



*Fylde and Wyre
Clinical Commissioning Group*

2030 VISION FOR HEALTH AND CARE IN FYLDE AND WYRE



A healthier future for our communities

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Throughout this document you will see a number of words in **bold**. Explanations of these words can be found on page 34.



We are facing some significant challenges in the years ahead: an ageing population, increasing numbers of people with complex long-term health conditions, rising expectations and increasing costs.

Our aim is to positively embrace these challenges to ensure people living in Fylde and Wyre have the very best health and health services possible. We welcome with excitement, and a deep sense of responsibility, the opportunity to work together to ensure the best quality care is available to all.

With this in mind, over the last few months we have worked with partner organisations, patients and the public, to develop a vision for the future. Our vision is outlined in this document.

We want to take a long-term view of local health services to reflect the significant changes required to tackle some of the challenges that we face. In addition, we want our plans to align with those of our partner organisations, including both Fylde and Wyre borough councils who also have long-term strategies. To ensure we are able to work effectively together, this document therefore looks to the year 2030, and seeks to describe the health service we would like to see in the future. We recognise that 2030 is 16 years away, and that our environment will undoubtedly change. However, our vision will guide us to where we need to be, and will inform our planning over the coming years.

I would like to thank all of those who have contributed. Your views have positively shaped this vision. It was most reassuring that the vast majority of the people we spoke to were in agreement about what our health services should look like in the future.

As you have told us – let's not continue to do what we have always done. Let's be visionary and work together to make sure local people have the best possible health and health services for the years to come. Let's get fit and well for the future together.

A handwritten signature in black ink, appearing to read 'T. Naughton'.

Dr Tony Naughton

Clinical Chief Officer

NHS Fylde and Wyre Clinical Commissioning Group

This document sets out a high-level long-term vision for local health services. It describes many of the challenges we face, how we aim to tackle these with our partners, and outlines our aspirations for local health services in 2030.

This vision will inform the development of more detailed five-year operational plans, and will continue to be the focus of our strategic planning in years to come.

People are living longer, and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. For example, patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.

Our aim is to create a health service that supports people to be as fit and well as possible. We also want to make sure that when people are unwell, they can get high quality treatment or advice as close to their home as possible. To do this within the resources available, we believe we need more and better community-based services. This includes using new technology to improve access to services and make it easier to remain at home for longer. People should only need to visit a hospital for specialised treatment – which will free up our hospitals to concentrate on services that only they can provide.

This document has been co-written by a number of local doctors, with support from **public health** colleagues and **commissioning** specialists. It is, of course, underpinned by **public health** and **commissioning** data, as well as best practice from across the world. We have also considered a wide range of policy and guidance, including *Everyone Counts*¹ (NHS England's five-year planning guide), the health service strategies being developed across Lancashire, and the plans of our local authority partners.

To develop our vision, we talked to a wide range of partners, patients, the public and their representatives through a series of focus groups, surveys and other mechanisms such as our regular drop-in listening sessions

held at libraries and health centres. In total, we spoke to nearly 3,000 people – some about our vision in depth, and some about the issues they are currently facing. As part of this we commissioned independent researchers Ipsos MORI to carry out a representative telephone poll of just over 1,000 people. This covered a variety of topics, many of which are outlined in this document.

We would like to take the opportunity to thank everyone who has contributed. Your experiences and opinions are so valuable, and we are extremely grateful for your feedback. You can see how your views have made a difference in the 'You said, we did' section in appendix 1. This feedback will also be used to develop the detail of how we will make our vision a reality, initially over the next five years. When completed, this five-year operational plan will be available on our website.

We cannot do this alone, and if we are to have any chance of success many of the challenges we face will require us to work together with other organisations, as well as patients and the public. Robust partnerships will be key, and will include local authorities, NHS bodies, other commissioners, the voluntary, community and faith sectors, non-NHS providers, educational and workforce planning bodies, and, most importantly, the public, patients and their carers. These partnerships will have to be reciprocal. While we will continue to involve partners in developing and implementing our plans, we too will need to influence our partners' plans to ensure a shared agenda. Part of this work will be implemented through the Lancashire **Health and Wellbeing Board** by agreeing how to best spend the **Better Care Fund**, the shared health and social care budget which aims to improve services for the most vulnerable.



Our aim is to create a health service that supports people to be as fit and well as possible.

¹Everyone Counts: Planning for Patients 2014/15 to 2018/19: NHS England (December 2013)

WHO WE ARE

NHS Fylde and Wyre **Clinical Commissioning Group (CCG)** is the organisation responsible for planning and buying health services in the area to meet patients' needs. This is known as '**commissioning**'.

Led by family doctors (GPs), the CCG currently serves a population of 151,436 people across approximately 320 sq km of coast and countryside. The majority live in the urban towns of Fleetwood, Kirkham, Lytham St Annes, Poulton-le-Fylde and Thornton, but a significant proportion live in rural villages. The CCG receives a set amount of money from the government – around £200million in 2014/15 – and is committed to spending this wisely for the benefit of local people.

The CCG's main area of responsibility is to commission hospital and community health services for local people. Another body, **NHS England**, commissions **primary care, specialised services** and health services for the Armed Forces. Public Health England and Lancashire County Council commission **public health** and **health improvement services**. We work in partnership with these other commissioners to ensure health services are joined up.

OUR STRATEGIC OBJECTIVES:

- Commission high quality, safe and cost effective services that reduce health inequalities and improve access to healthcare.
- Effectively involve patients and the public in decision making.
- Develop excellent partnerships that lead to improved health **outcomes**.
- Make the best use of resources.
- Develop and maintain an effective organisation.

OUR GUIDING PRINCIPLES

Our vision for the future is based on six guiding principles, which inform everything we do:

Everyone counts:

We use our resources to benefit the whole community, making sure people are not excluded. We recognise how we all have a part to play in making ourselves and our communities healthier.

Improving lives:

We are committed to improving people's experiences of the NHS and improving their health and wellbeing. We will work with all our partners to deliver the best **outcomes** for our residents. We will be honest about our point of view and what we can and cannot do.

Working together for patients:

We put patients first in everything we do. By reaching out to staff, patients, carers, families, communities and professionals outside the NHS, we put the needs of our patients and communities before organisational boundaries.

Commitment to quality of care:

We repay the trust that is placed in us by insisting on quality and striving to get the basics right every time – safety, **safeguarding** the most vulnerable, confidentiality, professional and managerial integrity, accountability, dependable services and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Respect and dignity:

We value all people as individuals, respect their aspirations and commitment in life, and seek to understand their priorities, needs, abilities and limits. We expect healthy challenge from our Governing Body members and practices as we take up the challenge of providing high quality healthcare services within available resources.

Value for money:

Every act of **commissioning** commits public money. We aim to ensure every one of these decisions is value for money.

OUR MISSION

We will commission appropriate high quality care delivered in a timely and effective way in the right place and time for the benefit of all our patients.



All NHS organisations are facing some very significant challenges. These include more people living longer with complex health conditions, rising expectations and increasing costs.

This is set against a backdrop of **flat funding**, which will result in a national funding gap of £30billion by 2021 if health services continue to be delivered in the way they are now. The NHS needs to change to meet these demands.

In this section we outline in more detail some of the challenges we need to take into account in order to improve service quality and health **outcomes** for local people in the future.

POPULATION CHALLENGES

The population in Fylde and Wyre has a growing number of older people. There are already 10% more adults aged over 45 and 8% more adults aged over 65 than the national average. By 2022 we expect to see the numbers of people aged over 70 increase by nearly one-third (28%), and by 2030 – the date by which we aim to deliver this vision – the number of people aged over 85 will have doubled. While it is obviously good news that people are living on average six years longer than they were 20 years ago, this increases the pressure on services because as people become older they are more likely to develop multiple long-term conditions such as diabetes, heart disease, breathing difficulties and dementia.

Within Fylde and Wyre there are also big differences in the health of people who live just a few miles apart. These are known as 'health inequalities'. In the most deprived parts of Fylde and Wyre men die, on average, 10 years younger than those in more affluent areas. For women the difference is six years. This is clearly unacceptable, and we must all work together to address it. While these differences can be caused by many things such as living conditions, diet, levels of smoking and drinking, better healthcare can have a significant impact too.

