Table of Contents

Glossary of Terms 4
Introduction 6
- Our Vision 6
- The Better Care Fund 7
- The Financial Outlook 7

Blackburn with Darwen Clinical Commissioning Group 8
- Our Aims and Objectives 9
- Our System Vision 9
- Our CCG and Local Authority 10
- Our CCG – Citizen Engagement and Empowerment 10
- Our CCG – The Commissioning Support Unit 11
- Our CCG – The Pennine Lancashire Health and Care Economy 11
- Our CCG – The Lancashire Health and Care Economy 12
- Our CCG – Direct and Co-Commissioning 12

Chapter 1 13
- Demographics 13
- Ethnicity 13
- Deprivation 14
- Life Expectancy 14
- Our Health and Wellbeing Strategy 15
  o Priority Programme Areas 16
  o Alcohol Strategy for Blackburn with Darwen 2014-17 16
  o Infant Mortality Prevention Action Plan 16
  o Integrated Wellbeing Service 16
  o Transforming Lives/Making Every Adult Matter 16

Chapter 2 18
The Provider Landscape 18
- System Vision 18
- Acute Hospital Services 18
- Primary Care Services In and Out of Hours 20
- Current Local Improvement Schemes 20
- General Practitioners with Specialist Interests 21
- Co-Commissioning 21
- Community Services 22
- Specialist Mental Health and Dementia Services 22

Chapter 3 23
Our plans for commissioning 23
- High Impact Change 1: Delivering High Quality Primary Care at Scale and Improving Access 24
- High Impact Change 2: Self-care and early intervention 30
- High Impact Change 3: Enhanced Integrated Primary Care Services 34
- High Impact Change 4: Access to re-ablement and Intermediate Care 38
- High Impact Change 5: Improved Hospital Discharge and Reduced Length of Stay 42
- High Impact Change 6: Community Based Ambulatory Care for 45
Specific Conditions
- High Impact Change 7: Access to High Quality Urgent Care 49
- High Impact Change 8: Scheduled Care 53
- High Impact Change 9: Quality 56

Chapter 4
**Collaborative Commissioning** 63
- Pennine Lancashire Collaborative Commissioning 63
- Lancashire Collaborative Commissioning 64
- Mental Health and Dementia Services 64
- NHS 111 and North West Ambulance Service 66

**Other Collaborative Areas**
- Child and Adolescent Mental Health Services 67
- Learning Disability Services 67
- Diagnostics/Pathology 67
- Stroke Review 68
- Cancer Services 69

Chapter 5
- Specialist Commissioning 70
- Direct and Co-Commissioning 70
- The Healthier Lancashire Programme 72

Chapter 6
- A Sustainable CCG and Health Economy 73
- Risk management 75

Chapter 7
**Governance and Delivery** 76
- Blackburn with Darwen 76
- Pennine Lancashire 76
- Lancashire CCG Network 77
- Lancashire Leadership Group 77
- Summary 77
- Conclusion 78

**Appendices:**
Appendix 1: Health and Care Needs In Blackburn with Darwen 79
Appendix 2: NHS Outcome Ambitions and High Impact Changes 83
Appendix 3: Plan on a Page 85
Appendix 4: Pennine Lancashire Clinical Transformation Board – Current Governance Arrangements 86
Appendix 5: Integrated Care (BCF) Programme Reporting Structure 87
Appendix 6: High Impact Change Funding 88
Appendix 7: Blackburn with Darwen CCG Committee Structure 89
Appendix 8: Integrated Commissioning Network Joint Decision Making and Accountability Structure 90
Appendix 9: Pennine Lancashire Health Economy Proposed Governance Structure 91
Appendix 10: Draft Expression of Interest Co-Commissioning Primary Care 92
Appendix 11: Primary Care (GP) Strategy 108fl
## Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>Providing short-term medical care especially for serious acute disease or trauma</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>Personal health care consultation, treatment or intervention using advanced medical technology or procedures delivered on an outpatient basis</td>
</tr>
<tr>
<td>Commissioner</td>
<td>A person or organisation that plan the services that are needed by people who live in the area that the organisation covers, and ensures that services are available</td>
</tr>
<tr>
<td>Community Services</td>
<td>Services that are provided outside hospitals such as district nursing</td>
</tr>
<tr>
<td>Co-production</td>
<td>When you as an individual are involved as an equal partner in designing the support and services you receive</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Joined up, coordinated health and social care that is planned and organized around the needs and preferences of the individual, their carer and family</td>
</tr>
<tr>
<td>Outcomes</td>
<td>This refers to an objective you would like to achieve or need to happen for example continuing to live in your own home</td>
</tr>
<tr>
<td>Primary Care</td>
<td>The part of the NHS that is the first point of contact for patients. This includes GPs, community nurses, pharmacists and dentists</td>
</tr>
<tr>
<td>Reablement</td>
<td>Reablement is a range of services focused on helping a person maximize their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>The process of ensuring that adults or children are not at risk of being abused, neglected or exploited and ensuring that people who are deemed “unsuitable” do not work with them</td>
</tr>
<tr>
<td>Secondary Care</td>
<td>Is medical care provided by a specialist or facility upon referral from a primary care physician that requires more specialist knowledge, skill or equipment than the primary care physician has</td>
</tr>
<tr>
<td>Self-care</td>
<td>Means looking after yourself in a healthy way such as adopting a healthy lifestyle and making choices that help you to stay well</td>
</tr>
<tr>
<td>Single Point of Access</td>
<td>A central place, site or phone number (e.g. NHS 111) which provides a gateway to a range of health and social care services</td>
</tr>
<tr>
<td>Sub-acute care</td>
<td>Sub-acute care is care needed by a patient who does not require hospital acute care, but who required more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility</td>
</tr>
<tr>
<td>Transfer of care</td>
<td>Transfer of care is the process whereby the responsibility for some or all of the care of a patient is transferred to another physician who</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>Also not-for-profit sector is the social activity undertaken by organisations that are not for profit or non-governmental. This sector is also called the third sector in reference to the public sector</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

explicitly agrees to accept the responsibility
Introduction

In December 2013, NHS England published “Everyone Counts Planning for Patients: 2014-2019” which identified seven national outcome ambitions, reflected in the policy themes set out in the guidance above. The CCG’s five year plan sets out how we intend to achieve these outcomes and deliver the required transformation.

The seven outcome ambitions are centred upon improving life expectancy and quality of life as well as the quality of care that people receive both in and outside of hospital. The CCG’s plan focuses on how these outcome ambitions, will be achieved and the difference they will make to the health and wellbeing of our local population.

The success of our plans will be demonstrated through the achievement of these outcome ambitions and those in the NHS Outcomes Framework, and will be visible through improved health, reduced health inequalities and greater parity of esteem which means that we will tackle both physical and mental health issues with the same energy and priority that we have tackled physical illness.

Our Vision

The CCG’s vision is “to deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough”. The aim for Blackburn with Darwen CCG is to secure better outcomes for patients as defined by the 5 domains of the NHS Outcomes Framework and uphold the pledges in the NHS Constitution.

Reducing inequalities and improving health in Blackburn with Darwen

Our commitment to reducing health inequalities in BwD is set out in our constitution this will be achieved by:

- Basing commissioning and investment decisions on rigorous assessment of need;
- Prioritising investment in services and interventions that are likely to reduce inequalities in health between socio-economic, gender, age or ethnic groups
- Assessing whether there is evidence of differential access, use and outcomes of commissioned services by socio-economic, gender, age or ethnic groups
- Ensuring that disadvantaged groups are involved in the design and planning of the services they use
- Using intelligence and evidence from the local population to identify those at highest risk, to intervene early and maximise the health benefits
- Integrating support in primary medical care to address the determinants of health to promote community and individual self-reliance (e.g. self-care).

In accordance with the CCG’s equality duties, equality analysis has been undertaken on the initiatives outlined within the plan to ensure we continue to promote fairness and equity of access for the population we serve and to ensure equality and inclusion supports our strategic work programme.
Quality is at the heart of everything we do, and this is demonstrated through our plans and the improvements we seek to the quality of services commissioned by the CCG. The CCG will continue to focus its efforts on local improvements in quality supported by the quality premium.

The Better Care Fund

The Better Care Fund (BCF) was introduced in September 2013 and charged CCGs and Local Authorities to integrate resources and services, be coordinated around the individual and the family, to deliver improved quality, efficiency and ensure that the majority of care is delivered outside of hospital where this is appropriate. This is in the context of the significant reductions required in public sector spending and there is a drive from the centre to accelerate the pace and scale of the required change. The need for consistent 7 day primary care underpins this vision and was set out in the Prime Minister’s Call to Action to encourage general practice to think innovatively around an extended and expanded model of primary care.

In a bid to support the NHS to radically redesign their health and care systems, NHS England has launched a national Acceleration Programme to fast track early adopters and roll out best practice. The programme draws upon models from around the world.

The Financial Outlook

We acknowledge the financial outlook for the CCG remains challenging, however the financial stability experienced in 2013/14 provides a sound starting point for this 5 year plan.

We will continue to plan to deliver a minimum of 1% surplus each year and operate within our running cost allowance. The CCG continues to experience increased demand for healthcare, and therefore resources are aligned to nine “High Impact Changes” that meet the needs of the local population. The increased demand is greater than the predicted uplifts to the resource, and as such the CCG will need to find efficiencies in order to maintain financial viability.

A detailed two year operational financial plan has been developed, and extended into a forecast plan for 5 years. This plan supports the commissioning intentions for this 5 year strategy.

Investments in the Better Care Fund and the High Impact Changes are planned to deliver these efficiencies. Such investments are designed to improve both quality and patient experience, whilst providing value for money. Reducing avoidable admissions and releasing this resource for care outside of a hospital setting will enable the CCG to deliver a sustainable financial position and by doing so in a planned way must deliver a sustainable health economy.
Blackburn with Darwen Clinical Commissioning Group (BwD CCG)

Blackburn with Darwen CCG is a vibrant membership organisation comprising 28 constituent practices who participate through the clinical senate, protected time learning and by attending annual, full membership meetings. Robust and strong clinical leadership is at the heart of our work and will:

- Improve healthcare by clinical leads (executive GP’s and member GP’s) at the centre of commissioning decisions and drive the future of health services in the area
- Redesign service with clinicians leading the process in the best interests of the public based on clinical evidence, local need and on the opinions and experience of patients/the public
- Improve access to, and the quality of, care by making sure that clinicians have accurate information about people’s experience of local services and pathways
- Promote the development of research and innovation opportunities

Blackburn with Darwen CCG enables its GP members to be involved, empowered and to collectively own and influence decisions through:

- Strong GP executive leadership on the Governing Body with defined clinical portfolios.
- Strong GP membership leaders with defined clinical portfolios reporting developments to the Governing Body and its sub-committees.
- Active representation of membership participating in the CCG Clinical Senate
- Strong communication activity through to practices using a variety of methods.

The membership agreed to the development of our four integrated primary, community and social care localities in BwD, and has elected a Chair and a Vice Chair. The localities are central to our developing plan for commissioning high quality, safe services over the next five years, and as such they are fully engaged across a range of programme areas and work streams. The Chairs and Vice Chairs also play an important role as we recognise that achieving such a scale of change can only be achieved through the development of a powerful vision for our CCG, through strong leadership, a skilled and capable workforce and most importantly, through robust engagement with our members, our public, our partners, our staff and our stakeholders. This will ensure we are commissioning high quality services for the population of Blackburn with Darwen and was evident in the 360° survey of the CCG stakeholders in May 2014, where it demonstrated stakeholder confidence in the leadership, engagement and governance of the CCG activities.

Our Organisational Development (OD) plan explains how this vision and the objectives associated with it, will be enablers to support the successful delivery of our ambitions outlined in this 5 year plan and other interlinked documents, such as primary care strategy.
Our CCG Aims and Objectives

As part of the Everyone Counts planning process and the development of this 5 year plan and linked to the CCG’s vision and values we have established 5 Corporate Objectives:

- **Corporate Objective 1** - We will fully play our part in helping the population of Blackburn with Darwen to live longer and live better, tackling health inequalities and promoting a culture of continuous improvement. We will do this by reducing the potential years of life lost from conditions considered amenable to healthcare, reducing hospital deaths attributed to problems in care and improving access to primary care.

- **Corporate Objective 2** - We will build and maintain successful partnerships so that care for people whether from an individual or organisation in or outside of the NHS is integrated with no gaps and no duplication. We will do this through the implementation and delivery of the Better Care Fund programme, and reducing emergency admissions through urgent care.

- **Corporate Objective 3** - We will effectively engage patients and the public in all our work and will encourage and enable people to take responsibility and control for their own, and their family’s health and wellbeing. We will do this by improving the take up rate of the friends and family test and ensuring it is rolled out across other services, working with our partners and stakeholders and improving the patient’s experience of NHS services. We will publish annual engagement plans and activities. Implement a system of patients in partnership across the 4 integrated localities for two way communications and be proactive with our media campaigns.

- **Corporate Objective 4** - We will co-commission and deliver continuous improvement in primary care services and tackle inequalities. We will do this working supportively with NHS England improving access to primary care and out of hour’s services, improving the quality of life for people with long term conditions, through the implementation and delivery of the Better Care Fund programme and reducing variation in primary care services.

- **Corporate Objective 5** - We will commission either independently, or in partnership with others, safe and clinically effective services which provide a high quality experience to those using them. We will do this by improving the diagnosis rate for people with dementia and improving patients’ experience of the services we commission, and reducing the number of cases of infection both in and outside of hospital.

**Our System Vision – (see Chapter 2)**

The CCG’s vision is to improve the health and well-being of its population and reduce health inequalities. To deliver this vision the CCG puts patients at the centre of its commissioning plans. Our vision is to have 4 integrated health and social care localities focused upon our registered general practice population. These localities will deliver a resilient and comprehensive service 24/7, which will meet the needs of people requiring a core primary care service. In addition we are developing an innovative and more radical intensive community offer which will ensure that people are cared for at home and avoid unnecessary hospital admission wherever possible. This will include community nurse and therapists,
social workers, specialist nurses, community matrons, care coordinators and care navigators. We are working with our practices and the hospital to consider more radical approaches for the most frail and complex, which may involve a ‘hospital without walls’ approach and intensive wrap around support services provided on an individual basis.

**Our CCG and the Local Authority**

BWD CCG is coterminous with the Local Authority (LA) and we have a strong track record of integration in our borough. We have a number of joint commissioning posts which we jointly fund with our Local Authority, and these support our key priorities including supporting frail elderly people, the commissioning of services for people with a learning disability, mental illness and children with complex needs. They also lead on Public Health Commissioning within Blackburn with Darwen. A Joint Commissioning Executive oversees this work programme and acts a senior sponsor to the emerging Better Care Fund developments. We have already agreed the development of a Better Care Fund Programme Office and Senior Responsible Officer has been identified. The Parity of Esteem agenda is reflected in all of our joint plans and in the innovative approaches that we have taken to improving the range of health and wellbeing services in the Borough. Our Health and Wellbeing Board that includes third sector and community partners, and the Health and Wellbeing Strategy are important vehicles for driving the required change and transformation.

**Our CCG - Citizen engagement and empowerment**

The CCG aims to ensure that the public, patients, carers, and stakeholders are aware of our commissioning intentions and that they are involved in and can influence commissioning developments and priorities. We will do this through high quality, meaningful and innovative engagement with patients and the public. We appreciate that patients and the public will prefer to engage with us in different ways and so we are committed to using a variety of approaches to make it easy for local people to be involved in ways that are meaningful to them.

Following any engagement event, we will explain clearly to participants and local people how their involvement has influenced decisions. We understand that prioritising local health needs may mean that we are not always able to do what people want; however on these occasions we commit to explain why and how we can be held to account for our decisions.

We will know if we have achieved our vision for engagement in Blackburn with Darwen if the public say:

- My views and opinions on local NHS and social care services are listened to and acted upon
- I feel well informed about what services are available
- I understand what major changes in local services are planned, the reasons behind the proposals and how to make my views heard
- The way care is organised makes sense to me. Care is easy to access, well-coordinated and information and plans about treatment are effectively and sensitively communicated to me and, where appropriate, my carers
- I know who can help me and how I can help myself
- If I have issues or concerns, I know where to go to talk about them, regardless of which service they relate to
Blackburn with Darwen CCG already has a well-established and successful Patient Participation Group (PPG) network centred on our member practices, and we have significant plans to develop this through our Patients in Participation initiative. This will offer a range of opportunities for patients, carers and the public to give views on what is best in local health services and what might need improvement. The scheme has been designed with GP surgery patient participation groups at its core and will also offer listening events across the area where local people will be invited to share their experiences of health services and there will be opportunities to contribute via the website and social media. There will also be specific engagement activity with hard to reach groups, including the travelling community, BME communities and those with physical or mental health conditions.

The model of operation we propose in Blackburn with Darwen by having four localities (outlined in more detail below) will enhance our engagement process as it allows for smaller interest groups and local people to have a meaningful voice in discussions about priorities for the area

**Our CCG - The Commissioning Support Unit**

The CCG operates its business within a limited resource, or running cost allowance. The CCG employs a number of staff to deliver its strategic functions, and this is supported by the Midlands and Lancashire Commissioning Support Unit whose staff provide “back office” services to enable the CCGs to realise efficiencies of scale. Our CCG has developed a sound working relationship with the CSU, who are expected to be a provider on the “Lead Provider Framework Agreement”. The CCG regularly reviews the services that it receives to ensure value for money.

**Our CCG – The Pennine Lancashire Health and Care Economy**

Pennine Lancashire is the area covering the boroughs of Blackburn with Darwen, Burnley, Hyndburn, Pendle, the Ribble Valley and Rossendale. In addition, it is the footprint for East Lancashire Hospitals Trust and our partner East Lancashire CCG is the lead commissioner. In order to determine our shared vision for health and care we have been required to work in close partnership and collaboration. The Pennine Lancashire based services already collaborate in the following areas:

- Urgent and emergency care
- Elective care
- Cancer care
- Transfers of care

Relationships and leadership are strong across the health and social care economy and this is reflected in the membership of the Pennine Lancashire Clinical Transformation Board (PLCTB), the Executive Officers Group and the various programme and project work streams. Our commitment to joint working is demonstrated by number of joint posts with East Lancashire CCG and these are overseen and monitored through a Memorandum of Understanding.

The PLCTB has been established for a number of years and currently works through a Compact Agreement, putting patients and quality at the heart of the agenda. Twelve months ago a revised governance proposal was agreed by the PLCTB which included the
development of an Executive Officers Group (EOG) to oversee programme delivery and provide assurance to the PLCTB that the necessary progress was being made. The national drive for more radical and innovative models of care, delivered at scale and pace, present an unprecedented challenge and plans for a more robust Programme Office function are being considered by Chief Executives across Pennine Lancashire.

**Our CCG – The Lancashire Health and Care Economy**

CCGs in Lancashire are building upon a strong history of collaboration and joint working. Two years ago a Lancashire CCG Network was established to oversee the programme of transition and set up arrangements to drive forward a collaborative programme of work in Lancashire. This has been supported by a Collaborative Arrangements Group (CAG). In addition NHS England has established the Lancashire Leadership Forum to support the delivery of a Healthier Lancashire Programme (see Chapter 5) overseeing the delivery of care both in and outside of hospital. The Lancashire CCGs are in the process of reviewing these arrangements with the Local Area Team (LAT) to ensure that they are integrated, fit for purpose and will deliver the required programme of change. As part of the Healthier Lancashire Programme, the LAT have been supporting the NHS Accelerate Programme and are exploring a variety of innovative models of care.

**Our CCG – Direct and Co-Commissioning**

NHS England is responsible for commissioning a range of services which have an impact, and need to be aligned with local CCG commissioning plans and pathways of care. More detail of these set out in Chapter 5 but also include the commissioning of specialised services which are led by the Cheshire Local Area Team (LAT).

In Lancashire, a strong clinical involvement has been central to the development of plans for direct and co-commissioning. NHS England is working closely in partnership with CCGs and frontline staff to ensure the whole patient pathway is as seamless and locally responsive as possible in meeting patients' needs.

Our plan provides the basis for robust engagement between NHS England’s LAT and providers of specialised services, to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.

Our CCG has an aspiration to adopt a co-commissioning approach with the Lancashire LAT in line with the national direction of travel. We believe that a co-commissioning approach will allow a stronger focus on local clinical leadership and ownership, and enable more optimal decision making about the balance of investment across primary, community and hospital services. Co-commissioning of Primary, Community and Social care will support co-ordinated care by enabling commissioners, providers and patients to work together to agree what integrated out of hospital care looks like, develop and negotiate new ways of contracting locally that encourage a shared responsibility for holistic care, deliver patient/population based outcomes and support delivery of the large scale transformation change required
Chapter 1

Health and Care Needs in Blackburn with Darwen

Our Integrated Strategic Needs Assessment

The Integrated Strategic Needs Assessment (ISNA) is prepared jointly with the Local Authority on behalf of the Health and Wellbeing Board and captures our shared understanding of health needs and assets in Blackburn with Darwen.

Demographics

As at March 2014, Blackburn with Darwen CCG practices reported a registered population of 169,318. This is higher than the resident population of the borough which is estimated at 147,713 indicating that there are a significant number of BwD practice patients who live outside of the Borough (particularly in neighbouring boroughs of Hyndburn and the Ribble Valley). The resident population pyramid (Appendix 1, fig. 1.) provides an age breakdown, and demonstrates how this compares with the England age profile.

The Borough’s age profile is considerably younger than average. 28.7% of its population is aged under 20, which is the fifth highest proportion of any local authority in England. The young age profile is consistent with a high birth rate. Blackburn with Darwen’s total fertility rate has been consistently higher than average for at least 30 years and in 2012 was the ninth highest out of all upper-tier local authorities in England.

New population projections were issued by ONS in May 2014, covering the period 2012-2037. The Blackburn with Darwen population is projected to age only gradually between 2012 and 2022, with the greatest increase being among those in their early seventies. By 2037, the projections show substantial increase in all the 65+ age-groups, accompanied by shrinkage in almost every younger age-group. In the longer term, therefore, Blackburn with Darwen is not immune to the inevitable challenges of an ageing population. However, the projections necessarily become more and more speculative as we look further ahead, and they make no attempt to allow for factors such as local or government policy, changing economic circumstances, or housing supply.

Ethnicity

The 2011 Census (Appendix 1, fig. 2) shows that White residents make up 69.2% of Blackburn with Darwen’s population, down from 77.9% in 2001. The borough has the 11th highest proportion of Indian residents of any local authority in England (13.4%), and the 6th highest proportion of Pakistani residents (12.1%).

Blackburn with Darwen’s minority ethnic communities have a much younger age profile than the White population. According to the 2013 School Census, very nearly half of all primary school-age pupils in the Borough belong to groups other than White British.
Deprivation

Blackburn with Darwen’s 91 Lower Super Output Areas (LSOAs), Appendix 1 (fig.3), are shaded according to the Index of Multiple Deprivation 2010 (IMD 2010). Ward boundaries are overlaid for reference.

