Blackpool Council

30 August 2016

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 7 September 2016 at 3.00 pm
in 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 20 JULY 2016 (Pages 1 - 6)

To agree the minutes of the last meeting held on 20 July 2016 as a true and correct record.

3 STRATEGIC COMMISSIONING GROUP UPDATE (Pages 7 - 10)

To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

4 HEALTH PROTECTION FORUM REPORT (Pages 11 - 14)

To receive a biannual update on work of the Health Protection Forum.

5 JOINT ARRANGEMENTS FOR HEALTH AND WELLBEING BOARDS IN LANCASHIRE UPDATE (Pages 15 - 52)

To receive an update on the latest stages of the development of the new pan-Lancashire model for health and wellbeing board governance, including key recommendations emerging from the Health and Wellbeing Board Summit held on 26 July 2016.

6 LANCASHIRE AND SOUTH CUMBRIA CHANGE PROGRAMME AND SUSTAINABILITY AND TRANSFORMATION PROGRAMME UPDATE (Pages 53 - 68)

To receive a report outlining the activities of the Lancashire and South Cumbria Change Programme over the last month and includes details on the progress to establishing the governance and programme structure arrangements.

7 FYLDE COAST CANCER STRATEGY (2016-2021) (Pages 69 - 108)

To consider and approve the Fylde Coast Cancer Strategy (2016-2021)

8 SPECIAL EDUCATIONAL NEEDS AND DISABILITY (0-25 YEARS) UPDATE (Pages 109 - 114)

To update the board on the progress of the implementation of the 2014 Children and Families Act across agencies and outline recent developmentsin the area.

9 FORWARD PLAN (Pages 115 - 120)

To consider the draft Forward Plan for the Health and Wellbeing Board.

10 DATE OF FUTURE MEETINGS

To note the dates of future meetings as follows:

19 October 2016

30 November 2016

18 January 2017

1 March 2017

19 April 2017

Venue information:

Ground floor meeting room, 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.

This page is intentionally left blank

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 20 JULY 2016

Present:

Councillor Cain, Cabinet Secretary (Resilient Communities), Blackpool Council

Councillor Clapham, Opposition Group Member, Blackpool Council
Councillor D Coleman, Cabinet Assistant (Resilient Communities), Blackpool Council
Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
Eddy Jackson, Blackpool Healthwatch Representative
Phil Jones, Area Group Manager, Lancashire Fire and Rescue Service
Dr Arif Rajpura, Director of Public Health, Blackpool Council
Mary Whyham, Blackpool Healthwatch Chairman

In Attendance:
Benjamin Barr, Senior Clinical Lecturer in Applied Health Research, University of Liverpool
Lennox Beattie, Executive and Regulatory Manager, Blackpool Council
Jane Beanstock, Consultant in Public Health, Lancashire Care NHS Foundation Trust
Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
Matthew Burrow, Head of Corporate Assurance, Blackpool, Fylde and Wyre Hospital
Lynn Donkin, Public Health Specialist, Blackpool Council
Steve Freeman, Treasurer, Lancashire Police and Crime Commissioner
Paul Greenwood, Interim Chief Executive, Blackpool Council for Voluntary Services
Liz Petch, Public Health Specialist, Blackpool Council
Ana Porroche-Escudero, Research Associate, Lancaster University
Chief Inspector Lee Wilson, Lancashire Constabulary
Steve Winterson, Engagement Director, Lancashire Care NHS Foundation Trust

Apologies:

David Bonson, Chief Executive Officer, Blackpool Clinical Commissioning Group
Delyth Curtis, Director of People, Blackpool Council
Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Jane Higgs, Director of Operations and Delivery, NHS England
Sue Moore, Chief Operating Officer, Lancashire Care NHS Foundation Trust
Dr Leanne Rudnick, GP Member, Blackpool Clinical Commissioning Group
Karen Smith, Deputy Director of People (Adult Services), Blackpool Council

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 8 JUNE 2016

The Board considered the minutes of the meeting held on 8 June 2016.

Resolved:

That the minutes of the meeting held on 8 June 2016 be approved and signed as a correct record subject to the addition of Steve Winterson, Engagement Director, Lancashire Care NHS Foundation Trust to those in attendance.

3 STRATEGIC COMMISSIONING GROUP (SCG) UPDATE

The Board received an update on the work of the Strategic Commissioning Group from Dr Arif Rajpura, Director of Public Health.

Dr Rajpura highlighted that the meeting scheduled for the 24 June 2016 of the Strategic Commissioning Group had been cancelled.

Dr Rajpura then provided a brief verbal update on the meeting of the Strategic Commissioning Group that had taken place earlier on the 20 July 2016. He highlighted two of the key items discussed at that meeting notably the performance monitoring from Quarter 1 of the Better Care Fund 2016/2017 and the drug and alcohol commissioning review.

Phil Jones, Lancashire Fire and Rescue Service provided information on the presentation given by his colleague, Group Manager Steve Morgan, on the transition to a more holistic approach in the introduction of prevention and wellbeing meetings in place of the previous home safety checks. Mr Jones outlined that the Fire and Rescue Service would be considering adopting the principles of Every Contact Matters as discussed at Agenda Item 5.

Resolved:

1. To note the verbal update from the meeting on 20 July 2016 and to note that the minutes of these meetings will be brought to the next Health and Wellbeing Board meeting on 7 September 2016.

2. To note that the meeting scheduled for 24 June 2016 had been cancelled.

4 HEALTH AND WELLBEING STRATEGY

The Board considered the Health and Wellbeing Strategy that had been developed and, following the meeting held on the 20 April 2016, subject to widespread consultation. The consultation had been in general supportive of the strategy and its vision and priorities. Following the consultation the Strategy was proposed for final approval in line with the draft approved on the 20 April 2016.

Representatives from Blackpool Healthwatch highlighted their concerns that the strategy did not include as one of the priorities mental health. The Board, while acknowledging the concerns of Healthwatch, felt that the strategy gave sufficient weight to the issue in the outcomes and overall in its implementation plan.

The Board noted that to the strategy in relation to performance monitoring arrangements. However given the possible changes to the Health and Wellbeing Board as part of the Lancashire and South Cumbria Change Programme, the Board felt that it would be preferable to delegate the development of a suitable performance management framework rather than agree at the meeting a framework that would be unachievable in the future.

Resolved:

1. To note the consultation summary, attached at Appendix 4b, to the report.

2. To approve the Health and Wellbeing Strategy, attached at Appendix 4a, to the report.

3. To delegate the approval of a performance management framework for the strategy to the Director of Public Health to reflect potential changes in the structure of Health and Wellbeing Boards.

5 MAKING EVERY CONTACT COUNT

The Board received a presentation on the Making Every Contact Count initiative from Jane Beanstock, Consultant in Public Health, Lancashire Care Foundation Trust.

The presentation outlined the aim of Making Every Contact Count which had been to develop a system of training to deliver health related interventions, through the equipping of staff with the knowledge to initiate health chats to provide brief advice and basic health information. The Board noted that the four health behaviours that formed the Level One programme namely; not smoking, sensible drinking, a healthy diet and regular physical activity were key detriments both in terms of mortality and morbidity. The aim of the initiative would be to maximise the number and quality of possible interventions and address the four behaviours in a consistent approach across partners. The Level One training had been developed to be directly relevant to all those who came into contact with the public. Ms Beanstock also highlighted the proposed development of Level Two programme for more specific staff roles.

The Board endorsed the Making Every Contact Count approach and noted the support offered at the meeting from Lancashire Fire and Rescue and Blackpool Teaching Hospital to further the implementation of the initiative, conditional on its approval through the respective organisation's decision making processes.

Resolved:

1. That the Board strongly recommends to partners to make a commitment to train their own workforce in Level One brief advice relating to health-related behaviours.

2. That Blackpool Teaching Hospital be requested to revise its existing training to incorporate the main elements of the Lancashire Care NHS Foundation Trust model so that there is a comprehensive and consistent approach across Blackpool.

3. To note that Level 2 training will then be developed to help specific staff take these messages out into the community and using them within their day-to-day contact with individuals and communities.

4. To note that Lancashire Care Foundation Trust, in partnership with Blackpool Council's Public Health Department, is currently in the process of applying for research funding in order that this system wide approach can be fully evaluated.

6 COLLABORATION FOR LEADERSHIP IN APPLIED HEALTH RESEARCH AND CARE NORTH WEST COAST

The Board received a presentation providing an overview of the work being carried out by the Collaboration for Leadership in Applied Health Research and Care North West Coast, of which Blackpool Council and Blackpool Teaching Hospital NHS Foundation Trust were both key partners. The presentation was given by Benjamin Barr, Senior Clinical Lecturer in Applied Health Research, University of Liverpool and Ana Porroche-Escudero, Research Associate, Lancaster University.

The Board noted that the focus of the research project was on identifying which aspects of out of hospital treatments and care would be most effective in reducing health inequalities and addressing the need for emergency treatment. The Board noted that Claremont ward in Blackpool had been selected as one of the survey areas. The project would involve trialling health interventions and the subsequent assessment of their effectiveness.

Ms Porroche-Escudero explained that a key focus would be working with the voluntary sector within the ward and she highlighted that the Claremont First Step Centre had been selected as the key partner for the Claremont area.

The Board endorsed the initiative but asked that steps be taken to avoid duplication with other campaigns and initiatives.

Resolved:

1. To note the presentation.

2. To agree to receive regular progress reports and learning from the new Collaboration for Leadership in Applied Health Research and Care North West Coast theme "new approaches to evaluating complex health and care systems".

7 DRAFT FORWARD PLAN

The Board considered the draft forward plan for forthcoming agendas, which would enable the Board to strategically plan its future agendas and ensure that items were relevant to the Board's priorities.

Resolved:

To approve the Health and Wellbeing Board Forward Plan as set out in Appendix 7a, to the report.

8 DATES OF FUTURE MEETINGS

Resolved:

To note the dates of future meetings as:

7 September 2016

19 October 2016

30 November 2016

18 January 2017

1 March 2017

19 April 2017

Chairman

(The meeting 4.50pm)

Any queries regarding these minutes, please contact:
Lennox Beattie, Executive and Regulatory Manager
Tel: 01253 477157
E-mail: lennox.beattie@blackpool.gov.uk

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health, Blackpool Council
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	7 September 2016

STRATEGIC COMMISSIONING GROUP (SCG) UPDATE

1.0 Purpose of the report:

1.1 To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

2.0 Recommendation(s):

2.1 To note that the Board has already received at its last meeting a verbal update from the meeting on 20 July 2016 and to note that the minutes of this meeting will be brought to the Health and Wellbeing Board in November.

2.2 To note that the next meeting is on 20 October 2016 and that the structure of future meetings will include a focus on a particular theme or issue to be debated and resolved.

2.3 To note the main actions arising from the work of the group.

3.0 Reasons for recommendation(s):

3.1 The Strategic Commissioning Group is a sub-group of the Board, which is responsible for overseeing the integration and alignment of commissioning across the Clinical Commissioning Group and the Council. It has a duty to update the Board on activity against its work programme and future planned activity.

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 alternative options

4.0 Council Priority:

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

5.0 Background Information

5.1 The Health and Wellbeing Board has already received an update on the meeting on 20 July which included:

- An update on work led by Lancashire Fire and Rescue to develop a pilot in Blackpool which shapes the transition from a Home Fire Safety Check (HFSC) to a new, co-designed, more holistic Prevention and Wellbeing Visit. This is focused around the person/family and aimed at reducing health inequalities by providing brief interventions and an onward referral service in six key areas of falls prevention; social isolation; dementia; diabetes; healthy homes/winter pressures; home security/arson vulnerability. Work is underway from an information governance perspective to examine the data that the Council holds on vulnerable people.
- An update on the quarter one performance monitoring of the Better Care Fund schemes. A small group has been set up to look at the schemes included in the Better Care Fund and establish what is included within each area.
- An update on the 0-19 public health commissioning review, which is considering the public health services that are currently commissioned for young people including health visiting and school nursing.
- An update on the drug and alcohol treatment service commissioning review which was initially brought to the Strategic Commissioning Group in April for discussion in relation to how to proceed with the adult commissioned drug and alcohol service moving forward.
- An update on the development of the Older People's Housing and Support Strategy which is examining future need for older people's supported and sheltered housing and the range of support currently available.

The minutes of the meeting will not be approved by the Strategic Commissioning Group meets next on the 20 October 2016 so the minutes will be brought to the subsequent Health and Wellbeing Board meeting.

5.2 The structure of future meetings will be slightly different with the agenda split to take account of the usual business of the Strategic Commissioning Group and allow for themed discussion of a particular issue. The next meeting agenda includes the following:

- A report from Disability First about the charitable and third sector
- A report on the commissioning review of domestic abuse services
- Consideration of quarter two Better Care Fund performance monitoring
- A themed discussion exploring issues around delayed transfers of care

5.3 In light of the future scheduling of Strategic Commissioning Group meetings, the Heath and Wellbeing Board will now not receive an update at its October meeting. The Board will from then only receive an update from the Strategic Commissioning Group when a meeting of that group has taken place.

5.4 Does the information submitted include any exempt information? No

5.5 **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

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Amy Cross, Cabinet Member for Reducing Health Inequalities and Adult Safeguarding
Date of Meeting :	7 September 2016

HEALTH PROTECTION FORUM REPORT

1.0 Purpose of the report:

1.1 To receive the biannual report of the Health Protection Forum and consider any issues raised by that Forum for escalation.

2.0 Recommendation(s):

2.1 To receive the Health Protection Report for the period 1 February 2015 to 31August 2016 to be given verbally at the meeting.

2.2 To consider further the issues outlined at Paragraph 5.2 and agree where necessary further action.

3.0 Reasons for recommendation(s):

3.1 To report on the work of the Health Protection Forum and consider any issues raised by the Forum.

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: "Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 The Health Protection Forum was established to provide a mechanism for warning and informing on local health protection arrangements within Blackpool to the Health and Wellbeing Board; providing information and advice on arrangements and plans in place to protect the health of the population of Blackpool. The Director of Public Health is responsible for the Council's contribution to health protection matters, including the local authority's roles in planning for and responding to incidents that present a threat to the public's health.

5.2 The following items have been identified for highlighting to the Board:

- **Infectious diseases, outbreaks and incidents:** On the whole these are in line with seasonal norms. Levels of Group A Streptococcal infection (Scarlet Fever) have been elevated over the past year or so with this infection accounting for 123/185 reported cases of infectious disease since the beginning of 2016. These elevated levels are being seen across the country. Typically there are seasonal rises in Scarlet Fever between December and April each year, and also a cycle of increases and decreases in incidence that repeats over a period of several years. This most recent increase is likely to be part of that cycle. Whilst Scarlet Fever used to be a serious disease, nowadays most cases tend to be mild and it can be easily treated with antibiotics. Information along with guidelines on infection control has been circulated to schools.
- **Seasonal Flu**: Arrangements for seasonal flu vaccination are underway. In recent years Blackpool has achieved good uptake amongst healthcare workers but lower rates amongst social care staff and some risk groups, notably pregnancy women and young children. This year's publicity will include a focus on improving uptake of the nasal vaccine for 2, 3 and 4 year olds. NHS England and Public Health England are leading a group including local authority and NHS representatives to coordinate local activity. Blackpool Council is planning additional promotion to frontline staff in Children's and Adults services.
- **Healthcare acquired infections:** A recent Clinical Commissioning Group report to the Health Scrutiny Panel highlighted healthcare acquire infection rates although these were not covered during the meeting. The Council's Public Health team is to raise this with the Clinical Commissioning Group.

- **Severe Weather Plan**: The Severe Weather Plan is a jointly produced by Blackpool Council, Blackpool Clinical Commissioning Group and Blackpool Teaching Hospitals. The document has recently been reviewed in line with the latest release of the Public Health England's Heatwave Plan and has been distributed across the local health economy.
- **Public Health England local health protection function:** Dr John Astbury is now Interim Head of Health Protection for the Cumbria and Lancashire team following the retirement of Kate Brierley.

5.3 Does the information submitted include any exempt information? No

5.4 **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

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Mark Towers, Director of Governance and Partnerships Blackpool Council
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	7 September 2016

JOINT ARRANGEMENTS FOR HEALTH AND WELLBEING BOARDS IN LANCASHIRE UPDATE

1.0 Purpose of the report:

1.1 To receive an update on the latest stages of the development of the new pan-Lancashire model for health and wellbeing board governance, including key recommendations emerging from the Health and Wellbeing Board Summit held on 26 July 2016.

2.0 Recommendation(s):

2.1 To note the development of the new pan-Lancashire model for health and wellbeing board governance.

2.2 To note that a report is to be considered by the Lancashire Leaders Group at its meeting on the 15 September 2016.

2.3 To agree to receive a further update at the next meeting.

3.0 Reasons for recommendation(s):

3.1 To ensure that the Health and Wellbeing Board is kept fully informed of developments arising from the Health and Wellbeing Board Summit.

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 alternative options

4.0 Council Priority:

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

5.0 Background Information

5.1 At their meeting on 23 May 2016, Lancashire Leaders agreed that work should be undertaken to move to a new model of health and wellbeing board governance, in the form of a single Health and Wellbeing Board for Lancashire, with five local area health and wellbeing partnerships, reflecting the local health economies. The first step to implementing the new governance model is for the upper tier authorities, who currently hold the statutory Health and Wellbeing Board duties, to develop a joint framework for delivering their statutory responsibilities.

5.2 In order to engage with existing Health and Wellbeing Board members, a health and wellbeing summit was held on 26 July 2016 at Deepdale, Preston, which allowed members to explore and agree how their statutory responsibilities could be jointly delivered. The comments and feedback received from the Summit have been considered by an Executive Officer Group, with senior representatives from the three upper-tier authorities, and recommendations for the developing framework are outlined within this report. The agenda for that meeting is attached at Appendix 5a and the presentation from that meeting is attached at Appendix 5b. A number of representatives of the Board were among the 64 representatives who attended the summit held in Preston. The attendees were reminded about the key statutory role of Health and Wellbeing Boards and then asked to offer their opinion about how these duties could be delivered through the new model and were particularly asked to consider:

- Governance and democratic influence
- Promoting integration
- Joint strategic needs assessments and health and wellbeing strategies
- Membership

5.3 The comments made during the Summit have been collated and analysed by officers supporting this work. The key themes from each of these discussions are highlighted within this report and recommendations are currently being developed by the Executive Officer group for discussion at the meeting of Lancashire Leaders.

5.4 Governance and democratic influence

Key themes emerging from feedback

- There is a need to make both levels operate effectively, take meaningful decisions and have productive discussions
- Decision making processes need to be robust and transparent
- Groups need to take into account what is "local" i.e. what does it actually feel like to live/work/visit the local areas
- Public and community engagement and empowerment is key
- There needs to be an agreed terms of reference which clarified decision making

5.5 Promoting integration, including Better Care Fund

Key themes emerging from feedback

- There should be a common set of goals and ambitions for integration across both levels – some comments suggested a third level, being that of neighbourhood/community level integration.
- There is a need for a pan-Lancs strategic framework but local influence to develop local delivery.
- A feeling that the Health and Wellbeing Board could "rise above" organisation boundaries and encourage what is right for people and the area - there is a need to be outcome focused, rather than organisational focused.
- There was lots of reference to pooled budgets, in the feedback as a collective aim but not at what level or what this would look like, or whether it was legally possible.
- Feedback from facilitators suggested there was a sense that pooled budgets should go beyond the Better Care Fund.
- There is a need to think about how we share resources; expertise; workforce; estates and IT.

5.6 Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Key themes emerging from feedback

- There were generally three options put forward by groups, which are summarised as:

    1. A single Joint Strategic Needs Assessment/ Joint Health and Wellbeing Strategy for Lancashire

    2. Five Joint Strategic Needs Assessments/ Joint Health and Wellbeing Strategies one for each Local Health and Wellbeing Partnership

    3. Replicate the current Lancashire model, which pulls out the overarching priorities for Lancashire, and is based on data from each area Clinical Commissioning Group (and as such includes Blackburn with Darwen and Blackpool)

- Engagement and consultation in Joint Strategic Needs Assessment/ Joint Health and Wellbeing Strategy is critical and should be undertaken at each level – what is important to local people is not always the same as what is important to organisations, we should take this opportunity to consider how we address this

5.7 Membership

Key themes emerging from feedback

- Core Membership for the pan-Lancashire Health and Wellbeing Board should be as small as possible.

- A core membership should be prescribed for the Local Health and Wellbeing Partnerships, with the flexibility to co-opt other members as locally relevant.

- A balance of elected member, public and voluntary sector representation was needed.

