Blackpool Council

2 June 2015

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 10 June 2015 at 3.00 pm
Solaris Centre, New South Promenade

A G E N D A

1 DECLARATIONS OF INTEREST

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

(1) the type of interest concerned; and

(2) the nature of the interest concerned

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

2 MINUTES OF THE LAST MEETING HELD ON 4TH MARCH 2015 (Pages 1 - 4)

To agree the minutes of the last meeting held on 4th March 2015 as a true and correct record.

3 HEALTH AND WELLBEING BOARD MEMBERSHIP UPDATE (Pages 5 - 8)

Following the Annual Council meeting on the 22nd May 2015 to receive an update to the membership of the Board.

4 STRATEGIC COMMISSIONING GROUP UPDATE (Pages 9 - 26)

To receive an update on the work of the Strategic Commissioning Group including the minutes of the meetings held on the 14th April 2015 and 21st May 2015

5 JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY SELF-ASSESSMENT FRAMEWORK 2014 (Pages 27 - 42)

To consider the Blackpool self-assessment framework.

6 LANCASHIRE SCREENING AND IMMUNISATION PROGRAMMES ANNUAL REPORT 2013-2014 (Pages 43 - 84)

To consider the annual report on the Lancashire Screening and Immunisation programmes.

7 FYLDE COAST NEW MODELS OF CARE- VANGUARD UPDATE (Pages 85 - 98)

To receive an update on the Fylde Coast new models of care and its inclusion in NHS England's Vanguard Programme

8 LANCASHIRE FIRE AND RESCUE SERVICE COMMUNITY SAFETY STRATEGY 2014-2017 (Pages 99 - 120)

To receive an update on the Lancashire Fire and Rescue Service's Community Safety Strategy.

9 DATE OF FUTURE MEETINGS

To note the date of future meeting as follows:

15th July 2015
2nd September 2015
21st October 2015
2nd December 2015
27th January 2016
2nd March 2016
20th April 2016

Venue information:

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

Other information:

For queries regarding this agenda please contact Lennox Beattie, Executive and Regulatory Manager, Tel: 01253 477157, e-mail : Lennox.beattie@blackpool.gov.uk

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

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 4 MARCH 2015

Present:

Councillors Clapham, Collett and Rowson

Dr Arif Rajpura, Director of Public Health
Simon Bone, Lancashire Fire and Rescue
David Bonson and Roy Fisher, Blackpool Clinical Commissioning Group
Jane Higgs, NHS England
Joan Rose, Blackpool Healthwatch

In Attendance:

Lennox Beattie, Executive and Regulatory Support Manager
Venessa Beckett, Corporate Development and Policy Officer
Stephen Boydell, Principal Public Health Intelligence Practitioner
Scott Butterfield, Corporate Development Manager
Neil Jack, Chief Executive
Carmel McKeogh, Deputy Chief Executive
Liz Petch, Public Health Specialist
Sally Shaw, Head of Corporate Development, Engagement and Communications

Hazel Walton, Lancashire County Council

Matthew Burrow, Blackpool Teaching Hospitals NHS Trust

Helen Lammond-Smith, Blackpool Clinical Commissioning Group

Apologies:

Councillors Blackburn and I Taylor
Delyth Curtis, Director of People
Gary Doherty and Ian Johnson, Blackpool Teaching Hospitals NHS Trust
Dr Amanda Doyle and Dr Leanne Rudnick, Blackpool Clinical Commissioning Group
Richard Emmess, Blackpool Council for Voluntary Service
Heather Tierney-Moore, Lancashire Care NHS Trust

1 APPOINTMENT OF CHAIRMAN

In the absence of the Chairman and Vice-Chairman, the Board considered the appointment of a Chairman for this meeting.

Resolved:

That Mr Roy Fisher be appointed Chairman for this meeting.

2 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

3 MINUTES OF THE LAST MEETING HELD ON 28TH JANUARY 2015

Resolved:

That the minutes of the meeting held on the 28th January 2015 be approved as a correct record.

4 STRATEGIC COMMISSIONING GROUP UPDATE

The Board considered an update on the Strategic Commissioning Group and received the minutes of the meeting held on the 28th January 2015, on which a verbal update had been given at the previous meeting.

The Board noted that subsequent to the agenda for this meeting being distributed, the meeting of the Strategic Commissioning Group scheduled for the 26th February 2015 had been cancelled.

Resolved:

That the update be noted.

5 BETTER CARE FUND UPDATE

The Board received a brief verbal update on the Better Care Fund from Mr David Bonson.

David explained that the Better Care Fund Project Board had been merged with the Strategic Commissioning Group to avoid duplication and ensure further service integration.

It was noted that Fylde Coast areas was being considered as part of the Wave 2 pioneer status and a meeting including a presentation had taken place on the 3rd March 2015 at the Department for Health in London. A further update would be provided to the Board on the outcome of that submission.

Resolved:

1. To note the update.

2. To agree that updates continue to be brought to the Board including on the submission to the Department for Health

6 LANCASHIRE CRISIS CARE CONCORDAT AND ACTION PLAN

Helen Lammond-Smith (Blackpool Clinical Commissioning Group) briefed the Board on the work being undertaken to deliver the mental health crisis care concordat requirements.

She explained that in order to address the obligations for crisis care in mental health it can be agreed to work on across wider area including Lancashire, Blackpool and Blackburn with Darwen and that in this programme was led by Blackburn with Darwen.

The crisis plan and action plan had been developed from a full-agency consultation day held on the 10th October 2014 at Lancashire Constabulary Police Headquarters. The action plan included priorities in four key areas namely access before crisis, emergency care, quality treatment and recovery provision.

Resolved:

1. To note the report and presentation.

2. To approve the Crisis Concordat Action Plan for Blackpool.

7 FYLDE COAST HIGHWAYS AND TRANSPORT MASTERPLAN

The Board received a presentation on the Fylde Coast Highways and Transport Masterplan from Hazel Walton, Transport Planning Manager, Lancashire County Council.

The presentation highlighted that the masterplan was joint document proposed by Lancashire County Council and Blackpool Council to transform road, rail, tram and cycle networks on the Fylde Coast. The proposals sought to boost the economy, reduce gridlock on the roads and support healthy lifestyles. The masterplan was currently being consulted upon.

The Board noted that the masterplan could provide opportunities to meet the Board's priorities especially in promoting healthy lifestyles.

Resolved:

To note the draft Fylde Coast Highways and Transport Masterplan and agree that individual organisations represented on the Board should respond to the consultation if they so wish.

8 PHARMACEUTICAL NEEDS ASSESSMENT

Further to the meeting on the 3rd September 2014, where the Health and Wellbeing Board approved for a sixty day consultation period the draft Pharmaceutical Needs Assessment, Liz Petch updated the Board.

The Board noted that the consultation period had been completed on Friday 19th December 2014 and feedback had been received from a number of organisations. It was explained that the consultation responses had resulted in some minor amendments but no significant changes and the consultation responses all endorsed the key finding of the Needs Assessment. The core findings namely that the Pharmaceutical Needs Assessment should be the basis for all future pharmacy commissioning intentions, pharmacies provide a wide range of services above core contracts and there was no identified need for new pharmacies.

Resolved:

1. To sign off the Pharmaceutical Needs Assessement, which has been amended after consultation.

2. To agree that the Pharmaceutical Needs Assessment is published on both the Health and Wellbeing Board and Joint Strategic Needs Assessment website.

9 PROJECT SEARCH

The Board received an update on Project Search, a one-year work placement programme for students with learning disabilities in their last year of high school.

Mrs Carmel McKeogh, Deputy Chief Executive, outlined the project and its classroom base. She highlighted the advantages for the organisation in terms of recruitment and retention, the work placements and the support for students through their family, a special education teacher and a support worker from Mencap. The key priority for all involved was a focus on an employment goal and supporting the student during this transition.

In addition Jake and Anna two of the students involving Project Search briefly outlined their personal experience of the programme.

Mrs McKeogh encouraged partners to consider being involved as part of Project Search and emphasised the advantages for the organisation and the community as a whole.

Resolved:

1. To note the positive impact of Project Search for the young people involve who are enrolled on the programme.

2. That Board members ask their organisation to consider becoming involved in Project Search either by providing employment opportunities or by replicating the model.

10 DATE OF NEXT MEETING

The Board noted the date of the next meeting as the 10th June 2015.

Chairman

(The meeting ended 4.45pm)

Any queries regarding these minutes, please contact:
Lennox Beattie
Tel: 01253 47 71 57
E-mail: Lennox.beattie@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Mark Towers, Director of Governance and Regulatory Services
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting :	10th June 2015

HEALTH AND WELLBEING BOARD MEMBERSHIP UPDATE

1.0 Purpose of the report:

1.1 To receive an update on the Board's membership following the annual meeting of the Council on the 22nd May 2015

2.0 Recommendation(s):

2.1 To note the membership update.

2.2 To note the appointment of Councillor Graham Cain as Chairman of the Board at the Annual Council meeting on the 22nd May 2015.

3.0 Reasons for recommendation(s):

3.1 The Board needs to receive a membership update following the Annual Council meeting on the 22nd May 2015.

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 to 'improve health and well-being especially for the most disadvantaged'.

5.0 Background Information

5.1 The Council at its annual meeting considers the appointment of its committees, in accordance with the Council's Constitution and the Local Government Act 1972. The appointment and formation of the Health and Wellbeing Board forms part of that consideration.

5.2 The Health and Wellbeing Board had originally been created by the Council at its meeting on the 13th May 2013 and the Council agreed to continue to appoint a Board in line with those principles. The split of membership between organisations would therefore remain the same as previously.

5.3 The Council did agree to revise the membership of the Board to reflect the revisions made to the Executive members' responsibilities. Councillors Graham Cain, Cabinet Secretary (Resilient Communities) and Councillor John Jones, Cabinet Member for School Improvement and Children's Safeguarding have now been appointed to the Board. Councillor Eddie Collett, Cabinet Member for Reducing Health Inequalities and Adult Safeguarding and Councillor Don Clapham, Opposition member, will remain the other two Councillor board members.

5.4 In line with the principle agreed on the 13th May 2013, that the Chairman of the Board should be the Council's statutory councillor appointment, Councillor Graham Cain, Cabinet Secretary (Resilient Communities) has been appointed Chairman of the Health and Wellbeing Board. The Board is asked note that appointment and to note that the Council has also appointed Dr Amanda Doyle to continue the role of Vice-Chairman.

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

None

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People, Blackpool Council
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting	4th March 2015

STRATEGIC COMMISSIONING GROUP UPDATE

1.0 Purpose of the report:

1.1 To receive a verbal update on issues related to the Strategic Commissioning Group.

2.0 Recommendation(s):

2.1 To note the update

3.0 Reasons for recommendation(s):

3.1 The Board has as a key responsibility to receive regular updates on the work programme of the Strategic Commissioning Group and to review future actions.

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:

There are no alternative options to be considered

4.0 Council Priority:

4.1 The relevant Council Priority is

"Improve health and well-being especially for the most disadvantaged"

5.0 Background Information

5.1 The next meeting of the Strategic Commissioning Group is due to take place on 26th February 2015, which is after the Health and Wellbeing Board papers are circulated; therefore a verbal update will be given at the meeting.

5.2 Agenda items include Better Start and Head Start Commissioning; an update on the implementation of the Care Act; and an update on the intermediate care review.

5.3 At its last meeting on the 28th January 2015 the Board received a verbal update on the meeting of the Group held on the 20th January 2015, those minutes are attached for information.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

Appendix 3a: Minutes of the meeting of Strategic Commissioning Group- 20th January 2015

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

Strategic Commissioning Group
Notes and Actions
14 April 2015, 3.00 – 5.00pm
Boardroom, CCG

Present	Delyth Curtis, Director of People (Director of Children's Services), Blackpool Council (Chair) David Bonson, Chief Operating Officer, Blackpool CCG (vice-Chair) Dr Amanda Doyle (OBE), Chief Clinical Officer, Blackpool CCG Gary Raphael, Chief Finance Officer, Blackpool CCG Steve Thompson, Director of Resources, Blackpool Council Wendy Swift, Director of Strategy/Deputy Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Val Raynor, Head of Commissioning, Blackpool Council Dr Arif Rajpura, Director of Public Health, Blackpool Council Dr Mark Johnston, Blackpool CCG Annette Algie (representing Merle Davies, Director of Better Start) Lennox Beattie (representing Mark Towers, Director of Governance and Regulatory Services)
Also present	Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council Pauline Wigglesworth, Manager Specialist Support, Blackpool Council Carmel McKeogh, Deputy Chief Executive Hilary Shaw, Head of Business Support and Resources, Blackpool Council
Apologies	Jane Higgs, Director of Operations and Delivery, NHS England Jane Cass, Head of Public Health, NHS England Karen Smith, Director of Adult Services Andy Roach, Director of Integration and Transformation, Blackpool CCG Judith Mills, Public Health Specialist, Blackpool Council Mark Towers, Director of Governance and Regulatory Services, Blackpool Council Liz Petch, Public Health Specialist, Blackpool Council

1.	**Welcome and apologies.** Del welcomed everyone to the meeting and apologies were given.
2.	**Notes and actions from previous meeting.** Notes from the previous meeting were agreed. **Actions were updated as follows:** **3. SCG Governance**

	The governance review will take place following the elections. **4. Adults and Children's Commissioning Strategy** Val and Kim met with Scott Butterfield to discuss the upstream direction for the Commissioning Strategy. **7. Budget issues** **Action** Del/David/Amanda to set up a discussion about the health economy looking at proposals and solutions to financial constraints.
3.	**Better Start Commissioning and Contracting Arrangements** Annette Algie presented the report setting out the commissioning and contracting arrangements for Better Start. Workforce implications were discussed and the need for this to be considered in the round; Wendy Swift is leading on workforce reforms. Evaluation was also raised as a key area; this is being considered by the Better Start Finance Group to ensure it was wide ranging and would meet the requirements of the project. It was proposed that the SCG provides 'oversight' to commissioning for 0-3's across Blackpool, which following discussion was agreed should be amended to 'assurance and oversight' to develop a more robust relationship.
4.	**HeadStart update** Pauline Wigglesworth briefed the group on the HeadStart project to date highlighting the two main aspects. Firstly, the delivery of the stage two pilot, which has grown and been extended until July 2016 to tie in with the school year. Secondly, the stage three bid, which is no longer a competitive tendering process but one where funding will be given to projects that demonstrate sustainability and systems change, including details of full costs; a deadline has not been set for the submission. The project currently focuses on four areas: a child's time at school; the family; the individual and digital. A delivery model is in place at two schools, with the HeadStart team supporting schools to deliver the Friends programme and the Adaptive Resilience programme. Big Lottery has been clear that they require the pilots to demonstrate systems change and sustainability with young people involved. Judith Mills is leading the local evaluation, while the Anna Freud Centre are leading national evaluation, and a workforce development plan is underway. A 'resilience model' is being developed, which will articulate how we can support young people to become more resilient. The governance structure is currently being aligned with Better Start governance arrangements. Commissions are in place for Stage two. Questions included: • When will we know if the bid has been successful? (AR) ▪ *The deadline hasn't been set as yet but expected to be early next year (PW)* • Will it be a partnership bid? (DC)

	▪ *Yes, the LA is the lead organisation, as are 11 out of the 12 areas taking part (PW)* • Will there be a match funding expectation? (DC) ▪ *Possibly, if it helps to show sustainability (PW).* ▪ *We need to make sure it is integrated into existing services (DB).* ▪ *The Exec Partnership will do this as it touches on lots of other services. (PW)* ▪ *It doesn't yet feel like there has been enough conversation about how we do this (GR).* ▪ *There is continuity though as many of the same people are on the various groups (ST)* • Who will write the bid? (DC) ▪ *This needs to be decided (PW)* ▪ *We can discuss at the SCG away day, it needs to be considered in its strategic context (DB).*
5	**The Care Act** Deferred to next meeting
6	**Intermediate Care Review** Helen Lammond-Smith advised that Blackpool CCG and Blackpool council adult social care are jointly undertaking a review of the intermediate care pathways. This will include areas such as ARC, rapid response, enhanced supported discharge, the hospital discharge team, equipment and vita line as examples. The aim is that we will have one single entry point into either a bed based or home based service. The timescales are aimed that implementation will commence after September this year in order to double run some bed based services over the winter period. **Action:** A report will be brought to the next meeting
7	**Vanguard** David Bonson updated the SCG on progress since the bid had been successful; advising that it is a model to get practices to work better together which involves redesigning services. A visit from the central team is expected at the end of April for us to demonstrate the extent of the project and how much it is likely to cost. Questions and comments included: • On the current model could we fast track some of the recruitment and associated spend? (GR) • Need to be creative with job roles – there are recruitment issues for care staff (VR) • We need an appropriate group of professionals (AR) • We need to do more work to pitch the bid right (GR) • We need to be mindful of work going on across other areas – Better Start are doing similar things (DC)
8	**Better Care Fund** In Andy Roach's absence, David Bonson advised that work was ongoing to implement Better Care.

	Questions and discussion included: • Are we able to evidence delivery? (DC) ▪ *Yes – much of the work is being done already for example around reducing non-elective admissions and transfer of care (MJ)* ▪ *It is seen as separate but is all similar work (DB)* • Where are we monitoring BCF for the national returns? (GR) ▪ *It should be here; Who would bring the report? (DC)* ▪ *It is picked up in item 11 however we need a reporting format*
9	**Tri-partite Commissioning Mapping** Val Raynor and Helen Lammond-Smith informed the SCG that the Council's Children's, Adults and Public Health departments were conducting a piece of work to map current commissioned contracts. The purpose was to identify possible areas of duplication and overlap. Initially 167 contracts had been identified, which were being considered in more detail. Comments and questions included: • The SCG needs to be clear about it's processes (GR) • We need assurance that we aren't duplicating, there is a potential to save money (AD) • Once this task is complete we can consider what the next steps are (DC) • We have a situation where organisations are bidding to many organisations to deliver the same service. Also does this work include tenders? (WS) • Discussion regarding tendering process – do we have to tender for everything? (AD) yes the local authority is bound by a legal framework that has to be followed (DC) • There is a problem with the types of tender particularly around skilled services and professionals – it is difficult to get people on short term contracts. We need to understand the wider implications of this and clinical risk associated (AD). **Action:** Venessa to circulate up to date terms of reference for the Commissioning Network.
10	**Public Services Transformation Network** Del informed the SCG that an offer had been made from the Public Service Transformation Network to do some work with Blackpool's public sector organisations; the offer would include looking at governance and financial spend and would aim to produce a public sector offer; the review would be carried out by PWC. Comments and questions included: • It will be interesting and ties in to some of the work Manchester have been doing on devolution (CMcK) • Would it include benefits expenditure as part of the public sector spend? (ST) • Manchester looked at income from taxation with benefit spend (GR) **Action:** Del to circulate specification.
11	**Section 75 pooled budget arrangements** Hilary Shaw presented the report advising that NHSE required BCF funding to be paid via a

	pooled budget, which required a legal agreement under s.75 of the NHS Act 2006. The SCG agreed to the recommendations in the report to: • Finalise the agreement • Appoint/nominate a pooled budget manager • Hold a risk workshop Gary Raphael praised the report and the work that had gone into preparing the agreement. **Action:** Hilary would meet with David Bonson to finalise the agreement
12	**Supporting the Voluntary Sector** Carmel McKeogh presented the report, which asked the SCG to consider how public sector organisations could appropriately support the voluntary sector in Blackpool by agreeing a joint commissioning agreement in three key areas, given that after this financial year there would be no further grant allocated to the voluntary sector. Carmel explained that this was not within the usual remit of the SCG however to develop and support the voluntary sector was in all of our interests. The three areas to be considered included: 1. A joint commission for infrastructure support for the voluntary sector for 2016-17 (to support CVS); 2. A joint commission for generic independent advice services for the year 2016-17 (to support the Citizen's Advice Bureau); 3. A joint commission for social inclusion support for the year 2016-17 (to support equalities groups). Discussion followed within which the value of the voluntary sector was recognised in supporting Blackpool's residents; and developing the capital of the voluntary sector around the health and social care agenda is linked to the neighbourhood models. It was agreed that it would be included with the current work to map commissioning spend. **Action:** Val and Helen to include the voluntary sector as part of the current mapping of commissioning contracts.
13	**SCG Away Day** Venessa Beckett advised that a date had been selected to hold a session for the SCG to set it's strategic intention, review the focus of it's work and identify key projects and workstreams that would be monitored. It was agreed that Venessa would meet with Del and David to develop the agenda for the day.
	DATES OF FUTURE MEETINGS Next meeting: • 21 May 2015, 3 – 5pm, Rm 2D, Bickerstaffe House • 1 July 2015, 2 – 4pm, venue tbc

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Strategic Commissioning Group
Draft Notes and Actions
21 May 2015, 3.00 – 5.00pm
Rm 2 D, Bickerstaffe House

Present	Delyth Curtis, Director of People (Director of Children's Services), Blackpool Council (Chair) David Bonson, Chief Operating Officer, Blackpool CCG (vice-Chair) Wendy Swift, Director of Strategy/Deputy Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust Val Raynor, Head of Commissioning, Blackpool Council Dr Arif Rajpura, Director of Public Health, Blackpool Council Lennox Beattie (representing Mark Towers, Director of Governance and Regulatory Services) Karen Smith, Director of Adult Services Judith Mills, Public Health Specialist, Blackpool Council Jane Cass, Head of Public Health, NHS England Liz Petch, Public Health Specialist, Blackpool Council
Also present	Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council Scott Butterfield, Corporate Development, Policy and Research Manager, Blackpool Council Jayne Bentley, Care Bill Implementation Project Lead, Blackpool Council Jeannie Harrop, Commissioning Manager, Blackpool CCG Superintendent Nikki Evans, Lancashire Constabulary Detective Inspector Ian Sewart, Lancashire Constabulary Superintendent Andrea Barrow, Lancashire Constabulary
Apologies	Dr Amanda Doyle (OBE), Chief Clinical Officer, Blackpool CCG Andy Roach, Director of Integration and Transformation, Blackpool CCG Gary Raphael, Chief Finance Officer, Blackpool CCG Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Lynn Donkin, Public Health Specialist, Blackpool Council Mark Towers, Director of Governance and Regulatory Services, Blackpool Council Merle Davies, Director, Centre for Early Childhood Development Steve Thompson, Director of Resources, Blackpool Council

1.	**Welcome and apologies.** Del welcomed everyone to the meeting and apologies were given.

2.	**Notes and actions from previous meeting.** The minutes were agreed as correct. **Actions from previous meeting:** **Item 7:** Del Curtis advised that a Public Sector Reform Board had been set up, chaired by the Council's Chief Executive, Neil Jack. It comprised of CCG, health, police and local authority and was looking at developing a 'public sector offer'. The PSRB would work with the HWB but had a wider remit than the Board. It was a working board, working with the Public Sector Transformation Network to look at all governance across the public sector; also mapping public sector spend. Del would provide further updates. **Item 11:** Final amendments were being made to the section 75 agreement. **Item 13:** The SCG away day was planned in place of the SCG meeting on 1 July; the meeting would be rescheduled.
3.	**The Care Act** Jayne Bentley presented a paper on the Care Act, which aims to bring existing legislation together, consolidate best practice and introduce reforms to the way that care and support is accessed and funded. There is also a focus on integration between health services and other council departments. Jayne advised that she had attended meetings across the council for example the Blackpool Safeguarding Adults Board, but needed to access community health teams to influence the prevention agenda and inform of the development of a universal advice service. Val Raynor advised that was a definite need to engage with neighbourhood teams and other colleagues across relevant organisations. David Bonson advised that there are monthly gatherings with neighbourhood leads. Jeannie Harrop is the lead for south and central areas. Karen Smith stated that there is a need to consider statutory requirements at leads meetings and what it means for organisations financially. Val asked if work needed to be done with police, and Andrea Barrow agreed this would be a good way forward **Action: Contact details for team meetings to be sent to Jayne so she can attend to inform of the Care Act implementation.**
4.	**Early Action Bid** Superintendent Andrea Barrow in conjunction with Superintendent Nikki Evans and Detective Inspector Ian Sewart presented the Early Action bid. They are the leads in each division, their role is to develop an approach to early action across police and bring together work across Lancashire. The aim is to develop a consistent approach based on best practice across the Lancashire area.

A funding bid was submitted to Police Innovation Fund, for £3.4 million. The bid was for a series of initiatives upscaling the early action agenda, working with the DPH, as an enabler to progress integration.

The bid includes:

Mental health response service – already in progress with CCG, involves three mental health nurses taking calls and three working with police up until 2am, already in operation so now extending programme; it was piloted here on a small scale, with some positive impact. Looked at West Midlands' model and took positives, now have linked with LCFT, and adapted work that's done with the Harbour and made it into a place of safety suite. The project is being evaluated from day one to see how effective it is working, which is key.

There is also a mental health co-ordinator to do work around mental health response and dementia.

The third part is for ambulance workers to be part of early action teams, targeting and signposting repeat ambulance service users, high intensive users

Other programmes include mobile data for police officers, linked to the B4me site; the Avert programme for female offenders who commit low level offences – they must engage with the women's centre for low level offending prevention, also upscaling and trialling a similar scheme for men who commit low level offences.

