Blackpool Council

3 July 2018

To: Councillors Callow, Mrs Callow JP, D Coleman, Critchley, Elmes, Hobson, Humphreys, O'Hara, Mrs Scott and L Williams

The above members are requested to attend the:

ADULTS SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE

Wednesday, 11 July 2018 at 6.00 pm
in Committee Room A, Town Hall, Blackpool

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 either a

(a) personal interest
(b) prejudicial interest
(c) disclosable pecuniary interest (DPI)

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 LAST MEETING HELD ON 9 MAY 2018 (Pages 1 - 10)

To agree the minutes of the last meeting held on 9 May 2018 as an accurate record.

3 PUBLIC SPEAKING

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

4 BLACKPOOL CLINICAL COMMISSIONING GROUP END OF YEAR PERFORMANCE REPORT (APRIL 2017 TO MARCH 2018) (Pages 11 - 28)

To consider the performance of the Blackpool Clinical Commissioning Group for April 2017 to March 2018.

5 ANNUAL COUNCIL PLAN PERFORMANCE REPORT 2017-2018 (Pages 29 - 52)

To present performance against Priority 2 of the Council Plan 2015-2020 for the period 1 April 2017 – 31 March 2018.

6 ADULT SERVICES OVERVIEW REPORT (Pages 53 - 62)

This report provides an update on the current status and developments in Adult Social Care.

7 PUBLIC HEALTH UPDATE ON STOP SMOKING PROVISION (Pages 63 - 100)

To present an update on the stop smoking service provision in Blackpool.

8 ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE WORKPLAN 2018-2019 (Pages 101 - 112)

To consider the Adult Social Care and Health Scrutiny Committee Workplan 2018-2019, together with any suggestions that Members may wish to make for scrutiny review topics.

9 NEXT MEETING

To note the date and time of the next meeting as Wednesday, 10 October 2018 commencing at 6pm in Committee Room A, Blackpool Town Hall.

Venue information:

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

Other information:

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

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

MINUTES OF ADULTS SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE MEETING - WEDNESDAY, 9 MAY 2018

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	Elmes	Hutton	Mrs Scott
Mrs Callow JP	Humphreys	Owen	L Williams

In Attendance:
Councillor Amy Cross, Cabinet Member for Adult Services and Health
Ms Nicky Dennison, Senior Public Health Practitioner
Dr Arif Rajpura, Director of Public Health
Mr Sandip Mahajan, Senior Democratic Governance Adviser

Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Ms Kate Dalton, Team Leader, Blackpool Clinical Commissioning Group
Mr Roy Fisher, Chair, Blackpool Clinical Commissioning Group
Ms Jeannie Harrop, Senior Commissioning Manager, Blackpool Clinical Commissioning Group
Ms Helen Lammond-Smith, Head of Commissioning, Blackpool Clinical Commissioning Group and Blackpool Council
Ms Michelle Sowden, Head of Mental Health and Learning Disability Services, Blackpool Teaching Hospitals
Ms Elaine Walker, Emotional Health and Wellbeing Manager, Blackpool Teaching Hospitals

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 14 MARCH 2018

The Committee agreed that the minutes of the Adult Social Care and Health Scrutiny Committee meeting held on 14 March 2018 be signed by the Chairman as a correct record.

3 PUBLIC SPEAKING

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

4 HEALTHY WEIGHT STRATEGY

Ms Nicky Dennison, Senior Public Health Practitioner presented a report on progress towards tackling childhood and adult obesity. Also in attendance was Dr Arif Rajpura, Director of Public Health.

She explained that the Council's Healthy Weight Strategy which had five local action themes: people better informed to make their own good health choices; focusing on young people; good weight management services; reducing sugar intake; and improving local environments to encourage health eating and exercise.

Ms Dennison referred to the Local Authority Health Weight Declaration, a national initiative, which the Council signed in 2016. There were a range of commitments progressing well. Councillor Cain, as the Chairman of the Blackpool Health and Wellbeing Board and Cabinet Secretary for Resilient Communities, had encouraged the work to be promoted further so four healthy weight summits had been held over the last year involving local businesses, schools and other public/voluntary sector partners.

She added that an annual Healthy Choice Award event had first taken place in 2017 with food outlets and other organisations helped to make simple changes to create healthier menus, e.g. more low fat condiments, smaller portions. One hundred businesses had been successful with this initiative including ethnic restaurants and the initiative had been spreading into children's centres and schools. Good hot/cold food and packed lunches were being promoted. St Johns Primary School was leading on a pilot that, following feedback from parents, would be rolled out further and St Georges School was promoting cookery skills. The healthy weight pilot had also proved successful so had been extended to 2019.

Ms Dennison reported that two successful Give Up Loving Pop (GULP) events had been held where whole classes were encouraged to stop drinking fizzy drinks for at least 28 days with an associated competition for classes to take part in. This would be extended to more year groups. Another benefit had been that children involved with the campaign had now started to check the nutritional information on products.

Other proactive work included providing planning policy with evidence of the impact of fast food outlets so their numbers could be controlled.

She referred to effective work being pursued through the Head Start Programme (emotional resilience for 10-15 year olds), e.g. using social media to get good health messages out. Early years (0-4 year olds) work was also being developed with the Better Start Programme (good nutrition focus) and the 'Food Active' organisation across the north-west.

The Chairman noted the Local Authority Declaration, summits and anecdotal feedback but enquired what empirical evidence there was to confirm that effective progress was being made. Ms Dennison explained that it was difficult to directly correlate interventions with outcomes but Blackpool figures from the National Child Measurement Programme indicated an improving trend over the last two years for healthy weight outcomes. However, those figures would need to be sustained before robust outcomes could be confirmed. She added that an evaluation of the Declaration would take place with Food Active.

Dr Arif Rajpura agreed that this was interim progress and momentum needed to be maintained with healthy eating/weight with robust messages delivered and a holistic approach particularly improving local environments and mind-sets for better health., e.g.

walking more. He cited the 'Fit to Go' for year four school-children which was a physical activity programme run by Blackpool Football Community Trust and jointly funded by the Trust, Blackpool Clinical Commissioning Group and the Council.

The Chair referred to the Wyre district which offered people free weight management programmes at local gyms and enquired whether a similar approach could be offered in Blackpool given that there were Council owned facilities. He also queried what publicity there was and whether people were able to self-refer for support programmes. Members added that support programmes needed to be long enough to ensure that there was sustainable improvement otherwise people might naturally revert back to unhealthy behaviours.

Members were informed that the Council did offer free access to its gyms for weight management support with a twelve week 'child and family' programme. People were usually referred to the programme following assessment through the National Child Measurement Programme. GPs were also being encouraged to make referrals ('Making Changes' pathway). Discounted access to gyms was also offered after free support finished.

The Chairman enquired why all schools were not adopting the 'Daily Mile' principal of classes sharing a walk together at the start of school days. Members were informed that the benefits had been promoted to all schools but most were independent academies which had various considerations such as budgets and staff capacity. Some were making use of proceeds from the sugar tax levy to develop initiatives such as track infrastructure which could cost as much as £3k.

Members noted that all schools already had playgrounds so should readily be able to promote exercise such as walking at no real cost.

In response to a query about recognising the need to support people with anorexia, it was explained that the focus was on healthy weight which applied to everyone. Obesity was a far more significant issue within Blackpool but there was support for people with anorexia.

Members noted that free school breakfasts promoted better nutrition although often 'rewards' were in the form of treats. Public Health officers agreed that sweet treats gave a contradictory message and explained that schools were required to have 'food plans'. Public Health did re-iterate healthy eating messages to schools and generally promoted healthy eating, e.g. at school fairs / public events.

Members noted that it was easy to safely cycle along the promenade but there were no fully joined-up safe cycling routes across town. They queried the development of strategic walking and cycling. It was explained that several years ago there had been good safe routes but these had been decommissioned. Department of Transport funding had recently been secured to develop local infrastructure planning for cycling and walking which was being pursued through a pan-Lancashire strategy.

In response to the harmful impact of advertising and marketing which promoted unhealthy foods, Public Health agreed that this had considerable impact and needed

stronger controls. These issues had been raised at a recent Health Select Committee debate. Officers added that new legislation such as the tax on sugary products would have a positive impact and the Government was drafting a new Child Obesity Plan.

Public Health officers re-iterated the message that cultural change took time and that support programmes were one tool as part of a range of options forming a comprehensive strategic family approach. There had been good focus on children which now needed to capture adults. There were a host of professionals from school nurses to Head Start officers involving in promoting messages. Value for money outcomes, with robust evaluation, needed to be achieved given funding pressures.

Members were informed that Blackpool had received national recognition for its healthy weight work and had become a beacon to areas with obesity challenges.

5 MENTAL HEALTH COMMISSIONING UPDATE

Ms Helen Lammond-Smith, Head of Commissioning, Blackpool Clinical Commissioning Group and Blackpool Council presented progress made and plans for improving mental health service provision.

Also present was Ms Elaine Walker, Emotional Health and Wellbeing Manager, Blackpool Teaching Hospitals and Ms Michelle Sowden, Head of Mental Health and Learning Disability Services, Blackpool Teaching Hospitals.

Representatives were present from Rethink (national mental health support charity) and the Blackpool Carers' Centre and Sergeant Peter Hannon, Lancashire Constabulary whose role incorporated mental health liaison within Blackpool.

Ms Lammond-Smith reported that three broad elements were being presented. There was a full review of current mental health service provision and proposed mental health integration of primary care (New Models of Care) across the Fylde Coast area as part of the 'Vanguard' programme linking in with community/ neighbourhood hubs.

The two parallel elements were the children and young people's mental health provision developments and a directory of Fylde Coast mental health services (part of Vanguard) aimed at GPs and other professionals / the voluntary sector.

She explained that the main areas of primary and community integration being considered included Improving Access to Psychological Therapies (IAPT) which recognised that many people had long-term physical conditions and developing a pool of 'connecting people' trainers (bringing public and professionals closer together). There were a number of challenges including accommodation with a shortage of beds.

A wide range of work was being pursued including creating multi-disciplinary teams for a genuinely 'single point of access', home treatment, investing in crisis support services and developing 'Core 24' support (24 hours per day, seven days per week). The work would help create better pathways of support including access to beds.

The Chairman cited an example of a patient from over one year previously being given

medication for depression but then told there would be a wait of over one year for any further treatment. Members felt that waiting times for Child and Adolescent Mental Health Services (CAMHS) were also too long. Members were informed that Blackpool services were currently performing well with 100% of people being assessed within target time (twelve weeks for CAMHS) and next stage targets had also been met. There was also support through YouTherapy and 'walk-in' options. The Transformation Plan for Children and Young People's Emotional Health and Wellbeing Members was developing the support options.

Members emphasised that it was important that young people were aware of the support available. They were concerned that the directory of mental health services was too complex to follow. It was explained that it was a comprehensive directory which had been developed after consultation with stakeholders who had given positive feedback. Target users of the directory found printed versions useful. The directory linked in with the recently launched public 'For your information' directory of wider public and community services/groups. The directory would evolve with feedback. The Rethink representative added that he had found the directory a good approach and that it would help him better support and signpost his members.

Ms Walker reported that she had just attended a parallel children and young people's event with around sixty young people present. They wanted access to services including making use of directories and digital information.

Members enquired what work was taking place with schools. They were informed that the Head Start Programme (emotional resilience and health and wellbeing for 10-15 year olds) included trained mental health coaches and that school nurses were another resource. Links with the various resources including CAMHS and YouTherapy were being developed within the neighbourhood hubs.

Members were informed that the patient experience survey (friends and family) covered a short period of time. In response to queries, it was explained that people could self-refer for support and this would be advertised through mediums such as Facebook.

The Committee expressed concern that the 'Men in Sheds' support concept bringing people together to share conversations and activities would have limited impact in preventing suicides. They were also concerned that stigma about mental health still existed. Members were informed that there were a range of options to support people and raise awareness, e.g. Mental Health Week was taking place later that month including tackling stigma through the 'Time to Change' work and that other activities and events were being promoted across wards.

The Chairman referred to the Committee's recommendation made at its meeting on 24 January 2018 (Public Mental Health item) that the Suicide Prevention Oversight Group for Lancashire and South Cumbria should consider introducing an aspirational target of zero suicides. Feedback from the Group had been that whilst the aspiration was commended, there were concerns that the zero focus created a negative climate for families of victims. Members noted the feedback but added that other areas such as Bolton Council's Public Health leads had recommended introducing the 'zero suicide' target and were confident that it would have a significant impact. The Committee re-iterated the recommendation

and that it needed to be escalated.

The Rethink representative added that it was important to improve the Crisis support available to people. He reported that the Rethink network was developing with more members able to attend local mental health meetings so was active resource, e.g. Rethink could help with service user surveys. However, he expressed concerns that some of his members had found communications from the Lancashire Care Foundation Trust difficult. Councillor Amy Cross, Cabinet Member for Adult Services and Health added that the Trust had not been attending Mental Health Partnership Board meetings which she chaired and Rethink attended. Members were informed that the Trust were usually good attendees at Scrutiny Committee meetings and participated well. It was suggested that the Trust's Director of Engagements and Partnerships, who had good involvement with Scrutiny, would be contacted and sent the meeting minutes to help resolve the concerns over communications and Partnership Board attendance.

Sergeant Peter Hannon explained that mental health issues presented a number of risks such as people going 'missing from home'. The police were working well in partnership with both the acute trust at Blackpool Victoria Hospital and mental health trust at The Harbour.

He cited the example of a shared mental health vehicle pilot with a police officer passenger, mental health professional (Crisis nurse) and also, if necessary, a paramedic. They had been able to respond to issues during unsociable hours where vulnerable people with apparent mental health issues had been involved. By sharing resource and good information at the scene they were able to ensure that people were supported appropriately, diverted from needing to attend accident and emergency or a police cell. The outcomes were better for vulnerable people and saved significant resource time and cost. For a standard evening shift, five people had bene diverted from accident and emergency saving an estimated £10k and also multiple hours of officer time.

Sergeant Hannon added that the police were getting more practical mental health training and having the Crisis nurse on-board was essential. He concluded that a simple solution of talking to people in good time, rather than accident and emergency assessments led to the best outcomes for all involved.

The Committee agreed:

1. To re-iterate the recommendation that a 'zero' suicide target should be adopted within Blackpool; and that Ms Judith Mills, Consultant in Public Health, Blackpool Council would raise the proposed target again at the Suicide Prevention Oversight Group for Lancashire and South Cumbria and, if required, escalate to the parent body providing a written response by the Committee's next meeting on 11 July 2018.
2. The Lancashire Care Foundation Trust's Director of Engagements and Partnerships would be contacted to resolve the concerns over communications with Rethink members and ensure good attendance at Mental Health Partnership Board meetings.

6 BLACKPOOL'S DOMESTIC ABUSE NEEDS ASSESSMENT AND STRATEGIC PARTNERSHIP ACTION PLAN

Mr Tony Morrissey, Head of Safeguarding / Principal Social Worker, Blackpool Council and Chair of the Blackpool Domestic Abuse and Interpersonal Violence Partnership Sub-Group presented an update on the completed Blackpool Domestic Abuse Needs Assessment and progress being made with delivering the Blackpool Domestic Abuse and Interpersonal Violence (DAIV)'s Action Plan.

The Chairman enquired why funding for domestic abuse services was 'fragmented and insecure' impacting upon the planning and effective delivery of services. Mr Morrissey explained that poor funding arrangements were a national issue. Some funding came from government, some was ring-fenced but there was no long-term sustained budget. He was aiming to promote the need for a pooled budget from across the Blackpool Domestic Abuse and Interpersonal Violence Partnership. This would provide better value and promote more effective commissioning of services including better support for domestic abuse refuges.

The Chairman also enquired why there were year-on-year increases in police call-outs for domestic abuse incidents. Mr Morrissey informed Members that Blackpool had a holistic partnership approach working with victims, families and perpetrators. There were a number of resources and programmes, e.g. Inner Strength Programme which provided a route for perpetrators to move away from patterns of violence andworking with schools to get across messages of health relationships including that domestic abuse was not acceptable or normal. Domestic abuse work was being taken forward as a public health issue, e.g. domestic abuse needs were evidenced within the Public Health Joint Strategic Needs Assessment (JSNA). He emphasised that preventing domestic abuse was paramount.

Mr Morrissey added that Blackpool was good at raising awareness of issues and tackling perpetrators. However, it was important to use evidence to evaluate the effectiveness of work, i.e. not to continue with approaches that were not having the right impact and outcomes sought to reduce domestic abuse. A university had been commissioned to undertake evaluation of work.

The Committee enquired how the effectiveness of the Troubled Families Programme was measured. Members were informed that the Programme came within government 'payment by results' criteria which covered more than domestic abuse work such as anti-social behaviour, employment opportunities and improving self-esteem. The Council's Families in Need Service led on the Programme offering a range of support including early help. He added that demand was high within Children's Services although causes and effective actions had been improved making some impact,

In response to a query about whether same sex abuse was an issue, refuge space for men and also keeping perpetrators away, Mr Morrissey explained that abusers and victims came from all groups and backgrounds. He added that male victims could be unwilling to come forward so it was important to offer a good range of support services for all victims. The police did have powers to tackle perpetrators.

Members expressed concern that the number of repeat cases discussed at Multi-Agency Risk Assessment Conferences (MARAC) had dropped to 74 in 2015-2016 from 153 in 2014-2015 but had then risen again to 153 in 2016-2017. Mr Morrissey explained that these were high risk cases. Blackpool's case numbers were high when compared nationally and the highest in the sub-region. There could be issues such as whether the pathway for making referrals through to action was right. He explained that the police were reviewing the process and looking into reasons for repeat cases. Managing demand was important.

The Chairman enquired whether there were sufficient refuge spaces for any urgent accommodation requests. Members were informed that refuge space was a national issue and there was high local demand. However, safe space would be found for anyone in urgent need which could include 'out-of-area' options; this might be best given that someone might be trying to flee from a local perpetrator. Empowering people was also highlighted as important so that they felt safe in a place.

7 HEALTH AND SOCIAL CARE INTEGRATION PROGRESS

Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group, presented an update on health and social care integration in Blackpool (as part of the wider Fylde Coast local delivery partnership) including Enhanced Primary Care and neighbourhoods work and planning for 2018-2019.

Also present were Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group; Ms Jeannie Harrop, Senior Commissioning Manager; and Ms Kate Dalton, Team Leader, Blackpool Clinical Commissioning Group.

Members had considered integration first in November 2016 in the early stages of development and received a further update in September 2017. They had felt that there was not sufficient detail of local work within the original Sustainability and Transformation Plan (STP) for Lancashire and South Cumbria nor financial costings.

There had also been concerns whether sufficient transformation progress was being made in good enough time to deliver the five-year plan to better manage integrated care for people's health and wellbeing and reduce service demand / cost pressures.

Members commented that the various changes referred to within the report were not easy to follow. Mr Bonson explained that the local delivery arm for pursuing transformation was the new Fylde Coast Integrated Care Partnership (ICP). This comprised of Blackpool Clinical Commissioning Group, Fylde and Wyre Clinical Commissioning Group and Blackpool Teaching Hospitals Trust working together to deliver shared plans as part of the wider Lancashire and South Cumbria Integrated Care System (ICS) which took forward Sustainability and Transformation Planning.

Mr Fisher explained that the Lancashire and South Cumbria finance lead, Mr Gary Raphael had become unavailable for the meeting but had suggested that a dedicated meeting be held on the wider sub-regional picture (i.e. Integrated Care System / Sustainability and Transformation Planning) allowing current focus to be on local delivery through the

Integrated Care Partnership. Ms Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group would also be requested to attend.

The Chairman referred to winter planning and the stated potential for an additional ninety beds. He also queried transformation progress, after three years planning, with reducing the number of unnecessary admissions to hospital, which was estimated to be around 25% and bed blockages/shortages particularly this winter. Members re-iterated previous concerns about delayed discharges from care.

Mr Bonson explained that provision was based on 2017-2018 outturns when extra beds had been taken from elective care wards following a bad winter with subsequent impact throughout the year. The ninety beds would be provision for unscheduled care. Bed availability would be managed through reducing unnecessary admissions, reduced length of stays (higher than the national average so a priority), improved discharges of patients (with effective case management) and better planning of elective care. Improving patient flow was central to all work. High priority areas, including elective cancer treatment, would not be impacted, i.e. would not be targeted for beds.

Mr Fisher explained that not all services had been commissioned through the sub-regional Sustainability and Transformation Planning. Most services (70%) were commissioned locally through the Fylde Coast Integrated Care Partnership. He added that innovative work was taking place through the neighbourhood hubs aiming to help to secure more outcomes at primary care stages. This local work was important as it brought together a range of health and social care professionals to offer integrated care and reduce the need for secondary care through hospitals.

Ms Harrop confirmed that beds were purchased at other hospital sites but patients' safety was maintained and GP consent had to be obtained. She added that innovative methods were being pursued to reduce hospital attendance, e.g. live case management system allowing patients' movements through the care system to be actively tracked. Ms Dalton added that the case management system coupled with shared information/discussions between the various neighbourhood hub professionals liaising with nurses allowed more effective pathways of care.

