Blackpool Council

6 December 2016

To: Councillors Callow, Mrs Callow JP, Elmes, Hobson, Hutton, Mitchell and Owen

The above members are requested to attend the:

HEALTH SCRUTINY COMMITTEE

Wednesday, 14 December 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 Governance in advance of the meeting.

2 MINUTES OF THE MEETINGS HELD ON 28 SEPTEMBER 2016, 12 OCTOBER 2016 AND 29 NOVEMBER 2016 (Pages 1 - 26)

To agree the minutes of the meetings held on 28 September 2016, 12 October 2016 and 29 November 2016 as true and correct records.

3 PUBLIC SPEAKING

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

4 EXECUTIVE AND CABINET MEMBER DECISIONS

To note that there have been no Executive or Cabinet Member decisions, within the remit of the Health Scrutiny Committee, made since the Committee's last meeting on 28 September 2016.

5 FORWARD PLAN (Pages 27 - 30)

To note that there are no (key decision) items within the Council's Forward Plan,

December 2016 - March 2017, relating to Health Scrutiny Committee (HSC) functions but work on the outline Pan-Lancashire Health and Wellbeing Governance Arrangements and the contract for the new integrated clinical recovery, drug and alcohol treatment service are of interest to Members

6 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017 (Pages 31 - 52)

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

7 COUNCIL PLAN PERFORMANCE REPORT - QUARTER TWO 2016-2017 (Pages 53 - 60)

To review performance against the Council Plan 2015-2020 for the period 1 July 2016 - 30 September 2016.

8 BLACKPOOL CLINICAL COMMISSIONING GROUP MID-YEAR PERFORMANCE REPORT (APRIL 2016 TO SEPTEMBER 2016) (Pages 61 - 78)

To consider the mid-year performance of the Blackpool Clinical Commissioning Group for 2016-2017 (April 2016 – September 2016).

9 WINTER HEALTH PLANNING (Pages 79 - 106)

To inform the Health Scrutiny Committee of the specific activities undertaken around winter health planning across the Blackpool Health Economy and Fylde Coast area (involving local health service commissioners and providers of services).

10 BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST: STRATEGY, AMBITIONS AND WORK PROGRAMMES (Pages 107 - 126)

To consider a progress report on Blackpool Teaching Hospitals NHS Foundation Trust's strategy, including progress against strategic ambitions and the financial position.

11 DATE AND TIME OF NEXT MEETING

To note the date and time of the next meeting as Wednesday, 22 March 2017 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

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**MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING –
WEDNESDAY, 28 SEPTEMBER 2016**

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	O'Hara
Mrs Callow JP	Elmes	

In Attendance:

Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group (BCCG)
Ms Yvonne Rispin, Director of Ambulance Commissioning, BCCG
Ms Jeannie Harrop, Senior Commissioning Manager, BCCG
Mr Mark Newton, Consultant Paramedic and Head of Service, Urgent Care, North West Ambulance Service (NWAS)
Mr David Rigby, Sector Manager, NWAS

Dr Arif Rajpura, Director of Public Health
Ruth Henshaw, Corporate Development Officer
Sandip Mahajan, Senior Democratic Governance Adviser

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 6 JULY 2016

The Committee agreed that the minutes of the Scrutiny Committee meeting held on 28 September 2016 be signed by the Chairman as a true and correct record.

3 PUBLIC SPEAKING

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

4 EXECUTIVE AND CABINET MEMBER DECISIONS

The Committee noted that the Health and Wellbeing Strategy had been approved at the Council meeting on 21 September 2016. At the Executive meeting on 12 September 2016, Healthwatch Blackpool had expressed concern that tackling mental health was not a priority in the Strategy. Healthwatch had been informed that the Strategy sufficiently incorporated mental health. Also in view of an expected Health and Wellbeing Strategy for Lancashire, the performance monitoring framework had not been set but delegated to Dr Arif Rajpura, Director of Public Health to develop so Members could have an interest in the progress with the Lancashire Strategy development and Blackpool monitoring

framework. Dr Rajpura confirmed that work was in still progress for the Lancashire Strategy and local monitoring framework.

Progress with implementing the Public Health Scrutiny Review recommendations and Health and Wellbeing Strategy Action Plan plus effectiveness of outcomes of both areas would be monitored through the Committee's Work Programme.

The Chairman referred to PH57/16, tendering of a new Integrated Clinical Recovery, Drug and Alcohol Treatment Service, and asked if the target £200k saving was built into the tender specification. Dr Rajpura confirmed that the tender required a minimum saving of £200k, with a single contract supplier, 'Prime Provider' model. The current provider, Horizon incorporated three sub-providers: Alcohol and Drug Services (ADS), Delphi for clinical health support and Renaissance for recovery support. The creation of one provider would simplify and streamline management structures, communications and performance management.

In response to questions from the Committee in relation to any impact on service delivery and reinvestment potential, Dr Rajpura advised that as the £200k savings related to management and office costs, he anticipated that there would be no service impact, although there would still be a £1.5million budget pressure.

5 FORWARD PLAN

The Committee noted that there were no items on the Forward Plan, October - December 2016 on this occasion within the portfolio of the Cabinet Secretary, Councillor Graham Cain relating to health scrutiny functions.

6 COUNCIL PLAN PERFORMANCE REPORT - QUARTER ONE, 2016-2017

Mrs Ruth Henshaw, Corporate Development Officer reported on key performance indicators (KPIs) April-June 2016 in relation to three groups - opiate drugs users, non-opiate drug users and alcohol users - and the percentages (%) of these substance users successfully completing treatment. She explained that for the drug users the KPIs included not re-presenting within six months. There had been steady progress with all three KPIs.

Mrs Henshaw referred to the 6 July 2016 meeting when the Committee had requested details of why there was significant difference in progress between the opiate and non-opiate users. Explanatory commentary had been added to the performance report.

Dr Rajpura referred to opiate users' success rates which were below the national target and explained that the KPIs for all drug users focused on the clinical health stage but took no account of sustained recovery. He suggested that as people did relapse without further support a better approach would be to focus on providing real recovery, i.e. recovery rates sustained for at least six months after clinical support.

Dr Rajpura went to explain that many opiate users faced deep-rooted complex conditions,

and that although some users did successfully recover, the KPI had been easier to achieve previously with more manageable clients.

The Committee queried the life expectancy of drug users and Dr Rajpura explained that locally and nationally there had been an increase in deaths caused by drugs related use. Around 50% of opiate users did eventually recover. However, there were a high percentage of opiate drug users that never recovered and died usually quite young e.g. before they reached 30 years old. In recent years, the purity of drugs such as heroin had caused a number of early deaths. Around 50% of opiate users died due to the drugs. Older opiate users would also face other health issues and their problems were another reason in the national rise in deaths.

Councillor Maxine Callow enquired how long an opiate user might be prescribed methadone. Dr Rajpura stated that methadone prescriptions might run for two years or more. In reality, many opiate users would still be on methadone when they died. He added that the very low expectancy for drug users, i.e. 30-40 years old, meant a low local life expectancy rate overall of just over 75 years.

In response to a question on drug users with multiple problems Dr Rajpura referred to the integrated service approach which would support many users with complex problems. He added that alcohol treatment had proven challenging and the new integrated approach would use more effective specialist support for each of the alcohol and drug areas.

With regard to integration into society, Dr Rajpura explained that it was important to focus on ensuring that some opiate users did recover and were supported through a range of wider long-term initiatives, e.g. to aim for homes, skills and employment, reducing social isolation and friendship. He highlighted the Camerados Café which had been introduced into Blackpool Library and had proven highly successful in supporting people including not only coming off drugs but finding activities, jobs and even starting businesses.

In relation to awareness raising of the risks of drugs and alcohol, Dr Rajpura confirmed that there were public health campaigns particularly targeted at young people including supporting schools with health education and wider awareness information. There were particular recent projects such as Better Start supporting parents and young children and Head Start to support teenagers build resilience.

The Chairman referred to the five KPIs that were only reported upon annually and enquired whether in-year progress could be reported if there were issues, i.e. an assurance check that there would no significant end-of-year under-performance. Dr Rajpura confirmed that work in all areas was on-going with regular performance management.

The Chairman asked why some KPIs were only measured against the previous year, which might be starting from a low base, but had no specific targets. He also suggested that actual numbers for each KPI would be useful in providing better context. Dr Rajpura agreed that there could be percentage targets for each year with numbers added in.

The Committee agreed that the Health Key Performance Indicators should all have specific targets for monitoring progress and actual performance numbers alongside percentages.

7 NHS BLACKPOOL CLINICAL COMMISSIONING GROUP - NEW MODELS OF CARE UPDATE

Ms Jeannie Harrop, Senior Commissioning Manager, BCCG presented an update on implementation of New Models of Care (NMC). These concerned new approaches to health (and social) care across Blackpool and also across the Fylde coast and Wyre districts. The Committee noted that update followed a report in March 2016 to the Resilient Communities Scrutiny Committee had previously requested an update on funding ('Value Proposition') and NMC impact including patient stories of their NMC experiences. Ms Harrop explained that communications staff were developing more channels for patients to feed back.

Ms Harrop explained that Blackpool and neighbouring areas were one of fifty 'vanguard' areas nationally leading on NMC pilots following successful funding bids to NHS England. The NMC aimed to achieved integrated approaches to health and social care, more community and neighbourhood based care i.e. healthcare 'hubs', better use of technology and reduced costs.

Members noted that there were two Extensive Care Service (ECS) centres – Moor Park and South Shore – covering six neighbourhoods that provided support to people aged over 60, with a small range of long-term conditions. Teams of health and social care professionals were based at the hubs and aimed to support people better manage their conditions and reduce the need for hospital-based care.

The Chairman noted the successful overall progress including numbers of referrals and asked if there were any specific demonstrable evidence of targets. Mr Fisher stated that progress was in line with expectations including cost savings and keeping patients out of unnecessary hospital trips and that it was a long-term transformational programme.

Ms Harrop explained that funding criteria limited the range of conditions that could be considered. Patient choice was also important although there was still room to reduce the number of people choosing to leave ECS and a number of older people did not wish to join mainly due to misunderstandings that they would be de-registered with their GP or simply preferred to be treated by their GP. She added that more detailed ECS progress along with patient stories were included in the report appendices.

In relation to the IT system challenges of compatibility referred to in the detailed progress appendix, Mr Fisher explained that patient records systems needed to work with community systems and work was in progress to deliver the changes needed. Ms Harrop added that the changes would allow healthcare professionals to work in communities with hand-held devices.

Ms Harrop explained that although substantial funding of £4.32m had been secured

recently to continue NMC work, the amount was far less than the £9.6m originally bid for. Therefore it had been necessary to substantially revise elements of the proposed programme although the ECS programme would be mainly unaffected.

The emerging Enhanced Primary Care (EPC) programme had had to be considerably revised. EPC would link in with ECS and would be rolled-out from October 2016 to provide health and wellbeing support for people with challenging long-term conditions aged over 18. A 'hub' based approach would be developed with GP referrals and professionals able to directly respond to calls or sign-post registered patients.

The reduced funding meant less staff being recruited, instead staff would work more directly across various areas and more closely with operational partners such as NWAS. She added that the Care Home Team would be working more directly with all fifteen care homes fielding all healthcare calls.

In response to a question on whether there were sufficient Care Home Team placements, Ms Harrop explained that six staff were proposed at the current stage of the pilot. Often transfer delays occurred between care homes and hospitals so the proposed approach to directly manage call home calls would reduce the need for hospital transfers.

The Chairman queried the significant funding shortfall on the EPC outcomes sought. Ms Harrop confirmed that ECS had received all funding bid for but EPC had got less than half sought. Therefore a much more integrated approach to EPC would be required which included staff working across both schemes.

In relation to the effectiveness of multi-agency working and sharing information for patients' benefits, Ms Harrop stated that understanding about the schemes was still developing and would involve partners such as the voluntary sector, Fire and Rescue and occupational therapists.

The Committee noted that other integrated approaches were being undertaken including those set out in the Health and Wellbeing Strategy, 'one stop' hubs involving partners such as Blackpool Council and NWAS and work being undertaken with care homes including the use of telecare. Members noted that all ambulance crews had been trained and understood the health and wellbeing options including tackling issues such as social isolation and safeguarding people.

Ms Harrop confirmed that pathways remained open, e.g. if discharged from ECS the patient might then be accessing the EPC hub.

Dr Rajpura explained that episodic care was also community-based with community representatives working with the police, healthcare staff and other local services for example the Fire and Rescue Service used social care visits to look at wider health and wellbeing issues such as trip hazards and smoking. Mr Rigby added that opportunities were made to ensure access to community defibrillators, such as those in new build designs working with Blackpool Coastal Housing (BCH).

8 NORTH WEST AMBULANCE SERVICE PERFORMANCE REPORT FOR BLACKPOOL

Ms Yvonne Rispin, Director of Ambulance Commissioning, BCCG presented details of NWAS's annual performance for 2015-2016 and up to the end of July 2016.

Ms Rispin explained that BCCG was responsible for commissioning ambulance services across the region on behalf of all the thirty-three CCGs. In addition to Paramedic Emergency Services (PES) provided by NWAS, BCCG commissioned the NHS 111 contract (for non-emergency calls) and the five Patient Transport Services (PTS) for non-emergency transport. NWAS jointly delivered the 111 service and provided PTS to three county areas including Lancashire. She advised that NWAS's annual budget totalled £320m of which £250m was for PES, £40m for PTS and £20m for NHS 111.

Ms Rispin referred to the headline national ambulance targets and NWAS' performance regionally and locally in Blackpool and explained the different call categorisation targets set out in the report.

In response to concern expressed that fast response vehicles were not always being available, Mr Newton stated that targets had to be pursued and vehicles deployed appropriately. He added that sometimes it was assessed that incidents were not critical and were downgraded. Ms Rispin added that there could be double-counting impacting upon targets, i.e. multiple callers for an incident but each having to be recorded separately.

Ms Rispin explained that although Red 1 and Red 2 performance were significantly challenging and that activity had increased by 13%, NWAS had the highest national performance for Red 1 and was second for Red 2. She added that there were various issues to manage such as frequent callers and patients with care plans.

Ms Rispin re-iterated earlier references to initiatives to divert people from unnecessary hospital trips, the pressure to 'turnaround' patients effectively at accident and emergency with 'knock-on' impact. She added that proposed clinical care hubs would prove effective in tackling various issues.

Members noted that during 2015-2016, there were over 1.217m paramedic call-outs requested of which Red 1 incidents accounted for 2.5% of the total, Red 2 for 39% and the remainder for 57.5%. Ms Rispin reported that from April to end July 2016, there had been 405k calls resulting in 402k incidents.

Regionally, NWAS came in at 74% for Red 1, 66% for Red 2 and 91% for Red 'All'. She emphasised that nationally ambulance services were struggling against ever increasing demand. NWAS had experienced a rise of 13% for total Red activity but still had nationally the best performance for Red 1 and second best for Red 2. Performance in Blackpool was even better due to it being a densely populated area within a relatively small terrain.

The Chairman noted that Red 1 performance had been boosted by support from the Fire

and Rescue Service but seemed an unreliable approach given that Fire and Rescue would also have their own pressures. Mr Newton explained that often the Fire and Rescue Service would arrive first at incidents so might be in a position to give immediate aid. There were 2,300 such incidents in 2015-2016 which amounted to under 1% of all incidents. Ms Rispin clarified that the support was not usually included in the performance figures. However, Red 1 performance had been at 74% which was just short of the 75% target required to secure 20% of the quality performance funding premium from NHS England. Therefore NHS England accepted that the 75% target had been achieved by including the additional support and £7.5m funding was secured.

The Chairman referred to a recent article in the Lancaster Post which had reported significant staffing issues with ambulance crews experiencing severe degrees of stress and low morale. Mr Rigby stated that staff turnover was low although it was recognised that ambulance crews undertook a lot of training and were highly specialised roles which were much more complex than in previous years. He added that demand for ambulances had increased significantly in recent years and therefore a range of health and wellbeing support was in place to support staff Furthermore patient treatment options needed to be considered other than hospital trips which might not be necessary.

Ms Rispin explained that a number of initiatives had been developed to tackle the growing demand to identify whether earlier alternative options were more effective than transporting people to hospital. Members noted that the 'Hear and Treat' service had managed 11% of calls by ascertaining whether a vehicle was needed and offering telephone advice 'See and Treat' required observations at the scene which led to no need for hospital trips and alternative support amounting to 22% of people. The remaining tier was 'See, Treat and Convey' which meant taking people to hospital and was 67% of patients. Mr Newton added that GPs' awareness of care plans and the need to avoid hospital admissions unless required was also helping manage pressures. Mr Rigby referred to other initiatives such as community defibrillators as a valuable resource in saving time, costs and ultimately lives.