Feedback from facilitators was the providers should be represented at the local area partnership level, rather than on the pan-Lancashire Health and Wellbeing Board.

5.8 Given that commissioning cycles are about to commence and engagement with existing Health and Wellbeing Board in regards to Clinical Commissioning Groups commissioning priorities usually takes place around September, the Executive Officer Group recommend that the new model for Health and Wellbeing Board governance

be implemented following the Annual Council (of the upper tier authorities) for the new municipal year, normally (May 2017).

5.9 Recommendations based on the feedback received at the summit are currently being developed by the Officer group and will be presented to the Lancashire Chief Executives and Leaders for consideration at their meeting on 15 September 2016, by way of an update of the development of the new governance arrangements.

5.10 Does the information submitted include any exempt information? No

5.11 **List of Appendices:**

Appendix 5a: Agenda from the meeting held on the 26 July 2016

Appendix 5b: Presentations from the meeting held on the 26 July 2016

6.0 Legal considerations:

6.1 Legal advice on all of these recommendations and options is now required, and the Officer Working Group will convene a meeting with legal representatives from each of the three upper tier authorities, to agree how the proposals can be enacted and the processes that need to happen to allow this.

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

PAN-LANCASHIRE WIDE HEALTH AND WELLBEING BOARD SUMMIT

26 JULY 2016
3.00 pm – 6.00 pm

THE GREAT ROOM, SIR TOM FINNEY STAND, PRESTON NORTH END FOOTBALL CLUB

AGENDA

1. Arrival and coffee – 2.45 pm – 3.00 pm
2. Welcome and introductions – County Councillor Mein (Lancashire County Council); Councillor Khan (Blackburn with Darwen Council) and Councillor Cain (Blackpool Council)
3. The changing landscape for health and wellbeing and the future model – Harry Catherall (Blackburn with Darwen Council)
4. The role of health and wellbeing boards – Directors of Public Health
5. Workshop – session 1: Statutory functions
6. Break
7. Workshop – session 2: Membership for the new structure
8. Feedback from workshop sessions (facilitators)
9. Next steps and close

This page is intentionally left blank

Appendix 5b

Pan-Lancashire wide Health and Wellbeing Board Summit

Health & Wellbeing Board
Start well | Live well | Age well

Lancashire Health and Wellbeing Board

Blackpool Council

Welcome and introductions

Councillor Jennifer Mein

Chair Lancashire Health and Wellbeing Board

Councillor Mohammed Khan

Chair Blackburn with Darwen Health and Wellbeing Board

Councillor Graham Cain

Blackpool Health and Wellbeing Board

Housekeeping

No fire drills are expected during the time of this event.

In the event of a fire, please use the closest signposted fire exit which is situated to your left and make your way to the assembly point.

Please do not use the lift.

Assembly point is the 'Splash' – statue of Sir Tom Finney which is situated on Sir Tom Finney Way/Car Park.

Toilets are to your left through the double doors/near lift on the 2nd floor and follow the signage for additional toilets on the 1st floor (directly outside the Sir Tom Finney Lounge).

AGENDA

- Welcome and introductions – County Councillor Mein (Lancashire County Council); Councillor Khan (Blackburn with Darwen Council) and County Councillor Cain (Blackpool Council)
- The changing landscape for health and wellbeing and the future model – Harry Catherall (Blackburn with Darwen Council)
- The role of health and wellbeing boards – Directors of Public Health
- Workshop – session 1: Statutory functions
- Break
- Workshop – session 2: Membership for the new structure
- Feedback from workshop sessions (facilitators)
- Next steps and close

The changing landscape for health and wellbeing in Lancashire

Harry Catherall

Chief Executive, Blackburn with Darwen Borough Council

Combined authority lead for Public Sector Reform

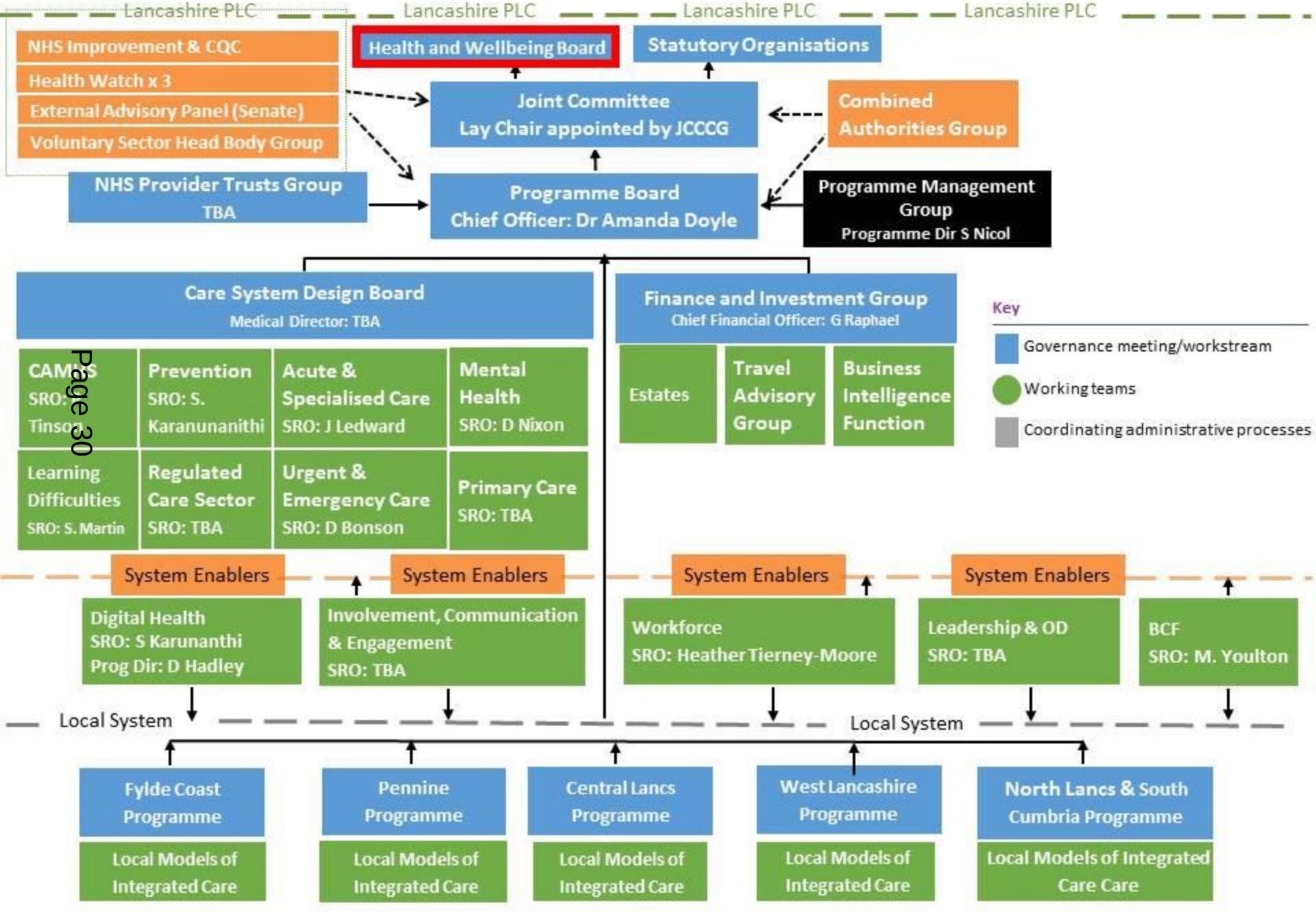
National context

- **Health and Social Care Act (2012)**:
  - formal establishment of health and wellbeing boards and their powers
- **Five Year Forward View for the NHS (2014):**
  - shared vision for the future of the NHS based around new models of care and radical upgrade on prevention
  - Confirms need for massive transformation by 2020, in order to address three widening gaps:
    - The health and wellbeing gap – inequalities will widen, if prevention isn't taken seriously
    - The care and quality gap – harness technology; reshape delivery and drive down variations in quality and safety
    - The funding and efficiency gap - £30bn gap by 2020
- **Comprehensive spending review 2015 –** system integration by 2020 and continuation of Better Care Fund for integrating health and care
- **Devolution Act 2016** – combined authorities and devolution deals, which can now include health and care
- **NHS planning guidance 2016/21:**
  - five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View
  - one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP

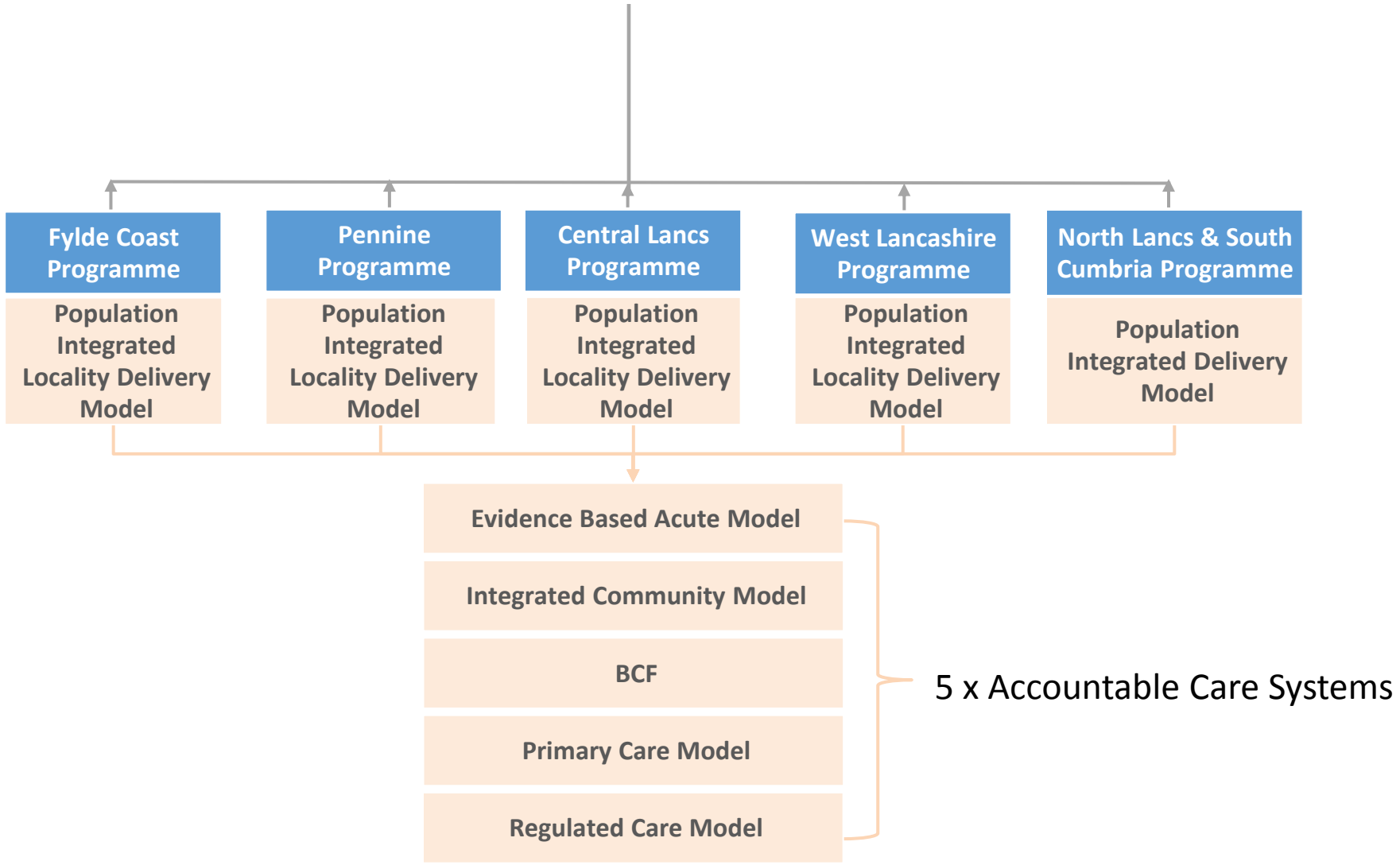
Local context

- Three statutory HWBB's – upper tier authorities
- Five local health partnerships under the Lancashire HWBB – district arrangements
- Combined authority:
  - Prosperous; Connected; Skilled; Better homes and Public Services Working Together
- Lancashire & South Cumbria Change Programme and Sustainability and Transformation Plan (STP):
  - Overarching STP ambitions, underpinned by five local delivery plans from the local health and care economies, based around their transformation programmes

Lancashire and South Cumbria Change Programme



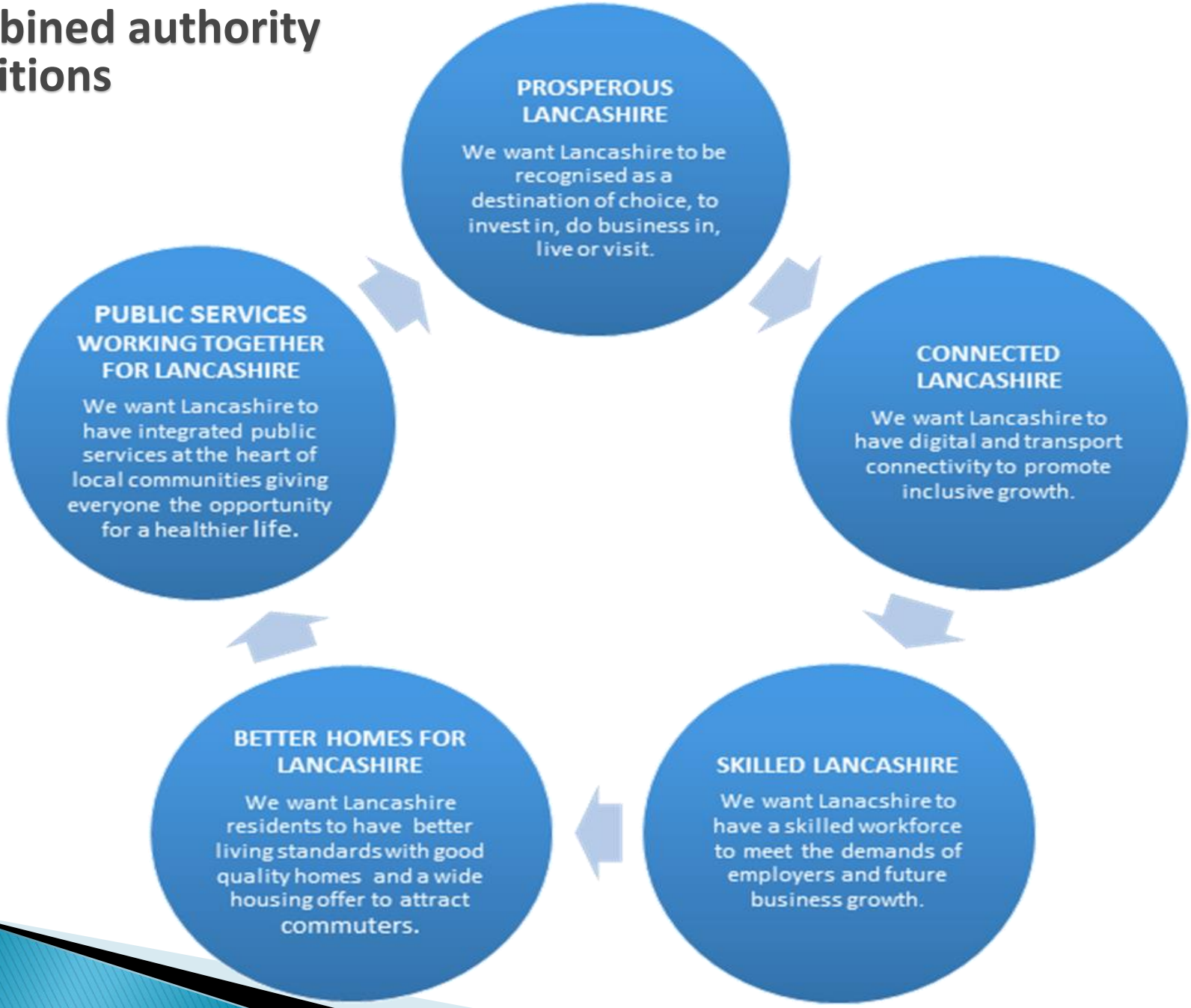
New Healthier Lancashire & South Cumbria Governance Structure



Once each LHE has completed their ACS model (March 2017) we will then model the 5 systems into

1. This is significantly less complex than trying to model the acute system at a lancashire level.

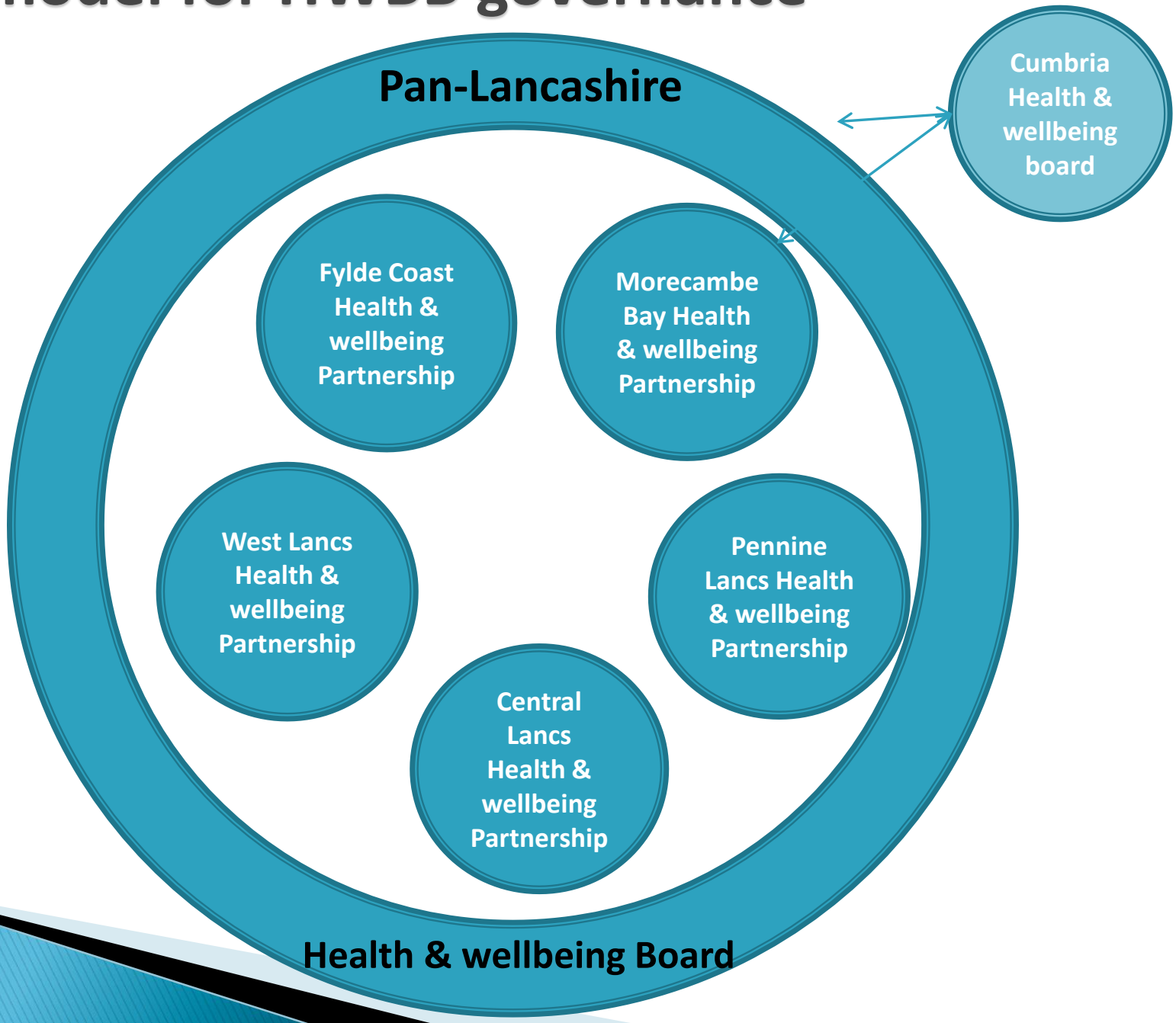
Combined authority ambitions



Why are we here

- Five Year Forward View moves towards place based planning
- Health and wellbeing “system” is changing at both pan-Lancashire level and at local delivery level
- We must provide the strongest collective influence and governance throughout the system
- Ensure robust accountability of system changes linked to the STP delivery and service reconfigurations
- Statutory functions must still be delivered, but in a way that makes best use of resources and exerts most influence
- Lancashire Leaders agreed a single Health and Wellbeing Board for Lancashire, with five local area health and wellbeing partnerships, reflecting the local health economies.
- Agreed that existing Boards need to develop a joint framework for delivering their statutory responsibilities
- Lancashire public services, in their widest sense, must step up their contribution to improving health outcomes and delivering a sustainable health system

A new model for HWBB governance



Benefits of the new model

- Ensure effective and meaningful democratic engagement at all levels of the health and care system transformation, including county; district and unitary elected members
- Ensure strategic accountability of and engagement in system change across the life course, i.e. Start Well; Live Well and Age Well on a pan Lancashire footprint
- Continuing to ensure formal HWBB decisions are linked to the decisions of the CCGs and Councils, relevant to the sustainability and transformation planning footprint and the local health and care economy areas
- Strengthened mechanism for harnessing local government and wider public sector contributions to system change
- Some uniformity and consistency in priorities and approach, whilst allowing for local differences and delivery

Potential challenges

- How willing are we to do something different?
- How ambitious do we want to be in enacting our new approach?
- How can we make the new model as effective as it can be?
- How will we maximise engagement with the public and our partners?
- How will we work with Cumbria Health and Wellbeing Board, to ensure joint oversight of the Lancashire & South Cumbria STP?

