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Blackpool Council

6 December 2022

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 14 December 2022 at 3.00 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 5 OCTOBER 2022 (Pages 1 - 6)

To agree the minutes of the last meeting held on 5 October 2022 as a true and correct record.

3 BLACKPOOL HEALTH DETERMINANTS RESEARCH COLLABORATION (Pages 7 - 18)

To update the Health and Wellbeing Board on the new Health Determinants Research Collaboration (HDRC) project.

4 BETTER CARE FUND UPDATE (Pages 19 - 42)

To provide the Board with an update on the financial monitoring of the Blackpool Better Care Fund.

5 BLACKPOOL JOINT STRATEGIC NEEDS ASSESSMENT UPDATE (Pages 43 - 58)

This presentation explains the statutory requirement for the Health and Wellbeing Board to undertake a Joint Strategic Needs Assessment (JSNA) and the purpose of the Joint Strategic Needs Assessment. The presentation then presents the impact of COVID-19 and current state of the Joint Strategic Needs Assessment and goes on to describe some of the challenges in maintaining the Joint Strategic Needs Assessment.

6 BLACKPOOL PUBLIC HEALTH ANNUAL REPORT 2021/22 (Pages 59 - 102)

The 2021/22 Public Health Annual Report explores some of the important challenges faced by coastal communities and disadvantaged areas. Health outcomes in Blackpool are poor for many residents of the town, as can be seen in the factors explored in this report and more comprehensively in the Blackpool Joint Strategic Needs Assessment.

Venue information:

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

Other information:

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

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

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 5 OCTOBER 2022

Present:

Councillor Farrell (in the Chair)

Councillors

Hobson Mrs Scott

Vicki Gent, Director of Children's Services, Blackpool Council
Dr Arif Rajpura, Director of Public Health, Blackpool Council

Roy Fisher, Non-Executive Director, Lancashire and South Cumbria Integrated Care Board
James Fleet, Chief People Officer, Lancashire and South Cumbria Integrated Care Board
Paul Hegarty, Programme Director, Lancashire and South Cumbria Integrated Care Board

Superintendent Chris Hardy, Lancashire Constabulary

Steve Christian, Deputy Chief Executive Officer, Blackpool Teaching Hospital NHS Trust

In Attendance:
Tammy Boyce, University College London
Stephen Boydell, Principal Epidemiologist, Blackpool Council
Judith Mills, Public Health Specialist, Blackpool Council
Lennox Beattie, Executive and Regulatory Manager, Blackpool Council

Apologies:

Tracy Hopkins, Voluntary Sector Representative
Beth Martin, Healthwatch

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 31 MARCH 2021

The Health and Wellbeing Board considered the minutes of the last meeting of the Board held on 31 March 2021.

Resolved:

That the minutes of the meeting of the Health and Wellbeing Board held on 31 March 2021 be approved and signed by the Chairman as a correct record.

3 HEALTH EQUITY COMMISSION

The Board received a presentation from Tammy Boyce, University College London, on the Health Equity Commission review recommendations for Lancashire and Cumbria. The Health Equity Commission review had engaged more people, partners, and community organisations than any previous Marmot Commission with over 2000 organisations having been engaged. This had resulted in over 70 recommendations which were noted by the Board and outlined in Appendix 3a to the agenda.

The Health Equity Commission report centred around a number of system-wide recommendations covering wider detriments of health in the longer term including ill health prevention, digital inclusion and equitable access. The Board noted that the recommendations of the Marmot review would impact upon all levels of the health economy.

The Board considered that, in terms of the recommendations, a number already reflected existing projects and/or aspirations within the area such as Betterstart, Housing regeneration and Place based approach and that it would be useful to evaluate where these areas were already under consideration. It also agreed with the Marmot recommendations as a basis for developing other strategies.

Resolved:

1. To endorse the Marmot recommendations and agree their use as part of policy and strategy development.

2. To map where recommendations are already being reflected in existing workstreams and practice.

4 HEALTH PROTECTION BOARD UPDATE

The Board received an update on the work of the Health Protection Board from Dr Arif Rajpura, Director of Public Health. Dr Rajpura reminded members of the longstanding commitment to health protection activities but equally that the Forum had been reconvened following the emergency measures for the Coronavirus pandemic.

Dr Rajpura highlighted that the membership of the Health Protection Board was as outlined at Appendix 4a to the agenda and included representatives of the Council (including social services and public protection), Blackpool Teaching Hospitals and UK Health Security Agency (UKHSA). Dr Rajpura remarked that it had represented a positive situation that the same representative of the UK Health Security Agency was on a number of Health Protection Forums including neighbouring Council areas as this allowed approaches and intelligence to be shared.

The Board noted that the Health Protection Board would have as its key priority to provide assurance to the Health and Wellbeing Board and its partner organisations on the delivery of health protection plans including outbreak management, infection prevention and control, public protection and the performance of immunisation programmes.

Resolved:

1. To endorse the structures and note the terms of reference of the Health Protection Board attached at Appendix 4a to the agenda and priorities summarised in the report.

2. To agree that the Health Protection Board will report at least every six months to the Health and Wellbeing Board and on additional occasions if significant concerns are raised by the Health Protection Board.

5 CHILD DEATH OVERVIEW PANEL (CDOP) ANNUAL REPORT 2020/21

The Health and Wellbeing Board considered a presentation on the work undertaken by the Pan-Lancashire Child Death Overview Panel (CDOP) during 2020/21, which included key findings from child death data, progress made on 2019/20 recommendations, partnership achievements; priorities and recommendations for 2020/21.

The Board noted modifiable factors identified to relate to child deaths in Blackpool namely smoking, alcohol/substance misuse in parent / carer, domestic abuse / violence, safer sleep and service provision. Members of the Board expressed concern particularly at the issue of alcohol abuse and the need to make progress on that issue with access to services and particularly community based services highlighted as a concern.

The Board considered the priorities identified which reflected a continuation of those previously identified issues:

- Improving the quality and outputs of the child death review processes by ensuring all child death review meetings inform the Child Death Overview Panel process.
- Strengthening exiting pathways
- Reducing the variability of reporting forms and routinely missing information e.g. male partners.
- Demonstrating improvements against national standards through self-assessment.
- Continuing to collect data for Adverse Childhood Experiences (ACEs) and analyse patterns in links between ACEs and child deaths.

Resolved:

1. To undertake a review of the modifiable factors and actions/response to these to be integrated into existing work-streams across the Council's Public Health team and with core partners.

2. That Blackpool as one of the (upper tier) locality area will develop over the next 12 months an Infant Mortality Strategy and Action Plan with an identified Group that leads, or it reports to, which is then accountable to the appropriate Health and Wellbeing Board.

3. To continuously improve data completeness, partners must ensure all professionals providing information to Child Death Overview Panel complete the forms as fully as possible before they are submitted. Improving this data will enable National Child Mortality Database to link with other data sets, leading to more comprehensive analysis in future.

6 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered the updated Pharmaceutical Needs Assessment which had been completed across a pan-Lancashire footprint, which outlined the pharmaceutical services available to the population and also included a number of key recommendations covering the period 2022 through to 20245. Mr Stephen Boydell, Principal Epimedologist explained that the Pharmaceutical Needs Assessment would once approved be used to support NHS England in making decisions to approve/reject applications to join the pharmaceutical list (also known as market entry), as well as applications to change existing pharmaceutical services. The Board noted that when making a decision NHS England would be required to refer to this document as the local Pharmaceutical Needs Assessment.

The Board noted that a significant finding of the updating of the needs assessment was that Blackpool was currently well served for pharmaceutical services with virtually all residents within a fifteen minute walk of a pharmacy.

Resolved:

1. To approve the new Pan-Lancashire Pharmaceutical Needs Assessment 2022 – 2025.

2. To note the finding that there is currently no need for any further additional pharmacies as current pharmaceutical service provision is deemed adequate across Blackpool.

3. To note the recommendations from the Pan-Lancashire Pharmaceutical Needs Assessment 2022 – 2025.

7 BLACKPOOL JOINT HEALTH AND WELLBEING STRATEGY

The Health and Wellbeing Board considered developing a new Health and Wellbeing Strategy as the previous Joint Health and Wellbeing Strategy 2016-2019 had elapsed. It considered that it would be beneficial to create a strategy that had strong links to the Health Equity Commission report and developing Lancashire and South Cumbria Integrated Care Board priorities.

The Board considered that the next strategy should be based on a 10 year timeframe with emphasis on the place-based aspects with care and wider detriments of health.

Resolved:

1. To agree the need to write a new Joint Health and Wellbeing Strategy for Blackpool.

2. To agree to appoint a task and finish group consisting of Councillor Jo Farrell, Dr Arif Rajpura, Director of Public Health and Steve Christian, Blackpool Teaching Hospitals Trust to develop an evidence-based strategy and report back to the Board.

8 FORWARD PLAN

The Board considered the development of a forward plan of items for future meetings. It noted the need to address the priorities outlined in the Health Equity Commission review and agreed that a report with a forward plan of future items be brought to a future meeting to ensure that these were addressed.

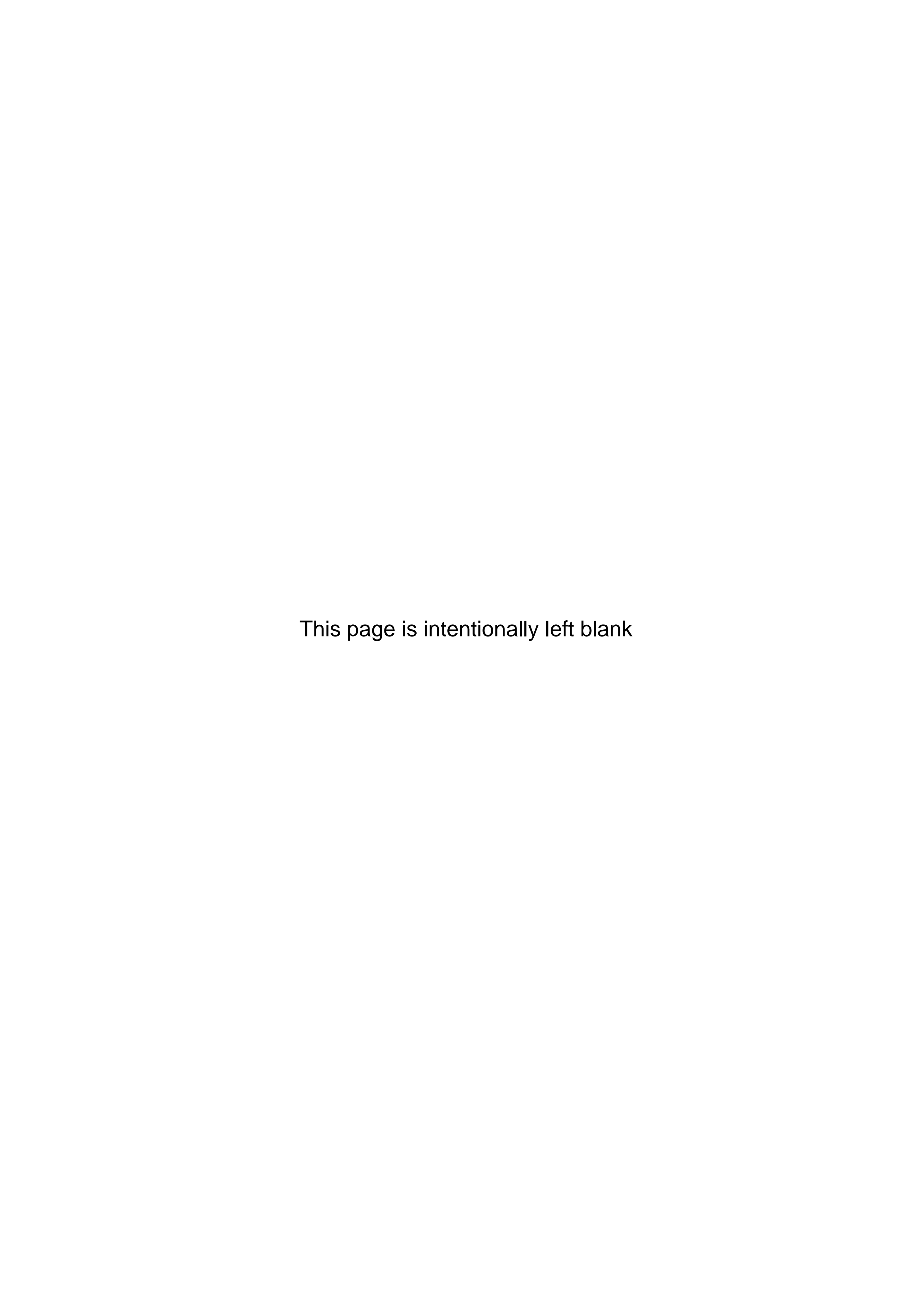
9 DATE OF NEXT MEETING

To note the date of next meeting as the 14 December 2022. The Board considered that it would be beneficial to hold this meeting and other future meetings at a range of community venues to improve accessibility.

Chairman

(The meeting ended at 4.30 pm)

Any queries regarding these minutes, please contact:
Lennox Beattie Executive and Regulatory Manager
Tel: 01253 477157
E-mail: lennox.beattie@blackpool.gov.uk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Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Pauline Wigglesworth, Health Determinants Research Collaboration Programme Director
Relevant Cabinet Member:	Councillor Lynn Williams, Leader of the Council
Date of Meeting:	14 December 2022

BLACKPOOL HEALTH DETERMINANTS RESEARCH COLLABORATION

1.0 Purpose of the report:

1.1 To update the Health and Wellbeing Board on the new Health Determinants Research Collaboration (HDRC) project.

2.0 Recommendation(s):

2.1 To support the Health Determinants Research Collaboration implementation and development over the next 5 years.

3.0 Reasons for recommendation(s):

3.1 The Health Determinants Research Collaboration will require the support of all partners across Blackpool, to be successful in addressing the wider determinants of health and their impact on health inequalities in the town.

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 Blackpool Council has been awarded £5 million over 5 years from the National Institute for Health Research to establish a Health Determinants Research Collaboration (HDRC) in Blackpool. The successful bid was co-developed with Lancaster University, Blackpool Teaching Hospitals and Empowerment Charity. Ten local authorities have been selected to establish Health Determinants Research Collaboration in 2022, with Blackpool being the only successful local authority in the North West of England.

6.2 The aim of the Health Determinants Research Collaboration is for Blackpool Council, in collaboration with local communities and partner organisations, to become a sustainably research active local authority, to embed a culture of evidence-based practice and co-produced research in line with local and organisational priorities and through this, to address the wider determinants of health that are producing stark health inequalities in Blackpool. In the initial years of our Health Determinants Research Collaboration, activities will be aligned to the priorities of the Place-Based Partnership – Housing; The first 1001 days of life; Education, employment and skills; and Mental health; with Healthy Lifestyles being a golden thread throughout.

6.3 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 3a – Health Determinants Research Collaboration Bid Summary
Appendix 3b – Health Determinants Research Collaboration Logic Model

8.0 Financial considerations:

8.1 None arising from this report and presentation which is seeking the support of the Board for the principles of the research collaboration. It should be noted that future decisions may also be required regarding expenditure which will be made in line with the Council's Executive decision making criteria.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 It is noted that 30% of the Health Determinants Research Collaboration budget is allocated to support the employment and training of 10 youth and 10 adult community co-researchers. These posts will only be available to people who are facing health inequalities and are experts by experience.

12.0 Sustainability, climate change and environmental considerations:

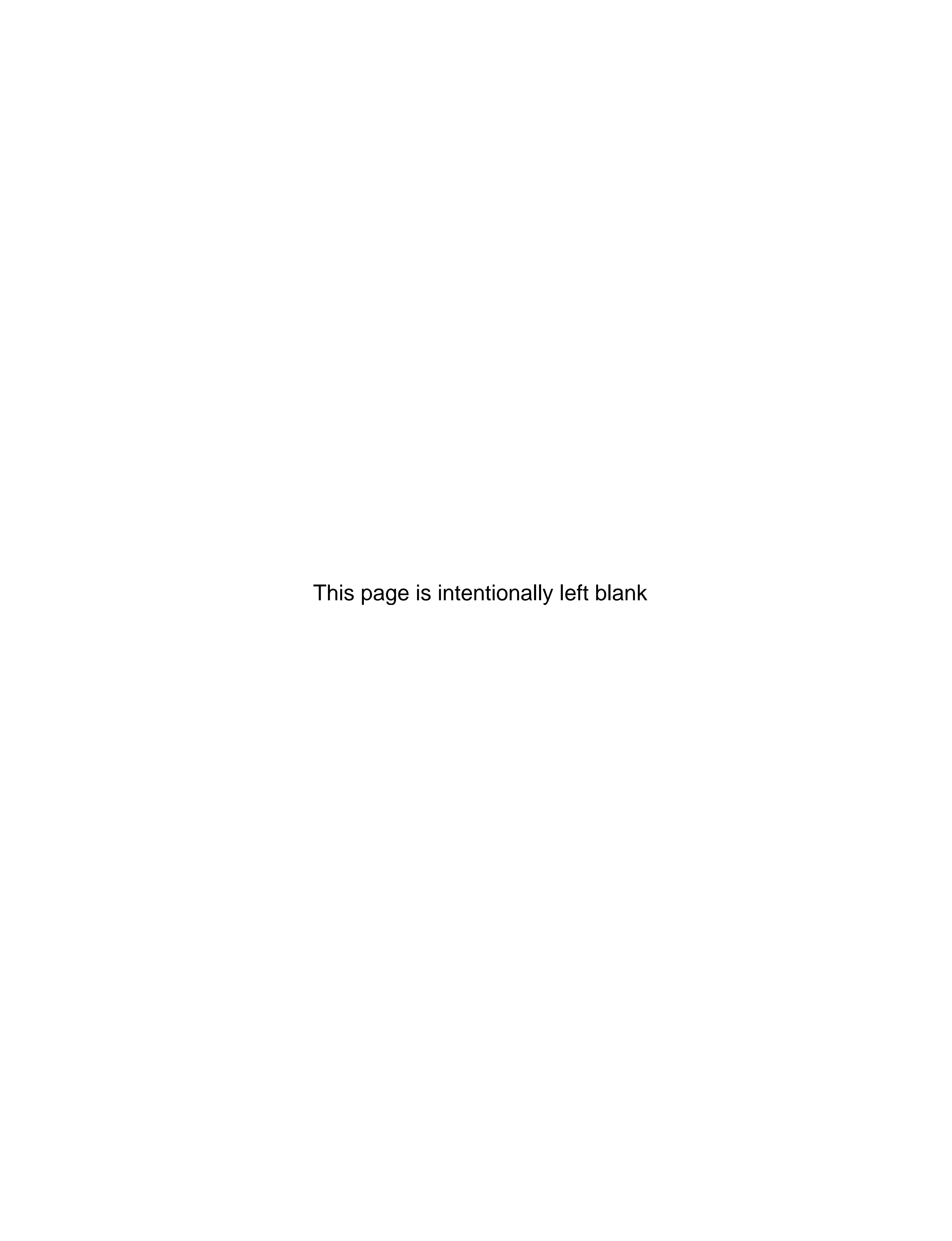
12.1 The Health Determinants Research Collaboration project will ensure that all aspects of the work will address sustainability, climate change and wider environmental factors.

