Blackpool Council

20 September 2016

To: Councillors Callow, Mrs Callow JP, I Coleman, Elmes, Hobson, O'Hara and Owen

The above members are requested to attend the:

HEALTH SCRUTINY COMMITTEE

Wednesday, 28 September 2016, 6.00 pm
Committee Room A, Town Hall, Blackpool FY1 1GB

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and
(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Services in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 6 JULY 2016 (Pages 1 - 10)

To agree the minutes of the last meeting held on 6 July 2016 as a true and correct record.

3 PUBLIC SPEAKING

To consider any applications from members of the public to speak at the meeting.

4 EXECUTIVE AND CABINET MEMBER DECISIONS (Pages 11 - 18)

To consider the Executive and Cabinet Member decisions within the remit of the Health Scrutiny Committee.

5 FORWARD PLAN

To note that there are no items on the Council's Forward Plan, October 2016 - December 2016, relating to Health Scrutiny Committee functions.

6 COUNCIL PLAN PERFORMANCE REPORT - QUARTER ONE, 2016-2017 (Pages 19 - 26)

To review performance against the Council Plan 2015-2020 for the period 1 April 2016 – 30 June 2016.

7 NHS BLACKPOOL CLINICAL COMMISSIONING GROUP - NEW MODELS OF CARE UPDATE (Pages 27 - 56)

To review progress made with the implementation of New Care Models across Blackpool and allow effective scrutiny of the approach taken.

8 NORTH WEST AMBULANCE SERVICE PERFORMANCE REPORT FOR BLACKPOOL (Pages 57 - 88)

To update members on the performance of the North West Ambulance Service (NWAS) commissioned by Blackpool Clinical Commissioning Group (CCG).

9 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017 (Pages 89 - 102)

To review the Health Scrutiny Committee's Workplan for 2016-2017.

10 DATE AND TIME OF NEXT MEETING

To note the date and time of the next meeting as Wednesday, 14 December 2016 commencing at 6pm in Committee Room A.

Venue information:
First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:
For queries regarding this agenda please contact Sandip Mahajan, Senior Democratic Governance Adviser, tel: 01253 477211, e-mail sandip.mahajan@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING - WEDNESDAY, 6 JULY 2016

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	Hutton
Mrs Callow JP	Elmes	

In Attendance:

Councillor Graham Cain, Cabinet Secretary for Resilient Communities

Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals NHS Foundation Trust
Mr Ian Ellwood, Discharge Manager, Blackpool Teaching Hospitals NHS Foundation Trust
Mr Steven Garner, Service Manager, Healthwatch Blackpool

Mrs Lynn Donkin, Public Health Specialist
Mrs Liz Petch, Public Health Specialist
Mrs Ruth Henshaw, Corporate Development Officer
Mrs Sharon Davis, Scrutiny Manager
Mr Sandip Mahajan, Senior Democratic Governance Adviser

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 PUBLIC SPEAKING

The Committee noted that there were no applications to speak by members of the public on this occasion.

3 EXECUTIVE AND CABINET MEMBER DECISIONS

The Committee noted that there were no Executive or Cabinet Member decisions on this occasion.

4 FORWARD PLAN

The Committee considered the items contained within the Forward Plan, July - October 2016 within the portfolio of the Cabinet Secretary, Councillor Graham Cain relating to health scrutiny functions. The Committee requested an update on the 'Health and Wellbeing Strategy' and was advised by Councillor Cain that public consultation on the draft Strategy had concluded and the final draft would be considered for approval by the Health and Wellbeing Board on 20 July 2016.

5 PUBLIC HEALTH SCRUTINY REVIEW - FINAL REPORT

Mrs Sharon Davis, Scrutiny Manager presented the Public Health Scrutiny report. She explained that the Resilient Communities Scrutiny Committee, who had been previously responsible for health scrutiny, had undertaken a review following issues identified in the Public Health Annual Report 2014. The Annual Report had been a response to the Due North report in 2014 which had looked at regional health equity issues. She added that the scope of the review had been extended to include consideration of the Joint Strategic Needs Assessment which formed the main evidence base for the Health and Wellbeing Strategy. Review meetings had been held and Cabinet Members with relevant health responsibilities had been consulted.

Mrs Davis referred to the six recommendations contained in the report which would be considered by the Executive following the Health Scrutiny Committee meeting. She added that the Cabinet Secretary, Councillor Graham Cain would take into account any scrutiny comments.

The Committee agreed to approve the final report for consideration by the Executive.

6 COUNCIL PLAN PERFORMANCE REPORT 2015-2016

Mrs Ruth Henshaw, Corporate Development Officer advised that Council Plan key performance indicators (KPIs) had been set by the Corporate Leadership Team. The report covered performance for 2015-2016 in relation to health KPIs. These had previously been reported to the Resilient Communities Scrutiny Committee who had been responsible for health scrutiny functions.

Overall performance was good but there were three exceptions where performance was not on target. These were non-opiate drug users completing treatment successfully and sustaining progress; numbers of overweight children aged 10-11 years old and the percentage take-up of NHS Health Checks (adults aged 40-74 years old).

The Chair queried why there was a significant difference in non-opiate and opiate drug users completing treatment successfully and sustaining progress. Councillor Cain explained that a drugs strategy was being developed and suggested that detailed information could be provided for the Committee's next meeting.

Members referred to tackling the problem of overweight children and raised concerns that vending machines selling unhealthy snacks were located in some health centres, and that with the high levels of tourism a large number of unhealthy snacks were readily available. The Committee also commented on the importance of parental responsibility and queried what work was being done with parents.

Councillor Cain noted the issue of overweight children and unhealthy snacks being sold in health centres and undertook to take the issue forward through the Health and Wellbeing Board. He added that there were various initiatives underway to support young people such as the Better Start Programme and the Head Start Programme supporting teenagers.

Mrs Lynn Donkin, Public Health Specialist explained that developing better health for people was a complex area with a range of work required. She gave the example of a

successful campaign 'Give up Loving Pop' (GULP) which had encouraged young people to give up fizzy drinks for at least a month. There was no direct work with parents although there were initiatives such as Better Start, an Outreach Strategy and healthy choices were promoted through an awards scheme for healthier catering. She added that the Council and partners had signed up to a 'Healthy Weight Initiative' and joint work had been developed through the Healthy Weight Steering Group.

Members queried why the percentage take-up of NHS Health Checks (adults aged 40-74 years old) had decreased. In response, Mrs Liz Petch, Public Health Specialist explained that this was mainly due to more accurate data recording at GP practices rather than a real drop in health checks. Some GPs had been recording health information in the wrong data fields but data quality had improved. She added that Blackpool was one of the top ten areas in the country for levels of health checks.

Members noted that one of the key projects in the 2015-2020 Council Plan period was the 'New Business District' which aimed to attract more professionals to work in Blackpool town centre. Members recognised that previously there had been an increase of professionals with a higher than average disposable income working locally and considered that professionals would have a positive impact on the wider wellbeing of the town.

The Chair queried how much confidence there was that red indicators would have improved for the next performance report in September 2016. In response, Councillor Cain explained that a lot of work needed to be undertaken in partnership and that all partners wanted to tackle areas of concern. He added that continuous improvement was always sought and best use needed to be made of resources including extra resource when viable.

The Committee agreed:

1. To receive detailed information on the significant difference in non-opiate and opiate drug users completing treatment successfully at the next meeting.
2. To receive an update from the Cabinet Secretary concerning progress with tackling overweight children with particular reference to unhealthy snacks being sold in health centres.

7 BLACKPOOL CLINICAL COMMISSIONING GROUP PERFORMANCE REPORT

Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group (BCCG) and Mr Roy Fisher, Chairman, BCCG presented the BCCG's performance report for March 2016 and for the full year, 2015-2016. Mr Bonson explained that the BCCG had to follow national reporting requirements and key target measures. The BCCG commissioned a range of services provided by other organisations and so shared performance responsibility. The key measures covered a range of access to service areas.

He highlighted areas where performance was below target and needed improving. The target for accident and emergency waiting times from arrival to being discharged after treatment was for 95% of patient visits to be achieved within four hours. The end of year outcome was under 93% and for March 2016 only around 86%. Mr Bonson explained that accident and emergency waiting times were nationally challenging and that winter

months had a knock-on impact for the rest of the year with ongoing efforts to regain performance. Members enquired about the two measures for types of accident and emergency attendance and requested more detailed information on the 'all types' of attendance measure. Mr Bonson explained that the walk-in health centre in Whitegate Drive, Blackpool offered a Tier 3 GP-led primary care service and this level of accident and emergency service had to be recorded separately and agreed to provide more detailed information following the meeting. Mr Fisher explained that the Tier 3 service at the walk-in centre on Whitegate Drive provided an important part of the care pathway including pointing patients in the right direction of care.

He added that urgent care systems were generally under pressure, e.g. ambulance emergency call-outs had increased. This had resulted in ambulance response times falling short on all targets for March 2016 and the full year 2015-2016 across Lancashire. Pressures were also seasonal with the greatest number of call-outs during the winter period. However, more recently figures were back on track for the Lancashire area.

Mr Bonson explained that although the performance report measures were for Blackpool, the BCCG was responsible for regional commissioning of the North West Ambulance Service (NWAS) and therefore the figures presented were for the wider area. It was noted that more localised performance figures demonstrated that the NWAS met targets within Blackpool and it was agreed that a more detailed discussion on the ambulance response rates in Blackpool would be brought to a future meeting.

Members sought clarification on the difference between two of the Category A red indicators which both required 75% of response times to be within eight minutes but were below target. Mr Bonson explained that the first red indicator was for life-threatening emergencies and the second red indicator for other extremely serious call-outs such as road traffic accidents. Members added that the public wanted reassurance that a good ambulance service was being provided and good work should be publicised.

Members enquired how Accident and Emergency services and ambulance services would cope with increased pressures particularly during the winter period and what planning was taking place. Mr Bonson explained that a multi-agency resilience group of key health and social care operational partners forecast pressures and reviewed resources and plans to manage pressures during winter and all year round. Specific winter planning started around September each year. Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals added that summer months were often the busiest period for accident and emergency with the increase in visitors, events and festivals. Delays discharging patients also had a knock-on impact.

Mr Bonson referred to the provision of mental services with particular reference to improving access to psychological therapies (IAPT) and recovery rates for psychological therapies. The Chairman asked for clarification on the meaning of the various terms.

Mr Bonson explained that the therapies focused on counselling and other forms of 'talking' therapies. The first measure, upon which the others were developed, was complex and was a national estimate on the percentage of the local population expected to need to access mental health services and the local access target. The recovery rate was an important and challenging measure. Services were performing poorly at just over 35% recovery, which was well short of the 50% target. He explained that recovery could

only be deemed successful if a patient had made significant progress although this might not mean a full recovery. The Committee requested that full definitions of measures be circulated following the meeting.

Members noted that early intervention with young people could reduce longer-term mental health problems and asked how young people were supported. Mr Bonson explained that mental health provision for young people and adults was provided by different services. He agreed to provide information on the provision of mental health services including progress with recovery rates to a future meeting.

Mr Bonson added that a backlog of IAPT work had arisen but more recently progress had been made and performance was now above target. A new system had been developed whereby patients could self-refer to the right pathway, rather than through their GP, for less complex services such as counselling which meant bottlenecks were reduced by ensuring patients were in the right pathway queue.

The Chairman noted that the report covered a wide range of performance data but nothing on quality. In response, Mr Bonson confirmed that quality of care data was collected including complaints data and use of the 'Friends and Family' test for whether people would recommend a hospital service. Mr Fisher added that GPs had Patient Participation Groups which fed into collated datasets. Quality of care data was considered through the BCCG's Quality and Engagement Committee and quality assurance could be reported back to Members.

The Chairman queried the performance of waiting times for cancer treatment and why the ultimate target was not set at achieving 100% performance success. Mr Bonson explained that monitoring against the target commenced as soon as a GP referral was made for assessment by a hospital consultant. However, the monitoring of performance did not take into account individual delays. There were various reasons for delays including patient choice, assessments identifying unexpected health problems and 14 cancer groups with different pathways. Some forms of cancer could be tested for and identified relatively quickly whilst others were extremely complex. He added that the national targets had been developed based on robust evidence.

Ms Oliver explained that the Hospital Trust considered approximately 1,000 patients each day for cancer related issues and gave assurance that the progress of each patient was carefully tracked.

Members queried the impact of financial penalties referred to in the performance report. In response, Mr Bonson explained that there was a national requirement to impose penalties on providers missing performance targets, in particular waiting list targets. However, rather than just imposing punitive penalties on struggling providers the best use of funds for a more patient-focused approach was pursued. Mr Fisher explained that fines imposed on Blackpool service providers were reinvested in those services to promote improvement.

Mr Bonson and Mr Fisher were thanked for their report.

The Committee agreed:

1. To receive detailed information on attendance types of patients at Accident and

Emergency.

2. To receive a full performance report on the ambulance service including response rates from Blackpool Clinical Commissioning Group and the North West Ambulance Service.
3. To receive definitions on the various terms and measures used concerning improving access to psychological therapies (IAPT) following the meeting from BCCG.
4. To receive information from BCCG on the provision of mental health services including progress with recovery rates at a future meeting.
5. To receive a quality of care performance report from BCCG at a future meeting.

8 HEALTHWATCH BLACKPOOL - PROGRESS REPORT AND PRIORITIES

Mr Steven Garner, Service Manager, Healthwatch Blackpool presented Healthwatch's Impact Report 2015-2016 and draft priorities for 2016-2017.

He highlighted that Healthwatch had undertaken a wide range of review and survey work throughout the last year identifying the effectiveness of health and social care provisions mainly based on the views and concerns of local people using services. Subsequent reports had followed with a number of recommendations mainly directed at service providers. Responses had been sought from the providers concerning the recommendations with progress on actions was also sought.

The Chairman noted that some providers had not yet responded to recommendations and queried the reasons for the lack of response. Mr Garner considered that there were no serious issues as providers had generally welcomed review findings. He added that there was no legal duty requiring providers to respond but just to note recommendations.

Mr Garner explained that the annual report outlined the impact of Healthwatch's work and recommendations. He advised that notable recommendations taken on board by providers related to people's wellbeing including increased food rotas and choice and better activities co-ordination at care homes. Other key work had included reviewing urgent care provision and why people were not making the best use of accident and emergency services. The urgent care review had also led to the service provider apologising for a lack of information being provided to patients whilst waiting for services and without refreshments. The provider aimed to ensure improved patient awareness in future.

Mr Garner added that a particularly important finding was that the 'voice' of service users was not currently being taken into account for the strategic development and commissioning of services. This was an important issue that needed addressing given that development and commissioning of services ultimately impacted upon the services available and delivery of services.

Mr Garner explained that consultation had taken place seeking the public's views on health and social care priorities for 2016-2017. The consultation had identified five broad priority areas which would be refined. The priorities were GPs, hospital services, emergency services, adult mental health and care homes.

The Chairman referred to the previous agenda item, Public Health Scrutiny Report which

included a recommendation that Healthwatch should look beyond its approach of surveys for identifying people's concerns and adopt a greater focus on work promoting public health and tackling health inequalities. Mr Garner responded that Healthwatch did work with Public Health partners and closer working would be developed further, in particular taking into account the 'voice' of service users. He gave examples of public health work including being on a steering group to tackle tobacco and alcohol issues. Healthwatch had also been involved in developing the Joint Strategic Needs Assessment for identifying and tackling local priorities to produce the Health and Wellbeing Strategy.

Members noted that adult mental health services had been identified as a priority. Members expressed concern that children's mental health services had not been prioritised citing that issues such as young people's stress and anxiety had been recently prominent in the local press. Members emphasised that early help for young people could alleviate a lot of future health issues. Members commented that they were aware of recent issues with Children and Adolescent Mental Health Services (CAMHS), such as the time taken to access treatment and assessments.

Mr Garner responded that Healthwatch had undertaken a small review of CAMHS alongside a wider review of young people's wellbeing. Issues identified included the need to send reminders for appointments, parents' concerns not being acted upon, the length of waiting time and lack of support between appointments. Healthwatch was aware that changes were being made to CAMHS and would pursue outstanding issues but did not intend to undertake another review. He added that the Health and Wellbeing Strategy had particular sections on young people's wellbeing and other initiatives were ongoing such as Better Start.

The Chairman asked what the Healthwatch working relationship was with the Care Quality Commission (CQC). Mr Garner advised Members that Healthwatch was independent but adopted close working with the CQC, e.g. Healthwatch had awareness of the CQC's inspection reviews and that in return the CQC did consult with Healthwatch when undertaking inspections.

The Committee's comments would be considered by Mr Garner and he was thanked for his report.

9 DELAYED TRANSFERS OF CARE

Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals (BTH) and Mr Ian Ellwood, Discharge Manager, BTH presented the Delayed Transfers of Care report. Transfers of care issues concerned delays affecting patients who had finished one stage of their treatment but then had to wait some time before bed facilities became available at the next stage. Transfers of care could be internal or external and could be to another health or social care provider. The next stage of care could be at a facility such as a care home or the patient's own home.