The whole is greater than the sum of it's parts…..

Aristotle

The role of health and wellbeing boards

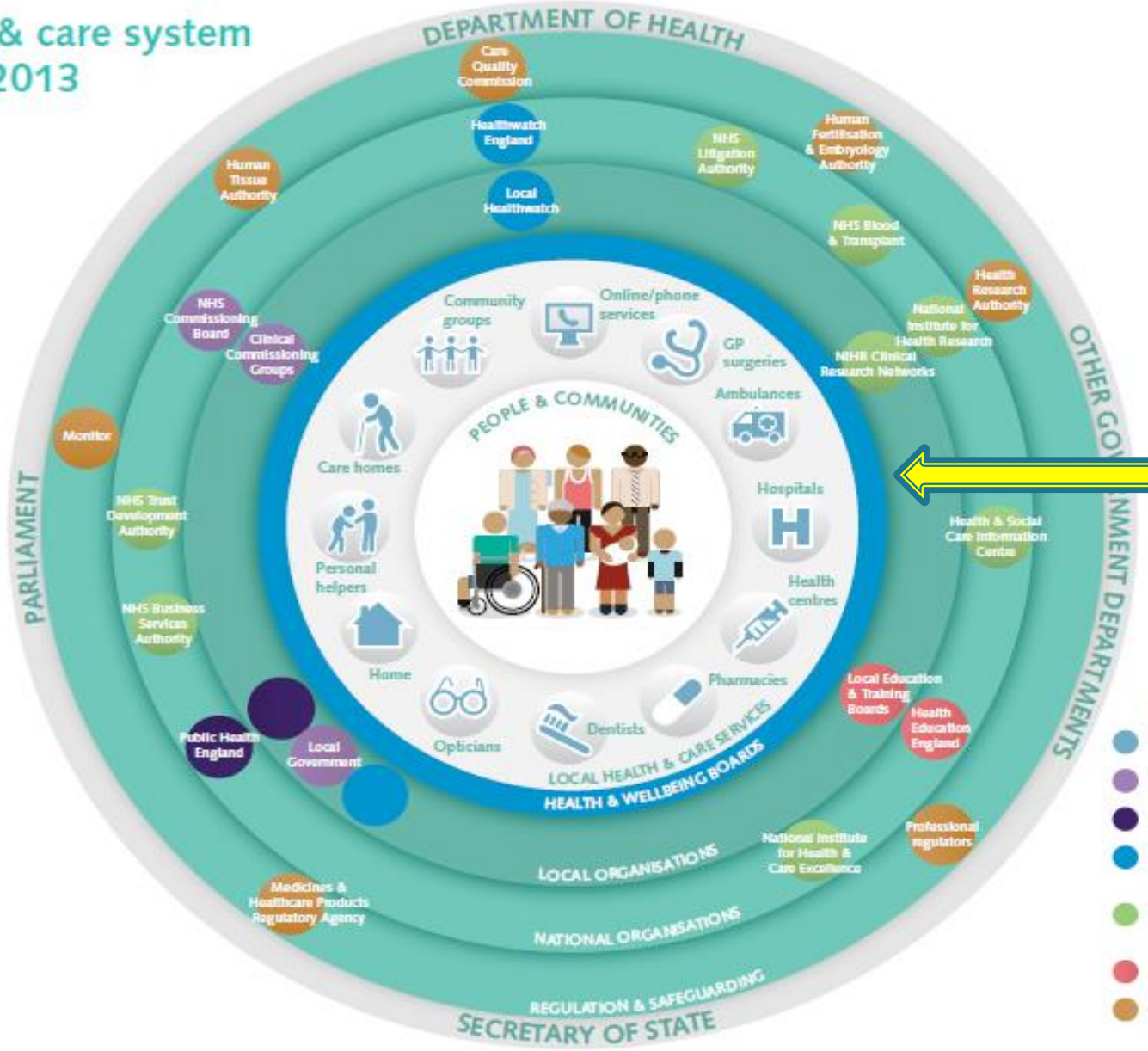
Dominic Harrison
Director of Public Health
Blackburn with Darwen Borough Council

HWBB – Purpose and Powers

- Established by the Health and Social Care Act 2012
- Effective from April 2013 at first tier Local Authority Level
- Purpose is to :
  1. Promote greater integration and partnership including joint commissioning, integrated provision and pooled budgets
  2. Produce a Joint Health and Wellbeing Strategic Needs Assessment (JSNA)
  3. Produce a Joint health and Wellbeing Strategy
- Powers:
  - Must effectively 'sign off' CCGs annual commissioning plans which in turn must adequately reflect the JSNA
  - If HWBB 'not happy' it can refer CCG Commissioning plan to the NHS Commissioning Board

NHS Confederation – Health and Wellbeing Board

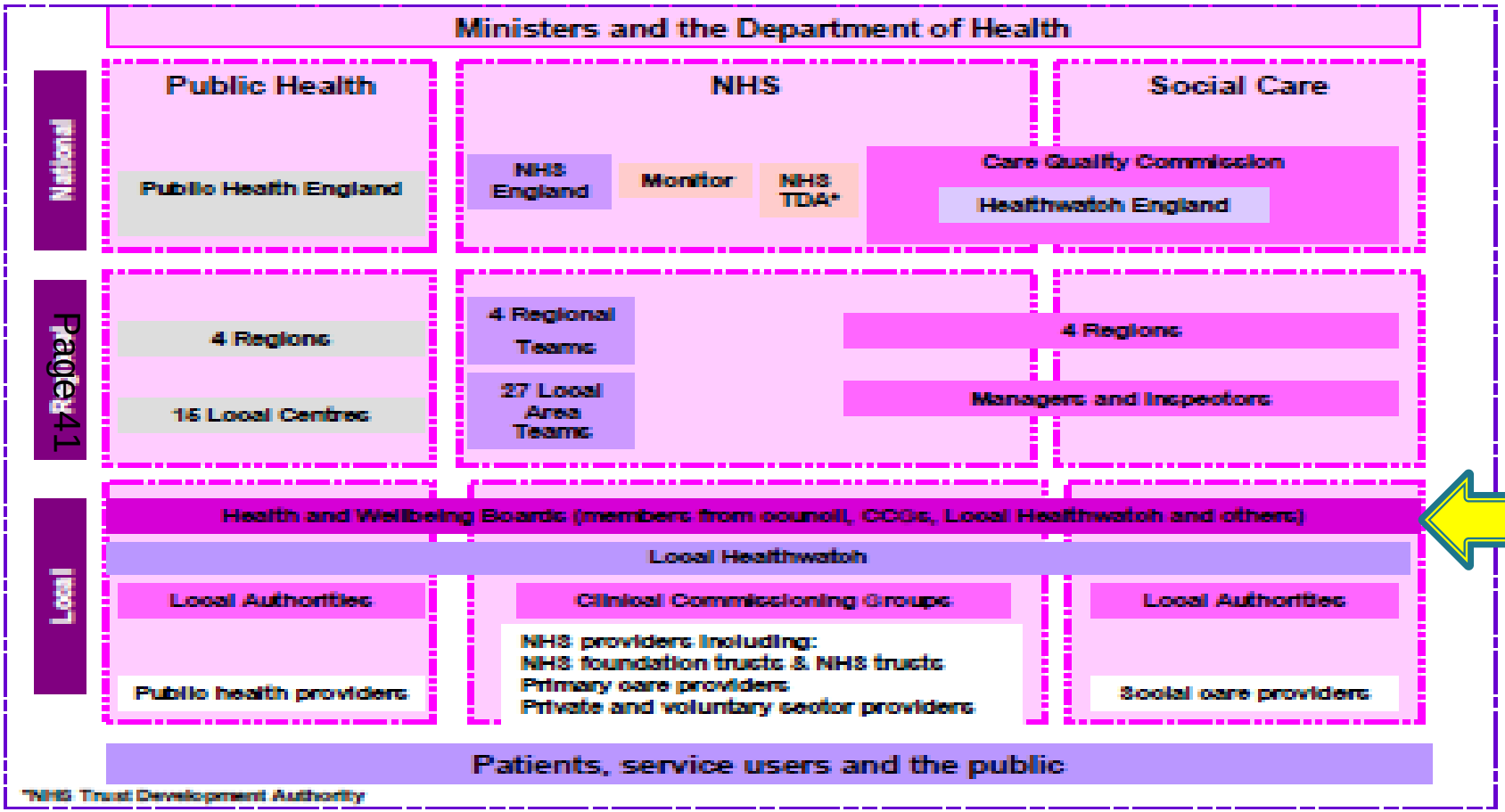
The health & care system from April 2013



HWBB

LGA – Health and Wellbeing Board

Overview of the new health and care system



HWBB

Fig 2 The health and care system – national, regional and local structures from April 2013 (adapted from presentation by David Buck, Senior Fellow, King's Fund)

LGA (2014) NHS Guide for Councillors

HWBB-Scrutiny-Healthwatch

Centre for Public scrutiny

Roles, relationships and adding value

HWBB-Scrutiny-Healthwatch

Centre for Public Scrutiny

- Share information from networks of voluntary and community groups.
- Gather and present evidence and information for Joint Strategic Needs Assessments and support council scrutiny reviews.
- Use good public engagement to demonstrate the 'real-time' experiences of people who use services.
- Highlight concerns about service to council health scrutiny.
- Cascade information to people who use services and the public about services that are available.

- Bring together individual and organisational knowledge, expertise and experience.
- Develop an area-wide view of health and social care needs and resources through the Joint Strategic Needs Assessment.
- Agree area-wide alignment of services to deliver improved health and wellbeing through the Joint Health and Wellbeing Strategy.
- Facilitate shared understanding of information to improve outcomes from decision making.

- Be a bridge between professionals and people who use services.
- Bring a collective memory of public engagement, policy development and local knowledge about community needs and assets.
- Be a valuable 'critical friend' throughout transition and beyond.
- Evaluate policies arising from processes and decisions and outcomes from services.
- Consider whether service changes are in the best interests of the local health service.
- Carry out pro-active qualitative reviews that can inform and enhance policy and services.

Source: CfPS (2014)

HWBB: Statutory Membership

Though health and wellbeing boards (HWBs) are formally committees of local authorities, they differ from other council committees in several important ways. The core statutory membership of each health and wellbeing board brings together political, professional, commissioning and community leaders as equal partners, with equal status. HWBs comprise:

- at least one elected representative, nominated by either the Leader of the council, the Mayor, or in some cases by the council
- a representative from each clinical commissioning group (CCG) whose area falls within or coincides with the local authority area
- the director of adult social services
- the director of children's services
- the director of public health
- a representative from the local Healthwatch organisation.

HWBB – Optional Additional Memberships

Place Based Planning: STPs : Para 9. Page 4 *"Success also depends on having an open engaging and iterative process that harnesses the energies of clinicians, carers, citizens, and local community partners including independent and voluntary sectors and Local Government through health and wellbeing boards"*

Source: LGA (2014) NHS Guide for Councillors

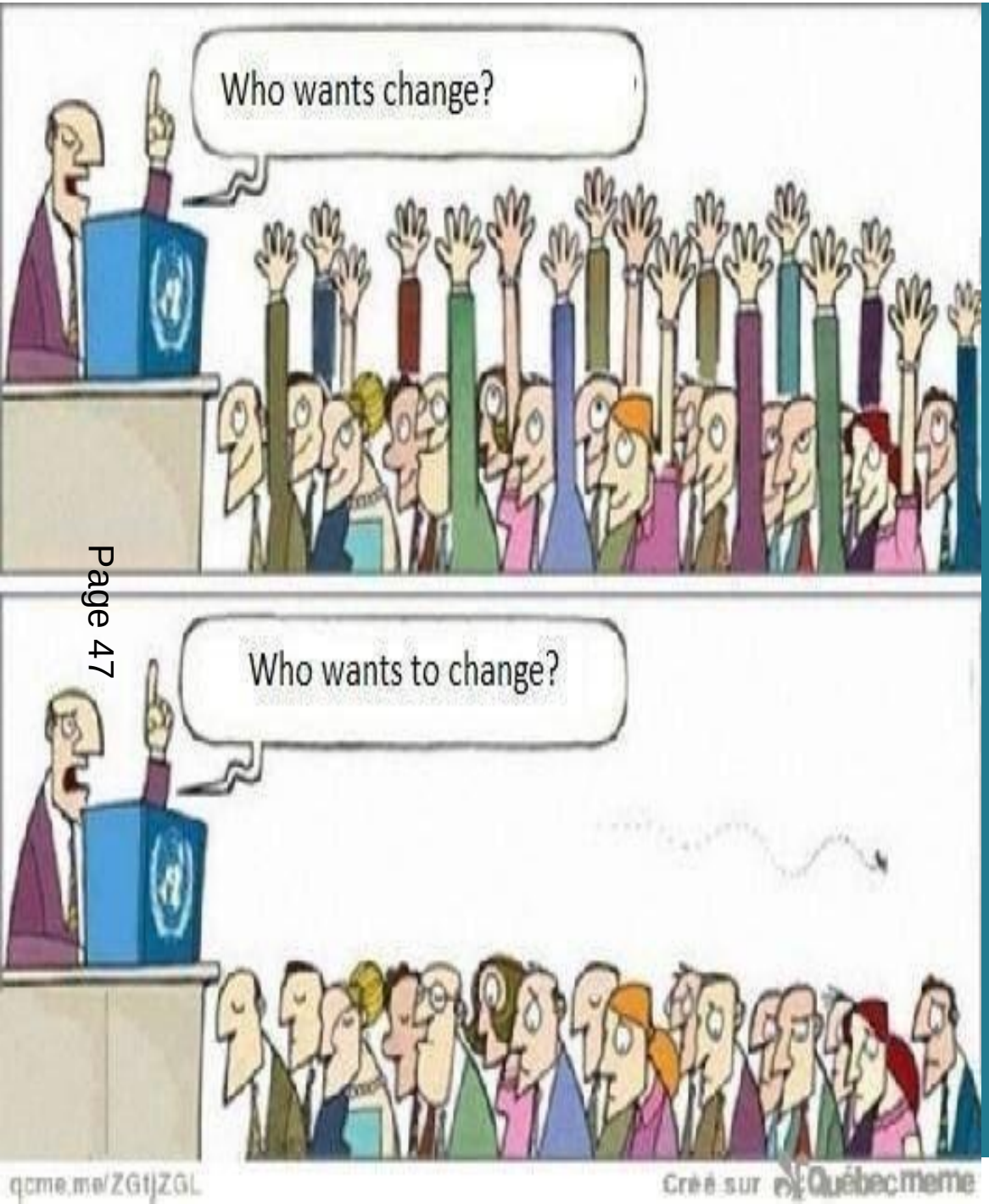
HWBB – Delegation Issues

(Subject to further legal advice)

- HWBBs can 'delegate functions and powers' but will need to retain legal responsibility for the decision making (whether delegated or not) under the Act.

- Any major reconfiguration of NHS services would need to be 'signed off' by the HWB Board as these would need to be compatible with the JHWB Strategy, JSNA and CCG Annual Commissioning Plan.

- Any 'amalgamated' Lancashire HWBB acting under local 'delegations' would need to be legally constituted with appropriate member and organisational delegations – with compatible voting powers.



The Health and Social Care System is going to change radically between now and 2020.
We need a HWBB structure fit for purpose to Governance these changes…..

Workshop session 1

Statutory functions –

- Ensuring integration
- Joint strategic needs assessments and Joint Health and wellbeing strategies
- Governance and democratic influence

Break

Workshop session 2

Membership for the new model

Next steps and close

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Amanda Doyle, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	7 September 2016

LANCASHIRE AND SOUTH CUMBRIA CHANGE PROGRAMME AND SUSTAINABILITY AND TRANSFORMATION PROGRAMME UPDATE

1.0 Purpose of the report:

1.1 This report summarises the activities of the Lancashire and South Cumbria Change Programme over the last month and includes details on the progress to establishing the governance and programme structure arrangements.

The report and the appended Programme Director's Report provides detail on the Programme's work to co-ordinate and support the Lancashire and South Cumbria health and care system's Sustainability and Transformation Plan, required by NHS England and their Delivering the 5 Year Forward View: NHS planning guidance 2017/18-2020/21.

This report aims to assure the Health and Wellbeing Board that the Programme is making good progress and to alert the Board to the activities, products and outcomes that it can expect in the next quarter of the year to inform its work programme.

2.0 Recommendation(s):

2.1 To note the progress that the Lancashire and South Cumbria Change Programme has made in establishing the requisite governance and programme structure arrangements.

2.2 To note the requirements of the Sustainability and Transformation Plans NHS and local government organisations and further deadlines of 16 September 2016 for financial plans, and supporting detailed narrative by 30 October 2016 to provide assurance that the health and care system can achieve financial sustainability at the end of this year and through to 2018.

2.3 To note the requirement for the Programme to report to the Health and Wellbeing Boards or to the Joint Health and Wellbeing Board through the Independent

Chairman of the Joint Committee (as set out on the governance structure) and the Senior Responsible Officer and Sustainability and Transformation Plan Lead who is the Chairman of the Programme Board.

2.4 To agree to receive and discuss the Case for Change and its proposed publication at a future meeting.

3.0 Reasons for recommendation(s):

3.1 The Health and Wellbeing Board should be assured that the Lancashire and South Cumbria Change Programme (LSCCP) has created a good infrastructure for the Sustainability and Transformation Plan. The governance arrangements for the Lancashire and South Cumbria Change Programme are now in place.

Attached to this report at Appendix 6a is the Programme Director's Report which was presented, discussed and its recommendations supported by the Lancashire and South Cumbria Change Programme Board at its meeting held on 17 August 2016. This provides further detail on the Programme's activities between 20 July 2016 and 17 August 2016.

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: "Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 Healthier Lancashire was first considered in autumn 2013, with the intention of developing a strategy for improving health outcomes for Greater Lancashire. With the appointment of a Programme Director in September 2014 and resource from NHS England the work to establish a collaborative programme of work to radically change the health and care system commenced in February 2015.

5.2 Following a piece of work to align the many plans and strategies across Lancashire and the publication of the Lancashire Forward View, there was absolute commitment to establishing and resourcing a programme of work that would not only improve the health outcomes of the population, but would make the radical changes to improve the quality of care, the efficiency and productivity of delivery of health and care and maximise the evidenced benefits of integration with health and social care. In November 2015, the Lancashire Health and Care System agreed to complete the strategic planning phase activities and establish the required governance (decision making) and programme arrangements to do this.

5.3 In December 2015 the NHS England planning guidance required 44 footprints across England to develop plans for sustainability in 2016/17 and 2017/18 as foundation years for transformation of the kind that Lancashire had already agreed was necessary. In January 2016 it was agreed by all stakeholders to include South Cumbria as an important and integral part of the Lancashire footprint, given the close working relationships across Morecambe Bay and patient flows into Lancashire. The Sustainability and Transformation Plan requires the Lancashire and South Cumbria Change Programme (LSCCP) to ensure the development of these plans and their implementation over the next five years.

5.4 The Programme Board has begun to meet each month and the Joint Committee, which includes representatives from top-tier authorities and district councils, will have its first meeting in October 2016.

5.5 The Collaborative Commissioning Board which precedes these arrangements is currently considering its role in respect of the Joint Committee and its role in holding the health and care system to account for the implementation, delivery and ongoing monitoring of commissioning decisions.