Ms Rispin clarified that whilst overall demand and activity had increased, the number of trips required to go to hospital had reduced. However, if demand pressures grew then as well as the current initiatives further consideration would need to be given to use of resources and further options.

Ms Rispin referred to the 'knock-on' demand pressures particularly with demand also rising in accident and emergency hospital wards. There was a handover and turnaround time of 30 minutes for hospital crews to pass on patients to clinical hospital staff. The same time requirement applied to acute hospital trusts to ensure space was made available to take patients. Fines could be imposed on the ambulance and acute trusts for breaches of time. Times were averaging 35 minutes for the North West but concordat agreements were being developed to press the time down.

The Committee noted that the NHS 111 service was for non-emergency calls and incorporated an advice line for patients including sign-posting to the right care service. The current five year contract started in 2015. There were four KPIs relating to prompt

call answering and, where appropriate, ensuring callers were directly transferred to clinicians. Most 111 calls resulted in primary care non-emergency services with 14% requiring an emergency vehicle. There were plans to build a 'virtual' call centre hub.

PTS was generally for pre-booked services with 2.2m patients carried annually for routine journeys Monday to Friday. There were five KPIs devised by BCCG for planned trips relating to answering calls in good time, maximising eligible bookings, waiting time for vehicles and travel time. Unplanned bookings could be at short notice and including weekends and bank holidays. Enhanced priority service trips were for renal and oncology treatment with more enhanced KPIs.

NWAS' PES coverage was geographically the largest in the country covering urban and rural areas with the second greatest population of 7.5m people. Patients were delivered to twenty-three acute hospital trusts including mental health sites. There were eighteen out-of-hours (OOH) services.

Ms Rispin referred to transformational work which also linked to NMC. There had been a national review of urgent and emergency care. A single pathway of service was being created which would be co-ordinated through clinical care hubs.

The Committee queried how the emergency services' Red 1 and other Red targets would be achieved in the event of a major incident and the impact on the wider community. David Rigby explained that all the emergency services and other key partners, including hospital trusts, ambulance services and health centres, had emergency plans, including cross border plans and undertook exercises. He highlighted the Cumbrian floods earlier in 2016 as a good example of major emergency co-ordination. There were various other initiatives such as 'night safe havens' offered by local authorities and open to visitors affected and he added that resources could be freed up such as the NHS 111 service.

With regard to a question of major incidents at local hotels, Mr Rigby replied that the Fire and Rescue Service deployed a lot of resources and sometimes only specific agencies were required.

The Committee referred to charges for PTS and how the system was managed for patients using PTS from outside the area. Ms Rispin explained that patients were not charged, but were directed towards the most appropriate form of transport based on their needs and that cost-effectiveness was considered, for example oxygen support might be needed or a taxi might be the best option. She added that patient choice and GP referrals from outside the area needed to be included in the criteria for use of PTS.

9 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

The Chairman referred to the Health Scrutiny Workplan for 2016-2017 and progress with the implementation of recommendations. The Chairman informed the Committee that the scheduled winter planning report, agreed at the last meeting, had not been produced. Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group (BCCG) stated that national guidance from NHS England had been received recently. The winter planning

needed to incorporate guidance requirements so an up-to-date report would be available for the Committee's December 2016 meeting

The Chairman added that the Care Quality Commission (CQC) had undertaken a recent inspection of a local GP health centre, Grange Park, which had resulted in a poor inspection and improvement plans being required, which would involve ongoing support from NHS England and BCCG with contingency plans. Members noted that the CQC were monitoring progress with a re-inspection due in October 2016 and therefore agreed to consider an update at the December 2016 meeting.

The Committee agreed:

1. To approve the Scrutiny Workplan subject to the inclusion of a progress update concerning improvements at the Grange Park Health Centre at the December 2016 meeting.
2. To note the 'Implementation of Recommendations' table.

10 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Tuesday 29 November 2016 in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.15 pm)

Any queries regarding these minutes, please contact:
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**MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING –
WEDNESDAY, 12 OCTOBER 2016**

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	Hutton
Mrs Callow JP	Elmes	

In Attendance:

Councillor Kath Benson
Councillor Amy Cross, Cabinet Member for Health Inequalities and Adult Safeguarding
Councillor Alistair Humphreys
Councillor David O'Hara
Councillor Danny Scott
Councillor Vikki Singleton

Dr Leon Le Roux, Clinical Director, Lancashire Care NHS Foundation Trust
Mr Steve Winterson, Director of Strategic Partnerships and Engagement, Lancashire Care NHS Foundation Trust
Bridgett Welch, Associate Director of Nursing (Safeguarding), Lancashire Care NHS Foundation Trust

Karen Smith, Deputy Director of People (Adult Services)
Les Marshall, Head of Adult Social Care
Jayne Gornall, Senior Service Manager, Mental Health and Learning Disabilities
Chris Kelly, Senior Democratic Services Adviser
Sandip Mahajan, Senior Democratic Services 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 LANCASHIRE CARE FOUNDATION TRUST: THE HARBOUR PROGRESS REPORT

Mr Steve Winterson, Director of Strategic Partnerships and Engagement, Lancashire Care NHS Foundation Trust (LCFT) explained that progress reports had been given in November 2015 and April 2016 to the Resilient Communities Scrutiny Committee concerning The Harbour, LCFT's adult in-patient mental health facility in Blackpool.

Improvements had been sought following public concerns and a Care Quality Commission

(CQC) inspection in 2015. The inspection and resulting improvement plan had covered LCFT's services across Lancashire including The Harbour.

More details had been requested following the April 2016 meeting concerning safeguarding of patients and the serious incident that resulted in a suicide on the Byron Ward (psychiatric care) in July 2015. Members noted that the Coroner had recently concluded his public inquest into the incident so comprehensive information was available.

Dr Leon Le Roux, Clinical Director, LCFT referred to the range of improvement work, challenges and plans.

Staffing and Patient Care

Dr Le Roux stated that staffing was arguably the biggest challenge trying to ensure that staff resource, including nurses and doctors, was sufficient, highly skilled and the coverage right at all times. A Staff Strategy had recently been developed.

Dr Le Roux explained that recruitment was an ongoing demand with staff shortages often covered by agency staff and the Trust's own (on-call) 'banked' staff. He acknowledged that using agency staff was not ideal in terms of continuity and familiarity of staff and higher costs but stated that permanent staffing was a national problem and agency staff allowed greater flexibility although the Trust was aiming to eliminate use of agency staff. He added that securing medical staff at consultant level was particularly difficult and there was a high vacancy rate.

Members queried whether staff turnover was high for nursing staff due to their stressful occupations and what was learnt through staff exit interviews. Dr Le Roux explained that turnover of all staff was at times as high as 20%. However, with the use of banked staff, average rates were 50% better than a year ago. He noted that there had been an expected legacy issue when The Harbour had opened in 2015 whereby some staff had been geographically displaced so had chosen to work closer to home. Members expressed disappointment that development plans had been pursued notwithstanding awareness of staffing issues. They queried how many original staff remained and requested a written reply. Mr Winterson explained that LCFT's Chief Executive had addressed early staffing issues at previous meetings. Bridgett Welch, Associate Director of Nursing (Safeguarding) added that the Trust had been nominated as one of the Top 50 NHS employers and highly recommended for patient care.

Dr Le Roux agreed that staff were working in a tough environment where patients needed considerable care and emphasised the importance of retaining staff through effective support and training. He advised that banked staff had access to all training and some training was available to agency staff. Members queried how agency staff qualifications were verified. Ms Welch explained that recruitment agencies were responsible for vetting their agency pool. The Trust was also trying to set up its own agency in addition to its pool of banked staff. Members requested written information in relation to the numbers of

newly qualified staff when the Harbour started and the current numbers. Dr Le Roux gave an assurance that there was a good number of experienced staff.

Dr Le Roux added that sickness levels were an indicator of stress and levels were relatively low at 6.5% and decreasing. Ms Welch added that initiatives were in place such as a People Plan, a new Occupational Health provider and increased nursing supervision support across clinical networks. Dr Le Roux added that clinical psychologist numbers had been increased across wards and that the psychologists talked to patients and supported nursing staff through discussing cases, complex issues and providing briefing updates. Ms Welch added that those were opportunities for staff to share experiences and that the Personal Development Review (PDR) process was another opportunity for staff to pursue personal development. Members requested the results of the staff survey.

The Committee sought assurance that ward numbers were sufficient. Dr Le Roux stated that ideal bed occupancy rates would be 85% allowing capacity for emergency cases. However, rates of 95% were being experienced which equated to the national average and required extra staff. He stated that robust systems had been introduced so that staffing across wards could be monitored at any time including shift handovers. Daily electronic reports of shift patterns and patient requirements were reviewed by ward management including senior nursing staff (matron) and the Director of Nursing which allowed issues to be identified and practical action taken. Senior management also spent time on wards including week-ends. Dr Le Roux advised that there was always a range of operational and strategic staff at all levels either on-site or on-call. He added that there were good communications to ensure resilience for major incidents.

<u>Safeguarding</u>

Ms Welch explained that the Trust had statutory duties to comply with safeguarding legislation (Children's Act 2004 and Care Act 2014 for adults) although they provided no children's services in Blackpool. Members noted that there was a dedicated Safeguarding Team covering children's and adult services as well as mental health and that the Trust provided a wide range of training, ongoing support and advice to all staff. Safeguarding plans were linked to the Trust's quality plans.

Ms Welch stated that a proactive 'learning through practise' approach was undertaken with staff as well as bespoke training based on real experience.

It was reported that at the local level, the Safeguarding Team worked closely with the Blackpool Safeguarding Boards for children and adults as well as the other two safeguarding boards in Lancashire at a strategic board level and an operational level, as well as specific training and quality sub-groups and case reviews. She reported that the Team were involved with multi-agency audits of specific themes and cases as well as their own internal audits. In response to a question, she confirmed that the Safeguarding Boards independently audited the LCFT. Members noted that the Trust worked closely with the Council's services for children and adults and the Designated Nurse for

Safeguarding from the Clinical Commissioning Group (Blackburn with Darwen as the lead commissioner).

Ms Welch referred to the high number of safeguarding alerts raised concerning The Harbour and stated that a significant number had been due to being cautious and applying risk thresholds inappropriately. Ms Welch stated that too many unnecessary referrals put pressure on officers at the various safeguarding bodies and it was hoped that improved training for all staff would create a better understanding of thresholds and when referrals were appropriate. She added that it was good that staff had the confidence to make referrals. The Committee was advised that the Trust bench-marked their safeguarding performance against national standards for comparable NHS trusts.

It was reported that the Trust had been involved in helping re-design thresholds guidance for adults and Ms Welch took members through the safeguarding reporting and focused on the alerts that had been considered as genuine safeguarding concerns. A software system 'Datix' was used so that all incidents were investigated to ensure that there were no safeguarding concerns. Part of the awareness process involved the Safeguarding Team visiting wards and discussing best practice. Ms Welch stated that it was important to focus on protecting vulnerable people and supporting their needs but also recognising that incidents may not necessarily pose a risk. Members referred to recent press articles concerning patients wandering in the community seemingly lost. Dr Le Roux explained that patients were not in secure institutions (unless sectioned) and the focus was on caring for them to support recovery. Risk assessments were done and mitigation measures put into place to manage risk which could not be totally eliminated. He advised that that particular patient had been assessed and deemed to be safe to leave the grounds.

Ms Welch added that the Trust forecasted safeguarding demand pressures. She referred to the high numbers of assaults, which could include threats or offensive comments and explained that the assaults did not involve staff on patients. Ms Welch advised that there was zero tolerance to any type of assault so they were all investigated and members noted that multiple assaults could be recorded when one patient was particularly unwell and abused several people. In response to a question, Ms Welch confirmed that there were more assaults on older patients but that those reflected The Harbour's patient population. Members requested a written breakdown of the different types of assaults and numbers. In response to a suggestion for trained security staff helping with reducing the number of assaults, Dr Le Roux stated that The Harbour was an environment that endeavoured to provide care and recovery support for patients rather than a secure institution.

Members noted that the assaults and other issues had created a negative public image of The Harbour amongst some local residents who had raised concerns and conversely other residents had recognised the work of The Harbour. It was suggested that one proactive approach could be to create a more attractive physical environment that supported patients and projected a better image.

Dr Le Roux referred to the challenging patient environment where there were difficult

long-term conditions. He added that it was a constant learning curve for all staff and they recognised the need to be open to suggestions.

Serious Incidents

The Chairman referred to Healthwatch Blackpool's report undertaken in April 2016 concerning service users' experiences of The Harbour. Users had been concerned by the constant change of staff and not being available when patients needed them. Dr Le Roux explained that there were no bell pull cords (for safety) or other alarm for patients as it was felt they had the physical means to alert staff. There had been bells when The Harbour first opened but technical issues had arisen. He stated that staff now had their own alarms, new staff followed a structured programme including practical introductions to wards and that patients were risk assessed and under constant observation if necessary. Ms Welch added that Multi-Disciplinary Teams (MDTs) operated on wards and there was careful planning in place to manage any serious incidents.

Dr Le Roux referred to the serious incident that had led to a suicide on the Byron Ward in July 2014 and following which an external agency had been commissioned to undertake an independent investigation. He advised that staff had been new and had had limited experience. Members noted that one of the factors highlighted was the over-reliance on the observation policy which had not been strictly followed. It had been recognised that the policy was not clear with different staff interpretations and threshold risk levels for undertaking observation being changed. Dr Le Roux advised that the observation issues had been addressed and supported by training, however, all eventualities could not be guaranteed as staff were trying to manage unpredictable human behaviour. He advised that an enhanced risk assessment tool was used and summarised the main themes identified by the independent reviewer, namely low levels of staff experience, problems with the observation policy, need for robust clinical decision-making in line with national guidance and good management of patients with personality disorders. All the independent recommendations had been accepted and effective actions implemented.

The Chairman referred to the Coroner's findings and that clinical decisions had been made inappropriately. Dr Le Roux acknowledged that there had been failings but policies, procedures and systems had improved with increased training and effective staffing and that there was increased visibility of ward matrons. In response to questions, he added that processes were audited and incidents investigated and assured Members that compliance levels were high and operating procedures kept up-to-date.

Members expressed concern that at the time of the incident important evidence had gone missing. Dr Le Roux explained that often deaths occurred sometime after incidents as was the case for the relevant incident. He stated that 'scene of crime' guidance had been produced for staff concerning incident management including actions such as cordoning off areas at the right time and making use of the CCTV system. Members requested written evidence that procedures had been strengthened for ensuring 'scene of crime' material did not go missing.

Modelling Demand (Beds)

Dr Le Roux explained that service capacity modelling work had taken place working with the Network Director as providing a diverse service structure with the right capacity was the biggest challenge across Lancashire. Members noted that community provision was provided through a range of teams for patients able to manage their lives in the community with appropriate support and that in-patient beds were for the most acute long-term cases. Dr Le Roux stated that there was no middle option for people who might suffer from mild mental health problems but suddenly experienced short-term acute problems due to a single incident.

Dr Le Roux went on to give an example of a major incident which had occurred when over 90 new patients had suddenly arrived. All options had needed to be considered including working with acute trusts especially as there were no spare private beds.

The Committee noted that some progress had been made to improve bed capacity and plans were being accelerated working with service commissioners. New assessment units had been opened, acute units used and crisis housing support provided.

Dr Le Roux reported that 'out-of-area' bed placements (placing patients in units outside their local area) were a particular issue locally and nationally. Locally that required twice as much work without a parallel increase in staff numbers. He advised Members that the Trust currently had more than double the national average and was the second highest nationally. However, the 'out-of-area' level had recently reduced slightly. Dr Le Roux advised that work was being done with the NHS Benchmarking body to look at best practice at other trusts although change took time and that one London trust had needed eight years to make necessary changes. The Committee noted the government target of zero out of area placements by 2020 and that fundamental strategic changes were required in the health economy to achieve the target.

Members referred to original proposals when The Harbour was built that there would be other new sites. Mr Winterson explained that austerity measures had delayed the proposed new builds. However, there were still plans for two new sites and a written response confirming plans would be provided.