13.0 Internal/external consultation undertaken:

13.1 The Health Determinants Research Collaboration bid was developed alongside community co-researchers and wider consultation with the Voluntary, Community and Faith sector was carried out.

14.0 Background papers:

14.1 None.



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Appendix 3a: Blackpool Health Determinants Research Collaboration

This is a time of excitement and change in Blackpool, and this bid represents a collective ambition to ensure that transformation is led by co-produced evidence-based decision-making and practice, with our community at the heart of our work. Having secured a Town Deal of £39.5 million to deliver regeneration, our priority is ensuring this investment leads to improvements in the health and wellbeing of all our communities. We want to base our actions on evidence and evaluation and ensure that we share what works and what doesn't, nationally and internationally.

Blackpool is home to 139,446 proud residents and welcomes 18 million visitors every year. Of all English local authorities, it is the most deprived as well as having the lowest life expectancy and a high proportion of deaths in younger age groups from suicide, drugs and alcohol. Overall the health and wellbeing of children in Blackpool is significantly worse than England averages; there are 3 times the number of children in care than is seen nationally. Inequalities in the wider determinants of health, such as employment and housing, underlie these outcomes. People working in Blackpool are far more likely to be working in temporary and insecure employment and the average weekly wage is 30% less than average. Housing stock and neighbourhood environments in some areas of Blackpool are extremely poor, with a legacy of poorly converted former guesthouses.

However, we are a resilient town: creative and innovative in our thinking which has led us to believe passionately in the value of co-production. In Blackpool we have developed a model of co-production, which brings together people who research, design, deliver and evaluate, with those people who have lived experience of health inequalities. At the heart of this approach is empowering the most marginalised members of our communities to be trained and developed as co-researchers to play an equal role in co-researching, co-designing, co-delivering and co-evaluating services and initiatives across Blackpool.

Existing Research Activity and Structures

Blackpool Council already has a range of research projects that it hosts and supports, including in Public Health, but limited research that has been led by the council. Research and evidence-based practice are not embedded across all directorates; however existing structures, namely the Corporate Delivery Unit (CDU), are in place to support research. The CDU sits in the office of the Deputy Chief Executive and supports the delivery and review of priority programmes of work that crosscut multiple directorates. The CDU hosts or partners with Blackpool's flagship research projects where we collaborate with academics nationally and internationally: Better Start Blackpool, a research active programme of initiatives for improving early child development in children 0-4 years; and HeadStart Blackpool, a research-active multi-agency programme aiming to increase resilience in young people and improve mental wellbeing. The CDU structure, management and governance will form the basis for the HDRC.

Barriers to Research Activity and Development of the HDRC Bid

From 10/20-01/21 we collaborated with Lancaster University (NIHR 132481) to identify the barriers to Blackpool Council becoming a fully research active local authority. This involved a Delphi consensus process and included the views of our local communities, local NHS trusts, and service providers. The findings mirrored those found by other local authorities funded in the same call, with 4 overarching barriers identified:

1. ***Lack of funding and capacity for research***
2. ***Lack of research infrastructure, understanding of and expertise in research***
3. ***Existing culture of higher education led research with a limited culture of knowledge exchange within Blackpool Council***
4. ***Burden for small stakeholders and a lack of familiarity with council structures and processes***

Solutions were identified through the consensus process and further co-developed with our partners for each barrier, across themes of human resources, funding for research, training, information governance, collaborations and expert support, communication and inclusivity. The design of our HDRC directly follows the recommendations of that work and are in line with the Strategic Coordination of the Health of the Public Research committee goals. The attached organogram outlines the HDRC structure, governance, main collaboration model and wider engagement.

Overall Aim

For Blackpool Council, in collaboration with our local communities and partner organisations, to become a sustainably research active local authority, to embed a culture of evidence-based practice and co-produced research in line with local and organisational priorities and through this, to address the wider determinants of health that are producing stark health inequalities in Blackpool.

Objectives

1. To work in equal partnership with our local citizens and communities, especially those with lived experience of severe health disparities, to identify the priorities for, co-design, co-deliver and co-disseminate research on health determinants in Blackpool.

2. To develop a knowledge and skills framework, needs assessment and training programme to support the process of knowledge creation and implementation across all council directorates.

3. To strengthen council processes to support research delivery, including:

a) creation of a joint research office with NHS Blackpool Teaching Hospitals to utilise local expertise and create efficiencies in research finance, governance and delivery

b) strengthening evidence-based (allied) commissioning procedures, including high quality evaluation and support for research activity, especially within smaller and third sector providers

c) development of a simplified process for accessing and analysing council-controlled data for research, exploring opportunities with emerging local trusted research environments

4. To form a strong collaborative partnership with Lancaster University, NHS Blackpool Teaching Hospitals, Empowerment Blackpool and other relevant organisations to share expertise, resources, and intelligence, and co-produce high quality research funding proposals, alongside our local citizens.

5. To work within our Placed Based Partnership to identify priorities, engage in and lead wider collaborative research, and champion actions to support knowledge creation and implementation in partnership activities.

6. To develop a community of practice of local authorities, particularly those neighbouring councils in Lancashire and South Cumbria which are coastal councils with similar challenges to our own, where we can share our learning related to knowledge translation, cooperate on common problems, disseminate research findings and collaborate on research projects/bids.

Management and Governance

Blackpool HDRC will be integrated within our existing CDU under the Directorship of Antony Lockley, Director of Strategy and Assistant Chief Executive, ensuring it is driven by current council policy and that the evidence generated is integral to decision making. The CDU has an umbrella relationship across all council directorates, houses/partners with the council's existing research teams, and has responsibility for several functions key to research activity including policy and commissioning, performance management, climate emergency and ethical review of council research activity. This will allow the HDRC to build upon these existing activities and leadership to get full value from the NIHR investment.

The HDRC will be strategically managed by the Head of Research and Transformation within the CDU and led operationally by a Research and Development Manager. Research evidence reviews and funding bids will be led by an experienced Research Fellow (posts under this remit may be jointly recruited with Lancaster University to attract research qualified applicants). The HDRC Public Health Consultant will provide strategic scientific oversight to the work of the HDRC, and take a key role in dissemination of its co-created knowledge to academic, local government and community partners. In addition to staffing resource, the HDRC will hold a budget (£165k/year) for staff training programmes, engagement and dissemination activities, and flexible capacity expansion for time-limited opportunities.

The accountability and reporting mechanisms for the work of the HDRC core team will be through Blackpool Council's Corporate Leadership Team (CLT). This will ensure council-wide Director level accountability for the project, including the Director of Public Health. Project management tools, e.g. PRINCE 2, will be utilised to ensure a clear management and reporting structure is in place. An external steering group will be convened in line with NIHR's rule on membership and independence, and formal annual reviews to NIHR will involve all partners. Frequency of formal reports and meetings are outlined in the attached Gantt chart.

Collaborations and Partnerships

Alongside Blackpool Council, the collaboration will be Lancaster University, Blackpool Teaching Hospitals NHS Trust and Empowerment Blackpool (table 1).

Table 1. Collaboration Partners		
Organisation	**Function**	**Outline roles in collaboration**
Lancaster University	Higher Education Institution	• Academic research collaboration e.g. joint grant proposals, joint supervision of MSc and PhD students (students at Lancaster or partner organisation staff undertaking qualifications) • Educational courses e.g. Masters-level in clinical/health research, data science.

		• Honorary positions for collaboration partner staff, allowing access to library and software resources • Joint appointment of research-focussed HDRC staff • Gateway to NIHR infrastructure as host/ key partner in North West Coast ARC and CRN, SPHR (LiLaC) and RDS
Blackpool Teaching Hospitals NHS Trust	NHS Trust	• Formation of a joint research office with Blackpool Council • As host of a successful NIHR Patient Recruitment Centre, they will provide support and guidance on the management of a large NIHR infrastructure investment
Empowerment Blackpool	Charity	• Local charity providing advocacy for, and facilitating co-production with, marginalised communities • Co-lead development and implementation of the Blackpool Model of Co-production

A bid-writing committee with representatives from each organisation met fortnightly from Sept-Nov 2021, all contributing to the development of this application. The leadership teams in all partner organisations are excited by and fully supportive of this bid (see attached letters of support).

Developing and Leading a Research Culture and Influencing Leaders

Within Blackpool Council: With leadership from the Deputy Chief Executive**,** this HDRC bid acts as a catalyst for our developing research culture**.** Our research ambition is being embedded into the new Council Plan, clearly articulating the strategic partnership with Lancaster University. Key decision-making mechanisms, such as the CLT meeting, will have learning from research and evidence as a standing agenda item. In addition, all reports for CLT will have a section that requires the articulation of how evidence and research has informed the work.

Blackpool Council's Leadership Board will convene a shared space with Members, Directors and the Chief Executive to guide and be accountable for HDRC strategies and plans. This will enable an in-depth consideration of evidence reviewed and produced by the HDRC and determine how wider committees could be engaged. For example, links with the Executive, Health and Wellbeing Board and Scrutiny will enable a wider representation of elected members to engage, influence, support and scrutinise the work of the HDRC. Portfolio holders will oversee research projects in their areas via 1-1 meetings with senior officers and shape the response to emerging findings accordingly.

Within Blackpool and the Fylde Coast: The HDRC will act as a beacon for evidence-based practice in Blackpool and take a lead for health inequalities in the newly developed Fylde Coast Research and Evidence Forum. The forum will convene leads from across sectors to share, learn and collaborate on research into practice.

Within the wider region: We will create a Community of Practice (CoP) for research focussing on improving the wider determinants of health within the wider Integrated Care System of Lancashire and South Cumbria. This supports our co-productive principles by convening research-focused people

from different sectors, geographical areas and with differing expertise to come together and learn from each other. We will use this to share our learning from the Blackpool model of co-research and our programme of capacity building. Collaborative research bids/projects will be the practical outputs.

Co-Production

The model and practice of co-research piloted in Blackpool (see table 2) provides a practical framework for how community co-researchers will be employed, trained and supported to take an active role in all aspects of the HDRC work including priority setting, design, research delivery, analysis and dissemination. Existing relationships with a wide range of VCSFE partners support the recruitment of people impacted by inequalities, HR processes are tested and agreed, induction and ongoing support mechanisms have been refined. We are ready to scale up this successful innovative model; paying co-researchers the national living wage addresses individual inequality as well as the co-research addressing the town-wide inequalities.

Table 2. Examples of co-production in Blackpool's flagship projects
HeadStart: A Blackpool Council facilitated initiative which has placed young people at the heart of the 'Resilience Revolution', empowering them to overcome challenges caused by inequality and thrive both individually and as a community. Young people leading on co-production initiatives has been a hallmark of this programme, including being trained as co- Researchers and develop research and learning outputs, both formal and informal, on the impact of how multiple, systemic disadvantage creates barriers for them, their friends and their families getting on in life.
Blackpool Lived Experience Team: A team of individuals all of whom have experienced multiple disadvantage (Homelessness, Mental Illness, Substance Misuse and Offending). This team is working in partnership with the system to co-produce an integrated service pathway which offers effective solutions for people experiencing multiple disadvantage. The team has been trained as Peer Researchers and has proved to be highly effective in engaging with people who do not usually engage at all with health-related research.

Addressing the Wider Determinants of Health and Health Inequalities and Prioritising Local Needs

As an area with an often-overwhelming number of needs, it will be key for the HDRC to prioritise and focus research activity whilst developing further research capacity. In the initial years of our HDRC, we will align our activities to the priorities of the Fylde Coast Place-Based Partnership:

1. First 1001 days of life
2. Housing
3. Education, employment and skills
4. Mental health

These priorities were developed with a strong collaboration of leaders from VCSFE, Local Authority and NHS. Public Health data and intelligence was triangulated with the communities lived experience of health inequalities, specifically via the development of forums with advisors from communities such as those with learning difficulties, physical disabilities, young people, older people and LGBTQ communities.

The Public Health England Wider Determinants of Health Tool will be used to define the scope of the HDRC as well as guiding evaluation and outcomes. NIHR Northwest Coast Health Inequalities Assessment Toolkit will be used for every project with the aim of its use becoming routine in practice across Blackpool Council.

Capacity Building (Gantt chart attached)

Core HDRC development (0-9m)

1. Employment of Core HDRC Team
2. Establishment of joint research office with Blackpool Teaching Hospitals
3. Strengthening evidence-based (allied) commissioning procedures
4. Developing functioning partnership structures
5. Creation of the Blackpool Model (see below). We will refine and adapt existing frameworks that we will apply to the work of the HDRC and subsequent collaborative research projects, evaluate and disseminate through our CoP. We will work with our trained community researchers and consult with colleagues across the council and partners, to refine the frameworks to the needs of a local authority setting and our population.

Table 3. Developing "The Blackpool Model"

Function	Output	Existing Framework for Adaptation
The Blackpool Model of Co-Research on the Wider Determinants of Health	Model of co-production	Refinement of our existing model
	Framework for Implementing Evidence Based Practice	Knowledge to Action Framework
	Rapid evidence assessment toolkit	DEFRA/ NERC The Production of Quick Scoping Reviews and Rapid Evidence Assessments: A How to Guide
Knowledge and skills required for knowledge creation and implementation in a local authority setting	Knowledge and skills framework	Shaping Better Practice Through Research: A Practitioner Framework CAHPR
	Training needs assessment	Hennessy-Hicks Training Needs Analysis
	Training programme	Linked to the developed skills framework and the Blackpool Model of Co-Research
Evaluating, monitoring and supporting success of the HDRC	Evaluation Framework	Value Creation Framework

Capacity development within key council directorates (6-48m)

Based on priority areas, initial and intensive capacity development will focus on 5 key teams within the council: Children's Services Early Years team; Public Health; Housing (incl. Blackpool Coastal Housing Association); Economic Development, Employment and Skills team; and Adult Social Care Mental Health team (incl. mental health social work). In each department, 3 key activities will take place:

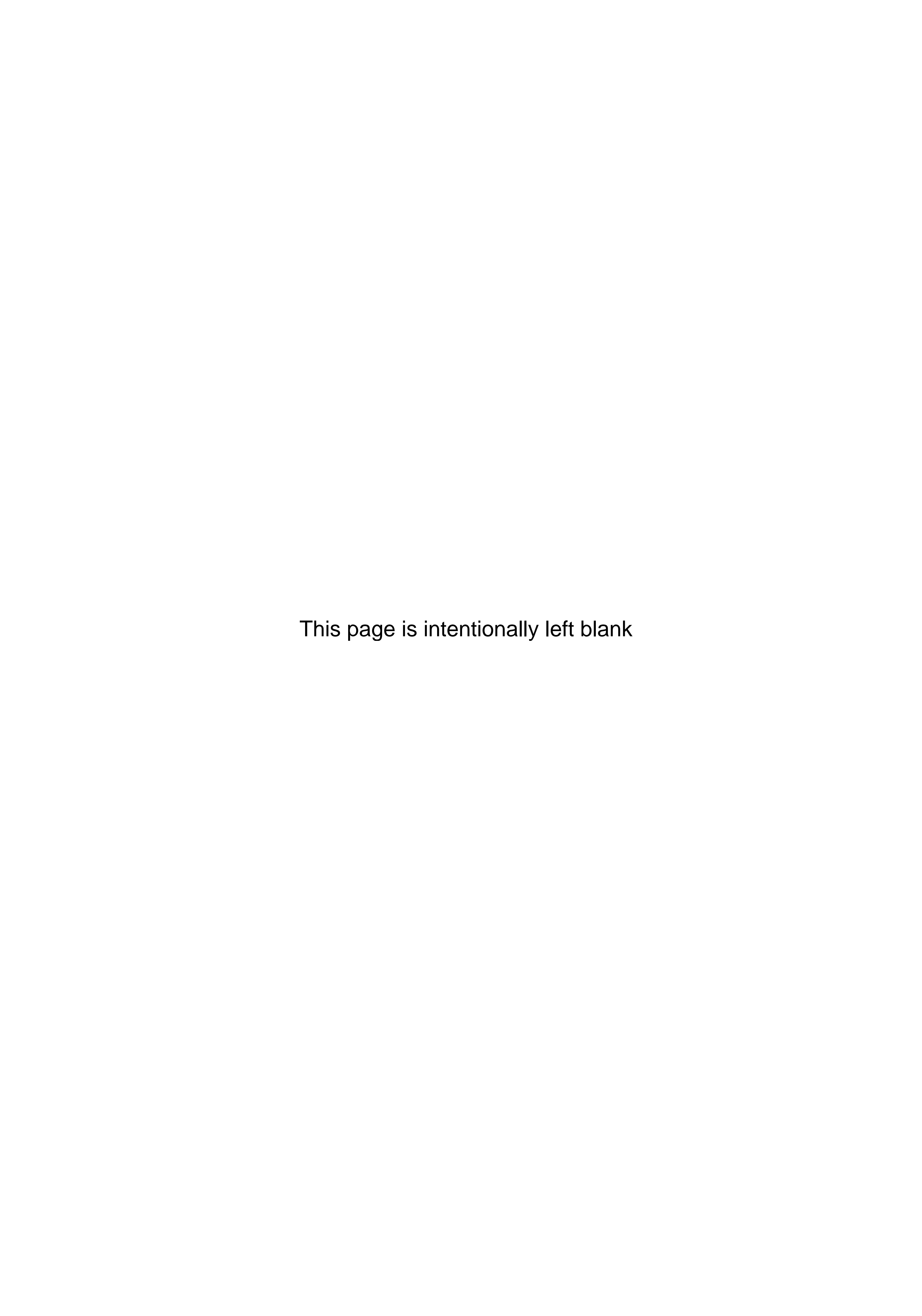
1. Training needs assessment, development and delivery of staff training programmes
2. Rapid evidence assessment based on the current work priorities to identify key research priorities
3. Joint working between the department and the HDRC partners to address research priorities

Sustainable capacity development within wider council directorates (24-60m)

Using learning from the intensive capacity development, a sustainable model of capacity building based on targeted intensive training and continuous professional development will be developed. This may include the development of online modules, seminars and workshops, alongside support to access NIHR academy opportunities. A train-the-trainer model will be developed to create research champions within directorates who will support managers with training needs assessment, signpost to training and collaboration opportunities, cascade updates and calls from the HDRC core team and partner organisations, and support colleagues to pursue the opportunities these offer.

