Strategic plan for high quality local health services
2012 - 2017
Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning health services from 1st April 2013. These plans are set out in the Health and Social Care Bill. The Bill paves the way for GPs and other local clinicians to have a greater influence on how the NHS budget is spent. There will also be a new NHS Commissioning Board to oversee the process.

‘Commissioning’ is the job of assessing the health needs of the local population, funding health services that meet those needs, and monitoring the quality of those services.

East Lancashire CCG is run by local GPs. As such we aim to commission high quality, safe, and effective health services that meet the needs of residents in East Lancashire. To do this we will use local clinical expertise, evidence of good practice and the experience of patients who use the services we commission. Our aim is to ensure that the right services are commissioned for patients to be seen at the right time, in the right place by the right professional.

The CCG will maintain a strong local focus, with leadership and the involvement of GPs in each of five localities in East Lancashire – Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale. Local clinical expertise and patient experience will be at the heart of all of our decisions and decision-making.

Over the forthcoming months, the CCG will actively seek the views of patients, carers, the public and organisations in East Lancashire regarding our commissioning plans and intentions. Your views about our plans are very important to us as they will help us ensure our plans are supported, or changed where required.

We would be pleased to receive your comments on any aspect of our strategic plan. However we are particularly keen to learn your views about our vision, values, and our commissioning plans. In particular we would like to know your views about our plans for:

- Acute (hospital) Planned Care
- Children and Young People
- Mental Health Services
- Unplanned (Urgent) Care
- Community Services
- Getting the Best from Medicines

There are many ways you can let us know your views. All comments and views are welcome.

Dr Mike Ions
Chair, East Lancashire CCG
East Lancashire ‘Plan on a Page’

Context
- Health Inequalities
- Low life expectancy
- High levels of deprivation
- Increasing demand
- Financial climate

Vision
- East Lancashire CCG will commission high quality, safe and effective health services that meet patients’ needs and improve their health

Strategic Objectives
- Right Treatment, Right Place, Right Time
- Optimise appropriate use of resources & remove inefficiencies
- Improve access, quality & choice of service provision within primary care
- Work collaboratively with colleagues from secondary care & Local Authorities to develop seamless pathways

Local Priorities Identified
- • Primary Care Development
- • Health Improvement
- • Pathway Redesign
- • Partnership Joint Working
- • Maternity Services
- • Transitional Care/ LTC
- • Medicines Management
- • Mental Health
- • Urgent Care
- • End of Life
- • Safe Care
- • Rehabilitation
- • Children, Young People & Families
- • Community Nursing
- • Community Hospitals’ Strategy
- • Specialist Care
- • Home Nursing
- • Integration of Health & Social Care
- • Demand Management

Outcomes
- Reduction in Unplanned care & emergency admissions
- Reduction in inappropriate referrals
- Measurably improve the experience & satisfaction of people who use health services including time, place & treatment
- Achieve Operating Framework Priorities
- Increasing the independence of vulnerable individuals, including carers & military veterans
- Reduction in disease & mortality and health inequalities within those areas with the greatest need
- Reduction in variations in quality and outcomes
- Achieve QIPP Targets

Cross Cutting Initiatives
- Information & Technology
- Communication, Engagement & Partnerships
- Estates Strategy
- Workforce & Core Competency Review
- Value for Money
- Pathway Redesign

Health Inequalities
- Low life expectancy
- High levels of deprivation

How to give your views
Please comment by the following means:
Email: consultation@eastlancspct.nhs.uk
Website: www.eastlancspct.nhs.uk/strategicplan
Freepost: FREEPOST RSSS-YJCX-TXLE
NHS East Lancashire CCG
Communication and Engagement Team
Walshaw House
Regent Street
Nelson
BB9 8AS
Phone: 0845 603 1068
This Strategic Plan is a key component of the East Lancashire Clinical Commissioning Group’s (CCG) commissioning process. It summarises the CCG’s strategic direction during 2012/13, and provides a clear outline of the strategic initiatives the CCG, along with its partners, will seek to deliver up to 2016/17. It will be reviewed and updated annually. The Strategic Plan also describes how the CCG is led and governed to serve its patients and population effectively and in line with Government policy. The Department of Health White Paper: Equity and Excellence: Liberating the NHS, published in July 2010 represents a fundamental shift in responsibilities and budgets for commissioning NHS healthcare and services. The Health and Social Care Bill which is anticipated to receive Parliamentary approval later this year, will enable CCGs to run as statutory bodies from 1st April 2013. In 2012/13, the CCG will be in ‘shadow form’ preparing for taking on responsibility for around £470m next year. It is run by local GPs and other health professionals on behalf of our population.

The East Lancashire Clinical Commissioning Group consists of five localities – Burnley, Hyndburn, Pendle, Ribblesdale and Rossendale. The CCG has a strong local focus, with local GPs and partnerships working to provide and secure services to meet the health needs of patients in each locality, based on our day to day experience of what is needed and supported by public health evidence and intelligence. This in turn will lead to reduced health inequalities, improvements to health services, and improved health outcomes and experience for local residents.

Throughout 2012, the objective of the CCG is to build upon the existing strong local joint working and governance arrangements in each of the five localities. Active engagement and delivery will continue at this level within the CCG as these existing forums are effective and trusted by the practices in each locality. Clinical commissioning through this structure provides us with the best opportunity to ensure that we maximise clinical, patient and stakeholder engagement in the challenges we face, drive clinical wisdom into the commissioning process and embed a local focus in our plans.

It is recognised that the CCG is operating within the context of increasing health care need, a tough economic climate and tight financial resources. To achieve its goals within this environment, the CCG understands the importance and usefulness of the efficiency programme known as QIPP (Quality, Innovation, Productivity and Prevention).

To realise this QIPP challenge we are committed to working collaboratively with clinicians from Blackburn with Darwen CCG and other neighbouring CCGs, and with CCGs across greater Lancashire.
We will also work collaboratively with East Lancashire Hospitals NHS Trust, Lancashire Care Foundation Trust and other healthcare providers to improve care pathways and further develop integrated care services with Lancashire County Council.

The Lancashire Health and Wellbeing Board and East Lancashire Health & Wellbeing Partnership are key forums for local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch to work together improve the health and wellbeing outcomes of our local communities and to reduce health inequalities. We recognise the importance of our membership of these groups in making sure we work together with our partners for the benefit of our population.

This strategy sets out how the CCG will take responsibility for service transformation that will improve outcomes, quality and productivity, whilst reducing unnecessary variation in services and reducing health inequalities in the population, whilst keeping within our budget.

The CCG will learn from and improve upon the experience of previous commissioning, planning and delivery. It is clear that a shift to CCG planning brings challenges as well as opportunities. The key opportunity lies in the GPs’ position as both a micro and macro commissioner – micro in our day to day prescribing, referrals and management of patients – macro in our expanded role of improving health at a population level. By bringing together the two roles there is an opportunity to accelerate action, improvements and learning. Commissioning should not be an end in itself, but should both steer and reflect the day-to-day business of improving services for patients. Real ownership of commissioning plans by GPs will speed delivery with this in mind.

From an organisational perspective, NHS Lancashire, the PCT Cluster overseeing the transition from PCTs to CCGs, will be the accountable NHS organisation for 2012/13. The CCG recognises that during the transitional period the PCT retains a depth of experience in commissioning and financial management, and possesses knowledge of the whole health system and commissioning that is vital for business continuity and to ensure a smooth transition to CCG leadership from 2013. The CCG will work closely with NHS Lancashire to ensure a trouble-free transition, by using existing organisational knowledge and experience to give the CCG the best possible start.

We would like to acknowledge the extensive contribution made to this document from the public, partners, clinicians and staff.
East Lancashire Clinical Commissioning Group

East Lancashire Commissioning Group has been established by local GPs from each of the five boroughs in East Lancashire – Burnley, Hyndburn, Pendle, Ribble Valley, and Rossendale. Towards the end of 2011, GPs in each of the localities recognised the benefits of working collaboratively within a single organisation to create value for money through economies of scale, sharing expertise and capacity. As a result, they agreed to join together as one large Clinical Commissioning Group. The localities have a track record of joint working and recognised that there was a firm foundation already in place to become one CCG with a strong locality focus. The proposed East Lancashire Clinical Commissioning Group will encompass 65 GP Practices, covering the boroughs of Burnley, Hyndburn, Pendle, Rossendale and the Ribble Valley (excluding Longridge), which has a combined GP registered population of 371,073 at 31st December 2011.

The Strategic Plan

The purpose of the Strategic Plan is to communicate our strategic priorities to improve health services and outcomes for patients over the next five years within the financial resources available. Our intention is that practices, partners, patients and the public will help us to shape the direction and what the CCG is trying to achieve and that the final document produced in June will be an agreed and shared strategy for East Lancashire.