Mr Winterson added that modelling reviews had taken place in 2005-2006 and 2011-2012 and that both had proposed reducing the number of beds significantly and increasing community service provision. Members noted however that beds had significantly reduced since 2005 but the 2011 target of reducing beds to 260 across the LCFT network had not been achieved to the desired range and there were still over 300 of which 154 were at Harbour. Dr Le Roux added that LCFT actually had below average numbers of beds against comparable neighbours which prevented the number of 'out-of-area' placements being easily reduced. He stated LCFT's vision was to reduce ward beds and increase the community focus and that steady progress was being made. He added that the voluntary and community sector was an important asset to work with particularly with respect to social care as part of integrated healthcare. In response to a question, it was confirmed that the Making Spaces charity was an active partner of the Council.

Financial and Long-Term Sustainability

The Chairman referred to recent local press concerns over value for money. Dr Le Roux referred to the financial challenges faced by the Trust and NHS generally. LCFT worked closely with commissioners of their services but also put forward robust, value for money cases for enhanced services. The contract was due for review and all the CCGs would be giving their views as to value provided and what should be provided.

Care Quality Commission Inspections

Mr Winterson referred to the 2015 CQC inspection and explained that there had been around 400 improvements required most of which had been implemented. Longer-term ones concerning the estate were still being pursued. Members enquired as to the provisional outcomes of the recent CQC inspection and Dr Le Roux outlined that the LCFT had been given a positive impression from the CQC who usually highlighted any serious concerns but there had been none indicated. However, LCFT was still pursuing ongoing improvement. The report was expected in November 2016 followed by a Quality Summit in December 2016.

Members noted the progress that LCFT had made at The Harbour in terms of safe and quality patient care and requested the latest CQC findings to provide on-site assurance and inform them as to any further progress reports.

The Committee agreed:

1. That LCFT would provide the following information to be circulated to Members -

    i) Percentage of newly qualified staff when The Harbour started in 2015 and the current percentage.
    ii) Number of original staff retained from when The Harbour started in 2015.
    iii) Results of the latest staff survey.
    iv) Different types of assaults and numbers for each type.
    v) Evidence that procedures have been strengthened for ensuring ‘scene of crime’ material does not go missing.
    vi) Confirmation of what new in-patient mental health sites were proposed and details of service capacity.

2. To review the CQC report, following their inspection in September 2016 of the LCFT, and use any relevant evidence including the CQC findings, to decide whether specific assurances of safe and quality patient care were still required through further meetings.

4 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Tuesday 29 November 2016 in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.30 pm)

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

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	Elmes	Mitchell
Mrs Callow JP	Hutton	Owen

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 Helen Lammond-Smith, Head of Commissioning, Blackpool Clinical Commissioning Group

Les Marshall, Head of Adult Social Care
Val Raynor, Head of Commissioning
Sandip Mahajan, Senior Democratic Governance Adviser

1 DECLARATIONS OF INTEREST

Councillor Martin Mitchell declared a personal interest as the Council's representative on the Board of Governors for Blackpool Teaching Hospitals NHS Foundation (none of the items directly related to Blackpool Teaching Hospitals).

2 PUBLIC SPEAKING

The Chairman explained that the BBC had commissioned local TV media to film a series of council committee meetings as part of a national project promoting local democracy. He welcomed Paul Faulkner from That's Lancashire Television who would also be attending the Committee's next meeting on 14 December 2016. The Committee noted that there were no applications to speak by members of the public on this occasion.

3 HEALTH AND SOCIAL CARE INTEGRATION IN BLACKPOOL

Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group and Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group presented an update regarding the development of health and social care integration in Blackpool (as part of the wider Fylde Coast partnership).

He explained that integration required strategic direction and practical changes to service delivery. Sustainability and Transformation Plans had been developed nationally as five-

year plans (2016-2017 to 2020-2021) across 44 'vanguard' pilot geographic areas which were leading on transformation and integration of NHS and Social Care services.

Mr Bonson referred to the Lancashire and South Cumbria Sustainability and Transformation Plan within which were five local 'footprint' geographic areas responsible for delivering services, one being the Fylde Coast area including Blackpool. The local areas were based on populations, locations of services and actual patient flow rather than traditional local authority boundaries.

He referred to a good history of partnership working across services within Blackpool and emphasised the need for real partnership working to drive Plans. Key partners included Blackpool Teaching Hospitals and Lancaster County Council. It was important to fully understand different systems and ways of working for effective change to be developed.

He added that service delivery changes would aim to deliver better health and wellbeing outcomes for people. Alongside transformation improvements was the need to ensure that services were sustainable. Current demand, in particular, for acute hospital services (physical healthcare and emergency treatment) was unsustainable based on resources. He advised the Committee that even though NHS funding was increasing, unlike local authority funding, current projections were for demand to exceed funding supply and that based on current projections the funding gap by 2020-2021 would be £572m for Lancashire and South Cumbria (approximately 25% of the overall health and social care budget).

Members noted that partners were developing an Accountable Care System which would promote further joint working but with a more rigorous formal approach including risk-sharing. Budgets would be pooled as already existed with the Better Care Fund for integration work which was around £15m (budget for 2015-2016). Co-commissioning for acquiring services would also be developed. Greater efficiencies were required for systems and ways of working.

Mr Bonson spoke about developing new more practical service delivery options and outlined that hospitals represented the greatest cost burden, in particular accident and emergency and non-elective treatment, and use of beds needed to be reduced. Instead, there needed to be a greater drive towards community-based care whereby people took greater self-care or were able to maintain some independence outside hospital whilst getting necessary treatment and care support.

He acknowledged that Sustainability and Transformation Plans did not provide all the answers to the range of challenges aimed to develop effective strategic approaches in response to the scale of challenge.

Members noted that the Plan was at an early development stage, the first of five years, and that it was a draft document (third version) that had been submitted to NHS England, the national funding body, for approval. NHS England had indicated broad contentment subject to final approval. However, the public and partners would still be able to influence development of future projects and programmes to transform services.

Mr Bonson explained that although the Plan was in an evolutionary phase, practical work had taken place over the last year. In particular, new Models of Care had been developed such as the Extensive Care System which mainly supported elderly people, with complex long-term conditions, who could be supported locally by professionals. More recently the Enhanced Primary Care Service, which located professionals around local GP centres, had been launched. Mr Fisher referred to national recognition given to the new Models of Care.

Mr Bonson concluded that service provision had to be fully integrated and partnership working was fundamental to achieving better health and wellbeing outcomes for people.

The Chairman referred to the Chartered Institute for Public Finance and Accountancy (CIPFA) who had recognised the importance of Sustainability and Transformation Plans but had identified that few nationally had demonstrated robust evidence of being able to deliver the scale of savings needed. He added that national media reports had referred to disquiet from MPs and even the Chairman of the British Medical Association, who represented GPs nationally, had referred to potential service cuts. The Chairman referred to the ambitious local Plan and queried what would happen if targets were not achieved in three years or so. It was also noted that nationally there had been little time given to develop Sustainability and Transformation Plans.

Mr Bonson agreed that there had been little time given to develop robust Sustainability and Transformation Plans with sufficient detail. He acknowledged that there had been mixed reactions although the local Plan had been well received by NHS England. He re-iterated that Sustainability and Transformation Plans provided the template for change but were not the actual change vehicle. He acknowledged that progress would need to be kept under review but provided assurance that cuts to services would not be required. Instead, funding growth had to be used more effectively to support hospital growth demand towards more manageable community-based care. He added that NHS funding growth was projected to rise by 2% annually but demand for hospital services was destined to grow by 5% without radical change. Mr Fisher added that future services could be quite different but sustainability of viable services was imperative.

The Chairman queried when it would be possible to receive a more accurate financial projection. Mr Bonson explained that Sustainability and Transformation Plans were being driven nationally and formal feedback would be received by NHS England within a few months. By the middle of 2017, there would be a clearer picture.

The Committee returned to the financial challenges and members noted that there was no evidence that the Plan could make sufficient savings to meet immediate requirements. £32m savings required in social care over the next year would grow to £129m by 2020-2021. The Committee expressed concerns that the savings could only really be achieved through service cuts. Mr Bonson clarified that the quoted figures were for Lancashire and South Cumbria and re-iterated that service change was needed shifting people away from hospital services to community care and more integrated approaches. He added that Blackpool Council had a good track record for making savings.

The Committee also cited information within the Plan such as savings of £160m required from hospitals within two years, £95m savings to be found through merging specialised hospital services. There had also been reductions in hospital beds in recent years with a parallel drop in staff numbers. There were concerns that more beds would be lost.

Delayed transfers of care (patients moving from different stages of treatment unable to secure a bed in the next health or social care setting) was a serious issue impacting upon the core roles of staff. Delays were also due to needing a senior professional to give relevant permissions. Any mistakes made by staff including relating to medication could also have a negative impact on patients. Mr Les Marshall, Head of Adult Social Care, Blackpool Council advised that delayed transfers were considered jointly by NHS and social care managers on a daily basis and performance in Blackpool was better than the national average. Ultimately the overriding issue was reducing admissions to hospitals and moving people towards community care. Mr Bonson added that streamlined processes were pursued through weekly planning meeting including the ambulance service. Developing improved processes needed to be from admission to discharge.

The Committee enquired about the cost of 'out of area' and overseas patients. Mr Bonson confirmed that there were national and international recharge processes.

The Committee understood that Blackpool Teaching Hospitals were trying to secure multi-million pound loans whilst interest rates remained low. Reference was made to the spiralling costs of Private Finance Initiatives due to interest rate changes and it was requested how much hospital stock came with these.

The Committee noted that the Blackpool Clinical Commissioning Group was an organisation run by GPs but the main savings were required from acute hospitals. In addition to NHS savings referred to within the STP, £65m savings were required involving council premises. Funding such as the social care precept was not significant enough to meet the savings required.

Reference was also made within the Sustainability and Transformation Plan of West Lancashire requiring savings of £45m for community services and £20m for urgent care provision and that West Lancashire was privatising social care to reduce the direct public service provision. Reference was made to needing to ensure contracted services used by STP partners involved contracted staff being paid the Living Wage in line with Council policy. Mr Bonson confirmed that there was no privatisation agenda.

The Committee referred to the severe challenges in Blackpool which housed a number of acutely deprived areas. People living in these areas needed good, simple access to services within a reasonable distance and sufficient opening times. People moving into the area were often unwell and there was a growing elderly population. There were concerns that acute and specialised services would move away from Blackpool although it was recognised that Blackpool and other local areas could themselves acquire some specialist services. Mr Bonson explained that specialist services did result in better health outcomes and that services needed to be reviewed to ensure sustainability. He accepted the deprivation and needs analysis adding these arguments were needed as evidence for

more funding and better services within Blackpool. He referred to progress being made with new Models of Care and patient satisfaction.

The Committee advised that the Plan needed to be written in much simpler language and be significantly shortened to make it more readable for the public to comment.

The Chairman emphasised that people were central to the Plan succeeding, in particular healthier lifestyles, as part of the preventative agenda and community-based support. He highlighted the severe challenge on the ground in view of poverty and other local issues embedded over generations. Major action was needed to improve people's lifestyles especially within the Plan timescale. He also referred to GPs' appointments of around ten minutes and enquired how GPs could best encourage patients within limited opportunities to promote and support self-help.

Mr Bonson agreed that the challenges were significant and he referred to smoking rates as being the worse nationally. He agreed GPs had a role to guide patients but they had limited time and services could not rely on telling people what to do. People had to be supported through sign-posting and other means such as community hub-based services where groups of professionals were able to provide guidance. In due course, the vision was for healthier and more resilient communities able to self-support.

The Chairman invited Council representatives to comment. Mr Marshall agreed that securing full integration was essential for the long-term sustainability of health and social care systems especially adult social care. Small scale integration had been achieved in some areas but there were many challenges to overcome for large scale integration. There was a steep learning curve in trying to understand and unify different systems. It was imperative to move from reliance on the acute care system to more community focused care. He agreed that the Plan currently lacked sufficient detail.

The Committee agreed to receive a progress report on health and social care integration, including the Sustainability and Transformation Plan and detailed financial profiling, for the July 2017 or September 2017 Committee meeting.

4 TRANSFORMING CARE PROGRAMME

Ms Helen Lammond-Smith, Head of Commissioning, Blackpool Clinical Commissioning Group presented an update regarding the development of Transforming Care for people with learning disabilities and/or autism and other challenging and complex behaviours.

She outlined the national background which led to the required local improvements. Crisis support existed in mental health nationally but until now had not for people with learning disabilities. NHS England had issued crisis support guidance.

Ms Lammond Smith stated that as with other health and social care work, it was necessary to help support people so that they had less need to access hospital services and could live independently, with support, in communities.

She referred to a key successful innovation 'Care and Treatment' Reviews which involved

a small number of professionals (clinician, 'expert by experience' and a Blackpool Clinical Commissioning Group officer as the commissioner of services). Care and Treatment Reviews looked at people's needs to establish the best support required and where that support should be and aimed to ensure that people were only in hospital if necessary and sought to promote community-based options. Members noted that assessments took place within ten days of an admission or before an admission occurred and then regularly every twelve months.

Ms Lammond-Smith explained that an 'at risk' register was maintained which identified people whose needs met relevant criteria for support and whose packages of care may be at risk of breakdown leading to an admission. There were nine patients in hospital under various levels of secure settings and around another twenty supported through community care. The register included contingency plans and contact details of carers/families.

She added that Care and Treatment Reviews were proving to be common for people with autism in mental health beds. The register also aimed to capture the transitional element to ensure people progressed effectively from children's services to adult services and were not 'lost'. Details of children in residential care, including 15-16 year olds, were held and details of families. Effective responses to breakdowns in children's care packages were prepared.

The Committee noted that key challenges included securing local specialist accommodation providers and good development support for well trained staff as current accommodation was costly as it was specialised and 'out of area'. Ms Lammond Smith stated that no local specialist facility existed but local provision needed to be developed. One problem for ensuring the most effective assessment decisions was that staff were usually housed within mental health services but not always dedicated learning disabilities beds available.

She added that 'delayed transfers of care' (availability of beds for patients moving between different stages of care in health and/or social care), as also referred to under the health and social care integration item, was a significant issue nationally and locally and also involving a great deal of reporting requirements.

She referred to the local governance arrangements for transforming care which were led by the Blackpool Clinical Commissioning Group and the Council who jointly shared transformation responsibilities.

The Committee referred to a recent local press article which had highlighted exceptional low budget levels for children's mental health services at just over 1% of commissioned health services locally which was one of the lowest rates nationally. Ms Lammond-Smith reported that the article was not precise or clear. Transforming Care was part of wider emotional health and wellbeing services which were well funded and Blackpool had one of the higher rates of investment amongst local neighbours.

The Chairman queried whether just having nine people in hospital meant that more people were being missed. Ms Lammond-Smith explained that hospital patients were

those needing the most support in secure beds and included people who had committed offences resulting in court orders to be detained. These were complex long-term cases ranging from as much as three to fourteen years in terms of hospital stays. She added that the joint partners had undertaken some good work before the Review of Winterbourne View recommendations had been made. She advised the Committee that learning disability needs had been incorporated within the Commissioning Strategy and that whilst some patients needed to be placed within secure accommodation the ethos was still on promoting community care in, or as close as possible to, people's homes.

The Chairman enquired what type of housing support provision existed. Ms Lammond-Smith explained that properties were mixed including some that offered support for 24 hours per day, 7 days per week and that most properties were shared occupancy.

The Committee enquired how many people with relevant conditions, who had committed crimes, were actually sent to prison rather than supported through transforming care. Ms Lammond-Smith did not have offending statistics but was able to confirm that relevant people would have assessments undertaken.

The Chairman referred to the community care focus and enquired whether safeguards were in place to ensure people were progressing well and safe. Ms Lammond-Smith explained that there were numerous process requirements for people securely detained under the Mental Health Act and that these included reviews, risk assessments and opportunities for patients to appeal against decisions. She added that people in hospital had the highest needs and costly, complex care packages.

Mr Marshall added that patients could be introduced through either the legal route or referrals from their GP and that for either route, best practice was for assessment and planning to start early at the admission stage with consideration being given early for progressing to community care and independence.

The Chairman requested assurance that families and friends were appropriately involved with patients' wellbeing. Mr Marshall explained that there was a statutory requirement to consult family and friends. Ms Lammond-Smith added that they were also involved in assisting with Care and Treatment Reviews and concluded that those were proving highly effective in supporting patients' needs and promoting their wellbeing.

5 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday 14 December 2016 commencing at 6pm in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 7.30 pm)

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

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Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Lorraine Hurst, Head of Democratic Governance
Date of Meeting:	14 December 2016

FORWARD PLAN

1.0 Purpose of the report:

1.1 To note that there are no (key decision) items within the Council's Forward Plan, December 2016 - March 2017, relating to Health Scrutiny Committee (HSC) functions but work on the outline Pan-Lancashire Health and Wellbeing Governance Arrangements and the contract for the new integrated clinical recovery, drug and alcohol treatment service are of interest to Members.

