Blackpool Council

8 October 2019

To: Councillors D Coleman, Mrs Henderson MBE, Hobson, Hunter, Hutton, Matthews, O'Hara, D Scott and Mrs Scott

The above members are requested to attend the:

ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE

Wednesday, 16 October 2019 at 6.00 pm
in Committee Room A, Town Hall, Blackpool

A G E N D A

1 DECLARATIONS OF INTEREST

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

(1) the type of interest concerned either a

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

and

(2) the nature of the interest concerned

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

2 MINUTES OF THE LAST MEETING HELD ON 3 JULY 2019 (Pages 1 - 8)

To agree the minutes of the last meeting held on 3 July 2019 as a true and correct record.

3 FORWARD PLAN (Pages 9 - 14)

To consider the content of the Council's Forward Plan, November 2019 – February 2020, relating to the remit of the Committee.

4 PUBLIC SPEAKING

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

5 ADULT SOCIAL CARE FINANCIAL SUSTAINABILITY (Pages 15 - 20)

To provide a detailed overview of funding to Adult Social Care, and any demand pressures, together with how these are predicted and addressed, in order to understand more about position in relation to the financial sustainability of Adult Social Care.

6 MENTAL HEALTH SERVICE PROVISION (Pages 21 - 46)

To provide an update on Lancashire Care Foundation Trust's (LCFT) and partners' progress in making improvement on the actions identified within the Care Quality Commission inspection report, the outcomes of the external review undertaken and the discussions and recommendations made at the special meeting of the Committee on 24 January 2019.

7 DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT (Pages 47 - 98)

To receive the Annual Report of the Director for Public Health.

8 INTEGRATED CARE PARTNERSHIP DEVELOPMENT (Pages 99 - 134)

The purpose of this report is to update the Committee on ICP development activities specifically in relation to:

- The development of the Fylde Coast ICP five year strategy;
- Progress with delivering the improvement/transformation agenda;
- Succession planning.

9 SCRUTINY WORKPLAN (Pages 135 - 156)

To review the work of the Committee, the implementation of recommendations and receive an update on the briefing received on Renal Dialysis Service Reconfiguration.

10 DATE AND TIME OF NEXT MEETING

To note the date and time of the next meeting as Wednesday, 11 December 2019, commencing at 6.00pm.

Venue information:

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

Other information:

For queries regarding this agenda please contact Sharon Davis, Scrutiny Manager, Tel: 01253 477213, e-mail sharon.davis@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 ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE MEETING - WEDNESDAY, 3 JULY 2019

Present:

Councillor Hobson (in the Chair)

Councillors

Baker	Hunter	O'Hara	Wing
D Coleman	Hutton	D Scott	

In Attendance:

Councillor Maxine Callow, Chair, Scrutiny Leadership Board
Councillor Lynn Williams, Cabinet Member for Adult Social Care and Health

Roy Fisher, Chairman, Blackpool Clinical Commissioning Group (BCCG)
Beth Goodman, Head of Acute Commissioning, BCCG
Berenice Groves, Interim Director of Operations for Unscheduled Care, Blackpool Teaching Hospitals NHS Foundation Trust (BTH)
Mark Lewis, Operations Manager, North West Ambulance Service (NWAS)
Les Marshall, Head of Adult Services, Blackpool Council
Peter Murphy, Director of Quality Governance, BTH
Kate Newton, Performance and Quality Manager, BCCG
Maxine Power, Director of Quality, Innovation and Improvement, NWAS
Ian Walmsley, Sector Manager, NWAS
Sharon Davis, Scrutiny Manager, Blackpool Council

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 13 FEBRUARY 2019

The Committee agreed that the minutes of the last meeting held on 13 February 2019 be signed by the Chairman as a true and correct record.

3 PUBLIC SPEAKING

There were no requests from members of the public to speak on this occasion.

4 EXECUTIVE DECISIONS

The Committee considered the Cabinet Member decision taken since the last meeting, PH15/2019 'Adult Services Fees and Charges 2019-20' and invited Councillor Lynn Williams, Cabinet Member for Adult Social Care and Health to outline the key changes to fees and charges made as part of the decision. In response to questioning, it was reported that 50% of people would be unaffected by the increases as they received care free of charge, of those that did pay for services, 22% would be expected to contribute an increased amount.

5 WHOLE SYSTEM TRANSFERS OF CARE SCRUTINY REVIEW

Ms Berenice Groves, Interim Director of Operations for Unscheduled Care, Blackpool Teaching Hospitals NHS Foundation Trust (BTH) and Mr Peter Murphy, Director of Quality Governance, BTH presented the Integrated Care Partnership's response to the recommendations made in the Whole System Transfers of Care Scrutiny Review. Ms Groves highlighted that hospital performance had improved in the winter of 2018/2019 in comparison to previous years citing increases in meeting the four hour standard measure of wait time in the emergency department and a fall in non-admitted breaches.

The Committee considered the response to each recommendation of the review in detail, asking questions regarding implementation and determining whether further information was required or if the recommendation could be signed off as complete.

The Committee agreed:

Recommendation	Action/update	Next steps
One – To consider introducing a policy to limit the number of family and friends attending the emergency department.	A policy had been introduced as per similar policies on the wards. Clinicians were also allowed to use their discretion in implementing the policy dependent on the severity of the illness or injury of the patient.	Completed.
Two – To review extended access appointments to look at usage, the reasons why the service was not more widely used and how to improve the use of appointments.	A review had been undertaken and take-up had been improved, however, there remained unused capacity. Members of the Committee also provided additional anecdotal evidence to suggest that not all GP surgeries offered extended access appointments as a matter of course. Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group highlighted the ongoing work to improve the offer of the appointments including undertaking a mystery shopper exercise. He advised that work was ongoing to ensure practice was embedded.	Completed.
Three – To explore the impact of delayed receipt of prescriptions from the pharmacy on discharges from hospital and identify a course of action to	It was noted that further work was required to roll out identified improvements across all hospital wards. A number of wards had been trialling different approaches and the use of Ward Pharmacy Technicians had proved positive. Members highlighted a number of issues with	Members were of the opinion that further work was required on the recommendation and requested a further response in approximately

address the delays.	dispensing of prescriptions which demonstrated that further improvements were required. It was also noted that the discharge lounge, where patients could wait for prescriptions, had recently started operating seven days per week.	six months.
Four – To identify ways to offer facilitated parking for discharge staff.	It was reported that this recommendation had been the hardest to achieve and that it had been an ongoing issue for a number of years. However, it had now been resolved and Mr Les Marshall, Head of Adult Services reported that staff had been appreciative of the resolution and productivity and efficiency of discharges had improved as a result.	Completed.
Five – To review discharge processes to ensure they are efficient, effective and to identify if any parts of the process could be carried out once a patient had left hospital.	Ms Groves highlighted that a number of pieces of work relating to improving discharge processes were ongoing. It was noted that each piece of work would be tracked with data to determine if it had impacted on performance. It was also noted that there had been a reduction in the length of stay of patients and the impact of the bed reduction pathways which could be shared with the Committee.	Members requested a further update on the impact of the initiatives to improve discharge processes in approximately six months.
Six – To work to improve communication with care homes.	Ms Groves reported that the Executive Director of Unscheduled Care had arranged to meet with the Chair of the Blackpool Care Home Provider Forum. An issue had been identified with care home staff being requested to remain in the emergency department with their resident and work was ongoing to ensure that all emergency department staff recognised that the duty of care for the patient had transferred to the hospital and that care home workers could leave if they needed to return to the care home.	Completed.
Seven – To utilise social media to send out alerts relating to emergency department waiting	The Trust had highlighted a number of issues with the recommendation, most notably suggesting that patients who needed to attend the emergency department being reluctant to do so	Upon further consideration, Members decided to withdraw the recommendation.

time, walk in centre waiting time and available GP appointments on a day.	due to the publicised wait times.	
Eight and Ten – To install signage at an appropriate point to the car park entrance alerting people to current waiting times and to consider how available marketing signage around the town could be used to promote positive NHS messages.	An overview was provided on the various ways in which signage was being utilised and Ms Groves updated the Committee to advise that the Trust was currently looking at putting in place signage at an appropriate point near the car park following discussions with colleagues at Lancaster Royal Infirmary who had implemented a similar action. It was noted that partners were working together and producing a joint communication plan.	Completed.
Nine – To consider offering parking refunds to patients attending accident and emergency inappropriately.	It was reported that consideration was being given to the first 30 minutes of parking being free, in order that patients who had inappropriately attended the emergency department could then leave immediately without facing a parking charge. The Committee suggested that consideration also be given to providing free parking tokens for people picking up patients in order to further speed up their discharge. Furthermore, it was considered that the Trust should also explore the costs of parking for low income families, cost of parking for families of patients who were admitted for a prolonged period and how widely refunds for parking for certain services such as maternity were advertised.	The initial recommendation was agreed as completed. Ms Groves was requested to respond to the additional recommendations in approximately six months.

6 BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST: PATIENT SAFETY

Mr Peter Murphy, Director of Quality Governance, Blackpool Teaching Hospitals NHS Foundation Trust (BTH) highlighted that there were national, ongoing reviews of clinical staffing and it had been recognised that there were not enough doctors and nurses for continuing demand. BTH currently had approximately 260 registered nurse vacancies.

With regards to the Standardised Hospital Mortality Index (SHMI), Mr Murphy reported that the current measure was 116, which was a small increase since the last reported quarter's value of 115 in quarter 2 of 2018/2019. The Committee considered the SHMI in

detail and was informed that the index was calculated using algorithms and being above the average of 100 did not necessarily mean that there was a specific issue, but that the hospital should investigate potential problems. Blackpool Teaching Hospitals NHS Foundation Trust sought to learn from all deaths and had commissioned two external reviews to gain assurance and develop appropriate action plans with a focus on pneumonia, Chronic Obstructive Pulmonary Disease (COPD) and sepsis. The intricacies of responding to subtle symptoms which did not necessarily indicate a serious condition and diagnosing patients correctly was also discussed in detail.

The Chairman highlighted that Blackpool Victoria Hospital had been an outlier for the SHMI since 2011 and queried why the hospital had been performing poorly with regard to the indicator for such an extended period. Mr Murphy advised that work had been ongoing to review deaths and understand the ways in which they had been documented. Once a diagnosis had been made, the patient would be given a code that reflected the diagnosis. Work was ongoing to determine the accuracy of the coding and its reliability. If a patient was coded incorrectly, the recording of any future death could also be recorded incorrectly.

Ms Maxine Power, Director of Quality, Innovation and Improvement, North West Ambulance Service (NWAS) advised the Committee that the SHMI was a complex indicator based on unexpected patient death up to 30 days following original diagnosis, whether the patient had died within the hospital setting or elsewhere. Therefore, a wide range of partners and systems outside of the hospital also contributed to the SHMI performance. It was queried whether data was available to demonstrate the number of patients that died unexpectedly within the hospital in comparison to the number who died after leaving hospital. Mr Murphy agreed to investigate the level of data held and supply the information to the Committee as appropriate.

The Committee went on to consider the Care Quality Commission (CQC) Inspection of the Emergency Department carried out in January 2019 and queried whether all the actions identified by the CQC had been implemented. It was noted that the actions had been implemented and that the Trust had been subject to a fully comprehensive CQC inspection of all services, the outcome of which was expected later this year. Mr Murphy highlighted that the Executive Team of the Trust's primary focus continued to be the quality of care for patients.

The Committee agreed:

1. To receive the CQC inspection report of Blackpool Teaching Hospitals NHS Foundation Trust when published.
2. To request that the data held on the number of unexpected deaths (those that the SHMI was based upon) within the hospital and outside of the hospital following discharge be circulated to Members.

7 BLACKPOOL CLINICAL COMMISSIONING GROUP END OF YEAR PERFORMANCE

Ms Kate Newton, Performance and Quality Manager, Blackpool Clinical Commissioning Group (BCCG) presented the BCCG report on end of year performance for 2018-2019.

The Committee drew attention to the continued poor performance for the percentage of

patients being seen within two weeks of referral for breast cancer symptoms, noting that the target was being substantially underachieved, with a target of 93% and performance of 34%. Ms Newton advised that the deterioration in performance had been attributed to physical capacity constraints in terms of both imaging and clinic space. Members noted that the reason for poor performance had changed and that the last time the Committee had considered the performance for the target the reason for the poor performance then had been cited as a lack of consultant radiographers. Ms Newton advised that the previous issues had been resolved and that a plan was in place to ensure targets were met by the end of July 2019, highlighting that new equipment had been purchased. Further concern was raised regarding the length of time it had taken to resolve the issues and the number of women that had been put at risk as a result and Members were advised that the BCCG was reviewing the situation on a weekly basis and was involved in the process to recover the target as quickly as possible.

Concern was also raised regarding the number of 12 hour trolley waits in the emergency department, noting that there had been 300 in 2018-2019, of these 212 were mental health related. Ms Groves, Interim Director of Operations for Unscheduled Care, Blackpool Teaching Hospitals NHS Foundation Trust (BTH) highlighted that the indicator had been a focus of attention for BTH. The Psynergy pilot scheme had been introduced to alleviate the number of inappropriate mental health attendances at the emergency department and it was hoped the scheme would have a positive impact on the number of mental health patients waiting for more than 12 hours.

Mr Mark Lewis, Operations Manager, North West Ambulance Service (NWAS) advised that the Psynergy vehicle was currently in operation from 4pm until midnight, however, it was hoped the timeframe could be expanded if additional funding could be identified. The pilot commenced in November 2018 and had attended 950 patients. Of those patients, 11% had been transferred to the emergency department, a reduction from the 100% that an ambulance would have transported. The patients transferred to the hospital by the Psynergy vehicle had already received a mental health assessment before attendance at the emergency department, which therefore also speeded up their admission. It was considered that the Psynergy vehicle would have a positive long term impact and NWAS aimed to roll out the scheme to other areas in the North West.

Ms Groves also highlighted that the emergency department regularly coped with 200 attendances per day without any delay, however, on a number of days attendances could be between 230 and 260, which did cause significant delays in the speed in which patients could be seen. The links between discharge of patients and patient flow were highlighted and it was noted that all the measures in place to improve discharge would have a positive impact on emergency department wait time, however, it was recognised that it was unacceptable that any patient should have to wait for more than 12 hours.

The handover time from ambulances to the emergency department was also considered and Ms Maxine Power, Director of Quality, Innovation and Improvement, NWAS highlighted the importance of handover times on improving response times. She highlighted that there was robust monitoring in place to ensure that standards were met. In response to questions, Ms Power advised that there was not a consistent pattern of demand within Blackpool due to surges in peak tourist season and the large number of events that took place.

Members noted the national shortage of doctors and nurses and queried if the ambulance service also struggled to recruit. In response, Mr Ian Walmsley, Sector Manager NWAS reported that there was not currently a shortage, however, the bursary for student paramedics was no longer in place and the impact of its removal upon applications was not yet known. NWAS was working with the NHS to develop a robust workforce plan.

The Chairman highlighted the indicators relating to incomplete pathways and noted that performance had decreased. Ms Beth Goodman, Head of Acute Commissioning, BCCG reported that all partners were working as a system in order to find different solutions to improve performance. She advised that work was ongoing to create a single Fylde Coast waiting list to ensure no patient was disadvantaged by the treatment choice they had made and was confident that the next time the Committee considered the performance of the indicator that improvements would have been made.

The Committee discussed the targets to be met for each indicator, suggesting that all indicators should have a 100% target. Whilst agreeing with the Committee, Ms Newton advised that the indicators had national targets to be met, however, all organisations would agree that they were looking to achieve perfection.

Anecdotal evidence was also provided by a number of Members relating to hospital stays and in particular the comfort of the chairs provided for patients waiting to be seen in the emergency department was raised. Ms Groves agreed to investigate the facilities and set up provided to determine any improvements that could be made.

The Committee went on to consider the updates to recommendations made by Members when the performance of the CCG was last reviewed and discussed the recommendations identified as incomplete in detail. It was noted that the developers of the patient access app had advised that including signposting to extended access appointments was not under the scope of the app at this time. However, the CCG had recognised the value in the Committee's recommendation and would continue to work with the developers to amend the app in the future, when possible. Subject to the CCG retaining the recommendation on its action plan, the Committee agreed the recommendation as completed.

With regards to succession planning, Mr Roy Fisher, Chairman, BCCG reported that the issue was ongoing. A new GP recruitment programme aimed at providing an interesting role to GPs to both recruit and ensure their retention would commence in September 2019. The Integrated Care System was also considering how resources could be shared in order to future proof service provision. It was agreed that a further update on succession planning would be provided to the Committee at the next meeting as part of the report on the Integrated Care Partnership (ICP).

The Committee agreed:

1. That the provision of facilities including the comfort of chairs provided to patients waiting in the emergency department be considered.
2. That BCCG add the inclusion of extended access appointments to the Patient Access App to their action plan.
3. To receive a further update on succession planning to the next meeting of the

Committee as part of the report on the Integrated Care Partnership.

8 SCRUTINY COMMITTEE WORK PROGRAMME

The Committee noted that the workplan would be updated based on the topics identified at the recent workplanning workshop.

The implementation of the previously identified recommendations was discussed and it was agreed that the action relating to the Healthwatch contract could be signed off as complete. It was agreed to defer consideration of the response regarding the 'healthy weight' letters until the next meeting.

The Committee also approved the Healthy Weight Scrutiny Review scoping document and agreed to carry out the review as a whole committee, subject to individual availability in November 2019.

9 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday 16 July 2019, commencing at 6.00pm.

Chairman

(The meeting ended at 8.00 pm)

Any queries regarding these minutes, please contact:
Sharon Davis, Scrutiny Manager
Tel: 01253 477213
E-mail: sharon.davis@blackpool.gov.uk

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mrs Sharon Davis, Scrutiny Manager.
Date of Meeting	16 October 2019

FORWARD PLAN

1.0 Purpose of the report:

1.1 To consider the content of the Council's Forward Plan, November 2019 – February 2020, relating to the remit of the Committee.

2.0 Recommendations:

2.1 Members will have the opportunity to question the relevant Cabinet Member in relation to items contained within the Forward Plan within the portfolio.

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

3.0 Reasons for recommendations:

3.1 To enable the opportunity for pre-decision scrutiny of the Forward Plan items.

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

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

- Communities: Creating stronger communities and increasing resilience.

5.0 Background Information

5.1 The Forward Plan is prepared by the Leader of the Council to cover a period of four months and has effect from the first working day of any month. It is updated on a monthly basis and subsequent plans cover a period beginning with the first working day of the second month covered in the preceding plan.

5.2 The Forward Plan contains matters which the Leader has reason to believe will be subject of a key decision to be taken either by the Executive, a Committee of the Executive, individual Cabinet Members, or Officers.

5.3 Attached at Appendix 3(a) is a list of items contained in the current Forward Plan. Further details appertaining to each item contained in the Forward Plan has previously been forwarded to all members separately.

6.0 Witnesses/representatives

6.1 The following Cabinet Members are responsible for the Forward Plan items in this report and have been invited to attend the meeting:

- Councillor Lynn Williams (Cabinet Member for Adult Social Care and Health).

Does the information submitted include any exempt information? No

List of Appendices:
Appendix 3(a) – Summary of items contained within Forward Plan.

7.0 Legal considerations:

7.1 None.

8.0 Human Resources considerations:

8.1 None.

9.0 Equalities considerations:

9.1 None.

10.0 Financial considerations:

10.1 None.

11.0 Risk management considerations:

11.1 None.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/ External Consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.

This page is intentionally left blank

EXECUTIVE FORWARD PLAN - SUMMARY OF KEY DECISIONS

(NOVEMBER 2019 TO FEBRUARY 2020)

*** Denotes New Item**

Anticipated Date of Decision	Matter for Decision	Decision Reference	Decision Taker	Relevant Cabinet Member
January 2020	To agree the 2019/2022 Alcohol Strategy	22/2019	Executive	Cllr Williams
January 2020	To agree the 2019/2022 Drug Strategy	23/2019	Executive	Cllr Williams
*November 2019	Learning Disability and Autism Short Breaks Service	26/2019	Executive	Cllr Williams

This page is intentionally left blank

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Karen Smith, Director of Adult Services
Date of Meeting:	16 October 2019

FINANCIAL SUSTAINABILITY OF ADULT SOCIAL CARE

1.0 Purpose of the report:

1.1 To provide a detailed overview of funding to Adult Social Care, and any demand pressures, together with how these are predicted and addressed, in order to understand more about position in relation to the financial sustainability of Adult Social Care.

2.0 Recommendation(s):

2.1 Members are asked to note the contents of this report and to identify what, if any areas require further exploration by Scrutiny.

3.0 Reasons for recommendation(s):

3.1 To facilitate appropriate Scrutiny overview of the financial consequences of meeting the needs of adults with Social Care needs in Blackpool, and how well these are being resourced.

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

Is the recommendation in accordance with the Council's approved budget? Yes

4.0 Other alternative options to be considered:

4.1 Not applicable

5.0 Council priority:

5.1 The relevant Council priority is both:

- The economy: Maximising growth and opportunity across Blackpool.
- Communities: Creating stronger communities and increasing resilience.

6.0 Background information

6.1 The budget for Adult Social Services comprises a mix of core budget, supplemented by a range of temporary additional funding, announced at various points over the last few years, designed to shore up spend in an area of nationally-acknowledged demand growth, and taking into account knock on impacts to the NHS relating to keeping people out of hospitals, helping them get home from hospital as soon as practicable, and keeping people well-supported at home. In addition, some areas are funded from one-off savings from previous years.

6.2 In 2019/2020 the net budget for Adult Social Services is £54.5million, supplemented by £1.5m of additional funding via the improved Better Care Fund (iBCF) and the budget is largely in balance. The Better Care Fund is a joint Health and Social Care budget under a formal Section 75 agreement that funds a range of health and social care services – primarily those around keeping people out of hospital and Transforming Care. Temporary sources of funding have included the Adult Social Care precept, Winter Pressures funding, and Adult Social Care Grant. However, policy announcements indicate the intention to maintain these at current levels, although the Adult Social Care Grant has been non ringfenced from adults and is now used to support the pressures in Children's Social Care.

6.3 Adult Social Services has, over the last several years consistently achieved a balanced outturn budget year on year, but with demand pressures building, and some sources of funding due to end, there is a future pressure if maintain services are to be maintained at the same level.

Nationally, the policy direction under the NHS Long Term Plan is to have integrated Health and Social Care Services, and using the mechanism of the Healthier Lancashire and South Cumbria Integrated Care System (ICS) and locally the Fylde Coast Integrated Care Partnership (ICP), the Council has been working with Health partners to identify which areas will require additional investment or a transfer of funds from elsewhere in the system in order to maintain service.

6.4 Demand is increasing in most, if not all areas. This is in no small part due to successes in achieving improved performance in both helping people out of hospital quickly and preventing them going in at all, including all of our joint work with health colleagues both in the Acute Hospital and in the Neighbourhoods. In nearly all areas, improved performance results in additional cost to Adult Social Services. Unfortunately, the national policy intentions to transfer funds across the system from Health to Adult Social Care to compensate for this have not become a reality, as demand pressures within the Health system are absorbing the resources freed up. For example, as Delayed Transfers of Care (DTOCs) have reduced, Home Care hours have increased by 1,000 hours per week, representing an additional cost to Blackpool Council of £750k per annum. Nevertheless, this is not saving money in the Health system that can be transferred, as rising demand and average Lengths of Stay not reducing

significantly mean the resources are unable to be freed up to transfer.

6.5 The main areas of additional investment for have been as follows –

1. Supporting a fee level to independent care at home and residential care providers that enables them to meet the statutory Living Wage uplifts as well as increases in general running costs.
2. Additional Social Workers in all areas of the system, including in A and E, the Hospital Discharge team and the GP Neighbourhoods to ensure that assessments and reviews are always timely, and the needs of people with Learning Disability and Autism as part of Transforming Care are well-met
3. Additional Care at Home staff in the in house service to pick up rapid response, crisis demand and a lack of capacity in the contracted external care at home services.
4. Additional care at home hours in the contracted external care at home services.
5. Additional Vitaline units to get people home quickly and provide oversight via technology with help available at the press of a button.

6.6 Demand shifts and spend patterns are monitored closely by both the finance team and the operational teams using the Joint Strategic Needs Assessment to consider demographic pressures, and trends over time with regard to demand patterns and spend against budget. At the present time, demand pressures are starting to outstrip the increases in available budget and work is underway with Health partners to work through what action is needed in relation to managing this from 2020/21.

6.7 Work has also been undertaken in some areas where more efficient working can lead to better services for our residents, whilst at the same time reducing spend.

Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 5(a): Adult Services Revenue summary – budget, actual, and forecast

8.0 Legal considerations:

8.1 Services provided by the Council in Adult Social Services must be compliant with the requirements of CQC registration for care providers and with The Care Act 2015 and associated legislation for assessment, Social Work, and meeting people's needs.

9.0 Human resources considerations:

9.1 The majority of spend in Adult Social Services is directly or indirectly related to staffing.

10.0 Equalities considerations:

10.1 Adult Social Services provides for meeting the eligible needs of some of our most vulnerable residents, many sharing one or more protected characteristics. In addition, the care industry working population is significantly female, and in independent provision, is typically a National Living Wage-level provision.

11.0 Financial considerations:

11.1 Adults Social Services is a complex financial area for both income and spend. The department operates to a comprehensive Medium Term Financial Sustainability Strategy that supports the Council's overall Medium Term Financial Plan.

12.0 Risk management considerations:

12.1 The consequences of having insufficient resources to meet demand are a mix of longer waiting times, bottlenecks in all area of the health and care system, deteriorating conditions requiring greater levels of care down the line, and blocking of hospital beds.

13.0 Ethical considerations:

13.1 The Council is committed to supporting Adult Social Services to the extent that it is financially able, and to working in collaborative partnership with Health and other colleagues.

14.0 Internal/external consultation undertaken:

14.1 n/a

15.0 Background papers:

15.1 None.

Blackpool Council - Adult Services

Revenue summary - budget, actual and forecast:

FUNCTIONS OF THE SERVICE	BUDGET	EXPENDITURE			VARIANCE	
	2019/20					2018/19
	ADJUSTED CASH LIMITED BUDGET	EXPENDITURE APR - JUL	PROJECTED SPEND	FORECAST OUTTURN	F/CAST FULL YEAR VAR. (UNDER) / OVER	(UNDER)/OVER SPEND B/FWD
	£000	£000	£000	£000	£000	£000
ADULT SERVICES						
NET EXPENDITURE						
ADULT SOCIAL CARE	6,187	2,380	3,774	6,154	(33)	-
CARE & SUPPORT	5,241	3,169	2,089	5,258	17	-
COMMISSIONING & CONTRACTS TEAM	41	104	(63)	41	-	-
ADULT COMMISSIONING PLACEMENTS	42,337	9,648	32,956	42,604	267	-
ADULT SAFEGUARDING	719	69	636	705	(14)	-
TOTALS	**54,525**	**15,370**	**39,392**	**54,762**	**237**	**-**

Commentary on the key issues:

Directorate Summary – basis

The Revenue summary (above) lists the latest outturn projection for each individual service within the Adult Services Directorate against their respective, currently approved, revenue budget. Forecast outturns are based upon actual financial performance for the first 4 months of 2019/20 together with predictions of performance, anticipated pressures and efficiencies in the remainder of the financial year, all of which have been agreed with each head of service.

Adult Commissioning Placements (Social Care Packages)

The Adult Commissioning Placements budget is forecasting a £267k overspend on £60m gross expenditure budget. There is expected to be an overspend on both complex cases and care at home placements, partly offset by the demographics budget and increased non-residential income.

Adult Social Care

Adult Social Care is currently forecast to be £33k underspent due to vacant posts within the service.

Summary of the Adult Services financial position

As at the end of July 2019 the Adult Services Directorate is forecasting an overall overspend of £237k for the financial year to March 2020 on a gross budget of £82m.

Budget Holder – K Smith, Director of Adult Services

This page is intentionally left blank

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Caroline Donovan, Chief Executive, LCFT
Date of Meeting:	16 October 2019

MENTAL HEALTH SERVICE PROVISION

1.0 Purpose of the report:

1.1 To provide an update on Lancashire Care Foundation Trust's (LCFT) and partners' progress in making improvement on the actions identified within the Care Quality Commission inspection report, the outcomes of the external review undertaken and the discussions and recommendations made at the special meeting of the Committee on 24 January 2019.

2.0 Recommendation:

2.1 To scrutinise the update provided by Lancashire Care Foundation Trust, identifying any areas of concern, improvements required or recommendations that Members might wish to make.

2.2 To seek an update on the implementation of the recommendations identified by the Committee at the special meeting on 24 January 2019. (Highlighted in paragraph 6.4 of the report)

3.0 Reasons for recommendation:

3.1 To ensure the Committee is satisfied with the improvement being made to mental health services.

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

4.0 Other alternative options to be considered:

4.1 None.

5.0 Council priority:

5.1 The relevant Council priority is:

- Communities: Creating stronger communities and increasing resilience.

6.0 Background information

6.1 At the Adult Social Care and Health Scrutiny Committee meeting held on 10 October 2018, Members raised a number of concerns which are summarised below:

- The citing of staffing issues as a reason for poor performance, Members highlighted that huge risks were being taken with patients in life or death situations.
- That a number of the 'must do' actions from the CQC inspection were basics of care that should not fail to be undertaken by the Trust.
- That the response provided by Blackpool Clinical Commissioning Group did not give sufficient assurance that the situation would be monitored with steps taken, where required, to address failures.
- GPs were frustrated that patients were not receiving the treatment that their GP would like to see them have. Key concerns included the lack of a crisis team at Accident and Emergency to enable a quick decision on whether a patient needed admitting.
- That there were a number of very vulnerable people in Blackpool who required an immediate intervention and raised concerns that the only proposals being made were for long term solutions.
- Key officials from LCFT had not been attending meetings with partners despite confirming attendance.
- Emails sent requesting information and liaison from senior Council staff to LCFT representatives had not been answered.
- The issues relating to poor communication had been ongoing for over 12 months and were not one-offs.
- Discussion had been held at the Health and Wellbeing Board relating to the basic action plan that had been provided to address concerns with no detail of how improvements would be achieved or when.
- Anecdotal evidence had been received relating to poor patient management, including lack of communication with a suicidal patient regarding their discharge.
- The issues with staffing would not be rectified without addressing the culture of the organisation, accepting failures and improving staff morale.
- The speed in which LCFT was addressing the actions contained within the CQC report.

6.2 The Committee resolved that a written response be provided within 21 days to the key concerns raised by the Committee and that a special meeting be established in January 2019 to consider the progress made by the Trust in addressing the 22 'must do' and 'should do' actions contained within the CQC report.

6.3 The response letter was provided to the Chairman within 21 days as requested and was subsequently circulated to all Members of the Committee.

6.4 The special meeting of the Committee was held on 24 January 2019 and was attended by the Executive Team from LCFT. The minutes of that meeting have been included at Appendix 6(b) for information. The recommendations made at the meeting were as follows:

1. That LCFT be requested to identify all voluntary and community mental health support groups in Blackpool and arrange to meet with them quarterly to ensure the views of service users were truly reflected and understood.
2. That LCFT consider setting all targets for completion of mandatory training, completion of appraisals etc at 90% with a view to incrementally increasing the target to 100%.
3. That all representatives be requested to attend a further meeting of the Committee in approximately six months to further update on progress made and to:
   - Provide feedback on the implementation of the Committee's recommendations.
   - To provide evidence of the work undertaken to reduce the number of four and 12 hour delays at Accident and Emergency and the impact of that work.
   - To report on the outcomes of the external review and action taken to implement the actions.

6.5 Representatives from LCFT will be in attendance to speak to the report provided in Appendix 6(a) and to answer any questions from Members. Representatives from the Integrated Care Partnership will also be in attendance for this report.

Other representatives from a range of partners have also been invited to the meeting to provide additional information.

Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 6(a) Report provided by LCFT
Appendix 6(b) Minutes of the special meeting of the Committee on 24 January 2019

8.0 Legal considerations:

8.1 Contained within the appendix.

9.0 Human resources considerations:

9.1 Contained within the appendix.

10.0 Equalities considerations:

10.1 Contained within the appendix.

11.0 Financial considerations:

11.1 Contained within the appendix.

12.0 Risk management considerations:

12.1 Contained within the appendix.

13.0 Ethical considerations:

13.1 Contained within the appendix.

14.0 Internal/external consultation undertaken:

14.1 Contained within the appendix.

15.0 Background papers:

15.1 None.

Appendix 6(a)

Lancashire & South Cumbria NHS Foundation Trust

Mental Health Service Provision Briefing Report

Prepared for:
Adult Social Care and Health Scrutiny Committee
Wednesday 16 October 2019

1.0 Introduction

The Lancashire & South Cumbria NHS Foundation Trust Executive Team attended the Adult Social Care and Health Scrutiny Committee in January 2019 to discuss a number of issues that were of concern to the Committee. This report is to update the Committee on progress made since January 2019, specifically in relation to the recommendations regarding Mental Health Services in Blackpool.