5.6 The Lancashire and South Cumbria Change Programme governance arrangements however are awaiting the confirmation of discussions to form a single Health and Wellbeing Board that would hold the Joint Committee responsible and accountable.

5.7 The Lancashire and South Cumbria Change Programme has begun the recruitment process for an Independent Chairman and would like the Health and Wellbeing Board's advice on how the Lancashire and South Cumbria Change Programme should report to it, through the Independent Chairman of the Joint Committee and the Programme Senior Responsible Officer and Sustainability and Transformation Plan Lead who chairs the Programme Board.

5.8 The Programme Board commenced the discussion about decision making and work has just begun to consider what decisions are taken where and why. This will result in the Programme considering a number of scenarios through which the decision

making process can be tested and agreed to ensure that any potential barriers to reaching consensus (such as legal, cultural, constitutional) can be identified and mitigated for.

5.9 The supporting programme structure has now been established and with an initial focus on population health, urgent and emergency care and adult mental health; while keeping a strategic oversight on the regulated care sector, primary care and acute and specialised care workstreams (see Appendix 6b).

5.10 The programme's distributed leadership is now beginning to take shape, with all senior responsible officers in place. There is still however, significant concern about the capacity and capability of the system to support the activities that will be undertaken through the solution design phase. In particular the availability of clinicians and professionals to support the solution design work that is due to commence in September with the publication of the Case for Change.

5.11 The Board will note from the attached paper, the Case for Change at the moment is still being co-produced with stakeholders. The solution design phase will also require the engagement of the public and local elected representatives. The details of the process, resources and timescale will be presented to the Programme Board in September. It is expected that the Health and Wellbeing Board will receive the Case for Change.

5.12 The governance and programme arrangements have been designed to deliver the large scale transformation that is needed to deliver the improvements and remain financially sustainable, but following the second submission of the draft Sustainability and Transformation Plans, NHS England (NHSE) has made it clear that Sustainability and Transformation Plan health and care footprints must assure them of a joined up view of the future and joined up plans that are being delivered and ensure financial sustainability in 2016/17 and 2017/18.

5.13 By 16 September 2016, a revised set of financial plans showing how Lancashire and South Cumbria Change Programme expects to achieve financial sustainability will be submitted and a shared narrative describing how this will be done to be agreed and submitted by end of October 2016. Currently the Sustainability and Transformation Plan s have remained draft working documents and this is expected to be the case in October. The development of the Sustainability and Transformation Plan is involving all partners and the recently appointed, Lancashire and South Cumbria Change Programme Involvement, Communications and Engagement Director is currently working with colleagues to develop a robust approach to communications and engagement across the system.

5.14 It is recommended that the Health and Wellbeing Board has the opportunity to contribute to this and understand how the Case for Change will be used to engage

and involve all stakeholders (workforce, public, politicians).

5.15 There is well established Digital Health Programme that has had to submit a Digital Road Map alongside the Sustainability and Transformation Plan and this programme has begun to establish the technical infrastructure to allow the sharing of information across health and social care and which over the solution design phase will consider the appropriate new technologies that can be introduced to support people to look after their own health better or to manage their ill health more effectively.

5.16 The Lancashire and South Cumbria Change Programme Team continues to engage with stakeholders on an individual and group basis and has agreed over the coming weeks and months to work more closely with a number of interested parties to develop their understanding of the programme and to involve them in the Programme's activities and solution design

5.17 Does the information submitted include any exempt information? No

5.18 **List of Appendices:**

Appendix 6a: Programme Director's monthly report
Appendix 6b: governance structure diagram

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 and further information:

13.1 Delivering the 5 Year Forward View: NHS planning guidance 2016/17-2020/21 published 22 December 2016 by NHS England.

Appendix 6a

Lancashire and South Cumbria Change Programme (and STP) Director's Report for July and August 2016

Introduction

As part of the programme structure supporting the governance structure, a Programme Board has been established for the LSCCP and this Board will also receive the STP as an output of the Programme.

The formality of the Programme Board will require a Programme Director's Report each month. The meeting on 17 August 2016 is only the second meeting of the Programme Board and this is the first monthly Director's report.

The Director's Report will set out in a summary form the work of the LSCCP over the previous month, and provide the context and an ongoing developing narrative that will be supported by more detailed Board papers on specific elements of the Programme and the STP.

These monthly reports will form part of the regular communication across stakeholder organisations and can be used by Programme Board members to brief their organisations or other stakeholder or interested groups.

For further information on any of the items in the Report please contact Samantha Nicol, Programme Director, either by email on samanthanicol@nhs.net or via the LSCCP Office on 01253 951630.

This report covers LSCCP activities from 20 July to 11 August 2016 and includes:

1. Progress on establishing the governance and programme structure and mobilising the Solution Design Phase (SDP)
2. The Collaborative Commissioning Board – 9 August 2016
3. Sustainability and Transformation Plan update
4. Developing the Case for Change
5. Digital Health Programme update
6. Involvement, Communication and Engagement
7. Key risks

1. Governance, structure and mobilising the Solution Design Phase

The Joint Committee of Clinical Commissioning Groups (JC CCGs)

A third draft of the Terms of Reference (ToR) of the JC CCGs was circulated to the clinical commissioning groups' (CCGs) governing bodies again during July and August. This followed on from a meeting with Gerard Hanratty, the LSCCP legal advisor, from Capsticks LLP, with the CCGs. Mr Hanratty also reviewed the CCGs' constitutions and along with a revised draft of the JC CCGs' ToR, CCGs who were required to make amendments to their constitutions were advised in writing.

All CCGs have now confirmed that their governing bodies have seen the ToR and confirmed in general their agreement to the ToR. There still remains the requirement for a written Minute of Decision and these will be requested over the next week, although this will not hold up the establishment of a schedule of dates for the JC CCGs.

There are further discussions taking place with the Cumbria CCG in respect of their role on the JC CCGs given the escalated pace of developing the STP. Non-voting members, NHS England (including specialised commissioning) and local authorities have already confirmed their agreement to the ToR and advised of their representatives. The local authorities have ensured that these representatives cover the footprint and include county, unitary and district councils.

It is expected that the first JC CCGs will be held in October. Following on from the last Programme Board on 20 July, the job description and person specification, for the Independent Chairman, was circulated to Board members and comments received back have been considered and incorporated as appropriate. The advertisement and recruitment process is being supported by the Commissioning Support Unit. The LSCCP will also be requesting the leaders of its partner organisations to consider using their networks to alert prospective suitable candidates to the vacancy. An interview panel will be convened, and this will include an external assessor.

The Programme Board

As Board members will have seen, following the discussion at the meeting on 20 July and further comments received subsequently, the Programme Board Terms of Reference has been amended.

Programme Structure

As Programme Board members are aware the programme structure utilises a dispersed leadership approach, following on from the commitment at the Leadership Summit on 19 November 2015 to utilise existing groups in the Programme and to put resource, including people into it. There was the requirement to develop the clinical leadership for the Programme. It is therefore, with pleasure that we are able to announce the appointment of Dr Malcolm Ridgeway, from Blackburn with Darwen, as the Senior Responsible Officer (SRO) for the Primary Care Transformation Workstream, and he will be further aided by Dr Mark Spencer, from Fylde, as the Clinical Lead. Working alongside Dr Amanda Doyle, SRO for the Programme and the STP Lead, as well, is Mr Andrew Curran, ED Consultant, Lancashire Teaching Hospitals NHS Foundation Trust. Mr Curran has been tasked with setting up the System Design Group, which will include senior medical, nursing and professional colleagues with the remit to oversee the design of proposed options for meeting the health and wellbeing and care and quality gaps.

In addition the system has also supported Prof. Heather Tierney-Moore's nomination to be the SRO for the Leadership and OD enabling workstream.

Mobilising the Solution Design Phase (SDP)

On 15 July the senior responsible officers from across the Programme had their first

meeting. The SROs are a vital part of the LSCCP, in developing the dispersed leadership approach they have come together to design and agree their role and identify the skills required and to consolidate as a team.

It is important that the Programme Board note that in the main the SROs are undertaking these roles on top of their existing 'day jobs'. Most of these individuals do not have any backfill and many are having discussions with their organisations and teams about how their workload is shared or about what doesn't get done. There are without doubt significant risks in terms of capacity and capability.

The SRO group met again on 5 August and invited the local health and care economy programme directors to join them. The objective of the session had been to sign off the role description and to work through what activities or design work was taking place in individual CCG areas, local systems as well as STP footprint level. The intention had been to then use the results of this to develop scenarios to discuss where decisions were or needed to be taken. The group had planned to look in detail at the proposed solution design process and consider what and how they needed to undertake this, recognising that some workstreams have already been in existence and working prior to the Programme. Interestingly the discussion about what was being done on what level in the system raised the issue of local programme design work versus STP footprint design work. This has raised a critical issue in respect of where decisions are taken and more importantly how they are adhered to.

As yet the governance structure and therefore the decision making process has not been tested. It is however, becoming a constant theme through the local programmes, the Collaborative Commissioning Board and the workstreams, while discussions on the role of the Health and Wellbeing Board(s) continue. In preparation for taking and holding to decisions in the future through the delivery of the Programme and the STP there is a clear need to take a more disciplined approach to testing the decision making arrangements out at this early stage, to minimise disruption or resistance when it might be more mission critical.

The Programme Board will be asked to contribute to this debate, by considering a couple of scenarios, which the SROs involved in the work have developed. The intention is to build up a picture of the potential issues, barriers or resistance to decisions through these discussions and to then look to ensuring that the governance arrangements are fit for purpose. This might also be related to behaviours, assumptions and mindsets and identifying these will help to inform proposals for leadership development and design of appropriate system interventions.

The SRO and Programme Directors have now been asked to consider where their local programmes and workstreams are in relation to it. They will meet again on 9 September and this will be the commencement of the SDP.

2. The Collaborative Commissioning Board – 9 August 2016

The Director's Report would not normally feedback on the Collaborative Commissioning Board. It is only included here because of several important pieces of work that the Programme Board should be aware of and which have interdependencies with the

Programme and the STP.

The work in local systems to develop integrated services between health and social care to support the implementation of new integrated models of care, predicated on community support, but including local hospital services. Together with the work in local authorities, particularly some commissioned work by Lancashire County Council, to develop new approaches to public sector service delivery has raised the desire to consider the requirement for changes in the way services are commissioned. Dr Doyle has agreed to gather together a small group of volunteers to consider what these conversations need to be, who they need to be with and when, with the objective of engaging and involving the right people and organisations in helping to develop options for consideration over the coming months.

At the last meeting of the Programme Board there was a request to investigate the opportunity to pause expected procurements. This was based on the need to focus efforts and capacity on the STP, but also to ensure that proposed procurements would not adversely affect or impact on future proposals or necessary decisions.

This request was taken back through the CCB, with the CSU compiling a spreadsheet of current and proposed procurements being undertaken across Lancashire. The CSU also provided advice on the level of risk in relation to pausing these in relation to the stage that the procurement had progressed to. This exercise raised a number of interesting questions and issues, which the CCB required further exploration on before being able to take a decision in relation to the request to pause.

Not all the CCGs had contributed to the exercise and so the detail on the procurements needed to be completed in full. There were a number of these that were already well progressed and so were considered in the high risk category. So these needed to be considered in relation to the size or value of the tender; the impact or interdependencies across the STP, on other services or organisations; the impact of pausing at an advanced stage of the process. The same was true for those procurements that had not yet commenced. There was also the need to ensure that any of these would not prejudice the co-design of solutions through the Programme or limit future options proposals.

Carl Ashworth, from the CSU, has been asked to set up a small task and finish group to undertake this work and to present back to the CCB at its September meeting. Mr Ashworth has also been asked to work with the Programme Director and Dr Doyle to develop a revised ToR for the CCB and a proposal for its role in relation to the LSSCP and the STP going forward. A first iteration of this will be discussed at the CCB at its meeting on 13 September 2016.

3. Sustainability and Transformation Plan (STP) update

As Board members are aware the second draft STP was submitted to NHS England on 30 June 2016, this comprised of 30 slides. There was a local assurance meeting with NHS England and colleagues from across the health and care system on 5 July to prepare for a meeting with Simon Stevens and other colleagues from the national teams of NHS England and NHS Improvement on 20 July 2016 in Leeds.

The meeting was structured around service proposals, finance and (political) engagement. This was a 45 minute meeting which focused on the plans that the Lancashire and South Cumbria health and care system had for delivering on its targets, while closing the financial gaps in 2016/17 and 2017/18. Our proposals for the future and our arrangements for working together and taking decisions together were seen as very good; there was a significant emphasis on the need to achieve financial sustainability in this year and next to establish the foundations for transformation in years three, four and five of the STP. This was about not waiting until year five to deliver everything, but to spread the work to bridge the gap, avoid cost and take cost out over the whole lifetime of the STP.

The STP footprints have been asked to submit further detailed financial analysis on the plans for 2016-18 and show how the financial gaps will be bridged, by 16 September 2016. It is expected that these, along with direction in recent financial guidance issued by NHS England, will be used to ensure that contracts with NHS providers are developed during October and November and contracts for two years will be signed by Christmas 2016, bringing forward and truncating the contracting round that usually commences in October to conclude at the end of March.

Further detail on the expectations of STP footprints in September and October were provided at a meeting of the North Region STP leads and NHS England local directors of commissioning operations from the North, alongside the NHS England North's Director, Richard Barker, colleagues from the Care Quality Commission (CQC), Public Health England (PHE), NHS Improvement (NHSI), National Institute for Health and Care Excellence (NICE); held on 10 August 2016.

NHS England and NHS Improvement described what they had gathered from the 44 STPs so far, the common themes, common enablers, common issues and requests that have been made by STP footprints. The common themes included urgent and emergency care, mental health, and elective care. Common issues were delivering at scale and pace, cross boundary issues, fostering a collaborative culture, implementing good practice at scale, and the issue of being transparent and engaging stakeholders in exploring radical solutions. Everyone was clear that an aligned position across the STP footprint was important and that the triple aims were all equally important.

By 16 September 2016 STP footprints have to submit a set of financial returns. By the end of October these financial plans will need to include a clear narrative that sets out how the triple aims will be addressed with a coherent story that includes provision and commissioning. The STPs need to show a joined up view of where the system needs to get to by 2020. The STP will set out the journey from sustainability to transformation year on year over its lifetime. The detail of years one and two are expected to be reflected in the operational plans required by December from organisations.

Chief Executives and Accountable Officers from across the health and care system attended a briefing with Dr Doyle on 22 July and agreed to come together regularly over the coming weeks to ensure that the work being undertaken to develop the STP is supported. There are four leaders meetings planned. The first one held on 11 August was to set out a number of pieces of work that have been set off and to request further information from organisations and local systems about the detail of their existing plans. The next meeting on 19 August

will consider how the local delivery plans and organisational plans meet the triple aims and to consider the impacts across the system and to consolidate performance against plan for this year and consider any remedial actions. The third meeting will then consider the level of transformation that will need to be brought forward to next year for delivery in order to meet the financial challenge.

There is a real desire and an imperative to engage clinicians and others in the development of the STP through to end of October and Roger Baker, ICE Director will be looking to support this with the LSCCP Team.

4. Developing the Case for Change

Over the last couple of months, a number of colleagues have been meeting as an Editorial Panel to begin to draft the Case for Change. It is obvious that this needs to support the narrative for the STP too. The Case for Change should establish a sense of urgency for change. It is often a skipped step in many change programmes or it is assumed that the sense of urgency is already shared broadly among stakeholders in the system, which it rarely is. One of the best ways to cultivate a sense of urgency is to craft a powerful Case for Change.

Simply put, the Case for Change is a *narrative* that explains the changes coming to the system and why they are necessary. Its objective is to provide a common baseline of awareness and understanding among stakeholders.

Currently we are working on a fourth draft of the Case for Change, but following the discussion with the STP leads across the North of England and the arm's length bodies there is an opportunity to engage further expertise and involve others in putting this important document together.

5. Digital Health Programme Update

It has been agreed that Declan Hadley, Programme Director and Sakthi Karunanithi, SRO for the Digital Health Programme will present a full update on this at the Programme Board in September. The following is a short summary of work underway.

A Lancashire and South Cumbria Wide Digital Road Map (LSCDRM) has been created as a key driver to support the better alignment and access of information across health and social care. The LSCDRM is owned by the Digital Health Board who has established a governance structure and a number of key work streams in support of the LSCDRM:

- **Lancashire Person Record Service (LPRES)**

  By the end of 2016 all the provider organisations in Lancashire will be able to send and receive any document to any GP anywhere in Lancashire and South Cumbria. It will also be able to provide – subject to Data Sharing and Information Governance agreements – a view of data sets e.g. EpaCCS, urgent care and care plans.

- **Collaboration across systems for Providers and Primary care**

  Through the Chief Information and Chief Clinical Information Group all clinical systems are being reviewed and where possible procurement of new systems is co-ordinated to

improve collaboration i.e. PACS.

- **Citizen free Wi-Fi**

The North West Shared Infrastructure Service (NWSIS) working with Blackpool Council and the Midlands and Lancashire Commissioning Support Unit has rolled out a programme of free public Wi-Fi to most NHS premises across Lancashire (including GP practices). This has been a real success and is now routinely accessed by thousands of patients and staff across Lancashire.

- **Information Governance and Data Sharing**

Information Governance has been an important element within the overall digital agenda and the Cumbria and Lancashire Information Governance Group, which is led by Helen Speed, has created an electronic Information Governance Register which simplifies the creation of data sharing agreements and the provision of Privacy Impact Assessments. It is currently being evaluated by the Information Governance Team at HSCIC to assess its suitability for a national rollout.

6. Involvement, Communication and Engagement (ICE) update

Roger Baker, ICE Director, will at a future meeting present the proposed plans for involvement, communication and engagement around the Case for Change, the STP and related to other elements of work across the LSCCP.

Even in the height of the holiday season however, there have been a number of meetings and discussions with colleagues from across the system. These have included a joint workshop with the communication and engagement partners and the workforce workstream. This was followed by a very productive discussion with union representatives. Both were about developing a good approach to communicating and engaging with staff in and about the Programme, and to understand from the staff's perspective what was important and would be helpful to them going forward.

There have been presentations to the Lancashire's Public Sector Leaders' Group on the STP and a commitment for someone from the LSCCP to attend that meeting on a monthly basis. The Health Watches have come together to also look at how they can support the Programme and will be coming back to the Programme Board with some proposals. The Lancashire Health Scrutiny Committee continues to be actively engaged and the Chairman, County Councillor Steven Holgate and Officer, Wendy Broadley have taken time to give some direction to what they would like the Committee to engage with at their meeting in October.

To continue to develop good relationships with colleagues in Cumbria, Brenda Smith, Director of Adult Social Services, Cumbria County Council has taken time to meet with the Programme Director and has been invited to be a member of the Programme Board. There have been meetings too with Lindsey Hoyle, MP and council colleagues at Chorley Borough and with Blackpool Council's Adult Care Senior Management Team.

7. Key risks

Currently the single biggest risk to the LSCCP is capacity and capability of the Programme Team to co-ordinate, facilitate and produce all the required elements of the STP and to mobilise the Solution Design Phase within given timelines. The Team is looking to manage this with some additional capacity to support the Finance Director, and plans to secure further help are being considered.

Alongside this is the capacity of the system to be able to participate in the activities that are taking place both in local systems and across the Lancashire and South Cumbria footprint. This is being mitigated by ensuring there is prioritisation and good communication to allow people to attend and speak for each other.

Failure to secure the appropriate commitment to the governance arrangements or to design robust decision making arrangements which will cause decisions to either not be taken or not to be supported and outcomes not delivered. This is why the discussion on decision making and testing this through scenarios is so important.

Conclusions

Despite it being the holiday season, the LSCCP continues to move forward and gather momentum. The last three weeks have been exceptionally busy with work to establish the governance arrangements and mobilise the programme structure and prepare to commence the Solution Design Phase. The Case for Change is a critical element of the Solution Design Phase and this requires further support and development, alongside the push to have a third draft of the STP by the end of October, and financial plans in more detail to be scrutinised by 16 September. Involvement, communication and engagement is a critical part of the LSCCP Team's work and the last few weeks have been no exception.

It is clear that there is a growing collaboration across health and social care organisations that is focussed on achieving the plans to really impact on health outcomes, while doing so within the given resource envelope. The discussions and commitment to working together is unprecedented and is already ensuring that the complex issues are brought to the fore and activities are focused on looking for solutions together.