HEALTH CHALLENGES

A higher percentage of people in Fylde and Wyre are affected by a long-term health problem than the national average. These include diseases of the heart and blood vessels, diabetes, kidney disease and stroke. The number of people with dementia is also higher than the national average. Our ageing population means that these numbers are bound to increase. We need to work together to prevent ill health and support people with long-term conditions to live healthier lives for longer.

The current major causes of deaths in the area are:

- cancer – 28.1%
- diseases that affect the heart and blood vessels – 27.8%
- diseases that affect the airways – 13.9%
- diseases that affect the digestive system – 4.7%

In addition to this, we have some other problems that we need to tackle. More pregnant women smoke than the national average and we have low rates of breastfeeding. In addition, there has been an increase in alcohol-related harm in recent years both nationally and in some areas locally. It is estimated that the numbers of people who drink at high levels will continue to increase above the national average.

A photograph of two elderly women with short, curly white hair, smiling warmly. They are wearing white tops. The woman in the foreground is laughing heartily, while the woman behind her is also smiling broadly. The background is a plain, light-colored wall.

Did you know?

Around 90% of care is carried out in community-based settings, such as your local clinic or family doctor's surgery. But we spend more than half of the local healthcare budget (54%) on hospital treatment.

FINANCIAL CHALLENGES

The costs of healthcare are increasing while the NHS funding we receive is not. To bridge the gap, the NHS in England needs to make efficiency savings of £30 billion by 2021. This equates to just over £6.2 million for Fylde and Wyre CCG.

We currently receive around £200 million a year from the government to pay for local health services. That's about £1,300 for every resident. To put this into perspective, a heart bypass operation costs about £8,100, a hip replacement £7,700, and a cataract operation £1,500.

Currently around 70% of the NHS budget is spent supporting and treating the 30% of people who have more than one long-term condition. If we carry on delivering services in the same way this will become unsustainable as the population ages and the numbers of people with complex medical problems rise.

Locally, we spend more than the national average on treatments for **musculoskeletal** problems, heart and breathing diseases, and cancer and mental health, yet our patients report worse **outcomes**. This clearly needs addressing.

ADDRESSING THESE CHALLENGES

Within Fylde and Wyre, different geographical communities face different health challenges. We need to ensure that the most appropriate services and support are available to meet the needs of different populations.

Doing nothing is simply not an option; we cannot meet these future challenges without change. We will only succeed if we work in partnership with others. Where we directly commission services, influencing change is more straightforward; where we don't we will need to work with our partner commissioners to make sure our plans align.

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

We know from talking to you that there are a number of things that are really important to you.

- You want high quality, safe services.
- These services should be more personalised and, where possible, based in your community.
- You want your health service to help keep you and your family well, and make it as easy as possible for you to make healthy choices.
- When you are unwell, you want to get the best treatment or advice as quickly as possible.
- You want to be treated with dignity and respect.
- Where services are run by different organisations, you want your treatment to be coordinated.
- You want better information so you can make informed choices about your health and healthcare.

We have listened to you and taken all of this on board. We will make sure that what's important to you is at the heart of everything we do. The table in appendix 1 has a brief summary of what you have told us, and how it has influenced the vision outlined in this document.





Taking on board your feedback, we believe the following is crucial if we are to address the challenges we face:

- Supporting you to keep well both mentally and physically to prevent ill health in the first place
- More support to help you manage your condition at home to keep as fit and well as possible
- Better information to support you to make informed choices about your health and healthcare
- More coordinated and integrated health and social care planned around your needs
- Access to many services seven days a week
- More community and home-based care
- Care in hospitals for **specialist services** only
- Better use of technology to improve access to services and improve productivity

We believe that we will only meet the health challenges facing us if you are empowered to make informed decisions about your health and healthcare, and are enabled to participate in shaping the development of health and care services. We know this is important to you too.

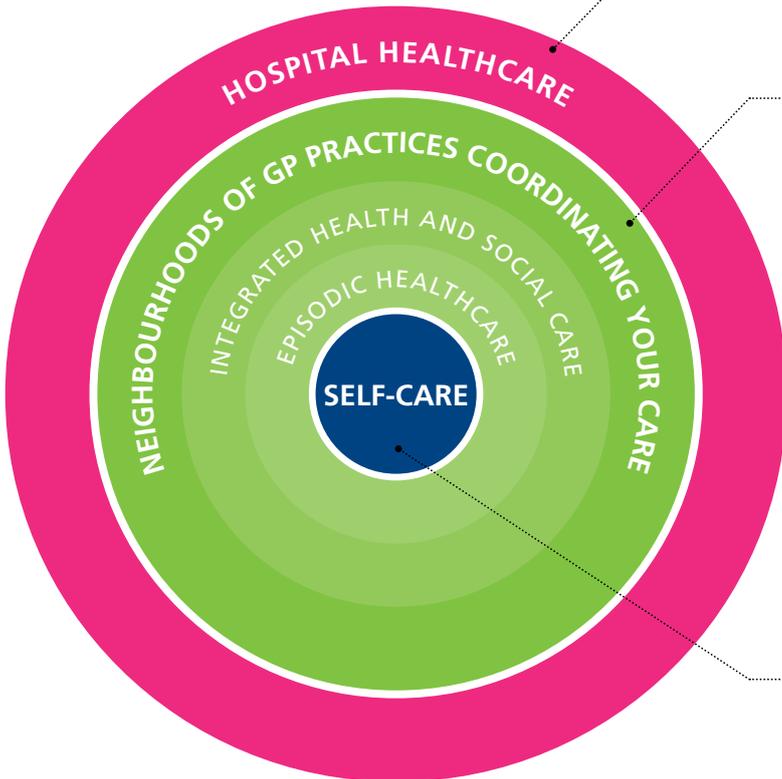
For this to happen, the CCG will need to work with its partners as well as the public, patients and their carers to ensure people have the knowledge, skills and confidence to be able to take ownership of their own health and wellbeing. It will also require the relevant organisations to work together to provide joined-up support and care tailored to the needs of individuals and their communities.

Your GP practice will be at the heart of making these changes happen. As well as coordinating your individual care, practices will work with patients and other partners to decide how to best tailor services to meet the needs of local people.

We are now talking to practice staff to agree how groups of practices will come together in geographical **neighbourhoods** to coordinate services, and what support they will need to do this. This will involve practices coordinating doctors, nursing teams, pharmacy, social care, the voluntary sector and other professionals so they deliver a joined-up service in different **community settings**, including people's homes. It will also involve practices working in partnership to determine what services are needed to meet the needs of their population. This new way of working has been strongly supported by people living in Fylde and Wyre.

We cannot do this alone. We must strengthen how we work with partner organisations such as local authorities, other commissioners, the voluntary sector and advocacy groups in order to make our vision a reality. We also recognise the enormous contribution of carers, who we consider to be key partners.

The diagram illustrates how health services will be delivered in the future.



HOSPITAL CARE

- Care in hospitals when you need specialist care that can't be provided in a community setting or at home. For example, immediately after a heart attack or a stroke.

NEIGHBOURHOODS OF GP PRACTICES COORDINATING YOUR CARE

Integrated health and social care

- When you have a more complex and ongoing condition(s). For example, after a stroke when a person needs both medical and social care (e.g. their blood pressure needs managing as well as needing help with eating and bathing).
- Will include support from a variety of agencies such as pharmacy, the local authority and voluntary sector.

Episodic healthcare

- When you occasionally need care for minor health issues. For example, when earache in children fails to get better in three days.

SELF-CARE

- Support to help you manage your condition at home and keep fit and well. For example, people with a long-term chest condition having antibiotics at home.
- Self-care includes support from a variety of agencies such as pharmacy, the local authority and voluntary sector.

We sought the views of people across Fylde and Wyre

83%

support GP practices working together to address the challenges faced by the NHS

85%

agree that GP practices should have more responsibility for coordinating their care

74%

agree that GP practices should make sure services meet the needs of their particular population

88%

would like more advice and support to manage their health condition at home

As described, our vision is for a health service which supports people to be as fit and well as possible, and provides high quality, responsive services when they are needed.