There is also money to scope a shared ICT system (£30K); to scope out what's possible and if it is doable.

Gun and gang intervention funding (joint with BwD).

£100K for quantitative and qualitative evaluation, to map the journey, working with UCLAN to develop the methodology. Some things can be done on a pan-Lancs footprint – evaluation might be one. An initial meeting has taken place to discuss.

In terms of governance an oversight group looks at the pan-Lancs aspect, Supt Barrow asked where does the bid fit locally? And does it fit with our existing structures?

A lengthy discussion followed:

It was suggested that all of the relevant partners are here so this would be good place for it to sit; the SCG has direct links to the HWB and we are trying to get one place where all of these connected bids and programmes come; we need to tie this with the locality work.

Supt Barrow asked what happens after two years with regards to community step down, stating that the projects need continuity, and must create personal and community resilience.

David Bonson said the same issues exist for health services, suggesting one co-ordinator for community resilience.

Val Raynor suggested it is also about infrastructure particularly in relation to the third sector.

David advised that at a recent Healthier Lancashire meeting, it had been identified that the training and support of volunteers required funding, and that we needed a better way of working with them.

Andrea Barrow asked if it would be possible to recruit people across sectors as volunteers.

Ian Sewart advised that there is an ICT system that tasks and manages volunteers across the

sector, the police want to introduce this across the public sector in Lancs; it is cheap to integrate and can combine all volunteer efforts into one combined community step-down.

Judith Mills commented that it is partly about but then also about new people with issues.

David Bonson advised that work ongoing with mental health teams to remove artificial barriers.

Del welcomed the system approach to volunteering, commenting that Blackpool does not have a hugely resilient base of volunteers; it needs co-ordinating and they need upskilling, all key projects need to be considered together, in a common pool.

Arif Rajpura agreed and referred back to the question of what do we want public sector Blackpool to do; it also needs paid professionals in the health model with generic skills, talking about similar sorts of roles, and talking about it in Better Start and HeadStart.

Scott Butterfield advised of a Public Health Talent Management Group who are a group of people across Lancashire taking part in a development course who are looking for a project to implement. He offered their support in this.

Supt. Nikki Evans stated it was about taking silos away, and capturing skills to add value – how do we put people in the right places to address the issues we want to address? The more effectively we do that better it will be, we could get to a place where you can advertise a skill needed and people will volunteer to do it.

Karen Smith commented that that was the role of volunteer bureau although it brokers to other voluntary organisations rather than the public sector.

Arif said we have just described asset based community development.

Andrea Barrow advised that the next oversight meeting was in a few weeks, some proposals were in development, and she would bring them back to the next SCG meeting.

Karen asked if the group would think of how this dovetails to the neighbourhood models.

Del state that all projects have an underlying reliance on a pool of people but we haven't got that pool of people sorted yet.

Andrea advised that the oversight group looks at the model and integrated teams; the model is about bringing people in. For example mental health nurses would sit on a multi-agency panel, and develop programmes of interventions for people.

Arif stated that some of this already operated within Moya's team (Early Help)

Nikki Evans stated that we need to get the step up/down processes right, unpicking issues and providing most appropriate services. How do we rationalise the number of meetings about same people?

David suggested that the SCG had had the same discussions, which would feed into the away day.

There was a question of where the operational issues would sit and it was agreed that the SCG would take ownership.

Judith Mills would draft a paper about rationalising the number of similar panels, Del advised that it also needed to pick up volunteering, perhaps as a task and finish group.

	Action: Andrea Barrow to send the Early Action bid to Venessa Beckett for circulation. **Action: Andrea Barrow to report back to next SCG meeting on proposals regarding volunteering.** **Action: Judith Mills to produce a report on rationalising panels and creating a co-ordinated model for volunteering.** **Action: The membership of the SCG would be considered at the away day.**
5	**Intermediate Care Review** Jeannie Harrop introduced the intermediate care review which is intended to ensure that patients end up in the right place with the right care. Finance and Operational subgroups are in place, the former needs to produce an action plan in September. The review is linked into pathway work around dementia and stroke. There are gaps and fragmentation in intermediate care, the review will look at co-ordination and if patients are in the right place, look at pulling them out of hospital to give care at home where necessary. Financial implications may include redesign and reemployment of services – hence the massive scoping exercise and will look at duplication and inefficiencies. The review will need to look at coordination as part of the model. The review needs to fit in with new models of care; involvement with neighbourhoods/ extensive care is needed. The review will make sure we reduce the length of stay in hospital and get the right wrap around services – this is what the report will recommend. Make sure we've capacity to do it too. Very aware of adult equipment budget. David commented that the work has a big scope. The work needs to be completed by September, and must be carefully managed. **Action: Intermediate care Review as a standing item at each meeting until complete**.
6	**Vanguard** David Bonson talked through the bid for the Fylde Coast Multi Speciality Community Provider. He advised that the new models of care team recently visited from London, their feedback was very positive, as highlighted in the letter they sent. The bid as described in the document is beginning to develop and discussions have begun at the health centres in Lytham and Moor Park. The new models of care team will support the CCG to get the bid through NHS England, and the CCG will keep bringing it back here to receive feedback and update progress. The extensivist model and enhanced primary care model were discussed with the team; this model of care will include every aspect. Differences between Blackpool and Fylde and Wyre were recognised – these are apparent to us and so the solutions are different even though they are both about neighbourhood models; this is what needs to be described as well as the governance arrangements. David referred to the diagram: the Vanguard programme board has full delegated

	responsibility and accountability. The Vanguard steering group is responsible for operational delivery. The diagram is for the Fylde Coast, we need to replicate this for Blackpool. Mapping of groups has begun. Potential questions include; Do we need project type people? Part of the bids might include a co-ordination role across Blackpool. Things are beginning to move quicker. It seems that for the new government this is the answer – more out of hospital care. Judith Mills asked how long can the funding be taken over? David answered this year and possibly next year. **Action: Vanguard to be standing item at each meeting** **Action: Governance to be discussed at SCG away day**
7	**Better Care Fund Quarterly Reporting** David Bonson updated on the Better Care Fund, it's still there and being performance managed, no sense it will be stopped centrally, will have s75 agreement in place soon, and agreed it will fund some existing projects such as the extensivist model, then the element of reporting will be attached. In relation to the template sent from NHS England, the CCG do not hold this information; the local authority is completing the template to return to NHS England before the deadline of 29 May. It will be circulated to the HWB once it has been submitted due to timescales. Wendy Swift questioned where the monitoring will take place? David advised that the CCG had been told to plan for 3.5% reduction, but have to submit 1.6% increase. The monitoring will be done by NHS England. **Action: Completed BCF quarterly reporting template to be circulated to HWB.**
8	**Commissioning Mapping** Val Raynor presented the report and an additional paper outlining the different phases identified within the process of mapping commissioned contracts. The purpose is to map all contracts across social care, public health and the CCG to see if any lead commissioning can be carried out. The work runs alongside the commissioners joint network meeting, and how to take forward the market and JSNA. Phase 1 has involved establishing a database of contracts, which commissioners are responsible for updating. Phase 2 will involve looking at identified themes i.e. intermediate care is purple. Those without a colour are things that are commissioned individually. Val also raised the issue of the police and how their procurement and commissioning processes might be aligned with our own; and advised that this is the first step in the process. Some areas can have a lead, some areas can come together e.g. advice and information. Val advised that it is a huge piece of work, with some quick wins but not as many as originally anticipated. Del asked about timescales for phase 2 – it is expected to completed in August 2015 David pointed out that the themes are useful to see where things can be aligned.

	Val pointed out the need to tease out standalone contracts, Del advised that some are particular solutions at a point in time and that circumstances can change. Val said that BCF will start to join resources together, while David added that it is a good starting point to get to how Blackpool commissions care, demonstrating that we need some consistencies.
10	**JSNA** Liz presented the report advising that the website domain had been moved, and was currently being built. At the end of June to beginning of July, editing, review and transfer info onto new site would take place. The website would have a new structure taking on a life course approach. There have been difficulties getting some info from the CSU. A workplan is in place, we need to think about what we want on website in terms of breadth or depth, currently have depth, however are getting lots of requests for information from voluntary organisations. David suggested we concentrate on the priorities of the HWB. Scott agreed, referring to the separate question about how we go about taking forward the new priorities and developing the strategy. The website is due to go live in December. **Action: Liz to report back to the SCG as the website develops**
9	**HWB 1:1's summary and recommendations** Venessa Beckett presented the report summarising the feedback from one to ones with members of the HWB. The main findings were that the Board • Needs a greater role in shaping discussions – reports should have recommendations rather than being 'for information' or 'to note' • The board needs to add value; refocus work on making key decisions and discussing plans/strategies applicable to most/all partners • Board needs to set the public agenda and conversation on the health system. Need to shape a plan for Blackpool's health and wellbeing generally, not just the existing public health focus through the HWB strategy. • Need a revised Health and Wellbeing Strategy based around the new priorities, to inform the forward plan. A number of recommendations were shared including: 1. Discussions to take place with the new chair to feed back these recommendations on how the Board could operate more effectively in future. 2. Introduce a new structure to the Board meetings with a two-part agenda: Part A for the formal business – ratification and approval of reports, and Part B (not open to the public) to have thematic discussions to identify common approaches to collective issues. **Action: Venessa to circulate the report to the SCG for further comment prior to sharing with**

	the Chair of the Board.
	DATES OF FUTURE MEETINGS • Next meeting to be arranged • 1 July 2015, 1.30 – 5pm away day, venue tbc
	AOB **Action: Venessa to look at consistent timings for future meetings**

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Deputy Director of People
Relevant Cabinet Member:	Councillor Eddie Collett, Cabinet Member for Reducing Health Inequalities and Adult Safeguarding
Date of Meeting:	10th June 2015

JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY SELF-ASSESSMENT FRAMEWORK 2014

1.0 Purpose of the report:

1.1 To update on the self-assessment framework submission 2014 on behalf of the Blackpool area.

2.0 Recommendation(s):

2.1 To note the self-assessment framework submission 2014 on behalf of the Blackpool area.

2.2 To support the development of an improvement plan to address the 'red' categories identified in the assessment.

3.0 Reasons for recommendation(s):

3.1 There is a national requirement by the Association of Directors of Adult Social Services and NHS England for every local area to complete an annual Learning Disability self-assessment. The assessment provides a baseline of how mainstream and learning disability services are ensuring access and equity for people with a learning disability and their family carers. This is undertaken by submitting data against a range of measures which are rated against a nationally benchmarked Self-Assessment Framework.

Each local area is required to present the assessments findings to their Health and Wellbeing Board, to inform future commissioning priorities, identify successes and examples of best practice and highlight areas where further work is needed.

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?	No

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 The Learning Disability Health Self-Assessment Framework has been used in England since 2007. It has become an important guide for NHS and Local Authorities, in helping them to recognise the overall needs, experience and wishes of young people and adults with learning disabilities and their family carers.

5.2 The aim is to provide a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met. Locally, this will help Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. And provides a sound evidence base against which to monitor progress.

5.3 Nationally, this is used to report publicly to Ministers on the progress in providing services in every part of the country to meet the aspirations of *Healthcare for All* and of *Transforming care:* Locally, it is used to inform:

- Joint Strategic Needs Assessments
- Health and Wellbeing Strategies
- Commissioning intentions/strategy
- Winterbourne improvement joint plans
- Learning Disability Partnership Board work programmes

5.4 The Self-Assessment Framework is split into three 'sections':

- Staying Healthy
- Staying Safe
- Living Well

5.5 Each section consists of nine distinct measures which are scored by applying a red, amber, green rating.

In the light of learning from the assessment undertaken in 2013 the structure of the framework has been carefully reviewed and changes have been made, which include:

Learning identified from 2013	Changes made
Burden of collecting information should be reduced where possible	Data against a number of measures under **staying healthy** are now supplied and scored by Public Health England (IHAL – Improving Health and Lives Team)
The voices of people with learning disabilities and their carers should be incorporated in the principal ratings	Inclusion of two measures designed to completed by self-advocates and family carers under **staying safe** and **living well**.
The need to allow for comparisons between years and reduce ambiguity of questions.	Rewording of measure under **staying healthy** to focus on understanding the treatment and outcomes for people with Learning Disability with long term conditions

5.6

Learning Disability Self-Assessment Framework 2014

Each local area is required to complete the local verification of the assessment. A group of representatives undertook this on behalf of Blackpool, which included family carers, self-advocates, Blackpool Clinical Commissioning Group, the Community Learning Disability Team, Adult and Children's Social Care commissioners and Blackpool Teaching Hospital NHS Foundation Trust.

The submission date for the 2014 assessment was 30 January 2015. A Pan-Lancashire 'Moving Forward' event took place on the 13th May 2015 which brought together representatives across the Pan-Lancashire health and social care economy with families, carers and self-advocates to review the outcome of this year's assessment and to identify priorities and opportunities to improve care and tackle health and social care inequalities. Improvement plans will now be drawn up by each local area to be reviewed and signed off by Learning Disability Partnership Boards.

5.7 **Blackpool Learning Disability Self-Assessment Summary and findings**

The summary below should be reviewed in conjunction with the Learning Disability Self-Assessment Summary included as Appendix 4a. A summary of the assessment findings for Pan-Lancashire is included as Appendix 4b.

Section One: "Staying Healthy" was locally verified against the benchmark measures as scoring: 1 Green, 4 ambers and 2 reds. From the previous year, one score has dropped from green to red and we are awaiting 2 scores to be provided centrally. The reason for the drop is due to a change in focus of the measure on long term conditions. The measure now focuses on understanding the treatment and outcomes for people with a learning disability against the general population. Whilst comparative rates are known in some areas there is limited evidence about treatment and outcomes.

Section Two: "Staying Safe" was locally verified against the benchmark measures as scoring: 3 greens and 6 ambers. One score has dropped from green to amber. This is due needing a score of 100% to achieve a Green rating against the measure for learning disability contract compliance (i.e. all learning disability contracts must have received an annual review), whilst the reviews had been scheduled they had not taken place at the time of submitting the assessment, however we anticipate a green score next year. The rest have remained consistent with the previous year's scores.

Section Three: "Living Well" was locally verified against the benchmark measures as scoring: 4 greens, 4 ambers. Two of the scores have improved from amber to green, the rest have remained consistent with last year's scores.

5.8 Improved scores for Blackpool were due to the work in the following areas

Staying Healthy	**Referral Gateway form** used by Blackpool CCG. This is completed by Primary Care colleagues to other health care providers. The form highlights Learning Disability status and what reasonable adjustments are required. Over 300 patients with a learning disability have been flagged via the referral system.
	NHS Podiatry services, a direct payments system is in place to support individuals with low level foot care giving them greater choice and control over how their needs are met.
Living Well	**Peer Support network** has been established which enables people to safely build confidence in groups and access community activities. Transport has been an

	ongoing area of interest from local Ride-a-Bility to the generic bus service. These discussions have enabled improvements in relation to accessible travel.
	Local Carers Satisfaction survey has been devised to understand how satisfied family carers are in relation to health checks, carers assessments and provision of advice and guidance. Whilst a very small group have been consulted with initially; plans are in place to carry out the survey at intervals throughout the year to build on the data.

5.9 Areas where scores have not improved in Blackpool

Staying Healthy	Evidence collated from GP practice registers shows that in Blackpool only 40% of people with a learning disability have had an annual health check. Blackpool Clinical Commissioning Group notes that there is a level of inconsistency across practices and an improvement plan will be developed to address this area.
	Unable to evidence that the annual health check and the health action plans are integrated. Data shows that in Blackpool fewer than 50% of Annual Health Checks generate specific health improvement targets (health action plan). Blackpool Clinical Commissioning Group notes that there is a level of inconsistency across practices and an improvement plan will be developed to address this area

5.10 **Emerging themes and next steps**

The themes and issues that have emerged from the 2014 assessment were discussed at the Pan-Lancashire 'Moving Forward' event and include:

- The need for comparative data to review the outcomes for people with a learning disability with long terms conditions against the general population
- Increase in the numbers of people with a learning disability having an annual health check
- Ensuring that people with learning disability have equity of access to universal services
- Continue support for people with a learning disability into employment through the development of employment strategies
- Good performance evident in relation to Safeguarding
- Improvements have been made in learning disability contract compliance

- Ensure ongoing involvement in service planning and decision making for people with a learning disability, their families and carers
- Continue to take forward issues raised by self-advocates and family carers via Learning Disability Partnership Boards

A commitment was made at the event to develop local improvement plans to address the themes and issues raised. Plans will be overseen by Learning Disability Partnership Boards and used to monitor progress against areas of further work and provide ongoing assurance to Health and Wellbeing Boards that progress is being made.

5.11 Does the information submitted include any exempt information? No

5.12 **List of Appendices:**

Appendix 4a: Blackpool Learning Disability Self-Assessment Summary 2013 and 2014
Appendix 4b: Pan-Lancashire Self-Assessment Findings 2014

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 A Lancashire wide Joint Strategic Needs Assessment report highlighted that people with learning disabilities are
one of the most excluded groups in the community:

- Nearly half live in the most deprived areas of Lancashire
- Fewer than 15% Lancashire are in employment across and in Blackpool this figure is lower.
- The housing needs of people with learning disabilities are considerable and will increase.
- People with learning disabilities experience much poorer health outcomes across a range of conditions including respiratory diseases, sensory impairment, gastrointestinal cancer, depression, dementia and challenging behaviour
- Prevalence and need is increasing whilst available budgets have been decreasing and are likely to continue to decrease.

- This has major implications for how services are delivered and will require a different approach to commissioning and developing co-produced services.
- The Learning Disability Self-Assessment Framework is a key mechanism to inform the different approaches that will be required to ensure appropriate services are developed and commissioned.

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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Blackpool Joint LD Self-Assessment 2014 – Summary

Domains					
Staying Healthy		**Keeping Safe**		**Living Well**	
Measure	**RAG Rating**	**Measure**	**RAG Rating**	**Measure**	**RAG Rating**
Q1 All people with LD are on the QOF Register to ensure equity of access to healthcare	Amber	Q1 Individual health and social care package reviews	Amber	Q1 Effective Joint working	Amber
Q2 Comparing treatment and outcomes for Long Term Conditions for people with LD and the non-LD population	Red	Q2 LD services contract compliance	Amber	Q2 Local Amenities and Transport	Green
Q3 Numbers of people with LD who have had an annual health check*	To be completed by IHAL	Q3 Monitor assurances	Green	Q3 Arts and Culture	Green
Q4 Health action plans generated at time of annual health check	Red	Q4 Adult safeguarding	Green	Q4 Sport and Leisure	Green
Q5 National Cancer screening programme (bowel, breast and cervical) *	To be completed by IHAL	Q5 Involvement of self-advocates and carers in recruitment and training	Amber	Q5 Employment	Amber
Q6 Primary Care Communication of people with LD to other healthcare providers	Green	Q6 Compassion, Dignity and Respect. Answered by self-advocates and family-carers	Amber	Q6 Transition to Adulthood	Amber
Q7 LD liaison function or equivalent process in acute setting	Amber	Q7 Commissioning strategy impact assessments	Green	Q7 Involvement in service planning and decision making	Amber
Q8 Reasonable adjustments in NHS Commissioned primary care (podiatry)	Amber	Q8 Complaints lead to changes	Amber	Q8 Carers Satisfaction rating	Green
Q9 Offender health and the criminal justice system	Amber	Q9 Mental Capacity Act and Deprivation of Liberty Safeguards*	Amber		

Blackpool Joint LD Self-Assessment 2013 – Summary

Domains					
Staying Healthy		**Keeping Safe**		**Living Well**	
Measure	**RAG Rating**	**Measure**	**RAG Rating**	**Measure**	**RAG Rating**
Q1 All people with LD are on the QOF Register to ensure equity of access to healthcare	Amber	Q1 Individual health and social care package reviews	Amber	Q1 Effective Joint working	Green
Q2 People with LD are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy	Green	Q2 LD services contract compliance	Green	Q2 Local Amenities and Transport	Amber
Q3 Numbers of people with LD who have had an annual health check	Amber	Q3 Monitor assurances	Green	Q3 Arts and Culture	Amber
Q4 Health action plans generated at time of annual health check	Red	Q4 Adult safeguarding	Green	Q4 Sport and Leisure	Green
Q5 National Cancer screening programme (bowel, breast and cervical)	Amber	Q5 Involvement of self-advocates and carers in recruitment and training	Amber	Q5 Employment	Amber
Q6 Primary Care Communication of people with LD to other healthcare providers	Amber	Q6 Commissioners can demonstrate that providers recruitment and management of staff is based on Compassion, Dignity and Respect and comes from a value based culture	Amber	Q6 Transition to Adulthood	Amber
Q7 LD liaison function or equivalent process in acute setting	Amber	Q7 Commissioning strategy impact assessments	Green	Q7 Community Inclusion and Citizenship	Amber
Q8 Reasonable adjustments in NHS Commissioned primary care Dentistry * Optometry * Community Pharmacy * Podiatry * Community nursing and midwifery	Amber	Q8 Complaints lead to changes	Amber	Q8 Involvement in service planning and decision making	Amber
Q9 Offender health and the criminal justice system	Amber	Q9 Mental Capacity Act and Deprivation of Liberty Safeguards	Amber	Q9 Family Carers	Green

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LD Self-Assessment Framework 2014

Pan-Lancashire

Section A – Staying Healthy

	MEASURE	BLACKBURN with DARWIN	BLACKPOOL	LANCASHIRE
A1	LD QOF register in primary care			
A2	Finding and managing long term health conditions. Obesity, diabetes, cardiovascular disease, epilepsy			
A3	Annual Health Checks and registers			
A4	Health Action Plans. Specific health improvement targets generated at the time of the Annual Health Check			
A5	National Cancer Screening Programmes, Cervical,Breast Bowel			
A6	Primary care communication of LD status to other healthcare providers			
A7	LD Liaison function or equivalent process in acute settings			
A8	Universal services flag, identify and make reasonable adjustments. Primary Care, dentistry, optometry, community pharmacy, podiatry			
A9	Offender health and the Criminal Justice System			

Section B – Keeping Safe 2014

MEASURE		BLACKBURN with DARWIN	BLACKPOOL	LANCASHIRE
B1	Individual health and social care package reviews			
B2	LD services Contract compliance			
B3	Assurance of Monitor compliance			
B4	Assurance of Safeguarding in *all* provided services and support			
B5	Self-Advocates and carers Involvement in training and recruitment			
B6	Compassion, Dignity and Respect. To be answered by self-advocates and family carers			
B7	Commissioning Strategies and Equality Impact Assessments			
B8	Complaints lead to changes			
B9	Mental Capacity Act and Deprivation of Liberty Safeguards			

Section C – Living Well 2014

	MEASURE	BLACKBURN with DARWIN	BLACKPOOL	LANCASHIRE
C1	Effective joint working			
C2	Local amenities and transport			
C3	Arts and culture			
C4	Sport and leisure			
C5	Supporting people with LD into employment			
C6	Preparing for adulthood			
C7	Involvement in service planning and decision making			
C8	Carers satisfaction rating. To be answered by family carers.			
C9	Overall rating for the assessment. To be completed by IHAL			

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Jane Higgs, Director of Assurance and Delivery, NHS England
Relevant Cabinet Member:	Councillor Eddie Collett, Cabinet Member for Reducing Health Inequalities and Adult Safeguarding
Date of Meeting:	10th June 2015

LANCASHIRE SCREENING AND IMMUNISATION PROGRAMMES ANNUAL REPORT 2013-2014

1.0 Purpose of the report:

1.1 The purpose of this report is to present the Lancashire Screening and Immunisation Annual Report 2013 – 2014 to the Blackpool Health and Wellbeing Board, and to advise the Board of additional work that has been undertaken since the report's publication.

2.0 Recommendation(s):

2.1 To consider the information contained within the report, and in particular the key points relevant for Blackpool, which are highlighted in section 5; as well as the achievements and challenges.

3.0 Reasons for recommendation(s):

3.1 The Board must be assured that effective screening and immunisation programmes are in place for the local population.

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 Priorities are:

- Tackle child poverty, raise aspirations and improve educational achievement
- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

Context

5.1 On 1st April 2013 responsibility for the commissioning and oversight of all national screening and immunisation programmes transferred from Primary Care Trusts to a number of new organisations including NHS England Area Teams and Clinical Commissioning Groups, Public Health England and Local Authorities.

5.2 Legitimate concerns were raised at the time that this fragmentation of responsibility would lead to a reduction in programme quality, safety and performance. These concerns led to the publication of a 'National Delivery Framework and Local Operating Model for Screening and Immunisation Programmes' which attempted to set out more clearly the roles of all parties.

5.3 Since April 2013, governance arrangements have been streamlined so there is one Screening and Immunisation Oversight Group (SIOG). It is their responsibility to oversee a collaborative approach to the delivery of quality assured screening and immunisation programmes for the local population.

5.4 **Key points to note for Blackpool Health and Wellbeing board – June 2015**

Introduction

Since the 2013/2014 report was written a lot of work has been carried out that NHS England is confident will have a positive impact upon the performance of the screening and immunisation programmes into next year.