Success measures, dissemination, knowledge exchange and impact

Our Key Performance Indicators and methods for monitoring and supporting success were developed as part of our previous NIHR project (see logic model). Recognising the complexity of identifying and tracking evidence of culture change, systems resilience and sustainability of research-focused activity over the long term, we intend to use inter-linked and consistent forms of evaluation across activities, based on the Value Creation Framework. In conjunction with stakeholders, members of council departments and council leaders, we will regularly complete the tool throughout the wider HDRC work, and it will be integrated as part of the core structure of individual projects. The result is a wide-ranging set of Value Creation Stories from the perspectives of all stakeholders which, along with the quantitative data sources, will help us to understand the wider impact of the HDRC.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Report to:	HEALTH AND WELLBEING BOARD
Relevant Officer:	Lucia Plant, Lead for Better Care Fund, Blackpool Council
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Adult Service and, Community Health and Wellbeing
Date of Meeting:	14 December 2022

BETTER CARE FUND UPDATE

1.0 Purpose of the report:

1.1 To provide the Board with an update on the financial monitoring of the Blackpool Better Care Fund.

2.0 Recommendation(s):

2.1 To note the report and any verbal update.

2.2 To support the continuation of the Better Care Fund Monitoring Group which would be responsible for day to day monitoring and management of the Better Care Fund and report to the Health and Wellbeing Board on at least a 6 monthly basis.

2.3 To confirm the Board's approval of the Better Care Fund planning template for 2022/23 attached at Appendix 4a.

3.0 Reasons for recommendation(s):

3.1 The report is for information to ensure that the Board is kept aware of the status of the Blackpool Better Care Fund and future actions.

3.2 The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006.

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 governance requirements contained within the 'Framework Partnership Agreement relating to the Commissioning of Health and Social Care Services and Other Arrangements' require Blackpool Council to provide regular monitoring of the Better Care Fund (BCF) to the Health and Wellbeing Board.

6.2 Whilst the individual organisations (Blackpool Council and Lancashire and South Cumbria Integrated Care Board) are still monitoring their respective schemes as part of their own financial reporting requirements officers have been unable to submit a consolidated report for this financial year, this is due to the continued delayed publication of the Better Care Fund Policy Statement.

6.3 Blackpool Council and Lancashire and South Cumbria Integrated Care Board were required to complete a planning template (Appendix 4a) to show the expenditure plan for 2022-23, and to outline the expected impact.

6.4 As it was not possible to present the plan to the Health and Wellbeing Board prior to the submission deadline, it was signed off by Councillor Farrell on their behalf on 22 September 2022.

6.5 The Better Care Fund plan 2022-23 is yet to receive assurance and approval from NHS England. This is pending.

6.6 There is an addendum to the Better Care Fund and additional planning templates are due for submission on 16 December 2022 as the Adult Social Care Discharge Fund is being distributed via the Better Care Fund. The funding will be provided in 2 tranches – the first (40%) in December 2022, and the second (60%) by the end of January 2023 for areas that have provided a planned spending report and fortnightly activity data and have met the other conditions.

6.7 The Section 75 agreement, which underpins the Better Care Fund Plan has required extensive revision due to the enactment of the Health and Care Act 2022 and the transfer of Clinical Commissioning Groups to Integrated Care Boards. A decision on this has been made by the

Council's Executive at its meeting on 5 December 2022, reference EX49/2022.

6.8 Does the information submitted include any exempt information No

7.0 List of Appendices:

7.1 Appendix 4a: Submitted Blackpool 2022-23 Better Care Fund Planning Template

8.0 Financial considerations:

8.1 As explained in the body of the report.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 None.

12.0 Sustainability, climate change and environmental considerations:

12.1 None.

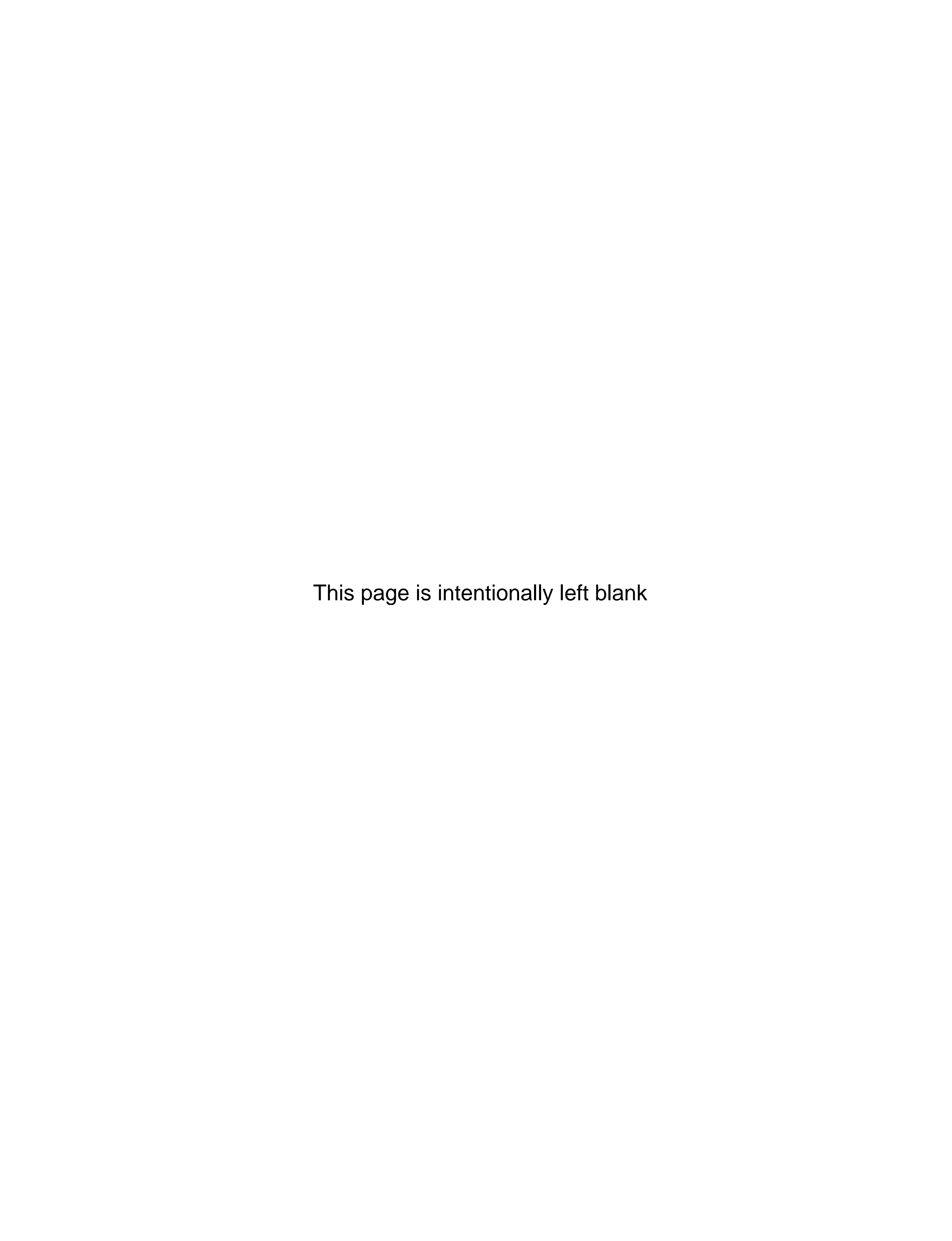
13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 Better Care Fund 2022-23 Planning Requirements- link

Addendum to the 2022-2023 Better Care Fund policy framework and planning requirements- link



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BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution.
4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.
5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

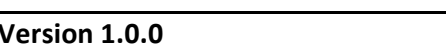
3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.



Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Blackpool
Completed by:	Lucia Plant
E-mail:	lucia.plant@blackpool.gov.uk
Contact number:	(01253) 477107
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Councillor
Name:	Jo Farrell

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Jo	Farrell	jo.farrell@blackpool.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Sam	Proffitt	sam.proffitt3@nhs.net
	Additional ICB(s) contacts if relevant		Jeannie	Harrop	jeannie.harrop@nhs.net
	Local Authority Chief Executive		Neil	Jack	neil.jack@blackpool.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Karen	Smith	karen.smith@blackpool.gov.uk
	Better Care Fund Lead Official		Lucia	Plant	lucia.plant@blackpool.gov.uk
	LA Section 151 Officer		Steve	Thompson	steve.thompson@blackpool.gov.uk
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Blackpool

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,614,944	£2,614,944	£0
Minimum NHS Contribution	£16,978,856	£16,978,856	£0
iBCF	£10,875,315	£10,875,315	£0
Additional LA Contribution	£1,366,927	£1,366,927	£0
Additional ICB Contribution	£7,806,645	£7,806,645	£0
Total	**£39,642,687**	**£39,642,687**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,824,909
Planned spend	£4,911,441

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£11,171,999
Planned spend	£11,355,026

Scheme Types

Assistive Technologies and Equipment	£2,578,717	(6.5%)
Care Act Implementation Related Duties	£387,391	(1.0%)
Carers Services	£1,701,537	(4.3%)
Community Based Schemes	£3,915,382	(9.9%)
DFG Related Schemes	£2,614,944	(6.6%)
Enablers for Integration	£11,849,156	(29.9%)
High Impact Change Model for Managing Transfer of (	£3,802,554	(9.6%)
Home Care or Domiciliary Care	£2,932,604	(7.4%)
Housing Related Schemes	£169,163	(0.4%)
Integrated Care Planning and Navigation	£889,467	(2.2%)
Bed based intermediate Care Services	£4,563,258	(11.5%)
Reablement in a persons own home	£0	(0.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£2,527,698	(6.4%)
Prevention / Early Intervention	£1,089,901	(2.7%)
Residential Placements	£0	(0.0%)
Other	£620,915	(1.6%)
Total	**£39,642,687**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.6%	98.6%	96.9%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	426	465

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Blackpool

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Blackpool	£2,614,944
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,614,944**

iBCF Contribution	Contribution
Blackpool	£10,875,315
Total iBCF Contribution	**£10,875,315**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Blackpool	£1,366,927	Additional funding for scheme extensions
Total Additional Local Authority Contribution	**£1,366,927**	

NHS Minimum Contribution	Contribution
NHS Lancashire and South Cumbria ICB	£16,978,856
Total NHS Minimum Contribution	**£16,978,856**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Lancashire and South Cumbria ICB	£7,806,645	Additional funding to support new and existing
Total Additional NHS Contribution	**£7,806,645**	
Total NHS Contribution	**£24,785,501**	

	2021-22
Total BCF Pooled Budget	**£39,642,687**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Blackpool

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,614,944	£2,614,944	£0
Minimum NHS Contribution	£16,978,856	£16,978,856	£0
iBCF	£10,875,315	£10,875,315	£0
Additional LA Contribution	£1,366,927	£1,366,927	£0
Additional NHS Contribution	£7,806,645	£7,806,645	£0
Total	**£39,642,687**	**£39,642,687**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,824,909	£4,911,441	£0
Adult Social Care services spend from the minimum ICB allocations	£11,171,999	£11,355,026	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Disabled Facitilites Grant-Capital	Adaptations to enable independent living	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,614,944	Existing
2	Phoenix Centre	Mental Health Crisis Team	Prevention / Early Intervention	Other	To Avoid Hospital Admissions	Social Care		LA			Local Authority	Minimum NHS Contribution	£502,726	Existing
3	ARC inc Support Team	Residential Reablement Service	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,242,407	Existing
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,638,539	Existing
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£1,294,065	Existing
5	Vitaline	Assistive technology service, including falls response. NWAS triage	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	iBCF	£749,185	Existing
5	Vitaline	Assistive technology service, including falls response. NWAS triage	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Additional LA Contribution	£544,882	Existing

6	Keats	Day centre providing carer respite and support for people with	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£238,376	Existing
7	Extra Support Service	Short term interventions for LD cases in crisis to get back on track to	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,527,698	Existing
8	Coopers Way	Residential respite service for adults with learning disability	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£672,342	Existing
8	Coopers Way	Residential respite service for adults with learning disability	Carers Services	Respite services		Social Care		LA			Local Authority	Additional LA Contribution	£632,349	Existing
10	Primary MH Care	MH social care team	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£259,599	Existing
11	Hospital Discharge Team	Integrated hospital discharge team	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,528,983	Existing
12	MH Day Services	Mental Health day support services	Prevention / Early Intervention	Other	Health and well-being	Social Care		LA			Local Authority	Minimum NHS Contribution	£307,890	Existing
13	CHC Team	Continuing Health Care social care team	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Continuing Care		LA			Local Authority	Minimum NHS Contribution	£98,948	Existing
14	Additional Social Workers- neighbourhoods	Social care posts within neighbourhood teams	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£459,648	Existing
16	Preparing for Adulthood	Dedicated autism posts to work alongside LD team	Care Act Implementation Related Duties	Other	Transitions Specialist Worker	Social Care		LA			Local Authority	Minimum NHS Contribution	£39,245	Existing
17	Autism	Dedicated autism posts to work alongside LD team	Care Act Implementation Related Duties	Other	Autism Specialist Worker	Social Care		LA			Local Authority	Minimum NHS Contribution	£348,146	Existing
21	Quality Assurance Team	QA team to monitor provider standards	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£411,182	Existing
22	Adults Equipment	Community equipment service to enable independent living	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Additional NHS Contribution	£1,082,750	Existing
23	Care and Repair Contract-BCH	Handyman and repair service	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£169,163	Existing
24	Spending Review Original Ibcf	Uplift in provider rates	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	iBCF	£8,371,989	Existing
27	Childrens Equipment	Community contract allocation	Assistive Technologies and Equipment	Community based equipment		Other	Children's Services	LA			Local Authority	Additional NHS Contribution	£13,032	Existing
27	Childrens Equipment	Community contract allocation	Assistive Technologies and Equipment	Community based equipment		Other	Children's Services	LA			Local Authority	Additional LA Contribution	£188,868	Existing
28	Hub Manager	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	Minimum NHS Contribution	£56,998	Existing

29	Speech and Language	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	Minimum NHS Contribution	£45,598	Existing
30	YOT	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	Minimum NHS Contribution	£14,186	Existing
30	YOT	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	iBCF	£428	Existing
30	YOT	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	Additional LA Contribution	£828	Existing
31	Care Co-ordinator Manager	Community contract allocation	Other		Children's services	Other	Children's Services	LA			Local Authority	Additional NHS Contribution	£6,218	Existing
32	Enhanced Primary Care and Care Homes	Deveopment of neighbourhood care team and care home	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£731,595	Existing
33	Out of Hospital IV therapy service	Community IV therapy service for walk in, housebound and care	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£279,285	Existing
34	Frequent Callers	More than 5 calls in a rolling 7 days results in addition to a daily	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Continuing Care		CCG			NHS Community Provider	Minimum NHS Contribution	£75,784	Existing
35	Intermediate Care model	Step up / step down provision for intermediate care with	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Continuing Care		CCG			NHS Community Provider	Minimum NHS Contribution	£1,127,290	Existing
36	Carers support workers/grants	Targeted support for patients who access primary care regularly	Carers Services	Other	Carer advice and support	Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£158,470	Existing
37	Rapid Response	Step up / step down provision for intermediate care with	Bed based intermediate Care Services	Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£512,957	Existing
38	HD Team	Multi-disciplinary team covering all wards in acute settings to enable	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£144,183	Existing
39	Hospital Aftercare service (existing)	Voluntary sector service providing aftercare on discharge from acute	High Impact Change Model for Managing Transfer	Engagement and Choice		Other	Red Cross	CCG			Charity / Voluntary Sector	Additional NHS Contribution	£40,476	Existing
40	Extensive Care Service	Community frailty service providing different levels of	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,299,161	Existing
41	GP Plus NEL scheme	GP utilisation of care coordination to avoid non-elective admissions	Community Based Schemes	Integrated neighbourhood services		Primary Care		CCG			CCG	Additional NHS Contribution	£2,411,602	Existing
42	Enhanced Supported Discharge	Community service providing nursing and therapy to support	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£375,429	Existing
43	Speech & Language-BTH	Community service providing speech and language provision	Other		Children's services	Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£496,659	Existing
44	Richmond Fellowship	Community support and housing to support mental health patients	Integrated Care Planning and Navigation	Care navigation and planning		Other	Richmond Fellowship	CCG			Private Sector	Minimum NHS Contribution	£161,138	Existing