2.0 Recommendations:

2.1 Members will have the opportunity to question the relevant Cabinet Member in relation to items, being progressed or on forthcoming Executive agendas, relevant to Health Scrutiny Committee functions.

2.2 Members will have the opportunity to consider whether any of the items should be subjected to pre-decision scrutiny. In so doing, account should be taken of any requests or observations made by the relevant Cabinet Member.

3.0 Reasons for recommendations:

3.1 To enable the opportunity for pre-decision scrutiny and/or consider progress being made.

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 The Pan-Lancashire Health and Wellbeing Governance Arrangements are being considered by the Executive on 15 December 2016. The proposals are to bring together existing arrangements for the three strategic Health and Wellbeing Boards across Lancashire for delivering cross-boundary work in parallel with other Pan-Lancashire health and social care developments such as Sustainability and Transformation Plans.

5.2 Members have previously questioned the relevant Cabinet Member, Cllr Cain, at their meeting on 6 July 2016 before the Blackpool Health and Wellbeing Strategy was considered by the Executive and approved by Council. Progress with the Blackpool Strategy's Action Plan is scheduled to be considered at the Committee meeting on 22 March 2017 meeting. Members may wish to question Cllr Cain concerning the Pan-Lancashire proposals.

5.3 The contract for the new Integrated Clinical Recovery, Drug and Alcohol Treatment Service (starting 1 April 2017) will be awarded on 20 December 2016. Members have previously questioned the Director of Public Health, Dr Arif Rajpura, at the Committee meeting on 28 September 2016. The integrated service will be of interest to Members as it will directly affect key performance indicators for health improvement (item seven on the agenda). Key elements of the new service including a more holistic approach to supporting people with substance misuse issues, use of one 'prime' provider and securing around £200k of savings through management efficiencies. Members may wish to question Cllr Cain and/or Dr Rajpura as to further progress.

5.4 Witnesses/representatives

5.4.1 The following Cabinet Member is responsible for the items in this report and has been invited to attend the meeting: Councillor Cain.

Does the information submitted include any exempt information? No

List of Appendices: None

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.

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Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Lorraine Hurst, Head of Democratic Governance
Date of Meeting:	14 December 2016

HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

1.0 Purpose of the report:

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

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 Health Scrutiny Committee'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 Workplan**

5.1.1 The Health Scrutiny Committee Workplan 2016-2017 is attached at Appendix 6 (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 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 Health Scrutiny Committee Review Checklist is attached at Appendix 6 (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 table attached to Appendix 6 (c) has been developed to assist the Health Scrutiny Committee to effectively ensure that recommendations made are acted upon and also to review the effectiveness of outcomes. The table will be regularly updated and submitted to each meeting. 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 Health Scrutiny Committee to monitor.

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 6 (a), Health Scrutiny Committee Workplan 2016-2017
Appendix 6 (b), Health Scrutiny Committee Review Checklist
Appendix 6 (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.

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HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017	
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 national guidance (NHS England) and local information updates. 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. Note - this may include a brief update on the Care Quality Commission's (CQC) re-inspection of the Grange Park Health Centre else after the CQC's report which is expected around 16 December 2016. 5. **Ambition Targets and Work Plans including Economic Recovery** - Blackpool Teaching Hospitals. Note - item deferred from September 2016 meeting. 6. **Harbour Progress update** following the CQC report of the September 2016 inspection. Note - this item is only provisional but will not be held (or deferred) if the CQC report provides good quality and safety assurance. As of early December 2016, the report is still expected so this item will be considered when appropriate.
22 March 2017	1. **Council Plan - Quarter Three 2016-2017 Performance Monitoring** **2. Health and Wellbeing Strategy 2016-2019 - Action Plan and Progress Report.** Note - deferred from March 2017 and may be affected by longer-term Pan-Lancashire Health and Wellbeing proposals. 3. **Public Mental Health Strategy** - **Action Plan** to be considered and will complement the item on young people's mental health YOUNG PEOPLE'S HEALTH THEMED MEETING 4. **Young People's Mental Health.** Hear from young people concerning mental health concerns/support and the Child and Adolescent Mental Health Services (CAMHS) provider. 5. **Young People's Physical Health.** Consider progress with tackling child obesity and the Oral Health Strategy. 6. **Young People's Health Needs in Care.** Consider this issue which was raised by the Care Quality Commission (CQC) during mid-2016 ('Not seen Not heard' report). The CQC have since undertaken an inspection of services within Lancashire (not including Blackpool) leading to an action plan. Although services in Blackpool not considered there may be parallel lessons. 7. **Sexual Health Strategy - Action Plan** to be considered. Likely to be considered at July 2017 meeting.
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/Duration of GP Appointments (Access to Services and Quality)** 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	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 including an update on the PH Annual Report.
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 have been invited to attend the meeting as the issues are of a cross cutting nature.

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 (now end Nov 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 national targets with continuous improvement being pursued and was sustainable. 27 June 2016 -	Not yet due

					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 update - 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. 28 Sept 2016 - to close this action unless further	Green

					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 (now 14 Dec 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.	Green
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. Update provided for the implementation of fluoride in milk scheme for schools ref progress with the scheme, parental choice and safety assurances etc. The update covered implementation to date (schools started introducing the scheme in Sept 2016 with full implementation due 7 Nov 2016), support and advice being given to schools and the milk supplier and also compliance with international health guidance and quality control checks etc. A poster used within schools (for the two choices of milk) was also provided. See comprehensive update at end of table.	Green
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. Update provided.	Green
10	RC	The Committee agreed to invite	6 July	Blackpool	To be transferred to Health Scrutiny Committee.	Green

	Comm 17.03.16	relevant NHS organisations to a future meeting in order to discuss discharges that had been delayed as a result of the NHS.	2016	Hospitals Trust/Blackpool CCG	Report from BTH being considered on 6 July 2016. 28 Sept 2016 - to close this action unless further details required. No further action sought.	
11	RC Comm 14.04.16	To receive an update from LCFT on The Harbour in approximately six months.	Oct 2016	Lisa Moorhouse / Steve Winterson	To be added to workplan. To be transferred to Health Committee. A special meeting will be arranged for either 12 or 24 Oct 2016. Special meeting arranged for 12 Oct 2016. Update given, progress made. Further assurance sought ref CQC on-site inspection Sept 2016 (report due Nov/Dec 2016). Subject to satisfactory assurance, action will be complete.	Amber
12	RC Comm 14.04.16	To receive a full response to the questions regarding the incident on Byron Ward, The Harbour, from a clinician following the meeting.	Oct 2016	Lisa Moorhouse / Steve Winterson	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 Oct 2016. Update given on 12 Oct 2016 by Dr Le Roux, LCFT Clinical Director. Lessons learnt acknowledged, further assurance sought on implementation of lessons learnt. Subject to satisfactory assurance, action will be complete.	Not yet due
13	HSC 06.07.16	To receive detailed information on the significant difference in non-opiate and opiate drug users completing treatment successfully at the next meeting.	28 Sept 2016	Ruth Henson	On agenda for 28 Sept 2016 as part of the Council Plan Performance Report. Explanation given concerning opiate users facing far more complex, deep-rooted problems than non-opiate users and focus on needing to improve long-term sustainable recovery and better life outcomes for both opiate and non-opiate users. Information also provided on the proposed new integrated drug and alcohol service. See minutes of meeting for more details.	Green
14	HSC 06.07.16	To receive an update from the Cabinet Secretary concerning progress with	28 Sept 2016	Cabinet Secretary	Comprehensive update received from Lynn Donkin, Public Health Specialist, on behalf of Cllr Cain.	Green

		tackling overweight children with particular reference to unhealthy snacks being sold in health centres.		[Public Health]	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. See end of table for remainder of full comprehensive update. Proposed that this action is considered complete unless further details required. Action complete	
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. Requested again on 25 Oct 2016. Will be requested again at 14 December 2016 meeting.	Amber
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. Action complete.	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	28 Sept 2016	David Bonson, CCG	Update to be sought for 28 Sept 2016. Requested again on 25 Oct 2016. Will be requested again at 14 December 2016 meeting.	Amber

		from BCCG.				
18	HSC 06.07.16	To receive information from BCCG on the provision of mental health services including progress with recovery rates at a future meeting.	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. Requested again on 25 Oct 2016. Will be requested again at 14 December 2016 meeting.	Amber
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 done for 14 Dec 2016. Will be requested again at 14 Dec 2016 meeting.	Amber
20	HSC 28.09.16	Health Key Performance Indicators should all have specific (baseline) targets for monitoring progress and for performance, actual numbers alongside percentages.	14 Dec 2016	Ruth Henshaw	25.10.16 The change is being prepared for the next Council Plan Performance report (Quarter Two). Baseline data added for the three regular indicators (drugs and obesity).	Green
21	HSC 12.10.16	Percentage of newly qualified staff when The Harbour (LCFT) started in 2015 and the current percentage.	Oct / Nov 2016	Steve Winterson	22.11.16 According to the LCFT Electronic Staff Record system, there are 156 staff occupying nursing positions (including matrons and senior matrons) – of these 20 meet the definition of "newly qualified" which equates to 12.8%. "Newly qualified staff"" are defined as a nurse who is on the bottom incremental point on the Agenda for Change Band 5 scale (i.e. within their preceptorship period). Percentage still required (if Members wish) for parallel figures in 2015.	Amber
22	HSC 12.10.16	Number of original staff retained from when The Harbour (LCFT) started in 2015.	Oct / Nov 2016	Steve Winterson	22.11.16 64% of staff who were based at the Harbour in Apr 2015 (according to ESR) are currently working there now – this is for all staff groups.	Green
23	HSC 12.10.16		Oct / Nov 2016	Steve Winterson	22.11.16 The turnover rate for the 12 months ending Sept 2016 for all staff working at The Harbour was 9.50%.	Green

24	HSC 12.10.16	Results of the latest staff survey ref The Harbour (LCFT).	Oct / Nov 2016	Steve Winterson	22.11.16 There is a staff survey which closes on 2 Dec 2016. This is part of the national programme which enables our results to be compared to other Trusts and the results will be shared as soon as available.	Not yet due
25	HSC 12.10.16	Sight of CQC recent inspection (covers LCFT as a whole so aspects relevant to Harbour for highlighting)	Oct / Nov 2016	Steve Winterson	22.11.16 Reports expected late Dec 2016. Reports will be shared as soon as available. Lkely that there will be a specific report on In Patient Mental Health Services rather than specifically The Harbour.	Not yet due
26	HSC 12.10.16	Latest figures on different types of assaults and numbers for each type (and comparable data for the previous year / period).	Oct / Nov 2016	Bridgett Welch / Steve Winterson	25.10.16 Comparable data request added post-meeting. Explanatory commentary welcome. See end of table below for detailed breakdown. Action complete.	Green
27	HSC 12.10.16	Evidence that procedures at The Harbour (LCFT) have been strengthened for ensuring 'scene of crime' material does not go missing.	Oct / Nov 2016	Leon Le Roux / Steve Winterson	22.11.16 It should be noted that terminology such as "scene of the crime" is inappropriate in relation to Serious Incident investigations. Any incident concerning with mental health issues should not be considered as a criminal situation. Since 2014 the Trust's Incident Policy (June 2015) has been revised and Section 4.5 specifically states: "Senior Managers, Managers and Clinicians are responsible for taking immediate action following an incident to support people who are affected, preserving any evidence for future investigation and implementing any required immediate safety measures;" This is reflected in the Draft Standard Operating Procedure for the Investigations and Learning Team.	Green
28	HSC 12.10.16	Confirmation of what new sites [in-patient mental health facilities in	Oct / Nov	Steve Winterson	22.11.16 Proposals are being developed to support the wider health and social care transformation	Green

		Blackpool] were proposed and details of service capacity.	2016		agenda and will be considered by Blackburn commissioners / Lancashire Scrutiny early in 2017.	

Action 8 - see above for summary response, below comprehensive response ref update on **Implementation of the Fluoridated Milk Scheme** (28 Sept 2016)

February 2016 - Resilient Communities Scrutiny Committee - Extract of Minutes

Members further queried how schools would manage the logistics and ensure that children were given the correct milk. Councillor Cross advised that schools had a process in place and Headteachers would be able to amend the milk order to ensure the right level of delivery of milk and milk with fluoride. In response to further questions, Councillor Cross reported that if parents were confident that their child was obtaining enough fluoride through the use of high fluoride toothpaste or diet then they could opt out of the scheme. She added that the milk contained a recommended level of fluoride and reassured Members that research provided by a number of health organisations had demonstrated that the level was safe.

The Committee agreed: 1) To receive an update on the uptake of milk with fluoride in approximately six months; and 2) To receive a briefing note from Councillor Cross on the research undertaken on the safe level of consumption of fluoride for children.

Response from the Director of Public Health on behalf of the Cabinet Member for Health Inequalities, Councillor Cross

Fluoridated Milk is due to be fully implemented on 7 November 2016 when fluoridated milk will be available for those children whose parents have opted into the scheme. At the start of the Autumn Term 2016, schools were provided with further information on the scheme, and opt-out forms to enable parents the opportunity to opt their children out from the scheme if they so desired. Schools were instructed to facilitate this process, and were notified that we [Public Health] will be requesting numbers of opt-out from Friday 30 September 2016 to allow sufficient time for the return of their forms from parents/carers.

The Public Health Team leading on implementation have been in regular contact with schools, with regular updates via email, enquiries and meeting in person with school heads where requested. The Council has been working closely with the Dairy supplier and the school milk administrators to ensure that systems will be in place by early October 2016 to allow for supplies of fluoridated and non-fluoridated milk in time for the start of the scheme on 7 November 2016.

The Public Health lead for scheme implementation has had a number of discussions with school heads on operational and logistic issues ensuring that children receive the correct milk. The Council provided posters for each class showing the graphic of both fluoridated milk (in yellow carton) and non-fluoridated milk (in green cartons) with room for children, and staff, to write their names. The majority of schools reported they are ready for scheme implementation and confident and comfortable with facilitating the process.

Only two schools raised some concerns around children that were used to drinking more than one carton of milk a day in the school. These schools were advised that a child should only receive one carton of fluoridated milk a day, and if there are spare cartons this should not be shared with other children or used in other ways in the school e.g. for cooking, or used in other drinks. The School Food Trust's (http://www.childrensfoodtrust.org.uk) advice is that that milk should be provided once a day, and public health advice is that children who are thirsty should be offered plain water. This is perfectly acceptable nutritionally and in developing healthy eating preferences.

The schools were advised to review their milk standing orders and amend them accordingly, to more accurately reflect the number of cartons that were required. On discussion with schools it was apparent that there was a considerable excess carton of milk being used or disposed of per week unnecessarily. Cartons of milk (both fluoridated and non-fluoridated) can be refrigerated as normal and used the next day. Thus this will reduce costs to the Council and avoids waste; and removes the potential of a child drinking more than one carton of fluoridated milk a day.

Under the proposed fluoridated milk scheme each carton of milk will contain 0.8mg Fluoride in 189 ml of milk (equivalent to 4.2 parts per million). Levels of Fluoride in the milk are proceeding in line with the WHO guidance on milk fluoridation (Banoczy J, Petersen PE, Rugg-Gunn AJ. *Milk fluoridation for the prevention of dental caries. World Health Organisation, Geneva 2009)* http://www.who.int/oral_health/publications/milk_fluoridation_2009_en.pdf. Product quality control and monitoring of fluoride levels in the milk is arranged with the Dairy supplier and part of school milk procurement arrangements.

Action 14 - see above for first half of comprehensive response ref update on **Progress with Tackling Overweight Children** (28 Sept 2016)

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 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.

Action 26 - see below for breakdown of (safeguarding) assaults at The Harbour (12 Oct 2016)

Definitions of Incident Levels

Level 1 – Insignificant:	*Aggression (verbal and physical) with no actual or potential harm or negative clinical outcome.*
Level 2 – Low:	*Physical assault resulting in minor harm to people (e.g. first aid assistance) or property.*
Level 3 – Moderate:	*Physical assault resulting in moderate harm to people (e.g. A&E assessment) or property.*
Level 4 – Severe:	*Physical assault resulting in severe harm to people (e.g. fractures or long term conditions / disability) or property (including all attempted or actual rape or hate crime). Severe verbal aggression including racial abuse, discrimination and sexual advances.*

Incident Type	April 2016 to June 2016 Q1 2016/17		
	No	**Category**	**Reported Incident Level on Datix**
Sexual	0		`
Verbal	0		
Physical	1	Patient on Staff	Level 2 = 1
	72	Patient on Patient	Level 1 = 15 Level 2 = 49 Level 3 = 8 A safeguarding alert was raised in respect of the Level 3 incident
	2	Patient on Other	Level 2 = 2

	1	Alleged Staff on Patient	Level 3 = 1
With a Weapon	3	Patient on Patient	Level 2 = 1 Level 3 = 1 Level 4 = 1

Action 28 - Confirmation of what new LCFT sites [in-patient mental health facilities in Blackpool] were proposed and details of service capacity (12 Oct 16)

The Trust and its commissioners continue to work together to determine the range of mental health services that will be required for Lancashire in the future. Part of this involves determining how many beds will be needed in the future and on a broader scale what other types of services are needed to keep people well and supported within the community, which serves to prevent the need for admission in the first place.