- Development of a **practice level performance dashboard**.
- Use of the dashboard to prioritise the poorest performing practices followed by **targeted practice visits.**
- Development of a primary care **screening and immunisation resource pack** with top tips for primary care staff to support the improvement of screening and immunisation uptake.

- A series of **sharing best practice events** across Lancashire with all Primary care teams invited to attend. The events focused on improving uptake in (i) cervical screening (25-34yr olds) and (ii) pre-school immunisation.
- Improvement in the contracting and monitoring arrangements with secondary care providers

Bowel screening

- Since 2013/2014 an increase in Bowel screening uptake for Blackpool CCG from 48% in 2013 to 53.6% in 2014 has been seen.
- Implementation of the new bowel scope programme took place in February 2014. Blackpool GPs were the first to be included in the new programme.

Breast screening

- 2014/2015 full years coverage data is not available until the autumn. Early indications are that coverage has declined in line with the continuing national trend.
- Problems with roundlength mean that up to 10% of women screened are not counted within the coverage data which may partly explain the fall.

Cervical screening

- Coverage remained the same for Blackpool in 2014. This represents a halt in what was previously a steady decline.
- Improving coverage remains a priority especially in the younger age groups (25-35 year olds).

Diabetic eye screening

- No cause for concern

AAA

- The good coverage seen in the first year of the AAA programme has been maintained.

0-5 Immunisations

- Age 1 cohort: The uptake in Blackpool has been over 95% and the CCG is one of five CCGs achieving the WHO 95% target
- Age 2 cohort: The uptake for Hib/Men C, Pneumococcal Booster and 1st MMR has been over 92% that has been a steady improvement in each quarter in this cohort
- Age 5 cohort: The uptake figures for pre-school booster and 2nd MMR in this age group remain poor between 88% and 90%.

School Age Immunisations

HPV Year 8 Girls

- The uptake figures in 2013/2014 were poor at 79% (target 90%). Following work with providers the uptake has improved and is over 95% (1st dose) for

2014/15.
(HPV immunisation has recently been reduced from 3 doses given within 12 months to 2 doses given one year apart. 1st dose given in Year 8 and 2nd dose in Year 9).

Adult immunisations

Seasonal Influenza

- The slight fall in uptake in 2014/15 was due partly to concerns raised at the ineffectiveness of the vaccine against all types of circulating flu strains.
    - Uptake in over 65s - 74% in 2013/2014 cf 73% in 2014/2015
    - Uptake in < 65s - 52.6% in 2013/2014 cf 50.6% in 2014/2015
- Improved uptake achieved among pregnant women in 2014/2015 - 33.7% in 2013/2014 cf 39.8% in 2014/2015

Pertussis in pregnant women

- Uptake has been improving across all the CCGs and in Blackpool uptake since April 2014 has been over 50% each month

Shingles

- Uptake figures have been steadily increasing in both 70 and 79yr cohorts from the month of September 2014

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Appendix 5a: Lancashire Screening and Immunisation Programmes Annual Report 2013 – 14.

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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Public Health England

NHS England

Lancashire Screening and Immunisation Programmes

2013/14 annual report

Contents

Introduction

The following report provides an overview of the performance and quality of the national screening and immunisation programmes delivered across Lancashire during 2013-4.

Context

Each year the screening and immunisation programmes commissioned by NHS England Lancashire Area Team issue approximately 1.5 million letters to people of all ages inviting their participation in the various programmes (appendices 1 & 2).

All of the programmes are evidence based and each carries enormous potential for good. However, if they are not delivered to their required national quality standards, they also have the potential to cause unintended harm.

Changes following the Health & Social Care Act 2012

On 1st April 2013 responsibility for the commissioning and oversight of all national screening and immunisation programmes transferred from Primary Care Trusts to a number of new organisations including NHS England Area Teams and Clinical Commissioning Groups, Public Health England and Local Authorities.

Legitimate concerns were raised at the time that this fragmentation of responsibility would lead to a reduction in programme quality, safety and performance. These concerns led to the publication of a 'National Delivery Framework and Local Operating Model for Screening and Immunisation Programmes' which attempted to set out more clearly the roles of all parties:

NHS England – would commission the national programmes and, via its embedded Screening and Immunisation Team (SIT), provide local system leadership to ensure national specifications were in place for current and new programmes. The SIT would support the delivery of quality improvement and any required programme change. It would oversee the investigation of serious incidents and contribute to the investigation of vaccine preventable disease outbreaks.

Public Health England – would employ the screening & immunisation staff working in NHS England and provide them with professional support. Via its regional quality assurance teams it would provide external oversight and assurance of the quality and standards of individual screening programmes and via its health protection teams, maintain the surveillance of infectious disease incidents and provide expert advice in the investigation of immunisation (cold chain) incidents.

Local Authorities via Directors of Public Health – would provide independent scrutiny and challenge to the arrangements of NHS England, PHE and service providers in the delivery of screening and immunisation. Directors of Public Health would advocate within the local authority and with clinical commissioning groups and other key stakeholders to improve programme access and uptake. They would take a lead in public-facing promotional campaigns and their teams would work closely with the SIT to ensure local population needs were understood and addressed.

Clinical Commissioning Groups (CCGs) would commission those elements of the screening pathways that had remained within their acute trust contracts e.g. colposcopy services within gynaecology contracts and antenatal and newborn screening services within midwifery contracts, as well as treatment services for referrals of screen positive patients. They would promote immunisation programmes by routinely including staff flu targets within their contracts.

The CCGs would also work with NHS England Lancashire Area Team Nursing & Quality directorate and the SIT as part of their duties to improve quality in primary medical care services delivered by GP practices and to reduce inequalities in access to health services and health service outcomes.

Service Providers – would ensure that all staff directly involved in immunisation or screening programmes had the required knowledge and skills to undertake their role. They would work to national programme specifications or, for GPs, to standards outlined in national contracts, and deliver their elements of the pathways to the required standards. They would report and investigate any incidents promptly in line with national guidance.

Programme Governance

At 1st April 2013 local governance of the screening and immunisation programmes was provided through fourteen multi-agency boards and six or more operational groups, each accountable to NHS England Lancashire Area Team. Initially all of these groups met and reported quarterly to the senior management team but, in February 2014, arrangements were streamlined with the setting up of a single multiagency Screening and Immunisation Oversight Group (SIOG), chaired by the area team director of commissioning and linked to the Lancashire Quality Surveillance Group.

The purpose of the SIOG was to receive summarised feedback from the fourteen programme boards and oversee a collaborative approach to the delivery of quality assured screening and immunisation programmes for the local population. By sharing data and intelligence it would be able to provide a rounded view of the performance of all programmes; an early warning of any risks developing across the programme pathways; and an opportunity to coordinate actions to drive improvement.

Further work is now underway to reduce the number of screening programme board meetings to one per programme across Lancashire, supported where necessary by operational groups at service provider level. (A map of the revised structure is included at appendix 3)

Incidents and Significant Events

The screening and immunisation team has put in place a robust mechanism to deal with any incidents and significant events that occur within the Lancashire programmes.

Screening and immunisation incidents require specific attention and management as:

- they have the potential to affect a large number of individuals:
- seemingly minor incidents in one organisation or department often have a knock-on effect along the whole programme pathway
- local incidents can adversely affect public confidence in a national programme beyond the immediate area involved
- as individuals respond to an offer of screening or immunisation in the expectation that it will be beneficial, there is an added ethical imperative to prevent and respond effectively to quality problems
- dissemination of learning from local screening incidents should be shared with the rest of the national programme in order to help prevent incidents elsewhere

During 2013/14 there were 24 incidents and significant events notified to the screening & immunisation team, the largest number of which were in the cervical screening programme. Ten of these met the threshold for reporting onto STEIS (the Strategic Executive Information System used by the NHS to report and record serious incidents) and were investigated according to national guidance with a look back if required and a full root cause analysis.

	Serious Incidents	**Significant Events**
Bowel	2	1
Breast	2	
Cervical	5	4
Diabetic Eye	1	1
Abdominal Aortic aneurysm		1
Antenatal & Newborn	3	2
Immunisation	1	1

For all incidents the completion of any recommended actions was overseen by the lead provider organisation and also by the relevant programme board. Any lessons learned were shared with other programmes and practitioners as required.

A report on all incidents is made quarterly to the Screening & Immunisation Oversight Group.

Screening Programmes Performance

Bowel Screening

Cancer Detection

The aim of bowel cancer screening is to detect bowel cancer in its earliest stages as well as pre-cancerous adenomas which may develop into cancer if not removed. The earlier the cancer is diagnosed the more effective treatment is likely to be.

In 2013/14 100 cancers were detected by the Lancashire programme (table 1). 75% were early stage (Dukes stages A and B) and only 6% were only suitable for palliative care (Dukes stage D). With a maximum response rate of 58%, the implication is that there were potentially a further 80 people with undiagnosed and mostly treatable bowel cancers who did not accept the offer of screening.

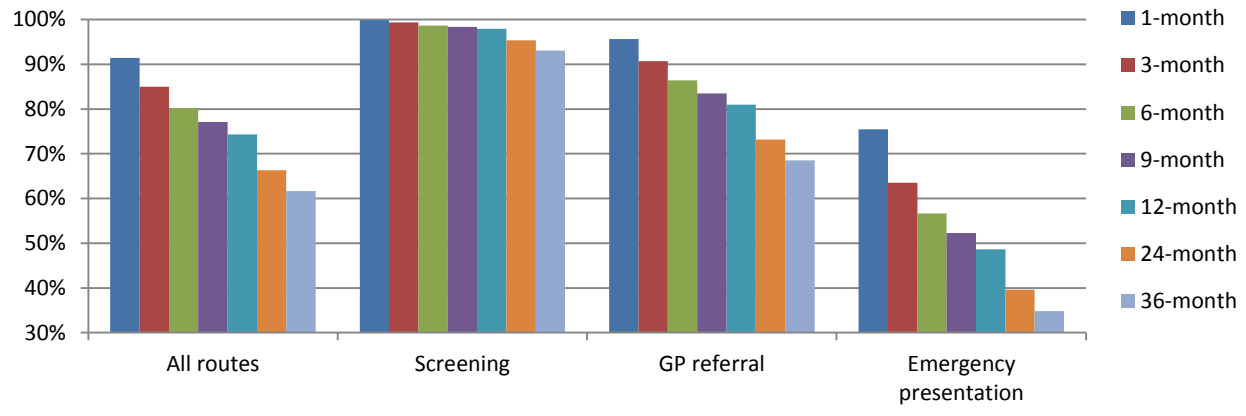
Table 1: Screen detected bowel cancer by CCG (2013/14)

CCG	Uptake	Cancers detected	Estimate cancers undiagnosed	Patients with polyps (high risk polyps)
Blackburn with Darwen	49%	6	6	56 (10)
Blackpool	48%	11	11	78 (15)
Chorley & South Ribble	54%	16	13	68 (11)
East Lancashire	55%	23	18	149 (42)
Greater Preston	54%	8	6	74 (16)
Lancashire North	57%	10	7	57 (12)
West Lancashire	53%	7	6	44 (6)
Fylde and Wyre	58%	19	13	75 (16)
Lancashire		100	80	601 (128)

Source Bowel Cancer Screening System (OBIEE)

When bowel cancer is detected early, treatment effectiveness and survival rates improve dramatically. Figure 1 shows comparative 1-36 month survival rates by route of diagnosis.

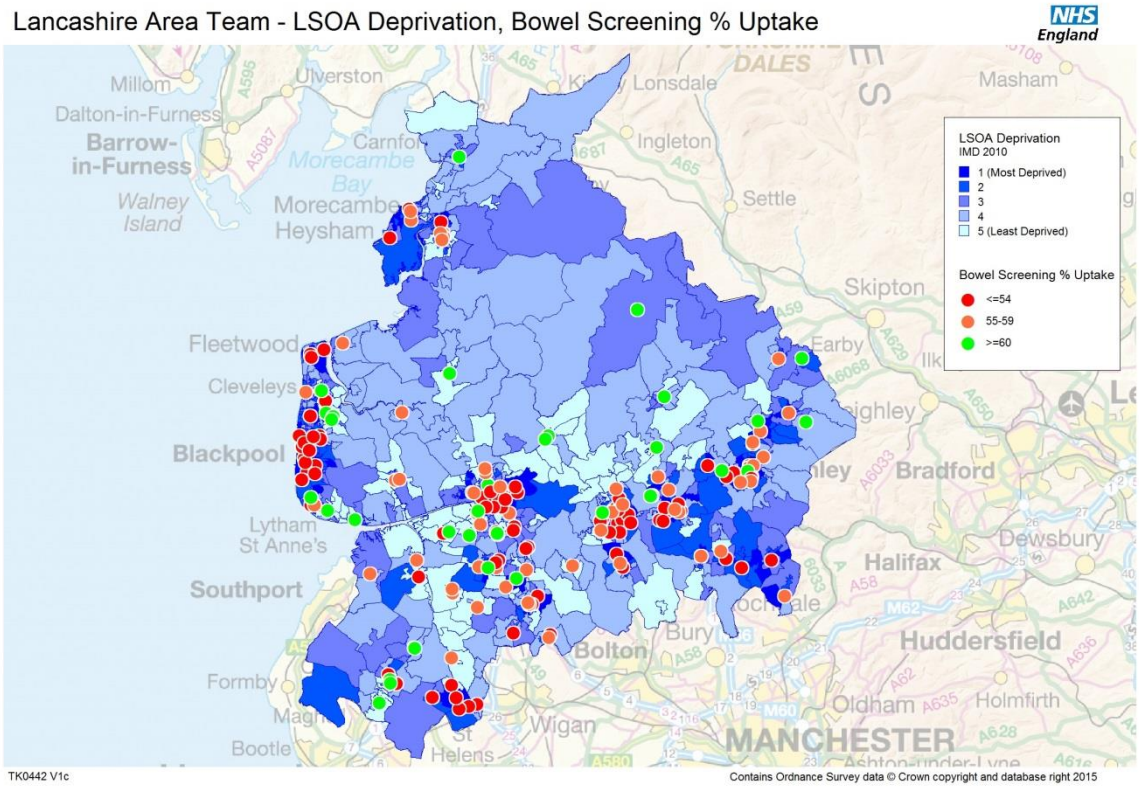
Figure 1. Relative survival estimates by route of diagnosis for colerectal cancer 2006-2010



Screening uptake

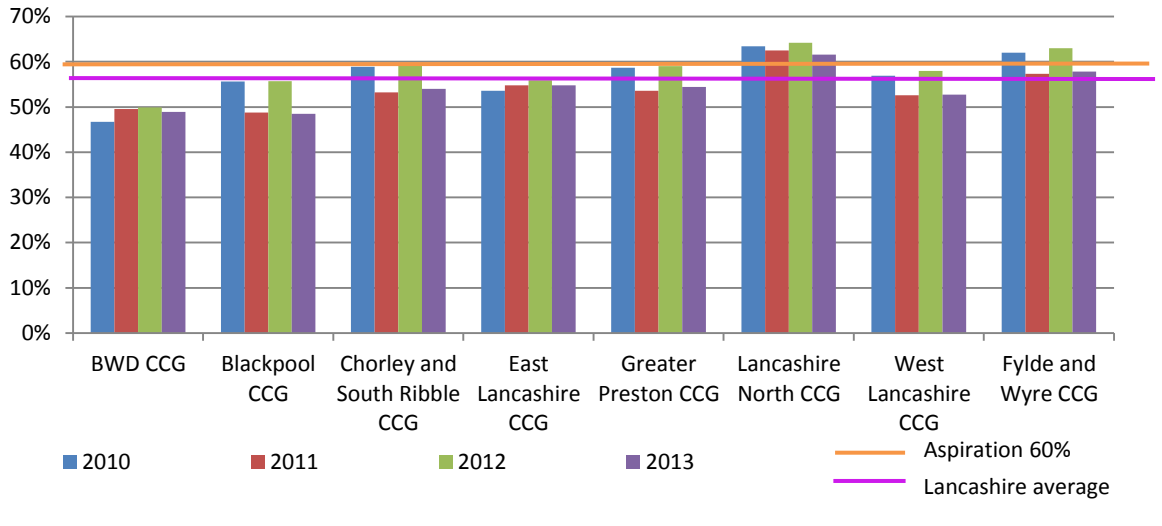
Figure 2 maps uptake by practice and confirms that, while many practices reach >55%, lower uptake rates tend to be linked to populations in the more deprived areas of Lancashire namely Blackpool, Preston, Skelmersdale, Blackburn and Burnley.

Figure 2 Bowel screening uptake by general practice (2013/14)



Source: Office for National Statistics (ONS) and national bowel screening systems (OBIEE)

Figure 3 Trends in Bowel cancer screening uptake by CCG (2010-2013)



When it was set up, the bowel screening programme aimed to achieve an uptake rate of 60%. Figure 3 above shows that in 2013/14 only Lancashire North CCG achieved this.

The screening process involves self-completion of a fairly complicated test kit in the home and the national programme office is aware of problems with the current kit's acceptability. In 2014/15 a simpler test kit is being piloted which it is hoped will increase acceptance and uptake rates.

Bowel Scope screening

The Lancashire bowel scope screening programme is a new programme offering a flexible sigmoidoscopy examination of the lower bowel to men and women at 55years of age.

It is being offered in addition to the existing bowel screening programme and has a similar aim to detect and treat polyps early before they can develop into cancer.

Bowel scope is currently offered as a single examination providing a level of reassurance for the next 5 years. All participants, when they reach the age of 60, are then automatically invited to participate in the regular bi-annual screening programme using the home testing kits.

The bowel scope programme is being slowly rolled out across England and commenced in Blackpool in December 2013. Initial uptake looks promising and a phased roll out across Lancashire is planned for completion by 2016.

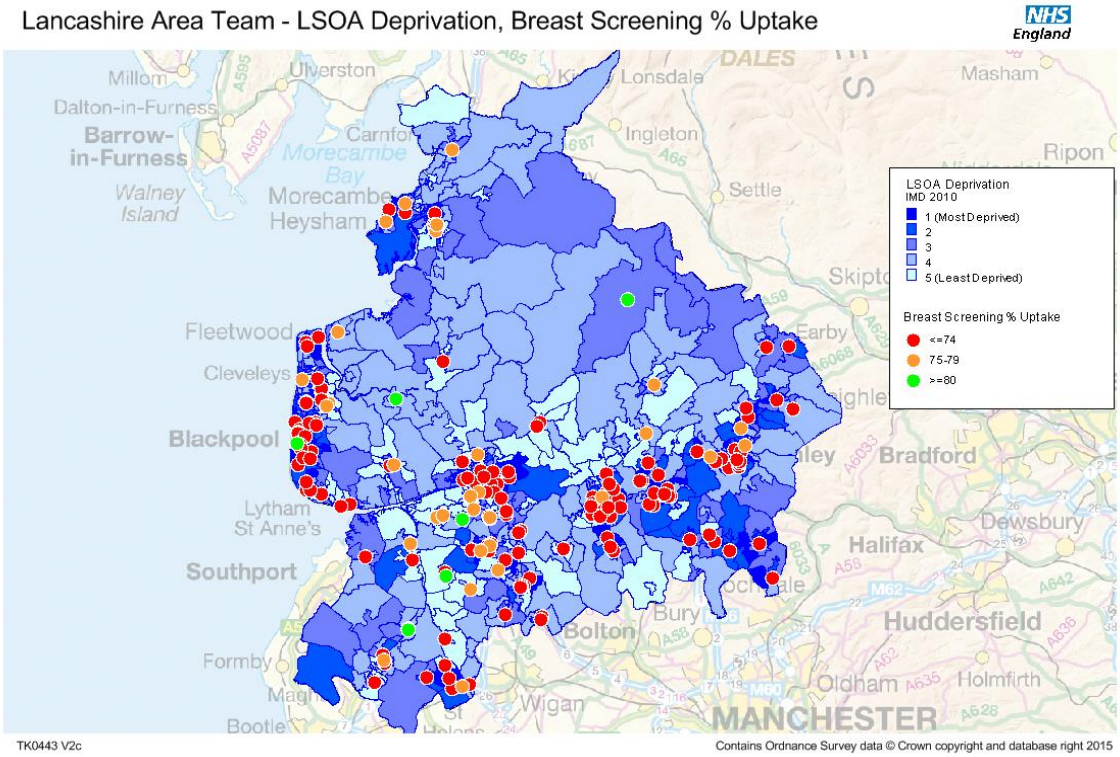
Breast Screening

Coverage

Breast Screening coverage is defined as the proportion of resident, eligible women who have had a mammogram with a recorded result at least once in the previous 3 years.

Figure 4 maps uptake by practice and shows that very few practices reach the target of 80%. As expected, lowest uptake tends to be linked to populations in the more deprived areas of Lancashire.

Figure 4 Breast screening coverage by General Practice (September2013)



Source: Office for National Statistics (ONS) and Primary care support services (PCSS)

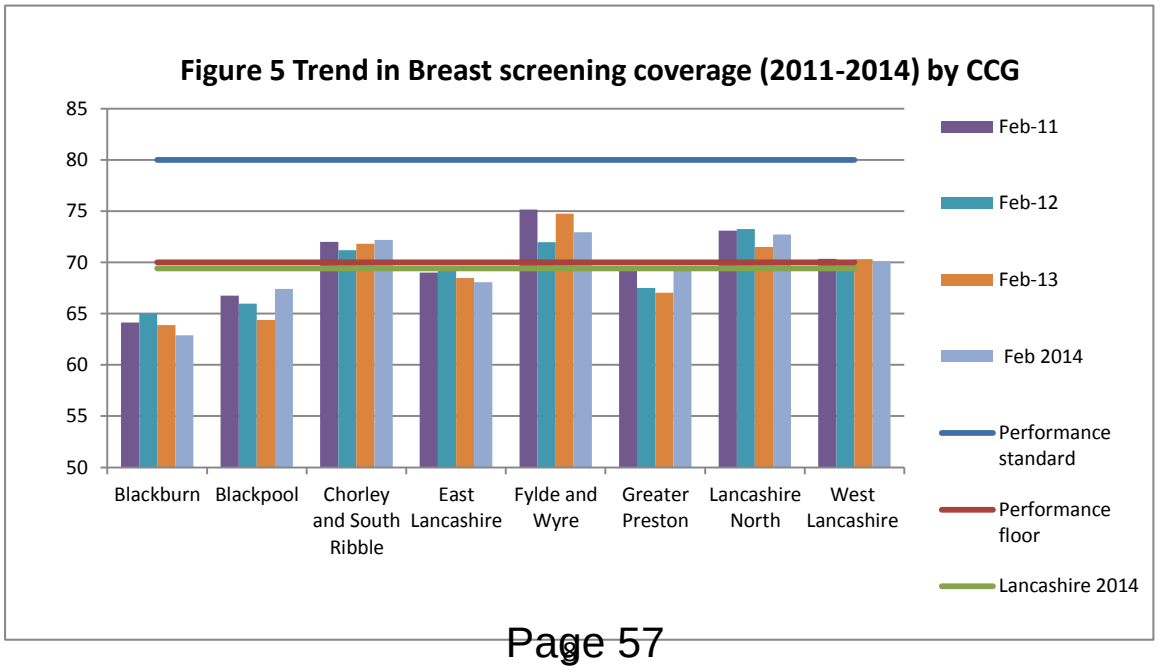
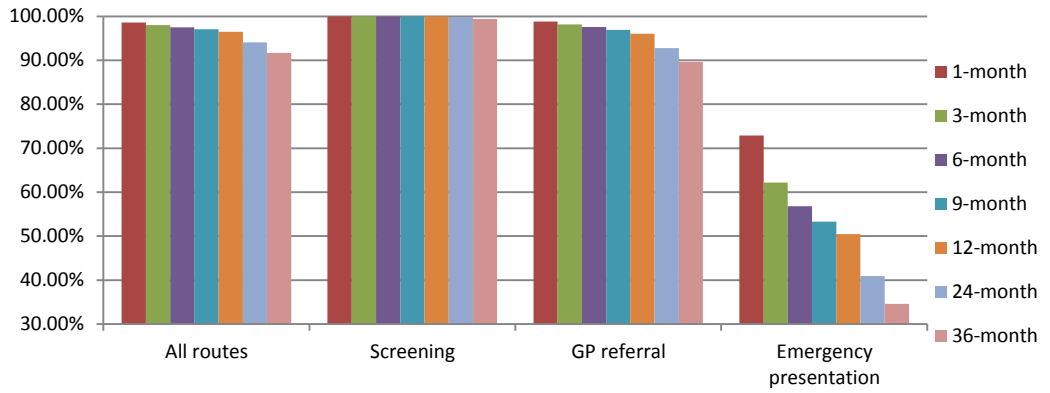


Figure 5 shows that coverage has decreased or remained almost static in most Lancashire CCGs since 2011, the exceptions being Blackpool and Chorley & South Ribble.
Coverage is lowest in Blackburn with Darwen and Blackpool CCGs, but while the rate is showing signs of recovery in Blackpool, there is a continued decline in Blackburn with Darwen and East Lancashire.
The decreasing trend in coverage mirrors the national picture and addressing falling local rates is a priority for NHS England Lancashire Area Team. Screening and immunisation co-ordinators are working with the screening programmes and general practices in lower uptake areas on ways to improve acceptability and attendance.