In response to concerns raised by some Members, the representative from Blackpool Carers' Centre reported that carers formed part of the neighbourhood teams. Ms Harrop added that care services were also commissioned from other organisations such as the British Red Cross. She and Ms Dalton offered to discuss the concerns raised outside the meeting to help identify best support options. Contact details for all the neighbourhood hubs would be forwarded to Members.

In response to a query about people being able to access social care payments, Members were advised that social workers were in the neighbourhood teams so provided support with payment arrangements.

The Committee agreed:

1. To receive a further report on health and social care integration, focusing on the Lancashire and South Cumbria Integrated Care System / Sustainability and Transformation Planning.
2. To request that Ms Harrop forwarded contact details for all the neighbourhood hubs.

8 ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE WORKPLAN 2017-2018

The Committee agreed:

1. To approve the Scrutiny Workplan subject to receiving a further report on health and social care integration, focusing on the Lancashire and South Cumbria Integrated Care System / Sustainability and Transformation Planning.
2. To note the 'Implementation of Recommendations' table.

9 NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday 4 July 2018 commencing at 6pm in Committee Room A, Blackpool Town Hall subject to confirmation at Annual Council.

Chairman

(The meeting ended at 8.00 pm)

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

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Date of Meeting:	11 July 2018

BLACKPOOL CLINICAL COMMISSIONING GROUP END OF YEAR PERFORMANCE REPORT (APRIL 2017 TO MARCH 2018)

1.0 Purpose of the report:

1.1 To consider the performance of the Blackpool Clinical Commissioning Group (BCCG) for 2017-2018 (April 2017 - March 2018).

2.0 Recommendation(s):

2.1 To comment upon progress being made, propose potential improvements and consider whether any areas would benefit from further scrutiny.

3.0 Reasons for recommendation(s):

3.1 To ensure constructive and robust scrutiny of the end-year health performance reporting relation to commissioned hospital, ambulance and some GP 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 2017-2018 year end 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 4 (a): Blackpool Clinical Commissioning Group
Performance Report 2017-2018.

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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NHS
Blackpool
Clinical Commissioning Group

Blackpool Clinical Commissioning Group

Performance Report 2017/18

April 2017 – March 2018

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 an end of year summary of all the relevant indicators, as published by NHS England, with an exception narrative for any indicators not meeting the requisite target.

Summary for 2017/18

Metric	Year-end Position	Target	Page No.
NHS Constitution Measures			
Referral to Treatment (RTT) Incompletes (c)	87.38%	≥92%	4
Diagnostic Test Waiting Time (c)	0.60%	≤1%	4
A&E waits (c)	84.43%	≥95%	4
Patients seen within 2 weeks of a GP referral for suspected cancer	94.58%	≥93%	5
Patients seen within 2 weeks of a GP referral for breast cancer symptoms	96.27%	≥93%	5
Patients receiving definitive treatment within 1 month of a cancer diagnosis (c)	96.20%	≥96%	5
Patients receiving subsequent treatment for cancer within 31 days (Surgery) (c)	96.02%	≥94%	5
Patients receiving subsequent treatment for cancer within 31 days (Drugs) (c)	100.00%	≥98%	5
Patients receiving subsequent treatment for cancer within 31 days (Radiotherapy) (c)	99.03%	≥94%	5
Patients receiving 1st definitive treatment for cancer within 2 months (c)	77.98%	≥85%	5
Patients receiving treatment for cancer within 62 days from an NHS Screening Service (c)	79.31%	≥90%	5
Patients receiving treatment for cancer 62 days upgrading their priority (c)	89.96%	≥85%	5
Category 1 Ambulance Calls	No year-end data available as reporting changed in December 2017	<=7 mins	5
Category 2 Ambulance Calls		<=18 mins	5
NHS Constitution Support Measure			
Referral to Treatment waiting times more than 52 weeks (incomplete) (c)	10	0	4
A&E waits 12 hour trolley waits (p)	266	0	4
Mixed Sex accommodation breaches (c)	17	0	6
Cancelled Operations (p)	96	0	6
Mental Health (c)	96.14%	≥95%	6
Primary Care Dementia (c)	79.57%	≥67%	7
Incidence of Healthcare Associated Infection (c)	MRSA – 2 C-Diff - 45	0/58	7
Financial Sanctions			
Possible Sanctions excluding Admitted and Non-Admitted RTT	Year End Position	£4,119,213.38	
Overall Summary of Blackpool CCG Improvement and Assessment Indicators	Year End Position	Page 13	

Achievements

- The % of patients waiting 6 weeks or more for diagnostic tests has remained below the target of <1% for the year 2017/18 at 0.62%.
- Blackpool CCG cancer waits have met seven (7) out of nine (9) constitutional targets for the year 2017/18.
- The % of patients on a care programme approach discharged and followed up within 7 days has remained above target for the year 2017/18 at 96.14%.
- Blackpool CCG estimated prevalence for people over 65 with dementia against the CCG's actual dementia diagnosis rate remains above the target of ≥ 67% for the year 2017/18 at 79.57.
- The Clostridium difficile (CDI) incidents for both Blackpool CCG and Blackpool Teaching Hospitals remain within trajectory for 2017/18.
- Improving access to psychological therapies (IAPT) has achieved all targets for the year 2017/18.

Areas for focus / information

- Blackpool CCG has not met the referral to treatment target (RTT) for incomplete patient pathways in 2017/18. Performance has been influenced by the continued effects from system pressures experienced following the winter months
- There were 10 Blackpool CCG patients waiting more than 52 weeks for treatment in 2017/18.
- Blackpool Teaching Hospitals' performance against the 4 hour A&E waiting time target has remained below target for the year 2017/2018 at 84.43% below the target of 95% at the end of March 2018.
- The Trust has had a total of 266 12-hour decision to admit breaches for the year 2017/18. Root cause analyses have been received for all breaches in line with national policy in order to provide assurance from the Trust that patient safety has been maintained and to gain an understanding of the complex reasons for the breaches occurring.
- There have been ninety-six (96) patients operations cancelled which have been unable to be rescheduled within 28 days reported at Blackpool Teaching Hospitals for the year 2017/18; this is due to the cancellation of elective activity within the hospital and reduced bed capacity due to winter pressures.
- There have been two (2) incidents of MRSA bacteremia attributed to Blackpool CCG for the year 2017/18.
- There has been one (1) incident of MRSA bacteremia attributed to Blackpool Teaching Hospitals for the year 2017/18.

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 1 April to 31 March 2018

RTT (c)		Organisation	Target	Year End position	Performance (April - March)	No. of Excess Breaches
* Patients on incomplete pathways treated within 18 weeks		CCG	≥ 92%	87.38%	↓	5994
Patients waiting for more than 52	Incomplete pathway	CCG	0	10	↓	10

Blackpool CCG has not met the referral to treatment target (RTT) in 2017/18 for incomplete patient pathways. Performance has been influenced by the continuing effects of system pressures experienced in the winter months at Blackpool Teaching Hospitals which was emulated both regionally and nationally. Plans are in place to improve this position throughout 2018/19. There have been ten (10) Blackpool CCG patient's waiting more than 52 weeks in 2017/18. All breaches have been investigated by Blackpool Clinical Commissioning Group and reported to the Finance and Performance Committee. Six of these breaches took place at Manchester University Hospitals Foundation Trust due to the lack of capacity to undertake a specialized breast reconstructive procedure. Alternative commissioning arrangements have been made whilst the waiting list for this procedure is addressed; GP's have been asked to refer patients to Whiston, Preston, Stoke or Birmingham Hospitals. Three of these breaches took place at Spire Fylde Coast Hospital; however these were as a result of patients being outsourced from Blackpool Teaching Hospitals due to capacity issues. One breach took place within Trauma and Orthopaedics at the Countess of Chester Hospital and was due to a complex patient pathway.

Diagnostic Test Waiting Time (c)	Organisation	Target	Year End position	Performance (April - March)	No. of Excess Breaches
% of patients waiting 6 weeks or more	CCG	≤ 1%	0.60%	↑	0

Diagnostic waiting times have remained below target for the year 2017/18.

A&E Waits (c)	Organisation	Target	Year End position	Performance (April - March)	No. of Excess Breaches
*4 Hour A&E Waiting Time Target	CCG	≥ 95%	84.43%	↓	12,202

Blackpool Teaching Hospital's performance against the 4 hour A&E waiting time target has remained below target for the year 2017/18. An NHS England (Lancashire) escalation process remains in place with daily reporting and weekly updates being followed in addition to local and regional teleconferences. Nationally the position replicates the issues being experienced locally and regionally. The table below shows performance against the 4 hour waiting time target at all treatment centres on the Fylde Coast.

A&E Waits ©	Target	BTH	Urgent Care Centre	Whitegate Drive	Fleetwood Same Day Health Centre	Total Economy Monthly Performance	Sustainability Transformation Funding Plan	YTD Total Economy Performance (March 18)
April 2017	≥ 95%	73.83%	100.00%	99.91%		88.74%	92.9%	84.43%
May		66.51%	100.00%	99.93%		84.97%	93.0%	
June		70.41%	100.00%	99.96%		87.16%	93.3%	
July		61.62%	99.93%	99.97%		83.33%	93.4%	
August		56.00%	100.00%	99.98%		80.88%	93.8%	
September		62.50%	100.00%	99.95%		83.95%	91.1%	
October		74.82%	100.00%	99.95%		90.83%	90.6%	
November		57.82%	99.82%	99.95%	99.90%	84.55%	92.8%	
December		40.14%	99.62%	99.66%	100.00%	78.67%	92.8%	
January 2018		53.79%	99.58%	99.99%	100.00%	84.75%	89.7%	
February		51.35%	100.00%	99.85%	99.86%	83.32%	91.8%	
March 2018		48.27%	99.63%	99.63%	100.00%	81.94%	95.00%	

12 Hour Decision to admit waitsin A&E (p)	Organisation	Target	Year End position	Performance (April - March)	No. of Breaches
12 Hour decision to admit waits in A&E	Provider - BTH	0	266	↓	266

The Trust continues to experience significantly increased pressure in Urgent Care services. CCG and Blackpool Council colleagues have been working closely with the Trust to ensure patients are discharged safety in order to improve patient flow throughout the Hospital. The Trust has had a total of 266 12-hour decision to admit breaches for the year 2017/18. Root cause analysis reports have been received for all breaches in line with National policy and weekly teleconferences are being held with multi-agency input to monitor the situation. The position has been escalated through all appropriate reporting channels.

Cancer Waits (c)		Organisation	Target	Year End position	Performance (April - March)	No. of Excess Breaches
% seen within 2 weeks of referral		CCG	≥ 93%	94.58%	↓	0
% seen within 2 weeks of referral – breast symptoms		CCG	≥ 93%	96.27%	↓	0
31 Days	% of patients receiving definitive treatment	CCG	≥ 96%	96.20%	↓	0
	% of patients waiting no more than 31 days for subsequent treatment – surgery	CCG	≥ 94%	96.02%	↔	0
	% of patients waiting no more than 31 days for subsequent treatment - drug therapy	CCG	≥ 98%	100.00%	↔	0
	% of patients waiting no more than 31 days for subsequent treatment – radiotherapy	CCG	≥ 94%	99.03%	↑	0
62 Days	% of patients waiting no more than 62 days from urgent GP referrals to first definitive treatment	CCG	≥ 85%	77.98%	↓	34
	% of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment.	CCG	≥ 90%	79.31%	↓	9
	% of patients waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade.	CCG	≥85%	89.96%	↑	0

Seven of the nine constitutional targets for cancer waits have been met in the year 2017/18; the exception being the percentage of patients waiting no more than 62 days from urgent GP referrals to first definitive treatment and the percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment.

The number of patients waiting no more than 62 days from urgent GP referrals to first definitive treatment are small. The reasons for these breaches are varied but include patient choice, complex diagnostic pathways and medical reasons.

Patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment do so for very similar reasons to those breaching the 31 day target. Work is ongoing across Lancashire to rapidly improve the Cancer waiting time targets.

Ambulance Performance Reporting

Performance under the new ambulance response programme has been reported as being extremely challenging and has required wholescale organisational change requiring review of how calls are answered and responded to before dispatch and the resource deployed to each incident. North West Ambulance Service (NWAS) does not have comparative performance information and the standards cannot be compared like for like with the previous targets. In November 2017 the new reporting categories were introduced.

For information purposes the new categories are defined as below.

Category 1
Time critical and life threatening events requiring immediate intervention, such as cardiac arrest (heart stops) or respiratory arrest (the patient stops breathing); airway obstructions and ineffective breathing.
NWAS aim to respond to these calls within an average time of 7 minutes and at least 9 out of 10 times within 15 minutes.

Category 2
Potentially serious conditions that may require rapid assessment, urgent on-scene clinical intervention/treatment and / or urgent transport. These cases include patients such as those with non-life threatening breathing problems, patients with burns who have no life threatening symptoms.
NWAS aim to respond to these calls within an average time of 18 minutes and at least 9 out of 10 times within 40 minutes.

Category 3
Urgent problem (not immediately life-threatening) that requires treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.
NWAS aim to response to these calls within 120 minutes in 9 out of 10 cases.
Category 4 / 4H / 4Health Care Professionals (HCP)
Non urgent problem (not life-threatening) that requires assessment (by face to face or telephone) and possibly transport within a clinically appropriate timeframe. We aim to response to these calls within 180 minutes in 9 out of 10 cases.
These categories are grouped together within this report for brevity however they are technically independent with the following meanings.
CAT 4H: calls which following Ambulance Medical Priority Despatch System (AMPDS) coding are deemed appropriate for triage.
CAT 4HCP: Calls from a HCP where a response time of 1, 2, 3 or 4 hours has been agreed.

Reporting level	Organisation	Target	Dec	Jan	Feb	Mar	Apr
Category 1 Mean Performance	CCG	<=7 mins	00:09:11	00:08:22	00:06:34	00:07:11	00:08:04
Category 2 Mean Performance	CCG	<=18 mins	00:41:51	00:34:25	00:23:17	00:24:54	00:29:59

Mixed Sex Accommodation Breaches

Mixed Sex Accommodation Breaches (c)	Organisation	Target	Year End position	Performance (April - March)	No. of Breaches
Breaches of same sex accommodation	BCCG	0	17	↓	17
	Provider - BTH	0	13	↓	13
	Provider - Spire	0	0	↔	0

All of the seventeen (17) breaches which occurred for 2017/18 were due to the lack of suitable specialist beds being available following the decision to step down the patients care from the critical care unit. Six (6) of the mixed sex accommodation breaches occurred at Blackpool Teaching Hospitals, ten (10) at Lancashire Teaching Hospitals and one (1) at University Hospitals of Morecambe Bay. The CCG has been assured that the privacy and dignity of all the patients was maintained at all times.

Cancelled Operations (p)	Organisation	Target	Year End position	Performance (April - March)	No. of Breaches
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	96	↓	96

There have been ninety-six (96) cancelled operations for patients which have not been rescheduled to take place within 28 days reported at Blackpool Teaching Hospitals in 2017/18; this was due to the cancellation of elective activity within the hospital and reduced bed capacity due to winter pressures.

Mental Health (c)	Organisation	Target	Year End position	Performance (April - March)	No. of Excess Breaches
% of Mental Health patients on Care Programme Approach (CPA) discharged from hospital and followed up within 7 days	Provider - LCFT	≥ 95%	96.14%	↓	0

The % of Mental Health patients on a Care Programme Approach (CPA) discharged from hospital and followed up within 7 days has remained above target for the year 2017/18.

Dementia (c)	Organisation	National	Year End position	Performance (April - March)	No. of Excess Breaches
CCG's estimated prevalence for people over 65 with dementia against the CCG's actual dementia diagnosis rate	CCG	≥ 67%	79.57%	↓	0

The CCG's estimated prevalence for people over 65 with dementia against the CCG's actual diagnosis rate has remained significantly above target for the year 2017/18.

Incidence of Healthcare Associated Infection (c)	Organisation (assigned)	Threshold	Year End position	Performance (April - March)	No. of Excess Breaches
Incidence of MRSA bacteremia	CCG	0	2	↓	2
	Provider	0	1	↑	1
Incidence of Clostridium difficile* (CDI)	CCG	58 (2016/17)	45	↓	0
	BTH	40 (2016/17)	33	↓	0

* *Data source; Public Health England HCAI Monthly Reports, throughout 2017/18.*

The table above shows the breakdown by month and split between CCG and Trust apportioned cases of MRSA bacteraemia and Clostridium difficile infections (CDI).

Summary of C-Dlifficile– Blackpool CCG
There were forty-five (45) incidents of CDI attributed to Blackpool CCG for the year 2017/18. The CDI trajectory for Blackpool CCG for 2017/18 was 58 cases.

Clostridium difficile infections - Blackpool Teaching Hospitals NHS Foundation Trust
There were thirty-three (33) incidents of CDI attributed to Blackpool Teaching Hospitals for the year 2017/18. The CDI trajectory for Blackpool Teaching Hospitals for 2017/18 was 40 cases.

MRSA bacteraemia – Blackpool Clinical Commissioning Group
There have been two (2) incidents of MRSA bacteraemia reported for the year 2017/18 for Blackpool Clinical Commissioning Group patients.

MRSA bacteraemia - Blackpool Teaching Hospitals NHS Foundation Trust
There has been one (1) incident of MRSA bacteraemia reported for the year 2017/18 at Blackpool Teaching Hospitals.

Mental Health Improving Access to Psychological Therapies	Organisation	Expectation	Year End position	Performance (April - March)	No of Excess Breaches
IAPT access proportion rate (3.75% quarterly, suggested 1.25% monthly, yearly 16.8%)	CCG	16.8% Yearly trajectory	17.9%	↑	0
*IAPT recovery rate (50% monthly)	CCG	50%	51.00%	↑	0
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment	CCG	75% per month	94.00%	↑	0
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment.	CCG	95% per month	100%	↑	0

Waiting times and access proportion rates have consistently met targets for IAPT for the year 2017/18.

Aristotle Business Intelligence

Performance Scorecard

Metric	Level	Period	Target	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	March 2018	YTD
NHS Constitution measures																
Referral To Treatment waiting times for non-urgent consultant-led treatment																
62: Referral to Treatment (Non-Admitted)	CCG	March 18	95%	91.29%	90.74%	90.50%	89.10%	90.1%	89.41%	89.66%	89.06%	88.20%	85.39%	87.77%	86 95%	89.20%
1291: Referral to Treatment (Incomplete)	CCG	March 18	92%	90.43%	89.86%	89.39%	88.66%	88.40%	88.80%	88.88%	88.12%	86.20%	85.26%	83.95%	81.13%	87.99%
Diagnostic test waiting times																
1828: % of patients waiting 6weeks or more for a diagnostic test	CCG	March 18	1%	0.16%	0.74%	1.14%	0.74%	0.46%	0.39%	0.37%	0.54%	0.95%	0.68%	0.33%	0.82%	0.60%
Cancer waits – 2 Week Wait																
191: % Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY)	CCG	March 18	93%	94.17%	93.57%	94.39%	95.65%	93.12%	94.13%	94.25%	95.20%	94.81%	95.59%	96.92%	93.98%	94.58%
17: % of patients seen within 2weeks for an urgent referral for breast symptoms (MONTHLY)	CCG	March 18	93%	100.00%	96.23%	92.50%	80.43%	94.34%	97.44%	100.00%	100.00%	96.77%	100.00%	100.00%	97.50%	96.27%

Metric	Level	Period	Target	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	March 2018	YTD
NHS Constitution measures																
Cancer waits – 31 days																
535: % of patients receiving definitive treatment within 1month of a cancer diagnosis (MONTHLY)	CCG	March 18	96%	100.00%	95.65%	95.19%	89.89%	92.11%	96.15%	96.43%	97.83%	98.41%	100.00%	98.63%	98.57%	94.20%
26: % of patients receiving subsequent treatment for cancer within 31 days (Surgery) (MONTHLY)	CCG	March 18	94%	93.75%	90.91%	92.86%	100.00%	100.00%	94.44%	93.75%	100.00%	100.00%	90.91%	92.31%	100.00%	96.02%
1170: % of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY)	CCG	March 18	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
25: % of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) MONTHLY)	CCG	March 18	94%	100.00%	100.00%	100.00%	100.00%	95.65%	100.00%	100.00%	100.00%	100.00%	96.88%	100.00%	96.67%	99.03%
Cancer waits – 62 days																
539: % of patients receiving 1st definitive treatment for cancer within 2 months(62 days) (MONTHLY)	CCG	March 18	85%	80.77%	75.00%	74.36%	72.22%	85.71%	67.57%	68.89%	80.00%	90.32%	70.00%	76.47%	97.50%	77.98%
540: % of patients receiving treatment for cancer within 62days from an NHS Cancer Screening Service (MONTHLY)	CCG	March 18	90%	100.00%	90.91%	84.62%	52.38%	82.61%	100.00%	100.00%	100.00%	No data available	No data available	50.00%	100.00%	79.31%
541: % of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY)	CCG	March 18	85%	100.00%	93.33%	96.00%	78.95%	92.31%	80.00%	80.00%	95.65%	95.83%	76.47%	92.31%	94.74%	89.96%
Metric	Level	Period	Target	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	March 2018	YTD

NHS Constitution measures continued																	
Category A ambulance calls																	
Category 1 Mean Performance	CCG	March 18	<=7 mins									00:09:11	00:08:22	00:06:34	00:07:11	00:08:04	
Category 2 Mean Performance	CCG	March 18	<=18 mins									00:41:51	00:34:25	00:23:17	00:24:54	00:29:59	

Metric	Level	Period	Target	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	YTD
NHS Constitution support measures																
Mixed Sex Accommodation Breaches																
1067: Mixed sexaccommodation breaches - AllProviders	CCG	March 18	0	0	0	1	3	5	1	1	2	1	0	2	1	17
138: Proportion of patients on(CPA) discharged from inpatient care who are followed up within 7 days	CCG	QTR 4 2018	95%	96.26%			94.81%			96.84%			96.36%			96.14%
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	CCG	March 18	0	0	0	1	0	0	0	0	1	1	2	4	1	10
1928: 12 Hour Decision to Admit (DTA) waits inA&E	Hospital Provider (BTH)	March 18	0	5	0	0	0	0	1	2	16	75	106	30	63	266

Metric	Level	Period	Target	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	YTD

A&E waits															
1926: A&E Attendances: Type1	BTH	March 18	Actual	7,141	7,588	7,262	7,742	7,491	7,098	6,585	6,034	6,029	5,434	5,307	6,244	79,955
1927: A&E Attendances: All Types	BTH	March 18	Actual	16,667	16,941	16,759	17,849	17,250	16,610	18,125	16,533	17,079	16,534	15,556	18,092	203,995

CCG Improvement and Assessment Framework

The NHS England CCG Improvement and Assessment Framework below provides a summary of Blackpool CCG against the appropriate indicators.