The five shades of purple represent national quintiles on the IMD. More than half (47 out of 91) of Blackburn with Darwen’s LSOAs are shaded in the darkest colour, which means they are among the 20% most deprived in England.

Even more acute levels of deprivation are also over-represented in Blackburn with Darwen. For instance, 21% of the Borough’s LSOAs are among the 5% most deprived nationally, and over 15% are among the 3% most deprived in England.

The IMD can be summarised across the whole borough in various ways, but the most common approach is to take a straight average of the LSOA scores. On this basis, Blackburn with Darwen is the 17th most deprived out of 326 upper-tier authorities in England.

Life Expectancy

Life expectancy in Blackburn with Darwen is on a rising trend, reaching 76.5 years for males and 80.9 years for females in 2010-12. However, it still shows little sign of closing the gap with England (Appendix 1, figs 4/5); the borough ranks 8th lowest for males and 16th lowest for females out of 324 local authorities.

It is possible to work out how much higher Blackburn with Darwen’s life expectancy would be if the borough was able to match the national average death rate from various causes. For both males and females, the biggest impact on life expectancy would come from closing the gap in Coronary Heart Disease deaths.

The Slope Index is a measure of how much life expectancy differs as we move from the most deprived to the least deprived small areas within each local authority. For males, Blackburn with Darwen had the fourth highest Slope Index in England in 2010-12, and the highest in the North West:

Male life expectancy in the most deprived tenth of the Borough was 11.5 years lower than in the least deprived tenth. This is partly a reflection of the wide range of deprivation levels found within the borough. However, the deprivation gradient for female life expectancy is much less strong.

Other key issues

Blackburn with Darwen’s economic activity rate (i.e. the proportion of its working-age population either in work or actively looking for work) is the seventh lowest out of 150 upper-tier authorities. This rate varies considerably across the borough, as can be seen in Appendix 1 (fig. 6)

- As at August 2013, 9.7% of Blackburn with Darwen’s working-age population was claiming incapacity benefits. This is the fourth equal highest rate in England, and partly accounts for the high rate of economic inactivity.
- The Borough’s housing stock is dominated by older terraced stock, much of it in poor condition. 27,000 houses are estimated to be ‘non-decent’, often because of poor energy standards and excess cold. According to the government’s new, rather complex definition, Blackburn with Darwen is in the worst quintile nationally for fuel poverty.
Official estimates of Child poverty suggest that 26% of Blackburn with Darwen children were living in low-income families in 2011, compared to 20.1% in England overall. At the ward level, this ranged from 3.2% in North Turton with Tockholes, to 43.7% in Shadsworth with Whitebirk.

As stated in the latest Child Health Profile, “the health and wellbeing of children in Blackburn with Darwen is generally worse than the England average”. In 2010-12, the Borough had the eighth highest rate of infant mortality out of 150 upper-tier authorities, although there are indications that the 2011-13 rates will be considerably better.

Blackburn with Darwen has a significantly higher than average proportion of underweight children, both in Reception and in Year 6. In 2012/13, 3.45% of Year 6 children were underweight, which was the highest rate out of 150 upper-tier authorities.

At 25.8%, Blackburn with Darwen’s smoking prevalence in 2012 was the seventh highest out of 150 upper-tier authorities. In 2010-12, its rate of smoking-attributable deaths from both heart disease and stroke was the second highest in England.

Alcohol is a major contributor to ill-health in Blackburn with Darwen. There are now two main measures of alcohol-related admissions, an older (‘broad’) indicator and a new (‘narrow’) one. Blackburn with Darwen comes 9th highest or 30th highest in 2012/13 depending which is used. Public Health England prefers the new narrow rate, as it is believed to be less susceptible to ‘coding inflation’.

Although Blackburn with Darwen is still higher than average, it has been steadily improving since 2009/10 on the new indicator (Appendix 1, fig 7.). Even on the old indicator, there are signs that the gap with the North West and England may at last have started to diminish.

The number of years a person can expect to spend free from limiting long-standing illness is known as Disability-Free Life Expectancy (DLFE). In 2008-10, Blackburn with Darwen males could only expect to live 57.4 years free from disability, which put them 9th lowest in England (average 63.6 years). Females in the Borough could expect 59.9 disability-free years (England average 64.8).

Above the age of fifty, a substantial proportion of patients with a long-term condition will in fact have two or three, which greatly adds to the impact on their lives and the cost of supporting them.

Our Health and Wellbeing (HWB) Strategy

To address the many challenges identified, and following public and stakeholder engagement and consultation, the BwD Health and Wellbeing Board has developed and agreed our HWB Strategy as the overarching plan through which the public, private, community and voluntary sectors, as well as residents themselves, will work together to improve health and wellbeing for and with local people.

Based on evidence of what works, and where joint action across all partners can make the greatest difference, the Strategy’s six principles and five priority programme areas are as follows:

Principles:

- There is no health without mental health and wellbeing
• Focus on prevention and early help
• Work together on the wider determinants of health
• Build on strengths, take an assets-based approach
• Promote good governance, through ensuring accountability and transparency
• Integrate care and support to promote a person-centred approach

Priority Programme areas:

Programme area 1 – Best start for children and young people

Programme area 2 – Health and Work

Programme area 3 – Safe and healthy homes and neighbourhoods

Programme area 4 – Promoting health and supporting people when they are unwell

Programme area 5 – Older people’s independence and social inclusion

Many of the CCGs initiatives set out in Chapter 3 are part of one or more Programme of the Health and Wellbeing Strategy.

Other key initiatives rooted in the Health and Wellbeing Strategy, which will have a particular focus on health inequalities include the following:

Alcohol Strategy for Blackburn with Darwen 2014-17

This is sponsored by BwD CCG, BwD Council, and Lancashire Constabulary, to address licensing and trade responsibility, health and wellbeing services, and prevention across the life course, and protection for the community.

Infant Mortality Prevention Action Plan

Working across Lancashire to address smoking in pregnancy, infant feeding and safer sleeping, and across Pennine Lancashire to address congenital anomalies, particularly recessive disorders, maternal social needs, mental health and healthy weight.

Integrated Wellbeing Service

A single point of access / referral to Council Wellbeing Services, including Drug & Alcohol, Health Trainers, Healthy Lifestyles – Stop Smoking, Healthy Weight, Active Living – physical activity on prescription, community CVD, pulmonary and falls rehabilitation, Self Care, Free & paid leisure opportunities, Housing repairs, Financial Advice, with planning underway to extended to 3rd Sector wellbeing services.

Transforming Lives/Making Every Adult Matter (MEAM)

Developed in BwD with Department for Communities and Local Government (DCLG) funding for roll out across Pennine Lancashire, to ensure that public services intervene with individuals who are victims or perpetrators of violent crime and/or misuse alcohol/drug and a history of significant childhood adversity, at the earliest possible opportunity, to develop appropriate and effective solutions which prevent their escalation into crisis point interventions. Incorporates Making Every Adult matter (MEAM), an innovative Blackburn with Darwen partnership which is delivering a programme of intensive, tailored support to
individuals currently living in a House of Multiple Occupation (HMO), who have some of the most complex problems of mental ill health, addiction, prolific acquisitive crime and homelessness, while HMO licensing and enforcement is driving up standards in the HMOs themselves.
Chapter 2

The Provider Landscape

System Vision

The CCG’s vision is to improve the health and wellbeing of its population and reduce health inequalities. To deliver this vision the CCG puts patients at the centre of its commissioning plans. Our vision is to have 4 integrated health and social care localities focused upon our registered general practice population. These localities will deliver a resilient and comprehensive service 24/7, which will meet the needs of people requiring a core primary care service. In addition we are developing an innovative and more radical intensive community offer which will ensure that people are cared for at home and avoid unnecessary hospital admission wherever possible. This will include community nurse and therapists, social workers, specialist nurses, community matrons, care coordinators and care navigators. We are working with our practices and the hospital to consider more radical approaches for the most frail and complex, which may involve a ‘hospital without walls’ approach and intensive wrap around support services provided on an individual basis.

Acute Hospital Services

The majority of acute hospital services for our population are provided by East Lancashire Hospitals NHS Trust (ELHT). A number of other North West hospitals, both NHS and Independent Sector organisations, are also contracted to provide either additional capacity in selected specialties or to provide more specialist services (see Table below)

Table 1: Contracted Providers 2014-15

<table>
<thead>
<tr>
<th>Provider Description</th>
<th>2014-15 Contract Plan (£'000)</th>
<th>2014-15 % Contract Value</th>
<th>General / Specific Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alder Hey Childrens NHSFT</td>
<td>£ 127</td>
<td>0.1%</td>
<td>Specialist &amp; Complex Conditions - Children</td>
</tr>
<tr>
<td>BLACKPOOL TEACHING HOSPITALS</td>
<td>£ 481</td>
<td>0.4%</td>
<td>Cardiology and Clinical Haematology</td>
</tr>
<tr>
<td>BMI - Blackburn</td>
<td>£ 5,752</td>
<td>3.4%</td>
<td>Scheduled Care Activity - In selected specialties</td>
</tr>
<tr>
<td>BMI - Gisbourne Park</td>
<td>£ 176</td>
<td>0.2%</td>
<td>Scheduled Care Activity - In selected specialties</td>
</tr>
<tr>
<td>BOLTON NHS FOUNDATION TRUST</td>
<td>£ 258</td>
<td>0.2%</td>
<td>Scheduled and Emergency Activity</td>
</tr>
<tr>
<td>CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</td>
<td>£ 1,356</td>
<td>1.2%</td>
<td>Vascular and Ophthalmology</td>
</tr>
<tr>
<td>EAST LANCASHIRE HOSPITALS NHS TRUST</td>
<td>£ 96,465</td>
<td>88.6%</td>
<td>Minor District General Hospital</td>
</tr>
<tr>
<td>LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>£ 4,659</td>
<td>4.3%</td>
<td>Plastic Surgery, Burns, Cancer, Disabilty Services, Major Trauma</td>
</tr>
<tr>
<td>Ramsays Operations (UK)</td>
<td>£ 323</td>
<td>0.3%</td>
<td>Scheduled Care Activity - In selected specialties</td>
</tr>
<tr>
<td>SALFORD ROYAL NHS FOUNDATION TRUST</td>
<td>£ 362</td>
<td>0.3%</td>
<td>Scheduled and Emergency Activity</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST</td>
<td>£ 404</td>
<td>0.4%</td>
<td>Scheduled Activity / Long Term Ventilatory Support</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST</td>
<td>£ 79</td>
<td>0.1%</td>
<td>Scheduled and Emergency Activity</td>
</tr>
<tr>
<td>WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST</td>
<td>£ 528</td>
<td>0.5%</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£ 108,873</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The CCG is an Associate Commissioner to the East Lancashire Hospitals NHS Trust contract which is co-ordinated by East Lancashire CCG. The trust provides a range of accident and emergency services, outpatient clinics, inpatient (elective and non-elective) interventions, direct access diagnostics and some block contract activity delivered across a number of sites including:

- The Royal Blackburn Hospital
- Burnley General Hospital
- Accrington Victoria
- Pendle and Clitheroe Community Hospitals

In 2013 ELHT was identified as an outlier for mortality and subsequently as part of the Keogh investigation, placed in special measures to address key issues around quality and safety. It is also a hospital that continues to experience considerable challenge around 18 week waiting times in selected specialties, pressures in the delivery of non-elective care and A&E performance, particularly with regard to the 4 hour target. Significant progress has been made and we are working closely with the acute hospital to re-design pathways with an early focus on non-elective care as part of our Better Care Fund proposals. Innovative developments include primary care collocation in the urgent care centres in Burnley and Blackburn, the development of an ambulatory care centre (which is the process of being fully evaluated) while the Trust is also working on the development of a frailty unit.

Some specialist services, commissioned directly by NHS England are based in ELHT; however more activity goes to specialist centres such as Central Manchester University Hospital NHS Foundation Trust.

**Primary Care Services – Out of Hours and In Hours**

We have 28 GP practices in Blackburn with Darwen. We have recently agreed with our senate, our Local Authority and our community trust that we will co-locate and integrate all of these services around four localities which are Darwen and Blackburn East, West and North. We intend to have the majority of the co-location in place in 2014/15 and this is set out more clearly in the Better Care Fund section of this plan.

General Practice services are in the main currently commissioned by NHS England through national contracting frameworks; these provide core primary care delivery for patients operating 5 days per week 8.30 am until 6pm. The CCG does commission additional services through general practice this includes:

**Current Local improvement Schemes**

The CCG have developed and commissioned a Dementia Local Improvement Service (LIS) which will support our joint priority to close the Dementia diagnosis gap and provide earlier interventions for people with Dementia. April 2014

- The LIS will be supported by an In-Reach Memory Assessment Team who will work with GP surgeries to actively case manage people who may have Dementia and diagnose them appropriately. April 2014
The CCG has developed a Quality and Access LIS which aims to improve quality in terms of access and reduce variation in safety, patient experience and effectiveness for patients living in Blackburn with Darwen.

Cancer LIS is designed to enhance the care delivered within primary care for cancer patients in primary care throughout the cancer pathway. The expectation is that this LIS will improve the quality of care along with improved medico/socio outcomes for cancer patients.

A Specialist Advice Service LIS has been developed to support a referral management scheme. The scheme will enable GPs to seek specialist advice from consultants at the Hospital Trust prior to making a secondary care referral. The advice requests will be made through the current Choose and Book infrastructure, and all specialist advice will be returned to the requester within 2 working days.

In addition the CCG commissions practices through NHS standard contracts to deliver former Enhanced Services:

- Clinical Haematology
- Diabetes (NICE 9 care processes)
- Deep Vein Thrombosis (DVT) D-Dimer Testing
- Minor Surgery
- Near Patient Testing-Amber Drugs (monitoring patients on specialist drugs)
- Respiratory (Asthma and Chronic obstructive pulmonary disease (COPD)
- Vasectomy

**General Practitioners with Special Interest (GPwSI):**

There are currently 5 GPwSI contracts across Blackburn with Darwen which provide the following specialisms:

- Anti-coagulation
- Cardiology
- Dermatology
- Diabetes
- Ophthalmology

GPwSI services are provided by individual GPs who have expert knowledge in the above specialisms. The GPs who provide these services accept referrals from all other practices across Blackburn with Darwen. Patients are referred into the GPwSI services by their own GP, and will be assessed and treated by the GPwSI, therefore preventing the patient having to attend hospital.

The provider for out of hours services in Blackburn with Darwen is East Lancashire Medical Services (ELMS), a not for profit Social Enterprise. The service is provided from a number of centres across the local area and operates from 6:30pm until 8am on weekdays and also covers bank holidays and weekends. Additional services provided by ELMS include an emergency dental helpline and the GP acute visiting scheme currently being piloted across Blackburn with Darwen. ELMS is also delivering a co-located primary care solution within the urgent care centres in Blackburn and Burnley as part of our Pennine Lancashire Urgent
Care Strategy. The CCG’s Governing Body has recently agreed to develop an integrated 24/7 specification for urgent primary care across the practices, localities and urgent care centre.

Co-Commissioning

Blackburn with Darwen CCG has submitted an expression of interest to co-commission primary care (General Practice) with NHS England Lancashire Area Team. The CCG believes this will build upon the solid relationship it has with the area team and enable the development of primary care at scale and pace to provide improved quality of services for the population and greatly assist in transforming the local health economy – thereby enabling it to be sustainable in the future.

In taking this collaborative approach to the commissioning of General Practice services with a stronger focus on local clinical leadership and ownership will allow more optimal decision making about the balance of investment across primary, community and hospital services. Co-commissioning of Primary, Community and Social care will support co-ordinated care by enabling commissioners, providers and patients to work together to agree what integrated out of hospital care looks like; develop and negotiate new ways of contracting locally that encourage a shared responsibility for holistic care; deliver patient/population based outcomes and support delivery of the large scale transformation change required.

(See Appendix 10 Draft Expression of Interest)

Community Services

Lancashire Care NHS Foundation Trust (LCFT) is the main provider of Community Services for Blackburn with Darwen. They are contracted for community services via a NHS standard contract which is co-ordinated by Chorley & South Ribble CCG. These are a comprehensive range of services which provide a vital link between primary and secondary care services for both planned and unplanned care and support the key national outcome measures in relation to avoiding unnecessary hospital admission, delivering high quality scheduled care and ensuring rapid and effective hospital discharge. Services include district nursing and health visiting teams which are linked to the individual practices and localities, and services which deliver specialist assessment and support discharge such as the Rapid Assessment and Treatment Team which works into the Medical Assessment Unit and hospital ward in ELHT. The services they offer integrate seamlessly with patient care ranging from primary prevention with GPs to supported rehabilitation following an acute episode such as a stroke. There is a full range of therapy and scheduled care services, to support our move to community based ambulatory care models including diabetes, pulmonary rehabilitation, falls and sub-acute rehabilitation. There is movement to more integrated services within community services for Blackburn with Darwen by Speech & Language, Occupational Therapy, Physiotherapy and Special School Nursing now becoming Children’s Integrated Nursing Services (CITNS). A key focus for quality improvement is the accuracy and timeliness of data to facilitate effective quality improvement processes to be enacted. We have recently agreed with the provider that we wish to co-locate the majority of our community and mental health services around the four GP localities as set out above and we are now in the process of a significant programme of transformation and transition.
There are a range of specialist community based services for people with Learning disability in the Borough including support into schools to care for children with complex needs

**Specialist Mental Health and Dementia Services**

Blackburn with Darwen CCG co-ordinates the contract with Lancashire Care NHS Foundation Trust for mental health services, with 7 CCGs who are associates to the contract. The contract covers a range of services including Adult Mental Health, Older Adult and Dementia Services, Children and Adolescent Mental Health Service (CAMHS), across Steps 2-5 including Dementia services. LCFT is currently half way through a major reconfiguration programme across Lancashire which includes the re-design of specialist community services to support a significantly reduced in-patient capacity. This supports the national direction of travel to deliver high quality services in both the home and community settings and provide alternatives and choice to avoid unnecessary hospitalisation. The reconfiguration is due to end in 2017 and will have reduced the number of beds from 790 to 260, 15 sites to 4 sites and 1 specialist dementia unit based in The Harbour in Blackpool. This is governed through the Lancashire Collaborative Commissioning Arrangements group and a programme board which oversees transition.

The CCG’s priorities are the development of the specialist dementia teams (to support the requirement to improve early diagnosis and treatment) delivery of the national requirements for improving access to psychological therapies, supporting parity of esteem and a major re-design of the urgent care pathway in line with the recently published Crisis Concordat. The new Pennine Lancashire in-patient site is due to be completed by 2016/17. In addition the CCGs in Pennine Lancashire have commissioned a bespoke Older Adult Liaison Service to work into ELHT to improve the care and treatment of people with mental health, dementia and long term conditions and support early discharge. This team will soon be co-located as part of single integrated discharge facility.
Chapter 3

Our Plans for Commissioning

The CCG intends to commission its transformational programme through a number of high impact changes. In total we have identified 9 of these which comprise a number of initiatives to be delivered over the life time of the 5 year plan. These are in line with the approach set out in the “Anytown” Modelling Tool and have been evaluated through our development work. They are all consistent with our corporate aims and objectives as set out earlier in the plan. In addition, they will support the delivery of the 7 national outcome ambitions, our constitutional standards and our operational plan which was submitted in April 2014.

Our joint BCF submission sets out an ambitious approach to the integration of health and care within the Borough. The approach will improve outcomes for individuals by keeping more people at home and reducing the requirement for long term care and unnecessary hospitalisation. This is consistent with best practice guidelines and the expressed preferences of our population. Our approach includes the segmentation of client groups, focusing on frail elderly in the first instance and includes adults with complex mental health needs and learning disability and children.

This is also central to our programme of QIPP as they are vital opportunities to reduce the number of attendances in hospital and unplanned admissions.

The high impact changes described below are explicitly linked to our BCF and they address issues of self-care, high quality planned, ambulatory care and urgent care, disease and case management approaches. A summary of our High Impact Changes and initiatives, linked to the 7 NHS Outcome ambitions is set out in Appendix 2 and summarised further in Appendix 3.
High Impact Change 1 – Delivering high quality primary care at scale and improving access

We will know if we have achieved our vision for Primary Care at Scale in Blackburn with Darwen if our patients say that they:

- Can get the care they need, closer to home
- Have access to high quality acute Primary Care both in and out of hours (24/7)
- Receive early diagnosis and systematic care planning
- Get high quality safe, effective, personal and consistent care
- Are provided with care in accessible, modern, fit for purpose premises

Metrics:

- Increasing the number of people having a positive experience of care outside of hospital by reducing the number of poor responses across GP practice and out of hours services from 6.1 (2012/13) to 4.7 per 100 patients by 2018/19
- Improving access to psychological therapies to national target of 15% by Quarter 4 2014/15
- Increase the diagnosis rate for people with dementia from 53% (2012/13 to 67% of estimated prevalence by 2014/15

Our vision for Primary Care is to provide high quality and seamless service for the population through the delivery of an integrated health and social care model, building upon a flourishing Voluntary Community Faith (VCF) sector in the Borough. This will be achieved by the following initiatives:

Initiative 1 – Pro-active disease management and Local Improvement Schemes (High Quality Scheduled care)

The CCG is utilising both enhanced services and Local Improvement schemes (LIS) to further support delivery through general practice and wider primary care. We want to improve patient experience, care outside hospital and ensure the necessary quality and planned efficiencies across the whole scheduled care system. Schemes and services will be further reviewed to both extend and ‘stretch’ services over the lifetime of the 5 year plan. Our Current Local Improvement Schemes include the following:

- The CCG has developed and commissioned a Dementia Local Improvement Service (LIS) to support our joint priority to close the Dementia diagnosis gap and provide earlier interventions for people with Dementia. (April 2014)
- The LIS will be supported by an In-Reach Memory Assessment Team who will work with GP surgeries to actively identify people who may have dementia and diagnose them appropriately. (April 2014)
- In 2013-14 the CCG identified diabetes care as a key area of focus. We will reinforce this by revising the Diabetes LIS and reviewing the pathway from primary to secondary care and within the community
The CCG has developed a **Quality and Access LIS** which aims to improve quality in terms of access and reduce variation in safety, patient experience and effectiveness for patients living in Blackburn with Darwen.

A **Cancer LIS** is designed to enhance the care delivered by primary care services for cancer patients throughout the cancer pathway which should improve outcomes for cancer patients.

In addition the CCG is committed to developing a skilled workforce in primary care and we have been progressing this through our GP with Specialist Interest (GPwSI) programme. At present we have GPwSIs in the following specialities: Anti-coagulation, Cardiology, Dermatology, Diabetes and Ophthalmology.

GPwSI services are provided by individual GPs who have expert knowledge in the above specialisms. The GPs who provide these services accept referrals from all other practices across Blackburn with Darwen. Patients are referred into the GPwSI services by their own GP, and will be assessed and treated by the GPwSI, therefore preventing the patient having to attend hospital.