Healthier Lancashire and South Cumbria Dispersed Leadership Model

Appendix 6b

Lancashire PLC

NHS Improvement & CQC
Health Watch x 3
External Advisory Panel (Senate)
Voluntary Sector Head Body Group

Health and Wellbeing Board

Statutory Organisations

Joint Committee
Lay Chair appointed by JCCCG

Combined Authorities Group

NHS Provider Trusts Group
TBA

Programme Board
Chief Officer: Dr Amanda Doyle

Programme Management Group
Programme Dir S Nicol

Care System Design Board
Medical Director: TBA

CAMHS SRO: Tinsley	Prevention SRO: S. Karanunanithi	Acute & Specialised Care SRO: J Ledward	Mental Health SRO: D Nixon
Learning Difficulties SRO: S. Martin	Regulated Care Sector SRO: D Curtis	Urgent & Emergency Care SRO: D Bonson	Primary Care SRO: TBA

Finance and Investment Group
Chief Financial Officer: G Raphael

Estates
Travel Advisory Group
Business Intelligence Function

Key
- Governance meeting/workstream
- Working teams
- Coordinating administrative processes

Local Workforce Advisory Board
H. Tierney-Moore & J. Cavalot

System Enablers

Digital Health
SRO: S Karunanthi
Prog Dir: D Hadley

Involvement, Communication & Engagement
SRO: R Baker

Workforce
SRO: D Gallagher

Leadership & OD
SRO: H. Tierney-Moore

BCF
SRO: M. Youlton

Local System

Fylde Coast Programme
Local Models of Integrated Care

Pennine Programme
Local Models of Integrated Care

Central Lancs Programme
Local Models of Integrated Care

West Lancashire Programme
Local Models of Integrated Care

North Lancs & South Cumbria Programme
Local Models of Integrated Care Care

This page is intentionally left blank

Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Rosalyn Bradshaw, Commissioning Manager, Blackpool Clinical Commissioning Group
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	7 September 2016

FYLDE COAST CANCER STRATEGY (2016-2021)

1.0 Purpose of the report:

1.1 To present the Fylde Coast Cancer Strategy for 2016-2021. The Strategy has been developed in conjunction with the key stakeholders of the Fylde Coast Cancer Steering Group, which includes Blackpool Clinical Commissioning Group, Fylde and Wyre Clinical Commissioning Group, Blackpool Teaching Hospitals NHS Foundation Trust, Social Care and Public Health.

2.0 Recommendation(s):

2.1 To support and endorse the implementation of the Fylde Coast Cancer Strategy as attached at Appendix 7a.

3.0 Reasons for recommendation(s):

3.1 To have a Fylde Coast Cancer Strategy for 5 years (2016-2021) that has been ratified by all key stakeholder organisations by the target date of 1 August 2016.

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:

To consider any additions or amendments to the Fylde Coast Cancer Strategy, or to provide limited support and endorsement to the strategy with proposed additions or amendments.

4.0 Council Priority:

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

5.0 Background Information

5.1 The Fylde Coast Cancer Strategy 2016-2021 is a 5 year Strategy which has been led and developed by Fylde and Wyre Clinical Commissioning Group on behalf of the Fylde Coast Cancer Steering Group. The Strategy has been developed in conjunction with the key stakeholders of the Fylde Coast Cancer Steering Group, which includes Blackpool Clinical Commissioning Group, Fylde and Wyre Clinical Commissioning Group, Blackpool Teaching Hospitals NHS Foundation Trust and Public Health and Social Care colleagues from the Local Authority.

5.2 The Fylde Coast presents a varied and challenging demographic characterised by an ageing population and a higher than average burden of long term conditions with co-morbidities. There are areas of extreme deprivation within the Fylde Coast, including Blackpool, which has high levels of unemployment and transience while neighbouring Fylde and Wyre localities have a higher than average elderly population. Life expectancy in some areas is markedly below the national and North West average with cancer as the second largest cause in reduction of life expectancy.

5.3 The Terms of Reference and Structure of the Fylde Coast Cancer Steering Group focus on strategic development and transformational change, the development and implementation of the Strategy is considered to be essential to support the process.

5.4 The Strategy aims to outline the changes required to make a demonstrable improvement in Cancer services, patient outcomes and experiences for the Fylde Coast over the next 5 years. Fylde and Wyre Clinical Commissioning Group, Blackpool Clinical Commissioning Group and Blackpool Teaching Hospitals are jointly responsible for the achievement of the actions identified within the Strategy. The outcomes to be delivered from this framework are to:-

- Raising awareness of and improving earlier diagnosis to reduce the number of late presentations
- Promoting lifestyle changes to reduce cases of preventable cancers
- Improving survival rates, improve support services for those living with and beyond cancer
- Reducing Variations in care between diagnoses
- Prompt treatment following diagnosis
- Implementing comprehensive holistic care and support for increasing numbers of

patients in recovery

- Improving patient experience of cancer services
- Providing the best possible quality of life, including end of life

5.5 The Steering Group's objective is to work in collaboration with key partners to deliver integrated cancer services that are affordable, sustainable and effective. More specifically, working with partners to improve the 1 year and 5 year cancer survival rates, improve cancer waiting times (2 week, 31 days and 62 day waits), improve quality of life for the Fylde coast cancer patients, promote self-care and management of patients own care and identify and support the design and implementation of innovative cancer services.

5.6 To drive forward the Fylde Coast Cancer Strategy, 6 priority areas have been defined :-

1. Prevention (including awareness and early detection)
2. Investigation
3. Diagnosis
4. Treatment
5. Living With and Beyond Cancer
6. Palliative and End of Life Care

5.7 A number of smaller work streams will underpin the delivery of the strategy, each with detailed action plans for delivery of elemental parts of the plan. Delivery against the aspirations of the plan will be monitored via the Cancer Steering Group for the Fylde Coast.

5.8 Drafts of the strategy have been presented to partner organisations. The strategy has been amended to reflect any feedback received, particularly to place a greater emphasis on prevention. The revisions to the strategy have been discussed and agreed by the Fylde Coast Cancer Steering Group.

5.9 Following final approval of the strategy an action plan to prioritise and implement components of the strategy will be developed by the Steering Group. Any elements of the strategy which represent a large scale change and/or have a significant impact on the Steering Group member organisations or partner organisations in terms of resource or otherwise will be highlighted to relevant organisations, as and when proposals are developed.

5.10 Does the information submitted include any exempt information? No

5.11 **List of Appendices:**

Appendix 7a: Fylde Coast Cancer Strategy

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 An Equality Impact Assessment has been produced for the Fylde Coast Cancer Strategy and issues will continue to be assessed as the strategy is implemented and plans are created.

9.0 Financial considerations:

9.1 Any elements of the strategy which represent a large scale change and/or have a significant impact on the Steering Group member organisations or partner organisations in terms of resource or otherwise will be highlighted to relevant organisations as and when proposals are developed.

10.0 Risk management considerations:

10.1 Once the Fylde Coast Cancer Strategy has been approved, the Steering Group will develop a Cancer Strategy risk register that will identify, analyse, evaluate and control the risks that threaten the delivery of the Strategy. The risks will be reviewed, updated and monitored on an annual basis. Risks will be assessed in terms of proximity and how likely it is that they will occur.

10.2 The potential key risks which have been identified at the outset of the strategy are considered to be both physical (in terms of staffing resource to implement the plan) and financial (in terms of investment required to develop and implement new services).

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 In addition to consulting with partner organisation, engagement activities have been undertaken across the Fylde Coast to engage with the members of the public:

- Patient and Public Involvement Forum (PPI) – Blackpool Clinical Commissioning Group
- Patient Participation Network Group (PPG) – Blackpool Clinical Commissioning Group
- People's Panel - Fylde and Wyre Clinical Commissioning Group
- Patient Participation Groups (PPE) - Fylde and Wyre Clinical Commissioning Group
- Communication and Engagement Team – Drop in session at (Blackpool Teaching Hospitals Trust)

13.0 Background papers and further information:

13.1 The sources of information that informed the strategy are as follows

- Five Year Forward View (NHS England 2014)
- Cancer Survivorship Initiative Vision Document (DoH 2010)
- Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020 (Independent Cancer Taskforce)
- Living with and Beyond Cancer. Taking Action to Improve Outcomes (National Cancer Survivorship Initiative 2013)
- Suspected Cancer: Recognition and Referral
- (NICE guidelines June 2015)
- Joint Strategic Needs Assessment Blackpool

This page is intentionally left blank

NHS

Blackpool Clinical Commissioning Group
Fylde and Wyre Clinical Commissioning Group
Blackpool Teaching Hospitals NHS Foundation Trust

Fylde Coast Strategy for Cancer 2016-2021






Contents

Introduction

The Fylde Coast presents a varied and challenging demographic characterised by an ageing population and a higher than average burden of long term conditions with co-morbidities.

There are areas of extreme deprivation within the Fylde Coast, including the town of Blackpool, which has high levels of unemployment and transience whilst neighbouring Fylde Coast areas have a higher than average elderly population.

Life expectancy in some areas is markedly below the national and North West average with cancer as the second largest cause in reduction of life expectancy.

Approximately 1,000 people in Blackpool and 1030 people in Fylde & Wyre are diagnosed with cancer each year; approximately 500 Blackpool residents and 464 Fylde & Wyre residents die from the disease each year. Over the last 15 years there has been a steady increase in the incidence of cancer across all ages with the most common diagnoses in lung, breast, skin and bowel cancers across the Fylde Coast. With one in 3 diagnoses attributable to alcohol, smoking or obesity.

As diagnosis, treatment and advances in care improve survival rates, the number of people living with and beyond cancer increases. In Blackpool around 3,000 people are already living with a previous diagnosis of cancer.

As people are surviving and living with the consequences of cancer, there is a need to consider this condition as a long term condition. Living with other long-term conditions as well as cancer reduces people's chance of survival and increases their level of support needs.

Whilst outcomes are improving for Cancer, the Fylde Coast still has a number of significant challenges to improve consistency and outcomes for cancer patients and our vision over the next five years is to improve the outcomes for people effected by cancer and therefore the strategy aims to outline the changes required to make a demonstrable improvement in Cancer services, patient outcomes and experiences for the Fylde Coast over the next 5 years. The outcomes to be delivered from this framework are to:-

- Raising awareness of and improving earlier diagnosis to reduce the number of late presentations
- Promoting lifestyle changes to reduce cases of preventable cancers
- Improving survival rates, improve support services for those living with & beyond cancer
- Reducing variations in care between conditions
- Prompt treatment following diagnosis
- Implementing comprehensive holistic care and support for increasing numbers of

patients in recovery

- Improving patient experience of cancer services
- Providing the best possible quality of life, including end of life

Our objective is to work in collaboration with key partners to deliver integrated cancer services that are affordable, sustainable and effective. More specifically, working with partners to improve the 1 year and 5 year cancer survival rates, improve cancer waiting times (2 week, 31 days and 62 day waits),improve quality of life for the Fylde coast cancer patients, promote self-care and management of patients own care and identify and support the design and implementation of innovative cancer services

To drive forward the cancer agenda, 6 priority areas have been defined and include:-

1. Prevention (including awareness and early detection)
2. Investigation
3. Diagnosis
4. Treatment
5. Living With and Beyond Cancer
6. Palliative and End of Life Care (outlined in the Fylde Coast EOL Strategy 2016 - 2021)

A number of smaller work streams will underpin the delivery of the strategy, each with detailed action plans for delivery of elemental parts of the plan. Delivery against the aspirations of the plan will be monitored via the Cancer Steering Group for the Fylde Coast.

Summary

Challenges to Delivering Effective Cancer Care on the Fylde Coast

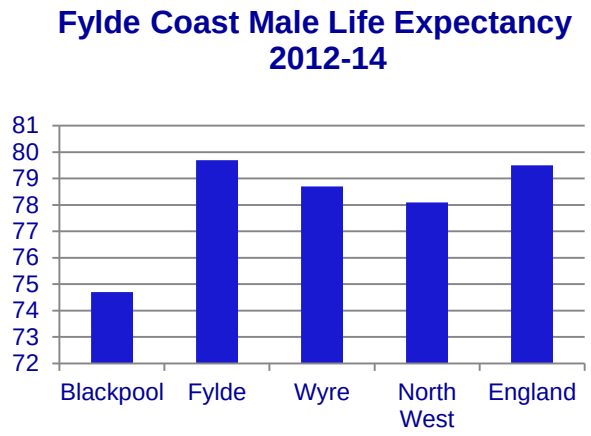
Deprivation

The Fylde Coast has considerable variations in levels of deprivation with some of the highest and lowest rankings in the country. Blackpool experiences considerable levels of disadvantage, and in 2013 ranked 4th most deprived of 354 local authorities in England. 46 out of 94 small areas within Blackpool are amongst the 20% most deprived in the country. There are no areas in Blackpool within the 20% most affluent in the country. Blackpool's relative position in the national deprivation rankings has worsened over the last 5 years from 12th most deprived in 2007 and 4th in 2013. Additionally, in the 2013 Indices, Blackpool ranked 1st for the concentration of deprivation.

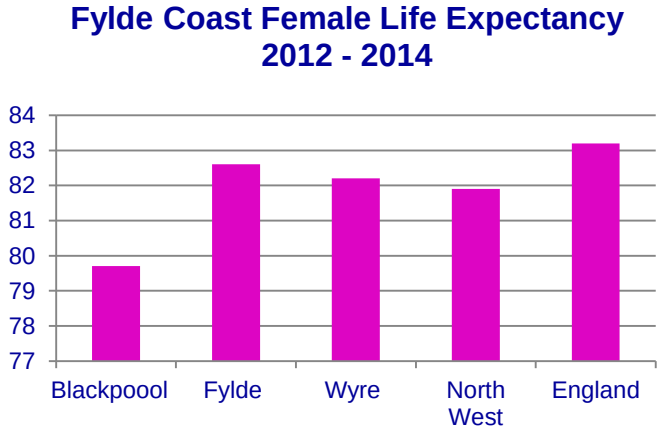
Fylde and Wyre have a more varied picture with both having lower than average deprivation in general but with clusters of wards with high levels of deprivation, which are equally as high as Blackpool. In 2013 Fylde's ranking out of the 354 local authorities was 218th with Wyre's at 167th. An indication of the variation across the area is that Wyre local authority is ranked 61st for the concentration of deprivation whilst Fylde local authority is ranked 191st.

Life Expectancy Fylde Coast

Life expectancy is one of the key indicators of health in a population; in the life expectancy for men in the 2012 – 2014 figures published by the Office for National Statistics[1] Blackpool, at 74.7 years and is the next to the lowest in England and the lowest in the North West. Whilst for Fylde male life expectancy is 79.7 years which is slightly higher than the national (79.5yrs) and Wyre at 78.7 years is still almost a year less than the national average.



Women can expect to live longer than men; however life expectancy for women in Blackpool is 79.6 yrs joint lowest in the North West and over 3 yrs less than the national average. Women in Fylde have a life expectancy of 82.6 yrs and women in Wyre have an expectancy of 81.9 yrs. All the figures for female life expectancy are below the national average of 83.2 years.



Even within local areas there are considerable differences in life expectancy. In Blackpool men in the least deprived areas of the town can expect to live nearly 10 years longer than men in the most deprived areas. Similarly, for women this difference is eight and a half years. Not only do people in Blackpool live shorter lives, but also spend a smaller proportion of their lifespan in good health and without disability.

In Fylde and Wyre analysis of the latest ward level male life expectancy figures (2008-12)[2] indicates that within the Fylde & Wyre area the wards of Central, Jubilee Kirkham South, Mount, Pharos, Rossall and Warren all have life expectancies significantly below the England national average with five of the seven wards listed being in or around the Fleetwood area.

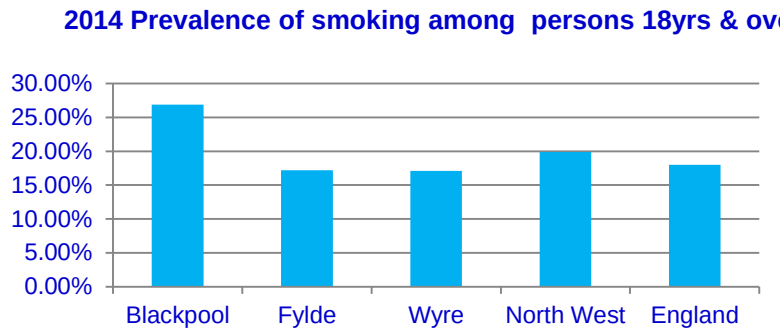
The female life expectancy figures indicate that once again the main areas of concern are around the Fleetwood area with the wards of Bourne, Jubilee, Kirkham South, Medlar-with-Wesham, Mount, Pharos, Rossall and Warren.

There is clear evidence that disadvantaged groups are more likely to have a cluster of unhealthy behaviours – smoking, drinking, low consumption of fruit and vegetables, low levels of physical activity. People in the most disadvantaged groups are significantly more likely to engage in all of these behaviours.

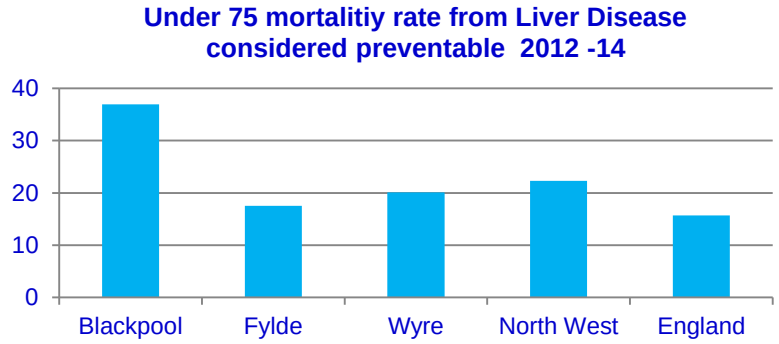
More than 4 in 10 cases of cancer are caused by aspects of our lifestyles which we have the ability to change. Tobacco remains the main risk factor, followed by obesity

1

Smoking is the largest preventable cause of cancer, with an estimated 19% of cancer cases and more than a quarter of cancer deaths in the UK linked to exposure to tobacco smoke. Whilst Fylde and Wyre are just below the 18% national average Blackpool is almost 10% higher.



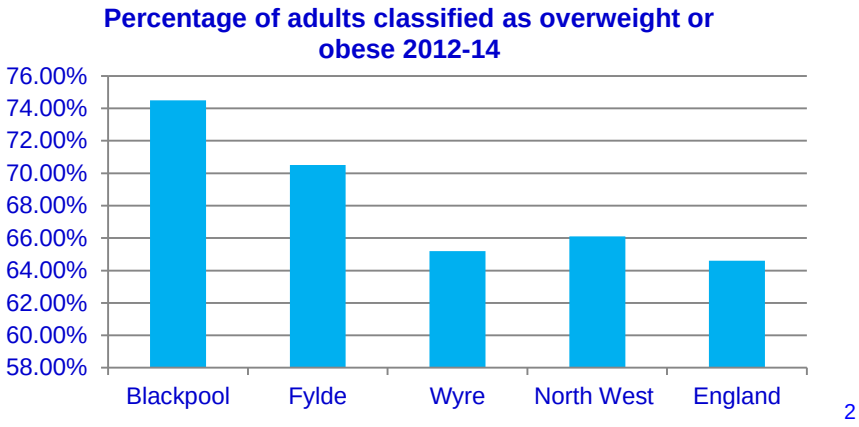
Excessive alcohol consumption leads to around 12,800 UK cases of cancer each year and is linked to several different types of cancer. Alcohol consumption has increased dramatically over the last 50 years, with the Fylde Coast figures below reflecting this picture.



1. 1 Source; Figures calculated by ONS using ONS mortality data and mid-year population estimates 2012-14
2. Source: ONS ward level female life expectancy at birth 2008-2012

Obesity combined with low levels of activity and poor diet constitutes a critical challenge to the Health Economy. England is among the worst performers in obesity in Western Europe [3] .The figure below demonstrates the position across the Fylde Coast communities in relation to the North West and national rates.