45	Community End of Life Team	Community team overseeing the development of EPaCCS	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£114,760	Existing
46	Adult Beds	Community service responsible for providing beds for housebound	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Acute		CCG			NHS Acute Provider	Additional NHS Contribution	£423,292	Existing
47	Community Stroke and Neuro	Service providing support for stroke and neuro patients	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£89,859	Existing
48	Rapid Response	Step up / step down provision for intermediate care with	Bed based intermediate Care Services	Rapid/Crisis Response		Social Care		LA			Local Authority	Additional NHS Contribution	£480,274	Existing
49	50% Quality Assurance Manager	Health contribution to management of quality assurance team.	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Additional NHS Contribution	£25,000	Existing
50	CCG Contribution to Adults safeguarding	Contribution towards multi-agency Safeguarding Adults	Enablers for Integration	New governance arrangements		Social Care		CCG			CCG	Additional NHS Contribution	£40,985	Existing
51	Additional Homecare Hours	Social care posts across Adult Social Care	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£468,730	Existing
52	Health Inequalities	Social care posts across Adult Social Care	Enablers for Integration	Integrated models of provision		Community Health		CCG			CCG	Additional NHS Contribution	£3,000,000	Existing
53	ARC rehabilitation GP support	Residential Reablement Service	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			CCG	Additional NHS Contribution	£124,546	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Blackpool

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	303.1	321.1	325.5	259.6	The target has been set based on the number of avoidable admissions in 2019/20 =1309. This is due to the declining impact of the COVID 19 pandemic.	The Rapid Response Team includes 2 Qualified Social Workers and works 7 days 8am-8pm, to avoid hospital admissions and readmissions. it provides crisis support and urgent care following requests directly from A+E to avoid hospital admission. Neighbourhood hubs work as multi-disciplinary teams within local communities providing ongoing support to avoid admissions into hospital and/or re-admissions. Crisis support is available to community patients with joint visits/working following health requests from within multi-disciplinary teams (MDTs). Blackpool's In-House Homecare Service provides flexible support which is not always available from the independent sector, to people at risk of hospital admission. Home's Best is a scheme which offers care outside of typical provision or same day response. A+E has direct access to this provision via a Social Worker or Emergency Duty Team out of hours. Home's Best provision also supports community referrals from the Neighbourhood Teams to divert people from A+E and/or hospital admissions. Primary Night Care (Overnight Care) offers support and care overnight through both planned and unplanned visits ensuring peoples overnight care needs are met. There is a direct referral pathway from the Council's Emergency Duty Team (EDT) for 'urgent care' and Rapid Response for 'crisis care' to prevent overnight conveyances to A+E and/or admission to hospital. The reablement service can be accessed by health and social care professionals to provide intermediate care services to people who may otherwise be admitted to hospital, and the availability of discharge support for people leaving the residential reablement service means that readmission to hospital is less likely, and beds are made available to positively contribute to patient flow across the health and social care system.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	372	416	420	412		
	Denominator						

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.0%	93.5%	92.4%	91.9%	The target has been set taking into account previous performance (average 2020/21 = 92.8%). It is noted that an increased number of people are being discharged back to their usual place of residence. This is due to the continued effort by the acute trust and local authority to adopt a 'homes first' approach and to reduce the amount of people who enter 24 hour care.	Patient care is assessed throughout admission with those no longer meeting the criteria to reside supported in the identified discharge pathway. On admission patients may have lived in their own home and have had little support, upon discharge after the triage process within the Transfer of Care hub, it may be necessary to support the patients in different ways eg a package of care or a discharge to assess bed to identify further levels of care. The discharge destination is decided on medical advice and discussion with the patient (capacity aware) and the families. There is a profound shortage of homecare capacity across the locality at the moment, this is a national issue, every effort is taken to support patients going directly to their home but due to growing pressures Fylde Coast has purchased 12 short term beds to allow patients to move from the Trust into a transitional area until the homecare is available. If patients are to return to a care/nursing home this is again at the agreement of the patient (capacity allowing) family and the provider of this care. Many homes will not be able to meet the needs of the patient if they are not at their previous baseline, if this is the case the patient is referred to our Care Home Select service who are mandated to find a new placement and discharge within 5 days, again unfortunately due to the current climate within social care etc placements are taking longer to find. There is also the discharge to assess pathway when a patient is assessed as needing 24 hr care with an assessment period of 4 weeks and a review taking place regarding the final placement. The discharge to assess process has undergone some significant changes since the start of the pandemic and services have developed and responded to meet the challenges. The Home First process is becoming more established and discharge slots into this service are increasing with workload increasing in line with demand. The team respond to day three Home First reviews, undertake Care Act Assessments, complete CHC check lists, undertake Mental Capacity Assessments for both care and finances, commission and review ongoing packages of care and remain involved for Decision Support Tool assessment meetings if required. They provide ongoing monitoring and review in an attempt to prevent re-admissions into hospital and step up services if the needs of the discharged patient deteriorate. Equipment provision and technology enabled care offer additional ways of supporting people to return home. The capacity of technology enabled care has been increased to respond to same day installations which can help people to be discharged to their normal place of residence. Blackpool's In-House Homecare Service provides flexible support which is not always available from the independent sector, to people leaving hospital who may have complex needs which cannot be met by other providers.
	Numerator	3,906	3,932	3,567	3,420		
	Denominator	4,200	4,205	3,861	3,721		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	91.6%	98.6%	96.9%	99.0%		
	Numerator	467	479	463	478		
	Denominator	510	486	478	483		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	425.6	731.4	523.9	465.1	Based on previous years and adjustments.	The stretch target has been set taking into account performance pre COVID-19 and current operating pressures in the system e.g. lack of capacity in the care at home sector. Blackpool Council and Blackpool CCG have several existing integrated care pathways, aligned to a focus on promoting independence and supporting people in the community, rather than residential care settings. The neighbourhood care teams (PCNs) are based around GP practices, to provide care and support for people to maintain their independence for as long as possible. There is a focus on care coordination, supporting patients with goal setting and coaching, to evolve the model on from a focus solely on medical interventions. Health and wellbeing support workers are supporting the input of specialist clinicians by, for example, supporting patients with prescribed rehab activities, with focus being placed on those most at risk of losing their independence. The multi-disciplinary Rapid Response teams continue to provide 7 day services to prevent admission to residential setting where possible. The integrated services continue to work well together and further integration is planned with frailty, community stroke rehabilitation and intermediate care pathways. The Assessment and Reablement Centre (ARC) provides health and social care input as a step down between hospital and home, or a step up to avoid hospital or residential admission. Ongoing assessments during a stay of up to six weeks ensures that a strength-based approach to maximising skills and independence is applied to promote returns to home. Blackpool Council's In House Homecare Team is also able to provide home care services to support discharge from the ARC to ensure that they are as successful as possible. In addition, this team offers a range of care and support responses, including night care services; reablement at home; longer visits for those who need them; same day response, support to people with mpre complex needs. These can be accessed by the community social work and integrated teams to offer alternative, person-centred solutions to maintain independence. An enhanced assistive technology offer and falls response services provide early intervention options to support people to safely remain at home for longer. Supporting carers contributes to reducing long term admissions to residential settings. Our aim is to ensure that their caring role is sustainable, and that the person they care for can remain living in the community. Alongside funding for day care for people living with dementia, to provide respite for their carers, additional funding in the BCF plan covers: • Flexible breaks for carers, e.g. joining a gym, pamper sessions, taking up a hobby or training course, going on holiday. • Support for carers to ensure that their caring role is appropriate and sustainable. • Support for carers in their own right to maintain their health and maximise their wellbeing.
	Numerator	121	211	151	135		
	Denominator	28,433	28,823	28,823	29,029		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.2%	83.3%	81.9%	80.0%	Episodes of reablement were decreasing in 2021 due to flexing in-house services to meet demand for crisis care and hospital discharge due to the decline in capacity in wider care market. These episodes of reablement do not include where	Plan to resume higher levels of reablement care if capacity allows for this. Demand remains for the service, however, national recruitment issues are also having an impact on capacity.
	Numerator	112	115	86	60		
	Denominator	138	138	105	75		

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Blackpool

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	The plan has been signed off by the Chair of the Health and Wellbeing Board on behalf of the Board. It will be ratified by the Board at their next meeting in 10/22. The local authority and ICB has worked closely with partners at the acute trust (Blackpool Teaching		
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Fylde Coast ICP Strategy 2020-2025 Joint Health and Wellbeing Strategy for Blackpool 2016-2019		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	 Narrative plan Confirmation sheet	Yes	Fylde Coast Self-Care Strategy 2017-2020 Blackpool Council's Housing Plan for the Ageing Population 2017-2020 Blackpool Council Housing Strategy 2018-2023 – Making Blackpool Better		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Adult Service and, Community Health and Wellbeing
Date of Meeting:	14 December 2022

BLACKPOOL JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

1.0 Purpose of the report:

1.1 This presentation explains the statutory requirement for the Health and Wellbeing Board to undertake a Joint Strategic Needs Assessment (JSNA) and the purpose of the Joint Strategic Needs Assessment. The presentation then presents the impact of COVID-19 and current state of the Joint Strategic Needs Assessment and goes on to describe some of the challenges in maintaining the Joint Strategic Needs Assessment.

2.0 Recommendation(s):

2.1 To reflect on the presentation and consider any changes that could be implemented to improve the Joint Strategic Needs Assessment process.

3.0 Reasons for recommendation(s):

3.1 To inform Health and Wellbeing Board members of the current state of the Joint Strategic Needs Assessment process and website and to continue to improve the Joint Strategic Needs Assessment process.

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 Joint Strategic Needs Assessment (JSNA) describes a process that identifies current and future health and wellbeing needs and the causes of poor health. Became a statutory duty from April 2008. From 2012 Local Authority and Integrated Care Boards have an equal and joint duty to prepare a Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy, through the Health and Wellbeing Board.

6.2 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 5a: Joint Strategic Needs Assessment presentation December 2022

8.0 Financial considerations:

8.1 None.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 None.

12.0 Sustainability, climate change and environmental considerations:

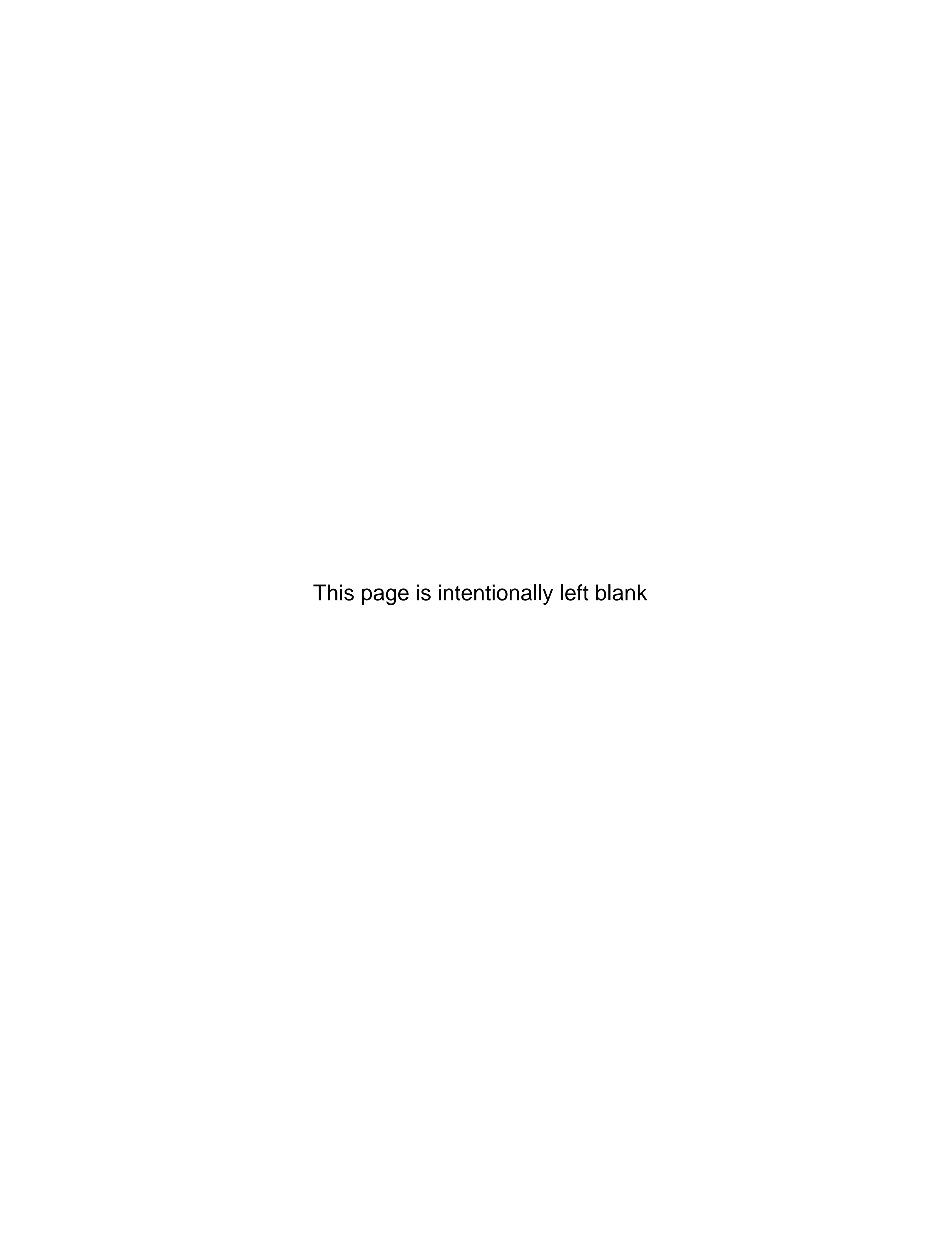
12.1 None.

13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.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Appendix 5a

Blackpool JSNA

Dr Arif Rajpura - Director of Public Health

Stephen Boydell - Principal Epidemiologist

What is the JSNA?

- Joint Strategic Needs Assessment (JSNA) describes a process that identifies current and future health and wellbeing needs and the causes of poor health
- Became a statutory duty from April 2008. From 2012 Local Authority and CCGs/ICBs have an equal and joint duty to prepare a JSNA and Joint Local Health & Wellbeing Strategy, through the Health & Wellbeing Board
- Aim to promote a common understanding of health and wellbeing and provides transparency with regard to the local decision making processes
- The Health & Wellbeing Board and its partners are expected to prioritise based on the information and evidence identified by their local JSNA, as it highlights where there are gaps in knowledge or services and so helps inform effective decision making

Assessing Need and Prioritisation

- JSNA informs the prioritisation process by comparing the health and wellbeing characteristics of Blackpool against other areas and examines how these characteristics change over time
- JSNA is also used to determine where inequalities exist between different communities within the town and identify communities with specific health needs
- As part of the JSNA process the views of the public and service users should be gathered to determine the expressed needs of the community and the strengths and assets found within the community
- Priority may be given where:
    - There is a deteriorating trend
    - There is significant need identified in Blackpool when compared against national or other comparators
    - There are significant inequalities between communities
    - There is a gap in current service provision

The Commissioning Process

Blackpool Council

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

The Strategic Planning Process

Strategic planning identifies how resources will be allocated and improvements will be made to achieve this vision. Priorities are set to focus on achieving the vision.

The JSNA process should inform all strategic plans, e.g.

- Joint Local Health & Wellbeing Strategy
- Blackpool ICB/PBP commissioning Plans
- Blackpool Council Plan
- Etc..

The JSNA website

An inclusive process, involving all local stakeholders, to identify the health and wellbeing needs of Blackpool, which provides simple to use outputs that are widely used by partners.

- **Move away from Pdf reports and towards web based content**
- **Sections that describe the life course**
- **Content of sub-sections to follow a template where possible**
    - **Introduction**
    - **Facts, figures and trends**
    - **National and local strategies (current best practices) – evidence of effectiveness**
    - **What are the inequalities/unmet needs/service gaps?**
    - **Views of the local community**
    - **Recommendations for consideration by key partners**

The JSNA website

Blackpool Profile

- Births and Deaths
- Ethnicity
- Infant Mortality
- Life Expectancy and Mortality
- Migration
- Population
- Religion and belief

Starting Well

0-4 Years old age
- Foundation stage attainment
- Immunisation and vaccination

Maternity
- Antenatal and newborn screening
- Maternal mental health
- Smoking in Pregnancy

Newborn
- Breastfeeding

Developing Well

Children and young people's health
- Alcohol
- Childhood obesity
- Immunisation and vaccination
- Long term conditions in children
- Sexual Health
- Smoking
- Substance Misuse
- Teenage Pregnancy

Children and young people's wellbeing
- Child and adolescent mental health
- Not in education training and employment
- Road safety
- School life
- Youth Offending

Living and Working Well

Health conditions
- Asthma
- Cancer
- CVD
- COPD
- Diabetes
- Mental Health

Health Protection
- Communicable disease
- Sexual Health

Healthy Lifestyles
- Adult obesity
- Alcohol
- Drug misuse
- Smoking
- Workplace and ill health

Ageing Well

Keeping well
- End of life care
- Excess winter deaths
- Mental Health

Living well
- Falls and mobility
- Independence and older age
- Isolation in older people
- Residential and nursing care
- Transport accessibility

People and Places

Vulnerable group
- Carers
- Children in poverty
- Offender health
- People with learning disabilities
- Veterans….