CCG Summary Dashboard

NHS Blackpool CCG

2016/17 Year End Rating: **Good**

Better Health

			Period	CCG		Peers	England	Trend
R	102a	% 10-11 classified overweight /c	2013/14 to 2015/16	38.0%	↑	8/11	178/207	
	103a	Diabetes patients who achieved	2015-16	44.0%	↓	3/11	13/207	
	103b	Attendance of structured educa	2014	1.9%	↓	9/11	153/207	
R	104a	Injuries from falls in people 65y	16-17 Q4	1,862	↓	2/11	94/207	
R	105b	Personal health budgets	17-18 Q1	18	↑	6/11	58/207	
R	106a	Inequality Chronic - ACS & UCSC	16-17 Q4	4,335	↓	11/11	207/207	
R	107a	AMR: appropriate prescribing	2017 06	1.310	↓	8/11	204/207	
R	107b	AMR: Broad spectrum prescribi	2017 06	4.9%	↓	1/11	4/207	
	108a	Quality of life of carers (not available)						

Sustainability

			Period	CCG		Peers	England	Trend
R	141b	In-year financial performance	17-18 Q1	Amber	↓			
R	144a	Utilisation of the NHS e-referral	2017 06	83.0%	↓	2/11	22/207	

Leadership

			Period	CCG		Peers	England	Trend
R	162a	Probity and corporate governan	17-18 Q1	Fully Compliant	↔			
	163a	Staff engagement index	2016	3.79	↓	7/11	110/207	
	163b	Progress against WRES	2016	0.16	○	10/11	166/207	
	164a	Working relationship effectiven	16-17	73.93	↓	3/11	53/207	
	166a	CCG compliance with standards of public and patient participation (not available)						
R	165a	Quality of CCG leadership	17-18 Q1	Green	↔			

Key

	Worst quartile in England
	Best quartile in England
	Interquartile range

Better Care

			Period	CCG		Peers	England	Trend
R	121a	High quality care - acute	17-18 Q1	61	↑	7/11	61/207	
R	121b	High quality care - primary care	17-18 Q1	71	↑	1/11	6/207	
R	121c	High quality care - adult social c	17-18 Q1	64	↓	1/11	28/207	
	122a	Cancers diagnosed at early stag	2015	41.7%	↓	11/11	205/207	
	122b	Cancer 62 days of referral to tre	16-17 Q4	79.3%	↓	9/11	129/207	
	122c	One-year survival from all cance	2014	68.1%	↑	9/11	173/207	
R	122d	Cancer patient experience	2016	8.8	↑	6/11	58/207	
R	123a	IAPT recovery rate	2017 06	43.8%	↑	9/11	187/207	
R	123b	IAPT Access	2017 07	3.2%	↓	2/11	57/207	
R	123c	EIP 2 week referral	2017 08	75.0%	↑	9/11	125/207	
	123d	MH - CYP mental health (not available)						
	123f	MH - OAP (not available)						
	123e	MH - Crisis care and liaison (not available)						
R	124a	LD - reliance on specialist IP car	17-18 Q1	85	↑	11/11	193/207	
	124b	LD - annual health check	2015-16	34.2%	○	9/11	132/207	
	124c	Completeness of the GP learning disability register (not available)						
R	125d	Maternal smoking at delivery	17-18 Q1	24.9%	↓	11/11	208/207	
	125a	Neonatal mortality and stillbirth	2015	5.4	○	7/11	147/207	
	125b	Experience of maternity service:	2015	77.1	○	10/11	155/207	
	125c	Choices in maternity services	2015	62.1	○	8/11	166/207	
R	126a	Dementia diagnosis rate	2017 08	80.0%	↑	4/11	23/207	
	126b	Dementia post diagnostic suppo	2015-16	80.0%	↑	3/11	70/207	
R	127b	Emergency admissions for UCS (	16-17 Q4	3,207	↓	4/11	183/207	
R	127c	A&E admission, transfer, discha	2017 09	83.9%	↑	10/11	177/207	
R	127e	Delayed transfers of care per 10	2017 08	16.5	↑	7/11	159/207	
R	127f	Hospital bed use following emer	16-17 Q4	584.8	↑	7/11	180/207	
	105c	% of deaths with 3+ emergency admissions in last three months of life (not available)						
R	128b	Patient experience of GP service	2017	87.0%	↑	4/11	61/207	
	128c	Primary care access (not available)						
R	128d	Primary care workforce	2017 03	0.96	↓	4/11	106/207	
R	129a	18 week RTT	2017 08	88.4%	↓	9/11	145/207	
	130a	7 DS - achievement of standards (not available)						
R	131a	% NHS CHC assesments taking p	16-17 Q4	38.5%	○	2/11	76/207	
	132a	Sepsis awareness (not available)						

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Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Ruth Henshaw, Development Delivery Officer
Date of Meeting:	11 July 2018

ANNUAL COUNCIL PLAN PERFORMANCE REPORT 2017-2018

1.0 Purpose of the report:

1.1 To present performance against Priority 2 of the Council Plan 2015-2020 for the period 1 April 2017 – 31 March 2018.

2.0 Recommendation(s):

2.1 To comment upon progress being made, propose potential improvements and consider whether any areas would benefit from further scrutiny.

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?	Yes
3.3	Other alternative options to be considered:	N/A

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience".

5.0 Background information

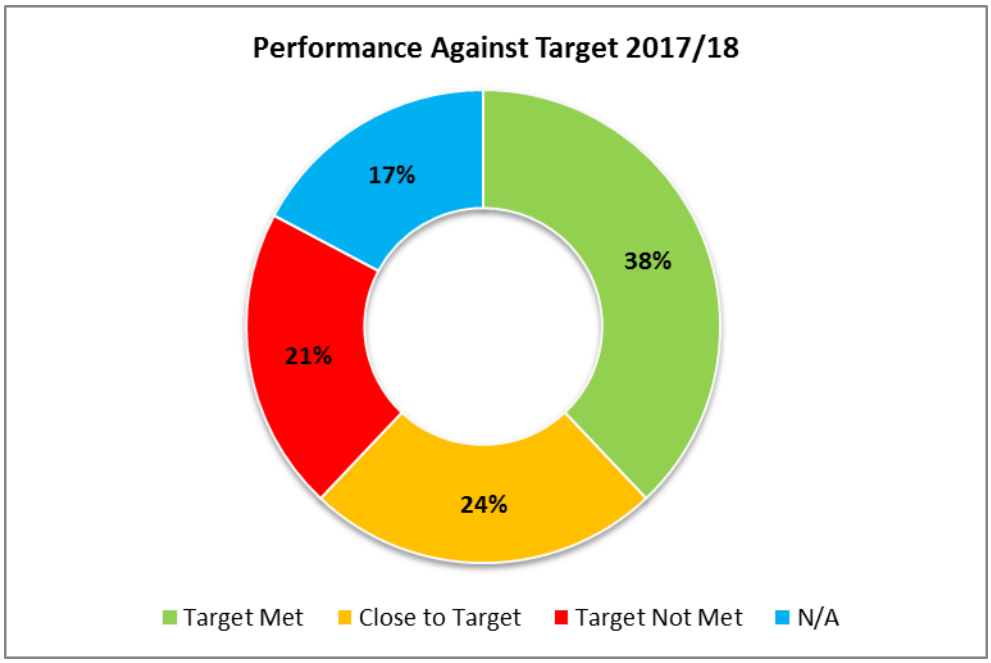
5.1 The list of corporate performance indicators covers a wide range of service areas that link directly with the Council's vision and priorities. The measurement of performance across these key areas enables the organisation to monitor the direction of travel, and

more accurately focus on, specific services and outcomes that determine the success of Blackpool as a place to live and visit.

6.0 Overview of Performance

6.1 There are 30 performance indicators in Priority 2 which fall within the remit of the Committee. Data is available for 29 of these indicators (please see **Appendix 5(a) – End of Year (EoY) 2017-2018 Key Performance Indicators (KPI) Summary**).

6.2 The chart below shows the direction of travel when performance is compared with the annual targets for 2017-2018.



6.3 Five indicators have no annual targets and therefore it was not possible to compare performance. Of the remaining indicators, the majority achieved their annual targets.

6.4 There are seven indicators where performance has deteriorated compared with 2016-2017 and/or the annual target has not been achieved. Further information on these indicators can be found in **Appendix 5(b) – EoY 2017-2018 Exception Reports**.

6.5 In terms of performance for the Priority 2 outcomes relevant to this Committee:

- Performance around Adult Social Care is good, with areas such as service users in receipt of a community based service, admissions into residential care and reablement / rehabilitation services performing well.

- Public Health performance is mixed. Half of the indicators, including those

around sexual health, new birth visits and waiting times for alcohol / drug treatment services have achieved their annual targets. The remaining indicators are showing less favourable performance.

6.6 As well as monitoring performance against the corporate outcomes, the Performance and Delivery team have produced an overarching position statement for Priority 2 which focuses on the wider Blackpool outcomes which the Council's work should ultimately influence (see **Appendix 5(c) – Priority 2 Context and Outcomes**).

6.7 The indicators included in the position statement provide population context and show performance against longer-term strategic outcomes, with some datasets using data from previous years. Changes in these outcomes take time and the impact of even large scale local interventions can be negated or reversed by a combination of national policy and economic conditions. These indicators therefore cannot be considered as corporate KPIs, as the Council is not solely or mainly responsible for influencing performance.

7.0 Performance Framework 2018-2019

7.1 As part of the current review of the Council Plan, the set of corporate performance indicators has been revised from over 100 indicators to a much smaller set of headline performance indicators (see **Appendix 5(d) – Headline KPIs 2018-2019**). These indicators relate directly to corporate objectives and are designed to provide a short, focused sweep of performance across the core business of the Council. Also included, are a number of headline indicators relating to the performance of the wholly owned companies, as these companies make crucial contributions to the delivery of our corporate objectives.

7.2 Sitting underneath the headline KPI's are a structured suite of supporting performance indicators which give context and challenge to the headline indicators, and will be monitored and presented to the relevant boards / committees to support effective, evidence-based decision making.

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 5(a) - EoY 2017-2018 KPI Summary
Appendix 5(b) - EoY 2017-2018 Exception Reports
Appendix 5(c) – Priority 2 Context & Outcomes
Appendix 5(d) – Headline KPIs 2018-2019

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

Appendix 5(a) - End of Year 2017-2018 KPI Summary

Performance as at 31st March 2018

KEY:			
☺	Performance is improving	**DoT**	Direction of Travel
😐	Small change in performance	**A**	Annual
☹	Performance is deteriorating	**N/A**	Not Applicable

Priority 2: Communities - create strong communities and increase resilience

Cabinet Secretary for Adult Social Care and Health														
	Indicator	**Outturn 2014/15**	**Outturn 2015/16**	**Outturn 2016/17**	**DoT 2014/15 v 2016/17**	**Q1 17/18**	**Q2 17/18**	**Q3 17/18**	**Q4 17/18**	**Outturn 2017/18**	**DoT Previous Performance**	**Target**	**DoT Against Target**	**Notes**
	Overall satisfaction of people who use services with their care and support	68%	68%	74%	☺	**A**	**A**	**A**	**69.4%**	**69.4%**	😐	**75%**	😐	There has been a small reduction in satisfaction compared with 2016/17, meaning the annual target has not been achieved. However, performance over the last 5 years has been consistently better than both national and regional averages.
	Social care-related quality of life	19.2	19.3	20	☺	**A**	**A**	**A**	**19.4**	**19.4**	😐	**20.2**	😐	Maximum score is 24. Performance has deteriorated slightly compared with 2016/17 and the annual target has not been achieved. However, performance conitnues to be better than both national and regional averages.
	Number of carers receiving a carer's assessment	561	698	954	☺	**257**	**482**	**681**	**938**	**938**	😐	**1,000**	😐	The number of carers receiving an assessment has decreased slightly compared with 2016/17 and the annual target has not been achieved.
	Proportion of service users with a completed review in year	54.8%	48.5%	68.4%	☺	**25%**	**43.6%**	**64.5%**	**81.5%**	**81.5%**	☺	**70%**	☺	The annual target has been achieved and performance has improved compared with 2016/17.
	Delayed Transfers of Care - delays which are attributable to Adult Social Care (only)	New PI			N/A	**6.0 per 100,000 pop.**	**6.0 per 100,000 pop.**	**6.3 per 100,000 pop.**	**5.9 per 100,000 pop.**	**5.9 per 100,000 pop.**	**New PI**	***No Target Set***	**N/A**	Average number of delayed transfers of care each day reported as a rate per 100,000 population (18+). National targets are set through the Better Care Fund but these have not been updated in line with the new DToC measures. Performance is below the England average (4.4) but better than the regional average (6.3).

Cabinet Secretary for Adult Social Care and Health

	Indicator	Outturn 2014/15	Outturn 2015/16	Outturn 2016/17	DoT 2014/15 v 2016/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Outturn 2017/18	DoT Previous Performance	Target	DoT Against Target	Notes
Adult Social Care	Delayed Transfers of Care - delays which are jointly attributable to Health and Social Care	New PI			N/A	**0.8 per 100,000 pop.**	**0.9 per 100,000 pop.**	**1.5 per 100,000 pop.**	**1.4 per 100,000 pop.**	**1.4 per 100,000 pop.**	**New PI**	***No Target Set***	**N/A**	National targets are set through the Better Care Fund but these have not been updated in line with the new DToC measures. Performance is slightly higher than the England and North West averages (0.9).
	Proportion of service users in receipt of a community based service	78.9%	72.8%	70.5%	☹	**70.6%**	**71.5%**	**71.5%**	**71.8%**	**71.8%**	☺	**73%**	😐	Performance has improved compared with 2016/17 but the annual target has been narrowly missed.
	Permanent admissions of people (18-64) to residential and nursing care homes per 100,000 population	17.8 per 100,000 pop.	19.2 per 100,000 pop.	19.4 per 100,000 pop.	☹	**0.0**	**3.7**	**7.3**	**14.6**	**14.6 per 100,000 pop.**	☺	**19.2 per 100,000 pop.**	☺	Data subject to external validation. Performance has improved compared with 2016/17 and the annual target has been exceeded.
	Permanent admissions of older people (65+) to residential and nursing care homes per 100,000 population	876.5 per 100,000 pop.	983.1 per 100,000 pop.	928 per 100,000 pop.	☹	**291.2**	**396.5**	**614.1**	**889.4**	**889.4 per 100,000 pop.**	☺	**925 per 100,000 pop.**	☺	Data subject to external validation. Performance has improved compared with 2016/17 and the annual target has been exceeded.
	Proportion of older people who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation	78.6%	78.1%	83.9%	☺	**A**	**A**	**A**	**90.4%**	**90.4%**	☺	**85%**	☺	Performance has improved compared with 2016/17 and the annual target has been achieved.
	Proportion of older people (65+) offered reablement services following a discharge from hospital	1.8%	1.9%	2.8%	☺	**A**	**A**	**A**	**Data available end of June**			**3.5%**		
	Proportion of people using Adult Social Care who receive Direct Payments	16.6%	21.6%	22.5%	☺	**21.6%**	**21.9%**	**21.7%**	**24%**	**24%**	☺	**23%**	☺	Data subject to external validation. Performance has improved compared with 2016/17 and the annual target has been achieved.
	Proportion of Adults with Learning Disabilities in paid employment	4.4%	5.5%	4.9%	☺	**3.4%**	**3.9%**	**4%**	**4.4%**	**4.4%**	😐	**5%**	😐	Data subject to external validation. Performance has worsened slightly compared with 2016/17 and the annual target has not been achieved.
	No. of Deprivation of Liberty Safeguarding Applications	346	573	800	N/A	**225**	**205**	**229**	**223**	**882**	**N/A**	***No Target Set***	**N/A**	There has been an increase in applications compared with 2016/17. This is in line with the national trend. No annual target set as performance in this area is demand led.
	No. of Deprivation of Liberty Safeguarding Authorisations	282	530	688	N/A	**179**	**172**	**191**	**193**	**735**	**N/A**	***No Target Set***	**N/A**	There has been an increase in authorisations compared with 2016/17. This is in line with the national trend. No annual target set as performance in this area is demand led.

Cabinet Secretary for Adult Social Care and Health

	Indicator	Outturn 2014/15	Outturn 2015/16	Outturn 2016/17	DoT 2014/15 v 2016/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Outturn 2017/18	DoT Previous Performance	Target	DoT Against Target	Notes
	No. of Deprivation of Liberty Safeguarding's in place at end of period	163	365	494	N/A	**521**	**566**	**573**	**591**	**591**	**N/A**	***No Target Set***	**N/A**	There has been an increase in DoLS in place compared with 2016/17. This is in line with the national trend. No annual target set as performance in this area is demand led.
Public Health	Number of opiate drug users successfully completing treatment	New PI			N/A	**19**	**30**	**41**	**37**	**127**	**New PI**	**200**	☹	Annual target has not been achieved. Please see **App 5(b) - Exception Reports** for more details. New service contract commenced Apr 2017 so cannot compare performance with previous years.
	Number of non-opiate drug users successfully completing treatment	New PI			N/A	**10**	**11**	**21**	**10**	**52**	**New PI**	**200**	☹	Annual target has not been achieved. Please see **App 5(b)- Exception Reports** for more details. New service contract commenced Apr 2017 so cannot compare performance with previous years.
	Proportion waiting more than 2 weeks for drug treatment	New PI			N/A	**0**	**0**	**0**	**0**	**0**	**New PI**	**0 clients waiting**	☺	Local provider data is used for this PI. New service contract commenced Apr 2017 so cannot compare performance with previous years.
	Number of takeaway establishments signed up to Healthier Choices Award	New PI		13	N/A	**36**	**18**	**19**	**14**	**87**	☺	**75**	☺	Annual target has been achieved and performance has improved considerably compared with 2016/17.
	% of Long Acting Reversable Contraception (LARCS) fitted in under 18s that attend sexual health services	New PI	49.3%	45%	☹	**45.6%**	**48%**	**50%**	**51%**	**49%**	☺	**>38%**	☺	Performance has improved compared with 2016-2017 and the annual target has been achieved.
	Chlamydia testing coverage rate 15-24 (number of chlamydia tests reported)	New PI	26.9%	38.6%	☺	**28.8%**	**30.2%**	**30%**	**28.5%**	**29.4%**	☹	**>30%**	😐	Performance has worsened compared with 2016-2017 but the annual target was only narrowly missed. Please see **App 5(b) - Exception Reports** for more details.
	People taking up an NHS Health Check invite per year	73.1%	43.1%	33.9%	☹	**58%**	**57.1%**	**56.5%**	**Data available Jun 2018**		☹	**Maintain 75%**	☹	End of year data not available until June, however it is unlikely that the annual target will be achieved. Please see **App 5(b) - Exception Reports** for more details.
	% HIV late diagnosis	New PI	33%	36%	☹	**33%**	**A**	**A**	**A**	**33%**	☺	**>30%**	😐	
	% of school milk ordered that is fluoridated	New PI		75.8%	N/A	**71.3%**	**72.5%**	**74%**	**70.6%**	**72%**	😐	**Maintain above 70%**	☺	Performance has worsened slightly compared with 2016-2017, however the annual target has been achieved.