It is well recognised that the CCG and its partners, face major challenges in tackling the significant levels of health inequalities and poor health outcomes in East Lancashire. It is acknowledged that there is a strong record of partnership working in East Lancashire evidenced by existing strategies that describe and evaluate the local environment and strategic approach. These include the Commissioning Strategy Plan for East Lancashire 2008 – 13 (CSP); Joint Strategic Needs Assessment (JNSA) and locality profiles. These are built upon in this Strategic Plan, but we have taken the opportunity to review our objectives to ensure that they encompass current challenges, particularly through the transition to new NHS organisations.

Mission

Whilst recognising previous commissioning strategies, the CCG is a new and different organisation and will promote a new culture and working ethic which will be demonstrated over the coming months. The CCG has developed a mission statement which is the foundation for this Strategic Plan, and will be its pledge to its patients, partners and stakeholders.
“The CCG will use our local clinical expertise, the available evidence and patient experiences to ensure that the right services are commissioned for patients to be seen at the right time, in the right place by the right professional. The CCG will maintain a strong locality focus, with clinical expertise and patient experience at the heart of all decision-making. It will harness the efficiency and effectiveness that working across five localities of East Lancashire brings and it will seek to commission safe, stable, high quality services where best practice is the standard”

Vision
“East Lancashire Clinical Commissioning Group will commission high quality, safe and effective health services that meet patients’ needs and improve their health”

CCG Principles
The CCG intends to be a reputable organisation which operates with integrity and trust as core principles. For this reason it has adopted the ‘Seven Principles of Public Life’ which will be the core that runs through everything that it does.

The principles of Public Life are outlined in the ‘Nolan Principles’ which are available at www.public-standards.gov.uk and are:

- Selflessness
- Integrity
- Objectivity
- Leadership
- Accountability
- Honesty
- Openness

Strategic Objectives
The CCG has four strategic objectives:
1. Commission the right services for patients to be seen at the right time, in the right place by the right professional
2. Optimise appropriate use of resources and remove inefficiencies
3. Improve access, quality and choice of service provision within primary, community and secondary care
4. Work with colleagues from secondary care and local authorities to develop seamless care pathways
Values
The CCG’s values reflect the NHS constitution, and are:
• Engage meaningfully with patients throughout the commissioning cycle
• Collaborate purposefully with partners and providers to optimise service delivery
• Be transparent and evidence-based in all our planning, decision-making and actions
• Engage regularly and meaningfully with clinicians in primary, community and secondary care
• Ensure value for money, efficiency and productivity is obtained from all our commissioning decisions
• Bring innovation and creativity to improve health service delivery and to meet patient needs
• Promote social value and capital through local commissioning and service delivery enabling the CCG to be seen as a “good corporate citizen”
• Focus relentlessly on prevention, early intervention and reducing health inequalities
• Educate and inform localities and all stakeholders through clear and understandable communication
• Harness new technologies and innovations where there is evidence of effectiveness and value for money

What do we want to achieve?
• An engaged population – where people are motivated to look after themselves and work with health professionals to use NHS services appropriately. This is critical if we are going to direct services to support those in greatest need. An example of this is patients who frequently attend Urgent Care Services when their need relates to social circumstances. We will work with East Lancashire Hospitals NHS Trust and Lancashire County Council to identify the support that they need.
• Engaged GPs - in each locality who will contribute to developments, and help us create the strong local focus that we need to make commissioning relevant and effective.
• Services designed closer to people’s homes to promote independence and strengthen local services
• Through organisational development – the CCG becomes a highly effective and efficient CCG that is highly regarded by all its members, those who work with it, and, most importantly, the population we serve
• High quality services delivering improved clinical outcomes
• High levels of patient satisfaction
East Lancashire Health Profile

Demographics

The resident population of the five East Lancashire districts as at mid-2010 is estimated at 359,343 (Table 1, below). Resident population is the number of people living in a particular area/borough.

Table 1: Estimated resident population by age group, East Lancashire districts

<table>
<thead>
<tr>
<th>Age band</th>
<th>0-14</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnley</td>
<td>16,300</td>
<td>11,700</td>
<td>20,900</td>
<td>22,500</td>
<td>14,100</td>
<td>85,300</td>
</tr>
<tr>
<td>%</td>
<td>19.1</td>
<td>13.7</td>
<td>24.5</td>
<td>26.4</td>
<td>16.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Hyndburn</td>
<td>16,000</td>
<td>10,900</td>
<td>20,500</td>
<td>20,800</td>
<td>12,900</td>
<td>81,100</td>
</tr>
<tr>
<td>%</td>
<td>19.7</td>
<td>13.4</td>
<td>25.3</td>
<td>25.6</td>
<td>15.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Pendle</td>
<td>17,000</td>
<td>11,600</td>
<td>22,100</td>
<td>24,000</td>
<td>14,500</td>
<td>89,300</td>
</tr>
<tr>
<td>%</td>
<td>19.0</td>
<td>13.0</td>
<td>24.7</td>
<td>26.9</td>
<td>16.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Ribble Valley*</td>
<td>6,001</td>
<td>3,784</td>
<td>8,180</td>
<td>10,938</td>
<td>7,340</td>
<td>36,243</td>
</tr>
<tr>
<td>%</td>
<td>16.6</td>
<td>10.4</td>
<td>22.6</td>
<td>30.2</td>
<td>20.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Rossendale</td>
<td>12,600</td>
<td>8,600</td>
<td>17,100</td>
<td>18,900</td>
<td>10,200</td>
<td>67,400</td>
</tr>
<tr>
<td>%</td>
<td>18.7</td>
<td>12.8</td>
<td>25.4</td>
<td>28.0</td>
<td>15.1</td>
<td>100.0</td>
</tr>
<tr>
<td>NHS EL</td>
<td>71,600</td>
<td>49,200</td>
<td>93,500</td>
<td>103,500</td>
<td>63,100</td>
<td>359,343</td>
</tr>
<tr>
<td>%</td>
<td>18.8</td>
<td>12.9</td>
<td>24.5</td>
<td>27.2</td>
<td>16.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Some numbers do not sum exactly due to rounding. Source: ONS Mid-year population estimates, 2010
*Excludes Longridge, which is part of Greater Preston CCG.

It is projected that between 2008 and 2020, the East Lancashire resident population will grow by an estimated 7,800 (2.0%). This is proportionally less than the projected growth across the County (4.3%), the North West (4.3%) and England (8.9%). There are important differences according to age group. The 0-19 years age group in East Lancashire is projected to decline by an estimated 4,300 people (4.3%) by 2020, whereas the over 65 age group is projected to grow by an estimated 18,100 people (29.7%). As long-term conditions increase with age this means that our population will have increasing needs for health care even if other risk factors remain unchanged. There are differences within East Lancashire, for example, the population of Burnley is expected to reduce while the number of people in the Ribble Valley will increase.
Mid-2009 estimates indicate that just less than 1 in 10 (9.0%) East Lancashire residents belong to a south Asian ethnic group (predominantly Pakistani heritage), a higher proportion than for Lancashire County (4.1%), the North West (4.7%) and England (6.1%). The south Asian population in East Lancashire is markedly young, with 35% aged below working age (i.e under 16 years) compared to 20% in the population as a whole. Between 2001 and 2009 the south Asian population in East Lancashire has grown by an estimated 6,900 people (or 25%).

In 2010, there were 5,070 live births to women resident in East Lancashire. Fertility rates in East Lancashire have increased over time, as has been the case nationally. Rates in all East Lancashire districts, except Ribble Valley, are higher than the England and Wales average and above what is known as ‘replacement levels’ (i.e. a rate at which the childbearing population replaces itself from one generation to the next, other things being equal).

There are 65 GP practices in East Lancashire and, as at December 2011, there were 371,073 registered patients. Ethnic group is not routinely recorded on the list of patients who are registered with GPs. However, the software Nam Pehchan, which recognises south Asian names, provides an estimate of the proportion of the GP registered population which belong to a south Asian ethnic group. Nam Pehchan estimates that there are 46,789 south Asian patients registered with East Lancashire GPs (12.1% of total registered population). Health status in East Lancashire, as measured by life expectancy, is improving. However, there are wide social inequalities in life expectancy within East Lancashire and between East Lancashire and the national figure. There is evidence that these inequalities are widening. However, East Lancashire should not be stereotyped. There are some areas of great affluence, most notably in the Ribble Valley, but overall wealth and prosperity in East Lancashire suffers from considerable deprivation.
The difference in social deprivation between areas is a major determinant of health inequality. The evidence suggests that whilst, in absolute terms, social determinants of health have improved, the inequality between East Lancashire and the rest of the country has tended to widen.