The future model for mental health services is being planned as part of the Lancashire and South Cumbria Change programme. At present an options appraisal is being undertaken to determine the range and scope of provision for Lancashire in the future and this will also set out options for provision in Pennine Lancashire and Central Lancashire.

The option to purchase land and develop a mental health facility adjacent to the Royal Blackburn Hospital site remains. Among the range of options being considered is the original preferred option of redeveloping a site on the Royal Blackburn Hospital estate. This will help to manage the increase in patients presenting at A&E and will also further enhance joint working between mental health and A&E teams and complement additional provision that has been put in place at the hospital recently.

Further information about the options will be made available and engagement will be undertaken prior to a final proposal being presented to Lancashire scrutiny committees early in 2017.

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Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Ruth Henshaw, Delivery Development Officer
Date of Meeting:	14 December 2016

COUNCIL PLAN PERFORMANCE REPORT - QUARTER TWO 2016-2017

1.0 Purpose of the report:

1.1 To present performance against the Council Plan 2015-20 for the period 1 July 2016 - 30 September 2016.

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:	None

4.0 Council Priority:

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

5.0 Background information

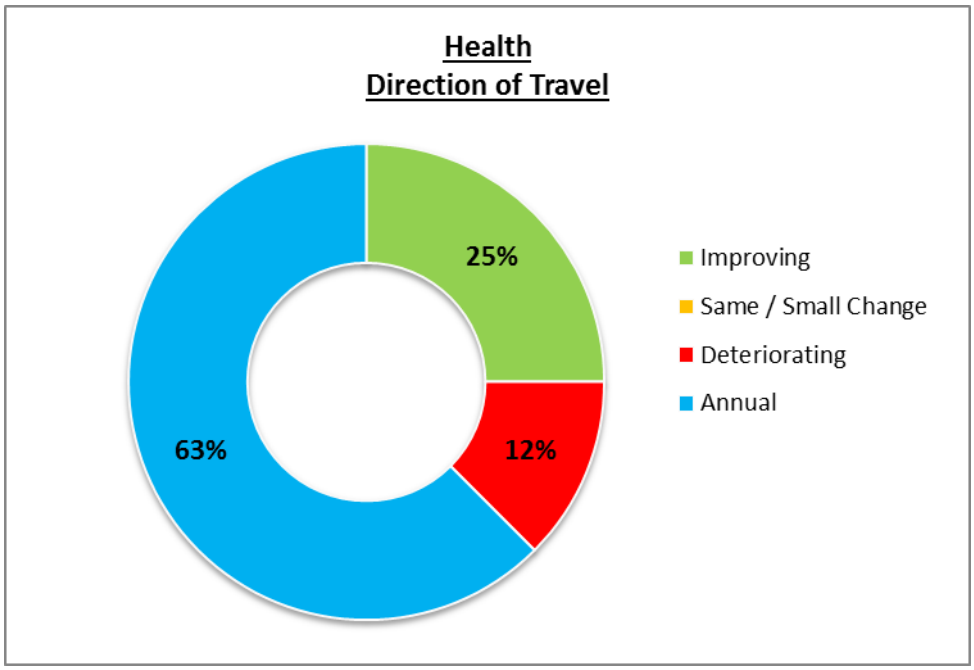
5.1 This report reviews performance against the priorities in the Council Plan 2015 - 2020. The report focuses on a set of core performance indicators which have been developed in consultation with the Corporate Leadership Team.

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

quarterly basis.

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 when performance in Quarter Two 2016-2017 is compared with the same period in 2015-2016.



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, 2 are showing an improvement on performance when compared to the same period in 2015-2016.

6.3 Further information on the indicators where performance is below target or where performance has deteriorated during the quarter can be found in **Appendix B – Quarter Two Exception Reports**.

7.0 Trajectories

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

- Percentage 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 Six children (ten to eleven years old).

As data for the prevalence of excess weight in Year Six children (ten to eleven years old) is available on an annual basis, the trajectory for this indicator will be included in the end of year Council Plan performance report.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 7 (a): Quarter Two - Key Performance Indicators (KPI)
Appendix 7 (b): Quarter Two Exception Reports

8.0 Legal considerations:

8.1 None

9.0 Human Resources considerations:

9.1 None

10.0 Equalities considerations:

10.1 None

11.0 Financial considerations:

11.1 None

12.0 Risk management considerations:

12.1 None

13.0 Ethical considerations:

13.1 None

14.0 Internal/External Consultation undertaken:

14.1 N/A

15.0 Background papers:

15.1 None

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Corporate Key Performance Indicators

Performance as at 30 September 2016

KEY - Direction of Travel Icons:

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
Cabinet Secretary (Health)	Cllr Cross	% of opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	*n/a (measured differently)*	*5.75%*	*6.3%*	⇧✓	5.7%	5% (54/1074)				**8%**	⇩✖	⇩✖	5% compared with 6.4% in Q2 2015/16. Please see App B - Exception Reports for more details.
	Cllr Cross	% of non-opiate drug users successfully completing treatment who do not re-present to treatment within 6 months	*n/a (measured differently)*	*51.22%*	*44.7%*	⇩✖	51.2%	55.5% (136/245)				**55%**	⇧✓	⇧✓	55.5% compared with 46.9% in Q2 2015/16.
	Cllr Cross	% of successful completions of alcohol treatment	*54.6%*	*44.5%*	*45.5%*	⇩✖	44.6%	42.1% (212/504)				**Increase on last year**	⇧✓	⇩	42.1% compared with 41% in Q2 2015/16.
	Cllr Cross	Smoking prevalence in adults aged 18 or over	*29.47%*	*26.5%*	*26.93%*	⇩✓	A	A	A			**25%**	**Annual**		
	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**		
	Cllr Cross	Prevalence of excess weight in Reception children (4-5 years)	*25.54%*	*26.79%*	*25.72%*	⇧	A	A	A			**< 25%**	**Annual**		
	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**		
	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**		

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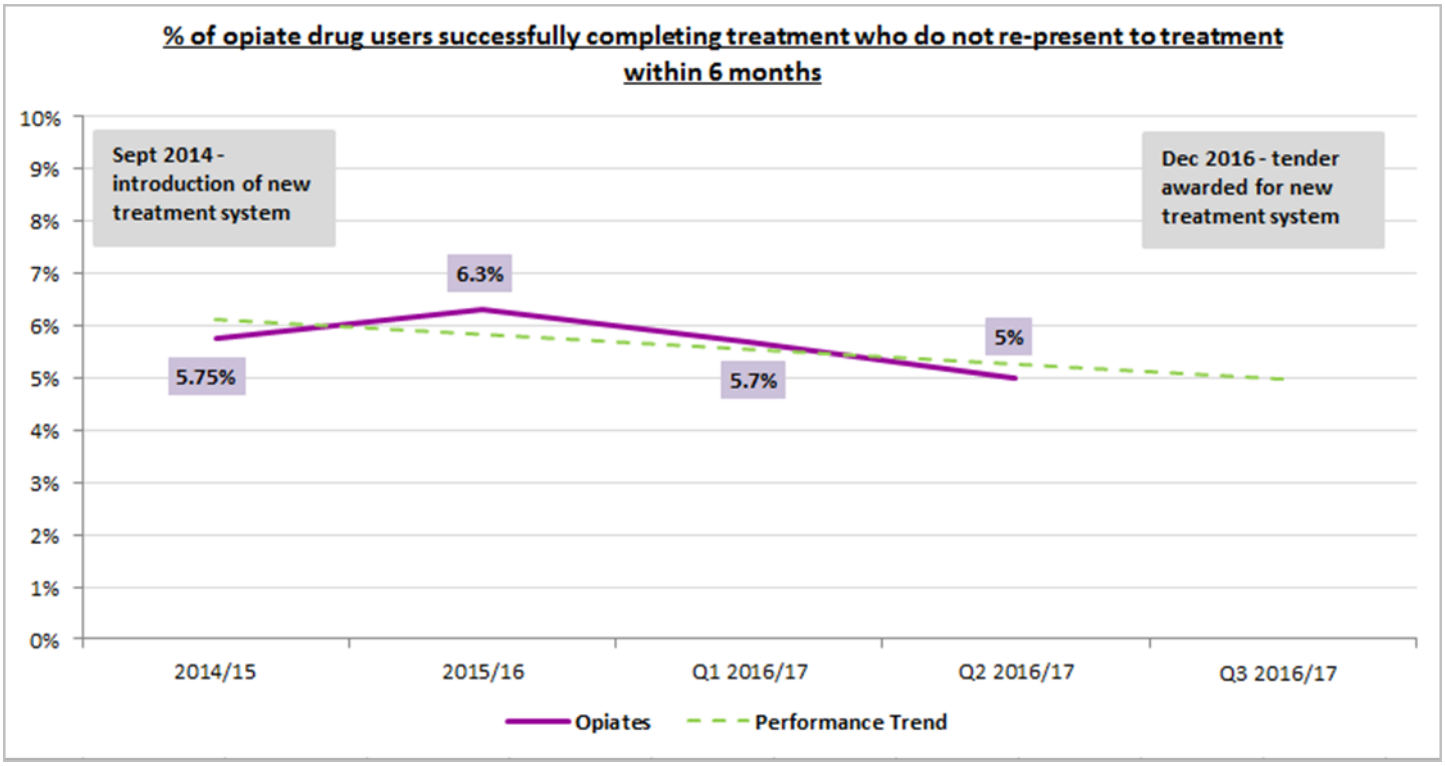
CABINET SECRETARY (HEALTH)

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

	2014/15	2015/16	2016/17				DoT
			Q1	Q2	Q3	Q4	
Opiates	5.75%	6.3%	5.7%	5%			⇩ ✖



Commentary:

The percentage of opiate drug users successfully completing treatment who do not re-present to treatment within six months has reduced slightly in Quarter Two when compared with Quarter One and when compared with the baseline.

A commissioning review was undertaken in order to understand the effectiveness, areas of improvement and outcomes of the adult drug and alcohol treatment system. This included extensive client consultation. The findings from the review were used to design an improved service model to meet needs including; integrated health and wellbeing support, including a focus on mental health and psychological support; a community focused approach with service provision integrated within GP neighbourhood teams, radical philosophy to treatment, creative recovery and peer approach, employment/meaningful activity modernisation and improved building/locations. As well as being fit for purpose and able to improve outcomes, the model has facilitated financial efficiencies. The procurement process is underway and the contract is due to be awarded on 20 December 2016.

Appendix 7 (b) - Exception Reports (Quarter Two 2016-2017)

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mr David Bonson, Chief Operating Officer, NHS Blackpool Clinical Commissioning Group
Date of Meeting:	14 December 2016

BLACKPOOL CLINICAL COMMISSIONING GROUP MID-YEAR PERFORMANCE REPORT (APRIL 2016 TO SEPTEMBER 2016)

1.0 Purpose of the report:

1.1 To consider the mid-year performance of the Blackpool Clinical Commissioning Group for 2016-2017 (April 2016 – September 2016).

2.0 Recommendation(s):

2.1 To receive and scrutinise the report.

2.2 To make any recommendations to the Blackpool Clinical Commissioning Group.

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

3.0 Reasons for recommendation(s):

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

3.2 To note the reported exceptions and support the Blackpool Clinical Commissioning Group in its actions to improve performance.

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 Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group will be in attendance at the meeting to present the 2016-2017 mid-year performance summary and answer any questions on performance against the national NHS measures: including NHS Constitution measures such as referral to treatment; cancer waiting times; mixed sex accommodation breaches and cancelled operations.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 8 (a): Blackpool Clinical Commissioning Group
Performance Report mid-year 2016-2017.

8.0 Legal considerations:

8.1 None

9.0 Human Resources considerations:

9.1 None

10.0 Equalities considerations:

10.1 None

11.0 Financial considerations:

11.1 None

12.0 Risk management considerations:

12.1 None

13.0 Ethical considerations:

13.1 None

14.0 Internal/External Consultation undertaken:

14.1 N/A

15.0 Background papers:

15.1 None

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Health... at the heart of life in Blackpool

NHS
Blackpool
Clinical Commissioning Group

Blackpool Clinical Commissioning Group

Mid-Year Performance Report 2016-2017

April 2016 - September 2016

Introduction

This report is to provide the Health Scrutiny Committee with assurance in relation to the indicators within the national Clinical Commissioning Group (CCG) Assurance Framework. The report includes a summary mid-year position of all the relevant indicators, as published by NHS England, with an exception narrative for any indicators not meeting the requisite target.

Summary for April 2016 – September 2016

Metric	YTD Position	Target	Page
NHS Constitution Measures			
Referral to Treatment (RTT) Incompletes (c)	92.79%	≥92%	4
Diagnostic Test Waiting Time (c)	0.42%	≤1%	4
A&E waits (c)	89.60%	≥95%	4
Patients receiving definitive treatment within 1 month of a cancer diagnosis (c)	97.29%	≥96%	5
Patients receiving subsequent treatment for cancer within 31 days (Surgery) (c)	96.15%	≥94%	5
Patients receiving subsequent treatment for cancer within 31 days (Drugs) (c)	100%	≥98%	5
Patients receiving subsequent treatment for cancer within 31 days (Radiotherapy) (c)	99.36%	≥94%	5
Patients receiving 1st definitive treatment for cancer within 2 months (c)	82.89%	≥85%	5
Patients receiving treatment for cancer within 62 days from an NHS Screening Service (c)	95.74%	≥90%	5
Patients receiving treatment for cancer 62 days upgrading their priority (c)	89.13%	≥85%	5
Red 1 Ambulance Calls (c)	86.01%	≥75%	6
Red 2 Ambulance Calls (c)	77.17%	≥75%	6
Category A Ambulance Calls (c)	91.08%	≥95%	6
NHS Constitution Support Measure			
Referral to Treatment waiting times more than 52 weeks (incomplete) (c)	0	0	4
A&E waits 12 hour trolley waits (p)	0	0	4
Mixed Sex accommodation breaches (c)	0	0	6
Cancelled Operations (p)	0	0	6
Mental Health (c)	95.73%	≥95.73%	7
Primary Care Dementia (c)	89.2%	≥67%	7
Incidence of Healthcare Associated Infection (c)	MRSA – 1 C-Diff - 6	See Page 7	7
Financial Sanctions			
Possible Sanctions excluding Admitted and Non-Admitted RTT	YTD Position	£173,680.00	

Overall Summary of Blackpool CCG Improvement and Assessment Indicators	October Position	Page 14

Key		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

Achievements

- There have been no 12 hour trolley waits reported this year (Based on decision to admit guidance).
- There have been no further mixed sex accommodation breaches since May 2016
- C-Difficile incidents for both Blackpool CCG patients in the community and at the Trust remain within trajectory
- Diagnostic waiting times have remained below target since April 2016
- Eight of the Nine of the constitutional targets for Cancer waits have been met year to date
- There have been no cancelled operations reported at Blackpool Teaching Hospitals in 2016- 2017
- The % of Mental Health patients on a CPA discharged and followed up within 7 days has remained above target since April 2016
- The CDI trajectory for BTH for 2016/17 remains the same as 2015/16 (BTH 40 cases) Blackpool CCG and the Trust currently remain within trajectory.
- Waiting times have consistently exceeded targets for IAPT in 16/17

Areas for focus / information

- Blackpool Teaching Hospitals' performance against the 4 hour A&E waiting time target has remained below target since April 2016
- NWAS call response rates for Category A Calls resulting in an ambulance arriving at the scene within 19 minutes has not met the target set so far this year.
- The IAPT access and recovery rates are below target; however it has improved from 34% in August to 36% in September.