As part of the whole system approach we will expand and explore the innovation that could be introduced into the current GPwSI contracts to provide a broader range of specialities and treatments within a Tiered model of Primary Care. An example of this is to explore the potential for a GPwSI to provide Ear, Nose and Throat (ENT) services.

**Initiative 2 – Improving the quality of urgent care and care of vulnerable people**

Our CCG has embarked on an ambitious approach to systematically improve and integrate services for the adult population to avoid unnecessary hospitalisation. Whilst the BCF is central to this, the CCG intends to implement an agreed plan which is consistent with the accountable GP proposals for patients aged 75 and over, and the Direct Enhanced Service which is aimed at avoiding unplanned admissions. Proposals include a single point of access linked to the GP out of hour’s service and the 111 telephone service using a directory of services, intensive support for patients registered within nursing homes including the use of telemedicine. This will be introduced from the autumn of 2014.

The 4 localities are also exploring proposals for extended primary care access to respond to the Prime Ministers “Call to Action” and a proposal will be presented to the CCG’s Commissioning Business Group shortly. In addition the Governing Body has just agreed that we will develop an integrated specification for the Urgent Care System to include the practices, localities, extended access including GP Out of Hours (OoHs) and the current GP Acute Visiting Service (AVS).

The CCG is responsible for monitoring the quality of the GP OoHs and has mechanisms in place to identify and act on concerns on feedback received. This is achieved through formal contract monitoring, use of national quality dashboards and gathering information using patient feedback.
**Initiative 3 – Redesigning primary care delivery and seven day working**

The CCG is working closely with member practices to further develop the four localities (Blackburn North, East and West and Darwen). These localities will have several key functions which include: coordinating service delivery for the locality population, developing resilience by taking forward an approach to practice federation which will support 7 day working and informing the commissioning and planning of services for the locality population.

In summary the localities are being developed with the intention of working with practices on a larger scale to maximise economic and quality benefits for patients, enabling them to operate with integral sub-specialisation through an extended primary care team providing increased care in the community. This is in addition to developing the localities to enable frontline clinicians to be able to design and commission services closer to the local population.

We have set out a programme for change through **Developing the Provider** (General Practice). This programme initiates a framework for transforming General Practice and ‘wider local Primary Care’ at scale to develop the overall strategic vision and implementation along with credible timescales. The CCG will help and support the facilitation of ‘new GP Champions/ leaders, creating time for the design and implementation of new models and organisational operating forms through grouping arrangements (federations). These would operate within the 4 geographical localities in BwD with the ambition to extend the range of services for patients, thus providing a sustainable model of primary care which delivers consistent high quality outcomes for patients, and works in a resilient and flexible way both in and out of hours on a seven day basis. The CCG will engage and involve the public in these strategic changes to deliver the aspirations of the local population and ensure that they are actively involved in evaluation of the services.

The CCG will support General Practice, and develop the primary care workforce by taking forward the concept of Multi-disciplinary General Practice. This will focus on enhanced skill development for professionals, to create new roles and enhance sustainability of the workforce and Primary Care as a whole. This will include increased numbers of Advanced Nurse Practitioners (ANPs) developing Practice Nurses (PNs) and Health Care Assistants (HCAs). This will allow GP’s to become Expert Generalists being able to focus on more complex work. The CCG will also further develop GPwSI’s to not only establish improved services in the community i.e. diabetes service but also as a way of attracting GP’s into the area who wish to extend their skill portfolio to improve the sustainability of primary care within the district.

Recognising that major service change and delivery will require appropriate high quality estate and supportive infrastructure including Information Technology and data sharing, the CCG will review current arrangements with local partners and NHS Property services to inform the future estate landscape.

The review process and estate development will naturally be driven by the service delivery model, the expectation being through a hub and spoke model within each of the 4 localities. Initially the review will consider all community estate assets including all Primary Care Centres and surgeries and would be associated to the Community Asset review being undertaken by Blackburn with Darwen Borough Council. The review will focus on current provision across all organisations and identify the future requirements in determining the
required space and location in particular with the widening accessible primary care along with the appropriate shift in services from the hospital site. This review approach will facilitate linkage of estate strategies across partner organisations to ensure that investment and disinvestment in the estate is tied to future service delivery.

**Initiative 4 - Improving quality and reducing variation in practices**

The CCG has invested in a primary care quality function within its core management. This has focused on supporting the practices in key quality improvement areas as identified within the primary care development, the integrated needs assessment and the implementation of a bespoke quality LIS plan (see page 18).

Our commitment to this agenda is reflected through our intention to co-commission primary care (General Practice) services that will have major impacts by increasing access to and quality of service provided. We intend over the next two years, to take back the full primary care commissioning budget and responsibilities in a phased approach, with NHS England managing the assurance in our delivery. This will enable us to redesign primary care together with general practitioners locally. We will have a clear and strong relationship with the area team in influencing service development and delivery through the other contractor groups (dentistry, pharmacy, optometry) working together to widen primary care provision for our patients.

**Medicines optimisation**

This is a priority programme in BwD and provides the opportunity to raise quality and improve outcomes for patients. The medicines management team in Blackburn with Darwen have introduced a shared approach to medicines use, providing patients with better access to support for medicines taking which improves the safe use of medicines in all care setting, harnessing the expertise of professional and patients working together. The changing national shift from “medicines management” to medicines optimisation will be recognised within the CCG through the medicines optimisation strategy aligned to the NHS Outcomes Framework (Department of Health, 2011) with an emphasis on achieving better outcomes, 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.

We will support prescribers in optimising prescribing quality and improve the position of the CCG in the national QIPP Prescribing Comparator rankings. The incidence of significant prescribing related harm to patients will also be reduced through working closely with prescribers both in primary care and across the interface.

The CCG’s medicines management team, will provide support to vulnerable patient groups who often have difficulty in accessing services, through a range of approaches including: provision of advice/training to care homes; provision of clinical medication reviews and advising on transfer of care issues across and between a variety of interfaces including primary and secondary care, community pharmacists and care homes.

Medicine optimisation initiatives are a key opportunity to tackle health inequalities in the borough, which align to the National Audit Office report which identified a number of cost effective high impact interventions and these are as follows:
As one of the British Heart Foundation’s 50 Heart Towns, the CCG recognises the importance of both optimum blood pressure control and low cholesterol in improving life expectancy and will continue to work with prescribers and public health to increase prescribing of medicines for these conditions. The CCG will continue to work with prescribers and patients to ensure that targets for Blood Pressure control (BP) and cholesterol targets are achieved. The CCG will actively search for those people with untreated/uncontrolled hypertension or hypercholesterolemia and support the prescribing of, and adherence to, the optimum treatment. For those patients with Diabetes, the CCG has a local improvement scheme for 2014-15 which incentivises practices to undertake comprehensive cardiovascular risk assessments, including blood pressure and cholesterol checks. The CCG will work with primary care to ensure that every patient aged over 40 years are offered a Cardiovascular (CV) risk assessment and that if necessary, medication is initiated appropriately.

We recognise that there is an urgent need to improve the diagnosis of Atrial Fibrillation (AF) and to encourage better uptake and adherence to oral anticoagulant (OAC) therapies within the primary care setting and reduce the incidence of potentially preventable strokes. The CCG has worked with the Lancashire & Cumbria Stroke network in 2013 to identify those people at risk of stroke and not receiving OAC, and offered support and on-going education to review these patients and ensure appropriate OAC was initiated. The medicines management team will continue to work with the GPwSi to ensure at-risk patients receive appropriate OAC, including managed introduction of the new agents on the market.

We will continue to work with other partners to offer regular educational events on the importance of good primary care management of diabetes. Our integrated community diabetes service (with GPwSi and consultant input) will provide assessments and treatment of the condition, including insulin initiation when required to ensure improved blood sugar control. This service incorporates all elements of specialist diabetes management including a structured patient education. A prescribing incentive scheme incorporating national prescribing indicators for diabetes management will ensure evidenced based, cost effective prescribing is practiced with improved blood sugar control.
High Impact Change 1: Delivering High Quality primary care at scale and improving access

1. Pro-active disease management and Local Improvement Schemes
   - Design
   - Extend & Stretch LIS/ES Services
   - Sustain
   - Improving and integrated services for the adult population in place and unnecessary hospitalisation prevented

2. Improving the quality of urgent care and vulnerable people
   - Design
   - Single Point of Access
   - Sustain
   - Over 73 Intensive Support Team
   - Sustain
   - Nursing Home Service
   - Sustain

3. Re-designing primary care delivery and seven day working
   - Design
   - Locality Model
   - Sustain
   - Developing the Provider
   - Sustain
   - Workforce/Skill Development
   - Sustain
   - Estates & Infrastructure
   - Sustain

4. Improving quality and reducing variation in practices
   - Design
   - Primary Care Commissioning
   - Sustain
   - Medicines Optimisation
   - Sustain

Overall Outcomes:
- Access to psychological therapies improved to national target of 15% by Quarter 4 2014/15
- The diagnosis rate increased for people with dementia to 67% of estimated prevalence by 2014/15

Extended primary care delivered in the community
High quality Primary Care services in place and variation between practices reduced

The number of people having a positive experience of care outside of hospital increased and the number of poor responses across GP practice and out of hours services reduced to 4.7 per 100 patients by 2018/19
High Impact Change 2 – Self-care and early intervention

We will know if we have achieved our vision for Self-care and early intervention in Blackburn with Darwen if our patients say that they:

- Feel empowered and know where to gain support in their homes & communities
- Access health services only when they really need to
- Can retain a life of independence and live better and live longer
- Can choose the right option for them at the most local level and in their neighbourhood
- Have all the necessary information about their condition to manage themselves

Metrics:

- Reducing the potential years of life lost from causes considered amenable to health care by 3.2% per annum (PYLL)
- Improving the health related quality of life for people with long term conditions up to national average levels by 2018/19
- Maintain current levels of performance of the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (88% in 2012/13)
- Improving access to psychological therapies to national target of 15% by Quarter 4 2014/15

Central to our BCF submission and the aspirations of our population, we recognise the need to improve the way we support individuals in their self-care. It is essential that we equip people with the skills and behaviours to protect their independence, promote better outcomes and reduce any unnecessary reliance on hospital based care. We will build our capability to offer proactive early interventions for our patients reducing the need for intensive, hospital-based interventions for problems which, if addressed earlier, might have been avoidable.

Initiative 1 – Achieving self-care project

The organisation Lancashire MIND have been funded by the Department of Health Innovation Fund for three years to work in the East locality to focus proactively on people who are identified at risk of unnecessary hospital admission, exacerbation of a long term condition, social isolation and general inability to cope unsupported. People are identified through a range of sources which develops a real in-depth understanding and intelligence about the needs of these individuals. People can be referred by their GP or the team will proactively contact individuals and invite them for a consultation. This will include all elements of the health, social and emotional wellbeing and support the development of individual resilience. It will also support the navigation and signposting of individuals to the wealth of resources within the locality. The project commenced in June 2013 with a full evaluation being conducted by the University of Liverpool with first year results expected in summer 2014.

Initiative 2 – Remodel and grow the Voluntary, Community and Faith Sector
Blackburn with Darwen Borough Council, in partnership with the CCG, is remodelling and seeking to increase the capacity of the Voluntary Community and Faith sector, in the Borough. This will be achieved by using an integrated commissioning and delivery model to drive a more collaborative approach to the co-ordination of advice and information, signposting and locality-based informal support. Going forward the focus will be on people who are at ‘tipping point’, not yet requiring statutory services, but without intervention likely to be at risk in the near future. It is anticipated a co-ordinated approach to lower level support will prevent and delay the demand on statutory services for both health and social care.

**Initiative 3 – Think! Campaign**

As part of the work with East Lancashire CCG we launched the Think! Campaign in December 2013, across the area telling people about the best places to access appropriate care when they are ill. The campaign was developed with the input and views of patients and includes a range of leaflets available from GP surgeries and other sources of advice and information.

**Initiative 4 – Improving Access to Psychological Therapies (IAPT) and Parity of Esteem**

Common mental health disorders, such as depression, generalised anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time. With variation in their severity all of these conditions can be associated with significant long-term disability but the vast majority of depression and anxiety disorders can be treated in primary care (up to 90%). However, many individuals do not seek treatment and common mental health disorders often go unrecognised. Recognition of anxiety disorders is particularly poor in primary care and only a small minority of people experiencing anxiety disorders ever receive treatment.

The Improving Access to Psychological Therapies (IAPT) programme is aimed at people with common mental disorders such as depressions and anxiety. The CCG is redesigning the current service in Blackburn with Darwen in partnership with the LA (public health) to develop an integrated service that delivers approved interventions and offers a broader wellbeing service in partnership with third sector and wider wellbeing services. The aim is to offer an effective IAPT service with reduced waiting times and improved recovery rates for patients. This will closely link to GP practices and be co-ordinated across the four Blackburn with Darwen localities as part of the wider Integrated Care Model.

The IAPT service currently is available Monday – Friday, 9am-5pm and will be subject to change as 7 day working becomes more widespread. Referrals are accepted from GPs, Mental Health professionals, other practitioners as well as self-referrals. We aim to provide an effective IAPT service ensuring that a maximum number of patients have access to effective IAPT treatments within four weeks of referral and meet our required prevalence target of 15%.

**Initiative 5 – Your Support, Your Choice**
The “Your Support Your Choice” Programme supports people who are not yet eligible for formal health and social care services but are at risk of requiring such support and intervention. The programme was developed in consultation with residents, service users, and third sector partners and aims to improve resident’s quality of life by providing quality information about health and social care services. In February 2013 an innovative walk-in advice hub was opened in Blackburn town centre providing health and social care information, advice signposting and advocacy through internet, telephone and face to face contact. The service supports people of all ages and their families who need help to remain independent. To support the walk in advice hub, an extended reablement offer, including informal, community-led ‘Home from Hospital’ and Good Neighbour schemes are now up and running.

In August 2013, three new Community Wellbeing Co-ordinators have been recruited to take “Your Support Your Choice” out into the localities. The Community Wellbeing Co-ordinators are working with some of our most socially isolated residents, taking time to get to know them, their interests and aspirations, and helping them to connect with people in their local community.

**Initiative 6 – Assistive technology the Safe and Well Programme**

The CCG in partnership with the LA is an early adopter of the Assistive Technology “Safe and Well” Programme. The programme provides and promotes a range of Assistive Technology services and products that could make life easier for our patients and help them to feel safer, more confident and which reduces the reliance on care provided by others. This approach has been piloted with people with learning disability and it has enabled individuals to have more independence and reduced the requirement over night for “sleep-in” carers. This is being extended across a broader range of people.

In addition, we are piloting this as part of our early assessment and diagnosis of people with dementia as it could help avoid prolonged diagnosis and unnecessary hospitalisation in many cases. This will be fully evaluated.
High Impact Change 2: Self Care and Early Intervention

Key:
- **Plan/Design**
- **Implement**
- **Sustain**
- **Outcome**

1. Remodel and grow the Voluntary, Community and Faith Sector
2. Achieving self-care project
3. Think Campaign
4. IAPT and Parity of Esteem
5. “Your Support, Your Choice” Programme
6. Assistive Technology “Safe and Well” Programme

Remodel

Achieving Self-Care

Pilot Evaluation

Service Redesign

IAPT Service Roll-Out

Design

7 Day Working Implementation

Service Roll Out

Joint Commissioning Strategy

Socially isolated residents are connected with people in their local community

Individual resilience developed and supported by a team consulting on health, social and emotional wellbeing

Patients supported to know the best places to access appropriate care when they are ill

Access to psychological therapies improved to national target of 15% by Quarter 4 2014/15

Reliance on care provided by others reduced

Demand on statutory services for both health and social care delayed and prevented

Overall Outcomes:
- Potential years of life lost from causes considered amenable to health care reduced by 3.2% per annum (PYLL)
- Health related quality of life for people with long term conditions improved up to national average levels by 2018/19
- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reabilitation/rehabilitation services increased to 95% by 2018/19
High Impact Change 3 – Enhanced Integrated Primary Care Services

We will know if we have achieved our vision for Enhanced Integrated and Primary Care services in Blackburn with Darwen if our patients say that they:

- They feel empowered and know where to gain support in their homes & communities
- Access health services only when they really need to
- Can retain a life of independence and live better and live longer
- Can choose the right option for them at the most local level and in their neighbourhood
- Have all the necessary information about their condition to manage themselves

Metrics

- A reduction in the number of council supported permanent admissions of older people to residential and nursing care down to national rates by 2018/19
- Maintain current levels of performance of the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (88% in 2012/13)
- See a reduction in delayed transfer of care (delayed days) from hospital per 100,000 population from a baseline 2012/13 of 196.1 to 145.3 by 2018/19
- Reduce amount of time people spend avoidably in hospital through a reduction in emergency admissions for ambulatory care sensitive conditions from 3484 per 100,000 admissions (2012/13) to 1994 per 100,000 admissions by 2018/19

As part of our BCF we are intending to deliver an enhanced range of primary care services which will build upon the core primary care services described in High Impact Change 1. For the purposes of the BCF enhanced primary care includes a number of key principles which are patient centred care and incorporate risk stratification, care and case management and utilise an intensive and segmented approach for key user groups.

Initiative 1 – Integrated Locality Teams

The CCG in partnership with the LA is proactively working with our providers and partners to develop a locality-based delivery, 24/7 integrated care system across primary, secondary, community health and social care. The ambition is to develop fully integrated health and social care teams, working together to ensure services are coordinated to maximise their impact for the local population. The integrated teams, built around the registered practice populations, will work closely to provide better care to patients, through shared care records, proactive care planning and integrated case management. General practice will be integral to the transformation providing strong clinical and strategic leadership to support care as close to home as possible.

The core teams utilise a full spectrum of multidisciplinary teams. The core team will provide a range of interventions and complete high level assessment of both physical and social
Blackburn with Darwen CCG has established a ‘Primary Care Education and Development Steering group’ to support Practice Nurses working in General Practice. The group is led by the ‘Head of Quality and Nursing’ with members being from a variety of disciplines, working together to develop a programme of education and development needs.

The overall aim of the programme is to improve health outcomes for patients living within Blackburn with Darwen by assessing the education and development requirements of Practice Nurses working in Primary Care and support their continuing professional development (a requirement for maintaining registration with the Nursing and Midwifery Council).

The programme is delivered through Monthly Practice Nurse Forums. These sessions provide an opportunity for Practice Nurses, who often work in isolation to network and share good practice. The timetable has been developed to meet the developmental needs of the Nurses whilst delivering the CCG strategic objectives.

The revised approach to Primary care will support patients with long term conditions, the frail elderly and those most at risk of hospital admission or at ‘tipping points’. The approach will also seek to provide increased access to step-up services to prevent non-elective admissions along with reduced step-down building-based services. A broader focus on whole population health and the promotion of wellbeing will enable a whole system approach to be adopted for the benefit of Blackburn with Darwen residents. This approach is referred to as the ‘core offer’ and will be fully operational by April 2015.

An Implementation Group has been brought together with representation from LCFT, ELHT, the LA, patients and VCF. The work is being supported by a Better Care Fund Programme management office that will oversee delivery of the programme, minimise duplication and ensure that efficiencies are made where possible.

**Initiative 2 - Case Management (built around, risk stratification, care coordination and intensive home support).**

To support the development of locality teams, the most vulnerable individuals will be identified using a predictive risk stratification tools and techniques (including health professional’s knowledge) that will provide clear information on population need in each locality. Blackburn with Darwen CCG is working with the Lancashire Commissioning Support Unit and GP Practices to embed risk stratification in GP Practices. Following patient/service users being identified their care will be reviewed as part of an integrated multi-disciplinary team meeting and a case manager will be selected depending on patient/service user need. Case managers will coordinate care across mainstream and more specialist services, acting a single contact point.

An Intensive Homes Support service is being developed to provide support in the community to people with the most complex medical and social needs. The service will focus on case management of patients requiring short term acute care at home. In June 2013, Blackburn with Darwen CCG and Local Authority invested time and resource to develop an Enhanced Integrated Community Care Pilot in the East of BwD. The focus for the Pilot was to test risk...
stratification, case management and an intensive home support model of community care. The results and clinical experiences from the Pilot are being gathered by The University of Liverpool and will inform the introduction of an intense home support service across BwD.

To complement this activity, Blackburn with Darwen CCG will build on our existing Acute Visiting Service model to align provision with the development of integrated locality primary care teams. We will scope the opportunities to deliver a 24/7 365 day primary urgent care offer within the community. Working closely with North West Ambulance Service through our paramedic pathfinder we will ensure clear pathways of referral into enhanced primary care services including patients requiring Intensive Home Support.
High Impact Change 3: Enhanced Integrated Primary Care Services

Overall Outcomes:
- The number of council supported permanent admissions of older people to residential and nursing care reduced down to national rates by 2018/19
- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services increased to 95% by 2018/19
- Numbers of delayed transfer of care (delayed days) from hospital per 100,000 population reduced from a baseline 2012/13 of 196.1
- Amount of time people spend avoidably in hospital reduced through a reduction in emergency admissions for ambulatory care sensitive conditions down to national average rates by 2018/19
High Impact Change 4 – Access to Re-ablement and Intermediate Care (and links to BCF)

We will know if we have achieved our vision for providing access to high quality reablement and intermediate care in Blackburn with Darwen if our patients say that they:

- Have access to a high quality and appropriate reablement and rehabilitation services, in a setting closer to home and appropriate for their levels of medical needs.
- Have returned to independent living and have a reduction in the likelihood of accessing longer term residential care in the future.
- Patients and their families feel less stressed and anxious as they are being managed at home rather than in a residential setting;

Metrics

- Maintain current levels of performance of the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (88% in 2012/13)

It is our intention to re-balance community transitional support services and short term bed based services to meet a whole width of patient need and ensure each individual is given every opportunity to recover and achieve their optimal level of skills, confidence and independence, as well as being able to step up into the system to avoid an unplanned admission into hospital or care home where an alternative exists. This will include the remodelling of short term placements, residential and domiciliary intermediate care, crisis response provision, re-ablement, early supported discharge of stroke patients and end of life care. BwD is an outlier for patients recieving long term residential care and we recognise that there are significant opportunities to develop real alternatives for individuals which build upon our core values of promoting independance and securing the best outcome for individuals.

It is the aim of the project to focus on reviewing the existing number of community intermediate care beds available to BwD registered patients. This will include detailing the category of beds eg sub-acute and social care intermediate care, step up beds and Continuing Health Care (CHC) assessment beds. The project will also review and redefine the long term location of these beds, define where these are to be located in the interim period of 18 months – 2 years, whilst new estate is being scoped out and defined. The scoping out of beds via this project will then allow commissioners to inform the number and location of these beds in the community and to match nursing/therapy/service needs to patients depending on acuity of care. This will help ensure system resilience and enable flexibility to meet increased demand and pressures in the urgent care system.