It is important to note that since the last Committee, a new CEO has been appointed to take forward the improvements required for the Trust. In order to support and enhance this, the new CEO has made some senior appointments, including an interim Director of Operations from Northumberland Tyne & Wear (NTW), Director of Nursing & Quality, and a Director of Improvement & Compliance. Further appointments are in recruitment.

2.0 Mental Health System Challenges

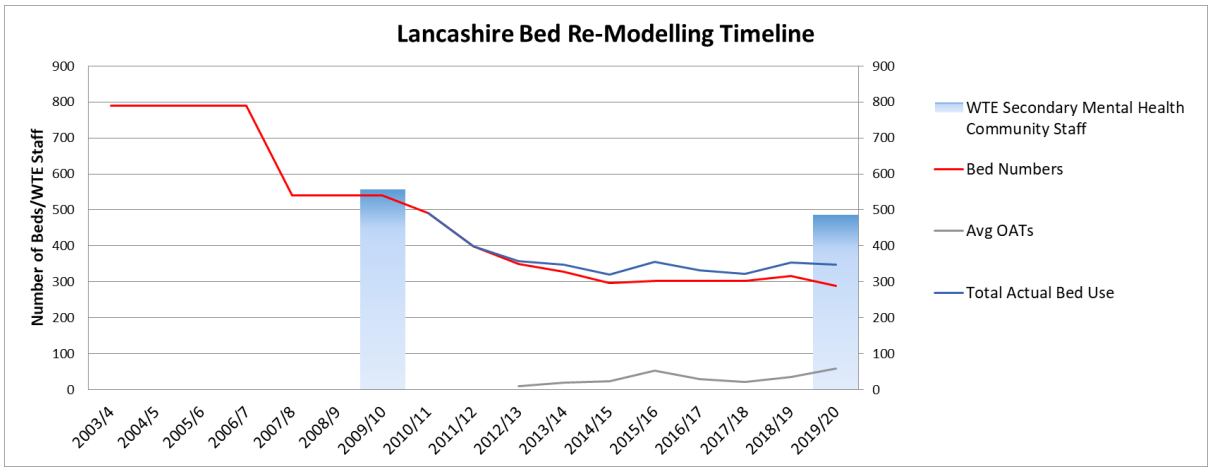
2.1 NTW Review

There have been considerable pressures within the adult acute pathway in Lancashire over the last two years. These pressures were leading to increasing concerns about patient safety and experience, a growing number of A&E 12-hour breaches impacting on acute trusts and a significant increase in Out of Area Placements (OAPs). As a result, the ICS commissioned an external system review of the pathway which was undertaken by Northumberland, Tyne and Wear NHS Foundation Trust (NTW). This review reported in May 2019 and highlighted a number of issues that needed to be addressed by LCFT, commissioners and wider system partners.
This improvement plan recognises the need to make immediate changes in the provision of mental health services, with a significant focus being given to increasing access to alternatives to inpatient admission. Examples including:

- extending access to Crisis Teams/ Homed Based Treatment Teams,
- promoting the use of Crisis Houses, and
- developing a Frequent Attenders Services.

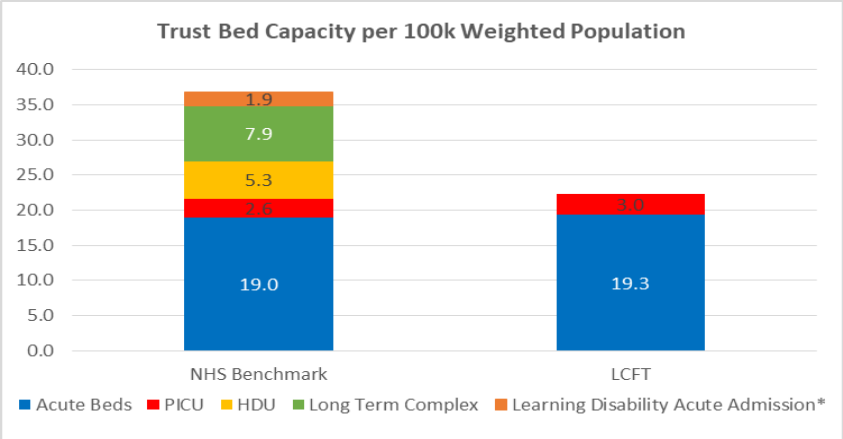
The NTW review triangulated the experiences of staff, service users, other stakeholders and a variety of data sources to reach the recommendations. In doing so, gaps in specialist in-patient provision were identified, specifically in relation to HDU, long-term complex rehabilitation and Learning Disabilities assessment and treatment beds. There is no capacity currently commissioned within Lancashire from LCFT. Following the review, further analysis of these findings in relation to beds has been undertaken.
Graph 1 below shows the reduction in mental health acute bed stock within LCFT over the last 10 years from 800 beds to under 300 beds. The graph also shows however that there has not been the expected corresponding increase in community investment during the same time period. A reduction in beds without enhancement to deliver a robust 24/7 community support offer is one of the significant contributing factors to the patient flow pressures currently experienced. It should also be noted that a further 13 beds were closed in November 2018 as part of a reconfiguration programme.

Graph 1: LCFT bed reconfiguration v community investment



Graph 2 shows the national benchmarking bed capacity data for acute and specialist provision and demonstrates that there is broadly sufficient acute provision but with a considerable gap in specialist beds. It should be noted however that the benchmark data precedes both the recent bed loss of 13 beds and the growth in OAP's, both of which have led to the conclusion that there is also now a gap in general adult acute provision. There are on average circa 55 people in adult acute and PICU OAP's and a further 76 in LD and rehabilitation OAP's directly commissioned.

Graph 2: General and specialist benchmarked bed capacity



In addition to the lack of capacity identified, there are currently circa 80 people in locked rehab OAP's which are commissioned directly by CCG's at significant cost.

2.2 CQC Inspection

The following sections within the report outline the findings from CQC inspections in 2019, and also the immediate actions taken, along with information on the improvement plans in place.

2.3 CQC Mental Health Act 136 Focussed Visit

On 28 February 2019, the Trust received notification from CQC of their intention to undertake a focussed Section 136 visit to The Harbour, which included visiting other locations in the Blackpool area specifically. The visit formed part of the CQC's preparation for the full inspection that LCFT received in May/June 2019 and supported wider intelligence gathering. The visit to The Harbour took place on Thursday 14 March 2019, with CQC also visiting Blackpool Victoria A&E on Monday

18 March 2019, as well as the MHDU and MHLT, which are both based at the hospital. The Trust received the report of the Section 136 focused review from CQC on 8 May 2019.

The report and the CQC requirements in the Section 136 focussed visit report made reference in a number of places to the review of the urgent mental health pathway in Lancashire and South Cumbria, which was undertaken by Northumberland, Tyne and Wear NHS Foundation Trust (NTW), as outlined above. The results of the NTW review were made available week commencing 19 June 2019, whilst the process was ongoing for completing the CQC Provider Action Response to the CQC Section136 focussed visit. Some of the Section 136 focussed visit actions related to the work of the Multi Agency Oversight Group (MAOG) which has a reconstituted membership, which includes a representative from Blackpool Council. This group will take forward those actions that require a multi-agency approach. All the actions that related to LCFT have been completed.

2.4 CQC Inspection 2019

The CQC inspected the trust in May/June 2019, undertaking a Core Service Inspection of the trust's clinical services and a well-led inspection of the leadership. Five of the trust's core services were inspected, which were as follows:

- Community dental services;
- Acute wards for adults of working age and psychiatric intensive care units;
- Community based mental health services for adults of working age;
- Child and adolescent mental health wards;
- Mental health crisis services and health-based places of safety.

The final report was published by CQC week commencing 9 September 2019. The outcome is that the Trust has retained an overall rating of Requires Improvement. The following table provides how the overall Trust-wide ratings have been amalgamated by each domain for the 2018 inspection and the 2019 inspection:

Below shows the detailed CQC ratings by core service.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement 2017	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Requires improvement 2017
Community health services for children and young people	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community health inpatient services	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018
Community dental services	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Community health sexual health services	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Overall*	Requires improvement 2019	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019

Below shows the detailed ratings by core service for our mental health services.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Aug 2019	Requires improvement →← Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Inadequate ↓ Aug 2019	Inadequate ↓ Aug 2019
Forensic inpatient or secure wards	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018
Child and adolescent mental health wards	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Wards for older people with mental health problems	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community-based mental health services for adults of working age	Requires improvement ↓ Aug 2019	Requires improvement →← Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Mental health crisis services and health-based places of safety	Requires improvement 2019	Inadequate ↓ 2019	Inadequate ↓↓ 2019	Inadequate ↓ 2019	Inadequate ↓ 2019	Inadequate ↓ 2019
Specialist community mental health services for children and young people	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community-based mental health services for older people	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community mental health services for people with a learning disability or autism	Good 2017	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017
Overall	Requires improvement →← 2019	Requires improvement →← 2019	Good →← 2019	Requires improvement ↓ 2019	Requires improvement →← 2019	Requires improvement →← 2019

2.5 Positive feedback from the inspection and key areas of challenge:

2.5.1 Positive feedback

- Community Dental Services were inspected for the first time in 2019, resulting in an overall rating of Good, with the Caring domain being rated as Outstanding.
- The Cove (the mental health inpatient service for children and young people) showed significant improvement moving from Requires Improvement to Good across all domains.
- CQC also observed that our staff are kind, caring and motivated to providing the best care and treatment that they can for patients.

Ten out of the fourteen trust core service areas (as described by CQC) are rated as Good
These are:

1. Community health services for adults
2. Community health services for children and young people
3. Community health inpatient services
4. Community dental services
5. Community health sexual health services
6. Forensic inpatient or secure wards
7. Child and adolescent mental health wards
8. Wards for older people with mental health problems
9. Specialist community mental health services for children and young people
10. Community-based mental health services for older people
11. Community mental health services for people with a learning disability or autism

2.5.2 Key areas of challenge

- Mental health crisis services and health-based places of safety have been rated as Inadequate.
- Acute wards for adults of working age and psychiatric intensive care units have been rated as Inadequate.
- Community-based mental health services for adults of working age have been rated Require Improvement.

During the inspection, the CQC issued the Trust with two Warning Notices under Section 29A of the Health and Social Care Act 2008. The Warning Notice is a statutory enforcement notice, requiring the Trust to make significant improvements to its service. The first Warning Notice related specifically to care of patients who remain in Places of Safety (136) after the section expiry (24 hours) and to patients who remain in MHDUs after the 23 hour maximum admission period. The second Warning Notice related to Acute wards and Psychiatric Intensive Care Units. Both Warning Notices required significant improvements to be made as soon as possible.

Immediate actions were taken by the Trust in response to the Warning Notices issued and in response to the feedback from CQC. Actions taken were as follows:

- Significant improvement in performance for Section 136 breaches, relating to patients waiting for inpatient admission more than 24 hours, when detained under Section 136; this improvement has been recognised by ICS and regulators;
- Investment and recruitment of medical staffing, which has resulted in no Consultant vacancies and a full establishment of trainees in inpatients wards;
- Investment in nurse staffing on inpatient wards, both registered and unregistered staff, following a safer staffing review;
- Improvements to medicines management in inpatient units, specifically focusing on education for medical trainees and more scrutiny of practice;
- Investing in an electronic system to record and monitor clinical supervision; this has resulted in an improvement to 76%;
- Additional training for staff in resuscitation has been delivered;
- There has been focussed work on seclusion, working with service users, focusing on processes of seclusion and environment etc.
- Compliance for both Mandatory Training and Appraisals continue to be monitored through the CQC weekly Mandatory Training Action Group to improve compliance levels. This has resulted in increased capacity being put in place and mandatory training figures are now at 88%, which represents an increase and are above trust target. The training team also deliver non mandatory training subjects including Mental Health First Aid, Registered First Aid and Venepuncture. Our training delivery includes both face to face and e- learning. The ‘our e-learning’ suite hosts over 100 training modules. We use blended learning techniques for some courses which includes both an e –learning and face to face component. Future E-learning enhancements include the development of a new immersive e-learning video for Violence Reduction Training as we look to address the quality of the learning experience.
- For Appraisal, our position in September is that we have an in year compliance rate of 71.5% against a target of 80%. This is an improving position and there is trajectories for improvement across all services, which are being monitored.

As well as immediate actions taken, there is an improvement plan in place, being scrutinised by the CEO and senior team on a regular basis. An Improvement and Compliance Group is meeting fortnightly to take forward the actions and monitor delivery and sustainability. This group escalates any issues and provides assurances to the appropriate forums, internally and externally to the Trust.

3.0 Mental Health Improvement Plan

In response to the NTW review, a robust system wide improvement plan has been developed. This plan is led and scrutinised by the ICS and focuses on immediate and long term improvements required for the acute care pathway across the system. From a governance and oversight perspective the plan is reviewed on a monthly basis by the ICS Mental Health Improvement Board, which is a collaboration between commissioners, health and social care providers and the police.
Improvements include:

3.1 A&E Liaison

The trust is responsible for providing a range of mental health services within the local acute trust, with the key focus being on mental health assessments in the A& E Departments, as well as ward based consultations. Most recently, the pressure has been within the A& E Department as a result in patients presenting with mental health needs. Additional resources has been allocated to the trust from the National Crisis & Liaison Transformation Fund. This will enable the trust to enhance the current liaison psychiatry service, working in partnership with commissioners and acute care colleagues, to help to meet the growing demand.

3.2 24/7 Home Treatment Team

The Home Treatment Team service is now a 24 hours a day, 7 days a week service. This has been achieved by investment in the Home Treatment Team workforce. This provides a rapid response to people who need assessment and treatment at home and provides gatekeeping for inpatient admissions. This will also result in less people presenting to A&E and also being detained under Section 136 Mental Health Act.

3.3 Crisis House

The Trust have received additional resource to provide a Crisis House in Blackpool.
The crisis house currently provides short-term (up to seven days) intensive 24 hour, specialist mental health support to people who are assessed by the local Crisis Intervention and Home Treatment Teams as needing additional support to avoid admission to hospital.
The service will be delivered in a house in a residential property, staffed by a team of mental health support workers and a service manager. The service will offer a holistic support package that considers the individual's housing, employment, educational, physical, social and emotional needs, supported by appropriate medical intervention from the Crisis Team.

3.4 Community Mental Health Teams

In order to provide the adequate care to service users within our community teams, the CMHT workforce has been enhanced to ensure each Mental Health Practitioner has the capacity to support service users aligned to their case load. This will further enable them to provide the care co-ordination to people necessary to prevent relapse, support recovery and develop strategies to enable to live in their own home. This extra capacity will also allow a full caseload review and earlier discharge as people recover.

3.5 Frequent Attendance Team

This is a new service to support those individuals who frequently attend A&E, working collaboratively with the Police, NWAS, Third Sector and Community Services The team will provide outreach work, visiting service users in their homes and using a holistic approach to aid engagement with services to meet individual needs, and to prevent 'inappropriate' attendance to A&E. This is being developed within each of the 4 localities in Lancashire, and is expected to be fully implemented by end October 2019.

3.6 Psynergy Street Triage

The Psynergy pilot has been in place in Blackpool since December 2018, with agreement to continue for a further year. The aim of this team of Police, NWAS and LCFT Mental Health Practitioners, is to respond to people in the community who are in Mental Health crisis, and who may have previously been automatically brought through to A&E or placed on a section 136 of the Mental Health Act.
This team will rapidly respond and assess individuals to explore alternatives ways to support the person through the crisis rather than the default of A&E or Section 136 detainment. The team will have access to a broad range of information, both clinical and non-clinical, to enable them to make an appropriate decision that best supports individual, with the principle of diversion to alternative provision being the key outcome. As the trust and the local system develop more services that are accessible on a 24- 7 flexible basis, this will, further enhance this model. There are numerous examples of this approach being adopted nationally.

3.7 Development of Mental Health Rehabilitation Beds

Within the current LCFT acute bed provision, there are a substantial cohort of long stay patients who require longer term rehabilitation interventions, although there is no current provision for these service users. This has resulted capacity issues in the acute wards, which in turn has impacted on the acute care pathways and the availability of timely inpatient care. The Trust is therefore planning to develop a rehabilitation facility on the Fylde Coast, likely to be on the Wesham Hospital site; this is likely to be in place summer 2020.

This development will replace an original proposal which was to develop the Parkwood site at Blackpool Victoria Hospital (BVH) and integrate the crisis mental health teams, a Mental Health Decision Unit (MHDU) and the Acute Therapy Service. The proposal has now realigned to focus on multi-developments to improve Mental Health care across the urgent care pathway, discharge pathway and preventative interventions.

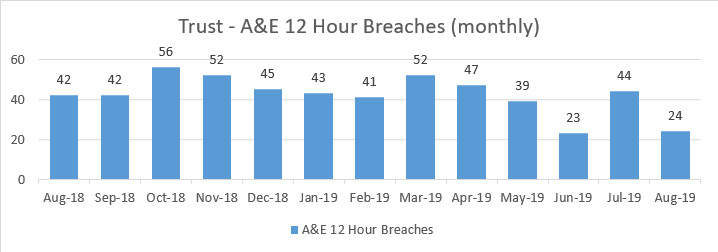
3.8 Closure of Blackpool MHDU

Blackpool MHDU was established to provide an enhanced assessment function for individuals who had come through the A&E department and were viewed as requiring a further period of review and assessment prior to a decision being made about possible admission to an acute ward. This service was provided in collaboration with the Richmond Fellowship. It was always intended that this service would be reviewed in terms of its medium term viability as a number of concerns were soon highlighted in terms of its clinical credibility, and associated governance arrangements. This MHDUs came under greater scrutiny during the CQC inspection of the Trusts Urgent Care Pathway in June 2019. Concerns were raised regarding the suitability of the facilities, as well as the trusts ability to work to our own operational policy and procedures by ensuring that individuals did not remain in the MHDUs for longer than 24 hrs. A decision was taken by the new CEO to close these facilities in a phased way between August and October 2019, which was subsequently agreed by the Board of Directors. Following the closure of the Blackpool MHDU in August 2019, the Richmond Fellowship staff were redeployed into roles within the urgent care pathway.

3.9 Impact of actions to date

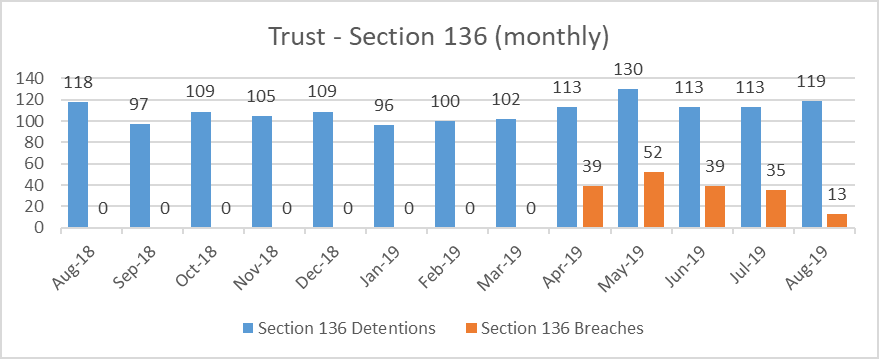
There are a number of early indications of improvement as a result of the actions taken that are being monitored through a number of measures. In particular, the number of 12 hour A&E breaches has been gradually reducing in the last 3 months as a result of the immediate actions implemented. This is shown in Graph 3 below. To note, that September has continued to see a reduction although this data is currently subject to validation.

Graph 3: A&E 12 hour breaches



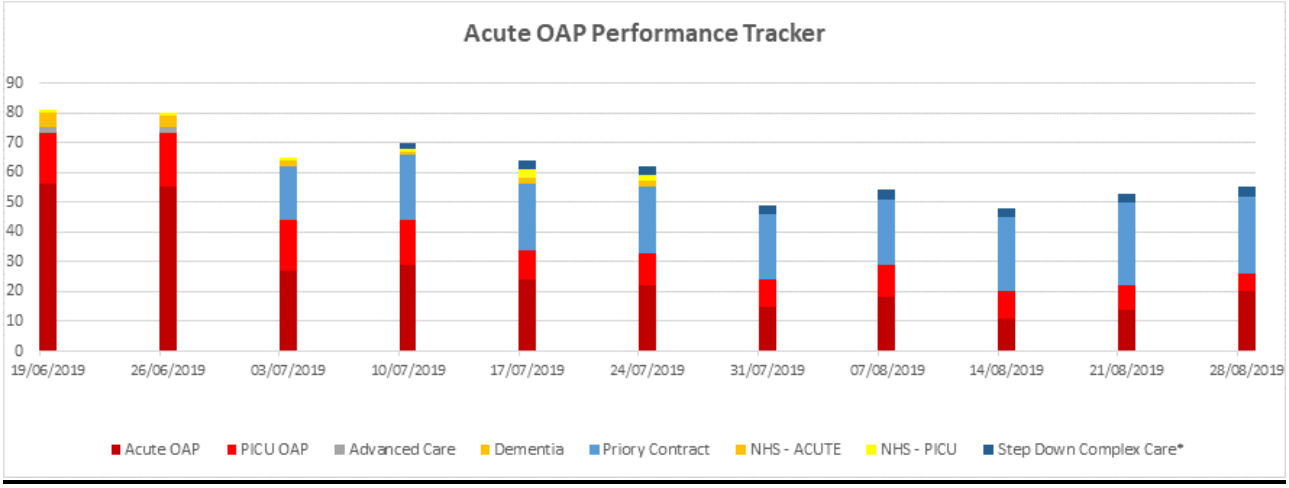
In addition, although the volume of section 136 detentions across the county has continued at previous levels, there has been a marked reduction in the number of service users who go on to breach the 24 hour standard as can be seen in Graph 4.

Graph 4: Section 136 detentions



There has also been a positive reduction in the last three months in the number of Out of Area placements which are measured in occupied bed-days, having reduced by circa 50% between June and August 2019.

NHS Improvement Indicators					
Indicator	**Target**	**Q1 19-20**	**Jun-19**	**Jul-19**	**Aug-19**
MR16 - Inappropriate AMH OAPs OBDs (monthly target)	257	**5284**	**1311**	**982**	**634**



4.0 Financial Position

4.1 Additional funding for Mental Health

In addition to developments in CAMHS, Learning Disability and Rehabilitation, the Trust has sought funding to support the mental health urgent care pathway across Lancashire and South Cumbria. The total requested at the beginning of 2019/20 was £15.5m, comprising:

MH Urgent Care	**Plan Requirement £m**
Home Treatment	5.4
CMHT Capacity	4.4
A&E Liaison / Core 24	1.4
Enhanced Bed Management	1.7
Frequent Attenders	0.7
Crisis House * 2	1.0
Crisis Café * 3	0.9
Total	**15.5**

Monies totalling £3.4m was secured in the contracting round for 2019/20 leaving a recurrent residual balance of £12.1m. The Trust has subsequently secured additional funding amounting to a further £5m in year. This was a combination of £2.9m of national non-recurrent funding and £2.1m of resource from within the ICS. Mobilisation and recruitment to these services is currently underway.

The Trust has also separately secured £2.2m of funding nationally in 2020/21 against specific bids.

The remaining recurrent gap to be addressed by the system is £9.9m in 2020/21, rising to the full £12.1m in 2021/22 and there is ongoing discussion with commissioners relating to this. Indicatively, Blackpool CCGs share is c12%, so £1.2m in 2020/21, rising to £1.45m in 2021/22.

5.0 Recommendations from previous Overview & Scrutiny Committee

5.1 Management of aggression and challenging behaviour Harbour

The trust previously recognised that there were emerging concerns raised regarding incidents of violence and aggression in the harbour inpatient unit. In response to this, the trust implemented actions, including the following:

- Development of new training for staff (Positive and Safe) which is being rolled out across the Trust;
- Improving liaison with the police;
- Reviewing the environment and clinical practices and taking action to ensure these are not triggers for violence;
- Implementation of new clinical practices, such as zonal observations for older adult wards, to reduce triggers for violence;
- Violence reduction specialist nurses put in place to support wards to manage violence.

During the CQC inspection it was recognised that these measures were in place, with the CQC stating: ‘the wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately and when things went wrong, staff apologised and gave patients positive information and suitable support’.

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating, and managing challenging behaviour. Staff use restraint and seclusion only after attempts at de-escalation had failed'.

5.2 Partnership working with Voluntary & Community Mental Health support Groups

The Director of Nursing and Quality and the Chair of the Trust Board are holding an Open Space event in November 2019. An invitation will be extended to voluntary and third sector partners, people with experiences of care, families and carers. The event is to agree the service user and carer strategic plan, to adopt a co-production way of working with people using/with experiences of services, carers, families, clinical teams and communities in equal partnership.

An example of a Fylde Coast quality improvement initiative having this principle at the core is:

5.2.1 'Young onset, young outlook' -Living well with young onset dementia

A member of the Quality Improvement team is working with the Fylde coast MAS team and a number of younger people with dementia and community groups to co-design their improvement ideas with a local focus. This work is aligned with the national Always Event programme supported by NHS England. A launch event is taking place on 2 October led by the co-design group and involving community groups, GP's, clinicians and other public sector partners. The improvement group will share their experience journeys through services and their ideas for improvement asking the group to co-produce solutions.

5.2.2 Rethink

Since the last Scrutiny committee, the local mental health management team have had a series of meetings with Mr Clayton and other members of the Rethink group to understand their challenges and keep them informed of developments. The group are also involved in some specific pieces of work including being part of the Blackpool crisis café Task and Finish group. Regular meetings are now set up with Fylde family group for the next 12 months.

5.2.3 Peer Support Workers

The Calico Group were commissioned to provide 18 Peer Support Workers within Community Mental Health Teams across the Fylde Coast and 5 Recovery Liaison Workers (RLW) within the Blackpool Mental Health Liaison Team. Peer Support Workers and Recovery Liaison Workers are members of staff with lived experience of mental health, substance misuse or other social or psychological issues. The intention of the role is to utilise these experiences as a basis for encouraging recovery-orientated behaviour change.

The Peer support workers are working specifically with individuals referred to Blackpool, Fylde, and Wyre CMHTs. The intention is to improve engagement, overcome barriers to recovery, and offer hope through their own lived experience. The key difference between Peer Support Workers and the traditional Support Worker role within Community Mental Health Teams is that of having lived experience, with an emphasis on client-facing tasks and service-user engagement. The Peer Support Workers are working with people to achieve their recovery goals.
Recovery Liaison Workers are embedded within the Blackpool Mental Health Liaison Team and are tasked with completing a one-hour 'meet and greet' function, primarily within Accident & Emergency but occasionally on other wards within the hospital. The intention is to ensure patients understand the process they will follow, whilst responding to their immediate needs and concerns
Since the last OSC we have engaged with the following groups across the Fylde Coast around our Peer Support Model

- Fylde Family Support Group
- Mental Health Partnership
- Drug and Alcohol Forum

Feedback from people using the services and staff has been positive overall with examples being:

"My worker has given me hope, understanding and patience helping me be a better person"

"Care coordinators are able to focus on the support for people needing their skills and expertise with the Peer support workers able to focus on their recovery goals supporting people with their wider needs having positive impacts overall on people's mental health".

5.2.4 Health and Wellbeing Engagement - Health, advice, recovery, resilience, information (HARRI)

HARRI is our health and wellbeing engagement vehicle enabling us to travel around Lancashire to talk with the local communities and individuals. The HARRI team:

- Engage with the public; to share our ideas and plans for the future and to gain insight into what people's needs are, their feedback and improvement ideas.
- Offer simple signposting, advice and guidance to offer the right help at the right time in the right place for people.

The team manning HARRI varies but typically a mixed group from within the NHS and beyond enabling the sharing of a wide range of information on many of the issues: debt, quit smoking, diabetic DESMOND, Steady On, My Place, Lancashire Victim support and much more. The vehicle includes a private consulting area with disabled access.
HARRI is one of the ways Lancashire Care NHS Foundation is using to reach out to communities to promote positive aspects of mental health and wellbeing. HARRI has been at various events across the Fylde Coast these include:

- Sat 20th July in partnership with local mouth cancer charity – Mental Health Awareness
- Tuesday 17th Sept HARRI Road show involving, for example, the Mental health helpline, CVS, Blackpool coastal housing.
-

Future dates planned across the Fylde Coast include:

- 22nd October – St Johns Square Blackpool
- 19th November – Men's Health Day Blackpool Football Ground.

5.2.5 Recovery College

The Trust has worked with partners across Blackpool to develop a Recovery College offer and from September this year have been offering sessions across the Fylde Coast. A Fylde advisory group has been established in collaboration with Blackpool Council. An event was held on the 13th June 2019 at the Energy HQ with partners from across Blackpool to talk about recovery and develop a recovery offer. A brochure is available listing all the forthcoming events and courses in Blackpool.

5.2.6 Collaborating with the third sector

Other examples of partnership working with the voluntary sector include:

- Healthwatch Blackpool
- Healthwatch Lancashire
- MIND
- Blackpool Carers
- NCOMPASS Northwest
- Empowerment Charity
- AGE UK Lancs
- Lancashire carers
- Clover leaf

6.0 Summary

In summary, the trust recognises the challenges in taking forward improvement and the leadership team are committed to responding in an open and transparent way. The trust has made significant improvements, via working in partnership, securing investment, and putting improvement strategies in place. The Committee is asked to note the updates as provided in this report.

This page is intentionally left blank

MINUTES OF ADULTS SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE MEETING - THURSDAY, 24 JANUARY 2019

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	Elmes	Hutton	Mrs Scott
Mrs Callow JP	Humphreys	O'Hara	L Williams

In Attendance:

Dr Arif Rajpura, Director of Public Health, Blackpool Council
Ms Karen Smith, Director of Adult Services, Blackpool Council
Mrs Sharon Davis, Scrutiny Manager, Blackpool Council

Councillor Amy Cross, Cabinet Member for Adult Services and Public Health

Mr Andrew Bennett, Healthier Lancashire and South Cumbria Integrated Care System
Ms Sheralee Birchall-Turner, Healthwatch Blackpool
Mr Stuart Clayton, Rethink
Ms Sharon Doherty, STAR
Mr Damian Gallagher, Director of Workforce and Organisational Development, Lancashire Care Foundation Trust (LCFT)
Mr Bill Gregory, Acting Chief Executive Officer, LCFT
Police Inspector Peter Hannon, Lancashire Constabulary
Mr Paul Hopley, Midlands and Lancashire Commissioning Support Unit
Ms Jessica Johnson, STAR
Mr Paul Lumsdon, Director of Nursing and Quality, LCFT
Mrs Jo Moore, Director of Operations, LCFT
Mrs Sue Moore, Director of Strategic Developments, LCFT
Dr Richard Morgan, Deputy Medical Director, LCFT

Apologies:

Apologies for absence were received on behalf of Councillor D Coleman who was on official Council business.

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 28 NOVEMBER 2018

The minutes of the meeting held on 28 November 2018 were agreed as a true and correct record.

3 LANCASHIRE CARE FOUNDATION TRUST PROGRESS REPORT

The Chairman highlighted that the Committee had requested the special meeting with Lancashire Care Foundation Trust (LCFT) following consideration of an item presented by the Trust in October 2018 regarding the May 2018 Care Quality Commission (CQC) Inspection outcome of 'Requires Improvement' when the Trust had been judged as not safe, not effective and not well led. The May 2018 inspection followed previous inspection outcomes of 'Requires Improvement' in November 2015 and 'Good' in January 2017. He reported that the Committee had not been assured that sufficient improvement was being made by LCFT at the previous meeting and had been unhappy with the quality of reporting.

Mr Bill Gregory, Acting Chief Executive Officer, LCFT placed on record an apology for the Trust's poor attendance at the previous meeting and highlighted that the Trust was taking the concerns raised by the Committee very seriously.

Mr Paul Lumsdon, Director of Nursing and Quality, LCFT provided an overview of the focus being placed on quality and how the Trust was going beyond the requirements set out in the action plan developed following the CQC inspection. He also addressed issues including ensuring accessibility of mandatory training and that staff were supported. It was reported that a key concern was the high level of Band 5 Staff Nurse vacancies, reasons for which included a reduction in the number of European nationals taking positions and the low number of nurses on the national register. In order to address the number of vacancies work was ongoing to improve recruitment and retention with a focus being placed on good leadership to ensure workers wanted to remain with the Trust.