In partnership with local people we have developed a series of public pledges against which the delivery of our plans can be measured. In future you will be able to see how we are doing against these by visiting our website. We will also update you on progress in future annual reports.

By 2030, you will consistently:

- 1 Have clear information relevant to your health and wellbeing which is easy to understand
- 2 Have the opportunity to live a healthier lifestyle and be supported to keep well both mentally and physically
- 3 Be more involved in decisions about health services and your healthcare
- 4 Receive safe, high quality healthcare
- 5 Have services which are easy to access, timely and appropriate for your needs
- 6 Have services tailored to the needs of your **neighbourhood**
- 7 Receive care in a **community setting** or at home, where appropriate
- 8 Be supported by organisations that work together to provide the care and support services you need
- 9 Be supported using the most appropriate technology and equipment as it becomes available
- 10 Receive value for money from your local health service

By analysing the health needs of our population within the context of the challenges we face, we have prioritised eight specific areas to focus on.

When we tested these with the public there were seven, but people consistently felt that learning disabilities should have a greater focus. We agree, and so have added this as an eighth service area. Almost without exception people also told us that preventing ill health should be a priority for us too – this is why it forms a key theme across all service areas.

Our eight priority service areas are:

CANCER

CHILDREN AND MATERNITY

END OF LIFE

LEARNING DISABILITIES

LONG-TERM CONDITIONS

MENTAL HEALTH AND DEMENTIA

PLANNED CARE

URGENT CARE

This section will look at each of these areas in turn, describing some of the current challenges and our vision for the future.

CANCER

WHAT IT IS

Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.

WHAT HAPPENS NOW

- Cancer causes 28% of deaths in Fylde and Wyre. This increases to 40% for people aged over 75.
- Of all of the Lancashire CCG areas, Fylde and Wyre has the highest rate of cancer (2.8%) and the second highest rate in England (the England average is 1.93%).
- The survival rate for cancer in Fylde and Wyre is slightly better than the Lancashire average.
- Residents in the most deprived areas are almost 50% more likely to die when they have cancer than those in more affluent areas.
- The three most common cancers for men within Fylde and Wyre are prostate, lung and bowel. Between 2005 and 2009 the number of men diagnosed was: prostate – 750; lung – 451; bowel – 434.
- The three most common cancers for women within Fylde and Wyre are breast, lung and bowel. Between 2005 and 2009 the number of women diagnosed was: breast – 945; lung – 374; bowel – 361.

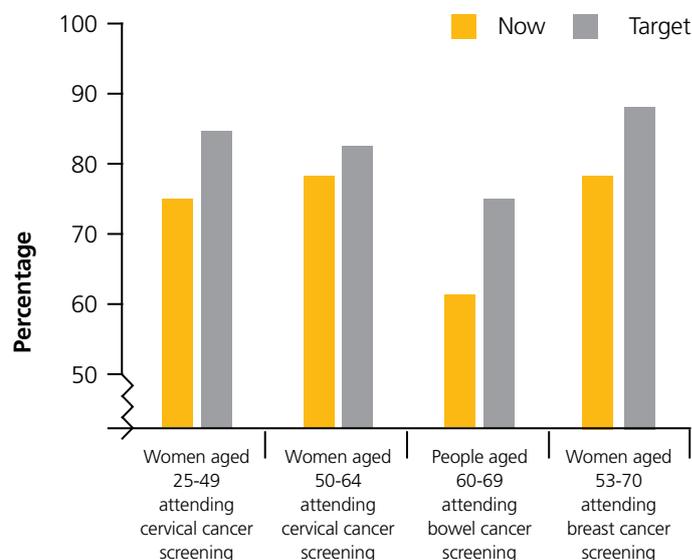
OUR VISION FOR CANCER

Ensuring patients receive a faster diagnosis and better treatment.

WHAT WE'LL BE DOING BY 2030

- Fewer people will develop cancer due to better awareness of keeping well and the active promotion of healthy choices, with more people taking responsibility for their own health and wellbeing. This will be supported by teaching cancer prevention in schools.
- There will be a reduction in the number of cancer-related premature deaths of people aged under 75 due to early diagnosis and treatment.
- Waiting times for referrals for suspected cancers will be reduced from the current two weeks to a maximum of one week.

- People will be more aware of cancer symptoms and will be diagnosed earlier, and so the numbers diagnosed through emergency health services (e.g. after going to **A&E**) will reduce from 25% now to 15%.
- Patients will be given a choice of alternative therapies as part of their treatment (including those to improve mental health and wellbeing, such as yoga).
- Survivorship through motivational training will become part of a patient's treatment, e.g. regular physical activity has a key role in cancer survival and reducing the risk of cancer returning.
- Patients will be given a choice of support at the end of their treatment, including peer support.
- Technology will be used to better inform and support patients and their families and carers.
- Patients will be able to choose to have their treatment in a community-based setting where appropriate, and will only need to go to hospital for more specialist treatment.
- **Primary care** staff will have a better understanding of cancer **referral pathways** through improved education.
- Collaborative working with agencies outside of health such as football clubs and the Fire Service will raise awareness of cancer, encourage screening and signpost patients to appropriate services.
- We will have equalled the cancer five-year survival rates achieved by the best European countries.
- More people will attend screening for different cancers than do now.



WHAT THE CHANGES MEAN FOR...

PATIENTS

- More aware of prevention and early symptoms, fewer people will develop cancer and those who do will present earlier and have a much better **outcome**.
- More informed to make decisions about their lifestyle, care and treatment options.
- Included in the **multidisciplinary** discussions about their treatment and care.
- Greater choice about where to access care.
- More informed and supported to manage their condition and symptoms at home, including access to their **treatment plan** and summary of their treatment via online access.
- Actively supported to stay healthy and take part in individualised exercise programmes.
- Able to play a pivotal role in the development of services.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to available support, including health and care services.
- Will actively encourage people to attend screening.
- Joined-up services will support earlier diagnosis.
- Use of advocacy and support groups to support patients.

SERVICES

- Majority of diagnostics available in **community settings**.
- Hospitals and GPs working more closely in joint decision making with the patient regarding their care.

“It is essential that healthcare professionals and the public work together to reduce the disastrous impact that cancer has on society. This includes social awareness and responsibility as well as clinicians working hard to detect this disease at a much earlier stage.”

Dr Adam Janjua,

GP and the CCG’s clinical lead for cancer

CASE EXAMPLE

NOW

- Catherine, 53, is referred by her GP to hospital with a breast lump.
 - She is seen within two weeks and is diagnosed with breast cancer.
 - Catherine has her treatment, including chemotherapy, within her local hospital, but is referred to a different hospital for her radiotherapy.
 - Catherine’s treatment ends and she is left feeling like she is “falling off the edge of a cliff” – after months of multiple agencies being involved in her care she is now left with routine appointments and feels very isolated.
-

BY 2030

- Catherine, who has a breast lump, has an appointment with her GP.
- Her GP discusses the choices available to her and they jointly agree that she should be referred to the local breast service.
- Catherine is seen within one week of referral. She attends a multidisciplinary appointment and is told about her diagnosis.
- She works with the multidisciplinary team to develop her treatment and care plan, and has a named contact for the management of her care.
- She attends all her treatment locally and at the end of this has a motivational interview to decide whether she wants to participate in an exercise programme or receive peer support.
- Catherine has had access to her treatment plan at all times.

CHILDREN AND MATERNITY

WHAT IT IS

Children's services:

All areas of child health, from birth to age 19.

Maternity services:

Care for pregnant women, from conception to between 10 days and six weeks after birth.

WHAT HAPPENS NOW

- 4,200 children are living in **poverty** in Fylde and Wyre. This impacts on health through poor diet and living conditions.
- One in five expectant mothers smokes during pregnancy.
- Two in five mothers from affluent areas are still breastfeeding their babies at eight weeks. The figure for mothers in deprived areas is one in five.
- Many children are accessing the children's assessment unit at Blackpool Teaching Hospital for conditions that could be managed in other ways.
- Many children and young people feel that services are not young people-friendly or approachable.
- There are approximately 650 children between the ages of seven and 15 years who have a moderate, profound or severe learning disability or an autistic spectrum disorder.