The purpose of Intermediate Care is to:

- Support alternatives to inappropriate acute hospital admission;
- Support early discharge after acute illness or surgery;
- Delay admission to long term care.
Successful intermediate care services are based on competent multidimensional assessment of individuals' needs and potentials, interventions focused on individual patient goals, effective teamwork and performance management.

Similarly, reablement has been demonstrated to address, and contain the growing costs of an ageing population and specifically there is good evidence that reablement removes or reduces the need for on-going conventional home care and that it improves outcomes for people who use services. Blackburn with Darwen has created an integrated care vision that shifts the focus of care from bed based long term placements to support home based provision.

We are supporting the expansion of Extra Care Housing for older and working age adults and the extension of ‘Shared Lives’ service providing support within family homes. A major residential and nursing care development programme is underway to build two residential and nursing care facilities that will provide extended intermediate care and respite services.

These services will form a significant part of our integrated local pathways to ensure care closer to home and reduce hospital admissions and permanent admissions to long term residential care.

We will achieve our vision by working collaboratively across Blackburn with Darwen providers and commissioners and ensuring that at all times the patient and their family are at the centre of every decision made about their long term and on-going care needs.

**Initiative 1- Increased use of intermediate care and reablement as first intervention of choice**

We aim to significantly reduce admissions to long-term residential care by 2018 by offering time and opportunity to people to recover, recuperate and maximise their life opportunities following an acute illness or life crisis, through person centred re-ablement, planning and support, away from the acute hospital bed. This will allow people to make long term decisions about care and support when their needs are stable rather than in a time of crisis.

The increased use of intermediate care beds will be linked into the Integrated Discharge Team work project as Pennine Lancs look at redefining the function of this team. We will review and redesign existing services to develop:

- Step up beds for complex frail older adults to avoid hospital admissions, accessible by GPs
- Sub-Acute (step down), rehabilitation and recovery service
- Clinical in-reach into the person’s home and intensive domiciliary care and crisis support
- Intensive Reablement
- Person centred ‘End of Life’ care and support that enables people to die in the place they choose.
- A process by which patients are discharged to be assessed
Initiative 2 – Sub-acute rehabilitation

In October 2012 the CCG procured 10 sub-acute rehabilitation beds as part of a three year contract to replace the provision at Pendle and ensure local provision in the Borough. In addition to this in December 2013 we procured an additional 6 beds with the intention of using these beds on a flexible basis between sub-acute, step up step down and assessment. In January 2014 the CCG procured a further 2 beds to bring the total bed capacity available for sub-acute use to 18 of which 8 of those beds would be available for flexible use for a temporary period of time whilst the level of need is scoped across the health economy. We have the opportunity to investigate how these beds are staffed and reviewed the clinical services required for them. This may mean looking at the provision of geriatrician support from ELHT as a means of more patients being able to be discharged into sub-acute beds and hence freeing up hospital beds.
High Impact Change 4: Access to high quality reablement and intermediate care

1. Increased rehab and reablement as first intervention of choice
   - Design
   - Intensive Reablement and domiciliary support
   - Sustain

2. Sub-acute rehabilitation
   - Design
   - Clinical in-reach into home and intensive domiciliary care and crisis support
   - Sustain

Key:
- Plan/ Design
- Implement
- Sustain
- Outcome

Overall Outcomes:
- Admissions to long-term residential care significantly reduced.
- A comprehensive range of intermediate care services in place that flex across the continuum of health and social care needs.

Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services increased to 95% by 2018/19.
High Impact Change 5 – Improved Hospital Discharge and Reduced Length of Stay

We will know if we have achieved our vision for improving hospital discharge and reducing length of stay in Blackburn with Darwen when our patients say they have been:

- We have seen more patients being discharged to assess in an appropriate setting
- We have created an integrated single discharge team

Metrics:
- To see a reduction in delayed transfer of care (delayed days) from hospital per 100,000 population from 196.1 (2012/13) to 145.3 by 2018/19

Assessment (allocation and continuing care and support services) and discharge services for BwD residents (adults of all ages) across Pennine Lancashire are currently provided by a number of teams across five organisations. The CCG has also recently established an Older Adult Liaison Service which commenced in January 2014. This is based upon the successful RAID (Rapid Assesment Interface Discahrge Service) model developed in Birmingham and aims to support the discharge of frail older adults with both physical and mental health problems. This is currently being evaluated as part of a two year pilot project.

Through merging these discharge teams, it is possible to maximise resources to increase efficiency, reduce delays and expenditure, and improve the overall patient experience. It would also further facilitate a “pull” model through acute to community services through use of a Single Point of Access, supporting a change in culture to one of joint ownership and strong partnership working.

It is envisage that the integrated discharge team will be able to discharge directly to the integrated Locality Teams to which the service user is a registered patient. These Locality team will be able to provide intense home support and case manage the individual to prevent a re-admission.

We will improve hospital discharge and reduce length of stay by promoting the integration of services across health and social care through the following initiative:

Initiative 1 – Creation of single integrated and co located discharge team

This team will facilitate discharge from an acute setting and will be responsible for transferring a patient’s care to the most appropriate setting and monitoring the flow to the transitional system, including flexing the system at times of enhanced pressure across Pennine Lancashire.

A Pennine Lancashire Transfer of Care development Group has been established including representatives from BwD and EL CCG as well as representatives from both LA social care providers. Discussions from this group has lead to the decision that both CCGs want to work together to define and create a single pathway for all patients thus reducing inequalities and reducing barriers to care depending on which CCG area the patient is a registered patient.
Discussions are ongoing between all commissioners and providers to agree the functions of the Discharge Team to determine what functions are in and out of scope and whether this team will be responsible for carrying out discharge assessments or whether it will mobilise existing assessments. The Discharge Team will work 7 days a week and out of hours and will set usage of a Single Point of Access.

It is our ambition to see the transfers of care hub (TOC hub) as being able to support all people with a need to use short term health and social care services outside of hospital to support them through a period of:

- Crisis, requiring intensive community support.
- Recovery and recuperation.
- Rehabilitation and re-ablement.
- On-going assessment within a service
- End of life care

Services meeting the above needs are identified as the transitional care system. The TOC hub is designed to receive assessments that have identified the need for a transitional service of any kind, either from the community or as part of the discharge process from an acute setting, sense check those assessments in order to allocate them to the most appropriate support service. The TOC hub will then track individuals through those services and oversee discharge and any assessment required for on-going need.

The TOC hub will oversee and flex the flow and capacity of the transitional system so that it maintains quick access to each element of the system and ensures that the system responds to pressures emerging in the wider health and social care economy. It will also enable the implementation of integrated care planning and co-ordinating a comprehensive End of Life Care Pathway which is consistent across Pennine Lancashire and all disciplines.

In order to improve the Continuing Healthcare (CHC) element of a patients discharge experience, changes have been made to the pathway which reduces the length of time patients await a CHC assessment and also improves the quality of care by reducing the length of stay and ensuring that patients are provided with the appropriate care package to meet their needs.
• High Impact Change 5: Improved Hospital Discharge and Reduced Length of Stay

- Single integrated discharge team

Key:
- Plan/Design
- Implement
- Sustain
- Outcome

2013/14
14/15
15/16
16/17
17/18
18/19
19/20

Design
Creating a single discharge team
Sustain

Design
Integrating care planning
Sustain

Numbers of delayed transfer of care (delayed days) from hospital per 100,000 population reduced from a baseline 2012/13 of 136.1
High Impact Change 6 – Community Based Ambulatory Care for specific Conditions (and links to BCF)

We will know if we have achieved our vision for Community Based Ambulatory Care in Blackburn with Darwen if our patients say that they:

- Feel empowered and know where to gain support in their homes & communities
- Access health services only when they really need to
- Can retain a life of independence and live better and live longer
- Can choose the right option for them at the most local level and in their neighbourhood

Metrics

- Reduce amount of time people spend avoidably in hospital through a reduction in emergency admissions for ambulatory care sensitive conditions from 3484 per 100,000 admissions (2012/13) to 1994 per 100,000 admissions by 2018/19

- Improving the health related quality of life for people with long term conditions up to national average levels by 2018/19

Blackburn with Darwen CCG has a vision of delivering a local community ambulatory care service that optimizes access and takes a whole system approach to deliver an integrated service which is responsive to patients’ needs, effective in its outcomes and provides clinically safe and high quality effective intervention. The service will link closely to the secondary care ambulatory care service to ensure continuity of care and effective patient pathways are in place. The service will be flexible and highly accessible for patients, involving clinicians in primary care and other stakeholders in the provision of a range of primary care services to the local population, which are closer to patients’ homes. The service will be part of the growth of a broader integrated community service model for Blackburn with Darwen linked into the Better Care Fund.

The Community Ambulatory services commissioned by the CCG provide assessment and a range of treatments for minor injury, complex wound care, phlebotomy, BP recording, circulatory problems, ECG, community nursing team and ear irritation from a range of healthcare locations across Blackburn with Darwen including Barbara Castle Way, Darwen Health Centre and other satellite venues.

We intend to review the current service model in line with our vision for the future development of the service and the BCF, as part of the whole system approach to generate new ideas, innovation, clear patient pathways and consistently delivery of services. The review will include an examination of any other local interface with other commissioned services or pathways which may duplicate or prevent effective service delivery. This includes an evaluation of current Ambulatory Service provision to look for the opportunities for improvement accessibility, equitability, quality, productivity and value for money. We will
agree a common definition of Ambulatory Care and develop a local model of care and pathways. Specifically we are looking at 4 initiatives which are set out below

**Initiative 1 - Out Patient Parenteral Antimicrobial Therapy (OPAT)**

There is evidence that OPAT can shorten or avoid hospitalisation in carefully selected patients with infection and reduce potential risks associated with unnecessarily prolonged admission. Through the CCGs commissioned OPAT service provider, we will strengthen the current service to achieve admission avoidance for conditions such as cellulitis, funded by an acute ambulatory care tariff.

**Initiative 2 - Chronic Obstructive Pulmonary Disease (COPD) and Pulmonary Rehabilitation**

The CCG has a major initiative to treat Chronic Obstructive Pulmonary Disease (COPD) which focuses on equity, prevention, early identification and the management of respiratory disorders, which align to the six objectives set out in the DoH COPD Outcome Framework 2011. The CCG commissions a Respiratory Local Enhanced Service, provided by specialist respiratory nurses, that has been developed to ensure a proactive approach towards COPD patients and their management within Primary Care. It is designed to support prevention and early identification, correct diagnosis, improved quality of life, prevention of exacerbations, deterioration and hospital admissions. There are strong links between primary and community services, including Pulmonary Rehabilitation, Oxygen Services and the Community Respiratory Team. In addition, the CCG has recently developed a Respiratory Network, through which experts across primary, community and secondary care meet regularly to share best practice and review and redesign Respiratory pathways in order to ensure clinical efficiency, effectiveness and enhance patient experience.

**Strategic Initiative 3 - Integrated Care for Diabetes**

The GPwSI service provides a cost effective integrated community based diabetes care service for Type 1 and Type 2 diabetics which is an alternative to secondary care provision; reducing referrals, inappropriate admissions and follow up visits. As a result, secondary care services are able to increase their capacity to treat a greater number of patients with more specialist diabetic needs. The GPwSI also plays a key role in education and mentoring of local GPs and health professionals working within primary care to ensure high quality diabetes care is provided to all patients. More information about the GPwSI programme is detailed in High Impact Change 2.

The integrated community diabetes service works in conjunction with the GPwSI Tier 2 service and other primary care services such as podiatry, treatment room and vascular services to provide local provision for people at greatest risk of complications with an HbA1c >8.5%. The service provides insulin initiation for those patients who require it. An important part of the service is to offer patients and their carers/families information, advice and support on the management of Type 2 diabetes and in particular through the X-Pert patient programme. Education also takes place for nursing and residential care homes through quarterly awareness sessions. In 2013-14 the CCG identified diabetes care as a key area of focus. We will build on this by revising the Diabetes LIS and reviewing the pathway from primary to secondary care and within the community. In 2013-14 the CCG identified diabetes care as a key area of focus. We set ourselves a target of ensuring at least 56% of patients
on the diabetes register across Blackburn with Darwen having received all 9 of the NICE recommended care processes by March 2014. We exceeded this target and reached an achievement figure of 65%. We will build on our success and aim to keep the momentum in improving outcomes for our patients with diabetes. We will hold workshops directed at GPs and practice staff to provide peer education and clinical support around the area of diabetes. We will revise the Diabetes LIS and review the pathway from primary to secondary care and subsequent discharge within the community. The shift from a PCT to a CCG and a revised locality structure has provided us with the perfect opportunity to target specific areas of performance in diabetes care which is pertinent to each of our 4 localities. We will tackle specific areas of variation in diabetes care within each locality. We will also aim to better find patients with diabetes or pre diabetes that are unknown to the service in order to pick the condition up early. As is the case with the majority of conditions, the earlier they are identified, the better the potential outcome for the patient. People living with diabetes or at risk of diabetes have a higher risk of other cardiovascular (CVD) conditions such as heart failure, chronic kidney disease and stroke. We aim to identify a greater proportion of patients with CVD related diseases who also have diabetes that were previously undiagnosed.

Initiative 4 - Acute Model for Ambulatory Care

The Pennine Lancashire health economy experiences high rates of emergency admissions for patients with Ambulatory Care Sensitive conditions which may be suitable for alternative management outside of secondary care. The Ambulatory Care Unit was opened on 23rd January 2014 to provide a sustainable, systematic, integrated and personalised approach for patients on certain pathways. This enables patients to receive a comprehensive assessment in an outpatient setting. The service is being evaluated using a small number of pathways with a view to extending to a full 7/7 service incorporating all 49 ambulatory care sensitive conditions in the future.
High Impact Change 6: Community based ambulatory care for specific conditions

1. OPAT iv therapy
   - Design
   - Roll out commissioned OPAT service
   - Sustain
   - Outcome: Hospitalisation in carefully selected patients with infection shortened or avoided

2. COPD
   - Respiratory Local Enhanced Service
   - Sustain
   - Outcome: Respiratory disorders prevented, identified early and managed.

3. Diabetes
   - Design
   - Revise LS and review pathway
   - Sustain
   - Outcome: Referrals, inappropriate admissions and follow up visits reduced

4. Acute Model
   - Design
   - Ambulatory Care Unit
   - Sustain
   - Outcome: A sustainable, systematic, integrated and personalised approach for patients on certain pathways in place

Overall Outcomes:
- Amount of time people spend avoidably in hospital reduced through a reduction in emergency admissions for ambulatory care sensitive conditions down to national average rates by 2018/19
- Health related quality of life for people with long term conditions improved up to national average levels by 2018/19
High Impact Change 7- Access to High Quality Urgent Care

We will know if we have achieved our vision for Urgent & Emergency Care in Blackburn with Darwen if our patients say that they:

- Have access to a high quality and appropriate urgent care service, regardless of the time or day
- Understand the services available to them, and under which circumstances to use them

Metrics:

- Reduce amount of time people spend avoidably in hospital through a reduction in emergency admissions for ambulatory care sensitive conditions from 3484 per 100,000 admissions (2012/13) to 1994 per 100,000 admissions by 2018/19
- Increasing the number of people having a positive experience of hospital care by reducing the number of poor responses to CQC inpatient services survey (from 155 negative responses to 115 per 100 patients)
- Increase in response rate and quality of experience as reported through Friends and Family Test

Blackburn with Darwen CCG’s vision for Urgent & Emergency Care is to provide a range of high quality, 24/7 services to meet the needs of those in our population that find themselves acutely or urgently unwell.

As part of our strategic alliance with East Lancashire CCG (as the Pennine Lancashire health economy) we have developed a joint vision and action plan for Urgent & Emergency care to ensure a coordinated response for adults and children who present with an acute or urgent health issue. We want to consider the appropriate delivery and transformation of health and social care services 24/7, to reduce the reliance on Accident and Emergency (A&E) as a point of delivery for urgent care services and improve outcomes and patient experience. We will do this through the development and delivery of an overarching Pennine Lancashire Unscheduled Care Strategy.

We will achieve our vision for urgent and emergency care by working on several programmes across our 3 footprints.

Initiative 1 - GP Acute Visiting Service

The Acute Visiting Service (AVS) Model was developed as a 13 month pilot up to 31st March 2014. The scheme enables patients to be referred with urgent symptoms that might need hospital treatment for a home visit by a GP. Referrals to the service come from other GPs and the local ambulance service. The service runs from 8.30am – 6.30pm Monday – Friday.

As part of this model a referral pathway was developed for the direct referral of appropriate 999 calls following an assessment by paramedics using the Paramedic Pathfinder Protocol. This has resulted in an alternative pathway for patients who do not require attendance and
an urgent care centre or emergency department but can have their needs met within primary care.

The AVS pilot has been extended for a further 12 months to align provision with the development of integrated locality primary care teams and to scope the opportunities to deliver a 24/7 365 day primary urgent care offer within the community. This will include work with North West Ambulance Service (NWAS) through the Paramedic Pathfinder to ensure clear pathways of referral into enhanced primary care services including virtual ward.

**Initiative 2 - Primary Care Pathway in Urgent Care**

A primary care pathway has been implemented following a pilot in 2013/14 within the two Urgent Care Centres (Royal Blackburn Hospital and Burnley General Hospital). Implementation of the pathway has been extended for a further 12 months and enables patients attending with primary care needs to be assessed and allocated to a primary care pathway within urgent care which meets their immediate needs. Evaluation of the pilot will be undertaken in 2014/15 in order to inform the future commissioning model for urgent care.

**Initiative 3 - Early Action Police Liaison**

An Early Action Police Liaison role is in development which will be delivered from the Accident & Emergency Department at East Lancashire Hospitals Trust. The expected deliverable benefits will be achieved by focusing on frequent attenders and the integration of the role across key services within the health economy e.g., Mental Health Liaison Team, Hospital Alcohol Liaison Team and the Pennine Lancashire Early Action Team therefore having a wider impact from both a health and social care perspective. Secondly the integration of the Mental Health Liaison Service (LCFT) and the Hospital Alcohol Liaison Service (HALS) to provide a better quality treatment and approach which produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. An integrated service model will be scoped and agreed with key organisations.

**Initiative 4 - Clinical Advice**

Pennine Lancashire was a participant in the Northwest NHS 111 pilot in 2011. As part of the service model, calls to 111 are answered by non-clinicians who triage the caller’s needs and determine the most appropriate course of action. Whilst non clinical advisors are supported by clinicians and NHS Pathways as part of the NHS 111 service the health economy had seen an increase in demand on the Out of Hours and Urgent Care System. Therefore, in order to improve quality of the service and reduce the demands on Out of Hours Services, Pennine Lancashire CCGs supported a business case to implement a GP Clinical Advice Pathway Pilot to minimise the demand and support the local urgent care system.

**Initiative 5 – Stroke Review**

We are carrying out a current state review of stroke pathways across Lancashire including prevention, primary care, TIA, hyper-acute care, acute care, rehabilitation (inpatient and community), early supported discharge and review life after stroke. We are also reviewing data and understanding the reasons for any identified performance concerns/issues. In line with that we are reviewing the RCP National Clinical Guideline for Stroke and the NICE
clinical guideline for stroke and undertake a baseline assessment of current service provision against and agreed ‘best practice’ service model. We will then engage and involve primary care clinical champions to undertake a pilot focusing on AF to include identification, anticoagulation, training and education and make recommendations for further service improvement or transformation opportunities which will ensure equitable access to a seven-day, high quality stroke service for the population of Lancashire.

**Initiative 6 - Reducing Paediatric Admissions**

Across Pennine Lancashire we have established a dedicated clinically led network, the Pennine Lancashire Paediatric Pathways Group that aims to reduce unnecessary paediatric attendances and admissions at hospital, improving outcomes for children and families by ensuring that families access the right care at the right time in the right place. A number of schemes and initiatives have been developed and implemented including the Children’s Community Nursing Service expansion following a successful 12 month pilot to provide acute services in the community at evenings and weekends. In July 2014, an interactive electronic resource will be hosted on the Blackburn with Darwen CCG website which provides information and guidance on the treatment and management of common childhood illnesses, also providing details of where and when to access services. We are working with clinicians across the health economy to review the current paediatric pathway and the usage of the Short Stay Paediatric Assessment Units at both Royal Blackburn Hospital (Children’s Observation and Assessment Unit (COAU)) and Burnley General Hospital (Children’s Minor Illness Unit (CMIU)). It is the intention to develop a local assessment tariff for activity within these units to be implemented by April 2016; this will have a significant impact on the number of paediatric admissions across the health economy.
High Impact Change 7: Access to high quality urgent care

<table>
<thead>
<tr>
<th>Key:</th>
<th>Plan/Design</th>
<th>Implement</th>
<th>Sustain</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Visiting Scheme (AVS)</td>
<td>AVS Pilot</td>
<td>Sustain</td>
<td>Non-elective admissions and A&amp;E attendances reduced by a 24/7 365 day primary urgent care offer within the community</td>
<td></td>
</tr>
<tr>
<td>2. Primary Care Pathway in Urgent Care</td>
<td>Primary Care Pathway Pilot and Roll Out</td>
<td>Pilot Evaluation</td>
<td>Patients directed from A&amp;E to an appropriate Primary Care Service</td>
<td></td>
</tr>
<tr>
<td>3. Early action police liaison</td>
<td>Design</td>
<td>Early Action Police Liaison</td>
<td>Outcomes improved for individuals with co-occurring mental and substance use disorders</td>
<td></td>
</tr>
<tr>
<td>4. Clinical Advice</td>
<td>Design</td>
<td>NHS 111</td>
<td>999 calls and A&amp;E attendances reduced by an out of Hours information and triage system</td>
<td></td>
</tr>
<tr>
<td>5. Stroke Review</td>
<td>Design</td>
<td>Stroke Review</td>
<td>Stroke outcomes improved by a high quality service for the population of Lancashire</td>
<td></td>
</tr>
<tr>
<td>6. Reducing Paediatric Admissions</td>
<td>Design</td>
<td>Children's Community Nursing Service</td>
<td>Unnecessary paediatric attendances and admissions at hospital reduced. Outcomes for children and families improved by ensuring that families access the right care at the right time in the right place.</td>
<td></td>
</tr>
</tbody>
</table>

Overall outcomes:
- Amount of time people spend avoidably in hospital reduced through a reduction in emergency admissions for ambulatory care sensitive conditions down to national average rates by 2018/19
- Number of people having a positive experience of hospital care increased by reducing the number of poor responses to CQC inpatient services survey
- Response rate and quality of experience increased as reported through Friends and Family Test
High Impact Change 8 – Scheduled Care

We will know if we have achieved our vision for scheduled care in Blackburn with Darwen if our patients say that:

- Safe and effective services are provided when and where they are needed most, making sure that the quality of those services meets the expectations of the local population.