Members noted that a number of initiatives had been put into place in order to improve recruitment and retention including increased staff involvement in creating the vision and values of the Trust, meaningful appraisals and nurse degree apprenticeships whereby nurses would be employed from the beginning of their training and receive a contribution to fees. Mr Damian Gallagher, Director of Workforce and Occupational Development, LCFT advised that evidence had demonstrated that those applying for apprenticeships were often from the local area and more likely to remain in the area following completion of their apprenticeship.

It was reported that turnover at the Trust had reduced from 14% to 8% over the previous 12 months which was a significant positive reduction. In the same period sickness remained approximately 9% to 13%. In response to questioning, it was reported that there had been incidents of verbal and physical abuse against staff members and that working in facilities such as The Harbour could be a stressful job. Training of staff had been focussed on in order to assist staff in dealing with incidents and to also reduce the number of incidents through de-escalation.

The Committee discussed staff appraisals in detail, noting that the Trust was achieving its target of 80% completions. Concern was raised that an 80% target was not sufficiently high enough for an annual performance appraisal and it was noted that a large number of targets relating to staff training and supervision had also been set at 80%. Mr Lumsdon advised that the Trust had wished to set realistic targets that could be met and would

review targets regularly with the intention of incrementally increasing the figure. Despite the response, Members remained concerned that 80% was not a sufficient enough target to drive improvement.

Ms Jo Moore, Director of Operations commented that addressing the pressures on emergency services required a collective approach. She highlighted the services provided by LCFT and noted that The Harbour provided 40% of the Trust's inpatient bed stock across Lancashire. The Trust also provided a crisis service, mental health response team and community mental health team amongst others. Service provision in Blackpool was slightly more complex than other areas as Blackpool Teaching Hospitals NHS Foundation Trust provided a small part of the mental health pathway that was provided elsewhere in Lancashire by LCFT.

It was reported that from April 2018, there had been a significant rise in the number of patients presenting at accident and emergency with mental health needs in Blackpool. The increase in numbers had contributed to the increase in significant waits at accident and emergency and the high numbers of four and 12 hour breaches. Other factors contributing to the delays included a significant rise in the number of s.136 detentions equating to a need for approximately 40 beds. Ms J Moore reported that services were working collaboratively in order to address the number of breaches and had made some key improvements including addressing inpatient flow, work around escalation and communication and the introduction of a new personality disorder pathway. Members expressed serious concerns regarding the substantial number of breaches and whether the work ongoing was sufficient enough to reduce the number of breaches.

Mr Andrew Bennett, Healthier Lancashire and South Cumbria Integrated Care System (ICS) highlighted the recent peer review of services carried out by Northumberland, Tyne and Wear NHS Foundation Trust and that the report was due imminently. The review had been commissioned by the ICS and the outcomes would require whole system, collective implementation. In response to questioning, he reported that the headline findings included improved partnership working across Lancashire, work with the voluntary and community sector and that the recommendations posed a challenge to the whole partnership to provide an appropriate response. He also reported that funding had been acquired for a new mental health decision unit at Blackpool Victoria Hospital which would allow for assessments to be carried out more efficiently.

Following the introductory presentation from LCFT, the Chairman invited updates from partners on their views of progress made since the previous meeting of the Committee. Dr Arif Rajpura, Director of Public Health, Blackpool Council highlighted the prominence of mental health in the new NHS 10 year plan. He reported that there had been little change to the experience of service users and emphasised the continued lack of community support. He added that the whole mental health pathway required review and that Public Health wished to work with NHS colleagues in order to improve the patient experience. He added that the review must be co-designed with service users.

In response, Ms J Moore reported that emphasis was being placed on the urgent care pathway due to the significant pressure on services. She added that work was also ongoing to consider community mental health teams, ensure the right skill mix and optimise clinician time, however, significant work still needed to be undertaken which

would require resourcing and time. Furthermore, she reported that a review was ongoing to determine the reasons for the significant increase in the number of presentations in order to address the reasons for the increase.

At the invitation of the Chairman, Ms Karen Smith, Director of Adult Services, Blackpool Council commented that conversations with LCFT had improved since the meeting in October 2018, which had been welcomed. However, areas for concern remained including evidence of serious incidents at The Harbour. She advised that Adult Services received daily reports from service users reporting that wards were in chaos and that in some areas patients and family members were concerned for their own safety. Concern was raised that, despite the information presented earlier in the meeting by Trust officials relating to staff training and support that the actual experiences of staff and patients did not reflect what the Committee was being told. She also reiterated concerns raised by Dr Rajpura that the whole system required review to ensure that it was fit for purpose and meeting the needs of the population.

By way of a response, Mr Lumsdon advised that he was aware of the issues raised by Ms Smith and was working with the Police in order to ensure that staff were safe. He highlighted that it was important to increase community resilience and work together to improve the pathway. It was emphasised that patients were looked after and that staff were supported to deal with such incidents.

Police Inspector Peter Hannon, Lancashire Constabulary added that the Police attended The Harbour regularly and solutions were being sought to increase the consequences for patients such as the potential introduction of a system to issue penalty notices and undertaking interviews on site. He also highlighted the successful pilot of the Psynergy vehicle in reducing the number of section 136 referrals.

Despite the testimonies of Mr Lumsdon and Police Inspector Hannon regarding the support for staff, concern remained that little work was being undertaken to determine the causes of the degeneration in behaviour of patients whilst in The Harbour and that the way in which patients were treated in the facility and the length of time patients were kept waiting for treatment must be considered as factors. Councillor Amy Cross, Cabinet Member for Adult Services and Public Health added that although attendance of LCFT representatives at meetings had improved, further improvement was still required in consulting and discussing new ideas and initiatives with partners.

The representatives of the voluntary and community sector were invited to contribute their views on mental health service provision and highlighted the lack of engagement they had had with LCFT. Mr Stuart Clayton, Rethink reported that the sector was passionate about being involved in service improvement and that patients suffering from poor mental health would welcome more emphasis being placed on encouraging good outcomes and communicating how others had achieved good outcomes.

In response, Mrs Sue Moore, Director of Strategic Developments, LCFT advised that the Trust would welcome further engagement from the voluntary and community sector and reported that there had been some powerful success stories that could be shared. Members, however, raised further concerns that the Trust was not being active enough in pursuit of engagement and agreed to recommend that the Trust identify all voluntary and

community sector groups working within Blackpool and seek to meet with all groups on a quarterly basis.

The Committee went on to consider the concerns raised by the voluntary sector regarding the high vacancy rate of consultant psychiatrists. Dr Richard Morgan, Deputy Medical Director, LCFT advised that nationally, recruitment of consultant psychiatrists was problematic, however, the importance of stability for patients was recognised. He advised that improvements had been made and that The Harbour was now less reliant on agency staff. In order to address recruitment long term, additional training had been introduced and suitable candidates were being identified for development. Although no guarantees could be made, it was noted that the Trust considered it was in a substantially better position than 12 months previously.

In response to further questions raised regarding commissioning, Mr Paul Hopley, NHS Midlands and Lancashire Commissioning Support Unit reported that work was ongoing with all eight Clinical Commissioning Groups in Lancashire to identify funding requirements and actions required in order to ensure sustainable commissioning of mental health services. The Committee highlighted again the importance of engaging with small community and voluntary groups and suggested that Commissioners might consider committing as much funding as possible to supporting smaller groups.

Upon consideration of the CQC Action Plan, Members noted that three actions had been recorded as 'red'. Mr Lumsdon reported that two actions had remained red in order to accommodate additional engagement with staff and ensure that change was embedded. The Committee expressed concerns that all actions identified by the CQC as 'must do' and 'should do' were actions that the Trust should not have failed to be carrying out. In response to further questions, Mr Lumsdon added that the action plan set out the minimum standards required by the CQC and that the Trust was aiming to exceed those standards in areas such as supervision.

The Committee raised further concerns that the Trust appeared to be lacking in urgency in addressing areas requiring improvement. It was recognised that recruitment and embedding new ways of working took time. However, the Trust had been repeatedly told that service provision was in chaos and crisis and that there had been a number of incredibly serious incidents. Despite the seriousness of the incidents reported, Members expressed concern that it did not appear that immediate action was being taken to improve matters for those currently suffering in the existing system.

The Chairman referred to a number of statements contained within the CQC inspection report and sought assurance that the Trust had addressed the concerns raised. In response, Mr Lumsdon advised that the Trust had fully complied with the requirements to improve compliance of essential training and had also addressed the understanding of the role of Ward Manager to ensure Matrons had enough time to carry out their managerial roles.

In response to a question regarding the comments made by Dr Paul Lelliott, the Deputy Chief Inspector of Hospitals at the time of the CQC Inspection that 'the board and senior management team did not have sufficient oversight of staff supervision', Mr Lumsdon stated that he was happy that the Trust had addressed all the points raised in the CQC

inspection process and Mrs S Moore added that improvement was being fully monitored by the Trust's Board.

The Chairman concluded the item by requesting that the same representatives attend a further meeting with the Committee in approximately six months. He highlighted that the Committee had not received sufficient assurance regarding the Trust's ability to make the required reductions in four and 12 hour waits in Accident and Emergency for mental health patients and requested that further evidence be provided to demonstrate how reductions had been made and would continue to be made. Furthermore he cited the use of the words 'chaos' and 'crisis' throughout the meeting to describe current mental health services and commented that in six months time it was expected that the picture would be much improved, with reports from partners more positive. The representatives from the third sector would also be requested to attend the meeting in order to provide an update on the relationship with LCFT and partners following the implementation of the recommendation of the Committee that LCFT hold quarterly meetings will all mental health support groups in the sector.

The Committee agreed:

1. That LCFT be requested to identify all voluntary and community mental health support groups in Blackpool and arrange to meet with them quarterly to ensure the views of service users were truly reflected and understood.
2. That LCFT consider setting all targets for completion of mandatory training, completion of appraisals etc at 90% with a view to incrementally increasing the target to 100%.
3. That all representatives be requested to attend a further meeting of the Committee in approximately six months to further update on progress made and to:
    - Provide feedback on the implementation of the Committee's recommendations.
    - To provide evidence of the work undertaken to reduce the number of four and 12 hour delays at Accident and Emergency and the impact of that work.
    - To report on the outcomes of the external review and action taken to implement the actions.

4 WHOLE SYSTEM TRANSFERS OF CARE SCRUTINY REVIEW FINAL REPORT

The Committee considered the Whole System Transfers of Care Scrutiny Review Final Report and agreed to approve the report for submission to the Executive and NHS partners.

5 DATE AND TIME OF THE NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday, 13 February 2019, commencing at 6.00pm.

Chairman

(The meeting ended at 7.35 pm)

Any queries regarding these minutes, please contact:
Sharon Davis, Scrutiny Manager
Tel: 01253 477213
E-mail: sharon.davis@blackpool.gov.uk

This page is intentionally left blank

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Date of Meeting:	16 October 2019

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

1.0 Purpose of the report:

1.1 To receive the Annual Report of the Director for Public Health.

2.0 Recommendation(s):

2.1 That the Adult Social Care and Health Scrutiny Committee receives the Director of Public Health's report on the health of the people of Blackpool 2018.

3.0 Reasons for recommendation(s):

3.1 To allow for scrutiny of the annual report.

For members to complete the online survey in the report to enable public Health to understand if the format of the report is preferred to previous versions.

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

3.3 Is the recommendation in accordance with the Council's approved budget? Yes

4.0 Other alternative options to be considered:

4.1 None

5.0 Council priority:

5.1 The relevant Council priority is

- Communities: Creating stronger communities and increasing resilience.

6.0 Background information

6.1 The Director of Public Health has a statutory duty to write an annual report on the health of the local population.

The local authority has a duty to publish the annual report of the Director of Public Health (Section 73B(5) and (6) of the 2006 Act, inserted by Section 31 of the 2012 Act).

The report presents the Director of Public Health's independent assessment of local health needs, determinants and concerns.

This year's report focuses on the health and wellbeing of children and young people in Blackpool and shows how investment in these early years can help to build a bright and healthy future.

This report, and previous reports in the series, are available to view in public libraries across the town and published electronically to the JSNA website www.blackpooljsna.org.uk

The 2019 annual report can be found at the following link and is attached to the report as an appendix: https://joom.ag/5V3e

6.2 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 7(a): Director of Public Health's Annual Report

8.0 Legal considerations:

8.1 The local authority has a duty to publish the annual report of the Director of Public Health (Section 73B(5) and (6) of the 2006 Act, inserted by Section 31 of the 2012 Act).

9.0 Human resources considerations:

9.1 None.

10.0 Equalities considerations:

10.1 None.

11.0 Financial considerations:

11.1 None.

12.0 Risk management considerations:

12.1 None.

13.0 Ethical considerations:

13.1 None.

14.0 Internal/external consultation undertaken:

14.1 None.

15.0 Background papers:

15.1 None.

This page is intentionally left blank

Appendix 7(a)

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2018

Blackpool Council

CONTENTS

Foreword	4
Introduction	6
Getting the best start	10
School aged children	20
Adolescence	32
Recommendations	43
Appendix 1 Health Profile 2018: Blackpool	44
Appendix 2 Blackpool Child Health Profile 2018	45

WELCOME

Welcome to this year's Annual Report, which focuses on the health and wellbeing of our children and young people and how investment in these early years can help to build a bright and healthy future for Blackpool.

FOREWORD

FOREWORD

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

The way in which healthcare and social care are delivered in Lancashire and South Cumbria (including Blackpool and Blackburn with Darwen) is changing. Local authorities and NHS organisations are working more closely together towards delivering more integrated health and social care services. The Integrated Care System (ICS, known as "Healthier Lancashire and South Cumbria") undertaking this work have nominated me to be a Children's Champion and it is my responsibility to make sure the welfare and health of our children is pushed to the foreground in every aspect of the ICS's work.

From this point of view, I wanted to take a closer look at the health of children here in Blackpool and take this opportunity to highlight the great work being undertaken in the town and celebrate successes in improving our children's health.

Early in 2018 the children and young people's commissioning group for the ICS completed a needs assessment for the whole of Lancashire and South Cumbria, outlining key aspects of the health and wellbeing of our younger citizens and making recommendations for how to support this going forward. This annual report on the health of Blackpool's population draws from that needs assessment and other sources, to show how Blackpool compares to the regional and national picture and the ways in which we are already working to protect, promote and champion our children's health and the town's future.

There have been significant developments over the past few years in understanding the importance that children's health and wellbeing in early years plays in determining their health and wellbeing as adults. The environment and experiences a child grows up with can change the likelihood of developing poor health in adulthood and adversity in childhood has been linked to increased likelihood of diseases including cancer, cardiovascular disease, lung or liver disease, as well as increasing the likelihood of undertaking health harming behaviours such as smoking, drug or alcohol misuse and violence. With some of the highest levels of these diseases and behaviours in the country in Blackpool, it is imperative that we maximise all opportunities to reduce risks for our population.

Since last year's report, the Public Health Team has continued to work tirelessly to improve the health of all our citizens and have been working hard to make sure that the residents of Blackpool are at the heart of everything we do.

Our Citizens' Inquiry programme gives residents a chance to share their opinions and experiences and put forward recommendations of how to improve wellbeing in their community and the project was awarded Project of the Year at the Patient Participation Group Awards organised by the NHS Blackpool and NHS Fylde and Wyre Clinical Commissioning Groups (CCGs).

FOREWORD

We worked with Blackpool and Fylde and Wyre CCGs to create and promote Self Care Week in November - a campaign to encourage local people to 'choose self-care for life' by making health-savvy decisions. During the week, more than 70 self-care themed events were organised by local charities, organisations and community groups, ranging from mindfulness taster sessions, literature afternoons to HIV testing in Blackpool town centre. The initiative won a national award for exemplary partnership working.

Another success that demonstrates our commitment to putting our residents at the centre of our work has been the renovation and rejuvenation of @The Grange (previously the Blackpool City Learning Centre). The team received a Highly Commended Award for delivering better outcomes from the MJ Local Government Awards. The volunteering and community shop HIS Provision (also based at @the Grange) won the Tenant's Project Fund (TPF) Award from the Blackpool Coastal Housing Community Awards. This was particularly special as it is voted for by the community themselves (the tenants).

2018 has been a year of challenges, but also a year of hard work, progress and successes. I hope this report demonstrates how we are achieving improvements in children and young people's health and wellbeing with a view to securing a healthy future for Blackpool.

Dr. Arif Rajpura
Director of Public Health
Blackpool Council

> INTRODUCTION


Photo Credit

Children aged 0-19 years make up about a quarter of our town's population. Protecting and promoting the health and wellbeing of the children living in our communities is a key responsibility of the Public Health team at Blackpool Council, but should also be a priority for anyone living or working around Blackpool.

Childhood is a time of rapid development and growth and is full of opportunities for creating a good foundation for health across the whole lifetime. Body systems that are critical to health, including the brain, nervous, endocrine and immune systems are under construction even before birth and from the earliest moments of life, a child's experiences and environments exert powerful influences on his or her development and long-term health.

The social, cultural, and economic environment a child grows up in and the experiences they have all interact with their biology and genetics to shape future health and wellbeing. The environment, experiences and social interactions during childhood can alter the physical risks of disease later in life and can influence the beliefs and values people have about themselves and others and ways of behaving such as smoking, eating and exercise.

Childhood provides brilliant opportunities for maximising the health and wellbeing of the future of our town. As well as securing the health of the children themselves, investing in evidence-based and well implemented preventive services and in health and development interventions in the early years of life has been shown to deliver economic and social benefits for the wider population.

This report highlights the health of our children, the challenges they face but also the work and achievements being made in giving our children the best opportunities for good health now and in their future.

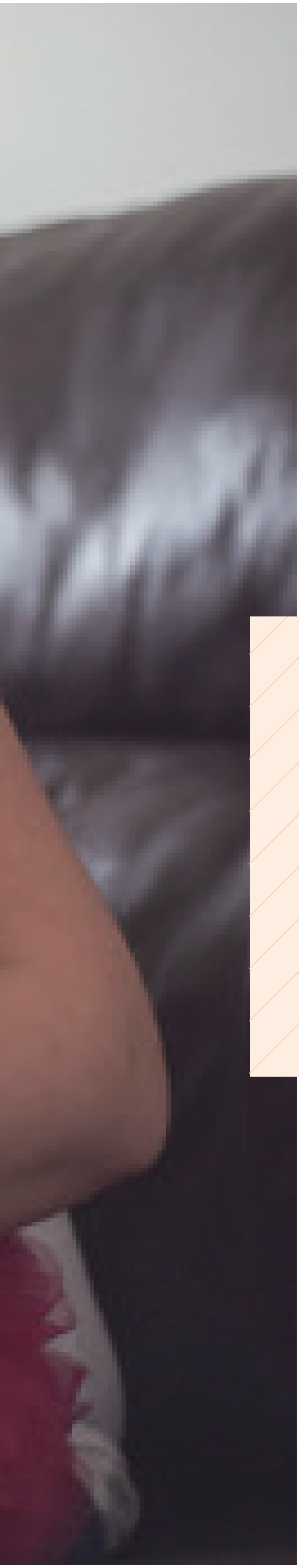
BLACKPOOL'S POPULATION

	BLACKPOOL	NORTH WEST	ENGLAND
Population (Mid-year estimate 2018)	69,146 Male 70,724 Female 139,870	3,581,219 Male 3,677,408 Female 7,258,627	27,481,053 Male 28,138,377 Female 55,619,400
Live Births (2017)	1,643	83,882	646,794
Children aged 0-4 (2017)	8,500 (6.1%)	439,200 (6.1%)	3,384,900 (6.1%)
Children aged 0-19 (2017)	31,800 (22.8%)	1,715,600 (23.6%)	13,169,100 (23.7%)
School children from minority ethnic groups (2018)	12.0%	23.8%	32.3%
Children living in poverty aged <16 (2016)	26.2%	18.0%	17.0%
Life expectancy at birth (2015-17)	74.2 Boys 79.6 Girls	78.2 Boys 81.8 Girls	79.6 Boys 83.1 Girls
Healthy life expectancy at birth (2015-17)	54.7 Boys 58.6 Girls	61.2 Boys 62.3 Girls	63.4 Boys 63.8 Girls

INTRODUCTION

GETTING THE BEST START

PREGNANCY INTO THE EARLY YEARS



GETTING THE BEST START

Research increasingly shows that events in the first thousand days of a child's life (from during pregnancy until around aged two) have significant impact on lifetime health and wellbeing. During pregnancy, its mother meets all of a baby's needs, so all factors affecting a mother's health such as stress, diet, drug use, alcohol use and smoking, can have a significant impact on the development of the baby both before and after birth. Securing good maternal health and wellbeing is fundamental to making sure Blackpool's children get a good start in life.

The importance of the earliest phase of life as an opportunity to intervene for the benefit of life-long health and wellbeing has been recognised by The Better Start Partnership. In collaboration with Public Health, NHS and community services, it is implementing a ten-year program aimed at improving the outcomes for a whole generation.

The first projects started in 2015, enabling every pregnant woman in Blackpool to have access to an evidence based programme of antenatal care. The Family Nurse Partnership (FNP) supports pregnant women aged 19 and under, and Baby Steps is designed for all those aged 20 and over.

The Better Start Partnership has also undertaken a full review and redesign of the health visiting offer in the town and Blackpool parents now receive a minimum of eight visits (nationally the minimum is five). It is expected that by increasing the number of contacts a family has with a Health Visitor, families who need help and support during the first five years of life will be easier to identify. The structure of the visits has also changed to be more trauma informed. Parents are encouraged to be actively involved in conversations with health visitors and be open about their concerns so the appropriate advice and support can be accessed.

FACTS AND FIGURES

In Blackpool, we have approximately 1,600 live births a year with a live birth rate of 70.6 per 1,000 women (known as the 'general fertility rate'). Only 3.9% of births in Blackpool were to black or minority ethnic (BME) mothers (2016/2017), which is in keeping with our relatively low proportion of the whole Blackpool population from BME groups (approximately 3%).

Being born prematurely or with a low birthweight (LBW) due to growth restriction during pregnancy (classified as below 2500g or below 2000g for very low birth weight, VLBW) can increase the risk of health problems in the first weeks of life and increase hospital stays for new-borns. LBW is associated with cognitive impairment and the development of chronic disease that can last into later life. In 2017, 5.3% of babies born at full-term had LBW (significantly higher than the England rate of 2.8%), and when incorporating premature births, 7.9% were LBW. Only 0.85% of all live births were classified as VLBW, which was not significantly higher than the national average.

Blackpool experiences higher than average stillbirth, neonatal and infant mortality rates; however the actual number of deaths each year is small, which means the rates are subject to large annual variation and need to be interpreted with caution. In the last three year period recorded (2015-2017) there were 6.4 per 1,000 infant deaths (under one year) per 1,000 live births (compared to 3.9 per 1,000 in England). In 2016, there were 9.4 stillbirths and deaths under 28 days per 1,000 births in Blackpool (compared to 7.1 per 1,000 in England).

THE FAMILY NURSE PARTNERSHIP work with young first time mothers, fathers and wider family to enable them to make choices which will support their child to achieve their optimum development, be school ready and have the best possible outcomes for the future. The same family nurse works with each family over two years to develop trusting, therapeutic relationships that promote engagement.

They support parents to consider their child's safety and think how their relationships can ensure a child is protected from harm. In 2018, the team worked with 150 families using a strength-based approach, underpinned by consideration of early trauma to ensure these often vulnerable families feel listened to and heard. Family nurses support parents to access other services, such as mental health or domestic violence services, in a targeted and individualised way to ensure families get the right support at the right time in the right place for them.

WHAT IS BEING "TRAUMA INFORMED"?

Trauma is “an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening”*.This can include events in adulthood but also covers some adverse childhood experiences that are known as ACEs (e.g. abuse, neglect or household factors such as domestic violence, parental incarceration or drug/alcohol misuse).

Experiencing trauma is relatively common, but the experience and its impact are often hidden. Over the last 20 years, it has become clearer that the experience of trauma can affect the likelihood of experiencing poor health and social outcomes, as well worse mental health.

The experience of trauma can affect individuals in a number of ways, including the direct impact of the trauma, its impact on a person’s coping responses and the impact on a person’s relationships with others and influence this has on help seeking and engaging with services.

Trauma Informed Practice is a way of working that recognises

- that anyone using a service may have experienced trauma or ACEs
- that people with a history of trauma may be less likely to engage with services
- the importance of relationships in preventing and recovering from the effects of trauma and ACEs.

Many organisations in Blackpool and Lancashire are working towards becoming more trauma-informed and understanding that trauma may impact the way clients cope with stresses or interact with staff and others. We are moving towards asking “What’s happened to you?” rather than “What’s wrong with you?”. We have a vision that all public services will eventually incorporate this understanding of trauma into all policies and areas of practice by:

- Creating physically and emotionally safe spaces
- Working transparently and establishing trust
- Giving people choice and control over their care
- Helping people to heal and develop healthy coping strategies
- Working in collaboration with service-users, respecting their experience and co-producing policies and materials wherever possible
- Creating a culture of compassion within the organisation.

*SAMHSA, 2014, p. 7

PERINATAL MENTAL HEALTH

Pregnancy related mental illnesses affects up to 30 in every 100 women following childbirth or during pregnancy[1]. It is becoming more recognised that around 10% men suffer impaired mental health around the time of becoming a father[2]. Pre-existing mental health conditions in parents can also affect children's health and wellbeing, and approximately 68% of women and 57% of men with mental health problems are parents.

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression. In Blackpool, 9.2% of births were registered by just one parent, which is higher than the average of 5.1%. Using the number of births which were registered by just one parent may give a rough indication of the number of women that are likely to lack the support of the father during pregnancy and as a new mother[3].

Poor parental mental health can disrupt the bond formed between a baby and its parents, and may affect the care they receive. Good mental health starts in infancy and research shows that when the bond between a baby and its parents is interrupted or not formed, there is a much higher risk of that baby developing mental health problems later in life, than a child with a strong connection to the person who cares for them.

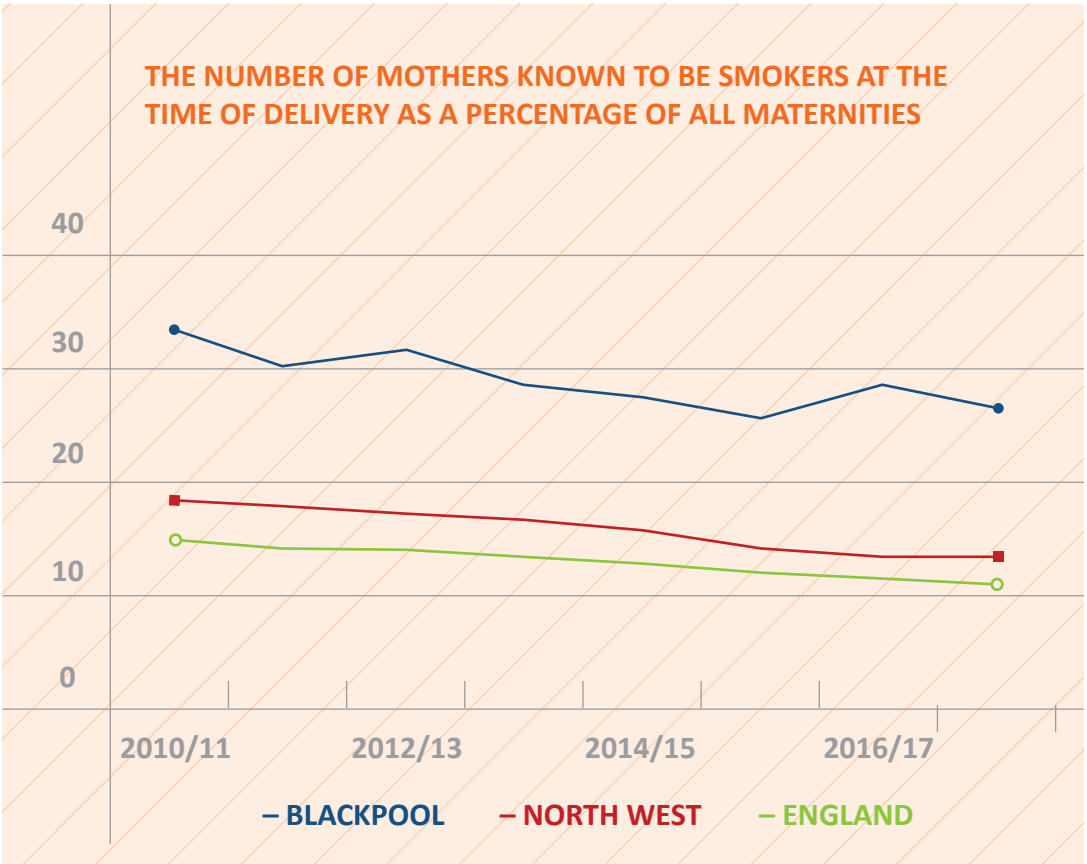
Blackpool Better Start run the Survivor Mums' Companion programme, designed to support pregnant women who have a history of childhood trauma. The programme aims to help survivors who are at risk of, or are experiencing, PSTD symptoms during pregnancy and helps them feel they are not the only one.

It is a telephone based service that provides pregnant women with information, emotional support and the opportunity to learn new skills. The service explores pregnancy and birth, PTSD symptoms, supports women to calm intense emotions and tackles any worries she may have about parenting and bonding with her baby.

1. https://maternalmentalhealthalliance.org/about/the-issue/
2. https://www.nct.org.uk/life-parent/emotions/postnatal-depression-dads-10-things-you-should-know
3. Mental health in pregnancy, the postnatal period and babies and toddlers: Report for Blackpool local authority. National Child and Maternal Health Intelligence Network, 2017.

SMOKING

Smoking in pregnancy is a risk factor for low birthweight and is associated with stillbirth, sudden infant death syndrome (also known as cot death), and asthma. Despite some improvement over the past eight years, the percentage of Blackpool mothers smoking at the time of delivery is more than double the national average and is significantly higher than the North West average.



As part of a National programme, in 2016/2017 Blackpool CCG received extra funding from NHS England to address high rates of maternal smoking. The Council's Public Health team has worked closely with the CCG to develop an evidence-based model to help women to stop smoking in pregnancy was developed; midwifery health trainers offer in-house stop smoking services including tailored behavioural support and direct access to nicotine replacement therapy for a minimum of 12 weeks. This model of stop smoking service includes an incentive scheme with the aim to support all pregnant women to set a quit date, achieve a carbon monoxide (CO) validated four week quit and sustain the quit with support throughout pregnancy and 12 weeks post-partum (post-natal or following pregnancy). Incentive payments are offered at stages throughout the pregnancy and evidence has shown this to be an effective adjunct to traditional smoking cessation methods. In 2018, there was a 44% increase in the number of women who quit when compared to 2017.

ALCOHOL AND DRUGS

Alcohol Exposure during pregnancy is considered one of the main preventable cause of birth defects and a diverse range of developmental disorders known collectively as Foetal Alcohol Spectrum Disorders. Harm caused by alcohol in pregnancy is significantly higher in Blackpool than the national average and is amongst the highest in the country. Members of the Public Health team and The Better Start Partnership have been conducting research to investigate local perspectives on the issue to better inform interventions to reduce alcohol consumption in pregnancy. As a result of this research, a 12-month media campaign was launched in November 2018, featuring a local Mum, Dad, Nan and best friend dressed as superheroes with the aim to reduce the number of alcohol exposed pregnancies in Blackpool.

The **PREGNANCY PARTNERSHIP CLINIC** was developed in conjunction with obstetricians, anaesthetists, midwives and addiction specialists to provide a multi-agency and person-centred approach to manage pregnancy in women with addiction issues. Women attend the clinic four weekly and are also offered weekly or fortnightly appointments with their key worker and a specialist midwife at Horizon. Referrals to additional support for domestic violence and mental health support are made as needed. The clinic facilitates delivery of high intensity behaviour change interventions, which are critically important at this stage in a woman's addiction to support safe delivery of a healthy baby and to provide the woman with the best possible opportunities to lead a healthier lifestyle for her and her family.

NUTRITION

Infant feeding involves both the dependent child and mother or caregiver and this relationship evolves during the early years of life until the child is able to eat independently. The nature of this relationship is a key determinant of the child's nutritional intake; the way in which food is offered or administered and the age at which foods are presented may affect acceptance of foods. This may either help or hinder broadening of the diet and may have long-term implications for eating behaviour and developing preferences for healthy foods.

