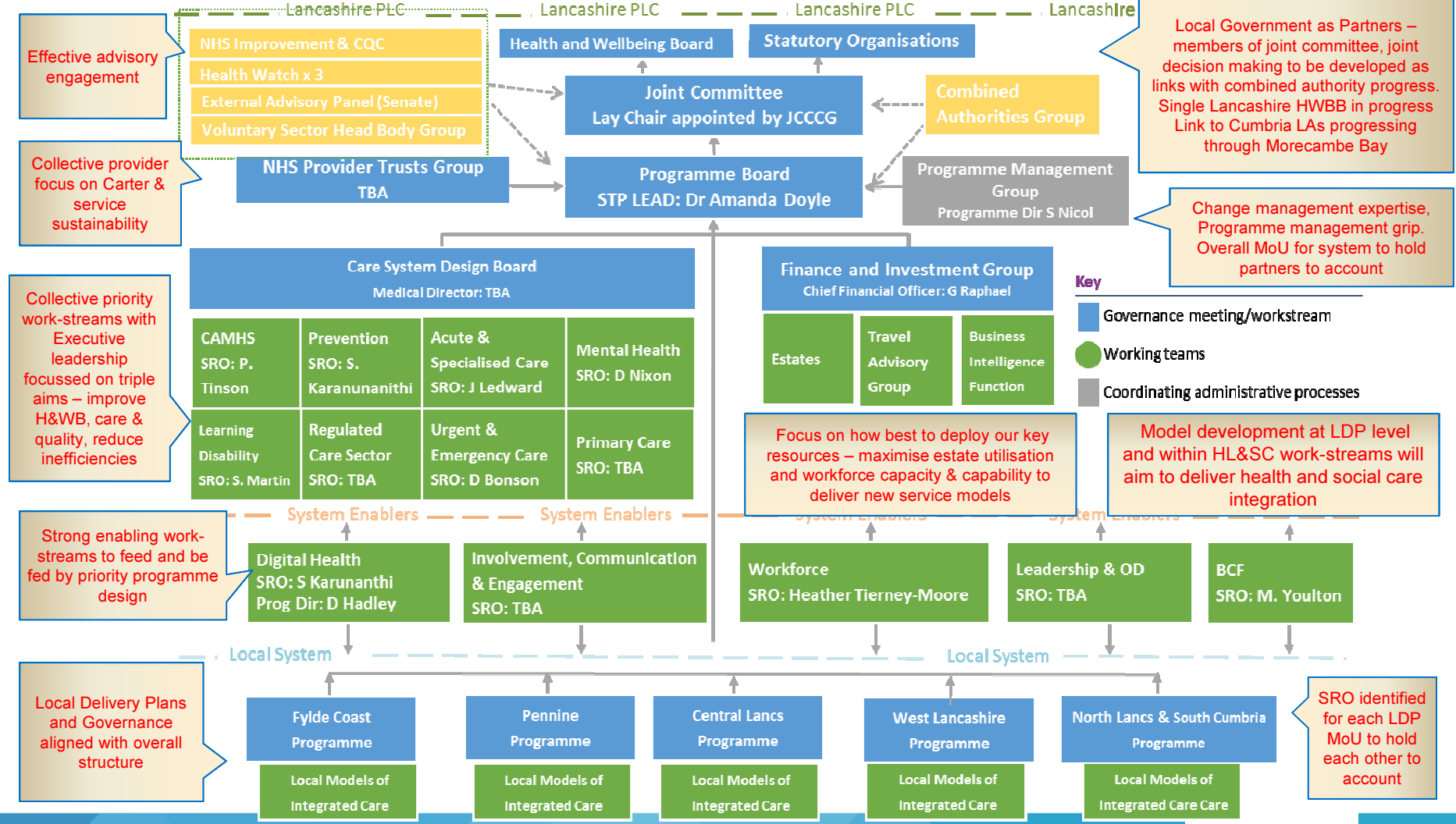
- **At a L&SC PLC level:** Seeking new opportunities for truly transformational change and leveraging system wide assets and influence
- **▶ At a Pan L&SC level:** Accepting compromise and agreeing consistent service models to enable efficiency for pan Lancashire organisations and make the system navigable for patients and care providers
- **▶ At a LHCE level:** Having a framework for commonality so system remains navigable and learning can happen across LHCEs and encouraging innovation at a local level as addressing truly local challenges and piloting at scale to the benefit of Lancashire. Working collaboratively between neighbours rather than against
- **▶ At an individual organisation level:** Ongoing relentless delivery of sustainable CIPs, QIPP and cost reduction will still be required