OUR VISION FOR CHILDREN AND MATERNITY

To ensure high quality, accessible, user-friendly services are available for children, young people and pregnant women. To support children, young people and pregnant women to be aware of their own health and wellbeing and to be engaged in maintaining good health.

WHAT WE'LL BE DOING BY 2030

- Expectant mothers will have more choice about where and how they use maternity services.
- Health promotion services, such as support to stop smoking, will be tailored to individual needs.
- A breastfeeding-friendly community will exist where women are encouraged and supported to breastfeed, and where most mothers are still breastfeeding at eight weeks, giving their babies the best start in life.
- Health and care services for children and young people will be coordinated, and will support their health and social care needs. Services, including sexual health services, alcohol and drug advice and support, will be delivered in child and young person-friendly ways.
- Children and young people will be supported to keep fit and well, both mentally and physically.
- Technology, such as internet-based education and support programmes, will be an integral part of children and young people's services.
- There will be a seamless transition between children's and adult support.
- Children and young people with long-term conditions or **palliative** care needs will have access to a **personal health budget** to allow them to tailor services to their needs, based on their **care plan**.

WHAT THE CHANGES MEAN FOR...

PATIENTS

- Children and young people will be more aware of their own health and emotional wellbeing and how to maintain it.
- Better coordinated, community-based services, with technology used to ensure wider access.
- Information and services will be delivered in ways that children and young people feel are accessible.
- Expectant mums will be supported to make choices about where and how they have their care needs met.

PARTNERS

- The promotion and support of good health and emotional wellbeing will be everybody's business.
- Will signpost to support available, including health and wellbeing services.
- All organisations will have a responsibility to contribute to the health and wellbeing of children and young people.
- More services will be jointly commissioned to ensure joined-up care.
- Agencies will work together to deliver comprehensive, young people-friendly information and support services such as sexual health, drug and alcohol support services.
- Existing schemes and activities for young people will promote health messages.

SERVICES

- Services will be responsive to and driven by the needs of children and young people.
- More creative use will be made of technology and innovation to provide support and information.
- There will be more focus on supporting young people to maintain their own health and emotional wellbeing through proactive education and peer support.
- Services will be provided in a young people-friendly **community setting** wherever possible.
- Specialist services will be centralised in order to deliver the highest quality of care.

CASE EXAMPLE CHILDREN'S SERVICES

NOW

- Philip, 14, has diabetes. He is just starting to take responsibility for managing his own condition but he has some worries and questions.
- Philip doesn't want to talk to his GP as he's worried his parents might find out.
- Philip feels uneasy about talking to his consultant as he views the consultant as being too old to understand.
- Philip can talk to the diabetes nurse but she can be very busy and he doesn't want to waste her time.

BY 2030

- The diabetes team at the hospital has introduced Philip to a peer support group where he can talk to other young people about having diabetes and about life in general.
- Philip can contact the diabetes team via various technologies such as text, email and web chat and get the support he needs when he needs it.

"Giving a child a good start in life is the best present we can give. We want our children to have the best possible chance of fulfilling their potential."

Dr Vellore Chandrasekar,
GP and the CCG's lead for children's and maternity services

END OF LIFE

WHAT IT IS

The care for people approaching the end of life when they are likely to die within the next 12 months.

WHAT HAPPENS NOW

- The CCG has a **commissioning** responsibility to ensure end of life services for adults aged 18 years and above.
- Home is often the preferred place of care and death for the majority of people and most do not change this preference. However, a substantial minority do not make home their first choice or change their minds.
- Older people are more likely to die in hospital, except in very old age.
- Nearly four out of five people are admitted to hospital once in their last year of life.
- People from the most deprived areas are more likely to die in hospital than those from more affluent areas. Around nine in 10 of those who die in hospital do so following an emergency admission.
- Of those patients with a **care plan**, 10% die in hospital compared to the 26% who die in hospital who do not have a **care plan**.
- There is limited access to out of hours end of life care in Fylde and Wyre.
- 98% of those registered on an **Electronic Palliative Care Coordination System** in England who say they would prefer to die in a care home achieve their preferred place of death. Only 1% of people registered say they would prefer to die in hospital.
- Across England a 10% reduction in the number of hospital admissions ending in death could potentially result in a saving of £52million.

OUR VISION FOR END OF LIFE

To ensure that high quality services are available in hospitals, care homes and community settings for all patients and carers, regardless of diagnosis, that offer dignity, choice and support in the last year of life.

WHAT WE'LL BE DOING BY 2030

- There will be 24/7 care provision for end of life care.
- Health, social care and other agencies, including hospices and the voluntary sector, will work collaboratively to increase the support available for patients, their family and carers in the community.
- Advance planning will identify those who are approaching the end of life to ensure their wishes are fulfilled.
- Patients, their families and carers will have an informed choice discussion regarding their preferred place of care and death.
- All clinicians will be trained to have end of life and **advance care plan** conversations with patients and their families.
- An individual's plan will be sensitive to personal, cultural and spiritual beliefs, and preferences will be shared between health professionals.
- Children with **palliative** care needs will have access to a **personal health budget** to allow them to tailor services to their needs, based on their **advance care plan**.
- There will be improved training for NHS staff and staff employed by care providers, particularly with regard to communicating with patients and their carers.
- Improved access to information and technologies to support patients and their carers.
- People will be offered a discussion about their end of life wishes, and this will include practical aspects such as funeral arrangements and finances.
- The needs of carers will be appropriately assessed, with support offered pre- and post-bereavement from a choice of bereavement agencies.
- Providers of care will be coordinated to ensure a joined-up service and consistent standards.
- The experiences of patients and their families will shape and inform service developments for end of life.
- Patients' care will be delivered within their home or a **community setting** where appropriate.

WHAT THE CHANGES MEAN FOR...

PATIENTS

- More likely to have their wishes fulfilled.
- Will have a named person to provide support and coordinate their care.
- Supported earlier and for longer.
- More care and support in **community settings**.
- Better support for families and carers.
- Improved access to information and technologies.
- Greater openness to end of life within **community settings**, with increased public acceptance to enable conversations regarding death.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to support available.
- 24/7 care through **integrated** service provision.
- Joined-up services will support rapid discharge of patients from hospital.
- Support for families post-bereavement.
- Training for health and social care professionals in advance care planning and communication skills.

SERVICES

- Closer working across all providers of care.
- All providers will be appropriately trained and quality assured, including care homes, private sector assisted living, hospices, domiciliary services, practices, community and hospital services.
- Improved communication with patients and carers about death and end of life care, including pre- and post-bereavement support.
- Better management in care homes to ensure patients are not admitted to hospital unnecessarily.
- Individuals will be treated in a hospital when more specialist care is required or where the patient has specified hospital as their preferred place of care/death.
- Clinical nurse specialists will work closely with the **primary care** team to identify patients at the end of life, and will also liaise with patients and their family/carers to ensure their wishes are fulfilled.

CASE EXAMPLE

NOW

- Judith, 82, is on the **palliative** care register with her GP practice and has been identified as being in the end stages of life.
- She has an **advance care plan** in place. However, despite her wishes on the **care plan**, Judith has repeated urgent overnight admissions to hospital.

BY 2030

- Judith and her family have worked with the appropriate clinician and have developed and agreed an **advance care plan**.
- Her wishes are to remain at home.
- Through the **advance care plan**, Judith's care is coordinated by a **multidisciplinary** team with multiple care agencies working together, and her care is delivered in her home.

“It is a fundamental right for patients to be allowed to die in a place of their choosing. This can only be facilitated by honest, open dialogue between healthcare professionals and the patient (and their family). Everyone deserves to die a good death, free from pain, anxiety and distress. Hopefully by working together we will be able to provide this to every patient in the future.”

Dr Adam Janjua,

GP and the CCG's end of life clinical lead

LEARNING DISABILITIES

WHAT IT IS

A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently.