Cabinet Secretary for Adult Social Care and Health													
	Indicator	Outturn 2014/15	Outturn 2015/16	Outturn 2016/17	DoT 2014/15 v 2016/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Outturn 2017/18	DoT Previous Performance	Target	DoT Against Target	Notes
	Number of successful smoking quitters at 4 weeks	1,064	686	842	☹	**146**	**42**	**10**	**Data available Jun 2018**		☹	**686**	☹	End of year data not available until June, however the annual target will not be achieved. Please see **App 5(b) - Exception Reports** for more details.
	Number of staff completing MECC e-learning module in Year 1	New PI			N/A	**50**	**18**	**10**	**3**	**81**	**New PI**	**300**	☹	The annual target has not been achieved depsite being revised to reflect that it is a non-mandated iPool module. Please see **App 5(b) - Exception Reports** for more details.
	Number of successful alcohol treatments (structured interventions)	New PI			☺	**56**	**73**	**78**	**46**	**253**	**New PI**	**500**	☹	Annual target has not been achieved. Please see **App 5(b) - Exception Reports** for more details. New service contract commenced Apr 2017 so cannot compare performance with previous years.
	Proportion waiting more than 2 weeks for alcohol treatment	New PI	0 clients waiting	0 clients waiting	☺	**0**	**0**	**0**	**0**	**0**	☺	**0 clients waiting**	☺	Local provider data is used for this PI. New service contract commenced Apr 2017 so cannot compare performance with previous years.
	Proportion of completed new birth visits by the Health Visiting Service	New PI	96.8%	96.2%	😐	**97.3%**	**96.3%**	**97.5%**	**98.0%**	**97.3%**	☺	**95%**	☺	Performance has improved compared with 2016-2017 and the annual target has been achieved.

PUBLIC HEALTH

Indicator Description	Better to be?
Number of drug users successfully completing treatment	High

	2017/18					Target
	Q1	Q2	Q3	Q4	EoY	
Opiates	19	30	41	37	**127**	**200**
Non-opiates	10	11	21	10	**52**	**200**

Commissioner Response:

Performance for both opiate and non-opiate drug completions is below the annual targets. However, the numbers of opiate users successfully completing treatment has continued to increase compared with Quarter 1 2017-2018 when the new Horizon service commenced. The reasons for this are:

- The new service is retaining people in treatment and maintaining abstinence. There is a different phasing of programmes and this means that the recording of a completion for structured treatment is done at a later stage than previously. In 2018-2019, the service will be recording completions when clients finish the structured treatment intervention, rather than when the recovery journey is completed.
- A more in-depth analysis of data by the provider is showing that non-opiate use is part of a poly-using pattern, with alcohol being the primary substance. This means that for recording purposes the non-opiate clients/outcomes are often included within the reported figures for successful alcohol treatment completions. This is attributed to be the main reason for a reduction in the number of non-opiate clients in recorded as in treatment and completing treatment successfully.
- In previous years national data has been collated to monitor performance against the business plan. This data was based on a rolling 12 month figure. For 2017-2018 the data source has changed and local data is now being utilised to monitor performance.
- There appears to be significant discrepancies in data reported by the previous provider. Having looked at the previous provider's submitted data, there is a discrepancy between the national Quarter 4 rolling figure (for 2016-2017) and the local figure for this same period. Taking these points into account it would appear that the baseline target set for the new provider in 2017-2018 was overly ambitious as it has been based on previously inaccurate local data. The local data from the new provider does reflect the nationally reported data and Blackpool is in line with the national average.
- National reporting of drug and alcohol treatment only concentrates on the Tier 3 subset of treatment (structured interventions of 12 weeks or more) whilst local reporting includes Tier 2 treatment delivery (interventions of under 12 weeks duration). Commissioners are currently in discussion with Public Health England in relation to recording all structured interventions nationally, irrespective of whether they are Tier 2 or Tier 3. This will mean that the reported treatment figures will change.

App 5 (b) - Exception Reports (End of Year 2017-2018)

Indicator Description	Better to be?
Chlamydia testing coverage rate 15-24 year olds	High

2015/16	2016/17	2017/18					Target
		Q1	Q2	Q3	Q4	EoY	
26.9%	38.6%	28.8%	30.2%	30%	28.5%	**29.4%**	**>30%**

Commentary:

Chlamydia screening activity has been investigated by the service this year due to a significant dip in performance reported on CTAD (the national reporting system). Data quality issues in lab submissions to CTAD were identified, with tests for the Connect Young People Service being miscoded and therefore not being picked up following submission.

The chlamydia screening activity, using locally reported data, is very marginally under target. The service have an action plan in place to improve on the chlamydia screening figures going forward so it is anticipated that there will be an improvement in Q1 2018-2019 reported activity.

Indicator Description	Better to be?
People taking up an NHS Health Check invite per year	High

2015/16	2016/17	2017/18					Target
		Q1	Q2	Q3	Q4	EoY	
43.1%	33.9%	58%	57.1%	56.5%	*Data available Jun 2018*		**Maintain 75%**

Commentary:

The figures represent the proportion of people invited for an NHS Health Check taking one up since the 1st April 2013.

To achieve the national target of 75% by March 2018, the uptake of health checks must be maintained at 75% or above in each period. Although Blackpool is below this national target, the attainment at each quarter in 2017/18 has been higher than the uptake both in the North West and England.

	Q3 2017/18
Blackpool	56.5%
North West	50.8%
England	48.5%

App 5 (b) - Exception Reports (End of Year 2017-2018)

Indicator Description	Better to be?
Number of successful smoking quitters at 4 weeks	High

2015/16	2016/17	2017/18					Target
		Q1	Q2	Q3	Q4	EoY	
686	842	146	42	10	*Data available Jun 2018*		**686**

Commentary:

Performance in Quarter 3 is much lower than the previous quarter and for the same period over the previous 3 years. This is due to the decommisioning of the specialist stop smoking service. The service ceased from the end of Quarter 2 but had stopped taking new referrals from the end of Quarter 1 to allow any new patients at that point to receive a full service. We also had a pause in provision between the end of the specialist stop smoking service contract and the interim arrangement we now have in place, provided by community pharamcies and some GP practices.

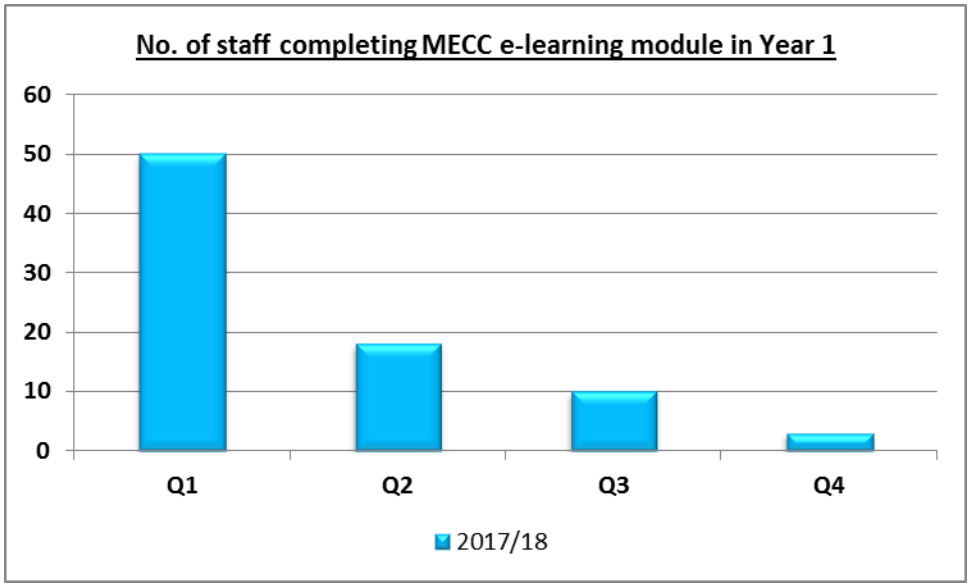
Although the numbers are now lower, we do expect to see these increase in Quarter 4 as the interim service in pharmacies and GPs advances. In the new interim service, payments are only made to the service on Carbon Monoxide verified quits whereas in the previous specialist service a number of the quits recorded were not CO verified (some were self-reported quits). With the interim service, although numbers will be lower, we can be assured that they are verified quits.

Work is underway to develop a new stop smoking model which will meet the needs of Blackpool residents. This new model is currently awaiting approval from the relevant commitees. Once the new model is approved, new targets will be introduced and it is expected that the number of successful smoking quitters at 4 weeks will increase significantly.

App 5 (b) - Exception Reports (End of Year 2017-2018)

Indicator Description	Better to be?
Number of staff completing Making Every Contact Count (MECC) e-learning module in Year 1	High

2017/18					Target
Q1	Q2	Q3	Q4	EoY	
50	18	10	3	**81**	**300**



Service Response:

It has been recognised that the uptake of the MECC training is much lower than expected.

There are now a number of interventions underway to improve performance. A campaign will be rolled out to promote the concept of MECC, with the aim of gaining 'buy-in' to the MECC model from staff. We then anticipate an increased uptake of the e-learning module. The campaign will involve attending Directorate Management Teams (DMTs) to deliver a presentation on MECC – demonstrating what MECC is, how it can fit into everyone's day to day roles and the benefits of delivering MECC to the individual, their own families and the wider community. The campaign will also include promotional posters and electronic information through a range of channels aimed at Blackpool Council staff and volunteers.

The first presentation was delivered at Adult Services DMT in February 2018, with the campaign materials also launching at the same time. Following this, some meeting dates have been booked in with individual teams within Adult Services. Dates are now to be set with other DMTs to promote the programme. We hope to see an increase in activity in Quarter 1 of 2018/19 as a result of this work.

App 5 (b) - Exception Reports (End of Year 2017-2018)

Indicator Description	Better to be?
Number of successful alcohol treatments (structured interventions)	High

2017/18					Target
Q1	Q2	Q3	Q4	EoY	
56	73	78	46	**253**	**500**

Service Response:

Performance for the number of successful alcohol completions is below the annual target. The reasons for this are:

- The new service is retaining people in treatment and maintaining abstinence. There is a different phasing of programmes and this means that the recording of a completion for structured treatment is done at a later stage than previously. In 2018/19, the service will be recording completions when clients finish the structured treatment intervention, rather than when the recovery journey is completed.
- In previous years national data has been collated to monitor performance against the business plan. This data was based on a rolling 12 month figure. For 2017/18, the data source has now changed and local data is being utilised to monitor alcohol treatment completions. Having looked at the previous provider's submitted data there is a discrepancy between the national Quarter 4 rolling data (for 2016/17) and the local figure for this same period.
- Taking these points into account it would appear that the baseline target set for the new provider in 2017/18 was overly ambitious as it has been based on previously inaccurate local data.
- The local data from the new provider does reflect the nationally reported data and Blackpool is in line with the national average.

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Appendix 5(c): Priority 2 – Context and Outcome Indicators

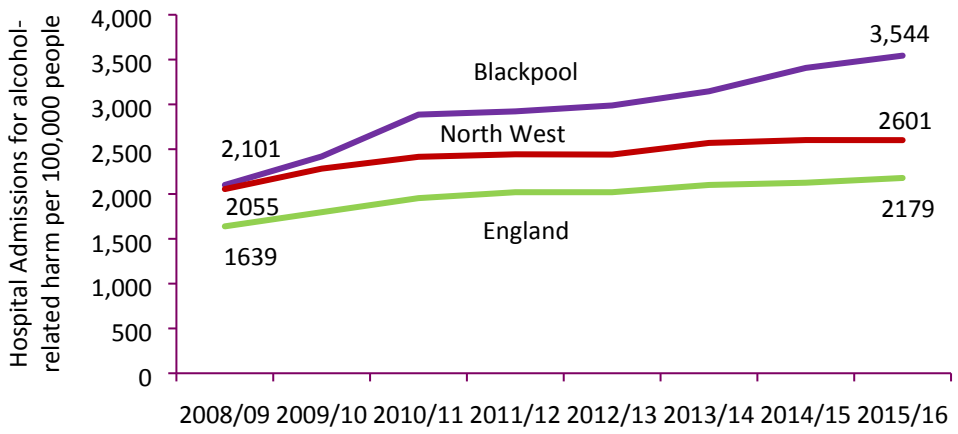
Indicator	Blackpool Value & Comparable	Regional Comparison	National Comparison	Commentary on trends, ranks or rates of change
Well–being (2016/17)				Well-being looks at the positive and negative aspects of people's lives. Well-being can reflect the nature of individual opportunities and community cohesion.
High Life Satisfaction "Overall, how satisfied are you with life nowadays?" (% scoring 7-10)	76.1	79.7	81.7	Life Satisfaction has been improving since 2014/15. High Life Satisfaction in Blackpool increased 2%pp in 2016/17, whereas the national average only grew 0.5% pp.
High General Happiness "Overall, how happy do you feel nowadays?" (% scoring 7-10)	71.8	73.7	75.2	Despite a small, but consistent, deficit compared to regional and national estimates, Blackpool's self-reported 'happiness' score has gradually increased over time. However, there was no change in high general happiness in Blackpool from 2015/16 to 2016/17.
Health and Social Care				
Life Expectancy in Years [Male and Female combined] (2012/14)	77.3	80.0	81.4	Female life expectancy has remained broadly steady since 2008–2010 though decreased slightly in 2012–2014. Male life expectancy in Blackpool has increased at a steady rate since 2009–2011. The gap between males and females is 5.2 years.
Childhood Obesity [%] (2016/17)	21.1	20.8	20.0	This measure of obesity is those who had a BMI greater than or equal to the 95th percentile of the UK90 growth reference. Childhood Obesity decreased for the first time in five years.
Emergency Admissions for Alcohol Abuse [per 100,000 people] (2015/16)	3,544	2,601	2,179	Hospital admissions due to alcohol abuse have kept increasing since 2008/09, the rate of admissions due to alcohol consumption is still 62.6% higher than the national average.
% aged 16+ participating in at least 30 minutes of sport at moderate intensity at least once a week (2015/16)	28.0	35.7	35.6	Blackpool's participation rates increased 2% pp, following a 6.3% pp drop the previous year.
Looked after Children [rate per 100,000 aged under 18] (2016/17)	184	86	62	The number of looked after children has increased over 15% since 2015/16 both nationally and regionally and remains over double the national average.

Indicator	Blackpool Value & Comparable	Regional Comparison	National Comparison	Commentary on trends, ranks or rates of change
Mortality Rate from Causes Considered Preventable [per 100,000 people] (2014/16)	316.1	223	182.8	The gap in preventable Mortality Rates has widened nearly 16% from the national average from 2012-2014 to 2014-2016. The preventable Mortality Rate for Blackpool is at its highest since 2008-2010.
Housing Quality				
Rate of homelessness acceptances per 1,000 households (2016/17)	0.8	1.5	2.5	Blackpool's rate of homelessness acceptances has fallen in contrast to the regional and national picture.
Known Private Sector Homes with Category 1 Hazards [rate per 1,000] (2015/16)	144		20	A category 1 hazard is an assessment where housing issues are of life threatening or serious nature. At present, Blackpool has 7 times the rate of private sector homes with category 1 issues than the national average, in part reflecting more inspection activity in Blackpool but also suggesting a high amount of poor quality stock.
Education				
Key Stage 2 Pupils Reaching Expected Attainment Score [%] (2017)	62	61	61	In Blackpool there was a 29.2% increase in KS2 pupils reaching their expected attainment for reading, writing and mathematics from 2016 to 2017, which was nearly double the increase seen nationally and regionally.
GCSE Attainment 8 Average Score per Pupil (2016/17)	38.2	45.3	44.2	Attainment 8 measures a student's average grade across eight subjects. Blackpool's average score per pupil dropped in line with the regional and national trend.
Adults Educated to an NVQ4 level or above [%] (2016)	25.7	34	38.2	Across Great Britain, the proportion of NVQ4 level or above residents increased, with a 3.8%pp increase in Blackpool from 2015 to 2016.

Indicator	Blackpool Value & Comparable	Regional Comparison	National Comparison	Commentary on trends, ranks or rates of change
Crime				
Violent Crime Rate [per 1,000 population] (2015/16)	36.7	17.6	17.2	Blackpool has the highest rate of violent crime in the North West. Violent crime rose at a comparable rate to the national average but nearly 10% lower than the North West average.
Children in the Youth Justice System (10–18 years old) [per 1,000 population] (2015/16)	9.5	5.8	5	Levels have remained the same in Blackpool from the previous year, whereas nationally and regionally, the number of children in the Youth Justice System has fallen year–on–year.
Re–offending Levels [%] (2014)	29.1	26.2	25.4	Re–offending levels have remained consistent following a decrease from 2011 to 2013.
Democracy (2017)				
Voter Participation (%)	63.0	68.0	69.1	Blackpool and the North West experienced around a 2% pp drop in voter turnout between the EU Referendum and the latest National Election, half the drop of the national average.
Environment				
C02 Emissions per Capita (tonnes) (2015)	3.8	4.7	4.8	Since 2012, emissions have dropped nationwide, emissions at all levels dropped between 0.2–0.3 tonnes from 2014.
Household Waste Recycled or Composted [%] (2016/17)	33.5	45.6	42.8	There was a sharp decrease in the percentage of household waste being recycled or composted in Blackpool, with a 25.7% decrease. This trend continued in the North West with a 0.9% decrease, this contrasted with the national average, with a 1.0% increase.

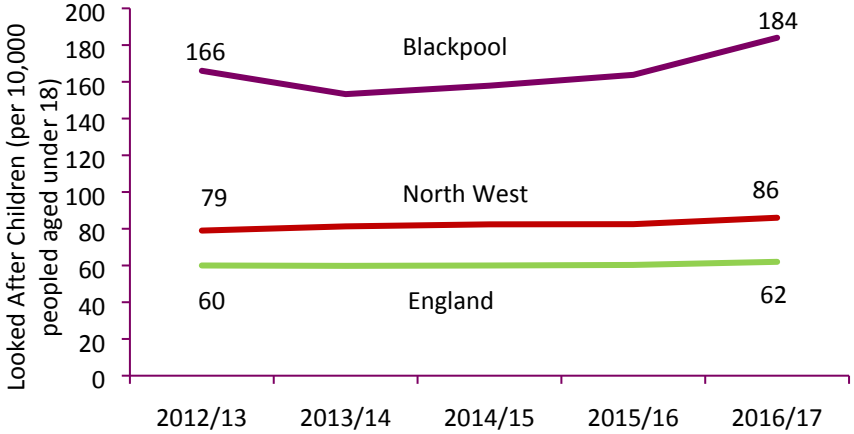
Indicator	Blackpool Value & Comparable	Regional Comparison	National Comparison	Commentary on trends, ranks or rates of change
Deprivation and Social Mobility				
Population Living in the 20% Most Deprived Areas [%] (2015)	49.6	31.9	20.2	Blackpool was ranked 2nd in Lancashire and 5th in the North West for the proportion of the population living in the 20% most deprived areas.
Index of Multiple Deprivation Rank (IMD) (2015)	1st			Blackpool's ranking dropped from 6th to 1st (Rank of average LSOA score) between 2010 and 2015.
Social Mobility Index Rank (2017)	313th			Blackpool was ranked 313 from 324 local authorities. A higher rank indicates a lower level of social mobility.
Transport (2013/15)				
People Killed or Seriously Injured (KSI) on the Roads (per 100,000 people)	43.4	39.4	38.5	People killed or seriously injured in Blackpool increased slightly from the previous time period, this differed from the North West and England as a whole, where the KSI rate decreased.

Trend – Hospital Admissions for Alcohol-related Harm



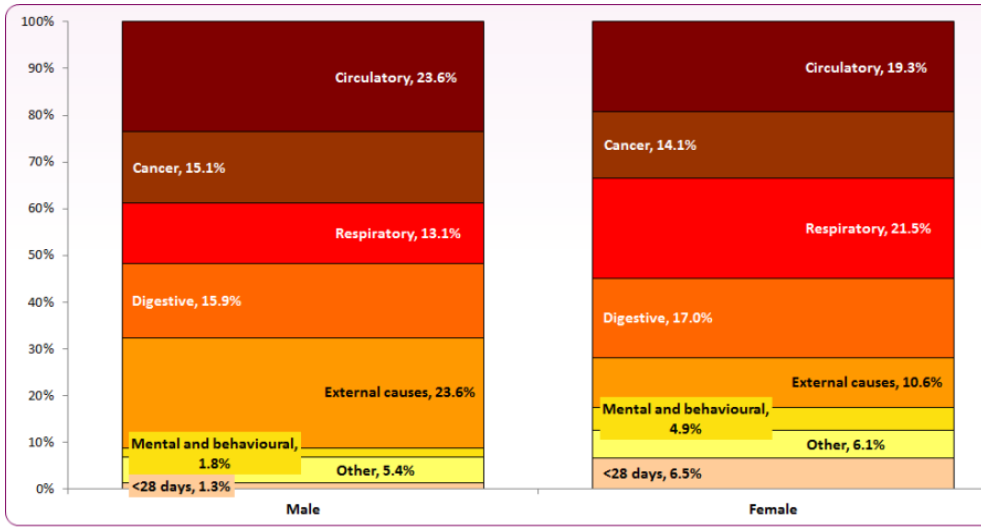
Alcohol-related harm remains a significant and substantial health problem in Blackpool and has increased dramatically between 2008 to the present, while national levels have remained broadly steady in recent years.