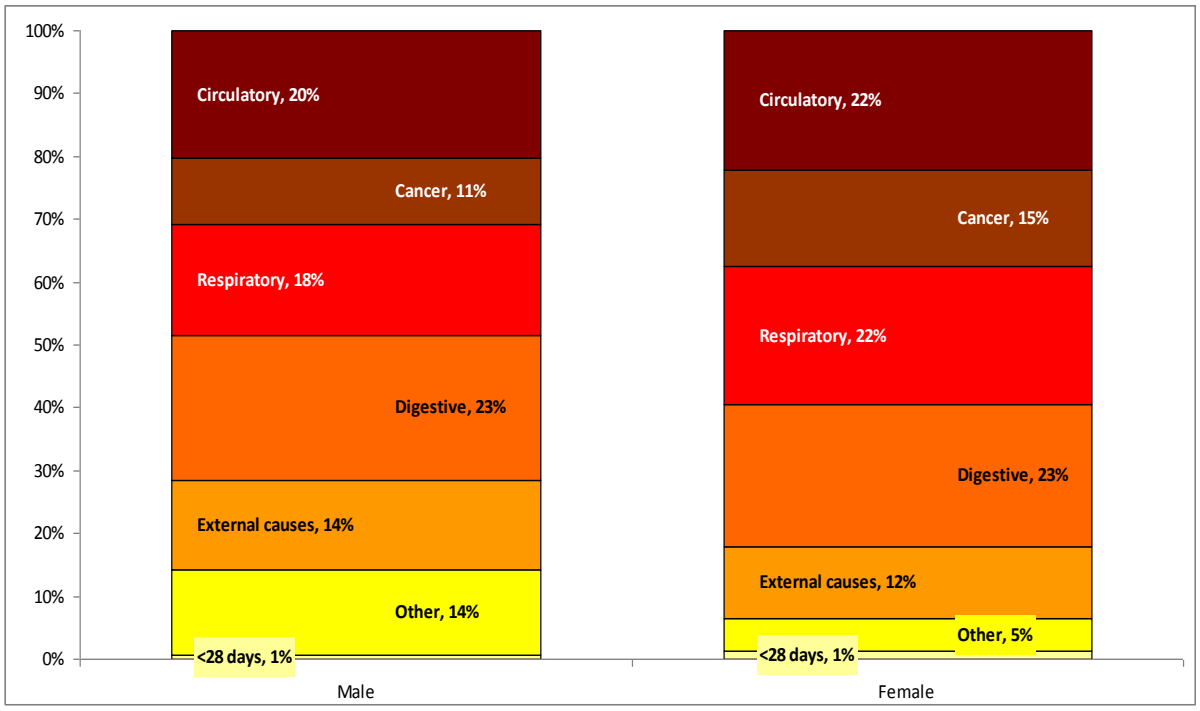
3.



2

Causes of Deaths across Fylde Coast Health Economy

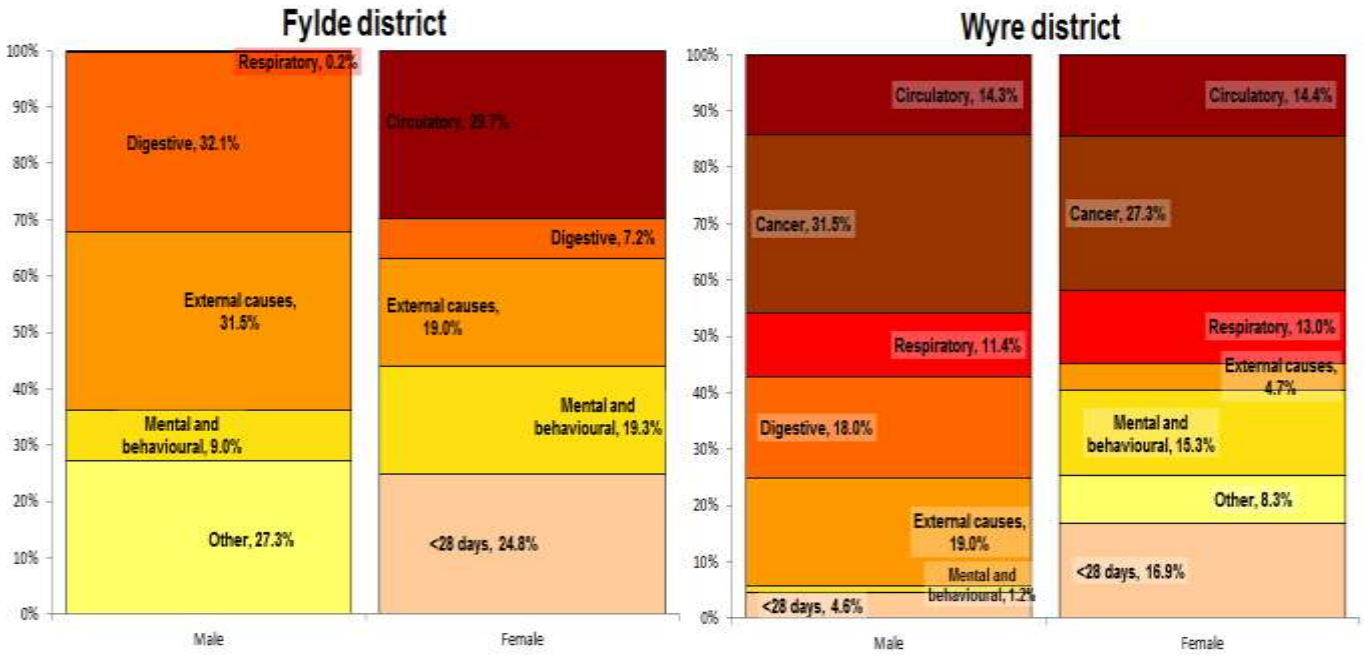
Blackpool



The key causes of shorter life expectancy in Blackpool are alcohol related diseases, circulatory disease, cancers (especially lung cancer), accidents and self-harm and respiratory diseases. Deaths in younger people contribute to a larger proportion of shorter life expectancy, as more years of life are lost. Over the last ten years death rates (for all ages and all causes) have fallen. Early deaths rates have also been falling for the two most common causes of death, circulatory disease and cancer

3. Achieving World –Class Cancer Outcomes A Strategy for England 2015-2020

which jointly make up almost 60% of all deaths. Although this is good news, death rates in Blackpool are higher than average and rates have not been falling as quickly as elsewhere.



Fylde and Wyre

The data demonstrates that the key cause of shorter life expectancy in women in Fylde is circulatory disease whereas in Wyre it is cancer. Shorter life expectancy within the male population, again for the Fylde area, are digestive and external causes whereas in Wyre it is cancer. There is a marked difference between the cause of shorter life expectancy between men and women in Fylde yet in Wyre the percentage rates between men and women in relation to cancer, circulatory disease and respiratory disease are very similar.

4. Source: Public Health England: Segmenting Life Expectancy Gaps by Cause of Death

Part 1 Prevention, Early Detection and Diagnosis

Nationally more than 4 in 10 cases of cancer are caused by aspects of lifestyle that we have the ability to change. Tobacco remains the main risk factor, followed by obesity. We need to continue to raise awareness of the impact that risk factors have on health, especially in selected populations and support people to make changes. Efforts to tackle smoking rates should continue at pace, with the ultimate aim of reaching 5% in adults by 2035. Locally it should be decided through the Health and Wellbeing Boards which combination of initiatives across education, housing, planning and healthcare would deliver the most impact and which should be led through workplace health and wellbeing initiatives.

With increasing numbers of people surviving their primary cancer, there needs to be a stronger focus on preventing secondary cancers, with NHS providers ensuring that all patients treated for cancer are given advice, tailored to their individual circumstances on how to improve their lifestyle and should include healthy eating, weight control, physical activity levels, smoking cessation and alcohol consumption.

There is considerable variation in the uptake of screening programmes resulting in health inequalities. Screening uptake is often lower in BME communities and in communities of lower socio-economic status.

Prevention

Cancer Research UK has highlighted the role of lifestyles in cancer prevention and estimate that 4 in 10 UK cases of cancer could be prevented, largely through lifestyle changes of:

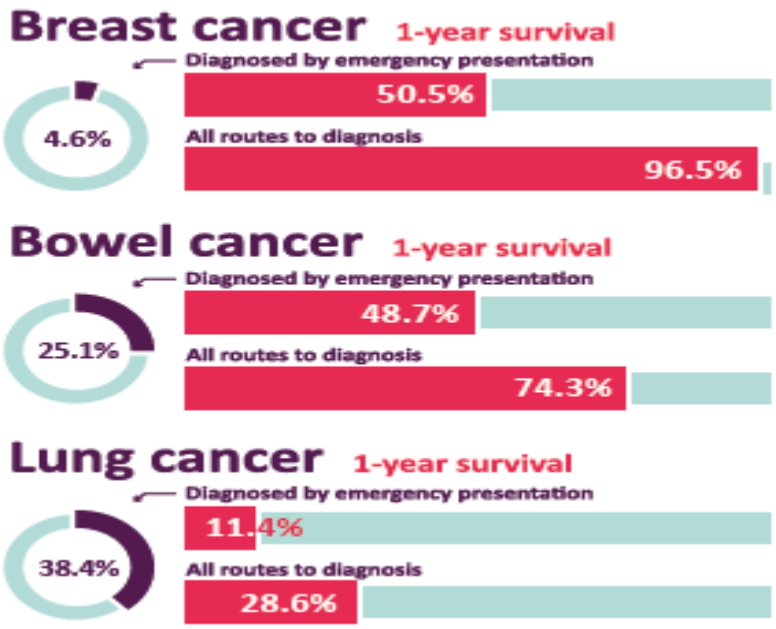
The people of Blackpool, Fylde & Wyre will be supported in making lifestyle changes, and making healthier choices will be promoted. This will be achieved through identifying and using as many opportunities as we can to promote healthier lifestyles and help people to make and sustain lifestyle changes, such as referral to stop smoking services, Health Care Professionals discussing lifestyle choices and risks with patients during NHS Health Checks, promoting physical activity and promoting healthy eating and other health campaigns

Early Detection and Diagnosis

Diagnosing substantially more cancers earlier could be transformative in terms of improving survival, reducing mortality and improving quality of life. Earlier diagnosis makes it more likely that patients will receive treatments such as surgery, chemotherapy and radiotherapy which contribute to the majority of cases where cancer is cured.

Cancer Research UK has estimated that there would be a 0.5% increase in 10-year cancer survival for every 1% increase in the proportion of patients diagnosed at the earliest stages (1 or 2), for all cancers combined.

Cancer survival rates in England are worse than comparable countries and the gap in survival is not narrowing. There are many factors which influence a patient's chances of surviving cancer, not least the treatment they receive.



Even for those cancers where, overall, our stage distribution compares favourably internationally, there is still unacceptable variation within England and no doubt that diagnosis at an earlier stage is associated with better outcomes.

To improve our early detection rates, we need to ensure our population are aware of important symptoms which need urgent investigation to exclude cancer, are aware of national screening programmes to pick up asymptomatic disease, attend for screening, are able to get quick access to diagnostics and results, are referred on efficient pathways and have their cancer risks accurately assessed and are referred appropriately.

Increased Awareness

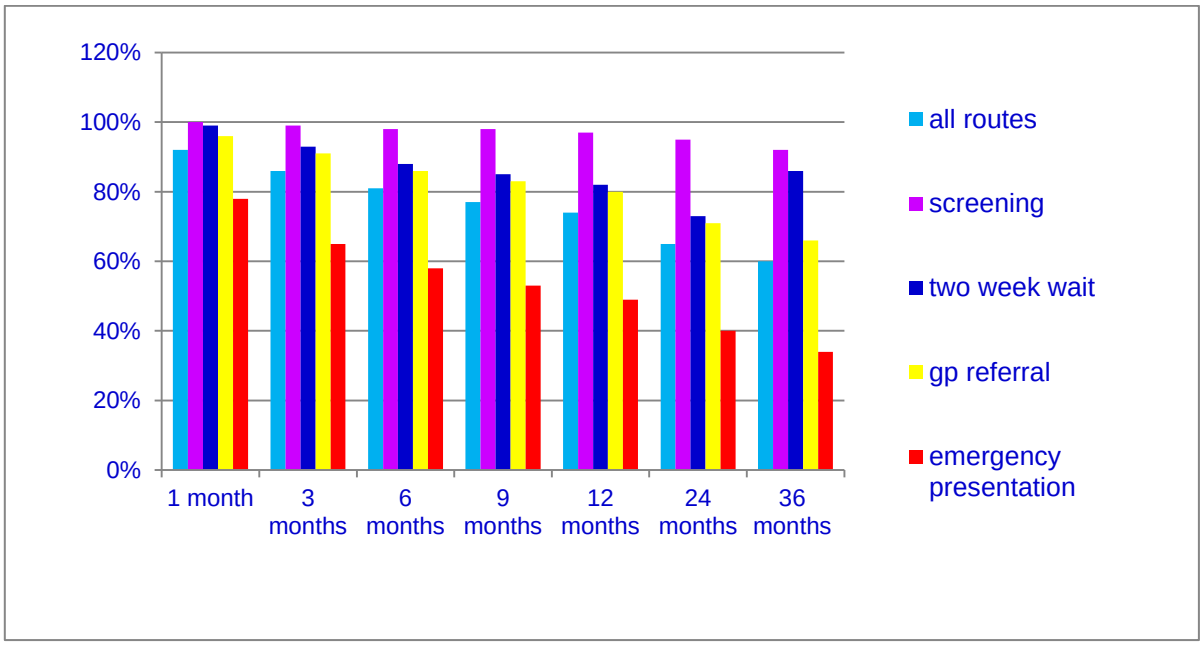
The National Awareness and Early Diagnosis Initiative - NAEDI - is a public sector/third sector partnership. It is led by Cancer Research UK, the Department of Health, NHS England and Public Health England. They work in partnership with other public and voluntary sector organisations to support and drive forward work on early diagnosis. Be Clear on Cancer campaigns aim to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. National Cancer Awareness Campaigns will be supported locally through the use of local media, social media, TV screens in healthcare and other available resources. Local awareness campaigns based on local data, prevalence and needs can be used to raise awareness in the local population.

Tackling late diagnosis is a multifaceted challenge and requires action across the whole pathway from public awareness and encouraging people to see their doctor, to

supporting GPs and other services so that all patients have timely access to tests, specialist advice and treatment.

Screening

There are established National Screening programmes in place for cervical, breast and colorectal cancers. It is well documented that early detection, offers patients the best prognosis. Screening offers the opportunity for earlier detection for some cancers at an earlier stage when treatment can be more effective.

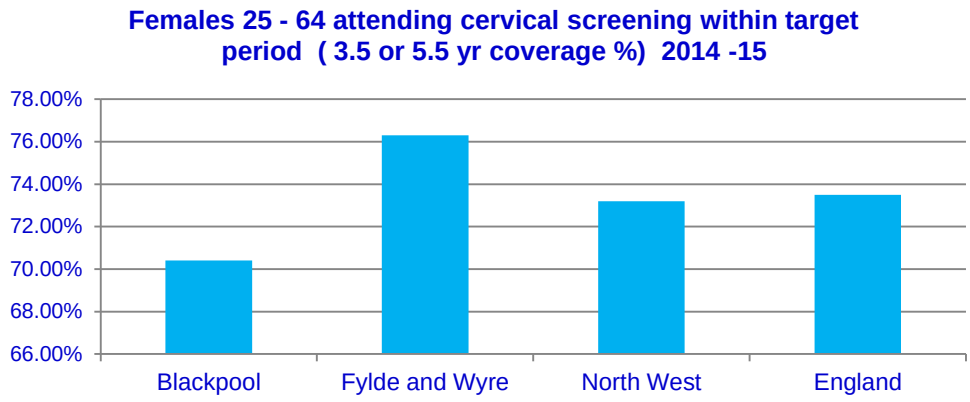


Relative survival estimates by presentation route and survival time for Colorectal Cancer 2006 -2013 **Source NCIN/PHE**

Improving screening uptake rates will require promoting screening programs through all communication channels available, ensuring attending local screening is convenient, identifying barriers to screening uptake and targeting harder to reach groups including people with learning disabilities. GP Practices play a key role in improving screening uptake, and they will be worked with to aid in the promotion of screening and to identify and target harder to reach groups and non-responders.

Cervical Screening

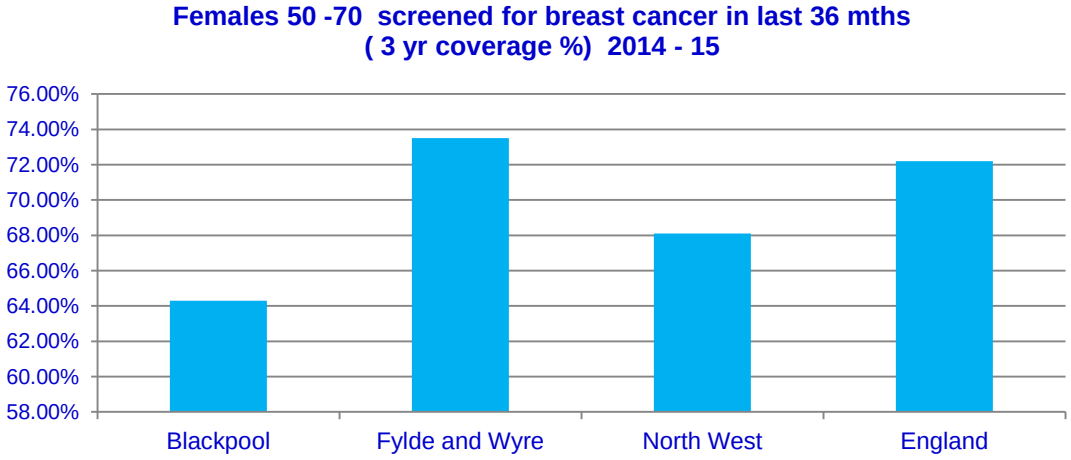
Experts estimate that cervical screening saves around 5,000 lives each year in the UK. The Fylde Coast has wide variations in uptake as can be seen below.



(Source: Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme)

Breast Screening

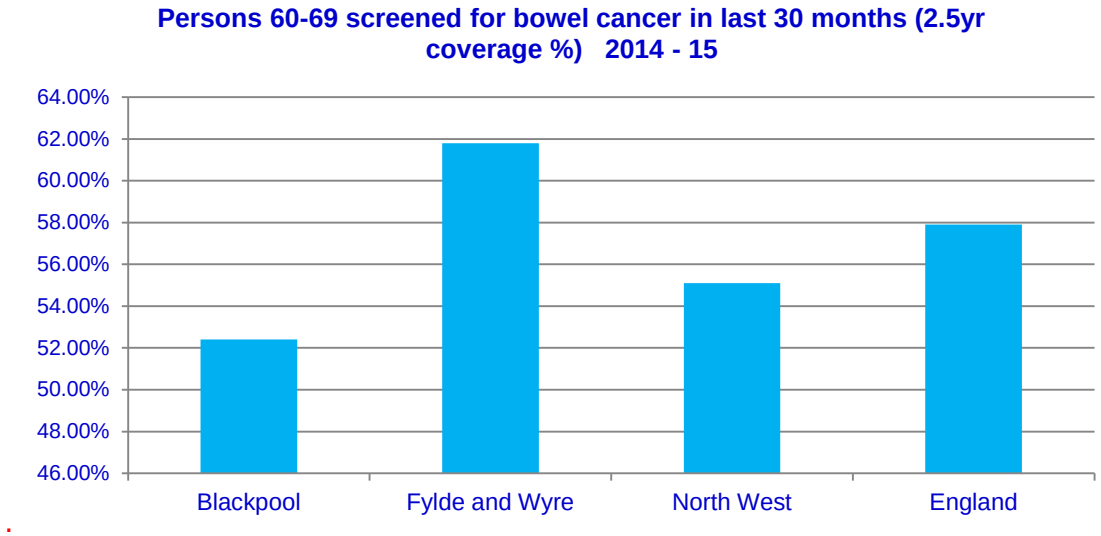
The National breast screening programme invites women aged 50-65 for a mammogram every 3 years. Again the Fylde Coast health economy has a wide variation in uptake between practices with some managing as little as 30%, while other practices manage over 70% uptake. There is a close correlation between the deprivation rates and the uptake level of screening offered.



(Source -Data was extracted from the NHAIS via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme)

Bowel Screening

The NHS Bowel Cancer Screening Programme (BCSP) has been running since 2006. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16% in the population invited Research has shown that for every 190 people screened, bowel scope stops one person from getting bowel cancer, and for every 490 people screened, saves one life from bowel cancer.



Source: Data was extracted from the Bowel Cancer Screening System (BCSS) via the Open Exeter system. Data was collected by the NHS Cancer Screening Programme

Whilst the aspirational target for the uptake of the bowel screening programme is 70% there is clearly much work to do to promote and increase awareness of the benefits of the programme both across the Fylde coast and nationally to achieve this goal.

Routes to Diagnosis and NICE Guidelines

GPs in England see fewer than eight new cancer cases per year on average, but many more patients present with symptoms which could be cancer. GPs are required to evaluate these symptoms and determine whether to refer for an investigative test which might then lead to a definitive diagnosis.