The World Health Organization (WHO) recommends initiation of breastfeeding within the first hour after birth, exclusive breastfeeding for the first six months, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond[4]. Babies who are not breastfed are more likely to suffer infectious diseases such as gastroenteritis, respiratory disease and otitis media (middle-ear infections) leading to increased hospitalisation, morbidity and mortality[5]. Children who have not been breastfed have increased rates of childhood diabetes and obesity, and increased dental disease[5].

Breastfeeding prevalence in Blackpool is low, and there has been little change at population level breastfeeding uptake in Blackpool historically. Women who are overweight and obese are less likely to initiate and continue to breastfeed. Breastfeeding initiation rates in 2016/2017 were 57%, down from 63% in 2013/2014, and maintaining breastfeeding to six to eight weeks similarly remains low at around 25%.

In both cases, the rates for Blackpool are considerably lower than the England average. It is likely that high rates of bottle feeding and risk associated to formula feeding and premature introduction of solid foods, with other practices is likely to contribute to increased admissions for gastroenteritis (which are significantly higher in Blackpool than the England average).

The Better Start Partnership is training volunteers to work with new parents to help them to feel confident in their choices about how they feed their baby, from birth through to weaning and beyond.

The Public Health team has also been developing a Junior Healthier Choices Award, to celebrate food establishments in Blackpool that welcome breastfeeding and bottle-feeding on their premises, offer smaller portions and healthier choices for infants.

4. https://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding
5. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Victoria, C et al. The Lancet, Volume 387, Issue 10017, 475 – 490. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01024-7/abstract

VACCINE-PREVENTABLE DISEASES AND IMMUNISATIONS

Many diseases that would once have caused widespread illness and deaths amongst children are now extremely rare due to the UK routine childhood immunisation programme. Most vaccines are given in the early weeks-months of life to equip the children's immune systems to deal with infections they may come across as they meet new people and encounter new environments.

The European Region of the World Health Organization (WHO) currently recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control (specifically, diphtheria, tetanus, pertussis, polio, Hib, measles, mumps and rubella). Coverage at a regional level should be at least 90%. The UK schedule includes additional vaccinations that are approved by the Joint Committee on Vaccination & Immunisation[6].

SUMMARY OF ROUTINE VACCINATIONS UP TO THE AGE OF 5 YEARS OLD

Disease (Vaccine)	Age	Notes
Diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (DTaP/IPV/Hib)*	1st dose: 8 weeks 2nd dose: 12 weeks 3rd dose: 16 weeks	Primary course
Pneumococcal disease (PCV)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course
Rotavirus	1st dose: 8 weeks 2nd dose: 12 weeks	Primary course
Meningococcal group B (MenB) (from September 2015)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course
Haemophilus influenza type b and meningococcal group C (Hib / MenC)	One year	MenC Primary Hib Booster
Measles/mumps/rubella (MMR)	One year	First dose
Pneumococcal disease (PCV)	One year	Booster
Meningococcal group B (MenB) (from September 2015)**	One year	Booster
Children's flu vaccine	Aged 2 to 8 years	Annual vaccination
Diphtheria, tetanus, pertussis, and polio (DTaP/IPV or DTaP/IPV)	3yrs/4 months to 5 years	Booster: 3 years after completion of primary course
Measles/mumps/rubella (MMR)	3yrs/4 months to 5 years	Second dose

6. https://files.digital.nhs.uk/55/D9C4C2/child-vacc-stat-eng-2017-18-rep.pdf

In general, Blackpool's rates of vaccination are similar to the national picture, however nationally there are concerns that rates are not high enough to prevent outbreaks and there is large variation in coverage when you look at smaller geographies.

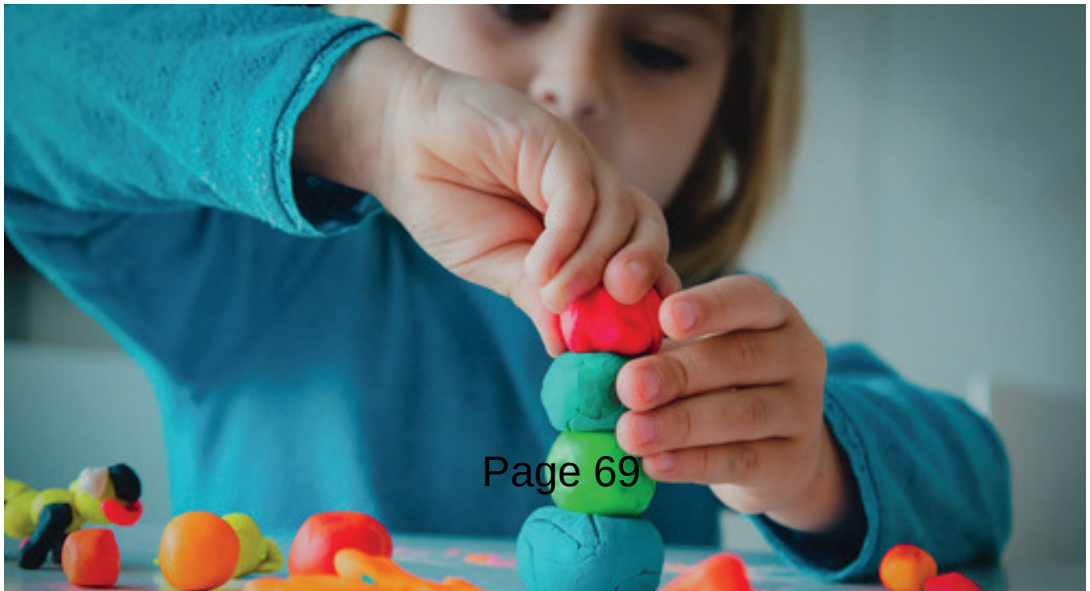
Only 88% of Blackpool's children were fully vaccinated against measles, mumps and rubella (two doses MMR by age five); a similar rate to the national average, but below the rate required for "herd immunity". The exact number of cases of measles mumps or rubella diagnosed in the town are not published, but there were 32 cases of measles and 86 cases of mumps confirmed in children aged 0-19 the North West region in 2017.

SCHOOL READINESS

The Early Years Foundation Stage (EYFS) sets standards for the learning, development and care of children from birth to five years old. All schools and Ofsted-registered early years' providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes. The areas covered by the EYFS include communication and language, physical development, personal, social and emotional development, literacy, mathematics, understanding the world, expressive arts and design. Children from poorer backgrounds are at greater risk of poorer development and the evidence shows that differences by social background emerge early in life. In 2017/2018, 67.9% of five year olds had achieved a good level of development at the end of reception, compared to 71.5% nationally. Only 54.7% of children eligible for free school meals (a crude indicator of socioeconomic deprivation) achieved a good level of development at the end of reception.

The development of a child's literacy skills are directly impacted upon by their early language skills. This relationship starts very early on in a child's life. A child's language skills at age two strongly influence their school readiness at the age of five and this can continue to impact upon their attainment and achievement throughout their school life[7]. The Better Start Partnership has introduced several interventions to promote parents' understanding of important role they play in supporting their child's communication and literacy skills. Activities include working with Dads to promote reading with their children, Book Start bundles of books and Literacy weeks with a variety of activities for families with children under five to take part in.

7. Roulstone S, et al 2011 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181549/DFE-RR134.pdf)



SCHOOL AGED CHILDREN

In the time between starting and leaving school, a lot can happen in a child's life. In order that our children can grow and learn and thrive, their health, wellbeing and the environment they live in needs to be at its best.

From a physical health point of view, Blackpool's children are more likely than the national rate to be admitted to hospital with asthma, diabetes or accidental or non-accidental injury and have a higher over-all rate of emergency admissions to hospital.

While good healthcare in both primary and secondary care settings is crucial, it contributes only around 10% of overall health. A further 10-20% of health is thought to be shaped by genetic factors, but even genes can be influenced by environmental factors. Most of what makes people healthy are the physical and social environments that they live in and giving children safe and healthy surroundings to grow up in can have significant impacts on their health, wellbeing and ability to learn and develop.

> The relationships between these "wider determinants of health" and health outcomes are complex, and it is the Public Health department's job to advocate and work towards improving the underlying foundations of health as well as targeting interventions more directly on improving health outcomes.

POVERTY

Around 26% of Blackpool's children (dependent children aged under 20) were living in poverty in 2016. This figure is likely to be higher when housing costs are taken into account. Bloomfield ward has the highest proportion of children (aged 0-15) living in poverty in the country, based on the Indices of Multiple Deprivation 2015 and Claremont and Brunswick wards also fall in the 20 wards with the highest levels of child poverty. About a quarter of Blackpool children are eligible and claiming free school meals and this has remained steady across the past four years[8].

Children from poorer backgrounds lag at all stages of education[9]:

- By the age of three, poorer children are estimated to be, on average, nine months behind children from more wealthy backgrounds.
- By the end of primary school, pupils receiving free school meals are estimated to be almost three terms behind their more affluent peers and this lag increases further by age 14 and 16.
- Children receiving free school meals achieve 1.7 grades lower at GCSE.

Poverty is also associated with a higher risk of both illness and premature death[10].

- Children born in the poorest areas of the UK weigh, on average, 200 grams less at birth than those born in the richest areas.
- Children from low-income families are more likely to die at birth or in infancy compared to children born into richer families.
- Children living in poverty are also more likely to suffer chronic illness during childhood or to have a disability.

8. https://fingertips.phe.org.uk/profile/child-health-profiles/
9. http://www.cpag.org.uk/content/impact-poverty
10. http://www.cpag.org.uk/content/impact-poverty

HOUSING AND FUEL POVERTY

Closely linked to poverty, the quality of housing can affect health and wellbeing of children as well as educational achievement. Children living in poverty are almost twice as likely to live in bad housing.

Fuel poverty also affects children detrimentally as they grow up as low income families do sometimes have to make a choice between food and heating. Long-term exposure to a cold home can affect weight gain in babies and young children, increase hospital admission rates for children and increase the severity and frequency of asthmatic symptoms.

Children in cold homes are more than twice as likely to suffer from breathing problems and those in damp and mouldy homes are up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared with those with warm, dry homes.

Struggling with high energy bills can have an adverse impact on the mental health of family members. Fuel poverty may even affect children's education – for example, if health problems keep them off school, or if a cold home means there is no warm, separate room to do their homework[11].

Last year's Annual Report focussed on the impacts of poor housing and transience within the town on health and highlighted the Council's Housing strategy that aims to deliver new housing supply, improve the private rental sector and to stabilise lives to prevent and resolve homelessness. This year the Public Health Team has taken on responsibility for the Warm Homes Fund and is delivering on two schemes for improving the energy efficiency and heating in houses in Blackpool.

WARM HOMES FUND SCHEMES

The Warm Homes Health Fund aims to help vulnerable households across Blackpool through two schemes to reduce fuel poverty.

Scheme 1 – The Energy Efficiency and Health Related Solution

- Conducting 'Energy Audits'

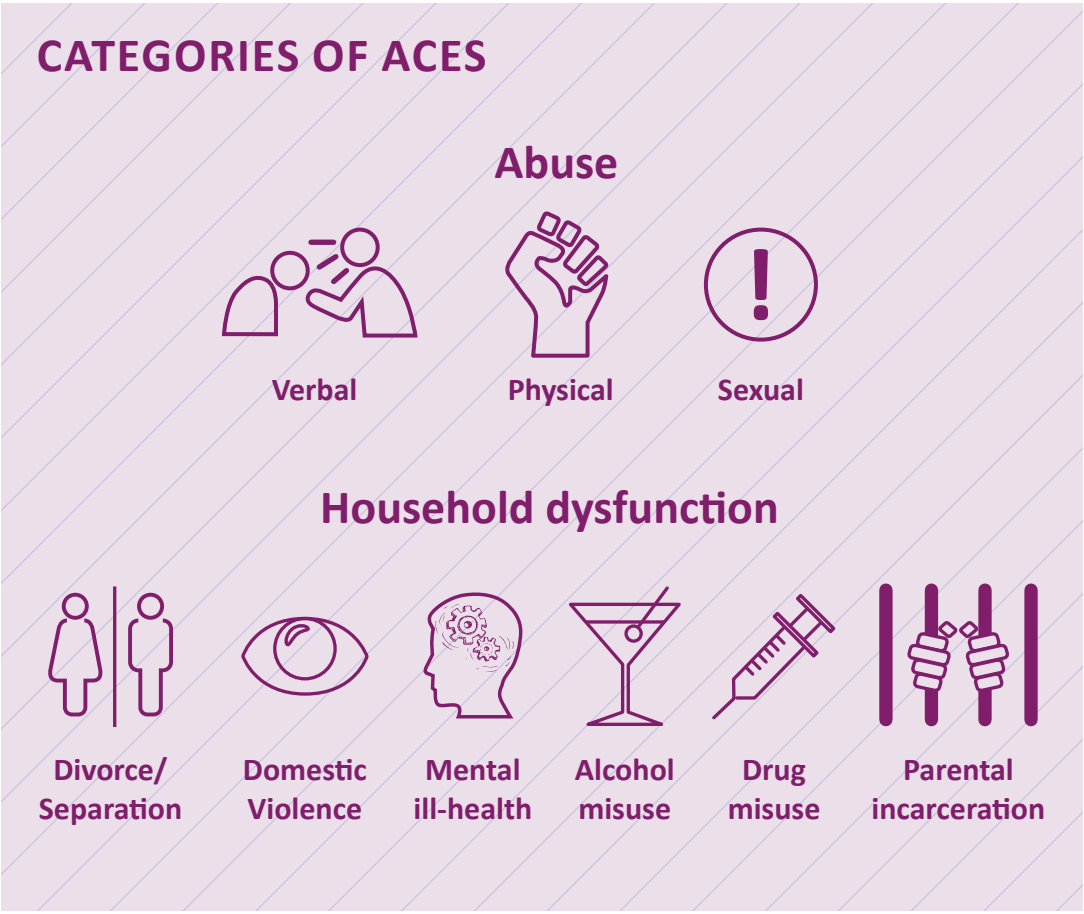
11. Pedro Guertler and Sarah Royston, Fact-File: Families and Fuel Poverty, Association for the Conservation of Energy

CHILDHOOD ADVERSITY AND EXPERIENCE OF THE CARE SYSTEM

Blackpool has the highest proportion of looked after children in the country with 185 children in care per 10,000 population aged under 18 years. Children and young people in care are among the most socially excluded children in England. Entry into the care system is associated with significant inequalities in health and social outcomes compared with all children and this contributes to poor health and social exclusion of care leavers later in life[12].

In general, the reasons why children enter the care system is through safeguarding mechanisms designed to protect them from adversities such as abuse, neglect and exposure to domestic violence or drug or alcohol misuse. To compound these early life experiences, children who come into foster households are typically from families/ communities, which already struggle with factors that correlate with social exclusion (unemployment, poor skills, low income, poor housing, high crime and bad health).

Children in care often have multiple risk factors that contribute to limiting educational attainment. A higher proportion of children in care have special educational needs and poorer emotional and behavioural health, again affecting educational attainment and in turn health outcomes in later life.



12. https://www.thetcj.org/foster-care/children-and-foster-care-inclusion-exclusion-and-life-chances

Adverse Childhood Experiences (ACEs – see image) such as those experienced by children in care as well as many others have been shown to have strong correlations with poor adult health outcomes. Studies conducted that looked at the ACEs experienced by adults in England[13] found that compared to those with no ACES, adults who had experienced four or more ACEs were:

- **2.3 times more likely to develop cancer**
- **3.1 times more likely to have cardiovascular disease**
- **2.5 times more likely to have liver or digestive disease**
- **2.1 times more likely to a regular binge drinker**
- **3.3 times more likely to be a current smoker**
- **10.9 times more likely to be a heroin or crack user**
- **7.5 times more likely to have been a victim of violence in the previous 12 months**
- **7.7 times more likely to have perpetrated violence in the previous 12 months**
- **11.3 times more likely to have been in prison or cells.**

ACEs have also been shown to have impacts on educational attainment, with poor childhood health and school absenteeism increased with number of ACEs reported. These findings indicate that ACEs are associated with significant burden on health and social care, the education and criminal justice systems and wider society.

Modelling based on the England ACEs study indicates that preventing ACEs in future generations could reduce levels of smoking by 22.7%, binge drinking by 11.9%, poor diet by 13.6%, violence perpetration by 52.0%, heroin/crack cocaine use by 58.7%, and unintended teenage pregnancy by 37.6%14.

Blackpool Council Public Health team is working in collaboration with partners from across Lancashire and South Cumbria, including local authorities, health services, education, policing and the Better Start Partnership to create “Trauma Informed Lancashire”. The aim is to establish an evidence base of interventions and ways of working designed to prevent ACEs, reduce their impact should they occur in childhood and enable adults with ACEs or other trauma to engage with services and activities that enable healing. The ultimate vision of this working group is to propagate a cultural shift towards the whole of Lancashire and South Cumbria becoming trauma informed and ACE-aware, with a view to reducing the poor health outcomes associated with ACEs and trauma.

13. Bellis MA et al. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. Journal of Public Health 2015 Jan-1;37(3):445-454.

ACEs have also been shown to have impacts on educational attainment, with poor childhood health and school absenteeism increased with number of ACEs reported. These findings indicate that ACEs are associated with significant burden on health and social care, the education and criminal justice systems and wider society.

Modelling based on the England ACEs study indicates that preventing ACEs in future generations could reduce levels of smoking by 22.7%, binge drinking by 11.9%, poor diet by 13.6%, violence perpetration by 52.0%, heroin/crack cocaine use by 58.7%, and unintended teenage pregnancy by 37.6%[14].

Blackpool Council Public Health team is working in collaboration with partners from across Lancashire and South Cumbria, including local authorities, health services, education, policing and the Better Start Partnership to create "Trauma Informed Lancashire". The aim is to establish an evidence base of interventions and ways of working designed to prevent ACEs, reduce their impact should they occur in childhood and enable adults with ACEs or other trauma to engage with services and activities that enable healing. The ultimate vision of this working group is to propagate a cultural shift towards the whole of Lancashire and South Cumbria becoming trauma informed and ACE-aware, with a view to reducing the poor adult health outcomes associated with ACEs and trauma.

EDUCATION

Educational attainment is linked with health behaviours and outcomes. Individuals that are more educated are less likely to suffer from long-term diseases and to report themselves in poor health, or suffer from mental disorders such as depression or anxiety. Pupils in deprived areas (such as Blackpool) are more likely to miss school and therefore have lower levels of educational attainment. Disadvantaged pupils are defined as those who are registered as eligible for free school meals, children looked after by the local authority and children who left care. In 2017, 45% of pupils at the end of KS2 were classed as disadvantaged in Blackpool.

Blackpool has 3,367 pupils with special educational needs (SEN) within its schools, this is 17.9% of all pupils and compares to 14.4% nationally. There are 957 children with a learning difficulty known to schools, the rate of 50.4 per 1,000 children is higher than the national average of 33.9 per 1,000. In 2018, there were 206 children with autism known to Blackpool schools.

Educational attainment is measures predominantly at Key Stage 2 (age 11 in year 6 of Primary School) and at Key Stage 4 (age 15, GCSEs or equivalent). Data for 2017 shows that overall, 62% of children in Blackpool attained the expected standard in all of reading, writing and maths, an increase from 48% in 2016. This is now the same as the national average. Only 53% of children classified as disadvantaged attained the expected standard, which is slightly better than the national level of 48%.

14. Bellis et al. BMC Public Health (2018) 18:792

At Key stage 4, the “Attainment 8” and “Progress 8” scores are used to assess how well pupils are performing[15]. The average Attainment 8 score for Blackpool pupils was 38.5 in 2017/2018, compared to 44.5 nationally. Disadvantaged students in Blackpool attained an average score of only 32.2, compared to non-disadvantaged pupils who attained and average score of 43.5[16].

The average Progress 8 score shows Blackpool pupils achieve over half a grade lower than similar pupils nationally and are making below average progress.

Work is being undertaken to improve the educational attainment of Blackpool’s children and Blackpool has been designated an “Opportunity Area”, with a strategy spanning 2017-2020 with the aims of

- Raising attainment and progress in Blackpool’s schools
- Supporting vulnerable children and families to improve attendance and outcomes and to reduce exclusions from school
- Improve advice and support for young people when moving between schools/colleges and into work.

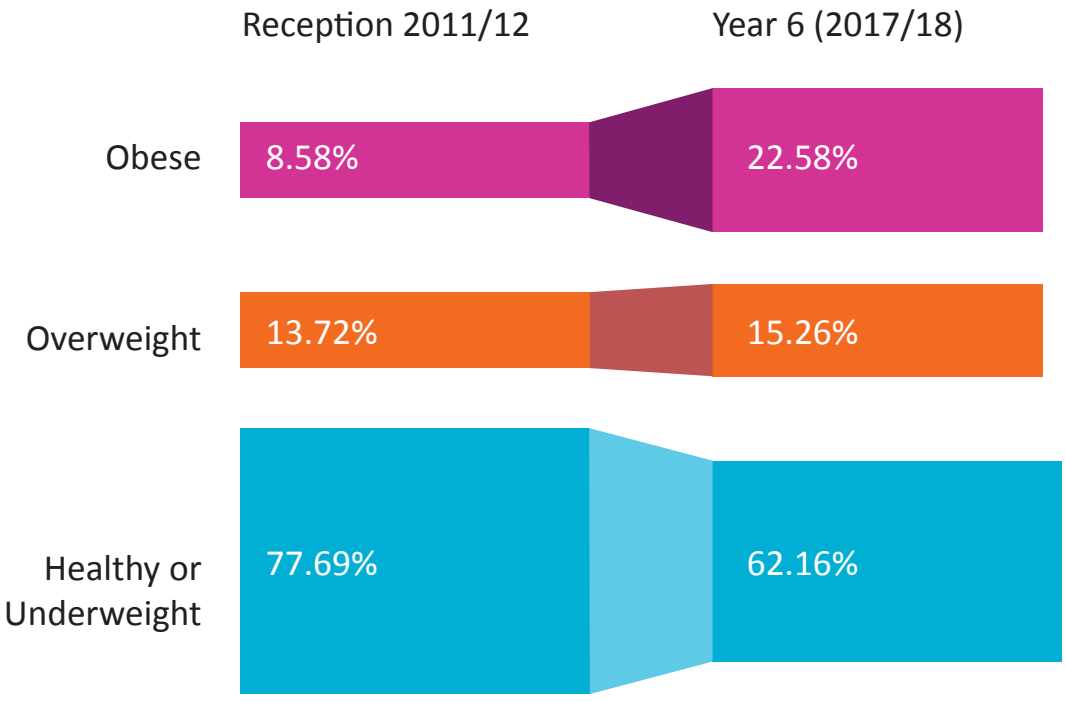
15. https://www.gov.uk/government/publications/progress-8-school-performance-measure
16. Data obtained from DfE https://www.gov.uk/government/statistics/secondary-school-performance-tables-in-england-2018-revised

HEALTHY WEIGHT AND PHYSICAL ACTIVITY

Obesity is defined as excess body fat accumulation that may impair health. The foundations of obesity start in childhood. The prevalence of obesity has trebled since the 1980s and well over half of all adults are either overweight or obese.

Over a quarter (27.1%) of children in Blackpool aged four/five years are overweight or obese when they start school. The proportion of children who are overweight or obese rises considerably during primary school years and 37.8% of today's year six children living in Blackpool are overweight or obese by the time they finish primary school at age 10-11 years compared to only 22.31% when they were in reception in 2011/2012. Within this expansion in numbers, obesity increases 2.5 times and overweight remains at a similar proportion. The prevalence of excess weight at year six is significantly higher than the England average (34.3%) and there is evidence that rates in disadvantaged areas continue to increase at a faster rate than less disadvantaged areas.

CHANGES IN PROPORTION OF BLACKPOOL CHILDREN IN OBESE, OVERWEIGHT OR HEALTHY WEIGHT CATEGORIES IN BETWEEN RECEPTION (2011/2012) AND YEAR 6 (2017/2018)



In January 2016, Blackpool Council became the first local authority in the country to sign a Local Authority Declaration on Healthy Weight and made a commitment to support employees and residents of Blackpool to tackle the issue of obesity. Work to achieve these commitments has been on going and during 2018,, the Public Health team has been working with a range of partners to develop a variety of interventions and actions to achieve them.

The children and families weight management programme, which is operated by Blackpool Council leisure services, continues to provide a programme which support families improve their knowledge and skills around healthy eating and physical activity, to enable them to use these skills to make and sustain healthy lifestyle choices.

The Council has made good progress during 2018 on tackling obesity in the town, but there is still more work to be done. As we look forward to 2019, the Public Health team will be undertaking a review of the healthy weight work and delivering a series of workshops on a whole systems approach to obesity to engage other council departments and work with key stakeholders across Blackpool. This work will help shape the future direction of the Healthy Weight strategy which will have a focus on our Early Years.

The Give Up loving Pop (GULP) campaign continues to grow from strength to strength within the Primary Schools, with the campaign being run for both Year 4 and 5 pupils encouraging children to choose sugar-free alternatives to fizzy drinks.

To build on this in November 2018 with the support of Better Start we launched an Early Years Gulp campaign 'Be Kind to Teeth'.

In addition to the work taking place specifically targeting obesity, there is complementary activity taking place to encourage children to become more physically active. Emerging evidence suggests an association between being physically active and academic attainment and attention. Being physically active also helps to promote physical and emotional health and wellbeing and children and young people who are physically active are more likely to continue the habit into adult life[17].

There are a number of Fit2Go programmes in the town including Family Fit2Go and Better Start Fit2Go. All these are about supporting children and families make healthier choices and live a healthier lifestyle. The Public Health nutritionist has been working with our primary schools to develop healthy packed lunch guidance to support parents with making healthy packed lunches and our the Blackpool Football Community Trust are promoting these resources as part of the Fit2Go programme in the primary schools.

17. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/469703/What_works_in_schools_and_colleges_to_increas_physical_activity.pdf

WOW – the year-round walk to school challenge is Living Streets' flagship walk to school scheme, is a pupil-led initiative where children self-report how they get to school every day using the interactive WOW Travel Tracker. If they travel sustainably (walk, cycle or scoot) once a week for a month, they are rewarded with a badge. On average, WOW schools see a 30% reduction in car journeys taken to the school gate and a 23% increase in walking rates.

Children are excited to walk to school every day because they want to earn a badge and they arrive to school refreshed, more focused and ready to learn having walked in the fresh air. In Blackpool 25 out of the 33 schools take part in the scheme supported by a local coordinator.

ORAL HEALTH

Good oral health is integral to a child's general health and wellbeing. Oral health affects how children grow, enjoy life, look, speak, chew, taste food and socialise, as well as their feelings of social wellbeing. Poor oral health and associated pain and disease can lead to difficulties in eating, sleeping, concentrating and socialising, thereby affecting health-related quality of life with individual, family and societal consequences (school absence, time off work and financial impacts to the individual and society). Tooth decay is the most common chronic disease in childhood even though it is largely preventable.

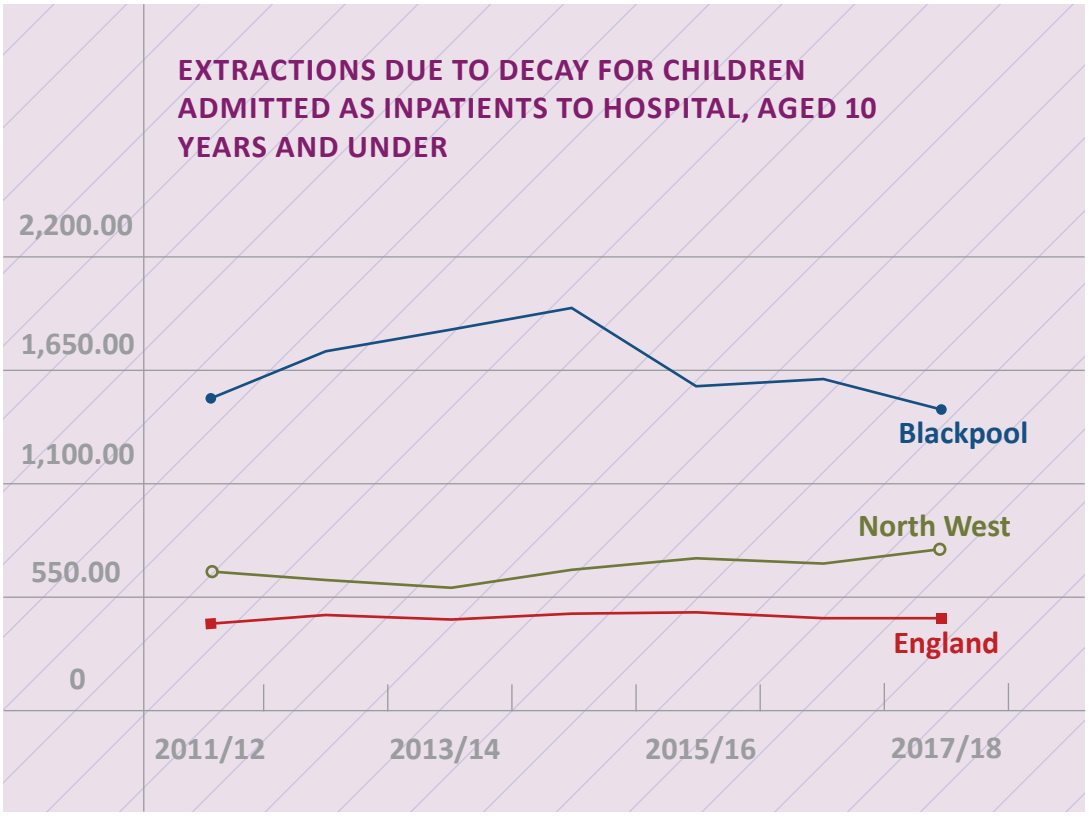
Often dental treatment for young children (such as extractions of decayed teeth) may only be done under general anaesthetic, which is both distressing for the families concerned and carries a financial burden. Tooth decay accounts for high numbers of child general anaesthetics and for children aged between five and nine years across England, it is the most common reason for hospital admission.

Tooth decay is the most common chronic disease in childhood even though it is largely preventable and is the top cause for hospital admission across England for children aged five to nine years.

Between 2014/2015 and 2016/2017 Blackpool's child dental health has improved significantly with the average number of decayed, missing or filled-teeth (DMFT) per five-year-old child reducing from 1.83 to 0.96, and the proportion of five year olds with no decay increasing from 57.5% to 75.1%. Tooth extractions due to decay for children admitted as inpatients to hospital, aged ten years and under had been increasing in the town, but since 2014 have had an overall downward trajectory, indicating that we have made some progress in improving our children's dental health.

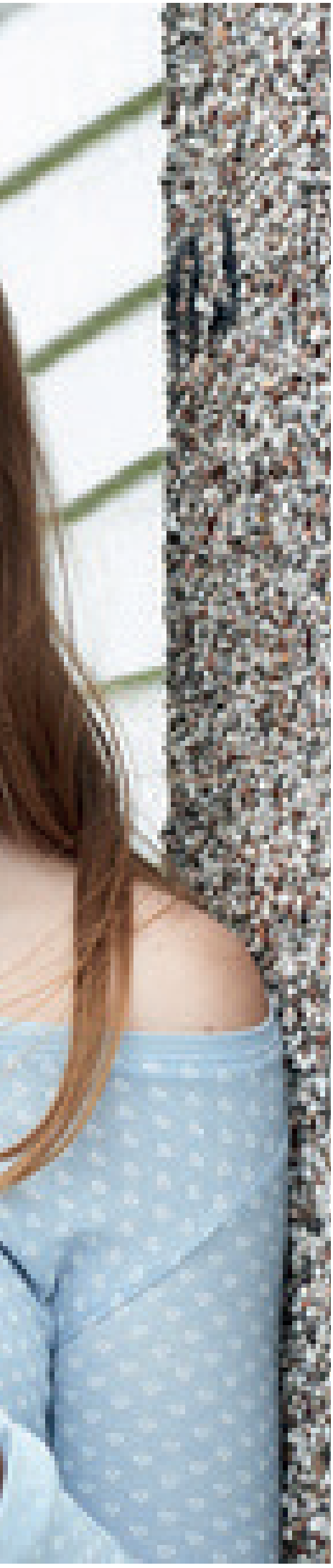
WHAT ARE WE DOING FOR BETTER DENTAL HEALTH IN BLACKPOOL?