Trend – Looked after Children



The Department of Education data shows the majority of children (61%) are looked after due to an initial need stemming from abuse or neglect. Most of the increase in numbers is due to more females starting to be looked after. However, more males (56%) require to be looked after than females (44%).

Scarf Chart showing the breakdown of the life expectancy gap between Blackpool as a whole and England as a whole, by cause of death, 2012-2014



Deprivation Rankings for Blackpool – 2015 – all domains

Indices of Deprivation Domain	Rank of Average Score	Rank of ar in most deprived 1
Index of Multiple Deprivation	1	7
Income	3	9
Employment	2	7
Education and Skills	17	24
Health Deprivation and Disability	1	4
Crime	9	7
Barriers to Housing and Services	326	264
Living Environment	23	20
Additional Indices		
Income Deprivation affecting Children	9	11
Income Deprivation affecting Older People	21	34

The key causes of shorter life expectancy in Blackpool are deaths from external causes (especially in males), cardio-vascular disease (CVD), respiratory disease (especially chronic obstructive airways disease in females), diseases of the digestive system and cancer. Deaths in younger people contribute to a larger proportion of the gap, as more years of life are lost.

Blackpool ranks amongst the poorest ranked authorities for nearly all domains. The Health domain showed the greatest degree of change toward more deprivation. This was driven largely by increases in acute morbidity and mental health need. Blackpool ranks well on Housing due to high affordability and close proximity to services.

Appendix 5(d) - Headline KPIs 2018-2019

Priority One – Strong Economy

Outcome	Headline Outcome Indicator(s)	Frequency
Blackpool will be the number 1 tourist destination in the UK	Visitor numbers	Annual
	Overall value of the visitor economy	Annual
	Tram ridership	Quarterly
	Combined attraction based indicator	TBC
People in Blackpool will have access to a range of employment options	Economically active	Annual
	Number of people supported into employment across all schemes delivered by Positive Steps	Quarterly
	New jobs created on the Enterprise Zone	Quarterly
	Enterprise Zone – jobs attracted	TBC
	Growth in rateable value per annum in the Enterprise Zone	Annual
The Council will support businesses to prosper and expand	Total number of new businesses assisted by the Council	Quarterly
	Jobs secured by Council projects	Quarterly
The town centre in Blackpool will be strong and vibrant	New bookings / events in the conference centre	
	Footfall	Quarterly
	Satisfaction of residents and visitors with the town centre offer (shopping)	TBC
Good quality and affordable housing which meets the needs of a varied population across the rental and privately owned sector in Blackpool	Number of new homes built	Annual
	Number of new, quality affordable rented units created by My Blackpool Home	Quarterly
	Satisfaction of BCH tenants with the quality of their home	TBC

Priority Two – Resilient Communities

Outcome	Headline Outcome Indicator(s)	Frequency
Families are supported to provide stable home lives where children and young people can flourish	Number of Children who are "Looked After"	Quarterly
Good quality education provision in Blackpool supporting all children and young people to develop skills and obtain qualifications which set them up for a range of employment options	The proportion of schools in Blackpool that are rated as "good" or better by OFSTED	Annual
	GSCE results data	Annual
	Percentage of young people who are not in education, employment or training	Annual
Improving health outcomes for people who live in Blackpool, with fewer people developing preventable long term health conditions	Mortality rate from conditions considered preventable	Annual
	Healthy life expectancy at birth	Annual
Communities in which people feel safe and secure in their immediate environment	Percentage of people consulted who say that they feel safe and secure in their community	TBC
When people in Blackpool are well enough to be discharged from hospital, there will be no delay as a result of the availability of support for their social care needs	Delayed Transfers of Care – Social Care Delays	Quarterly
People who need social care in Blackpool will receive an assessment in good time, have access to support from a range of good quality providers and they will have a regular review of their needs	Proportion of providers registered with CQC in Blackpool rated "Good" or better	Annual
	Average waiting time for assessment	TBC
	Percentage of long-term service users with an annual review	Quarterly

Organisational Resilience

Outcome	Headline Outcome Indicator(s)	Frequency
Budget Management	Council tax collected in year	Quarterly
	Business Rates collected in year	Quarterly
	% undisputed invoices paid within 30 days	Quarterly
	Value of efficiency savings achieved	Quarterly
	Forecast level of year end General Fund Working Balances	Monthly
	Level of earmarked reserves	TBC
Workforce	Average number of working days lost due to sickness absence per FTE (Council – current staff only)	Quarterly
	Staff satisfaction	Annual
	Gender pay gap	Annual
	Staff turnover	Quarterly
Residents are satisfied with Council services	Satisfaction with the way the Council runs things	TBC
	Channel Shift - % of online transactions versus traditional methods	TBC

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Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Karen Smith, Director of Adult Services
Date of Meeting:	11 July 2018

ADULT SERVICES OVERVIEW REPORT

1.0 Purpose of the report:

1.1 This report provides an update on the current status and developments in Adult Social Care.

2.0 Recommendation(s):

2.1 To comment upon progress being made, propose potential improvements and highlight any areas for further scrutiny, which will be reported back as appropriate.

3.0 Reasons for recommendation(s):

3.1 To ensure constructive and robust scrutiny of these areas of 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?	Yes
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 <u>Adult Care and Support</u>

5.1.1 The demand for Social Care provision increased over the winter period, which is typical although the demands this past winter were particularly high across the whole health and social care system, which created difficulties in the management of the volume and flow of people requiring both medical and social care interventions.

5.1.2 The demand and volume of people requiring social care provision has remained high after the winter period and the reduction anticipated as winter has passed is not evident; indeed over

the Christmas period Blackpool had 'no queue for care' for a significant period of time, however currently we do have a 'queue for care' albeit relatively small compared to other areas due to the additional investment into the Council's In House provision.

5.1.3 In response to some of the market challenges across the social care sector the Council took the decision to invest a proportion of the IBCF (Improved Better Care Fund) allocation into the development of the In-house Homecare Service to deliver different models of care provision and to increase capacity to meet demand at that time with a focus on preventing hospital admissions and enhancing hospital discharges to reduce the length of stay of people in hospital (DToC - Delayed Transfers of Care).

5.1.4 The additional IBCF investment was equivalent to an extra 1,100 care hours per week however this additional capacity has been used as demand has continued to increase and although the different models of care delivery are having positive impacts in terms of preventing hospital admissions and enhancing hospital discharges, we are not experiencing a reduction in demand for social care provision as a whole. The IBCF funding ends in March 2020 and there is a risk that the extra 1,100 care hours per week will be taken out of the system unless alternative funding is secured and/or new ways of meeting demand are understood. This forms part of our dialogue with Blackpool Clinical Commissioning Group (BCCG) and other Health partners, as well as featuring in our Care at Home re-tender exercise.

The table below illustrates the current level of:

Volume, Demand and Capacity across the In House Homecare Service:

Social Care Provision Type	**Total Number of Hours Delivered**	**Number of New Referrals (Sample week)**	**Total Hours for New Referrals (Sample week)**	**Comments**
Rapid Response, Blue Light, Urgent Care	127	12	92	Urgent care requested to maintain someone at home (Health related conditions)
Reablement	681	18	118	To prevent admissions to hospital/residential care and support hospital discharges
Care at Home	274	0	0	Maintain people at home to prevent admission to residential care and provide market resilience provision where other providers are not able to pick up packages of care
Residential intermediate Care Discharge Support	27	0	N/A	Support discharges form residential intermediate care service to support flow of patients
Palliative Care	217	0	0	End of Life specialist care at home to prevent admission to hospital/care home
Home's Best	480	8	54	Support people to 'get back on track' to prevent hospital admission and to enhance hospital discharges
Primary Night Care	232	0	0	Provision of overnight care through a combination of short visits and full overnight cover
Total	**2038**	**38**	**264**	1,100 of these hours is funded through IBCF which is due to end March 2020 *(Maximum capacity in service for provision 2,051 hours per week)*

Queue For Care (at a single point in time)

Provision Type	Number of Referrals	Number of Hours	Comments
Reablement (In House)	7	147	5 x referrals to support hospital discharges and 1 x preventing admission to hospital/care home
Home's Best (In House)	2	56	Support someone to remain at home and prevent admission to hospital/care home
Care at Home	30	258	Packages of Care waiting to be picked up by care providers as and when capacity allows
Total	**39**	**461**	**A total of 461 care hours required from the social care system and little capacity to meet this demand**

Significant variation occurs in these numbers as people move in and out of the system.

5.2 Commissioning and Quality Monitoring Update

5.2.1 Residential - Comparative Care Quality Commission (CQC) Ratings at 01.05.2018

Blackpool's contracted Residential and Nursing provision continues to compare favourably with homes in the North West and nationally.

	Blackpool	Blackpool	North West	North West	National	National
	Number	%	Number	%	Number	%
Outstanding	5	7.58%	28	1.57%	350	2.35%
Good	52	78.79%	1297	72.70 %	11442	76.94%
Requires Improvement	8	12.12%	399	22.37 %	2813	18.92%
Inadequate	1	1.52%	60	3.36%	266	1.79%
	66	100.00%	1784	100.00 %	14871	100.00%

A North Shore Nursing Home has received a letter from Ruth Holt (Director Of Nursing/ Independent Care Sector Regional Lead – NHS England) to congratulate them on achieving an 'Outstanding' rating following a recent CQC inspection.

This brings the number of Outstanding Residential and Nursing providers in Blackpool to five.

5.2.2 **Care At Home Comparative CQC Ratings at 01.05.2018**

Blackpool's contracted Care At Home provision continues to compare favourably with those in the North West and Nationally.

	Blackpool	Blackpool	North West	North West	National	National
	Number	%	Number	%	Number	%
Outstanding	0	0.00%	22	2.66%	187	2.74%
Good	20	95.24%	677	81.86%	5602	82.12%
Requires Improvement	1	4.76%	120	14.51%	973	14.26%
Inadequate	0	0.00%	8	0.97%	60	0.88%
	21	100.00%	827	100.00%	6822	100.00%

5.2.3 **Care at Home Retendering**

5.2.4 The contracts with our Care at Home providers are in place until the end of March 2019. The Council and BCCG are developing a common approach to commissioning Care at Home services across Blackpool. The commissioning team is currently working on the development of the new specification. The key developments for this piece of work include:

- A joint procurement exercise with BCCG
- Based on a single specification for use across both organisations
- A single fee rate, and continuation of the existing integrated performance monitoring function
- A zoned approached to the service delivery to minimise travel time for carers
- Incorporation of the Ethical Care Charter and Social Value specific to the delivery of a care at home services
- Recommendations in respect of the Oldland case
- Stakeholder involvement in the development of the Model and Service User involvement in tender evaluation

5.2.5 The revised approach aims to support and enable people to develop their potential, maintain their health and independence and improve their quality of life. One of the key priorities is commissioning for a rapid and real improvement in home care services across Blackpool. The Council's vision is of a model of ethical home care supporting sector wide improvements; which include taking active steps to tackle difficult issues such as staff recruitment and retention.

5.2.6 In February 2018, approximately sixty senior care provider representatives, Council and BCCG staff including Social Work Managers and fieldwork staff attended a care model design event hosted by Commissioners, the Director of Adult Services and Cllr Cross at the Winter Gardens. The aim of the consultation event was to shape and inform development of the new contract

and service specification for Blackpool. Provider representatives were also invited to a subsequent design update session at the Grange in May 2018.

5.2.7 Tender preparations are now well underway and a service specification has been drafted that will require bidders to commit to delivering on the three stages of Unison's Ethical Care Charter; which aims to reform care sector terms and conditions and raise quality standards across the local market. The care sector has some long-standing difficulties in attracting good quality applicants for staffing vacancies. However, Commissioners are optimistic that improved terms and conditions (as described in the Ethical Care Charter) should help raise the quality of care provision, recruitment and retention of care staff alleviating some recruitment challenges.

5.2.8 The new model of care at home is designed to increase the efficiency of current provision by reducing the amount of travelling time between visits. Providers will deliver care on a neighbourhood basis, across three localised areas (Blackpool North, Central and South). Fewer Providers operating in smaller condensed localities should lead to more efficient rotas and routes, which in turn should maximise contact time with service users, while minimising travel time between care visits.

5.2.9 The Council proposes to offer prospective care providers a number of opportunities and benefits including:

- Extended contract period of up to 10 years (with break clauses) providing increased financial security, sustainability and investment opportunities
- Pay a fair price for high quality person centred home care – hourly rate reviewed at least annually
- Patch based allocation of work, connecting neighbourhoods and people in that locality
- Prompt payments to suppliers
- Work in partnership with ethical, high quality providers, and engage with residents, sharing challenges and co-producing solutions
- Positively contribute and actively participate as a member of Fylde Coast Health and Social Care Career Academy – driving forward ethical service developments, training targeted at key skills gaps, improved recruitment and retention, promoting social care and health as a positive career choice, and improvements across the care sector
- Create an environment where transparency, creativity and innovation thrive
- Share resources to achieve common goals for example: training resources (online iPool), parking pass scheme, wellbeing and vaccination programmes for care staff
- Enhanced support e.g. provider expertise, pharmacy, access to training and support
- Collaborate with providers to promote a healthy workforce, prevent disease transmission and increase resilience across the care sector workforce and residents,
- Share economic development opportunities with contractors

5.2.10 In return, prospective care providers are invited to commit to:

- As a priority and where appropriate to utilise the local supply chain
- Employ a high percentage of local labour including at senior management positions

and support targeted employment opportunities apprenticeships / traineeships.

- Proactively engage with local communities to achieve the Council's priorities and deliver targeted outcomes with a focus on building resilience in local neighbourhoods
- Positively contribute and actively participate as a member of Blackpool's Care Forum, Fylde Coast Health and Social Care Career Academy – driving forward ethical service developments and improvements across the care sector
- Create an environment where transparency, creativity and innovation thrive; for example through open and honest discussions, demonstrating a positive approach to problem solving and pooling resources to achieve common goals
- Collaborate with the Council to promote a healthy workforce, prevent disease transmission and increase resilience across the care sector workforce and residents
- Demonstrable proof of investment in Blackpool

5.2.11 **Quality and Performance Monitoring**

5.2.12 Additional resource has been allocated to the monitoring of contracted Care at Home Services to support a more detailed approach to assuring quality. New monitoring processes have been put in place that focus more on seeking direct service user feedback and detailed analysis of Electronic Call Monitoring data.

5.2.13 The new processes will ensure that all stakeholders have a clearer picture of the quality of contracted care at homes services, and be able to identify specific challenges and areas for improvement within the section.

5.2.14 **Transforming Care - Mansfield Road Step Down Service**

5.2.15 A multi-disciplinary implementation group continues to meet to oversee development of the service. Active discharge planning continues. The transitional monies required to support each discharge is being worked through with Blackpool Clinical Commissioning Group.

5.3 <u>Deprivation of Liberty Safeguards</u>

5.3.1 A number of people in residential, nursing homes or hospital who lack capacity to agree to be there, and who would be stopped from leaving if they tried to, are subject to such restrictions in relation to their care that they are deemed to be deprived of their liberty. The legal authorisation for doing this is part of the Mental Capacity Act, and the process is known as the "deprivation of liberty safeguards". Case law in 2014 increased the numbers of people who would fall into this category, a rise of tenfold plus.

5.3.2 It is a legal requirement that people who meet the criteria above have their deprivation of liberty authorised by a procedure specified in law. The responsibility for legally authorising the deprivation falls to the Local Authority as the Supervisory Body.

5.3.3 The activity in relation to Deprivation of Liberty safeguarding assessments continues to rise. The Authority has been very successful in managing the increasing demand without resorting to "waiting lists". This avoids the risks associated with people being deprived of their liberty without the appropriate safeguards being in place, and possible legal challenge to that.

5.3.4 A lot of work has gone into ensuring that requests are dealt with in a timely manner and the processes of dealing with those are both effective and efficient. The numbers for the last two years are detailed in the table below.

	2016/17	2017/18	Increase
Total Rows Included in Return (Applications received in year plus those DoLS already in place)	1226	1434	17.0%
Applications Received in Year	798	881	10.4%
Number Granted in Year	692	768	11.0%

5.3.5 Not all applications that are received are granted, and there are a variety of reasons for this. These include the person moving accommodation/being discharged, of either being assessed as having capacity or not being subject to restrictions which amount to a deprivation, or of dying before the assessment is complete.

5.4 Mental Health Admissions

5.4.1 Some people are admitted to hospital under a relevant section of the Mental Health Act. Typically* this will involve two doctors and an Approved Mental Health Professional (AMHP, almost exclusively locally a social worker) assessing the person and making a decision that they need, on one or more of the following grounds, to go into hospital even though they do not want to: for their health, and/or their safety, and/or for the protection of others, and that this is necessary and there is no alternative.

5.4.2 The AMHP can only complete their application for admission if they have two completed medial recommendations by the relevant doctors. They then have responsibility to arrange the conveyance of that person to hospital in the most appropriate manner, which usually means via an ambulance.

5.4.3 For some time AMHPs locally have found themselves in the position of having assessed somebody as meeting the criteria for admission, with completed medical recommendations, but being unable to organise the conveyance due to no bed being available to admit the person to. This obviously causes a number of concerns in terms of risks to the person, their family/carers, others if living in a shared environment, staff who may have to care for them in the meantime, and the AMHP from a professional and regulatory standpoint.

5.4.4 In order to properly quantify the extent of this happening, we will from the beginning of June 2018 compile weekly statistics of the number of people who are unable to be admitted despite being eligible to be detained, and the number of delay days associated with each of those individuals who this occurs for. We will share this information with our Hospital Trust and BCCG colleagues as part of the regular and ongoing discussions concerning service delivery and safe and effective services.

*Some people will be admitted for assessment by the police under s135 of the Mental Health

Act, some via a court authorised warrant under s135 of the Mental Health Act, and these figures will form part of the detail described above.

5.5 Adult Social Care Grant

5.5.1 The Adult Social Care Grant is an additional short-term fund, which has been made available to the Council and is designed to support the delivery of services, which relieve pressure on the acute health system by preventing hospital admissions and supporting prompt discharges.

5.5.2 The grant has been allocated across the service in areas, which will have the greatest impact. There will be enhancements to the resource delivering the "Home First" project, a focus on the development of new assistive technologies and innovation, building on the expertise of the Vitaline service, meeting emerging need for specialist Autism services as evidenced in a self-assessment and roles which will work across Adult Social Care to ensure that key compliance and quality is not lost with the pressure to meet a higher level of demand across the system.

5.5.3 The funding has been used to create new roles (including apprentice opportunities) and create capacity in current systems to allow the benefits of new technology developments to be maximised.

5.5.4 There is no assurance of future funding from this source and this has been built in to the planning to ensure that there are no unforeseen revenue costs as a result of this spend.

Does the information submitted include any exempt information? No

List of Appendices:

None.

6.0 Legal considerations:

6.1 Contained within report.

7.0 Human Resources considerations:

7.1 Contained within report.

9.0 Equalities considerations:

9.1 Contained within report.

10.0 Financial considerations:

10.1 Contained within report.

11.0 Risk management considerations:

11.1 Contained within report.

12.0 Ethical considerations:

12.1 Contained within report.

13.0 Internal/External Consultation undertaken:

13.1 Contained within report.

14.0 Background papers:

14.1 None.

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officers:	Dr Arif Rajpura, Director of Public Health Liz Petch, Public Health Consultant Rachel Swindells, Public Health Practitioner
Date of Meeting:	11 July 2018

PUBLIC HEALTH UPDATE ON STOP SMOKING PROVISION

1.0 Purpose of the report:

1.1 To present an update on the stop smoking service provision in Blackpool.

2.0 Recommendation(s):

2.1 To comment upon progress being made, propose potential improvements and consider whether any areas would benefit from further scrutiny..

3.0 Reasons for recommendation(s):

3.1 To ensure constructive and robust scrutiny of the proposed model of stop smoking provision in Blackpool.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes
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 presents a summary of the process undertaken to develop a new stop smoking model for Blackpool.

5.2 A number of options for a new model of delivery and engagement have been explored as part of the full service review, including a comprehensive look at the evidence base and at good practice models of delivery across England.