Key		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

NHS Constitution for period ending September 2016

RTT (c)		Organisation	Target	Sept 16	YTD	Current Performance (Sept)	Performance (Apr-Sept)
* Patients on incomplete pathways treated within 18 weeks		CCG	≥ 92%	90.94%	92.49%	↓	↓
Patients waiting for more than 52 weeks	Incomplete pathway	CCG	0	0	0	↔	↔

Blackpool CCG (BCCG) has not met the RTT target for September 2016 for incomplete pathways; performance has been affected by BCCG patients breaching predominantly at Lancashire Teaching Hospitals NHS Foundation Trust.

Diagnostic Test Waiting Time (c)	Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr-Sept)
% of patients waiting 6 weeks or more	CCG	≤ 1%	0.54%	0.42%	↓	↑

Diagnostic waiting times have remained below target since April 2016.

A&E Waits (c)	Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr- Sept)
*4 Hour A&E Waiting Time Target	Provider - BTH	≥ 95%	89.32%	89.60%	↓	↓

Blackpool Teaching Hospitals' performance against the 4 hour A&E waiting time target has remained below target since April 2016. An NHSE (Lancashire) escalation process reamins in place with daily and weekly updates being followed in addition to local and regional teleconferences. Nationally the position replicates the issues being experienced locally.

12 Hour Trolley waits in A&E (p)	Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr-Sept)
12 Hour Trolley waits in A&E	Provider - BTH	0	0	0	↔	↔

There have been no 12 hour trolley wait breaches in A&E at Blackpool Teaching Hospitals so far this year, however due to the pressures within A&E additional quality assurance visits will take place to ensure assurance and triangulation.

Key						
		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

Cancer Waits (c)		Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr - Sept)
% seen within 2 weeks of referral		CCG	≥ 93%	94.11%	94.14%	↓	↔
% seen within 2 weeks of referral – breast symptoms		CCG	≥ 93%	100.00%	98.63%	↑	↔
31 Days	% of patients receiving definitive treatment	CCG	≥ 96%	97.94%	97.29%	↑	↔
	% of patients waiting no more than 31 days for subsequent treatment – surgery	CCG	≥ 94%	100.00%	96.15%	↔	↔
	% of patients waiting no more than 31 days for subsequent treatment - drug therapy	CCG	≥ 98%	100.00%	100.00%	↔	↔
	% of patients waiting no more than 31 days for subsequent treatment –radiotherapy	CCG	≥ 94%	100.00%	99.36%	↔	↔
62 Days	* % of patients waiting no more than 62 days from urgent GP referrals to first definitive treatment	CCG	≥ 85%	83.33%	82.89%	↓	↓
	% of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment.	CCG	≥ 90%	100.00%	95.74%	↑	↔
	% of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade.	CCG	≥85%	100.00%	89.13%	↑	↑

All of the constitutional targets for Cancer waits have been met year to date; except the percentage of patients waiting no more than 62 days from urgent GP referral to first definitive treatment. There are noticeably fewer patients within this category; consequently the number of patient breaches which infringe this target are also fewer; for example in September seven (7) Blackpool CCG patients have breached this target. Two (2) are due to patient choice; three (3) have been referred late into BTH by other providers and two (2) were complex cases.

Key		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

Category A Ambulance Calls (p)	Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr- Sept)
*Category A **calls** resulting in an emergency response arriving within 8 minutes (Red 1)	CCG	≥ 75%	84.62%	86.01%	↓	↔
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	CCG	≥ 75%	75.63%	77.17%	↑	↔
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	CCG	≥ 95%	92.27%	91.8%	↑	↔

Blackpool CCG NWAS Ambulance call response rates for Red 1, Red 2 have been met for September; and have remained this way since April 2016; however activity remains significantly over planned levels and is having an adverse effect on performance; particularly on category A calls arriving at the scene within 19 minutes.
In addition to activity growth, NWAS performance is also being significantly impacted by handover and turnaround issues at hospitals. Significant efforts have been made to reduce the turnaround times across the North West, with joint work being carried out with NHS Improvement, CCGs, Acute Trusts and NWAS.

Mixed Sex Accommodation Breaches (c)	Organisation	Target	Sept 16	YTD	Performance (Sept)	Performance (Apr - Sept)
Breaches of same sex accommodation	BCCG	0	0	0	↔	↔
	Provider - BTH	0	0	4	↔	↔
	Provider - Spire	0	0	0	↔	↔

There have been no further mixed sex accommodation breaches since May 2016. All of the breaches were due to no suitable beds being available other than within CITU, this was due to beds being occupied by non- cardiac patients and overnight stays being required for day-case patients.

Cancelled Operations (p)	Organisation	Target	Position	QTR 1	Performance (Cur' Period)	Performance (Last Period)
Patients whose operations are cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days.	Provider - BTH	0	0 (QTR 2 2016/17)		↔	↔

There have been no cancelled operations reported at Blackpool Teaching Hospitals since April 2016.

Key						
		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

Mental Health (c)	Organisation	Target	QTR 2	YTD	Performance (Sept)	Performance (Apr- Sept)
% of Mental Health patients on Care Programme Approach (CPA) discharged from hospital and followed up within 7 days	Provider - LCFT	≥ 95%	95.52%	95.73%	↓	↓

The % of Mental Health patients on a CPA discharged and followed up within 7 days has remained above target since April 2016.

Dementia (c)	Organisation	National	Sept 16	YTD	Performance (Sept)	Performance (Apr- Sept)
CCG's estimated prevalence for people over 65 with dementia against the CCG's actual dementia diagnosis rate	CCG	≥ 67%	91.6%	89.2%	↑	↑

The CCG's estimated prevalence for people over 65 with dementia against the actual diagnosis has remained significantly above target year to date.

Incidence of Healthcare Associated Infection (c)	Organisation (assigned)	Threshold	Sept 16	YTD	Performance (Sept)	Performance (Apr - Sept)
Incidence of MRSA bacteremia	CCG	0	1	1	↓	↔
	Provider	0	0	2	↑	↔
Incidence of Clostridium difficile* (CDI)	CCG	58 (2016/17)	0	6	↑	↓
	BTH	40 (2016/17)	1	6	↑	↓

* *Data source; Public Health England HCAI Monthly Report, August 2016*

There have been two (2) incidents of MRSA reported so far this year at BTH; both have been identified as contaminants. The Trust is in the process of undertaking an investigation into current practices relating to the taking of blood cultures and the requirement for further education and training.

The one (1) case of bacteremia incident reported in September for a Blackpool patient in the community is still under review.
Six (6) incidents of CDI have been reported by BTH year to date. The CDI trajectory for BTH for 2016/17 remains the same as 2015/16 (BTH 40 cases) Blackpool CCG and the Trust currently remain within trajectory.

Key						
		Failing target	↑	Improving and within target	↑	Improving and below target
		Target Achieved	↓	Deteriorating and within target	↓	Deteriorating and below target
	(c) / (p)	Commissioner level / Provider level	↔	No change and within target	↔	No change and below target

Mental Health IAPT	Organisation	Expectation	Sept 16	YTD	Performance (April - Sept)	Performance (Apr - Sept)
IAPT access proportion rate (3.75% quarterly, suggested 1.25% monthly)	CCG	≥ 1.25% monthly	1.22%	1.30%	↓	↓
*IAPT recovery rate (50% monthly)	CCG	50%	36%	34%	↑	↓
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment	CCG	75% per month	90%	79%	↑	↑
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment	CCG	95% per month	100%	99%	↑	↑

Waiting times have consistently met targets for IAPT in 16/ 17; however the access and recovery rates have not. The NHSE IST team has been working closely with the commissioners and provider to map capacity and demand and ensure clients are signposted appropriately at the commencement of their treatment. Detailed analysis around the factors affecting recovery rate is being continually applied and communicated to the team.

Aristotle Business Intelligence

Performance Scorecard

Metric	Level	Period	Target	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	YTD
NHS Constitution measures																
Referral To Treatment waiting times for non-urgent consultant-led treatment																
62: Referral to Treatment (Non-Admitted) (62)	CCG	Sept 2016	95%	93.6%	93.6%	93.9%	92.2%	93.9%	93.3%							93.42%
1291: Referral to Treatment (Incomplete) (1291)	CCG	Sept 2016	92%	93.32%	93.4%	92.7%	92.8%	91.83%	90.9%							92.79%
Diagnostic test waiting times																
1828: % of patients waiting 6 weeks or more for a diagnostic test (1828)	CCG	Sept 2016	1%	0.52%	0.3%	0.46%	0.40%	0.26%	0.54%							0.42%
Cancer waits – 2 Week Wait																
191: % Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY) (191)	CCG	Sept 2016	93%	95.10%	93.92%	93.06%	93.66%	94.91%	94.11%							94.14%
17: % of patients seen within 2 weeks for an urgent referral for breast symptoms (MONTHLY) (17)	CCG	Sept 2016	93%	100%	96.43%	98.63%	100%	98.36%	100%							98.75%

Metric	Level	Period	Target	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	YTD
NHS Constitution measures																
Cancer waits – 31 days																
535: % of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY) (535)	CCG	Sept 2016	96%	98.55%	98.99%	96.15%	95.29%	97.00%	97.94%							97.29%
26: % of patients receiving subsequent treatment for cancer within 31 days (Surgery)(MONTHLY) (26)	CCG	Sept 2016	94%	83.33%	100%	100%	92.31%	100%	100%							96.15%
1170: % of patients receivingsubsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY)(1170)	CCG	Sept 2016	98%	100%	100%	100%	100%	100%	100%							100%
25: % of patients receivingsubsequent treatment for cancer within 31 days (Radiotherapy Treatments)	CCG	Sept 2016	94%	96.00%	100%	100%	100%	100%	100%							99.36%
Cancer waits – 62 days																
539: % of patients receiving 1stdefinitive treatment for cancer within 2 months(62 days) (MONTHLY)	CCG	Sept 2016	85%	89.47%	83.72%	85.71%	68.09%	88.64%	83.33%							82.89%
540: % of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (MONTHLY)(540)	CCG	Sept 2016	90%	66.67%	100%	100%	100%	93.75%	100%							95.74%
541: % of patients receivingtreatment for cancer within 62 days upgrade their priority (MONTHLY) (541)	CCG	Sept 2016	85%	81.82%	89.29%	90%	85.71%	88%	100%							89.13%

Metric	Level	Period	Target	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	YTD
NHS Constitution measures continued																
Category A ambulance calls																
1887: Category A Calls Response Time (Red1) *(1887)*	CCG	Sept 2016	75%	92.41%	85.70%	79.10%	82.00%	92.55%	84.62%							86.01%
1887: Category A Calls Response Time (Red1) *(1887)*	NWAS	Sept 2016	75%	76.47%	74.28%	73.06%	70.45%	72.60%	69.49%							72.76%
1889: Category A (Red 2) 8 Minute Response Time *(1889)*	CCG	Sept 2016	75%	76.73%	83.20%	75.50%	74.46%	77.32%	75.63%							77.17%
1889: Category A (Red 2) 8 Minute Response Time *(1889)*	NWAS	Sept 2016	75%	67.46%	66.26%	66.20%	62.69%	65.25%	61.75%							64.90%
546: Category A calls responded to within 19 minutes*(546)*	CCG	Sept 2016	95%	91.90%	94.10%	91.20%	90.10%	91.26%	92.27%							91.80%
546: Category A calls responded to within 19 minutes*(546)*	NWAS	Sept 2016	95%	92.01%	91.47%	91.49%	89.81%	91.09%	89.04%							90.80%

NHS Constitution support measures																
Mixed Sex Accommodation Breaches																
1067: Mixed sex accommodation breaches - AllProviders (1067)	CCG	Sept 2016	0	0	4	0	0	0	0							4
Mental Health																
138: Proportion of patients on (CPA) discharged from inpatient care who are followed up within 7 days (138)	CCG	QTR 2 2016	95%	96.00% (Q1)			95.52% (Q2)									95.73 %

Metric	Level	Period	Target	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	YTD
NHS Constitution support measures																
Referral To Treatment waiting times for non-urgent consultant-led treatment																
1839: Referral to Treatment -No of Incomplete Pathways Waiting >52 weeks (1839	CCG	Sept 2016	0	0	0	0	0	0	0							0
A&E waits																
1928: 12 Hour Trolley waits in A&E (1928)	Hospital Provider (BTH)	Sept 2016	0	0	0	0	0	0	0							0
Activity Measures																
Elective																
77: Number of G&A elective ordinary admission FFCEs in the period (77) (Inpatient)	CCG	Sept 2016	Target	TBC	This data set is no longer available through the Monthly Activity Report. In future, this will be a NHS England report based on SUS data. The timetable for the publication of this data set has not been published by NHS England.											TBC
			Actual	322												322
71: Number of G&A elective FFCEs in the period - Day Cases (71) (Day cases)	CCG	Sept 2016	Target	TBC												TBC
			Actual	2516												2516
Non Elective																
72: Number of G&A non-elective FFCEs in the period - Total (72)	CCG	Sept 2016	Target	TBC	This data set is no longer available through the Monthly Activity Report. In future, this with be a NHS England report based on SUS data. The timetable for the publication of this data set has not been published by NHS England.											TBC
			Actual	2027												2027
Outpatients																
73: All first outpatient attendances (consultant-led) in general and acute specialties (73)	CCG	Sept 2016	Target	TBC	This data set is no longer available through the Monthly Activity Report. In future, this with be a NHS England report based on SUS data. The timetable for the publication of this data set has not been published by NHS England.											TBC
			Actual	5326												5326

Metric	Level	Period	Target	Apr 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	YTD
A&E waits																
1926: A&E Attendances: Type1 *(1926)*	BTH	Sept 2016	Actual	7,076	7,754	7,555	8,166	7,524	7,332							45,407
1927: A&E Attendances: All Types *(1927)*	BTH	Sept 2016	Actual	16,258	17,632	16,733	17,979	17,112	16,640							102,354

CCG Improvement and Assessment Framework

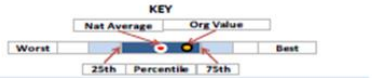
This new framework intends to provide a greater focus on assisting improvement alongside the existing statutory assessment function. It aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online; the table below provides a graphical illustration of Blackpool CCG's performance against the framework as released by NHSE on the 18th October 2016.

Blackpool CCG Improvement and Assessment Indicator Summary – October 2016

Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▼	Maternal smoking at delivery	Q1 16/17	25.5%	10.2%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	38.0%	33.2%		L	
▲	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c	2014-15	44.1%	39.8%		H	
▼	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	1.9%	5.7%		H	
◀▶	Injuries from falls in people aged 65 and over	Mar-16	2,447	2,014		L	
▲	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Jul-16	79.4%	52.0%		H	
◀▶	Personal health budgets	Q1 16/17	11.6	11.3		H	
▼	Percentage of deaths which take place in hospital	Q4 15/16	48.0%	47.0%		<>	
▼	People with a long-term condition feeling supported to manage their condition(s)	2016	65.9%	64.3%		H	
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	1,816	929		L	
▼	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	3,640	2,168		L	
◀▶	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Jul-16	1.3	1.1		<>	
◀▶	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Jul-16	5.1%	9.3%		<>	
▲	Quality of life of carers	2016	77.1%	80.0%		H	
	Better Care						
▲	Cancers diagnosed at early stage	2014	43.7%	50.7%		H	
▲	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 16/17	86.2%	82.2%		H	
▲	One-year survival from all cancers	2013	67.7%	70.2%		H	
▲	Cancer patient experience	2015	8.5			H	
▼	Improving Access to Psychological Therapies recovery rate	Jun-16	34.7%	48.9%		H	
▼	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Jul-16	71.4%	72.0%		H	
▼	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q1 16/17	83			L	
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	44.0%	47.0%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	10.4	7.1		L	
◀▶	Women's experience of maternity services	2015	77.1			H	
◀▶	Choices in maternity services	2015	62.1%			H	
▲	Estimated diagnosis rate for people with dementia	Aug-16	90.4%	67.3%		H	
◀▶	Dementia care planning and post-diagnostic support	2014/15	77.1%	77.0%		H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	2,928	2,359		L	
▲	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Aug-16	91.9%	91.0%		H	
▼	Delayed transfers of care per 100,000 population	Aug-16	11.4	14.1		L	
▼	Population use of hospital beds following emergency admission	Q4 15/16	1.2	1.0		L	
▼	Management of long term conditions	Q4 15/16	1,205	795		L	
▼	Patient experience of GP services	H1 2016	86.2%	85.2%		H	
◀▶	Primary care workforce	H1 2016	1.0	1.0		H	
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Aug-16	91.8%	91.0%		H	
▼	People eligible for standard NHS Continuing Healthcare	Q1 16/17	70.4	46.0		H	
	Sustainability						
◀▶	Financial plan	2016	Red			H	
◀▶	In-year financial performance	Q1 16/17	Red			H	
◀▶	Outcomes in areas with identified scope for improvement	Q1 16/17	83.3%	58.3%		H	
▲	Digital interactions between primary and secondary care	Q2 16/17	75.9%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes			H	
	Well Led						
◀▶	Staff engagement index	2015	3.8	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.5	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	75.2			H	
◀▶	Quality of CCG leadership	Q1 16/17	Green			H	

Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mr David Bonson, Chief Operating Officer, NHS Blackpool Clinical Commissioning Group
Date of Meeting:	14 December 2016

WINTER HEALTH PLANNING

1.0 Purpose of the report:

1.1 To inform the Health Scrutiny Committee of the specific activities undertaken around winter health planning across the Blackpool Health Economy and Fylde Coast area (involving local health service commissioners and providers of services).