- Dental Epidemiology
  The Public Health department is responsible for commissioning annual surveys to monitor children and young people's dental health
- Brushing for Life scheme
  Toothbrush and toothpaste distribution scheme to all new mums via Health Visitors
- Fluoridated Milk programme available to children in years one to six in primary schools



ADOLESCENCE

Adolescence is another period when experiences encountered can have a lasting impact on life-long health. Changes in brain structure, hormones and the physical body can interact with changing relationships, societal expectations and educational pressures to create a period of vulnerability to both mental and physical health challenges.



TOBACCO, ALCOHOL AND SUBSTANCE MISUSE

The harms to health from tobacco are well known; smoking is the leading cause of preventable illness and premature death in England. It is an addiction that is most commonly acquired in adolescence – in England in 2014, 77% of smokers aged 16 to 24 began smoking before the age of 18[18].

Short-term health consequences, such as shortness of breath, are experienced by teenagers who smoke almost three times as often as teens who do not. Smoking reduces young people's physical fitness in terms of both performance and endurance.

Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. Early signs of heart disease and stroke can be found in adolescents who smoke and there is an increased risk of lung cancer in those who start smoking early. For most smoking-related cancers, the risk rises as the individual continues to smoke.

There is also a threefold increase in alcohol use in smokers compared to non-smoking teens. They area also eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviours, such as fighting and engaging in unprotected sex[19].

The latest statistics on smoking in adolescence from 2014/2015 indicate that 13.4% of 15 year olds in Blackpool were current smokers at the time compared to 8.2% nationally (11% regular smokers in Blackpool versus 5.5% in England) and 33.9% of Blackpool respondents had tried e-cigarettes or vaping (18.4% in England). A more recent survey is due to be published on 25 July 2019 and will be available at http://digital.nhs.uk/pubs/sdd18.

As the evidence for what works to reduce smoking uptake and tobacco use in young people is limited[20], in 2018 Blackpool launched a pilot programme to engage with schools and other settings to engage young people and co-design a service tailored to them, with the appointment of a Children and Young People's Stop Smoking Advisor. The pilot will enable us to understand the most effective way to support young people to stop smoking and assess the demand for such a service, to enable us to shape future provision.

18. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
19. https://www.who.int/tobacco/research/youth/health_effects/en/
20. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003289.pub6/abstract

MENTAL HEALTH

Mental health can affect on all areas of young people's lives – how they feel about themselves and others, their relationships and their psychological and emotional development. Poor mental health underlies many risk behaviours, including smoking, alcohol and drug misuse and higher-risk sexual behaviour[21]. Being mentally healthy helps people to realise their potential, gives them strength to cope with change, overcome challenges and adversity and make a positive contribution to their community[22].

Blackpool has some of the highest levels of need with respect to mental health – it is estimated that 10.3% of children aged 5-16 are likely to have mental health disorders. One in every 100 children and young people aged 10-24 were admitted to hospital due to self-harm in 2017-2018, and around 3.3% of secondary school pupils are reported as having social, emotional and mental health needs.

Since 2017 the eight CCGs covering Blackpool, Blackburn with Darwen and Lancashire have been implementing a joint plan for the transformation of services for supporting resilience, emotional wellbeing and mental health of children and young people.

NHS Child and Adolescent Mental Health Service (CAMHS) provider organisations were tasked to work collaboratively with voluntary community and faith sector providers and with CCGs to co-produce a core model for CAMHS services across Lancashire and South Cumbria through a process of engagement and co-production with children, young people, families and wider stakeholders. The group of provider and CCG representatives leading this work are referred to as The Care Partnership.

In Phase 1 of the redesign, which took place in early 2018, children and young people told The Care Partnership that:

- there isn't enough support for young people from services
- people in communities as well as professionals need more knowledge about mental health and its impact
- waiting times are too long
- criteria get in the way of accessing support
- there needs to be more options for treatment
- there continues to be a negative stigma about mental health.

In line with the project timeline the Care Partnership Team submitted an outline proposal for a new care model in August 2018. This was evaluated by an independent panel and the panel's recommendations to proceed to Phase 2 of the project was approved by the Transformation Board in September 2018.

Preparations for Phase 2 (to take place in early 2019) involved development of a Phase 2 project timeline and a Co-production and Engagement Plan. The Phase 2 timeline was approved by the Transformation Board in October 2018.

21. Royal College of Psychiatrists Position Statement PS4 (2010)
22. World Health Organisation (2005) Promoting Mental Health; Concepts, emerging evidence and practice.

Blackpool CAMHS Based at Blackpool Victoria Hospital has set up a patient participation group called Entwined Minds (named by the service users), which runs once a month and is open to all ages. They discuss patient experiences and ask for young people's views on our website/waiting room/ leaflets with the plan for them to redesign tools and spaces within CAMHS. They have redesigned information leaflets and are in the process of redesigning the waiting room to make it a more welcoming place for children of all ages.

Since 2014, HeadStart have been working in collaboration with children and young people and various partner organisations in Blackpool to develop a programme of activities and action to create a cultural shift in support of building resilience in young people and Blackpool as a community. By taking a proportionate universalism approach, they aim to maximise the potential to achieve outcomes through supporting the whole cohort towards resilience. Activities undertaken include workforce development, with training of professionals in various fields being trained in the HeadStart concept of resilience, provision of the online counselling service KOOTH, "Saddle Up" - a project combining equine care and art therapy, youth work ,family support and peer mentoring, amongst others.

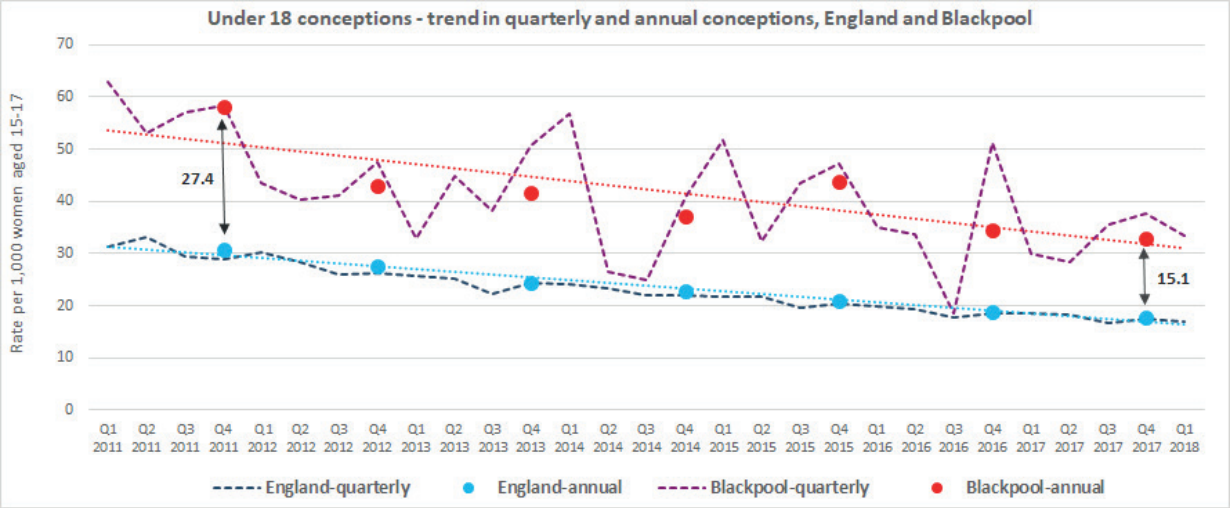
SEXUAL HEALTH

Young people aged 15-24 are the age group most affected by sexual infections and there are rising numbers of people under 24 years of age living with HIV[23]. Nationally around two thirds of new STI diagnoses are in women under 25 years old. Over half of new diagnoses in men are also in the under-25s[24]. Adolescence and young adulthood is a time when individuals often begin to explore their sexuality, and is an important time to educate about sexual health.

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill health, including symptomatic acute infections and complications such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility. The National Chlamydia Screening Programme recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent)[25]. Other infections with prominent emphasis for young people are the human papilloma virus (HPV), chlamydia, and, recently in the UK headlines, an increasing prevalence of multi-drug resistant gonorrhoea.

In 2017, Blackpool had the second highest rate of chlamydia diagnoses in 15-24 year olds, and this is reflective of the success of the 15-24 chlamydia screening programme, which achieved the third highest proportion of 15-24 year olds tested. Blackpool also has the highest rates of detection of STIs in under-25 year olds in the North West (excluding chlamydia).

HPV is a sexually transmitted virus that is associated with cervical (and other) cancers. In 2008 a universal programme of HPV vaccination in girls aged 12-13 years in schools was rolled out. Blackpool has achieved a similar rate of HPV vaccination coverage to the national rate (two doses for females 13-14 years old), but has not yet reached the ideal target of greater than 90%.



23. http://nursinginpractice.com/article/hiv-and-aids-update
24. https://www.nursinginpractice.com/article/sexual-health-young-people
25. https://www.gov.uk/government/collections/sexually-transmitted-[illegible]-surveillance-data-screening-and-management

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes; in particular, babies born to mothers under 20 years had a 30% higher rate of stillbirth than average and a 60% higher rate of infant mortality than average (England and Wales data).

Despite Blackpool's under-18 conception rate being approximately double that of England, over the past few years we have managed to narrow the gap. In order to continue this trend, new actions are needed and we need to be innovative.

Reduction in first and subsequent pregnancies has contributed to improving under-18 conception rates. We have worked to increase the uptake long-acting reversible contraception (LARC) by collaboration between and co-location of Sexual health and Termination of Pregnancy (ToP) services, enabling all women presenting for a ToP to have timely HIV/STI testing and seamless access to LARC.

In Blackpool, the Council has always prioritised teenage pregnancy, but with a smaller than average reduction of 32% and the highest under-18 conception rate in England, efforts have been redoubled.

To ensure consistent best practice in all schools, a new PSHE scheme has been developed, concentrating on sexual health and relationships, drugs and alcohol and emotional health and consent. Teachers and other school staff are trained in awareness of risky behaviours, a local support forum for PSHE leads has been set up. All schools have participated, with overwhelmingly positive feedback from pupils and positive comments from Ofsted in individual school inspection reports.

To strengthen targeted prevention, a domiciliary care pathway has been developed to enable joint visits with staff working with vulnerable young people, mental health, drug/ alcohol and learning disabilities. Domiciliary visits are working effectively as a multiagency approach, engaging with individuals who have previously not engaged with services and with a fast track to the LARC method of contraception.

TRANSITION INTO ADULTHOOD

The transition from childhood to adulthood is a challenging time for teenagers. Taking on adult responsibilities such as housing, budgeting and employment can be challenging for any teenager, but those with additional difficulties and vulnerabilities can need extra support.

One in five of 16 and 17 year olds experience five or more factors in their lives that may contribute to vulnerability. This equates to approximately 24,000 16 and 17 year olds in England[26]. Applying this statistic to Blackpool, over 600 out of approximately 3,000 16 and 17 year olds would fall into this category and likely more due to the levels of deprivation and numbers of children in care in the town.

Issues that lead to older teenagers being referred to children's services include domestic violence, mental ill health, drug or alcohol abuse and a risk of child sexual exploitation (CSE) and often these issues present in combination. For the 16- and 17- year olds experiencing a high number of risks and vulnerabilities, these issues are likely to remain, or intensify, as young people become young adults. Young people who are registered as 'children in need' are more likely to have poor educational attainments at the age of 17, more likely to be NEET (not in education, employment or training), claim benefits and experience homelessness than young people not in contact with social services.

In Blackpool in 2018, 18% of all 17-16 year olds were NEET (compared to the England rate of 6%), rising to 28.1% (England rate 9.6%) when looking at 17-16 year olds with Special Educational Needs (SEND). This puts Blackpool in the position of having the fourth highest rate of NEET in the country (third highest for SEND adolescents).

BYSTANDER

Tackling sexual/domestic violence is a key priority in the Blackpool Sexual Health Strategy and Action Plan (2017-2020) and the Domestic Violence Strategy and Action Plan (2017/2020). Through the Drug Strategy action plan there is an objective to support vulnerable people through early action, prevention and education across partner agencies, including domestic violence.

The bystander programme aims to equip individuals with the skills to help when participants witness behaviour that put others at risk. Bystander intervention aims to change the 'social norms' that this is 'normal' or 'acceptable' behaviour.

The strength of the bystander model lies in its emphasis on the role of peers in the prevention of violence. By treating young people as part of the solution to sexual assault, rather than part of the problem, bystander programmes limit the risk of defensiveness or backlash among participants.

26. https://www.childrenssociety.org.uk/sites/default/files/seriously-awkward-full-report.pdf

During 2018, a task and finish group was set up and an action plan developed. Links have been made with UCLAN, who have already piloted the programme with positive feedback, to align evaluation methodology for any future collaboration or comparisons.

The proposed programme is designed to be delivered by experienced facilitators. In support of implementation, a 'Train the Trainer' workshop was held on 14th December 2018, in preparation for a start date in February 2019.

TRANSITIONS

Transition describes the move from children's services to adult services. This can involve leaving school, transferring from children and family services to adult social care services and/ or transferring from paediatric services to adult health or mental health services.

These periods of transition are recognised as a time when young people may "fall though the gaps" and may not receive the care or services they need to stay healthy or fully engage in society.

Since 2010, the Government has put in place guidelines for enabling smooth and safe transitions and the Department of Education state that *"successful transition depends on early and effective planning, putting the young person at the centre of the process to help them prepare for transfer to adult services. The process of transition should start while the child is still in contact with children's services and may, subject to the needs of the young person, continue for a number of years after the transfer to adult services. This will ensure that young people and parents know about the opportunities and choices available and the range of support they may need to access.*[27]"

27. Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care, 25th February 2010.

CARE LEAVERS

Blackpool has the highest number of "Looked after Children" (LAC) in the country. Children in care must leave local authority care by their 18birthday. Local authorities must support care leavers until they are 21 years old (or 25 if they are in education or training)[28].

In the year ending March 2018, 44% of Blackpool's care leavers aged 17–18 and 46% of care leavers aged 19–21 were in education, employment or training. Around a fifth of the 19–21 age group that were NEET, were so due to pregnancy or parentingand about two fifths due to illness or disability[29].

A major issue facing care leavers is the availability of secure housing and a lack of skills to be able to maintain tenancies. Historically 100% of care leavers who were accommodated in Blackpool Coastal Housing (BCH) properties without floating support failed to maintain their tenancies. There were incidences of young people leaving semi-independent on their 18th birthday and presenting as homeless at Housing Options and the quality of available accommodation options in the private rented sector was problematic resulting in numerous failed tenancies.

The Positive Transitions Housing Model was developed in September 2017 following agreement by Corporate Leadership Team (CLT) for implementation in November 2017. The scheme provides accommodation in the social housing sector for young people who are 17 years of age and above and have low- medium support needs. The model is a step down from either semi-independent group living, flat with floating support or supported accommodation and foster care.

This model was introduced to improve outcomes for young people by supporting them in to safe, secure, quality assured accommodation that has the potential to be a long term home.

By the end of 2018, 18 young people had been through the Positive Transitions Housing Model and despite challenges encountered around antisocial behaviour, non-engagement and rent arrears (in some cases due to the introduction of universal credit), the scheme has been broadly successful and is certainly a move in the right direction for supporting some of Blackpool's most vulnerable young people.

28. National Audit Office. 2016. Care leavers' transition to adulthood
29. https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018

MENTAL HEALTH

Discharge from Child and Adolescent Mental Health Services (CAMHS) and a potential move to Adult Mental Health Services (AMHS) takes place at varying ages, but most commonly when young people are aged between 16 and 18. The point of transition is a time of potential upheaval for young people. They may find it difficult to navigate new service settings or to manage their mental health and wellbeing following discharge from CAMHS, especially as the availability and offer of support can change dramatically.

During May and June 2018, local Healthwatch teams from the Lancashire and South Cumbria local Healthwatch Collaborative supported the facilitation of several co-production workshops at a variety of locations with young people in a collaborative approach to improve how CAMHS services are delivered. The Transition workshop highlighted several areas of practice that need to be "fixed" and ways in which the transition period could be managed to be more person-centred. These findings were fed into the wider CAMHS transformation plan and work in this area is ongoing.

RECOMMENDATIONS

This report has highlighted the many opportunities during childhood at which we, as health and social care professionals, may take action to protect and promote health and protect our children from illness in later life.


Photo Credit

RECOMMENDATIONS

As mentioned in the forward, the Integrated Care System (ICS) is committed to keeping children's health and wellbeing at the core of all its activities and has suggested the following key impact areas to work on in the coming year:

- Smoking in pregnancy
- Perinatal mental health
- Infant feeding
- Dental health
- School readiness and 'life' readiness
- Taking an ACE/trauma informed approach

This report has shown that Blackpool is already making great strides to improve some of these areas (in particular smoking in pregnancy, dental health, the Health Visiting transformation and taking an ACE/trauma informed approach), and we are committed to taking action to improve the health of Blackpool's children at every stage of their lives. 2019 brings further opportunities to benefit the health of children as we embark on renewing our healthy weight and 0–19 strategies.

In light of all we have achieved so far and all that there is still to do, I make the following recommendations for ensuring the best health outcomes for Blackpool:

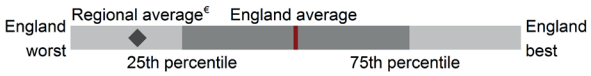
1. Continue to invest in early years interventions – for the health of our children and future health of Blackpool as a whole
2. Work with our partners across the whole system to continue to make progress towards the aims of the Healthy Weight Declaration
3. Continue to advocate wider measures to protect children's ability to engage in education and improve their prospects for the future (poverty, housing, preventing ACEs)
4. Commit to innovative and creative approaches towards reducing teen pregnancy rates to national levels
5. Work with Head Start to build personal and community resilience and give young people the tools to support their emotional and psychological wellbeing
6. Be proactive within the health and care sectors to advocate for our young people and ensure that no child or young person falls through the net at points of transition.

APPENDIX

Health summary for Blackpool

The chart below shows how the health of people in this area compares with the rest of England. This area's value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	74.2	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	79.5	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	2,093	545.7	333.8	545.7	215.2
	4 Under 75 mortality rate: cardiovascular	2014 – 16	456	118.8	73.5	141.3	42.3
	5 Under 75 mortality rate: cancer	2014 – 16	721	186.8	136.8	195.3	99.1
	6 Suicide rate	2014 – 16	57	16.0	9.9	18.3	4.6
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	195	46.6	39.7	110.4	13.5
	8 Hospital stays for self–harm	2016/17	774	578.9	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	165	575.8	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	301	44.7	52.6	39.3	61.9
	11 Diabetes diagnoses (aged 17+)	2017	n/a	80.0	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	1,726	78.5	67.9	45.1	90.8
Behavioural risk factors	13 Alcohol–specific hospital stays (under 18s)	2014/15 – 16/17	64	74.3	34.2	100.0	6.5
	14 Alcohol–related harm hospital stays	2016/17	1,589	1,151.1	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	24,850	22.3	14.9	24.8	4.6
	16 Physically active adults (aged 19+)	2016/17	n/a	60.4	66.0	53.3	78.8
	17 Excess weight in adults (aged 18+)	2016/17	n/a	63.5	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	82	34.6	18.8	36.7	3.3
	19 Smoking status at time of delivery	2016/17	507	28.1	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	1,068	59.2	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	28	5.4	3.9	7.9	0.0
	22 Obese children (aged 10–11)	2016/17	291	21.1	20.0	29.2	8.8
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	42.0	21.8	42.0	5.0
	24 Smoking prevalence: routine and manual occupations	2017	n/a	33.4	25.7	48.7	5.1
Wider determinants of health	25 Children in low income families (under 16s)	2015	7,205	27.6	16.8	30.5	5.7
	26 GCSEs achieved	2015/16	666	45.5	57.8	44.8	78.7
	27 Employment rate (aged 16–64)	2016/17	58,300	70.8	74.4	59.8	88.5
	28 Statutory homelessness	2016/17	612	9.6	0.8		
	29 Violent crime (violence offences)	2016/17	5,895	42.2	20.0	42.2	5.7
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	306	17.5	17.9	30.3	6.3
	31 New sexually transmitted infections	2017	1,010	1,154.3	793.8	3,215.3	266.6
	32 New cases of tuberculosis	2014 – 16	43	10.3	10.9	69.0	0.0

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

Blackpool Child Health Profile June 2018

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

↔ No significant change
↑↓ Increasing / decreasing and getting better
↑↓ Increasing / decreasing and getting worse
▪ Trend cannot be calculated

● Not significantly different from the England average
● Significantly better than England average
● Significantly worse than England average
○ Significance cannot be tested

England average | Regional average | 25th percentile | 75th percentile

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↔	***9***	5.4	3.9	7.9	1.6
	2 Child mortality rate (1-17 years)	▪	***5***	19.2	11.6	22.4	6.2
Health protection	3 MMR vaccination for one dose (2 years) ● ≥95% ● <90% ● 90% to 95%	↔	1,738	89.8	91.6	69.8	97.5
	4 Dtap / IPV / Hib vaccination (2 years)	↓	1,861	96.2	95.1	74.7	98.6
	5 Children in care immunisations	↔	315	94.6	84.6	5.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	1,141	66.7	70.7	60.9	78.9
	7 GCSE attainment: average Attainment 8 score	▪	-	38.8	44.6	37.6	56.2
	8 GCSE attainment: average Attainment 8 score of children in care	▪	-	20.4	22.8	12.1	34.2
	9 16-17 year olds not in education, employment or training	▪	300	8.8	6.0	44.8	2.1
	10 First time entrants to the youth justice system	↓	53	430.6	327.1	739.6	97.5
	11 Children in low income families (under 16 years)	↓	7,205	27.6	16.8	30.5	6.1
	12 Family homelessness	↔	15	0.2	1.9	8.4	0.1
	13 Children in care	↑	525	184	62	184	20
	14 Children killed and seriously injured (KSI) on England's roads	▪	***10***	39.4	17.1	46.8	1.3
Health improvement	15 Low birth weight of term babies	↔	52	3.5	2.8	5.2	1.3
	16 Obese children (4-5 years)	↔	161	10.0	9.6	13.5	4.8
	17 Obese children (10-11 years)	↑	291	21.1	20.0	29.2	11.3
	18 Children with one or more decayed, missing or filled teeth	▪	-	24.9	23.3	47.1	12.9
	19 Hospital admissions for dental caries (0-4 years)	▪	***68***	797.5	234.7	1,144.8	25.3
	20 Under 18 conceptions	↓	82	34.6	18.8	36.5	4.6
	21 Teenage mothers	↔	36	2.1	0.8	2.1	0.0
	22 Admission episodes for alcohol-specific conditions - under 18s	↓	***21***	74.3	34.2	100.0	6.5
	23 Hospital admissions due to substance misuse (15-24 years)	▪	***56***	339.0	89.8	339.0	32.1
Prevention of ill health	24 Smoking status at time of delivery	↓	507	28.1	10.7	28.1	2.3
	25 Breastfeeding initiation	↑	1,068	59.2	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	-	-	44.4	19.3	75.6
	27 A&E attendances (0-4 years)	↑	3,399	399.1	601.8	1,926.8	333.5
	28 Hospital admissions caused by injuries in children (0-14 years)	↑	433	181.1	101.5	190.5	43.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	↔	407	254.8	129.2	254.8	64.0
	30 Hospital admissions for asthma (under 19 years)	↑	141	465.6	202.8	497.5	63.6
	31 Hospital admissions for mental health conditions	↔	54	188.8	81.5	188.8	14.3
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	273	1,156.8	404.6	1,156.8	98.2

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2016/17
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2016/17
5 % children in care with up-to-date immunisations, 2017
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2016/17
7 GCSE attainment: average attainment 8 score, 2016/17
8 GCSE attainment attainment: average attaiment 8 score of children looked after, 2016
9 % not in education, employment or training (NEET) or whose activity is not known as a proportion of total 16-17 year olds known to local authority, 2016
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2016
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2015
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2016/17
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2017
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2014-2016
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2016
16 % school children in Reception year classified as obese, 2016/17
17 % school children in Year 6 classified as obese, 2016/17
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2014/15-2016/17
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2016
21 % of delivery episodes where the mother is aged less than 18 years, 2016/17
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2014/15-2016/17
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2014/15-2016/17
24 % of mothers smoking at time of delivery, 2016/17
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2016/17
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2016/17
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2016/17
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2016/17
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2016/17
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2016/17
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2016/17

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2019

Blackpool Council

Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	David Bonson (CCGs), Peter Murphy (BTH), Sharon Adams (ICP)
Date of Meeting:	16 October 2019

FYLDE COAST INTEGRATED CARE PARTNERSHIP (ICP) DEVELOPMENT

1.0 Purpose of the report:

1.1 The purpose of this report is to update the Committee on ICP development activities specifically in relation to:

- The development of the Fylde Coast ICP five year strategy;
- Progress with delivering the improvement/transformation agenda;
- Succession planning.

1.2 In addition to the above the ICP has also provided updates on various actions arising from the meeting in July 2019. This information can be found within the recommendations monitoring log at Item 9.

2.0 Recommendation(s):

2.1 The Committee is asked to:

- Note this update and;
- Contribute to the development of the Fylde Coast ICP five year strategy by providing feedback on progress to date, and sharing pertinent insights that should be considered as we further develop the strategy.

3.0 Reasons for recommendation(s):

3.1 To ensure that the Committee is apprised of ICP development activities and has the opportunity to input into the development of the Fylde Coast ICP five year strategy.

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

4.0 Other alternative options to be considered: Not applicable

5.0 Council priority:

5.1 The relevant Council priority is Communities: Creating stronger communities and increasing resilience.

6.0 Background information

6.1 **<u>The development of the Fylde Coast ICP five year strategy</u>**

a) The NHS Long Term Plan (LTP) mandate

Subsequent to the publication of the NHS LTP on 7 January 2019 (https://www.england.nhs.uk/long-term-plan/); the NHS LTP Framework was issued by NHS England and NHS Improvement on 27 June 2019 (https://www.longtermplan.nhs.uk/implementation-framework/). The key components of the framework cover:

a) Delivering new service models;
b) Increasing focus on population health;
c) More NHS action on prevention;
d) Delivering further progress on care quality and outcomes;
e) Staff support and wellbeing (supported by the Interim People Plan- https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/ Summary – https://www.nhsemployers.org/news/2019/06/interim-people-plan);
f) Delivering digitally enabled care;
g) Making best use of resources.

The framework provides a clear narrative and mandate for how the commitments in the NHS LTP will be implemented and delivered by local systems. This will be via an overarching Integrated Care System (ICS) five year strategic plan comprising:

- **A system narrative plan:** describing how systems will deliver the required transformation activities to enable the necessary improvements for patients and communities as set out in the LTP - with a phasing of actions over the next five years. ***(Initial draft submission 27 September 2019, final submission 15 November 2019);***
- **A system delivery plan which will be an aggregate of Integrated Care Partnership (ICP) plans:** setting the plan for delivery of finance, workforce, and activity, providing an aggregate system delivery expectation and setting the basis for the 2020/2021 operational plans for providers and CCGs. The system delivery plan will also cover the LTP 'Foundational Commitments' (Appendix 8(a)). ***(Initial draft submission 27 September 2019, final submission 15 November 2019)***

b) The Fylde Coast ICP five year strategy (forming part of the ICS five year plan)

As part of developing the ICS five year plan, the five ICPs across Lancashire and South Cumbria (L and SC) were required to submit (to the ICS) a brief ICP narrative, and nationally prescribed supporting technical plans for finance, workforce, activity, and LTP metrics built around four key areas:

1. Plans for achieving key transformation priorities;
2. Key ICP development activities;
3. Key assumptions and supporting narrative for finance, activity, and workforce plans;
4. Approach to system financial management.

These plans have been developed by strategy and planning leads across the Fylde Coast ICP via a joint leadership forum which has been established with the specific remit of developing, agreeing, and overseeing the:

- Fylde Coast Strategy (the narrative);
- Fylde Coast LTP Delivery Plan (the numbers);
- Fylde Coast 2020/21 operational plans (narrative and numbers);
- Fylde Coast ICP employee/wider stakeholder/resident communications and engagement plan.

The Fylde Coast ICP plans have been signed off by designated executive leads from the Trust and CCGs to form the ICP submission to the ICS; this was submitted on 23 September 2019.

The ICS have produced the first initial submission of the ICS plan which has been informed by an aggregate position of ICP plans; this was submitted to NHS England and NHS Improvement (NHSE/I) on 27 September 2019.
The system planning process adopted to produce this submission has been overseen by CCG Accountable Officers, Trust Chief Executives and Local Authority Chief Executives across Lancashire and South Cumbria via the Integrated Care System Board and the System Leaders Executive Group.

Ongoing dialogue will now take place between the ICS and NHSE/I in respect of the detail of the plans; this is expected to continue throughout October and early November 2019. The final plan is expected to be approved by NHSE/I at the end of November 2019. The Fylde Coast ICP submission can therefore not be shared as part of this report as this has not been ratified by NHSE/I and may be subject to further amendments.

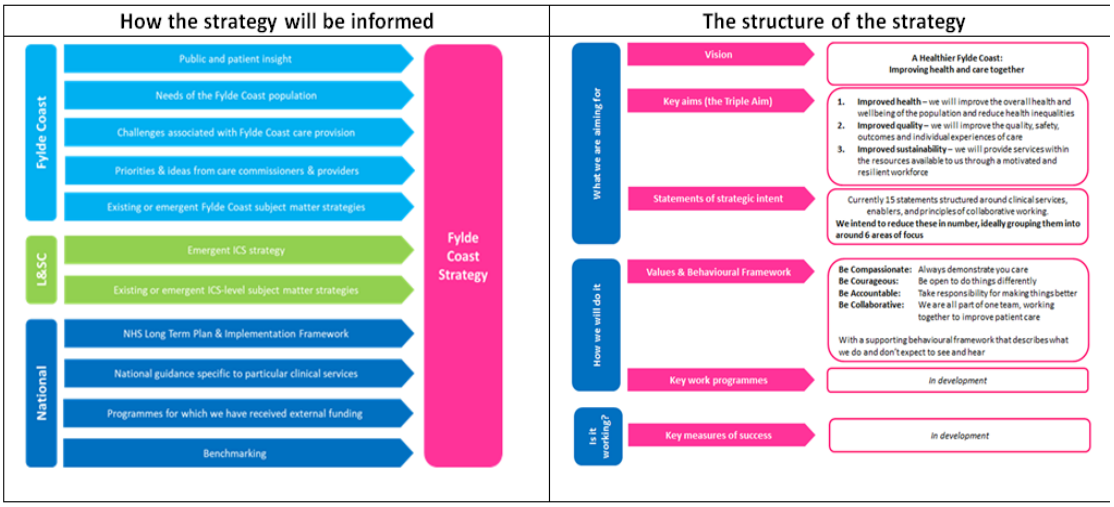
The final ICS plan for the 15 November 2019 submission will be refined by the ICS as directed by NHSE/I with involvement from ICPs as required. The plan will be approved by the System Leaders Executive Group and the Lancashire and South Cumbria ICS Board, with senior Local Authority representatives being members (elected and executive) of both of these forums.

The final approved ICS plan will then be published via communications channels across the Lancashire and South Cumbria system.

This plan will form the basis of 2020/2021 operational planning for the Trust and CCGs. The operational planning round will commence in December 2019 with agreed plans in place by the end of March 2020.

In tandem with this national requirement for the ICS to produce a five year plan, the Fylde Coast is developing the local ICP strategy for the next five years. Work is well underway to develop the content of the local strategy based on the NHS LTP requirements, wider national agendas and ICS strategies, whilst reflecting local nuances.

The approach to developing the strategy is illustrated below:



As part of our strategy work, Blackpool Council and Lancashire County Council Public Health colleagues have created a draft Fylde Coast population needs assessment which will inform the shape of the Fylde Coast strategy and underpin our decision making in determining priorities and key programmes of work over the next five years. This strategy is still in draft form and is subject to further refinements and ratification; therefore we have not been able to share this as part of this report.

The public and patient engagement work across the Fylde Coast to date has provided valuable insights into the needs of the Fylde Coast population in terms of how citizens would like to see health and care services evolve in their local communities. The Citizens Inquiries led by Blackpool Council have been a critical aspect of this engagement work in providing a key opportunity for health and care colleagues to connect better with local communities to gather insights that help to influence our decision making across the Fylde Coast. This has proved so beneficial that this

approach is being widened out across Fylde and Wyre constituencies.

An ICP communications and engagement plan is currently in the process of being developed in relation to the development of the ICP strategy. This is a critical element of the strategy development work in ensuring that we embed a robust approach to engaging with employees, wider stakeholders, and our resident population as we continue to develop and refine the strategy over the coming weeks.