Wider determinants of health
- Deprivation
- Employment and Income
- Environment
- Housing
- Transport….

Impact of COVID-19

- The JSNA process stopped during COVID-19 as resources were required elsewhere
- The Blackpool JSNA process was resumed earlier than other areas across the North West (approximately a year ago)
- A temporary contractor was brought in to support clearing the backlog
- The JSNA is now broadly up to date

Recent Updates

- Sexual Health
- Alcohol and Drugs
- Census 2021
- Children with Learning Disabilities and Special Educational
- Health Protection
- Health Conditions and Prevalence
- Autistic People
- Child and Adult Health Weight
- Etc….

Blackpool Council

Challenges

- It is challenging to maintain the JSNA at it's current size and level of detail
- Questions regarding…
  - The size of some sections
  - The frequency of updating some content
  - The format information is presented in and use of external content
  - The level of input from outside the Public Health team, particularly where Public Health is not the commissioner
  - Prioritising workload

Roles to Support the Blackpool JSNA Process

Strategic Leadership – JSNA Strategic Group

- Public Health Specialist
- Principle Public Health Intelligence Practitioner
- Director of Public Health
- CCG Director of Finance
- Corporate Development, Policy & Research Manager
- Head of Commissioning
- Director of People
- Deputy Director of People (Adult Services)

The JSNA Strategic Group's key role is to priorities JSNA development areas and release resources to complete agreed work plan

Temporary members of the JSNA Working Group

Ad-hoc Topic Based Expertise

- Health and Wellbeing Board Partners
- Voluntary Sector
- Blackpool Council and CCG commissioners
- Public Health Practitioners
- InFusion research

Permanent members of the JSNA Working Group

Wider JSNA Analysts

- CCG input provided by CSU Analysts
- Blackpool Council Business Intelligence Analyst
- Other analysts - e.g. police, NHS Trust, fire service...

JSNA Editorial Team

- Blackpool Council Public Health - Principle Public Health Intelligence Practitioner
- Blackpool Council Public Health - Senior Public Health Analyst
- Blackpool Council Corporate Development - Research Officer

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Report to:	**HEALTH AND WELLBEING BOARD**
Relevant Officer:	Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Adult Service and, Community Health and Wellbeing
Date of Meeting:	14 December 2022

BLACKPOOL PUBLIC HEALTH ANNUAL REPORT 2021/22

1.0 Purpose of the report:

1.1 The 2021/22 Public Health Annual Report explores some of the important challenges faced by coastal communities and disadvantaged areas. Health outcomes in Blackpool are poor for many residents of the town, as can be seen in the factors explored in this report and more comprehensively in the Blackpool Joint Strategic Needs Assessment.

A large focus of this report looks at the challenges faced by people experiencing the most severe forms of disadvantage. These are people who experience problems with substance misuse, poor mental health, domestic violence, homelessness and offending.

Support services across Blackpool recognise the complex circumstances many people who need support find themselves in. This report describes many of the services designed to support people experiencing problems and how they try to take a holistic, multi-agency approach rather than focusing on one issue at a time.

2.0 Recommendation(s):

2.1 To reflect on the findings of the Public Health Annual Report and in particularly consider the Recommendations for action.

3.0 Reasons for recommendation(s):

3.1 To inform Health and Wellbeing Board members and to continue to improve services for people experiencing multiple disadvantage.

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 both:

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

6.0 Background information

6.1 Public Health Annual Reports allow Directors of Public Health to provide independent advice and recommendations on population health to both professionals and the public.

6.2 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 6a:Public Health Annual Report 2021/22

8.0 Financial considerations:

8.1 None.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 The report describes some health inequalities.

12.0 Sustainability, climate change and environmental considerations:

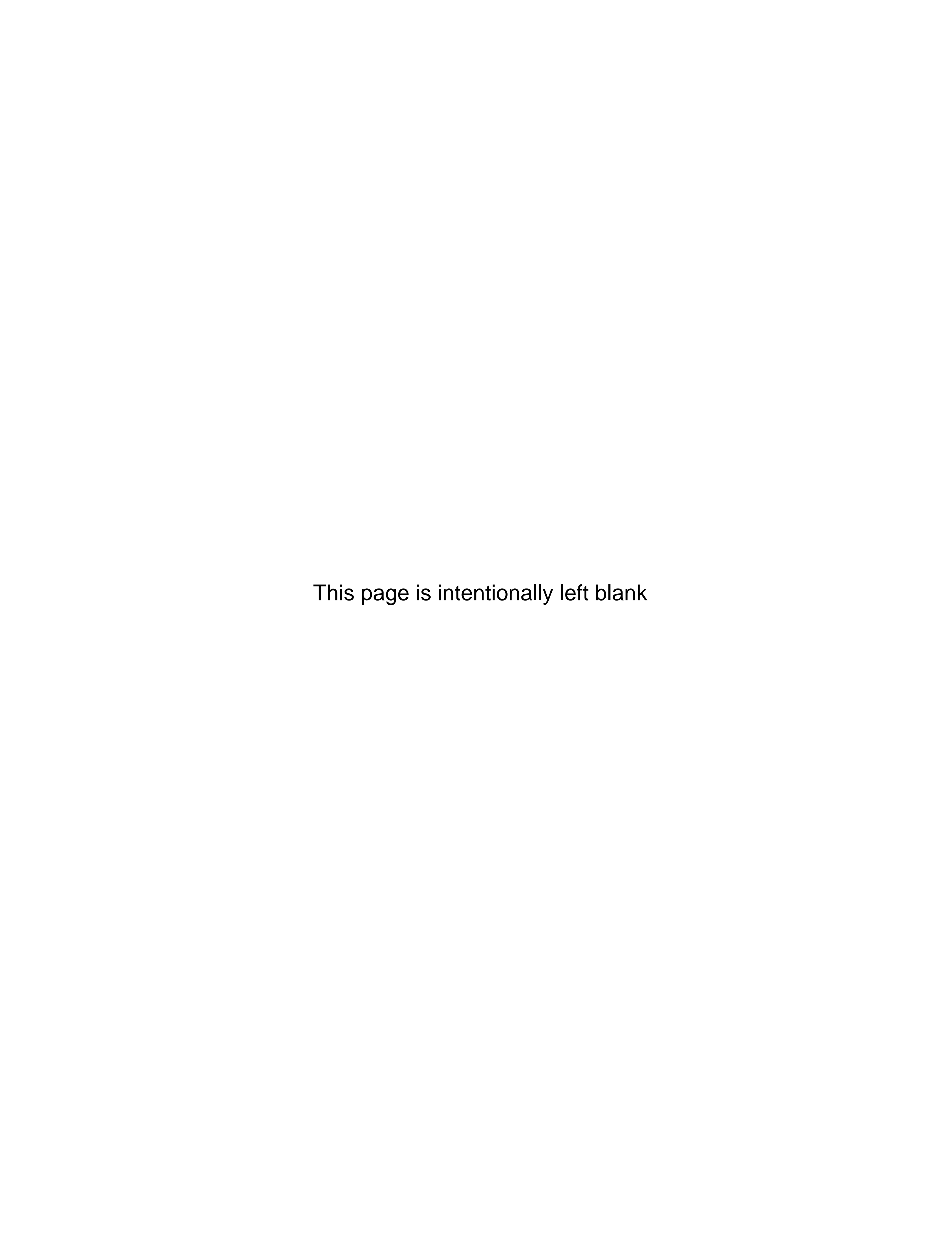
12.1 None.

13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.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Appendix 6a

Public Health / Annual Report / 2021

Blackpool Council

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Introduction

Dr Arif Rajpura
Director of Public Health

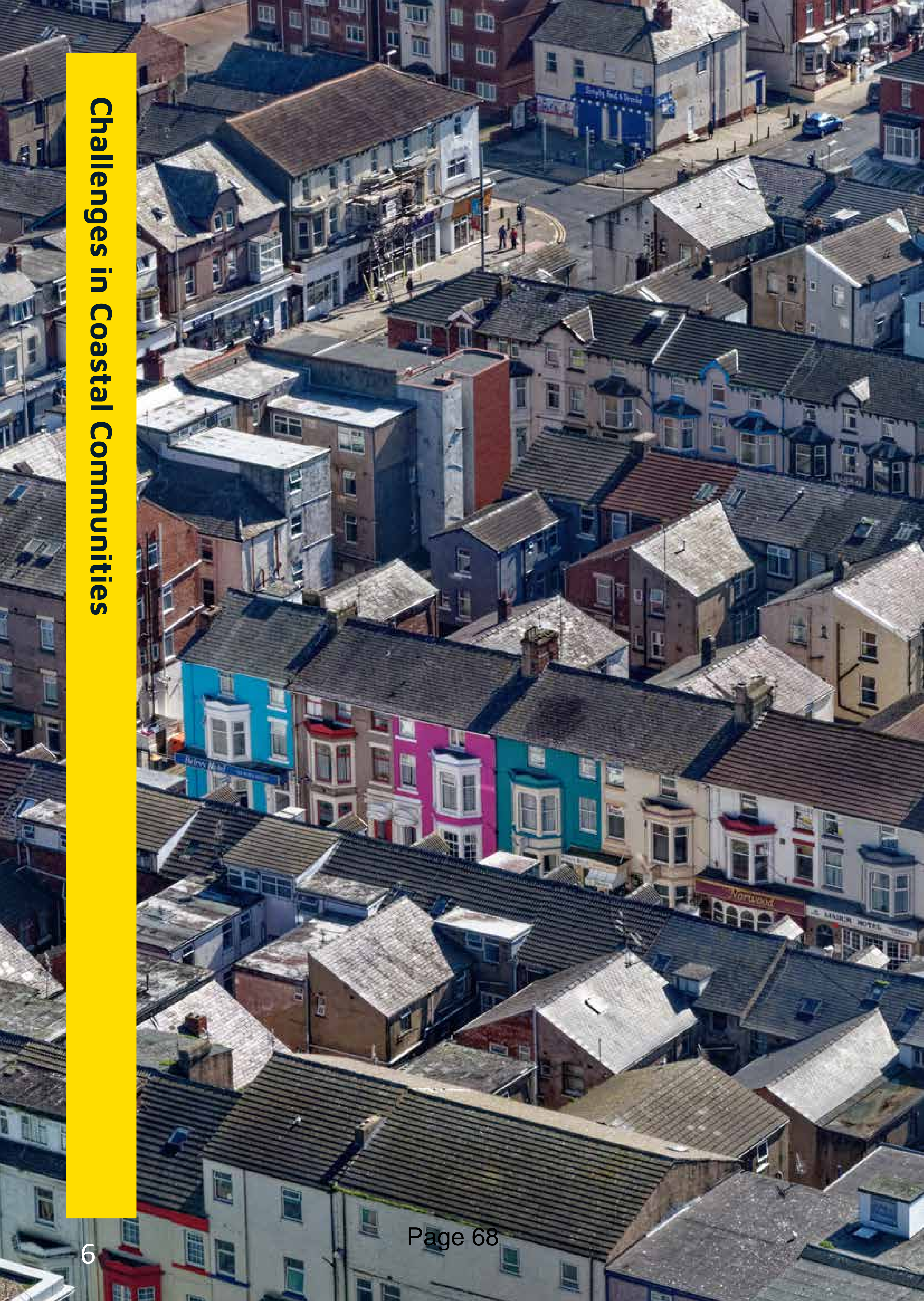
Foreword

This year's Public Health Annual Report explores some of the important challenges faced by coastal communities and disadvantaged areas. As the largest seaside resort in the UK, Blackpool is particularly vulnerable to these challenges. There is currently a national focus on coastal communities, as demonstrated by the Chief Medical Officer examining the tendency for poorer health in coastal areas and the driving factors behind this in his Annual Report. The Blackpool Health and Wellbeing Board, through local partnership working, is acting on the recommendations of the Chief Medical Officer's Annual Report to drive change locally.

Many exciting developments are underway in the town to ensure Blackpool remains both vibrant and attractive to visitors and also expands the local economic base, bringing in new businesses and innovation. This is essential to make sure that Blackpool's economy can support its residents to find rewarding work and provide opportunities for Blackpool's young people to develop the skills they need for their careers.

Health outcomes in Blackpool are poor for many residents of the town, as can be seen in the factors explored in this report and more comprehensively in the Blackpool Joint Strategic Needs Assessment. A large focus of this report looks at the challenges faced by people experiencing the most severe forms of disadvantage. These are people who experience problems with substance misuse, poor mental health, domestic violence, homelessness and offending. These issues can lead to extremely poor health outcomes for the individuals involved and also have a disproportionate impact on overarching measures of health outcome, such as life expectancy.

Support services across Blackpool recognise the complex circumstances many people who need support find themselves in. This report describes many of the services designed to support people experiencing problems and how they try to take a holistic, multi-agency approach rather than focusing on one issue at a time. For many people living in Blackpool these support services have made a huge difference to their lives, allowing them to deal with the problems they faced, be optimistic about the future again and contribute to helping others.



Challenges in Coastal Communities

Challenges in Coastal Communities

Chief Medical Officer's Annual Report 2021

Chief Medical Officer Professor Chris Whitty's second annual report[1] presents an analysis of the health and wellbeing of England's coastal communities. The report explored the burden of disease in coastal communities and the wider determinants of health, including a section examining the impact of poor housing. The benefits of living in coastal communities were also considered. Ten directors of public health in coastal local authorities were given the opportunity to provide case studies which explored the challenges and strengths of their communities.

The report highlighted that "the health challenges of coastal towns, cities and other communities are serious, and their drivers are more similar than their nearest inland neighbour. This means a national strategy to address the repeated problems of health in coastal communities is needed in addition to local action. If we do not tackle the health problems of coastal communities vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age."

A number of factors, specific to coastal communities, which influence health are identified. Coastal areas tend to attract older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has encouraged the conversion to Houses of Multiple Occupation (HMO) which leads to concentrations of deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder. Many coastal communities were created around a single industry, such as tourism in Blackpool, meaning work can often be scarce or seasonal. The report also identifies relatively high prevalence of mental health conditions and poor mental wellbeing, high prevalence of substance misuse and poor quality housing as being common features within coastal communities. These are key factors that define multiple disadvantage, as will be explored in this report.

1. www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

The Chief Medical Officer's Annual Report identifies three key recommendations:

1. Given the health and wellbeing challenges of coastal communities have more in common with one another than inland neighbours, there should be a **national strategy to improve the health and wellbeing of coastal communities**. This must be cross-government as many of the key drivers and levers such as housing, environment, education, employment, economic drivers and transport are wider than health.

2. The **current mismatch between health and social care worker deployment and disease prevalence in coastal areas** needs to be addressed. This requires action by Health Education England and NHS England/NHS Improvement.

3. The **paucity of granular data and actionable research into the health needs of coastal communities** is striking. Improving this will assist the formulation of policies to improve the health of coastal communities. Local authorities, the Office for National Statistics and NHS England/ NHS Improvement need to make access to more granular data available. Research funders, including National Institute for Health and Care Research and UK Research and Innovation, need to provide incentives for research aimed specifically at improving coastal community health.

Further more detailed recommendations can be viewed within the report summary, with a number being particularly pertinent to Blackpool:

1.1 Planning for the ageing population in coastal and other peripheral areas, with consideration to migratory patterns, and the potential for a deficit of social care and healthcare workers relative to older populations

1.4 Review of incentives in the private rental sector in coastal communities, specifically HMOs which draw a transient vulnerable population to coastal communities

1.6 Specific plans for major risk factors concentrated in coastal communities – especially high rates of smoking in pregnancy, alcohol and substance misuse

1.8 Making more of the potential health and wellbeing benefits of living in coastal communities

4.1 Continue work to ensure Directors of Public Health in every Integrated Care System (ICS) are an integral part of the ICS Executive leadership team/ board

4.2 The high rates of excess alcohol use in coastal communities, and specifically issues in resort towns, further strengthens the case that public health should be added as a licensing objective in the Licensing Act 2003

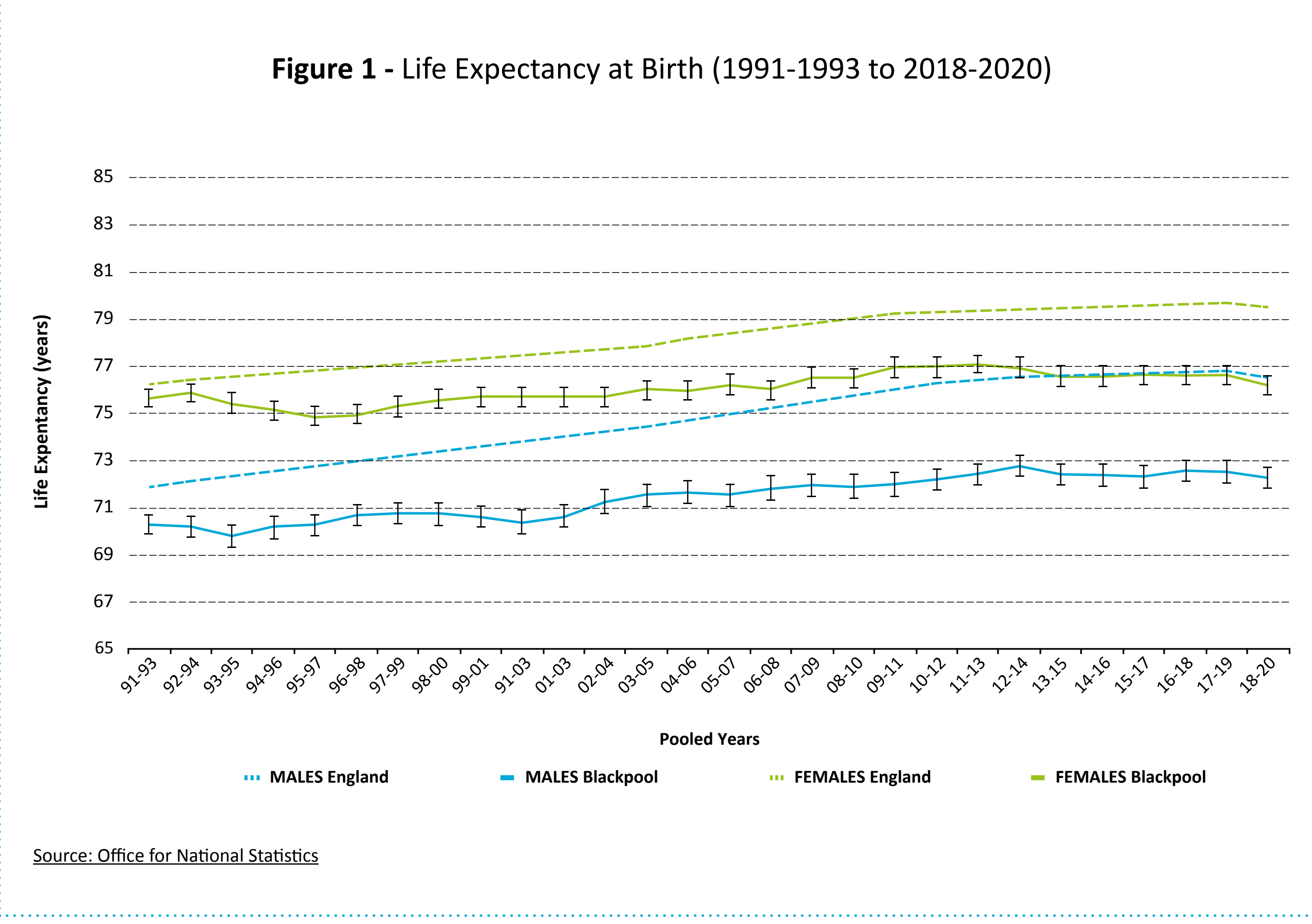
What do we see in Blackpool?