2.0 Recommendation(s):

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 winter health planning across the Blackpool Health Economy.

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 Clinical Commissioning Groups are responsible for engaging with all local service providers and local authorities to co-ordinate local resilience to seasonal surges in

health service demand and to undertake upward reporting to NHS England (NHSE) on a weekly/daily basis throughout the 'Winter' period (October - March). Blackpool Clinical Commissioning Group is responsible for engaging activity during October 2016 - March 2017 within the Blackpool Health Economy.

5.2 A key theme from the review of winter 2015-2016, is that operational escalation systems and protocols vary considerably from one local health economy to another. Whilst flexibility at local level is entirely appropriate and necessary, a lack of an overarching framework means that the variation encountered between different systems creates inefficiencies and can lead to sub-optimal outcomes.

5.3 In response, a national framework was introduced, that brings together all of the common themes, triggers and protocols described in the various systems used locally, and turns them into a coherent piece of guidance and actions to be universally followed in response to surge pressures.

5.4 The development of a single national system will bring consistency to local approaches, and better management of system wide escalation. It will encourage wider cooperation, and will also make regional and national oversight more effective and less burdensome.

5.5 A very detailed winter plan document has been developed by the Accident and Emergency Delivery Board, which is summarised in the attached presentation.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 9 (a): Winter Health Planning

6.0 Legal considerations:

6.1 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 Discussions held with all partner organisations regarding plans for winter, ongoing meetings taking place, discussed weekly at Emergency Strategic Resilience Group and Accident and Emergency Delivery Boards, which has representation from all stakeholders in the health economy.

13.0 Background papers:

13.1 None.

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Winter Planning 2016-2017

NHS Blackpool Clinical Commissioning Group

NHS Blackpool CCG

David Bonson

Chief Operating Officer

NHS
Blackpool
Clinical Commissioning Group

Introduction

- The winter period creates particular challenges for the entire Health Economy regardless of the additional pressures of pandemic disease or severe weather. This year is anticipated to be no exception but this winter will be set against the background of various NHS reconfigurations, Adult Social Care challenges, increased demand, staff deficiencies and the continued drive for efficiencies

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Clinical Commissioning Group

Winter Planning

- Fylde Coast Accident and Emergency Delivery Board
- Led by Wendy Swift, Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust
- Executive Level Membership from:-
  - Blackpool Teaching Hospitals NHS Foundation Trust
  - NHS Blackpool Clinical Commissioning Group
  - NHS Fylde and Wyre CCG
  - Lancashire Care NHS Foundation Trust
  - Primary Care
  - North West Ambulance Service
  - NHS England
  - Lancashire County Council
  - Blackpool Council
  - First Choice Medical Suppliers (health services provider)
  - PDS Medical (health services provider)

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Winter Reporting

- The CCGs are responsible for engaging with all local providers and local authorities to co-ordinate local resilience to seasonal surges in demand and to undertake upward reporting to NHS England (NHSE) on a weekly basis throughout the 'Winter' period (October - March)

- A key theme from the review of winter 2016-2017 is operational escalation know as Operational Pressures Escalation Levels (OPELs)

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New Escalation Levels

Operational Pressures Escalation Levels

- **OPEL 1** The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources
- **OPEL 2** The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation
- **OPEL 3** The local health and social care system is experiencing major pressures compromising patient flow and continues to increase
- **OPEL 4** Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required.

- Weekly 'Emergency System Resilience Group' meeting to discuss performance regarding the previous week

- Attendees form NWAS, Blackpool Teaching Hospitals NHS Foundation Trust, CCGs, Out of Hours providers, Primary Care, communication leads, Lancashire County Council and Blackpool Council

- Real time solutions delivered for emerging issues identified for the week's performance

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Primary Care
Over Christmas and New Year

- Additional GP Capacity at Whitegate Drive Health Centre, including-
  - Priority x-ray access
  - Additional clinical treatment rooms
  - Additional pre bookable appointments (7 days)

- All practices confirmed sessions open

- All practices adding more appointments for emergency appointments

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Pharmacy Opening Hours over Christmas and New Year

- 24th December (Christmas Eve) - All pharmacies will be open, however, opening times may vary as practices have different core hours on a Saturday

- 25th December (Christmas Day) - Whitegate Pharmacy will be open 8am – 9pm

- 26th December (Boxing Day) - 5 pharmacies will be open between 8am and 9pm

- 27th December (Tuesday Bank Holiday) - 6 pharmacies will be open between 8am and 9pm

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Emergency Dental Services over Christmas and New Year

- Patients directed via Single Point of Entry – Dental Helpline

- Additional sessions delivered from Whitegate Drive, Adelaide Street and Moor Park by First Choice Medical Suppliers, weekends, Bank Holidays and out of hours

- Any patient needing urgent/emergency care will go through the call handling and booked into the next most convenient appointment (in hours or out of hours depending on the time of day)

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NWAS

Graham Curry

Sector Manager South & Fylde

NHS
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Clinical Commissioning Group

NWAS

Appropriate additional operational/staff resources from the Paramedic Emergency Service (PES), EOC, Urgent Care Service (UCS), NHS111 and the Patient Transport Service (PTS) will be identified and profiled for the key dates.

All available emergency resources (PES and EOC) will be utilised on key dates and assistance will sought from the Voluntary Aid Societies (VAS e.g. British Red Cross, St John Ambulance and Mountain Rescue Teams), Private Ambulance Services (PAS- contracted in via an intermediary) as required, as circumstances dictate and as financial constraints allow.

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NHS 111

- In order to ensure the NHS 111 Service is able to manage the demand in a safe and efficient manner, the following steps have been taken to increase our resource position prior to Christmas and in readiness for winter;
- Significant recruitment and training of Health Advisors by both NWAS and our delivery partners.
- Recruitment and training of Non-Pathways Operatives.
- Recruitment and training of MTS Clinicians.
- Recruitment and training of Pathways Clinicians.
- Several Courses planned following the Christmas Period to supplement November and December's new staff intake.

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Integrated Virtual Care Hub - Delivered within FCMS

- The NWAS Urgent Care Desk operates as a virtual 'hub' with a base in Lancashire
- The desks utilise a robust telephone triage tool to support patient through a Hear & Treat model, answering low acuity calls
- The virtual hub also provides clinical advice and support to NWAS operational staff and a process for clinical leadership and support for all staff and managers has been developed to allow access to Paramedic, Senior Paramedics, Advanced Paramedics, Consultant Paramedics and occasionally, Doctors
- Senior/Advanced Paramedics may also be 'embedded' in Police/Fire & Rescue Command facilities to provide direct clinical support during periods of disruption or pressure
- These desks are able to provide:-
  - Clinical advice
    Support for solo responders (RRVs) to enable them to leave scene whilst awaiting transport
  - Access to senior clinical support for the Advanced Paramedics
  - Direct telephone consultations with patients after initial categorisation

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Blackpool Teaching Hospitals NHS Foundation Trust

Neil Upson

Deputy Director of Operations

NHS
Blackpool
Clinical Commissioning Group

Unscheduled Care

- Implement Frailty Service go live 5th December, frees up circa 5 observation ward beds to create A & E ward capacity
- Implement changes from rapid improvement event
- Reduce Unscheduled Care Clinic commitments to release senior decision makers to support morning discharges between the 19th December and 9th January
- Reallocate circa 18 beds from Scheduled to Unscheduled Care
- Appointment of locum team to support management of outliers

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ALTC Division

- Working with Blackpool Council to provide 15 additional Packages of Care
- Manage DTOC at Clifton
- Open 12 closed beds for CHC/DTOC
- Work with Social Services to maximise use of ARC
- IV Therapy Service to function as Nurse Led therefore freeing up space on PCAU for frail elderly model of care

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Scheduled Care

- All remaining scheduled care beds to be ring-fenced to maintain elective and emergency requirements
- Run emergency activity, cancer and day cases through theatres reducing bed requirements 19 December – 9 January
- Prepare Scheduled Care staff for transfer of Ward
- Provide specialist support to Emergency Department
- Review elective activity for post 9 January 2017 and assess the impact on RTT

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Families Division

- Theatres – Urgent, Cancer and Day Case activity only during 19 December – 9 January
- The inpatient areas will operate normal business
- CAU will be operating bank holiday hours for the main days/Bank Hols
- Clinics will be reduced and closed on Bank Holidays to free up staff to work on the wards

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Clinical Support

- Increase diagnostic Support to Whitegate Drive at evenings and weekends to reduce divert to Emergency Department
- Target CT & MRI capacity to support emergency care

- Target phlebotomy services between 19 December and 9 January to areas of greatest need

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For Further information

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Clinical Commissioning Group
Health... at the heart of life in Blackpool

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Clinical Commissioning Group

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Report to:	**HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mr Tim Bennett, Deputy Chief Executive and Director of Finance, Blackpool Teaching Hospitals NHS Foundation Trust
Date of Meeting:	14 December 2016

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST: STRATEGY, AMBITIONS AND WORK PROGRAMMES

1.0 Purpose of the report:

1.1 To consider a progress report on Blackpool Teaching Hospitals NHS Foundation Trust's (the 'Trust') strategy, including progress against strategic ambitions and the financial position. The report for consideration is attached as an appendix.

2.0 Recommendations:

2.1 To consider, scrutinise and comment upon the strategy and ongoing work of the Trust in relation to clinical and financial sustainability.

2.2 To consider what further progress assurance the Committee may wish to receive in relation to continued implementation of the work programmes.

3.0 Reasons for recommendations:

3.1 To ensure constructive and robust scrutiny of the clinical and financial sustainability of Blackpool Teaching Hospitals NHS Foundation Trust.

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 At the Resilient Communities Scrutiny Committee meetings on 5 November 2015 and subsequently 4 February 2016, Mr Tim Bennett, Deputy Chief Executive and Director of Finance at Blackpool Teaching Hospitals NHS Foundation Trust presented Members with detail of the Trust's financial deficit and the need to ensure that the financial position did not impact on the quality of care. The minutes of those meetings as attached at appendix 10 (b). The web link to reports is listed at paragraph thirteen below.

5.2 The Committee discussed the financial challenge the Trust was facing, the core reasons behind the deficit and the action being taken to address the deficit.

5.3 Members asked a number of questions including whether the Trust had developed a plan for financial recovery and was informed that this was the case. Mr Bennett agreed to return to the Committee at a future meeting to present a progress report concerning the Improvement Action Plan and Strategy for Financial Recovery that had been developed.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 10 (a): Strategy, Ambitions and Work Programmes.
Appendix 10 (b): Minutes extract of Resilient Communities Scrutiny Committee meetings held on 4 February 2016 and 5 Nov 2015.

6.0 Legal considerations:

6.1 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. Previous reports concerning sustainability issues from Blackpool Teaching Hospitals Trust to the Resilient Communities Scrutiny Committee on 5 November 2015 (http://tinyurl.com/jp7abvw) and 4 February 2016 (http://tinyurl.com/jfuyv8v).

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Blackpool Teaching Hospitals NHS
NHS Foundation Trust

The Trust's Strategy Ambitions & Work Programmes

Health Scrutiny Committee
Wednesday 14th December 2016

Tim Bennett
Deputy Chief Executive

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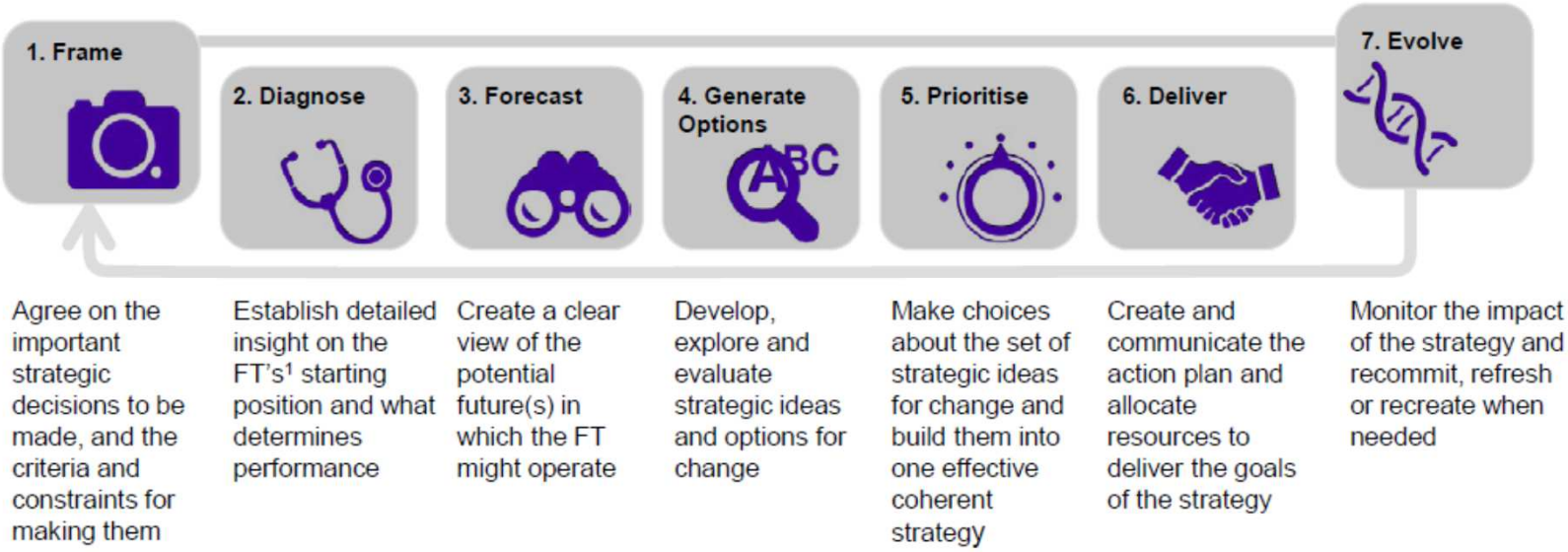
Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Our strategic review...

We began this process in June 2015, when the Board of Directors considered the Trust's clinical and financial sustainability

We asked leaders within the Trust and local health and social care economy to participate in all stages of our strategic review, sharing knowledge and experience at large-scale events and in smaller working groups



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Our strategic vision...