Specific learning disability services offer support to people with severe or profound learning disabilities, and specialise in supporting those with challenging behaviour and severe communication needs. People with learning disabilities should also be able to access **ordinary healthcare services**, such as their family doctor, dentist and hospital outpatient services, who should make reasonable adjustments to accommodate their particular needs.

WHAT HAPPENS NOW

- There are about 500 adults and 650 children with a learning disability living in Fylde and Wyre.
- People with learning disabilities can find it difficult to access **ordinary health services** and sometimes they might even find themselves excluded from care.
- People with learning disabilities are more likely to experience a number of other health conditions, including early onset dementia, diabetes and diseases of the heart and blood vessels.
- Not all people with learning disabilities have an annual health check and **health action plan**, and so their health needs and risks cannot be proactively managed.
- The Winterbourne Review (the report into events at Winterbourne View Hospital) identified that people in a specialist learning disability hospital should be supported to leave hospital sooner with proactive support packages tailored to their needs.

OUR VISION FOR LEARNING DISABILITIES

Ordinary and specific learning disability services will work together to bring the appropriate expertise and skills to meet a patient's needs. People with learning disabilities and their carers will have the information and support they need to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE'LL BE DOING BY 2030

- Those with learning disabilities will be supported to develop lifelong positive emotional and physical health.
- All services will make reasonable adjustments to support people with a learning disability, e.g. providing information in a variety of formats including pictorial leaflets, or offering the first appointment of the day to those who may find any wait distressing.
- Health risks and needs will be proactively managed, and those with a learning disability will have an annual health assessment and a **health action plan**.
- Services will respond to the needs of the individual, bringing the appropriate expertise and skills to the patient rather than the patient having to move between teams.
- Patients will be admitted to hospital less frequently and for shorter periods.
- There will be a seamless transition between children's and adult support.
- The community will be 'learning disability aware', where people with learning disabilities are accepted and are able to engage in all aspects of community life.

"I would like them [local health services] to listen more and be more understanding."

Service user, September 2013

"The service is good, but they need to make better adjustments and use large print."

Service user, September 2013

WHAT THE CHANGES MEAN FOR...

PATIENTS

- Patients, their families and carers will be provided with appropriate information and support to maintain good health.
- Much better access to services, with staff who understand about learning disabilities.
- More use of appropriate technologies and innovation to provide support and information.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to support available.
- More services will be jointly commissioned to ensure joined-up care that reflects the complex mix of health and social care required.

SERVICES

- Services will make reasonable adjustments to meet the needs of people with learning disabilities.
- Services will be responsive to an individual's needs, bringing the required skills and support to the patient rather than the patient having to move between teams.
- Only the most specialised and intensive support will be delivered in hospital, and patients will be admitted less frequently and for shorter periods.
- Community and specialist services will have excellent links, which will enable good planning and a seamless transition between services.

“Individuals with learning disabilities have a wide range of problems and are prone to develop serious medical conditions. They have the right to access medical and social care as they need it. We are committed to raising awareness of their needs and ensuring that appropriate adjustments are made to accommodate them in all the local services. We are working with partner organisations to ensure that our communities understand the needs of these individuals and go out of their way to meet those needs.”

Dr Kath Greenwood, GP and the CCG's clinical lead for mental health, dementia and learning disabilities

CASE EXAMPLE

NOW

- Susan, 36, has Down's syndrome and lives in supported housing. Her carer takes her to see her GP as she is unwell and feverish.
- Susan is also diabetic and on tablet treatment.
- The GP sees Susan and diagnoses that she has a chest infection. She gets better with antibiotics.
- The GP will see Susan whenever needed but the carers are often unsure of what to do if she is unwell and they need to consult the practice very often, usually at short notice. The carers do not always bring Susan for her regular diabetic check-ups as she is afraid of doctors and nurses.

BY 2030

- The GP sees Susan and diagnoses a chest infection. He invites Susan and her carers to attend for an annual health check when she is better.
- At the health check the GP writes a **health action plan** for Susan. This gives information on what symptoms Susan may experience and how the carers will manage.
- The carers have clear plans so they know when to consult a GP. They also understand all the regular check-ups that Susan needs.
- Susan gradually becomes comfortable attending the practice as she is invited in for sessions to let her become familiar in that setting.

LONG-TERM CONDITIONS

WHAT IT IS

A long-term condition is a health problem that can't be cured, but can be managed by medication and other treatments, e.g. diabetes, heart disease, stroke and respiratory disease.

WHAT HAPPENS NOW

- Around 30% of people living in Fylde and Wyre have at least one long-term health condition.
- More people have diabetes, heart disease, high blood pressure, stroke, kidney disease, asthma and respiratory disease than the England average.
- Patients with long-term conditions tell us that they do not feel supported in managing their condition.
- There is not a coordinated approach to the management of patients with more than one long-term condition. This particularly affects people over 65 years old with diabetes who can have as many as five other long-term conditions.
- Care across health, social and voluntary services is fragmented.
- People are referred to hospital for the majority of their care because provision is not fully available in the community.
- People with long-term conditions affecting the brain and nervous system attend hospital more often and stay in hospital for longer than the national average.
- There are currently some examples of good practice, but they are not applied consistently across the different parts of the healthcare system.
- There is no consistent focus on screening people at risk of developing a long-term condition to support early prevention.

OUR VISION FOR LONG-TERM CONDITIONS

Community-based services, particularly general practice, will play a central role in proactively supporting patients with long-term conditions through high quality, integrated and personalised care. People will have the information and support they require to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE'LL BE DOING BY 2030

- Everyone with a long-term condition will have a **care plan**, which provides information about their condition and empowers them to self-manage and make decisions about their care. It will be available electronically and linked to their GP health record. The **care plan** will be available to the organisations involved in a person's care, ensuring that the same information is used to inform decisions.
- Practices working across **neighbourhoods** will coordinate a broad range of care in a **community setting**, including in a patient's own home, working with community services, social care and expert clinicians.
- Healthcare professionals will have the tools to identify patients at high risk of their long-term condition worsening. Patients will be supported to stop their long-term condition getting worse.
- Thanks to improved community services, fewer people will be admitted to hospital. When people need to receive hospital care, it will be for as short a time as possible and their discharge will be supported by the community team.
- Healthcare professionals will be supported so they can confidently signpost people to a wide range of clinical, self-help, self-management and healthy lifestyle support.
- **Telehealth** will be regularly used by individuals to monitor and manage their condition at home.
- A continually updated list of services and information to support long-term conditions management will be available.
- Carers will have access to the same support and information as people with long-term conditions. Carers will also receive a joined-up assessment to identify their needs and any support required.
- People with long-term conditions will have access to a **personal health budget** to allow them to tailor services to their needs, based on their **care plan**.

“We currently look at what is provided in hospital first and then what can be provided in the community. We should be looking at what can be provided in the community first and then what must be provided in the hospital.”

Local resident, November 2013

WHAT THE CHANGES MEAN FOR...

PATIENTS

- Active participation in decisions about their care.
- A named person who is responsible for making sure their needs are met.
- More care at home and in a **community setting**, with active support to stay healthy.
- Earlier identification of problems through long-term condition screening.
- Living a healthier more empowered life.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will signpost to support available, including health and wellbeing services.
- **Integrated** teams will work together to support people with long-term conditions and identify people at risk of becoming ill earlier.
- Will support to help people use technology.
- Existing support networks around individuals and families will be strengthened.

SERVICES

- A greater focus on prevention, health promotion and self-care.
- Increased and broader-ranging services delivered in the community, including diagnostics.
- Better use of technology to widen access to services.
- Only the most specialised and intensive treatment will be delivered from hospital.

“Our patients and their carers have to manage all aspects of their lives, with their unique challenges. Our role as clinicians will be to listen to their concerns, to use our skills to offer them advice on the options available and guide them to the best treatment for their individual needs. This will be a long-term partnership, involving a range of resources in our community.”

Dr Peter Benett, GP and the CCG’s clinical lead for long-term conditions

CASE EXAMPLE

NOW

- Jack, 43, goes to see his GP complaining of tingling in his hands and often feeling extremely thirsty.
- After visiting his GP, Jack is diagnosed with type 2 diabetes.
- Jack struggles to manage his diabetes and subsequently is prescribed insulin.
- Following a trivial injury Jack develops complications linked to his diabetes and is admitted to **A&E**.