The Fylde Coast ICP strategy (five year plan) will be based around the following themes, all of which align with the priorities outlined within the NHS LTP:

Population Health Management and Prevention	Children and Families
Primary Care Networks and Community Based Care	Digital
Urgent and Emergency Care	Utilisation of Our Estates
Planned Care	Quality
Networked Provision of Secondary Care	Workforce
Cancer	Financial Sustainability
Mental Health	System Development (ICS/ICP)

Statements of strategic intent have been developed for each of the themes outlined above. These can be found in Appendix 8(b). There are currently fifteen statements; however the intention is to group these further into five or six key areas of work. Each statement of strategic intent will be underpinned by implementation plans to ensure delivery of the partnership's ambitions.

c) Next steps

Subject matter leads across the Fylde Coast are currently in the process of identifying transformation priorities and key programmes of work over the next five years based around the statements of strategic intent. This will result in a long list of priorities which will need to be reviewed as an ICP to agree a shortlist of priorities which are clinically driven in line with LTP expectations, whilst considering financial and operational implications. This work will be undertaken by the Fylde Coast Clinical Senate on 12 November 2019 via a workshop style session with attendance from clinical and managerial leaders across the Fylde Coast from the Trust, CCGs and Local Authorities. The recommended list of priorities from this session will then be referred to the ICP Steering Group (of which Local Authorities are members both as executive and elected members) for endorsement before seeking formal approval via the Trust Board of Directors and the CCGs Governing Body.

A robust communications and engagement plan will be agreed during October 2019 and implemented shortly afterwards.

The Partnership is aiming to have the initial phase of the Fylde Coast strategy work completed by December 2019, with the first draft of the strategy going through internal governance mechanisms during the latter end of the month/early January for feedback. Engagement activity on the first draft of the strategy will then take place during January/February, and the strategy will be further refined based on this engagement work. The final strategy will be approved during March and published via communications channels thereafter.

6.2 **Progress with delivering the transformation/quality improvement agenda**

For the purposes of this update, two key areas have been selected to apprise the Committee of in terms of progress with transformation/quality improvement across the Fylde Coast. These are:

i. Primary Care Transformation
ii. Blackpool Teaching Hospitals Quality Improvement

Primary Care Transformation

- **'My COPD Implementation on the Fylde Coast'**

The CCGs has been successful in its application for 1,435 (854 Blackpool and 581 for Fylde and Wyre) free lifetime licenses for the 'My COPD' app. The 'My COPD' is an app based pulmonary rehabilitation (PR) programme which supports people with severe or very severe COPD who have been referred to PR.

The Integrated Primary and Community Care (IPCC) Transformation Group considered the recommendations within the paper and further discussions are to take place to agree which Primary Care Networks (PCNs) are in a position to trial the app.

It was also agreed to gain support from the North West Coast Innovation Agency (NHS Partner) with aspects of the roll out and project management.

- **Diabetes Community Clinic pilot**

The commencement of the Diabetes Community Clinic pilot has been deferred from July until October 2019 in order to address staffing capacity issues. The two priority initiatives agreed at the Fylde Coast Executive Strategy Group in June 2019 were:

- The revised Diabetes Consultants job plans will be adopted in two phases; the first phase will ensure that the consultants will have the capacity to support the Community Clinic pilot that will run from October 2019 to March 2020 in Wyre Integrated Neighbourhood and Central West PCNs. The second phase will ensure that the consultants will have the capacity to support the rollout of the service from April 2020 onwards, following evaluation of the pilot.
- A consultant-led desk top review of patients that are currently on diabetes

outpatient clinic waiting lists will commence at the beginning of September 2019 (prioritising the patients from the two PCNs taking part in the pilot). This review will RAG (red, amber, green) rate the patients as below:

- Patients who meet the super six criteria and require specialist input would remain on the waiting list for an appointment – RED
- Patients who have poorly controlled diabetes would be added to the list to be seen in the Diabetes Community clinic – AMBER
- Patients who appear to be reasonably stable would be referred back to Primary
  Care (following consultation with the GP practice where appropriate) - GREEN

The Diabetes Community Clinic task and finish group is now meeting regularly in preparation for the commencement of the pilot.

- **Lancashire County Council (LCC) Collaborative Population Health Management**

A recent workshop took place with Lancashire County Council, Blackpool Council and District Council colleagues to discuss LCCs offer of their ring fenced Public Health grant towards testing joint efforts to support and mobilise people to self-care and deliver personalised preventative care at a neighbourhood place. The following priorities for integration were identified and are now being progressed:-

- Local Authority community development provision;
- Local Authority stop smoking commissioning and provision;
- Local Authority health check commissioning with broader NHS GP Practice/PCN
  Commissioning;
- Local Authority oral health prevention commissioning;
- Local Authority sexual health commissioning.

- **Stroke Rehabilitation Update**

The proposal to develop an Integrated Community Stroke and Neuro Rehabilitation Service has now been approved and the service specification is currently being finalised. This service will expand on current rehabilitation provision for both stroke patients and those suffering from a neurological condition across the Fylde Coast. The integrated delivery model will align with the Lancashire and South Cumbria Stroke Service Specification.

- **'Engagement Plan: Fylde and Wyre Citizen Inquiries' paper**

The Engagement Plan: Fylde and Wyre Citizen Inquiries paper outlined options for Fylde and Wyre CCG to mirror the work undertaken by Blackpool CCG (in partnership with Blackpool Council Public Health and Community Interest Company Shared Futures since 2017) to run six citizen inquiries.

The IPCC Transformation Group agreed to the undertaking of a compressed Citizen Inquiry process. Blackpool Council Public Health colleagues have kindly agreed to support Fylde and Wyre CCG to undertake this project.

Blackpool Teaching Hospital's Quality Improvement Approach

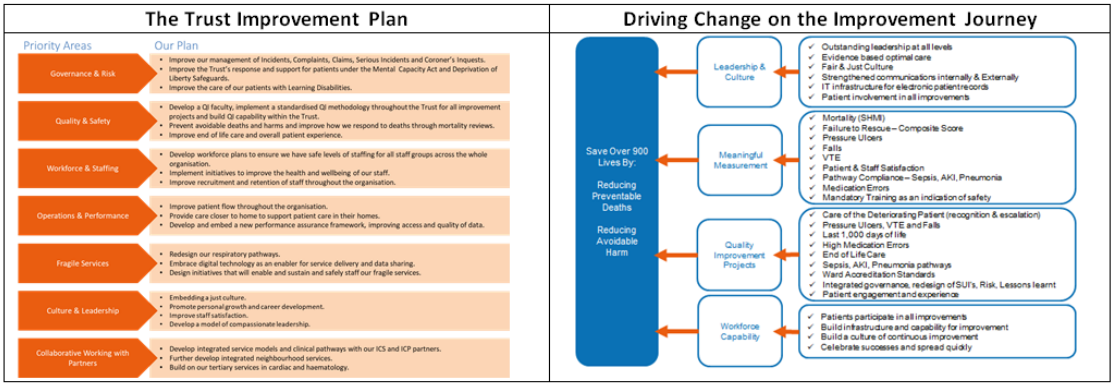
The Trust has recently introduced their Quality Improvement Strategy which has been approved by the Trust Board of Directors in early September 2019. The strategy brings together programmes of work that have been ongoing within the Trust and key issues that need to be addressed over the next three years.

A Quality Improvement Programme will be established with the aim of reducing harm and mortality. Key aims and ambitions are illustrated below:

The Trust will be focusing on both immediate short term priorities alongside longer term priorities to:

- Support improvement;
- Improve patient outcomes;
- Deliver service efficiencies;
- Improve compassionate leadership;
- Develop a just culture.

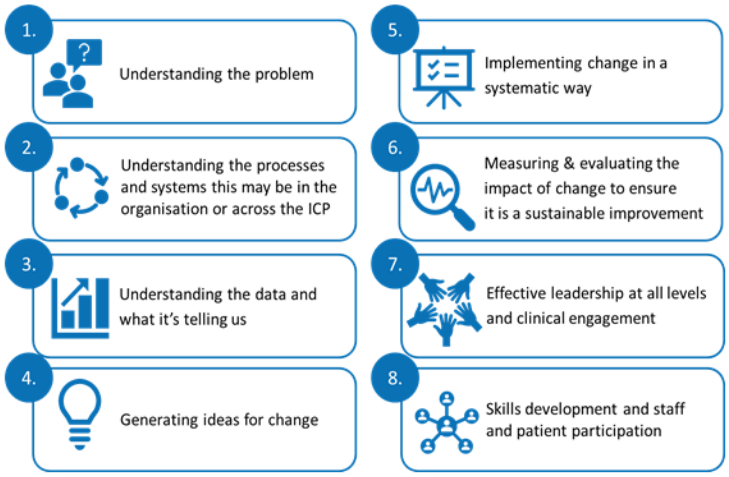
The Trust will be embedding a Quality Improvement Methodology to support staff to enable change. The Quality Improvement approach is outlined below:



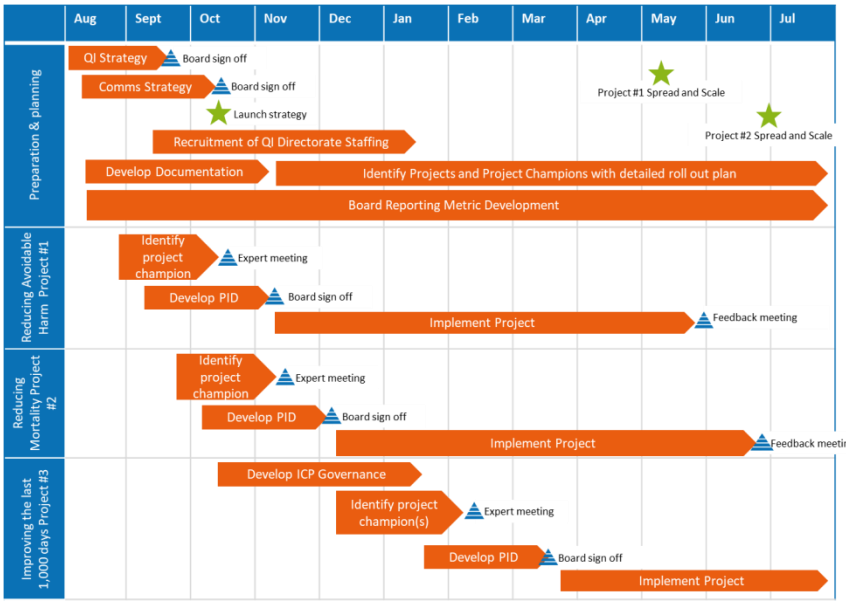
As part of the quality initiatives to achieve these ambitious goals, a number of key areas have been identified that will be subject to initial focus. These will be:

- Pressure Ulcers and;
- Care of the deteriorating patient.

The Quality Improvement Methodology will underpin improvement plans using the following principles:



The Trust will be developing a new Quality Improvement Directorate who will host expert advisors to help staff, patients and partner organisations plan and carry out improvement programmes aligned to Trust priorities. As this is a new programme the Trust have set out some high-level timescales and would like to start piloting two key projects over the next three to six months as outlined below:



More detail can be found within the Trust's Quality Improvement Strategy in Appendix 8(c).

6.3 - Succession planning

Blackpool Teaching Hospitals established its succession planning process in 2015. This process identified potential successors for key roles within the Trust and also highlighted areas of risk where there was a gap in short and medium term successors. The Executive Directors made a commitment to roll out succession planning across the organisation. There was also a commitment to integrate the activity into the appraisal process.

Each year, divisions and departments within BTH produce a succession plan. The succession plans contain details of all senior leadership and business critical roles. It also contains the names of potential successors and whether they will be able to undertake those roles within one, three or five years. Successors identified as future senior leaders within three or five years are invited to attend the Senior Collaborative Leadership programme.

This succession planning process has been shared across the ICP. It is intended that a similar process will be adopted within primary care and in particular, with the PCNs over the next twelve months.

A summary copy of the succession planning process is enclosed in Appendix 8(d).

In relation to succession planning at ICS level there are two main areas of work underway currently. These are:

The North Regional Talent Board
HR and workforce leads from the ICS are working with national system talent leads to support the development of and generation into a North Regional Talent pool of ready now executives. Assessment centres for potential HR Directors and Directors of Nursing are going live in October and December with a view to having the first pool available in early 2020. Further application windows for Directors of Finance and Clinical Leads will be opening in the final quarter of 2019.

The High Potential Scheme
In collaboration with the National Leadership Academy the ICS is one of seven pilots across the country (the only one in the North) who are developing and rolling out this programme aimed at rising stars at band 8a – 8d. The programmes will be experience based and assessment centres based on system leadership criteria will be going live in January 2020, with a view to having our first 20 candidates on the programme by May 2020 next year. These pilots will be evaluated by the National Leadership Academy and rolled out nationally in 2020.

Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 8(a) – NHS LTP Framework 'foundational commitments'
Appendix 8(b) – Fylde Coast ICP Statements of Strategic Intent
Appendix 8(c) – Blackpool Teaching Hospitals Quality Improvement Strategy
Appendix 8(d) – Succession Planning Process – Fylde Coast ICP

8.0 Legal considerations:

8.1 Not applicable.

9.0 Human resources considerations:

9.1 Not applicable.

10.0 Equalities considerations:

10.1 Not applicable.

11.0 Financial considerations:

11.1 Not applicable.

12.0 Risk management considerations:

12.1 Not applicable.

13.0 Ethical considerations:

13.1 Not applicable.

14.0 Internal/external consultation undertaken:

14.1 Not applicable.

15.0 Background papers:

15.1 NHS Long Term Plan https://www.england.nhs.uk/long-term-plan/
NHS Long Term Plan Framework https://www.longtermplan.nhs.uk/implementation-framework/
Interim People Plan https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/
Summary – https://www.nhsemployers.org/news/2019/06/interim-people-plan)

Appendix 8(a) – LTP Foundational Commitments

1. Transformed out of hospital care and integrated community based care
2. Reducing pressure on emergency hospital services
3. More personalised care, giving people control over their own health
4. Digitally enabling primary care and outpatient care
5. Better care for major health conditions
    - Improving cancer outcomes
    - Improving mental health services
    - Shorter waits for planned care
6. Increasing focus on population health – moving to ICSs everywhere (see ICS maturity matrix for key characteristics expected of ICSs)

This page is intentionally left blank

Appendix 8(b) - Fylde Coast ICP strategy development – statements of strategic intent

Theme	Statement of strategic intent
Population Health Management and Prevention	*We will take a greater role in improving the health and wellbeing of our population through an increased focus on prevention of ill-health and a more proactive approach to health and care, including closer collaboration with local authorities, voluntary and community organisations and wider partners, and supporting and empowering individuals and communities in self-care.*
Primary Care Networks and Community Based Care	*We will continue to support primary care networks and community services to increase the deliverability of out of hospital care and promoting wellbeing by building on our early work on new models of care and ensuring that our long term conditions specialist services evolve to support increased care in local communities. To do this it is essential that we will support the sustainability of primary and community care.*
Urgent and Emergency Care	*We will redesign our Urgent and Emergency Care pathways together with our health and care partners, relieving pressure on our emergency services, with a focus on improving flow in our hospitals in order to optimise length of stay.*
Planned Care	*We will ensure the provision of efficient, sustainable, local secondary and tertiary care elective services for the population of the Fylde Coast.*
Networked Provision of Secondary Care	*We will work with our health and care partners to increase the networked provision of secondary care services across acute trusts in L&SC with the aim of improving quality and sustainability of services, taking a leadership role where we are well placed to do so and being prepared to cede leadership to others where appropriate.*
Cancer	*We will redesign our cancer pathways together with our health and care partners to ensure we consistently provide appropriate and timely care, with improved outcomes and patient experience.*
Mental health	*We will work with our health and care partners to ensure that the mental health and wellbeing of children and adults are considered of equal importance to physical health through increasing community services to prevent the need for unplanned acute care and providing an environment more suitable for the assessment of people presenting in mental health crisis.*
Children and families	*We will work with our health and care partners to better support children , young people and families, with a focus on the first 1001 days of life, enabling our families to thrive and recognising the impact this has on children and on the wellbeing of future generations.*
Quality	*We will ensure that safety and quality are at the heart of everything we do, developing and embedding a consistent and ongoing approach to quality improvement and standardised pathways of care, resulting in improved clinical outcomes, enhanced patient experience and a more personalised approach to care.*
Workforce	*We will work together with our health and care partners to develop an integrated health and care workforce with the capacity and capability to provide safe and sustainable care, ensuring that we invest in the development and wellbeing of our people.*
Financial sustainability	• *We only spend the resources that we are allocated* • *Spend represents an effective use of resources* • *We have robust systems and processes to enable the above*

Utilisation of our estates	*We will make effective use of our existing estate and associated infrastructure, as well as investing in future developments, to support the delivery of safe and effective care in the most appropriate setting.*
Digital	*We will make better use of data and digital technology to provide improved access to health and care information for the population and our clinicians, supporting an increase in quality of care and patient experience, as well as modernising ways of working across our workforce.*
Developing the ICP	*We will further develop the Fylde Coast ICP in a way that supports strong clinical leadership in order to maximise opportunities and outcomes associated with collaborative working through the development and delivery of shared priorities, removal of duplication, and eradication of perceived organisational barriers.*
Participation in the ICS	*We will be active members of the L&SC ICS by supporting the development and delivery of the ICS strategy and implementation plan across clinical and non-clinical work programmes.*

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Improvement Strategy

2019 – 2022

@BTHImprov1

Contents

What are we trying to achieve? 3

Improving Quality - Why are we trying to do this? 4

Our Improvement Journey 5

- Driving Change on Our improvement Journey 6
- Aim 1 – Reduce Preventable Deaths 7
- Aim 2 – Reduce Avoidable Harm 8
- Aim 3 – Improve the last 1,000 days of life 9

Why do we need a Quality Improvement Methodology? 10

Governance 11

QI Methodology 12

Measuring Impact 13

High Level Plan 14

Communications Plan 15

Culture & Leadership 16

Tracking Our Return on Investment 17

What are we trying to achieve?

Our ambition over the next three years is to reduce our mortality rate to one that is below the national average, saving over 900 lives across the Fylde Coast.*

We will be putting Quality Improvement at the heart of everything we do, developing a portfolio of Quality Improvement projects to achieve our overall ambition. Across our hospitals and community services our staff, patients and partners will be empowered and supported to provide high quality, safe care for all, via a new Quality Improvement Programme with the aim to reduce harm and mortality.

We are committed to building a Quality Improvement focus across the organisation and this strategy builds on some great work that has taken place at grass roots level within the organisation already.

This document sets out our three-year Quality Improvement approach to achieve our goals.

- We will deliver a programme of quality improvement projects which will help staff make changes to provide high quality, safe and effective personal care to every patient, every time.
- We will focus our efforts on a targeted portfolio of projects which we believe will have a significant impact on unintentional patient harm and mortality. These projects are described in the document.

People Centred

Our plan is to train our staff in our chosen Quality Improvement approach. To support this, we will be developing a communications strategy to help raise awareness across staff, patients and key stakeholders.

Excellence

We will benchmark ourselves against peers and measure the impact of our improvement projects, celebrating successes along the way and learning lessons from failures, always striving for continuous improvement.

Positive

Each improvement project will be led by our frontline staff who will be developing Plan – Do – Study – Act (PDSA) cycles, learning from testing ideas and proactively making changes to improve the quality of care.

Compassion

We know we will not always get things right and we cannot do this alone. During these times we will listen and learn and put plans in place to make our services a safer place for staff and patients.

Our two high level Trust aims over the next three years are to:

Our high-level System-wide aim over the next three years is to:

*Lives saved indicated throughout this document refer to additional lives that could be saved

Improving Quality - Why are we trying to do this?

Since 2014, the Trust has been a national outlier for mortality indices SHMI and HSMR and since January 2019 has received six mortality outlier alerts from the CQC. More recently the Trust has undergone a CQC inspection, with the results due in October 2019.

The NHS Long Term Plan issued in 2019 highlights the need for local health systems to have the improvement capabilities, including Quality Improvement skills and data analytics, to implement change effectively using systematic methods of QI. These capabilities will support organisations, ICP's and ICS's to generate new ideas and practices to design and implement improved systems and processes to support the delivery of high-quality care and reduce unwarranted variation.

Quality Improvement is not new to our Trust and there have been a number of projects that have celebrated successes to date.

Emergency Department Sepsis Project

Our Emergency Department identified that patients with Sepsis experienced delays in receiving antibiotics. Using Quality Improvement methods, they understood the issues and implemented month on month PDSA cycles to implement changes. The overall result was that the number of patients who received antibiotics within an hour from presenting at the Emergency Department increased by 37%.

We recognise that we will not always get care right and there are areas we need to improve, we will build on the successes we have seen to date by wrapping around a standardised way of doing things and bring learning together, developing a Quality Improvement Community. Our ambition is to develop an approach that is recognised by our staff, patients and partners across the Fylde Coast.

We need to be responsive and reactive to patient care, however, we need to make sure that these actions are sustainable and have a long-term impact. Our Quality Improvement Strategy builds on the work our teams have done to date and compliments the new governance and assurance infrastructures being established.

Our Improvement Journey

Improving Quality is everyone's responsibility and we need to focus on:

Immediate improvement actions:

- Ensuring we are getting the basics right
- Stabilising services
- Creating the right conditions upon which we can continue to improve and ultimately transform care delivery.

Long-term priorities:

- Support improvement
- Improve patient outcomes
- Deliver service efficiencies
- Improve compassionate leadership
- Develop a just culture

As part of our Improvement Journey we have developed a plan on a page that sets out key areas we need to focus. This will be available as a separate document and the key themes are highlighted below:

Priority Areas	Our Plan
Governance & Risk	• Improve our management of Incidents, Complaints, Claims, Serious Incidents and Coroner's Inquests. • Improve the Trust's response and support for patients under the Mental Capacity Act and Deprivation of Liberty Safeguards. • Improve the care of our patients with Learning Disabilities.
Quality & Safety	• Develop a QI faculty, implement a standardised QI methodology throughout the Trust for all improvement projects and build QI capability within the Trust. • Prevent avoidable deaths and harms and improve how we respond to deaths through mortality reviews. • Improve end of life care and overall patient experience.
Workforce & Staffing	• Develop workforce plans to ensure we have safe levels of staffing for all staff groups across the whole organisation. • Implement initiatives to improve the health and wellbeing of our staff. • Improve recruitment and retention of staff throughout the organisation.
Operations & Performance	• Improve patient flow throughout the organisation. • Provide care closer to home to support patient care in their homes. • Develop and embed a new performance assurance framework, improving access and quality of data.
Fragile Services	• Redesign our respiratory pathways. • Embrace digital technology as an enabler for service delivery and data sharing. • Design initiatives that will enable and sustain and safely staff our fragile services.
Culture & Leadership	• Embedding a just culture. • Promote personal growth and career development. • Improve staff satisfaction. • Develop a model of compassionate leadership.
Collaborative Working with Partners	• Develop integrated service models and clinical pathways with our ICS and ICP partners. • Further develop integrated neighbourhood services. • Build on our tertiary services in cardiac and haematology.

In addition to complex improvement projects, team led innovations and improvement projects on a smaller scale/national collaborative participation will also continue to be identified and progressed. These include national initiatives such as "Getting It Right First Time" (GIRFT) and RightCare, as well as locally derived projects.

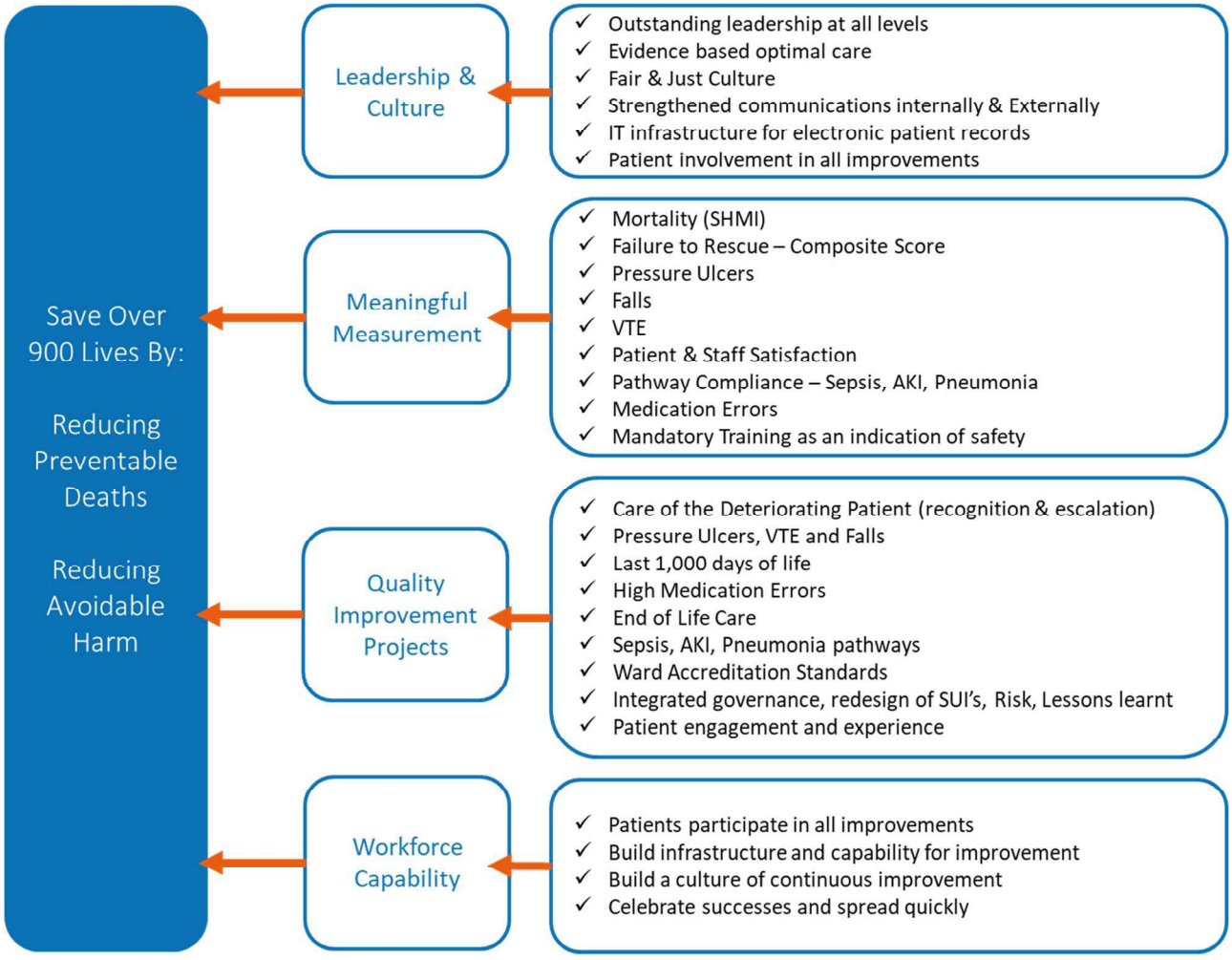
These will be required to align to and contribute to the delivery of the Trust priorities. Teams undertaking these smaller scale projects will receive support and facilitation of the QI Directorate and will be able to use our chosen Quality Improvement methodology to implement these changes.

Driving Change on Our improvement Journey

To deliver on our ambition to reduce our mortality rate to one that is below the national average, saving 900 lives, our Board of Directors have agreed that improvements need to be managed through an understanding of what will drive and influence change.

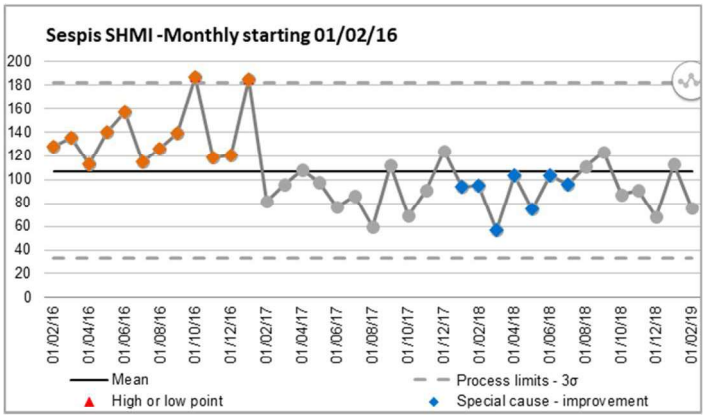
We will be developing Quality Improvement projects that will focus on reducing our mortality rate, through preventing avoidable deaths and reducing avoidable harm. Each project will set out the its aims and objectives that are Specific, Measurable, Achievable, Relevant and Time limited.

The driver diagram below identifies the Quality Improvement programme that will take place over the next three years and its organisational impact. This diagram helps to identify connections and interdependencies of what will drive and influence change.



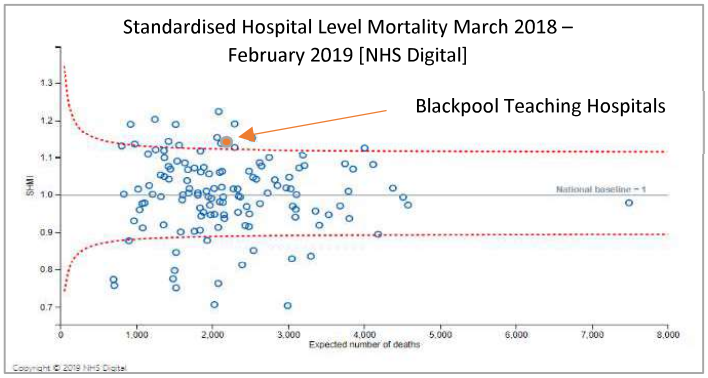
Aim 1 – Reduce Preventable Deaths

Summary Hospital-level Mortality Indicator (SHMI)



Over the last 12 months we have supported a number of discrete projects that have focused on improving our mortality. For example, our Sepsis mortality rate is improving, however, there is still more room for improvement.

Summarised Hospital Level Mortality is the ratio between the number of patients who die following hospitalisation and the number that would be expected to die based on the average England figures. If the Trust has a SHMI ratio value of 1.0 that means that the number of patients who died is the same as were expected. Our Trust remains an outlier for SHMI.



Number of Lives we can save

Between March 2018 and February 2019, we would expect approximately 2,055 deaths within the hospital. During this time frame we have experienced more deaths than have been expected. This means that in a 12-month timeframe we had the opportunity to save an additional 315 lives.

Site Name	Provider Spells	Observed Deaths	Expected Deaths	SHMI Value
Blackpool Victoria Hospital	54,530	2,370	2,055	1.1526

Deteriorating Patient Collaborative

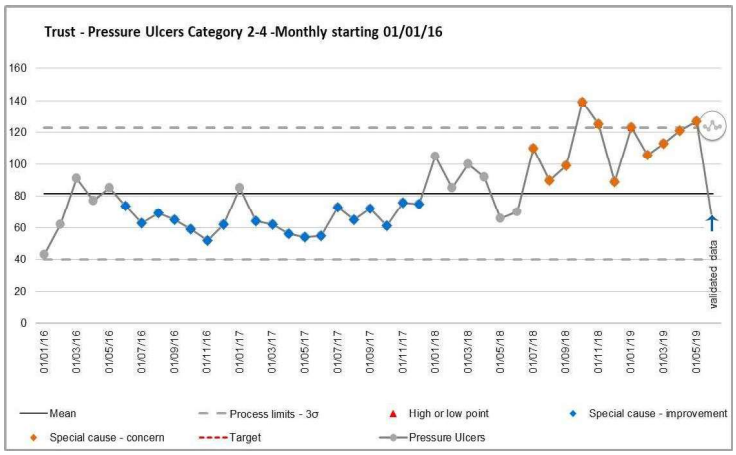
To support this initiative, we want to help set up a deteriorating patient collaborative to help develop new initiatives to test new ways of working that will help us to recognise the clinical deterioration of patients and be able to respond to it, safely and efficiently. For example, a group of wards may collaborate to test out new initiatives or changes to help recognise patients on their wards who are in need of care and at risk of further deterioration.

Our ambition is to bring our observed deaths in line with our expected deaths over a three-year period. Setting our ambition to save over 900 lives.

Aim 2 – Reduce Avoidable Harm

Pressure Ulcers

In June 2019, we held a call to action, engaging staff from throughout the Trust to understand the key drivers impacting patient harm as a result of pressure ulcers. It was recognised that data quality was a key issue in recording and validating data.