Health and Lifestyle surveys have shown the East Lancashire population live lives that are linked to poor health and early death. Death rates from smoking and rates of smoking which cause hospital admissions are high in East Lancashire relative to other areas, nationally. Levels of obesity and alcohol drinking are high and increasing. Low levels of exercise and poor diet contributes to this. Tackling these lifestyle factors, which are linked to deprivation and poor health expectations, is a key challenge which will require concerted and consistent approaches from a range of agencies.

East Lancashire has lower levels of life expectancy than the national average. This is mainly driven by relatively high early death rates from cardiovascular diseases, respiratory disease and cancers, but also by the small but important number of deaths at a young age from causes such as accidents, chronic liver disease, suicides and infant deaths.

East Lancashire has historically had poorer health outcomes than the England average, as the chart above, dating back to 1993, illustrates. East Lancashire is close to the North West average but some districts (Burnley, Rossendale, and Hyndburn) have high mortality whilst Pendle is better than the North West & Ribble Valley is better than the England average.

Cardiovascular disease (CVD) is the biggest killer in East Lancashire. Heart failure, a typical consequence of CVD affects around 10% of the population over 65 years of ages. Chronic Obstructive Pulmonary Disease (COPD), which is strongly linked to smoking, affects around 2% of the population in East Lancashire. Death rates from bronchitis, emphysema and other COPD are high at 33% per 100,000 population. Although the number of smokers has reduced over the past 20 years, smoking rates are higher in areas of deprivation.
The incident of cancer was 3% higher in East Lancashire than the rest of the county (2004-06). Among the East Lancashire districts, Burnley had an incidence of 13% higher than England. Lung cancer has been identified as one of the main reasons for the life expectancy gap in East Lancashire.

The East Lancashire infant mortality rate has reduced over time, but remains significantly higher than the England and Wales average. Between 2008 to 2010, an average of 30 babies per year in East Lancashire died before reaching their first birthday. The prevalence of long term conditions in East Lancashire is higher than the national average for: heart disease, diabetes, stroke, respiratory disease (COPD) and hypertension. It is important to ensure the delivery of seamless, integrated pathways with sufficient capacity from identification of disease to end of life.

Cardio vascular disease (CVD) is the biggest killer in East Lancashire. Heart failure, a typical consequence of CVD affects around 10% of the population over 65 years of ages. Chronic Obstructive Pulmonary Disease (COPD), which is strongly linked to smoking, affects around 2% of the population in East Lancashire. Death rates from bronchitis, emphysema and other COPD are high at 33% per 100,000 population. Although the number of smokers has reduced over the past 20 years, smoking rates are higher in areas of deprivation.


Key facts

- Liver Disease - those in the most deprived areas are 8.2 times more likely to die prematurely than those in the least deprived areas
- Mental health and wellbeing - those in the most deprived areas are 6.1 times more likely to experience extreme anxiety and depression than those in the least deprived areas
- Diabetes - those in the most deprived areas are 4.1 times more likely to die prematurely than those in the least deprived areas
- Quality of life - those in the most deprived areas are 3.4 times more likely to be experiencing extreme pain and discomfort that those in the least deprived areas
- Infant mortality - babies in the most deprived areas are 2.9 times more likely to die than those in the least deprived areas
- Coronary heart disease - those in the most deprived areas are 2.8 times more likely to die prematurely than those in the least deprived areas
- Lung cancer - those in the most deprived areas are 2.7 times more likely to die prematurely than those in the least deprived areas
- Stroke - those in the most deprived areas are 2.7 times more likely to die prematurely than those in the least deprived areas
- Child health and wellbeing - children and young people in the most deprived areas are 2.5 times more likely to die than those in the least deprived areas
- Accidents - those in the most deprived areas are 2.2 times as likely to die as those in the least deprived areas
A Programme Budgeting Perspective

Programme Budgeting is a well-established technique for assessing investment in the health of the population, rather than the services in isolation. All Primary Care Trusts (PCT) have submitted an annual programme budgeting return since 2003/4. The Department of Health commissioned the Association of Public Health Observatories to produce a factsheet for each PCT in England, led by Yorkshire and Humber Public Health Observatory. In East Lancashire the highest areas of expenditure are Mental Health, Circulation and Cancer & Tumours. The CCG will use the programme budgeting perspective to check that its investment in priority areas is improving health in those areas. In addition to programme budgeting, we will be using business intelligence tools including the NHS Atlas of Variation in Healthcare 2011.

Financial Assumptions over the Next Three Years

The CCG expects to have a budget in the region of £470m for 2013/14, to commission hospital and community services, but is taking on delegated responsibility for a budget of £710k in 2012/13 as a sub-committee of the PCT. The planning assumptions in Table 2, below, have been used throughout the financial modelling.

Table 2 Financial modelling and planning assumptions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth</td>
<td>2.8%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>PbR Tariff Inflation</td>
<td>2.2%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>PBR Efficiency</td>
<td>(4.0%)</td>
<td>(4.0%)</td>
<td>(4.0%)</td>
</tr>
<tr>
<td>Net In / (De) flation</td>
<td>(1.8%)</td>
<td>(1.5%)</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>Non-PbR</td>
<td>(1.8%)</td>
<td>(1.5%)</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>Prescribing Growth</td>
<td>5.0%</td>
<td>5.0%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Local Provider Landscape

The allocation of the budget in East Lancashire is distributed to health service providers to provide health services for patients in the area. Figure 2, below shows the breakdown of this by type of service.

Figure 2. PCT budget allocation to services

Seventy-three per cent of the current total PCT budget will be devolved to CCGs, the remaining 27% will move to the National Commissioning Board, which will be responsible for Primary Care and Specialist Care. The Public Health budget will be transferred to Public Health Lancashire.
The services are currently commissioned from:
• 22 Secondary Care Hospitals – 16 NHS (including 1 Mental Health Hospital) and 6 independent sector
• 236 GPs in 65 practices, of whom 16 are training practices

The main acute hospital service provider is East Lancashire Hospitals NHS Trust (ELHT), although a significant number of patients who reside around the borders of East Lancashire choose to use Pennine Acute Hospitals NHS Trust, Airedale NHS Foundation Trust or Lancashire Teaching Hospitals NHS Foundation Trust.

Community Services are provided by both ELHT and Lancashire Care NHS Trust.

Lancashire Care Foundation Trust provides mental health services both in hospital and the community.

Specialist services are commissioning on our behalf for patients whose conditions are rare or where the treatment required is very specialist and newly developed.

Responsibility for commissioning these additional services (including general practices) will rest with the National Commissioning Board from 1st April 2013.
Key Performance Indicators

The CCG is reviewing progress for the key performance indicators which the Department of Health measures each area against. The CCG is committed to improving the areas where locally, health services are not achieving the target, and will work collaboratively with key individuals and organisations to improve those areas. A comprehensive planning process is in place which is underpinned by detailed action plans, including timescales which are being performance managed on a regular basis. Although the CCG will not be the responsible organisation for all of these performance indicators, it recognises and understands the importance of its role in contributing to their achievement.

Table 3, below shows current performance for the Key Performance Indicators:

<table>
<thead>
<tr>
<th>Strong performance</th>
<th>Partially met</th>
<th>Area for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Targets</td>
<td>Cancer waiting times</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>Smoking Quitters</td>
<td>Cancer screening</td>
<td>Mortality</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>Immunisation</td>
<td>Health Checks</td>
</tr>
<tr>
<td>Mental Health Measures</td>
<td>NHS Dentistry</td>
<td>Delayed Transfers</td>
</tr>
<tr>
<td>Stroke</td>
<td>18 weeks</td>
<td>Emergency Admissions</td>
</tr>
<tr>
<td>VTE</td>
<td>HCAI</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Accident &amp; Emergency Targets</td>
<td></td>
</tr>
</tbody>
</table>
Explanation of the Case for Change

The NHS has been tasked with identifying efficiencies of £20bn. This is referred to as the QIPP (Quality, Innovation, Productivity and Prevention) challenge. In East Lancashire the target for 2012/13 is a £14.4 million. It is anticipated that there will be limited financial growth in the budget throughout the period from 2012 to 2016. At the same time, there is likely to be continuing growth in the need for services, as well as increasing public expectation and demand. The expectation is that the CCG will continue to improve the quality of services and the health of its population whilst responding to the financial and economic challenge. This will require the CCG to take a transformational approach to the delivery and commissioning of health services.

Figure 4, below, shows the resource allocation for the PCT from its commencement in 2006, projected to 2016/12 to demonstrate the lack of financial growth that is anticipated. It is a statutory (legal) requirement to balance the books and remain within budget. The CCG must therefore, have robust plans in place to keep their spending within their revenue resource limits.

Table 3, below shows the resource allocation for PCTs from 2006 and a projection for the CCG to 2016/17.