BY 2030

- Jack accesses a single point of information about diabetes and has an informed discussion with his named GP about his care.
- Jack and his GP put together a **care plan**, which includes advice from a community-based diabetes specialist.
- Following discussion with his GP, Jack is referred to a self-management course to learn how to use insulin.
- Jack sends monitoring information to his GP and **neighbourhood** team from home using **telehealth** equipment. His condition is managed remotely to ensure he remains well.

“Services do ‘to’ not ‘for’ and do not take into account the rights and wishes of the individual. They see an illness not a person.”

Local resident, November 2013

MENTAL HEALTH AND DEMENTIA

WHAT IT IS

Mental health refers to a person's condition with regard to their psychological and emotional wellbeing. Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities.

WHAT HAPPENS NOW

- The NHS in Fylde and Wyre spends more than the England average on mental health, but achieves poorer **outcomes**.
- The number of people with dementia in Fylde and Wyre is higher than the national average, and this is set to rise as the population ages.
- Access to the right mental health support can be complicated and may often involve waiting for too long.
- Services are fragmented; patients and health professionals find them difficult to navigate.
- Patients have to move between different teams and services in order to have their needs met.
- Mental health services are often not integrated with other health services.

OUR VISION FOR MENTAL HEALTH AND DEMENTIA

The support of good mental health and wellbeing will be central to all healthcare. Support for mental and physical health will be delivered through coordinated community-based services. People will have the information and support they need to understand their condition and feel confident to manage their own health and wellbeing.

WHAT WE'LL BE DOING BY 2030

- Mental health **outcomes** in Fylde and Wyre will be better than the national average.
- There will be just as much focus on improving emotional and mental health as physical health, with people supported to develop lifelong positive emotional health.
- Mental health support will be an integral part of all health and care services, available 24/7.
- In order to improve access and navigation, there will be one single point of entry to mental health services for people of all ages.

- Services will respond to the needs of the individual, bringing the appropriate expertise and skills around the patient.
- Technology, such as internet-based support programmes, will be an integral part of mental health support.
- The transition between children's and adult support will be seamless.
- Fylde and Wyre will be a 'dementia-friendly community' where people actively encourage those with dementia to participate in community life.

CASE EXAMPLE DEMENTIA

NOW

- Beryl, 72, has some short-term memory problems. She thinks that this is just part of getting old. She lives with her husband, Fred, who is her main carer.
- Beryl's condition deteriorates and Fred finds it hard to cope.
- They eventually visit the GP and are referred to the memory clinic. Beryl is started on medication and they receive some help from a dementia adviser.
- Fred tries to take Beryl out as much as possible but finds that it is very difficult to go shopping or to a café. The other customers and staff don't understand the problems and treat Beryl very impatiently.
- Fred finds it too difficult so rarely goes out any more. He has to find help with shopping and he and Beryl become socially isolated.

BY 2030

- Fred and Beryl see a poster in their surgery about the importance of an early diagnosis of dementia. They see the GP at an early stage, are referred to the memory clinic and receive a lot of support.
- Beryl responds well to treatment and they attend dementia cafés and other activities with peer groups.
- Most of the cafés and supermarkets in the area are 'dementia friendly' and Fred finds that if Beryl does behave strangely or becomes distressed when they are out people are kind and understanding.
- The couple are able to continue going out and Fred is able to do his own shopping, taking Beryl with him.

WHAT THE CHANGES MEAN FOR...

PATIENTS

- More aware of their own emotional health and how to maintain it.
- More aware of what help and support is available and how to access it.
- Better access to self-help and self-management support.
- Access care from home or in a **community setting** rather than at hospital.
- Support available 24/7.
- Increased education to improve good mental health.

PARTNERS

- The promotion and support of good mental health and emotional wellbeing is everybody's business.
- Will signpost to support available, including health and wellbeing services.
- Will identify and support individuals at risk of developing mental health issues.
- More services will be jointly commissioned to reflect the complex mix of health and social elements within mental health and emotional wellbeing.

SERVICES

- Greater focus on keeping people well.
- Patients admitted to hospital less frequently and for shorter periods.
- Specialist services centralised in order to deliver the highest quality of care.
- Only the most specialised and intensive treatment delivered from a hospital setting.
- Community and specialist services have excellent links, which enable good planning and a seamless transition between services.
- More creative use made of technology and innovation to provide support and information.

CASE EXAMPLE MENTAL HEALTH

NOW

- Jimmy, 48, has work-related stress. He is feeling very low and can't cope at home or at work.
- Jimmy goes to see his GP because he feels very down and often just doesn't want to get up in the morning.
- The GP has diagnosed Jimmy with a reactive depression, encourages Jimmy to have some psychological support, refers him to the local psychological therapies (**IAPT**) service and prescribes Jimmy some anti-depressants.
- Jimmy initially feels better but his mood worsens as he has a long wait to be seen for his talking therapy. He needs a higher dose of anti-depressant and is off work for many months.

BY 2030

- The GP has diagnosed Jimmy with depression and refers him to the local **IAPT** service, which holds sessions in the GP practice.
- The GP also gives Jimmy the details of the **IAPT** service website where he can access information and help. As the service is so immediate Jimmy declines anti-depressants.
- The **IAPT** service calls Jimmy later the same day to assess him. He is seen within two weeks and has regular treatment sessions. He accesses a peer support group. He doesn't need anti-depressants and is back to work within a few weeks.

"We are committed to improving access to psychological therapies for people with all types of mental health problem. We are working closely with providers to develop innovative services that can be accessed by patients at any time from their own homes. We are committed to helping patients manage their mental health with appropriate support."

Dr Kath Greenwood, GP and the CCG's clinical lead for mental health, dementia and learning disabilities

PLANNED CARE

WHAT IT IS

Planned care involves routine services with pre-planned appointments. These could be provided in a hospital or a **community setting** such as a health clinic, GP surgery or in a patient's own home.

WHAT HAPPENS NOW

- There have been improvements in waiting times and increased choice for patients in recent years.
- Patients are often seen in hospital when they could receive their care sooner in more convenient **community settings**.
- Many patients undergoing treatment feel their care is not coordinated and are frustrated that one person doesn't have overall responsibility for supporting them.
- 62% of the people we spoke to said they would like tests such as ultrasounds and MRI scans carried out in the community.
- Many patients are often not supported to maintain a healthy lifestyle or self-care, and as a result of this are more likely to need an operation or treatment in the future.
- Patients need the NHS every day, yet evidence shows that the limited availability of some health services at weekends can have a detrimental impact on **outcomes**.
- Many carers do not feel supported.
- Many people do not know about the range of services on offer because the information available can be confusing.

OUR VISION FOR PLANNED CARE

Our vision is to make sure that patients are seen by the right person in the right place at the right time by high quality, coordinated services that fit around their needs.

WHAT WE'LL BE DOING BY 2030

- There will be a much wider range of high quality services within the community so people have easier and earlier access to planned care, with many services available seven days a week. This will include the expansion of '**one-stop shops**' and diagnostic tests.
- GP practices – which will have overall responsibility for a patient's care – will be supported by teams to enable them to coordinate health and social care services.
- There will be much better information available so that patients and their families are able to make choices about their health and care, and know what services are available and how to access them.
- Patients will be able to leave hospital sooner after their treatment to recover, where possible, in their own home due to better community-based support. This will mean a significant reduction in follow-up hospital outpatient appointments, which will be done instead in a **community setting** or at home.
- Healthcare providers and patients will be able to access information about patients' health, so reducing possible errors and avoiding patients having to give the same information many times.
- To make sure the quality of care improves, services will be required to rigorously implement nationally and locally agreed best practice. This may mean that some highly specialised care is centralised at specific hospitals where more expertise is available more of the time.
- The new hospital appointment booking system, the **NHS e-referral service**, will improve the quality of the referral experience for patients, and better support clinicians and administrative staff.

WHAT THE CHANGES MEAN FOR...