The impacts of the disadvantage described in the Chief Medical Officer's Annual Report are ultimately seen in the high rate of mortality, low life expectancy and numbers of people living in poor health.

Life Expectancy

Life expectancy is one of the key indicators of health in a population. Life expectancy at birth is defined as the average number of years that a new-born is expected to live if current mortality rates continue to apply. Life expectancy for men in Blackpool is 74.1 years and for women is 79.0 (2018-2020), both lower than national averages. Figure 1 demonstrates that, while life expectancy in Blackpool has risen in the long term for both males and females, the gap in life expectancy between Blackpool and England has grown over the last 25 years. There are also considerable differences in life expectancy within Blackpool. Men in the least deprived areas of the town can expect to live 13.2 years longer than men in the most deprived areas. Similarly, for women this difference is 9.5 years.[2]

Figure 1 - Life Expectancy at Birth (1991-1993 to 2018-2020)



Source: Office for National Statistics

2. Life expectancy for local areas of the UK - Office for National Statistics (ons.gov.uk)

Whereas life expectancy is an estimate of how many years a person might be expected to live, healthy life expectancy is an estimate of how many years they might live in ‘good’ health. Healthy life expectancy is calculated using self-reported prevalence of ‘Good’ general health collected in the Annual Population Survey. Comparisons of healthy life expectancy between England and Blackpool show a greater difference than for life expectancy alone. From this it can be observed that residents of Blackpool live shorter lives than the national average, and furthermore spend a smaller proportion of their shorter lifespan healthy and disability-free. Healthy life expectancy for both men and women in Blackpool are the lowest of all local authorities in England, and healthy life expectancy for women in Blackpool reduced from 57.1 between 2016 and 2018 to 54.29 between 2018 and 2020.[3]

Drug Related Deaths

Drug misuse is a significant cause of premature mortality in the UK, and drug related deaths in England and Wales have been on an upward trend over the past decade. This is driven primarily by deaths involving opiates, though also from increases in deaths involving other substances such as cocaine.

Deaths from drug misuse are recorded where a drug, controlled under the Misuse of Drugs Act 1971, was mentioned on the death certificate and the cause of death is related to poisoning by drugs, assault by drugs or mental disorders related to volatile substances.

Blackpool has the highest rate of deaths from drug misuse in the country, with 76 deaths between 2019 and 2021 a rate of 19.4 per 100,000 population (directly standardised rate). The overall rate for England is 5.1 deaths per 100,000 (Figure 2). Whilst national and regional rates increased for the COVID-19 affected three year period 2019 to 2021, Blackpool’s rate fell from 22.1 per 100,000 in the 2018 to 2020 period to 19.4 per 100,000 in 2019-2021. This was due to the number of deaths to drug misuse reducing from 28 or 29 each year between 2018 and 2020 to 18 in 2021.

3. Health state life expectancy, all ages, UK - Office for National Statistics (ons.gov.uk)

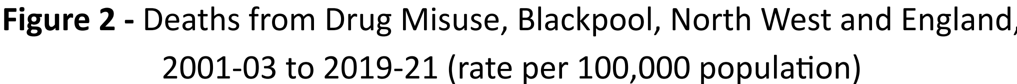
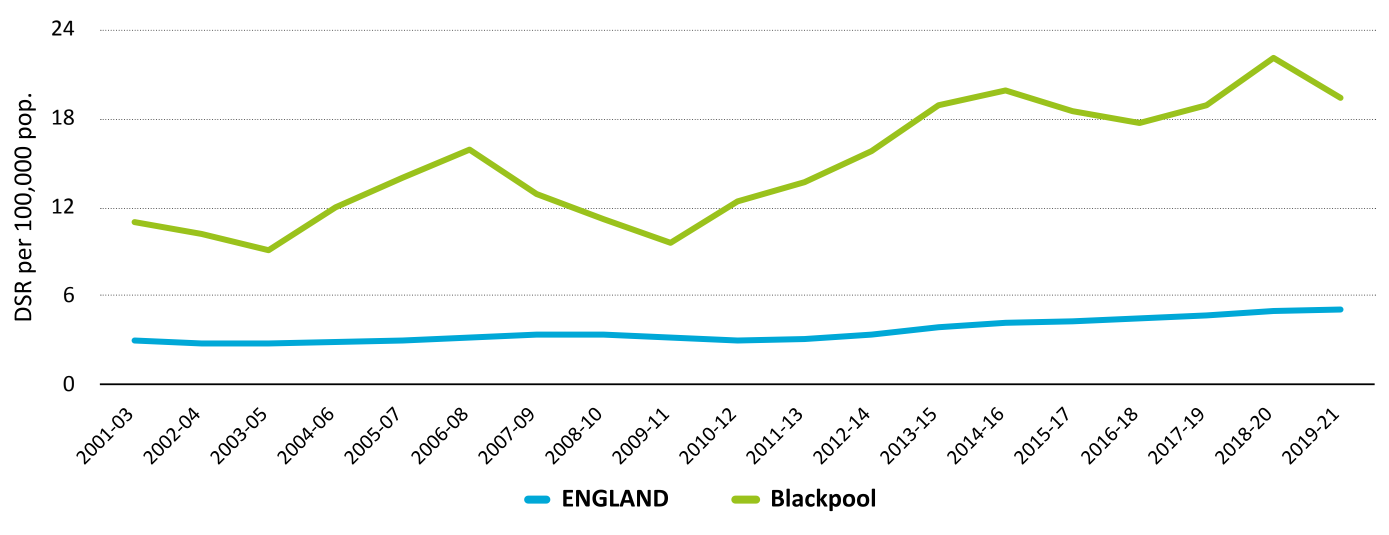


Figure 2 - Deaths from Drug Misuse, Blackpool, North West and England, 2001-03 to 2019-21 (rate per 100,000 population)



Source: Office for National Statistics (ONS) Deaths related to drug poisoning in England and Wales: 2021 registrations / OHID Public Health Profiles

Alcohol

Alcohol is the third leading risk factor for death and disability after smoking and obesity and has been identified as a causal factor in more than 60 medical conditions including cirrhosis of the liver, heart disease, depression, pancreatitis and stroke as well as a number of cancers. Alcohol misuse can be a long-term condition and dependent individuals may experience many health problems and are frequent users of health services. Excessive alcohol consumption is a major cause of preventable premature death.

Figure 3 shows alcohol specific mortality for males and females in Blackpool compared to the North West region and England as a whole. For males the rate in Blackpool had been showing a gradual decline until 2012-14 but did begin to increase again. However, the mortality rate has been static in recent years and is currently 39.2 per 100,000. This is approximately two and a half times higher than the national average of 14.9 per 100,000. For females, alcohol specific mortality had been increasing since 2010-12 although the rate fell in 2017-19 to 15.5 per 100,000. This compares to the England rate of 7.1 per 100,000. The rates are still significantly higher than national averages for both males and females.

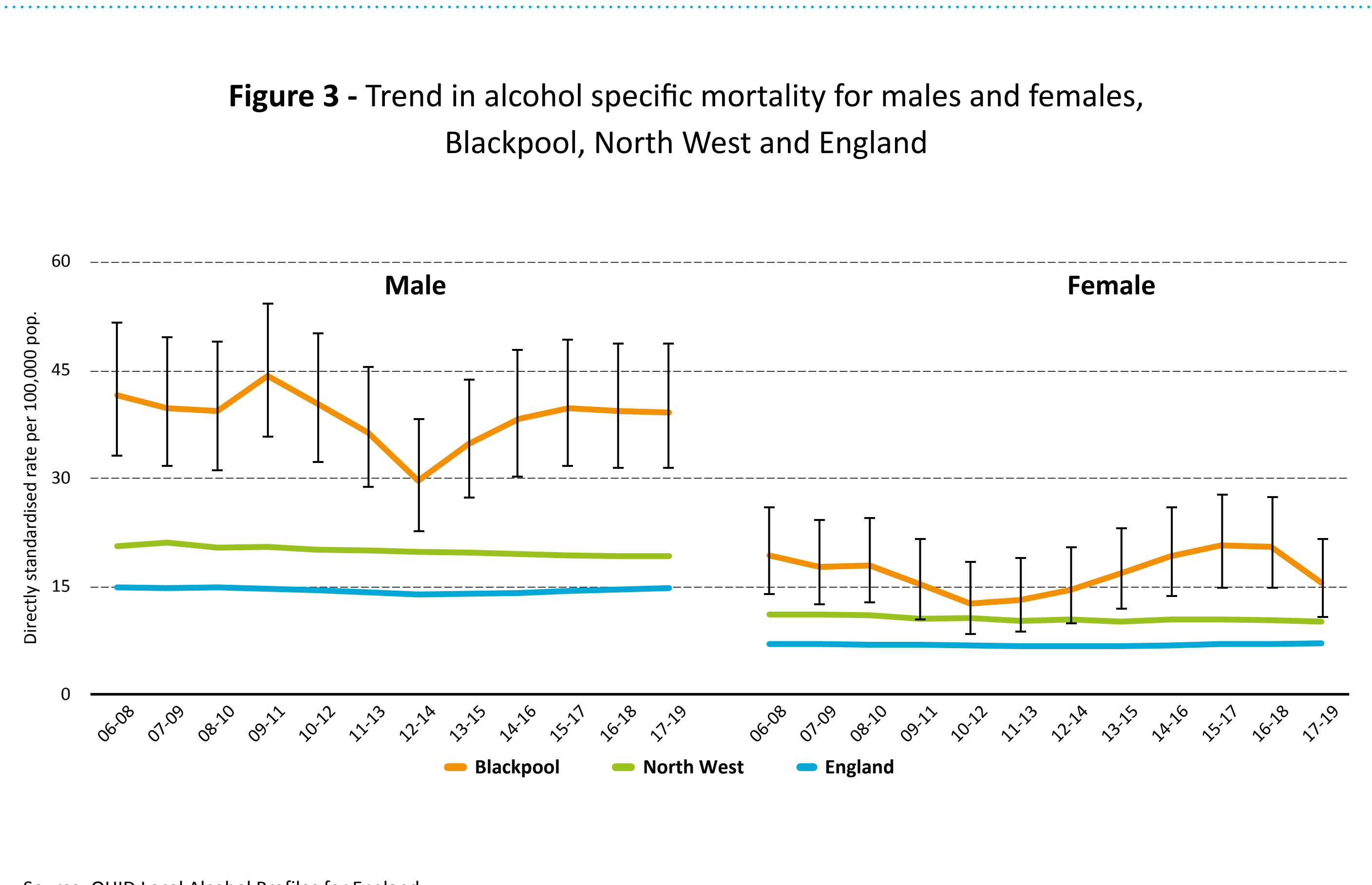


Figure 3 - Trend in alcohol specific mortality for males and females, Blackpool, North West and England

Source: OHID Local Alcohol Profiles for England

Suicides

Between 15 and 20 Blackpool residents take their own lives each year. Males are much more likely to take their own life than females, as is also seen nationally, although the suicide rate in females has risen in the last five years in Blackpool. The suicide rate in Blackpool is significantly higher than the rate for England as a whole 17.4 per 100,000 vs. 10.4 per 100,000 (2018-20). Unfortunately many people who take their own life are relatively young, with potentially many years of fulfilling life lost.

Projects to Revitalise Blackpool

This report describes some of the challenges that Blackpool faces as a community and later goes on to examine some of the programmes in place to support people facings multiple disadvantage. It is also extremely important that there are plans in place to continually develop the town to improve the prospects of future generations. This chapter describes some of the work already underway and some of the future plans for the town.

Levelling up

On March 17th 2022 Government unveiled new measures to help improve the lives of people in Blackpool by turning the tide on deprivation in one of the UK's most iconic seaside towns. Blackpool, which has 8 of the 10 most deprived neighbourhoods in England, will now receive support to deliver a root and branch transformation of the town. The package has pledged to include a crackdown on rogue landlords by scaling up the local enforcement team to deliver more action on those not meeting current standards and a transformative King's Cross style regeneration programme to create beautiful new homes and turbo-charge tourism in the area.

The plans have been developed by government, local leaders, businesses and community groups who are working together to tackle the entrenched inequalities that have held the town back, as part of a new strategic partnership.

Longstanding neglect by some landlords has led to Blackpool experiencing some of the worst housing conditions in the country, with at least 1 in 3 properties classified as 'non-decent'. An expanded local enforcement team will take tough action against those not meeting existing standards and measure landlords against future national standards. This extensive inspection programme will tackle exploitation in the private rented sector with a supported housing market driving up housing quality and protecting the most vulnerable.

Alongside this enforcement drive, Homes England will join forces with Blackpool Council, using additional funding of £650,000 to explore regeneration opportunities to improve Blackpool's housing stock and quality of place.

Cllr Lynn Williams, Leader of Blackpool Council, said:

"Locally, we have developed a unique partnership with business and the voluntary sector. Our ask of government was to work with this partnership to help deliver a step change that will transform the lives of our residents and our communities."

Christine Hodgson CBE, Chair of Blackpool Pride of Place Partnership:

"I am so pleased to see the government's commitment to Levelling Up, and really grateful that Blackpool has been chosen as the exemplar."

restaurant

Local infrastructure projects

A number of exciting new projects are planned, with many already underway, to aid Blackpool's economic recovery, particularly focused on the redevelopment of the town centre.

Town Centre Phase 2

- Work is underway on the £35m Phase 2 Talbot Gateway which is due for completion early 2023
- 144 bed Holiday Inn (4* equivalent)
- Marco Pierre White's New York Italian restaurant
- Ground floor retail units
- Interconnecting underpass under the hotel and high street for direct tramway access

Town Centre Phase 3

With a total project value of £100m, works will start on-site in summer 2022 with a scheduled completion date of summer 2024.

- 215,000 sq ft of BREEAM[4] Excellent office space
- The Department of Work and Pensions' new civil service regional hub
- Sustainable and energy-efficient design throughout
- Home to over 3,000 local civil servants
- Winner of the North West Business Insider Letting Deal of the Year 2022

Houndshill Phase 2 Extension

Blackpool Council acquired Houndshill Shopping Centre with the aim to catalyse the regeneration of Blackpool's retail core and secure the future of the shopping centre. Work is progressing on the £21m extension.

- 9 screen, 850 seat, 40,500 sq ft IMAX-ready multi-media cinema complex
- New eating outlets
- 22,500 sq ft Wilko store
- The biggest immersive screen in North West
- £5m Getting Building Funding

Abingdon Street Market

Work began on site to rejuvenate this heritage building in August 2021, giving the market a new lease of life and securing its long term future at the heart of Blackpool's town centre.

- An extended food and beverage quarter with 250 seats for market dining
- Stalls for food and beverage, artisan stalls and flexible retail units
- Coffee stall and bar area
- £3.6m Getting Building Funding

4. BREEAM or Building Research Establishment Environmental Assessment Method is used to masterplan projects, infrastructure and buildings.

Winter Gardens Conference & Exhibition Centre

Opened officially by the Prime Minister in March this year, the new £30m venue sits within the Winter Gardens complex that hosted this year's Conservative Party Spring Conference and now holds up to 7,000 delegates.

- 26,000 sq ft centre, set over two floors
- Cutting-edge audio-visual technology
- £17.8m of Growth Deal funding
- £3m from the Coastal Communities Fund

Showtown Museum

Blackpool's first dedicated museum will celebrate the town's role in developing and supporting British popular entertainment. The investment will support 296,000 annual visits, 39 full-time equivalent jobs, £13.16m of regional economic benefit and conservation of over 800 objects.

- £14.2m scheme
- £4.4m National Lottery Heritage Fund
- £4m Northern Cultural Regeneration Fund
- £1.75m Coastal Communities Fund

Blackpool Airport Enterprise Zone

One of the largest enterprise zones in the UK, Blackpool Airport Enterprise Zone will transform Blackpool and the Fylde's economic base over its 25-year lifespan, positioning itself as a premier business location in the North West. Blackpool Council has committed £29m+ over the next four years to deliver essential infrastructure to help unlock sites, kick-start development and attract investment to meet occupier demand.