Survival

When breast cancer is detected early, treatment effectiveness and survival rates are high. Figure 6 shows the positive impact of screen detected cancers on overall breast cancer survival rates

Figure 6 Relative survival estimates by route of diagnosis for breast cancer 2006-2010



Screen to assessment

A key performance indicator (KPI) for the programme is that all women with abnormal mammograms should attend an assessment clinic within 3 weeks. Many northwest programmes struggle with this KPI, including South Lancashire, who failed to achieve it throughout 2013/14 (Table 2). Concerns were raised by the Northwest Breast Screening Quality Assurance team and NHS England Lancashire Area Team and a service improvement plan was agreed with the providers for completion by September 2014.

Table 2 Screen to assessment - The percentage of women who attend an assessment centre within three weeks of an abnormal screening mammogram.

	July to Sept 2013		Sept to Dec 2013		Jan to March 2014	
	≤ 3 wks	>3 wks	≤ 3 wks	>3 wks	≤ 3 wks	>3 wks
East Lancashire BSP	99	1	97	3	98	2
North Lancashire BSP	90	10	86	13	90	9
South Lancashire BSP	89	10	83	16	79	20
Northwest	87.5	11.6	87.8	11.5	89.4	11.6
Minimum standard –≥ 90% Achievable- 100%						

Data source: NWBSP QA quarterly report

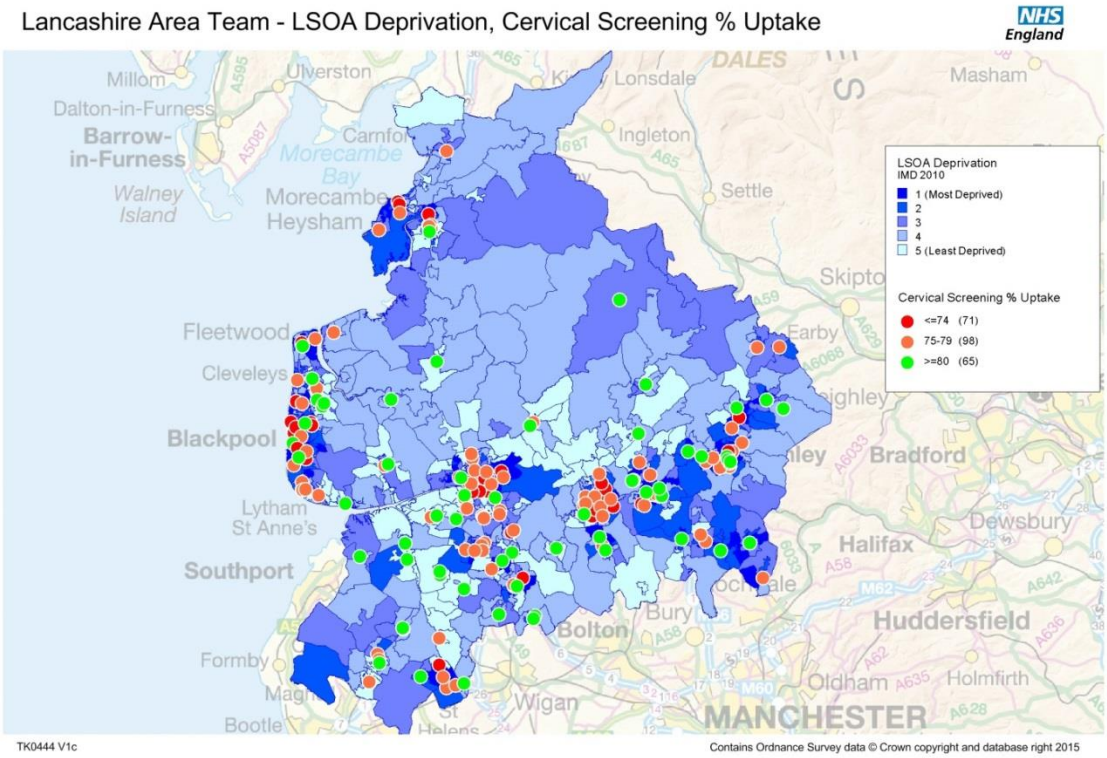
Cervical Screening

Coverage

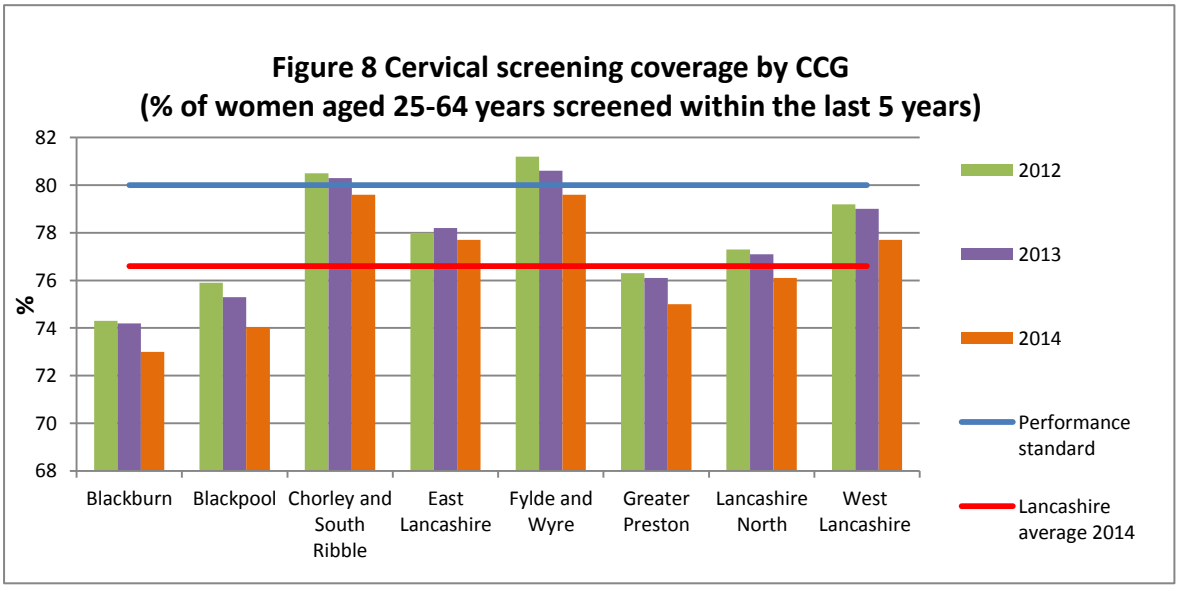
Cervical Screening programme coverage is defined as the percentage of eligible women (25-64yrs) who have a recorded, adequate test result within the last 5 years.

Figure 7 maps uptake by general practice and confirms that, while many reach the target of 80%, as expected, lowest uptake tends to be linked to populations in the more deprived areas of Lancashire

Figure 7 Cervical screening coverage by General Practice (December 2013)



Source: Primary care support services (PCSS)



Coverage across the northwest, and nationally, has shown a persistent downward trend for the past few years and this is now evident in CCG coverage (figure 8). In 2013/14 no CCG achieved the national target of 80% coverage for women aged 25-64 years.

However we are also aware that the fall in coverage has been greatest amongst younger women age 25-49 years. To make the information more meaningful for practices, table 3 provides an estimate of the number of additional smears that would be needed per practice per month to achieve the required 80% coverage. This data, together with advice on improving uptake, will be shared with practice staff during the individual practice visits planned for 2014/15.

Table 3

CCG	25-49years (screened over the last 3 years)				50-64years old (screened over that last 5 years)			
	Additional screens required to reach 80%				**Additional screens required to reach 80%**			
	Coverage (%)	**CCG per year**	**CCG per month**	**Practice per month**	Coverage (%)	**CCG per year**	**CCG per month**	**Practice per month**
Blackburn with Darwen	60.4	1847	**153**	**6**	73.0	823	**68.5**	**2**
Blackpool	64.4	1372	**114**	**5**	71.4	1193	**94.9**	**4**
Chorley and South Ribble	70.1	954	**79**	**3**	76.9	458	**38**	**1**
East Lancashire	67.2	2529	**210**	**4**	76.5	1031	**86**	**1**
Fylde and Wyre	70.1	700	**59**	**3**	77.5	345	**29**	**1**
Greater Preston	64.4	1766	**147**	**5**	74.8	827	**69**	**2**
Lancashire North	66.5	1045	**87**	**7**	75.1	592	**49**	**4**
West Lancashire	67.9	670	**56**	**3**	75.9	388	**32**	**1**

Improving cancer screening coverage

Improving coverage for all cancer screening programmes is a key priority for NHS England Lancashire Area Team. The Screening & Immunisation team are working with the programme providers, general practices, the Lancashire & South Cumbria Cancer Network and local health inequalities groups on ways to encourage more men and women to accept their screening offer.

Diabetic Eye Screening

The aim of the diabetic eye screening (DES) programme is to reduce the risk of sight loss amongst eligible people with diabetes by early identification and successful treatment.

All diabetic patients over 12 years of age are eligible for screening unless they:

- Have made an informed choice that they no longer wished to be invited for screening
- Do not have perception of light in either eye
- Are terminally ill or have a physical or mental disability preventing either screening or treatment
- Are currently under the care of an ophthalmologist for the treatment and follow-up management of diabetic retinopathy

Uptake is the percentage of invited patients that attend for an annual screen (Figure 9). The apparent variation in uptake between the three programmes is more likely to be due to software recording issues than actual differences in uptake. During 2013/14 the programmes all used different software systems but these are currently being rationalised to a national specification.

Figure 9 Diabetic eye screening uptake 2013/14

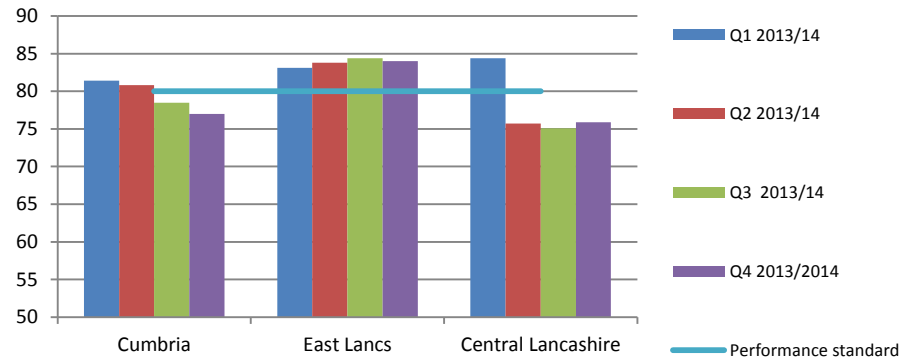
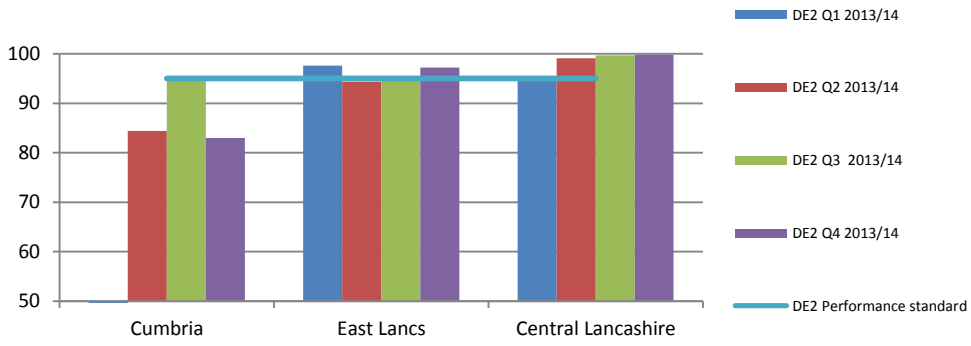


Figure 10 Diabetic eye screening results issued within 3 weeks 2013/14



Source: KPI returns 2013/14

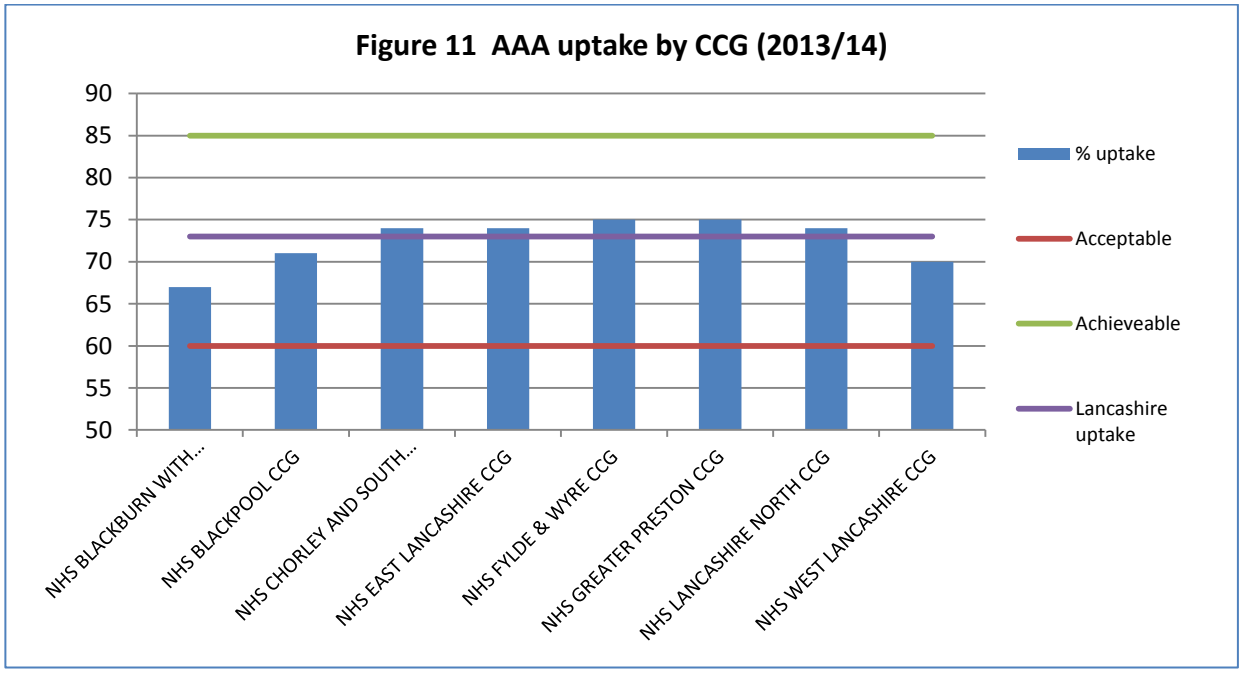
Results should be issued to 95% of patients within 3 weeks of their screen. The Cumbria programme had difficulty meeting this target during 2013/14 (figure 10) due to staffing issues which are now being addressed.

Abdominal Aortic Aneurysm (AAA) Screening

Prior to the introduction of the abdominal aortic aneurysm screening programme many men were at risk of dying from rupture of an undiagnosed aortic aneurysm. AAA screening aims to reduce this risk by detecting earlier, smaller aneurysms in younger and fitter men better able to withstand aneurysm surgery.

Uptake

AAA uptake is defined as the percentage of those offered screening who accept the initial offer (figure 11).



Source- AAA Screening programme data

Programme Outcomes

In its first year the programme offered screening to 13000 men in Cumbria and Lancashire.

In Lancashire (table 4) 7098 men accepted the offer of a screen (>70% acceptance) and an additional 389 were seen as self-referrals.
92 men were found to have an aortic aneurysm >= 3cm on initial screen

Table 4				
Measurement of Abdominal Aorta	<3.0cm	3.0-4.4cm	4.5-5.4cm	>5.5cm referred to vascular surgeon
Lancashire	**7006**	**68**	**8**	**16**

Source: C&L AAA screening programme data

The mortality rate among patients identified by the screening programme and operated on across the county in 2013 was only three in a thousand.

Antenatal & Newborn Screening

The collection of quality and performance data for the antenatal and new born screening programmes continues to develop and most trusts are now able to submit data from their maternity systems.

There are currently six antenatal and neonatal screening programmes:

- Infectious Diseases in Pregnancy
- Sickle Cell and Thalassaemia
- Fetal Anomaly including Downs Syndrome
- Newborn Bloodspot
- Newborn Infant Physical Examination
- Newborn Hearing

Each programme has specific key performance indicators (KPIs) and performance against these in 2013/14 is shown in table 5.

Infectious Diseases in Pregnancy Screening
This programme tests for infection with HIV, Hepatitis B or Syphilis and also assesses Rubella susceptibility.

KPI - ID1 HIV Coverage
This indicator measures the proportion of eligible women tested for HIV for whom a conclusive screening result was available at the day of report. The acceptable performance is >=90% and this was achieved by all Lancashire providers.

KPI - ID2 Timely referral of Hep B positive women
ID2 looks at the proportion of pregnant women with a positive screen for Hepatitis B, or who are already known to be Hepatitis B positive, who are referred and seen for specialist assessment within 6 weeks. The acceptable level of performance is >=70%.
Achievement of this indicator is affected by fluctuations in the small numbers involved and the fact that many women are already under the care of a consultant and may have been recently seen.

Sickle Cell & Thalassaemia Screening
KPI - ST1 Coverage
Coverage is defined as the proportion of eligible women for whom a conclusive screening result is available at the day of report. The acceptable performance is >=95% and has been achieved by all Lancashire Trusts

KPI - ST2 Timeliness of test
ST2 looks at the proportion of women having antenatal sickle cell and thalassaemia screening for whom a conclusive result was available by 10+0 weeks gestation. The acceptable performance threshold is >=50% but some trusts continue to struggle with this KPI. To achieve it, work needs to be done to encourage women to book early for antenatal care. The Board and operational groups are looking into the reasons for the delay in some areas.

KPI - ST3 Completion of Family Origin Questionnaire (FOQ)
This indicator looks at the proportion of samples submitted to the laboratory which are supported by a completed FOQ. The acceptable performance is >=90% and this is achieved by all trusts.

Fetal Anomaly and Downs screening
KPI - FA1 Downs Syndrome Screening - Completion of laboratory request forms

This KPI is based on the proportion of completed laboratory request forms submitted within the recommended timeframe of 10+0 to 20+0 weeks gestation. The acceptable performance threshold is >=97%.
All trusts made good progress with this KPI and only one had not yet achieved the target by the end of the year. Plans are in place to share best practice at the Antenatal and Newborn Programme Board and local operational groups

Newborn Bloodspot Screening (NBBS)
The Newborn Bloodspot programme offers universal screening for five conditions:

Condition	**Potential consequences if untreated**
Congenital hypothyroidism (CHT)	serious, permanent, physical and mental disability
Phenylketonuria (PKU)	serious, irreversible, mental disability
Cystic fibrosis (CF)	serious adverse effects on digestion and lung function
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)	seizures, coma and sudden unexpected death in infancy (SUDI)
Sickle cell disorders (SCD)	anaemia, obstructed blood flow and organ damage

Testing for a further four conditions is being piloted at Central Manchester laboratory, which serves the Lancashire population.

KPI - NB1 Coverage
Coverage is defined as the proportion of registered babies who are eligible for screening and who have a conclusive result recorded on the Child Health Information System by 17 days of age. PKU is used as a proxy for all tests. The acceptable level of performance has been set at >=95% and all trusts achieved this by quarter 4.

KPI – NB2 Avoidable repeats tests
Defined as the percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process
Although some blood spot tests will always need to be repeated, the minimum standard is that there should be no more than 2% avoidable repeats with a developmental standard of no more than 0.5%.

Most maternity units have made improvements in their avoidable repeat rates over the past 2 years. Further work is underway with midwives, including focused education for neonatal units.

KPI – NB3 Timeliness of result
This indicator looks at the proportion of results which are screen negative for all five conditions, available on the Child Health Information System for communication to parents within 6 weeks of birth. The acceptable threshold has been set at >=95% and is being met by all Trusts.

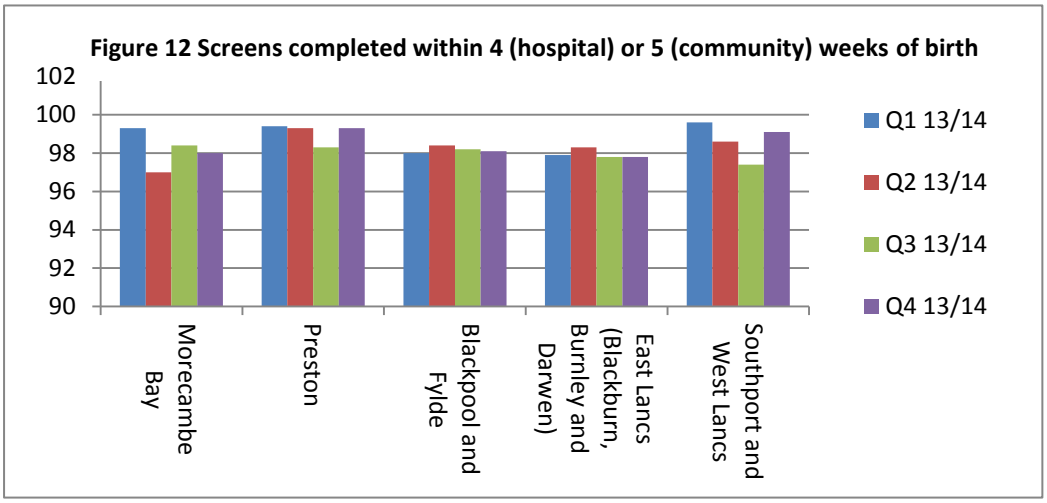
Newborn Infant Physical Examination Screening (NIPE)
Newborn Infant Physical Examination screening is a relatively new programme that includes a general overall physical examination of the infant as well as a more specific examination of the eyes, heart, hips and (in boys) testes. It is offered to all newborns and should be carried out within 72 hours of birth and again at 6-8 weeks of age.
While screening is being carried out in all units, recording and reporting is still being developed. All maternity units are required to have systems in place to record NIPE outcomes by April 2015..

Newborn hearing screening
The Newborn Hearing Screening Programme (NHSP) aims to identify, within 4-5 weeks of birth, all children born with moderate to profound permanent bilateral deafness. Infants

screening positive on initial testing are referred for treatment and should be seen within four weeks of the decision to refer.

KPI – NH1 Coverage

Coverage is the percentage of eligible babies in the birth cohort for whom the screening process is complete by 4 weeks corrected age (hospital programmes) or 5 weeks corrected age (community programmes). The target is 95% and is achieved by all programmes in Lancashire (figure 12).



Data source- KPI submissions

KPI - NH2 Timely Assessment for Screen Referrals

All referred babies should receive an audiological assessment within 4 weeks of the decision to refer or by 44 weeks gestational age. The target is 90% (achievable target 100%) but performance remains poor against this indicator (figure 13). The programme board has requested exception reporting on all children breaching the 4 week target to better understand the underlying issues. Screening programme leads have been asked to share best practice where improvement has been achieved.