The revenue currently allocated to the PCT will reduce to an estimated £470m. This reflects that some of the responsibilities of the PCT will transfer to the National Commissioning Board, Public Health England and Lancashire County Council.
The above chart illustrates the challenge for the CCG. The blue line demonstrates the increase in referrals to hospitals for advice or treatment based on trends over the last few years and the pressure that this will put on the Health Economy resources should this upward trend continue.

The red line demonstrates the impact that the QIPP plans for 2012/13 will have on reducing the demand on hospital activity by moving services closer to home or reducing clinically inappropriate activity. The green line demonstrates the estimated reduction the CCG needs to achieve to ensure financial stability.

It is notable that the QIPP plans for 2012/13 are sufficient to meet our targets, however, there is a gap for years 2013/14 & 2014/15.

Work will take place during the summer to ensure QIPP plans are in place to redesign clinical pathways to ensure high quality services delivered within the CCGs revenue allocation. Plans will be developed using an established methodology and available information including National benchmarking, clinical activity, trend analysis and public health data and evidence.
The challenge is for the CCG to ensure financial balance, whilst it redesigns services to meet the needs of its patients within national guidelines. For example, the aspiration of more support in the community and in patients’ own homes through investing more in community based care is only possible if we reduce the amount of money we spend on hospital services. Patients want assurance that hospitals are there for when they and their families may need them, but usually want to avoid hospital admission whenever possible. This means that the CCG will need to work with our public and with colleagues in hospital and community services to ensure that changes in services are supported and understood as being in the best interests of patients.

The CCG will provide information so that those affected by any proposals can judge the merits of our plans, and particularly whether they are supported by the clinical and research evidence base. We will work with our local councils, providers, patients and the public to make sure services are integrated. In doing so, we will adhere to the goal of “no decision about me, without me”.

Within the local health economy, East Lancashire Hospitals NHS Trust, (ELHT), has two main hospitals in Burnley and Blackburn, with both benefitting from significant capital investment during the last decade to modernise patient facilities. These new builds are funded by the Private Finance Initiative (PFI). There are three community hospitals (Accrington, Pendle and Clitheroe). We have no intention that any of these facilities should close, but they will need to change to meet the needs of patients, and the demands of modern health care. There are also seven new health centres across East Lancashire, with two new health centres planned, and we intend to create a new hospital development at Clitheroe to replace outdated accommodation.

The CCG will work in partnership with its providers and stakeholders to develop an estates strategy to manage what is the largest NHS estate in Lancashire, and to help us meet our strategic objectives. This will set out how we want to work with ELHT and other providers to maximise existing facilities. The CCG will need to consider the range of services that are delivered to make sure that it meets the needs of patients, remains clinically appropriate and responds to the opportunities to support independence and better home care that new technology allows. The CCG will have to make some difficult decisions, but these will be made transparently, in partnership with those who are likely to be affected, and by using consultation, engagement and equality impact assessments to avoid any negative consequences.
Supporting the Development of Strategic Objectives and Their Implementation

Strategic Objectives
The CCG recognises that we are operating in a transitional period, prior to authorisation. The strategy described here is, therefore, a starting point for discussion. Following feedback, it will be refined with our partners and patients.

The process of identifying and selecting CCG priorities will be driven by a number of factors which relate directly to the strategic objectives and value of the organisation, these include:
• Taking the best from strategies already agreed as a result of partnership working and consultation.
• National and Regional priorities and guidance either in regard to specific targets/services or requirements emerging through “The NHS Outcomes Framework 2011/12” and “The Operating Framework for the NHS in England 2012/13”.
• Commissioning safe, high quality and effective services ensuring the latest evidence, guidance and research is utilised to provide assurance.
• Current performance including national key performance indicators and our analysis of where we are spending more than similar CCGs.
• The wide determinants of transformational change required cannot be achieved by East Lancashire CCG alone and its priorities must complement and reinforce the priorities of its partner organisations.
• The need to tackle gaps in service provision including quality, safety and patient experience.
• Future levels of funding.
• Understanding patient and locality needs to ensure services are provided to meet these needs and deliver high quality and good outcomes.
• Systems and processes to ensure the CCG meet its statutory responsibilities.

Shadow Year – 2012/13
2012/13 is a critical year as the CCG will be working towards authorisation by the Department of Health, whilst we progress our commissioning priorities. A balanced number of high level key performance indicators and actions have been developed for the next 12 months and beyond. They have been developed from National policy, statutory obligations and the prioritisation process, and are outlined below. Progress will be monitored on a regular basis through the CCG Shadow Board and Local Delivery Group.
Operating Framework
The NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13. There are four key themes:
• Putting patients at the centre of decision making
• Development of the new system for delivery
• Quality, innovation, productivity and prevention
• Maintaining and improving performance

A number of areas have been identified requiring particular attention during 2012/13:
• Dementia and the care for older people
• Carers
• Military and veteran’s health
• Health visitors and Family Nurse Partnerships

The CCG will meet its commitments outlined in the NHS Operating Framework and the detail on how this will be done is explained in the NHS East Lancashire Operating Plan for 2012/13.

The NHS Outcomes Framework
The Department of Health White Paper, “Liberating the NHS” sets out a vision of an NHS that achieves health outcomes that are among the best in the world. The framework is outlined below:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long term conditions</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill health or following injury</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring that people have a positive experience of care</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>

All of the initiatives outlined below have been developed to meet the requirements of the NHS Outcomes Framework. This will be used as a touchstone of progress by the CCG.
Finance

As explained above in the Case for Change, commissioning bodies have a statutory duty to meet statutory financial targets. For the financial year 2012/13 this will be to:
- Achieve financial balance
- Operate within its capital resource limit
- Operate within it's cash limit

QIPP

The Quality, Innovation, Productivity and Prevention (QIPP) programme is a National Department of Health strategy. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15.

CCGs are expected to contribute to the cost to savings and will implement its own QIPP Programme. The CCGs savings requirement over the financial years 2011/12 – 2014/15 are as detailed below, in Figure 4.

Figure 4. NHS East Lancashire QIPP Targets for financial years 2011/12 – 2014/15

A QIPP programme with clinical leadership for 2012/13 has been produced which aims to achieve the £14.4m savings that are required locally. The CCG's strategic initiatives described below will support this in a way that meets patient's needs and is supported by the clinical and research evidence. The CCG also understands that it is imperative that it does not lose sight of its QIPP target for 2013/14 and planning has already commenced to develop its commissioning intentions for what will be its first year as a statutory organisation.
Demand Management

Demand management is directly linked to the CCG's strategic objective to optimise appropriate use of resources and remove inefficiencies and is key to the achievement of QIPP targets. The CCG is developing a Demand Management Strategy along with its health economy partner, Blackburn with Darwen CCG, which will be implemented during 2012/13.

The aim of the strategy will be to ensure that patients are only referred for a hospital appointment when it is clinically appropriate; the patient is fit for surgery if that is the intended outcome; that the patient has made an informed decision that they agree to be referred and that they are referred to the appropriate speciality. There is significant variation in the number of GP referrals to a hospital between practices, even when compared to other GP practices in areas with the same demographics such as age, and deprivation.

Figure 5. The level of variation in referrals between GP practices in East Lancashire

The CCG will use a number of tools and techniques to help manage this variation, and where possible reduce it during 2012/13. These include:

- Developing referral templates and mini-guides based on clinical evidence to improve the quality of referrals
- Peer review between clinicians with an aim to reduce referral variation between practices
- Triage of referrals in specialities under pressure such as Orthopaedics and Pain Management
- Ensure patients are fully involved in decisions regarding their treatment using Shared Care Decision tools as advocated by AQUA (Advancing Quality Alliance)
- Redesign pathways to remove inefficiencies and increase quality
Quality Outcomes Framework (QOF)
The Quality and Outcomes Framework (QOF) is a voluntary annual programme used to reward and incentivise good practice within GP surgeries in England. The CCG has recognised that QOF can be used to involve GPs and their practices in each locality directly to support its strategic objectives. In 2011/12, the CCG carried out two events which involved 75 GPs from East Lancashire and 60 out of a total 65 practices to identify priority demand management areas and agree action. Each GP practice has agreed to implement at least 6 notable improvements in practice or to engage in service redesign in the locality or across East Lancashire, which demonstrates effective demand management. The CCG is committed to supporting constituent member practices to deliver the above actions and to continue delivery of 2012/13 QOF indicators for quality and productivity to support demand management.