Our governance arrangements recognise the importance of working through distributed leadership. Dr Amanda Doyle is lead for the L&SC STP and SRO for the HL&SC programme, supported by an experienced senior team; Gary Raphael as Finance Director and Sam Nicol as the Programme Director. Each HL&SC work-stream has an identified SRO drawn from across member organisations, supported by a dedicated senior programme manager. Similarly, each LDP has an SRO and Programme Director, with local governance and work-stream arrangements aligned to the structure below.

1 Healthier Lancashire & South Cumbria Governance and Dispersed Leadership Model



Section 1: Leadership, governance & engagement (3)

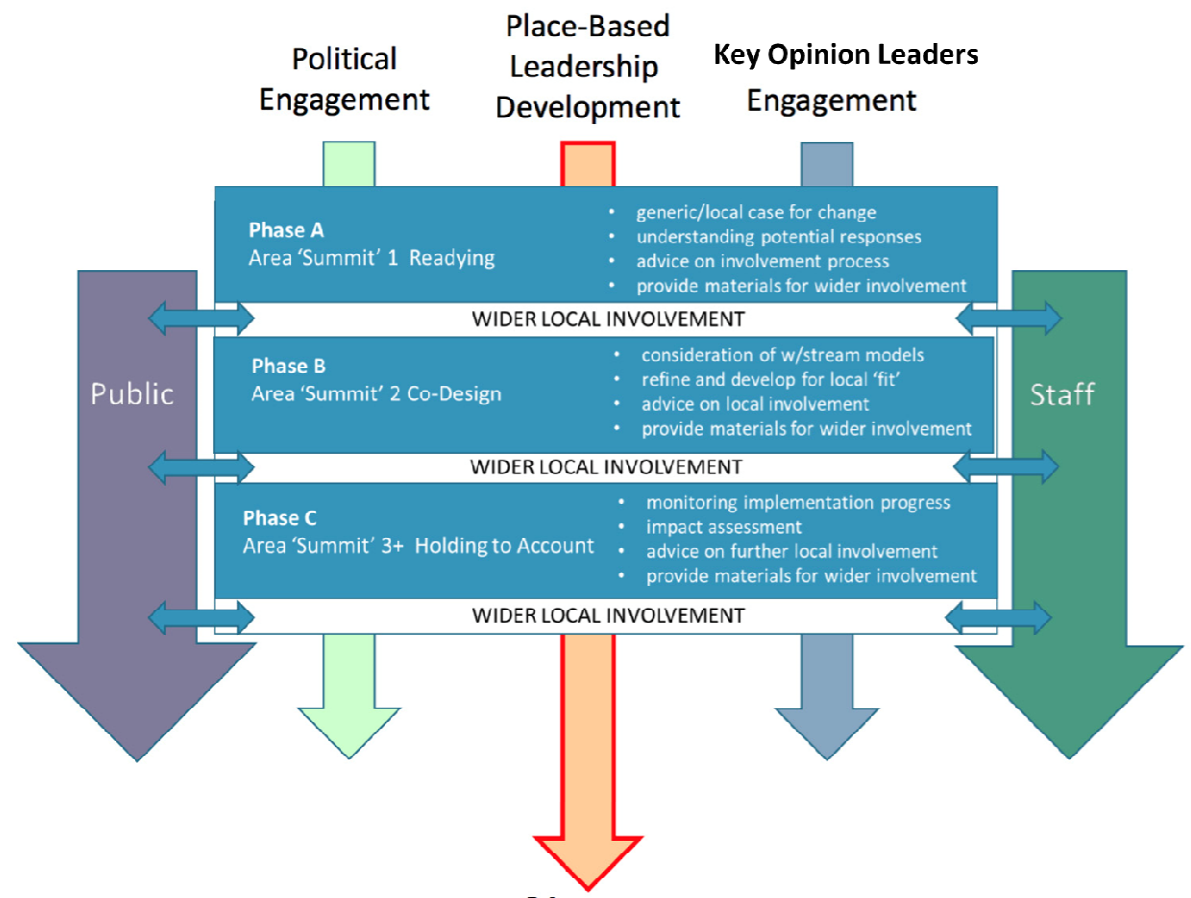


An inclusive process

Everything we will do together will be for the benefit of all of the people of Lancashire. We will build upon the collaborative change programmes that we are already delivering, within which we have undertaken extensive engagement on planning changes to service delivery. However, we are now looking for a step-change in that involvement so that our people become part of the change. Collectively we will co-design strategies, working towards a radically different, people-centric preventive system, addressing the wider determinants of health and so less reliant on costly infrastructure.