PATIENTS

- Will have the information and support they need to make informed choices about their health and healthcare.
- Will have timely and coordinated care, planned around their needs.
- Will be better equipped to take control of their own health conditions.
- Will have improved access to many services, seven days a week.
- Will have less need to go to hospital due to improved community-based support.
- When hospital treatment is needed, will increasingly be admitted, treated and discharged on the same day.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Much better coordination between all service providers, e.g. health, social care and the voluntary sector.
- Will help to signpost patients and their families to the most appropriate services.
- Will provide support to help people better self-care and manage their conditions.

SERVICES

- GP practices will take responsibility for coordinating a patient's care.
- Hospitals will only see patients for specialist treatment, with very specialist treatment centralised in centres of excellence.
- The availability of services seven days a week in the community will shorten waiting times.
- Joined-up health, social and voluntary care will be available as part of one clinic.
- Health treatments and services will be in line with nationally and locally agreed best practice.

CASE EXAMPLE

NOW

- Peter, 52, makes an appointment with his GP with knee pain after his knee gave way while jogging.
- He sees his GP who refers him to an outpatient clinic at the hospital for assessment.
- Eight weeks later Peter attends his hospital appointment and is told he needs an MRI scan.
- Six weeks later Peter attends hospital again for a scan.
- Peter then attends the hospital for a further follow-up appointment to receive the results of the scan. Peter is told he requires investigative surgery and is booked onto the waiting list.

BY 2030

- Peter sees his GP who books him in for a **one-stop shop** assessment and diagnosis clinic at a local health centre.
- One week later Peter attends the clinic and has an MRI scan.
- The next day the results of the scan are sent to his GP.
- The GP shares the results with Peter and they discuss treatment options.
- Peter considers the benefits and drawbacks of surgery with his GP and makes the decision to proceed with surgery.

“We want to improve every patient’s experience by ensuring that they are seen at the right time in the right place by the right person. We are particularly excited about the opportunities provided by new technologies to support patients to choose and manage their care.”

Dr Tom Johnson,
GP and the CCG’s clinical lead for planned care

URGENT CARE

WHAT IT IS

Urgent care cannot reasonably be foreseen and therefore must be available 24 hours a day. Provision includes support to people at home, in short-term residential settings, urgent or emergency GP appointments, 999 ambulance services and emergency (**A&E**) hospital treatment.

WHAT HAPPENS NOW

- The level of urgent care on the Fylde coast (e.g. ambulance call outs and **A&E** attendances) is rising, with **A&E** attendances up by 4% compared to 2011/12 and emergency admissions up by 2% in the same period.
- The disjointed pattern of services and poor information available can be confusing. This can result in many people using services that are not appropriate for their needs.
- Considerable work has been undertaken across Fylde and Wyre to reduce avoidable emergency hospital admissions, such as:
 - o Rapid Response Plus – an **integrated** health and social care access and assessment service for individuals who need an urgent response and may otherwise go to **A&E** and/or be admitted to hospital.
 - o Care Coordination Scheme – care planning with people who have long-term conditions and are most likely to be admitted to hospital. A patient's needs are identified in advance, and they are able to access advice and treatment 24/7 if they begin to feel unwell.
 - o Frequent 999 callers' prevention – an advanced paramedic identifies those individuals who are at greatest risk of needing to go to **A&E** via a 999 call and coordinates multi-agency support with GPs, housing providers and social services when required. This has resulted in an 88% reduction in 999 calls among the top 50 most frequent callers across the Fylde coast, which has been sustained for eight months.

OUR VISION FOR URGENT CARE

People who need urgent care will receive consistently high quality services in the right place, at the right time. Wherever possible, services will be joined up between health and social care and provided seven days a week in a person's home or local community.

WHAT WE'LL BE DOING BY 2030

- By building on these recent developments, a wider range of high quality services will be available within the community and in patients' homes to reduce the need for people to have to go to hospital for urgent or emergency care. As well as fewer **A&E** attendances, there will be a reduction in the number of people who are re-admitted to hospital soon after discharge and a reduction in ambulance call-outs.
- Services provided by different agencies will work together to ensure joined-up care.
- People identified as likely to need urgent care will have a joint assessment and a named health or care professional to help them stay well and better manage their condition.
- There will be much better information available so that patients and their families know what services are on offer and the easiest way to access them.
- There will be more joint health and social care services based in the community designed to promote self-care, wellbeing and support frail patients in need of rehabilitation or recuperation. This will allow more people to remain living independently at home for longer, and return home sooner after being in hospital.

“We must plan for a sustainable NHS which is fit to meet the future needs of our growing ageing population. I see most urgent care being provided in the community by enhanced multidisciplinary teams coordinated by GPs, with only the most seriously ill being managed in hospital by major emergency departments.”

Dr Rob Smyth,

GP and the CCG's clinical lead for urgent care

WHAT THE CHANGES MEAN FOR...

PATIENTS

- Much less likely to be admitted to hospital as an emergency, unless absolutely necessary.
- 24/7 health and social care support at home.
- Improved access to general practice.
- **Holistic** care and support to meet all needs.
- Better access to integrated rehabilitation and recuperation to enable longer independent living.
- Much better understanding of the services available and how to use them.

PARTNERS

- Will promote and encourage healthier lifestyles.
- Will help to signpost patients and their families to the most appropriate services.
- Teams from different organisations will work proactively together to make sure patients are supported in a **community setting** or at home.
- Will help to ensure patients and their families know how to access the services available.
- Better support in care homes to ensure residents are not admitted to hospital unnecessarily.

SERVICES

- Staff will work flexibly across traditional boundaries, focusing on the needs of their patients rather than the organisation.
- Delivery of more services outside of hospital.
- GPs working closer together and integrating with social care and community services.
- Fewer 999 calls by supporting those most at risk of emergency admission.

CASE EXAMPLE

NOW

- George, 83, visits his GP who diagnoses a urinary tract infection and prescribes antibiotics.
- In the pharmacy George seems confused. An ambulance is called and he is taken to **A&E**.
- George is admitted to hospital; his strange surroundings make him even more confused.
- Four weeks later George is still in hospital with both his physical and mental state having deteriorated.
- George has had various assessments and is now awaiting discharge to a permanent residential care home.

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BY 2030

- George is feeling unwell and visits his GP who prescribes antibiotics for a urinary tract infection. She refers George to his **neighbourhood** health team as he doesn't appear to be coping.
- George's immediate health needs are managed by the rapid response nursing team who maintain contact and treat him in his home.
- A team of health and social care professionals work with George to identify how he can be supported to remain as independent as possible.
- George receives six weeks' **reablement** in his home, attends voluntary groups twice a week and continues to have his care needs coordinated by a named health professional.





This document outlines our overarching vision for the future. It describes how we would like to see health services in 2030, but many of the changes we describe will be made sooner than this.

We are currently working on detailed two- and five-year plans which will start to make our vision a reality. These plans – which will contain measurable targets and financial information – will be continually updated as part of our annual planning process.

Once again we would like to thank all of those who took the time to give us their views and share their experiences about local health services. This feedback has informed our vision. As we develop our more detailed plans we will seek the views of patients and the public again, and so we thank you in advance for your contribution.

There are a number of ways for people to get involved in helping to shape health services in Fylde and Wyre, including joining our Affiliate Scheme.

More information is available on our website:

www.fyldeandwyreccg.nhs.uk

A&E:

Accident and emergency (A&E) is a service available 24 hours a day, seven days a week where people receive treatment for serious illness or injuries. These include loss of consciousness, severe bleeding and broken bones.

Advance care plan:

When people are reaching the end of their lives, a care plan is made in advance so that their wishes are known before their condition gets worse.

Better Care Fund:

A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.

Care plan:

A care plan identifies an individual's health and/or social care needs together with the appropriate professionals. www.nhs.uk/Planners/Yourhealth/Pages/Careplan.aspx

Clinical commissioning group (CCG):

These are the health commissioning organisations which replaced primary care trusts (PCTs). They are led by GPs and represent a group of GP practices in a certain area, and are responsible for commissioning healthcare services.

Commissioning:

NHS commissioning is the process of planning and buying health services to meet the needs of the population.