As a result we have been working across our acute and community settings to correctly identify and reduce the number of pressure ulcers that are Trust acquired, whilst improvements can be demonstrated, there is still work to do to ensure these changes become sustained improvements.

Indicator	Blackpool	Peer Average
Number of Pressure Ulcers Grade 2 and above Q1-Q3 Data	864	125

Pressure Ulcers, also known as Pressure Sores or Bed Ulcers are injuries caused to patients due to prolonged pressure. They can happen to anyone and any time but are commonly associated with people who are confined to a bed or sit for prolonged periods of time.

Number of Avoidable Harms – Pressure Ulcers

At Quarter 3 in 2018-19, we had recorded 864 Grade 2 or above pressure ulcers, compared to our peers who on average recorded 125. At Quarter 3 there was an opportunity to reduce 739 avoidable harm instances in relation to pressure ulcers. If we aggregated this up to Q4 this would mean an annual opportunity to avoid 985 instances of patient harm. Over a three-year period, this would result in avoiding 2,955 instances of harm, however, we know through validation and current work this number is not a true reflection of current harm, we recognise it is lower, but to our patients and public stakeholders we need to ensure our reporting is an accurate reflection of the care we provide and that we are doing something about avoiding harm.

Our ambition is to establish a true understanding of our baseline position for each harm group and develop initiatives to ensure our avoidable harm instances are in line with our peers. Examples of harm group metrics we will be looking at include: Hospital Acquired Pressure Ulcers

- **Non-Hospital Acquired Pressure Ulcers**
- **VTE**
- **Falls**
- **Sepsis**
- **Medication Errors**

Our improvement projects will work to baseline ourselves on these metrics, understand how we benchmark against peers and track the impact of these projects against these metrics and against our peers.

Aim 3 – Improve the last 1,000 days of life

We recognise that people get "stranded" in our hospital beds, particularly the elderly or chronically ill. A proportion of patients who are "stranded" in our hospital are in the last 1,000 days of their life, and we want to make sure that their time is not wasted being stranded so that they can make the most of their last 1,000 days in a setting they want, with the people they want.

There is significant evidence that immobility in hospital leads to deconditioning, loss of functional ability and cognitive impairment, all of which have the potential to increase a patient's length of stay, using up their valuable time.

"One week in hospital for a person of 80 years and over can equal 1.5kg of muscle loss and 10% deterioration in aerobic capacity. In addition hospital inactivity can result in accelerated bone loss, muscle weakness for 3-5 years and increase the risk of requiring institutional care by 5 fold. The leads to increase risk of falls, pressure damage, malnutrition and incontinence."

Chief Nurse, Blackpool Teaching Hospitals NHS Foundation Trust

Making these last 1,000 days meaningful is something we can not do alone. We need to draw on our system partners from GP practices to Community Services so we can all support patients to receive care in their place of choice. We will need to set up a forum with our partners which will act as a place to develop ideas as a system and collate examples of good practice.

We will develop metrics that help us recognise patients who are "stranded" and work with teams to develop ideas to improve.

We will be supporting two key initiatives that will help us kick start this campaign - Helping patients to get up and moving, the value of patient time (Last 1000 days) and Red to Green.

Our ambition is to develop specific improvement projects with our partner organisations that improve the lives of our patients and their families in the last 1,000 days of life.

Why do we need a Quality Improvement Methodology?

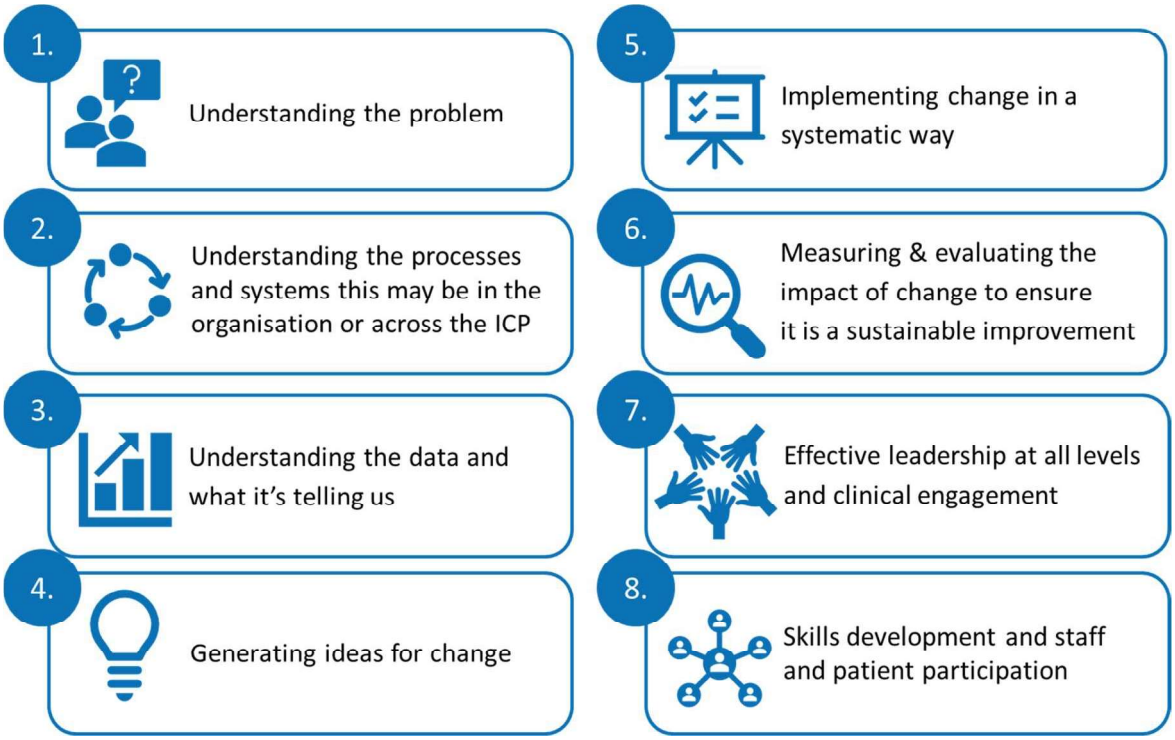
Quality Improvement is used to support continuous and sustained improvement in the quality of care and outcomes that we deliver.

We will do this by providing a structured approach with a clear methodology and systematic use of evidence-based tools, processes and measurement to support continuous and sustained improvement in the quality of care and outcomes that we deliver.

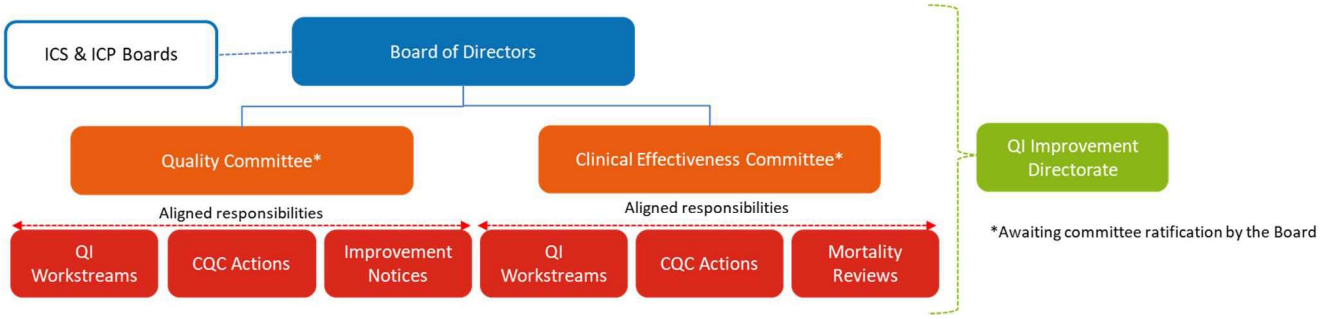
The rationale for, and Trust approach to QI, will be fully aligned and integrated to other enabling strategies within the Trust such as Digital Transformation and Workforce and Organisational Development. Where we can find solutions to support change in these areas we will link into them through our executive board sponsors to ensure that everyone is aware of any interfaces or interdependencies.

The QI methodology will underpin all our improvement plans, we recognise that not everything will be reliant on the methodology, as we will require specific organisational actions to respond and react to our challenges. Where we can use this methodology, we will.

The underlying QSIR principles we will take to QI will focus on:



Governance



Board of Directors

The Board of Directors is committed to supporting quality initiatives that meet the two key aims, reducing preventable deaths and reducing avoidable harm. This support will be shown directly to our front-line staff, devoting the first part of the Trust Board for our staff to present and update them regarding their improvement projects. Members from the Quality Improvement Directorate will be there to support our staff and be responsible for ensuring that all the correct documents are submitted to the board.

Quality Committee

The Quality Committee, will support and routinely monitor outcomes and ensure feedback on workstreams that fit its remit. These include projects that focus on pressure ulcers and care of deteriorating patients. The Quality Committee is will also be accountable for delivering on specific CQC actions and improvement notices and will develop new workstreams in response.

Clinical Effectiveness Committee*

The Clinical Effectiveness Committee, will support and routinely monitor outcomes and ensure feedback on workstreams that fit its remit. These include projects that focus on learning from deaths, mortality GIRFT and VTE. The Clinical Effectiveness Committee will also be accountable for delivering on mortality reviews, upholding royal college standards and delivering on specific CQC actions. The Committee will be able to develop new workstreams in response to these.

QI Workstreams

These are the individual workstreams, or improvement projects, led by our staff, this could be anyone from a ward clerk to a clinician or volunteer. We will train these staff in our chosen Quality Improvement Methodology and they will receive support from our Quality Improvement Directorate. Each project will identify a team to work together and be responsible for updating the Trust board on their progress.

Quality Improvement Directorate

This is our new directorate who will be there to support improvement teams from concept to delivery of outcomes. They will help teams develop project initiation documents, project plans and risk logs and coordinate the tracking of quality improvements. Not all our projects will result in the expected benefits, so we want the Quality Improvement team to learn lessons, so we can continuously improve.

ICP and ICS Boards

We recognise that some of the quality improvement projects cannot be done alone or in isolation. Working with our system partners we will develop system-wide projects to deliver benefits across our ICP and ICS footprint. Alongside our Board of Directors will report progress on supporting patients in their last 1,000 days to the ICP Board.

**Awaiting committee ratification at September 2019 Board of Directors*

QI Methodology

We will use the NHSI QSIR methodology, which stands for Quality, Service Improvement and Redesign. It is primarily based on the NHS National Institute for Healthcare Improvement 'Model for Improvement'. The approach brings together stakeholders to learn improvement theory, build capability, share and implement change ideas, which will be tested through PDSA cycles and underpinned by meaningful measurements, to drive improvement. It is designed for both clinical and non-clinical staff. For complex improvements, we intend to use this methodology, alongside a structured collaborative approach.

All complex improvement projects will have an identified Executive Sponsor and a structured programme of work that will encompass five phases:

1. Preparation and planning

At the start of each project we will match the project champion with a member from the QI Directorate who will help organise meetings, develop best practice and develop key timelines. They will start developing meaningful measurements, baselines and benchmarks and work with the performance and quality data teams to ensure we have one source of truth on reporting. We want to ensure we involve service users early to support co-design, co-production, review and learning and we will work with our patient influence panels to support patient and public involvement in improvements.

2. Expert Stakeholder Meeting

This is where the project champion comes together with individuals who have skills, experience or are subject matter experts. Staff working on improvement projects will commit to working together over a fixed time period, usually 12 months, and attend five one-day learning sessions which will provide instruction in the theory and practice of improvement. They will support and encourage each other to understand the preparatory work and develop a project plan and programme of improvement. This will then be translated into project documentation, such as Project Initiation Documents (PIDs) and Project Plans.

3. Development of Improvement Project Plan (Driver Diagram, measurements & timescales)

The project team will present the Project plans to the Board. This includes a description of the issue, what the project is attempting to address, timescales for implementation and expected benefits and potential return on investment. The board will use project plans to track if the project is running to plan or if they need to support the team to get it back on track.

4. Implementation of improvement Project Plan

The project team will commence a series of Plan-Do-Study-Act (PDSA) cycles and attend learning session in between these PDSA cycles to learn lessons, test changes and redesign improvements. During this time the teams will be supported by the QI Directorate and OD Directorate through a series of action learning sets, supportive ward/locality or department visits and access to the specialist team.

5. Review and Spread of Improvements organisationally

Evaluation of projects as well as the programme, will be rigorous from the start to ensure that we can continue to learn, improve on our approach and that we can celebrate our achievements, as individuals, as a team and as an organisation. We are a learning organisation and will encourage our staff to spread their learning and experiences with others.

Measuring Impact

The Board is committed to ensuring our QI methodology underpins everything we do and will be dedicating time at Executive Board to discuss our Quality Improvement projects. To support the board in overseeing the quality work, and for our teams to track improvements, we need high quality data.

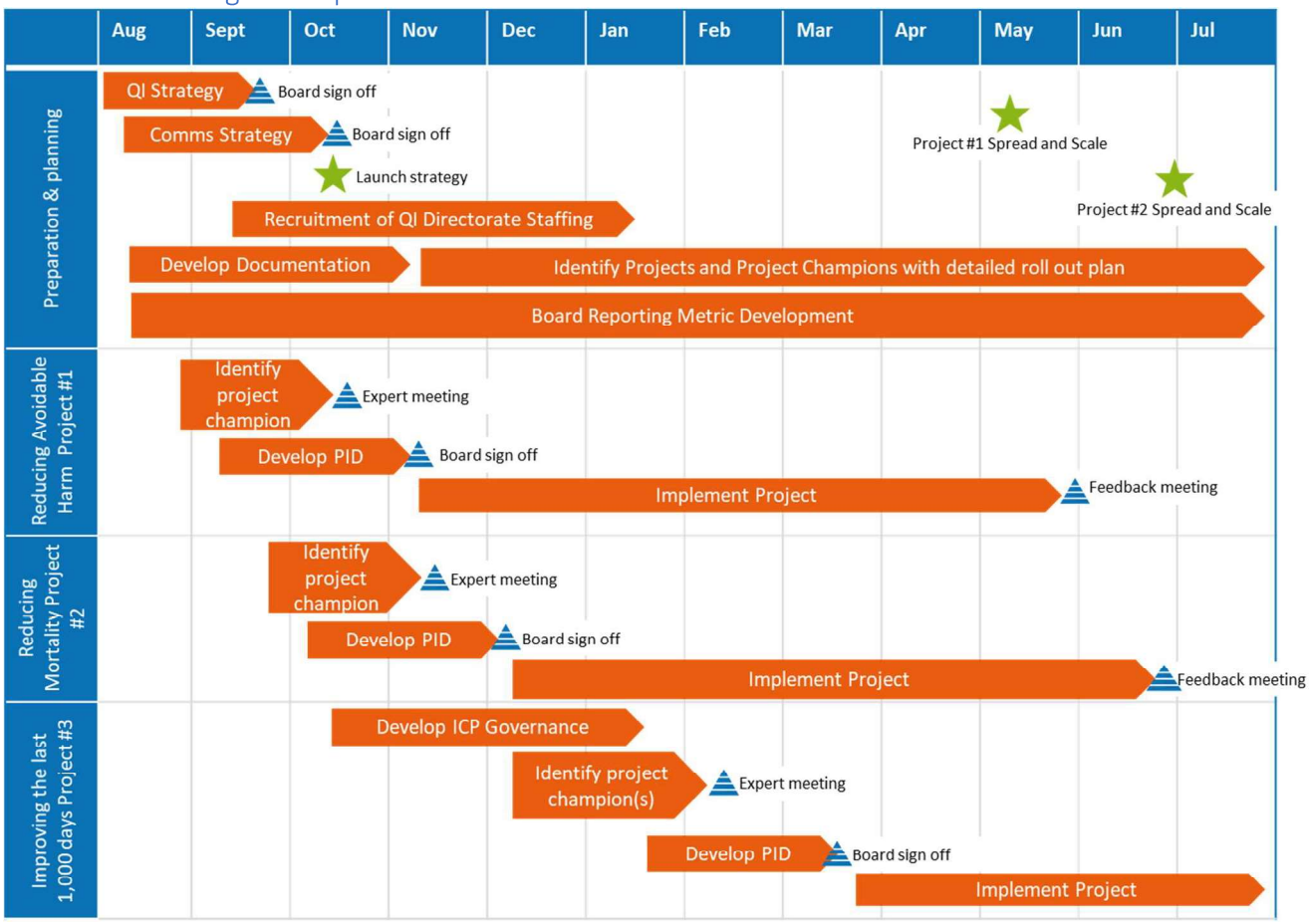
As part of our improvement journey we have set up a programme group to improve our Integrated Performance Reporting, to ensure we have one source of truth. This work to support managers, clinicians and project teams to track changes using one source where possible.

We will be developing statistical process charts to determine trends, shifts or special cause variation. Each project will develop their own set of meaningful measurements (process, outcome and balancing measures) which will track the achievement and sustainability of the project aim.

High Level Plan

We will be developing a new Quality Improvement Directorate who will host our expert advisors to help staff, patients and partner organisations plan and carry out improvement programmes aligned to our priorities. As this is a new programme we have set out some high-level timescales and would like to start piloting two key projects over the next 3-6 months. Once we have a fully established team we will be developing and publishing a more detailed Quality Improvement plan covering the next three years.

Year one initial high-level plan:



Communications Plan

A shared vision is the foundation for the success of our strategy of what we want to be in the future. To achieve this, we need to ensure that we provide staff with a clear understanding of the need for change whilst recognising that everyone in the organisation is doing their best and that their contribution is valued.

To do this, we need to communicate and articulate, to our staff:

- Our strategic direction
- The problems we face
- The approach to support delivery of the strategic priorities
- How staff and partners can play their part in the QI process to evidence that QI is everyone's business

Through consultation with our staff, we can begin to develop a common language for quality and begin to yield staff opinion about our new direction. We will also undertake a similar process with our service users and membership.

Over the coming months we will:

1. Develop a communications plan and supporting materials

   We will engage with our staff and patient involvement groups to understand the best forum and fora to receive materials relating to QI. We will develop templates to support the improvement projects and create checklists to help the project teams identify stakeholders and communicate effectively.

2. Launch our Quality Improvement Methodology

   In October, we will be hosting Professor Brian Dolan, Professor Dolan is the founder of the last 1,000 days initiative and we want to use his visit as a platform to launch our approach to Quality Improvement.

3. Support the pilot QI projects

   Each individual improvement project will have their own communications plan. We will be working with the three pilot projects to support them and develop our approach for future projects.

4. Develop a mechanism of feedback and recognition

   We want to recognise staff and help them build a sense of achievement along their improvement journey. We will ensure we give feedback to staff and the organisation and link in with our staff awards to ensure that improvement projects are recognised and rewarded. We will also work towards developing a system for accreditation that aligns with their capability.

Culture & Leadership

For the Trust to be most effective, quality must become the driving force of the organisation's culture. The presence of a positive and supportive organisational culture, with engaged and empowered staff encourages high quality care and an enthusiastic workforce. This is often underestimated but is essential to achieve patient focused services of the best standard. No QI methodology alone will drive improvement unless it sits in the right culture.

The Trust recognises that building and embedding a leadership and culture for Quality Improvement will only happen over time and requires a consistency and continuity of effort at all levels of the organisation. It also recognises that this will happen in steps and not a single event; it is however committed to a Board led culture which:

- Promotes the engagement of staff around the purpose of QI
- Empowers staff and supports the development of skills
- Enables staff to deliver safe and effective sustained improvements
- Encouraged to share and celebrate success

We will need to learn and embed quality improvement methods at all levels and within all teams in the organisation. This will require our clinicians and managers to demonstrate an unrelenting determination to stick to this agenda despite internal and external challenges.

There will be sustained leadership from the Board and senior management teams to embed improvement activity as part of the 'day job' rather than an optional extra; and through engagement and empowerment of our staff, we will create a culture of continuous quality improvement.

Our goal is to become a learning organisation in which every member of staff understands their role in delivering high quality care and works towards that goal every day. Emphasis will be placed on understanding our systems in more detail, working towards excellence in applying clinical systems, engaging all our employees in improvement, using small tests of change to build momentum and learning from our mistakes.

Tracking Our Return on Investment

Whilst the emphasis of QI is to improve patient outcome and experience, we recognise that there will be a paradigm of quality and efficiencies. It should be noted that not all projects will be able to quantify efficiencies, and some will be purely designed to improve outcomes to quality benchmark.

We will be transparent when a project is aimed only at improving quality of care. As part of the Quality Improvement process, each project will submit a Project Initiation Document (PID) which will evaluate the benefits, risks and potential return on investment. Any agreed metrics and their impact will be monitored as part of the suite of agreed metrics.

Whilst financial efficiencies will not be identified as an aim or driver of any QI project, the QI Team will work closely with the Trust's PMO to determine any financial efficiency, both recurrent and non-recurrent that may be realised as savings for the organisation.

It is also recognised that the current Transformation Team applies a pure project management approach to service change and will require training in QI methodology for sustainable improvement as part of the capability building of the organisation. As maturity develops and priorities evolve, how the two departments work together will be reviewed.

Examples of Efficiencies

Reducing Avoidable Harms

We will be looking to set up a collaboration initiative to support the reduction in the number of pressure ulcers reported, both in the hospital and in the community. We know that patients who experience pressure ulcers in a hospital, they stay for longer. If we can prevent or detect pressure ulcers sooner, patients will avoid the impact of pressure ulcers, that not only are painful but can take a long time to heal. A benefit of this would be that they not need to be in hospital for as long and we would expect to see a reduction in their length of stay additionally we would no longer need the budget size we currently have for wound dressings as a result.

Improving the last 1,000 days of life

Making the last 1,000 days of life count, not only to our patients but to their families. If we can improve how we get patients home or to their place of choice quickly, there is the opportunity to improve their quality of life in the last 1,000 days. By getting people out of hospital quickly and timely, we may be able to reduce our bed base or remove the strain of additional costs when we have to open beds and wards that are not funded.

TRUST IMPROVEMENT PLAN

Improving Quality & Safety is our principle Trust priority and we recognise the need to commence a journey of improvement across the organisation. In my short time as Chief Executive for Blackpool Teaching Hospitals I have had the privilege to witness staff who are caring, compassionate and take immense pride in their work.

The Trust's Improvement Plan sets out a series of organising principles that describe how we will set out to improve services. A complimentary Quality Improvement Strategy has been designed and approved by the Board of Directors. The strategy describes an ambitious aim to save additional lives and reduce harm. We will launch a number of improvement collaboratives designed to make real improvements to patient outcomes . New ways of delivering care will be co-designed by front line staff which will result in improvements to outcomes and experience. This is an exciting time for the Trust and with oversight from the board of directors and deep staff engagement I am positive we will be able to report positively on the progress we will make together.

IMPROVING GOVERNANCE & RISK

We will:	This will be measured by:
Implement New Risk & Governance Arrangements Across The Trust	
Review and assess our risk and governance arrangements across the Trust and focus on how we learn at a local and organisational level, from and how we manage incidents, complaints, claims, Serious Incidents and Coroner's Inquests, supported by risk and incident reporting training for all staff. Develop & deliver a Risk Management Strategy to underpin how we will deliver robust risk management & governance processes across the organisation which will align to the NHS Patient Safety Strategy; Safer culture, safer systems, safer patients, published in Jul 2019	• Serious Incidents • Complaints • Reduction in Regulation 28 notices • Revised committee structure and governance
Review All Safeguarding	
Deliver on safeguarding staff training to the agreed standards for adults and children and focus on the Trust's response and support for patients under the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) as part of a review of all safeguarding systems and processes. Review our current compliance with the National Learning Disability Standards and focus on addressing gaps to improve the care of patients with Learning Disabilities. Deliver learning disability training staff in line with the agreed national standards.	• Compliance with safeguarding, DOLS & Learning Disability Training • Serious Incidents

IMPROVING QUALITY & SAFETY

We will:	This will be measured
Develop & Launch our Quality Improvement Strategy	
Develop and launch the Trust's Quality Improvement Strategy which will provide a 3 year quality improvement plan and will aim to go beyond the immediate areas of focus and concerns raised by the CQC. We will engage our staff in delivering this strategy.	• 3 year Quality Improvement Strategy
Improving Safety	
Develop a Quality Improvement faculty and commence a series of improvement learning collaboratives involving staff across the Trust; Based on risk we will initially focus on our priorities of reducing the harm and improving patients experience for patients in our care in the following areas: pressure ulcers and VTE. We will also review how we manage our patients who deteriorate or who develop sepsis. Particular attention will be given to the implementation of robust medical handoff processes and Royal College standards with in depth reviews of any incident to learn lessons and implement system wide improvements that will drive safe care. Deliver the QI capability plan to support QI skill development and a culture of improvement being 'how we do it in Blackpool' and to facilitate local innovation and improvement Core nursing standards and improvement goals and plans will be developed for all wards and departments, supported by the implementation of a Nursing Assessment & Accreditation System	• Reduction in pressure ulcers • Reduction in Failure to Rescue • Improvement in sepsis pathway compliance • Improvement in VTE assessment and reduction in VTE • Implementation of Core Nursing Standards • Number of staff trained in QI skills
Improving Effectiveness	
Engage the Royal colleges to undertake a mortality review of sepsis and respiratory deaths, including our methodology to determine improvement actions. Develop a programme of work using mortality review data, HED and Dr Foster intelligence to reduce mortality. Review the current Morbidity and Mortality review process to support development of robust governance and a standardised reliable system to support learning from avoidable factors. Implement the Saving Babies Lives Care Bundle (2019)	•Reduction in mortality rate – HSMR & SHMI • Reduction in readmissions • Reduction in stillbirths • Reduction in neonatal deaths
Improving Patient Experience	
Improve End of Life Care for patients and their families across the Trust by focusing on bereavement care, engaging and working with staff across all wards and departments to roll out a new bereavement model (SWAN) to compliment our end of life model What matters most to me'. Review our National In-Patient Survey results to enhance the patient experience and embed responsibility within divisions Review and re-launch the Patient Experience Strategy	•Reduction in complaints •Improved National In-Patient Survey results •Patient Experience Strategy reviewed and re-launched

IMPROVING FRAGILE SERVICES

We will	This will be measured
Critical Care / High Care Units	
Stabilise staffing, including consultant and middle grade cover for ITU/ HDU, and ensure nursing and AHP workforce is adequate across our critical care units. Review the feasibility of integrated ITU services with CITU Review the feasibility of a Medical High Care Unit with robust processes for step up and step down of patients	• Staffing Levels are in place and adequate to meet demand • Staffing Levels are in place and adequate to meet demand
Improved Technology	
Implement the Health Informatics Strategy to support improved use of technology, efficiency in service delivery and data sharing. Digital will act as a core enabler in the transformation of clinical services performance where there is fragility in the workforce	• Digital maturity Index
Clinical Support Services — Radiology & Microbiology	
Stabilise the medical workforce to ensure adequate numbers of Consultants are in post to support delivery of clinical services and improved patient outcomes	• Staffing Levels are in place and adequate to meet demand
Non Invasive Ventilation Service	
Redesign the Respiratory Pathway, including the development of a Respiratory Assessment Unit, High Care NIV Unit, Community COPD and Home NIV services	• Reduced length of time and stay of patients on NIV • Reduced mortality of respiratory patients
Dermatology & Ophthalmology Services	
Stabilise the medical workforce and review demand and capacity to support sustainable services	• Staffing Levels are in place and adequate to meet demand

IMPROVING WORKFORCE & STAFFING

We will:	This will be measured by:
Improve Safe Staffing	
Carry out a review and assessment of all wards and departments against the National Staffing Standards and agree and develop a workforce plan to address shortfalls to ensure safe reliable nurse staffing. This will be complimented through effective rostering and the introduction of safecare module to support oversight of staffing capacity and demand. Following this review we will undertake a similar process for the community based workforce and AHP's Undertake a similar assessment for medical staffing, against national standards, 7 day working standards and GIRFT recommendations, particularly within fragile services. Deliver the Trust Recruitment & Retention Strategy to support having the right staff in the right place with the right skills and the introduction new models of working and roles.	•Staffing levels are in place and adequate to meet demand • Reliance on temporary staffing and locum agency spend reduced • Seven day service standards met • Retention levels and reduction in staff turnover
Deliver the Health & Wellbeing Strategy	
Encourage staff to receive the Flu vaccination to support their and patient wellbeing. Continue to deliver a range of initiatives to support staff physical and mental wellbeing in line with the Health & Wellbeing Strategy and publicise initiatives Deliver the Trust Health & Wellbeing Strategy over the next 3 years to support the health and well being of staff - our most valuable asset	• Staff engagement survey • Sickness due to work related stress • 80% of front line staff to receive flu vaccination

IMPROVING CULTURE & LEADERSHIP

We will	This will be measured by:
Deliver the Employee Engagement Strategy	
Continue the 'Big Conversations' initiative to help us look at ways to establish a great working environment which will support a just culture and a focus on staff & patient safety to enable high quality and safe care for our patients. Introduce 'a You Said, We Did' board which will help guide our staff ethos for the future. Deliver over the next 3 years the Employee Engagement Strategy to support embedding a just culture, promote personal growth and career development and improve staff satisfaction so Blackpool is a great place to work	• Increased NHS Staff Survey response rates • Improve staff satisfaction and engagement scores • Reduce turnover •Reduce sickness absence
Strengthen the Trust Leadership Model incorporating compassionate leadership and just culture	
Involve staff in developing improved operational site leadership teams and management of services across the organisation. This will be underpinned by the development of a divisional ownership and accountability framework. Leadership development support for all leaders within the Trust to drive engagement with staff, by treating staff fairly and with kindness. Introduce a structured safety walk-round programme for all senior leaders, clinical and non-clinical to participate in, in collaboration with our Executive, Non-Executive and CCG colleagues.	• Divisional structures and governance finalised • Divisional structures and accountability framework in place • Reduction in disciplinary cases and grievances • Reduced sickness absence Improved staff engagement • Reduced turnover •Safety Walk rounds across all organisational sites

IMPROVING OPERATIONS AND PERFORMANCE

We will:	This will be measured by:
Improving Patient Flow	
Implement SAFER model across all wards using SHOP to support Board & Ward rounds. Have in place robust systems and processes for the management and escalation of patient flow across the patient pathway to ensure patients receive the right care, at the right time, in the right place. This will include processes for Clinical Streaming, Admission Avoidance, Bed Utilisation, Assess to Admit and Effective & Safe Discharge. Patient flow will be supported by agreed standards which will ensure medically fit patients are transferred safely, timely and appropriately. Develop and launch a Clinical Strategy	• % of patients seen, treated, and discharged from ED within 4 hours • Reduction in patient Length of Stay in hospital • Number of admissions converted to same day emergency care • Number of cancelled surgery • Reduction in occupied bed days per 1000 population in patients aged 65 and over • Right patient, in right place, at right time
Providing Integrated Care Closer to Home	
Develop and enhance the Frailty Pathway to support patient care in our patients home in collaboration with Primary and Social Care Services . Develop and implement IAT / Adult Social Care In-each and Rapid Intervention Services. Develop Home First philosophy to improve patient pathways	• Reduction in delayed transfers of care • Number of admission avoidance through patient admission to frailty pathway
Improving Data Quality	
Review our data collection processes to ensure our data is reliable and available to help staff do their jobs and make improvements to service delivery, performance, patient care and experience. Review our Integrated Performance Report to ensure meaningful data is displayed to support informed assurance, decision making and fair challenge and accountability Working with our Booking & Scheduling staff, review our systems and processes for booking and managing patient appointments to ensure our appointment times meet national standards Develop and embed our Performance Management & Accountability Framework	• 18 week RTT performance •Development of Performance Management & Assurance Framework

IMPROVING COLLABORATIVE WORKING WITH PARTNERS

We will:	This will be measured by:
Strengthen Partnership Collaboration	
Redesign Emergency Care Pathways and deliver an Emergency Village approach to effective clinical modelling of patient care and information sharing Review clinical service delivery across Lancashire & South Cumbria working with other providers to deliver the best outcomes and ensure clinical sustainability Continue the development of integrated neighbourhood services to support our citizens to manage their long term conditions Continue to deliver integrated clinical pathways across the Fylde Coast Health Economy aligned to identified priorities —sepsis, Pneumonia, COPD, Diabetes Develop Tertiary Cardiac Services and Haematology Services	• Clinical Pathway Delivery / Compliance • Development of health economy pathways aligned to identified priorities • Reduction in >21 days & DTOC patients