Recently the National Institute for Health and Care Excellence (NICE) reviewed and updated the *'NICE Suspected cancer: recognition and referral guidelines'* in June 2015 and included a number of changes aiming to give GPs more flexibility to refer patients in order to help diagnose cancers earlier;

Lowered symptom thresholds; any sign or symptom that has a three in 100 chance (or more) of being caused by cancer are now included;
For children and young adults, that threshold has been lowered even further;

Guidance organised by signs and symptoms is now available, a format that much better reflects how patients present to primary care;

GPs recommended to refer patients directly for tests, such as CT scans and endoscopies for a number of symptoms. This should support more comprehensive rollout of direct access nationally;

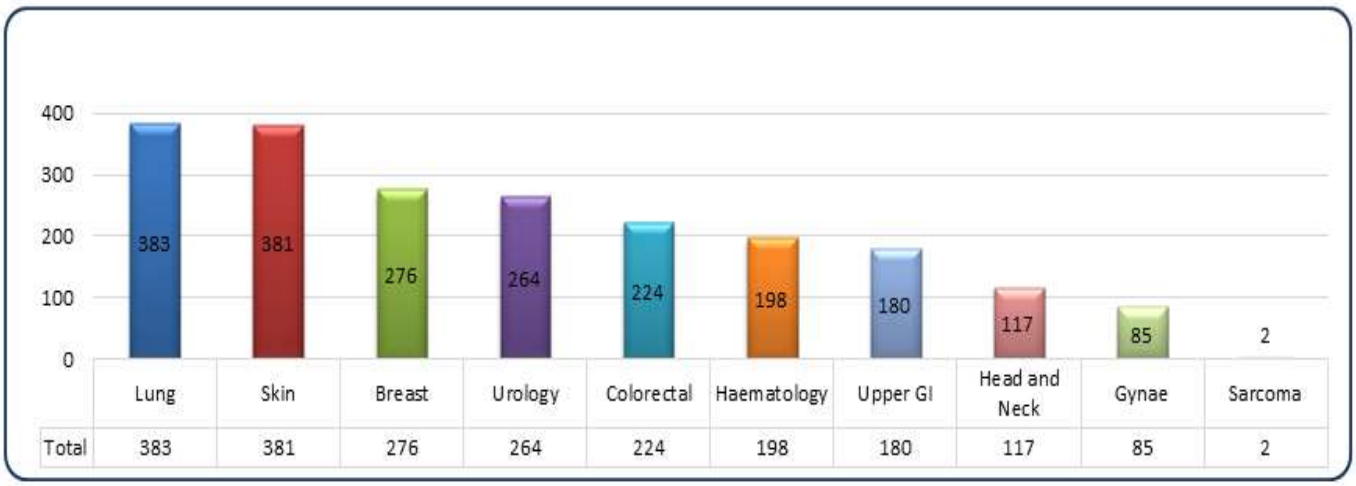
"**Very urgent" referrals now recommended** for some symptoms, where a patient should be seen within 48 hours;

Specific recommendations on 'safety netting' patients who are not displaying/or only vaguely displaying the level of symptoms which may indicate a cancer diagnosis are now given close follow up and monitoring of their symptoms.

The role of GPs in the early diagnosis of cancer is extremely challenging given there are more than 200 different types of cancer and many have vague symptoms. But it is also pivotal in making sure the patient gets on the right pathway at the earliest opportunity.

Blackpool Teaching Hospitals Cancer Patients Treated by Tumour Site

During 2014/15 approximately 2110 cancer patients were treated on the Fylde Coast. The highest tumour sites were both Lung (383) and Skin (381) Cancers closely followed by Breast (276), Urology (264) and Colorectal (224). The remaining tumour sites show Haematology (198), Upper GI (180), Head & Neck (117), Gynaecology (85) and Sarcoma (2).



Part 2 Support for Living with and Beyond Cancer

There are over 2 million people living with cancer in the UK and this is projected to rise to 4 million by 2030. The Fylde Coast had 9,788 people living with cancer in 2010.

There are currently 4,453 patients on the Cancer Disease Register (2013/14), who are registered with Fylde & Wyre CCG – This represents an increase of 4.3% against the previous years' figure of 4,284 persons. During 2013/14 there were 4,280 people on the cancer register living in Blackpool, this is a prevalence rate of 2.5% of the registered population, which is significantly higher than the national prevalence rate of 2.1%. Overall Blackpool has a slightly higher recorded prevalence of cancer compared with the national picture.

Over the last ten years (2003-2012) there have been a total of 12,898 new cancer diagnoses in the Fylde and Wyre districts, an average of 1,290 per year. In Blackpool, there were 694 new cancer diagnoses per 100,000 population in 2012. This is higher than the national average of 599.

It is estimated that the Fylde & Wyre male cancer incidence will increase by 55% between 2007 and 2030, whilst female incidence will increase by 35%. Based on this calculation, female incidence would go from 597 to 776, whilst male incidence would increase from 635 to 826. However, if we add this estimated increase to the 2012 figures, it suggests that in 2030 Fylde and Wyre will see 978 new female diagnoses and 937 new male diagnoses. In Blackpool, at the end of 2010, around 4,700 people in Blackpool were living with and beyond cancer. This could rise to an estimated 9,200 by 2030 (based on current 20 year prevalence and indicative future estimates).

The national Cancer Survivorship Initiative Vision Document (DoH: 2010), identified 5 key shifts to improve survivorship outcomes:-

1. A cultural shift in the approach to care and support for people affected by cancer – to a greater focus on recovery, health and wellbeing after cancer treatment.

2. A shift from a one-size-fits-all approach towards assessment, information provision and personalised care planning based on identification of individual risks, needs and preferences.

3. A shift towards support for self-management. This is a shift from a clinically led approach to follow-up care to supported self-management, based on individual needs and preferences and with the appropriate clinical assessment, support and treatment.

4. A shift from a single model of clinical follow-up to tailored support that enables early recognition of and preparation for the consequences of treatment, as well as early recognition of signs and symptoms of further disease.

5. A shift from an emphasis on measuring clinical activity to a new emphasis on measuring experience and outcomes for cancer survivors through routine use of Patient Recorded Outcome Measures (PROMs) in aftercare services.

Follow up should be risk stratified to individual patient clinical need and priority. Some patients, by the nature of site and complexity of surgery will require Consultant led follow up in the Acute Trust. However, a growing number of patients are prepared and supported to self-manage and these alternative methods of follow up have been widely researched; nurse led telephone follow up being the most popular and most researched method.

In order to unlock the financial and human resources, a dedicated programme of transformational work needs to be prioritised. Adoption of new models of care requires a reallocation of resources across the pathway and including between providers. Currently, in the majority of cases, the Acute Trust(s) maintain ownership of cancer patient follow up and this is typically for five years.

Routine follow up for cancer patients takes up a good deal of service capacity, time and resources and the care is often organised around the needs of the service rather than the patient's needs. Whilst there is a dedicated Macmillan Windmill Unit at Blackpool Teaching Hospitals, which is utilised for non-surgical oncology, haematology and palliative care and new and follow up consultations, there is no additional capacity to meet the increasing number of cancer survivors and thus a

change must be considered. Cancer patients at other points in their journey are frequently seen in often overstretched outpatient clinics and often experience long delays. For some patients, the experience of lengthy waits in busy outpatient clinics can be overwhelming and can actually cause increased anxiety.

The national cancer survivorship initiative (NCSI) have researched and tested new approaches to follow up and these have been tailored to the needs of individual patients using stratified pathways of care:-

1. Self-care with support and open access
2. Shared care between patient and clinician
3. Complex case management through the MDT

The aim of the service redesign is to change the way that patients experience follow up once they have completed curative treatment. The shift, for clinically eligible patients, is from a planned episodic outpatient approach to one where patients are suitably prepared to enter a pathway where they are supported to self-manage their follow up, and able to trigger their return for specialist advice, without recourse to going through their GP.

Key elements for this approach to aftercare in place are:-

Effective remote monitoring of surveillance tests, this is an IT solution which links to and is based within the organisation core IT systems; provides a range of surveillance schedules according to individual patient requirements; can alert to the need for test, and be auditable; can import test/diagnostic results; generates standard letters/treatment summary; is simple safe and secure.

Patient preparation, through: timely discussion with clinical professionals; tailored personalised information; and a self-management education event which enables confident self-monitoring for symptoms and recurrence, managing lifestyle change and goals for recovery and transition to ‘normal’

Clear contact point for issues of concern. Can be through CNS or coordinator support role.

Rapid and easy access back to the appropriate person/service in the pathway without recourse to GP. A clear contract with response times provided.

The overall aim of the approach is to improve key patient outcomes by tailoring aftercare and the embedding of self-management, education and support.

Supported self-management:

An essential and key component of stratified pathways of care is to support patients to self-manage their condition where and when appropriate. Pilots undertaken by NCSI demonstrated that:-

- 70–77% of breast cancer patients can self-manage from two to three months after the end of treatment, or one year after diagnosis.

- 40–45% of colorectal patients can self-manage from four to six months after the end of treatment or stoma reversal.

- 28–44% of prostate cancer patients can self-manage, usually from two years after treatment.

- Some lung cancer patients will be able to self-manage for some periods, but, in general, are not suitable for this pathway

- 90% of testicular cancer patients can self-manage from two months after the end of treatment.

Patients who have previously been diagnosed and treated for cancer are more likely to develop a second cancer or to have a recurrence. It is therefore essential that GPs are particularly alert to symptoms in these patients, and to refer quickly if such symptoms occur. With increasing numbers of people surviving their primary cancer, we need a stronger focus on preventing secondary cancers.

Fylde Coast New Models of Care

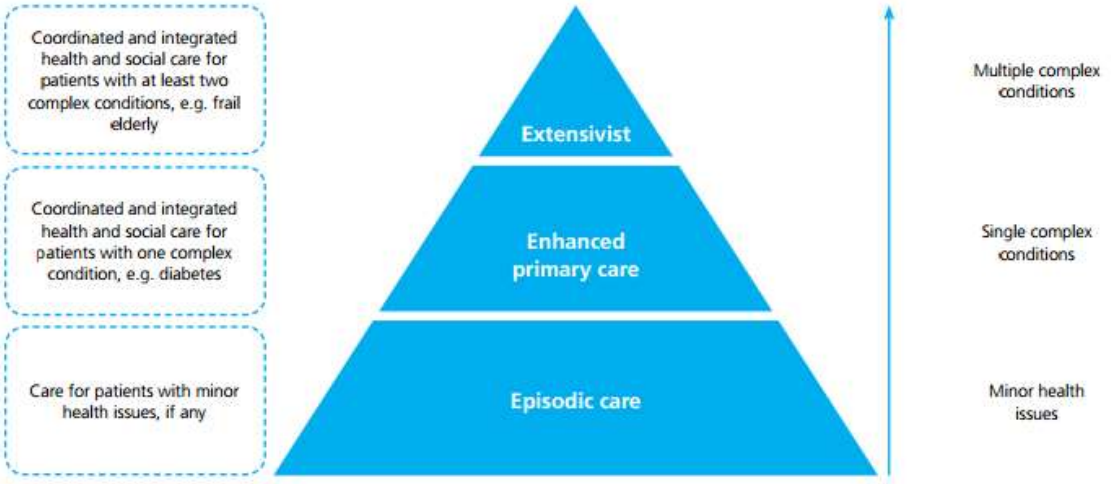
It is clear that fragmentation of care is a reality for patients across many health and social care pathways. Putting the patient at the heart of the re- design of services for cancer (and other long-term conditions) will require a will and determination that must be realised. This principle should be embedded in every aspect of the cancer journey, to ensure that services are responsive to patients' needs. It is estimated that 70% of cancer patients have at least one other long-term condition that needs managing and over a quarter have at least three other such conditions (ACHIEVING WORLD-CLASS CANCER OUTCOMES A STRATEGY FOR ENGLAND 2015-2020 Report).

In Blackpool, Fylde and Wyre cancer patients will benefit from the shift to new ways of working, benefiting from Enhanced Primary Care and Extensive Care services in the future. This will enable cancer patients to benefit from integrated care to meet their needs both in terms of the non-specialist elements of cancer care and a co-ordinated approach to manage co-existing long term conditions for the 70%.

Across the Fylde Coast, time has been spent understanding the challenges that are faced and identifying opportunities to improve the healthcare we commission. To make a difference to the lives of those with long-term conditions, care models have been assessed that exist across the world which focus on the provision of integrated and coordinated care for patients with the highest needs. There are two models – 'extensivist' and 'enhanced primary care' – which have been successful in improving quality, outcomes and patient experience with the use of fewer resources. Work is currently ongoing with local partners, with support from world experts, to design and pilot the models locally. Both models provide specialist, coordinated care and support to two distinct groups of patients:

1. those with multiple complex conditions – 'the sickest of the sick';
2. those with single chronic conditions.

In both models, the care team has holistic responsibility for an individual's care, acting as the coordinating point across the local health and social care system and holding other individuals and organisations to account with respect to their patients. Moreover, all care decisions are taken by the patient and their carers supported by the lead clinician and their team.



To reflect the feedback from our engagement exercise and our strong desire to work with NHS England to co-commission an improved model of primary care access, we are developing a third model called 'episodic care' to support patients with minor health issues. Self-care, community pharmacy, primary care nurses and other similar services will be maximised to free up GP time and expertise to focus on the provision of enhanced primary care, which we consider to be the GP role of the future.

Recovery Package

The recovery package is made up of the following key and integral elements:

- Holistic Needs Assessment (HNA)
- Treatment Summary
- Cancer Care Review
- Education and support event such as a Health & Wellbeing Clinic (HWBC)

Assessment and care planning:-

Conducting Holistic Needs Assessments in partnership with the patient, using appropriate assessment tools, and preparing a subsequent care plan, focusing time and resources on areas where need is greatest.

Developing patient education and support events, such as the Health and Wellbeing Clinic.

Holistic Needs Assessments should take place at or near diagnosis, and at the end of treatment. Further assessments may be required if circumstances change. Holistic Needs Assessments and care planning were included as a Cancer Peer Review measure in April 2011 and are still include in these Quality Measures. Pilots have indicated that conducting a Holistic Needs Assessment (including relevant paperwork) takes about one hour of nursing time. The cost of this proactive care planning will be offset by reduced unplanned contact, as it ensures that patients have appropriate information and a clear management plan.

In summary, holistic needs assessment matters because it:-

- Identifies people who need help

- Provides an opportunity for the person to think through their needs and, together with their healthcare professional, make a plan about how to best meet these.

- Helps people to self-manage their condition

- Helps teams to target support and care efforts and work more efficiently by making appropriate recommendations

The Treatment Summary should include the READ codes that inform the GP IT systems that the patient had cancer, their treatment and whether they are at risk of developing other conditions, such as cardiac disease, osteoporosis and diabetes. The purpose is to inform primary care of actions to be taken, and who to contact with questions. The patient should also receive a copy to improve understanding and share with others if they choose. It is available in an electronic format on the main cancer information systems – Somerset Cancer Registry and Infoflex CIMs Ltd.

The Macmillan Cancer Care Review templates enable GPs to code key areas of care consistently, and also act as an aide memoir for GPs to trigger discussions. There is now a requirement through the Quality Outcome Framework that all patients should have a cancer care review within six months of the GP practice being notified of a cancer diagnosis.

All key professionals and partners involved in the care for cancer patients should be working seamlessly to ensure that all elements of the recovery package are streamlined and used in combination to support patient recovery from cancer. The recovery package can also be used as an enabler to reduce emergency readmissions.

It is important to recognise that the interventions require a timely investment, at least initially. At present, clinicians will often conduct an assessment without discussing it with a patient, so moving to this more structured process will require an adjustment. Staff may need training in assessment and care planning.

Producing a Treatment Summary documenting the care provided, informing the GP and patient about prognosis and planned future care, and highlighting signs and symptoms of recurrence and consequences of treatment.

It will also inform the GP Cancer Care Review and enable the GP database to be kept up to date.

It is aimed at:-

- GPs and primary care professionals
- Patients
- Secondary care clinicians, particularly in A&E and for unplanned emergency admissions.
- Hospices, day centres and care homes.

Part 3 Reducing Inequalities

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have an impact, because they result in certain people experiencing poorer health and shorter lives. The aim of the Strategy is to reduce the difference in mortality and morbidity across these groups to increase quality of life and a sense of wellbeing of the whole local community. A key part of this project, will be working with the local authority on key themes as outlined below.

An action plan has been developed which is rag rated against the national world class cancer outcomes strategy. The key actions are embedded within the strategic action plan which will be monitored through the Fylde Coast Cancer Steering Group.

Prevention

To reduce the incidence of cancers associated with lifestyle factors.

Awareness and Early Diagnosis

To reduce overall cancer mortality through earlier presentation to primary care services.

Screening

To reduce mortality from cancers for which there is an NHS population based screening programme.

Diagnostics/Therapeutic

- Review/audit variation in direct access to diagnostics across geographic areas
- Review patient experience surveys to identify issues around decision making and supporting the development of materials appropriate for different population groups
- Supporting the commissioning of streamlined assessment and treatment pathways across all patient groups

Survivorship

- Promotion of lifestyle messages through all channels, for example, secondary care clinicians, specialist nurses, social care, third sector organisations, smoking and alcohol services

- Develop appropriate patient information and key streams of dissemination through patient sub-groups
- Collaboration between patient sub-group and clinical services to review/audit equity issues across the Fylde Coast and to take the appropriate action

Engagement

Engagement will be undertaken via triangulation of engagement activities with stakeholder organisations:-

- Strategic Clinical Network
- Local authority
- Social Care
- Public Health
- Health and Wellbeing Board
- Primary Care Teams
- Third sector organisations
- Screening providers
- HealthWatch
- Smoking Cessation and Alcohol Services

Part 4 Improving the Cancer Patient Experience

Cancer Services on the Fylde Coast must be responsive to the needs and wishes of the public, many of whom will use its services at some point in their lives. The Health Economy will ensure that public, patient and carer voices are at the centre of cancer services, from planning to delivery. Every level of the strategy and services will be informed by insightful methods of listening to those who use and care about our services.

Patients have a right to have their views taken into account on all issues that affect them. Participation activities will take into account barriers associated with language, age, access to information, disability etc.

To realise this overall vision we have set a series of ambitious aims for cancer services. These aims cover the effectiveness of clinical services, the experience of patients being treated, and the health outcomes achieved. A key aim is to deliver improvements to patient services as a direct result of implementation of the strategy. Patient engagement and feedback is the cornerstone of improvement of existing services and development of new services. The Health Economy will work in partnership with patients in order to:-

- improve patient experience by identifying themes and issues within the national cancer patient survey and act upon these issues
- ensure equitable access to excellent clinical care through integrated pathways across primary, secondary, tertiary, community and third sectors
- provide and develop local services where possible and centralised services where necessary
- to increase the numbers of patients enrolled in clinical trials to improve cancer care for all in our community
- to provide good information, and improve year on year patient and carer experience and quality of life.

The Health Economy approach will focus on working in co-design with patients, families and carers and collaborating to improve outcomes.

In addition to the above, consultation and input from the Patient Participation Subgroup will be invited regarding elements of the 5 year strategy, prior to implementation. Patients will also be consulted and involved in the implementation of elements of the National Cancer NICE Guidance

The CCG will develop a patient engagement plan which will encompass the following principles:-

1. Understand what individual patient participation is already happening locally. What are patients saying about how they are involved in their care? How can individual participation better meet their needs and improve outcomes?

2. Identify the gaps and what more is needed locally to ensure that patients and carers are involved in decisions about their healthcare, for example informed discussions with clinicians and considering how information and support can be targeted to ensure it reaches appropriate audiences, for example support for those who lack capacity.

3. Identify local champions and resources, linking in with local patient groups, voluntary organisations and other partners
.
4. Use the tools and support guides available nationally and online

5. Monitor implementation, and measure the impact of patient participation, for example on service improvement

6. Seek feedback about what is working well and areas for improvement, through commissioner assurance and wider patient engagement.

7. Share learning though local, regional or national networks.

8. The patient's wishes as regard to both treatment and end of life care will be at the core of all cancer management. There will be strives towards strengthening links with end of life care. The Steering Group is accountable for the end to end cancer pathways from prevention, screening, diagnosis and treatment through to survivorship and linking to the Fylde Coast Strategic End of Life Group and Fylde Coast End of Life Strategy and action plan for end of life care. It will monitor progress across the whole of the Cancer Action Plan and all its individual work streams.