5.3 The Public Health Senior Management Team, Cabinet Member for Adult Social Care and Health and Corporate Leadership Team (CLT) have been fully briefed at various milestones in the decision making process to ensure acceptability and agreement for conclusions and recommendations made to date.

5.4 In July 2017, Corporate Leadership Team were presented with the initial results of the review process with the recommendation to undertake further work on service re-design as supported by the Stop Smoking + model developed by Professor Robert West at University Central London.

5.5 The Stop Smoking + model adopts a population segmentation approach that uses three levels of support to engage smokers based upon their motivation to quit and/or their health needs:

- Self-management
- Brief support
- Targeted support for priority groups

5.6 Following further work on service re-design, a new model of stop smoking support, which includes a light touch universal element and a more proactive targeted approach to work with priority groups, was presented to and considered by the Executive Leadership on 12 March 2018. Comments were considered and amendments were taken to the Priority 2 Board on 10 April 2018.

5.7 Additional information was requested by the Priority 2 Board in April 2018 and an amended version of the model was presented back to Priority 2 Board on 6 June 2018. Agreement was given by the Priority 2 Board at this meeting to implement the new stop smoking model for Blackpool.

6.0 List of Appendices:

Appendix 7(a) : Public Health report on Stop Smoking Support in Blackpool
Appendix 7(b) : Framework of the different interventions and models of service delivery which have been considered for future service provision
Appendix 7(c): A summary of the new stop smoking service model for Blackpool

7.0 Legal considerations:

7.1 Contained within report.

8.0 Human Resources considerations:

8.1 Contained within report.

9.0 Equalities considerations:

9.1 Contained within report.

10.0 Financial considerations:

10.1 Contained within report.

11.0 Risk management considerations:

11.1 Contained within report.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/External Consultation undertaken:

Contained within report.

Background papers: None

BLACKPOOL COUNCIL **Appendix 7(a)**

DIRECTORATE OF PUBLIC HEALTH

Update on stop smoking support

Adult Social Care and Health Scrutiny Committee 11 July 2018

1. INTRODUCTION

This report outlines the different options and models considered as part of the decision making for an alternative stop smoking support model for Blackpool, presenting the new model of stop smoking support. The paper also includes a summary of the service review process which stop smoking provision in Blackpool has undergone.

2. PROPOSED SERVICE MODEL

A summary of the new service model is detailed below and further information is outlined in Appendix 7(c). The model is structured inside three levels of support.

Workforce training

All three levels of support will be underpinned by a programme of workforce training (in line with the National Centre for Smoking Cessation Training [NCSCT] Level 1 training programme) for health and other professionals to ensure smokers are identified across a range of settings, offered brief advice and signposted or referred according to their preferred level of support. The training will be offered to a range of professionals including;

- Primary care (GP practices)
- Pharmacy based support
- Integrated lifestyle and wellbeing services
- Neighbourhood Care Teams
- Youth provision
- Children's centres
- Secondary care setting
- Variations to existing public health contracts maypromote further opportunities to offer brief support.

It should be noted that this list is not exhaustive.

Level 1: Self-management

Smokers will be offered clear self-management advice and information on how to quit provided in digital or written format, for example web-based information and leaflets. Smokers will also be signposted to the national web-based and telephone helpline which will provide brief advice, behavioural support and advice on Nicotine Replacement Therapy (NRT) use.

Level 2: Universal support offer

A universal offer will also be available to ensure individuals can equally access stop smoking support, which provides a level of service sitting between Level 1 self-management and Level 3 targeted support across Blackpool. This level of support is open to all age groups (behavioural support is available to all age groups with nicotine replacement therapy only available to aged 12 plus due to the restriction of the product licence.). Local insight work found that services 'being local' was the most important factor to people accessing support and therefore the universal support offer will be provided in the following settings;

- **Level 2 (a): A Proactive telephone support service**
  This option will enable users of a proactive telephone support service to work with smokefree advisers to create their own personal quit plan, through a series of outbound support telephone calls to help and support with their quit attempt. Users of the service would receive a maximum of ten calls over a two month period.

- **A Community pharmacy-led stop smoking service**
  This service provides one-to-one stop smoking behavioural support and NRT provision in the pharmacy setting, through a payment by results model. The service aims to support patients for up to 26 weeks following their quit date.

- **GP Practice led stop smoking service**
  This service provides stop smoking behavioural support and NRT provision to patients, through a payment by results model.

Level 3: Priority Groups

This level of support will target priority populations where the evidence suggests we can have the biggest impact on reducing health inequalities.

i. Pregnant women

This level of support is provided by a team of Maternity Health Trainers employed within Blackpool Teaching Hospitals' (BTH) Maternity Service. The service provides tailored behavioural support and direct access to Nicotine Replacement Therapy, in line with National Institute for Health and Care Excellence (NICE) guidance, for a minimum of 12 weeks.

The Maternity Health Trainers provide the women with intensive and ongoing support throughout pregnancy and beyond. This includes regularly monitoring of a woman's smoking status using carbon monoxide (CO) screening.

The service also provides an incentive scheme. The aim of this scheme is to support all pregnant women to set a quit date, achieve a CO validated 4 week quit, sustain the quit hence support throughout pregnancy and 12 weeks post-partum (post-natal or following pregnancy), through offering incentive payment at stages throughout the pregnancy.

A risk perception intervention is also delivered by the Maternity Health Trainer service. The intervention enhances the existing antenatal smoking cessation pathway by delivering an additional intervention to those women who have not engaged with stop smoking support earlier in their pregnancy. This intervention is delivered at the first trimester ultrasound appointment (pregnancy divided into three periods of three months each or three trimesters) by a maternity health trainer.

ii. Smokers within secondary care services

This provision will integrate targeted tobacco dependence treatment support into the acute hospital setting, adopting NICE PH48 guidelines and the Ottawa model.

It is proposed that the service will sit within the respiratory division at BTH, led and championed by an existing respiratory consultant, although the service will not be limited to respiratory patients.

A dedicated team will be recruited by BTH to provide targeted stop smoking behavioural support at the bedside as part of an overall tobacco dependence treatment plan for patients. The service will also provide outpatient clinics and telephone support to ensure continued support for a minimum of 4 weeks post-discharge.

iii. Children and Young People

As the evidence is limited for stop smoking support for young people, we propose within the new model for Blackpool, a pilot is undertaken to test effective ways of engaging young people who smoke and effective interventions to support cessation amongst this age group. To deliver the pilot, an in-house fixed-term 'Children and Young people stop smoking advisor' post (Grade H2 + on-costs) will be recruited in order to work with schools and other settings to test the most effective ways of engaging and supporting young people to stop smoking.

We will ensure through the pilot that links are made with our A Better Start and HeadStart partners to ensure effective stop smoking support pathways for young people. The training offer within the wider stop smoking model will ensure that all relevant partners are able to access the training that will support them in delivering brief advice and onward referral for specialist stop smoking support for the young people and families that they work with.

All support across Level 3 will follow the NCSCT Standard Treatment Programme http://www.ncsct.co.uk

All aspects of the model will be piloted on a 12-month basis with clear KPIs set in order to measure effectiveness. Estimated quit rates for each element of the service are outlined in Appendix 7(c).

3. BACKGROUND

In 2015 local specialist stop smoking services in Blackpool were reviewed and re-designed, in-line with good commissioning and procurement practice and the latest evidence base. After a full procurement exercise, a new specialist stop smoking service provider was commissioned in addition to a new Payment by Results (PbR) Scheme introduced to GP practices.

The ambition was to make highly accessible services for local people and to address some of the considerable local challenges and health inequalities caused by smoking.

After 18 months of the new contracts being in place, a review was undertaken in March 2017 as part of the ongoing commitment to ensure that commissioned services were; cost effective, delivered excellent outcomes and met the needs of the population of Blackpool.

The review included three elements of locally commissioned stop smoking services:

1. GP Practice led Smoking Cessation Service
2. Specialist Stop Smoking Service provided by Solutions 4Health[1]
3. NRT prescribing budget managed by Solutions4Health

The review process involved: -

- Understanding smoking related health needs and inequalities through desk top research using the Joint Strategic Needs Assessment (JSNA) and other local data, such as the Local Tobacco Control Profiles[i].
- A literature review to explore the latest evidence base and appraise alternative service delivery models.
- An overview of contractual performance data and
- Engagement with stakeholders; including commissioners and service staff providing a richer understanding of stop smoking service provision.

In addition to this work Solutions4Health, within its contract requirements, was expected to undertake community insight work to inform the delivery of an integrated smoking and nicotine addiction prevention and treatment service. The purpose of this insight work was to better understand the behaviours of people who smoke (or used to smoke) and what they want / need from a stop smoking service.

Infusion Research was commissioned to undertake this piece of work and 614 street interviews were undertaken with smokers and ex-smokers in Blackpool between July and September 2016.

[1] Solutions4Health are a national Community Interest Company (CIC) / Limited (Ltd) company providing a range of health and wellbeing services including specialist stop smoking services.

The following key issues were highlighted in relation to aspects of service delivery under review:

GP Practice led Smoking Cessation Service

- High variation across GP practices in terms of the number of referrals being made to the specialist stop smoking service.
- GP Practices gained £15 per referral made to the specialist service. High attrition rates and poor quality referrals (low motivation from patients) resulted in this being a costly scheme to continue.
- Very few people setting quit dates went on to achieve longer term successful outcomes (< 1% of smokers were recorded as 26 week quitters. This equated to 4 individuals recorded as having achieved a 26 week quit during the 18 month period of the contract).

  It should be noted that payments to GPs for referrals-only to the specialist stop smoking service ceased from April 2017.

Nicotine Replacement Therapy (NRT) and other medication

- There were difficulties with the direct supply scheme for NRT managed by Solutions4Health, mainly practical issues with managing supply and demand locally. This is likely to have contributed to the poor patient outcomes seen in the service.
- There were considerable pressures on the 2016-2017 NRT budget due to overspend of predicted budgets.

Specialist Stop Smoking Service

- The specialist service underperformed on a number of key performance indicators during the period of the contract, including 4-week follow up for smokers and pregnant women setting quit dates. The dropout rate of pregnant women was particularly significant.
- Costs for staffing, management and premises were prohibitive.
- The insights work undertaken by Infusion Research found that of the 614 smokers interviewed, more than half of smokers had tried to give up with 'cold turkey' (self-management) by far the most popular approach but with mixed success, Two in five people were aware of the stop smoking service in Blackpool, with understanding lowest amongst 35 to 44 year olds and residents in the south area of Blackpool.
- The current service was not meeting these needs and provided limited outreach available.

Following consideration of the commissioning review of specialist stop smoking services, NRT budget pressures, and GP provision; on 4 April 2017 the Corporate Leadership Team (CLT) made the decision to decommission the specialist stop smoking service provision including the Nicotine Replacement Therapy scheme, as the contract reached its end date. They agreed that Public Health would look to explore alternative options and models for a new stop smoking provision.

4. CURRENT INTERIM PROVISION

Whilst Public Health have explored new models of engagement and delivery, interim services have been implemented for the period between the Specialist Stop Smoking Services came to an end and the start of a new model of delivery. This has ensured that support remains available to the residents of Blackpool. This interim support offer includes:

GP Practice led stop smoking service

This service provides stop smoking behavioural support and NRT provision to patients, through a payment by results model. The service aims to support patients for up to 26 weeks following their quit date. There are only 6 practices currently providing this interim support.

To ensure equity of provision across Blackpool, Public Health have also commissioned a community pharmacy led stop smoking service, which ensures people can access stop smoking support in areas where their GP practice is not actively providing the service. Where GP practices do not provide in-house stop smoking support they can, and do, refer patients to the community-led pharmacy stop smoking support service and/or the national stop smoking helpline.

Community Pharmacy led stop smoking service

This service provides one-to-one stop smoking behavioural support and NRT provision in the pharmacy setting, through a payment by results model. The service aims to support patients for up to 26 weeks following their quit date. There are 30 pharmacies accredited to deliver the service and currently 17 of these pharmacies are actively delivering the service, equally spread across Blackpool.

Smokefree National Helpline

The NHS provides a national web-based and telephone helpline that enables people to speak to a trained expert advisor for initial brief advice. The service also provides signposting information for local support options.

A list of GP practices and pharmacies providing local support in Blackpool has been provided to the national helpline.

5. OPTIONS CONSIDERED FOR FUTURE SERVICE PROVISION

A number of options for a new model of stop smoking support have been explored as part of the full service review.

The framework, see Appendix 7(b), outlines the different interventions and models of service delivery which have been considered for future service provision.

The framework provides a short summary of stop smoking intervention models, along with an indication of the likely effect size and a brief recommendation related to commissioning. A rating of effectiveness is also provided for each intervention which is based on information from the Cochrane Collaboration[ii], NICE (PH10[iii] and QS43[iv]), and the NCSCT Service and Delivery Guidance[v], rating different interventions according to evidence of effectiveness.

This framework was considered at CLT on 18 July 2017 and it was agreed that the following aspects of the framework would be developed further, to shape the new proposed service model:

- Self-management
- Brief Support
- Maternity 'in-house' stop smoking service targeting pregnant smokers
- Hospital 'in-house' stop smoking service targeting patients with long term conditions
- Provision for mental health patients in order to reduce health inequalities and address parity of esteem.

These aspects adopt a population segmentation approach that uses three levels of support to engage smokers based upon their motivation to quit and/or their health needs: 1. Self-management, 2. Brief support and 3. Targeted support. This is based on The Stop Smoking + model developed by Professor Robert West from University of Central London.

6. SUMMARY

This paper has provided details of the past, current and future provision of stop smoking support in Blackpool. It has also highlighted the current interim service provision in place and detailed the options which have been considered in developing a new proposed stop smoking service model. The new service model has been agreed by the Executive Leadership and the ambition is to have all aspects of the service fully implemented by 1 October 2018.

7. RECOMMENDATION

The Committee is asked to acknowledge and support the new model for implementation over the next 1-3 months, with the ambition to have all aspects of service fully implemented by 1 October 2018.

Update prepared by:

Rachel Swindells, Public Health Practitioner 21 June 2018

This framework outlines the different interventions and models of service delivery which have been considered for future service provision.

The framework provides a short summary of stop smoking intervention models, along with an indication of the likely effect size and a brief recommendation related to commissioning. A rating of effectiveness for each intervention is also provided which is based on information from the Cochrane Collaboration, NICE (PH10iv & QS43v), and the NCSCT Service and Delivery Guidance, rating different interventions according to evidence of effectiveness.

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
Online support	There is evidence that online information (websites) can be effective in supporting smokers to stop but none of the sites evaluated in randomised trials are available currently so websites should not be the only support offered to smokers [vi].	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty	Expected uptake rates for each and absolute quit rates derived from the NICE (2012) Return on Investment Tool:vii Internet 20% uptake; 8% absolute quit rate	Websites can be a very cost-effective way of informing smokers about methods of stopping. There may be opportunities to develop self-management tools and digital support in collaboration with local and pan Lancashire partners on shared resources.	If they are to be used as tailored support programmes it is important to understand that each website needs to be evaluated and these are not a substitute for the strongly evidence-based sources of support (behavioural support and pharmacotherapy). Investment will be required to develop and promote resources to local people and stakeholders.	Consider as part of a suite of self-management intervention options Yes, as part of suite of self-management options in level 1 of proposed model
Text messaging support	Although evidence is a bit more limited on text messaging, it is clear that it can improve quit success rates compared with nothing. Because we have less evidence it is important to use a programme that has been tested directly.	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty	40-80%	Smokers receiving **mobile support** (mainly text messaging) are around 1.7 times more likely to stay quit than smokers who did not receive programme. (9.3% quit with programmes compared with 5.6% quit with no programmes).[viii]	Investment will be required to develop and promote resources to local people and stakeholders.	If considering this option, commissioners should look to existing programmes that have been fully tested. It is not recommended that new local programmes are developed without evaluation. No, evidence limited
Print-based self-help materials	Print based materials, such a leaflets and booklets, are important to ensure equity of provision across the	The recommendation is supported by fair (reasonable) evidence, but there may be minimal	Print-based self-help materials increase quit rates at 6 months by	Utilising resources from NHS Smokefree and placing signposting information on local websites	Investment will be required to develop and produce resources.	Consider as part of a suite of self-management intervention options

[2] [4]Assessment of improved success rates complied by Professor Robert West based on combined evidence from peer reviewed publications and NICE Guidance.

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
	population, particularly for those groups who do not have access to digital forms of self-help support through the internet or phone platforms.	inconsistency or uncertainty	about 20% compared to no intervention.[ix]	The Organisation for the Review of Care and Health Applications (ORCHA) carry out independent and impartial reviews of health and care related apps using a clinically and academically validated assessment framework. There are additional opportunities around including stop smoking self-management resources in the new Directory of Services. This will include public/patient information and also resources for professionals and practitioners.		Yes, as part of suite of self-management options in level 1 of proposed model
Pro-active Telephone support	Offers a level of support sitting between brief support and targeted support. This option would enable users of a proactive telephone support service to work with smokefree advisers to create their own personal quit plan, through a series of outbound support telephone calls to help and support with their quit attempt.	The recommendation is supported by good (strong) evidence of programmes however, evidence of programmes from the UK is limited. This approach is currently being piloted in London and Greater Manchester – evaluation not yet available.	50-100%	The London and Greater Manchester pilot telephone lines have been developed and implemented across large geographical footprints and are therefore cost effective additions to stop smoking service provision. Serco have been commissioned to provide proactive phone line services in these areas as a variation to the existing NHS Smokefree contract with PHE. Serco also maintain and moderate the PHE smokefree social media sites including national Facebook pages. NHS Smokefree already provides text, email, webchat, on line apps and reactive telephone support. There is little value in replicating these existing resources. The addition of proactive telephone support locally could be delivered more cost effectively than traditional face to face models. GPs and other health and social care professionals trained to provide	Lack of evidence of effectiveness currently available until London and Greater Manchester models produce evaluation.	Either wait for results of London and Great Manchester evaluation are available OR implement local pilot based on international evidence of effectiveness and pilot to test effectiveness locally. Yes, as part of 6-month pilot in level 2b universal support of proposed model

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
				brief advice would be able to refer to the quit line for ongoing behavourial support. There is scope that a proactive telephone stop smoking support could be delivered on larger geographical footprint involving other local authorities and NHS Trusts.		
Self-help mobile phone apps	Online app stores including iTunes and Google Play feature thousands of health and self-care apps including smoking cessation.	To date there is little published evidence on the effectiveness of mobile phone apps to support smoking quit attempts.**Error! Bookmark not defined.**x App stores such as Google Play or i-Tunes do not offer any information on the quality or evidence base of mobile phone apps	unknown	Studies have shown that 31% of mobile phone users use apps to access health information.[xi] NHS Digital and ORCHA independently review apps as being rooted in evidence based practice and can be downloaded through to a mobile phone or computer through platforms including i-Tunes or Google Store. The NHS smokefree app remains free of charge to users.	There is no consistent monitoring or strict guidelines that digital developers must subscribe to when producing and marketing new mobile phone apps. Evidence suggests that consumers are more likely to rely upon the recommendations of others when selecting health care apps rather than those that have been appraised against evidence based literature.[xii] It should be noted that consumer ratings for the NHS Smokefree app are fairly low when compared with other apps available from online app stores.	There is limited evidence of effectiveness of for self-help resources in terms of mobile phone apps. However there is evidence that that such interventions are acceptable and cause no harms to most key groups of smokers. Yes, but only as suite of self-management options in level 1 of proposed model
Primary care (GPs)-brief support only[3]	Brief support and a stop smoking medication for those who want help but are not willing to commit	There is good evidence of the effectiveness of brief support provided through general practices with around 1 in 4 smokers	1% absolute quit rate at 52 weeks.	Smokers are provided with access to appropriate stop smoking medications, information/support and follow up to check progress.	Individual GP practices will need to sign up to provide the service, engage with relevant training and comply with monitoring data	This level of support is recommended within a structured model of tiered support services - with a focus on

[3] The only intervention known to have an effect is physician advice. Brief opportunistic advice from other health professionals may have an effect but to date there is no good evidence for this. Nevertheless they are recommended to give such advice so as to encourage smokers to use the Stop-Smoking Services which do have proven effectiveness.**Error! Bookmark not defined.**