Appendix 8(d) - Succession planning process across the Fylde Coast ICP

Proposed process

1. Meeting to be held with Chief Operating Officers from Fylde and Wyre and Blackpool CCG's to identify senior leadership and other business critical roles for inclusion in the succession plan. Those likely to leave the organisation within the coming 12 months could also be included in the succession plan. COO's to consider senior managers at bands 8A and above within their service for the exercise

2. At the meetings, a performance and potential matrix will be used to help assess the talent, performance and career aspirations of each senior manager

3. Managers will be categorised as a:-

    - Gold performer (high performer, high performance and personal aspirations for promotion)
    - Green performer (high performer, low potential and no personal aspirations for promotion
    - Orange performer (low performer, high potential as new in role)
    - Blue performer (low performer, low potential

4. Gold performers will then be assessed to establish how long it would take to develop them into a future senior leader within the ICP i.e. within 1, 3 years or 5 years and their names recorded on the ICS succession plan

5. Discussions should then take place with the 'successors' to establish their personal aspirations and the succession plan updated accordingly

6. The draft succession plan will be taken to Fylde Coast Executives for discussion, challenge and agreement.

7. The finalised succession plan will be agreed and outcomes of the exercise shared with the relevant leaders. Gold performers will be invited to attend a Development Centre to identify development gaps. This activity will be funded by grant secured from NWLA. Personal Development Plans will be produced for 'gold performers' to enable them to become 'job ready'

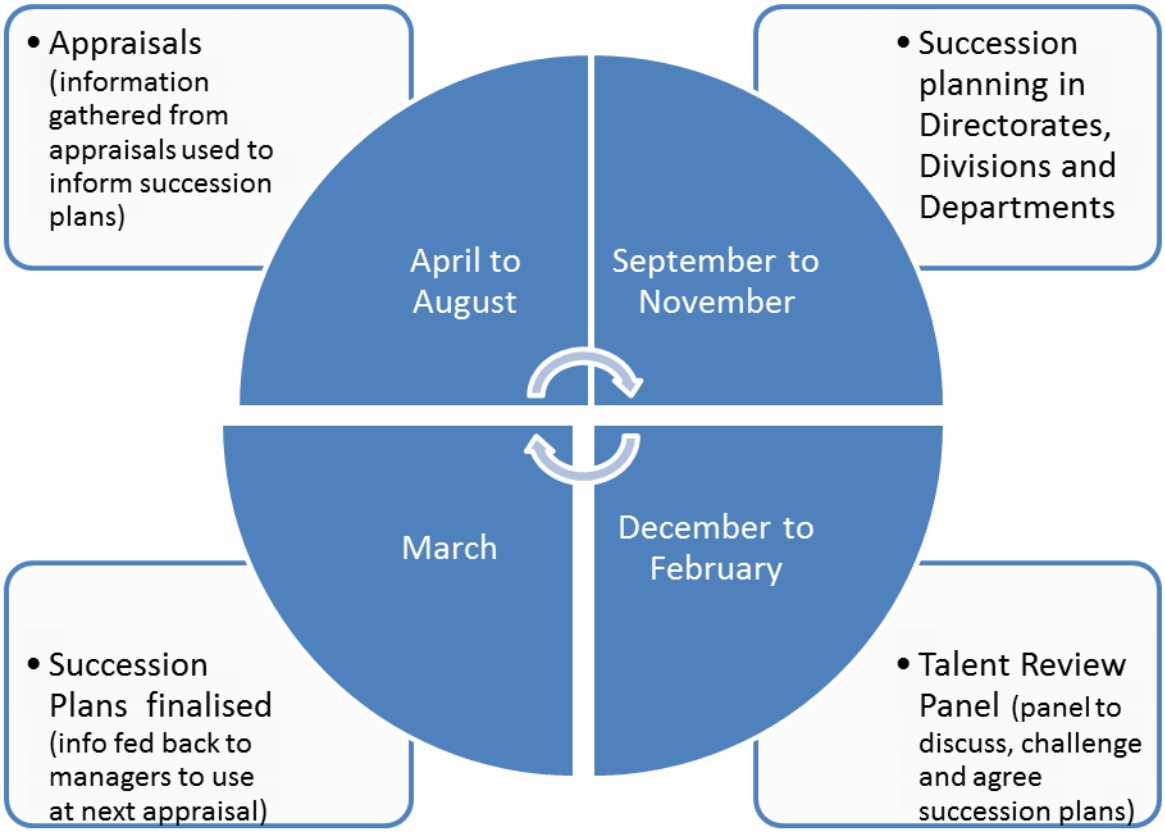
Next Steps – rolling out succession planning across the ICP

8.	Align succession planning and talent management activity with the appraisal process
9.	Invite relevant staff to attend appropriate leadership programmes (where necessary)
10.	Managers to undertake succession planning activity prior to holding appraisal discussions

11.	Establish a Talent Review Panel to assess the individuals selected as the 'leaders of tomorrow' using existing data sets such as appraisals and 360-degree feedback. The Talent Review Panel will also be responsible for tracking progress of individuals and evaluating the success of talent management initiatives across the Trust
12.	The Talent Review Panel should provide assurances to Fylde Coast Executives

A diagram explaining the succession planning process and its integration with the appraisal process can be found below.

The proposed succession planning process



Report to:	**ADULT SOCIAL CARE AND HEALTH SCRUTINY COMMITTEE**
Relevant Officer:	Mrs Sharon Davis, Scrutiny Manager.
Date of Meeting:	16 October 2019

SCRUTINY COMMITTEE WORKPLAN

1.0 Purpose of the report:

1.1 To review the work of the Committee, the implementation of recommendations and receive an update on the briefing received on Renal Dialysis Service Reconfiguration.

2.0 Recommendations:

2.1 To approve the Committee Workplan, taking into account any suggestions for amendment or addition.

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

2.3 To note the update from the presentation on Renal Dialysis Service Reconfiguration.

3.0 Reasons for recommendations:

3.1 To ensure the Committee is carrying out its work efficiently and effectively.

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

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

- Communities: Creating stronger communities and increasing resilience.

5.0 Background Information

5.1 Scrutiny Workplan

The Committee's Workplan is attached at Appendix 9(a). The Workplan is a flexible document that sets out the work that will be undertaken by the Committee over the course of the year, both through scrutiny review and committee meetings.

Committee Members are invited to suggest topics at any time that might be suitable for scrutiny review through completion of the Scrutiny Review Checklist which is attached at Appendix 9(b). The checklist forms part of the mandatory scrutiny procedure for establishing review panels and must therefore be completed and submitted for consideration by the Committee, prior to a topic being approved for scrutiny.

5.2 Renal Dialysis Service Reconfiguration

Representatives of the Committee attended a briefing session with Matron Nora Kerigan on the proposed service reconfiguration of renal dialysis services. Unfortunately the attendance at the session was poor, however, the information received by Nora was very interesting and informative. She highlighted that the current key problems with services included longer than recommended travelling times, not always able to dialyse in the patient's chosen location due to either low provision or inadequate provision and that patients choosing home dialysis must travel to Chorley for training no matter where in the Lancashire and South Cumbria region they lived.

An analysis had been undertaken of the location of all dialysis patients, where they currently received treatment and where they would receive treatment should they be able to attend their nearest dialysis centre, which demonstrated that a number of patients residing in Blackpool currently travelled to Preston for dialysis rather than using facilities at Clifton Hospital. The current service provided at Clifton had 20 dialysis points and no access for less mobile patients. It also has no isolation facilities.

In response to the proposed service reconfiguration, the current service provider had put forward plans to redevelop the Clifton site which would provide increased capacity, provision for less mobile patients and isolation facilities and Lancashire Teaching Hospitals Trust were in discussions with the provider in order to adapt and amend the specifications of the new proposals to ensure they were fit for purpose. Should an agreement be achieved, Clifton would be excluded from the further service reconfiguration.

The Members in attendance agreed that the proposals were positive and would benefit the patients that currently attended Clifton and also those patients that

resided in Blackpool but currently needed to attend Preston for dialysis. It was further agreed that should the proposal not be pursued and Clifton included in the wider service reconfiguration exercise that further details must be provided to the Committee at that time.

5.3 **Implementation of Recommendations/Actions**

The table attached at Appendix 9(c) has been developed to assist the Committee in effectively ensuring that the recommendations made by the Committee are acted upon. The table will be regularly updated and submitted to each Committee meeting.

Members are requested to consider the updates provided in the table and ask follow up questions as appropriate to ensure that all recommendations are implemented.

Members are requested to note, in particular, the response provided by Dr Arif Rajpura, Director of Public Health to the Committee's recommendation to the healthy weight letter distributed to children of overweight children and the updates provided by the Integrated Care Partnership.

5.4 **Healthy Weight Scrutiny Review**

At the Committee meeting in February 2019, it was agreed that a scrutiny review would be established to consider Healthy Weight in more detail. The date of the review has been set as 19 November 2019, commencing at 2.00pm. The Panel meeting has been fully scoped and the Scrutiny Manager is in the process of ensuring all relevant attendees are invited and the report is prepared by the deadline.

5.5 **Drug and Alcohol Policy Development**

A meeting has been arranged for 26 November 2019, commencing at 5.30pm to allow Members of the Committee to feed into the development of the new Drug and Alcohol Strategies. Members are encouraged to attend.

Does the information submitted include any exempt information? No

List of Appendices:

Appendix 9(a): Adult Social Care and Health Scrutiny Committee Workplan
Appendix 9(b): Scrutiny Review Checklist
Appendix 9(c): Implementation of Recommendations/Actions

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

Adult Social Care And Health Scrutiny Committee Work Plan 2019-2020	
16 October 2019	1 **Financial Sustainability of Adult Social Care** with increasing levels of demand 2 **Director of Public Health's Annual Report** 3 **Mental Health Service Provision –** update from all partners led by Lancashire Care Foundation Trust on progress against NWT Action Plan and provision in Blackpool, CQC inspection update and specific analysis of Psynergy pilot and the urgent care pathway. 4 **Integrated Care Partnership Development** to include consideration of five year plan and progress with delivering the improvement/transformation agenda, including succession planning.
11 December 2019	1 **Blackpool Safeguarding Adult Board Annual Report 2018/2019** 2 **Healthwatch Progress Report 2018/2019,** including 2019/2020 priorities 3 **Blackpool Clinical Commissioning Group Mid-Year Performance Report** attendance requested from partners in ICP. 4 **Provision of Supported Accommodation** specifically through the housing benefit route
12 February 2020	1 **Deprivation of Liberty Standards** key changes 2 **Community Engagement in Public Health** to consider the topic referred from Audit Committee 3 **Smoking Cessation** evaluation of initiatives and impact on smoking levels, has the council's priority been achieved 4 **Fulfilling Lives** Success of the project and legacy planning for support for people with multiple complex needs 5 **Whole System Transfers of Care Scrutiny Report** review of remaining outstanding recommendations implementation
29 April 2020	1 **North West Ambulance Service** detailed annual performance report 2 **Screening and Vaccination Uptake** to request NHS England attendance to consider uptake levels in Blackpool 3 **Breastfeeding Support** to consider the support on offer and the impact on the number of mothers choosing to breastfeed. 4 **Mental Health Services** to continue to monitor and evaluate the impact of changes in mental health service provision.
TBC June 2020	1 **Blackpool Clinical Commissioning Group End of Year Performance** attendance requested from partners in ICP.

Scrutiny Review Work	
19 November 2019	Task and Finish Scrutiny review of **Healthy Weight.**
26 November 2019	Input into policy development of Drug and Alcohol Strategies
TBC	Scrutiny review of **Drug and Alcohol Related Early Deaths.** Numbers have increased in both young and older people that misuse substances. To also look at preventing drug use (uptake of Hope and Wish). Potential to include a look at possible minimum price per unit of alcohol.
TBC	Scrutiny review of **one key theme identified from the ICP five year strategy**. Possible items include population health management, health inequalities, planned

	care and urgent and emergency care. To be identified at October 2019 Committee meeting.
TBC	Proposed joint piece of work with Children and Young People's Scrutiny Committee: **Child and Adolescent Mental Health** to include prevalence, performance of CAMHS, emotional health, looked after children and additional educational needs.

SCRUTINY SELECTION CHECKLIST

Title of proposed Scrutiny:

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

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

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

Please give any further details on the proposed review:
Completed by: **Date:**

This page is intentionally left blank

MONITORING THE IMPLEMENTATION OF SCRUTINY RECOMMENDATIONS

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
1	28.11.18	That the CCG report back to the Committee in July 2019 with the main areas of concern in relation to succession planning and an approach to be taken.	October 2019	David Bonson	Short update received at July 2019 Committee meeting. It was agreed that a further update would be received in October 2019. ***Update for the October 2019 meeting:*** Succession planning will be discussed as part of the Fylde Coast Integrated Care Partnership (ICP) report. The Head of Organisational Development for the ICP and Deputy Director of Workforce Education and Organisational Development for the Trust (same person) will be in attendance to support this discussion.	Ongoing
2	28.11.18	That future data demonstrate the number of patients experiencing a 12 hour wait due to attending the emergency department with drug and/or alcohol intoxication.	October 2019	David Bonson	This information is not currently collected; however business intelligence teams will commence collection of this from 1 July 2019. A review of all 12 DTA from July 18 to date has been undertaken see embedded table (10 patients in total have fallen into the category of 12 hr DTA due to drug or alcohol intoxication). ***Update for the October 2019 meeting:*** There is a clear Escalation Policy to raise concerns regarding mental health times to be seen in the ED which appears to be having a positive effect and the department has an excellent working relationship with the Lancashire Teaching Hospitals team who cover the ED. There have been 17 cases which have breached 12 hour DTA where drugs, alcohol or substance abuse have been involved since April 2019. Eleven of which occurred between April 2019 – July 2019, and six since the end of July 2019.	Ongoing
3	24.01.19	That LCFT be requested to identify all voluntary and	October 2019	Chief Officers of LCFT	Report on Mental Health Services on the agenda. **Members to determine whether recommendation has been completed.**	

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		community mental health support groups in Blackpool and arrange to meet with them quarterly to ensure the views of service users were truly reflected and understood.				
4	24.01.19	That LCFT consider setting all targets for completion of mandatory training, completion of appraisals etc at 90% with a view to incrementally increasing the target to 100%.	October 2019	Chief Officers of LCFT	Report on Mental Health Services on the agenda. **Members to determine whether recommendation has been completed.**	
5	24.01.19	That all representatives be requested to attend a further meeting of the Committee in approximately six months to further update on progress made and to: • Provide feedback on the implementation	October 2019	Chief Officers of LCFT	Report on Mental Health Services on the agenda. ***Update to support this discussion at the October 2019 meeting from Fylde Coast ICP in relation to 4 and 12 hour delays in the Emergency Department:*** Attached at Appendix 9(c)i is a full report of all actions that are being taken to date via BVH **Members to determine whether recommendation has been completed.**	

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		of the Committee's recommendations. • To provide evidence of the work undertaken to reduce the number of four and 12 hour delays at Accident and Emergency and the impact of that work. • To report on the outcomes of the external review and action taken to implement the actions.				
6	13.02.19	That attendees at the meeting give consideration to the process and the wording of the healthy weight letters sent and report back to the Committee at its	October 2019	Scrutiny Manager, Dr Arif Rajpura	Response received from Dr Rajpura: The letters that are sent out to our parents in Blackpool are based on the Department of Health/PHE template letters. However, last year the Blackpool Public Health Team worked with the School Nursing team to tailor the letter for our Blackpool parents. As part of the service around the NCMP letters, the School Nursing team will ring the parents when a child has been identified as very overweight or obese. This phone call is made prior to the letter being sent out, however, there are occasions	Members to determine if action is complete based on response. Deferred from

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		next meeting with a new draft of the letter.			when it is not possible to contact the parent and the letter is still sent out to the family. Included with the letter of children who are overweight, very overweight and obese a leaflet is enclosed from the Change4life information packs. In addition to this the parents are offered a referral to the children and family weight management service which is operated by Sport Blackpool. If the parents are not keen on the referral then the children and family weight management manager will make contact with the family to talk about the programmes and how they can help and support the family. The details are only passed over if the parents' consent to being contacted. We recognise that the letter isn't perfect, and each year we work with the PHE national team to review the format of the letter. It is appreciated that this is a very sensitive issue for parents and it isn't the intention of the service to cause offense. Blackpool sit on the National NCMP board, and the comments the Committee has raised will feed in to this process to help shape and change the letter to help improve this for the future. In addition to the letter, PHE are developing a series of resources to help and support health professionals approach these difficult conversations.	previous meeting.
7	13.02.19	To add in consideration of the outcomes of the Psynergy pilot to the workplan.	October 2019	Scrutiny Manager	Contained within the Mental Health Services Item. ***Update to support this discussion at the October 2019 meeting from the Fylde Coast ICP in relation to the Psynergy pilot:*** The present expansion of the Psynergy pathway is a continuation of the pilot service. The CCG is now putting in place a contract with key performance indicators around the number of patients not taken to ED and therefore supported via another service. UCLAN evaluation of the Psynergy model is being considered.	Green

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
					There has also been a discussion with partners regarding an NHS England/NHS Improvement document "Planning to Safely Reduce Avoidable Conveyance" Ambulance Improvement Programme. In the document there is a chapter titled "Patients Experiencing Mental Health Crisis" (page 15) which discusses patients facing mental health crisis. ***https://www.england.nhs.uk/publication/planning-to-safely-reduce-avoidable-conveyance/***	
8	13.02.19	That the Chairman request that consideration be given to providing suicide awareness training for all Members.	October 2019	Chairman	The Chairman to provide an update at the meeting.	
9	03.07.19	To receive the CQC inspection report of Blackpool Teaching Hospitals NHS Foundation Trust when it was published.	Tbc	Mr Kevin McGee, BTH/Scrutiny Manager to add to agenda.	To be advised by the Trust.	
10	03.07.19	To request that the data held on the number of unexpected deaths (those that the SHMI is based upon) within the hospital and outside of the hospital following	September 2019	Mr Peter Murphy, BTH	This data has been provided as requested, however without a detailed understanding of how the data is calculated and caveats associated with them, it may be difficult for members to draw conclusions. This is the only data that BTH can provide as the original detailed ask is not provided through the NHS dataset. Latest data from NHS digital for BTH NHSFT as requested:	Members to determine if satisfied with response.

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		discharge be circulated to Members.			Trust wide SHMI – 1.15 (115) Diagnostic groups for which SHMI is calculated and published by NHS digital (alphabetical order): Acute Bronchitis - 0.76 (76) Acute myocardial Infarction - 0.89 (89) Carcinoma of the Lung - 0.75 (75) Fractured Neck of Femur - 1.21 (121) Gastro Intestinal Haemorrhage - 1.09 (109) Pneumonia (not TB/STD) - 1.20 (120) Sepsis - 0.94 (94) High Risk diagnostic groups for which expected versus actual deaths but not SHMI's are published by NHS digital: Stroke Aspiration Pneumonia Congestive Heart Failure COPD & Bronchiectasis Intestinal Obstruction Without Hernia Any further queries regarding this, please contact peter.murphy12@nhs.net	
11	03.07.19	That the provision of facilities including the comfort of chairs provided to patients waiting in the emergency department be considered.	September 2019	Ms Berenice Groves, BTH	We have provided additional facilities for patients to wait in. We have also improved pathways therefore those appropriate for AEC will go directly there and wait in recliners. We are also ensuring that as many ambulance arrivals are assessed immediately and placed in comfortable wheelchairs where appropriate, they will be moved to the waiting area therefore creating capacity for patients who require a trolley. If patients are waiting for admission they are moved onto beds to wait but again we are reducing these waits. Finally we are planning to bring in a different type of bed for patients who require this more fit for purpose, plan is to have these replaced by end of Sept 19.	Members to determine if satisfied with response.
12	03.07.19	That the CCG add the inclusion of extended access appointments to the	September 2019	Mr David Bonson, BCCG	This will remain on the CCGs IT agenda, but is a national issue. The CCGs will continue to pursue this.	Completed

	DATE OF REC	RECOMMENDATION	TARGET DATE	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		Patient Access App to their action plan.				

WHOLE SYSTEM TRANSFERS OF CARE SCRUTINY REVIEW RECOMMENDATION MONITORING – OUTSTANDING RECOMMENDATIONS

	DATE OF REC	RECOMMENDATION	NEXT UPDATE TO BE REQUESTED	RESPONSIBLE OFFICER	UPDATE	RAG RATING
1	Updated 03.07.19	Blackpool Teaching Hospitals NHS Foundation Trust to explore the impact of delayed receipt of prescriptions from the pharmacy on discharges from hospital and report back to the Adult Social Care and Health Scrutiny Committee with the reasons for pharmacy delays and a course of action to address those delays at the Committee meeting in July 2019.	**January 2019**	Ms Berenice Groves, BTH	It was noted that further work was required to roll out identified improvements across all hospital wards. A number of wards had been trialling different approaches and the use of Ward Pharmacy Technicians had proved positive. Members highlighted a number of issues with dispensing of prescriptions which demonstrated that further improvements were required. It was also noted that the discharge lounge, where patients could wait for prescriptions, had recently started operating seven days per week. Members were of the opinion that further work was required on the recommendation and requested a further response in approximately six months.	Ongoing
2	Updated 03.07.19	That Blackpool Teaching Hospitals NHS Foundation Trust work with all relevant partners to review discharge processes and ensure they are efficient, effective and to identify if any parts of the	**January 2019**	Ms Berenice Groves, BTH	Ms Groves highlighted that a number of pieces of work relating to improving discharge processes were ongoing. It was noted that each piece of work would be tracked with data to determine if it had impacted on performance. It was also noted that there had been a reduction in the length of stay of patients and the impact of the bed reduction	Ongoing

	DATE OF REC	RECOMMENDATION	NEXT UPDATE TO BE REQUESTED	RESPONSIBLE OFFICER	UPDATE	RAG RATING
		processes could be carried out after the patient has left the hospital. To report back to the Committee meeting in July 2019.			pathways which could be shared with the Committee. Members requested a further update on the impact of the initiatives to improve discharge processes in approximately six months.	
3	Updated 03.07.19	That Blackpool Teaching Hospitals NHS Foundation Trust consider offering parking refunds to patients attending accident and emergency inappropriately.	**January 2019**	Ms Berenice Groves, BTH	It was reported that consideration was being given to the first 30 minutes of parking being free, in order that patients who inappropriately attended the emergency department could then leave immediately without facing a charge. The Committee suggested that consideration also be given to providing free parking tokens for people picking up patients in order to further speed up their discharge. Furthermore, it was considered that the Trust should also explore the costs of parking for low income families, cost of parking for families of patients who are admitted for a prolonged period and how widely refunds for parking for certain services such as maternity were advertised. The initial recommendation was agreed as completed. Ms Groves was requested to respond to the additional recommendations in approximately six months.	Ongoing

Work implemented to reduce 4 and 12 hour delays in the Emergency Department.

ED Performance

ED

This year	Total A&E Breaches	Total A&E Attend	Monthly Target	Monthly Achieved	Variation
April	3200	6878		53.47%	53.47%
May	2881	6865		58.03%	58.03%
June	2599	6571		60.45%	60.45%
July	2365	6852		65.48%	65.48%
August	2605	6524		60.07%	60.07%
September	907	2154		57.89%	57.89%
Total	14557	35844		59.39%	59.39%

Total Economy

This year	Total Econ Breaches	Total Econ Attend	Monthly Target	Monthly Achieved	Variation
April	3284	18884		82.61%	82.61%
May	2902	19202		84.89%	84.89%
June	2635	19076		86.19%	86.19%
July	2382	20292		88.26%	88.26%
August	2615	20023		86.94%	86.94%
September	913	6317		85.55%	85.55%
Total	14731	103794		85.81%	85.81%

Breaches

There are still areas for improvement particularly in the out of hour period in the ED. This is an ongoing improvement involving collaborative team working with the new role of Operational Directorate Manager, DM and HoD.

Breaches	Monday 19th Aug	Tuesday 20th Aug	Wednesday 21st Aug	Thursday 22nd Aug	Friday 23rd Aug	Saturday 24th Aug	Sunday 25th Aug	Total
Admitted	57	44	42	39	20	43	52	297
Non Admitted	46	49	29	23	11	35	44	237
Total	**103**	**93**	**71**	**62**	**31**	**78**	**96**	**534**

Appendix 9(c)i

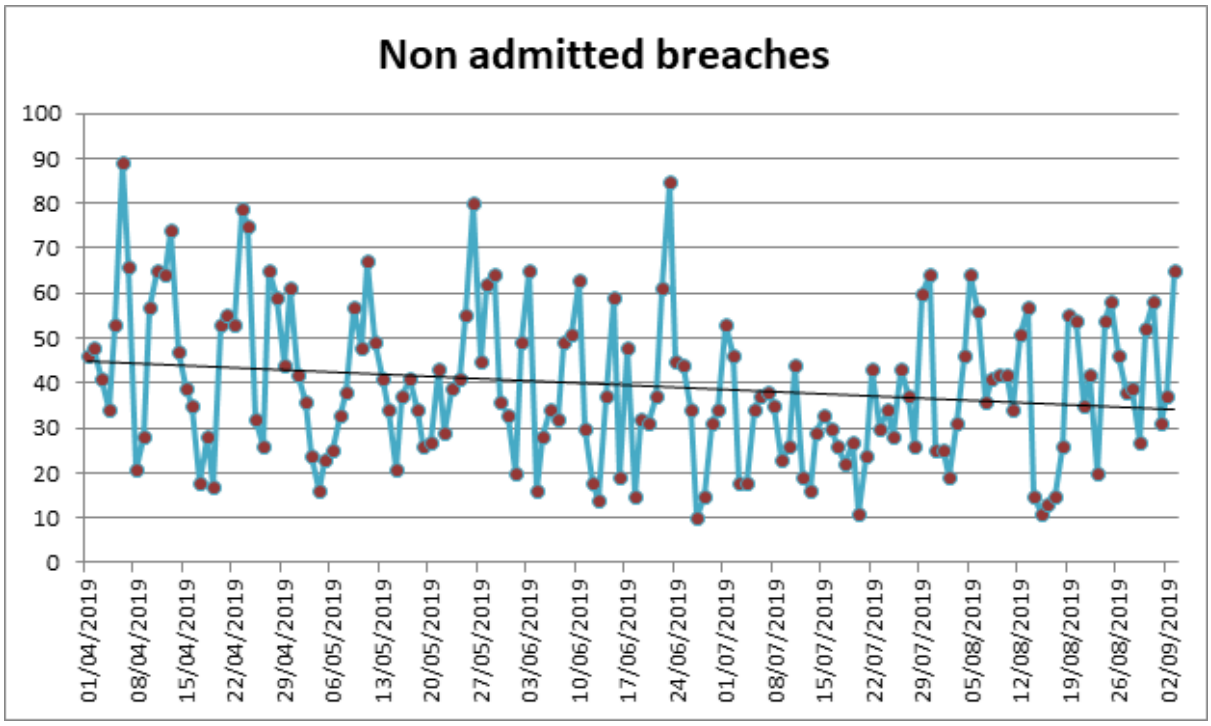
Work implemented to reduce 4 and 12 hour delays in the Emergency Department.

Breaches	Monday 26th Aug	Tuesday 27th Aug	Wednesday 28th Aug	Thursday 29th Aug	Friday 30thAug	Saturday 31st Aug	Sunday 1st Sept	Total
Admitted	45	47	40	48	51	49	34	314
Non Admitted	34	23	29	19	38	48	23	214
Total	**79**	**70**	**69**	**67**	**89**	**97**	**57**	**528**

Actions Taken to reduce the number of 4 hour breaches:-

- Embed the escalation and surge policy and liaise with Patient Flow Manager to ensure it sits in line with the trust escalation policy
- Regular safety huddles
- Allocation board to ensure all medics are distributed to all areas of the department
- Introduction of Band 3 Patient Flow assistants to support the NIC and EPIC
- Embed SOP and action cards for all staff in ED
- Ensure the EPIC model is robust and consistent over the 16 hour cover period.
- Implementation of streaming nurses to direct patients to AEC, UTC and SAU etc.
- ECIST support to facilitate 2 PDSA streaming days completed and 1 further date arranged for October.

Non-admitted Breaches



Work implemented to reduce 4 and 12 hour delays in the Emergency Department.

The ED is seeing a downward trend in the total reduction of non-admitted breaches; however the spikes in breaches are mainly out of hours and are particularly problematic on a Monday and Tuesday. We are aware that there is inconsistency with the non-admitted performance reasons and are working closely with CSU and Operational DM to improve this.

There is a view that it would be beneficial for the UTC to re-commence taking minor injuries overnight as this was only a winter pressure escalation they no longer accept them from 22:00hrs. However due to the time in season it would be more beneficial over the summer months and beyond. Discussions have taken place with FCMS regarding re-initiating the overnight service but this would require support from Commissioners.

The integration of Consultant late shifts will help to reduce the out of hours breaches. These are being incorporated into the rota on an ad-hoc basis with the view to being routine from mid-September and we will monitor the changes. We are also in the process of completing a business case for uplift in the consultant establishment to support the out of hour periods.

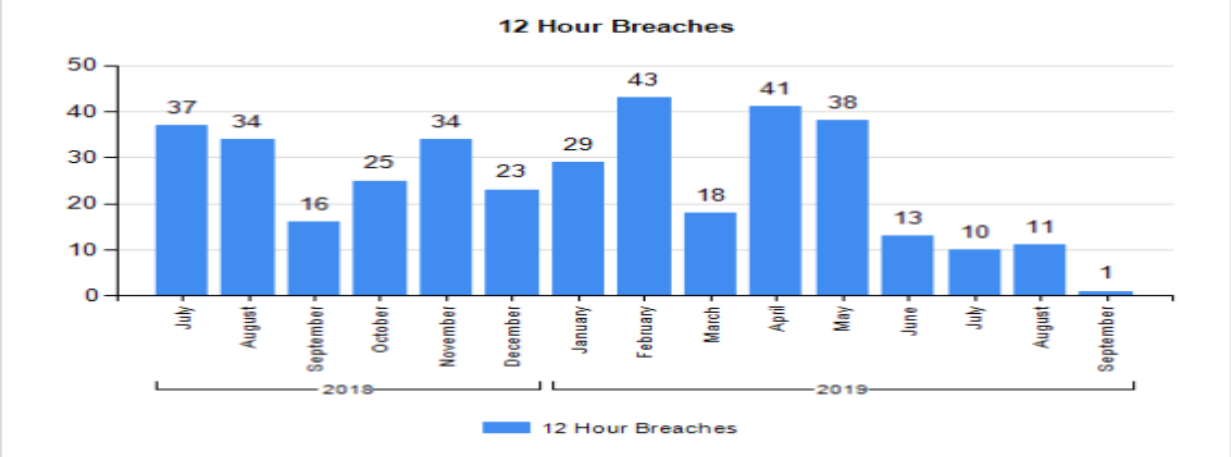
ECIST Breach Tool

ECIST breach tool is now being populated daily. We are unable to record on Maxims at the 4 hour point the breach reason, this is being addressed as a high priority but we do not have a date for this to change yet. In the interim the ED team are working in the department to ensure that we are recording the 4hr breach reason correctly to ensure that the information in the breach tool is correct and avoid having to validate retrospectively.

Actions from the ECIST Breach tool analysis;

- DDOP and Directorate Manager attending the Scheduled Care Divisional Board in September to discuss speciality review delays.
- Auditing CT investigation pathway, to assess where the delays are.
- Working with Mental Health and creating another assessment room.
- Exploring the benefits of overnight transport.

12 Hour Breaches



Appendix 9(c)i

Work implemented to reduce 4 and 12 hour delays in the Emergency Department.

We are now classing all medical 12 hour breaches as a never event. We have had 1 medical 12 hour breach and 4 Mental Health in the last 2 weeks. Following meeting on 3rd September the DM and Patient Flow manager agreed an escalation plan for potential medical breaches.

There is a clear Escalation Policy to raise concerns regarding mental health times to be seen in the ED which appears to be having a positive effect and the department has an excellent working relationship with the Lancashire Teaching Hospitals team who cover the ED.

Actions taken to reduce 12 hour DTA breaches:

- Long LOS meetings every Tuesday/Thursday with dedicated management and nursing support.
- ECIST support with boardrounds
- Pan Lancashire Escalation Policy followed by BTH and LCFT for MH presentations
- Local Agreement to escalate any 16-18 year olds presenting with MH issues for an urgent MDT to be coordinated
- Monthly Governance Meetings continue with FCMS / LCFT / BTH
- Bi-weekly MH meetings

Work implemented to reduce 4 and 12 hour delays in the Emergency Department.

This page is intentionally left blank