9. In addition to the above, the Health Economy will seek to develop new innovative methodologies and technologies for harnessing feedback from a broader range of patients and service users on a continual basis during the lifetime of the strategy

Part 5 Risks to Delivering Our Plans

Introduction

The Health Economy will develop a Cancer Strategy risk register that will identify, analyse, evaluate and control the risks that threaten the delivery of the Strategy. The risks will be reviewed, updated and monitored on an annual basis. Risks will be assessed in terms of proximity and how likely it is that they will occur.

The key risks which have been identified at the outset of the strategy are considered to both physical, in terms of staffing resource to implement the plan and financial, in terms of investment required to develop and implement new services.

Physical Risks

The delivery of the strategy is dependent on engagement and feedback of a wide range of stakeholders. There will need to be a commitment from all stakeholders to deploy the appropriate level of staffing resource to support the implementation of the strategy. However, it is recognised that this commitment may change over the life of the strategy as a result of competing demands and priorities in each of the stakeholder organisations.

Financial Risks

The Health Economy is working in a challenging financial climate and as a result of this, elements of the strategy which require significant investment may need to be deferred and could be dependent upon efficiencies being made elsewhere in the system. The financial plans of the Health Economy are reviewed and adjusted on an annual basis and therefore it is not possible to assess the longer term financial risk to the strategy. The Health Economy will also seek to secure external investment to develop services; again there is a risk that elements of the strategy will need to be deferred if funding is not secured.

Furthermore there may be financial risks at a national level which cannot be identified at the outset of the strategy as they are dependent and linked to Government National Policy.

It is not possible at the outset to identify and then fully implement actions that eliminate or minimise a risk. However, it is essential that the significance of the risk that remains is understood and the Health economy is aware of and accepts the level of risk.

Part 6 Governance & Delivery

Strategic Oversight

The Fylde Coast Cancer Steering Group is accountable for ensuring the delivery of the strategic cancer priorities across the Fylde Coast. These priorities are embedded in the Strategic Cancer Action Plan 2016-2021.

The purpose of the Steering Group is to ensure a collaborative, co-ordinated and consistent approach to cancer care delivery on the Fylde Coast. Its key role is the implementation of the action plan, which ensures that local cancer services are developed to provide optimal care to patients with, or affected by, cancer on the Fylde Coast. The Steering Group is accountable for the end to end cancer pathways from prevention, screening, diagnosis and treatment through to survivorship and linking to end of life care. It will monitor progress across the whole of the Cancer Action Plan and all its individual work streams.

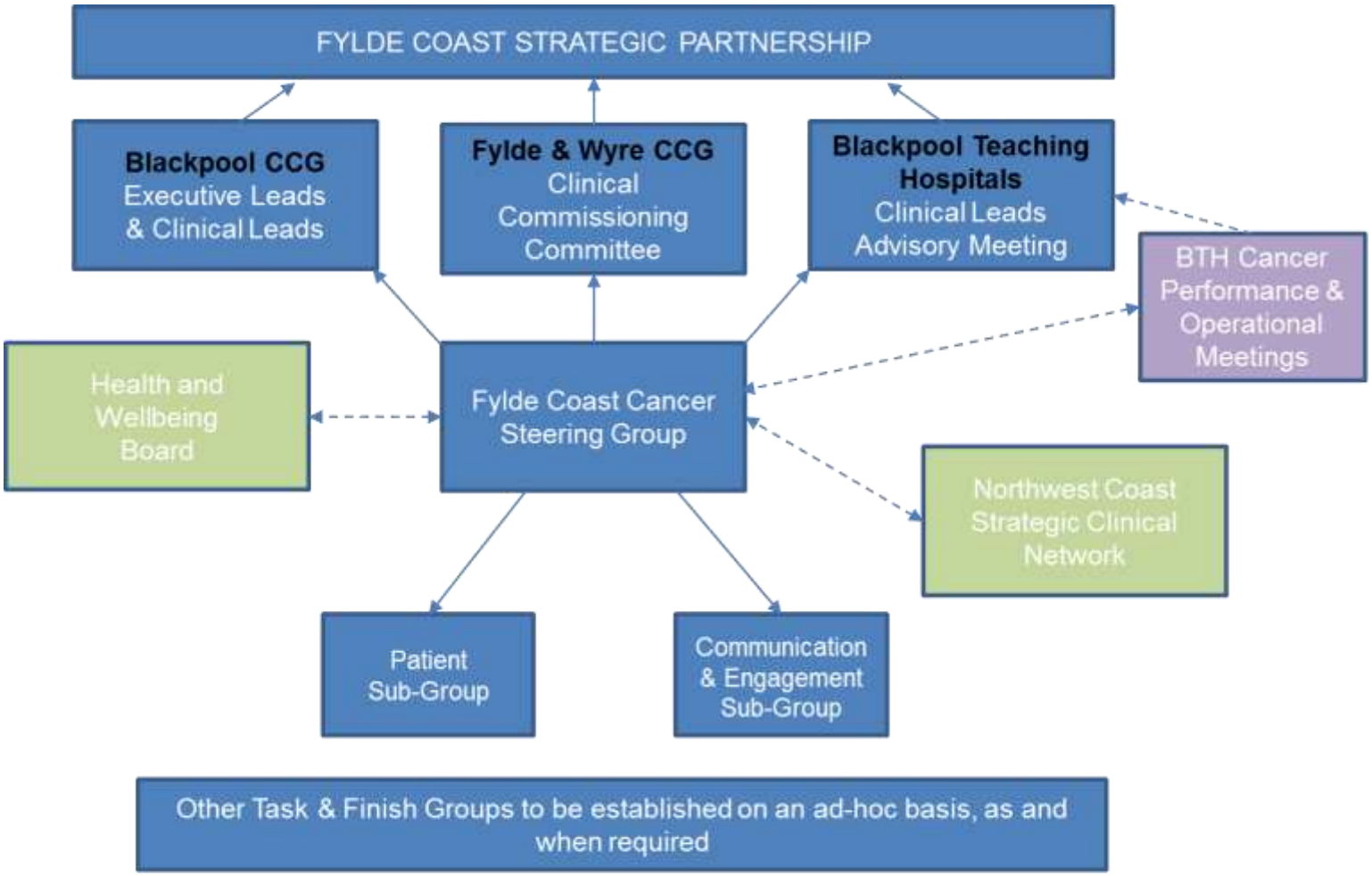
Implementation

The Steering Group is accountable for the delivery of all elements of the action plan through the formation of subgroups across the Fylde Coast to deliver different elements of the plan. The subgroups will have a clear remit, membership and reporting arrangements which will be set by the Steering Group.

These subgroups will report directly into the Steering Group where they will receive updates on the delivery on aspects of the strategy. The Steering Group will continually monitor progress against implementation of the strategy to ensure that the action plan is updated on a regular basis.

The Steering Group is also responsible for ensuring achievement of the national standards and to identify corrective actions/improvements should any performance decline.

FYLDE COAST CANCER GOVERNANCE FRAMEWORK



Clinical Commissioning Groups

NHS Fylde and Wyre Clinical Commissioning Group and Blackpool Clinical Commissioning Group are membership organisations with a combined total of 43 GP practices across the Fylde Coast. Clinical leadership is embedded into the working practice of the CCGs, with each GP Member of the Governing Body having lead responsibility for a particular area of care.

Blackpool Teaching Hospitals NHS FT

The Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was established on 1st December 2007. The Trust then gained teaching hospital status and became Blackpool Teaching Hospitals NHS Foundation Trust in 2010. In April 2012 the Trust

merged with community health services from NHS Blackpool and NHS North Lancashire as part of the Transformation of Patient Pathways Programme.

The Trust now serves a population of approximately 440,000 residents across Blackpool, Fylde, Wyre, Lancashire and South Cumbria and the North of England.

The Trust comprises Blackpool Victoria Hospital which is a large busy acute hospital, two smaller community hospitals (Clifton Hospital and Fleetwood Hospital).

Voluntary Sector

HealthWatch ensures that the public and patients continue to be consulted and influence the development of plans, as referenced in the patient participation engagement of the Strategy.

Across the Fylde Coast, the local Council for Voluntary Services (CVS) hosts a network of 300+ Voluntary Community Faith Sector Organisations who regularly circulate updates, invites to events and questionnaires on behalf of both Blackpool and Fylde & Wyre Clinical Commissioning Groups.

Fylde Coast Governance

The Fylde Coast Cancer Steering Group recognises that in order to meet the scale of the challenges of the strategy, the vision, objectives and implementation must align with partner organisations across the Fylde Coast.

The Fylde Coast Cancer Steering Group is responsible for oversight and delivery of the Cancer Strategy. However, each of the major stakeholder organisations (the CCGs and the Acute Trust) are accountable to their own organisations for providing assurance regarding delivery of the strategy.

Lancashire Wide & Regional Governance

The Fylde Coast Cancer Steering Group has clear links to the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network and will seek advice and support, as appropriate. However the group is not accountable to the Network.

The CCG is not accountable to NHS England in terms of delivery of the Strategy but is assured by NHS England in respect of a number of Cancer outcomes and measures, aspects of which may also be included in the Cancer Strategy.

Health and Wellbeing Board

The Health and Well Being Board is central to the development and implementation of joined up health and social care strategies which will also align to our Cancer Strategy.

Clinical Developments

The development of regional, UK and international evidence base on early diagnosis and treatment of cancer should be integrated into and educate our local service provision. We need to understand the impact on cancer survival in relation to our patterns of treatment (taking into account age, co-morbidities and stage of disease) e.g. lung cancer resection rates and the use of adjuvant chemo and radiotherapy.

Ours services should provide the use of the best clinically appropriate evidence based treatments as indicated by NICE, the Royal Colleges, the national quality indicators for cancer and our NSSGs that are appropriate to our population. These require ongoing review of the best place of care for all tumour sites and use of confederated services when appropriate to our community.

Research & Development

Recognising the importance of Research & Development in cancer care and also the need for this to be multicentre we would encourage an increase in the number of our patients recruited into regional, national and international Research & Development projects.

Annual Self-declaration of Cancer Quality

We intend to optimise the cancer quality surveillance process by the continuation of a robust governance process involving primary, secondary and CCG colleagues in the annual self-declaration.

Equality Delivery System

We use the Equality Delivery System (EDS) to drive improvements, strengthen the accountability of services to those using them and bring about workplaces free from discrimination

Our objectives are to improve access to health care for vulnerable people e.g. ensuring the homeless are able to register with a GP or access the Urgent Care Centre or GP Led Centre. We have also plans to integrate care for improving access to care services with other providers; Council/ Lancashire Care Foundation Trust and social services

Aims of the E & I strategy:-

- Develop better health outcomes for all;
- Develop improved patient access and engagement;
- Develop empowered, engaged and well supported staff, and;
- Develop inclusive leadership at all levels.

This page is intentionally left blank

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Simon Jenner, Principal Educational Psychologist/ SEND Service Manager, Blackpool Council.
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	7 September 2016

SPECIAL EDUCATIONAL NEEDS AND DISABILITY (0-25 YEARS) UPDATE

1.0 Purpose of the report:

1.1 To update the board on the progress of the implementation of the 2014 Children and Families Act across agencies and outline recent developments in the area. Written and verbal reports were previously made to the Health and Wellbeing Board in 2014 and October 2015.

1.2 To update on the new CQC /OFSTED inspection framework for SEND (0-25 year olds and their families) in a local area.

2.0 Recommendation(s):

2.1 To receive a presentation that outlined that current work continues to meet statutory obligations and to prepare for external inspections.

2.2 To agree to continue to have a monitoring report on the implementation of the SEND aspects of the Children and Families Act and the impact of this. This should be on a yearly basis.

3.0 Reasons for recommendation(s):

3.1 Blackpool is continuing to meet its statutory obligations and has been praised by the Department for Education as being one of the few national authorities to meet 100% of new statutory timelines.

Blackpool area needs to be ready for potential inspections. A self evaluation has indicated that there are still some areas that will form part of inspection needing further work.

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

3.3 Other alternative options to be considered:

None. The obligations are laid in statue and the CQC /OFSTED inspection framework is applicable to all local areas nationally.

4.0 Council Priority:

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

5.0 Background Information

5.1 The 2014 Children and Families Act was implemented in September 2104 (the youth offending aspects from April 2015). A national Code of Practice was released, outlining statutory and non statutory duties. There were significant changes for Special Educational Needs and disability, as outlined below, with Blackpool progress noted against the headings. Work streams that met since 2012 continue to meet, on a less regular basis, to review the implementation, including any changes required. These groups are currently being revised in terms of, for instance, avoiding duplication.

- **The approach to identifying Special Educational Needs was changed from service led to person centred**
  Significant training in person centred approaches, across health and education, continues to occur, with trainers trained in the area. The Department for Education Area Advisor, local charities and parent groups have noted how person centred the approach is now within Blackpool. The Council has been asked to share the approach with other local authorities regionally.

- **Statements of SEN have been replaced by Education, Health and Care (EHC) Plans**
  The Council has maintained our 100% record for completing these on time and regional moderation further develops them. Councils have to convert all existing Statements of Special Educational Needs to Education, Health and Care Plans within the next 2 years. Close work with health has ensured this is occurring, and

Blackpool is one of the few regional local authorities to be on track to do so.

- **Approaches have to be outcome focussed and aspiration driven**
  This has been a key ethos change away from the needs driven approaches used previously. Parents have commented how the person centred/ outcome focussed approach has made a big difference. The Council will need to ensure that the ethos change for service delivery is maintained as other pressures (budgetary/ meeting statutory targets) occur.

- **Increase to a 0-25 age range**
  The Act covers to the age of 25, whilst previously it was to the end of schooling. Post school it covers when the young person is in education and/or training. We are further investigating new national data about the number of young people with Special Educational Needs achieving qualifications, that indicate Blackpool students are not doing so well, which contradicts our local data.

- **Personal budgets**
  If there is an Education, Health and Care Plan the young person post 16, or parent, can have access to a personal budget for aspects of this. Blackpool has significant take up of the Care budgets, but none for health or education, so further work is occurring here.

- **Coproduction**
  All strategic and personal plans have to be coproduced with parents and young people. Blackpool has been praised by parents and charities for this, especially for personal plans. Further work is occurring to ensure this continues.

- **Local Offer**
  There is a duty on the local authority to host an offer of all provision available within the area for children and young people with Special Educational Needs and their families. It also acts as a conduit for service users to feed into the joint commissioning process. Following the work to ensure the offer meets all legal obligations, the next stages are to encourage more input via it into joint commissioning and to continue to work with users to ensure it meets their needs.

- **Joint Commissioning**
  This has to occur between the Clinical Commissioning Group and the Council. A strategic operation group was set up and this is being looked at as part of the group structure. The Joint Strategic Needs Assessment, other assessments and service user comment will all feed into this.

- **Early stages of support**
  Work is ongoing to ensure that needs are identified at as early a stage as possible and statistics indicate that this is the case. However there are corresponding increases in needs amongst early years (due for instance to more babies surviving

traumatic births), a rise in the number of cases of autism identified and Blackpool being a net importer of need.

Work has occurred with early year's providers, schools and colleges to improve their identification processes and provision. Further work is occurring to meet the increasing demands on early years and this may need to occur across agencies. It has longer term implications for the service.

5.2 CQC and OFSTED have been charged with inspecting local areas in relation to Special Educational Needs. The initial 8 inspections have occurred. The annual report to the Health and Wellbeing Board represents best practice and Board will be viewed positively by the inspection. This inspection will cover a local area, not just one agency, including strategic leaders, health (adult and children), the council (adult and children services) and providers (schools, colleges, early years settings, care providers for example).

5.3 There has been much work to prepare for the inspection, including a self evaluation framework (across agencies, the Clinical Commissioning Group has also done a national one), setting up a children and young peoples group, an up to date analysis of data (for the first time comparative national data sets have just been published), writing story boards to outline the main areas of work for the inspection (both for the team and for likely to be interviewed), establishing a SharePoint site to store information for the inspection and strategic preparation group called at directorial level. A recent peer challenge event from other North West local authorities also occurred.

5.4 Main areas of success identified are initial multi-agency work, the work around Education, Health and Care Plans, the ethos established locally and involvement of parents in the production of the initials strategies/ processes. Areas still to be worked on include key stage 4 results, re-invigorating joint commissioning and other strategic groups, some aspects of the recent national data which need further investigation, such as post 16 outcomes and co-production across all areas.

5.5 In terms of data for the Board a report is being written to be incorporated into the Joint Strategic Needs Assessment. This is currently being updated with the most recent data and should be available for a Board meeting later in the autumn.

5.6 Does the information submitted include any exempt information?

5.7 **List of Appendices:** No

None

6.0 Legal considerations:

6.1 The statutory obligations under the 2014 Act are monitored and continue to be met. National case study judgments from high courts and first tier tribunals are considered as part of future decision making.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 Under the Equalities Act the needs of those with disabilities are met. Race/ gender / free school meal data is kept to ensure no discrimination occurs.

9.0 Financial considerations:

9.1 The obligations are met within budget and the three new burdens grants from central government to all local authorities (covering the financial years 2014/5, 2015/6 and 2016/7). The Council is yet to hear of a grant for 2017/8, although the Council has been told this is likely, but will be the final year.

10.0 Risk management considerations:

10.1 If the Council fails to meet statutory obligations in terms of the Act the authority and/or health bodies would be at risk from individuals taking legal action and/or central government /CQC / OFSTED taking action.

11.0 Ethical considerations:

11.1 The needs of a vulnerable group within the town continue to be met appropriately.

12.0 Internal/ External Consultation undertaken:

12.1 There is a duty under the Act to co-produce all policies with parents and children/ young people (CYP). Positive feedback has occurred from parent and charity groups to the Department for Education about parental engagement and engagement with children/ young people was seen as not being a major concern on a Department for Education monitoring visit. However, it was been highlighted by internal self evaluation that engagement with children/young people could be better and work is has occurred to ensure this occurs. Further work to ensure that the legal duties to co-produce needs to occur on an ongoing basis. This has been an emphasis for the initial CQC/ OFSTED inspections.

13.0 Background papers:

13.1 None

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Scott Butterfield, Corporate Development and Research Manager
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	7 September 2016

DRAFT FORWARD PLAN

1.0 Purpose of the report:

1.1 To inform the Health and Wellbeing Board members of the draft Forward Plan that has been developed for the Board.

2.0 Recommendation(s):

2.1 That members of the Board consider the draft Forward Plan and advise of any forthcoming initiatives, projects, policy developments and any other agenda items from individual organisations that are of interest to and are the business of the Board.

3.0 Reasons for recommendation(s):

3.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, a draft Forward Plan has been developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to and relevant to the delivery of the Board's 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

4.0 Council Priority:

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

5.0 Background Information

5.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, a draft Forward Plan has been developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to and relevant to the delivery of the Board's priorities. This plan was agreed at the meeting of the Board held on the 15 July 2015 and has been reviewed at all meetings since then and it is intended that it will be reviewed at all future meetings to give the Board oversight of its workplan.

5.2 At the Strategic Commissioning Group away day on 1 July 2015, the link between the Health and Wellbeing Board and Strategic Commissioning Group was discussed. In order to maintain the relationship between the Board and Strategic Commissioning Group, and ensure that there is alignment between the Strategic Commissioning Group's commissioning priorities and the Board's strategic priorities, the draft Forward Plan will be included as a standing item at the Strategic Commissioning Group to enable relevant items from the Strategic Commissioning Group to be added on a regular basis for discussion and ratification.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

Appendix 9a – Draft Forward Plan

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

This page is intentionally left blank

Appendix 9a

(Draft) Health and Wellbeing Board Forward Plan 2016 – 17

BOARD MEETING	BOARD	BUSINESS ITEMS	THEMED DEBATE	DEADLINE FOR REPORTS
Wednesday 19 October 2016 3.00 – 5.00pm	Formal	**BUSINESS ITEMS** 1. Better Start (15mins) 2. Lancs and South Cumbria Change Programme/ Sustainability and Transformation Plan update (15mins) 3. Fylde Coast HWB Partnership (15mins) 4. Public Health Annual Report 2015-16 (15mins) 5. Health Watch Blackpool 2016-17 Priorities Survey (15mins)	**Healthy Weight Strategy update (30mins)**	All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 5 October 2016**

BOARD MEETING	BOARD	BUSINESS ITEMS	THEMED DEBATE	DEADLINE FOR REPORTS
Wednesday 30 November 2016 3.00 – 5.00pm	Formal	**SUB-GROUP UPDATES** 1. Strategic Commissioning Group update (10mins) **BUSINESS ITEMS** 2. CYP Emotional Health and Wellbeing Transformation Plan update (15mins)		All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 16 November 2016**

Future meeting dates:

18 January 2017

1 March 2017

19 April 2017

7 June 2017

19 July 2017

6 September 2017

18 October 2017

29 November 2017