We recognise that changes over the next five years can only be made by common consent with patients, the public, staff, local media and system partners – so everyone will need to be fully engaged to collectively develop the system-wide solutions needed to tackle system-wide problems. Consequently, we have designed a HL&SC involvement communications and engagement (ICE) programme.

Our ICE programme will create widespread understanding of the need for radical change; raise awareness of what individuals and communities can do to improve their health, resilience and behaviours; and ensure that change proposals are developed through co-design with clinicians, the public and service users. Our approach will be fundamental in demonstrating that we have met statutory requirements for robust evidence of inclusive engagement to facilitate implementation; convince politicians we are listening to local people; and withstand any legal challenge to the process. Therefore, we are appointing a Director of Involvement, Communications and Engagement to oversee delivery of this programme, supported by strong C&E lead network across L&SC.



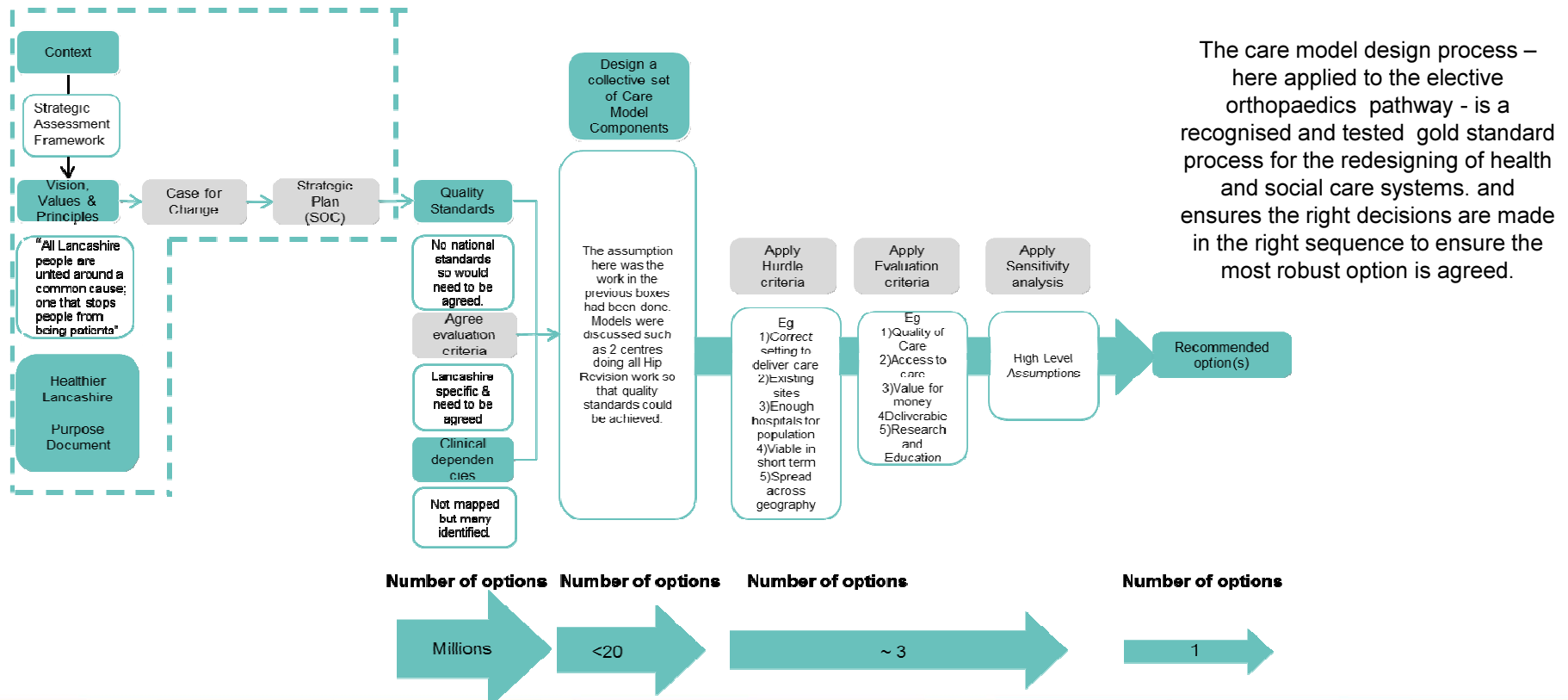
Section 1: Leadership, governance & engagement (4)