Metrics:

- Increasing the number of people having a positive experience of hospital care by reducing the number of poor responses to CQC inpatient services survey (from 155 negative responses to 115 per 100 patients)
- Increase in response rate and quality of experience as reported through Friends and Family Test
- Improving the health related quality of life for people with long term conditions up to national average levels by 2018/19

We will take a whole system approach to building and redesigning services around the changing needs of the patient. We will work in a collaborative manner with patients, carers, stakeholders, providers and primary care across our health and social care system to provide an excellent range of choice of services which are closer to home. This will enable us to meet our objectives in relation to ensuring that there is a reduction in unnecessary referrals and attendance to secondary care services.

We are undertaking a review of all Scheduled Care services and schemes in collaboration with the developing urgent and integrated care systems and new CCG Primary Care Strategy. This approach will ensure joined up commissioning of health services and an integrated delivery of services and pathways across our health and social care system.

We will conduct a review of the scheduled care services, schemes and key specialities to map current demand levels. We will engage with public, patients, carers and stakeholders to be part of decision making process to deliver innovative and high quality services which meet patient expectations. We will ensure all changes to services or systems are clinically led, aimed at reducing demand on secondary care and commissioning services in our community which are accessible, safe and effective.

Initiative 1 - Reduce referrals into secondary care

Referrals into and use of secondary care hospital services at present levels are unsustainable. Innovative and strategic solutions are needed to maintain and improve quality and provision of services. This will be achieved by developing a new Specialist Advice Service which will provide consultant advice in key specialities to GP’s to ensure appropriate referrals to secondary care.

Further work is being undertaken to introduce innovative referral management schemes and reduce the number of procedures with limited clinical value which are carried out across the system.
We will review our New to Follow up Ratios per speciality in partnership with secondary care to deliver an acceptable and safe follow up activity level that is consistent with other like trusts and ensure there is a continual improvement ethos in place to ensure minimised follow ups and therefore increasing patient satisfaction levels. We will ensure that outpatient follows up in secondary care are reduced and where appropriate ensure alternatives are available in the community.

**Initiative 2 - Review and Redesign Services**

We will conduct a review of the planned care services and pathways including key secondary care specialities to make changes in response to demand levels and developing an integrated community based approach to service delivery. We will also ensure all service redesign is clinically led and that patients and public are engaged in the process. We will review and redesign services such as Ambulatory Care (community), Dermatology, ENT, Urology, Ophthalmology, MSK/Pain Management and Rheumatology to increase access, introduce innovation and drive higher quality service delivery which are value for money. This will include the creation of a range of services for delivering diagnostics testing within a community setting or as part of an outpatient appointment. These will be placed at venues that are convenient and accessible for patients such as key health centres and GP practice level.

**Initiative 3 – Proactive Management of the Scheduled Care System and Services**

A strategic Scheduled Care Development Group will be formed in summer of 2014 to oversee the delivery of the Scheduled Care Strategy and work programme to manage the stepped programme of change to develop responsive and innovative high quality services for our population. The members of the group will include service providers, clinicians, GP’s with Special Interest, patients, third sector representatives and other key stakeholders to inform and guide the changes required to our services and pathways. This group will be informed by local knowledge, needs assessments and utilise evidence based approaches to deliver the ambitions.
High Impact Change 8: Scheduled Care

Overall Outcomes:
- Number of people having a positive experience of hospital care increased by reducing the number of poor responses to CQC inpatient services survey.
- Response rate and quality of experience increased as reported through Friends and Family Test.
- Health related quality of life for people with long term conditions increased up to national average levels by 2018/19.

1. Reduce referrals into Secondary care
   - 2013/14: Design, Implement, Sustain
   - 2014/15: Referal Management Scheme - Specialist Advice Service
   - 2015/16: Procedures of limited clinical value
   - 2016/17: Reduce outpatient follow ups
   - 2017/18: Sustain
   - 2018/19: Referrals into and use of secondary care hospital services reduced
   - 2019/20: Outcome

2. Review and Redesign Services
   - 2013/14: Design, Implement, Sustain
   - 2014/15: Community based Dermatology
   - 2015/16: Ophthalmology
   - 2016/17: MSK/Pain management /Rheumatology
   - 2017/18: Sustain
   - 2018/19: Diagnostic Demand Management
   - 2019/20: Sustain

3. Proactive Management of the Scheduled Care System and Services
   - 2013/14: Design, Implement, Sustain
   - 2014/15: Identify and Manage System Pressures
   - 2015/16: Sustain
High Impact Change 9 – Quality

We will know if we have achieved our ambition for quality, and that people continue to have good access to safe and high quality services, when we can demonstrate:

- Reducing the potential years of life lost from causes considered amenable to health care by 3.2% per annum (PYLL)
- Increasing the number of people having a positive experience of hospital care by reducing the number of poor responses to CQC inpatient services survey (from 155 negative responses to 115 per 100 patients)
- Increase in response rate and quality of experience as reported through Friends and Family Test
- Improving the health related quality of life for people with long term conditions up to national average levels by 2018/19
- Increasing the number of people having a positive experience of care outside of hospital by reducing the number of poor responses across GP practice and out of hours services to 4.7 per 100 patients by 2018/19
- Made significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.
- Improving access to psychological therapies to national target of 15% by Quarter 4 2014/15; of those who complete treatment a minimum of 50% will have moved to recovery
- Stay within nationally defined trajectories for *C Difficile* infections 2014/15 and have no patients with MRSA infection

Quality means different things to different people. As an overarching principle we believe quality to be the minimisation and eradication of harm and a continuous improvement in clinical effectiveness, patient experience and patient safety of health and social care services for the local population. This broadly includes:

- The safety of the care and treatment provided.
- The cost effectiveness of care and parity of esteem.
- The experience of care including accessibility, acceptability and appropriateness.

This is achieved through:

- Quality Governance – the values and behaviours and the structures and processes that enable us to discharge their responsibilities for quality.
- Quality Surveillance and Assurance – the systematic monitoring, management and evaluation of services that we commission to ensure high quality standards of care.
- Quality Improvement – continuously challenging assumptions and undertaking quality improvement evaluation and adapting our approaches to health care in order to achieve better quality outcomes.
**Initiative 1 – Quality Governance**

In accordance with Monitor’s Quality Governance Framework the CCG firmly believes that good quality governance is essential. To this end we have ensured that:

- The five year strategic plan encompasses and embeds quality throughout the plan;
- Quality improvement includes the continuous monitoring and improvement of quality outcome measures in line with research governance;
- A Quality Strategy will form part of this five year plan;

To ensure that patients have a positive experience of care we will:

- Ensure commissioned services are safe, personal and effective.
- Ensure the right quality mechanisms are in place so that standards of patient safety and quality are understood, met and effectively demonstrated.
- Provide assurance that patient safety and quality benefits are being realised and take action if the quality and safety of commissioned services are compromised at any time
- Promote the continuous improvement in the safety and quality of commissioned services.
- Ensure that the essential standards of quality and safety as determined by CQC’s registration are at a minimum being met by all commissioned services.
- Challenge any unexpected quality and performance data trends and/or benchmarked outliers by the use of reports and associated recovery plans from service providers to CCG Quality Performance Group and Quality, Performance and Effectiveness Committee meetings
- Undertake a regular cycle of quality review in line with the assurance of existing or new commissioned services including quality site visits to observe services, assess standard of clinical documentation and communicate directly with staff, patients and carers
- Support Information sharing with Lancashire Quality Surveillance Group

We cannot achieve these objectives on our own, effective partnership with key partners, providers, regulators, safeguarding boards and the public is vital. There are mechanisms that we can undertake to ensure success:

- Put patients at the heart of everything we do
- Promote and harness effective partnership working
- Monitor & review the quality of commissioned services using real time data and trend analysis
- Collaborate with regulatory bodies to ensure quality standards are achieved and/or improved where necessary
- Embed quality innovation and initiatives within every commissioned service contract
- Reduce health inequalities and improve parity of esteem
- Focus on continually improving care and issues resulting from poor practice that really matter to patient
- Challenge and support organisations where poor practice or performance is evident.
Initiative 2 - Quality Surveillance and Assurance

It is important when an organisation appears to be failing that we take immediate and effective notice of ‘early warning triggers’. We will work in partnership with our providers, partners and key stakeholders to collaborate and share both soft and hard intelligence to ensure when appropriate the organisation is supported and the issue resolved in order to minimise risk and harm. The lessons from the Francis Report, Winterbourne View, the Berwick Report and Munroe Review will be used to enhance and further develop quality within our organisation and within our commissioned services. These lessons will be applied to new contracts and Key Performance Indicators i.e. the National Quality Boards Guidance for the workforce will be embedded within our Quality Strategy and form the basis of our Quality Assurance Checklist for existing or new commissioned services.

To provide robust assurance we, in partnership with providers, have the ability to enable quality improvement through:

- Quality and Performance Dashboard scrutiny. We monitor the performance and quality of our commissioned services and have oversight of decreased trends in line with failing practice. We will work with providers through monthly quality and performance committees to monitor challenge and improve practice.
- Formal contract management boards take place with providers to monitor, manage and challenge quality. This takes the format of informal to formal challenge and assures us that quality failings are identified and improvement occurs.
- Higher level quality scrutiny occurs with partner organisations such as NHS England and our regulators i.e. CQC and Monitor. We work in partnership with these organisations to improve quality where harm has been identified and / or care unsafe. This includes the Quality Surveillance Groups and partnership risk summits.
- Where care has been identified as unsafe and at a degree of escalated threat to patient safety with no actions to resolve we, with NHS England and / or regulators, may have no other option but to suspend the service. Full consideration of resolution will be considered in the first instance.
- Quality Account approval and sign off. Providers are required to produce annual quality accounts which signify the quality of care provided in the latter year and the identified work that will take place in the following. As commissioners for quality it is our duty in accordance with the Health and Social Care Act 2012 to ensure that these are correct and a factual representation. This assures us of the work in place to improve quality.

Equally providers produce cost improvement plans and quality assessments of these plans. We will assess and assure these plans to ensure no detriment to quality occurs.

In summary in order for commissioned services to be considered as providing a high quality service, we will ensure that all five of the NHS Outcome domains are met.

Initiative 3 - Quality Improvement

Quality Improvement is the basis for which we continuously challenge our assumptions on what good care should look like based on patient experience, care free from harm, patient safety and evidenced based research.
Quality Improvement is embedded within our 5 year Strategy and within our Quality Strategy.

Working with providers we will ensure this culture of quality improvement is embedded within everything we do.

We will also use the Clinical Quality and Innovation Scheme (CQUIN) in acute, community, mental health and ambulance trusts to incentivize and improve quality care. Indicators are set at national and local level in three domains - patient safety, patient experience and effectiveness.

**Initiative 4 - Workforce**

Through workforce remodelling, working with the Local Education Training Board, universities and providers we will ensure that we have the right skill mix to deliver our ambitions.

**Mental Health Workforce**

Blackburn with Darwen CCG (Lead Mental Health Commissioner) have worked in partnership with Lancashire Care NHS Foundation Trust to embed consistent and standardised workforce data as part of the quality schedule (under formal contract) to ensure that commissioners are fully informed throughout the Mental Health reconfiguration programme.

It should be noted that the new inpatient site ‘The Harbour’ will set the benchmark for the development of all Mental Health In-patient services across Lancashire Care. Learning from the Harbour model will be used to inform the staffing model across the Lancashire-wide in-patient services and therefore commissioner’s focus will be prioritised here initially and the review of the community workforce model will run parallel to this.

The proposed staffing model has been designed using the following key principles:

- Effective multi-disciplinary teams are the heart of the model
- Clinical Leadership embedded and integral 7 days per week
- Holistic, personalised physical and mental health and wellbeing
- Maximise self-sufficiency of the model and minimise hand offs
- Administration roles to release time for clinical staff to care and lead
- Right bed first time and timely and supportive discharge
- Supportive and sustainable – high staff attendance, effective teamwork and continuity of care

**Community Nursing Teams and Therapies**

Programmes such as the Advanced Training Practice in primary care and the new student nursing programme inclusive of internships in primary care at the University of York have helped pave the way and the CCG will continue to work with provider and CCG members to build a future workforce, fit for purpose in line with our vision for success. As part of our BCF and the modelling of our strategic initiatives we have considered the impact upon our
community nursing services, intermediate care teams and therapists. Early modelling by Capita demonstrated that we would need to grow the primary and community workforce in with an expansion of the community bed base to effect the shift from acute to non-acute delivery of services.

We are working closely with the provider to understand how this additional workforce will be developed taking into account opportunities for service redesign, increased productivity and digital and telehealthcare technologies and opportunities. We are undertaking further analysis of these workforce requirements and these will be finalised by September 2014 and will inform our commissioning intentions for 2015/16.

**Initiative 5 - Safeguarding**

NHS Blackburn with Darwen CCG as well as with all the other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people, and to protect children, young people and adults from abuse or the risk of abuse. The CCG 5 year safeguarding vision is to commission services to promote and protect individual human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe. Also, that they are effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment, and treated with dignity and respect, and enjoy a high quality of life.

The CCG will demonstrate strong leadership, work as a committed partner and invest in effective coordination and robust quality assurance of its safeguarding arrangements and will continue to ensure that the organisations from which it commissions services have effective safeguarding arrangements in place.

NHS Blackburn with Darwen CCG will continue to demonstrate that there are appropriate systems in place for discharging their responsibilities in respect of safeguarding, including:

- Plans to train their staff in recognising and reporting safeguarding issues
- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements
- Appropriate arrangements to co-operate with local authorities in the operation of Local Safeguarding Children’s Boards (LSCB’s), Local Safeguarding Adult Boards (LSAB’s), and health and wellbeing boards
- Ensuring effective arrangements for information sharing
- Securing the expertise of designated doctors and nurses for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood, and having a safeguarding adult’s lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

In addition the CCG will demonstrate that their designated clinical experts are to be embedded in the clinical decision making of the organisation, with the authority to work within the local health economy to influence local thinking and practice. The designated professionals, as clinical experts will continue to be a vital source of advice to the CCGs, NHS England Area Team, local authorities, safeguarding boards and other health professionals.
The CCG have recently commissioned an independent ‘Safeguarding Review’ to review current safeguarding, assurance and capacity arrangements and the outcomes from this review will provide further assurances as well as influencing commissioning arrangements going forward.

**Quality Premium Indicator 2014/15**

NHS England’s “Quality Premium” scheme is designed to reward CCGs for the quality of the services that they commission and, for associated improvements in health outcomes and reducing inequalities. The maximum quality premium payment for the CCG will be calculated as £5 per head of population, which for Blackburn with Darwen is a total available premium of approximately £805,000.

There are five mandatory or ‘national’ measures against which all CCGs will be assessed, and one local measure selected by each CCG, which will count towards the achievement of the Quality Premium payment. The mandatory/national measures are:

- Reducing potential years of life lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15% of quality premium)
- Improving access to psychological therapies (15% of quality premium)
- Reducing avoidable emergency admissions (25% of quality premium)
- Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting the roll out of FFT in 2014/15 and showing improvement in a locally selected measure (15% of quality premium)
- Improving the reporting of medication related safety incidents (15% of quality premium)

The local quality premium measure selected is:

- Estimated diagnosis rate for people with dementia (15% of quality premium)

The quality premium payment will be reduced by 25% (per measure) if any of the following NHS Constitution Rights and Pledges is not met:

- Maximum 18-week waits from referral to treatment
- Maximum 4 hour waits in A&E departments
- Maximum 14-day way from an urgent GP referral for suspected cancer
- Maximum 8-minute responses for Category A red 1 ambulance calls
High Impact Change 9: Quality and Experience

Overall Outcomes:
- Potential years of life lost from causes considered amenable to health care reduced by 3.2% per annum (PYLL)
- Number of people having a positive experience of hospital care increased by reducing the number of poor responses to CQC inpatient services survey
- Response rate and quality of experience increased as reported through Friends and Family Test
- Health related quality of life for people with long term conditions increased up to national average levels by 2018/19
- Number of people having a positive experience of care outside of hospital increased by reducing the number of poor responses across GP practice and out of hours services to 4.7 per 100 patients by 2018/19
- Significant progress made towards eliminating avoidable deaths in our hospitals caused by problems in care
- Access to psychological therapies improved to national target of 15% by Quarter 4 2014/15; of those who complete treatment a minimum of 50% will have moved to recovery
- Nationally defined trajectories for C Difficile Infections 2014/15 met and no patients with MRSA infections reported
Chapter 4

Collaborative Commissioning

Pennine Lancashire Collaborative Commissioning

The Pennine Lancashire Health Economy is a natural footprint covering the boroughs of Blackburn with Darwen, Burnley, Hyndburn, Pendle, the Ribble Valley and Rossendale. For years, strong relationships have been forged across health and social care organisations in the area. We will formalise these arrangements in order to agree a Pennine Lancashire health and care strategy and establish a system design blue print which is resilient, sustainable and will meet the needs of future generations.

The Pennine Lancashire Clinical Transformation Board (PLCTB) has been established for a number of years and has provided high level clinical leadership across the health and social care economy. This is delivered by way of a Compact Agreement which places the patient, the public and quality at the heart of the agenda. Approximately 12 months ago a revised proposal for governance was agreed by the PLCTB which included the development of an Executive Officers Group (EOG) to oversee programme delivery and provide assurance to the PLCTB that the necessary progress was being made. A schematic of the current governance and work streams is attached at Appendix 4.

Capita were commissioned to support the CCGs and ELHT to explore the degree of change required across the Pennine Lancashire Health Economy and assess to what extent current commissioning plans were sufficiently at scale to deliver transformation. A detailed ‘Do Nothing’ scenario to 2018-19 was forecast based on ONS estimated population projections and age/sex case mix analysis to ascertain the potential increase in demand for secondary care services if nothing changed in the system. The estimated impact of CCG commissioning intentions on acute activity, beds and costs were explored through three impact scenarios (low/medium/high) while an attempt was made to quantify the associated shift to non-acute/primary/community services. Although the ‘high impact’ scenario will deliver a significant reduction in emergency admissions (approx. 100 beds) it is clear that a more radical at scale transformation across the local health economy and beyond would be required. To support this aim the CCGs have requested support from the Local Area Team, as part of the Healthier Lancashire Programme, for additional non-recurrent resource to support further modelling work, to develop and agree more innovative models of care deliver and the required system design. This will need to be underpinned by a robust conversation with the public, clinicians and other key stakeholders.

In recognition of the scale of this work programme and the need to drive forward a more radical and resilient health and social care system, a Programme Management Office (PMO) function has recently been approved by the Chief Executives from all organisations. It is intended that an Executive Steering Group will oversee Phase 1 of the work programme. A Design and Delivery Group will also be established and will require dedicated capacity in the form of executive officers, programme management, project support, finance and contracting (see also Chapter 7). Proposals are set out in Appendix 5 and this will have mandated authority form the organisations to take forward the required work plan.
Lancashire Collaborative Commissioning

We will work across the Lancashire footprint with our health and social care partners to deliver high quality care, both in and out of hospital, and work towards achieving a single vision for our health economy. As a CCG in Lancashire, we will collaborate with our partners to improve our resilience, reduce variation, share risk, and ensure equity of access and outcomes for our patients.

By working in partnership across the 8 Lancashire CCGs and their partners to enable the delivery of the Lancashire strategic vision for health and social care the CCG is further enabling the overall key strategic aims.

This is achieved through the delivery of shared programmes of work currently governed through the CCG Network, via recommendations from the Collaborative Arrangements Group (CAG).

Mental Health and Dementia Services (Lead – Blackburn with Darwen CCG)

Blackburn with Darwen, as the lead for the Lancashire Care Foundation Trust mental health contract, is leading a Lancashire-wide programme of reconfiguration and improvement in Mental Health and Dementia Services across the area.

Our vision for Mental Health and Dementia services across the Lancashire health economy is to ensure appropriate access and treatment for people with mental health problems and ensure they have timely and effective help at the right place and right time.

The new service model aims to treat people with mental health problems in specialist community mental health teams and reduce the requirement for mental health inpatient capacity. When hospital services are required, inpatient treatment must be delivered in modern and fit for purpose environments.

We will know if we have achieved our vision for Mental Health in Lancashire if our patients say that they:

- Have confidence in services
- Have the information I need- when I need it
- Have an active social life
- Know when and how to access services
- Not feel lonely, neglected or afraid
- Be cared for in my community where possible
- Keep my independence as long as I can wherever I am
- Be in control of my life
- Have a named worker (person) I can contact and see them regularly if I need to
- Find people helpful
- Have the best quality of life possible

The Lancashire CCGs are undertaking a significant mental health acute reconfiguration; in partnership with Lancashire Care Foundation Trust (LCFT). The new service model aims to
treat people with mental health problems in specialist community mental health teams and reduce the requirement from mental health inpatient capacity. The CCGs are in the third year of a 5 year programme of transition and so far have achieved £9 million of savings of a total £15 million due by 2017. The transformation programme would then undergo a period of evaluation to ensure all outcomes have been met.

The programme began in 2006 with an extensive consultation process on inpatient mental health facilities. This resulted in the 15 existing in-patient units being reduced to 4 more appropriate, modern facilities.

In early 2013 the programme moved on to look at dementia, and conducted another public consultation process focused on moving the majority of dementia care closer to home or in the community. The vision for dementia care across Lancashire is:

- Good quality early diagnosis, intervention and on-going support within dementia friendly communities
- Living well with dementia in care homes and the community and reduce the use of antipsychotic medication
- Improved quality of care in general hospitals
- Improved quality of care in specialist hospitals

Dementia in-patient services will now be consolidated onto one site (The Harbour, Blackpool) which is a brand new in-patient facility, due to open in March 2015.

Although good progress has been made, there are still challenges and the main priorities are:

- Single Point of Access (SPOA) to ensure that access to mental health services is managed through a single point; this is currently not functioning well. Over 50% of admission into the acute mental inpatient services present through Accident and Emergency (A&E) and are unassigned.
- Dementia Specialist Community Services, to review the overall implementation of IST and NHL function in all areas, aligning with integrated neighbourhood team developments and ensuring all gaps are addressed in 2014/15 through specific transition plan.
- Unscheduled Mental Health Care Pathway there is a requirement to redesign a number of current teams to introduce one single pathway to ensure better quality outcomes for patients whilst reducing duplication.
- There is a requirement to review the overall financial envelope of each CCG spend to ensure alignment against the planning and implementing of the transformation of in-patient Mental Health Services and Specialist Community Services as this is integral to the successful operation of the long term delivery of care pathways.

The programme of work receives assurance through a number of forums, for example the Transformation Oversight Group, which has representatives from LCFT, all Lancashire CCGs and Local Authorities that has accountability to monitor the progress against plans.
We also have a commissioning delivery group which has mental health representatives from all CCGs and local authorities to ensure that commissioned activity is planned and implemented on a pan-Lancashire footprint where appropriate.

**NHS 111 and NWAS (Lead Blackpool CCG)**

Work is on-going with the lead commissioner, NHS Blackpool to inform both the local and national model for NHS 111. This will also include the development of the local interface model and the local Directory of Service, to ensure access to the full range of community services. Local clinical triage will be scoped and modelled to enable a Commissioning decision to be made for the future delivery model.