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
	to a specialist course	taking up the offer of support with around 1% absolute quit rate at 52 weeks.		Local GP practices already have skilled staff to deliver stop smoking interventions. Scheme could be delivered through existing GP contract arrangements alongside specialist support services (this could compliment specialist support if offered as an option through primary care.)	requirements. Over recent years the Public Health Grant has funded NRT made available to smokers through the NHS specialist stop smoking service (SSS). From October 2017 the SSS has been decommissioned. Consideration will need to be given to the additional demand and resource required for NRT prescribing within primary care or whether smokers will need to self-fund NRT products	workforce training for brief advice Yes, as part of brief support level 2a in proposed model
Pharmacy based –brief support[3]	Brief support and a stop smoking medication for those who want help but are not willing to commit to a specialist course	There is limited evidence on brief interventions offered through pharmacies. Evidence for more intense behavourial support combined with access to appropriate stop smoking medications can increase quit rates in line with specialist support	unknown	Pharmacies often first point of contact for people accessing health services, and valuable asset for referring and/or supporting smokers who want to stop. Health Living pharmacies well placed to deliver brief advice and support. Other advantages include: - high footfall/high number of contacts/opportunities - skilled staff - NRT available to purchase on site with access to advice and information to self-manage NRT costs passed on to customer or opportunities to offer NRT through voucher scheme but budget implications	Limited evidence on pharmacies delivering brief support	This level of support is recommended within a structured model of tiered support services - with a focus on workforce training for brief advice Yes as part of brief support level 2a in proposed model
Stop smoking brief support offered through Integrated	HealthWorks are already commissioned to provide stop smoking support. The	Evidence indicates that stop smoking interventions should be	unknown	Health Works are already commissioned to provide stop smoking support. There are	Limited evidence on Integrated lifestyle services offering brief support.	This level of support is recommended within a structured model of

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
lifestyle/wellbeing services (for example – HealthWorks model)	existing service offers brief support and encourages smokers to self-manage their quit attempt using the app Smokefree-quit Smoking now and stop for good by David Crane.	targeted in isolation rather than multiple risk behaviour interventions. [xiii]		opportunities to enhance the existing service offer including ensuring appropriate training for staff and extending access to evidence based interventions including groups/peer support. Group support could strengthen the behavioural support offered to people accessing specialist support (section 3) Existing contract KPIs could be extended through contract variation	Issues relating to quality of service and capacity within current service delivery	tiered support services - with a focus on workforce training for brief advice Yes, as part of brief support level 2a in proposed model
Neighbourhood Care Teams to deliver Stop Smoking brief support to people with long term conditions.	There are opportunities for the Neighbourhood Care Team to support smokers through promoting self-management through to periods of crisis. NCT will include primary, community and secondary care services working closely with voluntary sector services with links to community assets.	No current evaluations on neighbourhood based approach to Stop Smoking Services.	unknown	Smokers could be identified through primary care GP registers and/or as patients of Blackpool Teaching Hospitals. Existing contract KPIs could be extended through contract variation	Issues relating to quality of service and capacity of current service delivery model.	This level of support is recommended within a structured model of tiered support services - with a focus on workforce training Yes as part of brief support level 2a in proposed model
Maternity 'in-house' stop smoking service based on the babyClear model[4]	This level of support offers specialist support of top quality to pregnant women. Thisprovision skills up Maternity Health Trainers, already intergrated within the maternity workforce, to deliver specialist stop smoking support to pregnant smokers, ensuring that this support remains within the	The introduction of the babyClear model can increase referrals by 2.5 times (incidence rate ratio = 2.47, 95% CI 2.16 to 2.81). The probability of quitting by delivery can also increase by nearly two-fold (adjusted OR= 1.81, 95% CI 1.54 to 2.12). [5]	To be determined because the proposed model will enhance existing babyClear scheme implemented in Blackpool (currently being tested and evaluated).	Maternity health trainer model currently being tested utilising funding from NHS England. If model proves successful, there will be a developed team established. Opportunities to deliver service in collaboration with pan Lancashire partners. Direct supply of NRT possible utilising BTH existing pharmacy provision (funding to be	Pilot does not achieve outcomes. If pilot achieves outcomes, case will need to be made to ensure continuation of funding to sustain this model within maternity services beyond pilot period (ends July 2018) and so depends on support from CCG and Trust partners	This model is currently being tested through an NSH England pilot and activity being closely monitored and evaluated. Yes, as part of level 3 priority groups in proposed model

4 BabyClear is a system-wide intervention to promote smoking cessation during pregnancy, developed by the Tobacco Control Collaborating Centre, part of Improving Performance in Practice. It comprises a package of measures designed to support the implementation of national guidance, including CO screening at every ante-natal contact, routine positive consent opt-out referral and risk perception intervention.

[5] The only intervention known to have an effect is delivery of the babyClear pathway by a trained midwife and referral to a community specialist stop smoking service. An alternative model is currently being tested locally where by elements of the babyClear pathway are delivered by a maternity health trainer and the maternity health trainer also holds a case load of women and delivers the specialist stop smoking support in house rather than referring out to a community stop smoking service. The delivery of support is equal to that delivered by a community stop smoking service, including face to face behavioural support and direct supply of NRT. The service also includes an incentive scheme available to all pregnant smokers.

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
	maternity care system, as identified as an important factor by pregnant women through existing local insight work.	The addition of an incentive scheme can have the largest effect size compared with a less intensive intervention (one study; RR 3.64, 95% CI 1.84 to 7.23) and an alternative intervention (one study; RR 4.05, 95% CI 1.48 to 11.11).[6]		determined)	NRT costs	
Hospital 'in-house' stop smoking service	Integrates specialist stop smoking support skills within existing knowledge and skills base of specialist healthcare workers within the inpatient hospital setting to provide specialist support at the bedside.	The delivery of hospital based smoking cessation programmes can deliver significantly lower rates of all-cause readmissions, smoking-related readmissions, and all-cause emergency department (ED) visits.[xiv] Behavioural interventions are supported but they need to be high intensity (Rigotti et al, 2012; Carson et al; 2012) and their effectiveness is enhanced by the addition of NRT and by being continued for at least a month after discharge (Rigotti et al, 2012)7 Physician and nurse led interventions were seen to be effective with intensity providing better results (Stead et al, 2013; Rice et al, 2013). The CURE programme in Great Manchester, based on the Ottawa model of smoking cessation, provides a good-practice	Approximately 25% of patients are likely to screen positive for smoking – and all should be offered a referral to an effective smoking cessation intervention, of which 30% are likely to accept [xvi] This would have to be a universal, hospital whole systems approach but would want to ensure priority groups (to be determined) receive intensive support as part of their treatment plan	Introduction of Preventing ill-health by Risky Behaviours (Smoking and alcohol) CQUIN in 2018 provides ideal platform for launch of a service (would ensure footfall through service and training delivery, as CQUIN focus is on training and increasing referrals to specialist support) Opportunities to embed service within key clinical areas – led by clinical champion Supports Trusts smokefree policy	NRT costs Lack of commitment from staff to CQUIN Lack of organisational leadership	Consider as an option Yes, as part of level 3 priority groups in proposed model

6 There is good evidence from systematic review findings (Chamberlain 2013, Cahill 2015, Morgan 2015) on the effectiveness of financial incentives for promoting smoking cessation in pregnancy.

[7] As will be noted later the evidence for community interventions is not strong and it may be that the reliance on referral to such services does not meet the intensity of provision that is suggested as necessary by the evidence.

Intervention	Summary	Evidence of effectiveness	Expected quit rates[2]	Benefits/opportunities	Risks	Commissioning recommendation and inclusion in proposed model (Yes/No)
		example of an effective stop smoking support pathway within the hospital setting[xv]				
Primary Care GP led specialist support	GP practices offering one to one specialist support with access to NRT	5.6% uptake specialist support with combined NRT	Could achieve 15 % absolute quit rates.	Local GP practices already have skilled staff to deliver stop smoking interventions. (This could compliment primary care based support if offered as an option through primary care.)	Individual GP practices will need to sign up to provide the service, engage with relevant training and comply with monitoring data requirements. NRT prescribing policy to determine eligibility criteria and budget to be determined to support scheme	Suggest utilise GP setting for brief advice – as above. And for those practices that choose to deliver the specialist support, contracts will be offered. Yes, as part of level 2b of proposed model
Mental Health Inpatient acute setting (Lancashire Care) - 'Inpatient stop smoking service and community out-reach'	Implementing a tailored tobacco dependence service in mental health trusts through the development of an integrated smoking care pathway, whilst offering flexible support for smoking cessation and reduction programmes through the use of dedicated staff to provide the service	Can result in a modest service uptake rate overall. However, in the inpatient setting, where smokers can be easily identified due to smoking status recording being mandatory, almost a quarter of all smokers are expected to engage with the service. [xvii]	unknown	Lancashire Care established Nicotine Management Policy including smokefree site Lancashire Care already prescribe NRT to all inpatients who are identified as smokers Opportunities to utilise peer support workers to support smoking cessation implementation[8][xviii]	Lack of commitment from staff in relation to training uptake or referring to inpatient service	Pilot service over 12 months to include full robust evaluation Yes, as part of level 3 priority groups in proposed model

[8] There is a key role for peer support workers (PSWs) in improving outcomes around smoking

Appendix 7(c)

Summary of proposed smoking cessation model 2018

Contents

Additional information 1

Smoking Cessation Model – 2018

(See annex A for estimate assumptions relating to this model)

Level 1 - Self-management

Self-management via existing internet, apps, national telephone line. Supported with local marketing

Natural quit rate of those smokers- who make a quit attempt = 2%
(This is the success rate of those who attempt to quit without support) (NICE, 2018). Smoking cessation interventions and services)

Estimated 4-week quits from entire stop smoking model

832 quits/yr (CO verified)

Cost per CO verified quit = £289

Estimated total cost for entire stop smoking model
(this includes training, level 1, level 2a,2b & 2c, Level 3a,3b & 3c)

= £353,614 (35% saving on previous service)

The previous specialist stop smoking service in 16/17 achieved 554 CO verified quits

Training

Brief support and signposting from GPs, pharmacies, youth services, Children's Centres, hospital CQUIN treatment services including drug and alcohol treatment

Level 2 - Universal support

Level 2a: Support via pro-active telephone line. 10 sessions for 2 months. Pay per contact

Awaiting evaluation of London and Manchester pilots to be published to be able to estimate quit rates for Blackpool model

Level 2b: Support via pharmacies. Self-funded NRT, Behavioural support, CO verified. Payment by Results

- Estimate 624 registrations/yr
- Estimate 168 quits/yr
- Quit rate at 4 weeks = 26%
- **Cost per quit = £109**

Level 2c: GP led support in some practices. Self-funded NRT, Behavioural support, CO verified. Payment by Results

- Estimate 548 registrations/yr
- Estimate 244 quits/yr
- Quit rate at 4 weeks = 45%
- **Cost per quit = £83**

Level 3 - Intense support for priority groups

Level 3a: Support via Maternity Health Trainers. Support through whole pregnancy, funded direct NRT supply, incentive scheme. Block payment (funded by LA & CCG)

- Estimate 372 registrations/yr
- Estimate 70 quits/yr
- Quit rate at 4 weeks = 18%
- Total cost per quit (CCG & LA) £2,227
- **Cost to LA per quit = £1,573**

Level 3b: Support via Stop Smoking Team in Blackpool Teaching Foundation Trust for inpatients (including follow-up as outpatients) Block payment, with BTH funding supply of NRT for inpatients and 7-day supply on discharge.

- Estimate 1,000 registrations/yr
- Estimate 350 quits/yr
- **Cost per quit = £263**

Additional information 2

Table 1. The difference between the current standard offer, by intervention/setting, and the offer that will be delivered in addition to the standard offer by introducing the new model.

Intervention/setting	Standard offer	Additional offer by introducing new model
Self-management	Self-management strategies and interventions may include printed leaflets, internet based interventions and mobile phone apps amongst others. A number of existing resources are available for individuals to access for self-management; • NHS Smoke free mobile app • NHS Smoke free Text Messaging The NHS Smokefree app has been reviewed by NHS Digital which endorses the app as being rooted in evidence based practice and can be downloaded through to a mobile phone or computer through platforms including i-Tunes or Google Store. The Organisation for the Review of Care and Health Applications (ORCHA) carries out independent and impartial reviews of health and care-related mobile apps	Smokers seeking information on quitting from generic websites and key front line staff will be signposted to the information available within the standard approach. The new model will require the following websites and other platforms to be updated to include the self-management information on stopping smoking including: Blackpool Council website Blackpool Teaching Hospitals Pharmoutcomes Fylde Coast Directory of Services Social media feeds including Facebook and Twitter will be used to promote national Stop Smoking campaigns for example Stoptober. Leaflets will also be produced to promote and encourage the use of the self-management resources locally.

	and presents the apps on a public and professionally facing digital platform[xix]. ORCHA has reviewed the following smoking app: • *Smokefree-quit Smoking now and stop for good* by David Crane Other apps include: PHE OneYou-Stoptober app Local people may also receive news and updates regarding stop smoking campaigns on social media feeds including Twitter and Facebook.	
Training	The National Centre for Smoking Cessation Training provides an online 'very brief advice' e-learning module which health professionals can access. PHE have produced a free online e-learning programme to support healthcare professionals to embed screening and brief advice about alcohol and smoking into their routine practice. It focuses on two brief interventions that are recommended by NICE and incentivised through the 2017/2019 CQUIN scheme:	The new model provides an offer of face-to-face training to supplement the existing online training offer under the standard approach.

	1. Very Brief Advice on Smoking, and 2. Alcohol Brief Advice	
Proactive telephone support	NHS Smokefree is a free reactive national telephone helpline. Smokers can phone the helpline and speak to trained advisers for information and support on stopping smoking. However it should be noted that the helpline only provides reactive support to callers with no follow up service.	The proactive telephone support approach is currently being piloted in London and Manchester. Existing telephone advisers are trained to deliver enhanced stop smoking support. This option would enable users to work with smokefree advisers to create their own personal quit plan, through a series of outbound support telephone calls to help and support with their quit attempt. Users of the service would receive a maximum of 10 calls over a 2 month period. A bespoke telephone number would be created and eligible people calling the generic Smokefree phone number (within the standard offer) are directed to the enhanced service. There is evidence that proactive quit lines are effective for stopping smoking and can be delivered to a large population of smokers. GPs and other health and social care professionals trained to provide brief advice would be able to refer to the quit line for ongoing behavioural support. Expert advisers are able to signpost to local pharmacies for (self-funded) NRT.
Community pharmacy	As part of the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract') pharmacies are required to participate in up to six public health campaigns at the request of NHS England. This involves the display and distribution of leaflets provided by NHS England. In addition, pharmacies are	**(Level 2b)** The Community Pharmacy Led Smoking Cessation Service is expected to deliver the following activity beyond the standard approach, following the NCSCT Standard Treatment Programme http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf • Structured individual Face to face consultations • Telephone counselling

	required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation. Under the contract community pharmacies are expected to help people who ask for assistance by directing them to the most appropriate source of help (for example stop smoking support services).	• Prompt and accurate client data input to Pharmoutcomes database and submission to commissioner • Provide advice on all NICE approved stop smoking medicines as first line treatment (selling NRT over the counter and request other medications i.e. Varenicline, where appropriate, via the client's GP) • As a minimum, clients are to receive face-to-face appointments at the following points during their quit journey; - pre-quit assessment - on the quit date - one per week for 4 weeks following the quit date - at 12 weeks following quit date - at 26 weeks following quit date Carbon monoxide breath tests should be taken at each visit The payment breakdown is as follows:

Activity	Value (£)	Measure
Patient sets a quit date*	20.00	Date set recorded
Patient achieves 4 week quit	35.00	CO Validated and recorded on database within set timescales
Patient achieves 12 week quit	50.00	CO Validated and recorded on database within set timescales
Patient achieves 26 week quit	50.00	CO Validated and recorded on database within set timescales

Total potential value = £155 per patient through service.
*setting the quit date forms part of the pre-quit assessment (1 or 2

		weeks prior to the actual quit date). This appointment can last up to 30 minutes and must include the following components to comply with the NCSCT Standard Treatment Programme; - assessment of the clients current readiness and ability to quit - information about the treatment programme - assessment of smoking history - assessment of past quit attempts - explanation of how tobacco dependence develops and assessment of nicotine dependence - carbon monoxide screen - discussion about withdrawal symptoms and stop smoking medications - setting the quit date, discussion regarding preparations and summary of session
General Practice	NICE Public Health guidance (ng92), 2018, recommends that asking about smoking status, giving advice and referring to specialist stop smoking support should be part of routine care. Where patients are not ready to quit, they should be provided with more information on the benefits of quitting and health professionals should use each contact to find out if they are ready to take up the offer for support. The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice	**(Level 2c)** The GP Practice Led Smoking Cessation Service is expected to deliver the following activity beyond the standard approach, following the NCSCT Standard Treatment Programme http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf • Structured individual Face to face consultations • Telephone counselling • Prompt and accurate client data input to Outcomes 4 Health database and submission to commissioner • Prescribe all NICE approved stop smoking medicines as first line treatment • As a minimum, clients are to receive face-to-face appointments at the following points during their quit journey; - pre-quit assessment

achievement results. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.xx Under the QOF framework there are a number of indicators relating to smoking:

Indicator
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months.
SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of

- on the quit date
- one per week for 4 weeks following the quit date
- at 12 weeks following quit date
- at 26 weeks following quit date

Carbon monoxide breath tests should be taken at each visit

The payment breakdown is as follows:

Activity	Value (£)	Measure
Patient sets a quit date*	20.00	Date set recorded
Patient achieves 4 week quit	35.00	CO Validated and recorded on database within set timescales
Patient achieves 12 week quit	50.00	CO Validated and recorded on database within set timescales
Patient achieves 26 week quit	50.00	CO Validated and recorded on database within set timescales

Total potential value = £155 per patient through service.

*setting the quit date forms part of the pre-quit assessment (1 or 2 weeks prior to the actual quit date). This appointment can last up to 30 minutes and must include the following components to comply with the NCSCT Standard Treatment Programme;

- assessment of the clients current readiness and ability to quit
- information about the treatment programme
- assessment of smoking history
- assessment of past quit attempts
- explanation of how tobacco dependence develops and assessment of nicotine dependence

	an offer of support and treatment within the preceding 24 months SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months.	- carbon monoxide screen - discussion about withdrawal symptoms and stop smoking medications - setting the quit date, discussion regarding preparations and summary of session
Maternity services (BTH)	NICE guidance 'Smoking: stopping in pregnancy and after childbirth (PH26)' recommends as standard practice, and within the Saving Babies' Lives Care Bundle[xxi], that all pregnant women are Carbon Monoxide (CO) screened and those with elevated CO levels referred via an opt-out system for specialist support. Blackpool Teaching Hospitals NHS Foundation Trust (BTH) Maternity Service implement these recommendations through an established opt-out smoking cessation pathway, ensuring that all women are CO screened at booking appointment	**(Level 3a)** This level of support is provided by a team of Maternity Health Trainers (MHTs) employed within BTH Maternity Service. The service provides tailored behavioural support and direct access to Nicotine Replacement Therapy, in line with NICE guidance, for a minimum of 12 weeks. The MHTs provide the woman with intensive and ongoing support throughout pregnancy and beyond. This includes regularly monitoring her smoking status using CO screening. The service also provides an incentive scheme. The aim of this scheme is to support all pregnant women to set a quit date, achieve a CO validated 4 week quit, sustain the quit hence support throughout pregnancy and 12 weeks post-partum, through offering an incentive payment at stages throughout the pregnancy.

	and at 36 weeks in their pregnancy by a midwife.	A risk perception intervention is also delivered by the MHT service. The intervention enhances the existing antenatal smoking cessation pathway by delivering an additional intervention to those women who have not engaged with stop smoking support earlier in their pregnancy. This intervention is delivered at the first trimester ultrasound appointment by a maternity health trainer.
Secondary care services (BTH)	The NHS commissioning for quality and innovation (CQUIN) scheme delivers clinical quality improvements and drives transformational change. There are 13 national indicators in the 2017 to 2019 CQUIN scheme, including the Preventing ill health by risky behaviours from alcohol and tobacco CQUIN indicator. To achieve this CQUIN Trusts will be expected to; 1. Establish information systems that enable alcohol and smoking interventions to be recorded. 2. Train relevant staff to confidently deliver alcohol identification and brief advice and tobacco very brief advice. 3. Establish a baseline level of performance against core parts of this CQUIN	**(Level 3b)** This provision will integrate targeted tobacco dependence treatment support into the acute hospital setting, adopting NICE PH48 guidelines and the Ottawa model. It is proposed that the service will sit within the respiratory division at Blackpool Teaching Hospitals NHS Foundation Trust led and championed by an existing Respiratory consultant. Although the service will not be limited to respiratory patients. A dedicated team will be recruited by Blackpool Teaching Hospitals to provide targeted stop smoking behavioural support at the bedside as part of an overall tobacco dependence treatment plan for patients. The service will also provide outpatient clinics (within Blackpool Victoria Hospital outpatients department and within community venues) and telephone support to ensure continued support for a minimum of 4 weeks post-discharge. The support provided will follow the NCSCT Standard Treatment Programme; http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf

	The core parts to this CQUIN indicator, to be delivered as routine practice are: 1. Tobacco screening, which involves asking and recording patients' smoking status. 2. Tobacco brief advice, which involves advising patients who smoke on the best way to quit. 3. Tobacco referral and medication offer, which involves offering patients who smoke stop smoking medication and referring them to an evidence-based stop smoking intervention. 4. Alcohol screening, which involves asking and recording patients' level of alcohol consumption. 5. Alcohol brief advice or referral, which involves advising patients, who are consuming alcohol at increasing and higher risk levels, on the benefits of cutting down and referring patients who are potentially alcohol dependent to further support. All of these activities are directly linked to CQUIN payments for Trusts.	