Ms Oliver outlined the wider background context of issues and pressures that could impact on patient discharge services. She referred to the earlier agenda item on the Blackpool Clinical Commissioning Group's performance report and issues concerning accident and emergency waiting times and ambulance response rates. She explained that 'front door' issues impacted upon 'back door' performance and vice-versa, for example a

patient unable to be transferred from a hospital bed impacted upon an accident and emergency patient. She added that there were three wards dealing with a range of patients with complex issues.

Ms Oliver explained that there many patients arrived in winter with respiratory diseases, heart attacks, infections and were generally frail and vulnerable people. There was a lot of pressure on local ambulance services due to much higher than average demand in Blackpool compared to regional neighbours.

Members requested if figures could be provided as to inappropriate use of ambulance services. Ms Oliver agreed to obtain inappropriate use figures from the North West Ambulance Service for a future meeting. She added that a joint piece of work was taking place with GPs concerning out-of-hours services with a view that GPs could direct appropriate cases to hospital in good time rather than people unnecessarily using emergency services.

Mr Ellwood explained that there was a national performance dataset for measuring delayed transfers of care as presented in the report and appendices. Figures were for a five week period (one month) from 13 May 2016 to 13 June 2016. The recent five week period was compared against the parallel five week period in 2015.

Mr Ellwood reported that the number of delays for the five week period in 2015 averaged around 30 per week, which had risen to around 50 for the parallel period in 2016. He explained that the number of corresponding lost bed days, which had also risen, depended on the complexity of individual patients' needs and reasons for delays. There could also be other factors such as seasonal variation due to bank holiday pressures.

Ms Oliver added that delayed transfers of care, with patients still resident in wards unnecessarily, could potentially have an annual financial cost of up to £1million for each ward of 20 beds. There were 25 wards and the delays equated to the loss of two wards amounting to an annual cost of up to £2million. The current pressures creating delays reflected a national trend and Ms Oliver advised that it was important to work towards reducing the number of delays to closer to the previous year's performance of 30 delays per week.

Mr Ellwood referred to whether delayed transfers were due to health or social care services. He explained that delays could be due to issues within NHS healthcare services, social care services such as care homes or both. Delays had risen in all three service groups compared to the last year reflecting the total rise in delays. He added that whilst most delays still stemmed from healthcare services proportionately this had changed. Healthcare service delays had accounted for over half in 2015 but were now less than half with social care and joint service issues rising.

Members noted the significant increase in delays in 2016 compared to 2015 and national trends and queried if the trend was to continue how increased pressures could be managed in 2017. Mr Ellwood agreed that there were lots of pressures resulting in a worsening national trend. He referred to reasons for delayed transfers of care and highlighted that nationally several categories were used for reasons for delayed transfers. These included waiting for professional health or social care assessments, further NHS treatment, funding delays, waiting for care home packages or placements and community

equipment being unavailable. The different causes in delays had all risen over the last year reflecting the total rise in delays, in particular delays in professional assessments, waiting for further NHS treatment and patient choice of care home. He added that proportionately the largest increase in cause of delay had been patient choice.

Mr Ellwood added that traditionally delays had been mainly due to internal hospital reasons such as complex assessments. However, this had shifted more towards external factors across the private social care sector. The two main factors were complexity of patients' needs such as dementia and behavioural issues and being able to find the right environment for them and also demand against limited capacity. Enabling care at people's home was being promoted but capacity was limited locally and nationally. Capacity had increased for issues such as dementia but pressures were constantly growing.

Mr Ellwood referred to work that had taken place over the last 18 to 24 months to tackle the range of challenges. Internal processes had been improved such as identifying robust evidence for funding and reduced bureaucracy but further improvement was still needed. Ms Oliver gave an improvement example of electronic referrals and added that communication was important in order to identify omissions or agree solutions. Mr Ellwood added that more work was taking place with multi-disciplinary teams and that improvements could be made through increasing social worker presence at hospitals in view of the increasing complexity of patients' needs.

He also added that better links had been created with social and community services as well as health and social care commissioners of services. The links had resulted in regular meetings with social care managers and commissioners with all partners collectively looking at individual bottlenecks in care transfers and agreeing appropriate actions to tackle delays. Actions included identifying potential capacity and streamlined ways of working, consideration was also given to whether a patient needed to be in hospital.

Ms Oliver highlighted concerns that wider social funding cuts had a detrimental health impact through increasing social isolation. There was a growing elderly population who were particularly affected. There had been a debate across Lancashire concerning social care needs and funding pressures, in particular the costs of residential care homes. Blackpool Teaching Hospitals Trust was promoting better use of community services through community teams. Members agreed that cuts had had an impact but were always carefully considered.

The Committee's comments would be considered by Ms Oliver and Mr Ellwood and they were thanked for their report.

10 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

The Chairman referred to the Health Scrutiny Workplan for 2015-2016 and progress with the Implementation of Recommendations. Members were informed that this was an initial outline Workplan which was evolving and aimed to focus on key strategic health issues and future health service plans. There were a range of actions to pursue following the earlier performance agenda item with Blackpool Clinical Commissioning Group (BCCG).

Members were informed that training seminars were being arranged with BCCG, Blackpool Teaching Hospitals and the Council's Public Health Team to learn more about their roles and work. Members were reminded that an additional meeting had been arranged on Wednesday 12 October 2016 to receive a progress update on issues at the Harbour care facility and improvements made.

The Committee agreed:

1. To approve the Scrutiny Workplan subject to the inclusion of the additional items identified for consideration with the Blackpool Clinical Commissioning Group.
2. To note the 'Implementation of Recommendations' table.

11 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday 28 September 2016 commencing at 6pm in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.00 pm)

Any queries regarding these minutes, please contact:
Sandip Mahajan, Senior Democratic Governance Adviser
Tel: (01253) 477211
E-mail: sandip.mahajan@blackpool.gov.uk

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Sharon Davis, Scrutiny Manager.
Date of Meeting	28 September 2016

EXECUTIVE AND CABINET MEMBER DECISIONS

1.0 Purpose of the report:

1.1 To consider the Executive and Cabinet Member decisions within the remit of the Health Scrutiny Committee (HSC).

2.0 Recommendation:

2.1 Members may use the opportunity to question the Cabinet Secretary or the relevant Cabinet Member in relation to the decisions taken.

3.0 Reasons for recommendation(s):

3.1 To ensure that the opportunity is given for all Executive and Cabinet Member decisions to be scrutinised and held to account. To ensure that the opportunity is given for all Executive and Cabinet Member decisions to be scrutinised and held to account.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	N/A

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 Attached at the appendix to this report is a summary of the decisions taken, which have

been circulated to Members previously.

5.2 This report is presented to ensure Members are provided with a timely update on the decisions taken by the Executive and Cabinet Members. It provides a process where the Committee can raise questions and a response be provided.

5.3 Members are encouraged to seek updates on decisions and will have the opportunity to raise any issues.

5.4 Witnesses/representatives

5.4.1 The following Cabinet Members are responsible for the decisions taken in this report and have been invited to attend the meeting:

The following Cabinet Members are responsible for the decisions taken in this report and have been invited to attend the meeting:

- Councillor Graham Cain, Cabinet Secretary for Resilient Communities
- Councillor Amy Cross, Cabinet Member for Health Inequalities and Adult Safeguarding

Councillor Amy Cross is unable to attend. No

Does the information submitted include any exempt information?

List of Appendices:
Appendix 4 (a): Summary of Executive and Cabinet Member decisions taken.

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None.

This page is intentionally left blank

DECISION / OUTCOME	DESCRIPTION	NUMBER	DATE	CABINET MEMBER
INTEGRATED CLINICAL RECOVERY, DRUG AND ALCOHOL TREATMENT SERVICE Re-commission an integrated clinical and recovery drug and alcohol treatment service under a Prime Provider Model. The decision would provide the opportunity to achieve transformational change throughout the treatment system and deliver improved outcomes through a whole systems approach as well as achieving the two Council priorities. Moving to the Prime Provider Model would help to achieve a £200,000 saving.	Tendering of the Drug and Alcohol Treatment Services to enable the new contract to be in place by the 1 April 2017.	PH57/2016	1/8/2016	Cllr Cross
PUBLIC HEALTH SCRUTINY REVIEW The Review recommendations were endorsed by the Health Scrutiny Committee on 6 July 2016 and the relevant Cabinet Member, Cllr Cain, questioned. The decision is included for information. Agreed the recommendations of the Public Health Scrutiny Review final report action plan as outlined below and work towards their implementation**:** 1. That the Council's Public Health department be recommended to explore avenues to connect more with children and their parents through sports clubs and activities being operated from parks within the town, in order to communicate public health messages.	Approve Public Health Scrutiny Review final report and Action Plan.	EX37/2016	12/09/2016	Cllr Cain

2. That Blackpool Healthwatch be recommended to consider adopting a greater focus in its work in promoting public health and tackling health inequality. 3. That a training session be provided by Public Health open to all Members explaining the Joint Strategic Needs Assessment process, demonstrating the website and explaining how it could be used by Councillors to assist in their roles. 4. a) Appropriate consideration of single people in the Health and Wellbeing Strategy in regards to ensuring housing of a decent standard and ensuring adequate provisions to prevent social isolation. b) The Health and Wellbeing Strategy to incorporate considerations of how healthy behaviours could be encouraged through the planning of the built environment. 5. That the Council's approach to social action and volunteering be presented to the Resilient Communities Scrutiny Committee for consideration once it has been established. 6. Future performance against the Health and Wellbeing Strategy be considered by the Health Scrutiny Committee.				

HEALTH AND WELLBEING STRATEGY The Strategy was considered by the Health Scrutiny Committee on 6 July 2016 as part of the Forward Plan and the relevant Cabinet Member, Cllr Cain, questioned. Recommend the Council to approve the Health and Wellbeing Strategy. Council is due to consider the Strategy on 21 September 2016.	Approve the final draft of the Health and Wellbeing Strategy.	EX37/2016	12/09/2016	Cllr Cain

This page is intentionally left blank

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Ruth Henshaw, Corporate Development Officer
Date of Meeting:	28 September 2016

COUNCIL PLAN PERFORMANCE REPORT - QUARTER ONE, 2016-2017

1.0 Purpose of the report:

1.1 To present performance against the Council Plan 2015-2020 for the period 1 April 2016 – 30 June 2016 (Quarter One).

2.0 Recommendation(s):

2.1 The Committee is asked to note the content of the report and highlight any areas for further scrutiny which will be reported back to the Committee at the next meeting.

3.0 Reasons for recommendation(s):

3.1 To ensure constructive and robust scrutiny of performance against the Council Plan 2015-2020.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	N/A
3.3	Other alternative options to be considered:	N/A

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increase resilience".

5.0 Background information

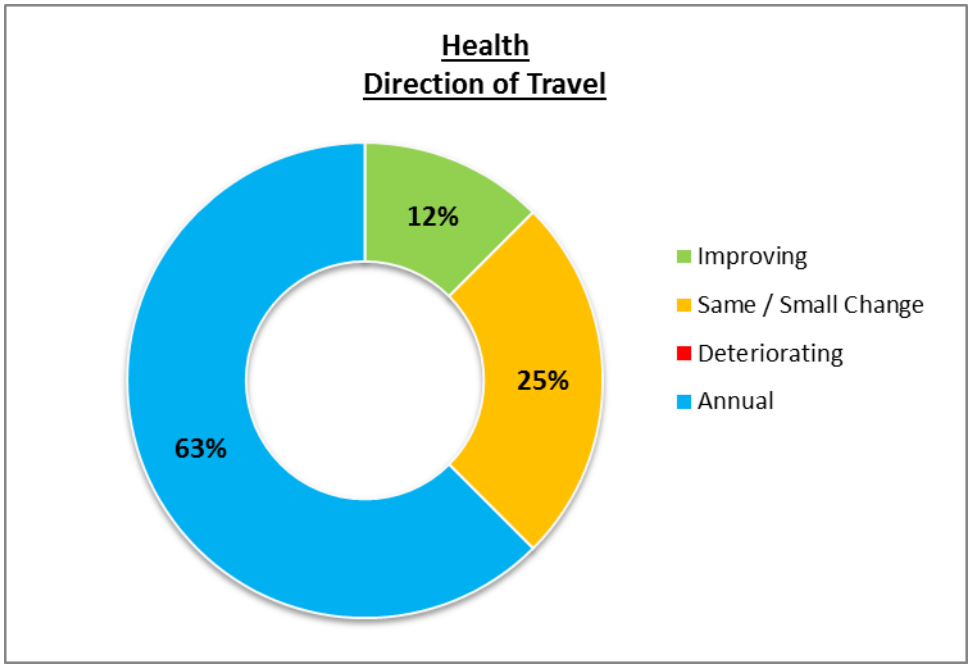
5.1 This report reviews performance against the priorities in the Council Plan 2015 - 2020. The report focuses on a set of core performance indicators which have been developed in consultation with the Corporate Leadership Team.

5.2 Performance against the health indicators will be reported on a quarterly basis to the

Health Scrutiny Committee.

6.0 Overview of Performance

6.1 There are eight indicators within the performance basket for Health. The graph below shows the direction of travel against performance in Quarter One (Q1) 2016-2017 compared with previous performance.



6.2 The majority of the Council Plan indicators for this Committee are either annual or bi-annual and therefore cannot be reported in this quarter. Of those indicators where data is available, only one is showing an improvement in performance. There are no indicators where performance has deteriorated in Quarter 1 2016-2017.

6.3 At the Target Setting Scrutiny Panel on 27 June 2016, the Panel recommended that the Committee receive performance trajectories for the following indicators:

- % of non-opiate drug users successfully completing treatment who do not re-present to treatment within six months; and
- Prevalence of excess weight in Year 6 children (10-11 years).

A trajectory for the percentage of drug users successfully completing treatment who do not re-present to treatment within six months has been produced for this report and can be found in **Appendix B – Q1 Trajectories**.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 6 (a): Q1 Key Performance Indicator (KPI) Spreadsheet
Appendix 6 (b): Q1 Trajectories

7.0 Legal considerations:

7.1 None

8.0 Human Resources considerations:

8.1 None

9.0 Equalities considerations:

9.1 None

10.0 Financial considerations:

10.1 None

11.0 Risk management considerations:

11.1 None

12.0 Ethical considerations:

12.1 None

13.0 Internal/ External Consultation undertaken:

13.1 N/A

14.0 Background papers:

14.1 None

This page is intentionally left blank

Corporate Key Performance Indicators

Performance as at 30th June 2016

KEY - Direction of Travel Icons:

⇧✓ / ⇩✓	Performance is improving or on target
⇧ / ⇩	Small deterioration in performance / slightly off target
⇔	No change
⇧✗ / ⇩✗	Performance is deteriorating or off target