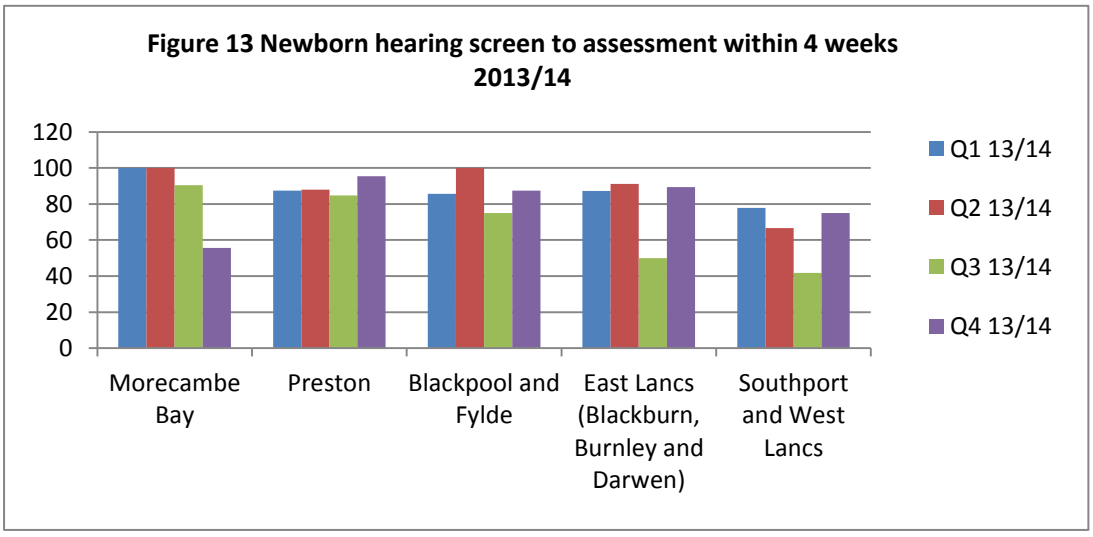


Table 5 Antenatal & Newborn Screening Programme KPI Performance 2013/14

Provider		ID1 ≥ 95%	ID2 (below standard ≤ 70%, acceptable 70-89.9%, achievable ≥ 90%)	FA1 (below standard <97%, acceptable 97% -99.9%. Achievable 100%)	STI (below standard <95%, acceptable 95% - 98.9%. Achievable 99% and over)	ST2 (below standard <50%, acceptable 50-74%, achievable over 74%)	ST3 (below standard <90%, acceptable 90-94.9%, achievable over 95)	NB2 (below standard > 2.0, acceptable 2.0-0.5, achievable < 0.5)	NP1 (Below standard <95%, acceptable 95-99%, achievable 100%)	NP2 (Below standard <95%, acceptable 95-99%, achievable 100%)
Blackpool	Q1 13/14	96	100	100	95	60.2	98.6	1.6		
	Q2 13/14	No submission	No submission	No submission	No submission	No submission	No submission	No submission		
	Q3 13/14	93		94.7	94.8	52.1	98.1	2		
	Q4 13/14	96.2		95.9	96.8	52.9	98.9	3.6		
East Lancashire	Q1 13/14	96.6	66.7	95	95.5	59.1	100	1		
	Q2 13/14	96.9	66.7	95	97	63	100	0.8		
	Q3 13/14	96.9	50	97.5	97.3	67.8	100	0.5		
	Q4 13/14	96.9	60	95	97.6	60	100	0.9	96.1	
Lancashire Teaching Hospital	Q1 13/14	99.2	no cases	98.4	99.1	56.9	99.2	0.8		
	Q2 13/14	98.9		99.3	99.1	54.5	99	1.5		
	Q3 13/14	98.9	100	98.8	98.9	50.3	99.3	2.1	90.3	
	Q4 13/14	99.4	50	99.7	99.5	40.5	97.7	2.2	91.7 (97 well babies)	66.7
Southport and Ormskirk	Q1 13/14	97	no cases	100	96.30%	28.2	97.6	2.7		
	Q2 13/14	99.4		96.7	98.5	15	97.2	2.4		
	Q3 13/14	98.5		94.6	98.5		99	2.9	97.8	100%
	Q4 13/14	98.1		98.9	97.6	32	94.6	2.4		
University Hospital of Morecambe Bay	Q1 13/14	99.4		84	100		100	3.0		
	Q2 13/14	100		94.2	100		99.3	2.3		
	Q3 13/14	99.9		91.7	100	48.7	100	1.2		
	Q4 13/14	100		94.5	98	47.8	98	2.1		

Table 4: Antenatal and Newborn screening KPI data submissions Date Source: Trust data

Immunisation Programmes Performance

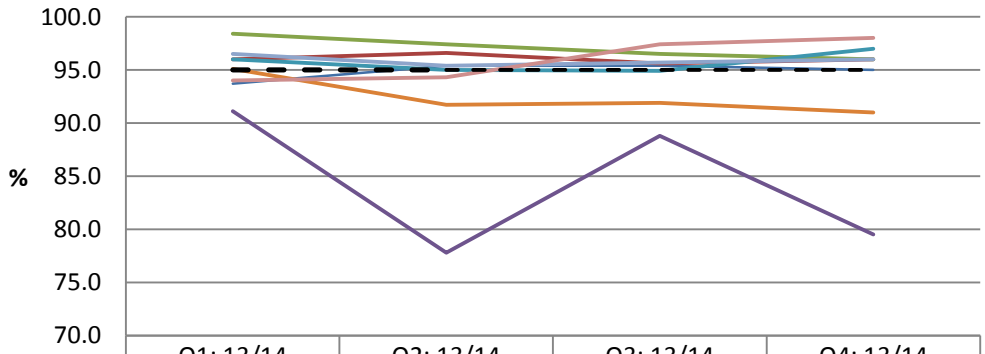
CHILDHOOD PROGRAMMES

The 0-5 immunisation figures are based on quarterly COVER data (Coverage of Vaccine Evaluated Rapidly) produced and published by Public Health England. COVER data is extracted from the Child Health Information Systems (CHIS) and so any errors in CHIS data are reflected in national coverage rates
Although immunisation uptake in 2013/14 was generally good, the following issues were noted:

- During 2013/14 NHS England Lancashire Area Team became aware of on-going data reporting and recording problems in East Lancashire. This was reflected in the apparently low coverage rates shown in figures 14-18 and in national COVER statistics. Investigation at the time provided reassurance that children were being vaccinated and a task group was subsequently set up, with membership from CHIS, the Clinical Commissioning Group, Commissioning Support Unit and Lancashire Area Team, to plan to resolve the data issues.

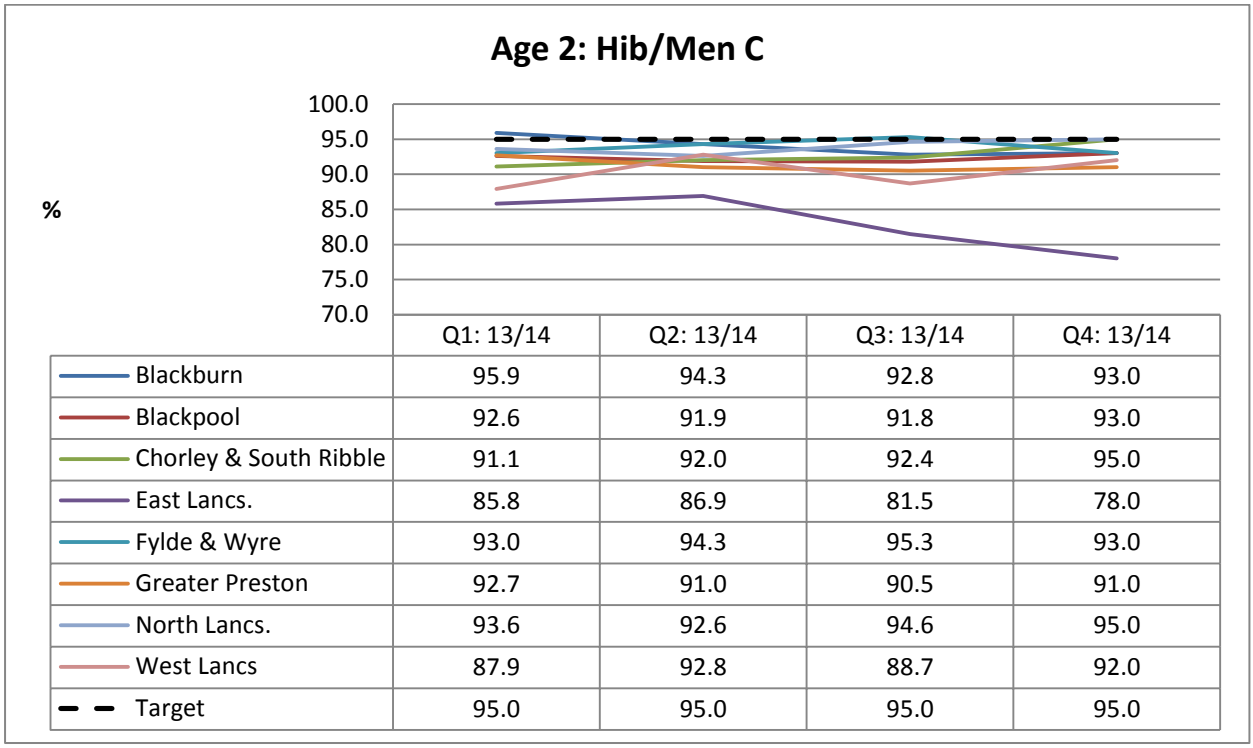
- Pre-school booster and 2nd MMR coverage rates remain a concern across all areas. For children to be fully protected against measles, mumps and rubella they require two doses of MMR before starting school. Figures 18 & 19 show that between 10% and 20% of children are starting school with incomplete protection. More reassurance is available from figure 20 which indicates that the majority of children have had at least one MMR dose by the age of 5 years.

Figure 14: Children with 3 doses of Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) by 12 months - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	93.7	95.4	95.4	95.0
Blackpool	96.0	96.6	95.6	96.0
Chorley & South Ribble	98.4	97.4	96.5	96.0
East Lancs.	91.1	77.8	88.8	79.5
Fylde & Wyre	96.0	95.0	94.9	97.0
Greater Preston	95.1	91.7	91.9	91.0
North Lancs.	96.5	95.4	95.7	96.0
West Lancs	94.0	94.3	97.4	98.0
Target	95.0	95.0	95.0	95.0

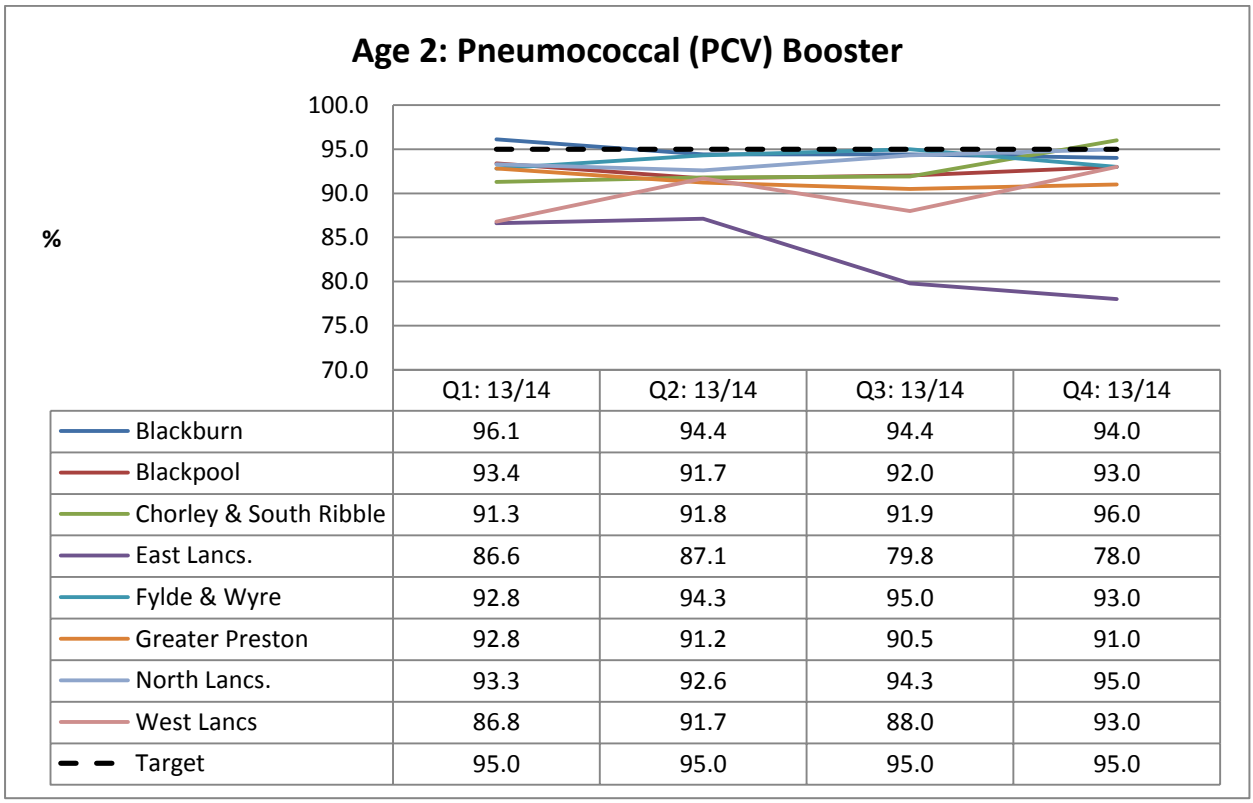
Figure 15: Children with Hib/ Men C Booster by 2 years - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	95.9	94.3	92.8	93.0
Blackpool	92.6	91.9	91.8	93.0
Chorley & South Ribble	91.1	92.0	92.4	95.0
East Lancs.	85.8	86.9	81.5	78.0
Fylde & Wyre	93.0	94.3	95.3	93.0
Greater Preston	92.7	91.0	90.5	91.0
North Lancs.	93.6	92.6	94.6	95.0
West Lancs	87.9	92.8	88.7	92.0
Target	95.0	95.0	95.0	95.0

The Hib/Men C booster should be given when children are 12 months old

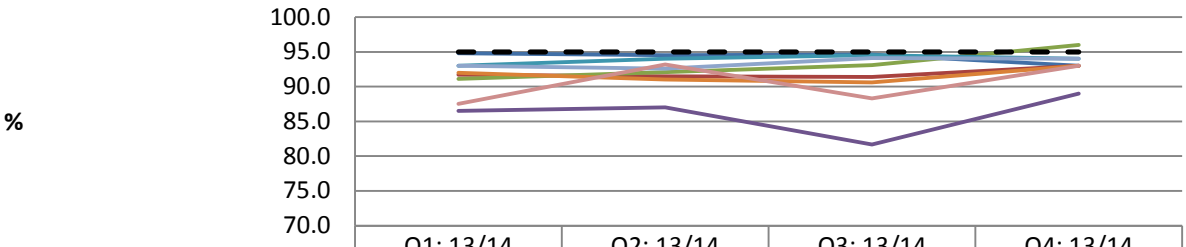
Figure 16: Children with Pneumococcal (PCV) Booster by 2 years - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	96.1	94.4	94.4	94.0
Blackpool	93.4	91.7	92.0	93.0
Chorley & South Ribble	91.3	91.8	91.9	96.0
East Lancs.	86.6	87.1	79.8	78.0
Fylde & Wyre	92.8	94.3	95.0	93.0
Greater Preston	92.8	91.2	90.5	91.0
North Lancs.	93.3	92.6	94.3	95.0
West Lancs	86.8	91.7	88.0	93.0
Target	95.0	95.0	95.0	95.0

The PCV booster is between 12 and 18 months old.

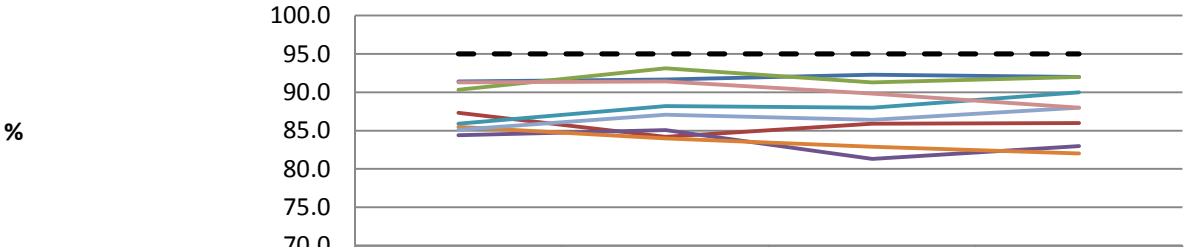
Figure 17: Children with 1st dose Measles, Mumps & Rubella (MMR) by 2 years - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	94.8	94.5	94.6	93.0
Blackpool	91.7	91.5	91.4	93.0
Chorley & South Ribble	91.1	92.1	93.1	96.0
East Lancs.	86.5	87.0	81.7	89.0
Fylde & Wyre	93.0	94.0	94.5	94.0
Greater Preston	92.0	91.0	90.6	93.0
North Lancs.	93.0	92.6	94.1	94.0
West Lancs	87.5	93.2	88.3	93.0
Target	95.0	95.0	95.0	95.0

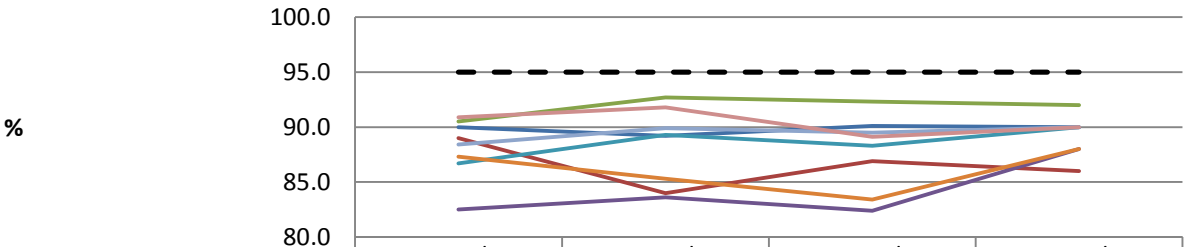
The first MMR dose should ideally be given at 12 months but, if missed, it can be given at any time (see graph 6 below).

Figure 18: Children with Diphtheria, Tetanus, Polio, Pertussis, (Pre-school booster) by 5 years - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	91.4	91.7	92.3	92.0
Blackpool	87.3	84.2	85.9	86.0
Chorley & South Ribble	90.3	93.1	91.3	92.0
East Lancs.	84.4	85.0	81.3	83.0
Fylde & Wyre	85.9	88.2	88.0	90.0
Greater Preston	85.5	84.0	82.9	82.0
North Lancs.	85.1	87.1	86.4	88.0
West Lancs	91.3	91.4	89.8	88.0
Target	95.0	95.0	95.0	95.0

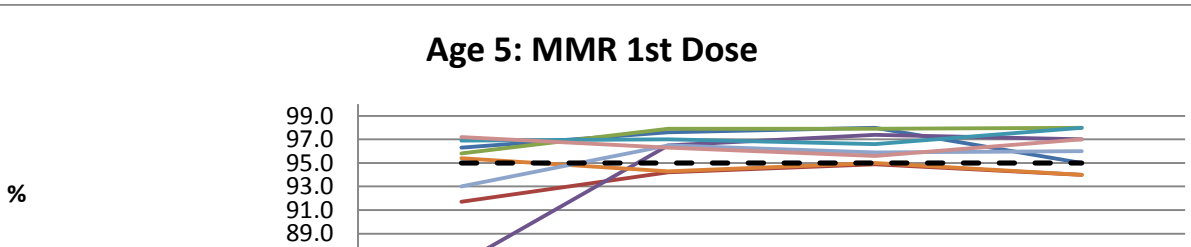
Figure 19: Children with MMR 2nd Dose by 5 years - 2013/2014



	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	90.0	89.2	90.1	90.0
Blackpool	89.0	84.0	86.9	86.0
Chorley & South Ribble	90.5	92.7	92.3	92.0
East Lancs.	82.5	83.6	82.4	88.0
Fylde & Wyre	86.7	89.3	88.3	90.0
Greater Preston	87.3	85.3	83.4	88.0
North Lancs.	88.4	89.9	89.5	90.0
West Lancs	90.9	91.8	89.1	90.0
Target	95.0	95.0	95.0	95.0

For children to be fully protected against measles, mumps and rubella they require two doses of MMR before starting school. The above graph shows that between 10% and 20% of children are starting school with incomplete protection. More reassurance is available from figure 20 which indicates that the majority of children have had at least one MMR dose by the age of 5 years.

Figure 20: Children with 1st dose of MMR by 5 years - 2013/2014



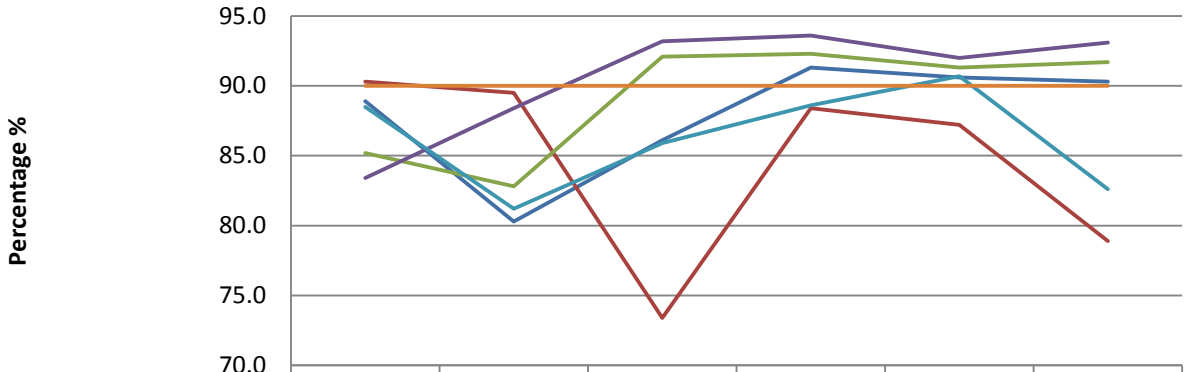
	Q1: 13/14	Q2: 13/14	Q3: 13/14	Q4: 13/14
Blackburn	96.3	97.6	98.0	95.0
Blackpool	91.7	94.2	94.9	94.0
Chorley & South Ribble	95.8	97.9	97.9	98.0
East Lancs.	86.5	96.5	97.4	97.0
Fylde & Wyre	96.9	97.0	96.6	98.0
Greater Preston	95.4	94.3	95.0	94.0
North Lancs.	93.0	96.5	95.9	96.0
West Lancs	97.2	96.3	95.6	97.0
Target	95.0	95.0	95.0	95.0

SCHOOL AGE PROGRAMMES

During 2013/14 there were three school age immunisation programmes in place, or being implemented, across Lancashire. They were the Human papillomavirus (HPV), School Leaver booster, and Adolescent Meningitis C.

Human papillomavirus (HPV)

Figure 21 Age 12-13: HPV All 3 Doses 2008-2014



	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
BWD	88.9	80.3	86.1	91.3	90.6	90.3
Blackpool	90.3	89.5	73.4	88.4	87.2	78.9
Central Lancashire.	85.2	82.8	92.1	92.3	91.3	91.7
East Lancashire	83.4	88.4	93.2	93.6	92.0	93.1
North Lancsashire	88.5	81.2	85.9	88.6	90.7	82.6
Target	90.0	90.0	90.0	90.0	90.0	90.0

The school HPV programme was set up in 2008 to provide HPV protection to girls aged 12-13 years before they become sexually active. The vaccine course consists of three doses within a twelve month period. Data on uptake is loaded onto the Department of Health Immform site by providers or commissioners, according to local arrangements, and this data is used to produce national comparative statistics.

Figure 21 shows that most CCGs across Lancashire have an uptake close to, or above, the national target of 90%. The downward trend in Blackpool in 2010/11 was due to negative media reporting of an incident that occurred in the Coventry programme. The more recent downward trend in Blackpool and North Lancashire is thought to be linked to capacity issues and is being investigated.

School Leaver Booster (Tetanus, diphtheria, polio)

The school leaver booster programme is offered to all Year 10 pupils with catch up programmes in Year 11-13. Rather surprisingly, the school leaver uptake figures are not nationally recorded.

The Department of Health, Public Health England and NHS England are currently working together to produce a national tool to record uptake figures for the school leaver booster. In the meantime we have developed a template for providers to use to record uptake across Lancashire.

Adolescent Meningitis C

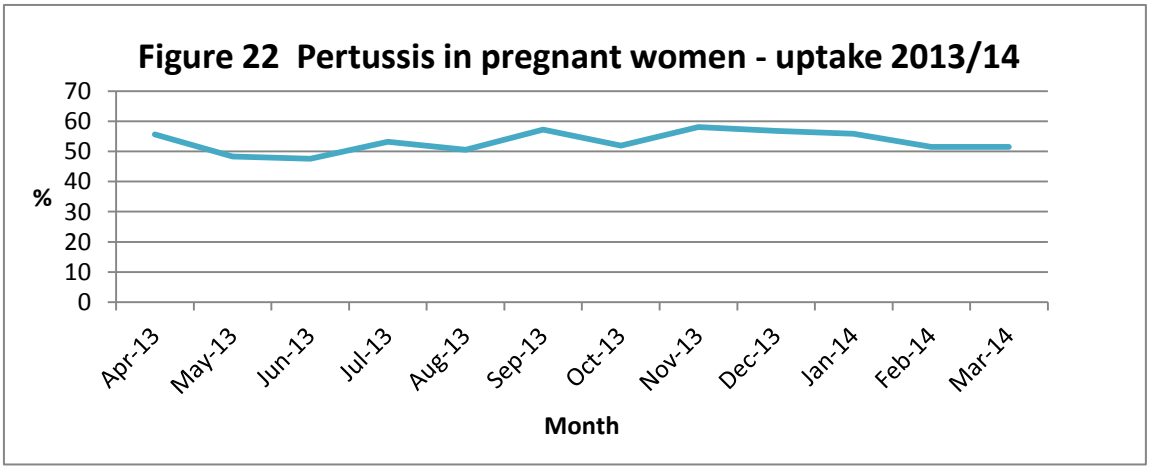
Changes to the childhood Meningitis C immunisation programme were announced in May 2013 with a proposal to move the second Men C dose from infancy to adolescence. The adolescent dose was to be given in year 9 or 10 and vaccinations were to begin in spring or autumn 2014. Unfortunately the savings in the primary care budget, from removal of the second dose in infancy, were not available to commission the adolescent programme as they had already been used to fund the new primary-care based Rotavirus immunisation programme. Implementation of the Men C adolescent programme was therefore an unfunded pressure on all Area Teams which was only resolved towards the end of 2013/14..
The programme began in spring 2014 in Blackpool and North Lancashire schools only, providing a single booster dose to Year 10 students.
From September 2014 the Men C booster will be offered in all schools across Lancashire. Due to the staggered start, there will also be a 2014/15 catch-up programme for any unvaccinated year 11 students.

ADULT PROGRAMMES

Pertussis (Whooping Cough) in pregnant women

The pertussis vaccination in pregnancy programme was introduced in October 2012 in response to a national pertussis outbreak affecting babies under two months of age i.e. before the age at which they could receive their primary immunisations.