Engaging clinicians and other NHS staff

Within the HL&SC governance arrangements, the System Model Design Group will be made up of senior clinicians and care professionals. All the identified work-streams and project groups will include hospital and community based clinicians and care professionals on the principle that frontline staff have to be involved in designing the solutions to make them deliverable. We will provide expert guidance on opportunities, interventions and evidence in support of our solution design process (example below)

Lancashire Elective Orthopaedic Update: Care Model Design Process Flow Chart



Section 2a: Improving the health of people in our area



We understand what is driving the excess mortality and ill health across our area. We have developed this understanding through a detailed analysis of health profiles in each of our five health economy foot prints and of the variation that exists across our area. In summary:

1. We have an ageing population - we have added years to life but not necessarily life to years. Healthy life expectancy is plateauing and in some cases, particularly in males, it is starting to decline. Socioeconomic and environmental factors play a significant role in determining the health outcomes.
2. We have a high prevalence of damaging behaviours - smoking, poor diet, increased alcohol use
3. The major reasons for the gap in life expectancy between Lancashire and England are due to circulatory diseases (includes coronary heart disease and stroke), cancer, respiratory and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis). There is a significantly higher proportion of external causes for men (includes deaths from injury, poisoning and suicide) compared to women. Circulatory diseases and mental and behavioural disorders for women (includes dementia and Alzheimer's disease) affect a higher proportion of women compared to men as the major reasons for the gap in life expectancy between Lancashire and England.
4. We also have pockets of higher infant mortality, low birth weight, tooth decay, under 18 conceptions, overweight and obesity at reception and year 6, and unplanned admissions due to injuries, asthma, diabetes and epilepsy in our children and young people compared to the England average.

Our hospital-centred model is increasingly unable to meet the needs of a modern healthcare system – we must prevent new cases of avoidable disease arising; improve community resilience and citizen independence; and manage the quality of life for people with multiple long term conditions. Keeping people safe and well, leading socially and economically active lives in their own homes and communities for as long as possible has to be the focus for the future of our sustainable L&SC health and care system. We need a **'population health system'**, with more health and social care focussed on preventing disease and promoting health. We need more of it delivered in homes, localities and neighbourhoods where we know early intervention can best stop problems becoming more serious and expensive to deal with. We will move from a hospital and illness based approach to a person centred and health based approach with a different and lower cost infra-structure.

Working with local authorities and the wider public, third sector and businesses, our population health system will make L&SC a safer, fairer and healthier place to be born, live, work and retire, and will improve health across all ages, building upon our existing programmes (see next page), sharing what works and implementing locally across Lancashire at pace and scale.