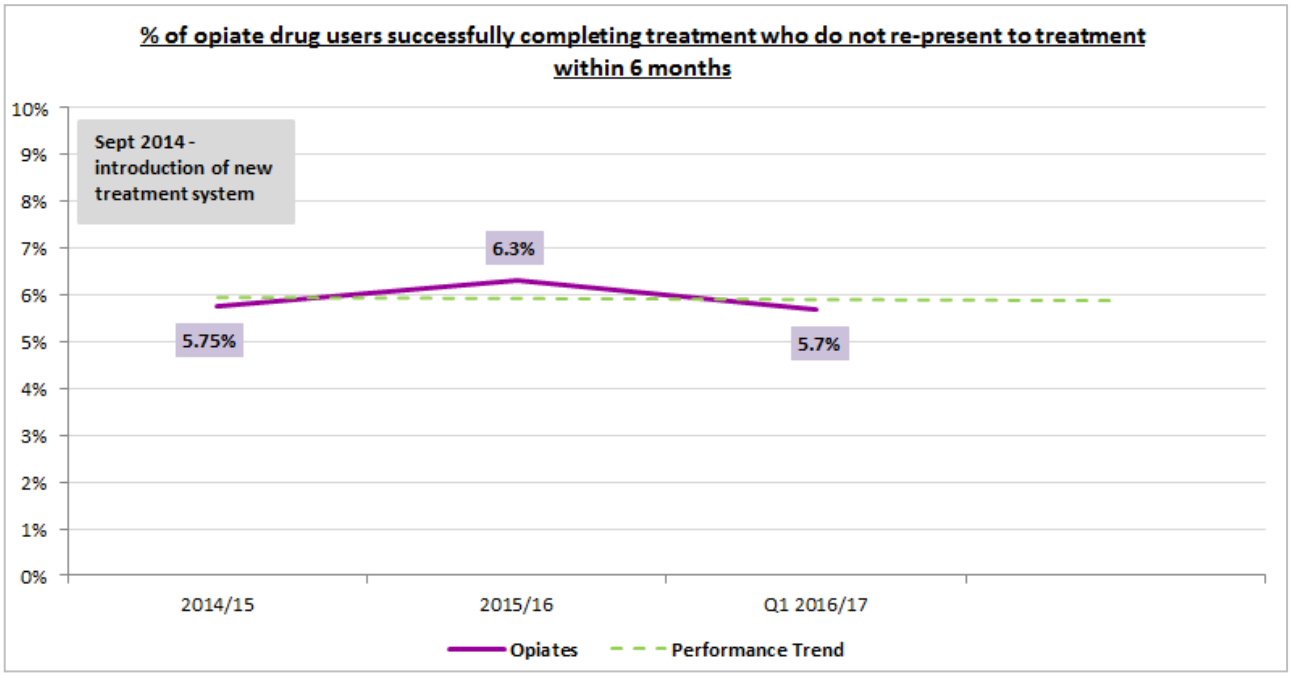
Lead Cabinet Member		Indicator	Outturn 2013/14	Outturn 2014/15	Outturn 2015/16	DoT (13/14 v 15/16)	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4	Outturn 2016/17	Target 2016/17	Direction of Travel Against Previous	Direction of Travel Against Target	Notes	Dept
Cabinet Secretary (Health)	Cllr Cross	% of opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	*n/a*	*5.75%*	*6.3%*	⇩✗	5.7%					**Increase on last year**	⇩	⇩		PH
	Cllr Cross	% of non-opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	*n/a*	*51.22%*	*44.7%*	⇧✓	51.2%					**Increase on last year**	⇧✓	⇧✓		PH
	Cllr Cross	% of successful completions of alcohol treatment	*54.6%*	*44.5%*	*45.5%*	⇩✗	44.6%					**Increase on last year**	⇩	⇩		PH
	Cllr Cross	Smoking prevalence in adults aged 18 or over	*29.47%*	*26.5%*	*26.93%*	⇩✓	A	A	A			**25%**	**Annual**			PH
	Cllr Cross	Smoking status at the time of delivery	*30.84%*	*27.48%*	*27.19%*	⇩✓	A	A	A			**25% or less by end of 2017**	**Annual**			PH
	Cllr Cross	Prevalence of excess weight in Reception children (4-5 years)	*25.54%*	*26.79%*	*25.72%*	⇧	A	A	A			**< 25%**	**Annual**			PH
	Cllr Cross	Prevalence of excess weight in Year 6 children (10-11 years)	*34.72%*	*35.67%*	*37.98%*	⇧✗	A	A	A			**< 37.98%**	**Annual**			PH
	Cllr Cross	% take up of NHS Health Checks per year amongst the eligible population (aged 40-74)	*76.08%*	*73.14%*	*52%*	⇩✗	A	A	A			**Increase on last year**	**Annual**			PH

This page is intentionally left blank

CABINET SECRETARY (HEALTH)

Indicator Description	Better to be?
% of opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	High

	2014/15	2015/16	2016/17				DoT
			Q1	Q2	Q3	Q4	
Opiates	5.75%	6.3%	5.7%				⇩



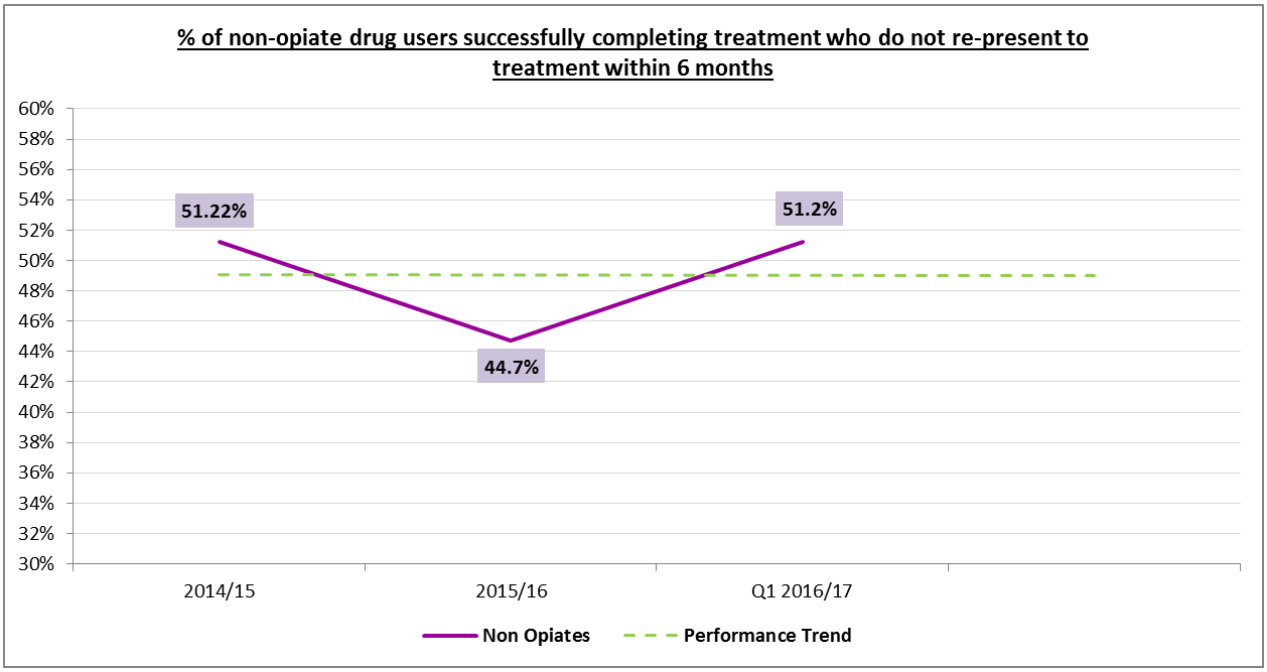
Commentary:

The percentage of opiate clients who successfully completed treatment and did not re-present within six months in Quarter One 2016-2017 has slightly decreased to 5.7% and continues to be below the baseline. This decrease in performance can be attributed to a change in the way treatment is delivered. Prior to September 2014 clients in treatment were exited immediately after their clinical intervention which was often too soon and meant clients relapsed. The new treatment system now includes a wider recovery offer; therefore clients remain in treatment for a longer period of time once the clinical intervention is completed. This work supports clients to maintain their recovery and reduces the number of relapses.

Appendix 6 (b) - Exception Reports (Quarter One 2016-2017)

Indicator Description	Better to be?
% of non-opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	High

	2014/15	2015/16	2016/17				DoT
			Q1	Q2	Q3	Q4	
Non-opiates	51.22%	44.7%	51.2%				⇧✓



The percentage of non-opiate clients successfully completing treatment in Quarter One 2016-2017 has increased to 51.2%. Blackpool is still performing within the top quartile range for comparator local authorities and is considerably higher than the national average of 38.5%.

In terms of the difference between the treatment outcomes for opiate clients and non-opiate clients, the number of non-opiate clients who access treatment services is considerably lower than the number of opiate clients. In Quarter Four 2015-2016, 215 non-opiate clients had been through the treatment service compared to 1,025 opiate clients. Non-opiate clients can be less complex and require a shorter period in treatment therefore the outcomes for these clients are very successful and they tend to not return to treatment. However, the opiate clients are far more complex due to the fact the clients are in more entrenched behaviours, have mental health problems, as well as general health problems. Due to the length of time opiate clients spend in treatment, the numbers for those who exit treatment is low. We also need to be mindful that these individuals can relapse due to their complex needs, but this can also be seen as a positive as they are returning to treatment for support.

This indicator measures the percentage of successful treatment completions as a proportion of all clients in treatment rather than as a proportion of clients leaving treatment. Therefore the percentages reported may not give a true reflection of performance in this area. The Committee may like to explore alternative performance indicators for measuring successful treatment completions going forward.

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Jeannie Harrop, Senior Commissioning Manager, NHS Blackpool CCG
Date of Meeting:	28 September 2016

NHS BLACKPOOL CLINICAL COMMISSIONING GROUP - NEW MODELS OF CARE UPDATE

1.0 Purpose of the report:

1.1 To review progress made with the implementation of New Care Models across Blackpool and allow effective scrutiny of the approach taken.

2.0 Recommendation:

2.1 To review the content of this update, scrutinise progress to date in relation to the ongoing implementation and identifying any topics for further consideration by the Committee.

3.0 Reasons for recommendation(s):

3.1 To ensure constructive and robust scrutiny of implementing New Care Models in Blackpool.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? N/A

3.3 Other alternative options to be considered: N/A

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 At the Resilient Communities Scrutiny Committee in March 2016, Members agreed to receive an update from NHS Blackpool Clinical Commissioning Group (CCG) on the progress made in implementing New Models of Care across Blackpool – including additional patient stories, the outcome from the submission of a Value Proposition and evidence of early impact. Responsibility for health scrutiny has since moved on to the new Health Scrutiny Committee.

5.2 **Value Proposition Update**

At the March 2016 meeting, members were informed that the CCG was awaiting the outcome from the submission of a Value Proposition (funding bid) to NHS England. This business case set out how we plan to invest central funding during 2016-2017 to deliver the maximum impact from our New Models of Care.

5.2.1 The CCG and other partners on the Fylde Coast were notified from an early stage of the bidding process that the amount of funding requested by 'vanguards' nationally exceeded the amount available by more than three-fold. There are 50 areas nationally, known as 'vanguards', that are developing New Models of Care using NHS England funding. These New Models of Care will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

5.2.2 As a result, the Fylde Coast vanguard programme was awarded £4.32m in funding. This was less than the £9.6m requested in the Value Proposition document but still substantially more than many other areas received.

5.2.3 As a result of this revised financial envelope, the speed and focus of change we had planned for has had to be adjusted accordingly. This is outlined within the sections below.

5.3 **Extensive Care**

The Fylde Coast Extensive Care Service (ECS) is a community based service which sees harmonised teams of different health and care professionals providing proactive and coordinated support to patients with often the greatest care needs. The aim is to support these patients to understand and manage their conditions better and thus reduce the likelihood of an admission to hospital and their overall demand on the healthcare system.

5.3.1 In order to be eligible for referral to the service, patients must:

- Be aged 60 or over
- Have two or more long-term conditions from the following:
    - Heart problems such as coronary artery disease, atrial fibrillation or congestive heart failure.
    - Respiratory problems, such as chronic obstructive pulmonary disease (COPD) or bronchitis.
    - Diabetes
    - Dementia

  (A pilot is currently underway to expand this list of conditions and increase number of referrals to the service).
- Have a risk score of greater than 20 or had two or more A&E attendances and/or non-elective contacts in the past three months.

5.3.2 This risk score is determined via a tool which combines secondary care data with GP practice data relating to long-term conditions and disease registers to predict the likelihood of hospital admissions and other non-elective activity within the next 12 months.

5.3.3 A second ECS site launched in Blackpool at South Shore Primary Care Centre during April 2016 and has received 267 referrals to date (as of 13 September 2016). The first site at Moor Park opened in July 2015. To date (as of 13 September) the two Blackpool sites combined have received a total of 652 patient referrals.

5.3.4 The original service blueprint modelled for each extensive care site to recruit a case load of 500 patients each – taking four months from launch to reach this capacity. The cohort of patients for this caseload was determined using data provided by the Commissioning Support Unit against the agreed referral criteria:

- Patient must be 60 or over
- Have two or more long-term conditions from an agreed list of six
- And have a risk score of greater than 20. This risk score is a metric which calculates likely future healthcare usage based upon age, health and wellbeing (using identifiers such as number of long-term conditions and other factors such as smoking) plus contacts with services in the last 12 months (such as hospital admissions and outpatient activity).

5.3.5 Across the Fylde Coast, the service has received a total of 1082 referrals to date (as of 13 September 2016). There are currently 592 active patients on the service caseload (referred, assessed and accepted). The table below provides a breakdown of the remaining 490 referrals.

5.3.6

Referrals no longer receiving Extensive Care Service (ECS) care	490
Successfully completed goals - discharged back to GP	104
Would not benefit from ECS input	73
Patient declined through choice	178
Self-discharged before completion of care plan	15
Non-compliance (multiple DNAs)	7
Patient passed away	54
No further treatment appropriate (palliative or conditions too severe to support)	17

Patient uncontactable after initial GP referral	14
Patient admitted to hospital before care plan signed off, re-referred after discharge	21
Patient moved out of area	7

5.3.7 The number of patients choosing not to enroll on the service is less than was modelled for in the service blueprint. The 16% of patients refusing the service is less than the 25% modelled for originally based upon evidence from successful international models.

July 2016 marked one year since the launch of the existing site at Moor Park Health and Leisure Centre. A review of the year document, including lessons learned and early impact seen from the introduction of the service across the Fylde Coast is attached for information at Appendix 1.

5.4 **Extensive Care Impact**

For the cohort of patients within the Extensive Care Services, early indications from the latest data available (as of 13 September 2016) show:

- A 19% reduction in Accident and Emergency (A&E) admissions.
- A 22% reduction in non-elective admissions.
- A 13% reduction in new out-patient attendances.
- An 18% reduction in follow-up out-patient attendances.

5.5 **Enhanced Primary Care**

At the previous meeting, members received the service description developed by the CCG for Enhanced Primary Care (EPC). To summarise, EPC will be delivered via Neighbourhood Care Teams working with the GP practices in their locality and is designed to provide an extra level of support to people who:

- Are aged 18 and over
- Registered with a GP in Blackpool, Fylde or Wyre.
- May have one or more long-term condition and other possible factors which impact on their general health and wellbeing.

5.5.1 The aim of the models is again to support these patients to manage their conditions better and reduce the likelihood of exacerbations in their conditions and thus activity within the local healthcare system. The CCG is working with neighbourhoods to begin the roll-out of this model across Blackpool from October 2016.

5.5.2 However, following the revised financial envelope within which the CCG must now implement this, the approach to recruitment of additional staff to deliver this model of care has had to be amended. Recruitment of additional staff has been scaled back

and a review of existing staff roles undertaken with some realigned in order to deliver the model as opposed to recruiting additional staff.

5.5.3 Core workforce roles within the Neighbourhood Care Teams delivering Enhanced Primary Care will include:

- Care coordinators
- Wellbeing support workers
- Therapists
- Combined admin/healthcare assistants role

5.5.4 Commissioners have been identified to work with the neighbourhoods to develop an integrated approach to patient care. Neighbourhood meetings are held monthly to discuss and agree staffing and processes and how the model will develop i.e. chronic disease management for house bound patients. The new staff detailed above will be part of an integrated neighbourhood hub which will coordinate patient care and signpost to other services as required.

5.5.5 The neighbourhoods are also developing strong links with a range of services including mental health, drug and alcohol, frequent callers, the voluntary sector, police, fire service, North West Ambulance Service (NWAS) and social care colleagues to ensure that the scope of provision meets the needs of their local population.

5.5.6 In line with this move to implement Enhanced Primary Care, the care home team commissioned by Blackpool CCG has also been changed from an education and training model to one that completes planned and unplanned care. A pilot will be commencing in October 2016 in the South neighbourhood area to target 15 care homes. The care home team will complete 'ward rounds' and planned care in the 15 care homes along with advice and visits for unplanned care. All phone calls from these care homes will be directed to the EPC care home team initially rather than primary care. The pilot will include the roll out of the Vanguard telehealth programme in care homes provision which will link to primary care.

Does the information submitted include any exempt information? No

6.0 List of Appendices:

Appendix 7 (a): Extensive Care - One Year On
Appendix 7 (b): Extensive Care Patient and Carer Story
Appendix 7 (c): Extensive Care Patient Story

Members are requested to view the Fylde Coast Extensive Care video before the meeting https://www.youtube.com/watch?v=wD8JqxhSIyI.

7.0 Legal considerations:

7.1 None.

8.0 Human Resources considerations:

8.1 None.

9.0 Equalities considerations:

9.1 None.

10.0 Financial considerations:

10.1 None.

11.0 Risk management considerations:

11.1 None.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/ External Consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.

Placing you **at the heart of** everything we do on the Fylde Coast

Fylde Coast Extensive Care - One Year On

your care our priority

Blackpool Council

Lancashire County Council

NHS


Lytham Road Pharmacy
NHS
Blackpool
Welcome to
South Shore Primary Care Centre

We're live!

In July 2015, partners across the Fylde Coast launched the new extensive care service – an integral part of our new care models which will revolutionise local healthcare.

These new models of care will not only improve the patient experience and outcomes but also deliver the necessary change the local healthcare system requires.

Health and care organisations across the region have long shared a collective vision to transform out-of-hospital services, through more coordinated and proactive support for the communities of Blackpool, Fylde and Wyre. The launch of extensive care was the first step on this journey towards delivering truly integrated out-of-hospital services.

Whilst the last year has not been without its challenges, we have already seen early indications of the positive impact extensive care is having on clinical outcomes as well as the experiences of our patients and staff.