- Create 5,000 new jobs
- Attract £300m private sector investment
- Provide enabling infrastructure of c.£72m
- Convert or build 260,000 sq m commercial space
- Attract over 200 businesses

BESIDE THE SEASIDE
IMAX
BACKLOT
CINEMA
wilko
TOWER COFFEE COMPANY
ABINGDON STREET MARKET

Multiple Disadvantage

Multiple Disadvantage

What is multiple disadvantage?

Measures of poverty and socio-economic deprivation are well established tools, often used to inform research, service development and funding. There is now also an increased national and local policy focus on the most extreme forms of disadvantage, which are often experienced in conjunction with each other. Problems such as homelessness, domestic abuse, drug and alcohol misuse, poor mental health, and offending behaviours are often experienced to a large extent by the same people.[5] In Blackpool there is now a clear focus on providing holistic support for people experiencing any number of these problems. This can be seen in the approach and type of support available in the Blackpool based programmes described later in this report. Many of these programmes are designed specifically to address multiple disadvantage, and longstanding services, such as drug and alcohol treatment, are tailoring their support offer to better address clients' wider problems.

Defining and estimating the extent of severe and multiple disadvantage (SMD)

Support programmes in Blackpool have their own, flexible definitions of what constitutes disadvantage, who can be offered support and how best to address clients problems. However to estimate the number of people experiencing SMD in Blackpool, and to allow this to be compared with other areas, a straightforward definition is required. There are usually five areas of severe disadvantage considered in the academic literature:

- Homelessness
- Offending
- Substance misuse
- Domestic violence and abuse
- Mental health problems

5. (Bramley et al., 2015; Department for Work and Pensions (DWP), 2012; Fitzpatrick et al., 2011, 2013)3.

However, when estimates of SMD are calculated it is most common to only consider three categories, with domestic violence and abuse and mental health problems omitted. This is primarily because using all five categories generates a very high overall estimate of SMD.[6] Administrative data has been used to estimate the number of people currently experiencing problems relating to homelessness, offending and substance misuse and who are known to services. This is likely to underestimate the true number of people experiencing disadvantage, as not everybody is known to services, however it does allow for a consistent approach between local authorities and for comparisons to be made. Due to issues with national data collection the estimates are based on 2010/11 data.

In 2010/11 Blackpool was estimated to have:

- 21.4 per 1,000 working age residents experiencing issues related to homelessness (3.8 times the England average)
- 17.0 per 1,000 working age residents in the criminal justice system (3.0 times the England average)
- 14.0 per 1,000 working age residents are being supported in alcohol and/or drugs treatment (2.4 times the England average)

From these datasets an overall estimate of the number of residents who experienced a combination of two or three of these categories of disadvantage can be made.

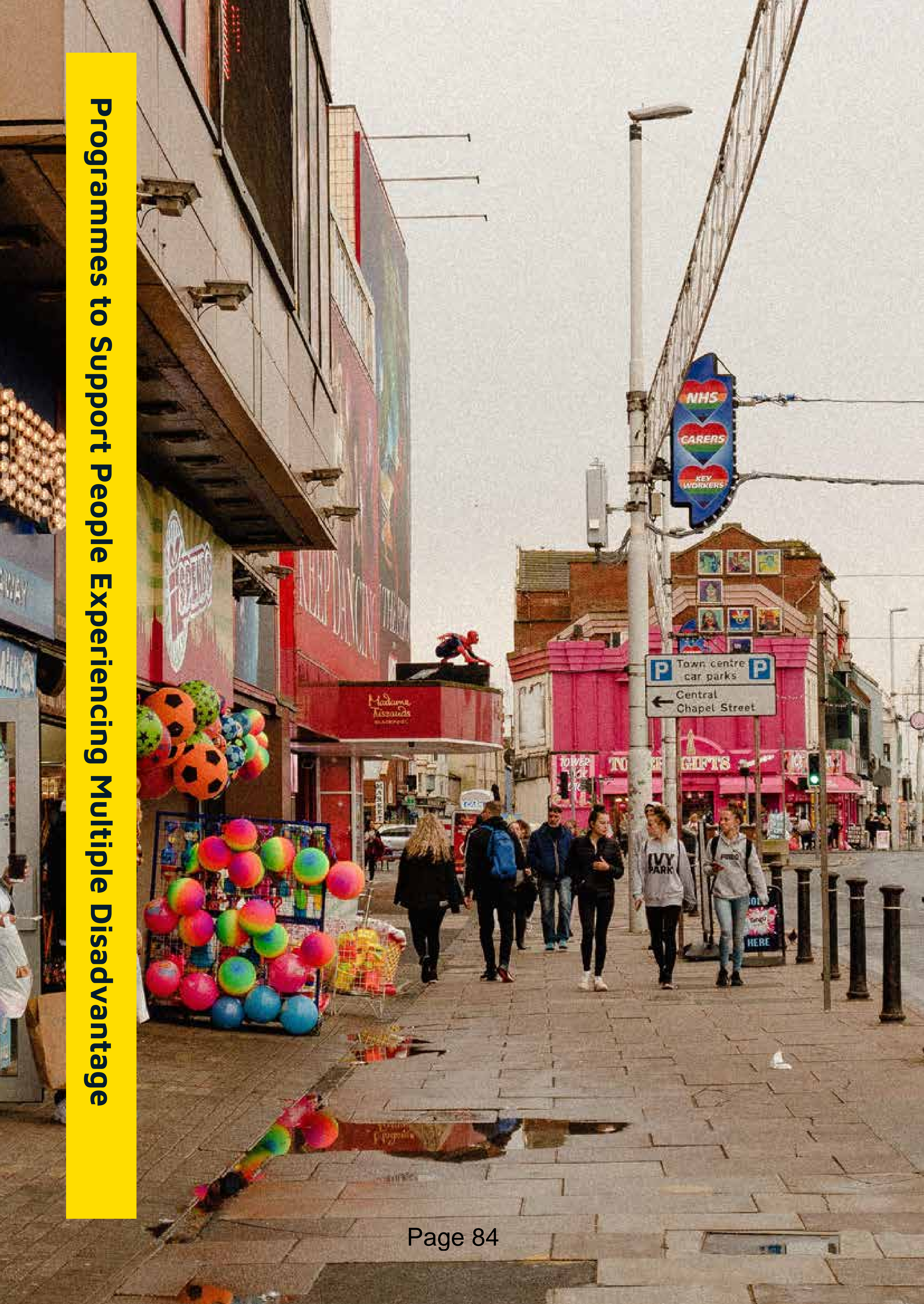
- 17.3 per 1,000 working age residents experience a combination of two or three of these categories of disadvantage (SMD2/3) (3.1 times the England average)

Based on these calculations Blackpool is estimated to have the highest rate of SMD2/3 of any local authority in England, with approximately 1,500 working age residents experiencing SMD2/3. [7] [8]

6. TechReport_V6final_clean_7-August.pdf (lankellychase.org.uk)

7. Mapping the 'hard edges' of disadvantage in England: adults involved in homelessness, substance misuse and offending — Heriot-Watt Research Portal (hw.ac.uk)

8. Hard Edges: Mapping Severe and Multiple Disadvantage in England – Lankelly Chase



Programmes to Support People Experiencing Multiple Disadvantage

Programmes to Support People Experiencing Multiple Disadvantage

Building on Fulfilling Lives into Changing Futures

Fulfilling Lives

Blackpool Fulfilling Lives ran for 8 years, from 2014 to 2022, supporting 530 beneficiaries with multiple complex needs such as homelessness, offending, mental health issues and substance use. A 'navigator model' of support was coordinated by people with lived experience of similar complex needs. Blackpool had significant involvement in developing the national learning and evidence base from the programme. The National Lottery Community Fund partnership published an evaluation of Fulfilling Lives. Key positive outcomes for beneficiaries included improvements in mental health and wellbeing, substance use, housing and offending. Financial savings were seen with respect to unplanned hospital attendances and admissions.

The subsequent Changing Futures Lancashire bid was co-produced with people with lived experience of multiple disadvantage, building on the most successful elements of Fulfilling Lives. These included:

- The Lived Experience Team (now part of Empowerment). Members of this team have personal experience of issues such as homelessness, mental health, offending and substance use. They are skilled in building trust with, and advocating for people facing multiple disadvantage.
- Small caseloads allowing frontline workers to work intensively with beneficiaries
- Regular beneficiary reviews and robust data collection
- Multi-agency care planning at the start of and throughout beneficiaries' journeys

Changing Futures

Changing Futures consists of 15 nationally funded partnerships aiming at improving outcomes for people experiencing multiple disadvantage. Changing Futures Lancashire is a county-wide programme with 4 localities. It is running from September 2021 to December 2023. Blackpool is the lead authority for the Fylde Coast Locality, which includes Fylde and Wyre boroughs.

The programme has aims at three levels:

1. Individual level aims

- to increase the likelihood that people experiencing multiple disadvantage will remain connected to support
- for people experiencing multiple disadvantage to be more empowered, informed and resilient and able to manage their recovery in ways that work for them

2. Service level aim

- for local services to become more person-centred, coordinated, flexible and trauma-informed and to support people make lasting positive change

3. System-level aims

- for the Lancashire system to implement long-term sustainable changes to benefit people experiencing multiple disadvantage
- to sustain the benefits of the programme beyond the lifetime of the funding

For people to enter the programme they must be over 18 years of age and be facing barriers to engaging with the services they need. They also must be currently experiencing multiple disadvantage. For Changing Futures this has been defined as a combination of at least 3 of the following:

- homelessness
- substance use (drugs and/or alcohol)
- mental health issues
- domestic abuse
- contact with the criminal justice system

The core Changing Futures offer for individual beneficiaries is a named peer mentor from the Lived Experience Team who will:

- build a trusted relationship with them
- connect them to their coordinated multiagency plan of support
- advocate on their behalf when the plan/system is not meeting their needs
- help them to recognise their own assets and build resilience so that, over time, they can become independent

Alongside expanding the Lived Experience Team, the programme is funding some local agencies to host posts with a specific remit for working in new ways with people with multiple disadvantage who often fall through the gaps of current provision. The Fylde Coast Locality has funded posts in Fylde Coast Women's Aid, mental health services (Blackpool Teaching Hospitals and Lancashire and South Cumbria NHS Foundation Trust), drug and alcohol services (Horizon and Change, Grow, Live), Blackpool Citizens Advice Bureau, Streetlife and in the housing teams of Blackpool, Fylde and Wyre.

From the start of the bid process, local agencies have been coming together to collaborate in Changing Futures. A monthly Fylde Coast Multiple Disadvantage Strategic Group has been established, chaired by the council's Public Health team, where over 30 different teams from different public and third sector agencies come together. This is an opportunity to share learning, network and address challenges together as a multiagency collaboration with a shared vision and to date has been well-attended with regular contributions from many members of the group.

In the period March 2022 to September 2022

Number of referrals	158	
Number of beneficiaries enrolled onto programme	96	
% of those experiencing 3/5, 4/5/ or 5/5 areas of MD	52%	of beneficiaries have 5/5 areas of Multiple Disadvantage.
	27%	of beneficiaries have 4/5 areas of Multiple Disadvantage.
	21%	of beneficiaries have 3/5 areas of Multiple Disadvantage.
		Mental Health needs are present with 87% of current open beneficiaries.
Gender	54%	Male
	46%	Female
Age range	6%	- 16-25
	25%	- 26-35
	39%	- 36-45
	24%	- 46-55
	6%	- 56-65

Beneficiaries say….

“Please thank everyone from Changing Futures for me, after 7 weeks back on the street, sleeping in derelict buildings, this placement is the best thing to happen to me. I will not mess it up. This will help me start again. I can’t thank you all enough.“

“Changing futures has been lifesaving. My LET worker is inspirational, very understanding and non-judgemental. I’ve gone from being homeless, to having somewhere to stay almost overnight. I have hope today.“

“Nice to know somebody cares. When they haven’t before.“

People in the Fylde Coast Changing Futures multidisciplinary team say…

> “Changing Futures is an excellent complement to the existing services that are working collectively to reduce the health inequalities for some of the most vulnerable people in our community, many of whom have previously fallen through the ‘net.’ This vital piece of the jigsaw has already made a difference to actual people. I am sure the learning from this provision will be a catalyst for long-term system change. It is a pleasure working with you all.“

> “Well, what can we say.....It’s been awesome to work as part of a team that has the same passion to actually Change Futures. To see so many go off into detox and rehab shows we are making a difference. We will always endeavour to do whatever we can for our clients.“

Next Steps for Changing Futures

The Fylde Coast Multiple Disadvantage Strategic Group...

> “As we move into the second year of Changing Futures Fylde Coast, we want to continue to nurture the strong partnerships that exist at both multidisciplinary team and multiagency levels, and to support our excellent Lived Experience Team to continue to expand and develop sustainably. We have an eye on the future and on working together to maintain the positive service changes that have started to happen. We need to examine the significant amount of data that has been collected to date to understand the reach and impact of the programme for both individuals and services. We have been involved in the co-production of six system change priorities for Lancashire, and are committed to supporting the county-wide work to see change in these areas become a reality. Above all, we want to continue to enable people facing multiple disadvantage to make lasting positive change.”

The Domestic Abuse Complex Needs Pilot

Overview

The Domestic Abuse Complex Needs Pilot project was commissioned to address a gap in service provision within Blackpool, Fylde and Wyre for victims of domestic abuse with complex and multiple needs – specifically related to mental health needs and drug and/or alcohol misuse. Prior to the pilot, it was often difficult for refuges to admit individuals with complex needs, and, as many support services are based within the refuges, this meant that domestic abuse victims with the most complex needs often had the least access to support. The project aimed to better support those with complex needs, by providing a dedicated bed within Fylde Coast Women's Aid and by enabling individuals both within the refuge and within other accommodation settings to access the bespoke, multi-agency domestic abuse support provided by the project. The project aimed to break the cycle of domestic abuse often observed for individuals with complex needs, address their drug, alcohol and/or mental health needs, and also help them in other areas of their lives such as tenancy and employment.

A first pilot project of 12 months' duration began in August 2017 and was funded by the Department of Communities and Local Government (DCLG) through an allocation of funds focused on preventing violence against women and girls. The focus of the pilot project was to provide a wrap-around, person-centred service for victims of domestic abuse with complex needs, and a multidisciplinary team was created to deliver the pilot. The team was led and supported by staff at Fylde Coast Women's Aid (FCWA).

Evaluation

An evaluation of the first pilot project, undertaken in 2018, found that clients who were referred benefited from all services, and that benefits were sometimes life-changing. Specific recommendations were made within the evaluation, which informed the later development of a second pilot project. A second pilot project, again funded by DCLG, ran from April 2019 until September 2020. The objectives and inclusion/exclusion criteria remained the same, and the make-up of the core project team was broadly similar.

An evaluation of the second pilot project was undertaken, based upon interviews with staff, and based upon monitoring data and case studies relating to 59 cases accepted between April 2019 and June 2020. This showed that referrals were received from various organisations, with the greatest proportion (25.4%) received from refuges. All clients identified as female, and the majority were White British. In two thirds of cases, the client was aged below 35 years. In all cases, the client was recorded as having mental health needs, and in 45.8% of cases the client was recorded as also having drug and/or alcohol misuse issues. In just over half of cases, the client was living in a refuge or hostel.

Support offer to clients

A wide range of support was provided to clients by project staff. Support was provided for mental and/or emotional wellbeing by the whole project team, with specialist input from the Mental Health Workers provided when needed. The mental health support provided within the project was highly valued by staff. Key elements of its perceived success included the speed with which clients could access mental health support; the flexibility with regards to the length and frequency of mental health support; the flexibility in being able to continue to offer mental health support despite a client's non-attendance at appointments, and the flexibility in the choice of venue. However, the lack of a designated suitable space in which to provide mental health support was challenging in some cases.

Clients were supported to access alcohol and drug recovery services, and project staff worked closely with these services. Project staff supported clients in their interactions with the police and through legal proceedings, such as those related to obtaining non-molestation orders and to child custody/contact. If necessary, staff liaised with the prison service and probation team. Clients were supported at Core Group Meetings and Child Protection Conferences, and project staff liaised closely with Children's Social Care when needed.

Project staff provided help to clients with sourcing and arranging a new property, including attending housing appointments with clients if needed, and providing practical support such as help in sourcing items for the new property and with moving in. Clients benefited from support with budgeting, applying for benefits and banking. Project staff supported clients to consider and enquire about potential education, training, employment and volunteering activities, and when needed clients were accompanied to sessions.

Practical support was provided when needed, for example to help clients obtain basic essentials. Project staff also worked closely with and referred to a number of other agencies, such as the FCWA Outreach team, the Lancashire Women's Centre and the Autism Initiatives charity. Clients were supported and/or accompanied to attend appointments, such as FCWA drop-in sessions, doctor appointments and community support group sessions.

Positive outcomes were observed for many clients. These included reductions in alcohol and/or drug use; securing of a tenancy; engagement with employment, volunteering and/or education or training, and the obtaining of a non-molestation order. In some cases, positive outcomes were observed with respect to clients' children, including the removal of children from an at-risk register, the return of a child to a client's care, and decisions made to allow a child to remain in the care of a client.

Staff placed high value on the long-term, holistic, comprehensive and personalised approach of the project. It was felt that, whatever the client's need, project staff would try to either address it themselves or identify appropriate avenues of support outside the project. The project team's independence to a client's family and friends and to any external agencies involved with the client was deemed important. Project staff were able to provide coordinated and joined-up support, working closely with each other and with the Women's Aid staff to address clients' needs. Project staff liaised with external agencies on clients' behalf, helping them access services if needed. Multi-agency working was a key element of the project, and the project benefited from the project staff's well established, strong working relations with external organisations and with the Independent Domestic Violence Advisors.