Communication and Engagement
The CCG has agreed a strategy for communication and engagement. The key communication and engagement objectives for the CCG are to:
• Engage, communicate and involve member practices regularly, and appropriately
• Explain commissioning plans, intentions and activities to the public and stakeholders
• Involve the public, patients and stakeholders at the appropriate stage in the commissioning cycle
• Use patient and public feedback to measure, monitor and improve commissioning and commissioned services, and
• Support self-care and promote appropriate use of services

Organisational Development
The CCG recognises the importance of organisational development to enable it to demonstrate it has the necessary competences to achieve future success, particularly around the six domains outlined in ‘Developing clinical commissioning groups: towards authorisation’. These are:
• A strong clinical and multi-professional focus which brings real added value
• Meaningful engagement with patients, carers and their communities
• Clear & credible plans with continue to deliver the QIPP challenge within financial resources; in line with national requirements and local joint health and wellbeing strategies
• Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commission all the services for which they are responsible
• Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support
• Great leaders who individually and collectively can make a real difference
The CCG has produced an Organisational Development Plan with timescales and measurable outcomes, to achieve these competencies.
Primary Care Development

Primary care has improved dramatically in East Lancashire over the past couple of decades. This is visible in the range and quality of services available in general practice and in the improved environment in which services are delivered. This is important because we believe that patients want services delivered as close to their home as possible and prefer services to be provided in their GP practice wherever possible. However variations in the range and quality of services remain and are often wider than we believe that they should be. Patients continue to tell us that they sometimes find it difficult to get an appointment when they need one.

Responsibility for contracts with primary care – GPs, dentists, pharmacists and optometrists – will be the responsibility of the National Commissioning Board rather than the CCG. However we believe that we won’t be able to deliver the vision outlined within this plan without improving primary care services and that to improve these services we will need to target investment in primary care. It is important that practices that have invested in their own development are not penalised for doing so and we will need to achieve a balance in our decision making. We are committed to the principle that all our patients should receive the services that they require in primary care.

As services are transferred from hospital into primary and community care it is important that the resource follows the patient, and that the additional pressure on primary care is recognised.

The CCG will develop a primary care development strategy that sets out how it will achieve its vision for primary care.

Within this the following are identified priorities:

• Increasing the number of practices who have enrolled on the Quality Practice Award scheme - a criterion-based quality accreditation process undertaken by Primary Health Care Teams across the United Kingdom. The purpose of the award is to improve patient care by encouraging and supporting practices to deliver the very highest quality care to their patients.
• Completion of the new health centres in Colne and Great Harwood
• Reviewing Local Enhanced Service (LES) Schemes to ensure that they are meeting patient needs and providing value for money
• Improving the integration of general practice with community staff – health visitors, district nurses, midwives and social care staff
• Considering the procurement arrangements for out of hours services
• Improving information and information systems within and available to primary care

The CCG will want to work with our primary care colleagues - dentists, pharmacists and optometrists – to identify ways that we can work together to improve health outcomes for our patients.

At an event earlier in the year, GPs asked us to redesign the pathway for joint injections.

From October 2012, it is intended that all knee and shoulder injections, where clinically appropriate, will only be delivered within a primary care setting.
Developing Choice
East Lancashire CCG is committed to working with secondary care clinicians and social care practitioners to develop integrated services. The priority is to develop high quality local services that meet the needs of our patients. Competition should be to improve services and meet patients’ needs, not as an end in itself. For some cases, competition can threaten integration and partnership working. For this reason we will focus on market testing services where we believe this will enable us to secure services that deliver better outcomes and value than current providers or improved access to services.

We will consider options for market testing on a case by case basis. One way of implementing patient choice, and a preferred model for market testing, is by procuring services using the ‘Any Qualified Provider’ (AQP) approach. AQP is a Department of Health initiative whereby a range of service providers are commissioned to provide a particular range of health services, rather than just one service. This allows patients to choose from a number of providers in different localities all of whom meet NHS standards and price.

Nationally, eight priority areas have been identified:
1. Musculo-skeletal services (MSK) for back and neck pain
2. Adult hearing services in the community
3. Continence services (adults and children)
4. Diagnostic tests closer to home
5. Wheelchair services
6. Podiatry services
7. Venous leg ulcer and wound healing
8. Primary Care Psychological Therapies (adults)

NHS Lancashire, including NHS East Lancashire, has identified 3 priorities from the national list. These are (1) Musculo-skeletal services for back and neck pain, (2) Diagnostic tests closer to home and (3) Adult hearing aid services in the community. This list reflects the three priority AQP services which will be implemented in 2012-13 but does not preclude consideration of other services, including those within the 8 previously identified by the Department of Health.

Locally, the PCT has already opened up some services to choice of ‘Any Qualified Provider’, such as the recent Minor Oral Surgery Scheme (MOSS). Through the AQP scheme, minor oral services have been commissioned that incorporate clinical referral triage to ensure that procedures are carried out by a dental provider where clinically appropriate, rather than an acute provider. To ensure quality is optimised, a Managed Clinical Network has also been established. Another service that has been procured as a local AQP is non cancerous lymphodema services.
The strategy described above has guided the development of a number of initiatives which have been designed to meet the challenges in East Lancashire. In each case, the initiative can be linked to National priority, the CCG’s Vision and values, and the Strategic Objectives.

It is important that the CCG chooses its key priorities and initiatives carefully to meet the challenges above. It is also imperative to ensure that the intentions are both clear in that its partners, key stakeholders and patients and the public understand what we intend to do. Each initiative will be clinically led with a focus on enhancing quality and promoting the most effective use of resources using programme management to ensure delivery.

The key priorities and initiatives are explained in detail on individual pages devoted to each priority. However in summary the key priority and initiative areas for East Lancashire CCG are:

1. Acute (hospital) Planned Care
2. Children and Young People’s Services
3. Mental Health Services
4. Unplanned (urgent) Care
5. Community services
6. Medicines Optimisation
Acute Planned Care

Acute planned care is the care provided in a hospital to people that is planned in advance, for example, surgery which a GP has referred a patient for or an appointment with a hospital consultant.

**Strategic Priority**
- Demand Management
- Redesign of clinical pathways to improve clinical outcomes, increase & ensure patient satisfaction
- Achieve National and Regional priorities
- Achieve CCG & Locality priorities

**Rationale**
- Right treatment, right time, right place
- Quality, Innovation, Productivity & Prevention (QIPP)
- National Institute for Health and Clinical Excellence (NICE)
- The NHS Outcomes Framework
- NHS Co-operation & Competition requirements,
- The Operating Framework for the NHS in England 2012/13
- Cancer Reform Strategy

**Why is change needed?**
- More can be done to remove inefficiencies in services
- Evidence suggests more treatments can be delivered out of hospital at reduced cost whilst achieving clinical outcomes
- Benchmarking shows East Lancashire as an outlier in some specialities
- Outpatient, day cases and admissions are increasing year on year
- Some Patients are waiting longer than 18 weeks in some specialities
- Some patients are waiting longer the 62 days for their first definitive cancer treatment
- Patients are travelling to an acute hospital for treatment that can be delivered closer to home
- There is variation between GP practices in the number and quality of hospital referrals
- GPs would like to have improved access to diagnostics

**How do we want the future to look?**
- More care delivered within localities
- High patient satisfaction
- Shorter waiting times for treatment
- Reduction of waste and duplication
- Patients, public and clinicians redesigning clinical pathways
- Reduction in referral variation between GP practices
- Clarity around the roles between primary and secondary care clinicians

**How will we measure success?**
- Patient Recorded Outcomes Measure (PROMS)
- National Benchmarking
- Patient Satisfaction Services Surveys
- Number of services & treatments available in the community
- Reduction in number of treatments carried out in an acute care setting
- The length of waiting times
- Monitoring of GP referral rates
- Demonstrable shift in spend from acute to community and primary care

**What are we doing about it?**
- Work with hospital doctors and GPs to carry out a comprehensive review of Ophthalmology services.
- Ensure patients with stable glaucoma can have their clinical appointments closer to home
- Redesign Ophthalmology services to provide ‘one-stop-shop’ clinics to avoid patient having unnecessary hospital appointments
- Commission a Specialist Pain Management Service
- Review ENT Service to identify procedures that can be carried out closer to home and to improve patient pathways
- Implement a programme of demand management projects to improve the quality of referrals and reduce unnecessary hospital appointments and review pathways for diagnostic tests.
- Work with our GPs to review a number of Orthopaedic Pathways to ensure patients are seen closer to home where this is clinically appropriate.
- Introduce evidence based clinical thresholds to ensure patients are receiving the right treatment at the right time and to ensure patients are not referred for treatment until it is clinical appropriate
- Work with the hospital to review cancer pathways to ensure patients do not wait unnecessarily for treatment.
## Children and Young People

Children and young people services are services that are designed specifically for children and young people in both hospital and the community.

### Strategic Priority

- Ensuring services meet minimum standards and best value for money
- Delivering improved outcomes for all children and young people.