Community setting:

Treatment or support provided in a non-hospital setting. This could be in a GP practice, health centre, via voluntary services or in a patient's own home.

Electronic Palliative Care Coordination System:

A system which enables healthcare professionals to record and share information relating to palliative care patients, including preferred place of care, details of carers, diagnosis, resuscitation preferences and other key information.

Flat funding:

A temporary freeze on NHS funding increases for a set period of time.

Health action plan:

Care plans written for people with learning disabilities. The purpose is to identify health actions that will make a positive difference to the health and wellbeing of the individual.

Health and wellbeing boards:

The aim of these local boards is to improve integration between local health care, social care, public health and other partners so that patients experience more joined-up care.

Health improvement services:

Services to support people to keep fit and well, such as stop smoking, sexual health and weight management services.

Holistic:

Treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.

IAPT:

Improving access to psychological therapies (IAPT) is a national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders.

Integrated care:

Coordinated care, with all parts of the NHS and social services working more closely and effectively together.

Multidisciplinary team:

A team consisting of representatives from several different professional backgrounds who all have different areas of expertise.

Musculoskeletal conditions:

Problems relating to the muscles, tendons, ligaments, bones and joints.

Neighbourhoods:

Geographical areas across which practices will coordinate health and care services to ensure joined-up care tailored to the needs of the local population.

NHS England:

This is the organisation that works with NHS staff, patients, stakeholders and the public to improve health outcomes for people in England and transparency in the NHS.

NHS e-referral service:

Developed based on feedback from patients and NHS professionals, this new service will replace Choose and Book and make the NHS much easier to deal with.

One-stop shops:

A service where a patient will be able to access the healthcare they need at the same time, in the same location, e.g. tests and treatment.

Ordinary health services:

Ordinary NHS services used by the majority of people, such as services provided by family doctors, dentists and hospital outpatient services.

Outcomes:

The difference in someone's health before and after treatment.

Palliative:

An area of healthcare that focuses on relieving and preventing the suffering of patients with life-threatening illness.

Personal health budget:

A personal health budget is an amount of money to support your identified healthcare and wellbeing needs, planned and agreed between you, or your representative, and your local NHS team.

www.personalhealthbudgets.england.nhs.uk

Poverty:

Families living on an income of £12 or less per day per person. www.barnardos.org.uk/what_we_do/our_projects/child_poverty/child_poverty_what_is_poverty.htm

Primary care:

Services which are the main or first point of contact for the patient, provided by GPs, dentists, opticians and pharmacists.

Public health:

Public health is about helping people to stay healthy, and protecting them from threats to their health.

Reablement:

Support for people with poor physical or mental health or a disability to help them live as independently as possible by learning or relearning the skills necessary for daily living.

Referral pathway:

The path a patient will take through the NHS system, from their first contact with a GP to the end of their treatment.

Safeguarding:

Safeguarding means protecting children and vulnerable adults from abuse or neglect, and promoting their health and wellbeing.

Secondary care:

Services provided by specialists and other professionals who do not generally have first contact with patients.

Specialised services:

Specialised services are services that affect fewer than 500 people across England or involve services where fewer than 500 highly specialised procedures are undertaken each year. www.specialisedservices.nhs.uk

Telehealth:

Services which use technology to help people to live more independently at home, e.g. equipment to measure blood pressure, blood glucose levels or weight. This can reduce the number of visits people make to their GP and unplanned visits to the hospital.

Treatment plan:

See care plan.

APPENDIX 1 – YOU SAID, WE DID

YOU SAID...	WE DID...
Helping to keep people well should be a top priority	We agree, which is why health promotion, education and supporting people to self-manage their conditions is a common theme.
Learning disabilities should be specifically addressed in the strategy	We have included learning disabilities as a specific priority.
85% of those who took part in our telephone survey said people should be given the tools and the freedom to manage their long-term condition	A very strong theme in this document is strengthening community-based support to enable people to better manage their conditions and stay as well as possible.
People need better information so they know what services are available and how to access them	We agree, which is why better communication – including the use of new technologies – is a key theme in this document.
A strategy looking to 2030 is not realistic. It also needs to have more about how you will actually achieve your vision	This document is meant to set out a high-level vision for the future that will be our 'guiding path'. We are developing detailed two- and five-year plans which will set out how we aim to achieve our vision, and these will contain measurable targets.
The CCG won't be able to achieve its vision alone	You are right, and this is why we have endeavoured to involve partner agencies in the development of our plans. We have also strengthened the narrative about partnerships in the document.
There is no mention of sexual health services, alcohol or substance misuse services	The CCG does not commission these services (see page 6). However, we do work with our partner commissioners to make sure services are joined up. This has been given particular mention in relation to children and young people.
Prevention of ill health needs greater prominence	Many people said this, and we do agree that supporting people to live healthier lives should underpin all of our work. People need to be empowered to take responsibility for their own health, and this was very much supported in the conversations we had with you.
Diabetes and stroke should be discrete priority areas rather than be under the heading 'long-term conditions'	Both of these illnesses affect large numbers of people locally and are priority areas for us. We had to give this document a structure, which is why they are under the heading 'long-term conditions', but this does not in any way diminish their importance.
Don't use NHS jargon, and give definitions where possible	We have tried to write this document in plain English, have given definitions for the different service areas and have included a glossary.

YOU SAID, WE WILL

YOU SAID...	WE WILL...
Care is often fragmented, and the different agencies providing services are not coordinated – this needs to change, and services need to be joined up	This is why we think a named person should be responsible for coordinating an individual's care – 86% of those who took part in our telephone survey agreed.
People at the end of their lives want more choice, and families/carers need better support	Health professionals will have better training to enable people to have their wishes fulfilled. Carers will be offered pre- and post-bereavement support.
Services should be tailored to the needs of individual communities	Practices working across geographical neighbourhoods should coordinate community-based services in their area, and make sure these are tailored to the needs of the local population – 74% of those who took part in our telephone survey agreed.
Health problems, e.g. cancer or long-term conditions, need to be identified earlier	Screening and better support for those deemed at risk have been highlighted as important ways to make sure problems are found as early as possible.
Carers are vitally important. Their contribution needs to be reflected, and they need more support	We believe carers are key partners. Our telephone survey revealed that 15% of people class themselves as unpaid carers, although we believe this to be an underestimate of the true picture. We want all carers to have a joined-up assessment to identify their needs and specific support requirements.
Concern that GP practices would not have the capacity to coordinate people's care or services across geographical neighbourhoods	We are working with GP practices at the moment to develop this new way of working, and as part of this will agree what level of support they will need to ensure they are effective in the future.
There needs to be better after-care and support in the community after patients have been discharged from hospital	Providing better community-based health services is a key part of our plans. Our vision is that people will leave hospital sooner due to better community-based support, with follow-up outpatient appointments carried out in a community setting as well.
People should take more responsibility for their own health – the NHS can't be expected to do everything	We aim to widen access to self-help, self-management and healthy lifestyles support. We think everyone should do their bit to keep as fit and well as possible.
Access to mental health services is poor, and better information about mental health and dementia services is needed	We aim to commission a single entry point for mental health services for people of all ages to improve access. We also want just as much focus placed on mental health as physical health.
Support for people with learning disabilities is variable across all services, suggesting that health professionals lack knowledge about the needs of people with learning disabilities	We will work with health providers to ensure that appropriate support is available to meet the needs of the people with a learning disability.
We need to ensure palliative care is available for children and young people	We agree and will use the development of personal health budgets to enable the tailoring of support to meet the needs of children and young people. Our local hospice provides services and support to children funded through charitable donations and some national funding. We will ensure that anything we develop links appropriately to these services.
43% of people with a long-term health condition say they have to repeat their medical history every time they see a health professional	Everyone with a long-term health condition will have a care plan , which will be linked to their GP record and will be available electronically. This will be available to all of the organisations involved in a person's care.



If you need this booklet in another format or language, please contact the customer care team on:

Freephone: 0800 032 2424

Telephone: 01772 777 952

Textphone: 01772 227 005

Email: customer-care@lancashirecsu.nhs.uk