Aims and Objectives	Our initial hypothesis for improving health and wellbeing
1. Promoting Wellbeing and addressing socioeconomic and environmental determinants of health	
<p>1.1 Fully engaging and activating the resourcefulness/assets of our residents and communities to improve wellbeing and resilience (grass roots third sector). We will also work in partnership with other public sector agencies.</p>	<p>We have numerous examples of exemplar initiatives within our STP area. Our key focus is on scaling up and spread of initiatives and to learn from other areas to implement best practice. The following examples demonstrate our thinking so far. We will further refine and prioritise these and also identify success measures to monitor and evaluate progress.</p> <ul style="list-style-type: none"> • Scale up our work with the VCFS sector to develop grass roots community resilience • Spread initiatives like Well Skelmersdale, Spice Time Credits and the learning from Carnforth and Millom experience • Maximise the role of Health champions/Health Trainers that already exist in our communities
<p>1.2 Breaking the link between poverty and ill health by improving early childhood development, health related unemployment, housing standards including fuel poverty and social isolation.</p>	<ul style="list-style-type: none"> • Achieve the key standards in the Better Births, the Healthy Child Programme and the National Troubled Families programme
<p>1.3 Maximise the role of LAs and public services in improving health outcomes</p>	<ul style="list-style-type: none"> • Further develop our Walking and Cycling Strategies across the STP area • Spatial planning policies to promote health and wellbeing (e.g Healthy New Towns) • Continue to improve road safety and community safety initiatives to address excess mortality and morbidity
2. Preventing illness and addressing variation in quality of care	
<p>2.1 Promote healthier lifestyles and maintaining independence by taking a place based and whole life course approach.</p>	<ul style="list-style-type: none"> • Focus on behaviour change and a healthy settings approach (e.g healthy cities, smoke free, dementia friendly) to achieve a step change in childhood obesity, smoking, alcohol, and physical inactivity
<p>2.2 Early identification and management of risk factors that cause the excess deaths and ill health.</p>	<ul style="list-style-type: none"> • Continue to improve uptake on NHS Health Checks and the roll out of the next phase of diabetes prevention programme • Improving quality of primary care in detecting and managing long term conditions • Improving screening uptake (breast and colon in particular) and early diagnosis of cancer
<p>2.3 Address variation in the quality of care across our area by learning from the right care approach and sharing good practice</p>	<ul style="list-style-type: none"> • Refer to right care opportunities for improvement in the 'Improving Quality Section' of this template
<p>2.4 Workplace health</p>	<ul style="list-style-type: none"> • Promote workplace wellbeing charter and spread good practice like Flourish at Work staff fitness programme in Morecambe Bay • Embed making every contact count across the workforce and the use of digital technology as key enablers of our transformation
3. Prolonging quality of life	
<p>3.1 Improve the quality of life for people with complex long term conditions through a strengths based self-management support and a community orientated integrated team working across the health and care sectors.</p>	<p>Systematic identification of the 2% complex patients through risk stratification People with complex comorbidities to have an integrated health and care plan Further enhance the self-management support for people with long term conditions</p>

Section 2b: Improving care and quality of services (1)



Understanding our care and quality gaps

We have poorer outcomes in L&SC – we are amongst the worst in the country on premature mortality. Our elective hospitalisation rates are much higher than both the England and North Region average. There are acute shortages of hospital doctors across some specialties and difficulties recruiting GPs to work in disadvantaged areas. Our regulated care sector market – vital to receive patients ready for discharge from hospital – needs urgent attention, and resources available for adult social care are falling. As health and social care becomes more integrated out of hospital, there is a need to make progress with the reconfiguration of hospital services at a time of financial pressures.

We are using the Right Care data packs to develop our understanding on the unwarranted variation in the cost and quality of our local services to identify key opportunities for collective action to avoid ‘postcode lotteries’. Where appropriate, we will use our ethical framework to review ineffective services to inform disinvestment opportunities. The table below provides a list of common areas of improvement across a range of disease pathways in Lancashire which will inform our work-streams.