The Paramedic Emergency Service Commissioning Intentions for 2014/15 were produced in collaboration with the 33 CCGs in the North West (NW), by utilising the governance framework agreed within the Memorandum of Understanding between the CCGs and the NW Ambulance Commissioning Team (ACT). Consultation and engagement was carried out with each group within this framework, the starting point being the ‘Clinical Development Group’. Following preparatory work and consultation, a NW workshop was held in December 2013, which was well attended by both commissioners and provider (North West Ambulance Service – NWAS). These outputs were then used to finalise the commissioning intentions document, which was agreed by the Ambulance Strategic Partnership Board (SPB) in January 2014.

The commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee ‘Urgent and Emergency Services’ report (July 2013), and the Keogh ‘Urgent and Emergency Care Review’ (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services. The document describes the incremental changes that will be required over the coming years, in order to allow PES to become “mobile urgent treatment centres” (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital.

The commissioning intentions then informed the 2014/15 contract negotiations. The contractual model for 2014/15 encourages a significant step towards the required strategic change, by incentivising through CQUIN a reduction in conveyance. This will allow NWAS to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Pathfinder, Referral Schemes into Primary Care, and Targeting Frequent Attenders, to name some examples.

A Virtual Task and Finish Group (TFG) has been established, which includes clinical and managerial representatives from each of the five county areas: Cheshire, Mersey, Cumbria, Lancashire, and Greater Manchester. This group will work with the ACT over the weeks ahead, in order to develop some generic narrative for the final version of the CCG Strategic Plans, for submission in June. CCGs will then be able to add further narrative where necessary, to form the appropriate links to their individual, local plans.
Other collaborative programme areas

Child and Adolescent Mental Health Services (CAMHs)

The Lancashire Child and Adolescent Mental Health Service is in the process of restructuring and integrating with Lancashire County Council, to provide a comprehensive and consistent service across the county that meets the nationally set quality standards. This involves a refresh of the strategy, a review of current services leading to new service specifications, models, oversight, monitoring and delivery of 8 work streams.

Our aim with this programme is to increase access and provide 24/7 services, agree an integrated CAMHS/ psychology service, implement and monitor a local and national reporting system and provide developmentally appropriate services for young people over the age of 16.

Learning Disability Services

The Learning Disability programme is our joint response to the Winterbourne Concordat and focuses on 3 main work streams:

- Enhanced Support Services

We are currently undertaking a review of the enhanced support services through current and future state mapping techniques. We will be supporting the establishment of a multi-agency steering group for the project allowing us to develop and implement a new referral process and pathway.

- Self-Assessment Framework

Following the recommendations made by the Winterbourne Report, we have identified the need to redesign our Learning Disability Service to ensure that patient needs are met and improved outcomes are delivered.

- Children/ Special Educational Needs & Disabilities (SEND)

Inequitable service provision across Lancashire has been identified by Ofsted and the CQC which, as a group of CCGs we have committed to address. We are therefore conducting a review of services, which will include the checking of compliance with national standards, and will make recommendations for areas of potential service improvement.

In addition to the review, we will be looking to implement a single service specification for Tier 2 and 3 services and to develop and deliver support for care pathways in and out of services.

Diagnostics/ Pathology

As new tests come in, and with an aging population with multiple conditions, there is a need to rationalise, determine where efficiency and cost savings can be made, and have agreement around use of tests, technology and good practice.
The Diagnostics & Pathology programmes looks to reconfigure pathology services including the laboratory testing element of the cervical cytology screening programme and pathology diagnostic services in the community, by developing a service specification for the pathology services which reflects current best practice.

As part of this programme we will develop standardised activity reporting and payment for Direct Access Pathology Services, benchmark practice utilisation of services and undertake review of service provision in support of wider Lancashire strategy.

The expected outcomes of the programme are:

- Common list of tests across all Lancashire providers with consistency in naming and units of measurement
- Updated specification for DA pathology
- Report on level of variation in use of diagnostic tests across Lancashire
- Agreement with providers on the process to address any variation
- Agreement with providers of Lancashire-wide disease specific testing algorithms

Stroke Review

We are carrying out a current state review of stroke pathways across Lancashire including prevention, primary care, transient ischaemic attack, hyper-acute care, acute care, rehabilitation (inpatient and community), early supported discharge and review life after stroke. We are also reviewing data and understanding the reasons for any identified performance concerns/issues. In line with that we are reviewing the RCP National Clinical Guideline for Stroke and the NICE clinical guideline for stroke and undertake a baseline assessment of current service provision against and agreed ‘best practice’ service model. We will then engage and involve primary care clinical champions to undertake a pilot focusing on AF to include identification, anticoagulation, training and education and make recommendations for further service improvement or transformation opportunities which will ensure equitable access to a seven-day, high quality stroke service for the population of Lancashire.

Stroke/ TIA/ Vascular

This programme has been identified as initially less than 12 months in duration on the basis that it is currently subject to a scoping exercise which will be reported to the CAG in June 2014. It is anticipated that the stroke review will offer a real opportunity to be transformational around 7 day working and potentially drive major reconfiguration.

The implementation of a screening programme is cited as a ‘must do’ in the NHS Operating Framework, focusing attention on the establishment of specialist interventional centres. It is intended to establish specialist vascular interventional centres covering the region, linked by a vascular network. This will in turn, identify pathways and commissioning issues and priorities for individual CCGs.

Our stroke/ TIA review will identify a best practice service model, assess our current service provision against this and recommend further service improvement or transformation opportunities to achieve a high quality stroke service for the population of Lancashire.
Cancer Services

At a Pennine Lancashire level, the Cancer Care Programme is our transformational programme of work for the next 3 years, which aims to improve cancer outcomes for our population. The programme covers the end-to-end cancer pathway from prevention, early diagnosis and awareness, management through to recovery and survivorship, using a prioritisation method to ensure that evidence-based initiatives / services are implemented.

The work aims to achieve:

- A reduction in premature cancer mortality.
- Improved cancer survival, in particular one year survival.
- Reduced cancer inequalities within our population.
- Improve patient experience across the cancer pathway

To deliver our aims, we recognise that there will be a need to develop and improve further all existing elements of the cancer pathway with key stakeholders, including primary care, secondary care, community engagement, social care and the third sector, re-orienting our services towards early diagnosis, awareness, supporting cancer survivors.

The cancer care programme is supported by a number of initiatives including a Primary Care Cancer Local Improvement Scheme (LIS) which has been signed up to by all practices across Blackburn with Darwen and East Lancashire CCGs. The scheme intends to achieve its aims through improved clinical leadership and knowledge and skills in primary care. Improved assessment and management of patients will be achieved through improved primary care responsiveness, referral pathways, diagnostic pathways and integrated cancer treatment. Recovery and survivorship will require moving care out of acute settings and focusing on health and not disease through supported self-management, lifestyle intervention support, physical activity and health checks.

Also supporting the Cancer Care Programme is the Macmillan Pennine Lancashire Cancer Improvement Project (MCIP) which aims to provide a comprehensive service redesign that enhances and coordinates patient pathways and embeds best practice across primary, secondary and social care to deliver better outcomes and experience for people affected by cancer in Pennine Lancashire.
Chapter 5

Specialist Commissioning

The vision for specialist commissioning is to consolidate and develop sustainable services based in fewer centres to create networks of excellence, aligned to research and innovation.

As a CCG, we are working with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider, recognising that there is a need to change the provider landscape in order to deliver services designed around patients and carers, and ensure our specialist centres are used to treat the most sick.

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffs, and the Berwick and Cavendish Reviews. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

Engagement and local knowledge will inform local strategy development ensuring that specialised services will be:

- Commissioned to deliver quality, better outcomes and value;
- Have a qualified workforce to enable better Equity of outcome and access and offer Sustainable quality against standards;
- Value for money;
- Based on integration of care Networks;
- Take account of Interdependencies and care bundling.

This process will impact on local and collaborative pathways and patient flows and has links to the overall Health and Care Strategy for Lancashire as this evolves. The Senate, SCN and AHSNs are expected to be an enhanced part of the system over 2015/2016. The CCG will continue to be a key partner as these structures, plans and processes begin to take shape.

Direct and Co-Commissioning

It is important that this Blackburn with Darwen strategy outlines the plan for the region as well as the CCG. We have therefore taken the time to understand the direct commissioning arrangements for our population and summary of these can be found below.

Public Health

The Area Team understands the health inequalities and inequities across Lancashire and has taken into account the findings from the Marmot Review that stressed the importance of
giving children the best start in life to reduce health inequalities and associated mortality and morbidity and life expectancy.

There is evidence to suggest that preventative health services have lower coverage and uptake amongst the more deprived and vulnerable population groups. The priority for the next 5 years will be to reduce variation, both locally across Lancashire but also between the Lancashire position and the best performing Area Teams in the country.

**Armed Forces & Veteran Health**

NHS England is responsible for the commissioning some health services for those individuals who are under the care of Defence Medical Services (DMS) GPs. This includes serving members of the Armed Forces, their families, veterans and reservists.

It is the objective of NHS England to ensure that the commissioning of services is organised in such a way as to provide the best possible patient outcomes and avoid any geographical or organisational variation that may have existed previously, whilst maintaining essential stakeholder relationships.

The focus over the next 5 years will be to support commissioners and providers of services to:

- Improve patient access
- Encourage transparency and choice
- Ensure patient involvement and participation
- Identify better data to drive improved outcomes and better commissioning
- Deliver higher standards and safer care.

**Health & Justice**

Prison health care across the Northwest has previously been commissioned in different ways and this is reflected in current patterns of provision which can, in some parts of the area appear fragmented. Our vision is to establish an integrated system with a single prime provider responsible for the provision of all health care within prisons and perhaps across clusters.

In addition, there will be opportunities to take advantage of new economies of scale to work with providers and explore potential new models such as, for example, secondary care in-reach, mobile diagnostics or different models of ‘inpatient’ provision.

In the North West we will, “work together with partners to achieve excellence in Health & Justice outcomes for the Northwest”:

- To ensure that specifications for commissioned services are in line with national guidance (e.g. NHS Outcomes Framework, Public Health Outcomes Framework, Securing Excellence)
- Supporting local and strategic partnership arrangements
- Ensure all commissioning is guided by robust health needs
The Healthier Lancashire Programme

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 health and social care together with the third sector and other agencies.

The strategy (‘Healthier Lancashire’) 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

The Healthier Lancashire Strategy is being developed to improve outcomes for the people of Lancashire, and consists of 7 main projects, as outlined below:

- In Hospital Care: this project is a clinically led assessment of opportunities to improve patient outcomes through provider collaboration for the provision of specialist and hard to recruit to services. The three main drivers are improved outcomes, clinical sustainability and financial sustainability.
- Out of Hospital Care: This project seeks to improve outcomes for patients who no longer require an acute hospital bed but who would benefit from further treatment or therapy delivered in a non-acute setting. The project would seek to provide health and social care support which cannot be provided in a person’s own home. It will address the long standing problem of hospitals (physical and mental health) being unable to discharge patients who require further rehabilitation, therapy or intermediate care in a timely fashion due to lack of suitable alternatives.
- Neighbourhood Pilots: All CCGs are developing a neighbourhood and locality approach for multi-disciplinary teams and multi agencies to work within community.
- Listen to Lancashire: this will aim to engage the public around why Lancashire’s health and care delivery needs to be transformed; to support the development of the strategy by engaging with public and stakeholders and to ensure that thoughts, ideas and concerns are part of decision-making and the strategy development process from day 1.
- Digital Health: this is about designing a new digital plan for Lancashire, which will harness digital technology to promote wellness and self-care; improve access and efficiency; offer new ways of accessing and delivering care.
- Facts and figures: this will involve creating a public document which sets out the position for health and social care in Lancashire for the period 2014 – 2020. It will include information on money, workforce, health outcomes, service sustainability and estates, and provide background information.
- Collaborative Leadership: this is about finding a collaborative team approach to address this strategy and work together across organisations streamlining our efforts.
Chapter 6

A Sustainable CCG and Health Economy

In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending and requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21.) This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.

It is anticipated that over the next decade the NHS can expect its budget to remain flat in real terms. Further to this, recent spending settlements for local government have also significantly reduced resources, placing greater demand on social care budgets with the potential consequence of increasing demand on health services and therefore increasing health costs.

In its first year as a CCG all of the financial targets were achieved:

- Operating within its running cost allowance
- Delivering a 1% surplus

The CCG has maintained its underlying surplus. Expenditure during the past year has been £201m of which £118m was on acute hospital contracts. The CCG is responsible for GP prescribing and in 2013/14 spent £26m in this area.

The investment plans of the CCG are aligned to the strategic goals of the organisation. These include investing in services that transfer care from the hospital into the community, avoiding unnecessary hospital admissions, and investing in integrated care that includes 7 day working.

In order to invest in these services the CCG predicts it will need to deliver a Quality, Innovation, Productivity, Prevention (QIPP) target each year in the region of £4m. This will be delivered primarily from secondary care and prescribing. 2013/14 was a successful year in terms of delivery of the CCG’s QIPP agenda. A total of £4.3m was delivered recurrently against a target of £4.0m. The QIPP savings targets for 2014/15 and 2015/16 are again £4.0m and plans are in place to deliver 88% of this through transformational change.

Project leads from senior positions within the CCG have been assigned to each scheme. Performance and delivery of the savings programme is managed through the CCG Operational Group which formally reports to the CCG Executive Team on a monthly basis.

The schemes have been aligned to the “9 High Impact Changes” thereby ensuring that they affect the priority areas identified by the CCG Membership and Governing Body.

Major transformational schemes will concentrate on Primary and Community Care and integrated Health and Social Care, with a view to significant reductions in avoidable admissions and reduced length of stay in secondary care.

Savings targets have been set at £4m for each of the final 3 years of the “5 year Strategic Plan” and Commissioners are working up detailed “Cases for Change” to inform future Commissioning Intentions.
The CCG’s intends to utilise the localities to inform investment decisions in order to commission services to meet the need of the population, and reduce the health inequalities in the borough.

The CCG has significant financial challenges going forward. It is required to maintain an underlying recurrent surplus of at least 2%, which can be spent non-recurrently following approval of the plans by the Lancashire Area Team. It must also deliver a 1% surplus each year.

The summary of the 5 year financial plan to support this strategy is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Programme Costs</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Running Costs</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Total Cost</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Surplus</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
</tbody>
</table>

The increase in resource allocation in 2015/16 is due to both the national uplift and the Better Care Fund allocation being routed through the CCG into the pooled budget arrangements with the Local Authority. The increase in resource in subsequent years is linked to the uplifts notified for planning assumptions. The increased expenditure in the programme costs is as a result of the investments in high impact schemes that are contained within the strategy.

The CCG has followed the Everyone Counts guidance in developing its financial plans. Efficiency savings of 4% per annum across all relevant budgets have been assumed in 2014/15.

This means the financial plans of the CCG include investments such as:

- Over 75’s pathway
- Call to Action/Transformation Funding
- Better Care Fund (BCF)

The CCG has robust reporting structures in place to monitor performance and will take mitigating action when appropriate, in order to live within its means. Such actions would include measures such as delaying or restructuring planned investments.

The table at Appendix 6 shows the schemes and initiatives planned by the CCG to deliver the Commissioning Intentions and QIPP savings for the 5 years of the Strategic Plan. The initiatives have been aligned to the “9 High Impact Changes” identified as priorities for the CCG by the membership and governing body.
2014/15 and 2015/16 are at operational level with the following 3 years at a more summary level whilst detailed robust plans are formulated.

**Risk Management**

The CCG has a number of risk management processes in place to support the successful delivery of its plans. An overarching Governing Body Assurance Framework document linked to the CCG’s Corporate Objectives and the delivery of our plan, has been developed. This provides a comprehensive method of focusing on the principal risks to the achievement of our objectives and also provides evidence for the CCG’s Annual Governance Statement. The framework focuses the Governing Body on the key priorities and actions in place to control the business risks.

Key risks, identified by the Governing Body are mapped to the CCG’s risk assessment scoring matrix; the framework also identifies the assurances that are in place to mitigate the risk, or where there are weaknesses in any control measures, the associated actions to reduce those weaknesses. Each risk has risk owner aligned to it, with responsibility for oversight and management of the associated risk controls and assurances.

Risks will be managed through the CCG Governing Body and its sub-committees which will provide quarterly updates. Operational control will include the creation of a Programme Office to support the delivery of the Better Care Fund. Governance arrangements between the CCG and the Local Authority have been established to provide the Health and Wellbeing Board with assurance on the development of this initiative.

The CCG Governing Body will be updated on the operational risks as well as the strategic risks and these generic risks, such as increased demand for health care will be managed and reported. One of the greatest risks facing the CCG is workforce, and the CCG is working with the Midlands and Lancashire CSU to ensure there is some resilience, recognising there are key posts and responsibilities held by CCG staff.

A strong risk management system will continue to be maintained as demonstrated through the independent risk management audit carried out in January 2014, when the CCG received “significant assurance” on the adequacy and effectiveness of its internal control within the organisation.
Chapter 7

Governance and Delivery – Blackburn with Darwen
Blackburn with Darwen CCG works within a national framework for NHS bodies and is governed through the constitution supporting policies and working within an agreed scheme of delegation (Appendix 7). The HWB oversees the implementation of health and care strategy across the borough and there are a number of key structures that underpin our joint commissioning arrangements these include an Integrated Commissioning Network (ICN), supported by an Integrated Commissioning Executive which makes key decisions and reports progress through Health and Wellbeing Board, Local Authority and CCG Governing Body as required (Appendix 8).

The delivery of the Better Care Fund will be monitored by the Integrated Commissioning Executive and a dedicated PMO has been set up to drive forward this work (Appendix 5) PMO). This PMO will lead on the transformational activity required by the BCF and also drive forward the development of the 4 integrated health and social care localities. Within the CCG the Governing Body holds overall responsibility for the delivery of the strategic plan with oversight of the plan through the Clinical Commissioning Business Group. The CCG’s Operational and Delivery Group provides a programme management approach overseeing the High Impact Changes and associated QIPP schemes within the CCG’s operational plan. Each scheme of work within the CCG’s operational plans has an associated impact measures and named CCG lead will be accountable for progress of the work and delivering the necessary financial and quality impacts.

The programme of work set out in the plan and programme of work will be overseen by the CCG’s Operational and Delivery Group, each scheme of work will follow a formal process including:

- Case for Change
- Business Case development
- Project plan and documentation including a risk register and issues log
- Monthly reporting on progress through the operational and delivery group
- Highlight and exception reporting through the CBG and Governing Body

We have utilised modelling tools to enable systematic modelling of activity and impact and an integrated programme and risk management tools to ensure systematic management and risk reporting.

Governance in Pennine Lancashire
Across the Pennine Lancashire health economy we have recently agreed a governance framework and programme of work which will be overseen by a steering group comprising all of the Pennine Lancashire Chief Executives a schematic of this is attached at Appendix 9 this will also be supported by an integrated PMO function will report progress and risks through the Executive Steering Group and through the Governing Bodies of the constituent organisations which include:

- BwD CCG
- East Lancashire CCG
- East Lancashire Hospitals Trust
Lancashire Care Foundation Trust
BwD Local Authority
Lancashire County Council
East Lancashire Medical Service

This piece of work is central in driving the overall system design and vision across the health economy.

**Lancashire CCG Network**
The Lancashire CCG Network was established by the 8 CCGs in Lancashire to develop arrangements to enable them to work together on matters of mutual benefit. Notwithstanding the benefits of working together each of the 8 CCGs are independent organisations with primary accountability to their (GP Practice) members. The Network was established to collaboratively commission efficient and effective health care across Lancashire for those services that would benefit from commissioning on a larger footprint. The services would be commissioned based on quality, safety and evidence with an initial focus on secondary care provision. The Network also works collaboratively to agree, direct and monitor performance of the effective use of the transformational fund. It also provides a representative role for Lancashire into a number of other key governance groups and boards.

**Lancashire Leadership Forum**
The Lancashire Leadership Forum is supported by a strategic framework which was established to provide a collaborative approach and oversight to system change and transformation of health and social care across Lancashire. The forum presents opportunities for working collaboratively to develop integrated out of hospital community services, preventing avoidable hospital admission and improving prevention and self-care.

**Summary**
The CCG’s plan sets out how we intend to achieve the CCG’s aims and objectives aligned to the 7 NHS outcome ambitions, and the system vision for health and integrated care over the next five years. Our plan centres on improving life expectancy and quality of life as well as the quality of care people receive both in and out of hospital. We will focus on these ambitions and the difference they will make to the health and wellbeing of our population.

We are committed to reducing health inequalities and promoting equality and inclusion within Blackburn with Darwen; we have based our plans and priorities on our population’s health and care needs linked to the Health and Wellbeing Strategy. An assessment of our current provider landscape is underway and we have already agreed to co-locate and integrate all of our primary care services across 4 localities within Blackburn with Darwen to support the delivery of our plans. The CCG intends to commission its transformational programme through a number of high impact changes, linked to delivering high quality and enhanced integrated primary care services at scale, self care and early intervention, reablement and intermediate care, improving hospital discharge and reducing the length of hospital stays, community based ambulatory care services, high quality urgent and scheduled care with quality at the heart of all we do. Our plan also describes how we will work with our partners across Lancashire to deliver high quality mental health and dementia services to ensure parity of esteem, tackling physical and mental health issues with the same energy and priority as we do physical illness.
These are consistent with our aims and objectives and support the delivery of the 7 NHS outcome ambitions, our constitutional standards and our detailed operational plan.

**Conclusion**
This document sets out the CCG’s five year plan which clearly outlines our ambition for the delivery of health services across Blackburn with Darwen and the wider Lancashire Health and Care Economy. We know the challenges locally are significant in terms of health inequalities and the financial challenges faced going forward. We know we cannot achieve our delivery alone, and will work in collaboration with our partner agencies to achieve mobilisation and implementation of the plan.