It was hoped that offering a single pertussis immunisation to pregnant women in the last trimester (after the 28th week of their pregnancy) would provide protection for both mother and newborn infant, and this was shown to be the case. Although initial uptake of the programme was poor, its obvious success in reducing infant deaths led to a national decision to extend it for at least a further 5 years.



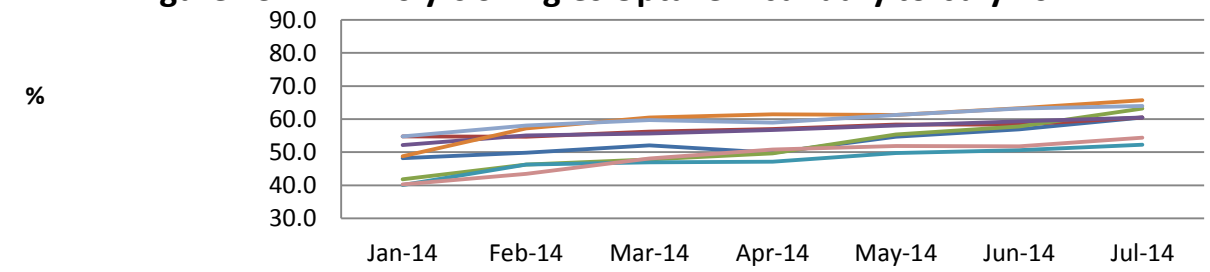
In the first months of the programme vaccination coverage was poor due to confusion about the appropriate timeframe in which to give the vaccine (any vaccine given before 28 weeks could not be counted) and clarity regarding responsibility for administration. There were also problems with data collection - the above Lancashire figures are based on data from only 50% of practices. From April 2014 more robust information will be collected quarterly.

During 2014/15 NHS England Lancashire Area Team plan to work with general practices and maternity services to more fully embed this programme into the maternity care pathway.

Shingles

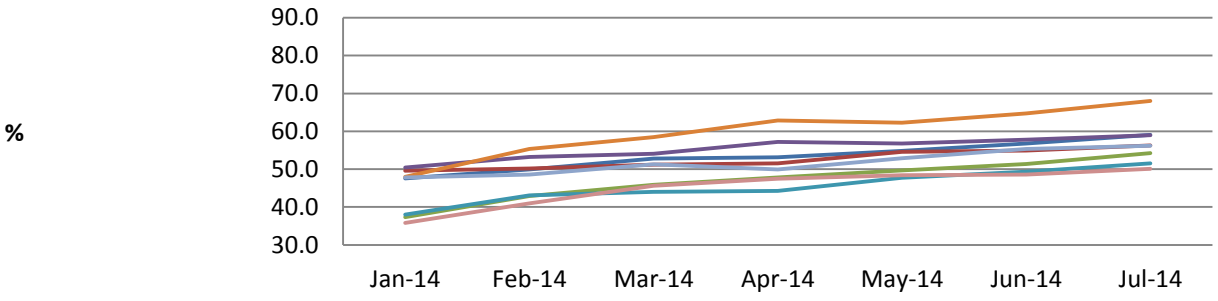
The new shingles vaccination programme was introduced in September 2013 but, due to restrictions on vaccine supply, was initially only offered to patients aged 70 years and 79 years as a single dose given in primary care.

Figure 23 70 yrs Shingles Uptake : January to July 2014



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
BWD	48.2	49.8	52.1	49.8	54.7	56.9	60.5
Blackpool	54.8	54.7	56.2	57.0	58.4	58.4	60.5
Chorley & South Ribble	41.8	46.3	47.8	49.6	55.4	57.8	63.2
East Lancashire	52.2	55.1	55.6	56.7	58.1	59.3	60.5
Greater Preston	40.1	46.3	46.9	47.1	49.7	50.6	52.3
North Lancashire	48.8	57.2	60.5	61.5	61.3	63.3	65.7
West Lancashire	54.8	58.1	59.7	58.9	61.3	63.2	64.0
Fylde & Wyre	40.3	43.5	48.1	50.8	51.9	51.8	54.4

Figure 24 79 yrs Shingles Uptake : January to July 2014



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
BWD	47.6	49.9	52.8	53.1	54.8	56.8	59.1
Blackpool	49.6	50.2	51.2	51.5	54.6	54.9	56.3
Chorley &South Ribble	37.3	42.9	45.9	47.8	49.7	51.4	54.2
East Lancashire	50.4	53.2	54.1	57.2	56.8	57.8	59.0
Greater Preston	38.0	43.1	44.0	44.3	47.7	49.3	51.5
Lancashire North	48.0	55.3	58.5	62.9	62.3	64.7	68.0
West Lancashire	47.8	48.6	51.3	49.9	52.9	55.3	56.2
Fylde & Wyre	35.8	41.0	45.6	47.5	48.4	48.6	50.1

Uptake rates (figures 23 & 24) are based on data from 223 out of 232 sentinel practices and have shown a steady increase since the programme began.

In 2014/15 the programme is being further extended and will be offered to patients aged 70, 78 and 79 years old.

Seasonal Flu 2013/14

The 2013/2014 seasonal influenza programme was implemented during a period of significant change but, despite the challenges, it achieved some significant success (fig 25):

- Lancashire was ranked number 1 in the country for its performance in immunising both the over 65s, and people under 65 years in clinical risk groups.
- Seven of the eight CCGs met the 75% uptake target for the 65 years and over group.
- 100% of Lancashire practices returned their data

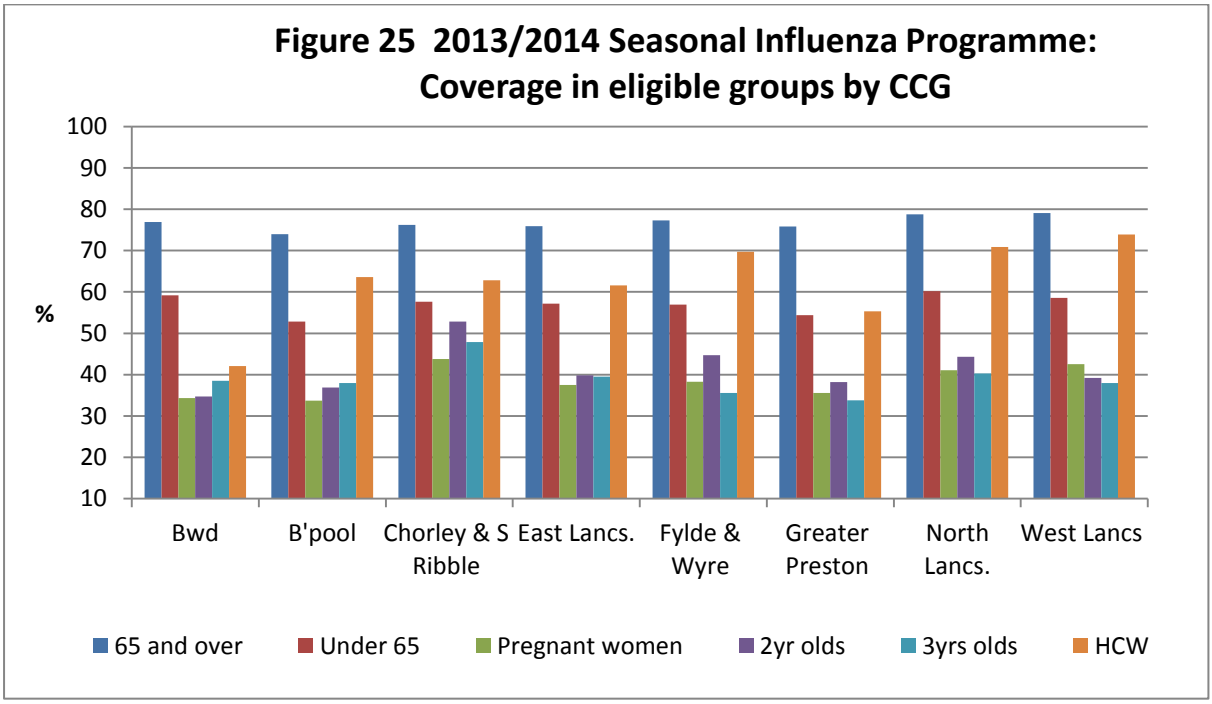


Table 6: 2013/14 Lancashire Area Team Uptake and national ranking for all eligible groups

	65 and over	Under 65	Pregnant women	2yrs	3yrs	HCW
Lancashire Area Team	76.5%	56.9%	37.8%	41.0%	39.0%	68.5%
National rank out of 25 Area Teams	1st	1st	20th	22nd	19th	3rd

However, despite the successes, performance and ranking was lower for children and pregnant women (Tables 6 & 7).

Table 7: Flu Immunisations (%) in Pregnant women 2010/2011-2013/2014

	Flu Immunisations (%) in Pregnant women			
PCTs	**2010/11**	**2011/12**	**2012/13**	**2013/14 (CCGs)**
Blackburn with Darwen	35.6	26	42.4	34.4
Blackpool	63	24	33.9	33.7
Central Lancashire	46.6	30	42.8	Chorley & South Ribble 43.8 Greater Preston 35.6 West Lancashire 42.5
East Lancashire	39.7	24.4	35.3	37.5
North Lancashire	50	29.1	38.5	Fylde and Wyre 38.3 Lancashire North 41.1

Table 8: Flu Immunisations (%) in Health Care Workers 2010/11-2013/14

	Flu Immunisations (%) in Health Care Workers			
PCTs	**2010/11**	**2011/12**	**2012/13**	**2013/14 (CCGs)**
Blackburn with Darwen	21	38	43.4	42.1
Blackpool	60	78.7	56.4	63.6
Central Lancashire	28.9	60.3	54.3	Chorley & South Ribble 62.8 Greater Preston 55.3 West Lancashire 73.9
East Lancashire	26.7	66.8	55.3	61.6
North Lancashire	36.1	43.8	53.9	Fylde and Wyre 69.7 Lancashire North 70.9

Immunisation in health care workers showed a steady increase between 2010/11 and 2013/14 (table 8).

A Lessons Learnt event was held in February 2014 and highlighted the need for a more co-ordinated approach to implementing future seasonal influenza programmes. It was agreed that:

- A Seasonal Influenza sub-group should meet monthly from April 2014 to offer commissioning advice and recommendations to the Immunisation Programme Board. Membership would be from all the stakeholders involved in the programme.
- Task and Finish groups would be established to deal with any urgent matters arising
- Regular flu updates and uptake data would be shared with stakeholders via the Screening and Immunisation Team
- The PGD subgroup would be requested to ensure that the seasonal influenza PGD is ready by September 2014
- A decision should be taken early on the role of pharmacies within the programme
- NHS England Lancashire Area Team would establish which trusts are already immunising pregnant women or are willing to offer this service
- A locally-applicable matrix of service provision, similar to that available via the Department of Health Vaccine Update, should be circulated before the start of the programme.

Achievements during 2013/14

Measles Outbreak and MMR catch up

In April 2013, at the creation of NHS England, the northwest region was experiencing a measles outbreak centred on Lancashire. There had been 341 reported cases in the first few months of 2013, compared with 92 confirmed cases in 2012. The distribution of cases in the outbreak crossed all ages but was showing a peak in the 10-16 year age group (the group who, as small children, had been most affected by the decline in MMR uptake due to parental concern at a suggested, but later disproved, link between the vaccine and autism.) Many of these unprotected children were in secondary school where the opportunity for the infection to spread rapidly was high due to school size and mixing patterns.

The northwest outbreak, together with larger outbreaks in the North East and South Wales, led to a joint decision by Public Health England, NHS England and the Department of Health to launch a national campaign to drive up demand for MMR among the 10-16 year group, while at the same time maintaining high coverage in the under-5s programme.
The campaign ran from April to the end of September 2013 and was co-ordinated by a joint MMR Working Group in each NHS England local area.

The Lancashire MMR Working Group was chaired by the Lancashire Screening and Immunisation lead and had representation from NHS England Lancashire Area Team; Public Health England; Lancashire, Blackpool and Blackburn with Darwen Councils; Regional and PHE communications leads.
The three components of the campaign were:

Awareness raising: used a combination of national, regional and local press releases and media interviews, digital media, flyers to children and parents through pupil post and school portals, posters and flyers to GP surgeries, children's centres, youth centres and all schools.

Identification of unvaccinated or partially vaccinated children: used baseline data from the Child Health Information System (CHIS) to estimate the vaccination status of children in the 10-16year age group at the start of the campaign. There were considerable difficulties in obtaining and interpreting this data due mainly to differences in the operating procedures of the different CHIS teams across Lancashire.

Operational: GPs were asked to contact the unvaccinated children aged 10-16yrs registered with their practice. Information was also gathered on children looked after and on potential numbers of children at traveller sites in case specific vaccination sessions were required for these groups.

<u>Monitoring</u>
Progress with the catch-up campaign was monitored nationally via the Immform data collection site. In April 2013, at the start of the campaign, only 86% of the 10-16year age group were recorded as having received at least one MMR dose. Four months later the figure had risen to 89%.

Due to major discrepancies between the information obtained from the child health system and from general practices, the MMR working group recommended a data cleansing exercise to gain a better understanding of vaccination levels in Lancashire. At the end of this process NHS England Lancashire Area Team commissioned a timed-limited project from providers who engage with marginalised and hard to reach groups. The project was to run over summer 2014 to develop and implement an action plan to improve immunisation uptake in these groups.

Training sessions for immunisers

Immunisation programmes had remained remarkably stable over many years but in 2013, at the point of wholesale re-organisation of the NHS, the Joint Committee on Vaccination and Immunisation (JCVI) announced six new or changed programmes. These included the introduction of Rotavirus vaccination to the infant programme; the introduction of an adolescent dose of Meningitis C in place of one of the infant doses; expansion of the Seasonal Flu programme to offer a new nasal vaccine to all 2 and 3 year olds; formalisation of a pilot Pertussis in Pregnancy programme; and the introduction of a Shingles programme for the elderly. On top of this a national measles outbreak was causing great concern and a catch up MMR programme for all unimmunised 10-16 year olds was also to take place.

The majority of this work was to fall on primary care and, as responsibility for immuniser training was unclear, the screening and immunisation staff in post at the time rapidly set up and ran a series of well attended immunisation training days across Lancashire.

Enquiry Line

Prior to April 2013, primary care staff had been able to telephone their local PCT and speak to an immunisation co-ordinator for advice on schedules, vaccine contraindications etc. In response to numerous requests for advice to the area team, the screening & immunisation team set up an enquiry line with a dedicated phone number and email address. The co-ordinators respond to numerous calls each week and, while most concern immunisations enquiries, there are also an increasing number on cervical screening issues.

With assistance from health protection staff in Public Health England, the team are in the process of setting up an interactive access database to record all calls. The intention is to analyse calls on a quarterly basis to discover any common themes. This will then inform the advice provided to practices via the regular local Screening & Immunisation Bulletin.

Diabetic Eye Screening in HM Prisons Garth and Wymott

In September 2013 NHS England Lancashire Area Team became aware that a large number of diabetic prisoners at HM Prisons Garth and Wymott had not had an annual Diabetic Eye Screen (DES) for periods of up to 4years. Initial attempts to resolve the problem were unsuccessful due mainly to complex IT issues, and a decision was taken to declare a serious incident. Fortunately no prisoner had been harmed by the delay and the resulting incident recommendations led to improved communication between prison healthcare and the DES programme administration; the purchase of a new retinal camera for use in both prisons; confirmation of IT support for the camera from Lancashire Care Foundation Trust; and the commissioning of extra regular community optometrist sessions into HMPs Garth and Wymott to prevent delays in the future.

Challenges

Data Analysis

A continuing challenge to NHS England Lancashire Area Team is the difficulty in sharing data across organisational boundaries, for example between public health staff in NHS England, Public Health England, and Local Authorities. While work is underway at a regional and national level to address this, by the end of 2013/14 all area teams struggled to draw up plans to address health inequalities using out of date data and lack of analytical support.

Child Health Information System (CHIS)

Restrictions within the inherited CHIS system limit the ability of the Lancashire Area Team to provide accurate information on screening and immunisations coverage for under 5s and school age children. Although the Rotavirus programme is now in place, it cannot be scheduled or recorded on the current CHIS system. In the absence of a new system this problem will be compounded when the expected Meningitis B programme is also introduced.

Lack of Assurance of Sample Taker Competency

Prior to April 2013 Lancashire and Cumbria PCTs each held a register of all cervical screening sample takers in their locality. The register enabled the PCT to monitor and be assured of governance and quality in cervical sample taking in primary care and community services. This information was also shared with the laboratory to allow them to verify or query the name of the sample taker when processing samples.
During the period of transition, apart from in Pennine Lancashire where the register went to the two CCGs, the PCT sample taker registers were not transferred to a responsible organisation as planned. The Screening and Immunisation team are currently acting as temporary care-takers of the registers until a more suitable arrangement can be put in place.

Looking Ahead to 2014/15

Practice visits and dashboard

The screening & immunisation team have developed a data dashboard of practice performance against a range of key performance indicators. The screening and immunisation co-ordinators are planning a series of targeted visits to practices to engage with those demonstrating good practice and to offer support to those with poor performance. The visits will be followed by a series of ‘Sharing Best Practice’ events towards the end of the year.

Diabetic Eye Screening reprocurement

A lack of confidence in the ability of two programmes to provide assurance on pathway performance and/or affordability has led to a decision to move to re-procurement of diabetic eye screening services across East and Central Lancashire in 2014/15.

Antenatal & Newborn Screening Programmes

Pulse oximetry testing on all newborns will be introduced in pilot areas in 2015. (The pilot areas are yet to be determined)

Shingles

In 2014/15 the shingles programme will be extended to include patients aged 70, 78 and 79 years old.

Human Papillomavirus (HPV) Programme

In the light of new evidence on its efficacy, the HPV schedule will be changing from 3 to 2 doses from September 2014. In Lancashire schools it will be offered as one dose in Year 8 and a second dose in Year 9.

Seasonal Influenza Programme 2014/2015

NHS England Lancashire Area Team plan to commission a greater number of community pharmacies to offer greater choice of access to flu immunisation for pregnant women, adults in clinical risk groups and the over 65s. Consideration will also be given to commissioning midwives to offer flu immunisation.

As part of the national expansion of the seasonal flu programme, from September 2014 all children aged 2 to 4 years will be offered the nasal influenza vaccine.

The Area Team has applied to be a pilot site for the 2014/15 Year 7 and 8 school based flu programme. The purpose of the pilot will be to test different options of delivery so as to inform best practice when the programme is rolled out nationally.

Appendix 1 Screening Programmes by Gender and Target Age Group

Target Group	Programme	Approximate annual target population
All pregnant women during the antenatal period	Infectious Diseases in Pregnancy	17,700
All pregnant women during the antenatal period	Sickle Cell and Thalassaemia	17,700
All pregnant women during the antenatal period	Foetal Anomaly Screening & Downs	17,700
All Newborns	Newborn Bloodspot screening for nine conditions	18,900
All Newborns	Newborn Hearing Screening	18,900
All Newborns and Infants	Newborn and Infant Physical Examination	18,900
Patients with Diabetes Mellitus aged 12 years and over all invited annually	Diabetic Retinopathy screening	75,300
Women aged 25-64 years 25 – 49yrs - invited every 3 years 50-64yrs – invited every 5 years	Cervical Cancer Screening	106,600
Women aged 50-70 years (pilot 47-73yrs) all invited every 3 years	Breast Cancer Screening	63,990
Men and Women aged 60-74 years all invited every 2 years	Bowel Cancer Screening	124,900
Men aged 65 years a single invitation at 65 yrs	Abdominal Aortic Aneurysm Screening	9,500

(Based on 2013 projected population estimates taken from the mid year 2011 census)

Appendix 2 Immunisation Programmes by Target Age Group

Target Group	Programme	Approx annual target population
2 months	Diphtheria, tetanus, pertussis (whooping cough), polio Haemophilus influenzae type b	18,900
	Pneumococcal disease	
	Rotavirus	
3 months	Diphtheria, tetanus, pertussis, polio Haemophilus influenzae type b	18,900
	Meningococcal group C	
	Rotavirus	
4 months	Diphtheria, tetanus, pertussis, polio and Hib	18,900
	Pneumococcal disease	
12-13 months	Haemophilus influenzae type b/ Meningococcal group C	18,900
	Pneumococcal	
	Measles, mumps and rubella	
2-4 years annual	Influenza	52,800
3 years 4 months	Diphtheria, tetanus, pertussis and polio	17,600
	Measles, mumps and rubella	
Girls 12-13 years (2 doses)	Human papillomavirus	16,000
14 years	Tetanus, diphtheria and polio	17,300
	MenC	
65 years Single injection	Pneumococcal disease	19,400
65 years + annual	Influenza	275,000
70, 78 and 79 years	Shingles	35,000

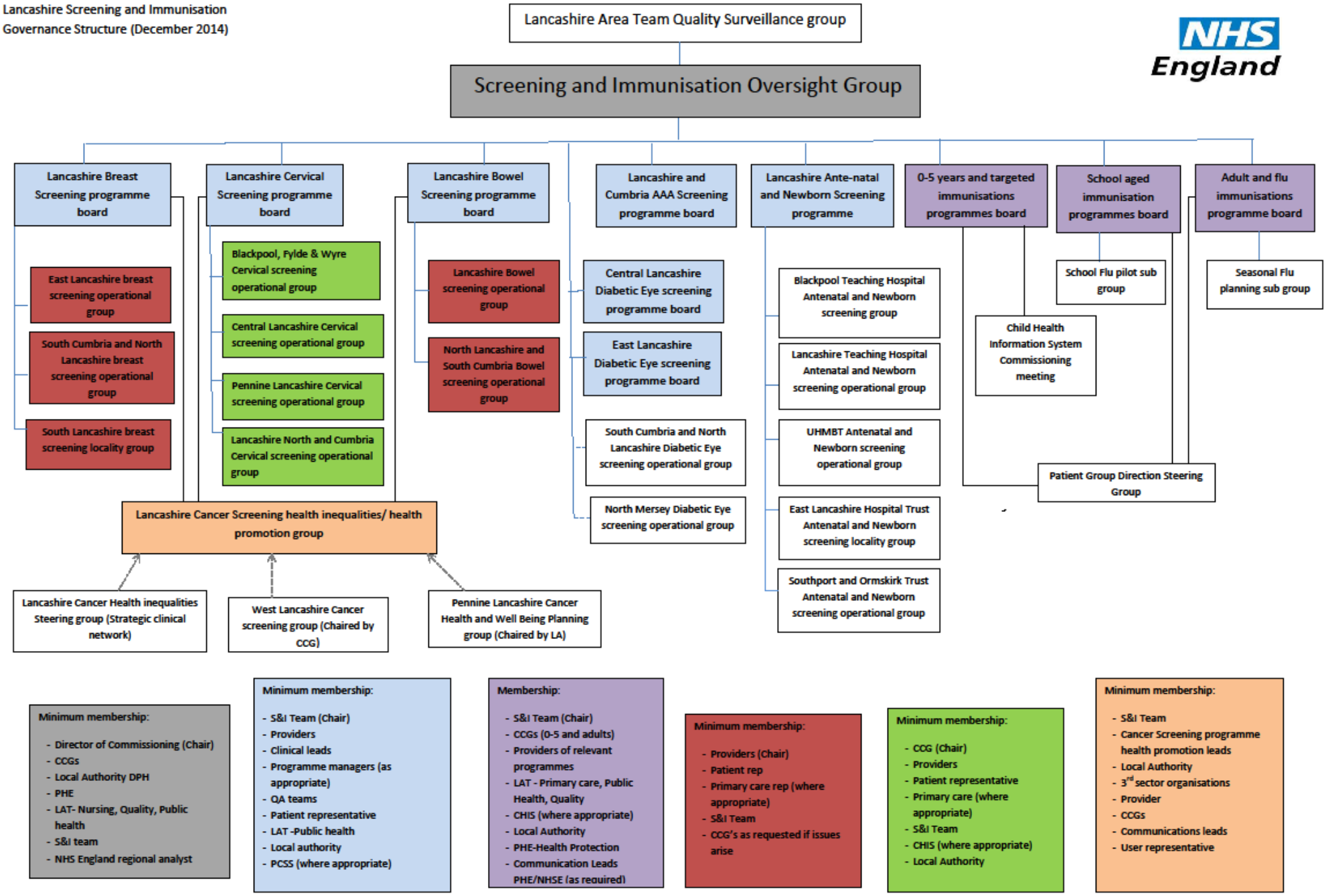
(Based on 2013 projected population estimates taken from the mid year 2011 census)

Immunisation programmes for defined <u>At Risk Groups</u>

At birth, 1 month, 2 months and 12 months	Hepatitis B
At birth	Tuberculosis – BCG
6 months - 2 years: annual	Influenza
1 month to 2 years: annual	Respiratory Syncytial Virus
2 years to 64 years: Single booster	Pneumococcal disease
5 to 65 years: annual	Influenza
All pregnant women from 28 weeks gestation	Pertussis
All pregnant women – anytime during pregnancy	Influenza

Appendix 3

Lancashire Screening and Immunisation Governance Structure (December 2014)



Minimum membership:

- Director of Commissioning (Chair)
- CCGs
- Local Authority DPH
- PHE
- LAT- Nursing, Quality, Public health
- S&I team
- NHS England regional analyst

Minimum membership:

- S&I Team (Chair)
- Providers
- Clinical leads
- Programme managers (as appropriate)
- QA teams
- Patient representative
- LAT -Public health
- Local authority
- PCSS (where appropriate)

Membership:

- S&I Team (Chair)
- CCGs (0-5 and adults)
- Providers of relevant programmes
- LAT - Primary care, Public Health, Quality
- CHIS (where appropriate)
- Local Authority
- PHE-Health Protection
- Communication Leads PHE/NHSE (as required)

Minimum membership:

- Providers (Chair)
- Patient rep
- Primary care rep (where appropriate)
- S&I Team
- CCG's as requested if issues arise

Minimum membership:

- CCG (Chair)
- Providers
- Patient representative
- Primary care (where appropriate)
- S&I Team
- CHIS (where appropriate)
- Local Authority

Minimum membership:

- S&I Team
- Cancer Screening programme health promotion leads
- Local Authority
- 3rd sector organisations
- Provider
- CCGs
- Communications leads
- User representative

Appendix 4 Operational Groups, Lead Area Teams and Geographical Areas covered.