Disease pathway	Common themes for improvement across Lancashire
Cancer (Breast, Colorectal and Lung)	Breast screening, Bowel Cancer screening, early diagnosis and starting definitive treatment within 2 months.
Diabetes	Control of blood pressure and cholesterol Retinal screening
Common mental health conditions	Improving access to psychological therapy completion and demonstrating reliable improvement
Heart disease	Control of hypertension and high cholesterol
Stroke	Treatment of TIA within 24 hours Patients with stroke spending 90% of the stay in a stroke unit Emergency readmissions within 28 days of discharge
COPD	Improving the identification of people with COPD on GP registers Measuring FEV1 to assess COPD
Asthma	Emergency admissions for children and young people (0-18)
Musculoskeletal	Management of osteoporosis EQ5D health gain for people undergoing hip and knee replacement Emergency readmissions within 28 days of discharge following hip replacement
Trauma	Falls in elderly, emergency readmissions within 28 days of discharge following hip fracture
Renal	Percentage of people with chronic kidney disease on home dialysis Percentage of people with renal replacement therapy who have renal transplant
Maternity and early years	Many areas have worse outcomes e.g. under 18 pregnancy, smoking during pregnancy, breast feeding at 6-8 weeks, childhood obesity at reception age, AE attendances for under 5s,

Section 2b: Improving care and quality of services (2)



Our emerging hypotheses for tackling the care and quality gap

We will improve significantly the care and the quality of services at a locality level through the integration of health and social care, and L&SC-wide we will improve quality, outcomes and safety through the achievement and maintenance of core standards across all hospital services accessed by our populations. We will reduce fragmentation through standardised approaches; implementation of evidence based components of care at scale and pace; and basing the design of services on agreed and evidence based standards (see slide 5 for an example of our care model design process).

We are already developing, implementing and testing new models of care within LDP footprints, and ensuring that learning from local and national vanguards is shared across the system to support implementation at scale as appropriate:

Central – Primary care at scale; MSCP across 3 localities

Fylde coast – Extensive care Vanguard; enhanced primary care; episodic care model across neighbourhoods

Morecambe Bay – Better Care Together - shadow accountable care system

West Lancs – Integrated health and social care at neighbourhood level via MCP model; community service procurement

Pennine Lancs – Accountable care system; Care sector (NH) Vanguard (Airedale)

We are establishing a provider group to focus on networking and collaborative opportunities across Lancashire providers, particularly the delivery of recommendations from the Carter review to deliver improvements in the quality and cost efficiency of care. The work of the group will also include the significant third sector providers who are seen as vital to the future delivery of care services.

A key driver is the workforce challenge already experienced across L&SC. We recognise that this will necessitate health and care services to be consolidated and require new roles and flexible working. We have established a work stream to not only look at supporting the existing workforce to be more effective, but working in partnership with schools and colleges to encourage the workforce of the future to choose health and care professions. We also have a significant digital health programme, establishing the infrastructure for sharing information across the system, and to enable the use of new technologies in supporting individuals to more proactively manage their own conditions. Our estates work-stream will look at estate utilisation across sectors and partners in the L&SC system to maximise support to delivery of new models of care; shifts of service provisions; and minimise spend on poor quality, under-used buildings.

Section 2b: Improving care and quality of services (3)



Our emerging actions on clinical priorities

We have already undertaken an alignment of plans exercise and through the case for change we will have a further level of detail against the identified opportunities for improvement. These include:

Primary care – building upon development of GP quality contracts, we will develop contracting support for new models of care; we will support delivery of 7 day access; workforce development, including advice on working at scale & opportunities for utilising pharmacy services; and we will develop a Lancashire primary care estates plan

Acute & specialised – we will build initially upon the collaborative work already undertaken on Stroke/TIA services across L&SC, implementing our end to end specification, focussing on prevention & self management and shaping the hyper-acute/acute/ rehab provider system. For Cancer & other specialised services, we will align our consideration of service configuration with the NHSE spec services outcomes work and its potential impact on the provider landscape.