We have confidence in the achievement our plans and our partners to help us deliver those plans. Over the next two years we have set out in detail how the initiatives linked to the Better Care Fund and our 9 high impact changes will improve health outcomes as set out in the CCG’s vision. This will support the delivery of effective, efficient high quality, safe, integrated care to improved health and wellbeing and reduce health inequalities both within the borough of Blackburn with Darwen, but also across the Pennine and Lancashire Health and Care Economy.
Figure 1 - Blackburn with Darwen population (mid-2012 estimate) compared with England
Figure 2 - Ethnicity in Blackburn with Darwen (2011 Census)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>1,280</td>
</tr>
<tr>
<td>Black</td>
<td>533</td>
</tr>
<tr>
<td>Other Asian</td>
<td>1,856</td>
</tr>
<tr>
<td>Chinese</td>
<td>721</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1,365</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>3,811</td>
</tr>
<tr>
<td>Indian</td>
<td>10,789</td>
</tr>
<tr>
<td>Mixed</td>
<td>1,023</td>
</tr>
<tr>
<td>White</td>
<td>10,009</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>14,788</td>
</tr>
</tbody>
</table>

Source: Table KFJQJB78

Figure 3 - Index of Multiple Deprivation 2010 (national quintiles)

[Map showing deprivation levels in Blackburn with Darwen]
Figure 4 - Male and female life expectancy (Blackburn with Darwen compared with England)

Figure 5 - Male life expectancy by deprivation decile within Blackburn with Darwen, 2010-12

Figure 1 - Economic Activity Rate, Output Areas in Blackburn with Darwen (2011 Census)
Figure 7 – Alcohol related admissions (new “narrow” measure)
### Summary of NHS Outcome Ambitions and High Impact Changes

<table>
<thead>
<tr>
<th>High Impact Change</th>
<th>Initiatives</th>
</tr>
</thead>
</table>
| Delivering high-quality primary care at scale and improving access | 1) Pro-active disease management and Local Improvement Schemes  
2) Improving the quality of urgent care and care of vulnerable people  
3) Redesigning primary care delivery and seven day working  
4) Improving quality and reducing variation in practices |
| Self-care and early intervention | 1) Remodel and grow the Voluntary, Community and Faith Sector  
2) Achieving self-care project  
3) Think Campaign  
4) APT and parity of esteem  
5) Your Support Your Choice  
6) Assistive technology the Safe and Well Programme |
| Enhanced and Integrated Primary Care and Better Care Fund | 1) Integrated Locality Teams  
2) Case Management |
| Access to Re-ablement and Intermediate Care | 1) Intermediate care and re-enablement as first intervention of choice  
2) Sub acute rehabilitation beds |
| Improved Hospital Discharge and Reduced Length of Stay | 1) Creation of single integrated discharge team  
2) Out Patient Parenteral Antimicrobial Therapy (OPAT)  
3) Chronic Obstructive Pulmonary Disease (COPD) and Pulmonary Rehabilitation  
4) Integrated Care for Diabetes  
5) Acute Model for Ambulatory Care |
| Access to High quality Urgent and Emergency Care | 1) GP Acute Visiting Scheme  
2) Primary Care Pathway in Urgent Care  
3) Early Action Police Liaison  
4) Clinical Advice  
5) Stroke Review |
| Scheduled Care | 1) Reduce referrals into secondary care  
2) Review and Redesign Services  
3) Proactive Management of the Scheduled Care System and Models |
| Quality | 1) Quality Governance  
2) Quality Surveillance and Assurance  
3) Quality Improvement  
4) Workforce  
5) Safeguarding |
<table>
<thead>
<tr>
<th>High Impact Change</th>
<th>Initiatives</th>
</tr>
</thead>
</table>
| Delivering high quality primary care at scale and improving access | 1. Pro-active disease management and Local Improvement Schemes  
2. Improving the quality of urgent care and care of vulnerable people  
3. Redesigning primary care delivery and seven day working  
4. Improving quality and reducing variation in practices |
| Self care and early intervention | 1. Promote and grow the Voluntary, Community and Faith Sector  
2. Achieving self care project  
3. Think Campaign  
4. IAPT and parity of esteem  
5. Your Support Your Choice  
6. Assistive technology the Safe and Well Programme |
| Enhanced and Integrated Primary Care and Better Care Fund | 1. Integrated Locality Teams  
2. Case Management |
| Access to Re-ablement and Intermediate Care | 1. Intermediate care and reablement as first intervention of choice  
2. Sub acute rehabilitation beds |
| Improved Hospital Discharge and Reduced Length of Stay | 1. Creation of single integrated discharge team |
| Community based ambulatory care for specific conditions | 1. Outpatient Parenteral Antimicrobial Therapy (OPAT)  
2. Chronic Obstructive Pulmonary Disease (COPD) and Pulmonary Rehabilitation  
3. Integrated Care for Diabetes  
4. Acute Model for Ambulatory Care |
| Access to High Quality Urgent and Emergency Care | 1. GP acute Visiting Scheme  
2. Primary Care Pathway in Urgent Care  
3. Early Action Police Liaison  
4. Clinical Advice  
5. Stroke Review |
| Scheduled Care | 1. Reduce referrals to secondary care  
2. Review and Redesign Services  
3. Proactive Management of the Scheduled Care System and Services |
| Quality & Outcomes | 1. Quality Governance  
2. Quality Surveillance and Assurance  
3. Quality Improvement  
4. Workforce  
5. Safeguarding |
To deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough.

### Outcome Ambitions

- Securing additional years of life for people with treatable mental and physical health conditions
- Improve QoL for people with one or more long term condition including mental health
- Reducing the amount of time spent avoidably in hospital through better and more integrated care
- Increasing the proportion of older people living independently at home following discharge from hospital
- The number of people having a positive experience of care inside and outside of hospital care
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

### High Impact Initiatives

1. **Delivering High Quality primary care at scale and improving access**: developing an integrated health and social care model
2. **Self Care & Early Intervention**: support individuals in their own care (BCF)
3. **Enhanced Integrated Care**: case management & care navigation delivered through enhanced primary care (BCF)
4. **Access to reablement and intermediate care**: re-balance community transitional support services (BCF)
5. **Improved Hospital Discharge and Reduced Length of Stay**: single discharge team and integrated care planning (BCF)
6. **Community based ambulatory care for specific conditions**: a whole system, local approach to community ambulatory care (BCF)
7. **Access to high quality urgent care**: ensure a coordinated response for adults and children who present with an acute or urgent health issue
8. **Scheduled Care**: a whole system approach to building and redesigning services around the changing needs of the patient
9. **Quality**: embedded throughout our plan to achieve continuous improvement in clinical effectiveness, patient experience and patient safety

### Enablers

- **System values and principles**
  - Population of BwD to Live Better & Live Longer
  - Build and maintain successful partnerships
  - Effectively engage patients and the public to take control of their own health
  - Co-commission and deliver continuous improvement in primary care services and tackle inequalities
  - Commission independently or in partnership safe, clinically effective services to provide high quality experience through implementation and delivery of Better Care Fund (BCF)

- **Measured using the following success criteria**:
  - A financially balanced health economy
  - Delivery of the NHS Constitution Measures
  - Delivery of Quality Premium Measures
  - Delivery of 7 National Outcome Measures
  - Improved access to Primary Care (7 day)

- **Overseen through the following governance arrangements**:
  - BwD Health & Wellbeing Board
  - Integrated Joint Commissioning Executive
  - Pennine Lancs Clinical Transformation Board
  - CCG Governing Body
Appendix 5

Integrated Care (BCF) Programme Reporting Structure

BwD Exec Joint Commissioning Group

Integrated Care Programme Assurance
Roger Parr SRO

Programme Management Office
Claire Jackson, Paul Hegarty, Christine Pye

Integrated Locality Team Operational Group
Chair - Penny Morris
SRL- Sally McIvor
Project Manager- Paul Hegarty
Lisa Kiernan CCG
Katherine White LA
LCFT
ELHT
VCF

Intermediate Care and Reablement
Steve Tingle SRL
Alison Shaw CCG
Ken John CCG
Peter Dillon LA

Discharge from hospital
Debbie Nixon SRL
Lisa Kiernan CCG
Katherine White LA
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Scheme</th>
<th>Funded in Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Delivering high quality primary care at scale and improving access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia Us</td>
<td>Recurrent Funding</td>
<td>£37,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Reach memory</td>
<td>Non recurrent Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment Team</td>
<td>Quality and Access</td>
<td>£238,000</td>
<td>£85,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Us</td>
<td>Non recurrent Benefits</td>
<td>£50,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving the quality of urgent care and</td>
<td>Recurrent Benefits</td>
<td>£851,000</td>
<td>£392,000</td>
<td>£220,000</td>
<td>£300,000</td>
<td>£2,181,000</td>
</tr>
<tr>
<td>care of vulnerable people</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redesigning primary care delivery and</td>
<td>Recurrent Funding</td>
<td>£25,000</td>
<td>£845,000</td>
<td>£96,123</td>
<td>£2,104,000</td>
<td>£3,000,000</td>
</tr>
<tr>
<td>providing day working</td>
<td>Non recurrent Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving quality and introducing variation</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in practices</td>
<td>Recurrent Benefits</td>
<td>£900,000</td>
<td>£800,000</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
</tr>
<tr>
<td>Medicines optimisation</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Self-care and early intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remodel and grow the Voluntary, Community and Faith Sector</td>
<td>Recurrent Funding</td>
<td>£80,000</td>
<td>£80,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieving self-care project</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Think Campaign</td>
<td>Recurrent Benefits</td>
<td>£400,000</td>
<td>£1,000,000</td>
<td>£400,000</td>
<td>£400,000</td>
<td>£2,104,000</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (MHT) and Parity of esteem</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You Support Your Doctor</td>
<td>Recurrent Benefits</td>
<td>£262,000</td>
<td>£262,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer Health Literature and Well</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme</td>
<td>Recurrent Benefits</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
</tr>
<tr>
<td>3 Enhanced Integrated Primary Care Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Locality Teams</td>
<td>Recurrent Funding</td>
<td></td>
<td>£859,400</td>
<td>£500,000</td>
<td>£2,104,000</td>
<td>£2,000,000</td>
</tr>
<tr>
<td>Case Management (built around, risk stratification, care coordination and</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>intensive home support)</td>
<td>Recurrent Benefits</td>
<td>£237,000</td>
<td>£353,001</td>
<td>£1,937,000</td>
<td>£3,000,000</td>
<td>£3,000,000</td>
</tr>
<tr>
<td>4 Access to Re-ablement and Intermediate Care (and links to BCF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase use of intermediate care and</td>
<td>Recurrent Benefits</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
<td>£500,000</td>
</tr>
<tr>
<td>Reablement</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of single integrated and co-located discharge team</td>
<td>Recurrent Benefits</td>
<td>£75,800</td>
<td>£75,800</td>
<td>£75,800</td>
<td>£75,800</td>
<td>£75,800</td>
</tr>
<tr>
<td>5 Specific Conditions (and links to BCF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out Patient Parenteral Antimicrobial Therapy (OPAT)</td>
<td>Recurrent Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) and Pulmonary Rehabilitation</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Care for Diabetes</td>
<td>Recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Model for Ambulatory Care</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Access to High Quality Urgent Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Acute Visiting Service</td>
<td>Recurrent Funding</td>
<td>£500,000</td>
<td>£3,678,000</td>
<td>£3,101,200</td>
<td>£895,000</td>
<td>£895,000</td>
</tr>
<tr>
<td>Primary Care Pathways in Urgent Care</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Action Police Liaison</td>
<td>Recurrent Benefits</td>
<td>£45,000</td>
<td>£45,000</td>
<td>£45,000</td>
<td>£45,000</td>
<td>£45,000</td>
</tr>
<tr>
<td>Stroke Review</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing Paediatric Admissions</td>
<td>Recurrent Benefits</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
<td>£70,000</td>
</tr>
<tr>
<td>9 Quality Assurance</td>
<td>Recurrent Funding</td>
<td>£267,000</td>
<td>£267,000</td>
<td>£267,000</td>
<td>£267,000</td>
<td>£267,000</td>
</tr>
<tr>
<td>Quality Governance</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Surveillance and Assurance</td>
<td>Recurrent Benefits</td>
<td>£65,000</td>
<td>£65,000</td>
<td>£65,000</td>
<td>£65,000</td>
<td>£65,000</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>Non recurrent Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td>Recurrent Benefits</td>
<td>£188,000</td>
<td>£188,000</td>
<td>£188,000</td>
<td>£188,000</td>
<td>£188,000</td>
</tr>
</tbody>
</table>
Integrated Commissioning Network

Integrated Commissioning Network - Joint decision making and accountability

Corporate Strategy

Health and wellbeing

Council Executive Board

Executive Joint Commissioning Group (Exec JCG)

CCG Governing Body

Health and Wellbeing Board

Joint Commissioning and Recommendation Group (JCRG)

Integrated Care Board

Management

Lancashire Care Trust, East Lancashire Hospital Trust, CCG LA, VCF

Members

Chris Clayton
Harry Catherall
Joe Slater
Cllr Khan

Officers

Sally McIvor
Debbie Nixon
Dominic Harrison
Claire Jackson

Members

Chris Clayton
Harry Catherall
Joe Slater
Cllr Khan

Officers

Sally McIvor
Debbie Nixon
Dominic Harrison
Dr Muzaffar
Steve Tingle
Claire Jackson

Joint business cases and delivery plans
Pennine Lancashire Local Health Economy Proposed Governance Structure

Appendix 9

Example workstreams and task and finish teams

Executive Steering Group for Pennine Lancashire Strategy
  • Chair:

Redesign & Delivery Team
  • Chair:

TBD  TBD  TBD  TBD  TBD  TBD  TBD
Blackburn with Darwen Clinical Commissioning Group
Draft Expression of Interest
Co-Commissioning Primary Care

Summary
Blackburn with Darwen CCG is submitting this Expression of Interest to co-commission Primary Care with the Area Team.

The CCG wishes to explore with the Area Team, opportunities in relation to delegated commissioning arrangements, whereby the CCG would carry out defined functions on behalf of NHS England and the Area Team hold the CCG to account for how effectively it carries out these functions.

The CCG believes that in undertaking this co-commissioning role it will further develop the positive relationship it has with the Area Team and will allow the CCG to implement its plans to develop Primary Care at a much faster pace. The CCG has an inclusive member driven primary care strategy (see appendix 1), that forms part of its 5 year strategic plan and sets out a clear direction with intended benefits for the local population and health and social care economy.

This expression of interest sets out which responsibilities are in scope, describes a phased approach to receiving these responsibilities and proposes how the CCG will deliver them in conjunction with key partners including Lancashire Area Team.

1.0 Introduction
Following Simon Stevens announcement on the 1 May 2014, the Commissioning Development Directorate of NHS England wrote to CCG Clinical Leads and Chief Executive Officers inviting CCGs to submit expressions of interest in developing new arrangements for co-commissioning of primary care services by 20 June 2014.
Blackburn with Darwen CCG is submitting this expression of interest to co-commission primary care (General Practice) with NHS England Lancashire Area Team. It is recognised that concerns regarding available capacity and resource still need to be addressed, however, the CCG is confident that in taking this approach, it will build upon the solid relationship it has with the area team and enable the development of primary care at scale and pace to provide improved quality of services for the population and greatly assist in transforming the local health economy – thereby enabling it to be sustainable in the future.

Blackburn with Darwen CCG believes that a collaborative approach to the commissioning of General Practice services with a stronger focus on local clinical leadership and ownership will allow more optimal decision making about the balance of investment across primary, community and hospital services. Co-commissioning of Primary, Community and Social care will support co-ordinated care by enabling commissioners, providers and patients to work together to agree what integrated out of hospital care looks like; develop and negotiate new ways of contracting locally that encourage a shared responsibility for holistic care; deliver patient/population based outcomes and support delivery of the large scale transformation change required.

2.0 Background
The current Registered Patient Population list size is 169,318 and general medical services are currently being provided through 28 General Practices operating in differing sizes from single handed to larger multi GP practices situated throughout the Borough. General practices provide the full range of contractual requirements along with enhanced services and local improvement schemes.

Blackburn with Darwen has now adopted a 4 locality approach to:
1. Provide a defined area for services to be delivered for the local people which is based on practice list population along with facilitating integrated working relationships.
2. Enable practices to work closer together to inform commissioning and service redesign
3. Enable development of new Primary Care provider organisation/s
2.1 CCG Vision

The vision for Blackburn with Darwen CCG is to secure better outcomes for patients as defined by the 5 domains of the NHS Outcomes Framework and uphold the pledges in the NHS Constitution. The CCG aim is: “to deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough”.

Across Pennine Lancashire (BwD and East Lancashire) we will work in an integrated system with our health and social care partners to deliver high quality care, both in and out of hospital, and work towards achieving a single vision for our health economy. As a CCG in Lancashire, we will collaborate with our partners to improve our resilience, reduce variation, share risk, and ensure equity of access and outcomes for our patients.

2.2 CCG and the Local Authority

The CCG is coterminous with the Local Authority and we have a strong track record of integration in BwD. We manage a number of jointly funded commissioning posts with our Local Authority, and these support our key priorities including the commissioning of services for the frail elderly, for people with a learning disability or mental health problems and for children with complex needs. A Joint Commissioning Executive oversees this work programme and acts as a senior sponsor to the emerging Better Care Fund developments.

The Parity of Esteem agenda is reflected in all of our joint plans and in the innovative approaches that we have taken to improving the range of health and wellbeing services in the Borough. Our Health and Wellbeing Board and the Health and Wellbeing Strategy are important vehicles for driving the required change and transformation.

2.3 Demographics

Residents of Blackburn with Darwen have relatively high rates of morbidity and poor life expectancy for men and women when compared nationally. The current life expectancy for both men and women in Blackburn with Darwen in 2012 is at national...
average levels for 2002. The ambition is set out within the Blackburn with Darwen Health and Wellbeing Strategy: “Year on year, to increase the life expectancy of Blackburn with Darwen citizens, and to reduce differences in life expectancy between Blackburn with Darwen and the national average”.

The local population is expected to increase by 2035, with the proportion of people aged 65+ increasing from 13% to 17%, and the number of very elderly residents (85+) almost doubling.

The young population are also expected to increase over the next 10 years. The Borough’s population is diverse, with the proportion of non-white residents, predominately from Indian and Pakistani backgrounds, amongst the highest in the region.

The Borough experiences high levels of material deprivation, being the 17th most deprived borough based on the 2010 Index of Multiple Deprivation, with eight small neighbourhoods amongst the most deprived 1% nationally. Some of our most deprived neighbourhoods appear to be becoming relatively more deprived through comparison between the 2007 and 2010 Indices of Multiple Deprivation.

As a consequence of local demographics, there is a larger than average proportion of people with multiple conditions, (by age 70, 50% of the population have two or more co-morbidities) and the population experience some of the highest rates of unplanned admissions to hospital in the country.

- There are 62,000 people in Blackburn with Darwen with at least one diagnosed Long Term Condition (LTC)
- Half the adult population has a LTC - 35% of the population as a whole
- The number of people with LTC will increase rapidly over the next 10-20 years
- The 35% of the population with LTC account for 70% of health care expenditure, about £200 million in Blackburn with Darwen
- These 62,000 people are offered annual reviews in primary care each year and account for half of all consultations in GP practice – nearly half a million consultations per year - and account for 70% of all days spent in hospital.
• Attendances and admissions for Ambulatory Care Sensitive Conditions are higher than the national average.

3.0 Scope of Co – Commissioning
Blackburn with Darwen CCGs’ intention is to take on delegated commissioning arrangements whereby the CCG will carry out defined functions on behalf of NHS England and that the area team will hold the CCG to account for how effectively the CCG carries out those functions.

3.1 In Scope (CCG responsibility)
• Working with patients and the public and Health and Wellbeing Boards to assess needs and decide strategic priorities.
• Designing and negotiating local population based quality primary care services/contracts that go beyond the core GP contract.
• Re defining Enhanced Services and Local Improvement Schemes
• Primary Care Development
• PMS Quality Premium
• Locally Commissioned Primary and Community Services
• Primary eye care services as part of the CCG’s strategy in managing long term conditions
• Out of Hospital Care (Continuity of Care)
• Quality and Outcomes Framework (QOF)
• 24/7 Urgent Primary Care (GP) Services including possible development of walk in type services and OOH.
• Discretionary payments for premises improvements (Estates management)
• Effectively managing financial resources (Devolved Primary Care Budget responsibility)

3.2 Out of Scope (Area Team responsibility in collaboration with the CCG)
• GMS/PMS/APMS Contract Management e.g. Management of mergers, Practice closures, branch closures, dissolutions, changes to named performers/providers, contract variations.
• Monitoring Contractual Performance against Core Primary Care Contracts
• Application of Contractual Sanctions against core Primary Care Contracts
• Management of Performer Lists
• Revalidation
• GP Appraisals

4.0 Governance Arrangements
The CCG acknowledges concerns related to the potential conflict of interest in GPs as both providers and commissioners of local health and care, their statutory duty to manage conflict of interest and to have regard to the statutory guidance on managing conflicts of interest and will continue to meet these duties and follow guidance in relation to primary care commissioning functions carried out on behalf of NHS England. The CCG has already built in a mechanism to manage business through the Governing Body’s via its terms of reference where GPs have a material conflict of interest. The CCG has implemented a conflicts of interest policy which the Governing Body and its staff abide by and active steps are taken in the CCG’s committees and sub-committees to record and act on conflicts of interest accordingly.

The CCG will work with the area team to best use available resources from both organisations to efficiently deliver co-commissioning. The CCG will nominate a lead commissioner who will work closely with a named link person with the Area Team. It is envisaged that most decisions will be made jointly in a commissioning decision group, which will also include partners from Public Health, and will ensure that all aspects of Primary Care system management are transparent. For example, if key decisions require to be made in commissioning services (e.g. DVT pathway) from General Practice, the Area Team representatives will be present, along with non-clinical CCG officers and public health, to ensure compliance with governance arrangements, thus mitigating any conflicts of interest.

The CCG will establish a programme management approach to the commissioning of out of hospital care, including delegated primary care functions, and will take advantage of synergies with existing CCG projects in order to enable functions to be discharged within existing CCG running costs as far as possible.
The CCG will work with the Area Team to agree a joint robust assurance process that will achieve high quality transparent process standards within strong governance arrangements.

5.0 Monitoring and Evaluation
The CCG will monitor and evaluate on the basis of evidence that demonstrates that patients can:
- Get the care they need, closer to home
- Have access to high quality Primary Care both in and out of hours (24/7)
- Receive early diagnosis and systematic care planning
- Get high quality and consistent care, thus eliminating variation
- Receive care in modern fit for purpose, accessible premises

Metrics will be jointly developed which will enable both organisations to measure the success of co-commissioning initiatives.

In addition, evidence of achievement of set contractual outcomes will be built into a programme approach to delivery of agreed co-commissioning plans.

6.0 Timescales
The CCG wants to progress on a two phase approach:

1st Phase 2014/15
- Working with patients and the public and Health and Well Being Boards to assess needs and decide strategic priorities
- Review Enhanced Services and Local Improvement Schemes
- Primary Care Development. Including Provider Development
- Out of Hospital Care (Continuity of Care)
- 24/7 Urgent Primary Care (GP) Services including possible development of walk in type services and OOH.

2nd Phase 2015/16
- Effectively manage financial resources (Devolved Primary Care Budget responsibility)
- Designing and negotiating local population based quality primary care services/contracts that go beyond the core GP contract,
- PMS Quality Premium
- Re defining Enhanced Services and Local Improvement Schemes
- Quality and Outcomes Framework (QOF)
- Primary eye care services as part of the CCG’s strategy in managing long term conditions
- Discretionary payments for premises improvements (Estates management)

7.0 Expected Benefits of Co-commissioning for Blackburn with Darwen CCG

7.1 Primary Care Vision
Blackburn with Darwen CCG’s vision for Primary Care is for it to function within an integrated health and social care model, having close interface and operating systems between all providers in the community, including all independent contractor groups and the voluntary sector (wider primary care) to provide high quality and seamless service for the population.