Programme Boards	Operational Groups	Lead Area Team for operational group	Areas Covered
Breast Screening	East Lancashire	Lancashire	Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
	North Lancashire	Lancashire	Blackpool, Fylde, Lancaster, Preston, Wyre
	South Lancashire	Greater Manchester	Chorley, South Ribble, West Lancashire, Wigan
Cervical Screening	Lancashire North & Cumbria	Lancashire	Lancashire North & Cumbria
	Central Lancashire		Chorley, South Ribble, Preston, West Lancashire
	Blackpool, Fylde & Wyre		Blackpool, Fylde & Wyre
	Pennine Lancashire		Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
Bowel Screening	Lancashire	Lancashire	All districts except population north of Garstang
	Cumbria	CNTW	Cumbria plus population north of Garstang
Diabetic Eye Screening	East Lancashire	Lancashire	Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
	Central Lancashire	Lancashire	Chorley, Preston, South Ribble
	Cumbria & North Lancashire	CNTW	Blackpool, Cumbria, Fylde, Wyre, Lancaster
	North Mersey	Merseyside	Sefton, North Liverpool, West Lancashire
Abdominal Aortic Aneurysm screening		Lancashire	All districts in pan Lancashire plus Cumbria
Antenatal and Newborn Screening	University Hospitals of Morecambe Bay	Lancashire	Lancashire North & South Cumbria
	Lancashire Teaching Hospitals		Chorley, South Ribble, Preston
	East Lancashire Hospitals		Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
	Southport & Ormskirk Hospitals		Sefton, West Lancashire
	Blackpool Teaching Hospital		Blackpool, Fylde & Wyre
Immunisations 0-5yrs and targeted			All districts in pan Lancashire
Immunisations school age children			All districts in pan Lancashire
Immunisation adult and seasonal flu			All districts in pan Lancashire

Appendix 5 Team Members

Screening & Immunisation Team	
Dr Shelagh Garnett	Screening & Immunisation Lead
Martin Samangaya	Screening & Immunisation Manager
Kerry Crooks	Screening & Immunisation Manager
Kathryn Lewis	Screening & Immunisation Co-ordinator
Wendy Allen	Screening & Immunisation Co-ordinator
Jacquelyn Phillips	Screening & Immunisation Co-ordinator
Jackie Bolton	Screening & Immunisation Co-ordinator
Kathryn Jones	Screening & Immunisation Co-ordinator
Lisa Vallente-Osborne	Screening & Immunisation Co-ordinator
Public Health Commissioning Team	
Jane Cass	Head of Public Health
Natalie Cross/Tricia Spedding	Public Health Commissioning Manager
Carol Ann McElhone	Public Health Programme Manager
Neil Swindlehurst	Public Health Contracts Manager
Chris Naish	Public Health Contract Support
Joanne Blackburn	Public Health Administrator

Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool CCG
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	10th June 2015

FYLDE COAST NEW MODELS OF CARE- VANGUARD UPDATE

1.0 Purpose of the report:

1.1 To update the Health and Wellbeing Board on progress following the successful application to become one of the NHS England's National Vanguard sites.

2.0 Recommendation(s):

2.1 To consider the proposals for the Multi-speciality Community Providers model, support the proposed governance arrangements and note the feedback letter from NHS England and next steps.

3.0 Reasons for recommendation(s):

3.1 The Board is committed to reducing health inequalities and improving health outcomes for the local population. The Multi-speciality Community Provider model proposed in the bid will significantly contribute to achieving the aims of the Board.

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:

No other options available

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0 Background Information

5.1 The Registration of Interest form at Appendix 6a provides an explanation of the purpose of the bid

5.2 Following successful application to become one of the National Vanguard Sites there was a site visit on the 28th and 28th of April 2015. The objective of the two day site visit was to reach collective agreement on what is required to deliver demonstrable improvements in patient care locally within a one, two and three year time horizon, including an in- depth understanding of year one of;

- The aims, objectives and expected clinical and non- clinical outcomes for the new care model;
- The progress to date and current position against the objectives;
- The support required to enable the Vanguard to overcome identified barriers and accelerate delivery;
- To start the dialogue about what the compact between the New Care Models team and Vanguard will look like.

5.3 The Clinical Commissioning has received a formal feedback letter from Louise Watson MCP National lead and is in the process of formulating a response in relation to the four areas identified under the next steps section of the letter. Fylde Coast New Care Models board have met and discussed the transition of the current governance arrangements to the new arrangements required in support of the vanguard programme. A proposed draft of the governance structure and supporting work streams is attached for information and discussion as to how this will connect and report into existing Blackpool governance arrangements including Strategic Commissioning Group.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

Appendix 6a: Registration of Interest
Appendix 6b: NHS England Visit feedback letter
Appendix 6c: Governance Diagram

6.0 Legal considerations:

6.1 None at this stage

7.0 Human Resources considerations:

7.1 None at this stage

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 The finance group is working up an investment case for support to Vanguard and will be submitted to NHS England's New Care Models Board in June 2015.

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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REGISTRATION OF INTEREST- Fylde Coast New Models of Care

Q1. Who is making the application?

(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

Applicant: Fylde Coast Local Health Economy which includes the following statutory organisations:

Blackpool CCG
Blackpool Teaching Hospitals NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Fylde and Wyre CCG
Lancashire County Council
Blackpool Council

Additionally, we would wish the panel to note that, although our application does not specify individual organisations, our programme also encompasses provision by voluntary & 3rd sectors.

Contact: Andy Roach, Director of Transformation and Integration Blackpool CCG and Programme Director - Fylde Coast New Models of Care Programme. (andy.roach@blackpool.nhs.uk or telephone 01253 956653)

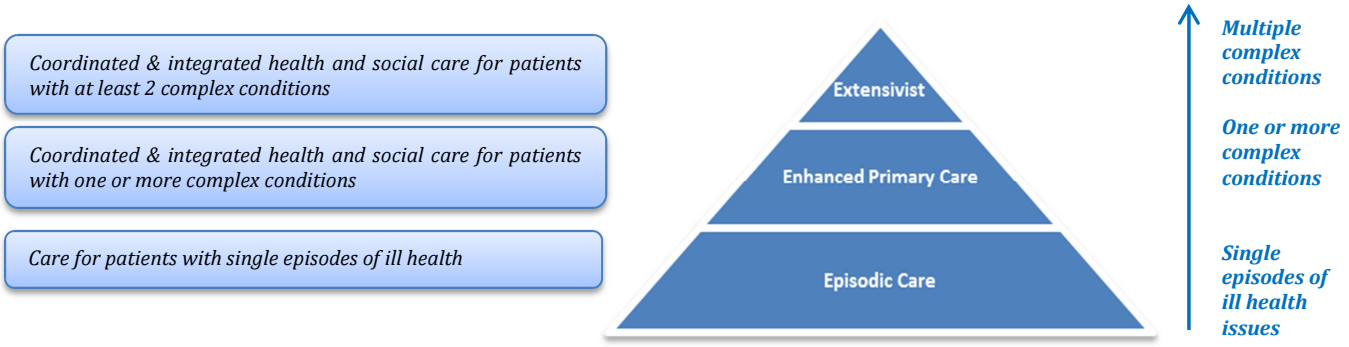
Q2. What are you trying to do?

(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

The vision for the Fylde Coast is to; create new models of care, wrapped around local populations, spanning across health and social care, to improve jointly the health and wellbeing of the Fylde Coast population, whilst maintaining financial stability. Our initial analysis (2014) of the Fylde Coast population shows that a substantial proportion of the healthcare resources are spent on a few patients only, notably those with multiple long term conditions. The evidence and examination of successful international models have shown an opportunity to deliver different models of care.

Our principle changes are to integrate community services and social care with primary care. This will reduce hand-offs, enable effective sharing of information and reduce the reliance on unplanned, reactive care currently delivered in a fragmented way.

In addition to this we are establishing a number of Extensive Care Services focused on elderly/frail populations which will free up capacity in general practice.



Enhanced Primary Care – we will provide primary care at scale by integrating all community services and primary care teams. Providing care to neighbourhood registered populations, patients will have a single point of access for all out of hospital care needs. Integrated Neighbourhood Teams will be using shared records and coordinate their workload to target patient needs effectively. They will ensure there are no gaps in service for patients to fall through.

Extensive Care – Our analysis demonstrates that 3% of our population uses 48% – 55% of our secondary care expenditure. Extensive Care teams with a range of clinical and non-clinical roles will provide proactive care with the explicit aim of reducing the proportion of income supporting this cohort of patients. The team will intensively manage long term conditions along evidence based pathways and coordinate care, with a single point of access to reduce the need for these patients to seek unplanned care.

Our community will have a care system which is orientated around their needs; care will be coordinated and integrated so that the system is simplified. Our care will overcome organisational divides so that provision across health and social care becomes seamless. There will be a beneficial impact on families and carers so that improvements in health and wellbeing are more widespread.

Our staff will be empowered to work across the traditional demarcations between health and social care. They will be connected to the community within which they work and navigate the system to coordinate care. Hand-offs will reduce and silos will be removed. Our plans include the development of new clinical and non-clinical roles, including training and development. There will be a Single Point of Access with a shared health record so that all clinicians will have access to the whole care history.

Benefits Realisation plans make explicit expectations that there will be reductions in unplanned admissions, out of hours contacts, A&E attendances and Outpatient referrals. We expect that more effective use of resource will generate capacity to improve access. Overall, we intend to shift the equivalent of £18m from secondary care expenditure to out of hospital services. Investment plans are in place to pump-prime developments 2015/16 with savings being realised and reinvested from 2016/17 onwards.

Q3. Which model(s) are you pursuing? (of the four described)

Multispecialty Community Provider - during 2014/15 the Fylde Coast Programme has taken a clinically led approach to the development of new models of care. Progress so far has focussed entirely upon models of care rather than organisational form but we anticipate that changes in form will follow implementation.

Q4. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

During 2014/15 we have progressed as follows in the following areas:

Planning

- All partners (commissioning, providers, health and social care) are committed to the implementation of New Models of Care
- Established a New Models of Care Programme Board with executive representation from all partners
- Established our governance structures and assurance processes
- Identified investment which is included in our 5 year planning assumptions
- Translated international models into clear implementation plans
- Invested in a Programme Management Office headed by a Programme Director
- Commenced the implementation of shared access so all patients records in EMIS web are available to view by clinicians in A&E, AMU, medical wards, urgent care and out of hours GP services.
- Developed an evaluation methodology (with support from NHSE) to establish evidence base through the early implementer sites for Extensive Care Services

Enhanced Primary Care

- Neighbourhoods of GP practices are developed.
- Multi-disciplinary teams integrate the practice team with community nursing

Extensive Care

- Funded significant protected time for senior clinicians to develop service models
- Developed a Clinical Blueprint for Extensive Care Service for our frail/elderly population
- Defined patient cohorts using risk stratification to analyse patient numbers across the new models of care
- Have identified sites
- Started recruitment
- Have confirmed go-live dates for two Extensive Care Services for April 2015)

Care Records

- A new care record system is being implemented across our community services meaning that a system for

shared records across community and GP provision will be implemented by April 2015

Q5. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.)

Enhanced Primary Care in April 2016 will be:

- Fully implemented throughout all of our neighbourhoods so that our integrated teams comprise of:
  - Community Nursing
  - Allied Health Professionals
  - Social Care
  - Mental Health
  - 3rd Sector

Extensive Care in April 2016 will be:

- Caring for 1000 people within our two Extensive Care Service early adopter sites.
- Have developed learning from our implementation and evaluation methodology to develop the model and create an evidence base
- Have finalised the Extensive Care model for the whole of the Fylde Coast, based on risk stratification & patient numbers
- Begun rollout of Extensive Care in remaining neighbourhoods across the Fylde Coast

Care Records

- Fylde Coast is part of the EMIS pathfinder initiative to develop systems specifically designed for MCPs. This will deliver a system to provide a single care record for teams which will be integrated with wider health and social care partners.

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Consistent with the needs we have already discussed as part of the New Models of Care Network, partners in the Fylde Coast would seek support in the following areas:

- Support to further the organisational development of out of hospital providers
- Provide a structured programme of independent support for providers (including small, medium and voluntary sector) to think innovatively about:
  - How they respond to the development of New Models of Care
  - Considering the future market place, both threats and opportunities
  - Considering the future contracting models, organisational models, operating models, service offers and strategic partnerships
- Support with information governance with Social Care to enhance the sharing of information.
- Support for IT providers for specific issues we encounter in developing single care records
- Support to develop and implement our Evaluation Methodology to develop the evidence base from the implementation on the Fylde Coast.
- Connection to other sites in the national programme to develop our models of care and create shared learning.
- Organisational development support for the development of the necessary skills in our workforce
- Support for whole systems change and integration to optimise the benefits of our plans
- Support to navigate competition rules which may put barriers in our way when developing MCPs.
- Facilitation of new contractual arrangements and associated financial frameworks
- Non-recurrent funding would significantly accelerate our implementation plan and achieve change at scale and pace

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New Care Models Team

Skipton House
80 London Road
London SE1 6LH
england.newcaremodels@nhs.net
12 May 2015

Dear Andy,

Thank you for hosting the New Care Models team's visit to Fylde Coast. It was a pleasure to begin building a relationship with your Vanguard and to hear about your plans to develop a multispecialty community provider in more detail. Thank you for providing Richard Emmess as your local citizen representative, he provided an excellent contribution to the panel over the two days. Please also pass on our thanks to everyone who helped make the two days so informative and enjoyable.

The purpose of the site visit was for the visiting team to gain a better understanding of your vision, the care model you intend to develop, and determine with you how the New Care Models programme can best support you to achieve your ambitions.

We found that the two days provided us with a clear view on the progress you have already made in developing a vision for the extentivist and enhanced primary care model for Fylde Coast. We were impressed by your plans to scale primary care with high quality evidenced based practice, pulling in out of hospital care and integrating this with services including; local voluntary sector organizations, social services and the police. We were reassured that this was motivated by a commitment from a variety of organisations across Fylde Coast and already supported by an established project team.

During the visit, we welcomed Andrew's description of your extensive care model. It was impressive that you had already come together to develop a strategy to better manage the care of the patients with at least two complex conditions. We look forward to hearing more about the success of Litham and North Shore when they go live in June. We would like to work with you as you replicate the model in your local system, as a mechanism to support wider replicability in the New Care Models programme in the future.

The strategy to support patients through coordinated and integrated health and social care when they had one complex condition, through the enhanced primary care offer was also discussed. We recognized that you are approaching this in different ways, reflective of the different styles of working in NHS Fylde and Wyre CCG and NHS Blackpool CCG. We look forward to, working with you to shape primary care so that it becomes recognized as a primary care service centered on the patient as opposed to a GP appointment service.

We gave you feedback that the extenvist model appeared more developed than the enhanced primary care models, which you acknowledged. We agreed that you would think through the further development of this model and the flow between the two models to ensure that patients were supported in the transition through different phases of care.

Feedback by domain

During the site visit, we discussed the development of specific components of your model and associated support you might find beneficial through four workshops. The outcomes of our discussions were as follows.

Finance, contracting and pricing

We discussed the projected costs in relation to the delivery of your Vanguard proposal including potential double running costs, which you described are due to your need to scale at pace. We agreed to share with you the details required for the financial bid to the transformation fund once the details have been finalised. You indicated you were preparing a business case for your own purposes that you would share with us. During the discussions, you commented on having modelled through some predictive data that you would also share with us. We also discussed the possibility of moving towards a population based contract and we offered support to you in developing this further.

Information technology and information governance

During the workshop, you described your need for a shared electronic record to operate across health, social care, police and voluntary and 3rd sector partners. It was impressive that you had started to achieve shared records through your GPs, community provider and soon your mental health provider using EMIS. We discussed however, that these were multiple versions of EMIS so data sharing is not seamless, and we agreed to look into how we could support this. We recognized that although this was the current route to data sharing, your requirement was for true interoperability and open APIs to enable sharing with any relevant partner. We committed to looking at this nationally across health and social care. We reflected on additional information governance challenges that the Vanguard partnership would bring about and agreed that there was a need to understand nationally what a good system wide information governance model looks like for integrated care.

During the visit we were also impressed by the work you were conducting with Lancaster University and IBM Watson on decision support to aid clinical delivery. We also discussed the evaluation you were conducting on the use of telehealth for the extensivist model and look forward to working with you on your findings from this report towards the end of May. It was recognized this would need to involve patient access to records to empower self-care and greater inclusion, and we offered to support you in this area.

Measurement and evaluation

We were really pleased to learn you had started to develop your logic model for the extensivist model with Method Analytics and Optimity Matrix and we look forward to seeing the fully developed model for the wider programme including enhanced primary care. It was also positive to see the development of metrics around patient evaluation, quality and safety. We discussed your need to develop further metrics on workforce and activity and offered you support to develop these.

During the workshop, you expressed an interest in playing a part in developing the national metrics to support the programme and we look forward to working with you on this, and then providing you with an ariel view of the national programme as discussed. We understand your access to data is limited and information governance issues need to be resolved, this is not uncommon in the programme and we will develop a workshop to bring sites together on this going forward. There was also a discussion on the need to develop quality based metrics, focusing around transformational and cultural change and we will also support you with this.

Workforce

During the workshop, it was good to see that you had a shared strategic vision relating to your service but recognized this hasn't yet transcended through all organizational levels. We

discussed how the cultural transformation, getting teams to work differently and together would be one of your biggest challenges and offered to provide support here. We look forward to working with you to instill a sense of hope and confidence in your staff when developing the new roles in line with the care model you described.

Whilst you did not yet have a whole health economy workforce plan or education and training strategy, it was positive that you were willing to develop one. We offered support in this area, including the sharing of best practice. It was clear you had a strong grip on workforce detail, including within primary care which enabled you to develop a stable workforce with investment in education and training. It was good to hear examples of this including your engagement in primary care with the HENW Workforce Transformation team and bespoke preceptor-ship programme, which had the potential for national development. It was a positive next step to agree the development of a dedicated sub-group on workforce in your MCP governance structure with support from HENW.

Leadership and change

We had an interesting discussion about the change methodology that you were using and it was clear that you were experienced in using a variety of traditional methods. You reflected on the need to bring the workforce together to build effective integrated teams and committed to develop your thinking about how this would progress. We discussed the use of social movement methodologies to support further sustained engagement with your workforce and offered support here if needed.

Next steps

We agreed that you would take some time to reflect on our visit before expanding on your initial Vanguard proposal, including the following areas:

1. Further development of your enhanced primary care model and the patient pathway from and to this model. We agreed this would include further detail around the scope of your vanguard and your plans for roll out. This would include a particular focus on what you are planning to achieve in year one.
2. We agreed that you would give further thought to how you plan to engage with the voluntary and third sector, and your community as a whole. This encompassed our discussions around a broader primary care service, rather than a GP focussed service.
3. An understanding about how your programme support is being developed to support the Vanguard process. This would include further clarification on your leadership team and core decision makers.
4. Crucially, as you develop the above, your early thoughts about the support you require from the New Care Models Programme to help you achieve your goals, including, but not limited to, the areas we discussed in break-out sessions as outlined above.
5. To share with us a letter that details how you wish to utilise the £150,000 programme support in order to provide you with headroom to develop your Vanguard.

In each of these areas it would be helpful for you to share with us

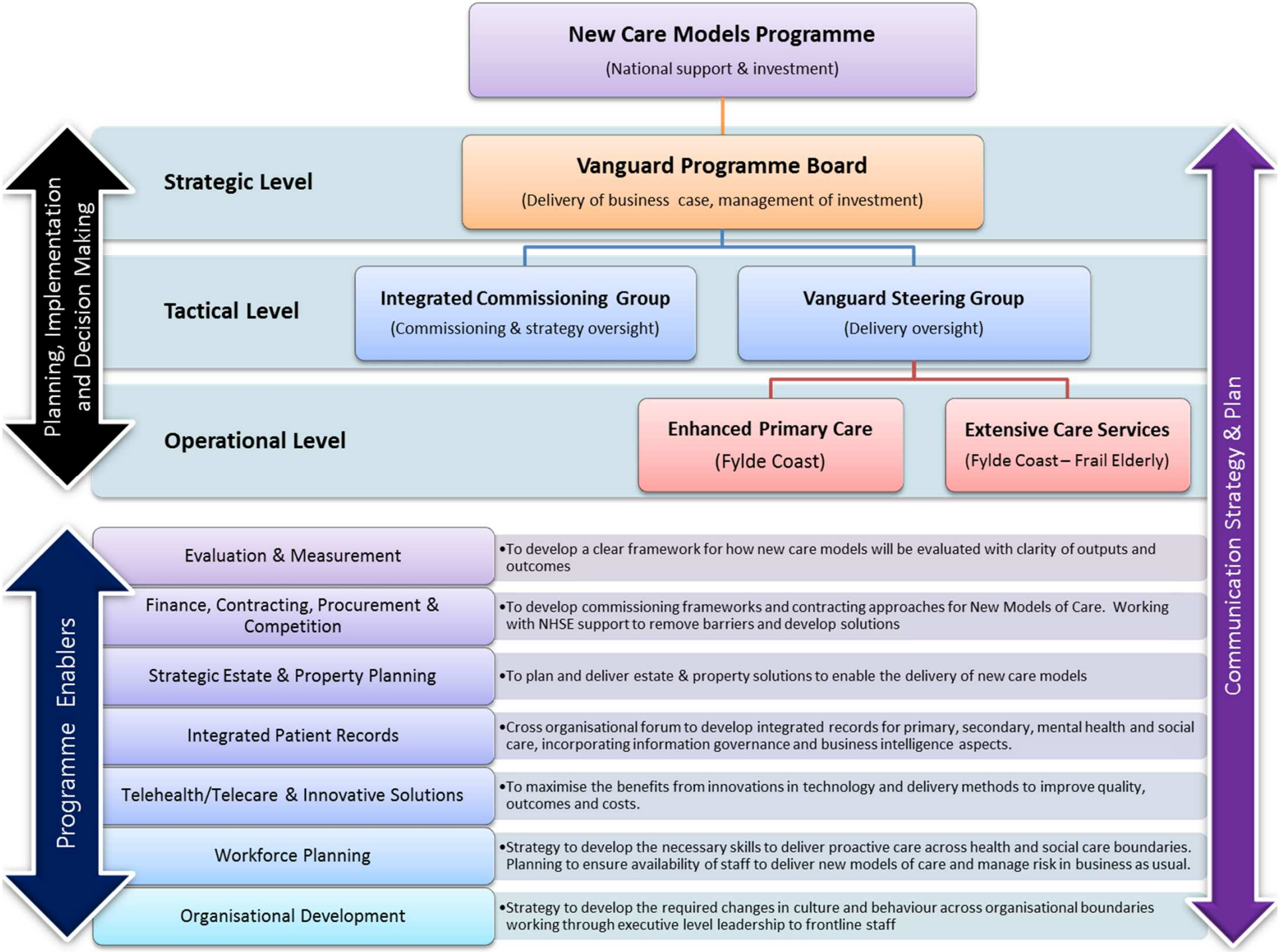
- The progress you have made so far in developing your model of care
- Any challenges you face as you look to further progress your work
- The nature of the support you require to overcome these challenges

We would be grateful if you could set out some of the above in writing, and share that document with us by **23 May 2015**. We will then consolidate this with the feedback from other vanguard sites before getting back in touch with you to co-design a bespoke support package.

Once again, please accept out thanks for welcoming the New Care Models team and colleagues to Fylde Coast. Your mutual commitment to improve the care and support for local people was hugely energizing and embodies the spirit of the Vanguard programme. I know I speak on behalf of colleagues from the team regionally and nationally in saying that we are very much looking forward to working together in developing and delivering the new care model.