About extensive care

Extensive care is a fundamentally different way of delivering care for patients with some of the most complex healthcare needs. The aim is to support these patients with proactive, coordinated care, which provides a single point of access, to reduce the likelihood of unplanned hospital admissions and out-of-hours contacts.

To be eligible for the service, patients must be over 60 years of age with two or more of the following long-term conditions:

- Heart problems such as coronary artery disease, atrial fibrillation or congestive heart failure.
- Respiratory problems, such as chronic obstructive pulmonary disease (COPD)
- Diabetes.
- Dementia.

The original service blueprint specified that suitable patients were also required to have a risk score of more than 20. However, this criteria was amended in January 2016 following feedback from GPs. Patients can now also be referred regardless of their risk score if they meet the age and long-term conditions criteria and have had two or more out-of-hours, A&E or non-elective contacts in the past three months.

Patients are referred to the service by their GP and an initial multidisciplinary assessment is then carried out with the patient. Once a patient joins the service, lead responsibility for the coordination of their care is transferred to the extensive care team from their GP practice (similar to the way in which care is provided when a patient is admitted to hospital).

With the support of their dedicated wellbeing support worker, patients are encouraged to set a number of goals and aims that they will work towards. These form part of a comprehensive 'My Plan' care plan which is developed in conjunction with the patient and carer to meet all of their health, wellbeing and social care needs. It also outlines the triggers that define when a patient's condition has worsened, and the action to take to support and stabilise them. The aim is to encourage the patient to self-manage their own condition and lifestyle wherever possible with the ultimate aim being to help patients reach a point where they no longer need the intensive support of the service.

The service operates from 8am-7pm, Monday-Friday, and 9am-1pm on weekends and bank holidays. The service was initially launched at two sites on the Fylde Coast, Lytham Primary Care Centre in Fylde and Moor Park Health and Leisure Centre in Blackpool before being rolled out to two further sites, Blackpool's South Shore Primary Care Centre and Wyre Civic Centre in April 2016.

The extensive care service sees a range of health and care professionals working together in one harmonised team. This includes:

- a lead consultant;
- sessional GPs;
- advanced practitioners;
- clinical care coordinators;
- pharmacists;
- wellbeing support workers;
- and administration staff.

Why the change?

For the Fylde Coast, the ambition to transform out-of-hospital services is a key part of how local partners plan to meet the challenges which the area faces.

The challenge we face across the Fylde Coast is significant. While the health of our residents is generally improving, it is still worse than England's average. Blackpool is still England's largest and most popular seaside resort attracting 11 million visitors annually. There is a considerable amount of transience, including movement in and out of the town, as well as movement within it. This, coupled with high unemployment and rising prevalence of long-term conditions, has led to significant levels of deprivation and health inequalities that rank among the worst in the country. Blackpool has the worst life expectancy in the country for men and the third worst for women.

Within the most disadvantaged areas of Blackpool men can expect to live 13.3 years and women 8.3 years less than people in the least disadvantaged areas. Not only do people in Blackpool live shorter lives, they also spend a smaller proportion of their lifespan in good health and without disability. In the most deprived areas of the town disability-free life expectancy is around 50 years.

In contrast, 57 per cent of the population in Fylde and Wyre live within two of the most affluent quintiles. But, there are more than 16,800 people living in neighbourhoods that are classified as being among the fifth most disadvantaged areas in England, with men dying on average, 10 years younger than those in more affluent areas. For women, the difference is six years. A higher percentage of people in Fylde and Wyre are affected by long-term health problems 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.

It is also predicted that the number of over-65s within the whole Fylde Coast population will rise to between 31 per cent and 35 per cent by 2028. As partners we recognised that continuing to deliver more care in its current form is not financially sustainable. We know more people are cared for in hospital than is necessary and that care can often be provided more effectively in the community or at home. The care we provide is not always as coordinated as well as it could be and this can lead to poor experiences for patients and their families too.

We reviewed successful models of care from America and Europe and undertook an analysis of how these could be implemented to meet the needs of our local population and of the wider health and social care system in the UK. During the development of the CCGs' five-year strategies, our vision was advanced and tested by extensive engagement with a wide range of partners, patients and the public. Hearing their experiences of local services has helped to shape how our new models of care look now.

Our challenges

An increasing number of people living with complex long-term conditions.

A population with a growing number of older people.

Different communities with varying needs.

Men living in the most deprived areas die around 10-13 years younger than those living in the least deprived.

Many patients with long-term conditions are not managed well and cared for in hospital when they could be better supported in the community.

Poor experiences for patients and families because care is not always co-ordinated well.

Financial challenges across the whole health and care system.

Women living in the most deprived areas die around 6-8 years younger than those living in the least deprived.

One year on... the successes

The introduction of our extensive care model has not only been new to us on the Fylde Coast but to the NHS across England. Launching four new service sites across the area whilst ensuring the necessary staff and skills were in place to deliver the effective service we aspired for has been a substantial achievement in its own right.

From the early indications wehave already started to see some positive outcomes too, including:

- A 13 per cent reduction in A&E attendances.
- A 25 per cent reduction in non-elective admissions.
- An 18 per cent reduction in out-patient appointments.

In addition, of those patients who qualify but are yet to be referred to the service, nearly 90 per cent recorded some acute activity. This is compared to just 74 per cent in patients receiving extensive care.

One big success over the last 12 months has been the service workforce. To date we have recruited 81.3 whole-time-equivalent staff across a variety of roles.

All staff undergo a thorough induction process and we have evolved this through three waves of recruitment to focus on developing a workforce which possesses generic skills. This means all staff in the service are able deal with varying patient needs but it has been particularly important within the role of our care coordinators.

The introduction of the wellbeing support worker role has been a huge success too. This is a completely new role to healthcare organisations on the Fylde Coast and plays a pivotal part in making sure that patients not only receive support which meets their health needs but equally focuses on their general wellbeing. Each wellbeing support worker develops an in-depth understanding of the patient through their regular contact, and tailors their one-to-one support accordingly. This is often wide-ranging and can include; reminders to attend appointments and take medication; acting as an advocate; accompanying to activities such as wellbeing exercise sessions; encouraging new interests and hobbies and confidence building. Combining health and wellbeing support in this way has meant that we are able to make a true difference for patients.

"We've seen great achievements since we launched the service. Without the hard work of service staff and the collaboration of partner organisations on the Fylde coast, the last 12 months would not have been possible."

Dr Andrew Weatherburn, clinical lead.

A further positive development has been the evolution of our medical consultant roles. The clinical lead was previously a secondary care geriatric consultant but has seen the role develop into a community based, primary care hybrid type role. This has not only allowed the clinical lead to benefit from the development of new skills but also allowed for strong working relationships with both primary and secondary care colleagues.

All four of the service sites sit within modern community facilities. Three within existing primary care centres and a fourth within a shared local authority building. This has allowed for close working between the service staff and other professionals.

The service has also established strong links with older adult mental health services, to the benefit of patients and staff over the last 12 months. This has included the regular attendance of older adult mental health professionals at weekly service MDT meetings. This has greatly supported our holistic approach to patient care.

The patient experience

Since the launch in July 2015, the service has cared for 577 patients with 98 per cent saying they would recommend the service to friends and family. Here's what some of these patients and staff within the service had to say about their experiences over the last 12 months:

John Kellow, 67-year-old Blackpool resident:
"If it wasn't for the extensive care service then I don't know where I would be… they take the time to listen to me and my issues. I have come on an unbelievable amount. They really are a lifeline. They have given me the confidence to take control of my life."

Rachel Howarth, wellbeing support worker:
"I really enjoy the work as it is very positive and person-centred. I get the luxury of having the time to spend with the patient and it is nice to build those relationships. Now when the patients are ringing us we know it is for a good reason as they have been empowered to deal with many things themselves."

Stuart Bradley, 64-year-old Freckleton resident:
"The goals are just simple things, but things that have become incredibly difficult in recent years. And the speed of the service is incredible. I know if anything goes wrong I can ring a number, 24/7, and someone will help me. I am not waiting a month to see a doctor any more. It is instant and for me, and Beryl, that provides huge security as I know in that place there is someone there if I need them."

Lee Jones, wellbeing support worker:
"This service is fantastic as, with myself and the other wellbeing support workers, we are able to get right to the very root of the problem and get it sorted. In a 10-minute appointment with a doctor, all they can do is diagnose a health complaint and arrange treatment, but through developing a relationship with Stuart I have been able to look at more preventative measures so, in the main, he is able to look after his conditions and avoid the need for emergency treatment."

"At first I didn't want to come to the extensive care service and I said no we're alright. I said I'll ring if I need help. You think you can do it, you think you don't need anybody. Well I did need help. I came in and they were absolutely wonderful. I'd recommend it to anyone!"

Lily Greenwood, wife and carer.

One year on... the challenges

Introducing a new way of working as we have with extensive care does not come without tests. Whilst we have had plenty of successes there have also been areas of challenge which we have had to embrace and adapt to accordingly since the launch.

One particular area of challenge has been referrals to the service. The overall number of referrals received by the service to date is less than expected. This has been due to a number of issues. Feedback from primary care colleagues told us that they found the referral criteria too rigid and that the lists of suitable patients they received based upon, risk stratification scores, data wasn't timely enough. As a result we flexed the referral criteria to allow practices to take a more subjective approach to potential referrals.

Patients are now able to be referred to the service regardless of their risk score if they meet the age and conditions criteria and have had two or more out-of-hours, A&E or non-elective contacts in the last three months. We are also now moving towards more real-time data flows across the local system which we hope will further aid the referral process.

Practices also told us that trying to 'sell' a new service to patients, the concept we had adopted from having studied international models, was time consuming and often resulted in the service being declined through patient choice.

Engagement between primary care professionals and the service has also been a challenge with the original positioning of the service presenting a barrier to good relationships initially.

We have also experienced difficulties with the interoperability of different IT systems. As a community based service, extensive care uses EMIS Community. However, primary care colleagues use a separate GP EMIS system and each practice has their own GP EMIS system which they manage. The GPs system and the extensive care system therefore do not 'talk to each other'. This has caused frustration for staff on both sides. As a result updating patient records, particularly with prescribing changes, has proven an onerous task. The current process means extensive care prescribers are required to have a separate login for every single GP EMIS system meaning they require a large number of individual logins each. This is obviously not the easiest or most convenient method.

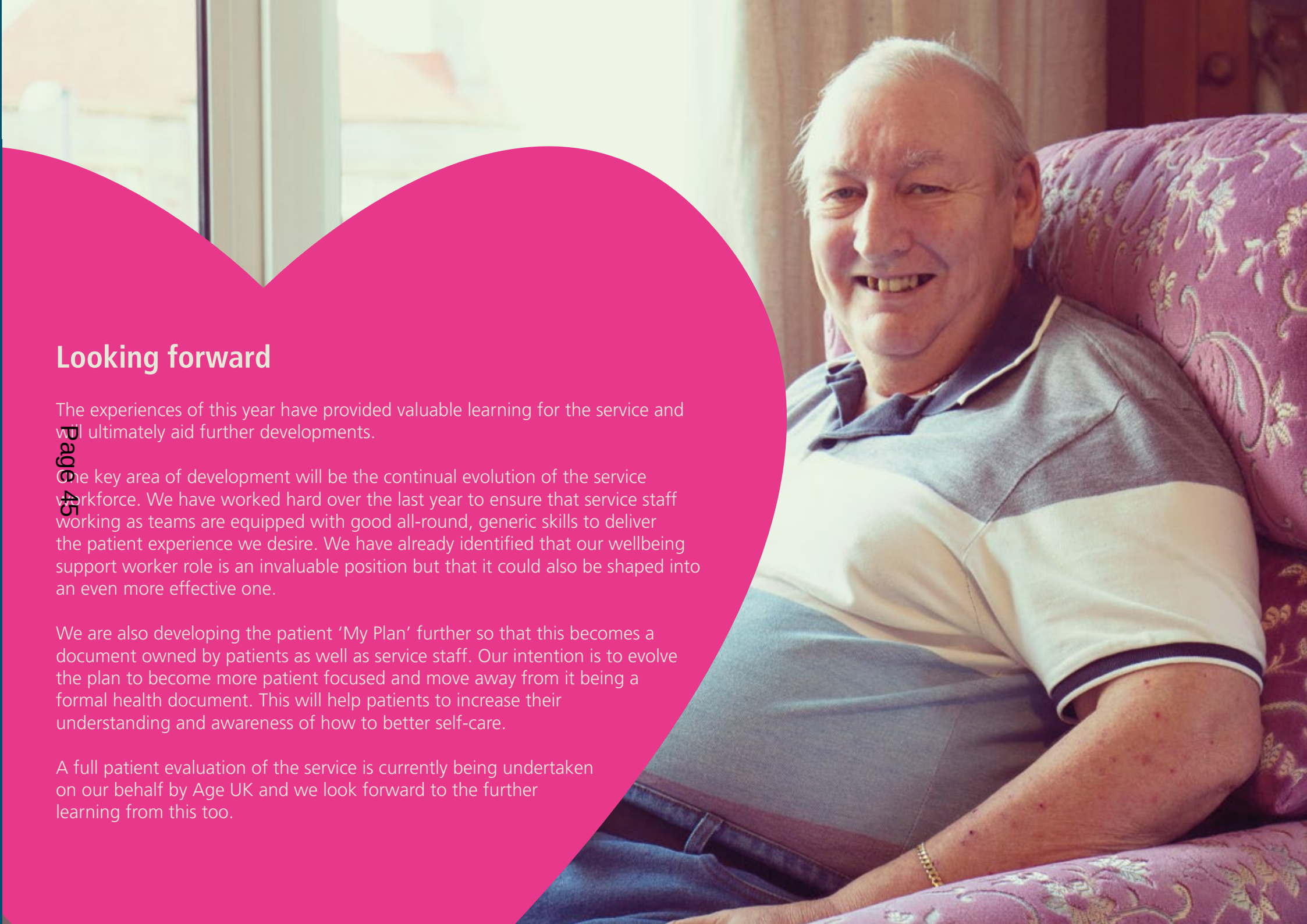
Looking forward

The experiences of this year have provided valuable learning for the service and will ultimately aid further developments.

One key area of development will be the continual evolution of the service workforce. We have worked hard over the last year to ensure that service staff working as teams are equipped with good all-round, generic skills to deliver the patient experience we desire. We have already identified that our wellbeing support worker role is an invaluable position but that it could also be shaped into an even more effective one.

We are also developing the patient 'My Plan' further so that this becomes a document owned by patients as well as service staff. Our intention is to evolve the plan to become more patient focused and move away from it being a formal health document. This will help patients to increase their understanding and awareness of how to better self-care.

A full patient evaluation of the service is currently being undertaken on our behalf by Age UK and we look forward to the further learning from this too.



Evolving our health and care system

The introduction of extensive care forms one part of our approach to implementing new models of care on the Fylde Coast.

In Autumn 2016 we will launch our enhanced primary care model which will be a universal service available to patients over 16 who require a greater level of support for the management of long-term conditions. Locally based neighbourhood care teams will be located within the 10 neighbourhoods on the Fylde Coast to deliver this enhanced level of support alongside GPs.

When both our enhanced primary care and extensive care models are implemented together we envisage a seamless care system which wraps care around patients according to need. This will enable GP capacity to be freed up so that they are available to better manage and support more complex patients, assuring adherence with best practice to improve outcomes.

Sharing our learning

As a vanguard site, we are committed to sharing our learning from the development and implementation of our new care models as we progress along our journey.

The extensive care team have facilitated a number of visits from other health and care economies looking to learn from the launch of the service on the Fylde Coast.

This has aided these other areas to develop their own thinking towards new models of care. Samuel Keong, service redesign programme manager, NHS Birmingham Crosscity CCG: "The extensive care service kindly hosted us when we came to see how their model worked. The learning was incredibly beneficial and has heavily influenced the way we're co-designing the service with partners on how this can be delivered effectively.

"The lessons they've learnt provided a better starting position for us, warning us of the potential pitfalls and key challenges that needed resolution in order to succeed."

The extensive care service team have also benefitted themselves from the learning of colleagues in both Yeovil and Selby who have also introduced similar extensivist models of care.

“We wanted to understand in more detail the work that the Fylde Coast team had done to establish the service and learn from them about the improved outcomes for patients and benefits realised to date. We were not disappointed.

“We have taken on board everything they’ve told us and have now set up our own Visioning Workshop later this month, to draft a model of extensive care that will support the patients of Tameside and Glossop. I’m sure our working relationship with the team will continue to grow as we build our service and hopefully we will be in a position to give them something back from our experience.

“We thank the Fylde Coast extensive care team so much for sharing their learning with us. They’ve given us the insight and inspiration to go ahead and develop a service that meets our local population needs.”

Angela Brierley, head of service transformation, Tameside Hospital NHS Foundation Trust.