### Rationale

- Right treatment, right time, right place
- Quality, Innovation, Productivity & Prevention (QIPP)
- National Institute for Health and Clinical Excellence (NICE)
- The NHS Outcomes Framework
- NHS Co-operation & Competition requirements,
- The Operating Framework for the NHS in England 2012/13

### Why is change needed?

- Identified as Commissioning Intentions
- Government & DH Policy (must do’s)
- To reduce health inequalities
- Identified as CCG priorities
- To improve quality and patient experience
- More can be done to remove inefficiencies in services
- National benchmarking suggests more treatments can be delivered at reduced cost whilst achieving improved outcomes
- There is variation between providers in the quality of services

### How do we want the future to look?

- Quality care delivered within localities, at best value
- High patient satisfaction
- Shorter waiting times for treatment
- Reduction of waste and duplication
- Patients, public and clinicians redesigning clinical pathways

### How will we measure success?

- Improved outcomes for children and young people
- Reduction in hospital admissions
- Reduced attendance at the Emergency Department and Urgent Care Centre
- Reduction in inappropriate referrals to CAMHS
- Increase in knowledge & early intervention within universal services
- Children and young peoples’ report positive experiences of services
- Increased involvement of C&YP

### What are we doing about it?

- Development of a single service specification and performance framework for pan Lancashire Tier 2 and 3 CAMHS and a review of inpatient unit specifications.
- Development of adolescent mental health services within the current envelope of funding within the adult mental health contract
- Improving Looked After Children and Young People’s Experience of health care
- Ensure early intervention & prevention is achieved in all areas
- Participate in and implement the Health Visitor Implementation Plan 2015
- Ensure the involvement of children and young people in the planning of services
- Implementation of the Pennine Lancashire maternity services specification from 1st April 2012.
- Review the antenatal care pathway utilising national guidance and service user feedback to inform best practice.
- Children’s Complex Cases and Acute Health Redesign
Mental Health Services

Mental health services are services that are designed specifically for people who require access for services that will deal with their mental health needs in both hospital and the community.

### Strategic Priority

- Reconfiguration in Adult Mental Health inpatient services
- Review care pathways and services to improve clinical outcomes
- Achieve National and Regional priorities
- Achieve CCG & Locality priorities

### Rationale

- Right treatment, right time, right place
- Quality, Innovation, Productivity & Prevention (QIPP)
- National Institute for Health and Clinical Excellence (NICE)
- The NHS Outcomes Framework
- NHS Co-operation & Competition requirements,
- The Operating Framework for the NHS in England 2012/13
- The Autism Act (2009)
- Fulfilling & Rewarding Lives (2010)

### Why is change needed?

- More can be done to remove inefficiencies in services
- There is variation between GP practices in the number and quality of referrals
- There is a need to ensure out of hours services and crisis services are high quality, effective and responsive
- Following a research pilot with Action for ASD (Autistic Spectrum Disorder) it was recommended that we should design, develop and implement an ASD assessment, diagnostic and follow-on care and support service in line with National policy
- Following a communication and engagement exercise it was identified that there was a need to improve the experience of people with learning disabilities whilst using mental health services
- Patients need to be supported in the community to avoid admission to hospital and allow patients to live a quality life in the community
- There is a need to improve services for those with a dual diagnosis

### How do we want the future to look?

- Mental health and learning disability services offering a wide range of clinically effective interventions
- High patient satisfaction
- Patients, public and clinicians involved in redesigning clinical pathways and services
- Appropriate services are available for those with a dual diagnosis

### How will we measure success?

- National Benchmarking
- Patient Satisfaction Services Surveys
- Number and range of services & treatments available in the community
- Reduction in admissions to hospital

### What are we doing about it?

- Working collaboratively with PCTs and CCGs in Lancashire to reconfigure hospital mental health services
- Working with CCGs and key stakeholders to ensure community and crisis services meet the needs of patients and reduce unnecessary hospital admissions
- Reviewing Dual Diagnosis services with the Communications and Engagement team to ensure key stakeholder involvement
- Formalising the assessment and diagnostic care pathway for people with mental health and learning disabilities.
- Reviewing access to psychological services (IAPT) and single point of access services
- Developing a diagnostic care pathway for Autistic Spectrum Disorder
# Unplanned (Urgent) Care

Unplanned (urgent) care is the care provided at an Urgent Care Centre, Minor Injuries Unit or Accident and Emergency Unit.

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to Urgent Care</td>
<td>• Right treatment, right time, right place</td>
</tr>
<tr>
<td>Deliver QIPP plan/savings (I, II &amp; III)</td>
<td>• Quality, Innovation, Productivity &amp; Prevention (QIPP)</td>
</tr>
<tr>
<td>Deliver Operating Plan 12/13 requirements</td>
<td>• National Institute for Health and Clinical Excellence (NICE)</td>
</tr>
<tr>
<td>Deliver Sustainable Performance</td>
<td>• The NHS Outcomes Framework</td>
</tr>
<tr>
<td></td>
<td>• NHS Co-operation &amp; Competition requirements,</td>
</tr>
<tr>
<td></td>
<td>• The Operating Framework for the NHS in England 2012/13</td>
</tr>
</tbody>
</table>

## Why is change needed?

- More can be done to remove inefficiencies in services
- Evidence suggests more treatments can be delivered out of hospital at reduced cost whilst achieving clinical outcomes
- Attendances and admissions are increasing year on year
- Patients are travelling to an acute hospital for treatment that can be delivered closer to home
- GPs would like to have improved access to Urgent Care

## How do we want the future to look?

- More care delivered within localities
- High patient satisfaction
- Shorter waiting times for treatment
- Reduction of waste and duplication
- Patients, public and clinicians redesigning clinical pathways
- Clarity around the roles between primary and secondary care treatments

## How will we measure success?

- Clinically appropriate patients attending secondary care
- Development of primary care services
- National benchmarking
- Improved patient satisfaction
- Improved clinical outcomes
- Sustained achievement of targets
- Reduced used of emergency and urgent care services

## What are we doing about it?

- Carry out a comprehensive redesign of UCC / Co-location and integration of OOH
- Piloting and procurement of 111
- Review access to urgent primary care
- Review and reduce levels of demand for emergency ambulances
- Implement the management of DVT within primary care
- Work with community and social care providers to improve discharge pathways
- Ensure appropriate arrangements in place for annual resilience (including Winter)
Community Services
Community services are designed to provide care outside of a hospital setting.

Strategic Priority
- Delivering improved outcomes for people with Long Term Conditions
- Developing capacity and capability in primary care
- Transforming Community Services to deliver care closer to home
- Development of NHS Health Checks programme
- Commence implementation of the Pennine Lancashire End of Life Strategy

Rationale
- Right treatment, right time, right place
- Quality, Innovation, Productivity & Prevention (QIPP)
- National Institute for Health and Clinical Excellence (NICE)
- The NHS Outcomes Framework
- NHS Co-operation & Competition requirements
- The Operating Framework for the NHS in England 2012/13

Why is change needed?
- Overriding desire to improve the quality and capability of primary care to deliver care closer to home
- To reduce health inequalities identified by National Support Team for Health Inequalities by the delivery of effective prevention programmes
- Government & DH Policy (must do’s) indicate a direction of travel that clinical commissioners must respond to
- National benchmarking suggests East Lancashire is an outlier for admissions for some people with ambulatory sensitive conditions and improvements in self-management and shared care/decision making can be delivered by integration of key components of health and social care
- Long Term Conditions identified as CCG priority and as such are part of the organisational commissioning intentions
- To improve quality, safety and patient experience of services commissioned by clinical commissioners
- More can be done to remove inefficiencies in services/optimise resources

How do we want the future to look?
- Commission a seamless health and social care system, providing care closer to home or when appropriate in the home
- Right care, right place, right time
- High quality safe care delivered within localities, at best value
- High patient satisfaction and experience
- Shorter waiting times for treatment
- Reduction of waste and duplication
- Patients, public and clinicians co-producing and redesigning clinical pathways
- Patients having the choice to die at home
- Access to rehabilitation and enablement to all patients who require it
- Patients empowered and confident to self-manage their long term condition

How will we measure success?
- Reduction in length of stay following admission by 15% over 5 years
- 20% reduction in admissions for ambulatory sensitive conditions over 5 years
- Demonstrable shift in spend from acute to community
- National benchmarking
- Improved patient reported outcomes
- Increase in the number of holistic health and social care assessments
- Increase in patients who are effectively managed with exacerbations of chronic illness in the community
- An improvement in the proportion of older people (>65) who remain at home 91 days after discharge from hospital into rehabilitation community services
- Reduce the number of emergency admissions at the end of life

What are we doing about it?
- Developing capacity and capability in primary care (LES, development of clinical networks e.g. dentists, pharmacists)
- Delivering improved outcomes for people with Long Term Conditions will reduce the burden on the wider health and social care community (e.g. pathway redesign, early identification, self-management)
- Transforming Community Services to deliver care closer to home (e.g. development of intermediate care, rehabilitation and re-ablement, carer support, voluntary sector development)
## Medicines Optimisation