Whilst the service model of the domestic abuse complex needs pilot has been discontinued, the learning gathered has informed the development of new services and pathways within Blackpool.

The new Blackpool Multi-Agency Risk Reduction Assessment and Co-ordination (MARRAC) team, which assesses risk in domestic abuse cases and coordinates appropriate action plans, works very closely with a substance misuse worker. This substance misuse worker is part of the substance misuse team, and has strong links with drug services. The close working between the MARRAC team and substance misuse worker reflects recognition of the importance of providing comprehensive support for victims of domestic abuse with complex needs.

Homeless support/Rough sleepers (Homeless Health/Homeless Mental Health Team)

A pilot project is currently underway to improve access to health care and support services for homeless people, or people at risk of homelessness. After an initial assessment, the Homeless Health Team aims to put in place interventions to achieve the following outcomes for people who require support:

- To ensure an effective and equitable use of resources
- To ensure that the health needs of the homeless population, who require clinical interventions, are safely met by offering an environment where they receive health care that is appropriate for their needs and provided by people with appropriate knowledge and skills
- To assess health needs and make onward referrals or signpost to the most relevant provision when appropriate to do so
- To work closely with the NHS and wider partners to ensure that there are no gaps in delivery

The team aims to pilot a new approach, over the course of two years, to support homeless people which:

a. Builds on the learning of the service which existed historically
b. Builds on the learning of the Covid-19 homeless response
c. Builds local knowledge around the health needs of the cohort, to be able to tailor this and other services to those needs
d. Grows and evolves in a rapid-testing/agile approach, informing ongoing and future development of the service

This will provide physical health input into a dedicated multi-disciplinary team for homeless people, including health care, social care, housing support, substance misuse support, to provide joined up, holistic health and care for homeless people on the Fylde Coast. The team will provide appropriate clinical decisions around the health and wellbeing of individuals who are rough sleepers or at risk of rough sleeping; this will frequently include direct intervention. The team aims to increase accessibility of health and care services for homeless people by co-locating with a multi-disciplinary team in a location familiar to and regularly attended by homeless people (the Bridge). Further, to support access into mainstream services where these are required, and support outreach to individuals who cannot attend the Bridge.

Additionally, the goal is to increase the health literacy and compliance with health prevention and treatment pathways for homeless people and ultimately reduce mortality in the cohort for conditions that are amenable to care and treatment.

Objectives

This service will be based on a number of key principles which support the provision of patient focused integrated care. These principles are:

- To provide the best service within the resources available
- To offer expert clinical decisions and interventions when indicated in line with the professional's scope of practice and in line with this service specification
- To engage and co-produce with the homeless population and wider stakeholders to ensure they are fully involved in service development
- To ensure clinical interventions and innovations are in line with best practice
- To deliver clinical care which is effective and can be measured
- To advise and consult to ensure care and support is delivered by the most appropriate person

Service Overview

As the pilot progresses the most common areas of health need will be kept under review. This will be supported by an initial health needs assessment, completed for each individual accessing the service. The team will work to develop approaches to support needs identified through the health needs assessment, and where this is not possible signpost people to appropriate services. In time it may be considered appropriate to bring additional support into the team.

Holistic care plans will be developed between the members of the multidisciplinary team and with the individual, in order to ensure a focus on the individual's goals and support them to comply with the plan and improve their health outcomes. As appropriate the team will initiate, administer and maintain treatments and interventions, and make referrals required to support the individual to meet the goals of their holistic care plan. As a minimum this is anticipated to be (dependent on patient need):

- Assessing wound care needs, applying and changing dressings and prescribing medication
- Identifying potential mental health needs and signposting and/or referring to appropriate mental health services for a full assessment
- Identifying potential substance misuse needs, signposting to support partners to undertake a full assessment of needs
- Completing screening processes for blood borne viruses and infections including assessment, blood testing, and administering treatment. This includes coordination with local delivery of the national Hepatitis C screening and treatment programme
- Assessing and diagnosing long term conditions and developing a joint management plan with the individual, and prescribing medication
- Signposting to other health services where the homeless health team are not able to support (e.g. where a long term condition requires specialist input)
- Support for delivering the local flu vaccination programme, linking in with other local providers to coordinate vaccination of people who are homeless. This may include direct delivery of coordination with other vaccinators, depending on vaccine availability

Decisions on the precise timing, combination and level of care provided will be made by members of the team, in a manner which minimizes risks to patients, whilst maximizing the potential for positive health outcomes, matched to patient needs.

Individuals using the service may use it on a medium to long term basis, moving between different parts of the team, accessing different support as required. For example an individual may attend the service for wound care and be signposted into the mental health provision, or vice versa. The service will run five days a week on a flexible timetable, totalling 37.5 hours of provision per week. Provision will be a mixture of bookable and drop-in appointments. Four days will be dedicated to patient facing contact, both on-site at the Bridge, and off-site as part of outreach opportunities (for example the "Health Bus"). Individuals will be offered the opportunity to access the service remotely (e.g. via telephone, where this is appropriate). The remaining day will be available to support team development, multidisciplinary team meeting discussions, and team administrative duties.

The service is not intended to be an urgent care service but rather support improving outcomes for ongoing complex needs. The purpose of the drop in element is to provide a flexible entry point to the service, not address urgent care needs. Urgent care needs will still be addressed using urgent care pathways, as appropriate to the individual's needs.

The team will coordinate and be part of regular, formal multidisciplinary team meetings, to share knowledge and gather information for holistic care planning.

During the dedicated patient facing contact on-site, patients will be offered flexible appointment options to meet their needs, with a minimum offer of a ten-minute appointment.

Project ADDER - Addiction, Diversion, Disruption, Enforcement and Recovery

Project ADDER is a joint Home Office and Department for Health and Social Care programme. The programme launched in early 2021 and initially, Blackpool was one of four pilot delivery areas. Funding for this programme has now been extended to March 2025.

Programme Aims:

- to reduce drug-related death
- to reduce drug-related offending
- to reduce the prevalence of drug use
- disruption of high-harm criminals and networks involved in middle market drugs supply

In Blackpool, a partnership approach was used by Blackpool Council Public Health to help develop the model, working closely with Lancashire Police who were awarded funding for enforcement activity. The programme focuses on complex adults, using heroin and/or crack cocaine, who are not engaged in treatment, as well as complex young people aged under 25.

A number of local organisations are involved in the delivery of the programme, including:

- Streetlife, Blackpool Council
- Renaissance
- Delphi Medical
- Blackpool Council Housing, Adolescent Service, Housing, Advice Team
- DWP
- Blackpool Teaching Hospitals NHS Trust Children's Mental Health Services
- Empowerment Lived Experience Team
- Probation Services
- Blackpool Football Club Community Trust

Intense support through a multi-disciplinary team is offered to people identified through a number of pathways (e.g. criminal justice), as well as rapid access to opiate substitute treatment prescribing and mental health support. Using a trauma-informed approach is an integral part of delivery, as well as provision of outreach support – going to where the person is, rather than demanding attendance in a prescriptive way that is likely to lead to non-engagement in people with more complex needs.

Since the start of the programme in 2021 to date (July 2022):

- 76 adults and 45 young people have been supported
- 256 'take home' Naloxone kits have been distributed to prevent deaths from opiate overdose
- 103 arrests
- 108 charges
- £300,000 of drugs seized
- £58,000 of cash seized
- 9 vehicles, 135 mobile phones and 21 weapons seized

Interim evaluation of the programme has shown how essential the role of lived experience within delivery has been for those participating. The evaluation also showed better engagement with services, reductions in illicit drug use and criminal activity and improved mental wellbeing for beneficiaries.

Case Study

Many people have made significant, life changing progress with the help of the ADDER programme.

This is one person's story….

'Katie' is a woman in her early 20s. She engaged with the service in November 2020 during the height of the COVID pandemic. In her past she had been bullied at school and becoming homeless at the age of 16 due to family breakdown.

She was alcohol dependant, drinking large amounts every day, suffered with anxiety and depression, and self-harmed. She was at risk of homelessness due to anti-social behaviour and been evicted from numerous hostels, with numerous arrests by the police.

As of September 2022 'Katie' has made tremendous progress:

- By completing alcohol detox and is no longer self-harming
- By completing probation several months ago and has no arrests or criminal engagement for nearly a year
- Has been in the same accommodation for 15 months and is settled and happy. No anti-social behaviour
- Started to attend college
- Her mental health is improved and frequently engages with meaningful activities and the Lived Experience Team

Quotes from 'Katie"
''If it wasn't for ADDER, I would be in jail'

''ADDER is successful getting us on our feet, we all stick together even when things are hard'' ''We do our best even though we are fighting our addiction, the trips we go on is a laugh, we get so close it makes us happy'' ''If it wasn't for the workers, I don't know where I would be''

Young ADDER quotes

"During my time at Young Adder I have had my ups and down but I have thoroughly enjoyed myself I've changed massively and improved on my physically health and my mental health without them I'd not be here today"

"Adder is successful getting us on our feet, we all stick together even when things can get hard"

"We all do our best even if we are fighting our addiction, the trips we go on is a laugh, we get so close that makes us happy"

"If it wasn't for the workers we don't know where we would be"

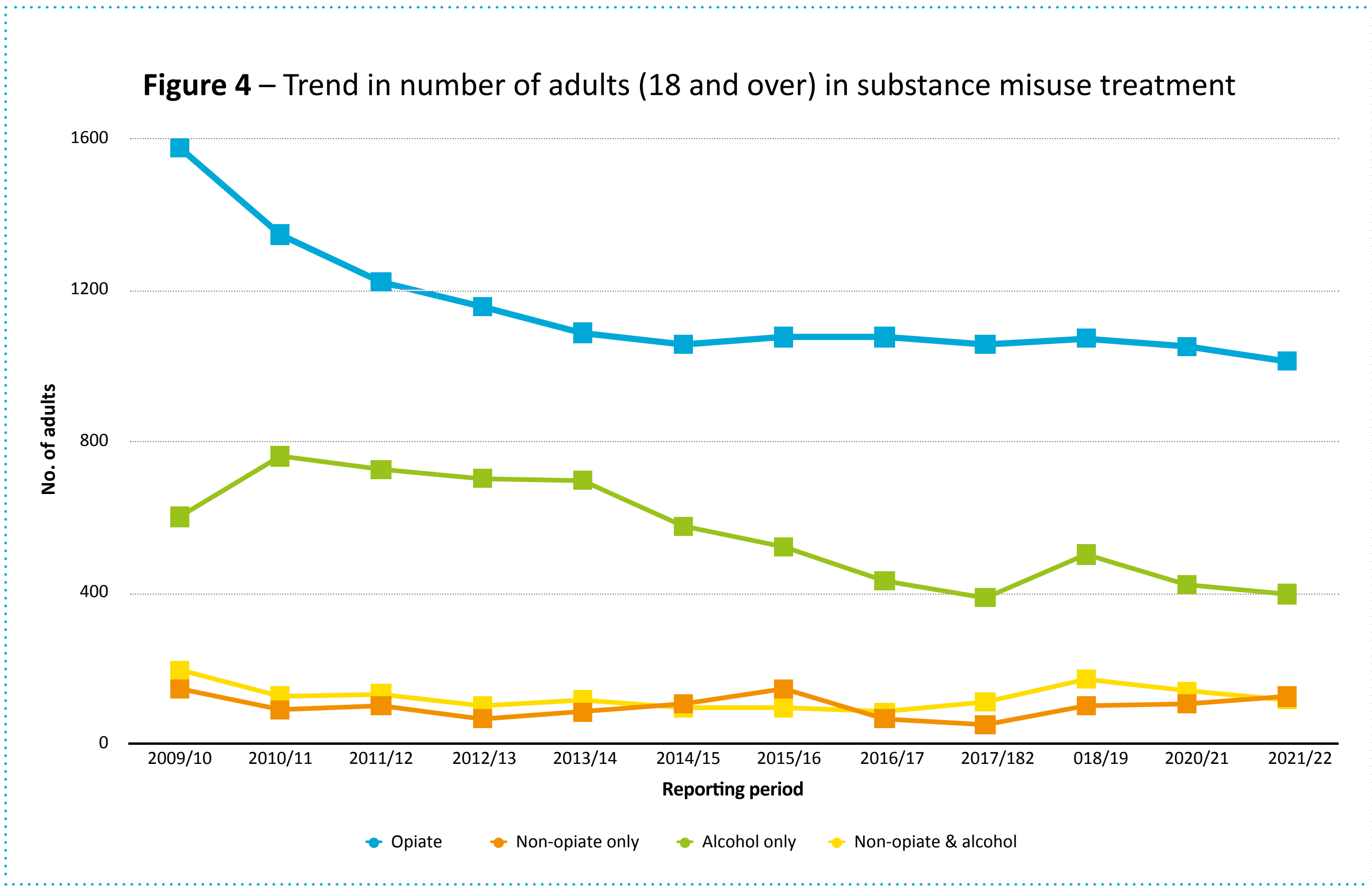
Horizon Drug and Alcohol Treatment Service

Drug and alcohol treatment in Blackpool is funded by the local authority through the Public Health grant. Horizon is the umbrella brand for this service and is provided by three organisations:

- Blackpool Council Adolescent Service – provides behavioural support for young people aged 10-24
- Renaissance – provides drug and alcohol harm reduction for people aged 18 and over e.g. outreach support and needle exchange
- Delphi Medical – provides clinical and behavioural support for people aged 25 and over, as well as clinical support for under 25s e.g. opiate substitute therapy

Public Health also commission online support with the 'Lower my Drinking' app which is available to anyone living or working in Blackpool – the app provides an online intervention for people drinking at harmful levels and will signpost to Horizon for in-person support if needed.

In-patient drug and alcohol detoxification and rehabilitation is commissioned from a number of providers.



In 2020/21, 1,645 people received structured treatment for drug and alcohol issues in Blackpool (not including residents accessing the Lower My Drinking app for alcohol support, or those receiving brief interventions through the harm reduction service).

The Light Lounge Crisis Support

The Light Lounge is a service, co-funded by the NHS and Blackpool Council, provided by Richmond Fellowship for Fylde Coast residents aged over 16. It is aimed at those people struggling socially and emotionally with life challenges or for those in a mental health crisis. Face to face or telephone support is offered up to 10pm, 7 days a week. The service was developed to provide an alternative to the emergency department for people needing urgent crisis support.

People can refer themselves either by contacting the team by telephone in advance, or by visiting during drop-in hours. They may also be signposted by their GP or other partner organisation.

The support offered includes:

- Professional and specific individual advice in accessing appropriate help
- Guidance and information on how to manage mental health and develop coping mechanisms through one-to-one and group support
- Peer support from people who have been through similar experiences in talking through any issues or concerns
- Access to other organisations to offer support with social crisis such as housing and benefits advice

The service offers support for individuals experiencing a wide range of mental health issues, such as anxiety, low mood and suicidal ideation.

Suicidal ideation was the most frequent reason for referral into the service, followed by anxiety and then support with emotional regulation. Over the 21/22 period, the service had 80 referrals for immediate crisis de-escalation, not including drop-ins.

The table below shows the number of drop-ins to the service for crisis in recent months.

Month	No. of crisis drop ins	No. of drop ins successfully de-escalated*
May	71	65
June	96	97
July	101	97

* "Successfully de-escalated" includes people who were successfully diverted from the Emergency Department and the Home Treatment Team.

Quotes – feedback from service users:

"Thank you to you for helping me to a better, brighter future even at 30 it's never too late to ask for help and try something new."

"Light Lounge have been there throughout the whole pandemic; they have never left anyone behind."

"I feel that they have gone above and beyond to reach out to all their service users, especially in these exceedingly difficult and unknown times."

"I have been given some of the best skills and coping strategies in all my years of dealing with different agencies."

"Light Lounge staff treat us as equals and don't make us feel small for being the way we are. They make us feel important and appreciated at a time we feel worthless and as though we don't matter."

"My life feels like it's now in colour and not black and white."

"I don't think I could have got to the place I am mentally if it wasn't for The Light Lounge itself. I will forever be grateful"

"Life has gotten a little easier. I no longer feel like I'm bottom of the pile. No longer feel like I'm walking through mud and find it hard to get up in the morning."

"I feel better. My family feels better. My workplace is better. Everything is better."

Recommendations for action

- Forge closer links with organisations in other coastal communities to share learning and implement best practice. The ADDER project pairs Blackpool with Hastings and links are being formed with the local authority Public Health team in Hull
- Implement the recommendations of the Chief Medical Officer's Annual Report 2021 that can be influenced locally
- Public health and targeted healthcare interventions should be incorporated into the development of the Levelling Up programme to ensure that the maximum possible benefit for the most disadvantaged communities in Blackpool is achieved
- Learning from the programmes to support people experiencing multiple disadvantage must be shared, to determine where further value can be achieved, and to establish a future direction for a collaborative response to supporting people facing multiple disadvantage. The Fylde Coast Multiple Disadvantage Strategic Group is an important forum for improving collaborative working practices
- Services to support people with complex needs are often funded as short term projects. Closer integrated working, via the Blackpool Health and Wellbeing Board, the Fylde Coast Multiple Disadvantage Strategic Group and the Integrated Care Board is required to ensure long term sustainable funding is available to tackle multiple complex needs
- Multi-agency partners should continue to collaborate in developing consistent workforce training and development in trauma-informed approaches. They should also work together to practically apply this trauma-informed approach at scale across local services.

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Stephen Boydell
Principal Epidemiologist

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Arif Rajpura
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Clare Boothroyd
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Brigit Chesworth
Public Health Specialty Registrar

Zohra Dempsey
Senior Public Health Practitioner

Nick Gerrard
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Denise Jackson
Public Health Business Manager

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Public Health Registrar

Judith Mills
Consultant In Public Health

Vikki Piper
Head of Housing

Laura Smy
Service Lead - Multiple Disadvantage

BlackpoolCouncil