If you would like to arrange an opportunity hear more about the learning from extensive care on the Fylde Coast then please contact the service directly via telephone on 01253 951400 or email extensivecare.service@nhs.net.

your care our priority

www.yourcareourpriority.nhs.uk

@YCOPFyldeCoast

/YCOPFyldeCoast

Blackpool Council

Lancashire County Council

NHS

This page is intentionally left blank

Patient story: extensive care
Peter and Lily Greenwood, Blackpool

Peter is a 78-year-old gentleman and retired book maker who lives with his wife Lily.

Peter sustained a stroke while on holiday in 2011, resulting in communication limitations and a change in his personality. From being a lively and outgoing person, Peter subsequently became socially isolated and reluctant to engage in conversations and activities. He is unable to have empathy for others or the ability to compromise and is occasionally verbally inappropriate. He also has frequent falls. A following diagnosis of Alzheimer's disease has also compounded his brain injury.

Lily is his main carer and has found the last few years increasingly stressful and frustrating. This has been made more difficult by Peter refusing to attend respite which has left Lily feeling socially isolated and exhausted. Due to this, Lily has neglected her own health which has begun to suffer as a result. Lily often feels lost and frustrated with Peter and in herself.

The extensive care team have worked with Lily and Peter to develop a care plan which focuses on four key goals:

- Reduce Peter's risk of falls.
- Improve communication and reduce frustration.
- Improve Lily's understanding and awareness of dementia.
- Reduce their social isolation.

Much of this support has centred on the service working with Lily as Peter is unable to engage with the team due to the nature of his dementia.

To reduce falls and maintain safety the team referred Peter to a community physio to assist with mobility and improve strength. They also set-up Peter with a Vitaline device to maintain safety and prevent the inappropriate ambulances calls. Peter's falls have subsequently reduced and with the implementation of Vitaline there have been no further inappropriate uses of the ambulance service.

Vitaline also provided a carer's emergency card to alert others that Lily is a carer to Peter. Unfortunately Lily had both emergency and elective admissions to hospital due to cardiac issues. The carer's emergency card alerted A&E that Lily was a carer and the contingency plan was successfully implemented, with as little distress to Peter as possible and Lily could focus on her own condition without worrying.

Joint efforts from a wellbeing support worker and social worker within the service resulted in appropriate respite being found for Peter. Provision which specialised in care for individuals with dementia was found to ensure Peter's needs would be met and that he was happy to attend. This enabled Lily to have some much needed rest and time to focus on her own needs and health concerns whilst also alleviating some of Peter's social isolation. The respite formed part of the contingency plan to maintain Peter's safety in the event of unforeseen circumstances.

Due to Peter's lack of ability to communicate attempts were made to improve his social isolation, which he continually declined. This caused additional stress and frustration for Lily. To address Lily's frustrations with Peter, she was introduced to the Carers Trust by the wellbeing support worker.

Lily went on to complete a four-week dementia education course following this. This was massively beneficial for Lily, who felt she learned better coping strategies and how to communicate more effectively with Peter. She felt she was better able to manage Peter and this hugely reduced her stress levels. It also enabled Lily to socialise with other carers and like-minded people.

Following the course, the Carers Trust asked Lily to return to talk to other carers and share her experiences to help other people in similar situations. She has featured in the local press, promoting the work of the Carers Trust and she is now also in the process of organising multiple charity events in aid of The Carers Trust. This has opened up a new social circle and increased her confidence massively.

Following the input of the service Peter has been able to continue living at home with Lily. Due to the successful completion of their goals, Peter has now been discharged back to the care of his GP. Lily has expressed how she feels much more in control of the situation and less reliant on health professionals for reassurance. She has expressed her gratitude for the input of the extensive care service, especially from her Wellbeing Support Worker, Brian. Lily said: "At first I didn't want to come to the extensive care service and I said no we're alright. I said I'll ring if I need help. You think you can do it, you think you don't need anybody. Well I did need help. I came in and they were absolutely wonderful. I'd recommend it to anyone."

Patient story: extensive care

Background
Medically the patient suffers with COPD, heart failure, type two diabetes, diverticulitis and cellulitis. In addition to this she has had various cancers (including chronic lymphoid leukaemia) treated with a mastectomy, chemotherapy and radiotherapy. The cancer treatment has left her with greatly thinned hair and a scar on her face. These factors have added to the patient's lack of confidence. She is 80 years old and lives alone in a privately owned flat. The patient's husband died a few years ago leaving her living alone with her cat and socially isolated. She has family in the form of nephews but they do not live close by and there are frictions in the relationships.

The initial assessment at the patient's house was carried out in the afternoon, she was still dressed in her night clothes and the house was quite cluttered and untidy. Socially she did very little, struggling to get out and about due to her mobility and the fact her disabled badge had expired. She also appeared quite low in mood. On the morning of her clinic appointment she attempted to cancel reporting that her IBS was playing up. However, after a wellbeing support worker arranged to meet her at clinic and go through the appointments with her, she felt more encouraged by this support and attended. The patient gets anxious about having to see people and has since tried attempted to cancel or not attended a number of appointments due to feeling unwell.

MyPlan
The myPlan goals for this lady were to:

- renew her blue badge;
- get a wig;
- arrange for a cleaner to help with her housework;
- and to look at her wellbeing needs through getting her involved in various social activities so as to reduce her loneliness and improve her mood.

Wellbeing Support Worker Input
The patient required a lot of support in achieving her goals, and at times is very difficult to engage with. The wellbeing support worker input has been very much focused on empowering her, and giving her the confidence to do things for herself by providing help and initial support. For example, the patient's wellbeing support worker provided a lot of support and encouragement in improving her attendance by meeting her for appointments and supporting her throughout. The patient now regularly attends.

Wellbeing support worker input has also continuously been concentrated on supporting the patient's anxieties, this has enabled her to go on respite at a care home and attend day therapy at Trinity Hospice. This has in turn increased her social activity. The patient was also encouraged to have regular coffee afternoons with her friend who lives in the same building but that she rarely sees, and she now has a much better relationship with this woman who has provided social support. The patient's wellbeing support worker also arranged with the cancer unit to send wig vouchers to help with the cost of a wig. Due to her anxieties it took a long time to obtain the wig as the patient kept cancelling her fitting appointment but with continued support she eventually attended.

After long discussions around the benefits, I referred this patient to social services and she now has daily carers who come in to bathe and cream her legs; she is delighted that her legs have improved drastically and cause her much less pain. We are looking in the future to increase this care package to include cleaning responsibilities as she has had a lot of problems with private cleaners - she initially wants to get used to having carers just coming in to provide care to her legs before we added more visits.

During time on service the patient was in a RTA and as a result I had to assist her in giving up her licence and getting her car SORN because she struggled with the paperwork and making the phone calls. Following this she no longer wanted to pursue renewing her blue badge so this goal was removed.

I provided the patient with a 'breathe easy CD' to help with relaxation, reduce anxiety, and improve her mood. I encouraged her to use it at night when she can't sleep, which she found beneficial. To reduce the stresses of remembering to take all her medications we have arranged blister packs to ensure she is taking all her medication in the correct manner, especially her anti- depressants.

Recently the patient was admitted to hospital and got in touch with me as she was concerned about her cat and who would be able to feed it. She asked me to contact her neighbour to ask her to feed it, however the couple were going on holiday so I referred the case to social services in order for them to deal with the situation. She was incredibly grateful for this and it significantly reduced her anxieties during her stay in hospital.

Future Plan
Overall, although there is still a lot of work to be done with this patient we have greatly improved her life in getting her a care package in place, improving her attendance record, supporting her to become more socially active, and building her confidence.
Work with this individual is ongoing, and I aim to work at increasing the care package to include cleaning visits to try and reduce the falls risk of her cluttered flat. Clinically she has a lot going on with medications so this is taking priority at the moment. We will be looking to discharge this patient once we have sorted these two issues.

Clinical Input
The patient was identified at her initial assessment to have a large number of problems including significant anxiety, chronic pain (requiring significantly high dose amounts of opiates), recurrent falls and poor mobility. These were in addition to her chronic long term conditions of COPD, diabetes (type II), narcolepsy, obstructive sleep apnoea, heart failure, haemolytic anaemia and chronic lymphocytic leukaemia. A plan was made to start to manage these problems with input from the Extensive Care Team. She was found to be vitamin B12 deficient and treatment was arranged with the support of the community nursing team.

The patient was subsequently admitted whilst on holiday in another part of the country. On her discharge and return she was reviewed and a number of investigations that had been suggested by the admitting team in their discharge documentation were avoided as they did not have access to local records. Additionally some simple investigations on our part excluded the requirement for more complex ones.

Given the patients multiple problems a DNA CPR order was discussed and agreed along with the completion of a Preferred

Priorities of Care document. She was also referred to and attended the local hospice day therapy unit.

Through monitoring of blood investigations it was noted that a previous haematological condition had relapsed. The team were able to act promptly liaising with the haematology team within the acute Trust. Also investigations were initiated from the community without the necessity of waiting for a specialty outpatient clinic. The patient was supported in the instigation of various new pharmacological agents such as high dose steroids and oral chemotherapy.

She received prompt assessment and treatment for a number of minor respiratory and urinary tract infections as well as episodes of lower limb cellulitis. A significant amount of input was given by the pharmacy team (lead pharmacist and pharmacy technician) due to major concerns regarding adherence especially high dose opiate medications. A full optimisation review was performed followed by further assessment with the support of her local pharmacy to determine the utilisation of her medications. Adjustments were made to her regime and excess medications removed from her home. For a period of time she received weekly input from the pharmacy team.

The patient's blood investigations are constantly monitored and when required arrangements are made for her to attend the Primary Care Assessment Unit as a day case patient for blood transfusions. She will require ongoing clinical support especially for her haematological problems.

This page is intentionally left blank

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Date of Meeting	28 September 2016

NORTH WEST AMBULANCE SERVICE PERFORMANCE REPORT FOR BLACKPOOL

1.0 Purpose of the report:

1.1 To update members on the performance of the North West Ambulance Service (NWAS) commissioned by Blackpool Clinical Commissioning Group (CCG).

2.0 Recommendations:

2.1 To receive and scrutinise the report.

2.2 To make any recommendations to the Clinical Commissioning Group.

2.3 To determine any future reporting from the Clinical Commissioning Group on the issues / identify any topics for further consideration by the Committee.

3.0 Reasons for recommendations:

3.1 To ensure constructive and robust scrutiny of the annual health performance report in relation to commissioned hospital services.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Not applicable (N/A)

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and

increasing resilience".

5.0 Background Information

5.1 Mr David Bonson, Chief Operating Officer will be in attendance at the meeting following attendance at the 6th July meeting which discussed 2015-2016 performance. Mr David Rigby, Sector Manager, NWAS may also be in attendance. Attendance at the 28th September meeting is to update on NWAS performance in the current year.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 8 (a) relating to Paramedic Emergency Services, NHS 111, Patient Transport Services and transformation under the Urgent and Emergency Care Review.
Appendix 8 (b) presentation document outlining the role and work of NWAS.

6.0 Legal considerations:

6.1 Not applicable (N/A)

7.0 Human Resources considerations:

7.1 N/A

8.0 Equalities considerations:

8.1 N/A

9.0 Financial considerations:

9.1 N/A

10.0 Risk management considerations:

10.1 N/A

11.0 Ethical considerations:

11.1 N/A

12.0 Internal/ External Consultation undertaken:

12.1 N/A

13.0 Background papers:

13. None

Chris O'Neill
Senior Ambulance Commissioning Manager
NHS Blackpool CCG

This page is intentionally left blank

Paramedic Emergency Services, NHS 111, Patient Transport Services and Transformation under the Urgent and Emergency Care Review

Introduction

Blackpool CCG manages the Paramedic Emergency Services (PES), the NHS 111 Contract and the five Patient Transport Services (PTS) contracts held on behalf of the 33 CCGs in the North West, in its role as Coordinating Commissioner for Ambulance Services.

The presentation document attached at Appendix 8 (b) was developed to aid Members' understanding of the services commissioned by Blackpool CCG from NWAS, receive assurance on the performance of NWAS within Blackpool and some of the opportunities to deliver services differently as part of transformation and modernisation coming from the outputs of the Urgent and Emergency Care Review.

Paramedic Emergency Services (PES)

At the end of 2015-2016, total activity for the North West in the PES service was 1.4% over planned activity, with an extra 2.5% planned growth in year. In actual real terms this represented a year on year growth of 3.9% in total activity. Of concern, was the increase in year in Red activity which is Red 1 and Red 2 incidents (particularly in Red 2, which is the serious but not immediately life threatening incidents requiring urgent or rapid responses). Growth in Red incidents is of concern nationally with all ambulance trusts seeing growth in this activity. Red activity incidents are those deemed by operators to require urgent or rapid responses usually following 999 calls and sometimes 111 calls.

Green incidents (lower activity outside the Red eight minute response time target) at the year-end were under plan, or just under the expected 2.5% growth that was allowed for by Commissioners.

NWAS did not achieve the Red 2 or All Reds (19 minute) performance targets at the end of 2015-2016, but did achieve the Red 1 target as additional activity responded to by the fire service was include in the year-end count.

Performance in the Blackpool area is consistently high due to the tight geography within which NWAS respond.

Cumulative Mar-16	R1			R2			All Reds			Green		AS3		All Incidents	
	Mar-16			Mar-16			Mar-16			Mar-16		Mar-16		Mar-16	
	R1 Activity	8 mins %	Variation %	R2 Activity	8 mins %	Variation %	All Reds Activity	19 mins %	Variation %	All Green Activity	Variation %	All AS3 Activity	Variation %	Total Activity	Variation %
NHS Blackpool CCG	1,033	88.5%	(7.7%)	14,592	83.70%	5.3%	15,625	94.70%	4.3%	20,265	(4.2%)	148	25.4%	36,038	(0.6%)
Lancashire	**6,166**	**71.5%**	**(7.7%)**	**96,351**	**69.00%**	**7.1%**	**102,517**	**91.10%**	**6.1%**	**141,568**	**(2.9%)**	**970**	**27.1%**	**245,055**	**0.8%**
NWAS	**28,984**	**74.8%**	**(5.8%)**	**452,121**	**70.40%**	**8.0%**	**481,105**	**92.60%**	**7.1%**	**670,580**	**(2.1%)**	**11,603**	**(11.7%)**	**1,163,288**	**1.4%**

Demand for PES services has continued in the first four months of 2016-2017, impacting on the performance of the Trust against the national Key Performance Indicatorss (KPIs) for R1, R2 and All Reds (19 minute). Commissioners allowed for 2.5% growth in the current year, but R2 demand is currently 11.3% over planned levels (13.8% year on year), and Green incidents are 5.5% over plan (8% year on year), whereas Green incidents were under plan at the end of 2015-2016.

From an NWAS perspective the Trust is not meeting any of the national targets for R1, R2 or All Reds (19 minute). From a Blackpool perspective the Trust is meeting the R1 and R2 targets.

Again, this must be set within the overall context of national performance. Despite the apparent deterioration in performance against the national targets, NWAS are the best performing trust nationally in relation to R1 incidents and the second best performing trust in relation to R2 incidents.

Cumulative Jul-16	R1			R2			All Reds			Green		AS3		All Incidents	
	Jul-16			Jul-16			Jul-16			Jul-16		Jul-16		Jul-16	
	R1		Variation	R2		Variation	All Reds		Variation	All Green	Variation	All AS3	Variation	Total	Variation
	Activity	8 mins %	%	Activity	8 mins %	%	Activity	19 mins %	%	Activity	%	Activity	%	Activity	%
NHS Blackpool CCG	344	84.50%	(9.8%)	5,188	77.55%	5.2%	5,532	91.83%	4.1%	6,850	(0.8%)	34	(38.6%)	12,416	1.1%
Lancashire	**1,944**	**71.81%**	**(7.6%)**	**33,475**	**63.82%**	**8.4%**	**35,419**	**89.26%**	**7.4%**	**48,482**	**4.3%**	**580**	**94.5%**	**84,481**	**5.9%**
NWAS	**9,344**	**73.56%**	**(4.5%)**	**157,749**	**65.61%**	**11.3%**	**167,093**	**91.17%**	**10.3%**	**231,220**	**5.5%**	**3,670**	**(13.6%)**	**401,983**	**7.2%**

Handover & Turnaround

Performance against the national targets is impacted by handover and turnaround issues at hospital. This has been of real concern with average handover and turnaround times now in the region of 35 minutes across the North West, compared with around 27 minutes at the same point in 2015-2016.

Blackpool Teaching Hospitals turnaround time is averaging just under 33 minutes, which although over the desired turnaround time, is more favourable than some hospital sites where average turnaround times have increased to over 40 minutes (Royal Preston, Southport and Ormskirk).

NHS Improvement, who support organisations to deliver better sustainable healthcare, is working with Commissioners, NWAS and Acute Trusts in responding to the challenges faced in improving flow through the hospitals and reducing ambulance resource delayed at hospital sites.