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that the principles of medicines optimisation underpin the commissioning of services where the use of medicines forms an integral part of the patient pathway (Development of a 3 year medicines optimisation strategy)</td>
<td>Delivery of joint health and wellbeing board strategy</td>
</tr>
<tr>
<td></td>
<td>Reduction in health inequalities</td>
</tr>
<tr>
<td></td>
<td>Outcomes Framework</td>
</tr>
<tr>
<td>Medicines optimisation to constitute an integral part of the CCG’s Quality, Innovation, Productivity and Prevention (QIPP) plan</td>
<td>Achieve the CCG's proportion of the national £20bn efficiency savings</td>
</tr>
<tr>
<td></td>
<td>Improving patient outcomes within available resources</td>
</tr>
<tr>
<td></td>
<td>CCG duty to have a credible QIPP plan</td>
</tr>
<tr>
<td>Promote innovation and the uptake of NICE-approved medicines, reduce variation in prescribing performance and proactively disinvest in medicines where these do not demonstrate best value in improving patient outcomes</td>
<td>CCG duty to promote innovation</td>
</tr>
<tr>
<td></td>
<td>NICE Compliance regime</td>
</tr>
<tr>
<td></td>
<td>CCG authorisation</td>
</tr>
<tr>
<td></td>
<td>Maintaining financial balance</td>
</tr>
<tr>
<td>Effective health economy arrangements in place for local decision making on new medicines and incorporation of NICE-approved medicines within the prescribing formulary and treatment pathways</td>
<td>Promotion of the NHS Constitution</td>
</tr>
<tr>
<td></td>
<td>NICE Compliance regime</td>
</tr>
<tr>
<td></td>
<td>Patient and public involvement in decision making</td>
</tr>
<tr>
<td>Further develop clinical leadership for medicines optimisation within the CCG through board-level leadership and locality leads</td>
<td>Clinical leadership and CCG development</td>
</tr>
</tbody>
</table>

Medicines optimisation provides the opportunity for a shared approach to medicines use, providing patients with better access to support for medicines taking. It offers the potential to improve the safe use of medicines in all care setting, harnessing the expertise of professional and patients working together. Ultimately, medicines optimisation will deliver better value for money from the significant investment that the CCG makes in medicines each year (at least £75 million in 2011/12). The changing national shift from “medicines management” to medicines optimisation will be recognised within the CCG through the development of a three year medicines optimisation strategy with an emphasis on achieving better outcomes from optimising medicines use, reducing health inequalities, and enhanced public and multi-professional engagement. The medicines-related aspects of service redesign will be considered in the commissioning of new treatment pathways.
Effective Implementation of NICE Guidance
The East Lancashire CCG will promote innovation by actively supporting the implementation of NICE guidance and monitoring the prescribing of treatments of proven benefit approved by NICE through its providers, and peer review of prescribing performance within the CCG. NICE recommended treatments will be incorporated into the CCG prescribing formulary within three months of the NICE determination. The CCG will routinely review its core spending on medicines with a view to disinvesting in those medicines where the evidence relating to improvement in patient outcomes does not support the level of resource invested.

Local Decision Making on New Medicines
The NHS Constitution requires NHS commissioners to have robust, transparent arrangements in place for the managed entry of new drugs. Working with clinicians, the East Lancashire CCG will ensure that it continues to make population and individual patient funding decisions relating to the commissioning and utilisation of medicines in a manner that is robust, rational and defensible. Building on existing Pennine Lancashire arrangements for local decision making the CCG will cooperate with neighbouring CCGs and provider organisations to facilitate a shared approach to medicines use, integrating medicines into care pathways and promoting inter- and intra-professional collaborative working within the Lancashire health and social care system. Not only is this in the best interests of patient care, but such an approach has the potential to deliver economies of scale, enhance quality and robustness of decision making, and promote equity in access to medicines.

CCG Quality, Innovation, Productivity & Prevention Plan (QIPP)
Opportunities to optimise the use of medicines and deliver efficiency savings will feature in the CCG QIPP plan and will reflect the content of the CCG Medicines Optimisation Strategy for the prioritisation and disinvestment of medicines and related services. Systems for ensuring the cost-effective use of medicines and budgetary management will include: mechanisms for reviewing expenditure data; peer review and the availability of prescribing support and advice; implementation of a health economy prescribing formulary; active planning for future developments and investment requirements; and robust management of expenditure associated with high cost drugs excluded from provider tariff payments.
Clinical leadership for Medicines Optimisation

The CCG Board level lead for medicines optimisation, with reference to relevant, expert advice, will advise the Board on the CCG’s medicines optimisation strategy. GP leads within the CCG locality structures will work with clinical colleagues, supported by appropriate, professional advice, to implement the CCG medicines optimisation strategy within and across the localities. Although community pharmaceutical services are to be commissioned by the National Commissioning Board, an effective relationship with community pharmacy will be instrumental in delivering the CCG medicines optimisation strategy. The CCG will seek to engage the local pharmacy profession in the delivery of the CCG priorities for medicines optimisation, recognising the important contribution of this sector to health improvement and protection.

How will we know we are succeeding?

• Effective uptake of NICE approved medicines as demonstrated by performance metrics
• Disinvestment in medicines determined to be of low priority
• Medicines optimisation principles considered in the commissioning of services and development of care pathways
• Improved performance against the NHS Outcomes Framework and patient outcomes optimised
• Robust arrangements in place for the managed introduction of new medicines that meet the requirements of the NHS Constitution
• Medicines optimisation a feature of the CCG QIPP plan
Realistic and achievable contracts are expected by all parties to be agreed during the contracting process. Any variations from the agreed contract by any health service provider will be reported internally within the PCT on a monthly basis. Material differences in the delivery of the contract will be highlighted internally within the CCG as soon as they become apparent, and discussed with the relevant health provider at the earliest opportunity. Material variation levels will be defined for each contract, and will be a mix of % and cash de minimus limits. For material variances an action plan will then be agreed between the provider and CCG as to how the position can be managed to avoid budgetary overspends and to remain within the agreed budget.

The CCG will have in place strong financial governance procedures and processes. In particular:
• Standing Financial Instructions
• Internal & External Audit Reviews
• Establishment of an Audit Committee
• Focus on delivery and financial performance through a Local Delivery Group and the CCG Shadow Board.
• Maintenance of a Corporate Risk Register to identify risks to delivery of statutory functions and mitigating strategies

The CCG will agree a Service Level Agreement with a Commissioning Support Service (CSS) which allows for monthly production of key financial and performance information for timely presentation to responsible GPs and locality managers. This is absolutely crucial for us to understand control and deliver its statutory targets. Key performance measures would focus on the delivery on information within agreed timescales, and error rates. Both are essential and will require monitoring on a monthly basis by senior members of the CCG.

The CCG will encourage joint working across Health Economies. The main vehicle for joint working in Pennine Lancashire is the Clinical Transformation Board. A similar arrangement is established for CCGs across Lancashire as a whole. QIPP will be a key enabler to identify recurrent resources for re-investment in alternative care pathways etc. The CCG will look to invest its 2% recurrent surplus on a non-recurrent basis to in turn assure QIPP delivery.

As part of authorisation process the CCG will plan for three different financial and activity scenarios. An outline of the 2012/13 financial plan for the shadow CCG is attached. The CCG is planning to achieve its statutory targets by a reduction in activity levels and hence costs from those reported in 2011/12, and some schemes are now in place that will contribute towards this. A number of additional non activity albeit cash releasing QIPP schemes have been also been identified for 2012/13 (eg Running Costs reductions, prescribing etc) which make a significant contribution to the savings requirement.
Financial Risk
The CCG will have a process in place to identify what the key risks are associated with the development and implementation of the CCP and its initiatives, for the coming year and beyond. An initial risk analysis has been carried out and mitigating plans have been put in place to manage or reduce potential impact, such as:

- appropriately skilled staff are available
- Robust monitoring to ensure that the establishment of a new organisation does not divert focus away from delivery
- Financial monitoring of current & forecast performance against a range of scenarios – good, most likely, bad
- Establishment of a contingency reserve, and careful management of this in line with forecast financial position

Financial Overview
A financial overview of the funding implications has been carried out to demonstrate how the proposals will be funded and from what source of funds

The CCG will receive an allocation based upon the Advisory Committee and Resource Allocation (ACRA) formulae, which are due to be published by the end of February 2012.

For the shadow year (2012/13), a methodology has been established to devolve commissioning budgets to the CCG, this is based on existing commissioning activities and excludes those areas of expenditure which are known to become the responsibility of other commissioning organisations.

When indicative CCG budgets are published the planned spend will be compared and this will indicate the potential spending gap.

