NHS England

Development and Implementation of the Health and Care Strategy for Greater Lancashire

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NHS England (Lancashire Area Team)

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1. Introduction

1.1 This paper, prepared during September 2013, is to be presented to the three Health and Wellbeing Boards across Lancashire, the Lancashire Leadership Forum, the Lancashire Clinical Commissioning Group Chairs Network and to other organisations as appropriate. It is intended to capture the current multi-agency thinking about the importance of developing an integrated health and care strategy for Lancashire and help with agreeing and co-ordinating the mechanisms for on-going progress and, ultimately, implementation.

2. Background

2.1 The need for an overarching Health and Care Strategy for Greater Lancashire is now widely agreed[1]. The case for a strategy has been promoted by the Lancashire Leadership Forum in the first half of 2013 and developed by a multi-professional group (Appendix 1). This thinking builds on work undertaken through the Lancashire Level 3 QIPP programme through 2011-12 and has included iterative presentations to the Lancashire Leadership Forum and a workshop led and facilitated by Sir Muir Gray[2]. The arrival of NHS England's *A Call to Action*[3] and the announcement of the requirement to integrate a proportion of NHS funding with Local Authority spending (Statement on the health and social care Integration Transformation Fund, 8 August 2013)[4] add to the sense of urgency and importance.

2.2 Dr Chris Clayton, Clinical Chief Officer, NHS Blackburn with Darwen Clinical Commissioning Group (CCG) and Chair of the Lancashire Network of CCGs said:

"The commissioners of health services across Lancashire are keen to undertake the development of a "Health & Care" strategy across the county which will build upon the work undertaken by the Lancashire Improving Outcomes Board and more recently, the Lancashire Transition Group. We recognise the need to bring together the shared ambitions of both commissioners and providers from both health and social care together with the voluntary sector and other agencies. It recognises the need to prioritise the strategies across the county based upon our current knowledge however, does not undervalue or underestimate the need for local ownership and implementation. The strategy shall be brought together by the Lancashire Leadership Forum but shall be shaped and implemented by those organisations allied to it, including the Health and Wellbeing Boards of Lancashire."

3. National Drivers for Change

3.1 NHS England's *A Call to Action* cites a number of national drivers for change across the health service. They include:

- an ageing and increasing population
- an increase in the number of people with one or more long-term health conditions
- a recognition that there is still a lot of unidentified, and therefore untreated, disease
- increasing demand for services
- rising costs and constrained financial resources

- unexplained and unwarranted variation
- evidence of unacceptably poor standards in certain areas
- increasing public expectation
- lifestyle risk factors.

In suggesting 'solutions', the Call to Action cites:

- harnessing technology to fundamentally improve productivity
- putting people in charge of their own health and care
- integrating more health and care services
- providing more care outside of hospitals
- refocusing on prevention
- matching services more closely to individual's risk
- moving towards more routine services being available 7 days per week[5].

3.2 The Local Government Association and NHS England's joint publication: *Statement on the health and social care Integration Transformation Fund* (Appendix 4) is described as : "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". Whilst the Integration transformation Fund (ITF) doesn't come into full effect until 2015/16 there is a requirement to have plans in place by March 2014. Nationally, there is an additional £200m transferring from the NHS to social care in 2014/15, in addition to the £900m already planned, and in 2015/16 the figure rises to a pooled budget of £3.8 billion. The conditions for full receipt of the money and implementation include:

- Plans to be jointly agreed
- Protection for social services (not spending)
- 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Bette data sharing between health and social care, based on the NHS number
- Joint approaches to assessments and care planning
- Risk-sharing principles and contingency plans if targets are not met
- Agreement on the consequential impact of changes on the acute care sector