Avoiding Admission

NWAS have made significant improvements in the number of patients being managed without being taken to hospital. Commissioners have worked closely with NWAS to manage more patients through Hear and Treat (managing the patients without

dispatching a vehicle), or See and Treat (managing a patient at scene without onward conveyance to hospital).

Despite the increasing demand for services NWAS have managed circa 46,000 patients through Hear and Treat (around 11% of activity), and 86,000 patients at scene without onward conveyance (around 21% of activity). NWAS have conveyed around 67% of patients to hospital, which despite the additional growth in activity is less than the number of patients conveyed to hospital in 2015-2016 (69%).

NHS 111

The NHS 111 service, for non-emergency calls and advice, was re-procured in 2015 with the contract going 'live' from October 2015. Performance in the early part of 2016 has not been at the desired levels, but Commissioners have been working closely with the 111 service and an improvement plan was introduced with remedial actions to resolve the poor performance being seen. Since then, performance has improved and is being closely monitored.

July 2016 performance has shown deterioration with performance at 82.9% of calls being answered within 60 seconds but on a number of days in the month the 95% target was achieved. The volume of calls answered within the month was 140,160.

Performance at weekends remains the main challenge. Staff currently in training have been recruited specifically to work at weekends and evenings which will address this issue; a large number of new staff commenced in July 2016 with smaller training cohorts due to be completed during July 2016.

Weekly monitoring of delivery of the Remedial Action Plan continues by the NHS 111 Lead Commissioning Team with progress now reported to the North West Ambulance Service's Strategic Partnership Board and NHS England.

Performance against the headline key performance indicators for July 2016 was:

- 82.9% of calls were answered in 60 seconds (against a target of 95%), withabandoned calls increased to 3.8% for the month (against a target of less than 5%).

- 32.8% of calls requiring a clinician were "warm transferred" from the 111 operator to a clinician and 37.9% of call backs (for those calls requiring a clinician that were not warm transferred) were made within 10 minutes. This performance is consistent with previous months and although below the contract targets, nationally NHS 111 providers are achieving approximately 40% for these two KPIs.

August 2016 performance improved significantly when compared with July 2016 to a year high figure of 90.4% of calls being answered within 60 seconds. The volume of calls answered within the month was 127,402. Abandoned calls were at 1.8%, which is lower than July 2016 and well within the contract requirement of 5%.

Month to date performance at the point of writing (19 September 2016) shows 87.7% of calls are being answered within 60 seconds. Abandoned call rate has increased to 2.1%. Although this appears to be deterioration in performance, this is in line with the performance seen in August 2016 where performance improved in the second half of the month. Weekly monitoring of delivery of the Remedial Action Plan continues.

Patient Transport Services (PTS)

The five non-emergency Patient Transport Services contracts were re-procured in 2015-2016 for services to commence on 1 July 2016. NWAS have retained the contracts for Lancashire, Cumbria and Merseyside. NWAS won the tender for the Greater Manchester contract which was previously awarded to Arriva Transport Solutions Limited. The tender for Cheshire and Merseyside was awarded to West Midlands Ambulance Service.

The new contracts are based on three separate specifications to provide clarity around the three service elements for Planned, Unplanned and Enhanced Priority Services (EPS). The Planned element of PTS is typified by routine outpatient appointments, the Unplanned element relates to discharging patients and short notice journeys and the EPS element is to deliver services for patients receiving renal and oncology treatment.

There are three different sets of KPIs for PTS; one for each specification. The KPIs but largely relate to ensuring that patients receive a good experience of the service. Consequently, the KPIs focus on how quickly calls are answered, ensuring that patients are delivered in time for their appointments and that they are collected after their appointments in a reasonable timeframe. There are more stringent KPIs for the EPS specification recognising that these patients rely on the service more than most for frequent treatment.

Performance reports at the time of writing are only available for July 2016 but these are showing good performance across the Lancashire, Mersey and Cumbria contracts, and improving performance against the Greater Manchester contract, following the transition from Arriva to NWAS.

Integrated Urgent Care

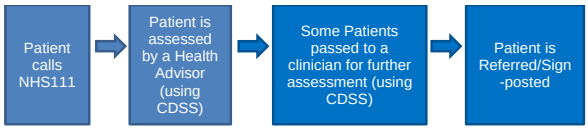
A significant amount of work has been taking place over the course of the last 12 to 18 months around how Commissioners can work with NWAS to modernise and transform the service, based on the outputs of the national Keogh Urgent and Emergency Care Review (which was led by NHS England's Medical Director, Bruce Keogh). Commissioning

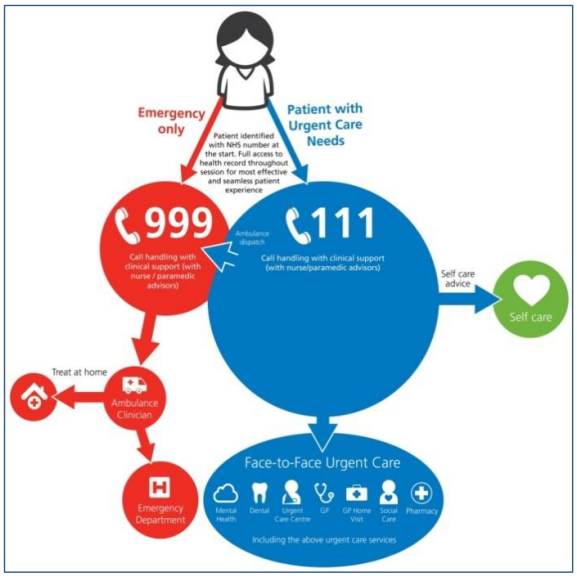
Intentions were drafted setting out the direction of travel and have been updated to reflect the more recent work following the Urgent Care Stocktake. NHS England have published documents at the end of 2015 around new models of care for ambulance services and payment regimes supporting the new models.

The Integrated Urgent Care Commissioning Standards describe a central objective around the development of a clinical hub. In the North West, there is a significant amount of on-going work around the development of an Integrated Virtual Clinical Hub. Several pilot schemes have already been run looking at directly booking patients into slots with Out-of-Hours (OOH) Providers and there is substantial discussion and piloting of the early transfer appropriate dispositions coming through NHS 111 into the OOH providers for further enhanced clinical triage, with the aim of avoiding unnecessary admission to hospital.

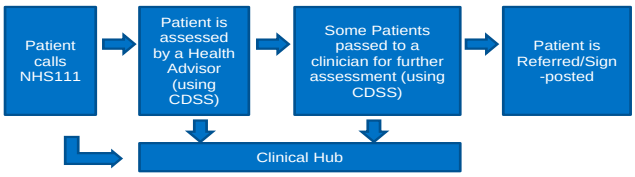
Work is on-going around how the hub can be developed at the local and North West level, and how the urgent and emergency care pathways can be more fully integrated.

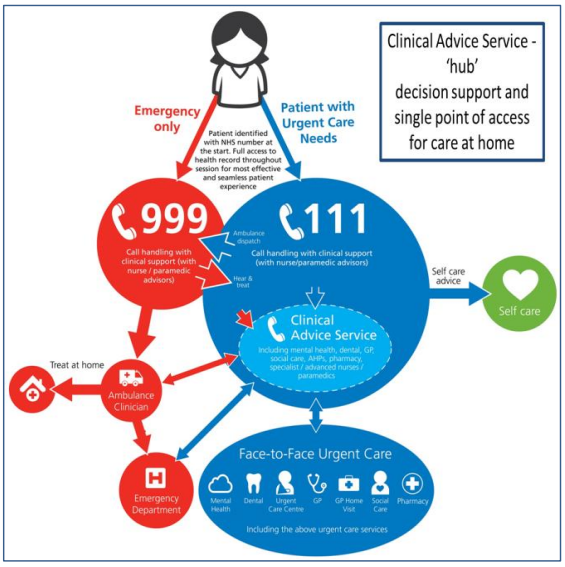
Current Patient Journey





Proposed Patient Journey





This page is intentionally left blank

NHS
Blackpool
Clinical Commissioning Group

Ambulance / 111 Commissioning in the North West

Yvonne Rispin
Director of Ambulance Commissioning
September 2016

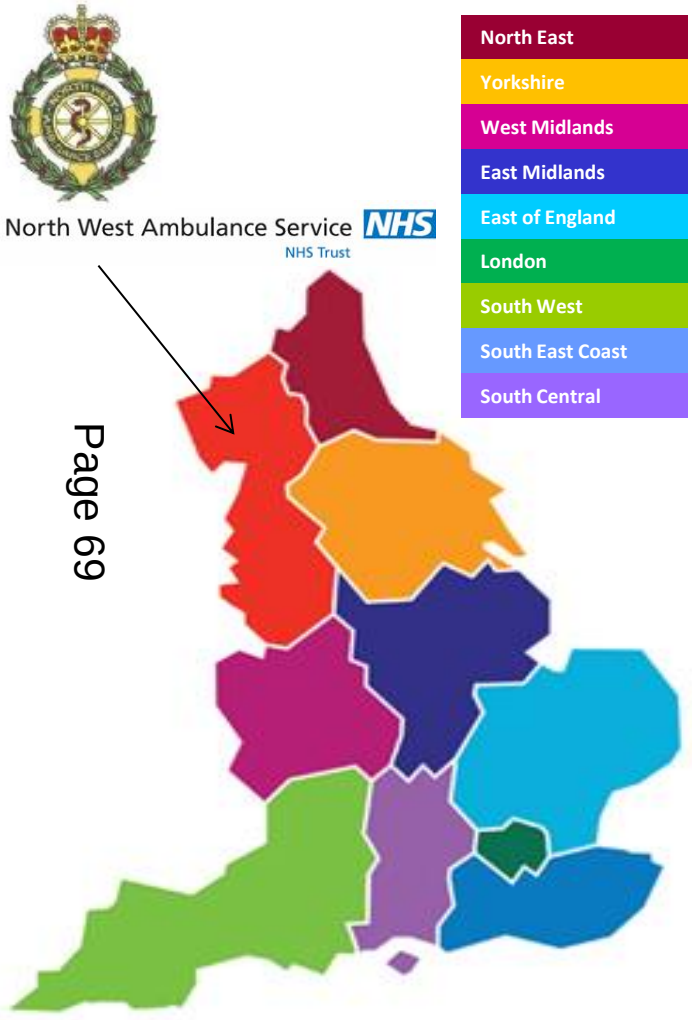
The North West

NHS
Blackpool
Clinical Commissioning Group

- Population of 7.5 million people
- Geography of 5,469 square miles
- A mix of rural and urban areas
- 33 Clinical Commissioning Groups
- 1 Ambulance Trust (NWAS)
- 23 Acute Hospital Trusts
  - 8 Mental Health
  - 7 Specialist
- 18 Out of Hour Services (OOH)

North West Ambulance Service

NHS Blackpool Clinical Commissioning Group

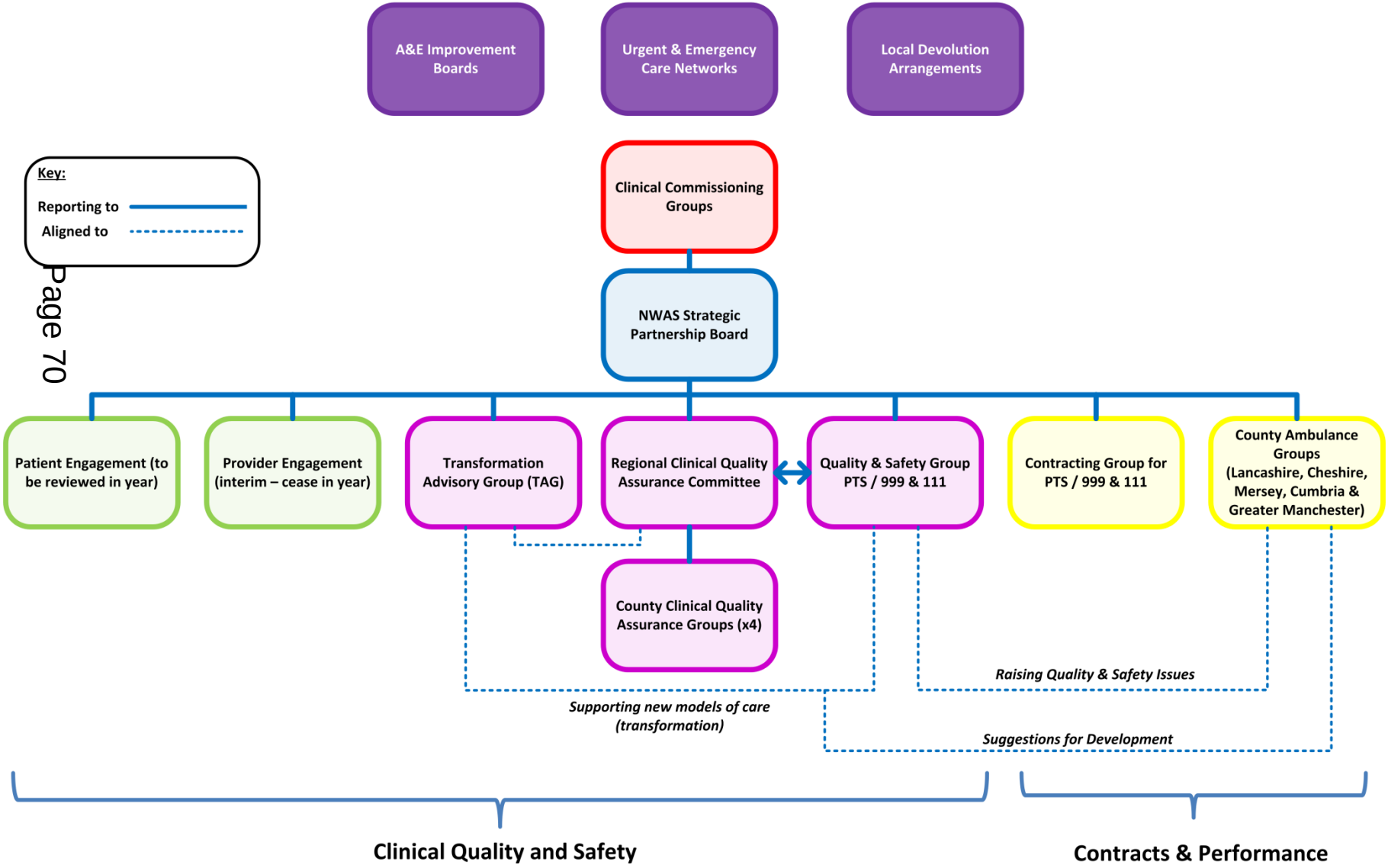


- 1 of 11 Ambulance Trusts
- Largest in terms of Geography
- 2nd Largest in terms of Activity
- Providing 3 Core Services
  - Emergency Ambulances (PES)
  - Patient Transport Services (PTS)
  - NHS 111 (with FCMS & UC24)
- Commissioned by Blackpool CCG
- Total Budget of circa £320m
  - Emergency Ambulances £250m
  - Patient Transport £40m
  - NHS 111 £20m

Collaborative Governance Arrangements

NHS Blackpool Clinical Commissioning Group

North West 999/PTS/NHS 111 Collaborative Commissioning Governance Arrangements



Paramedic Emergency Services

NHS
Blackpool
Clinical Commissioning Group

- ‘Blue Light’ Emergency Ambulances
- 2015/16 Activity
  - 1,216,754 Calls
  - 1,163,288 Incidents
- 2016/17 Activity (to the end of July)
  - 405,493 Calls
  - 401,983 Incidents

Call Categorisation:

- Red 1
  - Immediately Life Threatening (eg. Cardiac Arrest, Patient Not Breathing)
  - Account for 2.5% of total incidents (29,984 in 2015/16)
- Red 2
  - Serious but not Immediately Life Threatening (Stroke, Serious Injury, Trauma, Stabbing)
  - Account for 38.9% of total incidents (452,121 in 2015/16)
- Green
  - Serious but of lower acuity
  - Further sub divided into Green 1 to Green 4
  - Account for 57.6% of total incidents (670,580 in 2015/16)

National Ambulance Response Targets

NHS Blackpool Clinical Commissioning Group

- Red 1 (Immediately Life Threatening)
  - 75% of Red 1 incidents to have a response at scene within 8 minutes from the point of 'call connect' (the time the call hits the 999 switchboard)

- Red 2 (Serious but not Immediately Life Threatening)
  - 75% of Red 2 incidents to have a response at scene within 8 minutes from the first of:
    - Identifying the 'Chief Complaint'
    - Dispatching a Vehicle, or
    - 60 seconds

- Category A19
  - 95% of Red (R1+R2) incidents to have a vehicle capable of conveying a patient at scene within 19 minutes

NWAS Performance (end of July)