Whilst CCG planning guidance beyond 2012/13 is somewhat vague, the following assumptions have been made:

- The CCG will have to hold a 2% recurrent surplus which it will be able to deploy non-recurrently to lever service transformation
- The CCG will have to deliver a 1% operating surplus
- PCT running costs will reduce in 2012/13 from the 2011/12 reported position and from 2013/14 the CCG will operate within a running cost envelope of £25 per head of population.

The following table details for 2012/13 the source of new funding available to the shadow CCG and how it is planned those fund be applied.
## Resource and Application of New Funds (summary)

<table>
<thead>
<tr>
<th>Resources Available</th>
<th>Recurrent £’000</th>
<th>Non-Recurrent £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8% Growth per operating framework</td>
<td>19,793</td>
<td></td>
<td>19,793</td>
</tr>
<tr>
<td>Return of Lodgement</td>
<td></td>
<td>16,326</td>
<td>16,326</td>
</tr>
<tr>
<td>Return of Resource Surplus</td>
<td></td>
<td>3,324</td>
<td>3,324</td>
</tr>
<tr>
<td>Ring-fenced non-recurrent allocations</td>
<td></td>
<td>32,893</td>
<td>32,893</td>
</tr>
<tr>
<td><strong>Total New Resources Available</strong></td>
<td><strong>19,793</strong></td>
<td><strong>52,543</strong></td>
<td><strong>72,336</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Application of Resources Available</th>
<th>Recurrent £’000</th>
<th>Non-Recurrent £’000</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum 1% control total to be delivered</td>
<td>6,848</td>
<td></td>
<td>6,848</td>
</tr>
<tr>
<td>Additional 1% control total request</td>
<td>6,848</td>
<td></td>
<td>6,848</td>
</tr>
<tr>
<td>2% Recurrent Surplus (additional to make true 2%)</td>
<td>395</td>
<td></td>
<td>395</td>
</tr>
<tr>
<td>Ring-fenced non-recurrent allocations</td>
<td></td>
<td>32,893</td>
<td>32,893</td>
</tr>
<tr>
<td>Specific Commitments from Growth</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Operating Framework Commitments</td>
<td>4,050</td>
<td></td>
<td>4,050</td>
</tr>
<tr>
<td>Previously funded commitments</td>
<td>1,100</td>
<td></td>
<td>1,100</td>
</tr>
<tr>
<td>2011/12 purchase of out-turn / budgetary pressures</td>
<td>6,216</td>
<td></td>
<td>6,216</td>
</tr>
<tr>
<td>CCG Transition</td>
<td></td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>CQUIN &amp; Inflation</td>
<td>9,745</td>
<td></td>
<td>9,745</td>
</tr>
<tr>
<td>QIPP Target</td>
<td>(14,400)</td>
<td>(14,400)</td>
<td></td>
</tr>
<tr>
<td>Known 2012/13 pressures</td>
<td>1,423</td>
<td>1,145</td>
<td>2,568</td>
</tr>
<tr>
<td>Contract negotiations / code of conduct changes</td>
<td>2,000</td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Over-performance pressures</td>
<td>2,000</td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>Innovation Fund</td>
<td>500</td>
<td></td>
<td>500</td>
</tr>
<tr>
<td>Contingency (1%)</td>
<td>6,764</td>
<td></td>
<td>6,764</td>
</tr>
<tr>
<td><strong>Total New Resources Available</strong></td>
<td><strong>19,793</strong></td>
<td><strong>52,543</strong></td>
<td><strong>72,336</strong></td>
</tr>
</tbody>
</table>

| Balance (under)/Over Commitment                          | 0               | (4,009)             | (4,009)     |
Good governance is important to patients, the public and clinicians. There are a number of elements to governance: corporate, clinical, financial, information and research governance. During the transition or ‘shadow’ year East Lancashire CCG will ensure that it develops open and transparent systems and processes to manage all areas of governance in preparation for authorisation.

As part of the transition processes the CCG is involved in the business continuity arrangements and close down governance processes for the PCT. Experience and learning form this agenda will be used to further inform governance arrangements for the CCG.

For the transition period during the financial years 2011/12 and 2012/13 the CCG is established as a sub-committee of NHS East Lancashire Board with a range of delegated duties and responsibilities. As such, the CCG is bound by NHS East Lancashire’s corporate governance requirements, which includes its standing orders, standing financial instructions, scheme of reservation and delegation, codes of conduct and the key policies and procedures of NHS East Lancashire.

The CCG has established a Local Delivery Group (LDG) which reports to the Shadow CCG Board. The role of the group is to provide assurance that initiatives and priorities agreed for 2012 – 2013 are delivered during a period of structural change.

Over the coming months, the emerging CCG will undertake a series of comprehensive ‘steps to authorisation’ to ensure that the required governance systems are in place to:
- Commission healthcare safely
- Ensure we are financially viable
- Engage with local clinicians to shape local health services

During the transition period the CCG will establish robust governance arrangements to deliver its functional responsibilities, taking into account the national guidance on CCG constitutions, which is anticipated in March 2012.

Throughout the shadow year the CCG will further develop the governance arrangements for joint working with partner organisations and neighbouring CCGs (where necessary). It is recognised that the relationships with the local and district councils are at an early stage and Lancashire’s Health and Wellbeing Board is in its infancy.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQP</td>
<td>Any Qualified Provider. A Department of Health initiative whereby a range of service providers are commissioned to provide a particular group of health services rather than just one service.</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>C&amp;YP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child &amp; Adolescent Mental Health Service. CAMHS offers assessment and treatment of complex mental health difficulties of children up to 16 years old. It consists of a multi-disciplinary team, comprising of social workers, mental health practitioners, medical and nursing staff and a consultant psychiatrist with some input from a clinical psychologist.</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group. CCGs will become the statutory bodies responsible for commissioning (buying) health services from 1st April 2013 (subject to the Health and Social Care Bill). CCGs are a new and different type of organisation and are led by local clinicians (GPs and others).</td>
</tr>
<tr>
<td>Commissioning</td>
<td>The job of assessing the health needs of the local population, funding health services that meet those needs, and monitoring the quality of those services.</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>ELHT</td>
<td>East Lancashire Hospitals Trust. Local acute provider of services. Includes hospitals sites at Burnley General Hospital and the Royal Blackburn Hospital</td>
</tr>
<tr>
<td>ENT</td>
<td>Ears, Nose, Throat. Describes the service which specialises in the diagnosis and treatment of ear, nose, throat, and head and neck disorders. These could include: general ear, nose and throat diseases, neck lumps, cancers of the head and neck area, tear duct problems, facial skin lesions, balance and hearing disorders, snoring and sleep apnoea, ENT allergy problems, salivary gland diseases and voice disorders.</td>
</tr>
</tbody>
</table>
FOI Act | The Freedom of Information Act gives everyone the right to access information held by public services

HCAI | Health Care Associated Infections

Health Inequalities | Differences and gaps in standards of health from area to area, often linked to poverty and other social issues

IAPT | Improving Access to Psychological Therapies

JSNA | Joint Strategic Needs Assessment (information and data used to identify and tackle the most important issues)

KPIs | Key Performance Indicators

LDG | Local Delivery Group

LES | Local Enhanced Service

Long Term Conditions | There are around 15 million people in England with at least one long term condition – a condition that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – diabetes, asthma and coronary heart disease, chronic obstructive pulmonary disease (COPD) and mental health issues can all be included.

Nam Pehcan | Computer software which recognises names of a South Asian origin

NICE | National Institute of Clinical Excellence

Ophthalmology | Ophthalmology is a branch of medicine dealing with the diagnosis, treatment, and prevention of diseases of the eye and visual system. Ophthalmology integrates with many other branches of medicine – did you know that the commonest cause of visual impairment under the age of 65 years is diabetes?

Orthopaedics | Orthopaedics is the branch of surgery concerned with treating problems involving the musculoskeletal system. The musculoskeletal system includes bones, joints, ligaments, tendons, muscles and nerves.
OOH  Out of Hours (services operating outside of normal working hours)

PBR  Payment By Results (acute hospitals paid on the basis of the number of patients seen)

PCT  Primary Care Trust

PCT Cluster  The Lancashire PCTs working with a shared Board – the accountable NHS organisation for 2012/2013.

Programme Budgeting  A way of assessing investment in the health of the population

Providers  Organisations which provide health or social care services, such as acute (hospital) trusts

QIPP  An efficiency programme aimed at getting best value for money from services. It stands for Quality, Innovation, Productivity and Prevention.

QOF  Annual programme used to encourage good practice within GP Practices

Strategic Plan  The things which the CCG sees as most important to improve health and health services for the population of East Lancashire using the money available

UCC  Urgent Care Centre

VTE  Venous thromboembolism (VTE)
A condition in which a blood clot (thrombus) forms in a vein.

111  New NHS service – ring 111 when you need medical help and advice and the situation is not an emergency or life-threatening