4. Local Drivers for Change

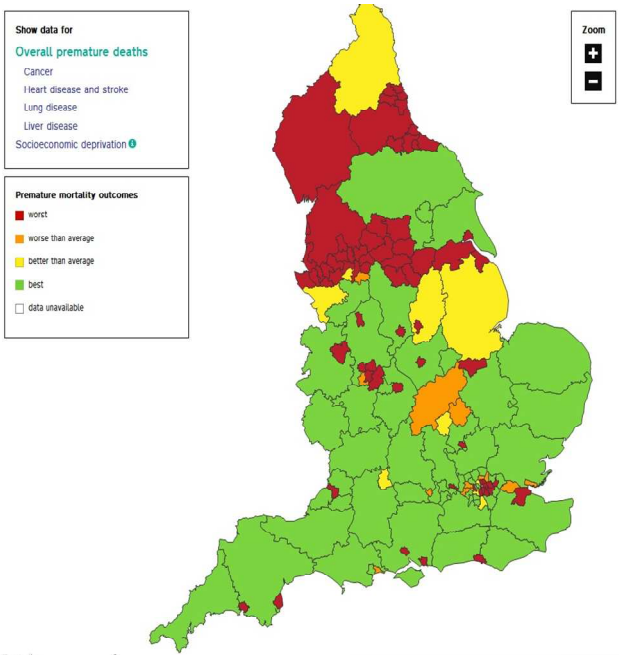
4.1 The work so far across Lancashire has recognised all of the drivers mentioned above. In addition, recent publications showing poor outcomes[6] and hospital reviews(Keogh)undertaken as a result of outlying Summary Hospital Mortality Indices (SHMI) and Hospital Mortality Ratios (HMR) add further impetus.

The National rankings for overall premature deaths rated by the 150 local authorities in England[6] show our three LAs in the bottom third: Lancashire at 103/150, Blackburn with

Darwen at 143/150 and Blackpool at 149/150. Further evidence of poor outcomes is shown in the Public Health England, Longer Lives data set.

Graphic 1. Ranking of Premature Deaths - From Public Health England – Longer Lives.

PHE – Longer Lives



Cancer

- Blackpool 141st out of 150
- Blackburn 97th out of 150
- Lancashire 95th out of 150

Heart Disease & Stroke

- Blackpool 149th out of 150
- Blackburn 145th out of 150
- Lancashire 100th out of 150

Lung Disease

- Blackpool Highest
- Blackburn 139th out of 149
- Lancashire 106th out of 149

Liver Disease

- Blackpool Highest
- Blackburn 145th out of 149
- Lancashire 104th out of 149

4.2 There are common themes in the commissioning intentions of the 8 Lancashire CCGs that chime with the aspirations of the 3 Upper Tier Authority Health and Wellbeing Boards. The Lancashire CCG Network, facilitated by the Staffordshire and Lancashire Commissioning Support Unit, undertook further scoping work over the summer of 2013. They produced and ranked a 'long list' of 46 opportunities for consideration within the strategy by referencing the CCG Spend and Outcomes Tool, CCG Commissioning Plans, the Joint Strategic Needs Assessments (JSNAs), CCG Indicators against Outcomes Framework Domains (from HSCIC), National Strategy, Emerging Health Technologies, the AQUA Clinical Inventory for Lancashire and the AQUA Improving Lancashire's Outcomes work. The format of the work is show below:

Table 1.

The Lancashire CCG Network – Summary of commissioning priorities June 2013 – Top 10 of 46.