NHS
Blackpool
Clinical Commissioning Group

- Red 1
  - 73.6% against the 75% target
- Red 2
  - 65.6% against the 75% target
- Category A19
  - 91.2% against the 95% target
- BUT:
  - all Ambulance Services nationally are struggling to meet targets due to significant continuing activity increases (Red activity is 12.8% up on last year)
  - NWAS are best performer nationally in responding to R1 incidents and 2nd best performer for R2 incidents

Managing Incidents Differently

NHS
Blackpool
Clinical Commissioning Group

- Significant focus by Commissioners and NWAS on managing activity differently through the national ambulance 'currencies':
  - Hear & Treat
  - See & Treat
  - See, Treat & Convey

- NWAS are managing significantly more patients without taking them to hospital
  - 11.3% of patients have been managed through Hear & Treat
  - 21.4% of patients have been managed through See & Treat
  - 67.3% of patients have been conveyed to hospital

- Despite activity increases, NWAS are taking less people to hospital

Handover & Turnaround

NHS Blackpool Clinical Commissioning Group

- NHS Standard Contractual Requirements:
  - Patients arriving by ambulance to be handed over to acute clinical colleagues within 30 minutes
  - Ambulance crews must clear site within 30 minutes of handover being completed
  - Fines are applied to both Acute and Ambulance Providers
- Handover & Turnaround times are deteriorating across the North West with average handover times around 35 minutes
- ECIP events overseeing Handover Concordat Agreements to improve the position

NHS 111

NHS
Blackpool
Clinical Commissioning Group

- **111** is a free-to-call, non-emergency, medical helpline operating in England as part of the country's NHS telephone triage and advice services
- Available 24 hours-a-day, the NHS 111 Service is intended for **'urgent but not life-threatening'** health issues
- **Provided nationwide**, you are able to pick up the phone at any location in England and Scotland and ring 111 and receive the same level of care
- Procurement of the service was completed and the service went live in October 2015 based on a 5 year contract

NWAS
NHS Urgent Care 24
fcm

CALL 111
when it's less urgent than 999

Access to the most appropriate care

NHS
Blackpool
Clinical Commissioning Group

111 National Targets

NHS
Blackpool
Clinical Commissioning Group

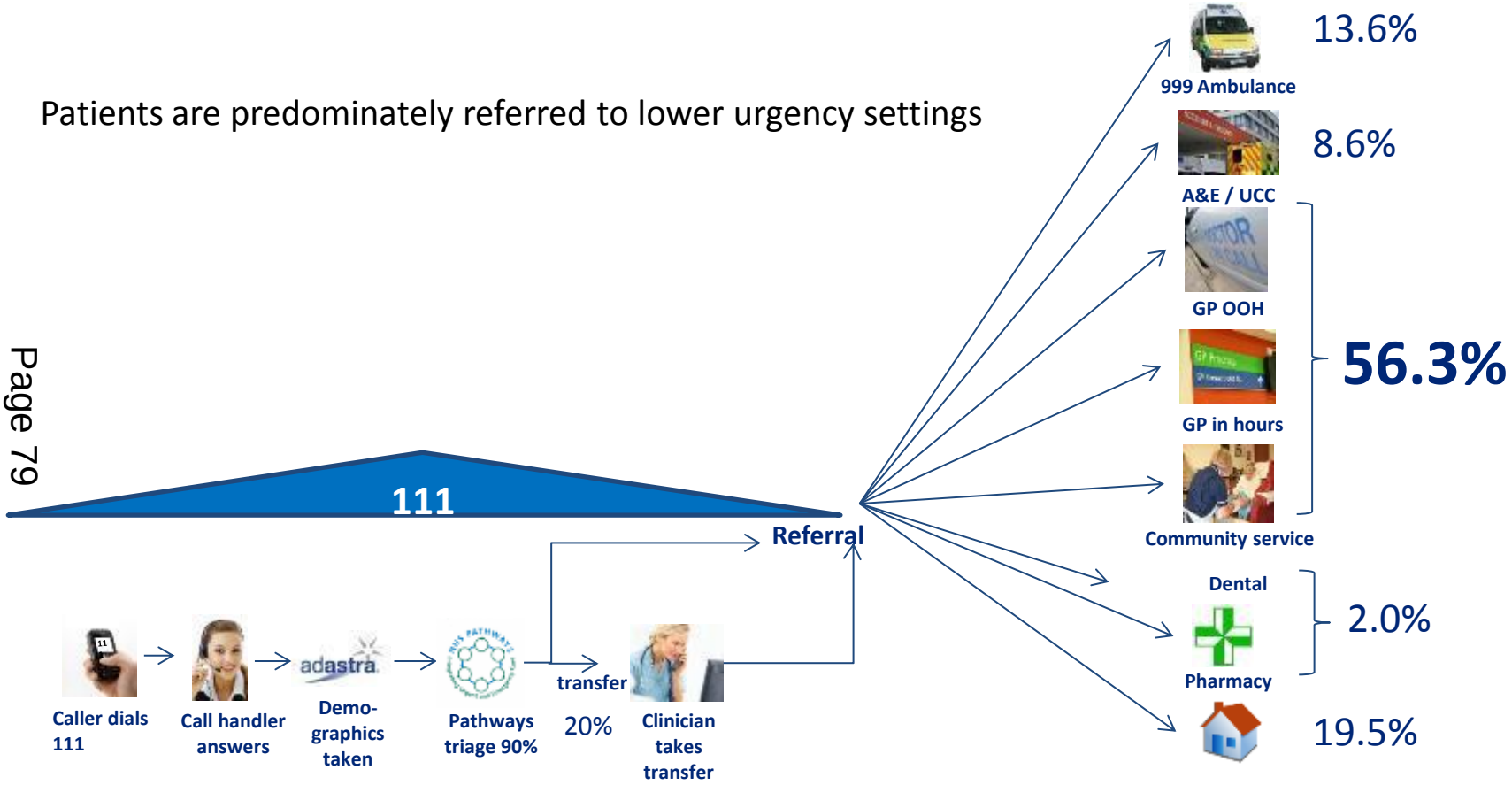
- 4 Primary KPIs measuring effectiveness of the service:
  - Call Waiting Time
    - 95% of all calls must be answered within 60 seconds of the end of the introductory message
  - Abandoned Calls
    - No more than 5% of abandoned calls (as a percentage of total calls offered and reaching 30 seconds following being queued for an advisor)
  - Warm Transfers
    - At least 75% of the total calls that are transferred to a clinical advisor must be “warm transfers” i.e. transferred while the call was live or the caller was on hold
  - Time taken for call back
    - Where a warm transfer cannot be achieved due to call centre demand, call backs should be successfully undertaken within 10 minutes of the end of the interim disposition in at least 75% of all call backs

CALL 111
when it’s less urgent than 999

Where Callers Are Referred To

NHS Blackpool Clinical Commissioning Group

Patients are predominately referred to lower urgency settings



CALL 111 when it's less urgent than 999

Patient Transport Services

NHS
Blackpool
Clinical Commissioning Group

- Pre-planned transport for eligible patients receiving NHS funded care
- Covers all North West patients irrespective of destination
- Delivers circa 2.2 million patients journeys per year
- Provided through 5 North West Contracts managed by Blackpool CCG:-
  - Lancashire
  - Cumbria
  - Greater Manchester
  - Merseyside

  NWAS

  - Cheshire

  WMAS

Patient Transport Services

NHS Blackpool Clinical Commissioning Group

- 3 Specifications Covering (for the Lancashire contract):
  - Planned Journeys
    - Routine transport eg. Outpatient Appointments
    - Monday to Friday 8am to 6pm
  - Unplanned Journeys
    - Short Notice / 'On The Day' bookings eg. discharges
    - Monday to Friday 8am to 8pm
    - Weekends 10am to 6pm
    - Including Bank Holiday Services
  - Enhanced Priority Services
    - more time critical service for patients receiving renal / oncology treatment
    - Monday to Saturday 6:30am to 1:00am the following day
    - Including Bank Holiday Services

- Sliding scale of charges based on patient mobility and distance travelled
- 3 Sets of Quality Indicators; one set for each specification

PTS KPIs – Planned / Unplanned

NHS Blackpool Clinical Commissioning Group

- No national KPIs for Patient Transport Services
- Commissioners included stringent KPIs in the tender process covering:
  - Call Answering
    - 75% within 20 seconds
  - Ensuring only eligible Patients access the service
    - 98% eligibility check
  - Patients travel time on vehicle
    - 80% of patients spend less than 60 minutes on vehicle
  - Patients arriving in time for appointments
    - 90% of patients arrive in time for their appointment (up to 60 minutes)
  - Patients being picked up quickly after appointments
    - 80% of patients collected within 60 minutes after their appt.

PTS KPIs – Enhanced Priority Service

NHS Blackpool Clinical Commissioning Group

- More stringent KPIs for Patients receiving renal / oncology treatment:
  - Patients travel time on vehicle
    - 85% of patients spend less than 60 minutes on vehicle
  - Patients arriving in time for appointments
    - 90% of patients arrive in time for their appointment (up to 45 minutes)
  - Patients being picked up quickly after appointments
    - 85% of patients collected within 60 minutes after their appt.

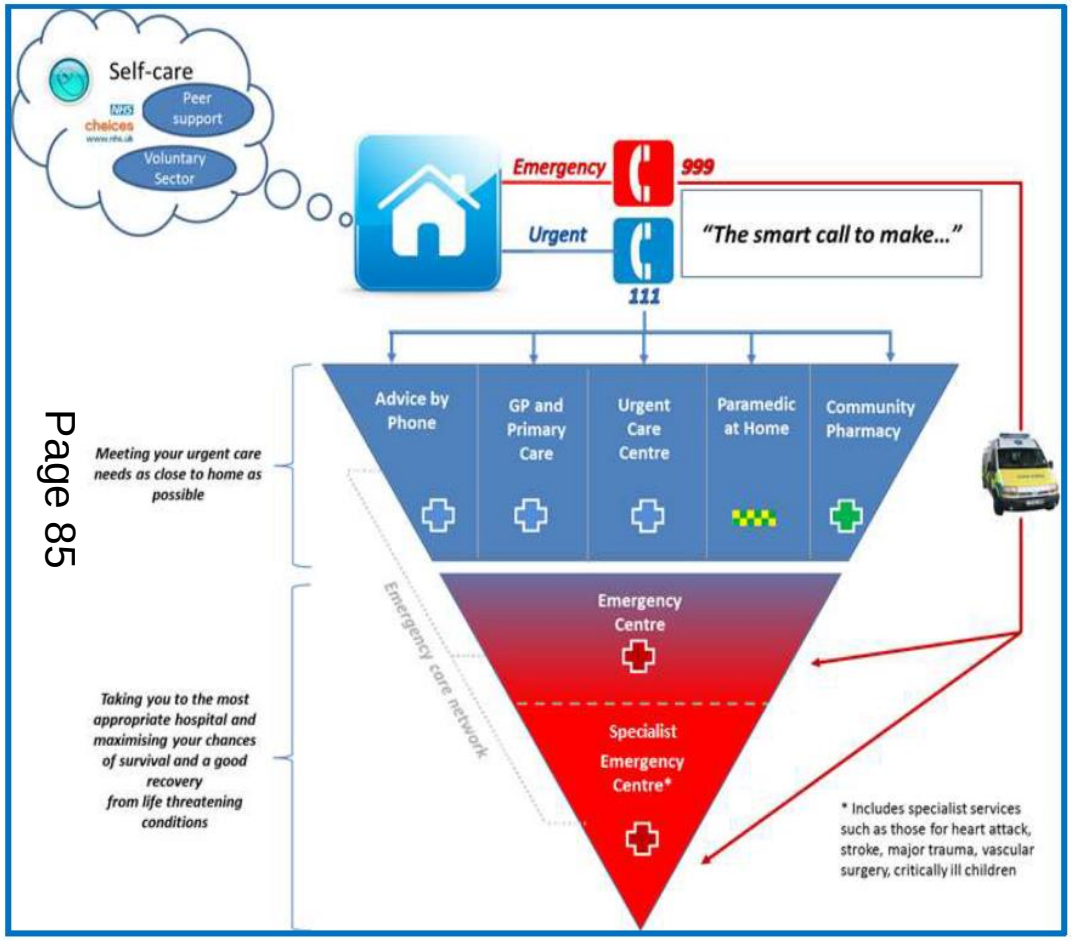
Integrated Urgent Care

NHS
Blackpool
Clinical Commissioning Group

- Commissioning Standards:
  - "A single entry point to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership"
  - Central to this will be the development of a "Clinical Hub"

The Urgent & Emergency Care Review

NHS Blackpool Clinical Commissioning Group

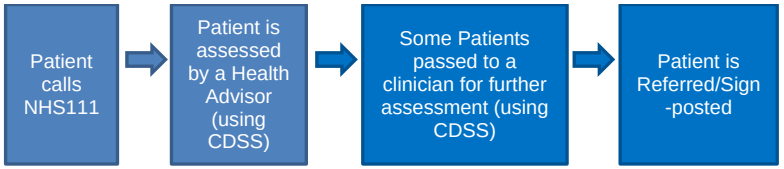


- Set out objectives for ensuring patients get safer care, closer to home through development of seamless access points into the urgent and emergency care system

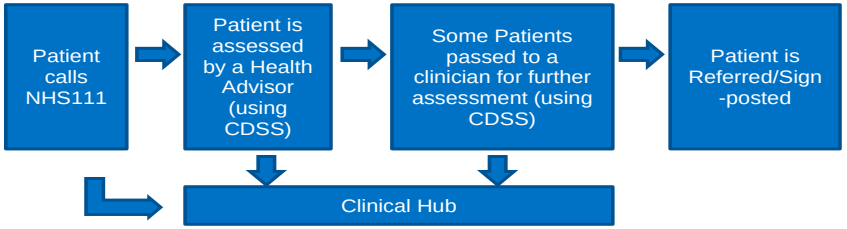
The Virtual Clinical Hub

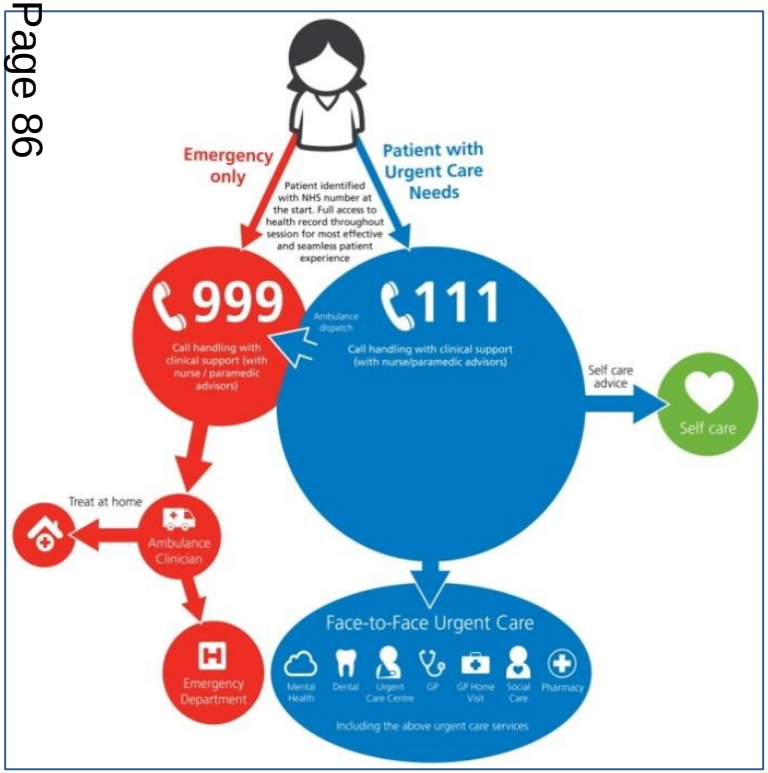
NHS Blackpool Clinical Commissioning Group

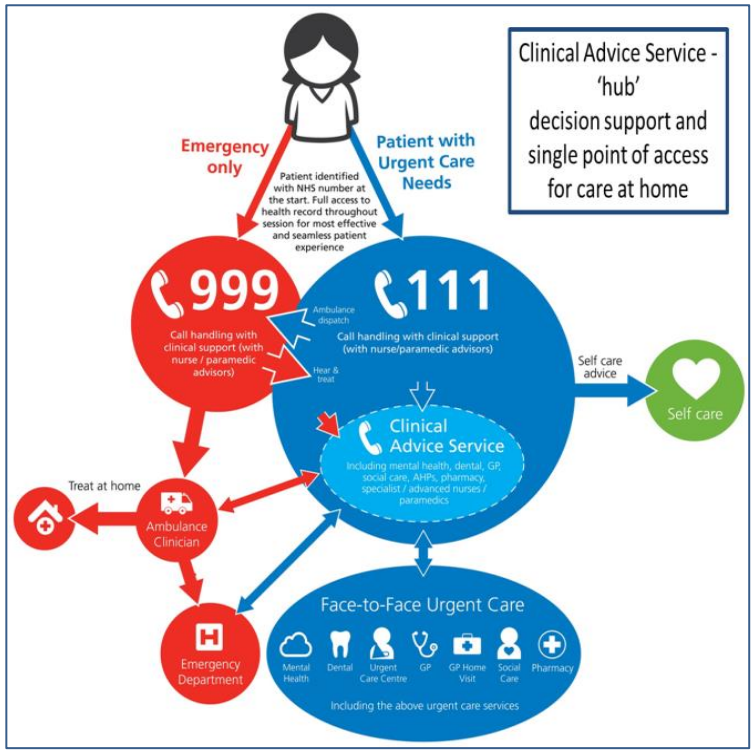
Current Patient Journey



Proposed Patient Journey







Questions

This page is intentionally left blank

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Sharon Davis, Scrutiny Manager.
Date of Meeting	28 September 2016

HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

1.0 Purpose of the report:

1.1 To consider the Health Scrutiny Committee (HSC) Workplan 2016-2017, together with any suggestions that Members may wish to make for scrutiny review.