Adult MH/Dementia – we will build upon the continued implementation of our MH hospital service reconfiguration, which has to date generated £13m of savings, by developing a new model of MH care and a reframed case for change to improve local diagnosis and early treatment, focussing on crisis care, parity of esteem and operational resilience

Urgent & emergency care – we will continue to develop our new system architecture model, including urgent & emergency care centres; paramedic at home services; MH crisis; self care; and support for care sector & primary care

Regulated care sector – we will work closely across health and social care to develop new models of care; funding system rewards; workforce resilience; in-reach to home; hospice model; self care; and market stimulation

CAMHS – We will continue our whole system transformation plan implementation, focusing on children in crisis and eating disorder services, improving access, effectiveness, pathways, and VFM

Learning disabilities – we will implement our Transforming Care plan, improving estates; engagement; community; service model; crisis support; positive behaviour support; and workforce development/training

Better Care Funds – we will continue to drive the BCF approach as a means to deliver integrated health & social care

Section 2c: Improving productivity and closing the local financial gap



Tackling our efficiency and financial gaps

An assessment of the health, quality and financial gaps in the STP footprint was undertaken by EY Consulting in the summer of 2015. It concluded that by 2020/21 the financial shortfall for adult services would be of the order of £805m or 23% of the combined turnovers of health and social care services organisations if no action was taken to address and resolve the potential financial shortfall arising from the growth in demand.

We are planning to transform health and social care services to better meet the needs of our populations in a clinically and financially sustainable way. We will develop transformation plans that enable the sustainability of services to be assessed across the following dimensions:

- improved efficiencies (reduction in unit costs) resulting from substantial rationalisation within clinical and non clinical support services to release resources for front line services
- standardisation of best practice clinical pathways, underpinned by integrated care records, to deliver more effective and efficient services and reduced unit costs
- transformation of out of hospital services to deliver more cost effective responses to the needs of local people and reduce demand for acute services
- development of staff with both generic and specialised skills and competencies that are better able to meet people's needs and generate the synergies among public services necessary to make the best use of more scarce resources

We have yet to model the extent to which our prevention and care model improvements will deliver reductions in anticipated levels of demand and the technical and allocative efficiencies that will be generated. However, overall we are not expecting to spend less on the population but to use the resources that we hold on their behalf more effectively and efficiently to meet and contain rising demand over the strategic timeframe. Overall NHS commissioner total place-based allocations will rise from £2,934m in 2016/17 to £3,267m by 2020/21, an increase of £333m or 11.3% over the five year period. However, the resources available for social care services will fall over the period. Therefore we will look at all measures that may be available to mitigate the impact of these reductions through the synergies expected to be generated in our joint work on new care models.

Section 2c: Improving productivity and closing the local financial gap (2)



Using our Transformation Funding

We anticipate that Transformation funding will be required in order to underpin delivery of the STP by covering the gap and unlocking transformation:

- provide double running costs associated with the migration from existing to more cost effective service provision. This will include rationalisation of clinical and non clinical support services and centralisation of back office functions
- provide pump priming money to enable new support services models to be implemented alongside existing services to ensure service continuity
- provide support to staff (training costs and back fill) as they acquire the new skills necessary to meet the needs of local people while providing more cost effective services
- invest in key enabling strategies, such as ICT, estates and transport, that support the patient empowerment programme and underpin integrated records for improved service provision

The focus will be on collaboration amongst all stakeholders to drive the changes required. A consistent and fair approach will be taken to the ways in which savings, mitigation and funding is managed across the STP footprint amongst all participating organisations. We will establish a robust process and principles against which bids for allocation of the Transformation Fund will be made to ensure fair effective and best-value utilisation of the fund.