LANCASHIRE CCG NETWORK - Long list of opportunities for consideration with Greater Lancashire Clinical Strategy										
Area	Detail	CCG Spend and Outcomes Tool	CCG Commissioning Plans	JSNA	Health and Social Care Information Centre: CCG Indicators against Framework Domains	National Strategy	Emerging Health Technologies	AQuA Lancashire Clinical Inventory	AQuA Improving Lancashire's Outcomes	RANK
Problems of the Respiratory System	Mortality from bronchitis and emphysema and COPD:Under 75	H	H	H	H	H		M	H	1
Cancers & tumours	Mortality from all cancers: Under 75	H	H	H	H	H			H	2
	Mortality from all cancers: All ages	H	H	H	H	H			H	2
	Mortality from lung cancer: Under 75	H	H	H	H	H			H	2
Problems of the Circulatory System	Mortality from all circulatory diseases: Under 75	H	M	H	H	H			H	5
	Mortality from coronary heart disease: Under 75	H	M	H	H	H			H	5
	Mortality from acute MI: Under 75	H	M	H	H	H			H	5
Cancers & tumours	Mortality from colorectal cancer: Under 75	M	H	H	H	H			H	5
	Mortality from breast cancer: Under 75	M	H	H	H	H			H	5
Problems of the Circulatory System	Mortality from stroke: Under 75	H	H	H		H	H			10

The full list is shown at Appendix 5.

4.3 The detailed work undertaken by the Advancing Quality Alliance (AQUA) in 2011-12 on behalf of Lancashire is referenced in the CCG Network's long list. In the Summary Paper (February 2012) Appendix 3, a number of clear priorities were identified which included:

a. Implementation of an agreed Cardiac and Stroke strategy for Lancashire with particular attention to the prevention projects within the strategy.
b. Implementation of the agreed cancer programmes with particular attention to prevention and early diagnosis.
c. Continuing prioritisation of work around myocardial infarction, heart failure and pneumonia with additional work focussing on Chronic Obstructive Pulmonary Disease (COPD).
d. Full roll out across the county of prevention projects operating well in certain parts, such as affordable warmth, smoking cessation, alcohol liaison etc.
e. Improving the quality of life for patients with long-term conditions paying particular attention to implementing the principles set out by Sir John Oldham: Early diagnosis and improved disease registers in primary care, risk profiling of populations, integrated health and social care teams, developing self-care, investing in tele-health and tele-monitoring where the evidence is strong.

f. Improve the care of patients with dementia. Reduce the number of specialised in-patient beds with a concomitant increase in community capacity.

4.4 The AQUA Report models substantial reductions in acute hospital bed capacity as a result of (and in part driven by) successful implementation of the initiatives. This constitutes a significant re-balancing of the structure and function of the local health economy in favour of up-stream interventions with increased focus on prevention, self-care and out of hospital based care (which includes social and health care).

4.5 Many of the initiatives described above are already taking place in parts of Lancashire, so there is almost certainly merit in using the strategy to 'main stream' these across the county. In addition, there are county-wide reconfigurations already in the late stage of development. These include the Implementation of the recommendations of the Lancashire and Cumbria Vascular Services review[7], moving to a clinical network based on two arterial surgery sites at Preston and Blackburn to serve the population of Lancashire, South Cumbria, Wigan and Bolton; the reconfiguration of dementia-care beds with a proposal to move to a single intensive-care in-patient unit for patients with dementia coupled with enhanced community services; and the reconfiguration of Rehabilitation Services across the Fylde Coast.

4.6 Finally, it is clear that the financial pressures facing the health and social care economy across Lancashire are severe and set to intensify. In addition to financial pressures there are significant work-force challenges in various clinical areas across the county. These include apparent shortages of midwives, neonatal nurses, GPs, Practice nurses, consultant grades in many specialities. The Chief Executive of the NHS, Sir David Nicholson, has stated that the NHS will need to make efficiency savings of as much as £30 billion by 2021. This equates to £762 million across Lancashire and, overall, the health economy of the County is expected to lose about £833 million by 2021, which represents 35% of the current total NHS allocation. Lancashire Health's share of the £3.8 billion Integrated Transformation Fund is £57.6m, which represents 3% of the commissioning budget of CCGs which will transfer to Local Government in 2015.

5. Developing the Strategy

5.1 In summary, there are compelling national and local reasons to develop and implement a *Health and Care Strategy for Lancashire*. Within this programme it will be essential to engage with service users and the public to identify priorities and test options and this work will necessarily take time. Nevertheless, there are quality and service improvements that can be implemented immediately on a county-wide basis if the will exists to do so. These initiatives can improve outcomes within the short and medium term whilst at the same time laying the foundations for more strategic developments in the future.