Additional information 3

The information below describes in further detail;

- **the estimated number of people expected to quit if no service existed**
- **the estimated number of smokers who are expected to stay quit after 12 months and the additional life years gained, following support from the new stop smoking service**

2% of people that attempt to give up smoking without any support remain non-smokers after 12 months[xxii].

- Of the 2,544 people who are expected to register for stop smoking support every year in the new model, 50 (2%) would still have quit if the service didn't exist.

It is estimated that approximately 65% of people who do not smoke 4 weeks after a stop smoking intervention remain non-smokers after 12 months[xxiii]. Once people have not smoked for 12 months the rate of relapse is negligible.

- This stop smoking service model is expected to achieve approximately 832 CO verified 4 week quits, therefore 540 (65%) will still not smoke after 12 months.
- After accounting for the 50 who would have quit anyway, 490 will still have stopped after 12 months because of the service.

On average people using the Blackpool stop smoking service in 2016/17 were aged in their late 40s. The World Health Organisations states that, for those who quit smoking at about the age of 50, they can on average gain 6 years of addition life[xxiv].

- If we use this figure of 6 years of life gained as a measure of the health benefit that this cohort of 490 people might expect to receive from stopping smoking via the new service model, we can estimate over these people's lifetimes they will gain 2,940 extra years of life. In the long term this will have a positive impact on Blackpool's mortality rate and overall life expectancy.

Based on NICE guidelines the NHS will pay £20,000 - £30,000 for treatment for each additional year of life gained in good health. Although not all of the estimated 2,940 extra years of life gained will be in good health (also NICE apply a 3.5% annual discounting rate), it is clear that following NICE guidelines the NHS would be willing to provide several million pounds of funding to achieve the kind of health benefits from medical treatments that the new stop smoking service model is expected to achieve.

This model's overall purpose is to achieve cost-effective health gains for the Blackpool population rather than cost-savings for the council.

Annex A

Estimate assumptions

The model estimates are based on evidence reviews and data from previous models implemented in Blackpool, including the Specialist stop smoking service, hospital in-house stop smoking service, pharmacy and GP pilot and maternity health trainer pilot.

Level 1

It is difficult to estimate the impact of Level 1 within the model but, where we can pull data from this level of support we will monitor performance. The amount costed to this element is to develop ensure self-management options are promoted through local marketing.

Level 2a Support via pro-active telephone line. 10 sessions for 2 months. Pay per contact

We are awaiting the evaluation of the London and Manchester pilots to be published before we can estimate quit rates for Blackpool.

Level 2b Support via pharmacies. Self-funded NRT, Behavioural support, CO verified. Payment by Results

Our assumption for registrations and quit rate is based on data from the pilot period between 1st January-31st March 2018.

In this period there were 17 community pharmacies actively delivering the service.

In this period there were;

156 registrations

42 x 4-week quits (co verified)

26 % quit rate

We estimate over a 12 month period, based on the pilot, there will be;

Approximately 624 registrations/yr

Approximately 168 quits/yr

Level 2c GP led support in some practices. Self-funded NRT, Behavioural support, CO verified. Payment by Results

Our assumption for registrations and quit rate is based on data from the pilot period between 1st January-31st March 2018,

In this period there were 5 GP practices actively delivering the service.

In this period there were;

137 registrations

61 x 4-week quits (co verified)

45% quit rate

We estimate over a 12 month period, based on the same 5 GP practices actively delivering the service, there will be;

Approximately 548 registrations/yr

Approximately 244quits/yr

Level 3a: Support via Maternity Health Trainers. Support through whole pregnancy, funded direct NRT supply, incentive scheme. Block payment

Our assumption for registrations and quit rate is based on data from the pilot period between 1st November 2017- 28th February 2018.

In this period there were;

124 registrations

23 x 4-week quits (co verified)

18.5 % quit rate

We estimate over a 12 month period, based on the pilot, there will be;

Approximately 372 registrations/yr

Approximately 70 quits/yr

Level 3b: Support via Stop Smoking Team in Blackpool Teaching Foundation Trust for inpatients (including follow-up as outpatients). Block payment

Our assumptions for registrations and quit rates are based on the NICE (2016) Preventing ill health: CQUIN Supplementary guidance;

- Estimated number of admissions (excluding maternity and day cases) = 54,000/yr
- Expect 90% screened for smoking (based on CQUIN target) = 48,690/yr
- Expect 25% of those screened to be a smoker = 12,000/yr
- Expect 30% of those smokers to accept support = 3,500/yr
- Expect 35% quit rate at 6 months = 1,100
- However, realistically based on capacity of the proposed service, the number of registrations is more likely to be in the region of 1000 patients registering for support, achieving 350 quits per year.

Additional information:

- This reasonable level of service could be achieved with the reduction in funding but is very reliant in particular on BTH to achieve the figures estimated for the inpatient stop smoking support – this is a potential risk in the model. The new CQUIN should support the high level of activity here. Additionally, the previous inpatient service did achieve 250 patients/month through which equates to the same estimates presented in the model based on the evidence base.
- It is difficult to estimate the impact of Level 1 within the model but, where we can pull data from this level of support we will monitor performance.
- The training element of the model is in relation to training the workforce and so estimates have been made on numbers of workforce to be trained – it is not relevant here to include quit numbers. It is estimated that at-least 500 staff will be trained through the new model.
- Level 3a, support for pregnant women who smoke, proposes a higher cost per quit rate than all other elements within the model. This is due to the inclusion of direct supply of nicotine replacement therapy and an incentive scheme. There is good evidence from systematic review

findings[xxv] [xxvi] [xxvii] on the effectiveness of financial incentives for promoting smoking cessation in pregnancy. Financial incentive schemes were found to be the most promising additional intervention when compared with counselling, feedback, health education and peer support, improve cessation rates, both in pregnancy and postpartum, and be effective when issued based on biochemically validated smoking cessation in pregnancy and until three months postpartum. Furthermore, 'if reward for cessation was effective it would be acceptable to the public and professionals'. NICE guidance[xxviii] states that ideally, pregnant or breastfeeding women should stop smoking without using licensed nicotine-containing products, but if this is not possible, these products may be used. As this group is such a priority it is deemed essential that the direct supply of NRT and an incentive scheme is included within this element of the model.

Glossary of Terms

ORCHA	Organisation for the Review of Care and Health Applications	
BTH	Blackpool Teaching Hospitals Foundation Trust	Local hospital provider
CCG	Clinical Commissioning Group	The local funder of NHS care
CHD	Coronary heart disease	
CKD	Chronic kidney disease	
CO verified	Carbon monoxide verified	Method to test whether an individual has remained smoke free
COPD	Chronic obstructive pulmonary disease	
CQUIN	Commissioning for Quality and Innovation	Scheme to incentivise best healthcare practice
LA	Local Authority	Blackpool Council
MHT	Maternity health trainers	Provide intensive support throughout pregnancy and beyond
NCSCT	National Centre for Smoking Cessation Training	Supports tobacco control and smoking cessation interventions

NICE	The National Institute for Health and Care Excellence	Provides national guidance to improve health and social care
NRT	Nicotine replacement therapy	Reduces withdrawal effects which may occur when stopping smoking
PAD	Peripheral arterial disease	
PHE	Public Health England	Provides evidence-based professional, scientific expertise
QOF	Quality and Outcomes Framework	A reward and incentive programme for all GP surgeries

References

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ii Cochrane Tobacco Addiction Group - http://tobacco.cochrane.org/evidence

iii NICE Public Health Guidance: Supporting smokers to stop - https://www.nice.org.uk/guidance/ph10

iv NICE Quality Standard: Smoking: Supporting smokers to stop - https://www.nice.org.uk/guidance/qs43

v NCSCT Service and Delivery Guidance - http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

vi Cochrane review: Civljak, M., Stead, L.F., Hartmann-Boyce J., Sheikh A, & Car, J. (2013). Can Internet-based interventions help people to stop smoking? http://www.cochrane.org/CD007078/TOBACCO_can-internet-based-interventions-help-people-to-stop-smoking

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[xvi] NICE (2016). Preventing ill health: CQUIN Supplementary guidance. https://www.england.nhs.uk/wp-content/uploads/2016/12/prevention-cquin-supplmnt-guid.pdf

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[xix] https://www.orcha.co.uk/
[accessed 4th October 2017]

[xxi] NHS England. Saving Babies' Lives - A Care Bundle for Reducing Stillbirth . 2016 (viewed June 2017)
[xxii] NICE, Smoking Cessation Interventions and Services, https://www.nice.org.uk/guidance/ng92/evidence/march-2018-economic-modelling-report-pdf-4790596573
[xxiii] Relapse prevention in UK Stop Smoking Services: current practice, systematic reviews of effectiveness and cost-effectiveness analysis, Coleman T et al, Health Technology Assessment 2010; Vol. 14: No. 49
[xxiv] World Health Organisation - Fact sheet about health benefits of smoking cessation, http://www.who.int/tobacco/quitting/benefits/en/
[xxv] Chamberlain, C, O'Mara-Eves A, Oliver S, Chaird JR, Perlen SM, Eades SJ, et al. (2012) Psychosocial interventions for supporting women to stop smoking in pregnancy. Cochrane Database Syst Rev.
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[xxviii] NICE, (2013) Smoking: acute, maternity and mental health services. Public health guideline [PH48] Published date: November 2013.

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Sharon Davis, Scrutiny Manager
Date of Meeting:	11 July 2018

ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE WORKPLAN 2018-2019

1.0 Purpose of the report:

1.1 To consider the Adult Social Care and Health Scrutiny Committee Workplan 2018-2019, together with any suggestions that Members may wish to make for scrutiny review topics.

2.0 Recommendations:

2.1 To approve the Adult Social Care and Health Scrutiny Committee Workplan 2018-2019, taking into account any suggestions for amendment or addition.

2.2 To monitor the implementation of the Adult Social Care and 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 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 **Adult Social Care and Health Scrutiny Committee Workplan**

5.1.1 The Adult Social Care and Health Scrutiny Committee Workplan 2018-2019 is attached at Appendix 8 (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.

5.1.3 Members may wish to consider opportunities for undertaking short, focused reviews through single dedicated meetings. There would be time for these in September 2018 and/or December 2019. Further discussion would be required with lead officers (and possibly health partners) to establish current challenges, work and plans and what additional value could be added through a review.

5.1.4. Subject to the above proviso, the following significant integrated topics may offer real potential:

- Delayed transfers of care / 'bed blocking'
- Accident and Emergency waiting times / ambulance turnover times
- Obesity - work being pursued by health partners
- Dementia - future provision

5.2 **Adult Social Care and Health Scrutiny Committee Review Checklist**

5.2.1 The Adult Social Care and Health Scrutiny Committee Review Checklist is attached at Appendix 8 (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 Committee, prior to a topic being approved for scrutiny.

5.3 **Implementation of Recommendations/Actions**

5.3.1 The table attached to Appendix 8 (c) has been developed to assist the Adult Social Care and 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..

5.3.2 Members are requested to consider the updates provided in the table.

Does the information submitted include any exempt information? No

List of Appendices:

Appendix 8 (a), Adult Social Care and Health Scrutiny Committee Workplan 2018-2019
Appendix 8 (b), Adult Social Care and Health Scrutiny Committee Review Checklist
Appendix 8 (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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Adult Social Care and Health Scrutiny Committee - Work Programme 2018-2019	
Sept 2018	Potential scrutiny review (single meeting) - significant added value themes to be identified
10 Oct 2018 (was 26 Sept)	1. **Health and Social Care Integration Progress** (focus on Integrated Care Partnerships / Sustainability Transformation Plans) 2. **Availability/Duration of GP Appointments and A&E waiting/turnaround times** (Access to Services and Quality) - may be considered as a dedicated single meeting review (see September above) 3. **Lancashire Care Foundation Trust - Improvement Plan** tbc 4. **'State of the Nation' Annual Report**
28 Nov 2018	1. **Blackpool Safeguarding Adults Board Annual Report 2017-2018, 2018-2020 Priorities** 2. **Healthwatch Progress Report 2017-2018 (Apr 2017 - Mar 2018), 2018-2019 Priorities** 3. **Priority Two - Key Priority Report: Public Health and Social Care** 4. **Blackpool Clinical Commissioning Group Performance Report - Mid-Year 2018-2019** 5. **Scrutiny review report (see September above)**
Dec 2018	Potential scrutiny review (single meeting) - significant added value themes to be identified
13 Feb 2019	1. **Adult Services Overview** (including Transforming Care for Adults with Learning Disabilities progress) 2. **Public Health Overview** 3. **Progress with breastfeeding / infant feeding support** tbc 4. **Scrutiny review report (see December above)**
Apr 2019 (Period for comments)	Note - Members' comments will be sought by email, final responses signed-off by the Chair 1. **Responses to draft quality accounts** • Lancashire Care Foundation Trust • Blackpool Teaching Hospitals • North West Ambulance Service
3 July 2019	Note - date subject to confirmation (Annual Council, May 2019) 1. **Blackpool Clinical Commissioning Group Performance Report - End of Year 2018-2019** 2. **Annual Council Plan Performance report on relevant Priority Two projects**, complete with 'Blackpool Outcomes' - for summer 2019. 3. **Adult Services Overview** 4. **Public Health Overview**

Items covered during 2018-2019	
11 July 2018 (was 4 July)	1. **Blackpool Clinical Commissioning Group Performance Report - End of Year 2017-2018** 2. **Annual Council Plan Performance report on relevant Priority Two projects**, complete with 'Blackpool Outcomes' - for summer 2018. 3. **Adult Services Overview** 4. **Stop Smoking - Service Model** - specification options)

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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:**

Date last updated: 03.07.18

Appendix 8 (c)

ADULT SOCIAL CARE AND HEALTH SCRUTINY - ACTION TRACKER

Colour code: red = significant risk of missing deadline / not being completed (mitigation required); amber = some risk; white = new action; green = complete

GREEN ACTIONS ARE ONLY SHOWN FOR THE IMMEDIATE MEETING FOLLOWING COMPLETION OF ACTION

AMBER ACTIONS

NEW ACTIONS (OR NOT DUE YET) - THESE ARE NOT COLOUR CODED

REC NO.	**DATE OF REC.**	**RECOMMENDATION**	**TARGET DATE**	**RESPONSIBLE OFFICR**	**UPDATE** (NOTE - ANY EXTENSIVE RESPONSES ARE FURTHER BELOW AFTER THE END OF THE TABLE)	**RED AMBER GREEN**
30	HSC 14.12.16	Update before the March 2017 meeting from Councillor Cross on GP patient referral rates for support to stop smoking.	Mar 2017	Cllr Cross, Cabinet Member for ASC / Health	17.04.17 Reminder to be sent, response expected before 26.04.17. 27.09.17 - a comprehensive report on the new service will be provided as part of the Public Health overview report (Nov 17). 28.11.17 - ref made during 15.11.17 meeting to new service to support smoking reduction to be commissioned in early 2018, Scrutiny will want opportunity to comment. 16.01.18 Potential new service specification / model will be considered at 14.03.18 meeting and can include an update on GP patient referral rates. 14.03.18 Item deferred. 01.05.18 - updated referral rates to be considered at 04.07.18 meeting (smoking service item) 23.05.18 - to be considered at 11.07.18 meeting (smoking service item). **11.07.18 Members may confirm that the report meets requirements, i.e. action to be considered complete**.	Amber
41	ASCH 15.11.17	Performance reports to include targets for all indicators in the main pages.	11.07.18 tbc	Ruth Henshaw, Council performance	**Note - next report (end year) due July 2018.** Interim response from ASC - not appropriate to set targets for every indicator. The performance report will explain where this is the case - Members can discuss and decide whether they still want a target. **11.07.18 Members may confirm that the report meets requirements, i.e. action to be considered complete**.	

REC NO.	DATE OF REC.	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICR	**UPDATE** (NOTE - ANY EXTRENSIVE RESPONSES ARE FURTHER BELOW AFTER THE END OF THE TABLE)	RED AMBER GREEN
42	ASCH 15.11.17	Target-setting methodology to be in performance reports where targets not being met or proposals to reset targets.	11.07.18 tbc	Ruth Henshaw Supported by service leads (Karen Smith, Arif Rajpura)	**Note - next performance report due July 2018** but if Directorate Overview reports (due March 2018) contain targets off-track / changes proposed then methodology info required. **11.07.18 Members may confirm that the report meets requirements, i.e. action to be considered complete.**	
44	AHSC 24.01.18	'Zero' suicide target should be adopted within Blackpool	14.03.18	Zohra Dempsey, Public Health	06.03.18 To be raised by Public Health (Judith Mills) at the next Suicide Prevention Oversight Group for Lancashire and South Cumbria on 19 March 2018. 01.05.18 Considered by the sub-regional group, recognise the aspiration for no suicides but some concerns that families of victims may feel they are at fault and that NHS England have set an achievable 10% reduction target nationally linked to funding support. Members may wish to consider whether they wish to accept this or reiterate their recommendation to sub-regional group (or higher, e.g. Sustainability and Transformation Partnership at board level) citing other areas which have set themselves a zero target, e.g. Mersey Care NHS, Bolton Council's Public Health. Other factors of interest include changes to Coroners' rules so that deaths may be recorded when suspected suicide (previously had to be no doubt of this) and that there are nearly no suicides within controlled health provider environments. 09.05.18 Re-iterated recommendation that a 'zero' suicide target should be adopted within Blackpool; Raise the proposed target again at the Suicide Prevention Oversight Group for Lancashire and South Cumbria and, if required, escalate to the parent body providing a written response by the Committee's next meeting on 11 July 2018. **23.05.18 Lancashire and South Cumbria Suicide Prevention Oversight Group signing up to zero suicide as a long-term aspiration locally. 10% reduction target by 2021 set out in the NHS Five Year Forward View is a national target and remains the same. Action complete.**	Green

REC NO.	DATE OF REC.	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICR	**UPDATE** (NOTE - ANY EXTRENSIVE RESPONSES ARE FURTHER BELOW AFTER THE END OF THE TABLE)	**RED** **AMBER** **GREEN**
47	AHSC 24.01.18	Consider targeted community options for support and mental health awareness-raising and report back on progress.	14.03.18	Zohra Dempsey, Public Health	06.03.18 This is being considered as part of the scoping work for a local adult mental wellbeing campaign using the five ways to wellbeing - the campaign will link people up with community-based options and there will be some targeting of those at risk of low wellbeing. There are also plans for a national campaign, raising awareness of mental health. The national campaign will concentrate on people without a diagnosis - those coping and those struggling. There will be a strong emphasis on self-care and how we can help other people. It may target particular populations (e.g. perinatal women). The campaign will cover anxiety, depression, sleeping, low mood and stress, debt, building resilience, exercise and mindfulness. It will also show people how to recognise the signs of stress in others, promote good listening skills and how to have supportive conversations. **Initial action completed (left on tracker for progress update in summer 2018). 03.07.18 Update to be sought.**	Not due yet
51	AHSC 24.01.18	A&E targets, with clear explanations, should be shown in future CCG performance reports	11.07.18 tbc	Kate Newton. CCG	**11.07.18 Members may confirm that the report meets requirements, i.e. action to be considered complete.**	Not due yet
52	AHSC 24.01.18	Dec 17 performance figures for NWAS would be provided by the Committee's next meeting on 14 March 2018.	14.03.18	Kate Newton. CCG	06.03.18 To be chased. 01.05.18 This will be provided before the 9 May meeting else shortly after. **23.05.18 To be provided before or for the 11 July meeting. 11.07.18 Members may confirm that the report meets requirements, i.e. action to be considered complete.**	Amber

REC NO.	DATE OF REC.	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICR	**UPDATE** (NOTE - ANY EXTENSIVE RESPONSES ARE FURTHER BELOW AFTER THE END OF THE TABLE)	RED AMBER GREEN
55	AHSC 09.05.18	Lancashire Care Foundation Trust's Director of Engagements and Partnerships to be contacted to resolve the concerns over communications with Rethink members and ensure good attendance at Mental Health Partnership Board meetings.	11.07.18	Sandip Mahajan, Scrutiny	23.05.18 LCFT Director (Steve Winterson) has been sent dates of Partnership Board meetings and has confirmed mental health rep will be attending. Suggested that an informal meeting take place between the Director and Rethink rep to discuss/resolve communications issues (date to be confirmed). The Director was sent minutes of the May meeting.	Green
56	AHSC 09.05.18	To receive a further report on health and social care integration, focusing on the Lancashire and South Cumbria Integrated Care System / Sustainability and Transformation Planning.	10.10.18	David Bonson, CCG	03.07.18 On agenda for 10.10.18.	Not due yet
57	AHSC 09.05.18	To receive contact details for all the neighbourhood hubs.	11.07.18	Jeannie Harrop, CCG	23.05.18 Received and emailed to Members.	Green