Yours sincerely,

Louise Watson
MCP Care Model Lead
New Care Models Team


New Care Models Programme
(National support & investment)
Planning, Implementation and Decision Making
Strategic Level
Vanguard Programme Board
(Delivery of business case, management of investment)
Tactical Level
Integrated Commissioning Group
(Commissioning & strategy oversight)
Vanguard Steering Group
(Delivery oversight)
Operational Level
Enhanced Primary Care
(Fylde Coast)
Extensive Care Services
(Fylde Coast– Frail Elderly)
Communication Strategy & Plan
Programme Enablers
Evaluation & Measurement
•To develop a clear framework for how new care models will be evaluated with clarity of outputs and outcomes
Finance, Contracting, Procurement & Competition
•To develop commissioning frameworks and contracting approaches for New Models of Care. Working with NHSE support to remove barriers and develop solutions
Strategic Estate & Property Planning
•To plan and deliver estate & property solutions to enable the delivery of new care models
Integrated Patient Records
•Cross organisational forum to develop integrated records for primary, secondary, mental health and social care, incorporating information governance and business intelligence aspects.
Telehealth/Telecare & Innovative Solutions
•To maximise the benefits from innovations in technology and delivery methods to improve quality, outcomes and costs.
Workforce Planning
•Strategy to develop the necessary skills to deliver proactive care across health and social care boundaries. Planning to ensure availability of staff to deliver new models of care and manage risk in business as usual.
Organisational Development
•Strategy to develop the required changes in culture and behaviour across organisational boundaries working through executive level leadership to frontline staff

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Simon Bone, Community Protection Manager, Lancashire Fire and Rescue Service
Relevant Cabinet Member :	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Decision:	10th June 2015

LANCASHIRE FIRE AND RESCUE SERVICE COMMUNITY SAFETY STRATEGY 2014-2017

1.0 Purpose of the report:

1.1 To update the Health and Wellbeing Board on Lancashire Fire and Rescue Service's Community Safety Strategy.

2.0 Recommendation(s):

2.1 To acknowledge the refreshed Community Safety Strategy for Lancashire Fire and Rescue Service.

2.2 To explore opportunities to develop or strengthen working arrangements for Lancashire Fire and Rescue Service to support the priorities of the Health and Wellbeing Board.

3.0 Reasons for recommendation(s):

3.1 Lancashire Fire and Rescue Service has refreshed its Community Safety Strategy. The Service is also reviewing their Prevention and Protection arrangements therefore it is timely to allow the wider partners to understand the priorities of Lancashire Fire and Rescue Service and how partners and it can work together to assist delivery against priorities.

3.2 There will be elements of the Health and Wellbeing Board's priorities and elements of Lancashire Fire and Rescue Service's Community Safety Strategy that are cross cutting priorities. Lancashire Fire and Rescue wants to work with its partners to better meet the needs of the cross cutting priorities.

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 for consideration.

4.0 Council Priority:

4.1 The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged
- Improve housing standards and the environment we live in
- Create safer communities and reduce crime and anti-social behaviour
- Deliver quality services through a professional, well-rewarded and motivated workforce

5.0 Background Information

5.1 Set out in Lancashire Fire and Rescue Service Integrated Risk Management Plan 2013/2017 is our Strategy. Its purpose is "making Lancashire Safer"

5.2 The attached Community Safety Strategy provides the reader with detailed information as to where the Service will prioritise its Community Safety activity.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

Appendix 7a: Community Safety Strategy
Appendix 7b: Service Plan and Vision Summary

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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Community Safety Strategy
2014-2017

Lancashire Fire and Rescue Service

making Lancashire **safer**

Contents

1. Introduction

On behalf of the Lancashire Fire and Rescue Service (LFRS), welcome to our Community Safety Strategy for the period 2014-2017 which updates and replaces the 2009-2014 version.

Much of which we advocated in our previous strategy continues to be valid, not least of which is a strong conviction that an integrated approach involving prevention, protection and emergency response remains an essential prerequisite if we are to be successful.

We know that the speed of emergency response alone will not reduce the tragic impact of fire and other emergency incidents. It is for this reason that we will, wherever possible, continue to aim to place 'prevention' and 'protection' before 'intervention', as the most effective means of reducing risk and improving public safety. In simple terms – prevention is better than cure.

The purpose of our Community Safety Strategy is to provide a clear framework for delivering services that will contribute to making our communities safer. It will focus our efforts and resources to deliver targeted services to the people and communities who are at greatest 'risk' in order to best meet our vision of 'Making Lancashire **Safer'.**

This strategy forms an integral part of our Integrated Risk Management Plan 2013-2017 and will ensure that we continue to work to anticipate risk and adapt our services to meet the needs of our communities. It is important because it sets out our operating philosophy and intended approach over the next three years, central to which are a number of high level ambitions. Behind each ambition will sit individual action plans, which will set out the steps we need to take to deliver our ambitions. We acknowledge that improved value for money in the way we deliver our services will be ever important during the life of this strategy given the challenging operating environment.

We trust this strategy document is helpful in explaining our approach, what we have to offer and, in seeking to continuously improve the service we provide, what opportunities may exist for us to work together.

Francesco De Molfetta
Chairman
Lancashire Combined Fire Authority

Chris Kenny
Chief Fire Officer
Lancashire Fire and Rescue

2. Risk in Lancashire

Within the fire and rescue service, we understand risk as the likelihood of an occurrence i.e. the probability that something will happen, multiplied by the consequences if it does i.e. the severity of the event. Using this approach, we define risk as:

PROBABILITY X SEVERITY = EXTENT OF RISK

To reduce risk and improve public safety, it is therefore apparent that the likelihood of the event needs to be reduced and/or the consequences diminished.

Our approach to community safety reflects the fact that risk in Lancashire is dynamic. By this we mean that the nature and extent of risk is different in different parts of the county and that it also changes over time e.g. by hour of the day. Fire in particular, disproportionately affects certain demographic groups, and whilst the cause is often quite generic, it is the underlying aspects associated with the individual that is the root cause of the fire, for example:

- Those living alone
- Those with health issues
- Drug and/or alcohol use
- Those with mobility issues
- Those affected by socio-economic deprivation
- Poor housekeeping

As risk is variable and different problems often require different solutions, no one risk reduction measure alone will improve public safety. In recognising this, we will continue to use an integrated approach involving;

prevention, protection and emergency response. Whilst the third aspect - what happens when an emergency occurs - is still probably most familiar to the public, our primary focus will very much remain based on the first two: prevention and protection. The rationale for this approach is simple:

- prevention is better than cure whatever the issue.
- minor injury is less traumatic than a serious one, or even worse a fatality.
- superficial damage is preferable to total loss.

3. Scope

This strategy outlines our ambition and commitment to reducing risk across four priority areas:

- **Home safety**
- **Business safety**
- **Road safety**
- **Working with young people**

We strongly believe that these four priority areas best reflect the work streams where LFRS can contribute most effectively to the community safety agenda.

Whilst we maintain four priority areas we acknowledge the need to provide local flexibility for staff to carry out specific community safety activity which is tailored to local risk. For example, Water safety.

We remain committed in working to reduce the incidence of deliberate fires and the consequences arising from them. In doing so, we recognise the need to continue to remain both creative and innovative in our work. We will seek to build upon what has already been achieved, key to which is the importance and value we place on working in partnership with others, in order to tackle the problem. Deliberate fire risk reduction is a central theme within this strategy, and will under-pin certain key aspects of our work across all four priority areas.

Home Safety

Risk in Lancashire is anything but uniform in nature, and the time and effort spent in evaluating where and how this risk materialises is absolutely crucial. For example, an obvious cause of deaths and injuries is that of fires in the home, so much of our research and analysis looks at dwelling fires and in particular, those which are started accidentally. We know that these events give us some opportunity to influence the number and severity of the fires that occur, so we have to focus our work on the groups and individuals who are seen as high risk in terms of vulnerability to fire.

We have learnt from incidents that although the causes of dwelling fires are often quite generic it is the underlying aspects associated with the individual that is the root cause of the fire. Those involved in fires within the home predominantly fell in to one or, on numerous occasions, more than one of the following categories:

- Older People.
- Those living alone.
- Those with health issues.
- Drug and/or alcohol use.
- Those with mobility issues.
- Those affected by socio-economic deprivation.

Bringing about positive change in people's behaviours within their homes is central to improving their safety. One of the main methods of delivery of this intervention is the Home Fire Safety Check (HFSC) where we give advice and guidance to people, to help reduce the risk of fire in the home. On many occasions, we have also fitted smoke alarms, so that even when a fire does start, it will raise the alarm and give occupants time to escape.

Moving forward it is essential that we examine how best we can re-shape our HFSC service. In doing so, we will maintain a strong focus, on ensuring that we continue to target and prioritise the delivery of the service, to individuals / households which are the most vulnerable and at greatest risk of having a fire within the home.

Road Safety

Lancashire Fire and Rescue Service (LFRS) deals with the consequences of Road Traffic Collisions (RTC's) and the impact they have on human life and our communities, on a daily basis. In fact, we are now called to rescue significantly more injured people from RTC's than from fires. Whilst no legal duty is imposed on us to carry out any preventative road safety work, we believe it makes sense for us to do so. Our staff are, by the nature of their role, at the heart of rescue activity involving road traffic collisions and are often exposed to traumatic experiences as a result. Put simply – we see it, we deal with it and we want to do less of it.

Outside of the emergency context, we are increasingly involved in road safety preventative activity, using education, as the primary means, to change attitudes and influence the behaviour of pedestrians and road users across Lancashire. In particular, we believe, that the Service's unique position within the community and the widespread respect in which fire and rescue staff are held across all age groups, offers an unparalleled opportunity to reduce deaths and injuries through the provision of a suitable range of risk reduction initiatives. To achieve this we will work closely with our partner agencies, by adopting a multi-agency approach to risk identification and risk reduction.

We recognise that RTC's do not affect everyone in the same way and particular groups of people are disproportionately affected. We know, for example, that RTCs represent the leading cause of death for young adults aged 15-24 in the UK, and they account for over a quarter of all deaths in the 15-19 age group. Drivers under 25 years of age are 7 times more likely to be involved in an accident on the road, especially during their first 2 years of driving. We also know that children are more likely to be injured or killed while crossing the road.

It is for these reasons, that we will focus on targeting our road safety preventative activity towards children, in particular, within a primary and secondary school setting and young people within the 17-25 age group.

Business Safety

We recognise the need to make sure that all buildings are safe, both for the public and our firefighters, in the event of a fire or other emergency occurring. We intend to reduce risk in buildings by targeting our resources to deliver information, education and legislative enforcement to help make Lancashire safer. We will aim to do this without imposing unnecessary burden on businesses within Lancashire.

Since the enactment of the Regulatory Reform (Fire Safety) Order in 2006, we have a statutory duty for fire safety enforcement in virtually all premises other than single private dwellings. It enables us to make sure that buildings that provide public access, public assets, and places of work are safe from fire and other types of incident. As such we will continue with our risk-based approach to fire safety audits – central to which will be prioritising audits of premises on the basis of highest risk, thereby ensuring that resources are targeted where they can be most effective.

We remain committed to providing the best possible service to our communities by appropriate and proportionate regulation. We are, however, also committed to using our enforcement and regulatory powers where necessary to ensure public safety.

We also recognise the importance of providing businesses with the right information and advice to support them in being compliant. Such an approach, will enable them to make informed decisions around fire safety matters and to safeguard people, reduce community risk and reduce the potential of large financial loss.

In practical terms we will focus our efforts and resources to support businesses that want it, and adopt a robust enforcement approach to deal with those who compromise on safety.

Working with Young People

We recognise that reducing fires and other emergencies is more than just providing an efficient emergency response service. It is about education, to prevent the type of behaviour which leads to a fire developing or a road traffic collision occurring in the first instance. None of us are too old to learn these important safety lessons, but by targeting our children and young people, we can embed behaviours which will make them and our communities safer for their entire lives. We believe in investing in the next generation and that firefighters provide strong role models who inspire and positively influence young people.

Children and young people are potentially both victim and perpetrator of incidents of accidental fire, anti-social behaviour (such as deliberate fire setting and hoax calls) and road traffic collisions, so the approach LFRS has taken is multi-layered.

At the most universal level we provide information and education in order that all children and young people have the opportunity to be made aware of the risks they face, understand the consequences and are able to make safe choices to protect themselves, their friends and families. Every primary school in our three Local Authority areas of Lancashire, Blackburn with Darwen and Blackpool has access to an annual on-site 'Childsafe' fire safety teaching session for both Y2 and Y6 children. These are delivered by operational and community fire safety personnel and take up is almost without exception. We also have SENDsafe, which is a toolkit of activities giving children and young people with Special Educational Needs and Disabilities the opportunity to learn about fire safety through sessions that can be tailored to their own specific circumstances and needs.

At a more targeted level we also deliver interventions designed to change behaviour where children and young people face higher risk or are more likely to commit crime or anti-social behaviour. The 'Heat of the Moment' programme focuses upon the consequences of anti-social behaviour and can be delivered to secondary schools on demand or where a need has been identified by either party. Involvement from partner agencies such as the Police and PCTs is encouraged. In addition, the Fire Intervention Response Education Scheme (FIRES) is aimed at children and young people who have developed a fascination with fire related behaviour and is usually delivered in the home or at school on a one-to-one basis with key adults in the child's life present as appropriate.

We remain passionate about developing young people so that they can reach their full potential and make their best contribution to keeping Lancashire safer as they grow.

4. Start Safe - Live Safe - Age Safe

Our approach in delivering prevention and protection services will be framed around an '**inner core**', made up of three inter-locking components:

- **Start Safe**
- **Live Safe**
- **Age Safe**

These three components will under-pin, all that we do now, and all that we plan to do in the future, with regards to the delivery of prevention and protection services. In simple terms – our prevention and protection services will be tailored towards one, or more, of the following:

Start Safe

We will focus our efforts and young people resources towards providing children with services which will help educate, support and protect them so that they are able to start their lives safely.

Live Safe

We will focus our efforts and resources towards providing young people and adults with services which help to educate, support and protect them so that they are able to live their lives safely at home, at work or in the wider community.

Age Safe

We will focus our efforts and resources towards providing adults with services which will help them to inform, support and protect them so that they are able to age safely.

Encompassing all three components is an **'outer core'** - our emergency response function, whereby, we will continue to plan and prepare for emergencies to ensure we continue to deliver an effective and efficient response.

It is this circle of activity which informs and drives our four priority areas as illustrated in section 5. We will review our priority areas on an annual basis to ensure that they remain fit for purpose.

5. Community Safety - Our Operating Framework

Our operating framework places prevention and protection at the core of our approach to reducing risk and improving public safety. Through our prevention and protection work we have reduced fires by two-thirds over the last 10 years and dramatically reduced fire deaths and fire-related injuries over the same period.

We will continue to endeavour to prevent and protect, but when all else fails, we will respond to emergencies with highly skilled staff and the latest equipment in order to try and mitigate the consequences.

We recognise that in the future we will need to target our prevention and protection activities in defined areas, increasingly focussing on those groups who are most vulnerable. Effective educational safety messages have been influential to our successes in the past. We strongly believe therefore, that there are particular times in people's lives, when they become more vulnerable and may need our advice or service.

Understanding the stages in life when we can best influence behaviour, is fundamental to reducing risk and improving public safety. We will therefore aim to develop and tailor our services towards those optimum times in life, where we believe, we can best influence behaviour and improve outcomes. For example:

- Early in education at Early Years-Foundation Stage and key stages one and two.
- At key stage three when young people become influenced by peer behaviour.
- At key stage four, when young people start to think about learning to drive.
- When young people leave school and choose to live more independently.
- When people start to drive.
- When people have children.
- When people buy or rent a home.
- If they have specific needs or a disability.
- As people get older or become infirm or less able to look after themselves.
- When people live alone

6. Our Ambitions

Our ambitions are there to provide the framework for our planning. What matters are the actions that are put in place to achieve them. Behind each ambition will sit individual action plans, which will set out the steps we need to take to deliver our ambitions.

Home Safety

Ambitions

Life Stages

1. We will deliver a home fire safety checks (HFSC) service to all members of our community, with the highest level of support being offered to those who are most vulnerable to fire or those living in very high or high risk households.
2. We will deliver targeted Home Fire Safety revisits, which are based on the risk assessment of an individual developed in partnership with other agencies.
3. We will pursue a more effective, streamlined inclusive approach to partnership working across health, social care service providers and commissioners in Lancashire.
4. We will pursue improved data sharing agreements and referral generation with key health and social care services, to better support the targeted delivery of our HFSC service, to the most vulnerable members of our community.
5. We will develop an improved HFSC referral process whereby all referrals are routed through a contact centre.
6. We will utilise the contact centre to quality assure our service delivery.
7. We will engage with partner agencies in order to deliver HFSC's on our behalf.
8. We will deliver further training to improve skills for all staff and our partners who will be delivering HFSC's.
9. We will continue to investigate fire trends and explore improvements in technology to enhance safety in the home.

Business Safety

Ambitions

Life Stages

10 We will aim to target audits at high risk business premises and issue enforcement notices where appropriate in line with the principles detailed in the regulators code.

11 We will develop a 'Business Support Programme' to support businesses that endeavour to comply with the regulations and will enforce appropriately when necessary. The principle of ***YOUR fire and rescue service, supporting YOUR business***, will sit at the centre of our programme.

12 We will aim to establish Primary Authority Schemes that complement our Community Safety Strategy.

Road Safety

Ambitions

Life Stages

13 We will aim to deliver road safety education to every child in primary education.

14 We will aim to deliver targeted road safety education to young people in secondary education.

15 We will aim to deliver targeted road safety education to young drivers aged 17-25.

16 We will further develop relationships with partners and stakeholders, to explore how we can become a preferred partner to deliver road safety education programms.

Working with Young People

Ambitions

Life Stages

17 We will participate in the schools initiative pilot establishing up to six Cadet Schemes to inform and develop our future thinking regarding Fire Cadet Schemes in LFRS.

18 We will explore the potential for establishing a new role of Apprentice Community Safety Advisor, with the aim of providing pathways to sustainable employment in companies and organisations across Lancashire.

19 We will continue to support our well established role in delivering the Princes Trust Team Programme across Lancashire.

7. Measuring Performance

As a public service, it is essential that people are clear on what we aim to provide in terms of enhancing Community Fire Safety and the associated ambitions. Together with our Risk Management Plan this Community Safety Strategy forms a key component of our risk management approach.

To complete the process and keep people informed we publish an annual Performance Report and Action Plan which formally details our achievements against key performance indicators.

Equally importantly, as part of this process we also explore a range of associated issues which allow us to learn from actual events and shape future community safety provision. We believe that continuous improvement can, and should, be pursued in order to provide the best possible service and improved value for money, and whilst an individual may be perfectly satisfied with the service they received, there may be room for further improvement.

If you need any community safety advice or guidance, please contact your local Community Protection Manager.
http://www.lancsfirerescue.org.uk/service-delivery/

For general information, you can visit our website at www.lancsfirerescue.org.uk

Alternatively, if you have any general observations, or would like any further information on the fire and rescue service in Lancashire please contact:

The Risk Management Team

Lancashire Fire and Rescue Service HQ
Garstang Road
Fulwood
Preston
PR2 3LH

Telephone 01772 862545

E-mail : rmp@lancsfirerescue.org.uk

Lancashire Fire and Rescue Service

@LancashireFRS

www.lancsfirerescue.org.uk

If you would like a copy of this document in large print, audio, braille or another language please telephone 01772 866791.

Polish
Jeśli chcesz otrzymać kopię tego dokumentu drukowaną dużą czcionką, alfabetem Braill'a, w wersji audio lub w innym języku, prosimy o telefon pod nr 01772 866791.

Bengali
এই তথ্যপত্রের তথ্য বড় অক্ষরে, ক্যাসেটে রেকর্ড করে, ব্রেইলে (অন্ধলিপিতে) বা অন্য কোনো ভাষায় অনুবাদ চাইলে অনুগ্রহ করে নাম্বারে ফোন করুন: 01772 866791 ।

Punjabi
ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਵੱਡੇ ਅੱਖਰਾਂ, ਆਡੀਓ, ਬ੍ਰੇਲ ਜਾਂ ਕਿਸੇ ਹੋਰ ਬੋਲੀ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ 01772 866791'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

Gujarati
જો તમે આ દસ્તાવેજની નકલ લાર્જ પ્રીન્ટ, ઓડીયો, બ્રેઈલ અથવા અન્ય ભાષામાં મેળવવા માંગતા હો તો કૃપા કરી 01772 866791 પર ટેલીફોન કરો.

Urdu
اگر آپ اس دستاویز کی کاپی بڑی لکھائی، آڈیو، بریل یا کسی دوسری زبان میں چاہتے ہیں تو براہ مہربانی ٹیلی فون نمبر: 01772 866791 پر رابطہ کریں۔

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Service Plan 2015

Our vision for a safer Lancashire

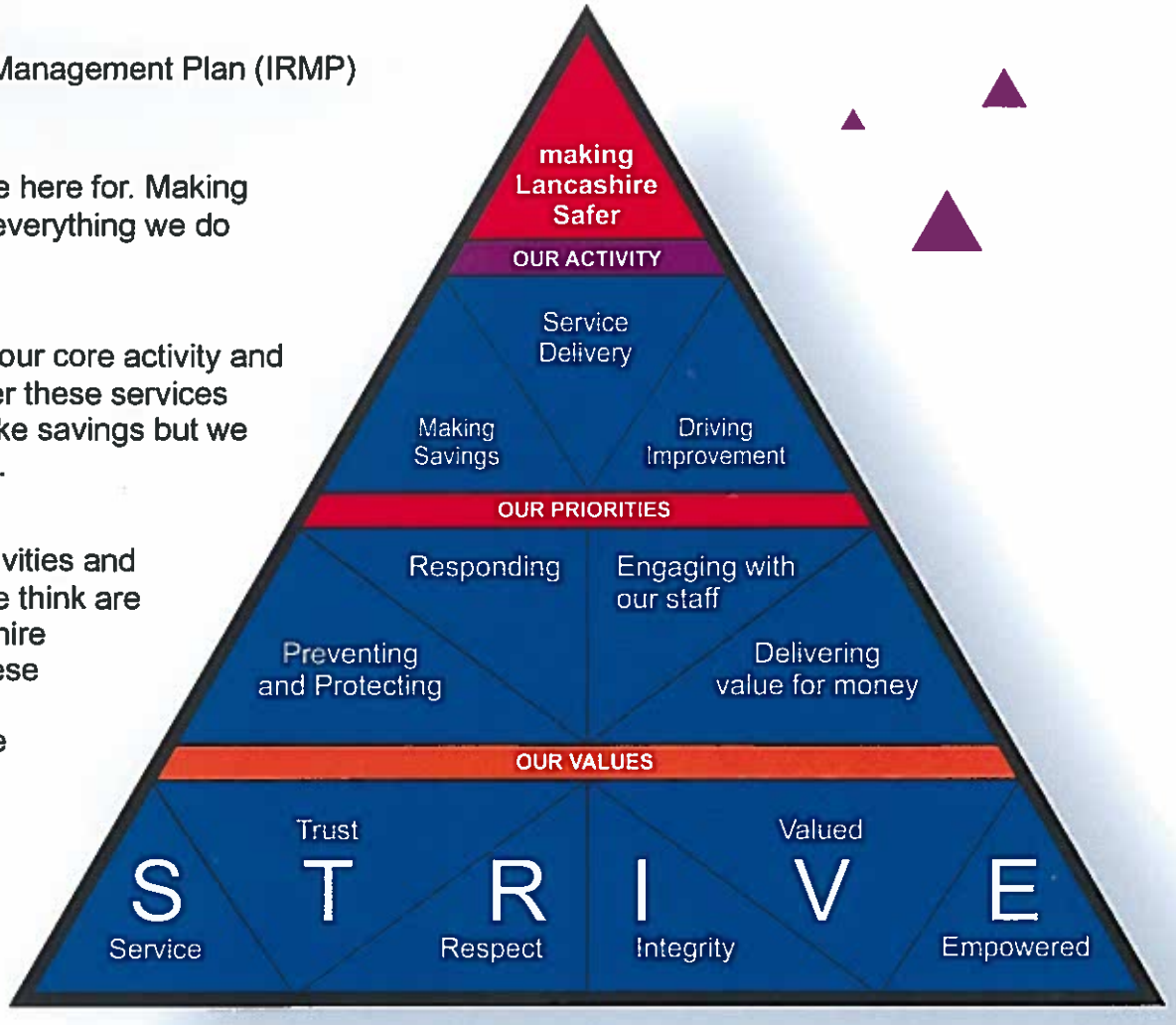
Our strategy – set out in our Integrated Risk Management Plan (IRMP) 2013/17 – is summarised in this simple triangle.

At the top we have **our purpose** – what we are here for. Making Lancashire safer is our commitment to make sure everything we do improves the safety of our diverse communities.

Our activity describes how service delivery is our core activity and reason for existence as an organisation. We deliver these services against a financial backdrop that requires us to make savings but we try to do this in a way that also drives improvement.

Our priorities are the things we focus our activities and resources on. They are the projects or activities we think are most important to help us achieve "making Lancashire safer". This **Annual Service Plan** sets out what these activities will be in the year ahead. Our **Key Performance Indicators** measure how well we are doing to achieve success in the areas we prioritise.

Our values are the qualities we hold to be important and we use them every day as the basis of what we do. They influence our decisions and every interaction we have with each other and our communities.



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