Section 3: Our emerging priorities

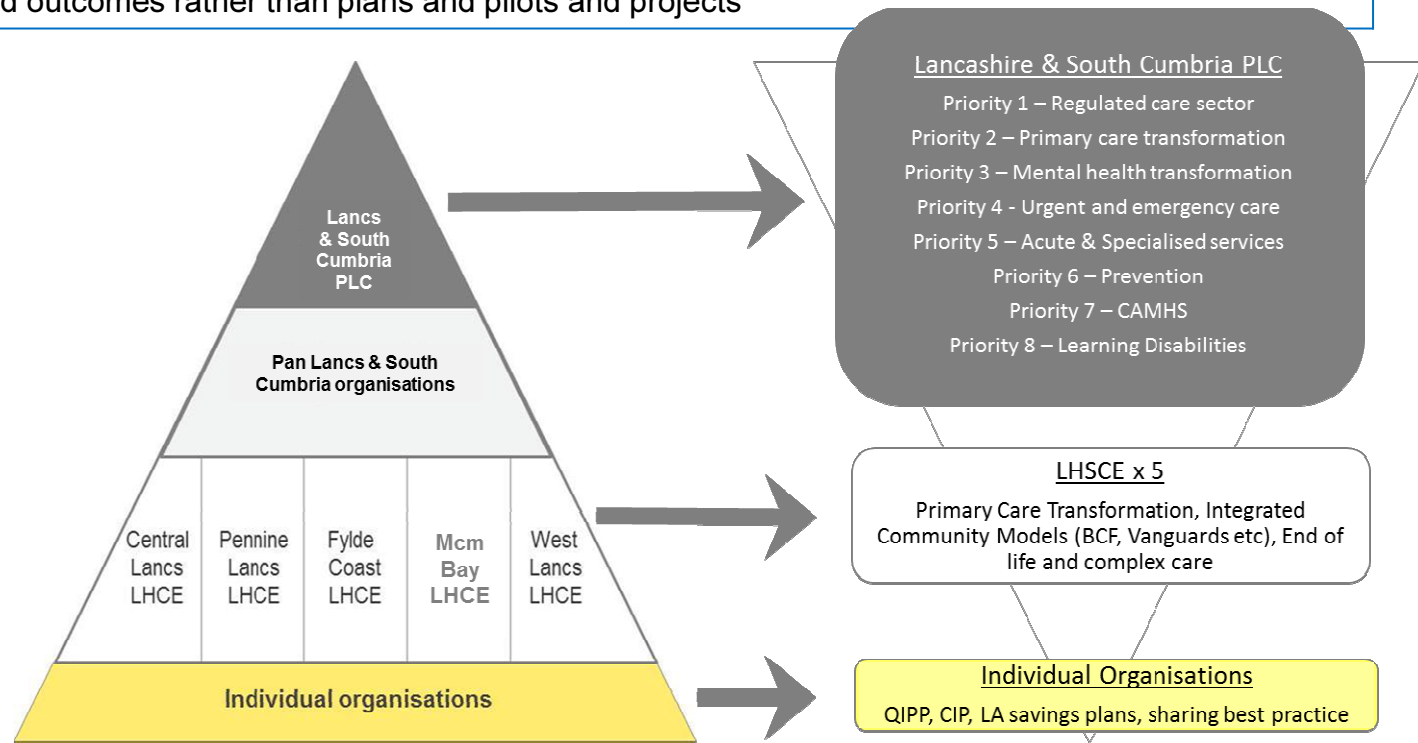


Emerging thinking on key priorities

We recognise that there are some big decisions that we will need to make as a *system* to drive transformation – our governance is designed to ensure that all members of that system are actively involved in the effective generation of innovative and impactful evidence-based solutions. Big decisions are likely to include:

- Acute services reconfiguration – all trusts to ensure all impacts, implications and interdependencies are managed
- Designing services to meet agreed standards and standardisation across Local Health and Care Economies and the Lancashire and South Cumbria footprint
- Resource allocations (transformation and sustainability), with new funding/contracting models
- Potential centralisation of specialist services in a designated hub
- Implementing and holding providers to agreements on solutions designed and commissioned
- Focus on agreed and shared outcomes rather than plans and pilots and projects

We have built the HL&SC governance and workstream structure around the priorities for action identified in the Healthier Lancashire Alignment of Plans analysis.



Section 4: Support we would like



Support/barriers/risks/good practice

- **Regional or national support** Vanguards rapid evaluation outputs and learning from these; advice on new funding and contractual arrangements; alignment of work with NHSE, NHSI, CQC re navigating choice and competition issues
- **National barriers or actions** – more around the use of money or the regulations e.g. the use of the 1%, and about the appropriate footprint i.e recognising it's both a local approach and a L&SC wide one too. Consistent messages and approaches.
- **Share good practice from other footprints.** National database of solutions that are truly radical and evidence based
- **Key risks** We have a risk register detailing the key risks to delivery of the STP, including resource limitations which may impact on time taken, availability of resource to double run to test at scale and pace before implementing, any one of the participating partners choosing to not commit to the L&SC footprint and the programme