5.2 Within this context, in developing *the Health and Care Strategy for Lancashire*, we propose to:

5.2.1 Develop a governance framework which links the developing strategy to the three Health and Wellbeing Boards across Lancashire and their Health and Wellbeing Strategies.

5.2.2. Share ownership of the strategy, the solutions and the outcomes.

5.1.3 Revisit the work already undertaken under the banner of Level 3 QIPP, including detailed analysis of capacity and efficiency in the acute hospital sector.

5.1.4 Implement recommendations of the Vascular Service Review and monitor and consider impact as this unfolds.

5.1.5 Implement the mental health service reconfiguration previously agreed by statutory boards.

5.1.6 Reflect national initiatives and requirements, including *A Call to Action* and the *Health and Social Care Integration Transformation Fund.*

5.1.7 Engage with staff, patients and the public to raise awareness of the challenges we face and to develop shared solutions to meeting our challenges and the aspirations the people have for their future health and care services.

5.1.8 Engage with key stakeholder organisations across the Lancashire health and care economy and use the developing strategy to align initiatives.

5.1.9 Pay particular attention to a primary care (out of hospital care) strategy. A two-day event is planned for 23rd and 24th October at the Dunkenhalgh Hotel. Day 1 is for commissioners and Day 2 for a wide group of stakeholders.

5.1.10 Develop two work streams to explore the changes needed to be secured in our of hospital care and to undertake a review of Acute provision.

5.1.11 Use best evidence where that exits

6 Recommendations

6.1 That the constituent organisations that make up the Lancashire Leadership Forum, the various board, groups and fora in receipt of this paper are asked to endorse the development and implementation of an overarching health and care strategy for Lancashire and the proposals set out at 5.2 of this report.

6.2 That the paper is presented to the three Lancashire Health & Wellbeing Boards to develop the engagement strategy in line with the Health & Wellbeing Strategies.

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Notes

1. Minutes of the Lancashire Leadership Forum
2. Muir Gray Presentation (See slide Appendix 2).
3. *The NHS belongs to the people*. A call to Action. August 2013.
4. *Statement on the health and social care Integration transformation Fund*. August 2013. Gateway Reference No. 00314.
5. *Improving General Practice – A call to Action*. August 2013.
6. *Longer Lives*. Public Health England. www.longerlives.phe.org.uk
7. *Reconfiguration of Vascular Services for Cumbria and Lancashire.* Independent Reconfiguration Panel. April 2013. www.irpanel.org.uk

Some supporting facts:

- Average life expectancy 78.2 for males and 82.3 for females. Largest growth in older age groups.
- 22% GPs over 55 compared to 17% in 2000. Increased number of GPs are salaried or part-time.
- First attendance at A+E increased from 10.6 million in 2008-9 to 11.6 million in 2010-11. DoH Hospital Episode Statistics.
- 55% people report that they have a long-standing health condition.
- 12% of people with a long-standing health condition feel they do not have enough support from local services to help manage their health.
- 5 in every 1000 people are in a nursing home.
- 51 in every 1000 claim disability allowance
- Lancashire continues to show a high level of unplanned admissions for chronic ambulatory care sensitive conditions – a group of diagnoses, including long-term conditions, for which there is evidence that care can be effectively managed outside hospital.
- There is very little difference in Quality and Outcomes Framework for General Practice (QOF) achievement across the country.
- In general, GPs are referring more patients to hospital for a consultant opinion. However, GPs are seeing more patients and the conversion rate of patients seen to referral has actually been falling (now 1:12).
- Emergency pressures are increasing – Attendances at type 1 A+ E units appear relatively static, whilst attendances in type 2 and 3 are increasing.
- Conversion rates from A+E attendance to admission are increasing.
- General and Acute emergency admissions are increasing.