2.0 Recommendations:

2.1 To approve the Health Scrutiny Committee Workplan 2016-2017, taking into account any suggestions for amendment or addition.

2.2 To monitor the implementation of the Health Scrutiny Committee's recommendations/actions.

3.0 Reasons for recommendations:

3.1 To ensure the Workplan is up-to-date and is an accurate representation of the HSC's work.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	N/A

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 **Health Scrutiny Committee (HSC) Workplan**

5.1.1 The HSC Workplan 2016-2017 is attached at Appendix 9 (a). The Workplan is a flexible document that sets out the work that the Committee will undertake over the course of the year.

5.1.2 HSC Members are invited, either now or in the future, to suggest topics that might be suitable for scrutiny in order that they be added to the Workplan.

5.2 **Health Scrutiny Committee Review Checklist**

5.2.1 The HSC Review Checklist is attached at Appendix 9 (b). The checklist forms part of the mandatory scrutiny procedure for establishing review panels and must therefore be completed and submitted for consideration by the HSC, prior to a topic being approved for scrutiny.

5.3 **Implementation of Recommendations/Actions**

5.3.1 The Resilient Communities Scrutiny Committee was previously responsible for health scrutiny. Actions requested by the Resilient Communities Scrutiny Committee have been transferred over to the HSC to monitor. The table attached to Appendix 9 (c) has been developed to assist the HSC to effectively ensure that the recommendations made by the HSC are acted upon. The table will be regularly updated and submitted to each HSC meeting.

5.3.2 Members are requested to consider the updates provided in the table and ask questions as appropriate.

Does the information submitted include any exempt information? No

List of Appendices:

Appendix 9 (a), Health Scrutiny Committee Workplan 2016-2017
Appendix 9 (b), Health Scrutiny Committee Review Checklist
Appendix 9 (c), Implementation of Recommendations/Actions

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

This page is intentionally left blank

HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017	
28 September 2016	1. **Council Plan - Quarter One 2016-2017 Performance Monitoring** 2. **Vanguard and New Models of Care Update -** Blackpool Clinical Commissioning Group OPERATIONAL PLANNING THEMED MEETING 3. **North West Ambulance Service - Performance Report.** Receive an update on the work and performance (response rates) of the NWAS including any other relevant information on priorities, budget and plans.
12 October 2016	1. **Harbour Progress** including clinician update
18 October 2016	Blackpool Teaching Hospitals - Training Seminar
16 November 2016	Public Health - Training Seminar
29 November 2016	HEALTH AND SOCIAL CARE INTEGRATION THEMED MEETING 1. **Health (including Public Health) and Social Care Integration** - Review Integration Models - Progress and Performance. To also include Sustainability Transformation Plan and Healthier Lancashire. 2. **Transforming Care for Adults with Learning Disabilities** - Winterbourne Review - Progress. Members of the Resilient Communities Scrutiny Committee will be invited to attend the meeting as the issues are of a cross cutting nature.
14 December 2016	1. **Winter Health Planning /Issues** - Blackpool Clinical Commissioning Group (with Blackpool Teaching Hospitals and North West Ambulance Service as appropriate). Note - item deferred from September 2016 meeting in order to allow time for new information. 2. **Health and Wellbeing Strategy 2016-2019 - Action Plan and Progress Report**. 3. **Council Plan - Quarter Two 2016-2017 Performance Monitoring** FINANCIAL PLANNING AND SUSTAINABILITY THEMED MEETING 4. **Blackpool Clinical Commissioning Group Performance Report - 2016-2017** (April – September 2016) for quality of care (for all commissioned services), CCG referrals and commissioned hospital and ambulance services, GP practices and financial performance. 5. **Ambition Targets and Work Plans including Economic Recovery** - Blackpool Teaching Hospitals. Note - item deferred from September 2016 meeting.
22 March 2017	1. **Council Plan - Quarter Three 2016-2017 Performance Monitoring** YOUNG PEOPLE'S HEALTH THEMED MEETING 2. **Young People's Mental Health.** Hear from young people concerning mental health concerns/support and the Child and Adolescent Mental Health Services (CAMHS) provider. 3. **Young People's Physical Health.** Consider progress with tackling child obesity and the Oral Health Strategy. 4. **Young People's Health Needs in Care.** Consider this issue which was raised by the Care Quality Commission during mid-2016 ('Not seen Not heard' report).
Potential Future Topics	1. **Local Health Service financial planning and long-term sustainability of key organisations** (alongside quality of service, i.e. whether financial pressures impacting on service delivery). 2. **Availability of GP Appointments (Access to Services).** 3. **Neonatal Review - Care Quality Commission**

Overview of areas /organisations to consider for the Health Scrutiny Work Programme

Rolling basis - 'Exceptions' performance / annual reports and plans from below at different meetings
Specific topics / issues - Significant concerns or plans, commissioners/providers on an ad-hoc basis

Providers / commissioners of key health services
Blackpool Clinical Commissioning Group; Blackpool Teaching Hospitals NHS Foundation Trust
Lancashire Care NHS Foundation Trust; North West Ambulance Service NHS Trust; other bodies e.g. GPs

Providers / commissioners promoting public health and tackling health inequalities
Blackpool Council - Public Health

Engagement / strategic partners
Healthwatch Blackpool; Health and Wellbeing Board Blackpool

National strategic commissioning / inspection bodies
NHS England, Care Quality Commission, Monitor

Proposals and consultations(commissioners and providers)
Proposals for major service changes, substantial developments and other consultations
(potential joint working with Lancashire Health Scrutiny Committee)

Other programme initiatives
E.g. Better Care Fund

COMPLETED HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017 **FOR INFORMATION**	
6 July 2016	1. Council Plan - End of Year 2015-2016 (April 2015 to March 2016) Performance Monitoring 2. Blackpool Clinical Commissioning Group Performance Report - Month 12 (March 2016) and end of year 2015-2016 for CCG referrals and commissioned hospital and ambulance services 3. Healthwatch Impact Report 2015-2016 and 2016-2017 Priorities Timeline 4. Public Health Scrutiny Report 5. Delayed Hospital Discharges
19 September 2016	Blackpool Clinical Commissioning Group - Training Seminar
28 September 2016	
12 October 2016	
14 December 2016	
22 March 2017	

SCRUTINY SELECTION CHECKLIST

Title of proposed Scrutiny:

The list is intended to assist the relevant scrutiny committee in deciding whether or not to approve a topic that has been suggested for scrutiny.

Whilst no minimum or maximum number of 'yes' answers are formally required, the relevant scrutiny committee is recommended to place higher priority on topics related to the performance and priorities of the Council.

Please expand on how the proposal will meet each criteria you have answered 'yes' to.

	Yes/No
The review will add value to the Council and/or its partners overall performance:	
The review is in relation to one or more of the Council's priorities:	
The Council or its partners are not performing well in this area:	
It is an area where a number of complaints (or bad press) have been received:	
The issue is strategic and significant:	
There is evidence of public interest in the topic:	
The issue has potential impact for one or more sections of the community:	
Service or policy changes are planned and scrutiny could have a positive input:	
Adequate resources (both members and officers) are available to carry out the scrutiny:	

Please give any further details on the proposed review:

Completed by: **Date:**

REC NO.	DATE OF REC.	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICR	UPDATE	RED / GREEN / AMBER (RAG)
1	RC Comm 02.07.15	Blackpool Teaching Hospitals Foundation Trust circulate regular information regarding Patient Experience outside of the Committee meeting to allow Members to escalate any issues to the Committee.	30 Nov 2015	Pat Oliver	First report circulated 18 January 2016. Second report circulated 15 June 2016. Ongoing.	Green
2	RC Comm 02.07.15	Healthwatch Blackpool circulate the outcomes from Consumer Reviews and Consultations to Resilient Communities Scrutiny Committee Members.	Ongoing	Steven Garner	Outcomes are regularly circulated. To date Members have received reports pertaining to: Mental Health, Outpatients, Dentistry, Maternity Services.	Green
3	RC Comm 02.07.15	Formal six monthly reporting from Healthwatch, with the ability for Healthwatch to raise any issues outside of this timescale informally to Members, who could escalate them to the next available Committee meeting.	6 July 2016	Healthwatch / Sharon Davis	Originally scheduled for 17th March 2016, delayed until May 2016 to alleviate workplan pressures. Annual Impact and Priorities report received from Healthwatch for 6 July 2016 meeting of the Health Scrutiny Committee (HSC). Note - proposed to move to annual reporting with provision retained for Healthwatch to raise in-year concerns.	Green
4	RC Comm 10.12.15	To receive an update on the progress to meet the national waiting list target for Psychiatric Therapies in six months.	30 June 2016	Helen Lammond-Smith, Blackpool Clinical Commissioning Group (CCG)	Update to be sought in June 2016. To be transferred to Health Committee. Update received 13 June 2016. The psychological therapy waiting time targets were achieved for April 2016, but not ratified yet by NHS England (two months lag period). 27 June 2016 – further information requested for 12 months (longer-term picture) and confirmation that the overall trend was meeting	Not yet due

					national targets with continuous improvement being pursued and was sustainable. 27 June 2016 - CCG actually have further targets to hit as they are a transformation area ref Fylde coast so need to increase access to 25% by March 2017. Latest figures expected 1 July 2016. 20 Sept 2016 - 14 Dec 2016 meeting for final figures else 22 Mar 2017 for enhanced targets.	
5	RC Comm 10.12.15	To receive the results of the additional piece of work regarding feedback from service users from Healthwatch Blackpool and Lancashire Care Foundation Trust (LCFT) in due course.	30 June 2016	Steve Winterson, LCFT	Timescales currently unknown. Feedback will be sought in due course. To be transferred to Health Committee. Update requested 13 June 2016. Update received on 27 June 2016 - due to the methodology of the original report, there was no way to identify which service (and therefore provider) service users were commenting on. LCFT is committed to support further work undertaken by Healthwatch and the Network Director for Adult Mental Health Services attended the Resilient Communities Committee meeting on 14 April 2016 to give a further update on the wide range of work being undertaken at The Harbour. LCFT remains committed to being open and transparent with the Health Scrutiny Committee and senior Lancashire Care Staff will attend future meetings when invited. LCFT also receives the national Community Mental Health Survey and the national Inpatient Mental Health Survey responses annually and works with our Experts By Experience to formulate action plans to tackle any issues that arise from these.	Green

					28 Sept 2016 - to close this action unless further details required.	
6	RC Comm 10.12.15	To receive performance reports from Blackpool CCG biannually commencing in six months.	Ongoing	Roy Fisher / David Bonson	First report due 6 July 2016. To be transferred to Health Scrutiny Committee. First report received for 6 July 2016 Health Scrutiny Committee.	Green
7	RC Comm 04.02.16	A report in approximately six months detailing the progress the Trust has made in relation to the ambition targets and work plans.	Sept 2016	Tim Bennett, Blackpool Teaching Hospitals	Update to be sought in September 2016. To be transferred to Health Scrutiny Committee. Tim Bennett unavailable for 28 Sept 2016 so on agenda for 14 Dec 2016.	Not yet due
8	RC Comm 04.02.16	To receive an update on the uptake of milk with fluoride in approximately six months.	Sept 2016	Councillor Cross	An update will be sought in due course. To be transferred to Health Scrutiny Committee. Update to be sought for 28 Sept 2016.	Not yet due
9	RC Comm 17.03.16	That the CCG provide an update report to a meeting of the Committee in approximately six months on the Vanguard/New Models of Care Project.	Sept 2016	David Bonson/Roy Fisher, CCG	To be included in workplan. To be transferred to Health Scrutiny Committee. On agenda for 28 Sept 2016.	Green
10	RC Comm 17.03.16	The Committee agreed to invite relevant NHS organisations to a future meeting in order to discuss discharges that had been delayed as a result of the NHS.	6 July 2016	Blackpool Hospitals Trust/Blackpool CCG	To be transferred to Health Scrutiny Committee. Report from BTH being considered on 6 July 2016. 28 Sept 2016 - to close this action unless further details required.	Green
11	RC Comm 14.04.16	To receive an update from LCFT on The Harbour in approximately 6 months.	October 2016	Lisa Moorhouse	To be added to workplan. To be transferred to Health Committee. A special meeting will be arranged for either 12 or 24 October 2016. Special meeting arranged for 12 October 2016.	Not yet due
12	RC Comm 14.04.16	To receive a full response to the questions regarding the incident on Byron Ward from a clinican following the meeting.	October 2016	Lisa Moorhouse	It has been agreed that the response will be provided in person by a clinician at the next meeting. To be transferred to Health Scrutiny Committee. To be covered at the special meeting in October 2016.	Not yet due
13	HSC	To receive detailed information on the	28 Sept	Ruth Henson	On agenda for 28 Sept 2016 as part of the Council	Green

	06.07.16	significant difference in non-opiate and opiate drug users completing treatment successfully at the next meeting.	2016		Plan Performance Report.	
14	HSC 06.07.16	To receive an update from the Cabinet Secretary concerning progress with tackling overweight children with particular reference to unhealthy snacks being sold in health centres.	28 Sept 2016	Cabinet Secretary [Public Health]	Update received from Lynn Donkin, Public Health Specialist, on behalf of Cllr Cain. The factors driving obesity levels are extremely complex. A Healthy Weight Strategy is in place and includes a particular focus on promoting healthier weight for children. Members of the Public Health team will be presenting an update to the Health and Wellbeing Board (HWB) in October 2016. A key achievement of the strategy to date has been the signing of a Local Authority Declaration on Healthy Weight in January 2016, Blackpool being the first authority in the country to adopt such a declaration. This offers the opportunity to encourage HWB partners to follow the Council's lead. Referring to the specific query regarding vending machines in Whitegate Health Centre, as this Centre is operated by Blackpool Teaching Hospitals NHS Trust, we have asked colleagues at the Trust to look into this. The Trust are active members of the Healthy Weight Steering Group and have a number of actions underway within the hospital including the development of a food and nutrition policy which includes adopting the Healthier Vending Guidelines developed by the Council's Public Health team. These guidelines recently featured as a good practice case study in the Local Government Association publication on Healthier Food Procurement	Green

					http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7931587/PUBLICATION. There is assurance that vending machines on local authority premises have already been the subject of action as a result of the Healthy Weight Strategy. The Healthy Vending Guidelines have been implemented across the authority and were the subject of a recent audit. The audit found only a few machines on local authority premises, these being in leisure centres. There are no machines at Bickerstaffe House or the Town Hall (a machine was found here and has been removed). Public Health have worked with the Procurement team to ensure that the content of machines in the leisure centres are compliant with the guidelines. Proposed that this action is considered complete unless further details required.	
15	HSC 06.07.16	To receive detailed information on attendance types of patients at Accident and Emergency.	28 Sept 2016	David Bonson, CCG	Update to be sought for 28 Sept 2016.	Not yet due
16	HSC 06.07.16	To receive a full performance report on the ambulance service including response rates from Blackpool Clinical Commissioning Group and the North West Ambulance Service.	28 Sept 2016	David Bonson, CCG; David Rigby, NWAS	On agenda for 28 Sept 2016.	Green
17	HSC 06.07.16	To receive definitions on the various terms and measures used concerning improving access to psychological therapies (IAPT) following the meeting from BCCG.	28 Sept 2016	David Bonson, CCG	Update to be sought for 28 Sept 2016.	Not yet due
18	HSC 06.07.16	To receive information from BCCG on the provision of mental health services including progress with recovery rates	28 Sept 2016	David Bonson, CCG	Update to be sought for 28 Sept 2016. Information to be received / circulated and progress tracked retaining option for a meeting report.	Not yet due

		at a future meeting.				
19	HSC 06.07.16	To receive a quality of care performance report from BCCG at a future meeting.	28 Sept 2016	David Bonson, CCG	Proposed to be included in current regular performance reports of CCG commissioned areas. Next performance report due 14 Dec 2016.	Not yet due