"As a high performing Trust, operating as part of an accountable care system for the Fylde Coast, we will provide high quality, safe and effective care in a financially sustainable way, through our skilled and motivated workforce"

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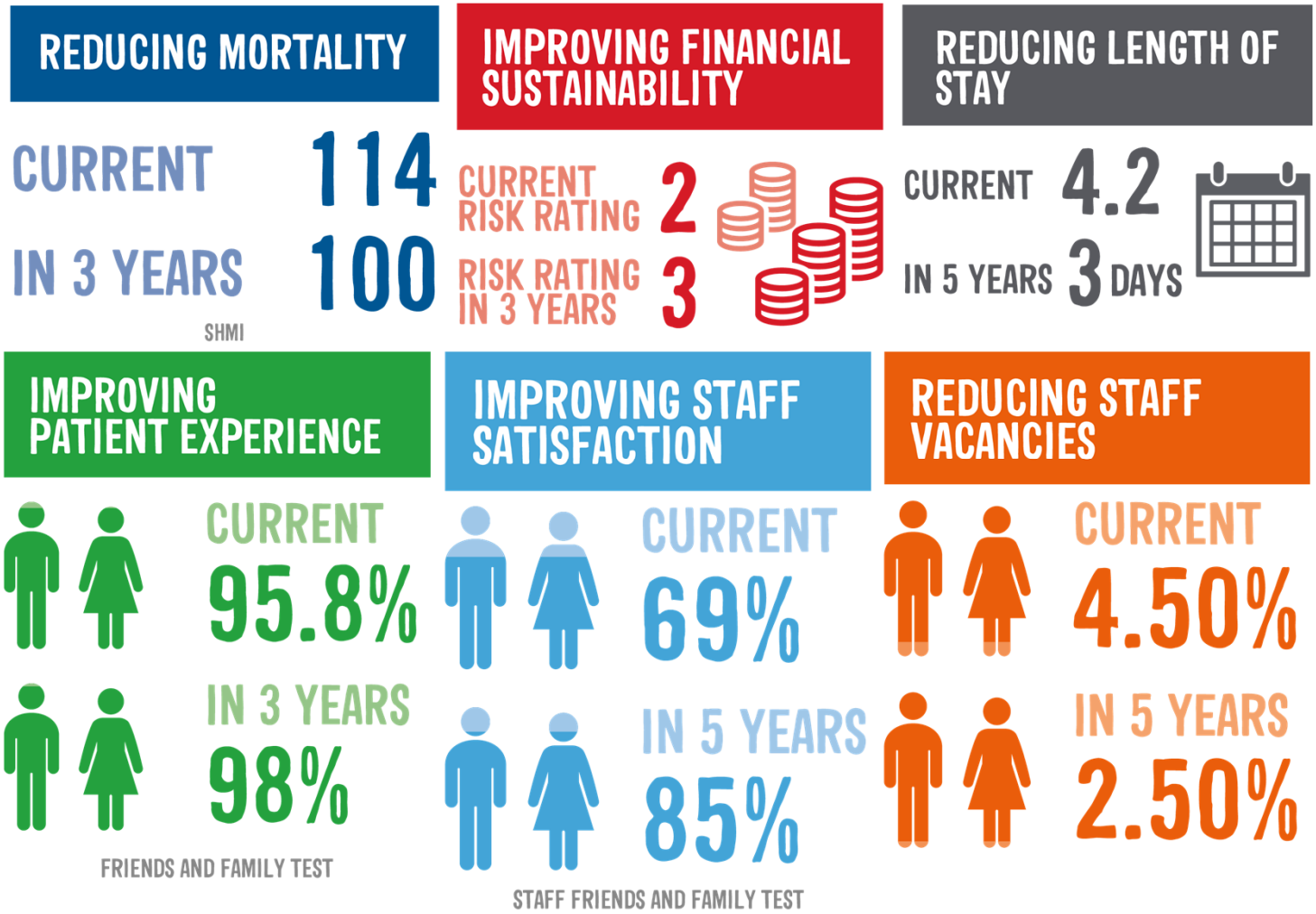
Our strategic ambitions...



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Our strategic work programmes...

Efficiency
Reducing length of stay to deliver high quality care affordably

Quality
Consistency in care provision to deliver high quality care to all patients

Value
Getting most value from all of our resources

Appropriate
Transforming non-elective points of entry into the healthcare system

Partnerships
Working as part of the local health economy to develop new, integrated models of care

Collaboration
Working as part of a Lancashire-wide redesign team to develop new models of care

Enabling
Putting in place enablers such as improved use of information technology, making good use of our estate and enhancing our communications

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Our progress to date: Quality

REDUCING MORTALITY

CURRENT 114

IN 3 YEARS 100

SHMI

SHMI	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	112.53	112.53		
Plan	111.35	110.32	109.29	108.25
Variance	**-1.18**	**-2.21**		

Although higher than planned, mortality (SHMI) is trending in the correct direction.

Key areas of focus to maintain trend and achieve plan:

- Collaborative working with CCGs on whole system pathway(s)
- Review of SHMI by condition

Key areas of risk:

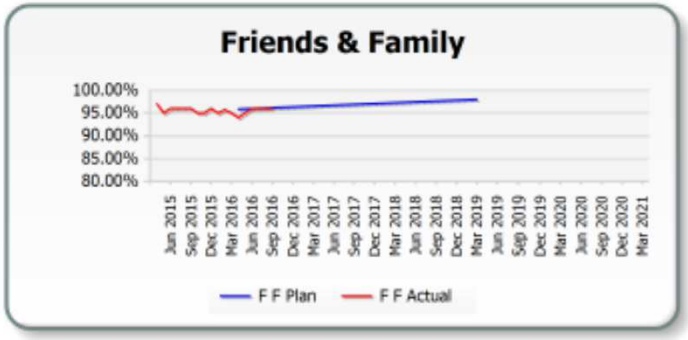
- Pathway compliance

IMPROVING PATIENT EXPERIENCE

CURRENT 95.8%

IN 3 YEARS 98%

FRIENDS AND FAMILY TEST



F&F	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	96.00%	96.00%		
Plan	95.98%	96.17%	96.35%	96.53%
Variance	**0.02%**	**-0.17%**		

Performance in the Friends & Family Test has shown improvement and is now broadly in alignment with plan.

Key areas of focus to maintain performance and achieve plan:

- Improve inpatient only response rates to above 30%
- Consistent Maternity and A&E response above 20%
- Improve access mechanisms

Key areas of risk:

- Waiting Times within OPD
- Communication and information provided
- Discharge information, completion and waiting times

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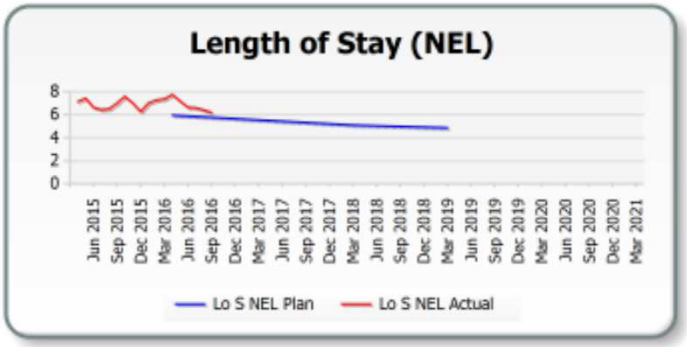
NHS Foundation Trust

Our progress to date: Operations

REDUCING LENGTH OF STAY

CURRENT **4.2**

IN 5 YEARS **3** DAYS



LOS NEL	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	6.65	6.21		
Plan	5.89	5.78	5.66	5.55
Variance	**-0.76**	**-0.43**		

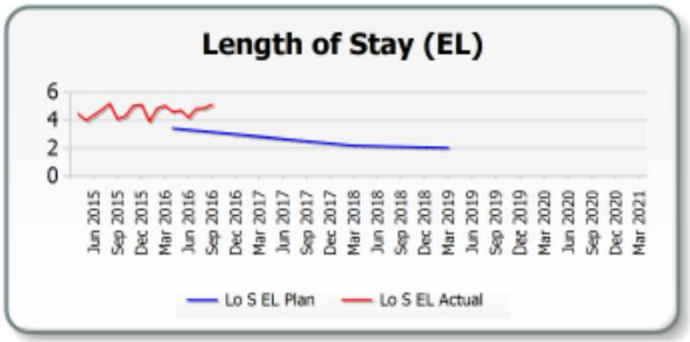
Non-elective (NEL) LoS is longer than planned, although it is trending in the correct direction.

Key areas of focus to maintain trend and achieve plan:

- Various activities to support improved care, including ambulatory care model
- Focus on top ten conditions

Key areas of risk:

- Significant increase in delayed transfers of care (LCC) – number and duration
- Increased number of admissions with higher levels of acuity



LOS EL	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	4.18	5.10		
Plan	3.29	3.14	2.98	2.83
Variance	**-0.89**	**-1.96**		

Elective (EL) LoS is longer than planned, and has not shown significant improvement during 2016/17.

Key areas of focus to improve performance and achieve plan:

- Sub specialty LoS improvement measures to be agreed
- "Excellence test of change" to continue. Weekly monitoring against KPIs to support sustainable change
- Focus on top ten conditions by CCS code

Key areas of risk:

- Medical patients displacing surgical patients increasing the risk of delays in pathways

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Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Our progress to date: Workforce

REDUCING STAFF VACANCIES

CURRENT
4.50%

IN 5 YEARS
2.50%

Vacancy	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	4.95%	6.29%		
Plan	4.40%	4.30%	4.20%	4.10%
Variance	-0.55%	-1.99%		

The vacancy rate was broadly in alignment with plan, but is now trending upwards. ***It should be noted that the Trust has introduced a recruitment freeze as part of its financial recovery.***

Key areas of focus to achieve plan:

- Focus on timely recruitment into clinical vacancies to ensure this is in line with the plan given the recruitment freeze for non-clinical posts

Key areas of risk:

- Medical and Dental
- Allied Health Professionals

IMPROVING STAFF SATISFACTION

CURRENT
69%

IN 5 YEARS
85%

STAFF FRIENDS AND FAMILY TEST

Staff Sat	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	58.00%	60.00%		
Plan	68.00%	69.00%	70.00%	72.20%
Variance	-10.00%	-9.00%		

Staff satisfaction rates are lower than planned, and has not shown any significant improvement during 2016/17.

Key areas of focus to improve performance and achieve plan:

- Improving response rate to survey to ensure it is representative
- Increase communication on what we have done with what staff have said
- Implementation of Divisional Improvement Plans

Key areas of risk:

- Implementation of ward moves
- Estates and Facilities

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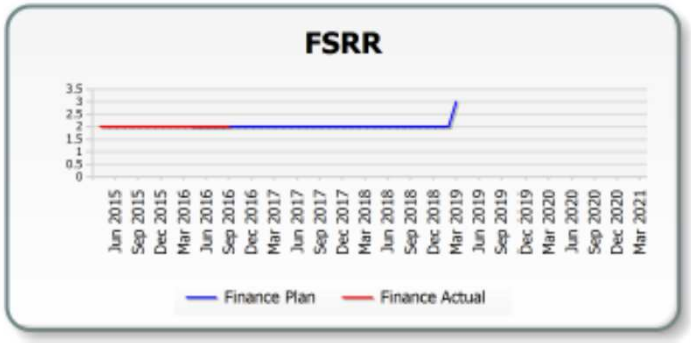
NHS Foundation Trust

Our progress to date: Finance

IMPROVING FINANCIAL SUSTAINABILITY

CURRENT RISK RATING 2

RISK RATING IN 3 YEARS 3



FSRR	Jun 2016	Sep 2016	Dec 2016	Mar 2017
Actual	2.00	2.00		
Plan	2.00	2.00	2.00	2.00
Variance	**0.00**	**0.00**		

The Financial Sustainability Risk Rating (FSRR) was not intended to change during 2016/17

It should be noted that this measure is being changed nationally by NHS Improvement and therefore future reporting against this strategic ambition will need to be amended to reflect this update.

Financial position

- The Trust ended the previous year with a significant deficit (+£14m);
- This was similar in size to the majority of NHS Trusts;
- At the start of 2016/17 NHS Improvement announced additional funding to help deliver sustainability and transformation.

	2016/17 (for reference)	2017/18	2018/19
STF Funding	£10.0m	£9.4m	£9.4m
Required control total	0	+£3.7m	+£8.6m

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NHS Foundation Trust

Blackpool Teaching Hospitals

- In order to achieve the control total targets we have to deliver high levels of efficiency
- During the strategy review we concluded that part of this should come from traditional transactional savings, part through schemes more transformational in nature and part through collaborative working with partner organisations
- In 2016/17 the savings are largely from traditional approaches but moving forward we will need to focus increasingly on transforming how we provide care and also how we work collaboratively with other health and care partners.

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NHS Foundation Trust

Questions

?

Appendix 10 (b)

MINUTES EXTRACT OF RESILIENT COMMUNITIES SCRUTINY COMMITTEE MEETINGS

RELATING TO BLACKPOOL TEACHING HOSPITALS TRUST'S SUSTAINABILTY ISSUES

FINANCIAL DEFICIT AND IMPACT UPON QUALITY OF CARE - 5 NOVEMBER 2016

Councillor Kath Benson, who had declared a personal and prejudicial interest in the item, left the room for the duration of its consideration. Councillor Andrew Stansfield was in the Chair.

Mr Tim Bennett, Director of Finance, Blackpool Teaching Hospitals NHS Foundation Trust advised that the Trust had a significant financial challenge that was not unique with 78 out of 83 foundation trusts' facing a financial deficit. He highlighted the key reasons for the deficit as the use of agency staff, the cost of pay awards and the increasing costs of clinical negligence.

Members queried the action the Trust would take in order to reduce the use of agency staff and increase recruitment and retention of NHS staff. Mr Bennett advised that agencies could charge a premium as demand for services exceeded supply of staff. To alleviate this pressure, a national policy had been put in place that would commence in 2016 and would limit the amount agency staff could be paid to 25% more than an NHS wage. This, in addition to the benefits of working for the NHS such as sick pay, annual leave and a pension, would hopefully have a positive impact on the retention of staff. Mr Bennett added that the Trust was also being innovative in its approach to recruitment and retention by seeking employees from outside of the UK and considering how to promote a better work life balance for current employees.

In response to further questions, Mr Bennett advised that the key reasons for employees' leaving the Trust had been identified as retirement and a desire to work more flexibly. He added that the NHS needed to be able to respond to agencies who could offer staff a working pattern that they could control.

Mr Bennett advised that the Trust was also aiming to reduce the length of stay in hospital and that Blackpool Teaching Hospitals Trust recorded a length of stay up to one and a half days longer than other trusts. He added that the Trust was hoping to achieve a reduction in length of stay through streamlining processes and ensuring patients were given an expected date of discharge upon admission, as this was proven to reduce length of stay.

In response to further questioning, Mr Bennett advised that the significant increase in the cost of clinical negligence was not due to an increase in claims, but a national policy to discontinue the 'no claims discount' previously awarded to Trusts with lower claims for negligence.

The Committee queried if the Trust had produced a plan for financial recovery that would allow Members to understand the key targets of the Trust and how it was meeting those targets. Mr Bennett agreed that he would present the recovery plan to a future Committee meeting in addition to the strategy that had also been developed.

The Committee agreed to add consideration of the financial recovery plan and strategy to the Workplan.

ACTION PLAN AND STRATEGY FOR FINANCIAL RECOVERY - 4 FEBRUARY 2016

Mr Bennett, Director of Finance advised that Blackpool Teaching Hospitals NHS Foundation Trust had reviewed clinical and financial sustainability over the previous 12 months. He highlighted the key challenges a growing financial deficit, higher than expected mortality rates as reported by the Keogh review in 2013, lower than desired Care Quality Commission (CQC) ratings, a growing demand for non-elective services, difficulties in meeting targets consistently and recruitment and retention of clinical staff. Mr Bennett advised that in order to provide a sustainable future the challenges must be addressed.

The Committee was informed by Mr Bennett that the Trust had established a number of working groups consisting of clinical and operational leaders in order to identify ways in which to address the identified challenges. He added that the working groups focussed on six subjects including urgent/emergency care and long term conditions/out of hospital care and that potential solutions had been divided into three timeframes. It was highlighted that some solutions could be achieved by the Trust and that others required a joined up working with partners.

Mr Bennett advised that the outcome of the working groups had been translated into six ambitions, each with a key measure of success. It was noted that the first ambition was to reduce the levels of morality from the current level of 112 to less than 100 in three years, which was the current national average. Mr Bennett reported that in addition to the six ambitions, seven work programmes had been developed including standardising care to deliver high quality to all patients and getting the most value from resources.

The Committee discussed the ambition in relation to staff satisfaction noting the considerable increase in target from 69% to 85% in five years and queried how the increase would be achieved. Mr Bennett advised that the Trust was implementing an organisational development programme to ensure that leadership was more clinically focussed and that it was envisaged that a more engaged workforce would improve patient satisfaction.

Members queried the work programme to standardise care, in particular relation to maternity services, and raised concerns that patient choice would be removed. Mr Bennett assured the Committee that standardised care would not remove patient choice

and that the work programme related to the standardisation of outcomes and not the standardisation of the pathway.

The Committee queried how the Trust would achieve the target mortality rate whilst managing the financial pressures of the organisation. Mr Bennett advised that there would be financial consequences to achieving the target and that the predicted cost had been included in the financial plan. He added that achieving the mortality rate target would be difficult as the national average would also continue to reduce.

In response to questioning, Mr Bennett advised that the Trust was trying to address the recruitment and retention issue in innovative ways. He added that there was a national shortage of consultant in many specialties including Dermatology resulting in a need to redefine and redesign service models rather than continue to rely on consultant led services. In response to a further question Mr Bennett advised that staff turnover was comparable to other Trusts in Lancashire and that there were a number of reasons staff left the organisation including age and career enhancement.

Members discussed the timescales in relation to the targets and Mr Bennett advised that progress would be monitored on a regular basis. The Committee requested that Mr Bennett attend a future meeting of the Committee to report on progress made against the targets identified by the Trust.

The Committee agreed to request a report from Mr Bennett in approximately six months detailing the progress the Trust had made in relation to the ambition targets and work programmes.

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