The CCG has already embarked on ambitious approaches to systematically improve services for its population. These strategic approaches embrace the integration of community services including social care, which has patients at the centre and which is led by General Practice. This forms the basis of the Better Care Fund (BCF) in the development and deployment of integrated care for the adult population, in particular for the older person along with people who have long term conditions.

This vision is set out in the CCG Primary Care strategy (appendix 1) which has been developed in conjunction with all member practices. This strategy describes the CCGs approach to transforming primary care (General Practice), to enable the foundations and future structures of General Practice to be sustainable and operate at scale to achieve the expectations made of it.

In developing Primary Care/General Practice, it is expected that Primary Care will exhibit core attributes of being **Comprehensive, Person-centred, Population oriented, Coordinated, Accessible, Safe and High Quality.** These attributes will then help the CCG’s ambition to improving access and tackling inequalities in life expectancy.
7.2 CCG 5 year plan

The following components of the 5 year plan will be accelerated through co-commissioning of primary care to realise expected benefits:

7.2.1 Pro-active disease management and Local Improvement Schemes (High Quality Scheduled care)

The CCG is utilising both enhanced services and local improvement schemes (LIS) to further support delivery through general practice and wider primary care. This aims to improve patient experience, encourage care out of hospital and ensure the necessary quality and planned efficiencies across the whole scheduled care system. Schemes and services will be further reviewed to either extend and ‘stretch’ existing services or redesign these services over time into a new outcome based contractual system. This aspiration will be enabled through co-commissioning and we would wish to work further with Area Team to develop the Prime Provider Model in particular.

7.2.2 Improving the quality of urgent care and vulnerable people

The CCG has embarked on an ambitious approach to systematically improve and integrate services for the adult population to avoid unnecessary hospitalisation. Whilst the BCF is central to this, the CCG intends to roll out an agreed plan which is consistent with the accountable GP proposals for patients aged 75 and over, and the Direct Enhanced Service which is aimed at avoiding unplanned admissions. Proposals include a single point of access linked to the GP out of hours service and 111 using a directory of services and intensive support for patients registered within nursing homes including the potential use of telemedicine. This development programme will commence in the autumn of 2014.

7.2.3 Redesigning Primary Care Delivery

The CCG is working closely with member practices to further develop the four localities (Blackburn North, East and West and Darwen). The localities are being developed with the intention of working with practices on a larger scale to maximise economic and quality benefits for patients rather than on an individual and isolated practice basis. This will enable them to operate with integral sub-specialisation, through an extended primary care team, providing increased care in the community.
This is in addition to developing the localities to enable frontline clinicians to be able to design and commission services closer to the local population.

### 7.2.3.1 Primary Care development

We have set out a programme for change through developing the provider (General Practice). This programme initiates a framework for transforming General Practice and ‘wider local Primary Care’ at scale to develop the overall strategic vision and implementation along with credible timescales. The CCG will help and support the facilitation of ‘new GP Champions/ leaders’ and create time for the design and implementation of new models and organisational operating forms through grouping arrangements (federations). These would operate within the 4 geographical localities in Blackburn with Darwen with the ambition to offer a wider range of services for patients with improved quality. This will provide a sustainable model of primary care which delivers consistent high quality outcomes for patients and works in a resilient and flexible way both in and out of hours on a seven day basis. The intention would be to review all enhanced services, local improvement schemes and associated funding to consolidate to a larger funding pool to further commission outcome based services through co-commissioning arrangements.

Underpinning the remodelling the CCG will facilitate conversations in engaging and involving the public in these strategic changes to deliver the aspirations of the local population and be actively involved in evaluation of the services. Blackburn with Darwen CCG has a well-established and successful Patient Participation Group (PPG) network centred on our member practices, in the four localities and we have significant plans to develop this through our Patients in Participation initiative. This will offer a range of opportunities for patients, carers and the public to give views on what is best in local health services and what might need improvement. The scheme has been designed with GP surgery patient participation groups at its core and will also offer listening events across the area where local people will be invited to share their experiences of health services and there will be opportunities to contribute via the website and social media. There will also be specific engagement activity with hard to reach groups, including the travelling
community, BME communities and those with physical or mental health conditions.

7.2.3.2 Workforce development
The CCG will support General Practice to take forward the concept of Multi-disciplinary General Practice through workforce review, skill development, and mix and develop new roles for professionals to create sustainability of the workforce and Primary Care as a whole. This could entail increasing Advanced Nurse Practitioners (ANPs) developing Practice Nurses (PNs) and Health Care Assistants (HCAs). This will allow GP’s to become Expert Generalists being able to focus on more complex work. The CCG will also further develop GPwSI’s to not only establish improved services in the community i.e. diabetes service but also as a way of attracting GP’s into the area who wish to extend their skill portfolio to improve the sustainability of primary care within the district.

7.2.3.3 Formation of Clinical Leadership Group
A new Clinical leadership group has been formed (within a supportive mentorship system) to drive forward plans for developing General Practice as a provider. The group will design the function and form of potential provider models by December 2014 through intensive engagement with general practice. This will be a Blackburn with Darwen approach with recognition of potential future synergies with East Lancashire. Co Commissioning with the Area Team has the potential to accelerate this development post December 2014.

7.3 Estates & Infrastructure
Recognising that major service change and delivery will require appropriate high quality estate and supportive infrastructure including Information Technology and data sharing, the CCG will review current arrangements with local partners and NHS Property services to inform the future estate landscape.

The review process and estate development will naturally be driven by the service delivery model, the expectation being through a hub and spoke model within each of the 4 localities. Initially the review will consider all community estate assets including
all Primary Care Centres and surgeries and is already associated, through the Better Care Fund, to the Community Asset review being undertaken by Blackburn with Darwen Borough Council. The review will focus on current provision across all organisations and to identify the future requirements in determining the required space and location in particular with the widening accessible primary care along with the appropriate shift in services from the hospital site. This review approach will facilitate linkage of estate strategies across partner organisations to ensure that investment and disinvestment in the estate is tied to future service delivery between partner agencies.

7.4 Improving quality and reducing variation in practices
Blackburn with Darwen CCG recognises that strong and effective primary care is essential to improving the health and health outcomes of the local population and as a result identified the development of primary medical care as a key enabler for transformational change across the health care system not only within the Primary Care Strategy but also within the 5 year (2014/19) Strategic Plan.

The key priority for Developing Primary Medical Care in Blackburn with Darwen is the continuous improvement in quality in primary care with a view to reducing unwarranted variation and the first year of implementation has focused on building strong foundations by supporting collaboration, continuous professional development and shared learning in order to build capacity and capability for the future.

The CCG has invested in a primary care quality function within its core management running costs. This has focused on supporting the practices in key quality improvement areas as identified within the primary care development dashboard, the integrated needs assessment and the implementation of a bespoke quality LIS.

Our commitment to improving primary care is reflected through this intention to co-commission primary care (General Practice) with the NHS England area team. This arrangement will be the key catalyst to make substantial change in primary care by commissioning services that will have major impacts in increasing access and the quality of service provided. This will enable us, together with local general practitioners, to redesign primary care and a clear and strong relationship with the
area team will help influence service development and delivery through the other contractor groups (dentistry, pharmacy, optometry) working together to widen primary care provision for our patients.

7.5 Same day/Urgent access
The CCGs’ vision for urgent care is to ensure a co-ordinated response for adults and children who present with an acute and urgent health issue with a view to reducing reliance on Accident and Emergency and improving the outcomes and experience of patients.

Blackburn with Darwen CCG together with East Lancashire CCG are developing an integrated approach to urgent and emergency care. A key priority is to improve the experience of patients requiring same day, urgent access to primary care services by ensuring equitable access to quality urgent care outside of a hospital setting for conditions that don’t require hospital urgent care or A&E. Currently CCGs are responsible for commissioning out of hours primary care, community services, mental health and secondary care while NHSE commissions in hours and extended primary care. Co-commissioning would enable the Blackburn with Darwen and East Lancashire CCGs to explore with all providers (Including GP Practices) and patients what a more cohesive out of hospital urgent care system would look like ensuring a shared vision and development of local patient focused outcomes based contracts that would support the delivery of integrated out of hospital care urgent care system.

7.6 Mental Health
The CCG is working with fellow commissioners (BwD is the lead commissioner for Mental Health across Lancashire) and providers across Lancashire to ensure appropriate access and treatment for people with mental health problems, ensuring timely and effective help at the right place and right time with a new services model which aims to treat people with mental health problems in specialist community mental health teams and reduce the requirement for in patient capacity. The co-commissioning of primary care would enable the Pennine Lancashire CCGs to work with all relevant providers including neighbourhood and GP practice teams to develop a more integrated IAPT service ensuring a shared vision and exploration of
opportunities related to developing local service specifications for the appropriate management of patients with mental health problems out of hospital.

Co-commissioning will give the CCG the opportunity to commission primary and community care to deliver against the stretching improvement targets in relation to IAPT and dementia diagnosis required to improve early diagnosis and interventions for people with dementia and mental health conditions.

8.0 Key Relationships

8.1 Relationship with the Area Team

Blackburn with Darwen and the Lancashire Area Team enjoy a good relationship in terms of working on local initiatives for example improving quality in General Practice (practice visits) and exploring federation models.

The CCG sees this relationship as invaluable going forward with regards to common principles, approach and clear and efficient communication systems. This positive approach will be a clear requirement with regards to the CCG and the Area Team having robust governance arrangements.

Co-Commissioning with the Area Team will enable the CCG to work much closer with colleagues in the commissioning of other primary care services:

- through the Local Professional Networks (Pharmacy, Optometry and Dentistry) to help frame joint agreed plans to enable a wider Primary Care approach to commissioning and provision of services for all sections of the population of Blackburn with Darwen.
- through close relationship with the head of public health at the Area Team
- Transparent governance in commissioning primary care services and contract management.
- Ensuring consistent, high quality across all primary care contractor groups

8.2 Relationship with Public Health

There would be significant opportunities for the Director of Public Health and team (Local Authority) to work much more closely with the CCG in the co-commissioning
of GP services in being a member of the Co-Commissioning Committee which would also include:

- Greater integration of wellbeing, health and care services; of universal, prevention services with targeted, early intervention and more specialist treatment services. We have already integrated the Council wellbeing services commissioned by the CCG and Public Health, to provide a single point of access for GP referral.
- Helping to raise standards of quality in general practice services; we are already working together closely on integrating community infection prevention and control arrangements across the Borough
- Increasing involvement of the wider community in the development of GP services in order to improve the quality of primary care for more disadvantaged areas and groups; we are already working together on CCG – Council locality arrangements to involve elected member representatives with GP leaders, taking an asset-based approach to finding locality solutions

9.0 Engaging Member Practices and Stakeholders

The CCG has a robust engagement plan for 2014/15 which includes practice newsletters, Clinical Chief Officer and Chair 1-1 practice visits along with the quarterly clinical senate meeting.

The CCG has engaged with members regarding its co-commissioning intentions through the four locality groups at meetings, seeking input to the expression of interest. It has also been discussed at the executive team and commissioning business group. The CCG recognises that to take this expression of interest forward, further discussions will be required through the governing body regarding the breadth of responsibility and accountability of this initiative.

The CCG has also engaged with Key Partners as below:
Blackburn with Darwen Borough Council
Public Health
East Lancashire Hospital trust
Lancashire Care Foundation Trust
Council of Voluntary Services
Calderstones NHS Trust  
Council Leader and Chair of Health and Well Being Board  
Healthwatch  
Patient Voices Group  
Family Health and Wellbeing Board Consortium  
BwD Healthy Living  
Older Persons Forum  
Age UK  
Mr Jake Berry, MP Rossendale and Darwen  
Mr Jack Straw, MP Blackburn  
Chief Officer – Project BME Lancashire  
Head of Twin Valley Homes.

CCG partnership working with stakeholders and local authority is well documented and was recognised in the positive outcome of quarter 4 CCG assurance process and the 360° survey.

As part of the developing CCG integrated model of primary care, community services and adult social care based on 4 localities, Practice Patient forums are being developed as one potential model for patient engagement going forward.

10.0 Conclusion

To conclude Blackburn with Darwen CCG views this Expression of Interest as an important milestone in developing services across the local health economy as the CCG recognises that to make sustainable positive impacts in how care is delivered, Primary Care (General Practice) is the catalyst for change. Being able to develop, re-focus and co-commission primary care is the essential lever for this.
Blackburn with Darwen CCG  
Primary Care (General Practice)  
Strategy  
February 2014

Introduction
Blackburn with Darwen Clinical Commissioning Group (CCG) is committed to improving the health and quality of care for the local population and patients as explicitly stated in its mission statement:-

'To aim to deliver efficient and effective high quality integrated health and social care, in order to improve the health and wellbeing of the population of Blackburn with Darwen and raise life expectancy in the Borough to the national average in the next 10 years'.

To achieve this aim it is imperative that Primary Care (General Practice) as the foundation of care needs to fundamentally change from its current model of fragmented services to an integrated high quality services model having collective responsibility for the health of the population with General Practice being the lynchpin of that responsibility and coordinated activity. These changes to be innovative and sustainable need to be General Practice provider driven and clinically led.

Primary Care is commonly described as community based health services that are usually the first and often the only point of contact that patients make with the health service. It covers formal professional services provided by General Practitioners (GPs), Community and Practice Nurses, Community Therapists (such as Physiotherapists and Occupational Therapists), Community Pharmacists, Optometrists, Dentists and Midwives. Care is also provided in a primary care community setting informally by family, carers and paid unqualified domiciliary staff.

This document in the main concentrates on General Practice as it is part of the wider local Integrated Community Care Vision. Also the 2012 NHS reforms place GPs at
the centre of clinical commissioning, which in turn has increased demands on GP time and especially practice partners. Practices also are reporting that the pace and intensity of workload has increased whilst investment has declined in real terms.

In Blackburn with Darwen, the current business model for many practices is based around relatively small organisations, working independently. The greatest potential for Primary Care could be reached by General Practice working together collectively. The shift of care to out-of-hospital settings is a significant opportunity for general practice, unfortunately the ability to maximise these changes is compromised by a fragmented and variable GP provider landscape.

Complementary with General Practice strategic development, Community and Social Care services will be delivered by integrated teams of professionals whose incentives and purpose will be aligned to prevent illness, promote healthy living, diagnose illness early, refer or treat, and educate the public in self-care and early recognition of illness.

This integration has now commenced and is in the process of being enlarged. The multi-disciplinary/ multi-professional (Integrated Teams) will be coterminous with the localities, and does support the agreed locality arrangements. National work has recently commenced in regards to community pharmacy (Improving Health and Patient Care through Community Pharmacy - A Call to Action) this will be informed further for inclusion in this strategy development process through Local Professional Networks.

**Service Vision.**

Blackburn with Darwen CCGs’ vision for Primary Care is to function in an integrated health and social care model having close interface and operating systems between all providers in the community including all independent contractor groups and the voluntary sector to provide high quality and seamless service for the population. Delivery of these services will be as close to home as possible through a modern fit for purpose hub and spoke estates solution, including appropriate community bed provision. Primary Care will be accessible on a 24/7 basis through core, extended and out of hours utilising the best in digital communication to improve access and
flow for patients and will provide community based services that are currently delivered in a hospital setting. (ref BwD CCG Care Strategy 2012)

**Why Change?**

Primary Care and in particular General Practice is accepted as the foundation of NHS provision providing people with first point of access, advice, diagnosis and treatment together with on-going support.

General Practice not only nationally but locally is under pressure from an increasing range of supply, demand and other health service factors as identified by NHS England Call to Action, these being:-

- An ageing population, growing co-morbidities and increasing patient expectations, resulting in large increase in consultations, especially for older patients along with the number of people with multiple long term conditions set to increase.
- Increasing pressure on NHS financial resources, which will intensify further from 2015/16
- Growing dissatisfaction with access to services. Most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services.
- Persistent inequalities in access & quality of primary care,
- Increasing workforce pressures, including recruitment and retention problems.

Along with these factors General Practice is being asked at the same time to do more to relieve pressure in urgent /emergency care, out of hours care, supporting integrated care, playing a central role in commissioning and look to providing 7 day care.

These pressures in tandem with relatively flat investment, revalidation and workforce issues potentially render the model in its current form unsustainable.

In understanding the current pressures and aspirations both from the Government and the Public to improve Primary Care, it would be necessary through good planning to introduce innovative solutions and actions to improve access through a
variety of means. These could include extending hours, using digital technology, and by local agreements in which patients could access other sites / practices for consultation visits, or referral into locally developed services, this in tandem with improving quality and its consistency including shifting care out of a hospital setting. Given the current and future directions and pressures, Primary Care (General Practice) locally is now at a staging post in which it can be proactive, taking ownership and control in determining its future with drawing in facilitation and support not only from the CCG through the quality Local Improvement Scheme (LIS) and investment through Everyone Counts planning guidance but also from NHS England – (Improving General Practice – A Call to Action)

In developing Primary Care / General Practice in achieving the demands being made it is expected that Primary Care would respond and exhibit the below core attributes:-

**Comprehensive**
The organisation is accountable for meeting the majority of patients’ physical and mental health care needs, including in relation to wellness, prevention, and acute and long-term conditions care. Where the right skills or services are not available within the primary care organisation, staff play a central role in coordinating virtual care teams involving professionals from other community services and specialists in secondary care, and signposting people to relevant local welfare and other social support services.

**Person-centred**
This is relationship-based, premised on trust, and concerned about the whole person. Patients and their carers’ are recognised as core participants in decision making about care and treatment. When registered with a primary care organisation, a patient benefits from continuity of care with a professional, when that is important to the patient and beneficial for their treatment. Person centred care takes seriously the ways in which broader life experiences (such as wealth, housing and family circumstances) carry consequences for an individual’s health and care.

**Population oriented**
The organisation is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include all individuals registered with the organisation; all those who are resident in a specific geographic area; and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless).

**Coordinated**
Care is coordinated across all elements of health care system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams.

**Accessible**
Patients experience appropriate waiting times for initial consultation and advice, diagnosis and care; they have 24/7 access to medical and nursing advice and Care, and organisations are responsive to patient preferences around access.

**Safe and high quality**
Care is evidence-based wherever possible and clinical decisions are informed by peer support and review. Clinical data are shared within the organisation to inform quality assurance and improvement. The organisation is financially sustainable, such that safety and quality standards will not be compromised by resource pressures.

*Adapted from the Patient Centered Medical Home model, as described by the US AHRQ (AHRQ, 2013) cited in Securing the Future of General Practice (Kings Fund & Nuffield Trust 2013)*

In recognition of the above GP’s and practices will need to take ownership of this major change along with considering financial viability and being able to achieve excellent outcomes on the aspirations made of them to set the future ‘GP practice’ on a firm and sustainable base.

Blackburn with Darwen CCG has committed to delivering services through the 4 locality model with the intention of working with practices on a larger scale to
maximise economic and quality benefits for patients rather than on an individual and isolated basis.

The challenge to Primary Care and General Practice providers in particular is their response to delivering this strategic vision of the future of Primary Care.

General Practice will need to consider alternative organisational operating forms, and develop a provider response model which could possibly be through grouping arrangements operating which may include Super- partnerships, federations / Networks, Community Health Organisations or similar within the 4 localities with the ambition to add improved and a wider range of services for patients.

The localities will be expected operate with integral sub-specialisation, through an extended primary care team providing increased care in the community. General Practice will need to support the concept of Multi- disciplinary General Practice through skill development, mix and develop new roles for professionals to create sustainability of the workforce and Primary Care as a whole. This could entail increasing Advanced Nurse Practitioners (ANPs) developing Practice Nurses (PN’s) and Health Care Assistants (HCA’s) allowing GP’s to become Expert Generalists being able to focus on more complex work. This would then enable the shift in care from the hospital through re-commissioned transformed services that would ensure quality improvement and reduced variation in care delivery.

What would success and patient benefits look like:-

- Appropriate shift of care and resources from secondary to primary care and delivery of the 'Care Closer to Home' agenda.
- Provision of high quality acute Primary Care both in and out of hours (24/7)
- Improved productivity
- Collective responsibility for the population health across a network of practices, providing - earlier diagnosis and systematic care planning and reducing health inequalities.
- Reduced Emergency Department and Urgent Care Centre attendances and reduced hospital admissions and readmissions utilising the potential development of locality care access centres (HUB)
- Extended Primary Care provision, this would include closer collaboration or potential business partnering arrangements with Pharmacy, Dental, Optometry, Community services, Mental Health, and 3rd sector.
- Improved quality – eliminated variation through standardisation and consistency of evidence based care.
- Improved staff recruitment, retention, education and skill development (career pathway opportunities).
- Improved patient access and flow.

**How will this be achieved?**

This strategic direction paper sets out a programme for change through **Developing the Provider** (General Practice) This programme initiates a framework for conversations to be had within General Practice and ‘wider local Primary Care’ to develop the overall strategic vision and implementation along with credible timescales. The CCG will help and support the facilitation of ‘new GP Champions / leaders and creating time for the design and implementation of new models. It will also enable the discussions and collaboration across all contractor groups to support organisational change and remodelling of provider organisations recognising that this will be **Provider Driven and Clinically led and independent from the commissioner role.**

The CCG will embed these changes through **Co Commissioning Primary Care** (General Practice) with the Area Team and Public Health Colleagues. Underpinning the remodelling the CCG will facilitate conversations in engaging and involving the public in these strategic changes to deliver the aspirations of the local population and be actively involved in evaluation of the services. The CCG will work closely with NHS England and gain support with other organisations e.g. NHS IQ, academia, the deaneries and a range of leadership development organisations such as the Leadership Forum (General Practice Work stream)
Estate and Infrastructure
Recognising that major service change and delivery will require appropriate high quality estate and supportive infrastructure including Information Technology and data sharing, the CCG will review current arrangements with local partners and NHS Property services to inform the future estate landscape.

The review process and any estate development will naturally be driven by the service delivery model, the expectation being through a hub and spoke model within each of the 4 localities. Initially the review will consider all community estate assets including all Primary Care Centres and surgeries and would be associated to the Community Asset review being undertaken by Blackburn with Darwen Borough Council. The review will focus on current provision across all organisations and to identify the future requirements in determining the required space and location. This approach will facilitate linkage of estate strategies across partner organisations to ensure that investment and disinvestment in the estate is tied to future service delivery. This approach also allows identification of opportunities for future sharing of property along with potential of estate rationalisation, and achieving the potential of freeing up resources for reinvestment.

Conclusion
There is an opportunity now for General Practice in Blackburn with Darwen to redefine primary and community care delivery for the benefit of patients and the local population. The approach taken within in this paper is to support Provider Development and ownership, enabling clinical provider led innovation through being proactive, setting the future of General Practice and Primary Care on a firm and sustainable footing to deliver excellent high quality service to the local population.